CREATIVE SERVICE ALTERNATIVES FOR INCREASED COMMUNITY INCLUSION

Persons With
Developmental Disabilities
Calgary Region Community Board

May 2001

Acknowledgements

This report was commissioned by the **Service Expansion Committee** of Persons With Developmental Disabilities Calgary Region.

Thank you to members of the Service Expansion Committee and members of the Dual Diagnosis Committee for supporting information and input.

Special thanks to those individuals who consented to share their stories in order to improve service options for individuals whose needs challenge the existing service systems in Calgary.

Report Prepared By: Brenda J. Simpson & Associates

Research Assistance: Lori Eberhart

APPENDIX

ALTERNATIVE SERVICE MODELS

Table of Contents

EXECUTIVE SUMMARY

In the Calgary region, the service system funded through Persons with Developmental Disabilities (PDD) supports a number of adults with developmental delays who are dealing with multiple complex issues that often include a mental health diagnosis and significant behavioral challenges.

Client Service Coordination estimates that there are approximately 50 to 60 adults within the Calgary Region at any given time who will encounter serious challenges in accessing appropriate services. Of this group, **a sub-group of 4 to 5 individuals per year face a complete lack of service options within the region** including failure of an existing placement or service option. For these few individuals the result is often a placement outside of their home region or within service options that are less than ideal. Currently these service options may include Michener, Alberta Hospital Ponoka, Correctional Centres, and short stay acute care psychiatric placements.

This study focuses on those **4 to 5 individuals per year for whom appropriate service options do not currently exist** within the Calgary Region PDD service system. The study considers a number of service models and service elements that could contribute to development of additional community based options that would complement and extend the existing PDD service system. Following is a brief summary of some of the findings.

Issues contributing to the breakdown of community placements include:

- Harm to staff resulting in staff refusing to continue working with client
- Potential for harm to self or community that exceeds staff ability to supervise
- Medical needs that exceed staff ability to manage
- Intermittent involvement with the justice system
- Guardians and/or client disagree with service or treatment options available
- Damage caused to physical environment becomes expensive for service agency

Placements typically break down only after extended periods of ongoing behavioral incidents that become increasingly difficult to manage in the community, placing the individual and those around them at risk.

Systems issues create additional challenges. Some of the systems issues include:

- Difficulty accessing mental health services as a proactive/preventative measure
- The transition from children's to adult service systems is often abrupt, without an appropriate period of introduction to community living experiences.
- Lack of service alternatives for a small percentage of individuals
- Service systems don't take joint ownership for complex cases. Individuals with complicated needs are often picked up and served by one service system at a time.
- Creating Excellence Together standards need to be interpreted with some flexibility for those individuals (or at particular times) where more external boundaries and limits are needed to protect the individual and those around them from harm
- Insufficient flexibility in eligibility criteria within systems restricts access to services for some individuals with low functional abilities and high support needs. For example, many children diagnosed with FAS who require highly structured and supportive

environments during their teen years, no longer qualify for support services under PDD eligibility guidelines after the age of 18.

What Works

Learnings from the case studies and exploration of innovative service models suggest program design elements that work. (see pages 18 to 21 for full details) Examples include:

- Opportunities for respite and stabilization as a proactive measure
- Physical environments that include safety and security features, spacious areas internally, campus environment externally, access to quite areas, individual and small group options
- Staff that are experienced, and well-trained, including mental health expertise, willing to set firm boundaries and provide some external direction or control when necessary, with quick access to back-up when necessary
- Wrap around service design with clearly structured predictable routines, flexibility to adapt quickly to changing situations, and proactive individualized service plans which include jointly developed protocols for staff and partner service providers
- Treatment program under the direction of psychologist with support of a psychiatrist and multidisciplinary treatment team, including access to medical support/personnel as required
- Collaborative multi-system involvement and commitment

Valued Experiences and Progress To Date

There are many examples of success and best practice within the existing service system in the Calgary region. Service agencies in Calgary have done an excellent job of developing a wide variety of creative models that successfully support individuals with very complex needs. Even those few individuals who at times run out of service options have usually experienced significant periods of tenure in community living environments supported by local service agencies. The Client Service Coordination team picks up those individuals who fall through the cracks and tenaciously works through the challenges of our imperfect service system until an appropriate alternative can be found or designed.

The Service Expansion Committee and Dual Diagnosis Committee provide a forum for collaborative action in tracking and understanding issues, working toward improved service coordination, advocating for improved service access and planning new service development. The PDD Police Advisory Committee works to create strong linkages with the justice system. Service providers speak highly of police support in maintaining protocols that support and protect those individuals with complex behavioral issues and community members.

Plans for a Dual Diagnosis Clinic will help to establish public recognition for the specialized expertise required to support individuals with multiple and complex diagnoses, help to support the development of this expertise, and pave the way for future collaboration between PDD and AMH systems.

There exists a wonderful opportunity to ground future service system developments in past successes and best experience.

9.0 Recommendations

9.1 Short Term Secure Treatment

A variety of small living environment secure treatment options should be developed within the adult system (see sample service model described on page 21). Short term secure treatment services should include **crisis respite**; **assessment** and **stabilization**; and **shorter term treatment** (3 to 12 months).

Ideally the living situation would be located in **campus environment**, with the possibility of several small group living arrangements (i.e. one to three persons per setting). Clustering the secure living arrangements would enhance opportunities for crisis response.

Services should be based on a **wrap around service model** that includes residential, social recreational activities and day/work activities as well as treatment services. **Core funding** should be provided in order to maintain expert staff and service stability over time. A **well-trained multidisciplinary staff group** which includes at least one staff with **mental health expertise** and at least one male staff should be used.

9.2 Long Term Secure Living Environments

Development of two or three longer-term secure placement options for those individuals who require highly structured environments for more than 12 months in order to **maintain stability.** These long term secure living environments might accommodate two to three individuals per placement and would include the appropriate level and type of security required by the individuals in question. See page 17 for potential security features.

A pool of highly trained staff available to support several secure living environments could provide the flexibility to allocate staff resources where most needed.

9.3 Support Service Access

Any new service development for more secure treatment options should be **closely connected with the planned Dual Diagnosed Clinic** in order to ensure a vital link with necessary multidisciplinary health services.

Easy access to the support of multidisciplinary professional health services is one of the key features found to work well in other best practice models.

9.4 Community Crisis Response Team

Develop an expert crisis response team consisting of two to three well-trained and experienced crisis workers to provide hands on emergency assistance for immediate crisis situations. The team should be available to all PDD funded individuals and their service agencies.

The crisis response team would help to **support and maintain** individuals in their community placements through times of crisis. The team would ensure that those individuals with a history of chronic and severe behavioral difficulties and placement

challenges have a **proactive "alternative" plan**, with pre-approved funding and/or service access protocols in place for those periods when escalating needs create placement instability or breakdown. Team members would provide **training for appropriate use of restrictive procedures**, and share their expertise in behavior management as members of **behavior support committees.**

9.5 Systems Level Protocols for Action

Develop **systems level protocols and service agreements** among key service systems such as PDD, AMH, CRHA and Justice, creating a **clear path for service access and response** during times of crisis. Representatives from the key service systems typically accessed for support/resolution of a crisis should be involved in development of the protocols.

Development of protocols and service access agreements would reduce the need to renegotiate necessary support services each time a crisis arises.

9.6 Transitional Options

Development of transitional options and experiences that prepare young people to move from highly structured children's programs into the adult service system should be explored collaboratively by PDD and Calgary Rocky View Child and Family Services.

One option suggested by the Service Expansion Committee, as an alternative to transitioning from children's to adult service system is to purchase an extension of the existing service placement. For some young people with high needs who have been doing well in their children's service placement, extending the same placement for a few more years (e.g. age 18 to 22) would provide continued stability and opportunity for personal development. Emphasis should be on development of independent living skills and increased personal decision making for a more gradual transition to adult services.

9.7 Improved Access

Individuals who have borderline cognitive functioning but experience serious functional limitations should have access to the new service options. A systems partnership approach to service development may help to extend eligibility criteria.

9.8 Shared Investment and Ownership

New service development to address the complex needs of those who find themselves without options in our current service system should be based on a systems partnership with shared investment, ownership and responsibility among the key service systems involved (i.e. PDD; AMH; CRHA; Justice; Calgary Rocky View).

Shared investment and ownership is a strategic approach that could reduce barriers that exist between major service systems and increase access to the multiple services and expertise required by individuals with complex needs. Shared investment might include funding, staff secondments, service access agreements, etc.

Shared ownership would require agreement regarding acceptable standards of practice.

1.0 Introduction

In the Calgary region, the service system funded through Persons with Developmental Disabilities (PDD) supports a number of adults with developmental delays who are dealing with multiple complex issues that often include a mental health diagnosis and significant behavioral challenges. The difficulties inherent in managing these complex issues sometimes lead to involvement with the justice system.

Client Service Coordination estimates that there are approximately 50 to 60 adults within the Calgary Region at any given time who will encounter serious challenges in accessing appropriate services. Of this group, **a sub-group of 4 to 5 individuals per year face a complete lack of service options within the region** including failure of an existing placement or service option. For these few individuals the result is often a placement outside of their home region or within service options that are less than ideal. Currently these service options may include Michener, Alberta Hospital Ponoka, Correctional Centres, and short stay acute care psychiatric placements.

This study focuses on those **4 to 5 individuals per year for whom appropriate service options do not currently exist** within the Calgary Region PDD service system. The study considers a number of service models and service elements that could contribute to development of additional community based options that would complement and extend the existing PDD service system.

2.0 Understanding The Complexity

Many individuals with complex needs who present a serious challenge to existing service systems are referred to as dual diagnosed. The National Association for the Dually Diagnosed define this situation as "the co-existence of the symptoms of both mental retardation and mental illness." [1]

Persons with a dual diagnosis can be found at all levels of mental retardation (mild, moderate, severe, profound). The NADD estimates that approximately 20% to 35% of all persons with mental retardation have a psychiatric disorder. Other research suggests prevalence rates of psychiatric disorder may range between 30% and 70%, depending on specific assessment procedures, diagnostic criteria, and the degree of mental retardation shown by the subjects. These figures represent a fourfold to fivefold increase over the prevalence of psychopathology shown by the general population.[2]

The types of psychiatric disorders persons with mental retardation experience are the same as those seen in the general population. Some of the common types are:

[1] Fletcher, Dr. Robert. (2001) Information on Dual Diagnosis. The National Association for the Dually Diagnosed, Kingston NY
[2] Kaplan, B. Sadock. V. (1993) Kaplan & Sadock's Comprehensive Textbook of Psychiatry. p.2223

Affective Disorders: The disorders are characterized by disturbance of mood as a predominant feature. Depression, bi-polar and mania are the major sub-categories of affective disorders.

Psychotic Disorders: the group of disorders indicate the presence of delusions, hallucinations, disorganized behavior and impairment in reality testing. Schizophrenia, schizoaffective and schizophreniform are some of the major sub-categories of psychotic disorder.

Personality Disorder: the group of disorders applies to an enduring pattern of dysfunctional behavior. Symptoms frequently found are personality traits that are inflexible and maladaptive and cause significant impairment or subjective distress. Paranoid, anti-social, borderline and avoidant are some of the major sub-categories of personality disorders.

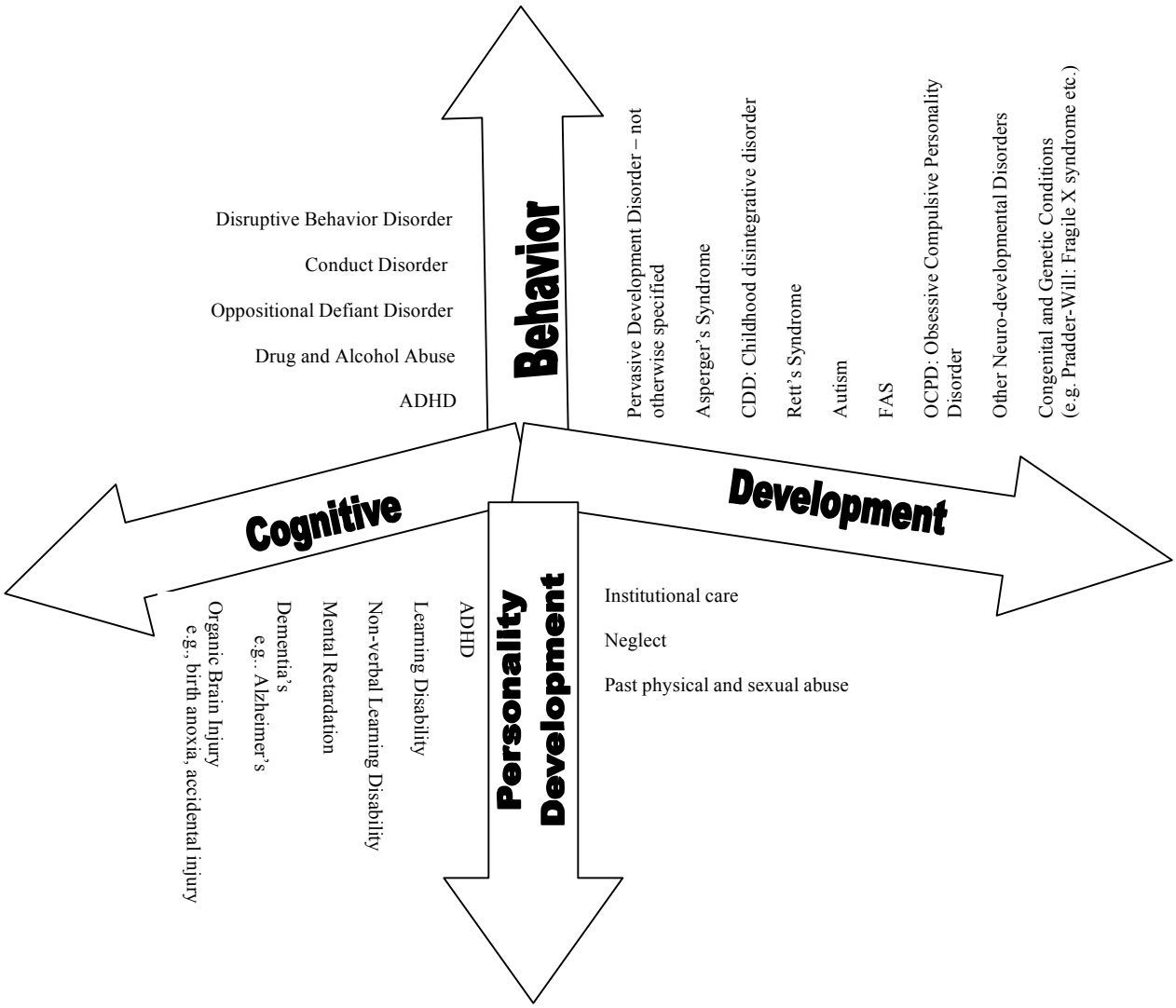
Anxiety Disorder: This group of disorders are indicated by the presence of excessive fears, frequent somatic complaints and excessive nervousness that can interfere with functioning. Panic attack, agoraphobia, obsessive-compulsive and post traumatic stress disorder are some of the major sub-categories of anxiety disorders.

Adjustment Disorders: The essential feature of this disorder in the development of clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor. The clinical significance of the reaction is indicated by either marked distress that is beyond that which is expected or by impairment in social or occupations functioning. Categories of adjustment disorder include adjustment disorder with depressed mood, with anxiety, disturbance of conduct and with mixed disturbance of emotions and conduct.

Other psychiatric disorders include: somatoform disorder, dissociative disorders, sexual and gender identify disorders, eating disorder, sleep disorders, substance abuse related disorders, impulse disorders usually first diagnosed in infancy, childhood or adolescence.

Another way of understanding the complexity presented by some individuals is to consider the various dimensions of developmental disorders. A recent report by the Greater Boston Physicians for Social Responsibility[3] uses a framework of intersecting arrays to illustrate the spectrum of developmental disorders and the possibilities for overlap between disorders. Each array represents a different dimension of function, along which the syndromes represent varying degrees of disability. The following chart has been adapted and expanded to include disorders encountered in adult population.

[3] Schettler, T. Stein, J. Reich, F. Valenti, M. (2000) In Harm's Way: Toxic Threats to Child Development. A report by the Greater Boston Physicians for Social Responsibility.


Behavior
Disruptive Behavior Disorder
Conduct Disorder
Oppositional Defiant Disorder
Drug and Alcohol Abuse
ADHD
Pervasive Development Disorder – not otherwise specified
Asperger's Syndrome
CDD: Childhood disintegrative disorder
Rett's Syndrome
Autism
FAS
OCPD: Obsessive Compulsive Personality Disorder
Other Neuro-developmental Disorders
Congenital and Genetic Conditions (e.g. Pradder-Will: Fragile X syndrome etc.)
Cognitive
Development
Personality Development
ADHD
Learning Disability
Non-verbal Learning Disability
Mental Retardation
Dementia's e.g. Alzheimer's
Organic Brain Injury e.g., birth anoxia, accidental injury
Institutional care
Neglect
Past physical and sexual abuse
Seizure Disorder
Physical Disability

The following example illustrates the complexity presented by overlapping syndromes:

Percent of children with ADHD that also have other developmental and social/psychiatric disorders

- 10-30% have learning disabilities
- 30-50% have language disability (a core symptom of autism when expressed in its extreme form)
- 30-80% have oppositional disorder or conduct disorder
- frequently associated with other neurodevelopmental disorders: Asperger's, obsessive compulsive disorder, tic disorder, and mental retardation, seizures, brain injury
- may accompany social and psychiatric disorder: anxiety, depression, schizophrenia.

The co-existence of a developmental disability, psychiatric disorder , behavior and emotional problems can have serious effects on a person's daily functioning by interfering with educational or vocational progress, jeopardizing residential placements and disrupting family and peer relationships. The overall result can be a serious impact on a person's quality of life.

While an accurate diagnosis can be very helpful in guiding treatment, the array of diagnoses offered in complex cases do not change the practical challenges of providing appropriate and adequate supports for community living. Courage, innovation and determination to find creative and workable solutions are equally as important as the diagnosis. One service provider summarizes the experience, and encourages us to trust our own best thinking and to move forward with caring, creativity and optimism.

Because we have had such a variety of diagnoses from such an array of experts, we have come to appreciate that there may be no one truth about a suitable psychiatric label. We have come to trust our own collective perceptions and the perceptions of the family as having at least equal value to the opinions of outside "experts".

4

Dealing with complex and overlapping issues requires a multidisciplinary approach that can cross boundaries and provide a holistic perspective. A strong advocacy role is required to ensure that the person as an individual remains the primary focus at all times. Advocacy provides the additional power and influence often required to navigate multiple complex systems, services and jurisdictions.

[4] Reid, D. Making Restitution To A Service System Survivor. International Journal of Practical Approaches to Disability, Vol. 22, No. 2/3

3.0 What is the Experience?

The following stories present four young people caught in a service system that has been unable to adequately support their full participation as valued community members. These real experiences provide learnings about what works and what is needed to complement our current service system.

3.1 Joe's Story

Joe is a 22 year old young man who lives in a supported living environment designed by Hull Homes Interdependent Living Services. He greatly enjoys working with computers and spends most of his days at the H.O.P.E. Work Experience program. Joe is friendly and outgoing in most social situations. He gets along well with his roommate. Joe has experienced varying levels of autonomy and independence in the community, including unescorted use of public transportation and shopping at local stores.

Joe has survived a long history of involvement with our children's service systems beginning in his pre-school years. Joe was diagnosed with a developmental delay when he was 2 years old. Some of his personal struggles may be rooted in his early experiences of abuse and sexual abuse. His school history involves attendance at nine different schools during his 10 or 12 years of schooling, including a number of sessions at the Hull school. Since he was 9 years old, Joe has lived in eight different foster home, group home and specialized treatment environments.

Joe was assessed at the Calgary General Hospital in 1996 and takes a number of different medications. Challenges which contribute to the system's inability to adequately serve Joe, include:

- multiple diagnoses that include autistic spectrum disorder, ADD, **mild or moderate developmental delay**, intermittent explosive disorder, impulsive, organic and immature personality traits and cerebral palsy.
- Intermittent episodes of aggression and property damage
- Verbal threats toward others and threats of self harm
- Difficulty controlling anger
- Impulsive behavior
- Anxiety which can escalate quickly into aggression
- Numerous occasions of inappropriate sexual behaviors (toward children, adults, roommates, etc.)
- Incidents involving playing with fire
- Personal vulnerability (sexually abused while unescorted in the community)
- Low internal motivation to work toward independent living
- Personal functioning which fluctuates depending on mental health status

One of Joe's more current coping strategies has been to express intentions of self harm and access in-patient psychiatric services where he feels safe and is able to

stabilize the stressors in his life and re-generate coping abilities. In the past six months Joe has used psychiatric hospital admissions four times.

Success: Joe is living in the community and regularly attending a work experience program with some prospect for a gradual reduction of the level of supervision currently in place. More attention is being paid to Joe's vulnerability to potential abuse in the community. Involvement with the Hull programs has been positive due to the close communication and teamwork among staff and the flexibility of being able to call on the program coordinator to fill service gaps when necessary (e.g. day time hours). The extension of Hull programs to include service to adults with developmental delays helps to ease the transition from the children's to adult service systems.

What Works for Joe: Structured environments with supervision, external controls and few expectations for self-help such as that at the hospital create a sense of safety and help to reduce the stresses associated with personal control of behavior and responsibility for managing one's own life. Access to regular psychiatric monitoring and follow-up is necessary to managing the fluctuations in Joe's mental health.

3.2 Linda's Story

Linda is a personable, energetic 23 year old with a great sense of humor. She has many hobbies and interests and loves socializing with family and friends. She is blessed with the loving and consistent support of her family.

Linda lives with the challenges of a **mild mental handicap** and accompanying mental health problems that are not clearly understood. She struggles to deal with past trauma resulting from sexual abuse she suffered as a child. Her most consistent diagnosis has been **Post Traumatic Stress Syndrome**. More recently she discovered that she has diabetes.

At the age of 8, Linda was posing serious challenges to her parents and teachers at school. She was prone to extreme temper tantrums that included sexualized and aggressive behavior toward others. During her early teen years, Linda and her family were supported at home through SCOPE outreach services. By age 15 aggressive incidents exceeded the family's ability to cope and Linda was admitted to psychiatric care for more than four months during which time more appropriate services were sought. From the hospital, Linda moved into Hull Home Cottage One. Linda thrived in this new environment, quickly came off all of her medication, lost weight, gained control over her anger and learned how to communicate openly about her feelings. She was proud of her achievements.

When Linda was 18 she had to leave Cottage One and move on to the adult service system. She spent about a year in a cycle that involved several short unsuccessful

stays in a variety of supported independent living arrangements provided through a number of different agencies. She assaulted numerous staff and was charged, spent time in the Remand Center, Forensic Unit and on general Psychiatry.

When she was 19, Linda entered the SCOPE Residential Support program. Linda was able to maintain herself in the community for one year with periodic hospitalizations when things got out of control for her. During the second year with SCOPE Linda experienced a steady deterioration in her ability to cope effectively in the community. Records for the period Oct. 1998 to Oct. 1999 indicate two to four aggressive incidents per month which required regular involvement of police and/or EMS, and five hospital admissions to help stabilize Linda's mental health. After Linda had been charged with assault four times, staff concluded that the use of EMS and police was ineffective in assisting Linda to manage her behaviors.

The community service system was running out of options for Linda resulting in a final hospital admission that extended from Oct. 1999 to Jan. 2000. Linda moved to the only highly structured and supervised service option available to her at Michener in Red Deer and has remained there for over a year.

Success: Linda has done very well in her Michener placement. She is highly motivated to seek out and receive assistance for her difficulties. She is eager to attend all appointments with physicians, psychiatrists, counseling therapists and probation officers. She takes her medication reliably and has been independently managing her own insulin injections twice daily. Linda has a boyfriend and enjoys a level of independence and freedom of movement around Michener grounds that was not possible for her in the community. She organizes her day, plans and attends her choice of activities with minimal supervision.

What works for Linda: Linda seems to need respite from the world on a fairly regular basis. One place that she can find this respite is the hospital. Linda feels safe in very structured environments. Linda has experienced success in environments such as Hull Home Cottage One and Michener. Linda thrives in enriched, stable environments that offer her all the therapeutic services she needs such as individual therapy, a peer group, family therapy, meaningful day activity/work or school options, rules and limits with clear predictable consequences and concrete rewards. Linda values the option of a secure time-out room (not necessarily locked) where she can go to calm down and keep herself and others safe when she is overwhelmed by feelings of aggression**.**

Linda is requesting less reliance on police involvement and more external controls built into her living environment which make it easier for her to cope. For example, Linda would like access to a secure time-out room and would like some external controls placed on her access to food to assist her in managing her diabetes.

3.3 Debbie's Story

Debbie is an energetic, adventurous 22 year old young woman with a warm engaging personality and a sense of humor. She has a generous nature, values personal relationships and enjoys helping others. Debbie's enjoys an active lifestyle full of varied activities, including homemaking, recreation/leisure and basic work activities. She takes pride in her home and her belongings.

Debbie lives with many challenges both past and present. She was apprehended from her mother at age 7 days due to severe abuse, and has not had any family involvement since that time. For the first 16 years of her life Debbie lived in many placements including, foster homes, crisis placements and Hull Child and Family Services. By age 17 she could no longer be managed in a family setting and was referred to Supported Lifestyles. For five years between 1995 and 2000 she was supported in a variety of community living environments. These included shared models with a peer roommate (both male and female) and 24 hour staff, a brief trial of a supportive roommate model, and a self-contained suite where she lived alone with 24 hour staff support.

Debbie faces a complex array of physical, psychological and medical issues including diagnoses such as FAS, epilepsy, cluster seizures, Double Cortex Syndrome, hypocalcemia, attachment disorder, visual impairment, scoliosis, Hypocorticio-Steroid Syndrome, self-abuse, low cognitive abilities and obsessive behaviours. At different times she has been noted to have **"severe mental retardation" and "moderate developmental delay."**

Since childhood Debbie has struggled with her medical problems and with episodes of aggression toward others. Debbie's experiences include extreme aggression toward others (often with significant physical injury); self-abuse; destruction of surrounding physical environment; obsessions; manic-like behavior; and episodes of uncontrolled "status" seizures. Interactions can easily erode if things move too fast or if Debbie is feeling overwhelmed by stimuli (people, noise, too many questions, interrupting her doing a task). Behavior can escalate quickly into a rage and be out of control before intervention strategies can be implemented. Triggers for escalating behaviors are often unknown. Debbie responds positively to active living experiences and support workers but her positive days can be "fragile". She can be too trusting in some situations that may leave her open to victimization.

In the year preceding her move to Michener, Supportive Lifestyles struggled to support Debbie in a safe and appropriate living environment. Group living models had not worked well for Debbie as her aggression was often targeted toward her roommates. As her situation deteriorated and the aggression became completely out of control, Debbie spent several months in psychiatric hospital with 1:1 staff support from Supportive Lifestyles. On release from hospital, staffing was increased to a

ratio of 2:1 for a short time while Debbie awaited access to a specially designed treatment program at Michener.

Success: Debbie has done well in her treatment program at Michener and is gradually transitioning back toward a community living model. Debbie initiates most of her self care needs, is accustomed to being responsible for her own home and knows the "chores" that need to be completed. In spite of her complex challenges, Debbie has lived with support in the Calgary community for many years. Supportive Lifestyles is committed to continue their support of Debbie when she is ready to return to Calgary.

What Works for Debbie: Debbie values autonomy, self determination and a sense of security in all aspects of her life. She is like many 22 year olds who strive to find value and self-worth in their actions and accomplishments; learning and exploring options to develop life experiences on which to build a future. She responds well to an active day with lots of variety and flexibility, coupled with a stable group of experienced support workers, and a home environment that can be a sanctuary to re-energize and re-focus when necessary. Ready access to medial support to assist with serious seizure episodes is important. Debbie likes to connect with people in the security of trusted relationships and common interests but needs support in establishing and maintaining relationships. Debbie's future goals might include a residential environment that supports the development of skills around living with others.

3.4 Karen's Story

Karen is a personable young woman of 23 with a good sense of humor, who enjoys spending time with her family and friends, playing cards, watching movies and TV. As she matures, Karen has been learning improved self care, homemaking and budgeting skills as she works towards more independent living. Her father describes her as a hard worker who needs to be "steered in the right direction". Karen enjoys going for coffee in restaurants and likes bottle picking. Karen has two sisters as well as a number of older half brothers and sisters. She enjoys the full support of her parents who take an active interest in her wellbeing as her legal guardians. Karen has a two and half year old daughter who is being cared for by her parents.

Karen has been described as a slow learner whose current functioning resembles that of a 14 year old. She often portrays herself as much lower functioning than she actually is. She experienced a relatively uneventful childhood until she was about 12 years old. As she entered adolescence and moved into Junior High school Karen began to experience difficulties within her family, with temper tantrums, aggressive incidents and running away from home. She moved to Hull Home when she was 14 but her placement appears to have been tumultuous with numerous episodes of running away and getting into trouble with the law. Following her Hull Home

placement, Karen has had a number of unsuccessful community placements within the adult PDD service system, the most recent of which has been a highly structured, supervised and controlled residential and day program with Median Project.

Karen struggles with low self-esteem, and a lack of internal structure to offer self-control, self-motivation and self-direction.

For the past ten years Karen has been caught up in a chaotic cycle involving brief periods of time at home with her family, longer periods of supported living in the community, ongoing behavioral difficulties, psychiatric and forensic assessments, and frequent incidents with the law resulting in placement at Calgary Young Offenders Centre or probation orders. During a two year period between 1994 and 1996 Karen frequently ran away from Hull Home and was involved in 12 offences, including assault, assault with a weapon and property damage. Karen has attempted suicide on five occasions and has been admitted to in-patient psychiatric treatment five times. Her most recent placement with Median Project's most secure community living home, Manor House, failed after her behavior deteriorated to the point where threatening behaviors toward staff required police intervention as often as twice a day, resulting in a need to increase staffing to a 2:1 ratio for safety.

Attempts to explain Karen's difficulties have included diagnoses such as pervasive development disorder, mild mental retardation, avoidant personality traits and social phobia. Some behaviors appear to be attention seeking or learned from other young people encountered during her placements. Karen's behaviors place both herself and others at risk. Behaviors have included lying, stealing, running away, self-mutilation and suicide attempts, impulsive acts of aggression toward others, and property destruction. She has intimidated people in malls for money, punched a pregnant woman in the stomach, shaken a baby in a stroller, and most recently entered a private home where she threatened the residents with a knife. Other behaviors include sexually inappropriate actions such as masturbating, exposing herself in public, and trading sex for cigarettes or money. She is very vulnerable to exploitation by others and reports having been raped on several different occasions. Although Karen understands the impact and severity of her behavior, she demonstrates very little remorse.

Success: Karen appears to have had some success in her Hull school placement, and she seems to be making progress in the development of basic self care and budgeting skills.

What Works For Karen: The service system has thus far been unable to design a program that can adequately support Karen. In order to contain the risk she presents to herself and others in the community Karen requires a residential/day program with 24 hour supervision and security features that would prohibit her running away. Access to her family is important to Karen, and a close working relationship with the family would allow them to contribute their input and guidance.

4.0 What Can We Learn From These Experiences?

The collective experiences represented in the stories of these four young people help provide information about what works. They offer ideas and opportunities for renewed creativity in developing and expanding service options.

Some learnings are related to current service system limitations. Other learnings are related to the specific issues or situations that contribute to the breakdown of community placements. And there are learnings that help us identify the individual characteristics that offer the most challenge to our existing systems.

4.1 Specific Individual Characteristics

- History of past trauma, abuse, neglect
- Chronic history of uncontrolled aggression – often escalating due to mental or physical health decompensation
- Unpredictable aggression - aggression or behavioral situations which escalate quickly without warning
- Present danger to self, staff and/or community
- Security issues for individual and/or community members if they run away from supervised settings or staff
- Involvement with justice system (usually as a result of uncontrolled behaviors)
- Poor impulse control
- May lack personal motivation to change behaviors
- Significant damage to surrounding physical environment often results from aggressive behaviors (e.g. broken windows, holes in walls, damaged equipment)
- Over stimulation (e.g. environment or program demands) can escalate anxiety and contribute to behaviors
- Consequences/behavior management strategies often ineffective
- Strong interpersonal relationships are important but not sufficient to mediate behaviors
- Individual is often vulnerable to others in the community
- Serious physical health issues may present additional challenges and risks
- A variety of diagnoses attempt to capture the complexity of the challenges facing the individual but do little to inform the development of practical approaches necessary to supporting community living
- Multiple residential placements resulting in fragmented, short term personal relationships, with little history of positive adult role models or consistent home environment

4.2 Issues/Situations That Break Down Community Placements

- Harm to staff results in staff refusing to continue working with client
- Intermittent involvement with justice system
- Potential for harm to self or community exceeds staff ability to supervise
- Medical needs exceed staff ability to manage
- Guardians and/or client disagree with service or treatment options available
- Damage caused to physical environment becomes expensive for service agency

Placements typically break down only after extended periods of ongoing behavioral incidents that become increasingly difficult to manage in the community, placing the individual and those around them at risk. In each of the case studies, the young people involved have spent significant periods of time in a variety of community living settings until the situation or issues escalate beyond the service's ability to ensure the safety of the individual and those around him/her.

4.3 Systems Issues

- The transition from children's to adult service systems is often abrupt, without an appropriate period of introduction to community living experiences.
- Many children diagnosed with FAS who require highly structured and supportive environments during their teen years, no longer qualify for support services under PDD eligibility guidelines after the age of 18.
- Creating Excellence Together standards need to be interpreted with some flexibility for those individuals (or at particular times) where more external boundaries and limits are needed to protect the individual and those around them from harm
- Insufficient flexibility in eligibility criteria within systems restricts access to services for some individuals with low functional abilities and high support needs.
- Difficulty accessing mental health services as a proactive/preventative measure
- Lack of service alternatives for a small percentage of individuals
- Service systems don't take joint ownership for complex cases. Individuals with complicated needs are often picked up and served by one service system at a time.

5.0 Service Models and Ideas - Here and Elsewhere

A review of service models that have been developed to support those individuals with complex needs, including dual diagnoses, involvement with the law and/or aggressive behaviors, uncovers a variety of interesting approaches. A broad continuum of service models already exist within the Calgary community, though the more secure highly structured treatment options are available only within the children's service system.

The following summary gives a basic overview of the range of service models reviewed. A more detailed description of specific models is contained in the appendix of this report.

5.1 Summary of Services Models

Offender/Rehabilitation Models

- special purpose facility for individuals with a developmental disability who have committed an offence. The primary emphasis is on security (locked and fenced).
- structured rehabilitation programs provided within the offender facility
- deal with high risk offenders who have a developmental disability and have been sentenced

e.g. Centre for Intensive Treatment – New York

Secure Treatment Models

- special purpose secure facility with option for locked doors and quiet/time out room
- focus on treatment
- other restrictive procedures options available (e.g. PRN medication)
- highly structured but flexible programming
- multi-disciplinary team approach
- programs have the capacity to serve voluntary and/or involuntary clients

e.g. Michener Centre; Hull Home Secure Treatment; Alberta Hospital Oliver

Staffed Facility Based Models

- special purpose facility with some security such as door alarms
- specially trained staff
- option for 24 hour staffing if required

e.g. Supported Lifestyles – Vista; Hull Home – Cottage One

Staffed + Live-in Facility Based Models

- special purpose facility with separate area for 24 hour live-in staff plus additional staff to supplement and cover other shifts
- may include some physical security features such as door alarms, room monitors, sturdy building materials, etc.

e.g. Hull Home – Cedarbrae Family Teaching Home

Staffed Non-facility Based Models

- option for 24 hour staffing if required
- facility is not special purpose, and usually not owned by service provider
- primary source of security is provided through staff supervision

Supported Roommate and Live-in Models

- individual lives in own home with supportive roommates, or
- individual lives in home with a family
- levels of support/supervision vary depending on needs

Supported Independent Living

- individual lives in own home or apartment with intermittent support from outreach staff

Wrap-around Service Models

- address full range of day activity, residential and recreation service needs often through individualized programs and comprehensive case management – inclusion of services accessed from a variety of sources

e.g. Closer To Home

Rural Living Options

- security for the individual and the community is provided through rural isolated environment, supervision, and low staff:client ratios
- spacious outdoor environment provides room for those who use physical space as an aid to reduce anxiety, control overstimulation, or express idiosyncratic behaviors

e.g. Kigep programs

Community Outreach Teams

- provide expertise in behavior management to families or service providers on an outreach basis
- provide advocacy for service access, and assistance with service planning

e.g. SCOPE

Case Management and System Coordination Models

- joint funding and responsibility for case management services where individuals cross systems such as those with developmental disabilities who have committed offences e.g. Lancaster PA
- community coalition accepts responsibility for joint case management and service planning for those individuals whose needs cross systems e.g Pueblo Consortium
- A.S.S.I.S.T. (Assault, Safety, and Social Intervention Systems Training) inter-system case monitoring and tracking system for individuals with developmental disabilities who have committed offences e.g. Pueblo Consortium

Special Treatment Programs and/or Philosophies

- **GENTLECARE** – focus on creating therapeutic environment, positive approach to managing aggressive behaviors
- **Dialectic Behavior Therapy –** is the application of a broad array of cognitive behavior therapy strategies to the problems of Borderline Personality Disorder including suicidal behaviors. There is an emphasis on "dialectics" or reconciliation of opposites in a continual process of synthesis – the need to accept patients just as they are within a context of trying to teach change.
- **Family Teaching Home** – structured incremental teaching of basic independent living and social skills. Specific goals and rewards for progress. (e.g. Hull Home, Closer To Home)
- **P.I.C. Progressive Integrative Conflict Control** – staff training for preventing/handling aggression
- **Level System** (e.g. CIT New York, Bluesky Colorado) – five level structured program linking behaviors to privileges and increasing levels of freedom and responsibility
- **ASSET approach** and Personal Stories – focus on individual's strengths, abilities, interests, opportunities as a basis for service provision (e.g. Bluesky Colorado, Arcane Horizons Winnipeg)
- **RESULTS** (Resocialization through Understanding, Limits, Training and Support) highly structured program which includes community based residential and day program options (e.g. Bluesky)
- **Safety First** – classes taught by police and firemen provide individuals with developmental disabilities an opportunity to develop a supportive rapport with these public servants (e.g. Bluesky)
- **Raising The Bar** – goal of maintaining functional stability and achieving maximum potential – based on expectancy effect theory. (e.g. Lancaster PA)
- **A.S.S.I.T.** – monitoring tracking systems which allows emergency personnel to immediately access important case information (e.g. Bluesky Colorado)
- **Diversion Program** – input into creative sentencing (e.g. Bluesky Colorado)
- **Company of Friends** – focus on building personal networks in the community (e.g. Manitoba)
- **Creating Excellence Together** – community inclusion philosophy and standards for individualized community based services (e.g. Alberta Association of Rehabilitation Centres)

5.2 Service Model Continuum

Service models range along a continuum from highly structured secure treatment options to unique individualized community living alternatives designed around the individual.
The attached chart illustrates the continuum of service models across two dimensions; 1) the level of specialization and security; and 2) the physical location.

5.3 Service Model Features

Each service model can be described as containing certain features related to the level of security offered; the physical location; the size of the facility; the service environment; the staffing model; the program or treatment model; built in support services; and the level of systems collaboration in service provision. In combination these features create a variety of environments and support services that address a range of individual characteristics and needs.

Security Features vary across programs depending on the level of challenging behaviors and/or risk presented. Security features may include:

- Locked facility
- Fenced yard
- Special physical design features to accommodate aggressive behaviors
- Other security measures (e.g. staff beepers)
- Quiet room or voluntary time out
- PRN medications
- Use of physical restraints (only as necessary)
- Door and window alarms (with or without additional option for locked doors)
- Close supervision with specific police protocols in place
- Supervision only

Location can be used to add a measure of security, as in those programs who intentionally use rural locations to decrease risk associated with frequent close contact with people. Location can also create a therapeutic environment through access to quiet and spacious outdoor areas. Three location types are illustrated in the service models reviewed.

- Rural locations
- Campus environments (often located within the community but with spacious grounds surrounding the home)
- Community (special purpose facility located within the community, or supported living environments)

Size of Facility as a service model consideration can have a variety of effects. Serving individuals in groups can reduce the cost of service, increase staff security through availability of back up staff and provide social opportunities for those living together. However, smaller groups and individualized service allow for a quieter environment which may decrease behaviors, more individualized service, and less risk of harm to roommates during periods of aggression. In the service models reviewed, facility size ranged from

- large scale settings (more than 12);
- group living situations of 10 or 11;
- group homes serving 3 to 6 individuals, and
- smaller living arrangements of one or two individuals.

Living Environment can have implications for permanency (owned vs lease or rent), and opportunity to offer special environmental features. Options include

- special purpose facility, often including at least some environmental modifications to accommodate the special needs of the individuals using the facility, or
- use of an already existing home or apartment in the community without any special modifications.

Staffing is used to provide varying levels of security, support and treatment. Staffing considerations in the service models explored include

- Highly trained, experienced staff
- Use of male staff as a safety feature and possible deterant to aggression
- Low staff/client ratios (1:1 where needed)
- 24 hour staffing
- Use of staff with psychiatric nursing experience
- live-in staff or house parents
- supportive roommate concept
- quick access to back up or on-call staff as needed

Program considerations in the support of individuals with complex needs may include:

- Highly structured programs
- Treatment orientation
- Behavioral programs with incentives/consequences
- Inclusion of day activities and access to recreation opportunities
- Flexible with less demands than regular community work/activity programs

Support Services are often multi disciplinary with cross-over expertise available from rehabilitation, mental health, health, and justice. Support services may include:

- Case management team
- Psychiatrist
- Psychologist
- Medical staff/nurse if required
- Rehabilitation staff
- Staff or expertise provided from justice system/parole
- Other special support services as required (e.g. dietician, physio, etc.)

System Collaboration is a key feature of the most successful service models.

- Service delivery and costs shared across systems
- Systems collaborate for planning, monitoring or tracking purposes

6.0 What Works?

Learnings from the four case study examples, and exploration of service models provide us with ideas of what works for those individuals whose complex needs have exhausted current service options in the Calgary community.

Opportunities for Respite and Stabilization

- A safe and supportive environment that provides:
  - a respite from the anxiety producing demands or stimuli experienced in the community living situation,
  - an opportunity for re-assessment and treatment to help stabilize a deteriorating mental or physical health problem,
  - an opportunity to regain control of behaviors and strengthen coping skills

Physical Environment and Safety Considerations

- Special purpose facility with safety features (e.g. where danger to self/community can be limited and where potential for environmental damage is reduced)
- Spacious physical environment – both within the facility or home (e.g. Vista) and the external grounds (e.g. campus or rural environment)
- Options for both individual and group care (within the same facility or location - where individual can live alone if necessary but also have access to group interaction when appropriate)
- Access to a quiet area or space to be alone, reduce anxiety and settle behavior in an area with minimal environmental stimulation (e.g. meditation room or time-out/quiet room or outdoor space)

Staffing Considerations

- 24 hour staffing with quick access to back-up staff when needed
- Experienced and well-trained staff with some background in Mental Health as well as training in Developmental Disabilities. This may be achieved with a mixed team such as rehabilitation practitioners and psychiatric nurse.
- Inclusion of male staff and/or staff who are not intimidated by aggressive behavior
- As much consistency and continuity of staffing and programming as possible while in community placements
- Staff willingness to set firm boundaries and provide some external direction/control when necessary (for example, when individual lacks inner resources to control destructive or aggressive impulses). Standards 2 and 13 of Creating Excellence Together provides the following guidelines: "**Unless his decisions jeopardize his health and safety, or that of others**, his choices should be respected and supported by the service provider wherever possible."

Program Considerations

- Proactive individualized service plans which include protocols for staff and partner service providers such as police, and are developed with input from all partners, as well as the individual and their family

- Opportunities for a variety of meaningful day activities, recreation and leisure, but less demanding routines than in the community
- Clearly structured predictable routines that retain the flexibility to respond to individual needs and changeable circumstances (e.g. good and bad days, or increasing anxiety levels)
- Opportunities for gradual transition when returning to less restrictive community living situations
- Family involvement (where-ever possible)
- Social inclusion - development of non staff, non paid personal relationships

Treatment Considerations

- Treatment program under direction of a psychologist, with the support of a psychiatrist and a multidisciplinary treatment team
- Access to other medical support/personnel as required (e.g. expertise of an RN with psychiatric specialty)
- Clear treatment plans and goals which allow for acknowledgement and celebration of incremental progress
- PRN options when necessary and recommended by a physician or psychiatrist
- Established treatment period and review dates with proactive planning for return to community alternative

System Considerations

- Collaborative multi-system involvement and commitment to treatment (PDD; AMH; Justice; Rocky View; CRHA)
- Proactive and longer transitional planning for those individuals moving from highly structured children's services to the adult service system
- Cross system responsibility to extend service to those adults with FAS who require ongoing supports as they move into adulthood
- Proactive planning based on understanding of chronicity of issues (versus reaction to crisis) – long term case management, improved access to periods of respite and stabilization as a preventive measure instead of crisis response only.

Other Suggestions

- A strong service system linkage should be designed between the new Dual Diagnosis Clinic when it opens and any more secure treatment option or facility developed in response to unmet needs in the Calgary community
- Possible scenario in which staff move with the client from community to stabilization unit and back again (this could be ideal for continuity, but may not work if aggressive episode has resulted in staff refusing to continue working with the client or if client/staff relationship has deteriorated)
- Keep client's community placement funded and open for eventual return from "treatment" to "home" (ideal but expensive, may need to be time-limited option)
- Long term community alternatives. Would it be possible to plan proactive ideal long-term placements for those with chronic high needs and unstable conditions?

- Support for service agencies to cover the expenses of damage to physical living environments caused when an individual is "out of control"
- Better service coordination with police, justice, Child Welfare and mental health.

7.0 Ideas for the Future – A Sample Service Model

Purpose:
- Stabilization (as alternative to lengthy hospital stay)
- Assessment when health or behavior is decompensating
- Proactive respite or "cooling off" option
- Post hospital or justice system discharge until community services can be organized
- Possible diversion from justice system for assessment and/or treatment before return to community

Description of Features:

Provide a 24 hour staffed facility based model that includes a variety of day activity options. A safe place for individuals and their support partners to go until the episode or difficulty is under control.

Perhaps a cluster of three special purpose homes located within the community but in a campus environment (like Bow Park Court; Hull Homes; Woods Homes).

- One group living situation for up to 3 individuals.
- One living situation accommodating 2 individuals.
- One living situation available to accommodate 1 or 2 individuals.

While at least one home would be fully staffed with experienced, well-trained staff, there may also exist the option of having an individual's existing support staff accompany them to the treatment facility and provide the necessary staff support under the direction of the treatment team until such time as the individual is ready to return to their community "home".

Special purpose facility designed to withstand aggression toward physical environment (e.g. like Vista). Spacious environment that allows individual to move away from others, find quiet spaces when feeling anxious or out of control. Access to pleasant and spacious outdoor areas.

Security provided through door alarm system and supervision, with option to secure the facility further if required (i.e. lock doors).

Access to quiet/meditation room
Access to PRN medication alternatives as required (under supervision of doctor or psychiatrist).

Staff who are well-trained and experienced, perhaps with mixed backgrounds such as rehabilitation, psychiatric nurse. Use of male staff where appropriate for very aggressive situations. Possible use of 1:1 staffing model. Alert on-call system with quick access to back up staff when required. Clustering the program components in proximity to each other would facilitate access to staff back up resources.

Consistent relatively structured routines but with less demands than community programs. Focus on assets/strengths of the individual, interests and opportunities. Provide interesting variety of day activity and recreation options. Viewed as temporary "treatment" program rather than long term "home".

Include options for more directive or limit setting approach from staff during periods when individual is unable to exercise internal control. Allow option to increase or decrease security measures as necessary (e.g. locked doors only if absolutely necessary, door alarms would be sufficient in most cases).

Case management team directed by psychologist and including key representatives from appropriate systems (i.e. PDD; MH; Justice; Rocky View; community service providers) as well as guardian or advocate representation. Any reliance on police should be pre-planned and monitored as part of the treatment plan and should include direct police input/advise in the planning stages.

Regular program review and guidelines/limitations for length of stay (e.g. 12 months).

8.0 Valued Experiences and Progress

The Calgary region has reason to be proud of the myriad of community based services designed specifically to address individual preferences and needs. In the search for service models, some of the most progressive and successful models exist in our own province. Service agencies have done an excellent job of developing a wide variety of creative models that successfully support individuals with very complex needs. Even those few individuals who at times run out of service options have usually experienced significant periods of tenure in community living environments supported by local service agencies.

The Client Service Coordination team picks up those individuals who fall through the cracks and tenaciously works through the challenges of our imperfect service system until an appropriate alternative can be found or designed.

The Service Expansion Committee provides a forum for collaborative action in tracking and understanding issues, working toward improved service coordination, advocating for improved service access and planning new service development.

Plans for a Dual Diagnosis Clinic will help to establish public recognition for the specialized expertise required to support individuals with multiple and complex diagnoses, help to support the development of this expertise, and pave the way for future collaboration between PDD and AMH systems. A recent proposal to move portions of the Alberta Hospital Edmonton program into more community based options suggests a willingness on the part of AMH to be involved in seeking solutions to address the complex needs of individuals with dual diagnoses.

The PDD Police Advisory Committee works to create strong linkages with the justice system. Service providers speak highly of police support in maintaining protocols that support and protect those individuals with complex behavioral issues and community members. The jointly produced safety videos help to educate individuals with developmental disabilities about protecting their own safety and the role of the police in supporting them.

There exists a wonderful opportunity to ground future service system developments and ideals in past successes and best experience.

9.0 Recommendations

9.1 Short Term Secure Treatment

A variety of small living environment secure treatment options should be developed within the adult system (see sample service model described on page 21). Short term secure treatment services should include **crisis respite**; **assessment** and **stabilization**; and **shorter term treatment** (3 to 12 months).

Ideally the living situation would be located in **campus environment**, with the possibility of several small group living arrangements (i.e. one to three persons per setting). Clustering the secure living arrangements would enhance opportunities for crisis response.

Services should be based on a **wrap around service model** that includes residential, social recreational activities and day/work activities as well as treatment services. **Core funding** should be provided in order to maintain expert staff and service stability over time. A **well-trained multidisciplinary staff group** which includes at least one staff with **mental health expertise** and at least one male staff should be used.

9.2 Long Term Secure Living Environments

Development of two or three longer-term secure placement options for those individuals who require highly structured environments for more than 12 months in order to **maintain stability.** These long term secure living environments might accommodate two to three individuals per placement and would include the appropriate level and type of security required by the individuals in question. See page 17 for potential security features.

A pool of highly trained staff available to support several secure living environments could provide the flexibility to allocate staff resources where most needed.

9.3 Support Service Access

Any new service development for more secure treatment options should be **closely connected with the planned Dual Diagnosed Clinic** in order to ensure a vital link with necessary multidisciplinary health services.

Easy access to the support of multidisciplinary professional health services is one of the key features found to work well in other best practice models.

9.4 Community Crisis Response Team

Develop an expert crisis response team consisting of two to three well-trained and experienced crisis workers to provide hands on emergency assistance for immediate crisis situations. The team should be available to all PDD funded individuals and their service agencies.

The crisis response team would help to **support and maintain** individuals in their community placements through times of crisis. The team would ensure that those individuals with a history of chronic and severe behavioral difficulties and placement challenges have a **proactive "alternative" plan**, with pre-approved funding and/or service access protocols in place for those periods when escalating needs create placement instability or breakdown. Team members would provide **training for appropriate use of restrictive procedures**, and share their expertise in behavior management as members of **behavior support committees.**

9.5 Systems Level Protocols for Action

Develop **systems level protocols and service agreements** among key service systems such as PDD, AMH, CRHA and Justice, creating a **clear path for service access and response** during times of crisis. Representatives from the key service systems typically accessed for support/resolution of a crisis should be involved in development of the protocols.

Development of protocols and service access agreements would reduce the need to renegotiate necessary support services each time a crisis arises.

9.6 Transitional Options

Development of transitional options and experiences that prepare young people to move from highly structured children's programs into the adult service system should be explored collaboratively by PDD and Calgary Rocky View Child and Family Services.

One option suggested by the Service Expansion Committee, as an alternative to transitioning from children's to adult service system is to purchase an extension of the existing service placement. For some young people with high needs who have been doing well in their children's service placement, extending the same placement for a few more years (e.g. age 18 to 22) would provide continued stability and opportunity for personal development. Emphasis should be on development of independent living skills and increased personal decision making for a more gradual transition to adult services.

9.7 Improved Access

Individuals who have borderline cognitive functioning but experience serious functional limitations should have access to the new service options. A systems partnership approach to service development may help to extend eligibility criteria.

9.8 Shared Investment and Ownership

New service development to address the complex needs of those who find themselves without options in our current service system should be based on a systems partnership with shared investment, ownership and responsibility among the key service systems involved (i.e. PDD; AMH; CRHA; Justice; Calgary Rocky View).

Shared investment and ownership is a strategic approach that could reduce barriers that exist between major service systems and increase access to the multiple services and expertise required by individuals with complex needs. Shared investment might include funding, staff secondments, service access agreements, etc.

Shared ownership would require agreement regarding acceptable standards of practice.

Centre for Intensive Treatment – Tupper Lake New York

Description: Joint project of justice and rehabilitation systems for developmentally disabled offenders who have a forensic issue. The program is funded 50% by the State and 50% federally. CIT is a special purpose facility which serves approximately 81 people. Secure facility, behavior modification focus, people progress through levels to gain responsibility and privileges such as increased freedom of movement and access. Minimize idol time. Provide a structured environment. Operational for past 6.5 years.

Objectives:
- To go through citizenship program to be deemed fit to stand trial, or
- to learn skills, be supervised, and undergo treatment.

Clientele
- Developmental disability and have a forensic issue
- Age range 16 to late 60's, typically upper 20's
- currently all men but can accommodate women
- treatment provided for assault/aggression, arson and deviant sexual. 50-65% are sex offenders, but only a small % involved in rapes or attempted rapes
- Typically people have multiple offences

Consent:
- People enter through OMRDD (developmental disability system) and justice system.
- Some people have consented to stay as part of their parole or probation (civil voluntary status), or are there on a voluntary basis, or have a certificate (2 physician opinions needed- reviewed every 60-days, 1-year, 2 years and every 2 years ever after).

Environment:
- Secure locked facility, 14 foot fence, in rural setting, nearest town 18 miles away.
- Level of security/freedom determined by hierarchical level system and key card access.

Other Security Measures:
- All staff wear a personal alarm, every room in facility has a receptor, main safety office, can dispatch additional personnel, (approx 20 people in 30 seconds), provides staff with a sense of security, behavior deterrent as clients become aware of the additional backup as well.
- They have nurses who will administer chemical restraints. Use of chemical restraints goes through a review panel and are approved by a Doctor.

Staffing model:
- Ratios: 3.5 staff to 1 client, including admin, support staff, and direct care staff
- Low staff turnover (facility situated in a remote area, people in the area tend not to job hop)

- provide additional staff training then OMRDD standards, psychologist conducts in-services on relevant topics

Support Services: 6 psychologists, 3 social workers, 5 nurses, 9 habilitation specialists, 1 special education teacher, 1 consulting psychiatrist, 1 Dr, 2 vocation counselors, active treatment coordinator (admin)

Program/Treatment Philosophy:
- Maximum length of stay is two years.
- Five level system for privileges such as increased access to areas of the facility and increasing levels of personal freedom and responsibility.
- Many different programs: vocational (people work with e.g. Maintenance man 50-70% of competitive wage, can buy TV. etc.
- Relapse therapy programs (arson, sex offenders, anger management, empathy)
- Skills training programs such as social skills, nursing/health, dietary, cooking, meal prep, educational opportunities, citizenship program.
- There is a maintenance level of intervention for offenders similar to models to treat alcohol and drug abuse.

Transition to Community:
- When client has progressed through treatment, participated in educational and vocational programs etc they typically enter a step down facility- regional behavioral intensive treatment unit, which is still secured, then would enter another arrangement which is not secure and is in the community.
- If staff are unsure about client's continued danger to others or self, or feel level of danger to self/others has decreased but client still needs a structured environment and long-term supervision, client is referred to a structured regional behavioral intensive treatment unit.
- The next step down is still under development. This step would involve local intensive treatment units that are not secured.
- If the person is quite stable they may enter or reenter the developmental disabilities system.

Biggest Challenge:
- How to keep re-approaching someone who does not seem to be progressing, likely due to a personality disorder or to a limited cognitive ability,
- keeping staff fine tuned to maintain a safe and secure environment

STARS Program – Alberta Hospital Edmonton
Specialized Treatment, Assessment and Reintegration Services

Description: Since 1994 the STARS program has provided secure inpatient psychiatric treatment services to dually diagnosed clients with developmental disabilities through a specialized 19 bed unit at Alberta Hospital Edmonton, with complementary outpatient and outreach services (SAAS) offered from a community based location. Average length of stay ranges from six weeks to six months. Community outreach services provide early intervention/prevention consultation, as well as transition follow-up support.

Clientele: Dually diagnosed (mentally handicapped and mentally ill) individuals between the ages of 16 and 65 who require crisis intervention, medication adjustment and behavioral management. Clients are admitted when all measures used by the community agencies to control extremely aggressive behavior have failed.

Services:

- short term comprehensive assessment
- crisis intervention
- medication review
- neurological investigation
- behavior management and group therapy
- after discharge from the unit extensive support is provided through SAAS
- SAAS provides outreach consultation and training to community agencies as a proactive measure in the management of complex situations

Staffing:

- A multi-disciplinary team approach that includes psychiatrist, nurses, social worker and psychologist
- Referral and consultation with other specialists as required (e.g. occupational therapy, recreational therapy, pharmacy or physical therapy, pastoral care services, food and nutrition services, education, speech therapy, dentists, etc.)

Michener Services – 215 Medley Drive Red Deer Alberta

Environment:

- Secure environment (option for external control of client's movements through locked ward)
- Indestructible environment – heavy walls, doors, unbreakable windows
- Spacious environment – allows client significant amount of personal space
- Quiet room – When behaviors or anxiety out of control can access a non-furnished time out room
- Campus environment provides degree of independence/freedom not possible in community

Staff:

- Well trained and experienced staff – consistent dedicated staff provide familiar faces
- Male staff who are not afraid of client's physical aggression
- Backup staff when needed
- Service continuum allows gradual transition to group living, more home-like environment
- Low staff ratios of 1:1 or 2:1 as needed

Wrap Around Support Services:

- Team approach
- Access to full treatment team – psychologist, psych nurse, dietician, rehab.

An example of the range of support services provided for one young woman includes:

- Medical/Nursing – extensive support from nurse, Wellness Centre, Red Deer Emergency Services and Red Deer Regional Health
- Psychology – assessment and follow-up counseling
- Dietitian – consultation, training and monitoring of food choice related to diabetes
- Physiotherapy and Occupational Therapy – assessment and exercise routine
- Pharmacy
- Social Services – assessment and placement plans
- Lifestyle Support Service (LSS) Outreach Team supports a meaningful day/lifestyle development
- LSS Recreation – support for use of all onsite Michener recreation opportunities
- Ventures/Alternatives – day activity/work program (attendance flexible)
- Smiley's Social Club
- Transportation – internal transit as well as "home van" used on regular basis
- Michener Store, Snack Bars and Clothing Store
- Laundry

Program/Treatment Philosophy:

- Staff will provide firm direction and set boundaries for client when necessary (for example, when client is not able to control their own behaviors)
- PRN medications can be administered when needed

Willow Creek Acreage – Edmonton

Description: The Willow Creek Acreage is a secure community based living option specially designed to provide nursing care and rehabilitation services for up to seven individuals from acute care who are unable to obtain long term placement in other programs due to complex needs. Key elements of the program include:

- Behavioral interventions to manage aggressive and inappropriate behaviors
- A secure environment to prevent wandering and elopement
- Regular nursing oversight to manage on-going health concerns and medication

Clientele: Adults from acute care settings who due to brain injury, physical disabilities, medical conditions and behavioral issues are unable to obtain long term placement in other programs. Individuals requiring medical and behavioral interventions on a daily basis. Individuals requiring nursing care to manage on-going health and complex medication issues, as well as rehabilitation services to ensure continuation of skills development.

Eligibility: All individuals must be referred from an acute care facility only after other residential options have been explored and no appropriate placement is available. In addition, individuals must meet at least one criterion from each of columns A and B.

A – Behaviors	B – Care Needs
• Frequent physical aggression/assaults • Frequent verbal aggression • Sexually inappropriate with residents/staff • Wandering/elopement risk requiring redirection/intervention • Ongoing behavioral management requiring interventions • Require up to two staff for management of aggressive behaviors	• Require 24 hour awake staff • Require RN/LPN services during days/evenings • Require up to two staff for mobility/transfers • Require up to two staff to provide ADL's • Require bowel/bladder management/retraining • Require supervision with smoking

Sample Behavior Incidents Recorded Over A One Year Period

Resident	Theft	Physical Aggression	Attempted Elopement	Elopement	Sexually Inappropriate
#1	0	28	0	0	0
#2	0	5	0	0	0
#3	3	0	20	1	0
#4	0	4	1	1	0
#5	0	0	2	0	0
#6	36	2	5	1	50
#7	0	2	5	0	0

Environment: Willow Creek Acreage accommodates up to seven adults in a safe and secure home-like environment. The home is barrier free with large common spaces and the ability to accommodate the needs of physically disabled residents. Doors have an alarm system to monitor resident's movement out of the house. A one acre yard with secured perimeter fence controlled by a keypad allows for walking and gardening.

Staffing: Willow Creek Acreage is staffed on a twenty-four hour basis with two staff on-site at all times. Staff consists of personal care aides, LPN and a team leader/supervisor who is a psychiatric nurse. All staff are trained in medication administration, CPR, behavior management programs, non violent crisis intervention, abuse prevention, and additional training related to residents special needs. The nurse/supervisor provides emergency on-call services as well a flexible service hours through the week. The nurse is responsible for delegating oral medication routines to staff and for administering all injectible medications. When a PRN medication is needed, support staff consult with the nursing supervisor for direction. Community Crisis Team and city police may also be accessed in crisis situations.

Program/Treatment Philosophy: Residents are encouraged to participate in household routines, and use community recreation and day program activities where appropriate. Recreation and day activities are provided in-home for those who are unable to use community services. . Staff arrange and accompany residents to all appointments and community outings. Residents use handibus transportation accompanied by staff. Residents pay their own room and board. Restrictive procedures and restraint interventions are employed only when all other less-restrictive interventions and strategies have been tried, and only when outlined in a documented and approved behavior management plan.

Support Services: Regular in-home support is available within the scope of nursing practice. Residents retain their own personal physician/psychiatrist/dentist who make regular house calls. Consultation services are available through the Glenrose Hospital.

Transition: The Adult Housing Client Service Coordinator, residents, guardian or the operator can initiative discharges from the program. This occurs when a resident no longer requires the resources of the program or when a resident's needs are no longer manageable within the program resources. Adult Housing Client Service Coordinator maintains accountability for the resident until they are successfully placed elsewhere. In the first year of operation five residents were discharged to more intensive treatment alternatives (2 to acute care after becoming medically unstable; 2 to acute care psychiatric units due to severity of behaviors; and 1 to forensic).

William Roper Hull Home - Secure Treatment Program

Description: Two secure facilities provide short term treatment services to children/adolescents who are court ordered to this program due to behavior which places themselves or others in danger.

Clientele: Children/adolescents with severe behavioral, emotional or mental health issues. Some individuals may have developmental delays as well as other issues. Must have Child Welfare status.

Consent: Clients are court ordered to this facility for a maximum of 7 days at which time the order is reviewed and may be extended. Typical length of stay is under 30 days.

Environment: Two secure/locked special purpose facilities located on Hull campus accommodates up to 10 children/adolescents each. Includes quiet areas and time out room.

Staffing: 24 hour staffing with approximately 3 clients to 1 staff during the afternoon/evenings and 4 clients to 1 staff during off peak hours. Staff includes 1 full time psychiatric nurse, plus a coordinator/housekeeper in each unit.

Program/Treatment Philosophy: Highly structured treatment program includes behavioral programming and counselling. Unlocked and locked confinement. Physical restraints if necessary.

Support Services: Two directors – one administrative director and one clinical psychologist. Two additional psychologists. Weekly access to psychiatrist.

Transition: May transition to any program within children's services such as another part of the Hull service continuum, a community group home, foster home or back to their family.

William Roper Hull Home - Cottage One Program

Description: Special purpose 10 bed facility located on the Hull campus. Average length of stay is 12 to 18 months but can extend to as along as 3 years.

Clientele: Adolescents with developmental delays and significant emotional and behavioral problems.

Program/Treatment Philosophy: Highly structured individualized treatment, basic life skills and social skills, based on a combination of behavioral and/or relationship based approaches. Families work as part of the treatment team helping to set and achieve goals with their children.

Staffing: A mix of well trained and experienced staff with backgrounds in psychology, social work and child care provide 24 hour supervision and treatment services. Staffing ratios are typically 3 or 4 staff to 10 clients during days and evenings, and 1 staff for overnight shift with access to back-up if needed.

Support Services: Weekly visit from a psychiatrist. Treatment team is headed up by a psychologist. Schooling, day activity programs and recreation are available on the Hull campus site.

Transition: Ideally young people transition from the Hull campus homes to a structured 6 bed Teaching Family Model home in the community (e.g. Cedarbrae) and from there possibly to a live-in roommate or independent living arrangement. Due to the severity of issues and complexity of individuals using Secure Treatment, some individuals do not transition off the Hull campus and into community options prior to entering the adult system.

William Roper Hull Home - Cedarbrae Teaching Home

Description: A six bed group home located in the community provides a supportive and intensive treatment program for adolescents who are dually diagnosed. Through combining a house in the community, a small staff group, live-in teaching parents and special events and activities, Cedarbrae provides support and teaching for anticipation in community activities and for development of independent living skills. Typical length of stay is about two years.

Clientele: Adolescents with complex needs (i.e. low intellectual functioning with emotional disturbance). Usually have transitioned from another Hull program such as Cottage One.

Staffing: Live-in parents plus 4 staff who provide rotating shift coverage during weekends and evenings.

Program/Treatment Model: Cedarbrae uses the Teaching Family Model which creates a home environment through use of live-in parents. The program is fairly structured with a strong focus on development of independent living skills.

Transition: The typical length of stay at Cedarbrae is about two years. Some young people move on to more independent living situations. Others stay in the Cedarbrae program until they move into the adult service system at age 18.

GENTLECARE Model – Deltaview Nursing Home B.C.

Description: The GENTLECARE philosophy supports a strategy that adjusts the organizational environment in which the person must operate. The model believes in the therapeutic potential of the physical environment. A prosthetic, or supportive living space is developed to accommodate the client regardless of his/her current functional ability. The focus of the GENTLECARE philosophy is on understanding the clinical implications of cognitive impairment, and becoming sensitive to the client's ecology, relationships and living context. Use of the GENTLECARE philosophy will assist staff and families to understand functional deficits in clients, anticipate difficulties and stressors, and avoid confrontation and crisis through support an creative problem solving. Moyra Jones Resource Ltd., founder of this care model indicates that the model is used in all provinces in Canada, 32 states, Italy, Asia, and South America. The model has application across many client populations. It originated around dementia but has been expanded to include ADD, brain injured, etc. The program interviewed in BC is funded through the Regional Health Authority.

Clientele:

- adults with chronic progressive dementia (within the last 2 (of 7) stages of Alzheimer's), diagnosed, aggressive behavior, elopement risk
- Prior to admission- violent, aggressive, sexually aggressive, combative
- Age range: 47-94

Consent:

- All clients have guardians.

Environment:

- Secure 40-bed facility. The whole building is specifically designed for this purpose. Another attached 40-bed unit for those bedridden.
- Length of stay: 1- 9 years
- Huge outdoor spaces (3), garden with water feature, big deck with awning, work area (wash cars, wheelbarrows etc, building diamond shape, no hallway comes to an end, in the corners there are lounges, main dining area in the middle.

Staffing:

- Ratios: day 1-8 (5 are care aides) p.m. 1-10 (4 are care aides), 1 ft music therapist (10-4), 1 ft activity coordinator (11-7), 1 RN, 2 housekeepers, 1 bath person
- Not a big staff turnover, the day team has been together for 10 years. Care aides are very creative. Nurses have been more of a challenge to get used to the model because of their medical perspective.

Program/Treatment:

- Big emphasis on reducing amount and kinds of medication, or eliminate medication altogether.
- Aggressions are managed by following the model. Behavior is not considered bad. Staff are challenged to be creative.

- Absolutely no restraining is their policy, no physical restraints of any kind, and no chemicals for the purpose of restraining.
- There are no locked doors (even offices), all separate bedrooms.

Support services:
- One doctor for 39 residents who is on site once a week, excellent communication, and believes in the model.
- Director belongs to a wide network of people who use the model. Moyra Jones (founder of model) comes and does ongoing staff training and consulting.

Challenges:
- maintaining positive environment, need a lot of energy to maintain positive environment in difficult situations,
- paperwork that precedes resident is very negative, a lot of labels, takes a lot of work to get people to not take that into account,
- people are poly-medicated, educating other professionals. People are assessed under a medical model, under medication as well.

Roostai Home - NE Alberta

Description: 4 bed treatment home with one extra bed for crisis**.** "Providing people innovative support and opportunities for personal growth through training, education and community involvement."

Objectives:

- to help the individual stabilize behaviors,
- providing structured routine

Clientele:

- developmentally disabled with additional issues such as aggression, mental illness, obsessive defiant disorder, secondary terms for people suspected of having FAS, aggressive etc
- must have a developmental disability as defined by PDD, referral from PDD only, people do not use weapons along with aggressive behavior, they don't exceed ability to be served,
- there is an admission panel (behavioral psychologist, team leader, WJS NE PDD manager), take into account current dynamics e.g. will not take in a sexual offender if there is victim of sexual violence currently staying there.
- **Age range:** last two years served only adults, previously no age restrictions, most inquiries are 14-25 years or age. Plans to reflect the need for that age range.

Consent issues:

- Guardian or self consent needed to stay and to develop restrictive procedures, aware of expectations and agree to them (e.g. House rules)

Staffing model: 24 hours

- **Ratios:** day time 2 clients to 1 staff, 12 hours at a time, single staffing during sleep time
- Staff are offered financial incentives to further their education, behavioral psychologist offers training as needed and oversees the entire program

Environment

- **Group home:** 4 aspects (crisis, assessment, respite, treatment
- **Secure:** people can leave and come as they wish, sound goes off when door is opened (like in a store)

Program/Treatment:

- very structured, people are aware of expectations, house etiquette rules etc upon entering, "you are coming into our program as opposed to we are coming into your home"
- maximum 12 month stay
- aggressions are managed by emphasizing stability, providing a structured routine,

- restrictive procedures rarely used, only as a last resort and for safety reasons. Procedures established on an individual basis and reviewed by board
- restrictive medication policy in place, used as a very last resort, often use emergency services to administer rather than staff

Transition:

- people can only stay up to a year, any exception must be approved by PDD, 80% of people come through crisis, if previous place of residence is no longer an option, hey will help to find a new place along with PDD, exit plans are developed, support may be offered (behavior consultations) ongoing with treatment or upon transition

Challenges:

- getting all parties to work together, once people enter through crisis they all tend to go away,
- working with all the dynamics of someone's life, housing that is affordable and appropriate e.g. if someone exhibits a behavior that causes toilets to be replaces or rails installed IF funding won't cover it and AISH is not enough

SUPPORTED LIFESTYLES – VISTA PROGRAM

Description: A special purpose 6 bed facility for adults with developmental disabilities and behavioral issues. Services include 3 spaces for longer term stabilization or transition periods ranging from one to three years; 2 relief/crisis beds for up to two 30 day stays with the option for two additional 30 day extensions; and one assessment space for 3 to 6 month assessments, usually in preparation for a stabilization bed.

Pre-service assessment and intake procedures based on a proactive approach to planned service provision may restrict ability to accommodate emergency respite placements.

Clientele: adults with developmental disabilities and behavioral issues. Do not accept individuals whose uncontrolled aggression poses a danger to others in the group living environment. Security levels are not adequate to accommodate individuals whose running away behaviors pose a threat to community

Staffing: Facility is staffed with experienced, well-trained staff during all hours except daytime period from 9:00 to 3:00. If an individual is unable to attend their regular day activity or work program, staffing can be adjusted to accommodate daytime coverage. Typical staff coverage is 2 staff to 3 full time clients. If warranted, an additional staff would be added for high need relief placements.

Environment: special purpose facility with medium level of security provided through door alarms and supervision. Group living environment within the community. Spacious environment within the home and option of quieter areas downstairs allows individuals to self-regulate their level of interaction with others.

Program/Treatment Philosophy: Thorough assessment and intake process allows for development of comprehensive individualized treatment plan. Longer term residents' treatment plans are supervised by a psychologist.

KIGEP – Wildcat, Cochrane Lake and Other Rural Programs

Description: A number of group homes and other living environments located in remote rural areas provide 24 hour services to nine developmentally disabled adults with complex needs including autism. Security is provided through high levels of staff supervision and through location within rural settings which provides the space needed by some clients. Other security measures are unnecessary in this environment.

Staffing: Usually 1:1 staff:client ratio especially during the day. Some locations can reduce staffing to 1:3 client for evening hours.

Program: Some clients participate in a day program in Cochrane. Others engage in day activities at their rural living environment. The program is particularly suited to those individuals who prefer a quiet non-stressful environment with somewhat limited social interaction.

Limitations: Due to the rural location, this program would not be as suitable for individuals who highly value socialization and social/recreational activities.

Oregon Service Continuum

Description of Three Service Models:

(A) Supported roommate (aka foster care)- adult or couple typically with a corrections background is hired and to provide support, 1:1 additional staff is hired for time away, models provides them with flexibility as to where they will live (e.g. away form schools etc), cost $3500 month per person, recidivism rate low, 30-40 homes out of that 3 people release revoked

(B) Group home, no more than 3 individuals, advantage is having more staff around to help with restraints if needed and paid awake shifts etc, $7000 month per person

(C) State run group homes, 3-5 people, typically use duplexes, 15 homes throughout state, primarily staffed by employees that worked in institution, cost $12000 per person a month, state had a level of commitment, liability to much for non profits, housing laws state no lock downs, windows and doors have alarms that activate vibrating pagers on staff, recidivism rate I offence since 1990

Clientele:

- state homes serve violent offenders (murder, sexual offences etc)

Support services:

- state employees are better connected to outside consultants

Transition:

- movement to least restrictive environment does occur (state home to non-profit agency)

Arcane Horizon Inc. - Manitoba

Description of Model:
Unique individualized programs in the community. Have been operating for 6 years. Serve 9 individuals age 17 to 34. One independent living arrangement, group home model (2 people), supported roommate situation.

Clientele:

Story

- self abusive, aggressive, biting, developmental disability, obsessive compulsive disorder
- man has 24 hour support, was in the psychiatric unit for crisis stabilization, provided 3:1 staff for him, almost killed himself due to self abuse, agency worked in crisis unit, did a social story, prepared him for the move to community, created a large profile, a lot of staff training, someone he already knew (from crisis unit) was in his home for 24 hours to be familiar for him and to model for staff
- he is now on his own at times, no official diagnosis, likely brain injury, setting limits and behavior modification did not work for him, staff followed unpleasant situation with a pleasant one, remained very calm, supported him through it gently, supported roommate situation
- able to decrease medications from two pages of meds to one consistent medication that works

Staff:

- 90% staff are male, that has made a huge difference for many people, size of men they support and size of staff need to be comparable
- learned if they did not use female staff, aggression decreased by 80-90%

Environment:

- no locks on doors,
- *man with pryder willie syndrome has fridge locked on particular cycles,
- one house has an alarm because man is suicidal,
- all knives are locked up,
- always have on call, they don't access emergency because they tend to be not helpful and hospital emergency room can be very unsafe
- they will call police if there is danger to themselves or to community
- 2 houses have complete Plexiglas windows, pictures are bolted, Plexiglas over T.V.'s, attempt to make it as normal as possible
- They own one home, they have a real estate agent, a landlord buys it they sign with the landlord for a long-term lease
- They have their own vans because people can't ride public transportation

Program/Treatment:

- do home schooling if required, individuals have day programs based out of home, they conduct their own missing person searches,
- write a lot of stories about people, why they do things, why they get support, to increase empathy in staff
    - based on gentle teaching model by John McGee, concept of interdependence, acknowledging history of people, staff becoming their friend, eg, staff ask someone to do something and they say no, do it for them, then do it with them, then hopefully do it on their own,
    - they acknowledge that physical restraints are not part of his model but they feel it is necessary at times eg, someone running after a little kid, serious property damage, etc.
    - attempt is made to reduce medications. All changes are agreed upon with person and their network

Support services:

- In Manitoba, 2 psychiatrists that work a half day a week for all special needs people in Province
- they do consult with a behavioral consultant 3 hours a week for one person, their case load are 60 people in crisis,
- they don't use community crisis unit because it has been ineffective in past

Challenges:

- inexperienced staff, training staff, retention of trained staff, no experience can be a good thing, lower wage as compared to working with other people without aggressive tendencies
- agency underfunded, a lot of work- making profile, plans, running agency, supervising staff, and providing direct support

Calgary Adult Service Continuum

Within Calgary there are a number of service providers who offer a range of flexible service alternatives to meet the unique needs of individuals with complex challenges. Through their creativity and flexibility, these service providers have successfully sustained individuals with significant complex intellectual, emotional, behavioral, physical and mental health challenges in the community for extended periods of time.

Residential service models include independent living with support; live-in supportive roommate models; supportive neighbor, and small group living options in the community (i.e. peer roommates supported by varying levels of support staff).

SCOPE

Description: SCOPE provides long term support to over 30 adults who have particularly difficult lives due to struggles that come from living with a mental handicap and accompanying mental health or other social problem. Support may include supported living as well as day activity, recreation and/or employment supports. The outreach team works with individuals, families, groups and agencies to support people of all ages in dealing with the social and behavioral challenges they face.

Counseling Services: SCOPE has three part time therapists who provide individual, family and small group counseling.

Supported Lifestyles

Description: Supported Lifestyles provides intensive residential services to people age 14 to 60 years, with intellectual challenges as well as behavioral, mental health and/or physical challenges. The agency also provides career/lifestyle planning and support services, as well as short term outreach support and assistance to those who are experiencing difficulties in their current vocational/day-alternative services.

Psychological Services: Supported Lifestyles has chartered psychologists on staff for assessment, consultation, individual counseling, and group counseling.

Crisis/Relief Services: Supported Lifestyles provides intensive relief services to people with intellectual challenges as well as behavioral, mental health and/or physical challenges that range in age from 17 to 60 years. Two crisis/relief beds are available at the Vista Heights Group Home.

Calgary Alternative Support Services

Description: Provide a variety of community support services including residential support, day supports and employment supports. Residential models include live-in or supported roommate models, independent living with outreach support and staffed homes usually based on a 24 hour staffed model.

Staffing: For staffed home models a total of 2 full time staff (per home) work in shifts to provide the 24 hour 7 day per week coverage typically used to support 2 individuals with developmental delays. In cases where aggression or property damage issues arise, staffing may be increased to a 1:1 staff:client ratio. All staff are CPI trained.

Limitations: Some of the circumstances which prohibit service provision include a difference in philosophy between the guardian and the service provider where the family prefer a more medical treatment model, want a more secure facility or require medically oriented support services, and situations in which the individual receiving service becomes increasingly agitated to the point at which staff are getting hurt during aggressive episodes.

Hull Interdependent Living Services

The ILS program provides developmentally delayed young adults with the stepping stones to successful independent living. Counselors assist young adults with daily routines, living skills, social skills, vocational skills and budgeting skills to enhance their belonging to the community. The degree of support ranges from counselors who live-in with a client, to more independent clients who are visited by counselors for a few hours each week.

Bluesky Colorado and Pueblo Consortium

Description: Bluesky serves approximately 800 people (children and adults) in it's continuum of services. 350 people are in 24 hour support programs. Entire budget is15 million dollars.

D.D. Offender "RESULTS" Program
Developed out of need determined by consortium. Has served 16 people to date.
Clientele:

- developmentally disabled individuals who have committed offences including assault, burglary, sexual assault on a child, substance abuse, child abuse resulting in death

Environment:

- highly structured and supervised residential setting serving maximum of 3 individuals at one time
- homes located in the community
- 1:1 supervision on community outings

Staff:

- team approach to service planning – includes five full-time and one part time residential providers and their supervisor, vocational program representative, individual's case manager, a psychologist, parole officer.
- Highly trained staff work 2.5 days, then 4.5 days off, 16 hour shifts, 5 hours sleep, time and half if less than 5 hours sleep,
- Staff members must be physically capable of dealing with individuals who may be physically aggressive
- team determines length of stay, they meet weekly, then every two weeks, team makes decisions about person moving to a less restrictive environment,

Program/Treatment:

- philosophy is based on levels program that involves earning losing and spending points according to individualized point/level program. The point/level system involves a series of 5 levels with accompanying responsibilities, privileges and criteria for movement to the next level.. Typically includes a token economy.
- Use full range of firm direction and sensitivity
- Try to access integrated community employment or work skills training.
- Have developed a separate day activity program located in rural area involving caring for animals

Managing Behaviors

- 2 people did go back to jail
- limited physical restraints taught through in service and training, must be approved through Human Rights Committee (outside organization of parents, and professionals, psychologist, nurse),
- chemical restraints- psychotropics can only be given to people with dual diagnosis, through Dr, according to state legislature
- they encourage people to file charges

Transition:

- a number of people have successfully moved to Personal Care Alternatives homes and one individual moved into independent living
- 2 individuals have returned to jail

Diversion Program

- creative sentencing - believe in person experiencing consequences if they break the law, personal support team provide input into appropriate sentence
- work with court to ensure that the consequence meets the person's understanding and need (e.g. tv taken away, restricted social activities), idea is to keep people out of jail or forensic psych unit

ASSET Therapy

- focus on positive strengths has been successful
- in past experiences people have not fostered healthy relationships, only worked on negative issues. If people are going to move on to independent living, get married etc, they need to know how to appropriately respond to others.

Safety First

- classes taught by police officers and firemen provide individuals with developmental disabilities an opportunity to develop a supportive rapport with these public servants.
- Has been a good experience

Pueblo Consortium

- has been operating for 14 years.
- gives input to prosecuting attorney
- learned that they can't do it all by themselves, need professionals from other areas,
- reverse of turf protection, voluntary cooperation, does not cost system any money
- judges involved and pleased with low rate of recidivism
- someone needs to take responsibility for the consortium to keep people coming, facilitate meetings, distribute flyers, call people, arrange dinners

Project A.S.S.I.T. (Assault, Safety, and Social Intervention Systems Training)

- recently developed by the Consortium
- Provides a voluntary, centralized identification and tracking system for individuals with developmental disabilities who are classified as offenders or who may otherwise com to the attention of law enforcement or emergency psychiatric or medical personnel due to behavior which is a danger to self or others.
- Contact number made available to police to immediately access critical information
- Training sessions provided annually to criminal justice system, police officers, probation officers, District Attorneys, Public defenders
- Enhances the systems ability to address the health, safety and wellbeing of all citizens

Raising The Bar - Lancaster PA

Description: Case management/case supervision which uses a dual-systems approach involving two person teams made up of one court-funded Probation Office and an MH/MR-funded Case Manager. Services are accessed through local agency service providers.

Environments:

- Personal Care Homes (used a lot) – owner administers program and provides room and board, supervision, care. May include additional care staff
- Group Homes staffed 24 hours per day
- Community Residential Rehabilitation Facilities (offered by 2 agencies)
- structured group living environment for 14 individuals with 24 hour staffing plus 1 treatment specialist on staff during day shift, no locked facilities

Challenges:

- residential placement is the biggest challenge
- community services don't deal with uncontrolled aggression
- bounce around the system for awhile, usually end up in and out of shelters or back in prison

Calgary PDD Police Advisory Committee

Description: a cross section of agency and consumer representatives meet monthly with police. Provides a link between the justice system and the PDD service system. Have developed two safety videos with input from consumers: "For Safety Sake" and "Safety On The Street". Police representative trains new recruits about people with disabilities in order to increase their awareness, understanding and ability to provide quality service.

Limitations: some legislation such as "Protection of Persons in Care Act" limits police authority to lay charges in cases where the person with a disability does not form the "intent" to commit a crime. Therefore, asking police to lay charges in cases of assault towards staff is often ineffective. It would be most helpful if police were involved in the original design of the treatment plan and protocols in order to provide sound advice re the most helpful and appropriate role for police.

Proposed Dual Diagnosis Clinic
Vocational Rehabilitation Research Institute - Calgary

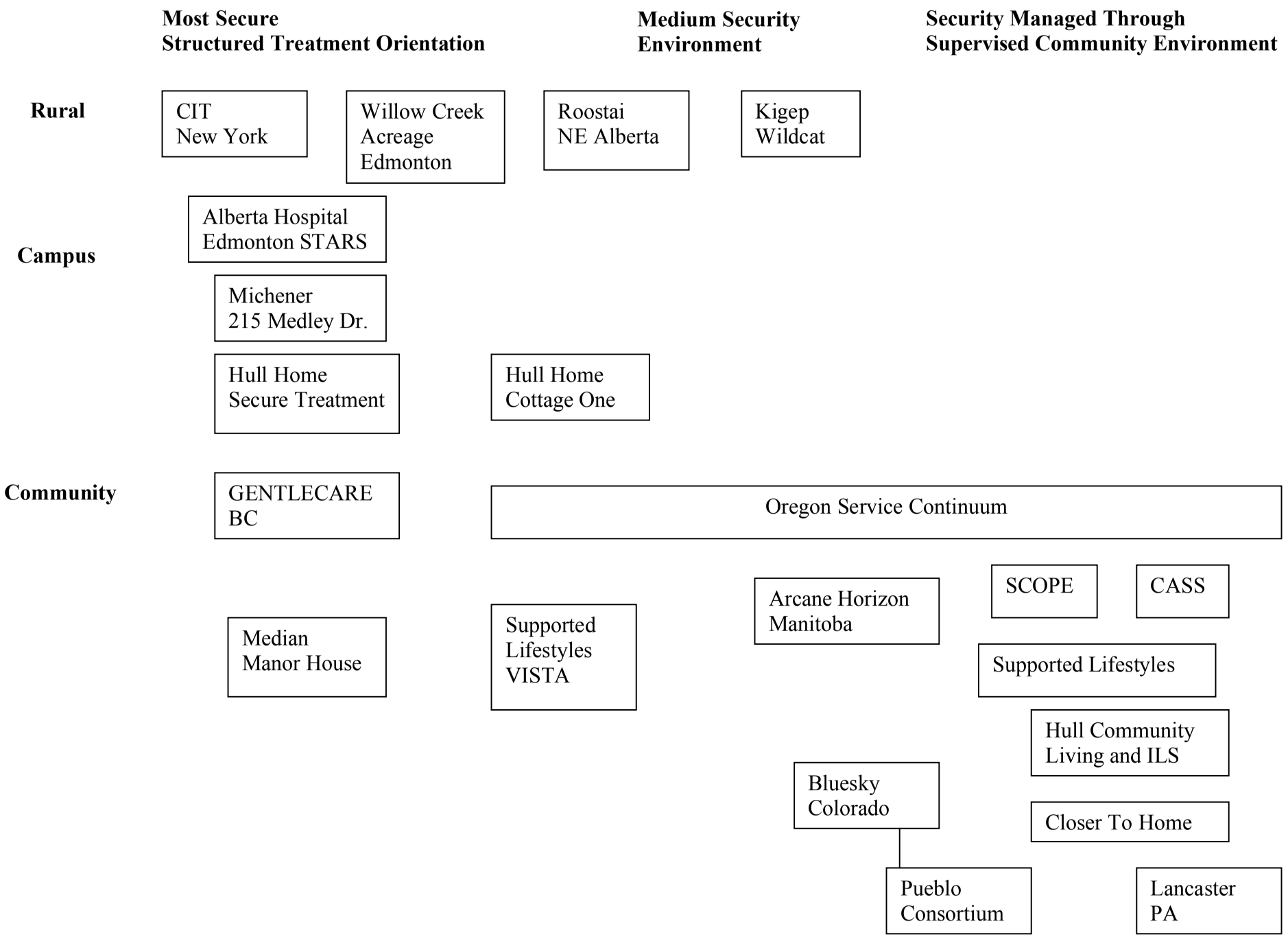
Description of Service Model: A clinic comprised of a core team of professionals who would provide case management (intake, referral, coordination and follow-up) for a full range of community services to address the needs of those individuals with a dual diagnosis involving a developmental disability and mental health or behavioral problems.

Staffing: The core team would include a psychiatrist, family physician, psychologist social worker, nurse/coordinator and a research evaluator.

Clientele: Individuals with developmental disabilities and other complex issues such as mental health or behavioral problems.

Services:

- mental health assessment and diagnosis
- direct, specialized medical, psychological and social work treatment to stabilize the situation for individuals in crisis and those moved from chronic care facilities
- proactive stabilization with a goal of avoiding costly inpatient treatment
- liaison and referrals to other service providers with special training including occupational and speech therapists, neurologists, vocational therapists, etc.
- ongoing professional relationships between the core team and a wide range of specialized service providers in Calgary
- provide education and training to partnerships community agencies
- clinical research


Most Secure
Structured Treatment Orientation
Medium Security
Environment
Security Managed Through
Supervised Community Environment
Rural
Campus
Community
CIT
New York
Willow Creek
Acreage
Edmonton
Roostai
NE Alberta
Kigep
Wildcat
Alberta Hospital
Edmonton STARS
Michener
215 Medley Dr.
Hull Home
Secure Treatment
Hull Home
Cottage One
GENTLECARE
BC
Oregon Service Continuum
Median
Manor House
Supported
Lifestyles
VISTA
Arcane Horizon
Manitoba
SCOPE
CASS
Supported Lifestyles
Hull Community
Living and ILS
Bluesky
Colorado
Closer To Home
Pueblo
Consortium
Lancaster
PA