NOVA SCOTIA

Standards for Mental Health Services in Nova Scotia

The standards are intended to provide guidance for quality service delivery and reduce variations across the province, while maintaining flexibility to adapt approaches to unique district, community and organization conditions.

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I. Introduction

This set of system-level standards for mental health services in Nova Scotia has been drafted by the Core Programs Standards Working Group of the Mental Health Steering Committee. Numerous system stakeholders were involved in reaching consensus on standards based on the best available information regarding effectiveness and/or best practice, balanced by the perspective of consumers, expert practitioners and educators. This process is not yet complete. Input will continue to be sought and revisions will be ongoing.

Generic and core program standards form the foundation for long-term improvement in mental health services. An overarching set of generic standards represent the preferred conditions relevant to all mental health service delivery. The core program standards define the key service components to be achieved within each of the core programs.

Core programs are accessible to all Nova Scotians as part of a comprehensive mental health system. Nova Scotia's core programs, as referenced in the work of the Federal/Provincial/Territorial Advisory Network on Mental Health, are :

Promotion, prevention and advocacy
Outpatient and outreach services
Community supports
Inpatient services
Specialty services

Program planning reflects developmental differences across the age span. Program components are provided within each health district, through partnerships/service agreements among/between districts or through designated sites which serve the entire population. Ultimately, location of services must be determined both by need and by quality considerations associated with community characteristics, capacity and critical mass required to maintain provider skill base.

The standards are intended to provide guidance for quality service delivery and reduce variations across the province, while maintaining flexibility to adapt approaches to unique district, community and organization conditions.

In some cases, the standards may represent maintenance of the status quo or minor changes to practice. In other cases, the standards will represent a challenge for mental health provider organizations and require the development of realistic action plans at the DHA level to achieve long-range milestones. Once approved, the entire standards for mental health cannot be implemented in a short period of time. Full implementation will be phased in over 5-10 years, aligned with the business planning process.

II Generic Mental Health Standards

1. Standards

1.1 all DHAs and the IWK apply the CCHSA accreditation standards, as well as professional and legislated regulations in the administration and delivery of mental health services

1.2 all DHAs and the IWK participate in the development and implementation of provincial system-level generic and core program standards

1.3 all DHAs and the IWK participate in the regular review and revision of provincial standards to reflect best practice

1.4 there is individual, family and community participation in the decision making process, planning, evaluation and delivery of mental health care

2. Access

2.1 core programs are accessible to all Nova Scotians provided within DHAs and the IWK through partnerships/service agreements among/between districts that ensure equitable access or through designated sites which serve the entire population

2.2 access to health services is not limited by an individual's place of residence; urgent or emergency services can be accessed in any place at any time. The District Health Authority may give priority to local residents for non-urgent/ emergency services except in those cases where a formal arrangement exists for one District to serve a larger area

2.3 for services provided through limited designated sites, clear provincial access protocols shall be established, distributed, regularly updated with appropriate input and monitored

2.4 information on the range of local mental health services, and how to access both local and non-local services appropriately, shall be made available to mental health service recipients as well as those who care for them in all sectors; referral protocols are routinely revised incorporating user input

2.5 common process for intake into the Mental Health System, incorporating eligibility screening and triage for urgency, is utilized in all DHAs and the IWK

2.6 eligibility and exclusion criteria for core programs within the mental health system are communicated to all potential referral sources and the community at large

2.7 where wait lists exist the service has a ‘wait list’ policy and procedures. The clinical team has a mechanism for assessing ‘urgency’, risk, and the need for timely/early intervention, as well as a mechanism for maintaining and reviewing ‘wait lists’

2.8 clear protocols for service transition between DHAs and the IWK and from child and youth services to adult services are established, distributed and regularly updated with appropriate input

2.9 services are sensitive to accommodating individuals with special needs

2.10 mechanisms to enhance access are utilized (example: telehealth)

3.0 Service Delivery:

3.1 the treatment/community support plan outlines mutually established goals and/or outcomes expected for the individual as well as a time frame for treatment. The goals and/or outcomes of treatment /community support plan are reviewed, evaluated and revised as necessary following the establishment of the treatment plan

3.2 the treatment/community support plan and discharge plan include appropriate linkage and coordination with professionals, community resources and more specifically primary care providers

3.3 vulnerable/high risk individuals have a plan developed by the primary clinician and, with the written consent of the individual (where necessary), shared with others who also have contact in a crisis situation

3.4 protocols identify interagency responsibilities associated with collaborative interagency treatments for various disorders where best practices dictate and efficiencies are to be gained

3.5 responsibility for mental health care resides within a core program until adequate alternate service provision is arranged or discharge is warranted

3.6 processes are in place to develop and monitor individualized follow-up plans made within and outside the mental health system

4. Planning, Evaluation and Monitoring

4.1 a provincial quality improvement approach forms the basis for planning and evaluating the mental health system.
this includes:

- annual monitoring of compliance with established standards for mental health system performance
- transparent , annual joint review of the utilization of mental health services with particular emphasis on the analysis of trends and patterns of service use across the province
- review of critical incidents to inform a province-wide risk management program

4.2 all DHAs and the IWK participate in provincial planning and evaluation initiatives such as the Provincial Mental Health Steering Committee and associated Working Groups

4.3 attention is paid to ensuring the accuracy of Canadian Institute for Health Information (CIHI) and MHOIS data as a valid source of information for planning and monitoring

5. Health Human Resources

5.1 DHAs and the IWK participate in the development of a provincial health human resource strategy
this includes:

- regular province-wide assessment of gaps and anticipated future requirements in human resources across the spectrum of professional disciplines
- mechanisms to identify core competencies for staff in each core program area and training requirements which warrant coordination of consistent province-wide training programs

5.2 training resources, which may be pooled among districts or at the provincial level to gain economies, are allocated to reflect emerging technology and to be in keeping with health system priorities

5.3 all mental health staff demonstrate knowledge, skills and competencies appropriate to the care/service provided and consistent with evidence and best practice literature

- any professional staff with the responsibility for independent practice are prepared at the Masters level (at minimum), are registered or licensed with a self-regulating profession and demonstrate competence in mental health assessment/diagnosis

(DSM-IV). Independent practice includes all of the following: rendering a diagnosis or diagnostic impression, providing mental health treatment and discharging from the service. Staff without Masters preparation shall be assigned tasks consistent with their training within appropriate supervision by Masters level clinicians

- for those staff who are not yet fully licensed or who cannot be licensed, appropriate supervision (in addition to that required by licensing bodies for candidates) is arranged.

- all mental health staff working in high risk areas (e.g. short-stay units, situations where crises are managed) are trained in non-violent crisis intervention

- all mental health staff working with persons with severe and persistent mental illness in the community or a residential setting are trained in psychosocial rehabilitation and case management

- all emergency, outpatient and community-based mental health staff are trained in suicide risk assessment

6. Governance and Funding

6.1 there is a Director of Mental Health Services in each district and the IWK responsible for mental health service planning and resource allocation, and accountable for the full range of mental health system performance

6.2 financial and statistical data collection and reporting related to mental health services are compliant with Guidelines for Management Information Systems (MIS) in Canadian Health Service Organizations

III Core Mental Health Program Standards

The core programs, although distinctly separated for the purpose of clarity, are interdependent and therefore must be well integrated, with sound communication and coordination mechanisms in place among formal and informal care providers. This set of system-level standards spans the age continuum.

The following elements for each of the core mental health programs in Nova Scotia are outlined:

- context and issues
- target population
- goals which specify endpoints or results to be achieved
- nature and intent of the program and its components
- specifications of the requirements of service in key areas
- the nature of evidence/information used to formulate the standards statements
- associated reference materials used in the development of the standards

In many cases, research-based evidence does not exist to substantiate mental health system processes. However, the expertise of knowledgeable care providers in Nova Scotia and information about the practices of other jurisdictions around the world were available to guide the standards development. Nature of evidence was classified as follows:

I. Research-based evidence of effectiveness
   - •studies/evaluations using control or comparison groups
   - •consensus panel
   - •quasi-experimental studies/evaluations

II. Expert consensus of effectiveness or value
   - •industry standard
   - •published best practice

III. Based primarily on expert opinion, with significant operational experience
   - •advice from individuals acknowledged as experts in their field
   - •experience, descriptive case studies from other jurisdictions

IV. Based on input/opinion of a significant number of stakeholders and/or the community

These standards are a work-in-progress and are intended to evolve over time.

Core Program Title: Prevention, Promotion and Advocacy (A)

Context & Issues:

It has been demonstrated that mental health promotion has a wide range of health and social benefits - improved physical health, increased resilience, greater tolerance, participation and productivity. Promotion also contributes to health improvements for people living with mental health problems and challenges stigma and discrimination, as well as increasing understanding of mental health issues.

Mental health promotion encompasses three levels: the whole population, individuals at risk of developing mental health problems and vulnerable people with mental health problems (Making it Happen, 2001). At each level, interventions focus on strengthening factors known to protect mental health or to reduce factors known to increase risk. Included are interventions to reduce stigma and discrimination experienced by people with mental health problems.

Promotion, Prevention and Advocacy are unique in that impacts are not evident for 2 to 3 years or longer. Research has demonstrated the cost of not supporting promotion, prevention and advocacy (University of Surrey 1998, National Children's and Youth Law Centre 1997). However, there is a paucity of research on programs with demonstrated efficacy. It has been demonstrated that targeting populations (high risk, vulnerable groups), at a provincial, state or country level have positive outcomes.

In order to focus on those initiatives which glean the most benefit, a provincial strategy shall be developed to identify priority groups and those strategies, supported by strong evidence of effectiveness, most appropriate to address them. The priority of the mental health sector is to focus on those at risk of developing mental health problems and vulnerable people with mental health problems through prevention and early intervention strategies. In addition, providers of mental health services collaborate with other agencies which are working towards enhancing the health status of the whole population (e.g. public health services).

Core Program Description:

The goal of promotion, prevention and advocacy is to provide information to the public designed to enhance and raise awareness and understanding of mental health issues, reduce stigma and promote positive mental health. A second goal is to engage in prevention activities directed at averting a potential mental health problem; secondary prevention directed at early detection and as appropriate intervention to prevent or delay onset or mitigate a mental health problem. A third goal is to provide education and training, through consultation and collaboration with those who have experienced mental health problems, families, providers and others in the human service systems. This education may include mental health aspects of health care and an understanding of the service delivery system. These activities may be provided by individuals who have experienced mental health problems employed as care providers or contracted to these individuals or others within human service systems outside of the formal mental health system.

Prevention is categorized as primary prevention directed at averting a potential mental health problem; secondary prevention directed at early detection and as appropriate intervention to prevent or delay onset or mitigate a mental health problem; or tertiary prevention, directed at minimizing disability or avoiding relapse.

Goal Statement:

The factors that sustain mental health and well-being are strengthened.

The risk factors associated with mental illness are reduced.

The stigma and discrimination associated with mental illness is reduced and tolerance promoted.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	A.1. A provincial strategy for secondary prevention of mental health problems exists, developed with stakeholder involvement including participation by the DHAs and the IWK in the development and implementation of the strategy.	IV
Appropriateness	A.2. The DHAs and the IWK identify and target high risk and vulnerable groups in their communities, with focused, evidence-based programs to address their needs.	IV
Efficiency	A.3. Partnerships to implement promotion, prevention and advocacy programs extend across all sectors including individuals, organizations and communities.	III
Accessibility	A.4. Education about mental illness, mental health care and the mental health delivery system is provided at a district level for individuals, families, staff and public.	III

Indicators:

Core Program: Outpatient and Outreach Services: (B)

Context & Issues:

The Outpatient and Outreach Program is often seen as the fulcrum of a comprehensive community mental health service. This program provides assessment and treatment for those individuals who have or appear to have a mental illness (e.g. depression, anxiety, schizophrenia), a mental, behavioural or emotional disorder, severe functional impairment and those at risk of severe functional impairment. Services include: Early Identification/Intervention Services and Assessment/Treatment Services as well as the potential for other services as defined by a particular facility or district. Each district has a cohesive program including both an Adult Service as well as a Child and Adolescent Service with explicit linkages to key community services (schools, Community Services/Children's Aid Societies, early childhood programs, probation, etc).

Early Identification/Intervention Services:

These services are usually targeted to various groups of adults, children and youth at risk. Their purpose is to prevent the emergence of disorder or dysfunction in these domains. Early intervention includes the teaching of pro social skills to groups of children already showing some signs of early behavioural problems and includes neurodevelopmental services.

These services promote the earlier identification and treatment of persons with mental illnesses and problems who may not otherwise be referred by other agencies and groups. Such agencies and groups would include primary care providers, justice/corrections agencies, community service agencies, seniors programs, etc. In such cases the recipient may be the agency/group as well as the person with mental health problems.

Assessment and Treatment Services:

These services are provided upon referral from a family physician or other primary health care professional, school, community services agency or other social agency, Justice/Corrections, or by self-referral. Treatment is time-limited. Services include: 1) crisis and emergency response services; 2) individual/group/family assessments and treatment services; and 3) consultation services. Districts may enter into agreements with other districts in order to provide access for their citizens to core services.

Intensive Community Based Acute Treatment Services:

Intensive community based treatment such as day treatment, day hospital, home and community-based services are also effective program elements which may be included in a district's services.

Intensive treatment services include day, evening, night and weekend mental health services which employ an integrated, comprehensive, and complementary schedule of recognized treatment approaches. These services are usually time limited, treatment services that offer intensive, coordinated and structured clinical services to individuals with significant impairment resulting from a psychiatric, emotional or behavior disorder.

The standards that follow do not address 'Early Identification/Intervention Services and Neurodevelopmental Services, Day Treatment, focus only on Assessment/Treatment Services.

Goal Statement: Residents of each district have access to comprehensive, community-based assessment and treatment services.

Core Program Description: Crisis and Emergency Response Services (B1)

The capacity to provide a crisis and emergency response is an integral part of a mental health service's continuum of care.

A Crisis Response Service (CRS) links children, youth and adults in acute crises with the appropriate community resources and/or establishes an immediate communication link and supportive intervention for children, youth and adults experiencing critical or emergency mental health problems. This service provides appropriate, timely, and well coordinated responses to those persons in crisis. With their specialized training and experience, CRS personnel provide the necessary support and interventions to individuals and/or their 'significant others', and consultation to community providers, mental health staff, family practitioners, police, etc.

Within the mental health environment, crises manifest themselves in many ways, ranging from an acute occurrence of mental illnesses to the emotional consequences of the loss of housing and support networks. A crisis occurs when an individual's usual coping strategies are suddenly overwhelmed and the individual requires an immediate response.

Not all crises result in mental health emergencies. However, when an individual's coping strategies are so overwhelmed and there is potential for harm to self or others, or the individual's well-being is drastically threatened, an immediate 'emergency' response is required. A CRS must have skilled professional staff who are able to differentiate between true emergencies which must be seen immediately in order to be treated and stabilized, and those crises which may be appropriately handled in other ways.

The availability of experienced professional staff to respond to the first telephone or walk-in contacts made to the service is crucial to effective management and control of the crisis. Critical information is gathered and important questions are asked which assists in the initial 'triage'. It is also an opportunity for the CRS staff to inform referring agents about the individual's clinical presentation and about the service's recommendations.

According to Best practices in Mental Health reform (1997), the range of functions provided by a CRS includes:
1) Stabilizing individuals in crisis in order to assist them to return to their pre-crisis level of functioning;
2) Assisting individuals and members of their natural support systems to resolve situations that may have precipitated or contributed to the crisis; and,
3) Linking individuals with services and supports in the community in order to meet their ongoing community support needs.
4) Linking individuals to appropriate follow-up mental health care.

Goal Statement: Residents of each district have access to a twenty-four (24) hour crisis response service.		
Domains (CCHSA	**Standards Statements**	**Nature of Evidence**
Accessibility	B1.1. A crisis response system (CRS) is available in each district and includes a plan for twenty-four (24) - hour service seven (7) days per week.	IV
Appropriateness	B1.2. CRS includes the capacity to respond in a timely manner to requests for telephone consultation about crises.	III
Competence	B1.3. The CRS has designated mental health staff with core competencies in risk assessment.	III
Safety	B1.4. The CRS has an established protocol for crisis/emergency and risk assessment.	II
Acceptability	B1.5. Recommendation for admission to a mental health/psychiatric inpatient unit is made by a mental health provider, or in consultation with a mental health provider, in order to assure the appropriateness of admission. CRS services has access to a district or regional psychiatric inpatient unit and crisis beds.	III
Accessibility	B1.6. Timely consultation is available to various service providers (e.g. physicians, guidance counselors, CAS workers, etc.) to assist in identifying and intervening in actual emergencies. Liaison protocols are available for primary health care services, hospital emergency departments, and the police.	III
Continuity	B1.7. CRS coordinate with other crises services in the community in a cooperative manner.	III
Safety	B1.8. A policy identifies those situations and circumstances in which medical clearance/assessment is required for individuals who are being assessed in a CRS .	III

Core Program Description: Early Identification Services (B2)

These services are usually targeted to various groups of adults, children and youth at risk. Their purpose is to prevent the emergence of disorder or dysfunction in these domains. Early intervention includes the teaching of pro social skills to groups of children already showing some signs of early behavioural problems and includes neurodevelopmental services.

These services promote the earlier identification of persons with mental illnesses and problems who may not otherwise be referred by other agencies and groups. Such agencies and groups would include primary care providers, justice/corrections agencies, community service agencies, seniors programs, etc. In such cases the recipient may be the agency/group as well as the person with mental health problems.

Goal Statement:

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessability	B2.1. Proactive outreach / referral finding is part of a process of facilitating referrals to the mental health system.	III
Acceptability	B2.2. Mechanisms are developed to provide collaborative early identification/intervention services in response to: 1) individual needs; 2) system needs; 3) other agency needs, related to mental health issues.	III

Core Program Description: Individual, Group and Family Services (B3)

Assessment and treatment services should be seen as part of a system of care with clearly articulated activities and a range of skills and expertise associated with a multi disciplinary approach to service delivery. These services are provided upon referral from a family physician, school, community service agency, corrections service or other human service providers or on self-referral. Services are provided for those individuals and or families who have or appear to have acute or chronic major mental illnesses, mood and anxiety disorders, disruptive disorders , or other mental health problems or functional impairments where the severity is such that these can be addressed by community-based out-patient treatment. Treatment is time-limited as appropriate.

There is a recognition that mental health services must have an increasing focus on partnerships with primary health care providers and other human service agencies. When individuals are shared between mental health services and these other agencies and providers, there is a greater opportunity to educate each other, to collaborate with each other, to plan together and to better use the resources available in the best interests of the individual. As a 'secondary care' provider, mental health services can better ensure maintenance and follow-up through this collaboration. For these reasons, collaboration should be initiated at the first point of referral of the individual to the mental health service through agency referral or should be reinforced by engaging, with the written consent of the individual, the primary care giver or service provider early on in the assessment/treatment process.

Goal Statement:

Residents of each district have access to a range of services that address significant mental health needs.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	B3.1. A standardized triage and screening assessment process is used for all referrals into the mental health system	II
Appropriateness	B3.2. Individuals meet eligibility criteria for treatment. Criteria are: • anxiety disorders • mood disorders • psychotic disorders • those other symptoms of behavior, emotion or cognition accompanied by significant and chronic functional disability • there is an expectation of benefit from treatment	III
Appropriateness	B3.3. Exclusion criteria for the service include those individuals with no concurrent mental health disorder (as above) who exhibit: • gambling problems • legal problems, including custody and access assessments • need for assessment for insurance claims • partner relationship problems • need for psycho-educational assessments • substance abuse/addictions problems	III
Acceptability	B3.4. Referrals are reviewed by a member of the clinical staff. Intake screening to determine eligibility criteria occurs at the earliest point of contact with the service (within one (1) working day). The triage process distinguishes between emergency, urgent and regular referrals.	II
Continuity	B3.5. Referred individuals not meeting eligibility criteria, are referred to another service/agency or considered for consultation (see consultation section). Protocols are available to refer to other services/agencies in the community.	III

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	B3.6. In emergency cases, a referral is immediately made to the Emergency Department and a mental health assessment is completed within twenty-four (24) hours.	III
Accessibility	B3.7. In urgent cases, a mental health assessment is offered within five (5) working days of the referral.	III
Accessibility	B3.8. For all other referrals, the clinical team determines case assignment for assessment within ten (10) working days.	III
Appropriateness	B3.9. A diagnosis or diagnostic 'impression' and case formulation is required at the initial assessment. This initial assessment is within ninety (90) days from time of disposition.	III
Continuity	B3.10. Ambulatory follow-up of individuals discharged from inpatient care is available within ten (10) working days following discharge or earlier if determined to be urgent.	III
Continuity	B3.11. Processes are in place to follow up all individuals who fail to attend the initial outpatient appointment.	IV
Efficiency	B3.12. Regular utilization review mechanisms are employed to assess appropriateness of cases not closed within expected time frame.	IV
Efficiency	B3.13. Case loads are managed within the context of geography and available services and according to case mix, intensity, and the needs and outcomes of individuals.	III

Core Program Description: Consultation Service (B4)

Outpatient/Outreach services must develop a close working relationship with the primary health care sector and other human service agencies. Four areas of focus for this working relationship, beyond the provision of a secondary level of treatment, include:

1) education of the primary health care and human service sector in the effective screening and referral to the mental health service;

2) provision of consultation services, including treatment recommendations, based upon the assessment of individuals referred from family physicians and other human service agencies who meet the criteria for admission to the mental health service but who may be best managed in the primary health care or other human service setting;

3) provision of advice, education and support in the detection, assessment and management of mental health problems. These services are extended to a range of health problems (neurological, neurodevelopmental, chronic disease states, etc.)

4) development of collaborative interagency treatment protocols for various disorders where evidence or best practices dictate or where efficiencies are to be gained.

Primary care providers (human service agencies, Department of Community Services agencies - Childrens' Aid Society and family and Childrens' Services, Justice, schools, early childhood programs, substance abuse programs and day care) often request advice and assistance in responding to the mental health/psychological needs of the people they serve. These individuals may not require a 'secondary' level of care/treatment or the practicality of service provision would indicate that case management is retained at the primary care or agency level. Such cases could benefit from consultation on treatment approach or psychiatric medication management, differential diagnosis, etc. This consultation service is available to primary health care and human service providers at both pre-assessment and at post-assessment.

Goal Statement:

Primary health care providers and human service agencies have access to advice, consultation and support in responding to the mental health/psychological needs of people they serve.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	B4.1. Advice and consultation is provided to primary health care and human service providers. Providers of other programs are involved through consultation/liaison and joint planning in order to extend accessibility.	II
Continuity	B4.2. The availability of advice and consultation is communicated to service providers.	IV

Indicators:

Core Program Title: Community Mental Health Supports (C)

Context & Issues:

In 2000, the Department of Health published the document *Community Mental Health Supports for Adults*. This document, a collaborative initiative involving a diverse group of mental health system stakeholders, and based on extensive literature reviews, provides direction for developing a comprehensive system of community mental health supports for individuals with major illness and significant impairments. Although focused on adults, the document was used as the foundation for developing standards for the community support core program across the age continuum. Stakeholders involved in the mental health care of children and youth were engaged to add unique perspectives for the younger population.

Underlying the Community Mental Health Supports Program is a philosophy and a specific set of interventions which call for treating people with severe and persistent mental illnesses with the same dignity, rights and opportunities afforded to all citizens of Nova Scotia. This implies that the determinants of health are relevant for people with serious mental health disabilities, individuals are encouraged to do what they can to improve their health, and the outcomes of the program are those of the greatest importance to them. The desired service delivery for youth and adults is found in the literature on Psychosocial Rehabilitation (PSR) and Recovery (see appendix). The support network is a critical component in service provision for all age groups.

The target population for Community Supports Program is those individuals and their support network, who:

1. live with severe & persistent illness
2. And who:

a) have difficulty living in the community with a quality of life acceptable to them;
b) are not effectively supported by traditional mental health services , choose not to use them, or are involved with multiple agencies;
c) have significant impairments in dealing with many aspects of life (for example social, education, work, housing, self-care, and leisure);
d) are at higher risk for poverty, homelessness, criminal encounter, substance abuse, unemployment, discrimination and suicide;
e) often have poor response to traditional medications and programs, or have difficulty assessing comprehensive service supports (rural vs. urban, transportation, lack of outreach/case finding);
f) frequently have under recognized needs for medical care.

Core Program Description:

A Community Supports Program is designed to help individuals and their support networks in managing the demands of daily life and to promote full citizenship in community. Community Supports differs from traditional mental health services through the focus of interventions and by delivery in the individual's community environment. Staff collaborate with individuals and their support network around functional goals, and provide continuous outreach and support across service settings and as needs change. The range of intensity/frequency of service is based on need, and will vary by individual. Resources available(e.g. housing, human resources), and critical mass, may challenge health districts to create service access through partnerships or to modify model programs to their capabilities.

Community Supports include:

- Case management: a collaborative process which assesses, plans implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Access is available long term, and work with individuals primarily happens in natural community settings. (see appendix for differentiation from outpatient services)
- Assertive Community Treatment or Intensive Community Treatment Teams; Clubhouses; Consumer and Family Initiatives; Accommodation and Equality Initiatives; Housing, Employment and Education Supports.
- Proactive outreach/case finding: interventions that will increase help-seeking behaviour and find those who are at risk/hard to find/hard to serve.
- Components included in the treatment of disruptive behaviour disorders in children and youth may also include:
  - Multi-modal approach (a combination of psychological and educational treatments that receive empirical support for their effectiveness in addressing the needs of the behaviourally challenged youth)
  - Community-based approach (within the child's home community)
  - Early intervention approach (as early as possible within the developmental sequence of antisocial behaviour)
  - Multi-systemic orientation (i.e. takes place across multiple systems including the family, school, peer group, etc.)
  - Consistent use of behavioural techniques across multiple settings
  - Comprehensiveness and sustainability over time (long-term intervention for a long-term problem)
  - Maximization of protective factors (e.g. positive family functioning, child and family resilience)

Goal Statement:
Individuals with severe and persistent mental health problems, and who experience difficulty living in the community with an acceptable quality of life acceptable to them, have access to a network of community supports consistent with services based on best practice evidence.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	C.1. Cases assessed as meeting the eligibility criteria for community supports are referred to the appropriate service. Admission criteria are: • severe and persistent mental illness and/or severe disruptive behavior with significant impairment in activities of daily living and, • effective support can not be provided in a less intensive service and, • the individual will benefit from the community supports program supported by best practice evidence	II
Acceptability	C.2. Referrals to community supports are accepted from multiple sources including professionals, non-profit and other service agencies, homeless shelters, employment services and self-referrals. Pro-active outreach/referral finding is part of this process.	II
Appropriateness	C.3. Standardized, validated intake assessment is initiated within ten (10) working days of the referral.	II
Effectiveness	C.4. A comprehensive assessment, intervention plan, and individual progress review is undertaken that considers all domains in the individual's life and his/her support network. For youth and adults this is consistent with PSR best practices.	II
Effectiveness	C.5. The community supports plan outlines mutually established goals and/or outcomes expected for the individual and/or support network, where appropriate, as well as a time frame for treatment or goal attainment.	II

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	C.6. The community supports plan includes, where appropriate, linkage and coordination with all relevant professional and community resources.	II
Acceptability	C.7. Individual plans and interventions for youth and adults are developed to support quality, safe and affordable housing goals consistent with best practice.	II
Acceptability	C.8. Individual plans and interventions for children, youth and adults are developed to support / facilitate ongoing social/recreational networks consistent with best practice.	II
Acceptability	C.9. Individual plans and interventions for children, youth and adults are developed to support / facilitate ongoing individual educational and employment goals consistent with best practice.	II
Appropriateness	C.10. Case loads are managed according to case mix, intensity, and individual needs/outcomes; and within the context of geography , population and available service system.	III
Competence	C.11. Case managers/youth workers who are employed by the mental health program are supervised by mental health professionals and work in multi disciplinary teams which provide clinical supervision and back up.	IV

Indicators:

Inpatient Services - Adults, Children and Youth (D)

Context & Issues:

Best practice indicates that an array of treatment alternatives to inpatient hospitalization should be available and that long stay patients should be moved into alternative care models in the community. Inpatient stays should be as short as possible without harming patient outcomes. The need for service delivery models that link family physicians with mental health specialists is also emphasized.

There must be continuity between the parts of the mental health system such that 'ownership' of clinical problems is shared between inpatient and ambulatory services with minimal loss of continuity for the patient. Those discharged from inpatient care with persisting problems and known to require close/early community care should have ready access to ambulatory follow-up.

Although most mental health care is to be delivered in the community, every district must have access to acute inpatient care. This can be achieved through reasoned geographic placement and formal arrangements (including bed management processes) among health districts to ensure equitable access.

In 1998 a committee comprised of experts in adult inpatient care and representative of service providers, patients and general practitioners was formed to draft standards for adult inpatient care in Nova Scotia. The work of that committee forms the foundation for the standards related to adult care presented in this document.

All inpatient services are located within a facility as defined by the Hospital's Act. Inpatient mental health beds currently exist in 8 districts. The standards in section D1 apply to inpatient services for adults and children and youth requiring intermediate (>5 days - 6 months) stay. Intermediate stay beds for adults are located on a dedicated psychiatric unit which may be shared among districts. Intermediate stay beds for children and youth are located at the IWK .

Standards (D2) apply to children and youth receiving short stay inpatient services. Short stay beds should be located , at the discretion of the District, in the most appropriate place where standards can be met. They can be shared among districts.

Standards (D3) apply to children and youth receiving longer term residential treatment services. As of Spring 2002, planning is underway to develop a sixteen bed unit which will be a part of IWK mental health services.

The designated forensic care site for adults is the East Coast Forensic Hospital and for children and youth is the IWK Health Centre. Standards for forensic services inpatient rehabilitation services, and adult short stay services will be developed at a later date.

Core Program Description: Acute Inpatient Services (D1)

The purpose of acute inpatient care is to provide comprehensive multi disciplinary assessment and/or to stabilize the patient sufficiently so that indicated care can take place subsequently in the community.

The acute inpatient unit is able to deliver the following services:

1. Assessment leading to a diagnosis and the development, with input of the patient and relevant others, of a written treatment plan, a multi disciplinary team care plan and a discharge plan
2. The delivery of psychopharmacological treatments
3. Access to ECT treatment
4. Therapies focused upon grounding and problem-solving and aimed at stabilization and discharge
5. Recreation and other programming of unit activities focused upon stabilization and early discharge of the patient
6. Medical coverage, medical and other clinical consultations including anaesthesiology
7. Psycho education for the patient and concerned others
8. Linkage to outpatient mental health, partial hospitalization and community supports where available, addictions and other relevant services
9. Links/liaison with self-help and other community groups

The intermediate stay inpatient unit for children and youth is offered in only one location and is the most intensive level of the care continuum. It must have the capacity to provide comprehensive multi disciplinary assessment and make treatment recommendations for severe and persistent illness.

Goal Statement:

All Nova Scotians have timely access to inpatient services

Inpatient services, which are the most intrusive for the patients, and the most costly to the system, are used appropriately.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	D1.1. Patients meet admission criteria at admission and throughout their inpatient stay. Criteria for admission are: • the individual is currently mentally ill according to accepted criteria(e.g. DSM-IV, ICD -10) or there is a need for a period of intensive monitoring of the individual's mental status and symptoms to clarify an uncertain diagnosis • the individual may benefit from an acute inpatient admission • management of the patient in a less intrusive setting is inappropriate, inefficient or likely to be ineffective in addressing the presenting problem • the individual's medical state is not acute (and is not primarily responsible for the psychiatric presentation) and is safely manageable on a psychiatric unit • intoxication with alcohol or other psychoactive substances may occur along with psychiatric illness. Intoxicated adults should be referred to a Detoxification Unit unless the psychiatric condition of the patient dictates that a psychiatric admission is required.	I
Appropriateness	D1.2. Patients referred for elective admission to an inpatient mental health unit have a comprehensive preadmission mental health assessment by a mental health clinician(s).	I
Accessibility	D1.3. Assessment of the need for admission is available twenty-four (24) hours per day, seven (7) days per week.	III
Accessibility	D1.4. A patient accepted for admission as an *emergency* to an inpatient mental health unit is admitted within twenty-four (24) hours.	III

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	D1.5. For children and youth, telephone response regarding the suitability of emergency admission is available by the designated inpatient site (IWK) within one (1) hour of referral.	I
Appropriateness	D1.6. A written care plan is compiled from an admission assessment by nursing staff, at least one early assessment by a psychiatrist, a physical examination, input from members of the multi disciplinary team , patient and family or significant others.	I
Appropriateness	D1.7. The appropriateness of the care plan is overseen and revised at regular intervals throughout the admission by a psychiatrist.	III
Competence	D1.8. Clinical direction of the unit is provided by a psychiatrist.	I
Continuity	D1.9. There is a designated nursing position responsible for the ongoing continuity and coordination of patient care during regular business hours.	I
Competence	D1.10. The inpatient unit staff have access to an emergency response team, the members of which are appropriately trained according to a recognised program.	III
Domains (CCHSA)	**Standards Statements**	**Nature of Evidence**

Continuity	D1.11. The inpatient mental health team engages in collaborative planning to ensure that at discharge: • the objectives of the admission have been met or, if not, the specific reasons for failure to meet those objectives are documented • the patient may be managed in a less restrictive/intrusive setting • continuity and consistency are maximized by: - giving advanced notice of the discharge date to relevant community-based care providers and where appropriate, family members - developing a discharge plan in collaboration with mental health community teams to whom the patient is being referred at discharge - faxing interim discharge summaries and other pertinent forms/information to all relevant care providers, including the family physician, outpatient primary therapist and/or continuing care facility within seventy-two (72) hours of the discharge - disseminating full written discharge reports to the primary therapist, family physician and other relevant care providers within four (4) weeks of discharge	IV

Core Program Title: Inpatient Services - Short Stay Units - Children and Youth (D2)

Core Program Description:
The Short Stay Units, provide stabilization and intensive assessment service of less than5 working days duration at which time the assessment will indicate the most appropriate disposition. The ability to provide stabilization as close to home as possible improves the effectiveness of mental health inpatient services and minimizes disruption to children, youth and support networks.
The Short Stay Units will provide:
a) crisis stabilization
b) assessment
c) timely disposition.
These standards apply to hospital-based short stay units . It is expected that there will be regional cooperation in managing bed availability.

Goal Statement:
Nova Scotian children and youth and their families will have timely access to District or Regionally -based short stay units across the Province.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	D2.1. Short stay units utilize same admission criteria as noted in D1.1. In addition there is a reasonable expectation that the individual can be stabilized and / or referred to other services within five (5) working days.	IV
Appropriateness	D2.2. The Short Stay Unit will provide a comprehensive mental health assessment within two (2) working days of admission.	I
Appropriateness	D2.3. A disposition decision will be made within five (5) working days of admission to the Short Stay Unit .	I
Continuity	D2.4. Disposition decisions must address the issues of the presenting crisis upon admission to the Short Stay Unit.	I
Continuity	D2.5. It is the responsibility of the Short Stay Unit to ensure follow up upon discharge from the unit, including: a) briefing the next step care givers; b) arranging a timely follow up appointment; c) checking that the appointment was kept.	I

Core Program Title: Inpatient Services - Children and Youth Longer Term Mental Health Rehabilitation / Residential Treatment (D3)

Core Program Description:

The Rehabilitation/Residential Treatment Program for Youth provide mental health services to patients between the ages of 12 and the 19th birthday to attain/retain optimal functioning in psychological, social and education/occupational spheres. This includes ongoing treatment of the primary disorder and any functional decline that may occur as a result of that disorder. Lengths of stay are generally around 12 months.

Goal Statement:
Nova Scotian youth between the ages of 12 and the 19th birthday and their families have timely access to residential mental health treatment and inpatient rehabilitation services with the capacity to help them attain optimal functioning.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	D3.1. All admission criteria for the residential treatment/rehabilitation unit are met. Criteria are: a) chronic and persistent mental illness disorder(DSM-IV ICD-10) with serious/profound functional impairment and/or severe disruptive behaviour disorder b) evidence that treatment/intervention requires lengthy rehabilitation within a residential setting, i.e., the patient cannot be managed within a less restrictive setting c) evidence that residential treatment will contribute to the patient's reintegration into the community within about twelve (12) months d) family/care giver/referring service commitment to participate in the admission, treatment and discharge plans e) the patient is a resident of Nova Scotia	IV

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	D 3.2. Prior to admission, a comprehensive, mental health, multi disciplinary assessment is completed to demonstrate that the patient meets all of the admission criteria	IV
Accessibility	D 3.3. DHAs ensures that referral paths within Districts follow established protocols (i.e. referrals are accepted from intensive community-based teams where they are in place and, where they have yet to be established, from the District's formal mental health system).	IV
Competence	D 3.4 Treatment is provided by a mental health multi disciplinary team, consistent with the comprehensive assessment, intervention plan and patient progress review that considers all domains in child/adolescent/family life. The treatment plan clearly outlines mutually established goals and/or outcomes expected for the patient and/or family, where appropriate, as well as a time frame for treatment or goal attainment. The goals and/or outcomes of treatment are reviewed, evaluated and revised as necessary following the establishment of the treatment plan.	IV
Continuity	D 3.5. At admission and throughout the patient's rehabilitation/residential treatment, the treatment team involves the patient's family, referring service and other relevant agencies/services in discharge planning.	IV

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	D3.6. Discharge planning from the rehabilitation /residential program, which is initiated at the time of admission, includes: a) advance notice of anticipated discharge and referral to most appropriate agency/community-based team b) conference with mental health team to whom the patient is being discharged c) preliminary discharge summaries sent out to primary therapist and attending physician with seventy-two (72) hours of discharge d) discharge summaries are received by referral agency within four (4) weeks of patient discharge	IV
Continuity	D3.7 The rehabilitation team is accountable for ensuring that at discharge: a) the specific rehabilitation goals have been met or reasons given why they have not been met b) there are adequate discharge and follow up plans in place. This includes the scheduling of a follow-up appointment within a maximum of (10) ten working days following discharge as stated in the transition plan agreed to by all parties c) there is a process in place to monitor that the patient has been seen by the home agency as per transition plan.	IV

Indicators:

Core Program Title: **Specialty Programs- Eating Disorders (E1)**

Context & Issues: Eating disorders, for the purposes of this document, include conditions described under the diagnostic headings Anorexia Nervosa (AN), Bulimia (BN) and Eating Disorders NOS, as defined in DSM4 *. It does not include obesity or other nutritional states not covered by these rubrics.

Cases cluster in 15-34 age, in women, and in certain occupations and activities **. Extrapolating referenced prevalence and incidence figures to Nova Scotia (Census 2000), this translates into 4994 cases of AN,9988 cases of BN lifetime, with 73 and 100 new cases expected to present each year. [1] Data from provincial DOH sources are thought to underestimate both the need for treatment, and the numbers in treatment. Limitations in access, relative lack of visibility of services, and treatment by primary care practitioners and other agencies not tracked in mental health statistics may account for this. Outpatient data from MHOIS record 253 cases in active treatment 2000/01. Inpatient separations in medical and psychiatric services for the same period total 35. Similar deficits in treated versus expected numbers of cases are reported in other jurisdictions [2].

Attendance for treatment concentrates in 3 centres in the province. IWK has (47) cases, and adult centres at QE2 (51) and CBRH (61) in 2000/01. As referral centres, each served patients from other districts, though in relatively small numbers. Service is provided to small numbers of patients in each health district. Since 1997, no dedicated, specialty inpatient services have been provided in the province. Cases severe enough to warrant admission have been served in general mental health beds, or general medical beds. [3]

Current services for Eating disorders in NS are comprised of outpatient/day programs in district 8/9, and outpatient/inpatients in IWK. A network of interested professionals meets 3-4 times/year for educational, advocacy, and service coordination purposes. There is a limited number of specialty trained clinicians in Nova Scotia who work with patients with eating disorders. Moreover, there is a hesitancy on the part of many clinicians without specialty training to provide treatment in for eating disorders. This may be attributable to the complexity of cases, and the resistance or ambivalence to treatment of some patients.

Referrals outside the province to specialty treatment services cost between $140,000 and $202,000 per annum over the past 2 years. Four cases were sent out of province in each of those years. Data on NB, and PEI are not available. Predominantly these funds paid for inpatient care in specialty services in out-of-province locations, Credible anecdotal evidence from involved clinical staff suggests that these are underestimates. The process for accessing this care seems arbitrary, occurs in parallel with existing services, and is not coordinated or integrated. This has resulted in discontinuity of service and lapses in arranging follow up or ongoing care.

* *Lifetime prevalence of the disorders is reported to be AN-0.5-1.0% in women, and BN 1-3% lifetime prevalence in a North American population ... (refs DSM4). Incidence figures are reported to be 8.1/100,000 for AN, and 11.4/100,00 for BN (refs Framework for Mental Health Services in Scotland, Section 3, Eating Disorders)*

** *Data referred to in the document "Framework for Mental Health Service in Scotland" estimate specialty inpatient needs at 6 beds per million population ® Coll Psych special interest group on eating disorders). It is not clear if this refers to adult services only, such as in all discussions of bed needs, has to be viewed in the context of the range of other services in the region. Independently, the provincial network for eating disorders has recently reached consensus on the need for 6 specialty service beds. The Bland/Dufton report had also recommended 4 specialty beds.*

Core Program Description: Specialty Programs- Eating Disorders (E1)

Eating disorders call for a range of services to address the needs for prevention, education, assessment and care in primary, secondary and tertiary settings. A spectrum of services is required, at the appropriate site, spanning the range of severity and complexity , to individuals at different developmental stages and in treatment settings appropriate to the range of needs.
The service has a capacity for family and significant other involvement and treatment.

Although critical mass dictates that the expertise to treat the most severe cases should be concentrated (inpatient care in 1 centre, specialized consultation in 3 centres) promotion and prevention, screening, assessment, referral, follow-up and support must be available broadly and provided within each district. A network of linkages with Public Health, School boards, youth organizations etc is fundamental to carrying out this mandate.

Some resources should be coordinated centrally and made available to provider organizations across the province include:

- community and care giver education materials
- prevention and early detection approaches
- provider training
- epidemiologic and utilization data

A strong provider network is a cornerstone to facilitate information exchange and best practices. Each district supports participation on the provincial network.

Goal Statement:

All Nova Scotians have access to an integrated, comprehensive program for the management of eating disorders across the life span.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	E1.1. Each district identifies personnel to assess and either treat or arrange referral for individuals seeking care for eating disorders.	III
Competence	E1.2. These personnel are responsible to: a) Be a liaison with community agencies (schools, clubs etc) within their area b) Link to primary care clinicians c) Triage cases to appropriate level care at either local or provincial level for child/adolescent and adults d) Participate in the provincial network (referred to in context and issues section)	III
Efficiency	E1.3. A standardized initial assessment for eating disorders is used in each district. Standards for triage and initiation for service is as described in Section B2.	II
Appropriateness	E1.4. Cases meeting criteria established for referral to tertiary services (outpatient, day care or inpatient) are immediately referred to the appropriate center.	I
Accessibility	E1.5. Referral protocol for tertiary and consultation services is clearly documented, widely distributed and routinely revised, incorporating user input.	II
Appropriateness	E1.6. Appropriate and timely pediatric or medical consultation is obtained from clinicians knowledgeable and expert in eating disorders.	II
Appropriateness	E1.7. Treatment plans are formulated for all individuals seen, and are consistent with current best practice.	II

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	E1.8. In each district, information to assist the public, individuals, family, community groups, schools and other community agencies is available. This includes: a) An outline of the features of the disorders b) A description of the services at local and provincial levels, emergency access points, entry points for assessment and treatment, and guidance on local resources and supports.	III
Competence	E1.9. Treatment team members have access to appropriate and continuing education in eating disorder knowledge (includes tertiary and secondary team members).	II
Accessibility	E1.10. Access to consultation and supervision, at both district and specialty service level is provided.	I
Safety	E1.11. Staff in tertiary services provide education and consultation in clinical, research/academic, service organization and ethical/medicolegal issues as a resource to the province.	II

Indicators:

Core Program Title: **Specialty Programs - Sex Offender Treatment (Children & Youth) (E2)**

Context & Issues:

Primarily due to under reporting, (whether to avoid labeling or stemming from lack of awareness of the importance of early detection), the actual prevalence of child and adolescent sexual offending is not certain. Nova Scotia statistics for offenders with respect to sexual assault and sexual abuse for the years 2000-2001 shows a total of 39 young offenders, 30 having been convicted of sexual assault and 9 for sexual abuse. In one epidemiological study, a one-year prevalence rate of 1.5 official juvenile sexual offenders per 1,000 male population age 12-17 years was found (Epps 1999).* The only Canadian recidivism study by James Worling showed that youth who completed at least 12 months in that program showed 72% less sexual recidivism, 41% less violent nonsexual recidivism and 59% less nonviolent re-offending than the controlled sample.

In Nova Scotia, clinical services for adolescent sex offenders are almost exclusively offered by mental health professionals in private practice. There are no existing standards in Nova Scotia to identify appropriate credentials for the purpose, although specific standards are mandated for treatment of adults.

In contrast to the dearth of services for adolescents a range of services are available for adults. The program for adult male offenders, jointly sponsored by the provincial departments of Health and Justice, coordinated by the provincial forensic psychiatry service, is available to initially sentenced adult sex offenders. This provides services to low and moderate risk offenders and is offered jointly by mental health professionals and probation officers. Significant improvement in recidivism data was shown in a federally-sponsored study for those who completed treatment versus those who failed to complete and those who received maintenance sessions versus whose who received no maintenance sessions subsequently. These services for adults are not currently available for those under age 18.

A specialized assessment and treatment program for adolescent sexual offenders should be available for those children and young persons who abuse others, and those children and youth with paraphilias of potential harm to others. It may be appropriate to combine community and incarcerated youth in the same community group. The program should also be accessible to those adolescents who show evidence of sexual deviancy without necessarily having been convicted.

* Recidivism rates, both for sexual and nonsexual recidivism, is difficult to estimate because only a few studies have used comparison groups to measure treatment effectiveness and the length of follow up has been variable.

Core Program Description: Sex Offender Treatment (Children & Youth) (E2

This program provides assessment and treatment for those children and young persons who abuse others, and those children and youth with paraphilias of potential harm to others.

Referral and follow-up must be provided in all districts. Specialized assessment will be undertaken in one location with a team led by a clinician with specialized training and expertise in the assessment of sexual offending children and adolescents. Inclusion and exclusion criteria are determined and applied as appropriate.

Treatment, primarily in an outpatient setting, should be provided in the least restrictive setting consistent with the safety of potential victims. Those who pose an elevated risk to the community require stricter supervision and more intensive interventions and may require residential custody and treatment (Waterville or IWK). Treatment services will include primarily group work supplemented with individual and family therapy as required. Intervention should not deal with the child or young person in isolation, but in the context of the family situation and in close liaison with child protection and probation and parole services. Treatment will be offered in several Districts and accessed by residents across Districts.

Monitoring will be undertaken through collaboration with holders of national databases.

Goal Statement:

The harmful behaviour of child and adolescent sexual abusers is controlled and effectively managed.

All children and youth in Nova Scotia who show evidence of sexual deviancy receive appropriate assessment and treatment utilizing a best practice approach.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	E2.1. Referrals are made to the service only by Court or mental health practitioners within the district mental health program..	II
Accessibility	E2.2. A written referral protocol is distributed to youth / family courts and all DHAs.	III
Acceptability	E2.3. Referrals are accepted from the Courts post-conviction and ideally, pre-sentencing. Referrals are accompanied by Court documentation or, where the court is not involved, by a comprehensive mental health assessment indicating the reason for referral to the Sex Offender Service.	II
Safety	E2.4. For each referral, there is a full mental health assessment and a Formal Risk assessment completed.	II
Appropriateness	E2.5. Individuals meet eligibility criteria for treatment. Current priorities are: • convicted young offenders (15 to 17 years of age) • non convicted youth • younger children **(Criteria to be developed as this program is established)**	I
Acceptability	E2.6. Standardized validated assessment is completed for referrals within thirty (30) days of conviction or within thirty (30) days of acceptance of referral.	I
Safety	E2.7. A Formal Risk Assessment using appropriate specialized and validated instruments is completed.	I
Competence	E2.8. The assessments are completed by a team led by a mental health clinician with specialized training and expertise in the assessment and treatment of sexual offending children and adolescents.	II

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	E2.9. Participation in the treatment program which includes information transfer to and follow-up by a mental health practitioner and any designated officer of the Court is a pre-requisite to acceptance in the program.	II
Safety	E2.10. Treatment is initiated within 90 days of treatment being recommended. Higher risk individuals are given priority for treatment.	IV
Continuity	E2.11. The program initiates contact with the relevant mental health clinic at the time of entry into the program.	II
Competence	E2.12. Assessment and treatment team members are required to be eligible for full clinical membership of ATSA or possess equivalent qualifications.	II
Continuity	E2.13. Each DHA has access to designated staff to be involved in follow-up treatment.	I
Competence	E2.14. All designated staff have access to appropriate and continuing education in sex offender treatment for children and youth (includes tertiary and secondary team members).	III
Accessibility	E2.15. Access to consultation and supervision, at both district and specialty service level is provided.	I
Availability	E2.16. Staff in tertiary services provide education and consultation in clinical, research/academic, service organization, and ethical/medicolegal issues as a resource to the province.	I
Continuity	E2.17. Service providers develop linkages with representatives of Justice, Community Services and Education.	II

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	E2.18. Service providers develop appropriate linkages to provide services to special needs populations.	II
Appropriateness	E2.19. Assessment, intervention, and follow-up are performed based on ATSA Guidelines or equivalent and includes family education and support.	II

Indicators:

APPENDIX A
Prevention, Promotion and Advocacy (A1)

Examples of High Risk Groups:
children with early child behavioral problems, children with learning disabilities, mothers with depression, pregnant women with children, young single parents, young isolated mothers, children of divorcing parents, unemployed or divorce, recently bereaved, care givers

Making It Happen - A guide to delivering mental health promotion p. 85

Examples of Vulnerable Groups:
vulnerable children, street people, victims of domestic violence, minority people, individuals with alcohol problems

Making It Happen - A guide to delivering mental health promotion p. 86

Areas to Include in Combating Discrimination and Social Exclusion:
local media, information to general public, police, schools and colleges local businesses, mental health service providers, information for members of minority groups, elected municipal and provincial members

Making It Happen - A guide to delivering mental health promotion p. 86

Framework for Mental Health Promotion Strategy:
1. Agree on vision, aims and objectives
2. Identify gaps and duplications
3. Needs assessment: local needs, key settings, target groups
4. Make links with policy initiatives
5. Identify key stakeholders
6. Select interventions
7. Find evidence to support approach
8. Establish indicators of progress
9. Build in evaluation
10. Identify staffing and resource implications

Making It Happen - A guide to delivering mental health promotion p. 78

There is ample empirical evidence that mental health promotion programs are capable of increasing resilience and mental health factors such as:
self-esteem, problem solving skills, prosocial behavior, stress and conflict management skills, feelings of mastery and self-efficacy,
mental health promoting school climate, social support in stressful period

Public Health Approach on Mental Health in Europe p. 116

There is ample empirical evidence that mental health promotion programs are capable of reducing of a range of risk factors (threatening to mentally health development) such as:
low birth weight, pre-term deliveries, poor parenting behavior, child abuse and neglect, teenage pregnancies, aggression, victim of regular bullying, lack of early bonding and parental affection

Public Health Approach on Mental Health in Europe p. 116

There is ample empirical evidence that mental health promotion programs show a range of evidenced - based outcomes such as:
better academic achievement, lowering divorce rate, increase in productivity and reduction in productivity loss, reduction in family violence, reduction in youth delinquency, reduction in use of social services

Public *Health Approach on Mental Health in Europe p. 116*

Specific examples of the link between discrimination, conflict and violence and mental health include:
1) The University of Surry (1998) found that they most common results of discrimination to be lower self-esteem, social isolation, depression and anxiety, drug and alcohol misuse and suicidal feelings.
2) A large percentage of young people who attempt suicide are gay, lesbian or bisexual. (National Children's and Youth Law Centre 1998).

Mental Health Promotion Framework. 1998. VicHealth. Australia. p. 12 - 13

APPENDIX B
Outpatient and Outreach: (B)

Crises and Response Services:

Crises Response Plan:
Note: this plan is communicated effectively to physicians, emergency rooms, and the community at large (through sign age, telephone listings, clear messages on answering machines, etc).

Note: prior to the initial face to face contact with the individual, the telephone consultation is an opportunity for early identification of the issues, early intervention and building of supports, and a chance to redirect if appropriate. Following the face to face assessment there is opportunity for additional consultation and collaboration with referring agents.

APPENDIX C
Community Mental Health Supports (C)

(A) Psychosocial Rehabilitation

The core qualities of the approach provide a foundation for developing and implementing community mental health supports. Those qualities include:

- providing opportunities to participate as fully as possible in roles and relationships that give normalcy to their lives
- dealing with practical adjustment needs - for example, housing, coping skills, education, employment
- emphasizing social learning and behavioural change through everyday experiences
- minimizing differences in role, authority, and status between disabled individuals and professionals
- locating programs in non-clinical community settings
- using staff whose backgrounds are varied and whose roles are flexible
- creating a program environment characterized by realistic expectations designed to convey social competency and personal independence.

Community Mental Health Supports for Adults, Nova Scotia Department of Health,2000. p 8

(B) Psychosocial Rehabilitation Best Practices

"Psychiatric rehabilitation describes a set of treatment interventions designed to work with the whole person: mind, body, and spirit; to improve individual functioning, improve the individual's own management of his/her illness; and facilitate the recovery of the individual". *(page 2)*

Psychiatric Rehabilitation Practices which Support Recovery will have the following components: assessment and planning guidelines, Psychosocial interventions, management for recovery, cognitive interventions, and interventions for co-occurring substance abuse disorder.

(*For description of each component see pages 4-16)*

Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment, Approved by the Executive Committee of the International Association of Psyhcosocial Rehabilitation Services (IAPSRS), September 9, 1997

(C) Case Management

The intensity and frequency of individual contact by the case manager will vary depending on assessed need of individual. A continuum of case management will be accessible to individuals of District Mental Health Programs, with the low end being face to face contact a minimum of every second month and at the high end being Assertive Community Treatment (ACT) with a minimum of daily face to face contact.

(D) Caseload/ Workload, Assertive Community Treatment Team (ACTT)

"On average, there should be no more than 10 individuals to one staff member (excluding the psychiatrist and the program assistant)." *Page 3*

Ontario Standards for Assertive Community Treatment Teams, *Recommended Standards For Assertive Community Treatment Teams,* Published by the Ontario Ministry of Health, October 1998

(E) Psychosocial Rehabilitation Training/ Education

Center for Psychiatric Rehabilitation
Boston University
940 Commonwealth Avenue West
Boston, MA 02215

Certified / Registered Psychiatric Rehabilitation Program
IAPSRS Canada, 1999-2002.
www.iapsrs.org.bcentralhost.com/certification.htm

Psychosocial Rehabilitation Technology Training
Pineo, Donna and Janet MacBean
Beacon Program, Kings Regional Rehabilitation Centre

(F) Community Supports versus Outpatient Services

Outpatient Services: service is time limited, individuals come to service provider, therapy focused, usually medical model base, generally better resourced, and treatment oriented.

Community Supports: service is long terms, community based service providers go to consumers, support psycho social rehabilitation models of service.

APPENDIX D
Inpatient Services - Adults, Children and Youth (D)

Inpatient Unit Design:

Safety must be a primary concern during the design phase of new inpatient units. Those involved in such design exercises are strongly advised to consult documents dealing with these issues more fully.

- The number of entry points to the unit should be minimised
- Attention should be given to sight-lines
- There should be no dead-end corridors
- Units should be on the ground floor
- There should be single rooms for all patients with integral bathroom facilities
- Attention must be paid to ‘pull-away’ fixtures etc.
- Each unit should have access to a seclusion room

APPENDIX E
Specialty Programs-Eating Disorders (E1)

Specialty Programs
Sex Offender Treatment (Children & Youth) (E2)

A Formal Risk Assessment addresses:

a) the extent of denial and accountability
b) the range and number of sexual and non-sexual issues
c) the impact of this behaviour
d) indicators of sexual deviancy
e) history of delinquent behaviour
f) the level of victim empathy
g) the receptivity to treatment
h) the motivation for treatment
i) the social competence and peer relationships
j) level of community adjustment
k) the presence of significant mental illness
l) family assessment

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Glossary

Advocacy:
is the act of speaking in support of human concerns or needs. When people have their own voice, advocacy means making sure they are heard; when they have difficulty in speaking, it means providing help; where they have no voice; it means speaking for them.

Making Change: A Place to Start. Ministry for Children and Families, Advocacy Centre, Nelson; the BC Association for Community Living; The Office of Child, Youth and Family Advocate and the Penticton Advocacy Network.

Community Support Services includes:
1. Case management: a collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost- effective outcomes. This is usually long-term in nature and may be provided outside four walls. (See appendix for differentiation from outpatient services).
2. Community or Home based interventions: clinical treatment or procedures and psychosocial rehabilitation in the home or where the consumer requests service. For children and youth, this is time limited in nature.
3. Consultation/liaison: mental health care advice and recommendations to service providers outside the formal mental health system
4. Proactive outreach/case finding: interventions that will increase help-seeking behaviour and find those who are at risk/hard to find/hard to serve.

Discrimination:
is defined in civil rights law as unfavorable or unfair treatment of a person or class of persons in comparison to others who are not members of the protected class because of race, sex, color, religion, national origin, age, physical/mental handicap, sexual harassment, sexual orientation or reprisal.

National Institutes of Health

Emergency cases:
are those in which an individual suffering from a mental health problem is at immediate risk of harm to self or others and/or in which a delay in the provision of treatment would threaten the individual's life or functional ability.

Employment and education:
help consumers to prepare for, gain, and keep productive roles in the community.

(CMHSA Document, 2000. Page 16)

Individuals at Risk:
Individuals who are at higher risk for developing mental health problems when certain factors occur in their lives or environment. Some of these factors are physical, sexual abuse, emotional abuse or neglect, harmful stress, discrimination, poverty, loss of loved one, frequent moving, alcohol and other drug use, trauma, and exposure to violence.
http://www.pinofpa.org/resources/glossary.html

Individual community support/case management:
is designed to help consumers with severe and persistent mental illnesses to manage the expectations of daily living related to housing, income, social and recreational activities, self-care, and physical and mental health care. Community support workers collaborate with consumers, providing continuous outreach support, even when a consumer's needs change and cross service setting.
(CMHSA Document, 2000, page 15[1])

Individual housing supports:
help consumers find, keep, and live successfully in quality, independent, generic housing that may be located anywhere in the community.

Respite:
consists of temporary short-term supports provided either in the home or another setting to give relief to family care givers who are responsible for the ongoing care and supervision of adult relatives. Respite services are usually planned.

Intensive housing supports:
include small residence facilities integrate within existing communities that provide specialized tertiary treatment, active rehabilitation, and supports for adults with severe disabilities and very challenging behaviors.
(*CMHSA Document, 2000, Page 16)*

Paraphilia:
is a condition in which a person's sexual arousal and gratification depend on fantasizing about and engaging in sexual behavior that is atypical and extreme. A paraphilia can revolve around a particular object (e.g., children, animals, underwear) or around a particular act (e.g.,inflicting pain, exposing oneself). Most of the paraphilias are far more common in men than in women. The focus of a paraphilia is usually very specific and unchanging. For example, for someone who derives sexual pleasure from exposing his genitals, watching others engaging in sexual activity will not generally provide sexual gratification.

Prevention:
is categorized as primary prevention directed at averting a potential mental health problem; secondary prevention directed at early detection and as appropriate intervention to prevent or delay onset or mitigate a mental health problem; or tertiary prevention, directed at minimizing disability or avoiding relapse.

Promotion:
Process of actively supporting and enabling people to increase control over and improve their health.
(World Health Organization [WHO]) AIM Accreditation Program. 2001. Glossary. p.15

PSR Practices: Housing.
An effective assessment notes the individual's need for housing which is safe, affordable, decent, integrated into the broader community, and provides the level of support both needed and desired by the person receiving services. The possibility of home ownership should also be explored.

(*IAPSRS Guidelines, #4, Page 5)*

Examples of housing options:

licence boarding homes; small option homes; group homes; independent living; respite; intensive housing. Types of support: crisis response; individual & family support & skill teaching; mental health assessment & intervention.

Psycho social Interventions:
Develop individual client plans and intervention to support employment and/or education goals. Explanation: The return to work or school is a major step in the process of recovery. It is crucial that the supports and services be in place to facilitate the person's educational and employment goals.

(IAPSRS Guidelines, 1997. Page 10)

Resilience:
In 1984, Garmezy, Masten, and Tellegen operationalized resilience in one of their earlier projects as, "manifestations of competence in children despite exposure to stressful events." In 1985, Rutter defined resilience as facing ". . . stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility." In 1994, Masten defined resilience in this manner: "Resilience in an individual refers to successful adaptation despite risk and adversity." She goes on to say, "resilience refers to a pattern over time, characterized by good eventual adaptation despite developmental risk, acute stressors, or chronic adversities." In 1995, Gordon defined resilience this way: "Resilience is the ability to thrive, mature, and increase competence in the face of adverse circumstances. These circumstances may include biological abnormalities or environmental obstacles. Further, the adverse circumstances may be chronic and consistent or severe and infrequent. To thrive, mature, and increase *competence, a person* must draw upon all of his or her resources: biological, psychological, and environmental."

Fostering Resilience in Children. Bulletin 875-99. Ohio State University.

Social Recreation Networks:
Community based opportunities for interpersonal contact and play throughout the lifespan.

(*IAPSRS Guidelines, 1997. Page 11)*

Stigma (Psychiatric):
is the false and unjustified association of individuals who have mental illness, their families, friends and service providers with something shameful. It is often deeply hurtful....fosters hostility in the community and negative discrimination by services and employers. Stigma stirs up fears and discourages people who suspect they may have a mental illness from seeking appropriate timely help.

Rosen, A., Walter, G., Casey, D., Hocking, B. Combating Psychiatric Stigma: An overview of contemporary initiatives. Australasian Psychiatry. Vol 8, No 1. March 2000.

Supported Housing:
is generally long-term housing and designed to provide stable, independent living or to assist the persons served to obtained and maintain decent, affordable, and stable housing.

2002 Behavioral Heath Standards Manual. The Commission on Accreditation of Rehabilitation Facilities (CARF), Tuscon, Arizona, January 2002. Section 5.E.- 191

Tolerance:
the capacity for or the practice of recognizing and respecting the beliefs or practices of others.

Transitional Housing:
provides interim supports and services for persons who require a therapeutic setting because they are at risk of institutional placement or because they are trasitioning from insttutional settings. Transitional housing is typically provided for six to twelve months and can be offered in congregate settings that may be larger than residences typically found in the community.

2002 Behavioral Heath Standards Manual. The Commission on Accreditation of Rehabilitation Facilities (CARF), Tuscon, Arizona, January 2002. Section 5.E. -191

Urgent cases:
are defined as those in which an individual suffering from a mental health problem is at significant risk of increasing functional disturbance or increasing risk of harm to self or others if treatment is delayed.

Vulnerable People:
vulnerable populations are those groups of people "made vulnerable by their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively...[and] personal characteristics, such as race, ethnicity, and sex." http://www.ahcpr.gov/research/dec98/ra4.htm
Vulnerable people includes: children, victims of domestic violence, homeless, minorities, people with addictions, sexual abuse victims.

Youth:
in Mental Health Services the term “youth” is used to cover teenage and early adulthood years (example: 13 to 24 years of age)