Best Practices in Providing Specialized Mental Health Services to Individuals with a Dual Diagnosis

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Tara-Ann Glasow and Irene Carter

Introduction

This study explores the views of service providers regarding best practices for clients with a dual diagnosis at the agency, community, and inter-organizational levels in Middlesex County, Ontario, which includes the City of London. In Ontario, the term 'dual diagnosis' refers to a concurrent diagnosis of a mental illness and a developmental disability (Owen & MacFarland, 2002). This paper identifies various existing types of treatment for individuals with a dual diagnosis. It notes the current lack of integration (National Association of Dual Diagnosis [NADD], 2004) between agencies in the provision of services and aims to address the need for a specialized model of care.

Literature Review

Mental illness affects about 1 in 5 Canadians of all ages, races, genders, socio-economic, and educational levels (Health Canada, 2002). Causes result from an intricate combination of genetic, biological, personality, and environmental conditions. A medical doctor or psychologist identifies a diagnosis using criteria found in the *Diagnostic & Statistical Manual of Mental Disorders 4th edition [DSM-IV] (*American Psychiatric Association*, 1994).*

Researchers first began to believe that individuals with developmental disabilities could also have a mental illness in the 1970s (Bongiorno, 1996). In Ontario, Morris (2003) estimates that 38% of the 2.25% of the population with a developmental disability also has a mental health disa-

bility. Hassiotis (2002) estimates that 14.4% of adults with a mild to moderate developmental disability also have a mental disorder, a percentage that is in line with that of the general population. Literature suggests 33 to 49% of individuals with intellectual disabilities who access developmental services also have a diagnosis of a mental health disorder (Goldfarb & Frankel, 2007). Misdiagnosis (Bradley & Burke, 2002), varying definitions, and the exclusion of certain psychiatric disorders such as dementia or behavioural disorders (Canadian Mental Health Association [CMHA], 1998) result in inaccurate reporting of individuals with a dual diagnosis (Jopp & Keys, 2001). Clinicians often overlook symptoms, especially if individuals are non-verbal or have low cognition levels (Bradley & Burke, year?), pointing to the need to improve criteria regarding the diagnosis of a mental disorder among individuals with developmental disabilities.

Stigma is "the most formidable obstacle to future progress in the arena of mental illness and health" (Perlick, 2001, p. 1613). It results in systemic oppression (Thompson, 2006) that increases with multiple disabilities (Encinares & Golea, 2005). It affects the ability to care for one's self, achieve an education, secure housing, or uphold a full-time job (Corrigan, Watson, & Ottati, 2003).

Before the 1800s, those with mental disorders were often banished from their communities, jailed, chained, unkempt, and malnourished (Johnston, 2000). With renewed hope that psychiatric interventions might cure mental disorders, large medical institutions emerged throughout North America in the 20th century that housed and treated those with mental disorders (Mohr, 1998). As success rates for treatments were poor and

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patients showed little improvement, institutions eventually took on more of a custodial role.

Movement towards community-based treatment in North America began in the 1950s and 1960s when policy-makers became increasingly aware of the costs, substandard living conditions, and the inadequate level of care in psychiatric institutions. With the discovery of more effective psychotropic drugs, care providers adopted the strategy of providing community-based treatment. However, the specialized treatment needs of this population exceeded available government resources (Joint Developmental Services Sector Partnership Table, 2004). Thus, deinstitutionalization occurred without the provision of adequate supports, resulting only in modest benefits. Due to poverty, those discharged from hospital commonly secured substandard housing, which led to a worsening of their mental health condition, resulting in readmission to institutionalized care (CMHA, 1998; CMHA-Ontario Division, 2008).

Mental health organizations tend to exclude those with dual diagnoses based on the assumption that individuals with cognitive impairments do not benefit from therapy. Supporting individuals with a dual diagnosis in the community requires a continuing examination of the results of services designed to keep individuals within the community (Morrison, 2004). For example, to correct ineffective responses by the criminal justice system (Heerema, 2005), the Ministry of Health and Long Term Care (MOHLTC) identified mental health diversion and court support programs as hopeful strategies in improving outcomes by providing community support services, treatment, and probation for minor offences (MOHLTC, 2006).

Service Delivery for Individuals with a Dual Diagnosis

Canada assigns responsibility for health care to the provinces. Until 1974, the Federal government assigned developmental disability and mental health services to the MOHLTC. The *Developmental Services Act* (1990) created a separation in responsibility for services. Then, the Ministry of Community and Social Services (MCSS) assumed management of developmental disability programs, residential and vocational services, and the MOHLTC retained responsibility for mental health services. This fragmented service delivery model led to increasingly inadequate services and a poor quality of life for individuals with dual diagnoses, as they tended to fall between the cracks of both systems. Since 1988, with the publication of *The Graham Report* (MOHLTC, 1988), the MOHLTC began to prioritize their focus on this specific population (MOHLTC, 1988). Later, several mental health reform reports also promoted the needs of the dually diagnosed (Kirby, 2006; MOHLTC, 1999a). However, mental health service providers failed to develop formal evidence-based care guidelines for individuals with a dual diagnosis.

In the early 2000s, the government of Ontario engaged in mental health reform, resulting in rapid, frequent changes, which impacted both service providers and clients. The Ministry of Community and Social Services (MCSS; 2008) moved ahead with forming four Community Networks of Specialized Care across Ontario. Each network, which consists of professionals which can include, behavioural therapists, social workers, psychologists, and nurses, work collaboratively in assessing, diagnosing, and treating adults with developmental disabilities. These teams work closely with various community agencies, both from developmental services and the mental health system to improve specialized services for the dual diagnosis population. At the same time, *The Local Health System Integration Act* (2006) legitimated the MOHLTC's 14 Local Health Integration Networks (LHINs) which are organized across the province of Ontario. In April 2007, each LHIN assumed responsibility for 100% of their region's healthcare dollars, including decisions related to which areas would offer mental health and addiction services. MOHLTC focused on improving service delivery, being patient-centered, providing accountable, quality management, and showing favourable outcome measures. Teams from both the MCSS and MOHLTC now strive to work closely with community agencies

to improve specialized services for the dual diagnosis population (MOHLTC & MCSS, 2008).

Out-Patient Treatment Models

There are two main examples of treatment models for those with a dual diagnosis. The first is pharmacological treatment, which stresses the importance of psychoactive medication such as antipsychotics and/or antidepressants in treating and managing behaviour. Keeping individuals on the lowest effective dose of psychoactive medication and ensuring administration outweighs the risks reflects best practice (Holden & Gitlesen, 2004). The second model, the approach on which this paper focuses, is a specialized therapeutic model, which applies interventions from various theoretical approaches, such as interdisciplinary community treatment, psychotherapy, and cognitive-behavioural interventions (MOHLTC, 1999a).

Specialized treatment refers to specifically developed mental health programs, provided in the community and/or hospital setting, that target those with serious mental illness that is often complex and unstable (Kirby, 2006). Specialized treatments are conducted by interdisciplinary teams and are comprised of rehabilitation and support services to assist those living in the community. As the needs of individuals change, so do the levels of support, necessitating continual monitoring and reassessment. Common themes regarding outpatient specialized treatment interventions include models of community-based treatments, psychotherapy, cognitive-behavioural therapies, and substance abuse treatments.

Community-based treatment interventions provided simultaneously in the community (Rosen, Mueser, & Teesson, 2007) include modalities such as outreach teams, assertive community treatment, case management, and residential care (Cochrane, Goering, Durbin, Butterill, Dumas, & Wasylenki, 2000). Community-based treatment interventions use a strengths-based approach, working to reduce social isolation and promote empowerment, and they focus upon client skills and competencies, as opposed to limita-

tions. The constructive use of leisure time is an important component, often resulting in positive outcomes and decreases in challenging behaviours (Hassiotis, 2002). However, Nottestad and Linaker (1999) found excessively structured activities to be "tiresome" and to contribute inadvertently to "an increased frequency of behavioural problems" (p. 528). To maximize successful outcomes, Hassiotis also recommends the use of crisis intervention services. The community-based treatment model is consistent with MOHLTC's best practice principles regarding client-centeredness, promoting a client's choice in service provision and involving family members, as well as other care partners in the treatment plan (Kirby, 2006; MOHLTC, 1999a, 1999b).

Psychotherapy focuses on the internal or unconscious developmental thoughts and feelings of clients, and aims to help them move towards the goal of self-actualization. The results of psychosocial interventions typically impact positively on clients with a dual diagnosis (Bond, Drake, Mueser, & Latimer, 2001). The continued absence of group psychotherapy as a treatment option is likely the result of a sustained belief, within the field of mental health, that the dually diagnosed lack the necessary cognitive abilities to benefit from group psychotherapy (Taylor, 2005). This long-standing professional stance limits this population's opportunities for developing self-confidence and mental well-being.

Cognitive-behavioural therapy promotes positive behaviours using a system of rewards and punishments. As such, it aims to modify underlying motivations or thought processes that evoke certain negative behaviours such as self-harm or violence. Cognitive-behavioural therapy reduces symptom relapses and re-hospitalizations, as well as the severity of symptoms when accompanied by training on coping skills (Mueser, Corrigan, Hilton, Tanzman, Schaub, & Gingerich, 2002). Gaining prominence and replacing older methods of behavioural modification is the technique of positive behavior support. This method focuses on "relationship and instruction" rather than "consequence and punishment" (Bongiorno, 1996, p. 4), as well as the use of behavioural as-

sessments. Cognitive behavioural therapy is typically not indicated for individuals with a dual diagnosis because of the below-average mental capacities of this client population (Hemmings, 2006), despite the identification of its useful approaches to treat individuals with dual diagnosis.

Philips (2006) indicates that the prevalence of problem substance use in the dually diagnosed population with mild to moderate developmental disabilities is comparable to that of the general population. Promising results are predicted with the use of integrated treatment models that reflect the need for "comprehensive, including assertive outreach, case management, and stage-wise, motivational interventions for substance abuse" (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998, p. 5). Although best practice guidelines recognize the importance of harm reduction models in the recovery process (Health Canada, 2001), professionals often use an abstinence-based approach for those with a dual diagnosis (Degenhardt, 2000). Following a detoxification program, effective interventions involve social and environmental therapies which are comprised of goal setting, social skills training components, and psychotherapies, adapted to cognitive ability (Stavrakaki, 2002).

Best practice refers to the delivery of treatment based on information about effective practices. To avoid difficulties in implementation, those adopting best practices must consider the nature of the evidence and the environment, as well as experiential knowledge. For best practices to remain responsive to the needs of the dual diagnosis population, they must include a broad evidence base and be subject to continuing critique.

Methods

The researchers used the accepted procedures and techniques found in qualitative research (Bryman, 2004) to explore the experiences of professionals with regard to the identification and implementation of best practices in providing services to individuals with a dual diagnosis. The researchers aimed to understand the participants' experience from their perspective (Holosko, 2010), depending on the subjective interpretations of par-

ticular people in a specific social setting. They used descriptive data to present findings explored in the social context through which individuals subjectively ascribe meaning and understanding to their lives. Consistent with this method, the study involved developing general research questions, selecting relevant sites and participants, incorporating appropriate literature, collecting and interpreting pertinent data, and writing up the findings.

Research Questions

The essence of this study is captured by the following research question: What are the views of service providers about best practices for dual diagnosis clients at the agency, community, and inter-organizational levels in the City of London and Middlesex County? Other research questions include the following:

- What are the views of service providers in London and Middlesex County regarding the prevalence of dual diagnosis clients in their caseloads?

- What is the extent of collaboration between community agencies in providing mental health services for clients with a dual diagnosis?

- What are the existing gaps in London and Middlesex County in serving this population?

- What are the views about best practices with this population among service providers in London and Middlesex County?

- What are the current models of care used in London and Middlesex County in treating this population?

Sample and Interview Schedule

This study focused its interviews on health service providers from London and Middlesex County and, as such, is specific to this locale. The region of London and Middlesex County is locat-

ed halfway between Windsor and Toronto, Ontario. The geographic area is 2,233.37 square kilometers, with a metropolitan population of 477,600 (Statistics Canada, 2006). The area of London and Middlesex County is well known for its medical facilities and healthcare programs. The Department of Psychiatry, University of Western Ontario in London houses one of the few developmental disabilities divisions within Canada.

Personal contacts and snowball techniques were used to locate participants. Volunteer participants (N=14) selected for interviews were from various collateral agencies; for example, London Community Living, Canadian Mental Health Association, Regional Support Associates, WOTCH Community Mental Health Services, and the Strathroy Assertive Community Treatment Team. Participants met the inclusionary criteria of frontline managers and senior administrators who had worked in London and Middlesex County with this population for at least three years. The locations for the semi-structured interviews took place either at the participants' host organization or another preferred location, as named by the participant. Each face-to-face, audio-taped interview was about one-hour in length and was subsequently transcribed by an independent party.

Interviews were initiated after approval from the London-Middlesex County Dual Diagnosis Committee and final clearance from the University of Windsor Research Ethics Board. The interview used the following open-ended questions:

- Does your organization provide services to clients with dual diagnosis disorders?

- How many individuals do you serve in programs for clients with dual diagnosis disorders?

- What do you believe is the ideal/best practices approach to the delivery of services for clients with dual diagnosis disorders?

- Besides in-patient services, what model of treatment do you think inpatient facilities should use in the delivery of outpatient/ outreach services for these clients?

- How would you describe the relationship that your organization has with inpatient facilities?

- What do you believe would be the ideal linkage that your organization should have with inpatient facilities?

Coding and Developing Themes

Often qualitative researchers conclude their studies by identifying major themes that arise from their data. Theme development occurred in this study while creating research questions, conducting participant interviews, identifying ideas, creating codes, and categories. An analysis of the gathered data initially involved the first step of line by line analysis in the process of identifying concepts of information, termed codes. Groups of similar concepts became identified as a code and groups of codes resulted in the identification of categories. Creswell (2003) points out that in open coding, the researcher "forms initial categories of information about the phenomenon being studied by segmenting information" (p. 57). Reflecting on the data collected, 30 categories of codes surfaced as relevant to this study. Then, the researcher encouraged theme development, while reducing the possibility of biased results, by aligning the categories with each of the five main research questions.

Trustworthiness

To further strengthen the study's findings, a systematic review of best practice literature, as well as relevant government and program documents were used to supplement responses from the participants. Audio-taping participant responses, instead of detailed field notes, increased the accuracy of collected data. Audio taping interviews also allowed the researcher to remain a more attentive listener and focus on the exchange of information taking place (Patton, 2002). Transcribed interviews provide data which is less likely to contain errors, omissions, or misinterpretations. Conducting member checks further im-

proved the trustworthiness of this study. Five of the participants provided confirmation by verifying the conclusions made by the researcher. They agreed with the interpretation of the findings, and found the challenges and issues to be reflective of current practices.

Findings

Fourteen participants took part in 11 interviews, as three participants asked permission to allow a colleague to sit in on the interview. Fifty-seven percent of participants were from mental health organizations and 43% were from the field of development disabilities; 36% were male and 64% were female. All participants, except one, who was a coordinator, held management or senior administrative positions. Their formal titles included Manager, 36%; Coordinator, 29%; Director, 21%; and Supervisor, 7%. The study did not seek educational credentials; however, most informants commented on their post-secondary education, their leadership in the community, and their involvement in local planning and networking groups. Each participant confirmed that they had at least three years of experience working with individuals with a dual diagnosis. None of the participants identified any specific cultural or ethnic affiliations. Participants ranged in estimated age between 32 years to 58 years, and most fell between the ages of 35 and 45 years. In summary, participants represented well-trained, knowledgeable, and seemingly committed members of the selected geographic community who worked with clients with a dual diagnosis.

Three main themes, Service Delivery, Barriers to Mental Health Services, and Identifying Best Practices emerged from data, as listed below:

Main Theme 1: Service Delivery
  Category 1: Prevalence
  Category 2: Housing and Supports
  Category 3: Social Recreation and Vocational
               Activities
  Category 4: System Navigation
  Category 5: Specialized Programs
  Category 6: Community Support Services
  Category 7: Advocacy

  Category 8: Training and Education
  Category 9:   Special Initiatives
  Category 10: Alliances with Other Service Pro-
               viders
  Category 11: Primary Care
  Category 12: Emergency Services
  Category 13: Information and Referral Services
  Category 14: Financial Support Services

Main Theme 2: Barriers to Mental Health Ser-
                vices
  Category 15: Unaware of Community Resources
  Category 16: Lack of Expertise
  Category 17: Stigma
  Category 18: Issues with Diagnosing Dually
               Diagnosed
  Category 19: Service Gaps
  Category 20: Accessibility
  Category 21: Service Capacity
  Category 22: Issues between Ministries
  Category 23: Implications with In-Patient Ser-
               vices

Main Theme 3: Identifying Best Practices
  Category 24: Person-Centered
  Category 25: Specialized Services
  Category 26: Community-Based
  Category 27: Responsive Services
  Category 28: Sharing Knowledge
  Category 29: Coordinating Services
  Category 30: Advocating for Change

Main Theme 1: Service Delivery

Participants identified the types of services offered within the community for those with a dual diagnosis as direct service provision, indirect service provision, and other community resources. Few participants could provide specific numbers regarding how many clients they served with a dual diagnosis. Prevalence varied, depending on the degree of disability and whether there was a confirmed diagnosis. Further, inappropriate assessment tools and reliance on self-reporting measures, despite the fact that many individuals with a moderate to severe dual diagnosis have little to no ability to speak, contributed to varying reports on prevalence.

Housing for the dually diagnosed, as portrayed by most participants, included rehabilitation housing, staffed twenty-four hours a day, to semi-independent group homes and various housing initiatives, located in residential areas. A severe disability resulted in a more supportive housing environment, such as a group home with 24-hour staffing. Moreover, most participants recognized the complexities of customizing service for those with a dual diagnosis, pointing out that activities are an important part of a treatment plan in terms of achieving community integration, as noted in the following quotation:

> Their needs are too high. So in order for us to take these people with the expectation of them fitting into the typical day program it's not going work…we find out what things they enjoy doing and participating in, then, we make sure that we plan accordingly …

Participants agreed accessing services in the current health system can be challenging for those with a dual diagnosis and their families. They identified access and the ability to navigate the system as important. They further suggested that services should be offered through a coordinated central intake agency for clients in need of significant levels of services who were making the transition from the hospital to the community. Most participants described how other programs, not specifically designed for the specialized needs of people with a dual diagnosis, consistently made accommodations for this population. These included hospital admission, outpatient hospital services, mental health outreach and crisis services, multidisciplinary consultation services, chemical treatment, and developmental disability services. Community support services included various short and long-term case management services, composed of teams of professionals and intensive support services. For example, one participant noted:

> … we're a service community treatment team…that provides an integrated approach to people with mental illness, … dual diagnosis, and concurrent disorders. We have registered nurses which

work with occupational therapists, vocational specialists, therapeutic recreationists. Some teams have addiction specialists and a psychiatrist…

Indirect service provision applies more to the nature of relationships between agencies and the work they undertake to ensure quality services for those with a dual diagnosis. Participants spoke of advocacy for dually diagnosed clients as necessary on micro, mezzo, and macro levels to ensure that clients received the necessary care, housing, and financial support. They stressed that improving services entails training and education for professionals, as evident in the following quotation:

> The one thing that I see down the road is my staff getting educated from the health sector in everything to do with mental health, and the mental health staff getting educated by my people with regard to developmental disabilities. I think we've started to do that cross training between the two.

Participants described agencies as holding in-service training or providing cross-training for staff, and searching post-secondary institutions for relevant courses. The MCSS (2008) supported education by setting up special initiatives, such as Specialized Networks of Care and teleconferencing, allowing participants to share areas of expertise. The MOHLTC (2007) has also worked on special initiatives, helping service providers with e-health initiatives to improve the flow of health information. Describing the benefits of alliances with other service providers, most participants pictured how organizations work in various capacities with one another in linking clients with a dual diagnosis to suitable services. Although common strategies for sharing expertise included case conferences and committee membership, participants recommended the need for improvement and expansion of methods of sharing expertise.

Reflecting on other community services, most participants pointed out that the overt nature of mental and behavioural symptoms often resulted

in the neglect of physical health. Participants recommended that professionals remain cognizant of the fact that individuals with a dual diagnosis are often not able to voice concerns about their health. Many participants mentioned that they used community emergency services such as hospital emergency rooms as a means of getting individuals immediate medical care. Other participants commented positively about their relationships with local police and the use of the mental health court as an effective means of keeping individuals with a dual diagnosis out of the criminal justice system. Other participants noted how several agencies are taking a leading role in providing information and referral services to clients and their families.

Participants stressed income for the dually diagnosed remained a major concern that varied depending on the primary diagnosis. The MOHLTC Ontario Disability Support Program (ODSP) provides financial support for individuals with a primary diagnosis of a mental health disorder. For those with a primary diagnosis of a developmental disability, the MCSS provides the main source of income. In either case, individuals with a dual diagnosis suffer from a low socio-economic status and often do not receive needed basic resources and services.

Main Theme 2: Barriers to Mental Health Services

Barriers to mental health services include gaps in knowledge, service delivery issues, and confusing policies. Many participants described how they lacked knowledge regarding services or the capacity of services external to their agency, thus increasing the risk of spreading misinformation, as remarked in the following quotation:

> Certainly, there's lots of services available out here and I'm not very well versed in what they all are—we seem to stumble upon things, like by chance…based on client needs and what's going on.

Further, all participants reported a lack of expertise in treating clients with a dual diagnosis, span-

ning across both the mental health and developmental disabilities fields. For example, participants identified hospital staff, psychiatrists, clinicians, and rural police officers as having little to no training in dealing with this population. Reporting the issue of stigma as a prevalent one, most participants stressed the need for more education and training to reduce the impact of stigma on individuals with a dual diagnosis.

Most participants noted the difficulties involved in getting a clear diagnosis, and cited the lack of trained clinicians and suitable assessment tools as being particularly problematic. Many participants identified service gaps, describing programs and supports as "very fragmented and very flawed." Several participants revealed that services are often not available to those with mild disabilities, and that frequently the services that are available are inflexible and fragmented. Particularly, they noted that those with "moderate mental health issues" were "falling through all the cracks." Responding to the practice of using the degree of a client's primary diagnosis in deciding eligibility for services, one participant explained:

> …Years ago people didn't get wrapped up with diagnoses. When somebody came to you they came to you because they needed some support and they needed some help with whatever it might be, and then you figured out how to meet that…

In order to preserve fair access to services, the City of London and the County of Middlesex have developed waiting lists and processes for centralized intake that are managed by a few key agencies in the community. Many participants found that services based on priority "taxed" the teams "heavily." Participants spoke about the inability of their agencies to meet the needs of clients due to low capacity. Most notably, participants mentioned long waiting lists for suitable housing, high caseload ratios, and limited resources as directly impacting quality of service, suggesting the system must, without added funding, reconfigure to create more capacity.

Most participants voiced frustration about the changes and attempted improvements that have

been made as a result of confusing policies between the MOHLTC and the MCSS, as evident in the following quotation:

> …originally, it was like, the Ministries would work together and have a separate branch that would work with this, but it never went anywhere …although they sit at the same table, they still have their same policies and still have their different mandates…

Participants identified funding based on a client's primary diagnosis, the low priority given to those with a dual diagnosis, and the lack of specific funding for those with a dual diagnosis as continuing issues. They further suggested that service needs are more likely to be met when agencies' mandates are general enough to offer such services. Relations between community organizations and local hospitals appeared also to be affected by confusing policies. Participants from community and inpatient facilities recognized several contributing conditions to this issue, including weak liaisons and lack of discharge planning with follow up. Other factors cited include differences in professional cultures, consent issues, and a lack of expertise in skilled advocacy in order to gain suitable treatment.

Main Theme 3: Identifying Best Practices

Reflecting on service provision for clients with a dual diagnosis, most participants identified best practices, describing a holistic, person-centered model, individualized approach as involving wrap-around services, flexible support, and services based on needs. Participants regarded specialized services as being specifically designed to meet the needs of clients with a dual diagnosis, recognizing the need for services from many systems. All participants agreed that individuals with a dual diagnosis often needed specialized services which integrate expertise from both Ministries. They further linked success of treatment to various clinical supports, as well as both in-patient and outpatient services provided by expert staff.

Most participants appreciated the importance of community-based case management in keeping

individuals in good emotional and physical health within a community setting, as described in the following quotation:

> …we firmly believe everyone could be supported in the community…With some of the people we support here have been deemed never able to live in the community are successfully there. There's nobody in my estimation that can't be successfully supported given the right support services.

Parts of this treatment model included social recreation planning, community integration, and supporting brief hospital stays, in addition to suitable housing and supports. Participants shared the belief that as the deinstitutionalization movement progressed, resources would need to shift to provide greater support to those returning to the community. One participant suggested, "We'd like to see a split of about 60% being spent in the community and 40% in hospitals." Participants noted, in a system with "10 year waiting lists for group homes," that responsiveness to the needs of clients with a dual diagnosis needed flexible and satisfactory funding. They remarked that although the MOHLTC recognized these issues, the lack of flexibility in resources continues to affect service provision for individuals with a dual diagnosis.

Collaboration in best practices requires that agencies work together to meet the needs of clients with a dual diagnosis. Participants suggested that sharing knowledge in the form of cross-training and in-services played an important part in agency partnerships. All participants agreed the need for sharing knowledge is an important element to increase capacity and leads to a better quality of service for clients with a dual diagnosis. Consistent with best practice guidelines, participants strive to achieve coordinated services that are seamless, involving many different forms and levels of collaboration between agencies. Many participants stressed the importance of building and maintaining relationships with the Regional Dual Diagnosis Committee, the local Dual Diagnosis Committee, and the Mental Health Alliance, as prime strategies in addressing the service needs of the dual diagnosis population. Participants referenced advocacy as

another part of collaboration in promoting change, as pictured in the following quotation:

> … there was a lot of advocating…it was a matter of calling up some pretty big powers-that-be and saying—look it, we're getting doors shut on us left-right-and-centre, and this kid is in crisis… let's help this kid, and that's what happened. So the ability is there, the system just gets in the way.

Participants agreed that advocacy will continue to be pivotal in developing services to meet the needs of individuals and reduce the stigma associated with having a dual diagnosis.

In summarizing the findings, the first main theme, Service Delivery, identified many services in the region. However, participants described the service delivery system to this population as fragmented, with limited resources, outdated assessment tools, inadequate training, and as being in need of community integration and advocacy. Confusion regarding the incidence of individuals with a dual diagnosis identified the need to develop a more standardized method with consistent criteria for identification (Smiley, 2005). The second main theme, Barriers to Mental Health Services, revealed how only a limited number of services are geared towards those with a dual diagnosis and that specific barriers in service delivery include deficient knowledge, limited expertise, and a lack of clarity regarding the roles of organizations and government. The third main theme, Identifying Best Practices, stresses the need for organizations to find creative ways to work together to better serve this population.

Discussion

Separating responsibilities between the Ministry of Health and Long Term Care (MOHLTC) and the MCSS Ministry of Community and Social Services (MCSS) resulted in a fragmented service delivery system. Although participants recognized the responsibilities of each Ministry, they saw problems as persisting between the Ministries where a person's primary diagnosis, instead of

their needs, decides access to funding. Participants suggested a low number of individuals with a dual diagnosis seek services from the MOHLTC. Although those with a dual diagnosis were found to represent a larger segment of clientele under the MCSS, this Ministry does not provide funds for specialized services for those with a dual diagnosis. Both Ministries, as indicated by participants, recognized the need to revise their policies but found it challenging to move ahead in a way that would not negatively impact present service delivery.

Participants identified the importance of specialized community-based supports, such as outreach teams consisting of social workers, nurses, developmental workers, personal support workers, occupational therapists, psychiatrists, and the police. Also, participants recognized the need for access to adequate housing, such as independent housing units or group homes, and access to transportation as important. Participants stressed the value of developing social, recreational, and vocational activities to improve self-esteem and confidence by developing custom activity plans that avoid over scheduling. Last, participants recognized the need for advocacy for individuals with a dual diagnosis in order for them to access financial support, suitable housing, and necessary treatment.

Given the lack of cohesion and integration regarding best practices around treatment, there is still a need for improving a specialized model of care for increasingly diverse and complex clients. In an effort to bridge the gaps between health, corrections, education sectors, and mental health, the MCSS launched a special strategy to promote more collaboration through Community Networks of Specialized Care (Ministry of Community and Social Services, 2008). Partnerships across sectors in the form of policy, planning initiatives, and service agreements need to continue to create and implement effective support for those with a dual diagnosis and their service providers (MOHLTC & MCSS, 2008). At the present time, identifying the personal, holistic needs of clients, resulting in a person-centered, wrap-around, strengths-based approach that is empowering and lessens social isolation needs to be emphasized. Consistent with the MOHLTC's best practice principles, wrap-

around services respond to the various needs of individuals in the community while offering flexibility regarding shifting needs. Specifically, participants offered the following suggestions for promoting best practices when working with individuals with a dual diagnosis:

- Individuals benefit most from concurrent mental health services provided by MOHLTC and MCSS, hospital, and community service providers. They should continue to develop special initiatives that promote linkages and increase role clarification.

- Community-based treatment programs are the key to an individual's success in the community, and should involve efforts at community integration, including advocating for access to suitable housing, recreational planning, and brief hospital stays.

- In utilizing specialized services, there is a need for flexible and varying levels of support that are adaptable to a client's changing needs and which involve continuous monitoring.

- Cross-training and education is needed that involves training physicians and other professionals in improving assessment tools and tailoring treatment protocols, resulting in increased awareness and understanding of each other's role in treatment.

- As stigma continues to impede access to treatment and services, professionals need to advocate for treatment and services based on need, instead of diagnosis, and to recognize the importance of preventive services.

This research confirmed the need for improved, specialized mental health services for individuals with a dual diagnosis. The participants consisted of accredited and knowledgeable professionals. However, the sample size of this study, specific to the City of London and Middlesex County, Ontario is a major limitation. Also, service recipients did not participate in the study, partly due to concerns regarding aspects of informed consent and anonymity. Moreover, participants also reported limited

inclusion of family and care partners in treatment, a best practice listed in the literature. Several other areas concerning the needs of those with a dual diagnosis were beyond the scope of this research; for example, prevalence, diagnostic issues, psychotropic medications, adaptations to psychotherapeutic approaches and cognitive-behavioural methods, violent offenders, severe behaviours, and addiction issues. These interventions warrant future research.

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