



Dual Diagnosis Program

Moving Forward: National Action on Dual Diagnosis in Canada

(Developmental disability and mental health difficulties)

Prepared by:

The National Coalition on Dual Diagnosis

October, 2011



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NADD Ontario

The Coalition is grateful to the National Association for the Dually Diagnosed, Ontario Chapter (NADD Ontario) for their financial contribution to the writing of this report.

Introduction

People with a dual diagnosis are citizens of this country. They're entitled to health equity and equal opportunity to live and participate - with respect and dignity – when and how they choose – in Canada's communities (National Coalition on Dual Diagnosis, 2008)

The National Coalition on Dual Diagnosis¹ recruited an international Expert Panel (see Appendix 1 for membership) to begin a conversation about the necessary leadership at the federal level in order to improve the lives of people with a dual diagnosis. To inform their deliberations, they commissioned an international scan of legislation and policies that pertain to people with developmental disabilities and also for those with dual diagnosis. The recommendations contained in this paper are based on the findings of the scan (See Appendix 2)

The literature scan focused on the developed countries of Europe, United Kingdom, Australia, United States and Canada.

Context

In many countries, Canada included, it was originally thought that the deinstitutionalization of people with developmental disabilities was a solution unto itself. Once people were settled in the community, they would flourish. And with certain levels of support, they would also be able to access and make use of the same services as any other citizen would (housing, education, health and social services, for example). This proved to be an insufficient view of the scope of services needed for many. People with developmental disabilities have complex and multiple difficulties – some of which can be served by generic services, but many which cannot. Further, the community system lacked the necessary services to provide support.

In the specific case of people with a dual diagnosis (both a developmental disability and mental health difficulties),² generic mental health services did not welcome them, did not serve their needs well and mental health professionals did not have the expertise to diagnose or treat them effectively.

The estimated prevalence rate of developmental disabilities in the general population is between 1- 3 %³, and of these, approximately 40% also have a mental health problem.⁴

People who have both a developmental disability and a mental illness have more severe symptoms, are more likely to have co-occurring medical conditions and have fewer resources (access to education, social and economic supports). Due to lack of community and/or specialized supports, they are also

¹ For more information about the National Coalition on Dual Diagnosis and previous reports: <http://care-id.com/dual-diagnosis/>

² The term “dual diagnosis,” referring to both a developmental disability and mental health difficulties, is not used universally. However, after some consideration, this is the term that was adopted by the National Coalition and therefore will be used throughout this paper

³ World Health Organization (2001). Report 2001 -- Mental Health: New Understanding, New Hope. Geneva, Switzerland.

⁴ Cooper, S., Smiley, E., Morrison, A.W., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *British Journal of Psychiatry*, 190, 27-35.

likely to use emergency departments ⁵ and to be re-hospitalized ⁶ more frequently than the general population. Noteworthy is that adults with developmental disabilities represent the highest per-capita expenditures within the health system than all patient groups. ⁷

Summary of findings from the international scan

The National Coalition on Dual Diagnosis conducted an international scan of legislation and governmental policies as they relate to developmental disabilities and dual diagnosis. The purpose of the scan was to uncover examples where countries had acknowledged the needs of those with dual diagnosis and developed clear strategies, guidelines and policies which were leading to beneficial outcomes. With the exception of the United Kingdom where there has been extensive attention paid to people with learning (developmental) disabilities and mental health difficulties, the findings of the scan for other countries (including Canada) were that dual diagnosis is a neglected area of policy.

Specifically, it was found that the fate of people with a dual diagnosis is inextricably linked to the fate of people with developmental disabilities. If a country does not have legislation or policy regarding people with developmental disabilities, it will, by extension, not have legislation or policy for people with a dual diagnosis. For people with developmental disabilities, the scan revealed widespread inconsistency in terminology and fragmentation of services (where they existed at all).

There is also no common term for people with developmental disabilities and mental health difficulties. Dual diagnosis is only one version and a controversial one at that. When dual diagnosis is mentioned (by whatever name), it is part of a list of heterogeneous populations grouped under “complex needs” or “diversity.”

While defining and naming may seem like mere details, the reality is that it is not clear from country to country to what we are referring. Jurisdiction cannot talk to jurisdiction with any coherence. Research and basic surveillance is impeded. World-wide, there is limited surveillance data and little attention paid to research for people with developmental disabilities, in general and in particular. Without basic facts and figures, it is difficult to frame needs and argue for investment in services. The helping professions pay scant attention. Confusion in terms, confusion as to what, exactly, is wrong, confusion as to how to treat, and confusion about who is responsible for helping all contribute to the marginalization of the dual diagnosis field – where it exists - and thus, the people it serves.

Generic mental health services have not welcomed people with a dual diagnosis and have not served their needs well. Further, mental health professionals generally do not have the expertise to diagnose or treat them effectively. Additionally reference to children and in particular the transition from child to adult services is limited. Today, mental health and developmental services continue to live in separate worlds with separate cultures.

⁵ Lunsky, Y., Lin, E., Balogh, R., Klein-Geltink, J., Bennie, J., Wilton, AS., Kurdyak, P (2010). Are adults with developmental disabilities more likely to visit EDs? American Journal of Emergency Medicine. 29(4), 463-465. doi: 10.1016/j.ajem.2010.12.028

⁶ Lunsky, Y., Balogh, R. (2010) Dual Diagnosis: A National Study of Psychiatric Hospitalization Patterns of People With Developmental Disability. The Canadian Journal of Psychiatry, 55(11), 721-727

⁷ Polder, J.J., Meerding, W.J., Bonneux, L., & van der Maas, P.J. (2002) Healthcare costs of intellectual disability in the Netherlands: a cost-of-illness perspective. Journal of Intellectual Disability Research, 46(2), 168-178

Without basic data and with little research, advocacy for dual diagnosis is isolated and limited. Where success has been achieved, it has failed to spread or gains have been lost entirely with no sustained advocacy. Without strong, visible leadership, the needs of do not get the attention of decision-makers and funders.

Purpose of this document

This paper offers a series of guiding principles and recommendations based on the example of the United Kingdom and the general findings of the international scan. It describes the necessary actions at the *pan-Canadian level*, along with enabling activities which will encourage change and improve the lives of people with a dual diagnosis.

Guiding principles

While an important and welcome document, the United Nations Convention on the Rights of Persons with Disabilities (2008)⁸ paid limited attention to issues of mental health or mental illness. Thus, the following principles align with, but build upon the more general principles of the UN Convention.

Value for human potential: People with a dual diagnosis are entitled to live, learn and grow in places of their choice.

Full citizenship: People with a dual diagnosis are full members of Canadian society and, with help, support and barrier removal can make valuable contributions.

Reducing suffering: Government has a role to play in reducing suffering experienced by people with a dual diagnosis and their loved ones.

Stopping discrimination: People with a dual diagnosis deserve access to opportunities and to the goods and comforts that all citizens enjoy.

Protection: People with a dual diagnosis are vulnerable and require laws that protect them from neglect, exploitation, and abuse.

Access to effective help when needed: are entitled to effective supports, services and treatment. They are also entitled to have their disability taken into account when accessing services, supports or treatment or when they come into contact with the law.

Information, choice and participation: People with a dual diagnosis are entitled to be full participants in decisions that affect them and to have access to necessary information to inform that participation.

Community life and membership: When care is required, it should be delivered in the least restrictive setting possible. Communities must provide welcoming opportunities for participation for people with a dual diagnosis.

⁸ See: <http://www.un.org/disabilities/convention/conventionfull.shtml>

Recommendations

The findings of the international scan which point to widespread policy deficiencies for people with a dual diagnosis apply equally to Canada where there is no pan-Canadian legislation, policy or guidelines for developmental disabilities or for dual diagnosis. Change is required.

Respecting the different roles played by federal, provincial and territorial governments, the National Coalition on Dual Diagnosis's recommendations for federal leadership and action are the following:

1. **Mental health promotion:** People with developmental disabilities have a two to threefold increased risk of developing a psychiatric illness.⁹ To reduce their risk **population based health promotion strategies** targeting families, schools, community residences, developmental disability and mental health services should be implemented to ensure positive mental health and well-being is protected, nurtured and developed across the lifespan.
2. **Mental illness prevention:** Increase the capacity of families, schools and communities to promote mental health, reduce stigma, reduce mental illness and intervene early. **Screening guidelines** should be documented and disseminated to identify people with developmental disabilities who are at risk of developing a mental illness, along with the dissemination of effective models of prevention.
3. **Early intervention:** Increase the availability of **early identification and early intervention programs across the life span** e.g. best practice models for people with developmental disabilities should be developed, documented and disseminated to assist mental health and developmental services in designing and implementing mental health programs specifically for people with a dual diagnosis.
4. **Service access and coordination:** Individuals, families and paid caregivers have an inordinate amount of difficulty making their way through fragmented services in order to find help. Stronger coordination between community-based mental health, acute mental health, health, justice, education, and other social services through a **single point of information**, a one-stop-shop, would assist them to find sources of help and to more effectively navigate across the various service systems.
5. **Access to mainstream mental health and social services:** Mainstream mental health and social services are often the first point of contact for people with a dual diagnosis. Their health and mental health difficulties can also be life long. Modifications to usual care, including knowledge and skills related to prescribing of medication and providing psycho-therapeutic treatments are required. Similar to the Canadian consensus guideline on primary care of adults with disabilities¹⁰, **Canadian Guidelines for the Planning and Provision of Mental Health Services and Supports for people with a developmental disability** should be developed and

⁹ Emerson, E. & Hatton, C. (2007). Mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry*, 191, 493-499.

¹⁰ Sullivan, W.F., Berg, J.M, Bradley, E., Cheetham, T., Denton,R., Heng, J., Hennen, B., Joyce, D., Kelly, M., Korossy, M., Lunsy, Y., McMillan, S. (2011) Primary care of adults with developmental disabilities Canadian consensus guidelines. *Canadian Family Physician*, 57:541-53

disseminated to provinces and territories to assist mainstream services in providing services and supports across the lifespan.

6. **Access to specialized mental health services:** People with a dual diagnosis can have multiple and complex needs. To support mainstream mental health services **models, best practices and guidelines for specialized mental health treatment and consultation services should be incorporated into the Canadian Guidelines (per above).**
7. **Awareness and understanding of lifespan issues, particularly at key age related transition points:** Transitioning through age related services increases the vulnerability of people with a developmental disability to mental health difficulties. Transitions for children from elementary to middle and high school can be confusing and have an impact on social and academic progress – particularly for those with Autism Spectrum Disorder.¹¹ Insufficient planning and coordination¹² and very different philosophies (emphasizing choice and decision making) are among many of the issues faced by youth transitioning to the adult system. As people with a developmental disability age difficulties in detecting cognitive changes and lack of expertise related to end of life care occur.¹³ The new Canadian Guidelines should include best practices for **coordination, linkages and pathways between service sectors and systems at these transition points across the lifespan.**
8. **Help and treatment for children, youth and adults who encounter the legal system.** People with a developmental disability are 50 percent more likely to experience violent crime.¹⁴ Women with a developmental disability are 4 to 10 times more likely to experience sexual abuse in their lifetime than women with disabilities and are more likely to be re-victimized by the same perpetrator.¹⁵ People with a developmental disability or dual diagnosis are also increasingly being charged with major and minor offences.¹⁶ The new Canadian Guidelines should address **best practices in victim services and supports including testifying in court, as well as models of prevention, diversion and specialized mental health services** for those found in the criminal justice and forensic systems. **Special attention to Correction Services Canada** and its mental health services is necessary to develop expertise in helping offenders with dual diagnosis in custody and through the transition to community services and supports:
9. **Utilization of the latest knowledge and a culture of evaluation:** Peer reviewed research in the field is growing however the translation from knowledge to practice is lagging. There is also more experience now with consumer and family participation in the development of research

¹¹ Stoner, JB., Angell, M.E., House, J.J., Jones Bock, S. (2007) Transitions: Perspectives from parents of young children with Autism Spectrum Disorder (ASD), *Journal of Developmental Physical Disability* 19:23-39.

¹² Bhaumik, S., Watson, J., Barrett, M., Raju, B., Burton, T., Forte, J. (2011) Transition for teenagers with intellectual disability: Carers' Perspectives, *Journal of Policy and Practice in Intellectual Disabilities* 8(1) 53-61.

¹³ Noonan Walsh, P. (2005) Ageing and health issues in intellectual disabilities, *Current Opinion Psychiatry* 18, 502–506

¹⁴ <http://autismnow.org/in-the-community/safety/> Accessed October 27, 2011

¹⁵ Sobsey, D. (1994). *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance*. Baltimore, MD: Paul H. Brooks Publishing Co, Inc.

¹⁶ Jones, J. (2007) Persons With Intellectual Disabilities in the Criminal Justice System: Review of Issues *International Journal of Offender Therapy and Comparative Criminology* 51(6) 723-733

and evaluation. Best practices, performance indicators and outcome measures must be incorporated in the new Canadian Guidelines as well as guide planning and implementation of supports and services at the local level.

Enabling mechanisms:

The following five areas outline action that needs to be taken at the federal level to lay the foundation for achievement of the above recommendations:

UN Convention on the Rights of Persons with Disabilities

Establish a national advisory panel of national disability groups to explore how to move forward with the Convention and convene parliamentary hearings to hear testimony on the Convention from witnesses from the disability community.

Data collection

Surveillance efforts through the Public Health Agency of Canada currently focused on autism should expand to include other developmental disabilities and to specifically include surveillance of dual diagnosis.

The Canadian Institute for Health Information should track hospitalization, admission and re-admission data for people with a dual diagnosis, similar to the tracking conducted of other psychiatric populations.

Research

The Canadian Institutes of Health Research (CIHR), Expert Review Team Report for the Institute of Neurosciences, Mental Health and Addiction recommended a review of the mental health and addiction research strategy.¹⁷ This review must incorporate dual diagnosis.

The CIHR should establish an interprofessional cross sector Research Chair for Dual Diagnosis within the Institute of Neurological, Mental Health and Addictions to lead research activities.

A granting program should be funded to solicit proposals from researchers to identify a common terminology for dual diagnosis along with an agreed upon classification system. Additional grants must support the development of best practices, performance indicators and outcome measures for promotion, prevention, early intervention, access to and delivery of health and mental health services and programs. Measures of cost-effectiveness along with consumer and family satisfaction should be included.

Professional and inter-professional training

Building upon the Federal Inter professional Education for Collaborative Patient-Centred Practice (IPCC) initiative, a fund should be made available for universities and colleges to

¹⁷ <http://www.cihr-irsc.gc.ca/e/43605.html#a1>, accessed November 2, 2011.

develop education modules for under-graduate and graduate health and mental health related programs on developmental disabilities and dual diagnosis. Guidelines for developing post licensure inter-professional continuing education opportunities must also be developed.

Professional licensing bodies must be encouraged to approve the designation of a sub-specialty for members on developmental disability and dual diagnosis as has recently been accomplished within Family Medicine.

Cross-ministry cooperation

Within the context of Canada's Mental Health Strategy the federal government should establish cross-ministry planning and cooperation mechanisms with regard to the special needs of people with a dual diagnosis.

The federal government should also work with the provincial and territorial governments to establish a mechanism for inter-governmental collaboration that includes the special needs of people with a dual diagnosis.

A review of funding mechanisms to support legislation and policy implementation in the countries where such existed was beyond the scope of this project. To be effective federal action must be accompanied by enabling funding.

Conclusion

These recommendations build upon an international scan of legislation and policy, which demonstrated successes, and for the most part, large gaps in public policy related to supporting people with developmental disabilities and mental health difficulties. It provides the basis for conversation at the pan-Canadian level and identifies the role of federal leadership in helping people with a dual diagnosis to live fuller and more successful lives.

Appendix 1

Members of the International Expert Panel

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Appendix 2

Annotated scan of policies and legislation related to developmental/learning disabilities in combination with mental health problems, July 2011

The document is a support for the development of recommendations for national action on Dual Diagnosis in Canada. . Note that the summaries are, of necessity, brief and do not include every nuance in the policy or legislation. Instead, they offer a snapshot of activity in each jurisdiction.

Historical lessons from Europe. Pg 12

Recent developments in Europe

(including comments on the US and Australia) Pg 13

The review that follows provides a current sampling of the types of policies and legislation that have been developed by:

The United Nations Pg 15

The World Health Organization Pg 17

Countries considered relevant by the Expert Panel (documents included were either found by the researcher or recommended by the Panel)

United Kingdom Pg 18

United States Pg 21

Australia Pg 22

The scan concludes with the current policy situation in Canada. Pg 27

Note: There are varying terms for people with both an intellectual (developmental) disability and a mental illness. This scan uses the term “dual diagnosis” throughout.

Historical lessons from Europe¹⁸

Day, K. (1992). *Mental health care for the mentally handicapped in four European countries: The argument for specialized services. Italian Journal of Intellectual Impairment. Vol 5, pg 3 – 5.*

In Sweden and Denmark, it was thought that the needs of people with an intellectual disability and a mental illness or challenging behaviour could be served through generic mental health services but this has proved to be a failure. Other countries (Holland and the United Kingdom), noting this failure, are turning to specialized services for this group.

Brad, C. (before 1998). *Current trends in services for persons with mental retardation and challenging behavior in Germany. National Association for the Dually Diagnosed (NADD) Newsletter.*

Care for people with both an intellectual disability and challenging behaviours is best delivered within a community system of care with specialized programs and staff with specialized competencies.

Dosen, A. (2002). *Mental health in mental retardation: Current developments and future challenges in Europe. The NADD Bulletin. Vol 5 #3.*

There are two distinct periods in the development of care for people with intellectual disabilities and mental health problems in Europe. The first period ('60s – '90s) tackled the question of how to distinguish challenging behaviours from the symptoms of a psychiatric disorder and then, how to apply existing diagnostic criteria (like the DSM or ICD) to people with intellectual disabilities. The second period ('90s – 2002), saw the development of an integrative diagnostic process that includes five parts: traditional psychiatric diagnosis, an assessment of the onset mechanism, a bio-psycho-social (including environment) assessment, a developmental assessment and the treatment plan.

Salvador-Carulla, L. (before 1998). *The assessment of services for the dually diagnosed (mental retardation and mental illness) in Spain. NADD Newsletter.*

Post deinstitutionalization, services for people with intellectual disabilities were divided between two ministries and thus administered and delivered very differently. In 1977, Spain transferred many such services to a regionalized model with 17 regions each developing its own mix of service delivery approaches, leading to even further confusion. In 1985, the reform of the mental health system did not mention the dually diagnosed at all.

Dosen, A. (1993). *Development for mental health care for persons with handicaps in Europe. NADD Newsletter. Vol 10 #6.*

In Sweden, it is viewed that caring for people with intellectual disabilities in special settings will lead to segregation and discrimination. Thus, those who are dually diagnosed were to be served by the general mental health system – where there were no specialized services or specialized knowledge among professionals.

¹⁸ The articles in this section were provided in hardcopy by Expert Panel member Bob King. Given that they were published in the early '90s, they are not available online. Some of the photocopies did not include the date of publication. Where dates could be determined, they have been included. Note that no NADD Newsletter articles before 1998 are available online – the time at which it was renamed the NADD Bulletin.

In the UK, intellectual disability is a psychiatric specialty and thus receives much more attention. However, post-deinstitutionalization, the philosophies of normalization and social integration kindled a debate as to whether people with dual diagnosis should be served by mainstream mental health services or by a system specially developed for their needs.

In the Netherlands, this debate has been settled and specialized services have been developed.

In Germany, there was a debate between educators and psychiatrists as to whether psychiatric problems were a result of organic brain damage or behaviours resulting from stressful environments.

In 1978 in Italy, all institutions for intellectually disabled children under 15 were closed and it was only in the '90s when adults with intellectual disabilities were permitted to be admitted to psychiatric hospitals. Care is seen as a matter for the family.

In Belgium and Switzerland, the central problem was how to move people with intellectual disabilities to the community. Here, there is also a struggle between psychiatrists and educators as to who should take the lead in care for people with dual diagnosis.

In Spain, there is a resistance to recognizing mental illness within people with intellectual disabilities because of the prominence of the defectology model (a term used in the education field) which focuses on learning and training to the neglect of possible illness.

Recent developments in Europe (including comments on the US and Australia)

Bouras, N. & Holt, G. Eds (2010). Mental health services for adults with intellectual disability. Psychology Press: NY, NY.

United Kingdom

Post deinstitutionalization in Britain, meeting the needs of people with dual diagnosis became difficult. The expectation was that general mental health programs would provide all services required but they lacked the funding and expertise to do so. In response, Community Learning/Intellectual Disability Teams were created. The teams had multiple functions including providing mental health services. However, the teams had so many duties that they had difficulty meeting their multi-fold mandate. They were also unlinked to general mental health services. As in other jurisdictions, challenging behaviours and mental illness were often confused.

On the positive side, the Mental Health in Learning Disabilities (MHILD) service was established in South East London along with the Estia Centre which provides research and training for all levels of staff. Further, the Royal College of Psychiatrists established a specialization in intellectual disabilities.

Ireland

Ireland has not yet closed its institutions but has established some community services. It has also established a National Intellectual Disability Data Base but does not track figures for dual diagnosis.

Netherlands

This country had a history of showing little interest in the mental health needs of people with intellectual disabilities. However, it has established a professorship in dual diagnosis at Radboud University and there is now much more training in the mental health needs of people with intellectual disabilities for many professions, including teachers. There has also been progress in cooperation between mental health and disability services.

Spain

Care for people with intellectual disabilities has moved from health to social and education ministries. There are complicated regulations to overcome, but some services for people with dual diagnosis are being implemented. Some of the individual jurisdictional plans have included mention of the needs of people with intellectual disability and mental health problems.

Australia

The process of deinstitutionalization split care for people with intellectual disabilities between health and social service ministries. The various mental health plans have identified dual diagnosis (although the latest – 4th - has not). Today, there are few specialized services and they are ad hoc. The Carter Report (mentioned in more detail under the section on Australia in this report) established a Centre for Excellence for Behaviour Support.

Hong Kong

Post deinstitutionalization, one of the two psychiatric hospitals in Hong Kong developed specialized services for people with dual diagnosis. Also, outpatient services have been developed. The Royal College of Psychiatrists has established a training program to develop expertise in dual diagnosis. The other psychiatric hospital (Castle Peak) has followed suit and opened its own unit for dual diagnosis.

United States (Rochester)

In 1989, a comprehensive community based set of services were established for dual diagnosis but since has run into funding problems. Managed care was a model that did not serve high needs people well. The few services that survived were helped to increase their capacity. The university medical centre recognized the need for training for staff serving people with intellectual disabilities and with dual diagnosis as well. A few strong advocates have continued to obtain some results, however there are ever increasing demands. The intellectual disability group, as a whole, is aging and their needs are increasing, and generic services continue to lack training. However, there have been some formal, and some informal collaborations that have formed and are working well.

United Nations

UN Convention on the Rights of Persons with Disabilities (UNCRPD) (2008). Available at:
<http://www.un.org/disabilities/default.asp?navid=14&pid=162>

Below is a summary of the Convention from the website:

- “Countries are to guarantee that persons with disabilities enjoy their inherent right to life on an equal basis with others (Article 10), ensure the equal rights and advancement of women and girls with disabilities (Article 6) and protect children with disabilities (Article 7).
- Children with disabilities shall have equal rights, shall not be separated from their parents against their will, except when the authorities determine that this is in the child’s best interests, and in no case shall be separated from their parents on the basis of a disability of either the child or the parents (Article 23).
- Countries are to recognize that all persons are equal before the law, to prohibit discrimination on the basis of disability and guarantee equal legal protection (Article 5).
- Countries are to ensure the equal right to own and inherit property, to control financial affairs and to have equal access to bank loans, credit and mortgages (Article 12). They are to ensure access to justice on an equal basis with others (Article 13), and make sure that persons with disabilities enjoy the right to liberty and security and are not deprived of their liberty unlawfully or arbitrarily (Article 14).
- Countries must protect the physical and mental integrity of persons with disabilities, just as for everyone else (Article 17), guarantee freedom from torture and from cruel, inhuman or degrading treatment or punishment, and prohibit medical or scientific experiments without the consent of the person concerned (Article 15).
- Laws and administrative measures must guarantee freedom from exploitation, violence and abuse. In case of abuse, States shall promote the recovery, rehabilitation and reintegration of the victim and investigate the abuse (Article 16).
- Persons with disabilities are not to be subjected to arbitrary or illegal interference with their privacy, family, home, correspondence or communication. The privacy of their personal, health and rehabilitation information is to be protected like that of others (Article 22).
- On the fundamental issue of accessibility (Article 9), the Convention requires countries to identify and eliminate obstacles and barriers and ensure that persons with disabilities can access their environment, transportation, public facilities and services, and information and communications technologies.
- Persons with disabilities must be able to live independently, to be included in the community, to choose where and with whom to live and to have access to in-home, residential and community support services (Article 19). Personal mobility and independence are to be fostered by facilitating affordable personal mobility, training in mobility skills and access to mobility aids, devices, assistive technologies and live assistance (Article 20).
- Countries recognize the right to an adequate standard of living and social protection; this includes public housing, services and assistance for disability-related needs, as well as assistance with disability-related expenses in case of poverty (Article 28).
- Countries are to promote access to information by providing information intended for the general public in accessible formats and technologies, by facilitating the use of Braille, sign language and other forms of communication and by encouraging the media and Internet providers to make on-line information available in accessible formats (Article 21).

- Discrimination relating to marriage, family and personal relations shall be eliminated. Persons with disabilities shall have the equal opportunity to experience parenthood, to marry and to found a family, to decide on the number and spacing of children, to have access to reproductive and family planning education and means, and to enjoy equal rights and responsibilities regarding guardianship, wardship, trusteeship and adoption of children (Article 23).
- States are to ensure equal access to primary and secondary education, vocational training, adult education and lifelong learning. Education is to employ the appropriate materials, techniques and forms of communication. Pupils with support needs are to receive support measures, and pupils who are blind, deaf and deaf-blind are to receive their education in the most appropriate modes of communication from teachers who are fluent in sign language and Braille. Education of persons with disabilities must foster their participation in society, their sense of dignity and self-worth and the development of their personality, abilities and creativity (Article 24).
- Persons with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability. They are to receive the same range, quality and standard of free or affordable health services as provided other persons, receive those health services needed because of their disabilities, and not to be discriminated against in the provision of health insurance
- To enable persons with disabilities to attain maximum independence and ability, countries are to provide comprehensive habilitation and rehabilitation services in the areas of health, employment and education (Article 26).
- Persons with disabilities have equal rights to work and gain a living. Countries are to prohibit discrimination in job-related matters, promote self-employment, entrepreneurship and starting one's own business, employ persons with disabilities in the public sector, promote their employment in the private sector, and ensure that they are provided with reasonable accommodation at work (Article 27).
- Countries are to ensure equal participation in political and public life, including the right to vote, to stand for elections and to hold office (Article 29).
- Countries are to promote participation in cultural life, recreation, leisure and sport by ensuring provision of television programs, films, theatre and cultural material in accessible formats, by making theatres, museums, cinemas and libraries accessible, and by guaranteeing that persons with disabilities have the opportunity to develop and utilize their creative potential not only for their own benefit, but also for the enrichment of society. Countries are to ensure their participation in mainstream and disability-specific sports (Article 30).
- Countries are to provide development assistance in efforts by developing countries to put into practice the Convention (Article 32).
- To ensure implementation and monitoring of the Convention, countries are to designate a focal point in the government and create a national mechanism to promote and monitor implementation (Article 33).
- A Committee on the Rights of Persons with Disabilities, made up of independent experts, will receive periodic reports from States parties on progress made in implementing the Convention (articles 34 to 39).
- In Article 18- Optional Protocol on Communications allows individuals and groups to petition the Committee on the Rights of Persons with Disabilities once all national recourse procedures have been exhausted.”

Press release (2010). State parties on Convention on the Rights of Persons with Disabilities.

Available at: <http://www.un.org/News/Press/docs//2010/hr5030.doc.htm>

So far, there are 146 signatories to the Convention and 90 ratifications but this represents less than half of all states. At the implementation level, there is a lack of expertise for planning and executing (for those states which have signed).

Note: Canada has not signed the Optional Protocol.

Information from the Canadian Association of Community Living on Canada's position on the UN Convention on Rights of Persons with Disabilities

To ascertain a deeper understanding of Canada's position, the researcher contacted the Canadian Association of Community Living (CACL) for their views. The CACL reported that Canada will not sign the Optional Protocol in its current form. The concern relates to the monitoring and reporting system that the protocol offers which is currently under review because it appears not to work well. It is not known when the review will be complete or if the changes will meet with Canada's approval. The CACL also communicated its present call to action regarding the Convention developed in partnership with the Council of Canadians with Disabilities (CCD).¹⁹ They are jointly asking for the establishment of a national advisory panel of national disability groups to explore how to move forward with the Convention and that parliamentary hearings be convened to hear testimony on the Convention from witnesses from the disability community.²⁰

Information from the Canadian Association of Community Living on establishing a Canadians with Disabilities Act

The CACL does not see advocacy for establishing a Canadian Act as a priority at present. It reasons that, given the jurisdictional divides in Canada among provinces and territories, such an Act would have less power than in other countries. Also, their colleagues in the US report that the Americans with Disabilities Act has been effective in obtaining improved physical access but less so on issues of inclusion. Promoting inclusion is a central mandate for the CACL.

World Health Organization

WHO Atlas: Global resources for persons with intellectual disabilities (2007). Available at: http://www.who.int/mental_health/evidence/atlas_id_2007.pdf

There is no world consensus on a term. Many are used.

- Developmental disabilities
- Intellectual disabilities
- Learning disabilities
- Mental deficiency, disability or handicap

¹⁹ Anna MacQuarrie email communication on April 4th and 5th, 2011

²⁰ CDC-CACL Joint Working Paper on the UN Convention on Rights of Persons with Disabilities. Available upon request from CACL.

- Mental retardation
- Mental subnormality

There are a number of different systems of classification used across different jurisdictions, including the International Classification of Disease (ICD), the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV), and the American Association on Intellectual and Developmental Disabilities (AAIDD) criteria.

The findings of the Atlas were:

- Resources and services for this group are often embedded in other fields,
- There is no consensus on definition, and
- There is low visibility of this group, thus low priority for government, professionals, and citizens.

United Kingdom

UK Mental Health Strategy: No health without mental health: A cross-government mental health outcomes strategy for people of all ages (2011). Available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

Highlights of the section of the plan dealing with people with learning disabilities (the UK term for intellectual disabilities) and mental health problems:

- 20 – 45% of people with learning disabilities also have mental health problems,
- Emphasis on accessibility – for all disability categories,
- Early intervention for people with learning disabilities for prevention of mental health problems, two aspects:
 - Inclusivity of people with learning disabilities in mainstream mental health services
 - Development of skills and adjusting how services are provided in order to meet the needs of people with learning disabilities and autism,
- Implementation of the autism strategy: *Fulfilling and Rewarding Lives and accompanying statutory guidance document: Fulfilling and Rewarding lives: Statutory guidance for local authorities and NHS organizations to support the implementation of the autism strategy* – both documents are designed to ensure that people with autism (who do not fit easily into categorizations of the mental health or learning disability systems) are not denied service. Specifically to:
 - Develop diagnostic services and pathways to care and support,
 - Make available mental health services for people with autism where needed, and
 - Increase awareness of autism among health and social service providers

(Pg. 60 and 61 of the document)

Disability and Equality Act (2010). Available at:

http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001068

The Act replaces the Disability Discrimination Act although many of the same provisions still apply.

Definition: In the Act, a person has a disability if:

- they have a physical or mental impairment
- the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities

The Act is also accompanied by guidelines to help courts and tribunals specifically define “disability” in different circumstances. It will be amended in 2011.

The Act provides legal rights for disabled people in the areas of:

- employment
- education
- access to goods, services and facilities including larger private clubs and land based transport services
- buying and renting land or property
- functions of public bodies, for example the issuing of licenses

Autism Act (2009). Available at: <http://www.legislation.gov.uk/ukpga/2009/15/contents>

The revised version is currently disabled on the website.

National Audit Office Report: Supporting people with autism through adulthood (2009). Available at:

<http://www.nao.org.uk/publications/0809/autism.aspx>.

This report states that it will “wholly transform the way public services are planned, commissioned and delivered” (pg. 7) for people with autism.

The plan calls for the following:

- Increased awareness and understanding of autism,
- Increased awareness and understanding specifically in the health, social services and employment advice service sectors,
- Increased awareness and understanding of autism among employers in relation to the recruitment and retention of disabled persons,

- Improved pathways to diagnosis through the National Institute for Health and Clinical Excellence (NICE) developed clinical guidelines,
- Build local capacity with local autism teams using models proven to work,
- Emphasize the duty to serve under the NHS and Community Care Act (1990) to ensure access to services for people with autism,
- Fully utilize the Disability Discrimination Act (1995) to ensure improved access to needed services. Available at: <http://www.legislation.gov.uk/ukpga/1995/50/contents>. Note: This Act has now been replaced by the Disability and Equality Act (2010),
- Improved social work services to smooth the transition from child to adult services,
- Modify employment, benefits, and tax credit systems so that more people obtain employment,
- Build on the Joint Strategic Needs Assessment (2007) (Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097), ensure that all local services make changes so they can serve people with autism better, and
- Appoint a government Minister as chair to oversee implementation.

Fulfilling and rewarding lives: The strategy for adults with autism in England (2010). Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369

This plan builds on the *Autism Act (2009)* and the *National Audit Office Report: Supporting people with autism through adulthood*. It specifies:

- Autism awareness training across government services and for employers,
- Early and accurate diagnosis
- The creation of specialized local autism teams,
- Improved access to health and social services and alterations to make those services more effective,
- Work preparation programs to move people with autism from social assistance to employment, and
- Building local capacity by asking the each area develop their own plans to ensure implementation.

The plan will be formally reviewed in 2013 to assess progress.

Greenlight for mental health Part A (a service improvement toolkit for providing mental health services for people with intellectual disabilities) and Part B (a self-audit survey), (2009). Available at: <http://www.cqc.org.uk/guidanceforprofessionals/nhstrusts/annualassessments/annualhealthcheck2005/06-2008/09/quali/bestpracticeinmentalhealthservicesforpeoplewithalearningdisabilitygreenlighttoolkit.cfm>

The Royal College of Psychiatrists.

The College includes a specialty training section on learning disability. The College's focus on this area of practice has made its understanding and response to dual diagnosis more prominent.

United States

Americans with Disabilities Act (1990). Available at: <http://www.ada.gov/pubs/ada.htm>

The Act's definition of disability is extensive but begins with the following (as amended in 2008):

The term "disability" means, with respect to an individual

- a physical or mental impairment that substantially limits one or more major life activities of such individual;
- a record of such an impairment; or
- being regarded as having such an impairment

The Act also defines the changes that must be made to ensure equitable access to public transportation, public services, employment (including accommodation), housing and services operated privately (hotels and airlines, for example), and telecommunication devices.

Olmstead v L. C. 527 U. S. 581 (1999). Available at: <http://law.onecle.com/ussc/527/527us582.html>

The Americans with Disabilities Act has been clarified through a number of court challenges. The Olmstead ruling stated that undue institutionalization qualifies as discrimination.

US Department of Health & Human Services: Georgia Olmstead Agreement (Jan 15 2009) – Summary. Available at: <http://www.hhs.gov/ocr/civilrights/activities/agreements/georgiasummary.html>

The Olmstead ruling has had considerable consequences. In a test case, the U. S. Department of Justice obtained a judgment against the state of Georgia that specified that state psychiatric hospitals had five years to discharge people with a primary diagnosis of developmental disability to community settings. The judgment specifies exactly what services have to be developed and what the mechanisms for quality assurance will be. It charges the developmental disability and the mental health services sectors jointly with the responsibility of creating, implementing and managing these services. The specified services for people with a developmental disability and a serious and persistent mental illness include:

- Assertive Community Treatment (ACT) teams

- Community support teams
- Intensive case management
- General case management
- Crisis services including crisis stabilization programs, a crisis line, mobile crisis teams, crisis apartments, and access to psychiatric beds in community hospitals,
- Housing supports.

Georgia will receive \$44 M from the federal government to establish these services.

Communication (Joan Beasley) (March 2011): All states are watching this judgment closely. The federal government (through the home and community based waiver program of Medicaid) has a 50 -50 cost-sharing program to bring states in line with the Georgia provisions. Georgia, itself, received a larger allocation than simply cost sharing because it did not have many waiver services to use for funding (as is the case with many states).

Australia

Disability Discrimination Act (1992). Available at:

http://www.hreoc.gov.au/disability_rights/dda_guide/dda_guide.htm

The Act is administered under the Australian Human Rights Commission.

Definition of discrimination: “Disability discrimination happens when people with a disability are treated less fairly than people without a disability. Disability discrimination also occurs when people are treated less fairly because they are relatives, friends, carers, co-workers or associates of a person with a disability.”

The definition of disability for the purposes of the DDA is

- total or partial loss of the person's bodily or mental functions
- total or partial loss of a part of the body
- the presence in the body of organisms causing disease or illness
- the presence in the body of organisms capable of causing disease or illness
- the malfunction, malformation or disfigurement of a part of the person's body
- a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction
- a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.

Note that the Act includes temporary disability in its mandate. .

The categories of disability covered are mental/psychiatric, physical, sensory and intellectual disabilities.

The Act makes it illegal to discriminate against person with a disability in the areas of employment, education, access to premises, provision of goods and services, accommodation, buying land, activities of clubs and associations, sport, or in the administration of government laws and programs.

The law also states that the associates (friends, family members and carers or someone in a business, sporting or recreational relationship) of people with disabilities are to be protected from acts of discrimination.

Patmore, G. (2005). The Disability Discrimination Act (Australia): Time for change. Available at: http://www.law.illinois.edu/publications/cllpj/archive/vol_24/issue_4/PatmoreArticle24-4.pdf

A 2003 review of the Act (Review of the Disability Discrimination Act 1992) recommended no amendments but noted that it had been least effective in addressing discrimination in employment.

National Mental Health Consumer and Carer Forum (Jan 2010). Issue: Intellectual/developmental disability and mental health. Available at: <http://www.nmhccf.org.au/documents/Mental%20Illness%20and%20Intellectual%20Disability%20shorter%20revised%20draft.pdf>

This report describes the problems faced when attempting to access care:

- Psychiatrists report that they don't have the proper training to help.
- There are limited opportunities for all clinicians to obtain appropriate training.
- There is no proven mental illness diagnostic tool in Australia for people with intellectual disabilities.
- There are many barriers to access to mental health services and in navigating multiple service systems that are disconnected and hard to find.
- There is a tendency to see mental illness only in terms of challenging behaviours and then, to over-medicate.

Council of Australian Governments. National Action Plan on Mental Health 2006 – 2011. Available at: http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf

The plan calls for additional investment in respite care for families caring for people with a mental illness or an intellectual disability, the establishment of an intensive treatment and support program for those with dual disability (intellectual disability and a mental illness) by 2006, and the development of inreach services into prisons for those with either a mental illness or a developmental disability.

Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009 – 2014. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09>

“... a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.”

Reference is made to intellectual disability but only to point out that mental illness is more common in this group than the general population. There is no accompanying action plan.

The Second National Mental Health Plan is available at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-s-plan2>

The Third National Mental Health Plan is available at:

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-plan03>

National Mental Health Council (NMHC) (Feb 2011). Press release: Council of Australian Governments (COAG) paves way for mental health reform. Available at:

<http://www.mhca.org.au/MediaReleases/2011/CoAG%20paves%20way%20for%20reform.pdf>

No mention of concerns for people with intellectual disability and a mental illness.

Standing Committee on Community Affairs (Sept 2008). Towards recovery: Mental Health Services in Australia. Available at:

http://www.aph.gov.au/senate/committee/clac_ctte/mental_health/report/report.pdf

This report restates the commitment from the National Action Plan (as above) to establish an intensive treatment and support program for those with dual disability (intellectual disability and a mental illness), except the new date is by 2008.

Carter, W. J. QC (July 2006). Challenging behaviours and disability: A targeted response. Available at:

<http://www.communities.qld.gov.au/resources/disability/publication/positive-futures-investing-in-positive-futures-full-report.pdf>

A panel was convened to review the community care provisions for people with a developmental disability and challenging behaviours that put themselves or others at risk. The report offered 24 recommendations. The Queensland government's response was to provide \$113 M over four years to establish a centre of excellence with specialized services, purpose-built accommodation and 118 new staff positions. The Centre of Excellence for Behaviour Support was established at the University of Queensland's Ipswich campus. As part of its programming, the Centre includes a mental health outreach team. More information is available at: <http://www.communities.qld.gov.au/disability/key-projects/positive-futures/a-centre-of-excellence-for-behaviour-support>

Because mental health matters: Victorian mental health reform strategy 2009 – 2019. Available at:

http://www.health.vic.gov.au/mentalhealth/reformstrategy/documents/mhs_web.pdf

The document refers to the needs of people with co-existing disabilities, specifically defined as a mental illness in combination with intellectual disability, acquired brain injury or autism spectrum disorders or referred to as "people with other complex needs." The needs of people with a mental illness and intellectual disability are not dealt with separately.

Note that the body of the report offers a more expanded (and sometimes quite different) version of the reform descriptions as summarized at the beginning of the report. The following quotes are from the summary section (pg 13) but in the expanded version, the report makes it clear that these goals are referring to people with a mental illness in combination with an intellectual disability, acquired brain injury or autism spectrum disorder.

Reform Area 5, Participation in the Community - Goal 5.4 states:

“Explicitly consider the needs of people with mental illness, alongside people with other complex needs, as part of the planning and allocation of new and existing social housing, including that provided by Housing Associations, and new housing and support models.”

Reform Area 6, reducing inequalities - Goal 6.2

“Strengthen the capacity of mental health, disability and primary health services to identify, assess and treat people with a mental illness and co-existing disability by improving secondary consultation and creating a ‘no wrong door’ approach to the needs of this group.”

Commonwealth of Australia (2010). National standards for mental health. Available at:
[http://www.health.gov.au/internet/main/publishing.nsf/content/DA71C0838BA6411BCA2577A0001AAC32/\\$File/servst10v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/DA71C0838BA6411BCA2577A0001AAC32/$File/servst10v2.pdf)

In these standards, intellectual disability is referred to twice - categorized under “diversity” and under the needs of carers.

Standard 4: Diversity responsiveness

4.1 “The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.” (pg. 12)

Standard 7: Carers

“The MHS considers the needs of carers in relation to Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.” (pg. 16)

Commonwealth of Australia (2010). Implementation guidelines for public mental health services and private hospitals. Available at:
[http://www.health.gov.au/internet/main/publishing.nsf/content/B03A8ECFA52D3A53CA2577F9007DE3B8/\\$File/public.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B03A8ECFA52D3A53CA2577F9007DE3B8/$File/public.pdf)

This document accompanies the National standards for mental health document above.

10.2 Access

Identified needs (Criterion 10.2.1)

“The MHS needs to pay particular attention to the diversity of its consumers including Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age, legal status and socio-economic status.” (pg. 53)

10.3 Entry

Documented entry policy and process (Criterion 10.3.1)

“The MHS should have a documented entry policy and procedure which includes:

- the system of on call, entry and assessment
- how to ensure the needs of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons are met and that religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status are addressed in the entry process.” (pg. 54)

10.5 Treatment and support

Treatment and services (Criterion 10.5.2)

“Treatment options need to address Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, and take into account religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.” (pg. 62)

Memorandum of understanding: Between ageing, disability and home care, Department of Human Services and NSW Health in the provision of services to people with an intellectual disability and a mental illness (2010). Available at:

http://www.health.nsw.gov.au/pubs/2010/pdf/mouandguidelines_disabili.pdf

This document commits the disability and the mental health sectors, as well as relevant services provided publicly, privately and by non-government organizations, to working collaboratively to meet the needs of people with dual diagnosis. As an example:

3.2.1 “People with an intellectual disability and a mental illness have the same rights to access the full range of services provided by the NSW Government as other citizens.” (pg. 7)

Canada

Public Policy in a Federal System – the Canadian Experience In draft and not yet published.

The provision of health services in Canada is guided by the Canada Health Act but delivery is the sole responsibility of 10 provinces and three territories. Recent research (as reported in this paper) has found, as expected, that legislation concerning people with developmental disabilities is limited to four provinces with the rest having partial or no legislation at all specific to developmental disabilities. Those with legislation have defined developmental disability. While all provinces and territories have mental health acts, only five refer to developmental disability and then to describe it as an exclusionary criterion. No provinces or territories reference dual diagnosis in their legislation (where it exists), with only British Columbia, Ontario and Quebec having specific policies related to dual diagnosis. (Personal communication S. Morris, May, 2011)

Canadian Association for Community Living National Report Card on Inclusion (2010). Available at: http://www.cacl.ca/english/documents/ReportCards/REPORT_CARD_2010_ENG_web.pdf

The report card examines a number of life dimensions for people with intellectual disabilities (ID). For example, overall, 95% of children with ID are attending kindergarten or school. Within schools that are deemed “high inclusion,” the vast majority of parents (95%) feel their child is welcomed. Seventy percent of those who complete post-secondary education go on to secure employment. Nonetheless, 36% of children with ID report being assaulted at school or on the school bus, 41% report feeling threatened at school and 52% of young adults are neither working nor at school.

The report concludes that, overall, there are still numerous problems. Canadian adults with ID are three times more likely to live in poverty, almost 50% adults with ID are on social assistance and their employment rates are 1/3 of the general population.

The report does not mention the health or mental health concerns of people with intellectual disabilities.

The Mental Health Commission of Canada (2011). Draft mental health strategy. Available at: <http://www.mentalhealthcommission.ca/English/Pages/Strategy.aspx>

The Canadian strategy has been in development for two years. Presently, it has defined seven goals with eight strategic directions (five of which are considered strategic with the final three related to capacity building). The completed strategy document was not published at the time of this writing.

Seven goals:

1. People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
3. The mental health system responds to the diverse needs of all people living in Canada.

4. The role of families in promoting well-being and providing care is recognized, and their needs are supported.
5. People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs.
6. Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
7. People living with mental health problems and illnesses are fully included as valued members of society.

Eight strategic directions:

1. Increasing the opportunity for all people living in Canada to enjoy the best possible mental health
2. Actively engaging people living with mental health problems and illnesses and their families in decision-making
3. Improving pathways to recovery and well-being
4. Building welcoming communities and supportive environments
5. Seeking innovation with First Nations, Inuit and Métis to advance mental health
6. Funding transformation
7. Building infrastructure
8. Mobilizing leadership

The Commission generally uses the term 'complex' to refer to individuals with more than one problem. At this stage of development, it is unclear where dual diagnosis would be best placed – or if it will be referenced at all in the final strategy. Note: An earlier strategy document from the Commission, *Toward recovery and well-being: A framework for mental health strategy in Canada (2009)* mentioned dual diagnosis. Available at: <http://www.mentalhealthcommission.ca/English/Pages/Strategy.aspx>

Specifically, the document stated:

a) Target audience

“Similarly, people with... developmental disabilities, learning disabilities, dementia or autism may also experience mental health problems or illnesses” (pg. 12)

- b) “In a transformed system, people who have multiple and complex MH needs-such as mental health problems in combination with addictions, learning disabilities, chronic diseases or developmental delays – will have all their needs met in an holistic, coordinated fashion. No longer will they risk falling through the cracks while being passed from one type of service to another.” (p. 75)

Also, the Mental Health and the Law Advisory Committee of the Mental Health Commission passed a resolution regarding the discrimination that persons with a dual diagnosis experience. It takes the form of inequitable access to services and supports and also unfair legislation and policy. The Committee recommended that the commission include the unique mental health needs of persons with dual diagnosis as a part of their obligations to ensure equality and social inclusion; and that the needs for treatment, support and legislation are incorporated within the mental health strategy for Canada.

Ontario Ministry of Health and Long Term Care and the Ministry of Community and Social Services (Dec 2008). Joint policy guidelines for the provision of community mental health and developmental services for adults with dual diagnosis. Available at:

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

This Ontario policy describes the joint roles and functions of those who fund or deliver mental health and developmental services at both the Ministry and local levels. It provides for the establishment of Community Care Networks of Specialized Care whose mandate is to improve access for people with dual diagnosis, enhance service delivery and train and build capacity in the system.

Healthy minds, healthy people: A ten year plan to address mental health and substance use in BC. (Nov 2010) Available at:

http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

The policy promises the following actions:

- “By 2012, approximately 350 adults with neuro-developmental disorders such as Fetal Alcohol Syndrome or Pervasive Development Disorder (Autism Spectrum Disorder) will receive appropriate community personal supports.
- By 2011, an evaluation framework to examine the impact of the youth transition planning protocol will be developed.
- Models for integrated community-based treatment services for people with mental illness and/or problematic substance use and developmental disabilities will be developed by 2013.
- By 2013, service protocols, guidelines and tools will be available to ensure that youth and adults with a mental illness and/or problematic substance use who are in contact with the criminal and youth justice system have access to appropriate transition and support services.” (pg. 38)

The Cross-ministry Transition Planning Protocol for Youth with Special Needs (2009). Available at:
http://www.mcf.gov.bc.ca/spec_needs/pdf/transition_planning_protocol.pdf

The above ten-year plan promises also to implement this protocol which, among many other things, allows for better access to adult community mental health and addiction services for youth with dual diagnosis transitioning to the adult care system (see pg. 11).

