

***CARING FOR ADULTS WITH A
DUAL DIAGNOSIS IN GREY BRUCE:***

***PROTOCOL FOR LINKAGES BETWEEN
MENTAL HEALTH AND DEVELOPMENTAL
SERVICE PROVIDERS***

**Original Protocol Prepared by a Task Group of the Grey Bruce
Dual Diagnosis Planning Advisory Committee, June 2000
Facilitated by: Grey Bruce Huron Perth District Health Council Staff**

Most recent revision completed by the Grey Bruce Dual Diagnosis Committee

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Note: Please acknowledge source if utilizing or adapting this material.

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The Grey-Bruce Dual Diagnosis Committee has developed some great partnerships and working relationships over the years through a spirit of cooperation between Health, Developmental Services, Education, and Children's services.

The Grey Bruce Dual Diagnosis Planning and Advisory Committee and staff of the Grey Bruce Huron Perth District Health Council developed the original protocol in June 2000, with revisions occurring in September 2002, July 2004, December 2005, June 2007, May 2010, and March 2012

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VISION

Community mental health and developmental services for persons with a dual diagnosis and their families will be integrated, coordinated and operate responsively and proactively both within and across sectors.

INTRODUCTION

The Grey Bruce Dual Diagnosis Committee originated in 1989 in response to a recognized local need and a joint Ministry directive. As part of planning for mental health reform in Ontario, the Grey Bruce District Health Council and the Dual Diagnosis Planning Advisory Committee produced a needs assessment report entitled *Grey-Bruce Dual Diagnosis Planning Report, December 1997*. Two of the seven recommendations were related to access to mental health services and the role of developmental service providers on the mental health care team. This protocol document was developed to address recommendations #1 and #2.

Access to Mental Health Services in Grey-Bruce

Recommendation # 1 **☐ THAT partnerships be established between staff of mental health programs and developmental programs through the initiation of joint protocols.**

- Develop and implement protocols for staff of Developmental Service Provider agencies and staff of the Community Mental Health Teams in the district, to access each other's services and expertise.
- Develop a joint Crisis Intervention Protocol between Developmental Service Providers and the Grey Bruce Health Services Crisis Intervention Team.
- Identify mechanisms to monitor and evaluate the effectiveness of the above protocols.

Role of Developmental Service Providers on the Mental Health Care Team (CMHT)

Recommendation # 2 **☐ THAT Developmental Service Providers are included as an integral part of the care team of the person with a dual diagnosis during an admission to hospital and/or Community Mental Health Team.**

- Develop a protocol in order to facilitate the involvement of Developmental Service Providers on the care team of the person with a dual diagnosis while he/she is on the inpatient unit Grey Bruce Health Services or a supported person of a Community Mental Health Team.

PURPOSE OF PROTOCOL DOCUMENT

The purpose of this document is to outline how mental health and developmental service providers will co-ordinate their services for the care of people with a dual diagnosis. This document includes the following components:

1. Definition of Target Population.
2. Statement of Guiding Principles.
3. A Protocol for Linkages Between Mental Health and Developmental Service Providers In Grey Bruce.
4. A Protocol For Linkages Between the Specialized Mental Health Services – Dual Diagnosis Program [DDP] at Regional Mental Health Care – London, and Mental Health and Developmental Service Providers in Grey Bruce.
5. Grey Bruce Resources for People with a Developmental Disability or Dual Diagnosis.
6. Tertiary/Specialized Dual Diagnosis Services.
7. A process for the Implementation of the Protocols.
8. A process for the Monitoring and Evaluating of the Protocols.
9. Statement of a Protocol Agreement.

1. Definition of Target Population

The definition of a developmental disability has been changed to reflect the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2008)*.

A person has a developmental disability for the purposes of this Act if the person has the prescribed significant limitations in cognitive functioning and adaptive functioning and those limitations,

- (a) originated before the person reached 18 years of age;
- (b) are likely to be life-long in nature; and
- (c) affect areas of major life activity, such as personal care, language skills, learning abilities, the capacity to live independently as an adult or any other prescribed activity. 2008, c. 14, s. 3 (1).

[\(2\)](#) In subsection (1),

“adaptive functioning” means a person’s capacity to gain personal independence, based on the person’s ability to learn and apply conceptual, social and practical skills in his or her everyday life;

“cognitive functioning” means a person’s intellectual capacity, including the capacity to reason, organize, plan, make judgments and identify consequences. 2008, c. 14, s. 3 (2).

The target population for our purpose in this process will be “persons aged 16 years and over who have a developmental disability and mental health needs”. “Mental health needs” are defined as diagnosed mental illness or symptoms consistent with mental illness.

2. Guiding Principles

- Service providers will focus on the health and well-being of the individual.
- Clear, inclusive and timely communication is essential in order to promote cross-sector planning to facilitate access to local services in the health, mental health and developmental services sectors.
- The process of strengthening community capacity to address the needs of those with a dual diagnosis, through the provision of a coordinated, integrated and flexible service response will be ongoing.
 - By being proactive at the local community level there will be improved life quality for individuals with dual diagnosis and their families. Interventions should be appropriate to address the individual’s circumstances and needs and should progress as required along the continuum from the least restrictive and least intrusive to the most specialized response.
- Care will be provided as close to home as possible, with the person moving to more specialized services only as necessary.
- The primary service provider will develop a support plan for all persons with a dual diagnosis. The support plan will engage consumers, families/natural supports and service providers as partners in the planning and delivery of services.
- The vehicle for communication will be the Grey Bruce Dual Diagnosis Committee (see Appendix 2 for reference).

3. Protocol for Linkages Between Mental Health Service Providers and Developmental Service Providers in Grey Bruce

3.1 Access to Developmental Services

3.1.1 Developmental Services Ontario South West Region (DSO SWR)

The DSO can provide you with information about community services and resources. They are the access point for adult developmental services funded by the Ontario Ministry of Community and Social Services across the south west region. To contact DSO SWR call 1.855.437.6797, fax 519.673.1509, email maryregan@dsoswr.ca, mailing address is: 171 Queens Ave., Ste. 750, London, On N6A 5J7 or visit their website www.dsontario.ca

3.2 Access to Community Mental Health Team Services

3.2.1 Developmental service providers may access mental health services through either Community Mental Health Teams or the Schedule 1 facility. In keeping with the Ministry of Health and Long-Term Care philosophy and policy of providing services “as close to home as possible”, initial contact should be with the Community Mental Health Teams, with office locations in Markdale, Hanover, Wiarton, Southampton, Kincardine and Owen Sound. People can be routed to their closest mental health team by calling 1-877-888-5855.

3.2.2 Community Mental Health Team (CMHT) staff will provide direct service and coordination with the developmental service provider.

3.2.3 Admission to services of the CMHTs will be based on severity of mental illness (e.g., diagnosis, disability and duration).

3.2.4 The developmental service agency supporting the individual accessing CMHT services will be informed of possibility/probability of admission and estimated wait-time.

3.2.5 The CMHT staff member will meet with developmental service provider staff, supported person, family, and others to assist in developing:

- A personal care team around each supported person;
- Short-term and long-term goals;
- An Emergency Care Plan for use as required.

The Dual Diagnosis Coordinator may be asked to assist with the tasks listed above by anyone involved.

3.2.6 The CMHT staff member will facilitate assessment, treatment and coordination, as needed, with consultation/services at the Schedule 1 facility.

3.3 Access to Outpatient Dual Diagnosis Clinic (Meaford Hospital)

3.3.1 Access to the Outpatient Dual Diagnosis Clinic is via referral from primary health care provider. Under a Shared Care Model, the Dual Diagnosis Psychiatrist makes medication recommendations to the referral source and they in turn make any necessary changes and monitor the effect.

3.3.2 The Dual Diagnosis program staff schedule all appointments on a priority basis. They ensure that relevant background data and history is collected and can assist with follow up between appointments (e.g., via Community Outreach Treatment Team [COTT], referral to a Community Mental Health Team [CMHT], support of Dual Diagnosis Case Manager).

3.3.3 The Dual Diagnosis Clinic cannot provide crisis services. Crisis services must be accessed through local emergency department and/or crisis team. Contact with the Dual Diagnosis Clinic psychiatrist for suggestions/consultation, can be facilitated by the Dual Diagnosis Coordinator or Case Manager.

3.3.4 Eligibility for access to the Dual Diagnosis Clinic services are as follows: documented history of developmental disability or involvement with developmental services; mental health need must be present; no specific diagnosed illness is necessary.

3.3.5 Services available through the clinic include: medication reviews; symptom monitoring; establishment of a diagnosis; linkages to other relevant services (e.g., Regional Support Associates [RSA], CMHT's, etc.).

3.4 Access/Admission to Schedule 1 Facility (Grey Bruce Health Services):

3.4.1 The Dual Diagnosis psychiatrist cannot admit people to Schedule 1 facility at this time.

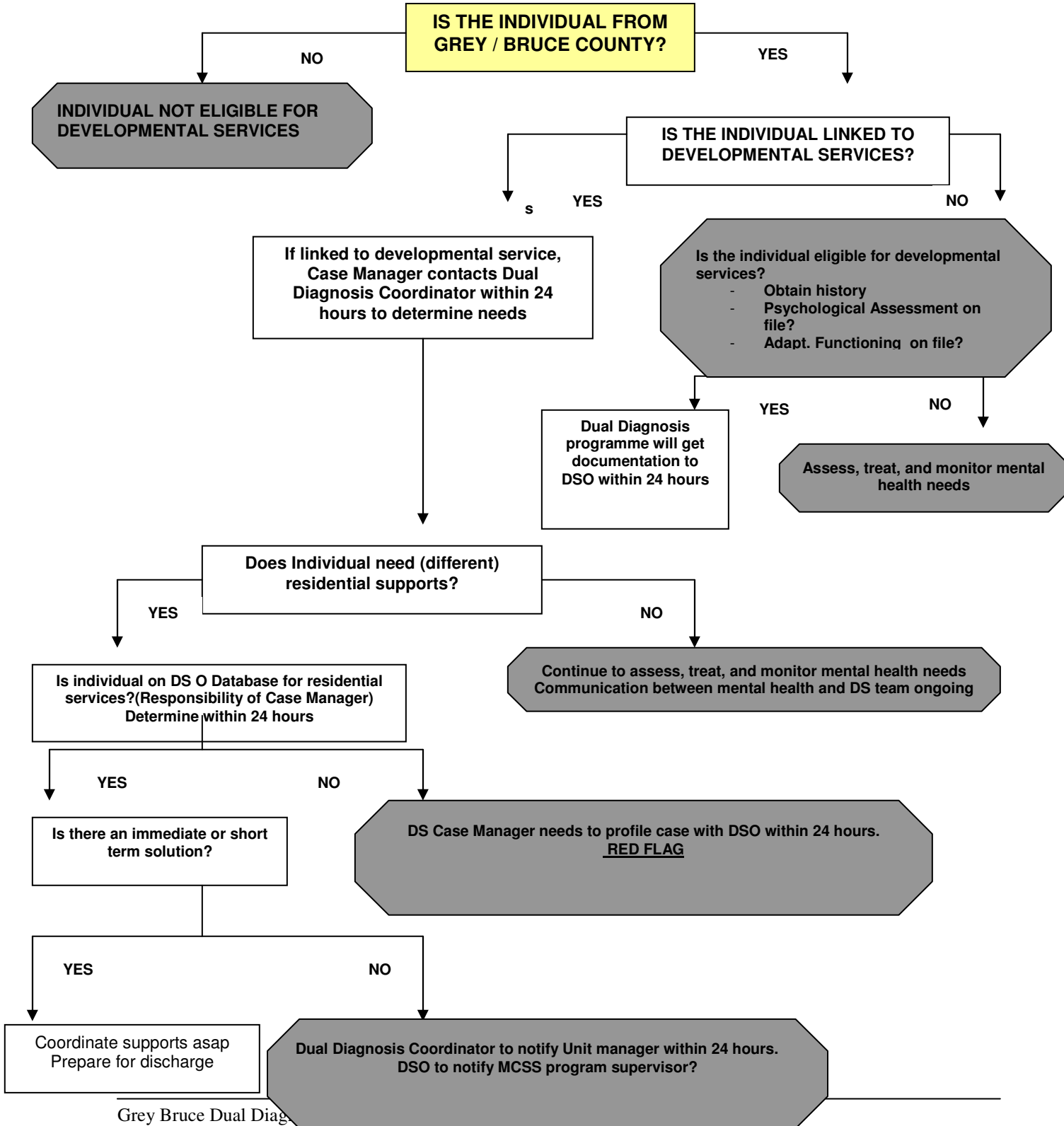
3.4.2 The Dual Diagnosis program will be notified by nursing case manager or Crisis staff whenever an individual with known or suspected dual diagnosis is admitted to the inpatient unit. The nursing case manager and the Dual Diagnosis program staff will work collaboratively to support the person's treatment needs.

3.4.3 Within 24 hours of the individual's admission, the Dual Diagnosis program staff will contact the family and/or identified support person to obtain as

much history as possible.

- 3.4.4 Under Mental Health Act RSO 1990, all persons are assumed to be capable of making treatment and financial decisions unless proven otherwise. The attending psychiatrist is obligated by law to assess capacity in these 2 domains, unless a Guardian for either of these domains has been previously assigned.
- 3.4.5 The Dual Diagnosis program staff will ensure that developmental services staff, families and caregivers are notified and involved throughout the period of hospitalization. This may include attending a case conference, attending regular clinical rounds, or provision of direct support to the person during his/her hospitalization.
- 3.4.6 Dual Diagnosis program staff are available to CMHT staff, community service providers and families for information and support prior to, and following, an admission to the Inpatient Unit.
- 3.4.7 If any person identifies a problem in this process they should discuss the problem with the appropriate manager (In-patient Unit or Developmental Service Provider Agency)
- 3.4.8 This outlines timelines for decisions, and responsibilities:

INDIVIDUALS ADMITTED TO ADULT PSYCHIATRIC UNIT



3.5 Discharges from Schedule 1 Facility (Grey Bruce Health Services Owen Sound - GBHS OS):

- 3.5.1 Dual Diagnosis program staff are involved in the discharge of individuals who are admitted to inpatient psychiatry services.
- 3.5.2 Discharge planning starts on admission to inpatient psychiatry services.
- 3.5.3 Discharge planning may involve a timely case conference, with relevant stakeholders. This case conference is organized by the clinical team and may be requested by developmental service providers.
- 3.5.4 If there are problems with housing, a Crisis Review meeting may be held. (See Appendix 1 for Crisis Review Procedure). The meeting may be requested by mental health or developmental services.
- 3.5.5 If the, requires long term care he/she will be referred to the Community Care Access Centre (CCAC) Placement Coordination Service located at GBHS - OS. The Placement Coordinator will initiate a process to assess the person for Long Term Care Facility placement.

3.6 Emergency Care Plans

- 3.6.1 It is the responsibility of the Dual Diagnosis program staff to ensure that Emergency Care Plans (ECP) are completed for persons who are at high risk to present to a local hospital. Ideally, the Dual Diagnosis program staff work collaboratively with the individual and his/her support system to develop an individualized ECP when the person is well. An ECP is to be used at the time that person presents to local Emergency department. An electronic 'flag' is placed on the chart for anyone within GBHS system, and the DS agency retains a paper copy for reference. An ECP is intended to serve as a quick reference document for Emergency staff unfamiliar with the person, with the goals of ensuring safety and optimal care.
- 3.6.2 The Emergency Care Plan will be copied and housed with all parties named in the plan, given consent. This may include but is not limited to: the closest hospital; the Schedule 1 Emergency department and Crisis team; the police; family members; developmental service agencies; and tertiary care hospitals.
- 3.6.3 Plans need to specify whether there is a Substitute Decision-maker in place. Documentation of this should be obtained and be placed in the chart at the time of writing the Emergency Care Plan.
- 3.6.4 The Emergency Care Plan is to be updated by the primary support agency

by the review date specified in the plan or as changes arise. It is the responsibility of the DS team to send the revisions to the Dual Diagnosis Programme team. Dual Diagnosis will ensure that the revised version is then processed appropriately.

Linkages Between Specialized Mental Health Services – Dual Diagnosis Program, (DDP) at Regional Mental Health Care – London and Grey Bruce Health Services – Owen Sound

4.1 Protocol for Accessing Services

4.1.1 In the majority of cases, persons requiring specialized dual diagnosis services at Regional Mental Health Care (RMHC) – London, will have already been admitted to Grey Bruce Health Services – Owen Sound through the Schedule 1 facility.

4.1.2 If it is determined specialized services are required, the Dual Diagnosis program staff will take the lead on contacting the DDP. Dual Diagnosis program staff will complete the centralized access package and send it to RMHC – London.

4.1.3 A complete referral package to Coordinated Access includes:

- referral form
- Adult Needs & Strengths Assessment
- Camberwell Assessment
- Concurrent Disorders Program referral form (if appropriate)

Coordinated Access will request additional information as required. They notify when a bed becomes available. There is communication between DDP unit, Dual Diagnosis programme, family (if applicable) and the DS provider agency prior to and during admission, as well as during discharge planning.

4.1.4. Any admission to the DDP is with the commitment that there will be a residence available upon discharge from the DDP.

5. Grey Bruce Resources for People with Developmental Disabilities and a Dual Diagnosis

5.1 Dual Diagnosis Coordinator – Phone: (519) 376-2121 ext. 2857
jhealey@gbhs.on.ca

The primary function of the Dual Diagnosis Coordinator is to establish and support service relationships between individuals, families and/or developmental services

staff and the local and regional mental health system. The Dual Diagnosis Coordinator’s duties include: involving service providers and caregivers in the process of a person’s hospitalization in the Grey Bruce Health Services system; consulting with staff in developmental or mental health services in order to support care for dually-diagnosed people; focusing on problem-solving and accessing services earlier in the process; coordinating education on dual diagnosis for both service provider groups and families; and creating a “clearinghouse” of resource information and contacts in the field of dual diagnosis. The Dual Diagnosis Coordinator also focuses on the systems, which serve dually-diagnosed people, through membership on the Grey Bruce Dual Diagnosis Committee.

5.2 Dual Diagnosis Case Manager – Phone: (519) 376-2121 ext. 2486
dcutting@gbhs.on.ca

The Dual Diagnosis Case Manager provides behavioural, symptom and medication monitoring at the request of the consulting psychiatrist, family physician and/or developmental service agency. This community-based role involves consultation, education and direct clinical services. The service covers the 2 counties.

5.3 Outpatient Dual Diagnosis Clinic – Phone: as above

Services available through the clinic are as follows: medication reviews; symptom monitoring; establishment of a diagnosis; linkages to other relevant services (e.g., Regional Support Associates [RSA], CMHT’s, etc. Access to the Outpatient Dual Diagnosis Clinic is via referral from a family physician.

5.4 Developmental Services Ontario South West Region

To access Adult Developmental Services
 The Professional Centre, 945 3rd Ave., East, Suite 12, Owen Sound, On
 N4K 2K8
 Phone: 519-371-8428, Fax: 519-371-4119
 Office Hours: Monday and Friday 8:30 to noon, Wednesday 8:30 to 4:30

5.5 Developmental Services

Support services, funded by the Ministry of Community and Social Services, specifically for people with a developmental disability (including dual diagnosis) in Grey-Bruce are provided by:

Developmental Service Agencies

Agency	Phone	Website	Email
Community Living Owen Sound & District	519-371-9251	www.communitylivingowensound.ca	
Community Living Kincardine & District	519 396- 9434	www.clkd.ca	clkd@tnt21.com

Bruce Peninsula Community Living	519-534-0553	www.communitylivingbp.org	
South-East Grey Support Services	519-924-3339		segss@bmts.com
Community Living Walkerton	(519) 881-3713	www.clwalkerton.org	
Community Living Meaford	(519) 538-4165		info@communitylivingmeaford.ca
Community Living Hanover	(519) 364-6100	www.clhanover.com	

Services Provided:

The availability of support services varies from agency to agency, but typically includes:

- ✓ Case management and family support;
- ✓ Infant development, employment support and work training opportunities, recreation, leisure and community awareness activities;
- ✓ Personal development;
- ✓ Respite and in-home supports for individuals living independently or with their families;
- ✓ Residential support in a variety of settings (residential support services range from occasional in-home supports up to direct assistance with all aspects of daily living, depending upon the individuals needs).
- ✓ Age of target population is infants to seniors.

5.6 Adult Protective Services –

Owen Sound - Phone: (519) 376-3431 Walkerton - Phone: 519-881-3772

Provide support, counselling, and information to developmentally challenged individuals who are eighteen years of age and over, and who are living or planning to live independently in the community.

1. Counselling (instrumental and affective).
2. Help in obtaining financial assistance, accommodation, medical and dental care.
3. Advocacy, including legal advocacy for individuals' rights.
4. Information and assistance in organizing groups.

5.7 Familyhome Program - Phone: (519) 371-2549

The Familyhome Program currently provides supports to 40 individuals living with 30 families throughout the total catchment area. The Familyhome Program has

offices in Listowel and Owen Sound and serves the counties of Perth, Huron, Grey, Bruce and north Wellington.

5.8 Bluewater Youth and Adult Services Phone: (519) 363-3514

- ✓ Provide rural residential supports to high risk dual diagnosis adults
- ✓ Provide independent living supports to assist developmental clients
- ✓ Provide Case management and family supports
- ✓ Target population 18 years and older
- ✓ To promote and assist adults with employment support, recreation, leisure and volunteer activities
- ✓ Provide safety and security to both clients and community through intensive supervision
- ✓ This is a fee for service agency

5.9 Participation Lodge – Holland Centre - Phone: (519) 794-3201

Participation Lodge provides the following services:

- ✓ Provide residence for 20 adults with special needs at the Holland Centre facility. Staff provides 24 hour care and support;
- ✓ 2 respite beds at the Holland Centre site;
- ✓ a small Acquired Brain Injury Program;
- ✓ 2 Supported Independent Living Apartment Programs, located in Owen Sound and Hanover, each providing support to 10 individuals in their own apartments with staff on site 24 hours a day;
- ✓ An Outreach Program for individuals requiring personal care. This assistance enables the individual to remain in their own home.

5.10 Regional Support Associates - Phone: 1-800-640-4108 or 1-519.421.4249 ext. 2212

Regional Support Associates (RSA) is an assessment, treatment and training program providing services to individuals with an intellectual disability or dual diagnosis across Southwestern Ontario. There is no cost for the services and anyone can refer through the DSO

RSA provides the following services:

- ✓ Provides specialized services such as:
 - Consultation on dual diagnosis and developmental disabilities to all sectors of the service system;
 - Specialized psychiatric/psychological/parenting/sexuality/behavioural/speech and language and other assessments and consultations

- Assist in the planning of services for an individual through all levels of the service system;
- Participate in research and evaluation in specialty areas;
- Clinical placements to students in the field of developmental disabilities.
- Provide a Workshop series each year as well as hosting an annual conference
- Referrals are through the DSO SWR

5.11 Enhanced Specialized Services offered through Regional Support Associates

To receive enhanced specialized services an individual:

- ✓ Shall have a diagnosis of a developmental disability
- ✓ Must be 18 years of age or older
- ✓ There are specialized needs resulting from challenging behaviours or a mental health need (dual diagnosis) that place the individual or others at immediate risk and are beyond the capacity of the persons current support system to manage
- ✓ Must be exhibiting either of the following difficulties:
 - the individuals current needs have exhausted the resources and services of provider/family/agency/staff.
 - there is a need for a specialized assessment or treatment not available through other community services
- ✓ The individual must be able to remain in or have a residence to return to upon completion of treatment

Engaging Enhanced Specialized Services

The process to engage Enhanced Specialized Services:

1) If the request meets the criteria for admission, the RSA staff associated with the individual will contact the clinical supervisor who will link with the Host Agency in that community or treatment space provider to advise them that enhanced specialized services are needed. If the person is not currently involved with Regional Support Associates an Urgent Referral will be made to RSA utilizing the referral process through the DSO SWR. The referral forms and process to make application are on the website www.regionalsupport.on.ca

5.12 Mental Health Court Support Services offered through Grey Bruce Canadian Mental Health Association (GB CMHA) - Phone (519) 371- 3642

There are 4 services offered through the Grey-Bruce Mental Health Court Support Services:

1. Court Diversion;
2. Case Management;
3. Court Support and Consultation;
4. Release Planning.

1. Court Diversion - is a post-charge, pre-trial procedure where Crown Attorneys can, at their discretion, decide not to prosecute persons accused of minor offences. In its place, the person agrees to embark upon an individual support/treatment program in the community, designed to address their needs. The goal is to minimize further involvement with the criminal justice system. With diversion, there is no trial or conviction. It is a voluntary service for people who have a serious mental illness, and/or a developmental disability or acquired brain injury who are charged with minor criminal offences.

2. Case Management - to promote compliance with the diversion plan, a case manager will be assigned to support the individual in the community. Updates will be provided to the Crown for up to one year after a charge is diverted.

3. Court Support and Consultation - are available to aid individuals and their support person(s) to access support for their mental health needs and refer them to community resources. Program staff provide consultation to the court with respect to individuals with mental health issues. Individuals can also receive support through the court process.

4. Release Planning is offered to individuals who are incarcerated and require support to develop a successful transition plan back into the community. The Release Planner would assist persons to access community resource such as housing, medication or medical monitoring, substance abuse counseling, family contacts or continuing case management.

Anyone can make a referral, such as the accused, family police, court personnel or a community agency and no referral form is required. CMHA Court Support Services have been strongly supported by the Courts in both Owen Sound and Walkerton. As the program developed we were able to establish a designated court time for the more vulnerable people served by Court Support Services in both courts. There is consideration given to the problems they struggle with and they are dealt with discretely in the afternoon without prolonged waits. We have succeeded in developing protocols with some police jurisdictions for Pre-charge services and continue to work to build these

relationships with other police services in our area. Police as first responders 24/7 would encounter an offender who appears to be or is known to be suffering from mental illness. Police believe that the offender could benefit from Pre-Charge Diversion Program. The offender voluntarily agrees to take part in a Pre-Charge Diversion Program similar to the Court Diversion prior to a criminal charge being laid. The benefits of CMHA Court Support Services have been proven in statistics that demonstrate prevention of recidivism, reduction in hospitalizations and increased access to services. This has been achieved through the development of collaborative problem solving approaches. We are grateful for the relationships we have been able to develop with the justice system and our other community partners that enable us all to best meet the needs of the vulnerable people we serve.

Hope Grey Bruce - Nortowne Plaza, 1101 2nd Ave E, Suite 206, Owen Sound, ON N4K 2J1 Phone: 519-371-4120

Services provided include:

- ✓ mental health counselling for those with serious mental illness
- ✓ mental health counselling for acute problems
- ✓ counselling for families
- ✓ post-emergency counselling for women who are survivors of sexual assault or childhood sexual abuse
- ✓ assessment, referral and community treatment for adults and youth with substance abuse and/or gambling problems and their families
- ✓ supportive, affordable housing, outreach support, life skills teaching, employment support and social/recreational services for those with serious mental illness
- ✓ community development, consultation, education and information services for service providers, consumer/survivors and family members and the broader community.

Self-help support groups are offered for people with mental illness and for family members of those with serious mental illness. Call for more information.

Programs include:

- ✓ Community Network Support Team;
- ✓ New Directions for Alcohol, Drug and Gambling Problems;
- ✓ Choices: Drug and Alcohol Counselling for Youth;
- ✓ Community Connections: Housing and Support;
- ✓ Consumer/Survivor Development Project;
- ✓ Family Support Initiative.

6. Tertiary Dual Diagnosis Services

6.1 CPRI – Child and Parent Resource Institute- London.

For information/outpatient services, local contact is 519-881-0328

Inpatient services vetted through Local Case Resolution Team (within Keystone Child, Youth and Family Services) 519-371-4773 ext. 114 or 190.

- **Dual Diagnosis Program**

This program provides community-based and residential interdisciplinary services for children up to the age of 18 years, with developmental and psychiatric or behavioral disorders.

Services may include:

- Psychiatry
- Behavioural Consultation;
- Psychology;
- Developmental Paediatrician
- Speech, OT, and PT
- Educational seminars/workshops on topics related to Dual Diagnosis.

Other programs offered to children and youth who have a developmental disability are as follows:

- Child Development Program;
- Emotional Disorders (Developmental Delay& Mood Disorder,or Anxiety Disorder)
- Pervasive Developmental Disorders (PDD)

Note – All referrals for diagnosis go to a screening clinic before they proceed to psychiatry for diagnoses.

6.2 Dual Diagnosis Program (DDP) – Regional Mental Health Care – London - Phone: 519-455-5110 ext 47700#

The Dual Diagnosis Program includes a 12-bed active treatment program, serving people between the ages of 18 – 64 years, which provides client-centered multidisciplinary care for individuals with a developmental disability and a mental health care need (a psychiatric disorder or a severe behavioural problem) in Southwestern Ontario. The program includes an inpatient component and an outpatient multidisciplinary clinic.

The multidisciplinary team attempts to provide an integrated mix of recreational and social activities, both on and off hospital grounds, which reflect the needs of the individual.

Whenever possible, individuals are seen first in an outpatient clinic in an attempt to avert the need for hospitalization.

Services are delivered using an approach that emphasizes equity in relationships between all stakeholders. Interdisciplinary collaboration involving the supported person, family members and community partners, characterizes the consultation, assessment, treatment, stabilization, habilitation/ rehabilitation, reintegration, placement, follow up and education processes. Regular team meetings provide an

opportunity for input in the form of feedback and sharing of information gained through the continual assessment/evaluation of the individual, and for modification of the treatment plan as necessary.

7. Community Networks of Specialized Care:

The Community Networks of Specialized Care were created to ensure a system which is:

Accessible- so that people and their caregivers/families can access the clinical services they need, when and where they need them.

Co-ordinated & Integrated- so that the services and supports from a number of programs, organizations and sectors are working together with people and their families to make a difference.

Accountable- so that we know the networks are actually making a difference.

This work is accomplished by meeting the Goals of the Southern Network of Specialized Care;

1. Coordinate Specialized Service System

The Southern Network of Specialized Care will strengthen and expand community relationships to ensure key stakeholders are collaborating on regional work plans that positively impact the quality of life for people with dual diagnosis.

2. Enhance Service Delivery

The Southern Network of Specialized Care will create and provide enhanced opportunities for Specialized Clinical Providers to generate, incorporate and exchange best practices that will positively impact the quality of life of people with a dual diagnosis.

3. Train & Build Capacity in the Community

The Southern Network of Specialize Care will provide opportunities to current and future direct support professionals for knowledge growth and exchange that will ultimately impact the quality of life of people who have developmental disabilities and dual diagnosis.

8. Local Service Delivery Network (LSDN):

At their October 25, 2006 quarterly meeting the Grey Bruce Dual Diagnosis Committee agreed to be the Local Service Delivery Network for the Southern Network of Specialized Care.

As the LSDN the committee's functions include:

- A focus on improving the delivery of services within their region through the development of protocols and strong relationships across their community
- Monitoring how Specialized Accommodations are utilized and delivered.
- In keeping with the focus on training and building communities, the LSDN collects information about its community needs, and shares them with the Facilitator, who voices their needs to the Southern Network of Specialized Care Advisory Committee and to the provincial partners.
- Sharing their experiences and outcomes with the other LSDNs, so that they can benefit from their shared wisdom.

9. Implementation of Protocol

9.1 Members of the Grey Bruce Dual Diagnosis Committee (See Appendix 2) were involved in the development, review and revision of this Protocol. To their best knowledge and understanding, the mechanisms outlined in this protocol are acceptable to and workable within their organizations, agencies or facilities.

9.2 This protocol will be implemented as a “Good Faith Agreement” among all Dual Diagnosis Committee Members and their representative groups.

9.3 It is the responsibility of all stakeholders to ensure their staff are aware of the protocol.

Education of front-line workers at each service provider agency regarding the protocols (i.e., Schedule 1 in-patient unit, community mental health teams, developmental service provider agencies, specialized services) will be the responsibility of the program manager or designate.

10. Mechanisms to Monitor/Evaluate Protocol

Review, revision and evaluation of the protocol will be undertaken by the Grey Bruce Dual Diagnosis Committee, biannually at a regularly scheduled meeting

Appendix 1

Developmental Support Network

Crisis Review Procedure (to be updated)

Purpose:

To implement an immediate community response to ensure that people with developmental disabilities who experience crisis in their lives are able to remain in their community.

Participants:

Community Living Owen Sound and District; Community Living Kincardine and District; Community Living Meaford; Bruce Peninsula Community Living; Community Living Walkerton; HARC; Participation Lodge; Familyhome Program; and Adult Protective Services and other identified community partners

Goals:

1. To assist in stabilizing situations until long-term planning can happen.
2. As a mechanism to share information on available support systems and how to access these systems.
3. As a means to explore alternatives and review decisions.
4. To keep M.C.S.S. and all participating agencies aware of crisis situations.

Process for Calling a Meeting:

Any member of the participating agencies above can contact the Lead Agency (currently Community Living Walkerton and District) and request a Crisis Review meeting be organized. This meeting should be held within 5 days.

The agency initiating the process will continue to plan for long-term services.

Crisis Review Team:

The Crisis Review Team will consist of a member of the Lead Agency and at least one delegate from a minimum of two of the other participating agencies. The Lead Agency will be responsible for taking minutes and organizing the meeting. The individual/agency requesting the meeting will clarify what they want from the Review Team (e.g., ideas of resources to explore, a sounding board for decisions, or assistance from another organization, etc.).

Minutes and Follow-up:

A system for follow-up will be agreed upon at the initial meeting. Minutes are sent to MCSS.

1. No names will be part of the minutes.
2. All participants receive minutes.
3. Copies of the minutes will be forwarded to M.C.S.S. so they are aware of crisis situations and possible funding implications.

Year-end:

An annual report will be prepared by the Lead Agency and shared with the Bruce-Grey Developmental Support Network, M.C.S.S.and the Grey Bruce Dual Diagnosis Committee for future planning.

Appendix 2

Dual Diagnosis/ Local Service Delivery Network Committee Membership- Grey Bruce				
NAME	EMAIL	AGENCY	ADDRESS	PHONE
Arnold, Elizabeth	arnoldr@bmts.com	Family Representative	510 Falconer St., Port Elgin, On N0H 2C2	519.832.5554
Brown-Anderson, Deane	Deane.Brown-Anderson@bgcfs.ca	Bruce Grey Child and Family Services	1290 3rd Ave. E. Owen Sound, N4K 2L5	519-371.4453 or 1.855.322.4453
Burnside, Oscar	oscarb@bmts.com	Georgian College	1450 8th Street East, Owen Sound N4K 5R4	519.376.0840
Campbell, Lisa	Lisa.Campbell@grey.ca	Grey County Housing	595 9 th Ave. East, Owen Sound, N4K 3E3	519.376.5744 or 1.855.322.4453
Carter, Bud	Bud.Carter@ontario.ca	MCSS	P.O. Box 5217, 217 York St. London N6A 5R1	1.800.265.4197 or 519-438-5111 ext. 3137
Chapman, Patty	Patty.Chapman@LHINS.ON.CA	South West Local Health Integration Network (LHIN)	201 Queens Ave, Suite 700, London N6A 1J1	519.672.0445 or 1.866.294.5446
Cutting, Dianna	dcutting@gbhs.on.ca	Grey Bruce Health Services, DDP	P.O. Box 1800, 1800 8th St. E. Owen Sound N4K 6M9	519-376-2121 ext. 2486
Dempster, Debbie	dempster.plap@bmts.com	Participation Lodge	RR#1 Holland Centre N0H 1R0	519.794.3333 ABI unit or 519-794-3201
Dodd, Phil	pdodd@brucetelecom.com	Keystone, Children's Mental Health	845 2nd Ave. E. Owen Sound N4K 2H2	519.371.4773
Froese, Liz	froese.network@sympatico.ca	Southern Network of Specialized Care	3280 Schmon Prkwy, Thorold, L2V 4Y6	1.866.486.1651
Hart, C Brodie	cbhart@clwalkerton.org	Community Living Walkerton	P.O. Box 999, 19 Durham St. E. Walkerton N0G 2V0	519-881-3713
Healey, Jennifer	jhealey@gbhs.on.ca	Grey Bruce Health Services	P.O. Box 1800, 1800 8th St. E. Owen Sound N4K 6M9	519-376-2121 ext. 2857
Hillis, Sue	shillis@daleservice.on.ca	Dale Brain Injury	815 Shelbourne St. London, On N5Z 4Z4	519.668.0023
Hong, Sandra	SH@alzheimergreybruce.com	Alzheimer Society of Grey Bruce	753 2nd Ave. E., Owen Sound, On N4K 3Z2	519.376.7230

Ipsen, Libby	l.ipsen@bmts.com	Bruce Peninsula Community Living	P.O. Box 95, 314 George St. Warton N0H 2T0	519-534-0553
Kanmacher, Melissa	mkanmacher@bmts.com	Planner	Paisley, On	519.353.4202
Legge, Lynda	llegge@wgh.on.ca	Southern Network of Specialized Care	911 Yonge St. P.O. Box 310, Walkerton N0G 2V0	519-881-0922 ext. 2405 or 1.800.640.4108
Martin, Ellis, Lezlie	lmartinellis@gbchc.org	Grey Bruce Community Health Corporation	1101 2nd Ave. E. Suite 206, Owen Sound N4K 2J1	519-371-4120
Maus, Barb	bmaus@fsph.ca	Family Home Program	901 3rd Ave. E. Suite 208, Owen Sound N4K 2K7	519-371-2549
McGilveary, Steve	smcgilvearybwyas@bmts.com	Bluewater Youth and Adult Services Ltd.	R.R 4, Chesley, On N0G 1L0	519.363.3514 x 33
McLeish, Anne- Marie	ammcleish@comlivos.on.ca	Community Living Owen Sound	769 4th Ave. E. Owen Sound N4K 2N5	519-371-9251
Oosthoek, Lee- Anne	LOosthoek@communitylivingmeaford.ca	Community Living Meaford	Meaford, On	519.538.4165
Pennington, Cathy	cpenningtonckd@tnt21.com	Community Living Kincardine and District	286 Lambton St., PO Box 9000, Kincardine N2Z 2X8	519.396.9836
Pfeffer, Christine	Christine_Pfeffer@bgcdsb.org	Bruce Grey Catholic District School Board	799 16 th Ave., Hanover ON N4N 3A1	519.364.5820
Pilkington, Jeff	jpilkington@rogers.blackberry.net	Community Living Hanover	521 11th Ave. Hanover N4N 2S3	519-364-6100 ext. 104
Roe, Pam	Pam.Roe@sjhc.london.on.ca	St. Joesph Health Care, RMHC London	850 Highbury Ave. N. Box 5532, London N5P 3V9	519-455-5110 x 47687
Rowney, Bruce	Bruce_Rowney@bwdsb.on.ca	Bluewater District School Board	P.O. Box 190 351 1st Avenue North Chesley, Ontario N0G 1L0	519-363-2014 ext 2004
Schwartz, Robert	Robert.Schwartz@bgcfs.ca	Bruce Grey Child and Family Services	1290 3rd Ave. E. Owen Sound, N4K 2L5	519-371.4453 or 1.855.322.4453
Symons, Chris	chrissymons@cscn.on.ca	Developmental Service Ontario South West Region	171 Aueens Ave. Suite 750, London N6A 5J7	1.877.480.2726 or 519- 438-4783 x 40 or 226.668.4817
Synder, Marjorie	Marjorie.Synder@bgcfs.ca	Bruce Grey Child and Family Services	1290 3rd Ave. E. Owen Sound, N4K 2L5	519.371.4453 or 1.855.322.4453

Timmerman, Ashley	AThom@cmhagb.org	Grey Bruce Canadian Mental Health Association (CMHA)	1024 2 nd Ave. East, Owen Sound N4K 2H7	519.371.3642
Voisin, Maurice	mvoisin.segss@bmts.com	South East Grey Support Services	P.O. Box 12, 24 Toronto St. Flesherton NOC 1E0	519-924-3339
Young, Jason	jyoung@wgh.on.ca	Regional Support Associates (RSA)	293 Wellington St.N. Woodstock, On N4S 6S4	519-421-4248 x 2216
Minutes Only				
Ackerman, Kathy	kackerman@harcinc.ca	Community Living Hanover	521 11th Ave. Hanover N4N 2S3	519-364-6100
Barbour, Bryan	bryanb@bmts.com	BPACL	P.O. Box 95, 314 George St. Wiarton NOH 2T0	519-534-0553
Baldwin, Karen	Karenbaldwin@dsoswr.ca	Developmental Service Ontario (DSO SWR)	845 3 rd Ave. East, Suite 12, Owen Sound N4K 2K8	519.371.8428
Gidman, Pam	pgidman@cmhagb.org	Canadian Mental Health Association, Southampton	P.O. Box 1342, 353 High St. Southampton NOH 2L0	519-797-2880
Heath, Heather	heh@bmts.com	Private Consultant		
Hill, Rick	rhill@comlivos.on.ca	Community Living Owen Sound	769 4th Ave.E. Owen Sound N4K 2N5	519-371-9251
Hood, Leah	lhood@gbhs.on.ca	Grey Bruce Health Services	P.O. Box 1800, 1800 8th St. E. Owen Sound N4K 6M9	519-376-2121
Kieffer, Kathy	kkieffer@clwalkerton.org	Community Living Walkerton	19 Durham St. E. P.O. Box 999, Walkerton NOG 2V0	519-881-3713
Kordowski, Melanie	Melanie.Kordowski@bgcfs.ca	Bruce Grey Child and Family Services	1290 3rd Ave. E. Owen Sound, N4K 2L5	519.371.4453 or 1.855.322.4453
MacPherson, Sue	Sue.MacPherson@ontario.ca		317057 6 & 10 Hwy. P.O. Box 307, Chatsworth NOH 1G0	519.794.7827
Schwan, Jacquie	jschwan@gbchc.org	Grey Bruce Community Health Corp	1101 2nd Ave. E. Suite 206, Owen Sound N4K 2J1	519-371-4120
Swan, Andy	aswan.clkd@tnt21.com	Community Living Kincardine and District	286 Lambton St. P.O. Box 9000, Kincardine, N2Z 2X8	519-396-9836

Appendix 3

Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with A Dual Diagnosis

December 2008

http://www.health.gov.on.ca/english/providers/pub/mental/joint_policy_guideline.pdf