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March 31, 2011

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RE: The new Mental Health and Addiction Strategy and People with Dual Diagnosis 1

Dear Ministers,

I am writing on behalf of the NADD Ontario Chapter in support of the recommendations from the two reports prepared by the Select Committee on Mental Health and Addictions and the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy.

The Select Committee in their report noted that individuals with developmental disabilities² (Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorders and Dual Diagnosis) are the orphans in the system. This is partly a result of the shift of responsibility for services to persons with developmental disabilities from health to social services in 1974. Services in both systems function separately, are poorly coordinated and there remains a serious lack of professional expertise in virtually all Ontario communities.

NADD Ontario believes that the forthcoming Mental Health and Addiction Strategy provides a unique opportunity to leverage the consensus achieved through the two reports into transformative change to address this long standing problem for our most vulnerable citizens. This can be achieved through:

- 1 Persons living with mental health difficulties in addition to a developmental disability (National Coalition on Dual Diagnosis, Canada, 2008)
- 2 Developmental disability includes Fetal Alcohol Spectrum Disorders or Autism Spectrum Disorders with significant impairment in adaptive living skills (National Coalition on Dual Diagnosis, Canada, 2008)

- a) A commitment to full access to health promotion, prevention, treatment and care for individuals with a dual diagnosis, in the same manner as all Ontario citizens
- b) A whole government approach that moves beyond the current model of an interministerial “guideline” (2009 Interministerial Dual Diagnosis Policy Guideline) to mechanisms that support interministerial stewardship and coordination
- c) A coordinated interministerial investment plan to address the shared responsibilities for health promotion, prevention, treatment and care for individuals with mental health and addiction concerns, including those with a dual diagnosis

A more detailed brief regarding the rationale for the above recommendations is attached.

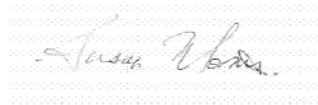
With regard to a leadership model for the new strategy, we agree that the Ministry of Health and Long Term Care is the appropriate lead ministry. Further, NADD Ontario proposes the following principles as the basis for bringing about the necessary system changes to support the above recommendations:

1. Policy, procedure and stewardship of outcomes is clearly established as a shared responsibility across all the appropriate government ministries
2. The authority and scope of responsibility of the selected leadership model for the strategy is clearly defined vis a vis planning, funding, monitoring and reporting responsibilities to government ministries, LHINs, etc.
3. Targets and/or benchmarks for interministerial stewardship, leadership and coordination are established, and
4. The MCSS Developmental Services Transformation and MCYS Realizing Potential strategies cannot stand alone from the whole government approach to mental health and addiction. Individual ministry strategies will need to keep pace with and be updated based on the established shared targets and benchmarks – particularly as it relates to individuals with developmental disabilities and mental health needs

In summary, as a province, we have an opportunity to move forward in a new way. Current fiscal realities require a prudent, careful and stepwise approach, but no longer as silos. The long term outcomes for individuals with a dual diagnosis – as with all Ontario citizens, is to have access to knowledgeable health and mental health prevention, promotion, treatment and care services, across the lifespan and available when needed. Similarly, like all Ontarians, individuals living with a dual diagnosis and their families must also be able to access specialized services when the need is more complex.

NADD Ontario looks forward to continuing to work with government representatives and community partners to achieve full access to health promotion, prevention, treatment and care for individuals with a dual diagnosis.

Sincerely,



Susan Morris
President, NADD Ontario
Clinical Director
Dual Diagnosis Program, CAMH

c.c. Susan Paetkau, Director, Health Program Policy & Standards Branch, MOHTLC
Carol Latimer, Director, Community and Developmental Services, MCSS
Aryeh Gitterman, ADM Policy Development, MCYS
Nancy Mathews, ADM Service Delivery, MCYS

Back ground brief

NADD Ontario is a voluntary provincial association that has represented families and service providers in the health and developmental service, adult and children's sectors for almost 20 years. We are a chapter of NADD international, the leading North American expert on mental health issues relating to persons with intellectual or developmental disabilities. NADD Ontario is a founding sponsor of the National Coalition on Dual Diagnosis, providing information and recommendations to Canada's Mental Health Commission. Our current activities focus on self determination for families and individuals and the development of a competent and capable workforce. Our goal is to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.

The Ontario Context

The Select Committee noted in their report that individuals with developmental disabilities (Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorders and Dual Diagnosis) as well as Eating Disorders are the "orphans" in the system. Canada's National Coalition on Dual Diagnosis has referred to this group as the worst example of what can go wrong in our system – because they fall through interministerial gaps and their needs are not understood at the service delivery level. The solutions proposed by the Coalition are:

- a. Enabling government policies and funding structures that support interministerial collaboration, monitoring and accountability
- b. Professional preparedness through training and education
- c. Easily accessible information, financial support, mental health care, respite, counselling and support for the caregiver and their loved ones
- d. Accurate data and research to describe needs, combat stigma and evaluate effectiveness of approaches

Ontario is in fact the only Canadian province or territory to have established a distinct policy Guideline in an effort to address these cross ministerial / cross sectoral issues. This has provided a framework for the planning, coordination and delivery of mental health and developmental services and supports. The first interministerial guidelines were released in 1997 and then updated in 2009. They incorporate directions for interministerial health and developmental system policy, planning and monitoring, and regional and local cross sector service development and implementation to promote improved access for persons 18 years and older. NADD Ontario has continued to monitor the impact of the guidelines over the last 14 years in relation to their intended goals. It is from this system level vantage point that our brief is written.

It is noteworthy that the two recent reports by the Select Committee on Mental Health and Addictions and the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy have similar recommendations. Both call for standards or guidelines of care, an "all of government approach", enhanced capacity and access through effective coordination of services, a decrease use of hospitals by focusing on the prevention of mental illness, integration of health and human services and investment in community care. The level of consensus across the two reports reflects

the progress that has been made in the last 20 years in understanding mental illness, its causes, treatment and care.

Therefore the forthcoming Mental Health and Addiction Strategy provides a unique opportunity to leverage this consensus into transformative change for those most vulnerable citizens of our province. NADD Ontario proposes three additional recommendations to further this direction.

Recommendation 1

Full access to health promotion, prevention, treatment and care for individuals with a dual diagnosis, in the same manner as all Ontario citizens

Rationale

The prevalence of mental health difficulties in the developmental disability population in Ontario is 40% – approximately 48,000 Ontarians. Their use of mental health services is different than the general population:

- Individuals with developmental disabilities have higher rates of emergency department visits when compared with the non-developmental disability group
- Psychiatric conditions account for nearly one-half of hospitalizations in people with developmental disability
- Young people with developmental disability are at highest risk of hospitalization
- People with developmental disability are more likely to have 2 or more hospitalizations during a year than the non-developmental disability group

In essence, emergency departments and hospitals are serving as a primary service provider – and obviously at a higher cost. This suggests that community treatment, housing, daily supports and prevention services provided by the range of government ministries involved in their care are not available or adequate.

Increasingly individuals with dual diagnosis are appearing in the forensic system. In Ontario speciality Psychiatric Hospitals (excluding the Penetang Maximum Security program)

- They comprise 13 % of the forensic inpatient population and 21% of the dual diagnosis inpatient population
- Most of these inpatients do not require specialty hospital care and are designated ALC (Alternate Level of Care).

Here again psychiatric hospitals are serving as primary service providers because community housing with either 24-hour on site support or daily access (such as through Assertive Community Treatment) and therapeutic/rehabilitation programming are not available or adequate.

The majority of individuals with dual diagnosis live with their families into adulthood. There are many complex issues associated with supporting families in this situation. Reports of compassion fatigue and worry are high, particularly when a child experiences challenging behaviours. Families also report difficulties engaging with

professional services. Families of youth report avoiding services because they feel the problem is temporary or not so serious. Families of adult children, in contrast, do not access services because of their negative evaluation of and lack of trust of professionals.

Therefore early intervention through outreach, health promotion and prevention strategies with younger families could prevent the negative experience that appears to develop as children age. Additionally, earlier access can prevent worsening behavioural difficulties. This requires the availability of a continuum of services that bridges across the life span, along with access to expertise at the entry points to the system (family physicians, hospitals). Specialized health and community service providers must also be available to augment generic services when necessary.

Recommendation 2

A whole government approach that moves beyond the current model of an interministerial “guideline” to mechanisms that support interministerial stewardship and coordination

Rationale

The policy guideline approach adopted by Ontario was successful in raising awareness of the specific individual, program and system level complexities associated with dual diagnosis. The 1997 guideline established outcome targets for the District Health Councils to work with regional Ministry offices and local cross sector committees that existed in most communities. This leveraged creative cross ministry program and individual client level responses e.g. protocols between community providers and local hospitals, introduction of crisis planning tools, shared approaches to case management and specialized local teams. At the government level the 1997 guideline was particularly successful because there was clear leadership between the Ministry of Health and Community and Social Services at the regional office level (offices appointed a lead person for the other to talk with – often for the first time). Regional office representatives attended local committees and facilitated regional problem solving. At the provincial level there was also a cross ministry steering committee within the government bureaucracy to review and monitor progress.

Since the 2009 update there is a sense of having lost ground. The updated document occurred within a different environment. The devolution of planning and funding to LHINS resulted in community mental health becoming an “orphan” within the government ministry structure. While most LHINs identified mental health and addiction as a priority, the new Guideline is oriented only to community mental health, thus creating a ‘new barrier’ to integration with hospital services. In addition, establishing effective linkages between LHINS and Regional MCSS/MCYS offices has been difficult in most regions, if not unsuccessful as their boundaries and functions differ. The Community Networks of Specialized Care – funded by MCSS to coordinate services for adults with a dual diagnosis and/or challenging behaviour, were appointed through the Guideline to plan with the LHINS – but this is not a relationship between functional equivalents. The result is significant inconsistencies in implementation and in a number of regions there has been little or no attention to the Guideline.

MCSS and its funded agencies now operate under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2009). At the core of this new legislation is a commitment to inclusion so that individuals with developmental disabilities can live successfully in the community. However there are no clearly defined inter-sectoral and inter-ministerial regulations or protocols to complement that direction and those referred to in the Guideline. The result is a lack of shared vision and direction regarding the required continuum of services and supports. The result will be the continued exclusion of persons with dual diagnosis from mental health promotion, prevention, treatment and support services, or from developmental disability services when each perceives that the other is responsible or has the expertise.

Another barrier within the system relates to the artificial boundaries between child/youth and adult services. The current Guideline reinforces this artificial boundary with the focus on age 18 and older. We know that the trajectory of care across the lifespan requires individuals to access services and supports under the auspices of many government ministries including child welfare, child and youth mental health, social services, housing, education, health and the justice system. In summary, the current structures and the Guideline approach does not effectively support integration across ministry boundaries.

The report of the Standing Committee on Public Accounts accentuates this core issue of the lack of a “whole government” (May 2010). The Committee has requested that MOHLTC and MCSS evaluate the Guideline in relation to:

- “How well new guideline is working in the field to assist” clients; and
- “Whether ... ministries are clear as to respective responsibilities and are ...coordinating services

NADD Ontario agrees that the Ministry of Health and Long Term Care is the appropriate lead ministry to oversee implementation of the new Mental Health and Addiction strategy. However we urge that this be used as an opportunity to affect transformational change by taking a different approach to address the structural issues outlined above. We propose the following four principles as the basis for a whole government approach:

1. Policy, procedures and stewardship of outcomes is clearly established as a shared responsibility across all the appropriate government ministries
2. The selected model of leadership for the strategy is accompanied with clearly defined authority and scope of responsibility regarding planning, funding, monitoring and reporting responsibilities to government ministries, LHINs, etc.
3. Targets and/or benchmarks for interministerial stewardship, leadership and coordination are established
4. The MCSS Developmental Services Transformation and MCYS Realizing Potential strategies no longer stand alone from the whole government approach to mental health and addiction. Individual ministry strategies keep pace with and are updated based on the established shared targets and benchmarks – particularly as it relates to individuals with developmental disabilities and mental health needs

Recommendation 3

Coordinated interministerial investment plan to address the shared responsibilities for health promotion, prevention, treatment and care for individuals with a dual diagnosis

Rationale

NADD Ontario recognizes that the current fiscal reality clearly limits the availability of new investments into the system. This does not mean that the need for increased investments can be underestimated. There have been many advances in the treatment, care and support of mental illness and dual diagnosis in the last 20 – 30 years. However when these effective practices are not consistently available or accessible to persons with a dual diagnosis, individuals with higher needs living in the community will continue to be under housed and under supported, and therefore cost more because of admission to hospitals or jails. There are approximately 12,000 Ontario citizens with developmental disabilities awaiting housing supports and registered with MCSS transfer payment agencies. A 10 year Mental Health and Addiction Strategy requires a coordinated investment plan with other ministries to address the shared responsibility for community care and treatment.

Current fiscal realities require a prudent, careful and stepwise approach, but no longer as silos. The recommendations by the Select Committee and the Minister's Advisory Committee provide an excellent foundation and opportunity to move forward in a new and transformative way. The outcome must be full access to a continuum of health promotion, prevention, treatment and care for individuals of all ages living with a dual diagnosis and their families.