NOVA SCOTIA

Standards for Mental Health Services
In Nova Scotia

July, 2009

*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.*

July, 2009

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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. Input will continue to be sought and revisions will take place every five years to keep pace with best practice evidence.

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 (2001), 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 that
            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 processes 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 have 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 treatment plans are formulated for all individuals seen and are consistent with evidence where it exists. 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 compliance to recommended joint treatment plans with outside mental health services

3.7 mental health services are provided in collaboration with other relevant care providers to individuals presenting with co-morbid disorders

3.8 uniform assessments are used throughout all mental health service programs.

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 planning, evaluation and research initiatives

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

4.4   standardized demographic, assessment and outcome data is collected for program evaluation purposes.

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 licensed with a legislated professional body, maintaining current licensure and operating within the full scope of their practice is expected.

- 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.

- delivery of core services is best accomplished through multi-disciplinary teams. Each member of a multi-disciplinary team is expected to contribute from their professional expertise to the overall benefit of client outcomes.

- 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 ?

- professional staff identified as providing mental health services within a specialty service must receive initial training and continuing education required for their level of service provision

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.

Prevention, Promotion and Advocacy (A)

Context & Issues:
It is widely recognized that prevention initiatives for mental disorders have positive outcomes on populations at risk of mental illness. It has also been demonstrated that mental health promotion initiatives have a wide range of health and social benefits including hope for the future, improved physical health, increased resilience and tolerance, and greater capacity for participation and productivity (Promoting Mental Health WHO 2004).

For people living with mental illness, mental health promotion also contributes to health improvements, to reducing stigma and discrimination, and to increasing understanding of mental health.

In the document entitled "Out of the Shadows at Last" (2006) Senator Kirby recommends that in order to end stigma and discrimination action must be taken on three fronts:
1) _education and awareness_ (only by changing our perception, removing the social stigma and understanding more about mental illness can we as a society begin to improve the treatment and care provided to the people who suffer from a mental disorder).
2) _media_ (the most effective means of spreading insightful information about mental illness).
3) _recognition of the seriousness of mental illness by all Canadians_ (important to treat mental and physical illness with equal seriousness both within the medical community and in society more generally).

Research on discrimination and stigma shows that the most effective strategies combine education and personal contact with someone representing a stigmatized group. Wisconsin United for Mental Health discusses mental illness as common, real, treatable (May 2002).

Mental illness prevention and mental health promotion initiatives have a varied and broad scope, and address three levels of need in the population:
1) all Nova Scotians
2) Nova Scotians at risk of developing mental illness and
3) Nova Scotians with mental illness (adapted from: Making it Happen, 2001).

At each level of need, interventions focus on factors known to either
1) strengthen mental health, or
2) reduce factors known to increase risk of mental illness, or
3) reduce stigma and discrimination experienced by people with mental illness.

Generally the results of prevention and promotion interventions are unique in that outcomes are not evident for 2 to 3 years or longer. Research has demonstrated there is an increased cost to the public heath care system when promotion, prevention and advocacy strategies are not implemented (University of Surrey 1998, National Children's and Youth Law Centre 1997).

Context & Issues cont'd.

The evidence currently available on mental health outcomes of public policies is limited; however, recent research reports demonstrate that targeting populations (i.e. high risk individuals, vulnerable groups) at a community, provincial, or a national level has positive outcomes.

The challenge of providing evidence of the positive effects of upstream interventions for policy makers is that many of the major social determinants of mental and physical health are not amenable to randomization.

Evaluative research on mental health outcomes of behavioral, organizational, psychological, or policy options is still relatively uncommon in most countries. One reasonable approach argued for by Sturm is that there is still a valuable role for longitudinal observational studies which can inform mental health policy by providing mental health monitoring data (Sturm 1999). The call for more robust outcome evaluations does not therefore preclude the contribution that can be made from the provincial strategy as found in "Our Peace of Mind" for Nova Scotia (2004). This strategy targets priority groups with prevention and early intervention initiatives that are supported by available evidence of effectiveness. The priorities of the mental health sector are initiatives targeting individuals at risk of developing mental illness, and individuals with mental illness who are at risk of relapse. It is incumbent upon providers of mental health services to collaborate with potential partner agencies and organizations who are observational data on determinants and indicators of mental health (Herman 2001) working towards enhancing the mental health status of Nova Scotia's.

In Nova Scotia, advocacy in mental health continues to be discussed and consensus by organizations, agencies and government as to a desired approach has yet to be reached.

"Advocacy by its nature involves not only the advocate and the individual, but also various organizations, agencies, and/or government departments; each has an important role in a successful advocacy system" (Position Paper: Advocacy. Crown Copyright, Province of Nova Scotia, 2005).

The "Aim of advocacy is to place mental health issues high up on the political and community agenda and effectively convince stakeholders to act in support of mental health." (WHO 2005:191)
Nova Scotia is becoming an increasingly diverse province. The way people use health care services, access and benefit from programs and approaches to care is impacted by individual characteristics such as gender, gender identity, sexual orientation, disability, language, race, ethnicity, and cultural background (Diversity and Social Exclusion Initiative, 2004).

"Provisions of mental health care services to respond effectively to the needs of patients and their families, recognizing the racial, cultural, linguistic, educational and socio-economic backgrounds within the community (Masi, 2000).

Resources available and competing priorities from the treatment side challenge health districts/IWK. This requires districts/IWK to continue their developing additional partnerships and modifying program models to meet their needs.

Program Description:
The overall objectives of the Core Program - Prevention, Promotion and Advocacy are as follows:
- to provide information designed to enhance awareness and understanding of mental illness;
- to reduce stigma and discrimination;(see Appendix A)
- to promote mental health;
- to support Department of Health Promotion and Protection and partner with the DHAs/IWK in mental health primary prevention activities directed at averting a potential mental illness;
- to lead in secondary prevention activities directed at early detection and intervention to prevent, delay onset, or mitigate a mental illness;
- to provide education and training on understanding the mental health service delivery system.

Prevention programs may be categorized according to focused outcomes:
- primordial prevention, directed at whole population
- primary prevention, directed at averting a potential mental illness
- secondary prevention, directed at early detection and intervention to prevent or delay onset, or to mitigate a mental illness
- tertiary prevention, directed at minimizing disability or avoiding relapse in those individuals diagnosed with a mental illness (see Table 1 Glossary).

[*The majority of initiatives carried out by mental health services/programs will be in the area of secondary prevention and guided by Our Peace of Mind (2004)].*

Maintaining good mental health may be challenging especially for those who have experienced mental illness. Specific attention may be required to address all the determinants of health especially for housing, education and employment.

Education and training programs need to be developed through consultation and collaboration with:
- those who have experienced mental illness
- service providers and experts in the field
- community and not-for-profit groups.

Goal Statement:
Nova Scotians, including those at risk and/or living with mental illness, are supported to move toward optimal health. (*Adapted from Department of Health Promotion and, American Journal of Health Promotion).*

Initiatives will be based on a foundation that includes:
- cultural and diversity competency;
- best practice interventions; and
- quality and evaluation components

Initiatives will focus on the following:

- awareness of mental health/mental illnesses;
- reduction of stigma associated with mental illnesses; and
- early detection and minimizing disability.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	**A.1.** Secondary promotion and prevention initiatives are reflective and responsive to the population we serve (culture, race, ethnicity etc.).	**II**
Effectiveness	**A.2.** Anti-stigma/discrimination activities are recovery-oriented, fact-based, and a positive portrayal of persons with mental illness. Targeted components include audiences in the population that can facilitate: • access to treatment; • the recovery process; • re-integration into community life; and • change in public attitudes and perceptions.	**III**
Efficiency	**A.3.** Partnerships to implement promotion and prevention programs extend across all sectors including individuals, organizations and communities.	**II**
Appropriateness	**A.4.** The DHAs/IWK identify and target at risk groups in their communities, with focused, evidence-based programs to address their needs.	**II**
Efficiency	**A.5.** Standardized provincial strategies are developed in collaboration with the DHAs/IWK, government departments and community groups.	**III**
Accessibility	**A.6.** Education about mental illness, mental health and the mental health delivery system is provided at a district level for all Nova Scotians.	**III**
Effectiveness	**A.7.** Prevention and promotion initiatives include mechanisms for quality review or evaluation.	**II**

Prevention, Promotion and Advocacy Glossary

Advocacy:
aims to support people who need assistance to express their views and to have their own stories heard and to safeguard people in situations where they are vulnerable. There are 4 types of advocacy 1) for oneself 2) for another person 3) for a group 4) for changing a system.

North Lanarkshire Council www.**north**lan.gov.uk
Canadian Treatment Action Council www.**ctac**.ca

Cultural Diversity:
refers to the unique characteristics that all of us possess that distinguish us as individuals and identify us as belonging to a group or groups. Diversity transcends concepts of race, ethnicity, socio-economic, gender, religion, sexual orientation, disability and age. Diversity offers strength and richness to the whole.

Hastings Institute   http://vancouver.ca/hastingsinst**itute**

Cultural Competencies:
is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables the system to work effectively in cross-cultural situations.

Cross et al., 1989; Isaacs & Benjamin, 1991

Determinants of Health and Population Health

Determinants of Health:

considers the entire range of individual and collective factors and conditions, and their interactions, that have been shown to be correlated with health status. Commonly referred to as the "determinants of health," these factors currently include: Social Support Networks , Education, Employment/Working Conditions, Social Environments, Physical Environments, Personal Health Practices and Coping Skills, Healthy Child Development, Biology and Genetic Endowment, Health Services, Gender, Culture.

Our understanding of what makes and keeps people healthy continues to evolve and be further refined. A population health approach reflects the evidence that factors outside the health care system or sector significantly effect health.

Population Health:
is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.   *Public Health Agency of Canada 2004*

Discrimination:
refers to inequitable or unfair treatment of people with mental disorders, which amounts to denial of the rights and responsibilities that accompany full citizenship. It is a natural outgrowth of stigma. Discrimination may occur at an interpersonal level, reflecting a desire for social distance and exclusion. It may also occur at a structural level when people with mental disorders are overtly or covertly excluded from public life through a variety of legal, economic, social and institutional means.

Fink and Tasman 1992; Link and Phelan 2001.

Health Promotion:

defined as action and advocacy to address the full range of potentially modifiable determinants of health (WHO 1998). Health promotion and prevention are necessarily related and overlapping activities. Because the former is concerned with determinants of health and the latter focuses on the causes of disease, promotion is sometimes used as an umbrella concept covering also the more specific activities of prevention.

Lehtinen, Riikonen & Lahtinen 1997

There is mounting evidence that it is possible to intervene at several levels, from local to national, to improve health (Benzeval et al., 1995). The factors over which individuals have little or no control require the collective attention of a society as encapsulated by the Ottawa Charter of Health Promotion (WHO, 1986). The five action strategies identified by the Charter remain today the basic blueprint for health promotion in many parts of the world.

Promoting Mental Health Concepts-Emerging Evidence-Practice WHO 2004

Mental Health:

means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental.

CMHA

Prevention:

refers to all the efforts involved in improving population health and preventing disease, disability, and premature death. Prevention is most easily understood as actions and interventions along a continuum of health, from wellness to illness. As such, disease prevention and disease management are not mutually exclusive. Prevention activities are generally categorized at the levels of primary, secondary, and tertiary

Primordial prevention:

is a significant component of prevention. Primordial prevention refers to negating the effects of social determinants of health and changing the quality of exposure to social determinants of health.

Table 1: Levels of Prevention *

Level of Prevention	*Primordial Prevention*	*Primary Prevention*	*Secondary Prevention*	*Tertiary Prevention/ Disease Management*
Targeted Population	Whole population	Whole population – Universal and targeted	At-risk individuals and groups	Individuals with established disease

Intervention Objectives	Preservation and promotion of healthy determinants and reduction of unhealthy determinants	Prevent individuals and groups from becoming "at risk." Modify risk factors/contexts	Lower incidence of established cases of disease	Eliminate or reduce long-term impairments, disabilities, and complications
Nature of Intervention	Change the quality of determinants of health. Modify the effects of determinants of health.	Promotion of healthy behaviors and supportive environments across the life span.	Periodic health examinations. Screening. Early intervention. Modification of risk factors.	Treatment. Self-management counseling and education. Rehabilitation.

H E A L T H   P R O M O T I O N

Adapted from National Pubic Health Partnership (Australia). Preventing Chronic Disease: Strategic Framework. 2001

Quality of Life:
ability to achieve satisfaction in key life domains including social relationships and support, financial stability, physical, social and emotional health, control over life choices, community involvement and personal empowerment.

Performance indicator for Mental Health Services and Supports 2001

Risk factors:
circumstances that make a particular population at greater risk for development of a disorder. Risk factors may be biological or social characteristics, or a combination of the two.

Stigma:
someone who appears to be different than us, we may view him or her in a negative stereotyped manner. People who have identities that society values negatively are said to be stigmatized.

Adapted from CMHA

Prevention, Promotion and Advocacy Bibliography

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Context & Issues:

Outpatient Services are part of a comprehensive community mental health service. The purpose of these services is to provide assessment and treatment for those individuals who have, or appear to have, a mental illness (e.g. depression, anxiety, schizophrenia, etc.); a mental, behavioural or emotional disorder with functional impairment; and those at risk of significant functional impairment. Services include Early Identification/Intervention Services; Assessment/Treatment Services; and Collaborative Care Services. Each district has services across the lifespan with linkages to key community supports and services.

Early Identification/Intervention Services:

These services are usually targeted to specific groups of adults, children and youth at risk. The purpose is to prevent the emergence or reduce the impact of a mental illness in these groups by, for example, the teaching of pro-social skills to groups of children already showing some signs of early behavioral problems. These services promote the earlier identification and treatment of individuals with mental illness who may not otherwise be referred at that time by other agencies and groups. This may provide an opportunity for collaboration with agencies and groups, including primary care providers, justice/corrections agencies, community service agencies, seniors programs, refugee support organizations, community-based organizations serving diverse racial and ethnic communities, women's support organizations, and community-based resources for the GLBTI community. In such cases, the service recipient may be the agency/group as well as the person with mental illness.

Assessment and Treatment Services:

Referral to these services may be made by a variety of sources, such as family physicians or other primary health care providers, and self-referral, etc. Services include crisis and emergency response service, and individual/group/family assessments and treatment services. Districts may enter into agreements with each other in order to provide access to core services for their clients. Caseloads are managed with reference to several variables - including programming priorities, available resources, geography, client and community needs - along with attention to the mix and intensity of specific cases and caseloads.
These services promote assessment and treatment of individuals who have been determined to have a mental illness and who are expected to benefit from assessment and treatment services. The timing of services might be impacted by urgency of need. Treatment is time-limited.

Collaborative Care Services:

These services are aimed at developing collaborative relationships with primary health care providers and agencies that provide various services to individuals and families. These collaborative relationships provide opportunities for knowledge transfer, education and consultation on treatment approaches, psychiatric medication management and differential diagnosis.

Goal Statement: Nova Scotians have access to a full continuum of supportive and therapeutic community-based assessment and treatment services.

Program Description: Early Identification/ Intervention Services (B1)

Early identification and intervention across the life span is founded on the understanding that collaboration with primary health and community agencies is essential.

Early identification/intervention services:
- identify and assess early signs and symptoms of mental illness;
- provide early intervention to prevent progression to a diagnosable illness;
- refer diagnosed metal illnesses for treatment and support
- reduce impact of mental illness; and
- foster hope for future well-being.

A framework of early identification and intervention services includes:
- identification of at risk individuals and populations;
- targeted intervention for individuals and groups at risk (i.e. young children, school age children, individuals with co-occurring mental illness and substance use disorders, older adults and individuals involved in the criminal justice system);
- links between mental health, primary care and community agencies for screening and intervention across the life span.

Goal Statement: Mental Health Early Identification/Intervention Services identifies individuals experiencing early signs and symptoms of mental illness and provides early intervention to prevent progression and/or reduce the impact of the mental illness.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Worklife	B1.1 DHAs/IWK initiate and build collaborative partnerships with primary health and community agencies to provide consultation, education and knowledge transfer on early identification and intervention for mental illnesses.	**IV**
Population Focus	B1.2 DHAs/IWK collaborate with primary health and community agencies to identify at risk individuals and groups.	**III**
Effectiveness	B1.3 DHAs/IWK collaborate with primary health and community agencies to deliver early screening services.	**IV**
Effectiveness	B1.4 DHAsIWK conduct assessments to determine individual intervention needs.	**IV**
Efficiency	B1.5 DHAs/IWK provide early interventions for at risk populations in collaboration with primary health and other community agencies.	**III**
Continuity	B1.6 DHAs/IWK refer to other services and programs as required.	**IV**

Program Description: Crisis and Emergency Response Services (B2)

The capacity to provide a crisis and emergency response service (CRS) is an integral part of a collaborative and culturally sensitive mental health service's continuum of care.

Due to the complexities of the presenting issues and the presumption that crises are determined and defined by the individuals experiencing them, there is a continuum of presentations of crises/emergencies and corresponding responses. The continuum moves from psychosocial crisis through to psychiatric emergency.

Psychosocial crises manifest in many ways, ranging from an acute presentation of mental illness to the emotional consequences of the loss of housing and other psychosocial stressors. A crisis occurs when an individual's usual coping strategies are overwhelmed by the presenting situation and the individual requires an urgent response. The goal of the intervention is to provide support to enable the individual to handle the crisis while remaining in the community (see Glossary).

Psychiatric emergencies occur when an individual's coping strategies are significantly compromised and there is potential for harm to self or others, or the individual's well-being is seriously threatened. An emergent response is required. The goal of intervention is to facilitate access to both a secure environment and active treatment (see Glossary).

A Crisis Response Service (CRS):

- uses skilled professional staff who are able to differentiate between mental disorder crises and psychiatric emergencies;
- ensures the availability of experienced professional staff to respond to the first telephone or walk-in contact made to the service;
- provides timely information gathering, assessment and intervention;
- links individuals in crisis with the appropriate community and/or hospital resources/services and
- provides coordinated responses to individuals and/or their significant others, and consults and collaborates with community providers, mental health staff, family practitioners, police, education, natural support systems (i.e. church, self help group), etc.

Serious and persistent mental illness can increase both the number of crises a person experiences as well as the individual's response to crisis. As well, the stress of a crisis can precipitate episodes of mental illness.

According to Crises Response Service Standards, Ontario (2005), Nursing Best Practices Guidelines Crisis Intervention, 2002 and APA Task Force, Psychiatric Emergency Services (2002) the range of functions provided by a CRS includes:

- stabilizing individuals in crisis in order to assist them to return to their pre-crisis level of functioning;
- assisting individuals and members of their natural support systems to resolve situations that may have precipitated or contributed to the crisis; linking individuals with services and supports in the community in order to meet their ongoing community support needs; and linking individuals to appropriate mental health care.

Goal Statement: Nova Scotians have access to twenty-four (24) hour crisis and emergency response services.		
Domains (CCHSA	**Standards Statements**	**Nature of Evidence**
Accessibility	**B2.1.** A crisis and emergency response service (CRS) is available in a timely manner in the most appropriate environment in each district and includes a plan for twenty-four (24) hour service seven (7) days per week.	**IV**
Accessibility	**B2.2.** There are established protocols for collaboration with primary health care providers, hospital emergency departments, the police and other emergency responders.	**III**
Appropriateness	**B2.3.** CRS includes the capacity to respond in a timely manner to requests for telephone consultation about crisis management.	**III**
Competence	**B2.4.** The CRS has designated mental health staff with core competencies in suicide risk assessment, violence risk assessment and comprehensive, focused mental health assessment.	**II**
Safety	**B2.5.** There are established protocols for the following: ▪ appropriate care provision to individuals during crisis/emergency situations; ▪ risk assessments; and ▪ continuity of care.	**III**
Acceptability	**B2.6.** The CRS has access to mental health inpatient services and/or crisis beds.	**III**
	B2.7. A recommendation for admission to a mental health inpatient service is made by, or in consultation with, a mental health service provider.	**II**
Accessibility	**B2.8.** Timely collaboration, education and consultation are available to various service providers to assist them in identifying and intervening in mental disorder crises and psychiatric emergencies.	**III**
Safety	**B2.9.** A policy identifies those situations and circumstances in which medical clearance/assessment is required for individuals who are being assessed by a CRS. See Appendix B2 - A: Guideline for Medical Assessment of Psychiatric Patients in the Emergency Department	**IV**
Safety	**B2.10.** Where a referral of an emergent patient is received from an emergency service, an assessment focusing on risk and current mental status is completed within twenty-four (24) hours.	**III**

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

Individual, group and family services are part of a broader continuum of services that are available in the community. A client-centered approach, which values the input and informed involvement of individuals receiving services, is a basic principle of service delivery. There are clear eligibility and exclusion criteria for service provision, and referrals are accepted from a variety of sources, including the client him/herself and families.

Individual, group and family services include screening, intake and case assignment; assessment; determination of diagnosis or diagnostic impression; and treatment/ support planning and delivery.

Where it is clear that a different service or agency may appropriately meet the needs of a referred person, there are identified methods of communication and collaboration to support the transfer of information and responsibility.

A continuum of services is built on the following elements:

- the belief that a therapeutic relationship is the foundation of effective treatment;
- a range of therapeutic support interventions such as psychosocial education groups, consumer and caregiver support groups, and counseling support to specialized treatment interventions such as individual and group psychotherapy;
- therapeutic interventions including quality review processes; defined, measurable goals / expected outcomes; treatment/support plans; and formal clinical review processes along with documentation of these things;
- continuity of care is supported by a multi-disciplinary approach to service provision, by the active development of appropriate and helpful partnerships, and by processes that support accurate and timely transfer of patient care-related information;
- clients are engaged in their own treatment as informed, consenting and active partners and not simply as recipients of service; and
- continuity is again ensured at the conclusion of service delivery through appropriate discharge planning and post-treatment follow-up.

Goal Statement: A range of individual, group and family services that address significant mental disorder needs is available to the population of each DHA/IWK.

Domains (CCHSA)	Standards Statements	Nature of Evidence

Efficiency	**B3.1.** Uniform and consistently-implemented triage and screening processes are used to respond to referrals in an appropriate and timely manner by members of the clinical team.	**IV**
Accessibility	**B3.2**. Referrals are reviewed by a mental health clinician within one working day to determine eligibility (i.e., subjected to a basic screening assessment).	**IV**
Accessibility	**B3.3** The triage process distinguishes between levels of need/distress and identifies procedures for response with respect to identified categories of referral. These categories* include Emergent, Urgent, Semi-urgent and Regular referrals. This process assists in the linkage between the level of need and the therapeutic service intervention continuum (see Appendix B3-A).	**III**
Population Focus	**B3.4.** Individuals are deemed to be eligible to receive services if they are experiencing mental illness or significant mental health problems with functional impairment, and if there is an expectation of benefit from treatment.	**III**
Accessibility	**B3.5.** Individuals are deemed to be ineligible to receive services if, in the absence of a mental illness or mental health problem as noted in B3.4, they require, or are requesting services for: ▪ primary addiction, substance abuse or gambling problems; ▪ legal problems, including custody and access assessments; ▪ assessment for insurance claims; ▪ partner/relationship problems; or ▪ psycho-educational assessments.	**III**
Population Focus	**B3.6.** Where individuals do not meet eligibility criteria, or where clinical review may determine that another service or agency may better meet the needs of an otherwise eligible individual, protocols are utilized to connect the individual to the appropriate provider or agency.	**III**
Accessibility	**B3.7.** Emergent referrals are immediately referred to an appropriate emergency service.	**III**
Domains (CCHSA)	**Standards Statements**	**Nature of Evidence**

Accessibility	**B3.8.** Urgent referrals are offered an appointment to carry out a mental health assessment to occur within seven (7) calendar days of the date of referral.	**III**
Accessibility	**B.3.9.** Semi-urgent referrals are offered an appointment to be seen within twenty-eight (28) days of the date for the referral.	**III**
Accessibility	**B3.10.** Regular referrals are assigned to a mental health clinician within fourteen (14) days of the date of referral.	**IV**
Accessibility	**B3.11.** Regular referrals are offered an appointment within ninety (90) days of case assignment.	**IV**
Efficiency	**B3.12.** Protocols are in place to support the appropriate assignment of referrals to triage categories and the offering of appointments within identified time frames.	**IV**
Population Focus	**B3.13.** A therapeutic service continuum includes a range of services from therapeutic supportive interventions to intensive therapy interventions.	**III**
Effectiveness	**B3.14.** An assessment process is in place for each therapeutic option.	**III**
Worklife	**B3.15.** Interventions are provided by mental health clinicians who possess sufficient clinical expertise or who have been assessed as competent to offer them.	**II**
Continuity	**B3.16.** Follow-up of individuals discharged from inpatient care is provided within ten days following discharge.	**IV**
Safety	**B3.17.** Follow-up protocols are in place for individuals who do not attend the initial outpatient appointment.	**IV**
Population Focus	**B3.18.** Protocols are used to monitor and manage wait lists and to keep clients informed of their status on any wait list.	**III**

Program Description: Collaborative Care Services - B4

Collaborative care is built on principles aimed at enhancing continuity of care through the entire continuum of service delivery, and upholds the value that consumers and caregivers are the experts in their own right and are to be respected partners in determining treatment options and setting goals in their recovery.

> "Collaborative mental health care is defined by four key elements: accessibility, collaborative structures, richness of collaboration, and consumer centeredness." (Macfarlane, Dianne, _Current State of Collaborative Mental Health Care,_ June 2005, CCMHI pg. 2)

Mental health services develop collaborative relationships with primary health care providers and community agencies that provide various services to individuals with mental disorders. Best practice literature supports this practice to truly build capacity of the system.

Primary health care providers and community agencies often request education and consultation in responding to the mental health needs of the individuals they serve, which might include individuals who may not require a 'secondary' level of care/treatment. Sometimes the practicality of service provision would indicate that case management is retained at the primary care or agency level. Such cases could benefit from the provision of education and consultation to the primary care provider on treatment approach, psychiatric medication management, differential diagnosis, etc.

Four areas of focus for collaborative working relationships, beyond the provision of a secondary level treatment, include:

1. Knowledge transfer between mental health services and primary health care providers in the effective assessment and treatment of mental health disorders.

2. Provision of consultation services to primary health care providers, including treatment recommendations and support.

3. Knowledge transfer between mental health services and community agencies in early identification of mental illnesses and referral to mental health services.

4. Development of processes that support collaboration between mental health services, and primary care providers and community agencies. These include shared care and interagency treatment protocols for various disorders where evidence or best practice dictates or where efficiencies may be gained.

Goal Statement: Mental health services collaborate with primary health care providers and community agencies for the benefit of individuals with mental health care needs and their families and communities.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Effectiveness	**B4.1.** Collaborative relationships are established with primary health providers.	**III**
Worklife	**B4.2.** Education and consultation on mental health issues/problems is provided to primary health care providers and community agencies.	**III**
Worklife	**B4.3.** The availability of education and consultation is communicated to service providers in primary health care and community agencies.	**III**
Efficiency	**B4.4.** Formal and informal processes exist to support a collaborative approach (e.g. service agreements, MOAs, collaborative networks, shared processes and procedures, verbal agreements).	**III**
Client Centered	**B4.5.** Consumers, families and their identified supports are integral partners in the collaborative process in planning, decision-making, service coordination and delivery and evaluation of their treatment.	**II**

APPENDIX B2 - A

GUIDELINES FOR MEDICAL ASSESSMENT
of Mental Health Patients in the Emergency Department

Preamble

The medical evaluation of a patient presenting to an emergency department for mental health evaluation represents a potentially high-risk encounter. Some of these patients have co-existing chronic medical conditions and/or may not be able to provide a thorough or reliable medical history.

Optimal patient care of these patients is dependent upon a collaborative approach that encourages direct communication between the emergency department provider and the psychiatrist. This document is intended to further that goal while minimizing the "one size fits all" approach that emphasizes testing over thoughtful clinical evaluation.

Basic Principles

1. 'Medical assessment' refers to the medical evaluation of patients who are being considered for psychiatric assessment and follow-up. It is intended to identify active medical problems that may require further medical care. Such problems may be causing the apparent mental health disorder, complicating an already present mental health disorder, or incidental to the mental health disorder but nonetheless need to be reported.

2. Medical assessment is indicated for most, but not all, patients being considered for mental health referral. A history and physical exam are the basic components of medical assessment.

3. Medical assessment does not end in the emergency department but continues as an ongoing component of inpatient care.

4. Emergency Department and mental health personnel should communicate regularly to address quality improvement issues.

GUIDELINES FOR THE MEDICAL ASSESSMENT WORK-UP

Different Patients have Different Needs

The level of medical assessment required depends on the clinical situation. Five patient groups can be distinguished with different needs:

1. Mental illness requires a thorough medical evaluation. Up to 60% may have medical, traumatic, or toxic causes for the mental health patients with known significant medical problems. Their known medical problems need medical evaluation appropriate to their medical condition.

2. Known mental health patients presenting with a medical complaint or confusion. Their medical complaint needs medical evaluation appropriate to their medical condition.

3. Intoxicated and/or confused patients need medical evaluation appropriate to their current medical condition.

4. Patients with a known mental illness history, a presentation similar to past evaluations, no history of major medical problems, and no medical complaint. These patients usually require minimal medical evaluation.

Psychiatrists, and emergency room physicians with the agreement of the psychiatrist, may waive medical assessment where it is unnecessary in their judgment based on the above guidelines.

The following are associated with a higher incidence of organic causes of cognitive or thought disorders:

1) First episode psychiatric symptoms
2) Age > 40 years
3) Abnormal vital signs
    a. Temp >37.5 C
    b. HR < 50 or >120/min
    c. BP <90 systolic or >200/120 diastolic
    d. RR >24
    e. Low O_2 saturation
4) Recent memory loss
5) Altered level of consciousness

A history and physical examination should be completed as per any patient presenting to the Emergency Department with a new or undiagnosed problem. Documentation should be clear and easy to follow.

Investigations

Laboratory testing should be guided by the clinical condition of the patient. In higher risk patients, the following may be of use:

* Urine may be tested for infection (or rarely porphyria.) Routine toxicology screening may be requested but the delayed results will not affect the patient's disposition.

- CBC
- Electrolytes
- Creatinine, BUN
- Blood Sugar
- CK or troponin (especially in elderly)
- TSH
- Urine Micro or dip *
- Tox screen: ASA, acetaminophen, EtOH**, (Osmol)
- 12 lead ECG, Diagnostic Imaging as needed

** A blood alcohol level may be used to identify the presence of alcohol and to follow levels over time but a particular level will not be used to determine clinical intoxication, readiness for psychiatric assessment, or readiness for admission.

Patients being held in the ED require regular re-evaluation and documentation.

Referral to Mental Health

Referral to Mental Health generally requires that a medical assessment be completed unless the patient has been medically assessed prior to admission to the Emergency Department or else the medical assessment is waived in consideration of the five levels of need as described above. The medical assessment may be done before or after the mental health assessment (unless triage suggests the possibility of an underlying medical problem in which case the medical assessment should precede the mental health assessment). The medical assessment should be clearly documented.

Referral also requires that patients with substance use be free of intoxication as evidenced by their willingness and ability to cooperate, ability to think and communicate clearly, and freedom from disruptive behavioral or emotional disturbance.

A mental health assessment should be completed as soon as possible when the patient is acutely psychotic, violent, or has been brought in by the police.

In cases where the psychiatric emergency service has accepted patients directly from the community without medical assessment, medical assessment may be requested should the patient's medical condition be of concern to them.

Adapted from CDHA, July26, 2008 document Guidelines for Medical Assessment of Psychiatric Patients in the Emergency Department)

Appendix B3 - A

Community Mental Health

Referral Triage is based on the level of symptoms, risk to self or others, functioning, and social supports available. Other factors considered include substance use, medical problems, housing issues, legal issues, frequency of crisis, treatment compliance, and the patient's readiness to participate in treatment, and the availability of community treatment and support.

The examples given are rough guides only. Actual disposition depends on consideration of the principles of priority assignment in the context of the information available about the case. The mental health team may contact the referring physician, agency or the patient, for more information, before setting the triage level.

Triage Level		Description	Examples	Referral Process	Target Wait Time
0	Emergent Send to ED	• Immediate and significant risk of harm to self or others. • Acute psychosis or mania which cannot be managed in the community.	• Acute suicidal thoughts with intent • Acute psychosis • Acute mania	**Send to local ED**	
1	Urgent See by end of 1 week	• Current risk of harm to self or others but judged safe for immediate provided treatment is made available within next week. • Escalating psychosis or mania with risk of rapid deterioration and need for hospitalization within a week or two. • Recent discharges from psychiatric inpatient units where rapid follow-up needed.	• Acute suicidal thoughts without intent • Mania • Hypomania • Psychosis	• Fax or mail referral form or note to one of the community mental health teams listed below. • Call and speak to Intake Clinician if deemed Urgent:	7 days
2	Semi- urgent See by end of 4 weeks	• Unstable with risk of acute decompensation due to unstable illness, personality, or circumstances. • Engaging in new or increased risk behaviors due to mental illness. • Acute deterioration in functioning and role performance due to mental illness. • Recent onset or exacerbation of suicidal / homicidal thoughts without current risk of harm to self or others. • Recent discharges from psychiatric inpatient units.	• Acute clinical depression • Symptoms of relapse of psychosis or mania. • Hypomania with promiscuous behavior and speeding. • Single parent with no supports & unable to care for children due to depression, send referral to child protection services. • Parent with mental illness suspected of neglecting children, also send referral to child protection services. • Depressed with suicidal thoughts but no intent, plan, or history of suicidal behavior.		28 days

3	Regular See by end of 3 months	• Chronic but stable patients where rapid deterioration is not imminent in the short-term. • Mental illness, emotional distress, coping difficulties, or personality disorder without short-term risk of harm to self or others and without significant loss of function or role performance. • Poor response to ongoing treatment by primary care physician.	• Depression • Anxiety • Anger Problems • Coping Problems • Personality Disorder		90 days

Wait Times: The Target Wait Time is the time from receipt of referral to face-to-face assessment which we aim to achieve. The Actual Wait Time shows the average time from referral to assessment measured over the last quarter prior to publication. (Adapted from CDHA, 2004 document)

Outpatient and Outreach Glossary

Clinical Case Review components include:

- Standardized review timelines
- Case Presentation overview
- Review of Intervention Plan
- Review of Progress
- Case Status decision and subsequent Intervention Plan

*Collaborative mental health care: "*one approach to improving the delivery of mental health services in primary health care settings.*" (*p 6 Canadian Collaborative MH Initiative: Key Messages in Support of Dissemination*)

*Collaborative primary health care: "*The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals,*

consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- *common goals or purpose*
- *a common language*
- *a recognition of and respect for respective strengths and differences*
- *equitable and effective decision-making*
- *clear and regular communication*

in order to

- *improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention, management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location*
- *deliver high-quality and effective health care*
- *make the most of resources*
- *improve outcomes for the consumer".*

(*CCMHI, Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners, 2007, p.91)

*Interdisciplinary: *"A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines".*
(*CCMHI, Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners, 2007, p.92)

Mental Health Crises:

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.

Adapted from: http://www.jibc.ca/police/main/PIIMIC/Glossary/c.htm

*Mental health specialist: *"An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation."*
(*CCMHI, Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners, 2007, p.92)

Psychiatric Emergencies:
A situation in which outside help is needed immediately as there is imminent danger of physical harm or life-threatening danger.
Adapted from Coping with Mental Health Crises and Emergencies www.heretohelp.bc.ca

*Primary health care: *"An individual's first contact with the health system characterized by a spectrum of comprehensive, co-coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management."*

(*CCMHI, <u>Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners</u>, 2007, p.92)

*Primary mental health care: *"Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes, correctional facilities and day care centers. Primary mental health care may also be available by telephone, health information services and the Internet."*
(*CCMHI, <u>Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners</u>, 2007, p.92)

Secondary care: *"The term secondary care is a service provided by medical specialists who generally do not have first contact with patients."* (Wikipedia, 2007)

Therapeutic Supportive Interventions include:

Consumer Lead Initiatives: Consumers / Clients utilize their expertise to lead or co-lead supportive interventions.

Psycho-Social Education: Therapeutic Support provided by Individual or Group educational sessions.

Supportive Counseling: Counseling is deemed to be current Life Skills and Coping strategy focused.

Intensive Therapy Intervention: *Individual, family, group psychotherapy*.

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Outpatient and Outreach Bibliography

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Community Mental Health Supports for Children/ Youth / Families (C) **March23, 2007**

Context & Issues:

In 2000, the Department of Health published the document *Community Mental Health Supports for Adults* which provided direction for developing a comprehensive system of community mental health supports for individuals living with major mental illness and significant impairments. Although focused on adults, the document was used as a beginning foundation for developing standards for the Community Mental Health Supports Core Program across the age continuum. In 2006, additional stakeholders involved in the mental health care of children and youth were engaged to add increased and unique perspectives on the younger population. These individuals worked as a sub-committee and was struck to develop revised standards related to children/youth and their families.

Underlying the whole Community Mental Health Supports Core Program is a philosophy that requires people with serious mental health issues be treated with the same dignity, rights and opportunities afforded to all citizens of Nova Scotia. This implies that the determinants of health are relevant for children/youth with severe and persistent emotional, behavioural and mental health issues and that children/youth and their families are encouraged to do what they can to improve their health, and the outcomes of the program are those of the greatest importance to these individuals.   The desired service delivery for children/ youth and their families is found in the various evidence-based practices. Strengthening support networks is a critical component in service provision to children/youth and their families. However, it is important to note that youth are not always treated with their families as this may not be appropriate.

The target population for the Community Mental Health Supports Core Program for Children/ Youth/ Families are those individuals/families and their support network, who:

1. Experience severe and persistent emotional, behavioural, and mental health issues;
2. And who:

   a) have difficulty living and participating in the community, in their family, at school, with peers and in pro-social activities with a quality of life acceptable to them;
   b) are not effectively supported by less intensive services (i.e. office-based mental health services), choose not to use those services, or are involved with multiple agencies;
   c) have significant impairments in dealing with many aspects of life (eg. family, social, education, work, housing, self-care, and leisure etc.);
   d) are at higher risk for poverty, homelessness, criminal encounter, school expulsion, school failure, substance abuse, unemployment, discrimination and suicide;
   e) often have poor response to previous interventions and programs, or have difficulty accessing 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 Mental Health Supports Core Program for Children/ Youth/ Families is designed to help children/youth/families and their support networks manage the demands of daily life, and to promote full engagement/citizenship in their community. Community Mental Health Supports differs from, but complements, less intensive mental health services (i.e. office-based), through the focus of interventions and by delivery of services in the community environment of the child or youth. Staff collaborate with children/youth/families and their support network to address functional goals and to provide ongoing outreach/support across service settings as needs change. The range of intensity/frequency of service is based on need, and will vary by the situation of the child/youth/family and their support network. The resources available locally and varying critical mass of clients, may challenge health districts to create service access by developing innovative partnerships or to modify model programs to their capabilities.

Community Mental Health Supports for Children/ Youth/ Families may include:

• Case management
• Intensive community-based treatment teams/family initiatives
• Accommodation/housing/employment and education supports
• Proactive outreach/case finding

Treatment of Children/ Youth/ Families may also include:

• Multi-modal approach
• Community-based approach
• Early intervention approach
• Multiple systems approach
• Maximization of protective factors

Goal Statement: Community Mental Health Supports for Children/Youth/Families Core Program is designed to support this population in accessing a network of community supports consistent with services based on best practice evidence, to attain optimal mental health and appropriate functioning at home, at school and in the community.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**C1.1.** Children and youth assessed as meeting the eligibility criteria for community supports are referred to the Child/ Youth/ Family Community Supports Service. Admission criteria are: a) severe and persistent emotional and behavioural mental health issues, and/or severe disruptive behaviour with significant impairment in activities of daily living and, b) effective support can not be provided in a less intensive service and, c) the individual will likely benefit from the community supports program based on best practice evidence. d) has been unable to benefit from a less intensive level of service.	**II**
Acceptability	**C1.2.** While referrals for community supports may be initiated by multiple sources (professionals, non-profit and other service agencies, homeless shelters, employment services, family and self referrals), the child/youth/family has to proceed through the established triage and assessment process for the child/youth mental health service. Pro-active outreach/referral finding may be part of this process.	**II**
Appropriateness	**C1.3.** Standard triage/intake is initiated within **ten** (10) working days of a referral. Following an initial assessment completed by a mental health clinician, and based on the assessment information, an internal referral is made to the more intensive Community Supports Service for Children/ Youth/ Families.	**II**
Effectiveness	**C1.4.** On acceptance into the Community Supports Service, a comprehensive assessment and intervention plan will be developed with the child/youth/family. Progress reviews are ongoing throughout the course of treatment and all domains in the child's/youth's/family's life and their support network are considered, including other clinical services for the family as appropriate.	**II**
Effectiveness	**C1.5.** The community supports intervention plan outlines mutually established goals and/or outcomes expected for the child/youth/family, and/or support network, where appropriate, as well as time frames for treatment or goal attainment.	**II**

Domains (CCHSA)	Standard Statements	Nature of Evidence
Continuity	**C1.6**. a) The community supports intervention plan includes linkage, advocacy, and coordination with all relevant professional and community resources as appropriate. b) If the child/youth/family is unable to benefit from the intensity of the service due to family instability or other competing demands, they may re-access the service at a later date, based on the clinical judgment of the team.	**II**
Acceptability	**C1.7.** Individual plans and interventions for the children/ youth/ families are developed to support/facilitate: a) improvements in family life/safe family functioning. b) ongoing pro-social networks consistent with best practice c) ongoing individual educational and employment goals consistent with best practice.	**II**
Appropriateness	**C1.8.** All contacts with an individual are documented on the individual's health record.	**II**
Appropriateness	**C1.9.** Number of clients assigned to a case manager/ youth worker is managed according to case mix, intensity, and individual needs/outcomes; and within the context of geography, population and available service system.	**III**
Competence	**C1.10.** Case managers/youth workers who are employed by the mental health program work in multi disciplinary teams that provide clinical supervision and back up.	**IV**
Transition	**C1.11.** A mechanism is available to call case conferences to transition clients who, due to a chronic diagnosis or persistent behavioural concerns, will require ongoing follow up. The case conference can be called by the community supports teams for either children/youth/families or adults. Information will be shared across teams to facilitate a smooth transition of services.	**III**

Community Mental Health Supports for Children/ Youth / Families Glossary

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the community program options and services required to meet the mental health needs of a child/youth/ family. This process uses communication and available resources to promote high quality and cost-effective outcomes. Work with individuals primarily happens in natural community settings.

Community-Based Approach - The term "community-based services" is used to describe both where the services are located (i.e., community settings, such as an individual's home or school) and a philosophy of care (i.e., one that is based on consumer empowerment and recovery principles). In the current application, these often combine the work of a multidisciplinary mental health treatment team with a tailoring of community support resources and services to assist the client/family in realizing the mutually agreed upon treatment goals.
> Source: Morrow, M., Frischmuth, S. and Johnson, A.: Community-Based Mental Health Services in B.C, Canadian Centre for Policy Alternatives, 2006

Critical Mass – A number of clients sufficient to warrant an identifiable program or service being offered. (i.e., because Halifax and Sydney both have large populations of children and youth requiring more intensive services, Intensive Community Based Treatment Teams were put in place in these areas. For districts with smaller populations of these children and youth there may be one position or a part of a position designated to provide specified services or there may not be a separate service at all, due to the smaller numbers).

Early Intervention Approach - Applies to children of school age or younger who are discovered to have, or be at risk of developing a handicapping condition or other special need that may affect their development. Early intervention consists of the provision of services such children and their families require for the purpose of lessening the effects of the condition. Early intervention can be remedial or preventive in nature, either seeking to remediate existing problems or preventing their occurrence. Early intervention may focus on the child alone or on the child and the family together. Such programs may be office-based, home-based, hospital-based, or a combination thereof. Services may range from identification to diagnostic and direct intervention programs.

> Sources: U.S. Department Of Education, Washington D.C. (see also www.kidsource.com) 2000;
> Early Intervention Nova Scotia (www.earlyintervention.net) 2006

Intensive Community-based Treatment Teams (ICBTT) /Family Initiatives: In Nova Scotia, the ICBT Teams of Mental Health Services seek to address the many concerns presented by children and their families, using a case management, community-based model of service delivery. The focal points of these interventions are the problematic family and community-based interactions that provide marked impairment in overall functioning.
> Source: Intensive Community-Based Treatment Team, Cape Breton District Health Authority, 2003

Model Programs – Are well-implemented, well-evaluated intervention programs according to rigorous standards of research. Developers ensure that such programs meet best practice standards for the provision of quality materials, delivery modalities, training, and technical assistance for their implementation.
Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention 2005 (www.modelprograms.samhsa.gov)

Multi-modal Approach – A combination of psychological and educational treatments that have received empirical support for their effectiveness in addressing the needs of behaviourally and emotionally challenged youth.

Multiple Systems Approach – Takes place across multiple systems including the family, school, peer group, etc., and promotes consistent use of treatment techniques across multiple settings.

Natural Community Settings – Home, school, neighborhood, (community) not office based.

Proactive Outreach/Case Finding – Community education to partner groups.

Pro-social Behaviour - Behaviour that is intended to benefit others or society as a whole. In the family and in school, this could involve young people being included when decisions are made that affect them. In the community, this includes opportunities to be involved in sports or community organizations. Pro-social activities have been identified as being positively related to achievement, school attachment and performance, ability to overcome adversity, willingness to help others, self-esteem, leadership qualities and more positive mental health outcomes.

Protective Factors – Characteristics of family, client, and community that improve resiliency and counteract risk factors.

Severe and Persistent Emotional and Behavioural Mental Health Issues - DSM-IV mental health disorder that has persisted for longer than six months and causes significant impairment in activities of daily living in multiple settings, i.e. home, school, community.

Support Networks – Informal (family, friends, recreational programs, religious groups). Formal (school/education, community agencies, justice, community services).

Youth – In Mental Health Services, the term 'Youth' is used to cover adolescent years age 13 to the 19th birthday.

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Community Mental Health Supports for Adults (C2)

Context & Issues

In 2000, the Department of Health published the document *Community Mental Health Supports for Adults* that provided direction for developing a comprehensive system of community mental health supports for individuals living with major illness and significant impairments.

Underlying the Community Mental Health Supports Core Program is a philosophy and a specific set of interventions that require people with serious mental illness be treated with the same dignity, rights and opportunities afforded to all citizens of Nova Scotia. This supports evidence that the determinants of health are relevant for people with serious mental health disabilities and individuals are encouraged to do what they can to improve their health. The outcomes of the program are those which are of the greatest importance to these individuals. The desired service delivery for adults is found in the literature on Psychosocial Rehabilitation (PSR) and Recovery (see glossary). Strengthening the support network is a particularly critical component in service provision to adults.

The target population for Community Mental Health Supports for Adults Core Program is persons living with serious mental illness.

"There are three dimensions used to identify individuals with serious mental illness/serious mental health problems: disability, anticipated duration and/or current duration, and diagnosis. The critical dimensions are the extent of disability and serious risk of harm to themselves or others, related to the diagnosable disorder:

- *Disability refers to difficulties that interfere with or severely limit an individual's capacity to function in one or more major life activities.*
- *Anticipated duration/ current duration refers to acute and ongoing nature of the problems identified either through empirical evidence and objective experience suggesting persistence over time or through the subjective experience that the problems have persisted over time.*
- *Diagnoses of predominant concern are schizophrenia, mood disorders, and paranoid and other psychoses.*
- *Many people who have a serious mental illness will have life long problems in coping and periodic episodes of acute illness that are characteristic of chronic illness or disorder."**

*Adapted from Source: Making it Happen: Implementation Plan for Mental Health Reform, Ontario Ministry of Health & Long Term Care: 1999, pp. 14-15.

In addition, there are a small number of persons with high needs and/or aggressive behaviors who will be served by Community Mental Health Supports for Adults Core Program. A description of these individuals who have multiple or complex needs is also in the document entitled Making it Happen. (*see Glossary)

Resources available (e.g. community housing stock, human resources), and varying critical mass of clients, may challenge health districts to be creative in developing partnerships and in modifying program models to meet the needs of the district.

Core Program Description

The Community Mental Health Supports for Adults Core Program is designed to help individuals achieve the highest level of recovery possible. Recovery is based on the Psychosocial Rehabilitation (PSR) principles of empowerment, recovery and self determination.

Staff of the Community Mental Health Supports for Adults Core Program collaborates with individuals around recovery goals, and provides outreach and support as individual needs change. The range of intensity/frequency of service is based on need, and will vary by individual and over time.

The Community Mental Health Supports for Adults Core Program approaches include*:
- Case Management (which may include ACT, ICM & Rehabilitation Case Management)
- Clubhouse
- Psychosocial Rehabilitation and Recovery Initiatives

For description of individual approaches please see glossary

Goal Statement

The Community Mental Health Supports for Adults Core Program is designed to support individuals in accessing services needed to attain optimal health, to manage the demands of daily life, and to enjoy full citizenship in their communities.

Domains (CCHSA)	Standards Statements	Nature Of Evidence
Appropriateness	**C.2.1.** While referrals for Community Mental Health Supports for Adults may be made by multiple sources (self referrals, professionals, and community agencies) the assessment will be made through the normal procedures of the adult mental health service.	**II**
Acceptability	**C.2.2.** Individuals assessed as meeting the eligibility criteria for an Adult Community Supports Program are referred to the appropriate service. Eligibility criteria are: Having serious mental illness (SMI)/serious mental health problems which includes the critical dimensions of: • disability, • anticipated duration and/or current duration, and • diagnosis. *(*see glossary of terms)*	**II**

Domains (CCHSA)	Standards Statements	Nature Of Evidence
Appropriateness	**C.2.3.** An intake assessment of functional domains is initiated within ten working days of the referral for case management services.	III
Appropriateness	**C.2.4.** The intake assessment is completed and documented within thirty working days for case management services.	III
Effectiveness	**C.2.5.** A comprehensive assessment is completed and documented within ninety working days for case management services.	III
Effectiveness	**C.2.6.** A service/intervention/recovery plan that considers all domains in the individual's life is prepared and documented within thirty days of the completion of the comprehensive assessment.	II
Continuity	**C.2.7.**The service/intervention/recovery plan outlines mutually established goals, time frames for goal attainment and linkages with all relevant professional and community resources.	II
Acceptability	**C.2.8.**Service/intervention/recovery plans may include mental health supports to individuals' goals for: (a) housing; (b) education; (c) employment; (d) social and leisure activities; and (e) physical, psychological and spiritual health.	II
Appropriateness	**C.2.9.** All contacts with an individual are documented on the individual's health record.	III
Appropriateness	**C.2.10.** A comprehensive annual review of the individual's progress towards all his/her goals is completed and documented at least once per year.	III
Competence	**C.2.11.** Case managers and unlicensed community support workers who are employed by a mental health program are supervised by mental health professionals and work in interdisciplinary teams which provide clinical supervision and back up.	IV

Domains (CCHSA)	Standards Statements	Nature Of Evidence
Continuity	**C. 2. 12.** A mechanism is available to organize case conferences which will develop early transition plans for clients of the Child and Youth Core Program whose ongoing recovery will/may require services or supports available from the Adult Core Program. A case conference may be initiated by a community supports team from either core program. Information is shared between teams in order to best support the client and to ensure a smooth transition across the programs.	III

Psychosocial Rehabilitation Training/ Education (Adults)

Promoting Recovery: Psychosocial Rehabilitation in Practice
Registered Nurses Professional Development Centre (RNPDC)
Capital District Health Authority
1278 Tower Road
Halifax, NS B3H 2Y9

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

Certified Psychiatric Rehabilitation Practitioner (CPRP) Program
www.uspra.org/certification

Community Mental Health Supports for Adults Glossary

Case Management
Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates community program options and services required to meet the mental health needs of individuals. This process uses communication and available resources to promote high quality and cost effective outcomes. Work with individuals primarily happens in natural community settings.

Case Management may include Assertive Community Treatment (ACT), Intensive Case Management (ICM).

(A) Assertive Community Treatment (ACT)
"Assertive Community Treatment (ACT) is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated and rehabilitative community support, crisis, and treatment interventions/ services that are available 24 hours/7 days per week."
Source: Medicaid Rehab Option: Assertive Community Treatment (ACT), Draft Definition of ACT Program, September 2006, State of Connecticut Department of Mental Health and Addiction Services, page 1.

(B) Intensive Case Management (ICM)
"Intensive case management is more than a brokerage function. It is an intensive service that involves building a trusting relationship with the consumer and providing on-going support to help the consumer function in the least restrictive, most natural environment and achieve an improved quality of life. The case manager maintains involvement, as consumer needs change and cross service settings."
Source: Intensive Case Management Service Standards for Mental Health Services and Supports, May, 2005. Ministry of Health and Long Term Care, Province of Ontario, p. 6.

Clubhouses
The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these Standards are at the heart of the clubhouse community's success in helping people with mental illness to stay out of hospitals while achieving social, financial and vocational goals. The Standards also serve as a "bill of rights" for members and a code of ethics for staff, board and administrators. The Standards insist that a clubhouse is a place that offers respect and opportunity to its members.
Source: www.iccd.org/ClubhouseStandards.asp

Intervention
"In the intervention phase, the plan is implemented by either skill development or support/ resource- development interventions. Skill development interventions directly teach clients the skills they lack (Direct Skills Teaching) or develop their use of the skills

they do not use effectively (Skills Programming)."
Source: Anthony, Wm et al, *Psychiatric Rehabilitation, Second Edition*, © 2002 by the Center for Psychiatric Rehabilitation, Trustees of Boston University p. 223.

Person with Multiple or Complex Needs
A person with multiple or complex needs: "a person who meets the criteria for serious mental illness, has had past episodes of aggressive or violent behavior and has one or more of the following characteristics:
- *three or more psychiatric hospital admissions within the last two years;*
- *has been detained in an inpatient facility for 60 or more days within this period: subject to two or more police complaints/ interventions within the last 12 months or has been incarcerated in a correctional facility for 30 or more days within this period;*
- *recently evicted from housing, or is homeless, or living in shelters;*
- *current problems with drugs and/or alcohol; and/ or problems following up with recommended treatment plans."**

*Source: Making it Happen: Implementation Plan for Mental Health Reform, Ontario Ministry of Health & Long Term Care: 1999, p.61.

Psychosocial Rehabilitation (PSR)
Diane Weinstein and Ruth Hughes) Chapter 2, Best Practices in Psychosocial Rehabilitation.
"The goal of all psychosocial rehabilitation is to restore each person's ability for independent living, socialization and effective life management (Hughes, Woods, Brown, and Spaniol, 1994). It is a holistic approach that places the person- not the illness- at the center of all interventions. The wishes of the person being served direct the rehabilitation process through working partnerships that are forged between the practitioner and the individual with mental illness. Effective (psychosocial) rehabilitation builds on a person's strengths and helps the individual to compensate for the negative effects of the psychiatric disability."
Source: Stout, Chris E. and Randy A Hayes, *The Evidence-Based Practice: Methods, Models, and Tools for Mental Health Professionals*, Copyright 2005.

Psychosocial Rehabilitation and Recovery Initiatives
Other programs operating according to the principles of psychosocial rehabilitation and recovery. [To be further developed in next revision]

Recovery
"As used in recent years in the field of psychiatric rehabilitation, this term refers to a model of service delivery that (1) looks beyond symptom management to the client's broader existential concerns; (2) recognizes that recovering from the consequences of the disorder, such as stigma, is often more difficult than recovering from the disorder itself; (3) recognizes that there are many pathways to recovery; and (4) emphasizes the recovery process as one that should be collaborative or client-driven rather than practitioner-driven. The recovery concept emphasizes the importance of conveying hope to clients, of restoring self-esteem, and of attaining meaningful roles in society."

Source: Davis, Simon, *Community Mental Health in Canada, Policy, Theory and Practice*, © UBC Press 2006, p.321.

Serious Mental Illness (SMI)
The three dimensions used to identify individuals with a serious mental illness/severe mental health problem are: disability, anticipated duration and/or current duration, and diagnosis. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

- *Disability refers to difficulties that interfere with or severely limit an individual's capacity to function in one or more major life activities.*
- *Anticipated duration/ current duration refers to acute and ongoing nature of the problems identified either through empirical evidence and objective experience suggesting persistence over time or through the subjective experience that the problems have persisted over time.*
- *Diagnoses of predominant concern are schizophrenia, mood disorders, and paranoid and other psychoses.**

*Adapted from: Ontario Ministry of Health and Long Term Care,_ Making it Happen: Implementation Plan for Mental Health Reform_, 1999, Ontario Ministry of Health & Long Term Care, p. 14.

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Acute Inpatient Services - Adults, Children and Youth (D) Approved: January 22, 2009

Context & Issues:

Acute psychiatric inpatient services provide interdisciplinary care for those of all age groups who cannot be effectively cared for in a less restrictive environment. 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. Inpatient services are located within a facility as defined by the Hospital's Act and are governed by that Act and by the Involuntary Psychiatric Treatment Act. Evidence driven practice indicates that treatment for children and adults who have mental disorders or who face mental health conditions are provided in an inpatient service when other services are not able to provide the level of intensive, safe, secure, effective care of the patient in the community. Thus, less restrictive alternatives to inpatient hospitalization must be considered prior to the decision to admit. Patients, their families and their other caregivers are provided services with respect for their culture, language, sex/gender, unique needs and rights. Patients and families are as fully involved in setting the parameters of the patient's care and treatment as they wish to be and are able to be.

Inpatient stays should be as short as possible without harming patient outcomes. Evidence indicates that once the illness has stabilized, patients recover more quickly when they return to as independent a level of living arrangements and functioning as possible.

There is continuity between the parts of the mental health system such that 'ownership' of clinical problems is shared between the patient, acute psychiatric inpatient units and ambulatory mental health services, primary care, family and other community partners, with minimal loss of continuity for the patient. Those discharged from acute psychiatric inpatient unit care have access to the level of ongoing care that their condition dictates.

Standards for services in acute psychiatric inpatient units must address the following :
- clear evidence of a patient centred/family centred philosophy
- the physical environment of the service
- the provision of care by interdisciplinary teams
- the promotion of a wellness lifestyle and a rehabilitative approach
- the provision of a full range of medical care
- the collection and analysis of outcome measures
- the special needs of differing cultures and vulnerable populations
- the initiation of discharge planning at the point of admission to the service
- clear accountability for the efficacy of services
- the provision of a continuum of care for patients both within the mental health service and with partner services in the community at large

Most acute psychiatric inpatient units are located within a facility as defined by the Hospital's Act. Acute psychiatric inpatient mental health beds currently exist in eight districts and IWK. The standards in section D1 apply to acute psychiatric inpatient units 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.

Program Description: Acute Psychiatric Inpatient Services (D1)

The purpose of acute psychiatric inpatient services is to provide safe, secure, active, energetic, comprehensive interdisciplinary assessment, stabilization, treatment initiation and service linkage back to the community, of those whose acute psychiatric condition cannot be managed in a less intrusive fashion. The goal is to ensure that the patient can resume normal community living as soon as feasible, thereby maintaining independence.

The service:

➢ Provides the highest attainable quality of patient care that is achievable within available resources, knowledge, skills and technology,

➢ Maintains an organizational culture that respects and values diversity, cultural safety and competence, promotes collaboration and teamwork, encourages professional and personal development of staff, and commits to providing the highest quality of service achievable,

➢ Proactively responds to change, improving existing services, and developing new programs to meet the needs of the patients served, and

➢ Shares knowledge and expertise and provides education, training, and services to meet the unique needs of the health care community and the public.

Goal Statement: All acutely ill Nova Scotians who require admission have timely access to acute psychiatric inpatient services**.**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Safety	**D1.1.** The physical environment and services are conducive to the safety and well-being of both patient and staff (see appendix D1-A).	**II**
Accessibility	**D1.2.** Assessment of the need for admission is available twenty-four (24) hours per day, seven (7) days per week.	**III**
Accessibility	**D1.3.** Patients meet established, evidence driven admission criteria at admission and throughout their acute psychiatric inpatient unit stay. *Criteria for admission are:* a) there is a medical clearance b) there is a comprehensive preadmission mental health assessment by a mental health clinician(s) c) there is an expectation the individual is likely to benefit from an acute psychiatric inpatient unit admission d) the individual is currently mentally ill according to accepted criteria(e.g. DSM-IV, ICD -10) See Appendix D1-B. or there is a need for a period of intensive monitoring of the individual's mental status and symptoms to clarify an uncertain diagnosis e) management of the patient in a less intrusive setting is inappropriate, inefficient or likely to be ineffective in addressing the presenting problem f) the individual's medical needs can be safely managed on a psychiatric unit *Criteria for exclusion are:* a) the individual's medical state is acute and is the primary reason for the psychiatric presentation b) intoxication with alcohol or other psychoactive substances will not be a primary reason for admission. c) similarly an Axis II diagnosis will not be a prima facia reason for admission, in the absence of factors above	**I**
Accessibility	**D1.4.** There is a clear referral path to the availability of medical and surgical services.	**IV**
Efficiency	**D1.5** A mental health assessment and disposition of patients in observation beds occurs **within eighteen hours.**	**IV**
Accessibility	**D1.6.** If the patient in an observation bed is determined to require inpatient psychiatric admission, this should occur in a timely fashion, and in all cases **within 6 hours**.	**III**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	**D1.7.** Telephone response regarding the suitability of emergency admission is available from the IWK to the designated acute psychiatric inpatient unit's site, within one (1) hour of referral.	I
Accessibility	**D1.8.** Acute Psychiatric Inpatient Units collaborate together with Emergency Departments in expediting admission for individuals and who require admission.	IV
Efficiency	**D1.9.** Collaborative processes with other health and human service providers and with hospital and health authority departments are used to maximize treatment and discharge planning.	IV
Competence	**D1.10.** Clinical direction of the service is provided by a psychiatrist.	I
Continuity	**D1.11.** There is a designated nursing position responsible for the ongoing continuity and coordination of patient care during regular business hours.	I
Safety	**D1.12.** Risk assessment is completed on admission. Areas include but are not limited to: suicide, substance use, access to weapons, self-harm, neglect, abuse, elopement and violence.	II
Safety	**D1.13.** A risk management plan, using recognized evidence-based tools or instruments, is in place and reviewed with the patient and staff weekly or more frequently if required.	III
Appropriateness	**D1.14.** Acute psychiatric inpatient units follow evidence based pathways where care paths have been defined.	III
Appropriateness	**D1.15.** The written care plan consists of information from an admission assessment by nursing staff, at least one early assessment by a psychiatrist, a physical examination, input from members of the interdisciplinary team , patient and family , significant others and community service providers.	I
Appropriateness	**D1.16.** The appropriateness of the care plan is overseen and revised weekly or more frequently if required throughout the admission by the interdisciplinary team which includes a psychiatrist.	III

Domains (CCHSA)	Standards Statements	Nature of Evidence
Client Centred	**D1.17.** Patients have access to a full range of programming through out the day specifically for psychosocial, education and mental health needs.	II
Worklife	**D1.18.** A Code White Team is accessible and fully trained, with annual recertification in non-violent crisis intervention and physical intervention techniques.	III
Safety	**D.1.19.** There is a review and evaluation on all codes called on the acute psychiatric inpatient units, as well as of all other serious adverse events	IV
Continuity	**D1.20**. The acute psychiatric inpatient service team engages in collaborative planning to ensure that throughout the stay: a) the objectives of the admission are being met or, if not, the specific reasons for changed objectives are documented; b) the patient continues to need acute psychiatric inpatient unit care and may not be managed in a less restrictive/intrusive setting; c) continuity and consistency are maximized and; d) discharge planning is ongoing.	IV
Continuity	**D1.21** Collaborative planning at discharge ensures that, with the patient's permission: a) advanced notice of the discharge date is given to the patient, relevant community-based care providers and family members; b) the acute psychiatric inpatient unit's treatment plan, the results of acute psychiatric inpatient unit's treatment, the discharge plan which was developed prior to/upon admission and which has been updated, and any other relevant information, are all distributed at time of discharge to all relevant care providers, including the family physician, outpatient primary therapist and/or continuing care facility; and c) full written discharge reports to the primary therapist, family physician and other relevant care providers will be provided within two (2) weeks of discharge.	III

Domains (CCHSA)	Standards Statements	Nature of Evidence
Safety	**D1.22.** The service has systems, processes and programs in place to maximize the safety of service users, staff and visitors.	III
Safety	**D1.23.** Clinical and security staff are educated in the recognition, prevention and de-escalation of potentially violent situations, and have regular updating of these skills.	IV
Safety	**D1.24.** There are best practice policies and protocols which address: therapeutic quiet rooms, observation and observation rooms, illegal substances on the unit, weapons on the unit, response to interpersonal assault, police presence on the unit, and the use, training and deployment of security guards.	II

Program Title: Short Stay Units – Children/ Youth and Adults (D2)

Program Description:
Short Stay Units for children, youth and adults, provide safety, stabilization and intensive assessment service of less than five (5) 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 acute psychiatric inpatient units services and minimizes disruption to children, youth and adult support networks.
Short Stay Units will provide:
   a) crisis stabilization
   b) safety and security
   c) assessment
   d) treatment
   e) timely disposition.

Goal Statement:
Nova Scotians across the age continuum have timely access to district or shared district-based short stay units across the province within reasonable geographic proximity to their homes.

Standards are the same as Acute Psychiatric Inpatient Units with the following additions

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	**D2.1.** Short Stay Services can be located outside the hospital but must meet the Hospital Act, be designated as a hospital and meet accreditation standards.	**III**
Appropriateness	**D2.2.** Patients meet established, evidence driven admission criteria at admission and throughout their acute psychiatric inpatient unit stay. *See D.1.3 above.*	**IV**
Appropriateness	**D2.3.** The Short Stay Unit will provide a comprehensive mental health assessment and treatment plan within two (2) working days of admission.	**I**
Appropriateness	**D2.4**. Discharge planning begins at admission and a disposition decision will be made within five (5) working days of admission to the Short Stay Service.	**III**

Continuity	**D2.5.** Disposition decisions must address the issues of the presenting crisis upon admission to the Short Stay Unit.	I
Continuity	**D2.6.** 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 appointments with appropriate resources.	I

Core Program Title: Acute psychiatric inpatient units - Children and Youth Mental Health Rehabilitation (D3)

Core Program Description:
The Rehabilitation Program for Children and Youth provide mental health services to patients between the ages of 5 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. Optimal length of stay necessary to attain treatment goals set on admission should be less than 12 months.

Goal Statement:
Nova Scotia children and youth between the ages of 5 and the 19th birthday have timely access to mental health acute psychiatric inpatient rehabilitation services to help them attain optimal functioning.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness and Accessibility	**D3.1**. Where possible, prior to admission a comprehensive, mental health, assessment is completed to demonstrate that the patient meets all admission criteria.	**IV**
Appropriateness	**D3.2** DHAs ensure that referral paths within Districts follow established protocols (i.e. referrals are accepted from intensive community-based team where they are in place and, where they have yet to be established, from the District's formal mental health system).	**IV**
Appropriateness	**D3.3**. The following admission criteria for the residential treatment/rehabilitation unit must be met: a) chronic and persistent mental disorder (DSM-IV CD-10) with serious/profound functional impairment b) evidence that treatment/intervention requires rehabilitation within the program 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. d) family/caregiver/referring service commit to participating in admission, treatment and discharge planning processes. e) the patient is a resident of Nova Scotia f) evidence that intensive work to manage the child/youth in community setting was ineffective.	**IV**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Effectiveness	**D.3.4.** At admission and throughout the patient's rehabilitation treatment, the treatment team will collaborate with the patient's caregivers, referring service and other relevant agencies/services in treatment and discharge planning. Continued inter-agency cooperation is expected.	**III**
Competence	**D3.5.** Treatment will be provided by an interdisciplinary Team as defined in the glossary and may be comprised of but not limited to social work, occupational therapy, psychology, psychiatry, education, nursing etc. This team will work alongside the child/youth and family and each member of the team will be allocated specific tasks and goals.	**IV**
Effectiveness	**D.3.6.** The rehabilitative process consists of a comprehensive assessment, intervention plan and patient progress review considering all domains of child/adolescent/family life.	**III**
Effectiveness	**D3.7.** The treatment plan clearly outlines mutually established goals and expected outcomes for the patient and/or family, where appropriate, as well as a time frame for goal attainment. The goals and/or outcomes of treatment are to be reviewed, evaluated and revised as necessary following the establishment of the treatment plan.	**III**
Continuity	**D3.8.** Discharge planning from the Rehabilitation residential program, which is initiated at the time of admission, will include: a) notice of anticipated discharge date at time of admission with referral to most appropriate agency/community-based team for post-discharge support b) transition planning c) communication/conference with the mental health team that is expected to follow up, will continue throughout admission d) preliminary discharge summaries are sent to primary therapist and attending physician within seventy-two (72) hours of discharge e) discharge summaries are received by referral agency within four (4) weeks of patient discharge	**IV**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	**D3.9.** The interdisciplinary team is accountable for ensuring that at discharge: a) specific rehabilitation goals have been evaluated, b) discharge and follow up plans are in place, the first appointment date offered is within (10) ten working days following discharge as stated in the agreed transition plan. c) a process is in place to monitor the completion of the transition plan.	**VI**

Appendix D1-A

Guidelines for an Acute Psychiatric Inpatient Unit
Organization and Environment

Several aspects of good acute psychiatric inpatient care include

a. Service culture –

 A range of elements apply:

- positive and supportive relationships between staff, patients, relatives and significant individuals other service providers

- a clear vision shared by all of how to help patients towards recovery

- individuals are, and feel, valued

- individuals encouraged to participate as fully as they can in their care and treatment

Important aspects of service culture will capture:

- User centred service;

- Focus on recovery;

- Focus on social inclusion; and

- Equality, diversity, cultural and spiritual awareness.

b. Physical environment -

Important aspects of the physical environment will capture:

- Cleanliness and hygiene;

- Maximum space standards with access to quiet areas;

- Healthy food and access to drinking water;

- Facilities for sleep;

- Toilet/Shower/bath room facilities;

- Access to exercise facilities;

- Well maintained furnishing and décor; and

- Rooms for consultations and private meetings.

c. Activities within the unit

● a range of daily activities available to all patients;

● different therapeutic activities should be considered (physical, fun, artistic and creative); and

● patients are encouraged to be involved in discussions about the kind of activities they would like to see.

d. Information

Patients have access to good quality, understandable information in a number of areas including:

- Participation in the development of their care plan;

- Who their consultant is, accessibility to care plan and role of key worker;

- Their illness and treatments, medication and psychological treatments;

- The admission and discharge process including ward activities; and

- Other services of relevance to them e.g. advocacy, housing benefits etc.

e. Access to staff

● Patients need regular access to key workers and to know they are being listened to.

● Complementary therapies;

● Access to interdisciplinary staff including peer support workers; pharmacists, dieticians, voluntary sector staff, physiotherapists and psychologists (in addition to doctors and nurses); and

f. Training Issues

All staff have access to ongoing appropriate training with monitoring mechanisms for uptake are in place.

g. Risk management and safety

Interventions include:

- good risk assessment and risk management procedures in place;

- least restriction being placed on patients;

- individual care plans provide a basis for the appropriate management of risk;

- the physical environment, operational processes and available resources of any are appropriate for the provision of the assessed care of individual service users, including the management of risk; and

- a clear local understanding of the degree of risk that can be safely managed in the acute psychiatric inpatient units service area.

h. Process issues

A number of process issues are of importance in the provision of good care. These include:

- Systematic collection and analysis of clinically relevant data;

- Good, collaborative and accessible interdisciplinary case records;

- Clear policies on referral, admission and discharge;

- Good discharge planning, commencing immediately on admission; and

- The need for protocols on how and when clinical information on patients should be shared between staff.

Adapted from: http://www.scotland.gov.uk/Publications/2006/12/21092519/4

Appendix D1-B

ACUTE OUTPATIENT MENTAL HEALTH SERVICES

TARGET POPULATION

Mental Health Services serves those with the following categories of mental disorders as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV), which is the uniformly accepted categorization of mental illnesses. The following major categories in the DSM-IV constitute the prime target groups for Mental Health Services:

- Major Mental Disorders
- Neurodevelopmental Disorders
- Adjustment Disorders
- Personality Disorders

The following issues/presenting problems are only seen when associated with one or more of the above categories:

- Developmental Delay
- Violent and/or Criminal Behavior
- Substance Related Disorders
- Partner and Family Relational Disorders
- Learning Disorders
- Grief/Bereavement

In determining whether service will be provided, and in what fashion, the degree of disability and impairment or risk of probable disability and the potential for an improved level of functioning will be important considerations

Inpatient Services Glossary

Interdisciplinary:
"a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, they create "formal" and "informal" structures that encourage collaborative problem solving. Team members determine the team's mission and common goals: work interdependently to define and treat patient problems; and learn to accept and capitalize on disciplinary differences, differential power and overlapping roles. To accomplish these they share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration."
Drinka (2000)

Multidisciplinary:
A group of care providers with shared values and goals, however, t each individual sees the task from his or her own perspective, and depending on the task, from their own unique worldview.
Dan Dangler *(2005)*

Code White:
In Canadian hospitals 'code white', usually announced overhead throughout the hospital followed by a location, signifies that there is person-to-person physical violence occurring within the hospital at this time. Other codes include code blue (cardiac arrest), code yellow (missing patient), code grey (spill), etc.

In most hospitals with psychiatric beds all staff will be trained to deal with potential or actual occurrences of violence on their units, some have gone further and provided training to the emergency department staff and others in the hospital. Some have gone further still and trained a 'super group', who would have considerably more training, including the use of take-down and control techniques, and these would be the designated Code White Team. These would be staff of all kinds and from all quarters of the hospital (nurses, cleaners, security guards, administration, lab technicians, physicians, etc) so that at any time of the night or day there would always be a core of individuals on site who would have this advanced training and be available to respond

Observation Bed:
An holding bed in a inpatient unit or emergency department for the observation of a patient until a determination for the need for admission can be made.

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Program: **Specialty Services - 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 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.*

Program Description: Specialty Services - 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 including:

- 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 B3.	**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**

Provincial Eating Disorder Services Model

Provincial	Shared District	District	Local

Network

•Provide,consultation, team conferencing, education and support to district and shared services

• Inpatient:
 • Specialty treatment

• Contribute specialized knowledge and research findings to the network

•Assessment for out of province referrals

• Provide consultation for assessments and conduct complex assessments, referred in from other districts

• Outpatient:
 • Intensive treatment
 • Day treatment

• Inpatient:
 • General medical/pediatric treatment
 • General psychiatry treatment with access to specialty teams and/or beds

• Assessment and triage

• Outpatient:
 • Individual treatment
 • Follow -up

• Inpatient:
 • Short stay with access to mental health staff member designated as eating disorder liaison network member

• Prevention and public education strategies

• Family support activities

•Primary Care (GPs)

Approved: Steering Committee May, 2003

1/22/2004 7:21 AM

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Core Program: **Specialty Services – Sexually Aggressive Youth (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 Worling (2000) 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 those 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: Sexually Aggressive Youth (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 (see Appendix E2-b).	**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	**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 that 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**
Effectiveness	**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**

Appendix E2-A

Sexually Aggressive Youth Program

Provincial   **Shared District**   **District**

Network

- receive referrals for sex offender assessment
- conduct comprehensive assessment and sex offender specific risk assessment
- develop individualized comprehensive treatment plan
- maintain communication with all team members
- initiate pre-group treatment plans for incarcerated
- provide team conferencing, emergency back-up and consultation

- conduct offence specific treatment group
- provide individual & family therapy
- hold monthly maintenance group sessions
- maintain communication with all team members

- designate mental health staff member as sex offender liaison- network member
- conduct comprehensive mental health assessments
- make referrals of voluntary clients
- maintain communication with all team members
- initiate pre-group treatment for community based clients
- provide appropriate local mental health outpatient services
- provide individual & family therapy
- develop individualized after-care plans

Approved
February 03, 2003

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Appendix E2-B

Sexually Aggressive 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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Core Program: Specialty Services -
                   Forensic Mental Health Assessments for Youth (E3)

Context & Issues:

One component of the clinical care path for the youth forensic population is the Forensic Mental Health Assessments completed as a result of a Court Order under the Youth Criminal Justice Act. Upon receipt of a referral from the Youth Justice Court, mental health professionals undertake a thorough psychosocial and mental health assessment in order to evaluate the contributors to a youth's antisocial behaviour, estimate the risk of future antisocial behaviour and violence, and to provide recommendations for interventions to reduce that risk and improve mental health functioning. The decision before the court may be to evaluate Fitness to Stand Trial, Criminal Responsibility or Making or Reviewing a Youth Sentence. In addition, there are a number of options where the Youth Justice Court may request an assessment to assist the Court in rendering a decision under Section 34 of the YCJA.

The best practice method of addressing these questions is a thorough risk/need assessment.   According to Andrews and Bonta (1998), a risk/need assessment should follow three major principles. The risk principle calls for the evaluation of an individual's level of risk for involvement in future antisocial behaviour and identifies factors contributing to that risk. The need principle focuses on the evaluation of individual dynamic factors (needs) that may be targeted for intervention in an effort to reduce risk (e.g., substance abuse, poor anger controls). The responsivity principle is concerned with gaining an understanding of the aspects of the individual and his or her environment that may impact on their response to intervention (e.g., family resources, intellectual level). Attention to responsivity issues helps to ensure that intervention strategies are appropriately matched to the individual's level of risk, resources, cognitive functioning, and learning abilities. Collectively, these three principles help to guide decisions pertaining to assessment, case management, and treatment planning, to best meet the youth's needs.

Experts on the assessment of youth who offend argue that one of the best methods of evaluating these issues is through the use of broad-based assessments (e.g., Hinshaw & Zupan, 1997; Hoge & Andrews, 1996, Hoge, 1999). Broad-based assessments focus not only on contributing factors within the youth, but also requires an evaluation of the youth's family dynamics, school functioning, peer relationships, and other environmental factors (e.g., neighbourhood, culture) that may potentially impact on their behaviour. Hence, a multidimensional approach to assessment is recommended (American Academy of Child & Adolescent Psychiatry, 1997; Hinshaw & Zupan, 1997).

Major Assessment Domains & Methods of Assessment

Reflecting the multi-determined nature of antisocial/criminal behaviour, there is substantial variability among antisocial youths (e.g., Halikias, 2000; Lahey, Loeber, Quay, Frick, & Grimm, 1997). However, despite this heterogeneity a number of consistent individual, family, social, academic, and community risk/need factors have been associated with antisocial and violent behaviour (for reviews see Andrew, 1981; Andrews, 1989; Loeber & Dishion, 1983, Loeber & Farrington, 1998; Moffitt, 1993; Moffitt et al., 1996; Stouthamer-Loeber & Loeber, 1988). As shown in Table 4.1, some of the more consistent of these factors include family dysfunction and poor quality parenting (e.g., family violence, poor parenting skills, poor family relationships), problems with academic adjustment (e.g., academic problems, disruptive behaviour), history of early conduct problem behaviour (e.g., aggression, lying, stealing, criminal history), substance abuse, poor social skills, association with antisocial peers, and adherence to values and beliefs that are supportive of antisocial behaviour. Although these factors are inter-related, the consensus is that the more of these risk/need factors present, the greater the risk of antisocial behaviour (e.g., American Academy of Child & Adolescent Psychiatry, 1997). Hence, professionals should be aware of the various factors that can influence the development and course of antisocial behaviour and of the most efficient methods of evaluating these risk/need domains. (See Appendix E3-a Table 4.1)

Core Program Description:
The program provides forensic mental health assessments for those youth who are subject to a court order for assessment under the Youth Criminal Justice Act (YCJA). Referral will be through the centralized tertiary site. Comprehensive mental health assessments will be conducted at a district/shared district level and follow-up on recommended services is provided both centrally and in the districts. Consultation and supervision will be accessible across all service levels in the province. Linkages will be established and maintained with Justice, Education and Community Service Departments.

Goal Statements:

All youth in Nova Scotia who are subject to a Court Ordered Assessment under the YCJA or the Criminal Code of Canada are able to access appropriate professional expertise to conduct a valid assessment.

The reports generated by mental health professionals in Nova Scotia for the Youth Justice Court are standardized, thorough, and based upon current knowledge on the best practices in this field.

The reports generated for the courts are useful for case management, specifically in planning interventions to both reduce the risk of re-offending, and to enhance mental health functioning of individuals. .

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E3.1.** Referrals for forensic mental health assessments on youth (age 12 to 18 years) are received from the Youth Justice Court by the IWK Youth Forensic Services through the centralized intake process.	**III**
Appropriateness	**E3.2.** Referrals will follow the procedures outlined in the "Court Procedural Manual". (See appendix E3-b)	**III**
Efficiency	**E3.3.** Referrals for mental health assessments on youth are accepted at any stage of the court proceedings, to address the question before the court i.e., Fitness to Stand Trial, Criminal Responsibility, or Section 34 under the YCJA.	**II**
Appropriateness	**E3.4.** The most accurate and up to date information for a Section 34 assessment is obtained after a finding by the court. Assessments undertaken prior to that time will be limited by the accused's rights to withhold information in order to formulate their own defence on the charges, and an enhanced social desirability response set in answering test questions. Additionally, information required to complete several of the risk assessment tools can only be obtained after a finding on the charges as this information impacts on the assessment of risk.	**III**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	**E3.5.** Standardized and valid assessment reports are completed for the Youth Justice Court within 5 days of the trial date given a minimum allowed time frame of 30 days.	**II**
Appropriateness	**E3.6.** Assessments for Fitness to Stand Trial, Criminal Responsibility and Section 34 of the YCJA follow standards adopted by the IWK Youth Forensic Services in "Guidelines for Completing Youth Forensic Assessments under the YCJA" (See appendix E3-C)	**II**
Appropriateness	**E3.7.** Court ordered forensic assessments use appropriate specialized and validated instruments incorporating multiple measures that cross multiple domains of an individual's functioning. Multiple domains include: • mental health status • situational factors • academic functioning • cognitive ability • social and emotional functioning • personality development • social skills • protective and resiliency factors. Methods of assessments include: • observation • interview • psychological tests that are derived from a variety of test construction methods including actuarial, clinical, self report, and structured professional judgement; • document reviews • collateral contacts. Multiple sources include: • school personnel • parents • extended family • employers • child protection workers • previous and/or current service providers	**I**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Safety	**E3.8.** Factors that need to be addressed in the assessment of risk for re-offending include both static risk factors that do not change and dynamic factors that are subject to change. When assessing risk for violent re-offending, a very thorough and complete assessment of risk factors is required, that is based upon the most up to date information on the youth and the most up to date methods for assessment.	**I**
Appropriateness	**E3.9.** Forensic assessments undertaken for the courts must give due consideration to the accuracy of the information that is gathered and give greater weight to information that comes from the most reliable sources.	**II**
Appropriateness	**E3.10.** Sex offender specific assessments undertaken for the Youth Criminal Justice Court comply with the Sex Offender Standards Assessment and Treatment under Section E2 page 8.8 of the Mental Health Standards for Specialty Services in addition to the Youth Court Assessment Standards. (See appendix E3-d)	**I**
Competence	**E3.11.** Assessments are completed by mental health professionals with training and/or experience in the forensic assessment of adolescents or under the supervision of or in consultation with an experienced clinician.	**II**
Appropriateness	**E3.12.** The following documents are required for completion of the referral for forensic court assessment: Crown Sheets, Criminal Records, Pre-Sentence Reports, and any other relevant legal documentation available on the youth such as a custodial record.	**III**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E3.13.** The report prepared for the Youth Justice Court will follow the standard format of the IWK Youth Forensic Services. The report must be easily understood by the courts, and be comprehensive and coherent. The report will include a diagnostic statement. The formulation made at the end of the report shall address the circumstances of the youth, as well as the personal abilities, traits, skills, attitudes and behaviours which brought this youth to this point. The formulation leads to the recommendations for services. (see Sexually Aggressive Youth Standards).	**IV**
Continuity	**E3.14.** The reports prepared for sentencing under Section 34 of the YCJA shall include a treatment plan described in the Formulation and Recommendation sections of the report. The Treatment Plan can be detached from the original report and form part of the clinical record of the youth and can be forwarded to the appropriate case manager (i.e., the probation officer or youth worker assigned primarily responsibility for supervision in the institution or community). (See appendix 3b-e).	**III**
Safety	**E3.15.** The report, which is kept on the IWK file relating to a youth referred by the Youth Justice Court will remain separate and apart from the central medical file of the IWK Health Centre and may only be accessed through court order, or, for treatment purposes, via informed consent provided by the youth and where appropriate, the youth's parent or guardian, in keeping with Section 125(6) of the YCJA, the Hospital's Act and the IWK Health Centre policies, regarding consent to release information.	**III**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Competence	E3.16. All professional staff conducting forensic assessments for youth before the courts are required: • to be registered with the appropriate licensing body for the Province of Nova Scotia • adhere to the user qualifications required in test manuals and will use tests and measures that have proven reliability and validity in the assessment of youth, and only with full knowledge of the limits and use of these tests • to attend court upon subpoena, to answer questions pertaining to the assessments that they have undertaken • attend legal case conferences with the consent of the youth or upon direction from	II
Competence	E3.17. Each DHA has access to designated staff with specialized training and experience to conduct youth forensic assessments for the Youth Justice Court.	IV
Competence	E3.18. All professional staff, undertaking forensic assessments, have access to appropriate continuing education in the area of forensic assessment in order to maintain competency in the field of forensic work and stay up to date on forensic issues in assessment and recommended treatments. A minimum of 40 hours of specialized educational training is required each year.	II
Accessibility	E3.19. Access to consultation and supervision, both at district and specialty service level is provided.	IV
Safety	E3.20. Staff in tertiary services provide education and consultation in clinical, research/academic, service organization, and ethical/medico legal issues as a resource to the province.	II
Continuity	E3.21. Service providers develop and maintain linkages with representatives of Justice, Community Services and Education.	II

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Forensic Mental Health Assessments for Youth (E3)

Appendix E3-A

Table 4.1: Correlates of Antisocial Behaviour and Violence in Youths.

Demographic Factors
- Being male[1, 2]
- Low family socio-economic status[2]
- Minority ethnicity[2]

Family Background Factors
- Family conflict/dysfunction[1, 2, 6]
- Low level of affection or cohesiveness/poor parent-child relationship[1, 4, 5, 6]
- Separation from parents/parental absence[3, 4]
- Family violence[1]
- Child neglect and inconsistent discipline/supervision[6]
- Poor supervision and discipline[1, 3, 4]
- Antisocial parents/parental criminality[1, 2, 3, 6]
- Parental substance abuse[1]

Social Factors
- Antisocial peers/associates during adolescence[2, 4, 5]
- General difficulties in relationships with others, especially during adolescence[2]
- Poor use of leisure and recreational activities[1]

Behaviour Factors

Conduct problems (e.g., aggression, lying, stealing, truancy, impulsivity, early sexual behaviour, substance use, risk taking behaviour)[1, 2, 3, 4, 5]

Early and diverse developmentally inappropriate misbehaviour displayed in a variety of settings (stealing, lying, aggression)[1, 4, 6]

Attitudes

Attitudes & values supportive of antisocial behaviour, violence and antiauthority[1, 5, 6]

Competency Factors
- Below average intelligence[1]
- Poor self-management & problem solving skills[1]

Academic Characteristics
- Poor School Performance and Achievement[1, 2, 3, 4, 5, 6]
- Problematic Behaviour in School[1, 2]

Community Factors
- Poverty[6]
- Availability of drugs[6]
- High crime neighborhood[6]

Note. This table is based on a literature review by Andrews (1989)[1] and meta-analytic and systematic reviews on the predictors of antisocial behaviour and violence, including Lipsey & Derzon (1998)[2]; Loeber & Dishion (1983)[3]; Stouthamer-Loeber & Loeber (1988)[4], Simourd & Andrews (1994)[5], and Hawkins et al., (1998)[6]

Appendix E3-B

**15 YOUNG OFFENDER MENTAL
DISORDER ASSESSMENT REPORTS
UNDER YOUNG OFFENDERS ACT
SECTION 13.2**

This policy addresses remands to determine NCR and fitness

NOTE: Psychological assessments (13.1) are covered under Chapter 16

This describes the procedure to be followed relative to processing assessment reports for individuals 18 years of age or younger.

Cross-Reference

Criminal Code Section 672
Young Offenders Act Section 13.2

Assessment Orders

Forms Used

NS Form 51/48 - Assessment Order (N.S. Forms Binder)
NS Form 52/49 - Warrant of Committal (N.S. Forms Binder)
NS Form 53 - Treatment Order (N.S. Forms Binder)
NS Form 54 - Disposition (N.S. Forms Binder)
NS Form 54A - Notice to Review Board (N.S. Forms Binder)

If the court orders an assessment of the mental condition of the accused:
- No treatment order can be made at this time (672.19)
- Immediately complete Assessment Order (NS Form 51/48) in duplicate as per Judges's instructions. Telephone ahead on assessments being completed by the Isaak Walton Killam Health Centre (IWK) (902) 492-2494, or Waterville Youth Centre (902) 538-8071, or Shelburne Youth Centre (902) 875-5602 with the following information:

1. Name
2. Date of Birth

3. Address
* This information should appear on all forms.

a. Give original assessment order, copy of the endorsed information(s), crown sheet (if available) to the Deputy Sheriff to be taken to the identified facility along with the accused. Mail if he/she remains in the community.

b. Where the court orders that the accused be assessed by a person other than the Isaak Walton Killam Health Centre (IWK), forward to the identified facility or person responsible for completing the assessment, the orginal assessment order, copies of the endorsed informations, and a copy of the crown sheet (CC:672.13).

c. Prepare any release documents required if the accused is not in custody.

d. Retain a copy of the assessment order on accused's file.

e. Enter Hearing Results in computer (Select Option 19 "Case Hearing Results" from Main Menu). Schedule for fitness hearings (FIT).

f. After verification, file in appropriate file.

g. IWK will fax the assessment report to the judge or clerk of the court.

h. The Court Administrator or his/her delegate should follow up on any outside assessment orders in order to obtain the report.

i. Please Note: When the court orders an assessment be done by a person or facility other than the IWK, fax a copy of the assessment order and final report done by an outside agency to the IWK, Attention: Dr Ruth Carter (902) 425-1413, and the ECFPH (902) 460-7343.

j. After the assessment report is received, the clerk of the court shall distribute copies as follows:

Original   Judge
Copy   Crown Attorney
Copy   Defence Attorney/Young Person
Copy   File
Copy   Parent of Young Person

k. All assessment reports are to be sealed and only released upon direction of the judge.

l. Upon request from the Crown or IWK, the court may schedule an earlier hearing date.

m. The court shall assess the issue of fitness of an accused. The accused is either found fit or unfit to stand trial.

FIT TO STAND TRIAL - Section 672.28 Criminal Code

Hearing After Receipt of Assessment Report

Where the accused appears before the court to review the assessment report on the date scheduled:

- bring the assessment order to the court
- bring all relative documents to court

Fitness to Stand Trial

If the accused is fit to stand trial, the case proceeds as if fitness was never in issue. The judge may (672.3 CC):

- Release or detain the accused in a correction facility in the ordinary manner (515CC) with appropriate conditions.
- Prepare whatever documents that are required and the usual court process is followed.
- Detain the accused in a hospital or youth centre until completion of the trial if the court believes that the accused would become unfit to stand trial if released (Form 52/49 - Warrant of Committal and a Treatment Order (Form 53) are prepared and sent with accused to IWK) (672.29 CC) - phone IWK - (902) 492-2494 if the accused is detained and sent to that facility.
- Enter hearing results.
- After verification, file in appropriate file**.**

UNFIT TO STAND TRIAL

Disposition Hearing (Section 672.45CC)

Where the accused is found unfit to stand trial, the court may:
- hold a disposition hearing
- or refer the matter to the Review Board (672.47CC)
- any plea is set aside and this is endorsed on the information (672.31CC)

If a disposition hearing is held, the court may either:

- detain the accused in custody at the IWK or a youth facility
- release the accused on conditions

Where the accused is held in custody, either as a result of a disposition hearing, or because the matter was referred to the Review Board.

- complete the appropriate forms per the Judge's instructions
  - Treatment Order (NS Form 53)
  - Warrant of Committal (NS Form 52/49)
  - Disposition Hearing (NS Form 54)
  - Notice to Review Board (NS Form 54A)

- Give original Treatment Order, Warrant of Committal and Disposition Order to the Deputy Sheriff to be taken to the identified facility along with the accused.
- Phone IWK, (902) 492-2494 to inform them of the detention.
- Complete a transcript with remarks of defense and crown and Judge's decision within fifteen working days as provided below.
- Forward the following to the Criminal Code Review Board (CCRB):
  - Notice to Review Board
  - Warrant of Committal
  - Transcript

    Criminal Review Board
    Chair
    Department of Justice
    P.O. Box 7
    5151 Terminal Road
    Halifax, Nova Scotia B3J 2L6
    Telephone: (902) 424-3880   Fax: (902) 424-0700
- Forward (fax or mail) the following to the **ECFPH Program Manager** and **IWK:**
  - Warrant or Committal
  - Treatment Order
  - Disposition Order
  - Notice to Review Board
  - Transcript

    East Coast Forensic Psychiatric Hospital
    88 Gloria McCluskey Avenue
    Dartmouth, Nova Scotia B3B 2B8
    Telephone: (902) 460-7301   Fax: (902) 460-7343

Isaak Walton Killam Health Centre
1464 Tower Road
Halifax, Nova Scotia   B3H 4L4
Telephone: (902) 492-2498   Fax: (902) 425-1413

- Retain copy for the accused's file
- Enter Hearing Results in the computer (Select Option 19 "Case Hearing Results" from Main Menu, use code **(ACU)** - accused unfit to stand trial.
- After verification, file in appropriate file.

UNFIT TO STAND TRIAL WHEN ACCUSED NOT HELD IN CUSTODY - Section 672.58CC and 672.46 CC

- Where the accused is not held in custody or detained after being found unfit to stand trial, the Judge may order one of the following:
  - Treatment Order (NS Form 53)
  - Disposition Order (NS Form 54)
  - Confirm or vary release terms (672.46, 515 CC)
  - Grant an absolute discharge
- Complete the appropriate form(s) as per the Judge's instructions.
- Complete **NS Form 54A - Notice to Review Board.**
- If the accused has been directed to submit to treatment by a person or a hospital, fax or mail Treatment Order (NS Form 53) and Disposition Order (NS Form 54) to specific person or hospital who will treat the accused.
- Complete a transcript with remarks of defence and crown and Judge's decision within fifteen working days.
- Forward the following to the Criminal Code Review Board (CCRB):
  - Notice to Review Board
  - Transcript
            Criminal Review Board Chair
            Department of Justice
            P.O. Box 7
            5151 Terminal Road
            Halifax, Nova Scotia B3J 2L6
            Telephone: (902) 424-3880   Fax: (902) 424-0700

Forward (fax or mail) the following to the ECFPH Program Manager and the IWK:
  - Treatment Order
  - Disposition
  - Notice to Review Board
  - Transcript
            East Coast Forensic Psychiatric Hospital
            88 Gloria McCluskey Avenue
            Dartmouth, Nova Scotia B3B 2B8

Telephone: (902) 460-7301   Fax: (902) 460-7343

Isaak Walton Killam Health Centre
1464 Tower Road
Halifax, Nova Scotia   B3H 4L4
Telephone: (902) 492-2498   Fax: (902) 425-1413

- Retain copy on the accused's file.
- Enter Hearing Results in the computer (Select Option 19 "Case Hearing Results" from the Main Menu, use code **(ACU) -** accused unfit to stand trial.
- After verification, file in appropriate file.

Not Criminally Responsible (NCR) - Section 672.34 CC

- If the accused is found NOT criminally responsible (NCR - Section 672.34) on account of a mental disorder, the judge may either:
  ▸ hold a disposition hearing (672.45CC), or
  ▸ refer the matter to the Review Board (672.47CC)

Disposition Hearing

If the judge holds a disposition hearing, the judge may order one of the following:

A.   Absolute Discharge
B.   Discharge with Conditions
C.   Detained in IWK or Youth Centre

Detained in Custody at IWK or Youth Centre

- Prepare disposition order (NS Form 54)
- Prepare Warrant of Committal (NS Form 52/49) and Notice to Review Board (NS Form 54A) as per Judge's instructions.
- Give original Warrant of Committal to the Deputy Sheriff to be taken to the identified facility along with the accused.
- Send a copy of the Warrant of Committal and original Notice to Review Board to the Criminal Review Board.

Criminal Review Board
Chair
Department of Justice
P.O. Box 7
5151 Terminal Road
Halifax, Nova Scotia B3J 2L6
Telephone: (902) 424-3880   Fax: (902) 424-0700

- Telephone the identified facility at (902) 492-2494 and inform them that the

accused is being transported to their facility and give them identifying information (i.e. the name of the accused, date of birth, address, nature of charge and other information which is important to security or medical issues).

- Fax (902) 460-7343 a copy of the Warrant of Committal, Disposition Order and Notice to Review Board as soon as practical to:

  East Coast Forensic Psychiatric Hospital
  88 Gloria McCluskey Avenue
  Dartmouth, Nova Scotia B3B 2B8
  Attention: ECFPH Program Manager

- Fax (902) 425-1413 a copy of the Warrant of Committal, Disposition Order and Notice to Review Board as soon as Practical to:

  Isaak Walton Killam Health Centre
  1464 Tower Road
  Halifax, Nova Scotia   B3H 4L4
  Attention: Dr Ruth Carter

> **NOTE:** Please ensure that these documents are faxed in a timely manner in order that the IWK may review them and ask for corrections prior to the accused arriving at the Centre to avoid IWK refusing to admit the accused due to improperly prepared documents.

- Complete a
  transcript of the disposition hearing with remarks of defense, crown and judge's decision within fifteen working days and send a copy (free of charge) to the Review Board and ECFPH.
- Retain copies of each form on accused's file.
- Enter Hearing Results in the computer (Select Option 19 "Case Hearing Results" from the Main Menu).
- After verification, file in appropriate file.

Absolute Discharge

If the judge discharges the accused, prepare the appropriate documentation.
- Retain copies of each form on accused's file.
- Enter Hearing Results in the computer (Select Option 19 "Hearing Case Results" from Main Menu).
- After verification, file in appropriate file.
- Fax (902) 460-7343 or mail copy of discharge document to East Coast Forensic Psychiatric Hospital.
- Mail a copy of the discharge document to the Review Board.

Review Board Reference

If the judge refers the matter to the Review Board, the judge may order:
- A.   A Warrant of Committal
- B.   Released the accused on conditions until the Review Board considers the case.

- Prepare disposition form (NS Form 54) and Notice to Review Board (NS Form 54A).
- If the accused is not detained in custody, prepare release documents as ordered (515.CC).
- If the accused is detained in custody, prepare Warrant of Committal (NS Form 52/49) and give the original Warrant and Disposition Form to the Deputy Sheriff to betaken to the identified facility along with the accused.
- Phone the identified facility informing them that the accused is committed to their care.
- Retain copies of each form on accused's file.
- Enter Hearing Results in the computer (Select Option 19 "Case Hearing Results" from Main Menu).
- After verification, file in appropriate file.

- Send a copy of the Disposition Form and original Notice to Review Board to the Criminal Code Review Board.

           Criminal Review Board
           Chair
           Department of Justice
           P.O. Box 7
           5151 Terminal Road
           Halifax, Nova Scotia B3J 2L6
           Telephone: (902) 424-3880   Fax: (902) 424-0700

- Fax (902) 460-7343 or mail a copy of the Warrant of Committal to:

           East Coast Forensic Psychiatric Hospital
           88 Gloria McCluskey Avenue
           Dartmouth, Nova Scotia B3B 2B8
           Attention: ECFPH Program Manager

- Fax (902) 425- 1413 or mail a copy of the Warrant of Committal to:

           Isaak Walton Killam Health Centre
           1464 Tower Road
           Halifax, Nova Scotia B3H 4L4
           Attention: Dr Ruth Carter   April 02, 2002

Appendix E3-C

16 MEDICAL/PSYCHOLOGICAL REPORTS
UNDER YOUNG OFFENDERS ACT
SECTION 13

Cross-Reference

NOTE: NCR and fitness hearings are covered under Chapter 15

Young Offenders
   Act Section 13

Forms Used

Young Offenders Act Form 9
Order for Examination and report
Information Check Sheet Respecting Medical and Psychological Reports Under
   Section 13 Young Offenders Act

If the court orders a medical and psychological report under Section 13 of the Young
   Offenders Act:

- Complete an Order for Examination and Report (Form 9 Young Offenders
  Act).
- Complete with the assistance of the Crown, Defence and Judge an
  Information Check Sheet.
- Complete whatever release documents are required (CC 515).

- Send copies of the documents to:
  Isaak Walton Killam Health Centre
  1464 Tower Road
  Halifax, Nova Scotia   B3H 4L4
  Attention: Dr Ruth Carter
- Send copies of the documents to the person or facility where the
  assessment is to be completed.
- Retain a copy of the Order for Examination and Report and Information
  Check Sheet on young person's file.
- Enter Hearing Results in computer.
- After verification, file in appropriate file.
- IWK will fax the medical and psychological report to the judge or clerk of the
  court.
- **The Court Administrator or his/her delegate should follow up on any
  outside assessment orders in order to obtain the report.**

- All assessment reports are to be sealed and only released upon the direction of the judge.
- After assessment report is received, the clerk of the court shall distribute copies as follows, unless the judge directs otherwise:

Original	**Judge**
Copy	**Crown Attorney**
Copy	**Defence Attorney/Young Person**
Copy	**Parents of Young Person**
Copy	**Persons as directed by Judge**

Appendix E3-D

**GUIDELINES FOR COMPLETING
YOUTH FORENSIC ASSESSMENTS
UNDER THE YOUTH CRIMINAL JUSTICE ACT**

**STANDARDS FOR MENTAL HEALTH ASSESSMENTS UNDER
SECTION 34 / 141 OF THE YOUTH CRIMINAL JUSTICE ACT
FOR MEDICAL AND PSYCHOLOGICAL REPORTS**

Section 34 under the YCJA makes provisions for Medical and Psychological Reports. As an introduction to Section 34 Assessments, a brief synopsis of this section of the act is provided.

At any stage in the proceedings against a young person the court may order an assessment under this section of the Act to be completed by a qualified person who will provide a written report to the court. These assessment orders can be made with the consent of the young person and the crown prosecutor or by the court on it's own volition when the court believes that the report is necessary based upon one of the following reasons: (1) the court has reasonable grounds to believe that a young person may be suffering from a physical or mental illness or disorder, a psychological disorder, an emotional disturbance, or a learning disability; (2) the young person's history indicates a pattern of repeated findings of guilt, or (3) the young person is alleged to have committed a serious violent offence. Section 34.2 refers to the purposes for which the reports will be used. These include: a) considering if the youth should be released from custody, b) deciding whether to impose an adult sentence or a youth sentence on the young person, c) making or reviewing a youth sentence, d) considering an application for continuation of custody, e) setting the conditions for conditional supervision, f) making an order after a review of a breach or alleged breach of conditional supervision, and g) authorizing disclosure of information about a young person.

Section 141 of the YCJA addresses the mental disorders provisions and refers to the Criminal Code of Canada. The mental disorders provisions of the Criminal Code continue to apply to youth under the YCJA as they did under the YOA. The mental disorders provisions refer to Fitness to Stand Trial assessments and assessments of Criminal Responsibility for criminal actions.

What follows is a set of standards to be applied to the preparation of the reports under the YCJA and Criminal Code of Canada as applicable to youth who charged with criminal acts.

SECTION 34 ASSESSMENTS

A. Understanding the Purpose of Section 34 Assessments:

Assessment reports designed to assist the court with sentencing or to assist the court in decision making regarding the best conditional supervision plan, or about custodial release / detention are requested when the court believes that a mental health assessment can add information to the decision before the court i.e., to assist the court in determining a course of legal action that may rehabilitate the youth and/or reduce the likelihood of repeated offences.

In conducting an assessment for sentencing/custodial supervision, the mental health professional will consider the needs of the youth and the risks that the youth poses to society. A comprehensive assessment is required to clearly understand the nature and dynamics of a particular youth's antisocial behaviour, as well as the contributing environmental and personal factors related to the antisocial behaviour, which then will identify appropriate intervention strategies to reduce the risk of the criminal behaviour reoccurring. The justice system's goal in requesting these assessments is to obtain reasonable and sound opinions from mental health practitioners on the types of intervention strategies that will reduce criminal recidivism. The goal of the mental health practitioner is to recommend services for the youth that are most likely to lead the youth to develop interpersonal and personal skills to conduct his behaviour within societal expectations. Psychologists conducting assessments related to sentencing will address the youth's social, emotional, and mental health needs, the school environment, the family structure, and the neighbourhood milieu and the peers that the youth associates with each day. Experts on the assessment of young people who are involved with the justice system and/or conduct problem youths argue that one of the best methods of evaluating these issues is through the use of broad-based psychological assessments. Broad-based assessments focus not only on contributing factors within the youth, but also requires an evaluation of the youth's family dynamics, school functioning, peer relationships, and other environmental factors (e.g., neighbourhood, culture) that may potentially impact on their behaviour. Hence, a multidimensional approach to assessment is recommended.

B. Guidelines for Section 34 Assessments

Halikias (2000) has recently recommended a general structure for the forensic evaluation of youths involved with the criminal justice system. These guidelines are similar to the assessment guidelines for conduct disordered youth developed by Waddell, Lipman, and Offord (1999) for Canadian professionals and those of the American Academy of Child and Adolescent Psychiatry (1997). To summarize these guidelines, the assessment begins with the mental health professional seeking to understand clearly the purpose of the assessment they have been asked to conduct. Once the purpose of the assessment has been clarified, the task of the

assessor is to obtain as much information as possible about the youth's social, developmental, medical, academic, criminal, and mental health history that is relevant to address the referral question. To achieve this multidimensional perspective, the assessment of antisocial youth should include multiple methods of information gathering (interviews, psychometric testing, file review), use multiple informants (e.g., parents, teacher, probation officer, social worker), and should include multiple settings (e.g., home, school, community). Based on a systematic evaluation of the obtained information, the assessor should be able to identify the contributing, risk, and protective factors that impact on the youth's general functioning and antisocial behaviour. Case formulation should identify targets for intervention and form the foundation of case management, planning, and recommendations. To be useful, it is important that recommendations be practical and fit the resources available to the youth. Various methods of gathering information for an assessment exist and a combination of these approaches is likely to yield the most balanced and meaningful perspective on the youth and his or her situation. Specifically, useful information can be obtained from a thorough review of case file information (e.g., school records, mental health records, criminal records, medical records), interviews with the youth, family, school staff, and other relevant parties (e.g., social workers, probation officers, youth workers), and psychometric testing (self-report and objective measures). When combined with other sources of information, psychometric testing can increase the convergent validity of the information obtained and decrease the possibility of errors.

C. Evaluating Risks / Needs Factors:

According to Andrews and Bonta (1998), a risk/need assessment of antisocial individuals should follow three major principles. The **risk principle** calls for the evaluation of an individual's level of risk for involvement in future antisocial behaviour and identifies factors contributing to that risk. The **need principle** focuses on the evaluation of individual dynamic factors (needs) that may be targeted for intervention in an effort to reduce risk (e.g., substance abuse, poor anger controls). The **responsivity principle** is concerned with gaining an understanding of the aspects of the individual and his or her environment that may impact on their response to intervention (e.g., family resources, intellectual level). Attention to responsivity issues helps to ensure that intervention strategies are appropriately matched to the individual's level of risk, resources, cognitive functioning, and learning abilities. Collectively, these three principles help to guide decisions pertaining to assessment, case management, and treatment planning to best meet the youth's needs.

As shown in the table below there are some consistent risk/need factors that impact on the risk of re-offending and these include: family dysfunction and poor quality parenting (e.g., family violence, poor parenting skills, poor family relationships), problems with academic adjustment (e.g., academic problems, disruptive

behaviour), history of early conduct problem behaviour (e.g., aggression, lying, stealing, criminal history), substance abuse, poor social skills, association with antisocial peers, and adherence to values and beliefs that are supportive of antisocial behaviour. Although these factors are inter-related, the consensus is that the more of these risk/need factors present, the greater the risk of antisocial behaviour. Hence, professionals should be aware of the various factors that can influence the development and course of antisocial behaviour and of the most efficient methods of evaluating these risk/need domains.

Correlates of Antisocial Behaviour and Violence in Youth

Demographic Factors
- Being male
- Low family socio-economic status
- Minority ethnicity

Family Background Factors
- Family conflict/dysfunction
- Low level of affection or cohesiveness/poor parent-child relationship
- Separation from parents/parental absence
- Family violence
- Child neglect and inconsistent discipline/supervision
- Poor supervision and discipline
- Antisocial parents/parental criminality
- Parental substance abuse

Social Factors
- Antisocial peers/associates during adolescence
- General difficulties in relationships with others, especially during adolescence
- Poor use of leisure and recreational activities

Behaviour Factors
- Conduct problems (e.g., aggression, lying, stealing, truancy, impulsivity, early sexual behaviour, substance use, risk taking behaviour)
- Early and diverse developmentally inappropriate misbehaviour displayed in a variety of settings (stealing, lying, aggression)

Attitudes
- Attitudes & values supportive of antisocial behaviour, violence and anti-authority

Competency Factors
- Below average intelligence
- Poor self-management & problem solving skills

Academic Characteristics
- Poor School Performance and Achievement
- Problematic Behaviour in School

Community Factors
- Poverty
- Availability of drugs
- High crime neighbourhood

D.   Major Assessment Domains & Methods of Assessment

Assessment of Family Functioning & Parenting Styles. An examination of family functioning can provide useful information regarding a youth's risk of future antisocial behaviour. Specifically, family dysfunction and poor parenting practices, especially harsh and inconsistent parenting, have often been linked to the development and persistence of antisocial behaviour. Hence, the assessment of antisocial youths should include a thorough evaluation of the family environment, including the quality of the parent-child relationship, parenting behaviours, characteristics of the family dynamics, and determination of family resources. This evaluation should also determine whether family violence and marital conflict are a concern.

Assessment of Cognitive and Educational Functioning. Academic underachievement, learning problems, and low intelligence have been associated with antisocial behaviour (Frick, 1998). An assessment of intellectual functioning can provide useful information regarding a youth's cognitive strengths and weaknesses, which has implications for intervention planning and responsivity issues. For example, the selection of intervention strategies for a youth who is academically underachieving because of a learning disability will be different from those selected for a youth that is underachieving because of behavioural reasons (e.g., truancy) despite a capacity to be successful in school. The Wechsler scales are the most commonly used and extensively researched measures of intellectual functioning. The Wechsler Intelligence Scale for Children (WISC-III) is appropriate for use with 6-16 year old, while the Wechsler Adult Intelligence Scale-III (WAIS-III) can be used for older adolescents and adults.

In addition to reviewing the youth's school record to gauge academic performance and behaviour in the school setting, some measures have been developed to objectively measure a youth's academic achievement relative to age appropriate norms. The Wide Range Achievement Test-third revision (WRAT-3) and the Kaufman Test of Educational Achievement (K-TEA; Kaufman & Kaufman, 1985) are two of the more commonly used standardized measures. Both instruments can provide an indication of whether the youth's performance is above, below, or consistent with what would be expected from youths of a similar age.

Assessment of Substance Abuse Problems. Another strong predictor of antisocial behaviour is the misuse of substances. Youths that abuse substances may commit antisocial acts in order to acquire money to purchase drugs. In addition, the risk of criminal behaviour and violence is increased during intoxication because of its interference with decision-making and problem solving abilities.

Hoge and Andrews (1996) have recommended the use of standardized instruments that are designed to evaluate aspects of substance misuse (type, severity, and

frequency of use). Such instruments include the Adolescent Drinking Index (Research Psychologists Press/Sigma), Drug Abuse Screening Test (Skinner & Sheu, 1982), Drug Use Screening Inventory (Tarter, 1990), and the Personal Experiences Screening Questionnaire (Winters, 1991). The use of self-report measures should be supplemented by interview and collateral reports.

Assessment of Interpersonal/Social Functioning. Evaluation of a youth's social functioning and peer group is an important component of assessment involving conduct problem behaviour. During normal adolescent development, the role of peers becomes more pronounced as youths become more involved with their peer groups and less involved with their parents. One of the more robust predictors of antisocial behaviour in later adolescence and adulthood is the association with antisocial peers during adolescence. Hence, assessors should inquire about the nature of a youth's peer group and the activities they involve themselves in (i.e., prosocial versus antisocial activities). In addition, it is useful to obtain an understanding of the youth's general interpersonal functioning (e.g., dating behaviour, quality of close friendships.

Information on social functioning and peers influences can be informally determined through interviews with the youth's parents, teachers, or other individuals involved in the youth's life. However, some standardized measures also provide a means of gathering information about the youth's social competencies. These include, the Child Behaviour Checklist (Achenbach, 1991) and the Social Skills Rating System (Gresham & Elliot, 1990).

Assessment of Emotional and Behavioural Problems. Longitudinal research indicates that one of the strongest predictors of later antisocial behaviour and violence is a history of conduct problem behaviour and aggression in early childhood and early adolescence. In addition, ADHD and substance abuse are often comorbid conditions of conduct disorder. Hence, an evaluation of a youth's current and early externalizing behaviour problems is important. Internalizing problems (e.g., anxiety and depression) are not usually directly linked to general antisocial behaviour, but are common among antisocial and conduct-disordered youth. As such, emotional problems should be evaluated as they may impact on treatment responsivity and long-term outcome. In addition, the evaluation of certain mental health symptoms and their severity (e.g., psychotic and anxiety symptoms) may be more relevant to understanding violent behaviour in adolescents. Thus, the nature of any emotional and behavioural problems should be carefully evaluated.

A number of behavioural rating or checklist instruments have been developed for the purpose of evaluating aspects of the youth's social, emotional, and behavioural competencies. Typically, these instruments are administered to the youth's parents/caregivers, teachers, and sometimes to the youth themselves. One of the most widely used measures is the 113-item Child Behaviour Checklist (CBCL; Achenbach, 1991a).

In interpreting behaviour rating measures however, assessors need to be sensitive to the fact that the responses reflect the *perspective* of the respondent, which may be biased to some degree. For example, young offenders tend to report the severity of their internalizing and externalizing problems as less serious than their maternal caregivers, while non-delinquent youth report higher levels of externalizing problems then their maternal caregivers. Teacher and parental reports are more likely to be consistent with each other then with the youth's self-report of their problem behaviour. Hence, the use of multiple informants and evaluation of other sources of information is essential to obtain a balanced impression of the youth's emotional and behavioural problems.

Assessment of Antisocial Behaviour, Attitudes, Values, and Beliefs. Official reports may underestimate the youth's antisocial behaviour because many antisocial acts go undetected. As such, a youth's self-report may provide a more realistic picture of their antisocial behaviour. Several instruments have been developed to specifically measure a youth's report of antisocial behaviour and the beliefs and values that may support such behaviour. For example, the Self-Reported Delinquency Scale (Mak, 1993) inquires about a wide range of antisocial activities (minor and serious) that the youth may have committed. The Self-Report Delinquency questionnaire (SRD; Elliott, Huizinga, & Menard, 1989) is also a useful means of obtaining information about the frequency of antisocial behaviour in 11-17 year olds. Evaluation of sexually deviant behaviour should involve a more specialized assessment protocol.

Only a few instruments have been specifically designed to tap the antisocial attitudes, values and beliefs that may play role in the maintenance of antisocial behaviour. The Modified Criminal Sentiments Scale (M-CSC; Simourd, 1997) is designed to assess the respondents attitudes towards the legal professionals (e.g., police and courts), their tolerance of breaking the law, and the extent to which they identify with antisocial individuals. This measure can be administered with the Pride in Delinquency Scale (Shields & Whitehall, 1991) to evaluate the individual's attitudes towards various antisocial activities. Currently, researchers are in the process of testing the properties and utility of an adolescent version of the M-CSC, referred to as the Beliefs and Attitudes Scale (Butler & Leschied, 2001) with promising preliminary results.

Assessment of Personality and Mental Health Concerns. Measures of a youth's personality functioning can provide useful information about his or her needs, responsivity concerns, and amiability to treatment. An evaluation of personality dynamics and psychological functioning can also help to identify any mitigating and aggravating factors that influence a youth's antisocial behaviour (e.g., impulse control problems, self-concept, and aggressive tendencies. In addition, certain personality disorder symptoms (paranoid, narcissistic, passive-aggressive) have been associated with a greater risk of committing violent and non-violent criminal acts in both males and females during adolescence and early adulthood.

A number of personality assessment measures have been studied in terms of their utility with adolescents, and more specifically, with antisocial youth. Two of the most commonly used measures of personality functioning and mental health problems for adolescents are the Millon Adolescent Clinical Inventory (MACI; Millon, 1993**)** and the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A; Butcher et al., 1992). Other instruments often used are the Jesness Inventory (Jesness, 1992; Jesness & Wedge, 1984, 1985) and the Basic Personality Inventory (Jackson, 1995). Weaver and Wootton (1992) found that some of the scales on the MMPI discriminated persistent from less persistent antisocial adolescents. Variations were also observed for high and low property offenders, serious offenders, and violent offenders. Like the MMPI, the MACI has been used with antisocial adolescents and some scales have been associated with aspects of violent behaviour, such as instrumentality and empathy/guilt issues. There is only limited research in support of the predictive validity of the classification system of the Jesness. The psychometric properties and utility of the Basic Personality Inventory have been supported with antisocial youth.

Assessment of Community/Neighbourhood Factors. Although not directly related to antisocial behaviour, systemic and social-ecological models of antisocial behaviour clearly speak to the indirect influence of the youth's community on the risk of antisocial behaviour. Communities that are dominated by a high level of poverty/low socio-economic status, disorganization, criminal activity, violence, and easy access to drugs may increase the youth's risk of antisocial behaviour. Clearly, not all youths from such communities will develop antisocial behaviour, especially in the presence of protective factors (e.g., positive family functioning, prosocial peers). However, clinicians should be aware of the increased risk represented by negative community influences, particularly when the youth may be returning to that environment. On the other hand, an evaluation of the community's strengths and resources may assist in case planning if the youth is able to take advantage of them. Information on the nature of the community and its resources can be obtained during interviews with the youth and his or family and from the assessor's general understanding of the community.

E.   Actuarial Risk/Need Assessment Instruments

The estimate of risk is important because it guides decisions regarding the nature, timing, and intensity of intervention strategies to best reduce the risk. It is clear however, that without the use of validated risk assessment measures and protocols, most professionals are only at chance accuracy in making such predictions. One reason that the use of validated risk tools increases the accuracy of our predictions is because these instruments are based on the static and/or dynamic risk factors that have been identified in the literature as predictive of criminal behaviour. These instruments have substantially improved the ability to estimate the risk of violence and recidivism in adults. However, compared to what is available for antisocial adults, there are comparatively few risk assessment tools for antisocial youth.

Two actuarial measures (described below) represent recent and promising Canadian efforts in the development of risk assessment protocols for antisocial youths.

1. Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 1994. The YLS/CMI is an empirically supported, broad-based risk/need assessment instrument developed in Ontario. This measure is completed by a trained professional after the gathering of information from interviews with the youth and collateral contacts, review of assessment results and file information, and observational data. Once completed, the inventory provides a total risk score and identifies need areas that may benefit from intervention to reduce risk. The YLS/CMI has adequate psychometric properties and assists in the identification of youths at risk and with various need levels (e.g., Simourd, Hoge, Andrews, Leschied, 1994). Although its false positive rate is somewhat high (36%) the YLS/CMI has discriminated general recidivists from non-recidivistic young offenders (Jung & Rawana, 1999).

2. Psychopathy Checklist-Youth Version (PCL-YV; Forth, Kosson & Hare, in press). The PCL-YV is an adolescent version of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991). Both the PCL-R and PCL-YV are designed to measure psychopathic personality traits and antisocial behaviour/lifestyle characteristics. The 18-item PCL-YV is completed by a trained professional following a semi-structured interview with the youth and an extensive review of the case file information and collateral contacts. Although the PCL-R uses a clinical cut-off to diagnose psychopathy in adults, such criteria has not been clearly defined for the PCL-YV. However, the dimensional nature of the PCL-YV can provide useful information about the nature and severity of antisocial and psychopathic traits and its psychometric properties are generally good (e.g., Brandt et al., 1997; Forth et al., 1990). The severity of psychopathic traits, as measured by the PCL-YV, can provide useful information regarding the nature of a youth's antisocial orientation and their risk of future violent behaviour. As such, the PCL-YV is useful as a component of protocols for the assessment of antisocial behaviour. However, given the developmental changes that occur during adolescence and the lack of prospective longitudinal research on psychopathy from childhood to adulthood, Edens, Skeem, Cruise, and Cauffman (2001) do not recommend the use of the PCL-YV in decisions pertaining to the long-term placement of youths.

F.   Special Considerations in the Section 34 Assessments

Developmental Issues. Some degree of antisocial behaviour is to be expected as part of normal adolescent development. Only about 5% of antisocial youths develop their antisocial behaviour in childhood and maintain such behaviour into adulthood (i.e., "life-course persistent. It is this smaller group of youths that are responsible for the majority of crimes. Thus, when evaluating the long-term risk of future antisocial behaviour, assessors should be aware that most antisocial youths tend to reduce or discontinue

such activity once they reach early adulthood.

In addition to changes in the rate of antisocial behaviour with adolescent development, there is some evidence that the influence of certain risk factors may also vary with age. For example, a meta-analysis of longitudinal data indicated that between the ages of 6 and 11, substance use and early criminal behaviour were the strongest predictors of later serious or violent criminal behaviour at 15-25 years of age. However, during early adolescence (12-14 years old) the strongest predictors of later serious or violent delinquency changed to a lack of social ties and association with delinquent peers. Clinicians should be aware of the developmental changes in the influence of risk factors when evaluating antisocial youth and may vary the weight given certain factors depending on the youth's age and developmental level.

Protective Factors. A number of experts have argued for increased attention to the strengths within the youth and his or her environment during assessments. In the past, there has been a tendency for clinicians to over focus on deficits, weaknesses, and risk factors. Identified strengths can provide useful information about *protective or resiliency factors*. In general, protective factors have been found to mediate the risk of antisocial behaviour via their interaction with the risk factors for this behaviour. In support of this argument, Hoge, Andrews, and Leschied (1996) have identified four protective factors against new criminal convictions. These are **pro-social peer relationships**, **good educational achievement**, **positive response to authority**, and **effective use of leisure time**. The positive influence of these protective factors occurred regardless of the youth's risk level (high or low). In addition, the positive effects of protective factors was stronger among older (15-17 years old) than younger adolescents (12-15 years old). **Other identified protective factors have included a high IQ, an easy temperament, areas of competence outside of school, and a positive relationship with at least one parent or significant adult** (American Academy of Child & Adolescent Psychiatry, 1997). Hence, an important component of the assessment of conduct problem youth is the consideration of protective factors to provide a more balanced perspective of the youth and their risk of persistent antisocial behaviour. Professionals may also draw on the strengths to develop effective case management strategies.

Gender. Most of the research on antisocial behaviour in adolescence has been conducted with males. Given the limited attention to females, it is not clear whether male derived risk factors for antisocial behaviour equally apply to females. Existing research on the predictors of female delinquency is ambiguous and limited by methodological difficulties. Some studies have supported the possibility that there are gender specific risk factors for delinquency. However, the origin of gender differences in antisocial behaviour is unclear and proposed explanations have generally not been well accepted (e.g., the rise in feminism, Power-Control Theory; Hoyt & Scherer, 1998). Additional empirical research is required to better understand possible similarities and differences in the predictors of antisocial behaviour in female and male adult and young offenders. Clinicians should be aware of this limitation when

assessing females with conduct problem behaviour.

G.   Summary of "Best Practice" in Section 34 Assessments

A review of the literature suggests that the most efficient means of assessing antisocial youth is to use a comprehensive and structured protocol that includes the administration of standardized assessment instruments shown to provide useful information about risk/need factors for antisocial behaviour. Such a comprehensive and empirically-based assessment protocol can assist professionals in understanding the dynamics of a youth's antisocial behaviour (e.g., mitigating and aggravating factors, risk factors), estimating the risk of future antisocial behaviour, and the selection of intervention strategies based on the youth's identified needs and responsivity concerns. As recommended by Hoge and Andrews (1996), the implementation of a standard set of assessment instruments across a system can be beneficial as it helps to ensure consistency in that system in terms of assessment practices and decisions based on those practices. The selection of the assessment battery should be driven by the type of information required to make the decisions for which the assessment is required (e.g., risk/need evaluation), use of multiple sources of information (e.g., parent, youth, teacher), and use of a variety of assessment formats (e.g., interviews, checklists, self-report).

Forensic assessments undertaken for the courts must give due consideration to the accuracy of the information that is gathered and give greater weight to information that comes from the most reliable sources.

FITNESS TO STAND TRIAL

A.   Understanding Fitness to Stand Trial

What Defines Fitness to Stand Trial: An individual, adult or youth, standing trial on criminal charges in Canada must be able to understand the nature of the criminal proceeding against them and be able to assist their attorney in their own defense. An individual is found unfit to stand trial if they cannot understand the court proceedings or assist the attorney in preparing their own defence. The individual may not be able to understand or participate in the court process due to a mental illness or mental retardation. Most adults found unfit to stand trial have serious (usually psychotic) mental illness or are severely mentally retarded. When a person if found unfit to stand trial, the trial is delayed until the person is treated and becomes competent to stand trial. During this process of recovery from a mental illness, periodic reviews are held to determine gains and to review the NCR status. If the individual cannot regain fitness,

such as a case where an individual has brain damage or severe developmental disabilities, the charges against the individual must be dismissed. Civil commitment remains a possibility if the adult or youth is a danger to himself or others as determined by civil commitment laws. If the person is found fit to stand trial, the trial proceeds in a normal fashion.

The Recent Increase in Youth being assessed for Fitness: In young offender matters, competence to stand trial has not been given the same degree of attention historically because the rights of juveniles were felt to be protected by the very fact of having a separate court system, a court system that was designed to be rehabilitative, not based upon the punitive adult model. When facing serious consequences for their actions in ordinary court, the rights of the accused clearly need to be safeguarded. As the media attention was drawn more and more toward the types of violent crimes that youth were engaging in, there were more attempts to make sentences tougher and to raise youth to adult (ordinary) courts. With longer sentences and imposed sanction similar to adults, came the concern about protection of the rights of the accused youth resulting in more requests for competence evaluations in youth court matters. However, in juvenile court matters, the issue of competence to stand trial has been more difficult to ascertain due to the immaturity level of the accused. More liberal minded courts have ruled that immaturity, not merely a mental disorder, could be the basis for a finding of incompetence to stand trial in juvenile court.

The Underlying Presumption of Competence: There is always a presumption of competence to stand trial unless a question is raised by the prosecution, defense or the judge. When the question is raised in court, an order is made by the judge to have a competence evaluation completed by a mental health professional. Depending upon the jurisdiction, psychiatrists, clinical psychologists, and clinical social workers have been requested to conduct fitness to stand trial assessments. The question of competence is usually raised because either the judge or the defense attorney has observed something in the young person's behaviour that suggests that there may be a mental disorder, disability, or other mental health problem that could potentially interfere with the defendant's ability to understand the nature of the trial process or to communicate with their attorney. Courts may misuse competence evaluations, calling for them without any particular interest in the defendant's competence, in order to obtain a psychiatric or psychological perspective on the defendant for other purposes. This happens less often in courts that have adequate resources and legal procedures for obtaining clinical evaluations without having to "disguise" the referral as a forensic question of competence.

The Process of Determining Fitness: Fitness assessments have short turn around times, between 7 days and 6 weeks, depending upon the Judge's order. Some of these assessments on juveniles are done at the inpatient facility, however it is recognized that most can be done in detention facilities or while the youth is out on recognizance, rather than have them housed in expensive inpatient units. The general

question in competency assessments is a mental health opinion on the issue of the **threshold of competence** to stand trial and, if the answer to this question is that the youth is unfit, the next question is, what is the likelihood that he will become competent or fit, with what types of interventions.

When Should Fitness Assessments be Considered: Grissco recommends that a Fitness assessment only be considered in certain circumstances. If the youth is age 12 or younger, the court or the attorney may wish to consider the utility of a fitness assessment. In addition, if the youth has had a prior diagnosis or has had treatment for a mental illness, or has a diagnosis of mental retardation, consideration should be given to requesting a fitness assessment. Another possibility may be that the youth has a record of borderline intelligence or learning disability that may impinge on the ability to understand the court process. In some such circumstances, modifications can be made to the language used in court to accommodate the needs of the youth. Yet another possibility is that the judge, the attorney, or the crown prosecutor has observed behaviour in the youth at pretrial that suggests deficits in the youth's memory, attention, or interpretation of reality. It should be noted that these behaviours should present to observers as so unusual for youth at that age that they raise concerns about the youth's mental state.

B.   **Areas of Assessment in a Fitness Evaluation**

•   **Functional Component of Assessment:** To assist the court in its determination of fitness by addressing the youth's abilities that are relevant to the legal question
Understanding of the charges and potential consequences
>   •   ability to understand and appreciate the charges and their seriousness
>   •   ability to understand the possible dispositional consequences of guilty, not guilty, and not guilty by reason of insanity
>   •   Ability to realistically appraise the likely outcomes

Understand the trial process
>   2..1   Ability to understand without significant distortion, the roles of participants in the trial process (e.g., judge, defense, prosecutor, witnesses)

>   2.2   Ability to understand the process and potential consequences of pleading and plea bargaining
>   2.3   Ability to grasp the general sequence of pretrial/trial events

Capacity to participate with attorney in defense
>   3.1   Ability to adequately trust or work collaboratively with attorney
>   3.2   Ability to disclose to attorney reasonably coherent description of

facts pertaining to the charges, as perceived by the defendant

    3.3   Ability to reason about available options by weighing their consequences, without significant distortion

    3.4   Ability to realistically challenge prosecution witnesses and monitor trial events

Potential for courtroom participation

    4.1   Ability to testify coherently, if testimony is needed

    4.2   Ability to control own behaviour during trial proceedings

    4.3   Ability to manage the stress of trial

The youth must be able to **understand** what they see, and hear during the process of the trial. They must be able to **appreciate** the significance of what they understand as it is applied to their situation, and they must have the **reasoning** ability to make important trial related decisions using the information that they understand and appreciate.

- **Causal Component of Assessment:** If youth show deficits in these abilities noted above, the report should address the probable reasons for these deficits. Most commonly the reasons are: mental disorder, mental retardation, specific learning disabilities or developmental immaturity. The opinions offered must connect the deficits in competence to the youth's clinical or developmental status.

- **Interactive Component of Assessment:** The connection between the functional deficits and the demands of the trial process must be established. Competence depends upon the degree of match or mismatch between the person's abilities and the actual demands of the situation. Greater demands for higher abilities might occur when the trial is in criminal court as opposed to youth court, or the trial is a transfer hearing to determine if the youth should be tried in adult court, or if plea bargaining is likely to be involved, or if the evidence against the youth is uncertain and the youth's need to provide a coherent statement of fact is especially relevant, if the trial process is likely to involve many witnesses, if the trial is likely to require a more complex legal defense, if the defendant is likely to have to testify on their own behalf, if the trial is likely to be lengthy, or if the defendant has few sources of social support.

- **Judgmental Component of Assessment:** Formulating a conclusive recommendation on Fitness Issue by weighing all of the functional abilities, the developmental or clinical causes, the manner in which the youth's deficits may impair their participation in the trial.

- **Prescriptive Component of Assessment:** If the judgement of the assessment is "Unfit to Stand Trial", the court must determine whether the conditions responsible for the lack of fitness can be changed. The professional must offer

an opinion on whether an intervention exists that could increase the defendant's relevant abilities, if there is a likelihood of change if that intervention were employed with this youth, and the time that it is likely to take to bring about the necessary change. This is not a regular treatment recommendation. Treatment recommendations are to address the specific areas that need to be addressed to increase competence to stand trial.

C.   Steps in the Evaluation Process

Clarify the Referral Question: Clarify if the court is requesting a Fitness and NCR assessment or which one. Talk to the court, the crown, and the defense attorney.

Obtain and Review Records: Review crown sheets related to the current charges, the type of hearing the youth is facing, the offense record and any social history before the court (i.e., predisposition reports, clinical reports).

Preparing the Youth for the Evaluation: At the first meeting clearly explain the purpose of the evaluation (i.e., to evaluate how the youth understands and can handle the court process). The youth should be told that the examiner is going to write a report for the judge and that the judge's decision will influence how soon the youth has a trial and whether the youth may need treatment before the trial happens. It is a good idea to have the youth repeat back to the assessor what they have understood from that in order to check their comprehension. When the evaluation is court ordered, the purpose of the process is not to obtain informed consent as this does not apply to this type of assessment. If the youth wishes to refuse the assessment process, he or she should be told that the judge will need to be informed of their refusal and that it would be advisable to speak to their defense lawyer prior to making this decision.

Content of the Interview: The interview should take about 45 yo 90 minutes and includes a brief inquiry into social history, inquiry into past legal and juvenile justice experience, the youth's report of the current legal circumstances, a competence interview focused on the relevant functional abilities for trial competence and a mental status exam and/or psychological testing.

   Social History: focuses primarily on the youth's past and current living arrangements (e.g., where the youth grew up, present location) past and current academic activities and performance, jobs held, special interests, history of injuries, and history of mental health services. Much of this information can also be obtained from other sources.
   Past/Present Legal Involvement: asks questions about past experiences with the police and courts, whether this is a first time the youth has been arrested or what previous experiences were like. Current charges are then discussed. The youth is asked about the circumstances of the arrest, the charges, and the youth's story about

the events surrounding the time of the offense. The objective is to test the youth's ability to recount his or her own version of the events in a way that allows someone else to follow the account and grasp the youth's meaning.

Competence Abilities Interview: asks the youth about the nature of the charges against him/her, the roles of the people in the court room, and the potential outcome of the court process for the youth (e.g., "What do you think is likely to happen if you are found guilty of the things they say you did?" "What does a judge do in a trial?" "Tell me about the last time you talked to your lawyer - like what was said, and what you thought about him/her." If the youth is expected to plea bargain, specific questions related to the youth's understanding of this term and the process should be asked. Ask for an example (i.e., "Imagine that the crown attorney comes up to your lawyer and says, 'Let's make a deal.' What could the crown attorney have in mind?") **What matters most is not that the youth does not know something, but it is their capacity to learn it that is crucial. They need to be able to understand the process if the process is explained to them.** "You remember a while ago I was explaining to you what a judge does in the trial? Can you explain that to me now?" Visual prompts such as drawings can be used to gain understanding and assess retention or knowledge. In addition, it is important to assess, not only what the youth knows about the roles of people in the courtroom, but also what he/she believes they do or will do, as paranoid ideation may interfere with their ability to participate in their own defense. Reasoning ability may be assessed by posing a hypothetical scenario where the youth has to reason out the best option in a plea bargaining scenario. You are assessing if the youth is considering various options and consequences and if the youth seems to compare the options or impulsively chose one option without thinking. You are also assessing if there is any evidence of delusion thinking or gross distortions of reality woven into the youth's discussion of hypothetical trial events proposed by the examiner.

Mental Status Exam: information for this section often comes, in part, from developmental and clinical history information and review of records, and observing the youth throughout the interviews. A formal mental status exam provides a more standardized clinical measure and assures that an adequate range of psychological functions has been examined.

Psychological testing is not performed in routine competence to stand trial cases.

D. **Interpretative Considerations in Formulating Opinion on Fitness:**

1. The average 13 year old has the cognitive capacity to understand and follow the court process.

2. Having a Disorder such as ADHD or Learning Disabilities does not mean that the youth is unable to understand or learn what is needed to be competent to stand trial. Disorders are not indicators of deficits in understanding.

3. Part of the interpretation of the evaluation data should focus on the youth's

deficits that might reduce the attorney's ability to represent the youth effectively (e.g., inability to perceive the lawyer as an advocate). This is the case with many young people, however, it is only relevant to the question of fitness if the youth involves the lawyer in a psychotic paranoid delusion that makes him unable to trust the lawyer, or if the youth has been extremely traumatized by adults during childhood and is unable to trust any adult relationship and refuses to even talk to adults, or if the youth is so fearful and immature that they cannot answer questions put to them except for shrugging their shoulders and saying "I don't know", or the youth is so oppositional that any point raised is met with argument, even if the attorney accommodates and supports the youth's position. It is this **pathological mistrust** or **extreme passivity** resulting from immaturity that can impair the ability of the defense to communicate with the accused. Deficits in the capacity to communicate with the attorney also arise in youth with **neurological deficits**. This would manifest itself in an inability to provide a coherent story or inability to relate historical information.

4.   The issue of whether a youth can make important decisions must be weighed. These decisions include the ability to waive constitutional rights, the right to plead guilty, and plea bargaining. Youth's capacity for decision making is very important in these matters. Abstract thinking ability must be assessed and the ability to consider more than one option at once or consider multiple consequences of various actions must be considered. Many immature youth or developmentally delayed youth look at the immediate consequences of their choice and not the long term consequences. Idealistic thinking characterizes younger youth. Younger youth may claim more fame by accepting responsibility for things they did not do to be seen as tougher or to feel that they belong to the antisocial peer group. Idealistic adolescents may often protect the image of abusive parents and not allow this information to be raised in court as a mitigating factor in their behaviour. Poor judgement is only a marker for fitness if the judgement is clearly influenced by psychopathology or by characteristics of the youth that are in developmental transition due to stage of development.

5.   The deficits that the youth has must be applied to the circumstances of the case against him. If the youth's behaviour is documented by several eye-witnesses, for example, the lawyer does not have to rely so much on the youth to provide a coherent story of the circumstances around the charge. Youth with attentional problems may be able to manage a brief trial but unable to follow a lengthier more complex trial. The presence of supportive parents might mitigate issues of fitness and psychosocial stressors may add more concerns regarding fitness.

E.   **What to Include in the Report:**
1.   Identification of the youth and the charges
2.   List of assessment procedures
3.   Description of what the youth was told about the assessment

4. Social, clinical, and developmental history
5. Mental status data
6. Competence data
7. Interpretation of the relevance of any deficits
8. Recommendations for remediation if necessary

The history should be brief and relate those facts relevant to the issue of competency. The court should not be burdened with a dutiful and standardized recitation of clinical and developmental points. **Do not include what the youth tells the assessor about the alleged offense as this can be used against the youth later in the trial process.** Factual data is provided up to the point of interpretation (#7). No new data should be presented in the interpretation section. Make recommendations specific to address fitness issues, not general (i.e., a focus on the specific abilities that, in this particular case, render the youth incompetent to participate in a defense and what will reduce those symptoms and how likely is it that the prescribed course of treatment will be able to do that and within what time frame.).

CRIMINAL RESPONSIBILITY ASSESSMENTS

A.   Understanding NCR Assessments

Defining Criminal Responsibility: An adult or a youth who commits a criminal act and was suffering, at the time of the criminal act, from a mental condition that would exempt the person from criminal responsibility can be subject to a verdict of NCR (Not Criminally Responsible). The Criminal Code of Canada states "No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong." Persons are assumed to be criminally responsible unless proven otherwise. The burden of proof for the NCR defense lies with the party who raises the issue. It has long been a principle of Canadian law that in order for a person to be guilty of an offence, they must have had the intent to commit the offence. Part of having the intent, is the **ability to form an intent** to commit the crime. The person has to be capable of appreciating the nature of the act or knowing that it is wrong. If the existence of a mental disorder precludes the person's ability to form intent, to appreciate the nature of the act or to understand that it is wrong, the person can be found not criminally responsible. It is the mental state at the time of the criminal act that is relevant and the assessor must reconstruct the defendant's thought processes and behaviour before and during the alleged offence.

The M'Naughten Test: The "M'Naughten test" of insanity was first used in courts in

1843 and became the accepted rule in both England and the US. This test states that "To establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong". This test was challenged many times, however, in the early 1980's the American Bar Association amended the M'Naughten test to state that the accused person may actually have the knowledge that the act is wrong but be "unable to **appreciate** the wrongfulness" of the behaviour.

Defining Mental Disorder related to NCR: The Criminal Code defines "mental disorder" as a "disease of the mind" and the scope of mental disorders subsumed under this category is unclear, but generally includes mental retardation (developmental delay), psychotic reactions, thought disorders including paranoid delusional systems, and severe depressive reactions as can occur post partum. If the disorder itself did not affect the defendant's actions at the time in question, it is irrelevant. It must be determined, but for the disorder, the criminal act would not have occurred.

Dispositions in NCR Cases: It must be determined that the person was guilty of the actions for which he or she is accused in order for the person to be found NCR. A person found Unfit to Stand Trial where the evidence against the individual is questionable, and the person has not pled guilty or is incapable of entering a plea, cannot be found NCR, despite a mental disorder, as the NCR disposition assumes guilt has been established. A person who has been found to be not criminally responsible will not receive an absolute discharge until he or she is deemed to no longer be a risk to public safety. The judge in an NCR finding may: (1) give the accused an absolute discharge, (2) give the accused a conditional discharge, or (3) give the accused over for a period of custodial supervision to an inpatient forensic facility or designated facility under the Hospitals Act. For youth under 19 years of age, the IWK Health Centre is the designated facility. The judge will base the disposition upon the level of risk that the accused poses to the community and how that risk can be managed. In coming to this conclusion, a risk/needs assessment of the adult or youth is important. A violence risk assessment may be undertaken by a psychologist to assist in the prediction of risk. In the determination of the issue of criminal responsibility itself, the mental health practitioner may be asked to assess the mental status of the individual at the present time and to project backward to the time of the offence to make some presumption of the mental state of the accused at the time of the crime. A psychiatrist and/or a psychologist may be asked to evaluate the mental status of the individual, including psychotic features, delusional belief systems, cognitive functioning, including collateral reports of the individuals behaviour over time to assess the duration of the illness or the possibility of malingering or factious disorders. Many persons with psychotic disorders can be successfully treated and rehabilitated with medications and other interventions and can successfully return to their home communities without posing

further risks to those communities. Persons with sustained brain injury or dysfunction or mental retardation may not respond as readily to therapeutic or rehabilitative interventions. Once a finding of NCR is made, the individual progress of the person and the amount of security that is required is overseen and determined by the Criminal Review Board.

B.   **Types of NCR Defenses:**

The standard for assessing insanity is not a rigid one. Defense counsel can claim a **volitional impairment** or inability for the defendant to conform their behaviour to societal rules due to a lack of voluntary control over their actions. For example, the **automatism defense** is a defense based upon a theory that the offender had no conscious control over their behaviour (e.g., sleep walking crimes, crimes resulting from brain injury/concussion, crimes resulting from metabolic disorders such as hypoglycemia, or drug or alcohol abuse). It must be proven in these cases that the disability has been experienced on previous occasions and that steps that reasonably could have been taken to prevent the criminal occurrence, were taken. Another argument for lack of volition or intent to commit a crime is the use of the **dissociation defense**. Conduct committed by a person who is in a dissociative or fugue state is probably best described as activity that, although purposeful in nature, is no longer subject to the conscious constraints of the superego or conscience and is therefore involuntary or automatic behaviour. The **chronic use of psychoactive substances** can be argued to be a disease of the mind and not to be under voluntary control of the individual if there is evidence of brain defect caused by overuse. Chronic use of substances is related to criminal offending in a decreasing volitional manner with increased chronicity. It is argued, for example, that the alcoholic is one who faces a choice that is (increasingly) more difficult than for most people. The choice to use is always there, but the choice is more difficult for the chronic user than for the average person. Other defenses have been used to excuse criminal intent including epilepsy, hypoglycemia, transient episodes of depersonalization or dissociation "black outs" for which often little evidence is available other than the subject's recall or claim to amnesia, and XXY chromosome abnormality.

Of some interest is the concept of **developmental delay** in the criminal justice system. Adults or youth with limited intellectual ability or developmental delay have some special difficulties in the investigation of their behaviour and the trial process. Developmentally delayed persons have limited communication skills and may be predisposed to "biased responding" (answering in the affirmative or the negative given the demands of the question) and may acquiesce to leading questions more easily. They may be reluctant to disclose that some questions are beyond their ability or knowledge and provide answers without understanding the questions. They may have difficulty processing large "chunks" of information at any given time and they may assume blame in an attempt to please the questioner. These concepts must be kept in mind when assessing an individual for competency to stand trial or culpability for their

actions. Developmentally delayed persons are easily led by others who have criminal intent and may not formulate the criminal intent or understand the nature of the actions they are undertaking.

C. The NCR Assessment Process:

A comprehensive assessment of the criminal responsibility of the individual involves collection of third party information and deriving information from the individual defendant.

Types of Third Party Information

1. Information re: evaluation itself
   - Referral source
   - Referral questions
   - Why evaluation is requested (i.e.., what behaviour triggered the evaluation?)
2. Offense-related information
   - From Attorney's notes
   - From witnesses, victim(s)
   - From confession, preliminary hearing transcripts, etc.
   - Autopsy reports
   - Newspaper accounts
3. Developmental/historical information
   - Personal data (traumatic life events, unusual habits or fears, places lived)
   - Early childhood illnesses (if organic deficit is suspected)
   - Family history (especially if young and or still living with family)
   - Marital history (especially in spousal homicide cases)
   - Educational, employment, and military history
   - Social relationships
   - Psychosexual history (especially if sex offense)
   - Medical and psychiatric records
4. Signs of trouble
   - Juvenile and criminal court records
   - Probation records
5. Statistical information (i.e., studies of the behaviour of individuals with the defendant's characteristics)

Sources of Third Party Information: An initial consultation with the referral source is crucial to understanding the scope of the assessment and the ethical obligations. Information describing aspects of the crime scenario, usually available from police and the attorneys, is essential for purposes of comparison with the defendant's narrative and for developing leads for further investigation. Developmental and historical

information can usually be obtained from the defendant and the pertinent records, the degree and amount of corroboration sought from friends and family of the defendant is dependent upon the assessor's judgement. Often records of prior hospitalization and treatment are available at the time of the assessment, having already been requested by the attorney; otherwise the examiner will have to get signed release forms from the defendant and wait until the information arrives to integrate it with the other data. Prior court records are usually more easily obtained, although juvenile records are sometimes expunged after a fixed time and therefore unavailable. The most essential third-party data are those pertaining to the crime scenario. This is usually obtained from the police files and from it the clinician can often get good descriptive statements of the defendant's behaviour. A verbatim transcript is preferred. Intellectually impaired persons often acquiesce to questions in statements and a transcript based mostly on yes responses with a low functioning individual is not valuable.

The interview with the defendant must begin with a review of the purpose of the assessment and an explanation of the limits of confidentiality. The defendant should be asked to state his or her perception of the purpose of the assessment and the potential uses of the report, and the assessor needs to answer any outstanding questions. The second phase of the assessment is to obtain the developmental and sociocultural history from the defendant. The third phase is to conduct a mental status, including current or recent symptoms of thought, mood, perception or behavioural disturbance. The fourth phase of the interview is when the examiner zeros in on the crime itself, inquiring about the defendant's recall of thoughts, feelings and behaviour at the time of the alleged crime. Information is also sought regarding situational variables (e.g., intoxicants, actions of others) that may have contributed to the criminal act.

Offense Related Information from the Individual Defendant

1. Defendant's present general response to offense including:
    - Cognitive perception of offense
    - Emotional response

2. Detailed account of offense
    - Evidence of intrapsychic stressors - for example delusions or hallucinations
    - Evidence of external stressors - for example, provoking events or fear or panic triggers
    - Evidence of altered state of consciousness - for example, alcohol-induced or drug-induced
    - Claimed amnesia - partial or complete

3.   Events leading up to the offense
   - Evidence of major changes in environment - for example, change in job status or change in family status
   - Relationship with victim
   - Preparation for the offense

4.   Post offense response
   - Behaviour following act
   - Emotional response to the act
   - Attempts to explain or justify act

Strategies to Detect Fabrication of Illness: During the inquiry into the defendant's attempt to explain or justify their actions, the examiner may change the tone of the interview to obtain accurate information by challenging information that the defendant has given, looking for inconsistencies in the stories, soliciting increasing information on specific details, asking more about the client's feelings, reactions, and memories at the time of the action. The examiner may ask the client to repeat the version of the story several times with the tone of the assessor changing from supportive to sceptical to confrontative, depending upon how the defendant's honesty and candor are perceived by the clinician. In order to evaluate malingering, the clinician may need to evaluate the information that the client provides, Malingerers are more likely than reliable defendants to recount symptoms of extreme severity, "over report" symptoms, describe symptoms that are inconsistent with clinical impressions, endorse highly specified symptoms that are inconsistent with clinical impression, endorse highly specified symptoms and exhibit a "heightened" memory of psychological problems. The examiner may seek to have the defendant endorse bogus symptoms by suggesting strange sounding symptoms that are merely fabrications (e.g., "When you experience these dizzy spells, do you also experience an itching behind one or both of your knees?") One of the most common bogus presentations by criminal defendants during pretrial evaluations is amnesia. Most of these claims are simulated. The use of psychological tests in assessing criminal responsibility is limited. Tests can be used most beneficially to detect possible malingering, or to make statements about "people who obtain this high a score on this scale are typically described as ......". Tests do not address the issues related to time of offense as they typically evaluate current levels of functioning. Test data may be used to confirm the presence of a disorder at the time of the examination, and to suggest, but not to ascertain, that the particular condition may have existed at the time of the offense. Psychological tests may be used as an adjunct or supplementary to interview and investigative procedures but their use is limited in understanding the person's mental status at the time of offense. Likewise, providing a diagnosis for a client is of limited value if the diagnosis is not explained in terms of how it impacted on the criminal behaviour at the time of the crime. Labels have no value for the trier of fact in making dispositional judgements. A concrete level of analysis of a defendant's behaviour is required for such decisions.

A finding that an accused is NCR triggers an assessment of his possible dangerousness and of what treatment associated measures are required to offset risk. If the review board does not conclude that the offender poses a significant threat to the safety of the public, it must grant an absolute discharge. A significant threat requires a real risk of physical or psychological harm to individuals in the community and that harm must be serious.   A small risk of great harm or a great risk of trivial harm is insufficient to warrant committal. Psychiatric treatment can only be ordered if the offender consents to the treatment. When a conditional discharge is given or a warrant of committal has been made, the offender is entitled to have his situation reviewed every year. In the meantime, he or she remains bound by the rules of the Review Board, until the Board determines that he or she is no longer a significant threat and orders an absolute discharge.

Appendix E3-E

IWK HEALTH CENTRE: Youth Forensic Services

A S S E S S M E N T   R E P O R T

CLIENT: **FILE #:F-**

_____

I.   IDENTIFYING DATA:

NAME:

DATE OF BIRTH:

AGE / SEX:

PARENTS:

II.   REASON FOR REFERRAL:

III.   ASSESSMENT PROCEDURES:

_____*(youth's name) and (his/her) parent(s) were seen on*
_____ *to discuss the reason for assessment and the mandate of the*
service as relates to court ordered assessments on youth before the youth court. They
were told about the limits of confidentiality, the expectations of the assessment process
and the fact that anything that was disclosed to the assessor could form part of the
report being prepared for the court. The youth and the parents signed an agreement
to the process of the assessment as described to them.

INTERVIEWS

▸

▸

COLLATERAL CONTACTS

▸

▸

TESTS ADMINISTERED

▸
•

DOCUMENTS REVIEWED

▸
▸
▸
▸

CASE CONFERENCE WITH MULTIDISCIPLINARY TEAM

IV.   RELEVANT BACKGROUND INFORMATION:

Family History
   • psychosocial history (who child lived with growing up, what the family
     circumstances were, how was discipline handled, when problems began, history
     of behavioural problems, family problems such as substance abuse or antisocial
     behaviour in family, sibling relationships historically, etc)
   • early development

Criminal History

School History

Mental Health History

Medical History

Substance Abuse History

V.   ASSESSMENT RESULTS:

Observations: (presentation of the youth)
Interview with _____ Information in this section of the report comes from interview with the youth, the parents, family

Clinical Profile: results of psychometric tests and clinical interview data re mental health issues/mental status

Personality Profile: results of psychometric tests and clinical interview/impressions

Offence Profile: Risk for Reoffending:
-           YLSI Results
-           results of psychometric tests.
-           offence history

Diagnosis

VI.   FORMULATION:

Issues for Consideration when formulating a case and source of information:
- Environmental Factors contributing to delinquency:
- Peer associations (PDR reports, parent reports, youth reports)
- Lack of Supervision (PDR reports, historical records, parent and youth reports)
- Antisocial Role Models in Family (PDR reports, historical records, parent and youth reports)
- Family violence (self and family reports, other records, collateral reports)
- Estrangement from Family / Peers / Community (same as above)
- Other Family Issues uncovered (same as above)
- High Crime neighbourhood (self description/ family description)
- School unable to meet the youth's needs (school and family reports)

Internal Factors contributing to delinquency:
- Interpersonal interactional style (personality development) (MACI, Jesness, Interview)
- Antisocial values (Criminal Sentiments Scale, Jesness, Interviews)

- Lack of self control (impulse control disorder / ADHD) (Historical description, test results, previous diagnoses, school reports)
- Mental Health Problems (depression, anxiety) (Mental health interview, MACI, parental interviews, reports from other professionals)
- Victim of violence / abuse / sexual assault (from Historical report, past records, family report, youth's own report)
- Neurological deficits / learning disabilities (from test results)
- Substance Abuse

The formulation should be a Risk / Needs summary of youth and what the youth would require to improve functioning and reduce the risk of reoffending.

VII. RECOMMENDATIONS:

It is recommended:

1. THAT

2. THAT

3. THAT

4. THAT

5. THAT

6. THAT

PREPARED BY:

(Name)
(discipline)
(registration #)

Appendix E3-F

Youth Court Assessment System Model - Nova Scotia

Provincial   **District /Shared District**

Network

• receive centralized referrals for forensic mental health assessment
• conduct standardized comprehensive mental health assessment under Sections 34 &141 of YCJA
• develop realistic treatment plans that will follow the youth
• ensure minimal annual specialized education received
• Establish and maintain linkages with Justice, Community Services and Education
▪ provide consultation & supervision
▪ collect & maintain data base

• designate mental health professional staff as network member
• conduct comprehensive mental health assessments and follow-up
• maintain communication with all team members at Tertiary & DHA level

Approved: November, 2003

Core Program: Specialty Program - Early Psychosis (E4)

Context & Issues:

For the purposes of this document, early psychosis is defined as the early stages of a major psychiatric disorder that involves psychosis. Early psychosis includes the so-called "prodromal" or "at risk" phase during which signs and symptoms are becoming more apparent but do not yet meet criteria for a DSM-IV diagnosis. Early psychosis continues on to the first diagnosis and the initiation of treatment and extends through the first two to five years of treatment.

The vast majority of early psychosis cases meet criteria for one of the following DSM-IV psychiatric disorders: schizophreniform disorder, schizoaffective disorder, schizophrenia, bipolar disorder (with psychosis) or psychosis NOS. Most individuals experiencing a first episode of one of these disorders are between the ages of 15 and 45.Research in Nova Scotia (1,2) indicates that, for these diagnoses, between 250 and 400 new cases appear each year in Nova Scotia.

These disorders are among the most serious of all psychiatric conditions in terms of the disability and suffering they can cause and the associated human and economic costs (3, 4). It is significant, as well, that these disorders appear in young people at a critical time in their psychological, social, educational and vocational development. As well, the average delay between the onset of psychosis and the initiation of symptoms is approximately one year (5). The field of early psychosis has emerged over the past decade as a major new area of research and service delivery in mental health (6,7,8). The goal is to detect the disorders as early as possible in the course of the illness and optimize treatment once the disorder has been recognized.

There is growing evidence (9) that early psychosis services improve outcomes. Recent research, for example, indicates that early psychosis services can reduce the delay between onset of symptoms and initiation of treatment (10) and improve adherence once treatment has started (11).

A growing number of specialized early psychosis programs have been developed throughout the world (7,9,12). Several countries, including Australia and the United Kingdom, have recognized the importance of early psychosis programs within the spectrum of mental health services. Service and practice guidelines have been developed (13,14,15).

In Canada, early psychosis programs have been in operation since the mid 1990s in London, Calgary, Toronto and Victoria along with a prototype program in Halifax (16). Programs in a number of other cities have been developed more recently. The Canadian Mental Health Association is carrying out a national initiative on early psychosis (17,18).

Core Program Description: Specialty Program - Early Psychosis (E4)

Early Psychosis services will be best provided through a formal network of mental health care professionals located in each DHA / IWK of the province, with consultative, educational, program evaluation and research support provided by a single provincial early psychosis program. In turn, this network will develop collaborative partnerships with local resources including other health care professionals and programs, community agencies, schools and governmental departments as appropriate.

Early psychosis services need to address a range of needs including prevention and early identification, assessment, treatment, psycho education and community based psycho social supports.

To provide cost effective, coordinated services throughout the province, a service delivery model is proposed that assigns specific responsibilities to (a) the health districts and the IWK, (b) a central provincial Early Psychosis Program and (c) local resources

Goal Statement:

All Nova Scotians will have access to phase appropriate early psychosis services aimed at a) detecting psychiatric disorders involving psychosis at the earliest possible point in the course of the illness and b) optimizing care and treatment once the disorder has been recognized consistent with best practices.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	**E4.1.** Designated mental health staff participate in a formal province-wide Early Psychosis network, collaborate in development and coordination of early psychosis services and liaise with the provincial program.	**III**
Accessibility	**E4.2.** Standards for proactive outreach/referral finding and early detection/intervention services, as described in Standards Section B2, are implemented and recognized as important in early psychosis. In this context, referrals are accepted from multiple sources including individuals, families, schools and community agencies as well as healthcare professionals, so as to maximize early detection.	**II**
Safety	**E4.3.** In mental health services and primary care, cases involving a suspicion of psychosis are treated as either emergent or urgent. Emergency assessment is completed with twenty-four (24) hours of the referral. Urgent cases are assessed within 5 working days of the referral**.**	**II**
Competence	**E4.4 .**Assessment and treatment are provided by a multi disciplinary team including primary care who provide continuity of care and active engagement during the critical first 2 - 5 years of treatment.	**II**
Accessibility	**E4.5.** Mental Health staff will have access to consultation and supervision at district and provincial level.	**II**
Acceptability	**E4.6.** Families /support systems will be actively involved in the engagement, assessment, treatment and recovery process with consent of the individual and consistent with optimal care.	**II**
Acceptability	**E4.7.** Individuals and families/support systems will be provided with comprehensive, current information related to psychosis, treatment, recovery and associated resources**.**	**II**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	**E4.8.** Collaborative partnerships are developed to facilitate a comprehensive range of local resources to support individuals, families and support systems.	**II**
Effectiveness	**E4.9.** Public and professional education initiatives are undertaken to enhance prevention, early identification and early effective treatment in coordination with the DHAs/IWK and provincial planning initiatives, and consistent with Standards Document Section A.	**II**

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Early Course of Psychotic Disorders
(adapted from Larsen 1996)

	Functional decline	**Onset Positive Sym**	**Start Treatment**	
premorbid	**at risk phase**	**psychosis**	**first treatment**	**remission**

DUP

Illness onset   **episode onset**

illness duration

psychotic episode duration
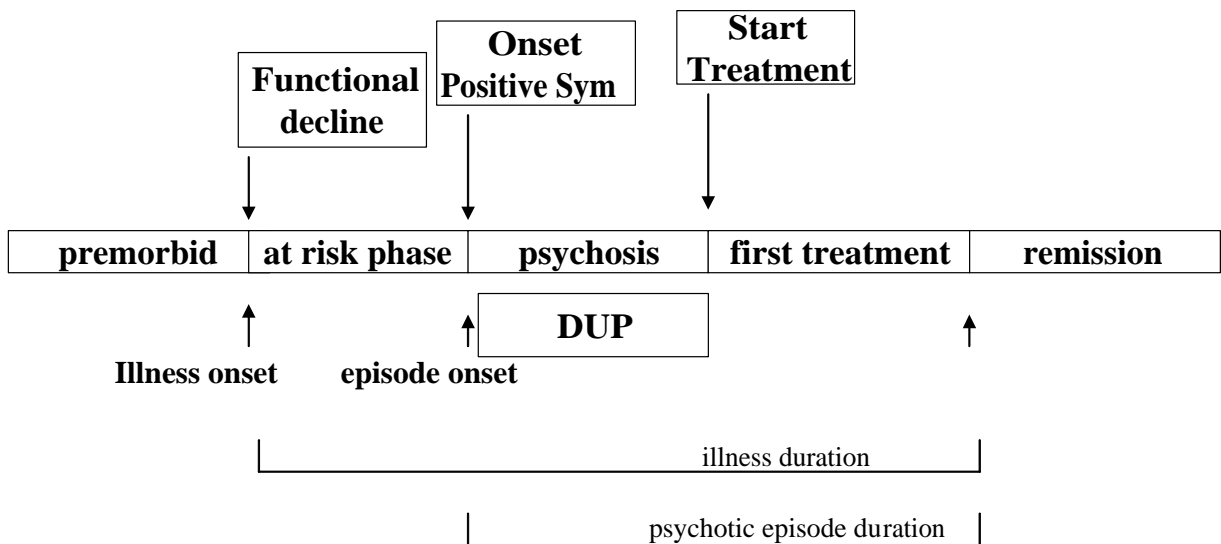
(Adapted from Larson 1996)

Appendix E4-B

Provincial Early Psychosis Services Model   Children, Youth and Adults

Provincial   **District/Shared District**   **Local**

Network

•Provide clinical consultation.

•Develop & provide professional education / training.

•Develop & support psycho-education resources for individuals / families.

• Collaborate in development & implementation of prevention and public education initiatives.

•Promote & carry out research.

•Collaborate in provincial program evaluation.

•Collaborate with DHAs/ IWK to develop & carry out program evaluation

• Coordinate & facilitate communication within a formal Early Psychosis Network of designated staff from DHAs /IWK

•Designate one or more mental health staff as liaison with the provincial Early Psychosis program and network.

•Participate in professional education/training.

•Provide intake, assessment and treatment.

•Provide individual / family education with support of resources developed by the provincial program.

• Identify, promote development of, and access to, local resources to support individuals and families.

• Collaborate in program evaluation activities.

•Facilitate referrals for participation in research.

•Collaborate in development & implementation of prevention and public education initiatives.

•Develop appropriate partnerships with local resources.

•Participate in education / training as appropriate.

•Collaborate in development & implementation of prevention and public education initiatives.

•Collaborate with DHAs / IWK to identify and promote development of local resources to support individuals & families.

•Collaborate in program evaluation.

Approved: Steering
October 16, 2003

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Core Program Title: Specialty Program - Seniors Mental Health (E5)   Jan29, 2009

Context & Issues

Like most industrialized countries, Canada is seeing an increase in its senior population. In recent decades, the Canadian population aged sixty-five years and older has grown to a total of four point three million in 2006. Seniors comprised thirteen percent (13%) of Canada's population in 2006, compared with ten percent (10%) in 1981 and only five percent (5%) in 1921. By 2056, the percentage of the population aged sixty-five years and older may reach twenty-seven percent (27%). Women are the majority among seniors, comprising fifty-six percent (56%) of persons aged sixty-five years and older and sixty-four percent (64%) of those eighty years and older in 2006. (http://www41.statcan.ca/2007/70000/ceb70000_000-eng.htm)

The most rapid growth in percentage of persons over sixty-five years is in the eighty years and older age groups. In 2006, three point six percent (3.6%) of the population was aged eighty years and older, and this figure could reach ten percent (10%) by 2056. (http://www41.statcan.ca/2007/70000/ceb70000_000-eng.htm) A Senate committee report in June 2006 determined that by 2031, thirty percent (30%) of Nova Scotians will be sixty-five years or older. (Strategy for Positive Aging in Nova Scotia.2005)

The majority of Nova Scotia seniors live in private households with their family [sixty-two percent (62%) with spouse or common-law partner, six percent (6%) with extended family, and two percent (2%) with non-relatives]; however, thirty percent (30%) of seniors live alone. The majority, ninety-five percent (95%)) of Nova Scotia seniors live at home in owned or rented accommodations [seventy percent (70%) own, twenty percent (20%) rent from the private market, four percent (4%) live in non-profit seniors apartments]. Less than one percent (1%) live in licensed residential care facilities and four percent (4%) live in licensed nursing homes. (Strategy for Positive Aging in Nova Scotia.2005)

Mental disorders are not part of "normal aging", therefore, there are challenges in managing mental illness in seniors. Their symptoms often differ from younger adults, making diagnosis more difficult. Ageism and stigma associated with service access and transportation limitations impact service availability. Lack of designated seniors mental health services and supports in rural areas makes access and availability even more difficult. In the past five years there has been significant progress in seniors' mental health. With the establishment of a seniors' network, all districts have identified clinicians to represent seniors' mental health issues and two districts have defined Seniors' Mental Health Programs. The seniors' mental health network has been making progress in capacity building, telehealth education, and knowledge transfer/exchange. There has been some improvement in partnerships between mental health services and service modalities such as geriatric medicine, emergency health services, home care, and continuing care. The move to Collaborative Care and the PIECES Program, along with the hiring of Challenging Behaviour Resource Consultants (CBRC) for the districts will make positive impacts on the service to seniors. The Seniors' Network continues an alliance with the Canadian Coalition for Seniors Mental Health (CCSMH).

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Context & Issues cont'd:

Family or unpaid caregivers are providing the majority of care for seniors. Seventy percent (70%) of caregivers are women and thirty six percent (36%) of these caregivers are over seventy years old. Unpaid caregivers save the public health services system over $5 billion per year in Canada and have not been given the attention and support they deserve and need. Up to forty-six percent (46%) of unpaid caregivers are depressed themselves; they lack meaningful mental health information and knowledge of local support groups, public health and continuing care services, and respite services. A recent Healthy Balance survey found women account for at least fifty-six percent (56%) of unpaid caregivers in Nova Scotia.
www.healthyb.dal.ca/Cargiver_Handbook_2007.pdf

It is possible to prevent deterioration in mental health, restore health, and enhance quality of life by treating mental illness. Access to seniors' mental health services is available across the province through a network of interested professionals addressing issues of education, advocacy, service coordination and the provision of support for complex cases.

Core Program Description: Seniors Mental Health

Seniors' mental health is a multidisciplinary, client and family-centred, community-based, outreach/outpatient/inpatient service which provides:

- complex assessments and specialized treatment;
- consultation to a full range of service providers in health and community sectors;
- early intervention;
- liaison with continuing care sector;
- health promotion, prevention, education;
- advocacy;
- research;
- program evaluation; and
- access to inpatient beds at the district/shared district level.

Goal Statement:

Nova Scotians have access to services for the assessment and treatment of seniors' mental illnesses.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	E5.1 Seniors' mental health services are available to assess, treat, and refer individuals.	**III**
Continuity	E5.2 Providers of seniors' mental health services collaborate with other health care providers on the continuum of care.	**IV**
Competence	E5.3 Seniors' mental health services in each district/ shared district consist of at least one clinician and one physician (generalist or specialist) with knowledge of seniors' mental health.	**III**
Accessibility	E5.4 Referral protocol for service and consultation is clearly defined, widely distributed and routinely revised.	**IV**
Appropriateness	E5.5 Referral criteria for seniors' mental health services are: • sixty-five years of age or older with first onset of psychiatric disorder, and/or new onset or exacerbation of existing psychiatric disorder complicated by aging process; or • dementia under or over age 65.	**III**
Appropriateness	E5.6 Referrals to seniors' mental health services are triaged by an intake worker or the mental health team.	**II**
Appropriateness	E5.7 Referral criteria for admission to specialty beds: • complex mental health problem associated with aging process requiring 24 hour nursing care for specialty assessment, diagnosis and treatment; • referral by public practice psychiatrist (where feasible) from district hospital unit; • agreement by the referring unit/residential facility to accept the patient back following discharge from a specialty bed.	**III**
Population Focus	E5.8 District seniors' mental health services collaborate with agencies and organizations providing care, treatment, and/or support to seniors and their families.	**II**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Competence	E5.9 Seniors mental health clinicians collaborate in the development of core curriculum for clinical training with secondary education organizations.	**II**
Client Centred	E5.10 Each district has available information to assist the public, individuals, family, community groups and other community agencies in understanding and accessing seniors' mental health services.	**III**
Competence	E5.11 Consultation is available from the tertiary Seniors' Mental Health Program to the district seniors' mental health services upon request.	**III**

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Seniors Mental Health Glossary

Target Population
In defining the target population for seniors mental health services it is necessary to address mental health needs at the local, district and provincial levels.

Local Level:
At the local level it is necessary to address the senior population as a whole. Seniors constitute an at risk population based on biological, psychological and social risk factors. When this is recognized, early intervention can reduce the risks, potentially delay or eliminate the onset of a mental health problem, and ensure early treatment where illness occurs. Mental health needs can be met at the local level by family physicians working collaboratively with seniors, their family members and other community care providers.

District Level:
At the district level the target population is seniors diagnosed with a mental health problem. Consultation between the primary care physician and the general mental health system can facilitate the provision of appropriate treatment. Consultation and follow-up should be available through outreach teams that have expertise in seniors' mental health.

Provincial Level:
At the provincial level the target population is seniors with a complex presentation of a mental health problem. The complexity is associated with the aging process or medical complications. The criteria for specialty treatment reinforces the concept that many mental health needs can be met at the primary and secondary care levels provided there is adequate knowledge and experience in identifying and responding to mental health issues in seniors.

Culture:
Is composed of language, concepts, beliefs, values, symbols, structures, institutions and patterns of behaviour, etc. A person's culture may or may not be the same as his or her ethnic origin or identity. In society, a person may have encountered a variety of cultural influences.
Culture is:
• Dynamic, ever evolving and changing, created through individuals' interactions with the world, resulting in ways of naming and understanding reality. Shared when individuals agree on the way they name and understand reality.

• Symbolic, often identified through symbols such as language, dress, music and behaviours.
• Learned and passed on through generations, changing in response to a generation or individual's experiences and environment.
• Integrated to span all aspects of an individual's life.

Diversity:
Differences among people as individuals or groups. Diversity includes difference in age, abilities, culture, ethnicity, gender, physical characteristics, religion, sexual orientation, values, etc.

Ethnic:
An adjective used to describe groups that share a common language, race, customs, lifestyle, social view, or religion. Everyone belongs to an ethnic group. The term is often confused with "minority". Ethnic, however, refers to those traits that originate "from racial, linguistic, and cultural ties with a specific group".

Seniors Mental Health (E5)
Appendix E5-A

Notes:

Long term care facilities are often referred to as the mental institutions in the future. The number of long term beds in Canada will increase by 61-170% by 2041 (9). Up to 90% of the seniors will have mental health disorders.

There is not enough public education of mental illness partly because of the stigma associated with mental health issues. As a result, it is difficult 'to get the message out' that mental illness is not a natural part of aging, and that treatment is highly effective. Health professionals are not adequately trained in mental health issues impacting seniors including preventive measure, early recognition and treatment strategies. There are significant problems with supply, distribution, recruitment, retention, remuneration and credentialing of professionals.

There is a lack of integration with local geriatricians or family practitioners interested in geriatric medicine and community agencies. Unfortunately, mental health has not taken advantage of the excellent telemedicine initiatives in this province to provide consultation and education to rural and remote areas. There is no demonstrated focus on "best practices" for policy, education, environment, assessment and treatment, public education health promotion research, human resources recruitment and retention in the province.

Target Population
In defining the target population for seniors mental health services it is necessary to address mental health needs at the local, district and provincial levels.

Local Level:
At the local level it is necessary to address the senior population as a whole. Seniors constitute an at risk population based on biological, psychological and social risk factors. When this is recognized, early intervention can reduce the risks, potentially delay or eliminate the onset of a mental health problem, and ensure early treatment where illness occurs. Mental health needs can be met at the local level by family physicians working collaboratively with seniors, their family members and other community care providers.

District Level:

At the district level the target population is seniors diagnosed with a mental health problem. Consultation between the primary care physician and the general mental health system can facilitate the provision of appropriate treatment. Consultation and follow-up should be available through outreach teams that have expertise in seniors mental health.

Provincial Level:

At the provincial level the target population is seniors with a complex presentation of a mental health problem. The complexity is associated with the aging process or medical complications. The criteria for speciality treatment reinforces the concept that many mental health needs can be met at the primary and secondary care levels provided there is adequate knowledge and experience in identifying and responding to mental health issues in seniors.

Promotion, Prevention, Advocacy

Targets:
- population as a whole
- individuals at risk
- vulnerable people with a mental illness

Interventions:
- strengthen the factors that protect health
- reduce factors that increase risk
- reduce stigma and discrimination

Core Program: Specialty: Concurrent Mental Health & Substance Use Disorders (E6)
Context & Issues: There has been a paradigm shift from institution-based services to community-based services over the past two decades. The deinstitutionalization of seriously mentally ill persons has provided opportunities for more normal living conditions and more appropriate treatment; however, the widespread availability of illicit drugs and alcohol have posed new risks for this population. Thirty years ago the trend was to separate mental health services and substance abuse services; in recent years the trend is towards integrated services. To develop a responsive system in Nova Scotia for individuals with concurring disorders, structural and organizational challenges need to be addressed: •   mental health and substance abuse services are now separated by department, by administration, by funding & by service delivery and integration needs to be explored; •   strict entry criteria practiced by each department need to be relaxed to an inclusive model of care; and •   access to services no matter where people live in the Province needs to be enhanced To be truly responsive to the needs of Nova Scotians with concurrent disorders, significant changes in the provision of publicly funded services need to occur.

Core Program Description: The nature of concurrent disorders necessitates multi-agency involvement with a full range of services to address individual's.   An inclusive and comprehensive framework for assessment and treatment services that best meet the persons' needs is required. The assessment and treatment services need to be provided in the community as well as in institutional settings.
  The range of services need to be accessible to individuals living anywhere in the Province. Referrals to services need to be accepted from multiple sources including self-referral and presentation at emergency departments.
  Service provider collaboration needs to be initiated at the first point of referral, and then flow continuously throughout treatment. A collegial provider network working with a client-centered approach is crucial with this population.
Service delivery will depend upon clearly articulated activities and a range of skills and expertise associated with a multi- disciplinary approach to care delivery. Mental Health and Addictions' staffs need to have an increasing focus on partnerships and collaboration within the client-centered approach.
  Comprehensive, continuous, integrated services for individuals with concurrent mental health and substance use disorders are desirable and achievable with framework guidelines. *[*such as the Comprehensive, Continuous, Integrated System of Care (CCISC) Model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD), by Kenneth Minkoff, MD.].*

Goal Statement: All Nova Scotians have access to coordinated, integrated, comprehensive services for the treatment of concurrent disorders across the life span.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	**E.6.1.** A structured integrated model between Mental Health Services and Addictions Services is established to facilitate the provision of services at the local level.	**II**
Efficiency	**E6.2.** Guidelines and policies are established to support integrated treatment.	**II**
Appropriateness	**E6.3.** Individuals seeking help for mental health treatment or substance use treatment are screened for co-occurring substance use disorders or mental health disorders	**III**
Appropriateness	**E6.4.** On the basis of a positive screen for either substance use, or mental health disorders, a comprehensive assessment is recommended to the individual to (a) establish diagnostic impression (b) assess the level of psycho social functioning and other disorder-specific factors; and (c) develop a treatment and support plan.	**III**
Competency	**E6.5.** Clinical treatments for individuals with concurrent disorders including: • acute stabilization • motivational enhancement • active treatment • relapse prevention • rehabilitation and recovery (See Community Supports Standards) • those based on current best practices, evidence based research and expert consultations. (See Glossary) (Minkoff, *Service Planning Guidelines, April 2001, page 5*)	**II**
Efficiency	**E6.6.** Outcome measures are established to evaluate integrated treatment.	**II**

Efficiency	**E6.7.** Retention and follow-up strategies are in place to support continuity of care.	**II**
Competency	**E6.8.** Core and specialty competencies are established and maintained. *Elements of a Dual-Diagnosis Program, August, 2003 (See Appendix D)*	**II**
Competency	**E6.9.** Staff training and education forms the foundation for development of an Integrated Concurrent Disorders service includes cross-training and continuing education.	**II**
Efficiency	**E6.10.** Province wide best practices are built and maintained on evaluation, shared experience and research.	**II**

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Concurrent Disorders (E6)
Appendix E6 - A

Examples of approaches (Adults)

For Individuals seeking help from Mental Health Services

Level I

Examples of approaches include:
- using an index of suspicion
- asking a few questions
- using a brief screening instrument
- using case manager judgment

Level II

Examples of approaches include:
- Dartmouth Assessment of Lifestyle Instrument (DALI)
- Short Michigan Alcoholism Screening Test (SMAST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)

For Individuals seeking help from Addictions Services
Level I

Examples include:
- using an index of suspicion
- asking a few questions

Level II

Examples include:
- psychiatric sub-scale of the Addiction Severity Index (ASI) device
- Mini Mental Status Exam

Reference:
Best Practices Concurrent Mental Health and Substance Use Disorders. Prepared by Center for Addictions and Mental Health. Health Canada. 2001 [pages 35 (2) and 39 (3)]

Specialty Programs
Concurrent Disorders (E6)
Appendix E6 - B

Prevalence

The number of individuals presenting to mental health services and to substance abuse services who have co-occurring mental health & substance abuse problems has been researched extensively over the past two decades. According to the literature, the prevalence of persons presenting to mental health and to substance abuse services who have a concurring disorder is estimated to be anywhere between 30-80%. (CAMH,2001). The percentage spread is due to numerous factors affecting prevalence estimates such as variability in assessment methods, diagnostic criteria, the skewed population due to assessment settings, demographic characteristics and time frames such as the present or lifetime occurrence. (Meuser et al. 2003, *Integrated Treatment for Dual Disorders*, pg. 4)

Core Program Title: **Specialty Standards: Mental Health Service Standards for Children & Youth with Neurodevelopmental Disorders (E7)**

Context & Issues: Children and youth with a variety of Neurodevelopmental disorders access mental health services. Neurodevelopmental disorders are those that typically show themselves early in life, are neurological in origin and have a significant impact on a person's learning, behaviour and adaptation to the environment. There are a range of neurodevelopmental disorders with some resulting in major functional impairment (e.g., autism spectrum disorders) and others less severe impairment (e.g., specific learning disorders). The neurodevelopmental disorder may be the focus of the referral (e.g., behavioural difficulties associated with impulsivity) or may be secondary to the presenting problem (e.g., a youth with depression who may have comorbid learning disorders).

There are currently few specialized services for children and youth with neurodevelopmental disorders who access mental health services. However, the prevalence of neurodevelopmental disorders indicates that a substantial number of children and youth have such difficulties and may access mental health services. Some studies indicate that a significant number of children are accessing mental health services with undetected neurodevelopmental disorders that may be contributing to their "mental health difficulties" and may have a bearing on the selection of treatment modalities. Cohen, Barwick, Horodesky, Vallance and Im (1998) found that 40% of children seeking services for mental health services also had previously undiagnosed language disorders. Many of these children were presenting with symptoms of Attention Deficit Hyperactivity Disorder. While some disorders present with relatively high prevalence rates and lower needs others may have substantially lower prevalence rates with very high needs for youth and the family. Mental health issues may be co-morbid with neurodevelopmental disorders. (See Table 1 Appendix E7-A).

Given the prevalence of neurodevelopmental disorders, the frequency of direct referrals for mental health services, and their presence in children and youth referred for other reasons, more attention must be paid to the needs of children with neurodevelopmental disorders and their families.

Children and youth with neurodevelopmental disorders need to have the same continuum of services that are available to other children and youth (i.e. inpatient, day treatment, residential programming etc.).

Mental Health staff with expertise in neurodevelopmental disorders may be required to provide direct mental health service for individuals with these disorders or may be required to provide consultation to primary clinicians and other service providers.

Special attention must be paid to children with Autistic Spectrum Disorder because of the intensity and breadth of services required. These children will access the mental health services available to all children with neurodevelopmental disorders. In addition, the severity of autistic spectrum disorder warrants early intensive behavioural intervention There is evidence that the impact of autistic spectrum disorder can be mitigated by intensive behavioural intervention [See Technical Report. (EIIS)]. Intensive behavioural intervention will be integrated with other services for children with autistic spectrum disorder.

Core Program Description:

Mental Health Neurodevelopmental Services are designed to help individuals and their support networks in managing the demands of daily life and to promote full citizenship in the community. Specialized services must be provided by appropriately trained clinical staff. Staff collaborates with individuals, their families and support networks around functional goals, and provide outreach and support across service settings appropriate to changing developmental needs. Service delivery is a continuing and integrated care model. In particular close collaboration with early intervention and schools is essential. The range of intensity/frequency of service is based on need, and will vary by individual (**and the needs of the individual/family**). The available resources and critical mass, may require collaborative arrangements among health districts.

Mental Health Neurodevelopmental Services provide:

- assessment, diagnosis, treatment, consultation, collaboration and case co-ordination to meet the individual and family needs.
- access across the life span as required
- services primarily within community settings.

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 identifies individual(s) to participate in the provincial network.

Goal Statement:

Children and youth with neurodevelopmental disorders have access to a network of integrated services for their mental health needs based on best practice evidence.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E7.1.** A uniform triage and screening assessment process is used for all referrals into the mental health system.	**III**
Appropriateness	**E7.2.** Eligible children and youth for this specialized service are those who present with a range of neurodevelopmental **and** behavioural or mental health issues. Individuals with neurodevelopmental disorders in the absence of any behavioural or mental health issues do not meet admission criteria. (See Table 1)	**III**
Continuity	**E7.3.** Referred individuals not meeting eligibility criteria are redirected to appropriate services where available.	**II**
Competence	**E7.4.** Primary health care providers and human service agencies have access to advice, consultation and support in responding to the mental health/psychological needs of individuals they serve.	**III**
Appropriateness	**E7.5.** Referrals are reviewed by a member of the clinical staff. Intake screening to determine eligibility occurs at the earliest point of contact with the service [within three (3) working days].	**II**
Accessibility	**E7.6.** Proactive outreach (case finding)/referral finding is part of a process of facilitating referrals to the mental health system.	**III**
Competence	**E7.7.** To provide appropriate mental health services for this population each DHA / IWK has access to specialists with advanced training in diagnosis of neurodevelopmental disorders (i.e. psychology, pediatrics, neurology and psychiatry).	**II**
Competence	**E7.8.** Each DHA/IWK has access to appropriately trained clinicians to treat mental health issues for individuals with neurodevelopmental disorders.	**II**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	**E7.9 .**The trained clinicians are responsible to: a) Be a liaison with community agencies (schools, clubs etc) within their district b) Link to primary care clinicians and crises services c) Triage cases to appropriate level care at either local or provincial level.	**IV**
Competence	**E7.10.** Each DHA/IWK has appropriately trained clinicians and para-professionals to provide intensive behavioural intervention for ASD.(See Appendix E7-B)	**II**
Appropriateness	**E7.11.** A diagnosis or diagnostic 'impression' and case formulation is required at the initial assessment. This initial assessment is completed within ninety (90) days from time of disposition. (The assessment may include but not limited to input from psychology, social work, neurology/ pediatrics/ psychiatry, speech- language pathology and OT).	**II**
Appropriateness	**E7.12.** Current reliable and valid tools are used in assessments.	**II**
Accessibility	**E7.13.** For services provided through limited designated sites, clear provincial access protocols shall be established, distributed, regularly updated with appropriate input and monitored.	**III**
Appropriateness	**E7.14 .**The range of services for children and youth with neurodevelopmental disorders may include inpatient, day treatment, residential etc.	**III**
Continuity	**E7.15 .**Established protocols ensure smooth transition from child and youth services to adult services with expertise in neurodevelopmental disorders.	**IV**

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E7.16.** Multi-disciplinary treatment plans are formulated and will specify: • goals set with the individual and/or support network • treatment, time frames for treatment, monitoring of outcomes and revision of goals as appropriate • the process to link and coordinate with all relevant professional and community resources (e.g. early intervention services and schools)	**II**
Accessibility	**E7.17.** In each DHA/IWK, information to assist the public, individuals, families, community groups, schools and other community agencies is available. This includes: a) 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. b) information about neurodevlopmental disorders and co-morbid mental health issues	**III**
Competence	**E7.18.** Team members have access to appropriate and continuing education in neurodevelopment disorders. Team members providing intensive behavioural intervention must complete intensive training and receive ongoing supervision by appropriately trained clinical staff. (See Appendix E7-B)	**II**
Competence	**E7.19.** The provincial network will provide a mechanism for on-going education, clinical consultation, and support for research, academic and systems issues.	**III**

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Neurodevelopmental Disorders Children & Youth (E7)

Appendix E7-A

Table 1

Neurodevelopmental Disorders Children & Youth Target Population (0 to 19 years)
Potential Comorbid Disorders As per DSM-IV
Mental Retardation Learning Disorders Motor Skills Disorders Communication Disorders Pervasive Developmental Disorders Attention Deficit and Disruptive Behavior Disorders

Appendix E7-B

Qualification for Therapists providing intensive behavioural intervention

Education

Level 1:
Bachelor's degree or equivalent with experience in autism and/or early childhood education

Level 3:
Master's or doctoral degree in psychology with knowledge of neurodevelopmental disorders and treatment.

Training

Level 1
4 weeks theory and exam
480 hours observational supervision

Level 3
480 hours supervision

Case Load/Supervision

Level 1
2:3 case

Level 3
1:6 intensive behavioural intervention programs (6 children) delivered by Level 1 therapist this ratio changes as level 2 therapist become available.

Level 2: to be developed in future years.

Appendix E7-C

A Discussion Paper: Susan E. Bryson, PhD, and Isabel M. Smith, PhD Dec. 2003

A model province-wide program is proposed for the treatment of young children with autistic spectrum disorders (hereafter autism) who reside in Nova Scotia. The program will encompass direct service, training of all relevant professionals/therapists and research. Service, training and research will be intimately connected to ensure that the program not only represents evidence-based methods of intervention training but also that research contributes to the advancement of practice. The program will be affiliated with the IWK Health Centre-Dalhousie University and other provincial universities. The core of the program will be located in Halifax, which will serve initially as the training center for satellite programs to be located throughout the province.

The core program will be developed in stages, beginning with the establishment of the treatment and training services--an *early intensive intervention program* for preschoolers with autism, and an associated *early intervention training program* for potential therapists. The intervention program will target critical functional domains of development (notably, communicative, cognitive, and social-emotional development), using evidence-based methods of applied behaviour analysis and social-communication training. The core (Halifax) program will accommodate a total of 6 to 8 children initially. The children will receive intensive intervention for a period of at least 6-18 months, depending on their individual needs, and the program will be designed to optimize successful transitions into regular preschools and schools. In order to ensure access throughout the province, courses will be available electronically and will be supplemented by comprehensive on-site didactic and hands-on-training.

Once a core group of professionals/therapists have been trained, it will be possible to set up satellite intensive intervention programs in designated sites throughout the province. These trainees will train others in their region, and, in order to maintain fidelity of treatment throughout the province, will remain connected with the central (Halifax) model service and training site. In addition, partnerships will be developed with provincial universities and affiliated schools/departments of study to set up systems whereby students and professionals will receive at least introductory training in the treatment of young children with autism. Research will be integrally connected to all aspects of the treatment and training programs, and will focus on questions regarding treatment efficacy, and cost-effective methods of training therapists/professionals and of delivering services across the province. Collaborative multi-disciplinary research projects will be developed among interested researchers in the province, who will seek research funds from federal as well as provincial granting agencies.

The proposed model program draws heavily on the experience of those who have developed leading programs for the treatment of autism elsewhere. Central to these programs are shared values, a mission to provide the best intervention and training

possible, close partnerships with parents, university affiliations, and a strong commitment to research and to the ongoing improvement of the lives of people with autism.

Appendix E7-D

**Early Intervention for Children with Autistic Spectrum Disorders:
Summary of Evidence-based Reviews
Isabel M. Smith, PhD, Susan E. Bryson, PhD, and Reginald Landry, PhD**

Background / Nova Scotia Context

In April, 2000, the Early Identification and Intervention Services Sub-committee (EIISS) of the inter-departmental Child and Youth Action Committee (CAY AC) submitted a technical report entitled, *A CA Y A C model for enhancing services in Nova Scotia for children under six years of age with special needs.* The specific focus of this document was on services for preschool-aged children with autistic spectrum disorders (ASD), and the recommendations reflected a process of review and discussion involving a large number of Nova Scotian stakeholders. The literature review conducted as part of this process included the report of the New York State Department of Health Early Intervention Program's *Guideline Technical Report: Autism/Pervasive Developmental Disorders.* This report was produced by a committee that systematically reviewed those studies that met stringent scientific criteria, and was considered the major critical evaluation of the evidence to that date.

The EIIS technical report based its conclusions on summaries of the scientific literature as of September, 1999, and was strongly influenced by the critical analysis provided by the New York report. Some of these conclusions are reproduced below, as presented in response to specific questions posed by EIISS (EIISS Technical Report, pp. 22-23; reference citations omitted):

6. What does the literature reveal about different interventions (both general and specific)? General Intervention
- The curriculum of an intervention program must be individualized to specific child.
- Applied behavioral analysis (ABA) behavior intervention is an important component of
any intervention strategy.

Applied Behavioral Analysis
- Research indicates that children who receive approximately 20-40 hours per week of

intensive behavioral intervention have significantly greater improvements.

- The duration of therapy should be dependent upon the child's progress.
- Parents need to be actively involved in the intervention process. This is to ensure that the family's priorities for intervention are incorporated into the program, and to ensure consistency in the intervention approach.
- Parents need to be provided with extensive and ongoing training, including consultation with a qualified professional.
- Siblings and other family members can be part of the parent training program.
- Behavioral interventions reduce maladaptive behaviors and increase positive behaviors.
- Behavioral techniques can increase and improve communication.
- Behavioral techniques can increase and improve social interactions.
- It is important that parents be active participants in the intervention.
- It can be useful to train peers to model appropriate behaviors.
- The use of physical aversives is not necessary for the success of a behavioral program.

Other Intervention Methods
- There are no other methods of intervention that have strong enough evidence to support

them as a *primary method* of intervention for children with autism.

7. What interventions result in best outcomes for a child with autistic spectrum disorder?
- No comparative studies have been done.
- Children who receive intensive intervention show greater improvements.
- Children with higher levels of functioning at baseline have better outcomes.

Subsequently, a consensus stakeholder group made recommendations to EIIS and thereby to CAY AC (EIISS Technical Report, p. 10). The following recommendation was among those approved by CAY AC on 2 February 2000:
Intensive programming should be provided based on best available research evidence. Rationale: Children who receive intensive interventions show greater improvements; Best available evidence states that children who receive approximately 20-40 hours per week of intensive behavioral intervention show significantly greater improvements.

Critical <u>Analyses of Autism Intervention Research,</u> 1999 - Present

Since the EIIS technical report, other relevant findings have been published in the research literature. Additional critical reviews of the evidence have also been disseminated. Each has built on those that preceded, resulting in a remarkably clear consensus on the state of the evidence. The following five evidence-based reviews form the basis of the present summary:

ECRI Health Technology Assessment Information Service (1999). *Comprehensive programs for the treatment of children with autism.* Plymouth Meeting P A: ECRI.

Bassett, K., Green, C.J., & Kazanjian, A. (2001, June). *Autism and Lovaas treatment: A systematic review of effectiveness evidence.* Vancouver BC: B.C. Office of Health Technology Assessment.

Lord, C., & McGee, J.P. (2001). *Educating children with autism.* Report of the Committee on Educational Interventions for Children with Autism, National Research Council. Washington DC: National Academy Press.

Ludwig, S., & Harstall, C. (2001, February). *Intensive intervention programs for children with autism.* HTA-8: Series B. Health Technology Assessment. Edmonton AB: Alberta Heritage Foundation for Medical Research.

McGahan, L. (2001, August). Behavioural interventions for preschool children with autism. Ottawa ON: Canadian Coordinating Office for Health Technology Assessment.

Smith, T. (1999). Outcome of early intervention for children with autism. *Clinical Psychology Science and Practice,* 6, 33-49.

The present summary is focussed on the evidence for effectiveness of comprehensive programs of intervention for preschool-aged children with autism. "Comprehensive" programs are defined as those that address multiple domains of development, rather than, for example, specifically addressing communication skills only. Each of the above reviews addressed this issue in somewhat different ways. However, none of these reviews resulted in conclusion that differ in any substantive way from those presented in the EIIS Technical Report.

The major advance in the field during this period was the publication of Smith, Groen and Wynn's (2000) randomized clinical trial of IBI. This study's methods were a considerable advance over those of previous studies. Smith et al. demonstrated that

intensive intervention, consisting of a mean of 24 hours per week of systematic behavioura1 teaching by a team of closely-supervised student therapists, resulted in significantly greater improvements for young children with autistic spectrum disorders than a parent training program based on the same behavioura1 principles. Intensive treatment was carried out for one year, with a gradual reduction of intervention hours over the following 1 to 2 years. Better outcomes were apparent on measures of cognition, language, and academic skills, although not on adaptive functioning or the presence of problem behaviours. An additional study by Smith and colleagues further supports the use of IBI by demonstrating greater gains on standardized tests for 4- to 7-year-o1d children who received 1 year of intensive behavioura1 treatment, compared with a group receiving similar amounts of "eclectic" treatment (Eikeseth, Smith, & Jahr, 2002).

The conclusions of all evidence-based reviews to date are consistent with the following claim: **Children with autism who receive intensive behaviourally-based intervention (IBI) as part of a comprehensive treatment program show improvements in various aspects of function.**

Qualifications to above statement:
- "Intensive" refers to a minimum of 20 to 25 hours of intervention per week, provided year-round.
- "Behaviourally-based" refers to programs that employ the procedures of *applied behaviour analysis,* that is, the systematic application of principles of1eaming theory to the acquisition of skills and reduction of maladaptive behaviours.
- Improvements have been measured in relatively limited realms, most often scores on measures of IQ, language, or adaptive functioning.
- Studies that attempt to demonstrate the effectiveness of specific models of IBI have significant methodological flaws, such that it cannot be stated with confidence that any single treatment model is more effective than any other.
- It is clear, however, that there is no scientific evidence of effectiveness for treatment approaches that are not based on behavioural principles.
- Thus, although many questions remain regarding the details of IBI (such as how many hours are needed to produce the greatest benefit for the greatest number of children, which children benefit most, etc), there is consensus from all scientific review that intensive behavioural intervention is the cornerstone of the best available evidence-based programs.

Lord & McGee (2001) provide perhaps the broadest perspective on the evidence,

integrating rigorous review of scientific evidence with expert consensus from leaders in the field. Their National Research Council document identifies the common characteristics of the most effective comprehensive intervention programs. The programs that the NRC Committee reviewed include both those for which there are published research studies, and those that have been described as model programs based on other criteria (e.g., expert opinion, receipt of peer-reviewed funding). Based on the shared characteristics of these model programs, the committee recommended:

- Intervention should begin as soon as possible after suspicion of an autistic spectrum disorder is raised.
- An individual intervention program for a child should consist of a minimum of 25 hours per week, 12 months per year of "systematically planned, and developmentally appropriate educational activity toward identified objectives".
- The specific content of an individual educational program should be determined by the child's age and level of development, profile of strengths and weaknesses, and by the needs of the family.
- Priority areas for intervention should be functional spontaneous communication, social interactions, cognitive and play skills, and *positive behavioural supports* to prevent behaviour problems.
- Inclusion with typically-developing peers is encouraged, insofar as this leads to the attainment of the goals of the individual child's program.

The Committee's report also refers to the pressing need for adequate support for coordination of services to children and their families, and to the dearth of trained individuals to provide direct care. Closely comparable conclusions, recommendations, and concerns have also recently been expressed by Iovannone, Dunlap, Huber and Kincaid (2003). Although questions remain outstanding regarding the effectiveness of specific models of interventions (form, timing, etc) for specific children, a clear consensus exists about the core elements of intervention for young children with ASD. In a recent review, Bryson, Rogers, and Fombonne (2003) asserted, "Early intervention in autism needs to be seen as similar to teaching language to deaf children or to teaching mobility and Braille to blind children - a necessary, publicly funded, rehabilitative service, without which outcomes cannot be meaningfully discussed" (p.511). Comprehensive, early, intensive programs that systematically teach relevant functional skills and provide support to parents make a difference for children with autism.

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Core Program Title: Specialty Standards: Mental Health Service Standards for Adults with Neurodevelopmental Disorders - Adults (E8)

Context & Issues: Individuals with a developmental disability represent 1-3% of the general population. It has been estimated that 40-70% of individuals with a developmental disability have diagnosable psychiatric disorders. Approximately 15% of those individuals have moderate, severe or profound mental retardation   (Silka, Hausey) . Those with mild mental retardation experience mental health problems that can be addressed by the general mental health services.

Those with a more significant developmental disability also experience a higher prevalence of associated disorders including but not limited to seizure disorders, sensory impairments, obesity, poor oral health and motor handicaps including cerebral palsy (Fisher).
Mental illness goes largely undiagnosed and consequently untreated in this population. Persons with developmental disabilities present challenges to health care professionals. There are aspects of mental retardation that confound the process of formulating a psychiatric diagnosis. These include intellectual distortion, psychosocial masking, cognitive disintegration and baseline exaggeration (Sovner).

Referral for mental health   assessment is often based on behavioral changes that result from life stressors that are poorly tolerated by individuals with a developmental disability. Symptoms such as depression, psychosis and anxiety are masked in behavioral changes in individuals who are limited in their ability to communicate abstract concepts. The behavior becomes the focus for a referral to mental health. When these stressors are recognized and early intervention initiated it is possible to reduce or prevent catastrophic responses.

Collaboration is key to the provision of mental health services .The capacity to assess an individual in their natural environment can contribute significantly to the formulation of an accurate diagnosis and an appropriate treatment plan. The opportunity to consult with the patient, their family and care providers is critical. Services should include a variety of options including but not limited to consultation, assessment, treatment, crisis intervention, behavioral intervention, pharmacotherapy and inpatient treatment.

Individuals with a developmental disability have complex needs that are influenced by psychopathology, an intellectual deficit, medical concerns and behavioral problems. Specialization of health care professionals is critical to the provision of an acceptable standard of mental health care. In this province there is a core group of dedicated experienced clinicians serving this population. However, there is a shortage of appropriately trained and interested clinicians who are prepared to meet the complex range of health needs that are present in the population. Education of clinicians in all health disciplines must include core information that will assist in the identification of and response to the mental health needs of those with a developmental disability.

Gaps in service may occur across the age continuum unless appropriate transition strategies are in place.

Context & Issues continued. Teams providing mental health services to the developmentally disabled population must recognize and respond to the burden of care that impacts family members and other care givers. There are significant recruitment, retention and burn out issues for care givers who are dealing with increasingly complex emotional, physical

and behavioral challenges in the population they serve. It is important to establish a close partnership with family particularly when a person is unable to consent to their own treatment and informed consent must be obtained from the next of kin.

The capacity to better respond to challenging behaviours and the mental health needs with approaches that are best practice standards and evidence based is critical for both health and community service care providers. This can be accomplished through the establishment of a Provincial Network for the provision of mental health services to the developmentally disabled population. Such a network can provide a platform for collaboration among service providers to establish common, integrated approaches to service delivery and the implementation of evidence based interventions.

The successful delivery of mental health services at the local, district and provincial level is incumbent on a successful partnership between the Health and Community Service sectors.

Core Program Description:
Mental Health Services for Adults with Dual Disorder are designed to respond to the complex biological, psychological, social and behavioural needs of this population. There is a continuum of services that provide assessment and intervention at the local, district and provincial levels. There is capacity at the provincial, district or shared district level to access multidisciplinary

team expertise for the purpose of assessment and treatment. This team includes but is not limited to psychiatry, psychology, speech therapy, nursing, social work, occupational therapy and therapeutic dietitian.

Service planning across the province is initiated by a Provincial Network of clinicians who provide care at the local, district and provincial levels. This network consists of expert clinicians who have the skill training and expertise to implement evidence based and best practice standards of care. Through the Network the training needs of those providing mental health care to individuals with Dual Disorders are identified and appropriate training and credentialing standards are defined and actioned. The Network develops and distributes educational materials to inform and support care providers across the province. Information is available to families and caregivers about where and how to access mental health services at the local, district and provincial levels. Members of the Network develop partnerships with a broad range of care and service providers at the local and district levels to ensure the needs of the population are met. These partners include primary care physicians, medical specialists, dentists, nutrition services, physiotherapy and occupational therapy to ensure the co-existing medical conditions are addressed.

It is recognized that a collaborative and mutually supportive relationship between Health and the Community Service sectors is fundamental to meeting the complex needs of the Dual Disordered population. The need for specialization of caregivers and the healthcare professionals is recognized and supported across the care continuum. At the provincial level there is a specialty service that is accessible to providers across the province. This service provides consultation, assessment, training and education for clinicians and access to tertiary level inpatient care. The provincial team has representation from the full range of health care disciplines that are required to meet the health care needs of those with a dual disorder. There is a plan in place to provide specialized training to those currently providing care without the benefit of training in core competencies.

Goal Statement:
To implement a continuum of mental health services that will meet the needs of individuals with a dual disorder of developmental disability and mental illness and will provide appropriate supports to individuals, families and care providers.

To ensure mental health needs of the dual disordered population are understood, recognized and responded to at the local, district/shared district and provincial level.

To design a provincial model for service delivery that is client/family centered, responsive to the unique needs of the population, facilitates access to service, provides multidisciplinary expertise, is built on collaboration between all service providers and incorporates a biopsychosocial approach to care.

To develop standards for minimal education/training for health care providers.

To enhance clinical expertise of those providing leadership in the field.

To educate across the continuum of care.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E8.1.** Individualized assessment and treatment are provided in the individual's natural environment whenever possible.	**II**
Appropriateness	**E8.2.** A comprehensive biopsychosocial assessment is completed to identify the multiple variables that can influence emotional health and behavioral changes. The assessment process involves the client, family and caregivers and supports client participation.	**II**
Acceptability	**E8.3.** The family participates in the assessment process and may contribute to goal setting and treatment planning as appropriate	**III**
Accessibility	**E8.4.** Access to specialized assessment and treatment is available at the district / provincial level. A multi-disciplinary team which may include but is not limited to psychiatry, psychology (behavioural and developmental), social work, nursing, occupational therapy and speech therapy.	**III**
Appropriateness	**E8.5.** A provincial consultation service is available for individuals with complex psychiatric and behavioral issues.	**III**
Accessibility	**E8.6.** Inpatient admission is available for individuals at the District / shared District level when required. Admission is subject to the admission criteria established for those services.	**III**
Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	**E8.7.** Admission to subspecialty inpatient beds will be based on consultation with or assessment by the sub specialty consultation team based on the diagnosis of a psychiatric illness and the expectation that there will	**II**

	be some health benefit	
Efficiency	**E8.8.** Admission to subspecialty beds for resolution or stabilization requires referral agent to accept the individual back upon completion of the treatment.	**II**
Appropriateness	**E8.9.** Individuals are discharged from inpatient care to the appropriate community setting. Transition is facilitated through collaboration, coordination and communication between all care providers to address discharge and follow up needs for the individual.	**III**
Continuity	**E8.10.** Attempts are made at the DHA level to established formal partnerships between health and community services to facilitate collaboration in meeting the needs of shared clients.	**II**
Accessibility	**E8.11.** Individuals with communication deficits have access to augmentative communication and speech therapy services.	**II**
Availability	**E8.12.** Information describing the presentation of and treatment options for mental illness in individuals with developmental disabilities is available for families, care givers, primary care physicians and health care professionals at a district level.	**II**
Availability	**E8.13.** Collaboration and partnerships facilitate the provision of information that will help people to access available services at all levels.	**II**
Accessibility	**E8.14.** Individuals with nutritional deficits have access to a full range of healthcare services including mealtime management and dysphasia assessment.	**II**
Competency	**E8.15.** Clinicians providing mental health services to this population have education in: a) Developmental disabilities and mental illness b) non-aversive behavioral interventions	**II**
Competency	**E8.16.** Competencies that define expertise are identified through consultation with recognized experts in the field.	**III**
Domains (CCHSA)	**Standards Statements**	**Nature of Evidence**
Competency	**E8.17.** Partnerships exist with post-secondary education facilities for the delivery of advanced competencies for direct care providers.	**II**
Equity	**E8.18.** A provincial network supports those providing mental health services to the developmentally disabled population. The network promotes best practice	**II**

	initiatives, provides leadership in defining educational needs and opportunities, provides advocacy to ensure the range of treatment options and service supports are identified and accessible. The Network promotes capacity building of service providers at the local and district levels.	
Appropriateness	**E8.19.** There are processes in place to transition individuals from youth to adult services to ensure that there is ongoing access to service.	**II**

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Additional Context and Issues

Historically, society devalues persons with disabilities and this reality holds true for those with developmental disabilities. This low status is a contributor to the difficulties experienced by this population when accessing health care services. Adults with a developmental disability and a mental illness do not gain significant skill sets as they mature. The full range of medical and social supports that are integral to the care and treatment of children with a developmental disability are also necessary for adults with developmental disabilities. The need for a continuum of services across the life span is evident. Cure is seldom a realistic objective for this population.

 for those with a developmental disability. The completion of school, the loss of familiar social contacts and activities and the absence of alternatives for those who reach 18 years of age often precipitate the first significant challenge to their mental health. It is reported that individuals wait up to 5 years to access new community programs after they leave school. In the meantime, there are no other activities or programs to provide interest, structure or stability. The   aging of parents who have been life long caregivers presents another significant stressor in the lives of those with a developmental disability.

Clinical expertise in the diagnosis and treatment of persons with developmental disabilities is limited at best. Mental health professionals including physicians, nurses, social workers and occupational therapists receive minimal to no education or clinical training in developmental disabilities. Few graduate or professional programs offer training in this specialty. In Nova Scotia, clinicians who are considered expert in the field clearly identify limitations in terms of their training and access to ongoing formal educational opportunities. (Document on Training of Psychiatrists)

Across districts and at the provincial level there is neither equitable nor adequate access to   assessment, diagnosis and treatment of mental illness and co-morbid medical problems. There is not adequate representation from or access to the full range of health care professionals who are essential members of a multidisciplinary team that is required to adequately address the mental health needs of the population. This includes but is not limited to psychology, psychiatry, medicine, behavioural specialist, social work, nursing, physiotherapy, occupational therapy, speech and language pathology and pharmacy. The absence of a behavioral psychologist as a core member of the multidisciplinary team creates a significant short fall in the provision of mental health service to the adult population with a developmental disability. Expert Consensus Guidelines as well as Best Practice Standards clearly define the role of the clinical psychologist as critical to the assessment, planning and evaluation of care and services.

Family members play a significant role in meeting the mental health needs of individuals with developmental disabilities. Client and family centered care is a best practice standard.
Health care professionals inform families that they do not have the knowledge or expertise to meet care needs. This is an unacceptable reality. Families and other

individuals providing care at home and in community settings are addressing very complex medical and behavioural issues with limited training and support. In the absence of adequate health care services the family becomes the expert. They search the literature and make inquiries about medications and treatment approaches that may help their family member. Family members support the findings in the literature that state that there are many barriers to accessing the services that do exist. There is little information about resources in both the health and community care sectors. Access routes are not well defined or advertised. These departments have separate mandates and the client can often be lost or excluded from one or other provider.

Care can be improved with a common philosophy and approach to the management of self-injurious and other aggressive behaviours and with the implementation of least restraint and non-aversive behavioural interventions. The core components of clinical care, education and research can be supported and promoted through the Provincial Network.

A small segment of this population has resided in congregate living situations for all or most of their lives. With the reduction in the number of Regional Residential Facilities most of these individuals have been moved to a variety of community based housing options. For some, this has been a successful transition. For others the transition has not been successful. Their complex physical, emotional, behavioural and social needs cannot be adequately met and consequently they have been increasingly ghettoized in their community settings. There are increasing numbers of failed placements and the health care sector is called on to admit to hospital with little hope of discharge. It is time to have the health and community care sectors come together to develop and action a response to this critical situation.

There is a need for open dialogue to address the needs of shared clients. This can be implemented through appropriate departmental initiatives and permissions respecting the boundaries of confidentiality.

Themes from Consultation with Stakeholders

Need	Reality
1. Access to service	Access routes not well defined or advertised (health and community supports).
2. Coordination between care/service providers	Separate departments. Separate mandates. Territorial. Communication challenges. No common approach to treatment, support, planning and delivery of services. Don't talk to each other.
3. Full continuum of care and services	Limited community supports are lost when adolescents turn 18 years of age. Access to activities for young adults is limited, not well defined. Families learn about services indirectly. Perception of "secrecy" when seeking services.
4. Family conference	Family not always involved. Care givers do not always follow-up with families. This creates frustration, sense of isolation, desperation. Care givers must listen to family.
5. Crisis intervention	Limited access to emergency care/respite. Limited pre-developed emergency treatment plans. Limited capacity for care givers to respond to urgent/crisis situations.
6. Well trained staff	Wide variation in health and community sector. Strong commitment to learn skills. Limited access to education / in-service. Need minimal competency training, skill sets, mental health information assessment skills.
7. Appropriate level of care facilities	Appropriate level of care does not exist, can't be accessed. Long stay in acute hospital beds. No right "fit" for an individual. Need to plan for success. **Ongoing – stability is fleeting.
8. Training in behavioural approach to care as a standard in the province	Limited in various settings.
9. Well informed doctors to address complex health care needs	Limited number of physicians willing to care for clients. Communication challenges. Disinterest. Limited skill related to assessment/treatment.
10. System capacity to meet client needs	Open admission by health care professionals that they do not know how or what to do for clients with complex significant needs. Unacceptable.
11. Adequate home supports	Does not exist. Parents pay the price for keeping children home. Decreased social adaptability, decreased stress tolerance – non socially acceptable behaviours.
12. Legislation to define services and ensure provision	Does not exist in broad sense.

13. Professional experts	Parents often take the lead – direct/inform care givers.
14. Range of treatment options	Standard approaches don't always work. Care providers must have or be able to access experts. It is not OK to say we don't know.
15. Assessment (MH)	Comprehensive assessment process is not defined.
16. Proactive treatment plans	There is little education and preparation to address crisis, complex illness/behaviour.
17. Strong advocacy and political clout	Very limited
18. Certification of care providers	No defined program for a baseline. Mental health training.
19. Access to service across the province	Limited resource in many areas. No defined model.
20. Partnerships around shared clients (health/community)	Exists in a limited way
Inventory of provincial resources what they are what they do what is needed Balance this against needs	Not available
Risk assessment	Needs development
Philosophical base, values, principles	Need development and then operationalize
Transition of care, child to adult, definition	No parameters. No process.
Staff training in communication – augmentative communication skills, speech therapy	Need training and access to experts
Skills training to address behavioural issue (clients)	Need provincial approach
Comprehensive programs – social, leisure, work, relaxation skills	Need

The Perspective of One Family

Turning point for their son when he finished school and there was no other option for his time… no structured activity

Access to limited activities was difficult due to extensive wait list and times

When they noticed a change in their in their son's emotional health they were lost

Family GP was excellent but not really well informed about mental health treatments for those with a dual diagnosis

Some psychiatric support was accessed locally but there was strong frustration, disappointment and dissatisfaction with the lack of communication from the psychiatrist to the family

None of the health care professionals recommended the COAST Service. This information came from the informal network of other families who had accessed the service. They question why the health care professionals did not direct them sooner to the COAST service.

They expressed the concern that health care professionals don't know that those with

mental retardation can experience other mental illnesses

There is a lack of respite options for families providing 24/7 care.

There is no information that is readily available to direct families on how to access the limited resources and help…word of mouth and accidental seem to be the mechanisms

Community Services is a challenging route for even the strongest advocates and there is a need to clarify, simplify and inform the public about services and how to access them.

Core Program Title: Forensic Services (E9)
Context & Issues:

Context & Issues:

Forensic mental health services for youth and adults in Nova Scotia fall under the jurisdiction of the Provincial Department of Health and are delegated to the IWK Health Centre and the East Coast Forensic Hospital. It is in the interests of consumers, professionals and the health and justice systems to have a set of standards in place regarding how this essential service is provided. While the standards are being conceptualised at a broad level that is generally applicable to both youth and adults, it is also important to note in these standards the areas of divergence between the two populations wherever they present with different issues/needs. (see Appendix E9-A for Continuum of Forensic Services)

Forensic services provide court ordered assessments and services to individuals found Not Criminally Responsible by reason of Mental Disorder (NCRMD), under sec. 16(1) of the Criminal Code of Canada (CCC), or unfit to stand trial under sec. 2 of the CCC. Such individuals are under the authority of the Criminal Code Review Board (CCRB) and are subject to one of three dispositions in accordance with sec. 672.54 of the Criminal Code. Individuals may be subject to a hospital detention order, a conditional discharge order allowing community tenure with adherence to stipulated conditions or an absolute discharge. Currently individuals designated as part of the Intensive Rehabilitation Custody and Supervision (IRCS) program are managed by Corrections Services and East Coast Forensic is not involved in the assessment of this group.

The Criminal Code Review Board (CCRB) operates within the provincial Department of Justice and is mandated to regulate the liberty levels of individuals who have been found Not Criminally Responsible by Reason of Mental Disorder (NCR/MD) for violations of the Criminal Code of Canada. The CCRB is required by law to consider the degree, to which an NCR/MD or Unfit client presents a significant threat to the safety of the public when it deliberates on, and sets, liberty levels for those clients. (see Appendix E9-B for Guidelines for Forensic Privileges)

Every patient within a Forensic Rehabilitation Program shall be entitled to the highest level of liberty consistent with their presenting **level of risk** to personal and public safety. (see Appendix E9-C Risk Management Guidelines)

Forensics Standards for Youth are found in Sections:
E2: Sexually Aggressive Youth
E3: Forensic Mental Health Assessment for Youth

Core Program Title:

Specialty Programs- Forensic Court Ordered Assessments (E9a)Criminal Responsibility, Fitness to stand Trial and Dangerous/Long Term Offender(DO/LTO) Status (Adult)

Core Program Description:
A Core component of Adult Forensic Services is the assessment of accused (or in the case of DO/LTO, convicted) individuals for the purposes of assisting the Courts in determining issues of fitness to stand trial, criminal responsibility and the application of the DO/LTO provisions under the criminal code.

In completing such assessments the ethical obligation of the forensic evaluator is to complete an objective, unbiased assessment for the Court. The position of the evaluator is not, as it is under normal clinical circumstances, one of assistance and advocacy for the patient/accused but is one of neutrality and support for the judicial process. Accordingly, evaluators must ensure that the accused is at all times aware that the assessment process may not render an opinion that is in their subjective best interests and allow accused individuals to exercise fully their legal rights during such assessments.

The authority for, the nature of, and the content and limits of an assessment order are found in Sections 672.11- 672.21 of the Criminal Code for issues of criminal responsibility and fitness to stand trial and in Section 752.1(1) for assessments pertaining to DO/LTO applications.

All assessments must rigorously adhere to the legal criteria laid out in the Criminal Code of Canada. The definition of Fitness to stand trial is found in Section 2 of the Criminal Code. The definition of Not Criminally Responsible by Reason of Mental Disorder is found in Section 16 and the definition of Dangerous offender and Long term offender is found in Section 753 of the Criminal Code. Evaluators must be aware of changes of legislation and key common law cases pertinent to the assessment undertaken.

Core Program Description:

The program provides forensic mental health assessments, on an in custody or out of custody basis, leading to an opinion to the Court on the specific legal issue(s) identified in the assessment order for adults subject to a court order for assessment under the Criminal Code of Canada.

Referrals are through the East Coast Forensic Hospital. Linkages are established and maintained with the Courts and the Department of Justice.

- **See Section E3 for Forensic Mental Health Assessment for Youth**

Domain (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E9a.1.** Referrals for Court ordered forensic mental health assessments on adults are received from the Court through the East Coast Forensic Hospital and assigned to an appropriate forensic assessor.	**III**
Appropriateness	**E9a.2.** Referrals for mental health assessments on adults are accepted at any stage of the court proceedings as allowed by Sections 672.11-672.21 or section 752 of the Criminal Code.	**II**
Efficiency	**E9a.3.** Standardized and valid assessment reports are completed and made available to the Court by the date given in the assessment order. In circumstances where the report cannot be made available by the date noted in the assessment order, the Court will be notified of such in writing along with a rationale for the delay and recommendations to the Court.	**II**
Appropriateness	**E9a.4.** Assessments for Fitness to Stand Trial, Criminal Responsibility and DO/LTO status follow best practices in the assessment and diagnosis of mental disorder, and the assessment of violent risk, are consistent with legal definitions found in the Criminal Code and pertinent common law case, and minimally contain the following elements: - Identification of legal issue - Sources of information - Opinion on specific legal issue - Rationale/support for opinion	**II**
Appropriateness	**E9a.5.** Court ordered forensic assessments use appropriate specialized and validated instruments incorporating multiple measures that cross multiple domains of an individual's functioning.	**I**
Safety	**E9a.6.** In completing DO/LTO assessments for the Court, factors that need to be addressed in the assessment of risk for re-offending include both static risk factors that do not change and dynamic factors that are subject to change. When assessing risk for violent re-offending, a thorough and complete assessment of risk factors is required, that is based upon the most up to date information on the offender and the most up to date methods for assessment.	**I**

Domain (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E9a.7.** Forensic assessments undertaken for the courts must give due consideration to the accuracy of the information that is gathered and give greater weight to information that comes from the most reliable sources.	**II**
Competence	**E9a.8.** Assessments are completed by mental health professionals with training and/or experience in the forensic assessment of adults or under the supervision of or in consultation with an experienced forensic clinician.	**II**
Appropriateness	**E9a.9.** The following documents are required for completion of the referral for forensic court assessment: Crown Sheets, Criminal Records, Pre-Sentence Reports, and any other relevant legal documentation available on the adult, such as a custodial record.	**III**
Appropriateness	**E9a.10.** The report prepared for the Court will follow the standard format of the East Coast Forensic Hospital. The report must be easily understood by the courts, and be comprehensive and coherent. The report will include a diagnostic statement and specifically address the legal issue identified in the assessment order.	**IV**
Safety	**E9a.13.** Staff in tertiary services provide education and consultation in clinical, research/academic, service organization, and ethical/medico legal issues as a resource to the province.	**II**
Continuity	**E9a.14.** Service providers develop and maintain linkages with representatives of the Department of Justice.	**II**

Core Program Title: Specialty Programs- Risk Assessments for Adults and Youth (E9b)

Core Program Description:

Risk assessments are done under specific pre-sentence or post sentencing situations. Violence risk assessment reports are provided to the CCRB, the Provincial and Youth Justice Courts, and to Department of Correctional Services by the East Coast Forensic Hospital and the IWK Health Centre in the context of their respective roles as designated facilities under the Hospital's Act. Violence risk assessments vary somewhat as a function of the referral context, however, these assessments are completed by qualified professionals or under the supervision of designated qualified professionals, and include: observation, interviews, psychosocial history, personal and professional collateral contacts, legal documents, medical history, mental status, diagnostic impressions, medication history, legal history, drug history, psychological tests, structured risk assessment measures, the contextual issues associated with risk of violence and mediating factors that could lower/moderate level of risk. The results of the risk assessment are shared with the client. The risk assessment results in a report for the referral source that documents the risks, offers opinion on the need for risk-reassessment and qualifies the conclusions as contextually dependent.

The primary role of forensic services in the community is risk management and monitoring the client's adherence to the disposition order. The Forensic Community Coordinator will consult with the community treatment team, review and modify current plans to attempt to mitigate risk for violent re-offending. If at any time risk increases it is the responsibility of the community co-coordinator to respond with modifications to protocols, notification of breach to CCRB and in extreme cases with readmission to the forensic inpatient service.

Risk assessments can be completed on an inpatient unit during admission or through outpatient services at either the IWK Health Centre or the East Coast Forensic Hospital.

Goal Statement:

Clients within the adult and youth forensic mental health systems (e.g., found NCR/MD or Unfit to Stand Trial and under the jurisdiction of the CCRB) can expect to have a risk assessment experience which conforms to the current best practises in the field. Forensic risk assessments include completion of widely accepted risk rating measures and address the needs of the CCRB, Supreme and Provincial Courts and the Department of Justice *(see Appendix E7-D for a listing of key evidence and references that support the practices being outlined in these standards)*.

Domain (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E9b.1.** Referrals are discussed at an intake meeting involving various clinicians involved in the client's assessment and treatment	III
Safety	**E9b.2.** A risk assessment completed by Community Forensic Coordinator is based on initial risk assessment, identified triggers and consults with forensic psychiatrist.	II
Acceptability	**E9b.3.** Clients undergoing forensic risk assessments receive a comprehensive introduction to the risk assessment process by the clinician conducting it, outlining its purposes, how it is undertaken, limits on confidentiality, who receives the report, and implications of the report	III
Efficiency	**E9b.4.** Standardized assessment reports are submitted to the CCRB within 10 days of the hearing date and for the Courts within 7 days of the hearing date.	II
Appropriateness	**E9b.5.** The following documents are required for completion of the forensic risk assessment: Crown Sheets, Criminal Records, Pre-Sentence Reports, and any other relevant legal documentation available on the client such as a custodial record, behaviour during past incarcerations (if applicable), records of previous hospitalizations (i.e., admission and discharge summaries plus nursing notes), outpatient mental health records (including psychiatry and psychology reports).	II
Appropriateness	**E9b.6.** Structured clinical judgment scales and actuarially determined assessments are the standard unless inapplicable to the population being assessed.	II
Continuity	**E8b.7.** Risk assessment findings are incorporated as part of a multidimensional clinical report that is provided to the CCRB or the Courts.	II
Safety	**E9b.8.** Risk assessments for CCRB must be updated annually at a minimum	III
Safety	**E9b.9.** Reports clearly identify areas of limitations in collateral information and risk instruments**.**	III

Domain (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	**E9b.10.** Subspecialty Forensic Risk Assessment Adults and youth found NCR/MD on sexual offences are evaluated for suitability for assessment by the NS Sex Offender Program (adult) or NSISAY (youth). For referral the client must present with sufficient social sophistication and psychological stability to stand up to the extensive testing and interviewing processes that are undertaken at that service. In addition one of these features must be included: • clear sexual violence or pedophilia issues (lending to plethysmographic evaluation) or • appearance of sexual deviance issues and patterns at play that require additional exploration	I
Safety	**E9b.11.** The risk assessment makes specific recommendations regarding types of programs, assessment and types of follow-up that are needed in order to ensure that risk is optimally managed on return to the community. (see Appendix E9-D Rehabilitation/Discharge Management Guidelines)	III
Appropriateness	**E9b.12.** Access to consultation for the assessor, both at district and specialty service level is provided by the IWK and the ECFH.	IV
Competence	**E9b.13.** Staff provides education and consultation in clinical, research/academic, service organization, and ethical/medico legal issues as a resource to the province.	II
Competence	**E9b.14.** Qualifications of Risk Assessors: Assessments are completed by psychologists or psychiatrists with training and/or experience in forensic risk assessment of the population served (i.e., adolescents/adults) or under the supervision of an experienced forensic clinician. All professional staff conducting forensic risk assessments are required to: • be registered with the appropriate licensing body for the Province of Nova Scotia • adhere to the user qualifications required in test manuals and be guided by best practice • attend legal case conferences with the consent of the youth or upon direction from the courts under YCJA	II

Core Program Description: Forensic Breaches of Conditions of Release (Ec)

Forensic services provide services to individuals found Not Criminally Responsible by reason of Mental Disorder (NCRMD), under sec. 16(1) of the Criminal Code of Canada (CCC), or unfit to stand trial under sec. 2 of the CCC. Such individuals are under the authority of the Criminal Code Review Board (CCRB) and are subject to one of three dispositions in accordance with sec. 672.54 of the Criminal Code. Individuals may be subject to a hospital detention order, a conditional discharge order allowing community tenure with adherence to stipulated conditions or an absolute discharge.

Goal Statement: Mechanisms are in place to support individuals on conditional discharge in the community and protocols are established to deal with breaches of the conditions of release

Domain (CCHSA)	Standards Statements	Nature of Evidence
Continuity	**E9c.1.** Forensic services support individuals in the community on conditional discharge by providing services that support the individual in adhering to required conditions of discharge, allow identification of alterations or deterioration in mental state and allow liaison with community based mental health services, which provide primary mental health care to the individual.	**III**
Safety	**E9c.2.** The primary role of forensic services in the community is risk management and monitoring the client's adherence to the disposition order. The Forensic Community Coordinator consults with the community treatment team, reviews and modifies treatment plan to attempt to mitigate the risk for violent re-offending. If at any time the level of risk increases it is the responsibility of the community co-coordinator to: • respond with modifications to protocols • notify of breach to CCRB • and in extreme cases with readmission to the forensic inpatient service.	**III**
Safety	**E9c.3.** When breaches of the conditions of discharge occur, forensic services personnel will immediately notify the CCRB in writing and await the instructions, if any of the Board.	**III**
Safety	**E9c.4.** If the breach, in the view of forensic personnel, constitutes an immediate risk to the safety of the public forensic services will recommend immediate detention of the individual at the designated forensic facility.	**III**
Accessibility	**E9c.5.** DHA's/IWK are responsible to provide treatment, including civil admission, for breaches caused by substantial deterioration in an individual's mental state, unless the risk is assessed to be such that the individual cannot safely be maintained in anything other than at a designated forensic facility.	**III**

Core Program: Rehabilitation Standards (Ed)

Rehabilitation services provided for those individuals found unfit to stand trial or not criminally responsible.

Goal Statement:
Individuals who have been found unfit to stand trial or who have been found not criminally responsible and who are being treated under the provincial forensic services mandate will have a client-centred, assessment, treatment and rehabilitation plan. Assessment, treatment and rehabilitation will take place in the least restrictive environment, with due consideration for the safety of the public, the direction of the CCRB and PSR principles.

Domain (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	**E9d.1.** An intake meeting is set up within one week of the recommendation for "not criminally responsible" or "unfit" to brief the clinical team and to make preliminary assessment plans.	III
Appropriateness	**E9d.2.** A written treatment plan is provided to the client and placed on the medical record within 4 weeks of the legal finding of "not criminally responsible" or "unfit".	III
Continuity	**E9d.3.** The treatment plan for inpatient clients is reviewed and updated by the team and the client every 8 weeks. For clients residing in the community the plan is updated on an as needed basis.	III
Continuity	**E9d.4.** The assessment and treatment process continues until an absolute discharge is granted to the client from the CCRB. An absolute discharge is granted when CCRB believes that the client no longer poses a significant threat to the community. This finding is usually based on the recommendations of the treating team. When an absolute discharge is granted the forensic service will advise the involved community supports of absolute discharge status and ensure a smooth transition to mental health services if appropriate and advocate for other supports as required.	III

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Forensic Services
Appendix E9- A Continuum of Forensic Services

Adult Assessment Court Ordered Remand

Sect 672 CC triggers inpatient/outpatient assessment

Child/Youth Assessment Youth Court Assessment

Sect 34 YCJA triggers inpatient/outpatient assessment

Court finds fit and responsible:
Exit Forensic System

Exit to Court

Court finds not fit
and/or not responsible*

Within 45 days of NCR if no disposition made or within 90 days if disposition made by

1ˢᵗ Review Board Hearing

FIT

UNFIT /NCR

Appendix A

Absolute Discharge:

-Exit Forensic System
-No Mandate
-Not available for unfit

Conditional Discharge:

-Treatment/Rehab guidelines

Custodial Disposition:
-East Coast Forensic Hospital/IWK
-Treatment/Rehab guidelines
-Risk management guidelines
-Privileges guidelines

EXIT

UNFIT
Focus on restoring to fitness

NCR

Subsequent Review Board Hearings

FIT

UNFIT or NCR

Absolute Discharge:

-Exit Forensic System
-No Mandate

Conditional Discharge:
-Treatment/Rehabilitation guidelines
-Risk management guidelines

Custodial Disposition:
-East Coast Forensic Hospital/IWK
-Treatment/Rehabilitation guidelines
-Risk management guidelines
-Privileges guidelines

EXIT

Conditional: clinical care provided at district level and maintenance of conditions of disposition managed by Forensic through community coordination.

Breach of Disposition Guidelines

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Appendix E9 - B

Guidelines for Forensic Privileges

Every patient within a Forensic Rehabilitation Program shall be entitled to the highest level of liberty consistent with their presenting **level of risk** to personal and public safety. Care needs to be taken to ensure that privileges are not used to deal with behavioral management issues unless explicitly outlined in a behavioral management plan that has been agreed to by the client.

Patients who are involved with the Forensic Service for the sole purpose of court ordered assessments shall only be permitted directly supervised privileges for purposes consistent with the completion of the required assessment. Exceptional circumstances may exist with youth that require special privilege consideration.

Access to privileges is based on the level of liberty granted in the Disposition of the Criminal Code Review Board. During the period from the court finding until the first CCRB hearing (which may be up to 90 days), only supervised privileges would be permitted.

Structure

All privileges will be structured to follow a progression from directly supervised by staff to indirectly supervised. Direct supervision indicates the need for staff to accompany the patient at all times. Indirect supervision indicates the need for staff to be aware of, and approve all activities and actions of the patient while using the approved privilege. Patients may actually leave the facility on their own while using indirect privileges. This level will include both facility grounds access as well as community access. Although individual wording may vary the basic standard structure will include:

1. Restriction to the individual unit the patient resides on.

2. Direct Supervision off the unit. This may include both facility grounds and/or community for the purposes of treatment and rehabilitation needs. Supervision is to be provided by facility staff.

3. Indirectly supervised off unit privileges on facility grounds.

4. Indirectly Supervised community privileges for day or overnight passes. Any conditions applied to this privilege level must be documented.

5. Conditional Discharge to the community.

Decision Making Process

- Any decision involving increasing or decreasing patient privilege levels centers on patient risk as it relates to safety of self or the public and will involve consultation between treating team members.
- The recommended privilege change will be reviewed and approved/not approved by the administrator named on the disposition or delegate. Short-term decreases in privileges can be made without approval of the administrator. In this case the team will review the privilege level at the earliest possible time.
- Once administrative approval is received, the treating psychiatrist will write a physician's order for the approved level, detailing particulars as to length of time and place as well as any other limitations to be observed.
- Patients should be made aware of avenues for having privileges reviewed and reconsidered, i.e. via patient representative or legal council

Notice of Warrant Status

Notification of Warrant status will be sent to Policing agencies on admission to the Rehabilitation Program of Forensic Services. Information communicated will include name, age, DOB, physical demographics, index offense, current legal status, and current disposition. A current photograph will also accompany this information.

Notification will be sent to HRM Police as well as the Policing Agency in the patient's home community.

Notice of Privilege Level

Notice to Police will be sent for each significant change in privilege level. A significant change is defined as one that involves a move from one level of liberty to another, i.e. from directly supervised to indirectly supervised, from facility grounds to community, from day passes to overnight passes, etc.

Notification to Criminal Code Review Board (CCRB)

The Criminal Code Review Board will receive written notification of any breach in the conditions set forth in the patient's disposition order.

The CCRB will receive written notice of significant decrease in patient liberty, which exceeds seven calendar days. For such cases, the CCRB may choose to hold a hearing to review the details of the restriction.

Appendix E9 - C

*Violence Risk Treatment Guidelines for Psychosocial Rehabilitation in
Forensic Populations**

Risk management in forensic population should be is multifaceted, multi-determined
and based upon a thorough understanding of the individual and the environmental
demands on that individual.

> No single intervention is likely to enable the successful management of potential violence. Multiple
> targets for intervention will exist, and they will differ from person to person…. Effective interventions
> need not eliminate all or even most of a person's risk factors. It should be sufficient only to reduce
> the presence of effect of these factors below the threshold (admittedly indeterminate at this point) at
> which their combined effect is likely to cross the threshold at which violence occurs. Although
> clearly it will be necessary to identify mutable characteristics of violence risk at which to target these
> interventions, not all need be effectively addressed for violence prevention to succeed. This should
> be taken as a bit of optimism in what to date has been area bereft of much encouragement.
> (Monahan et al., 2001, p. 143)

Principles in Risk Management

- ➢ Treatment initiatives should be driven by, and thus directly tied to, the results of a comprehensive risk assessment
- ➢ Wherever possible, risk assessments should only be completed once all outstanding/pending matters regarding charges have been resolved. In the context of unresolved charges, individuals can be unduly motivated to present in a manner designed to facilitate their legal defense, which may not be in the best interest of open disclosure needed for a risk assessment interview
- ➢ Specific treatments recommended to address risk management must focus on risk factors specific to that individual's historical and clinical presentation
- ➢ Risk management must include a long-term perspective that incorporates suggestions for monitoring and managing risk over time
- ➢ Whenever possible, interventions should have demonstrated utility (i.e., empirical support) and/or lend themselves to evaluation as to their effectiveness
- ➢ Certain populations may have specific and/or unique treatment needs (e.g., spousal abusers, sex offenders)
- ➢ Assessment, treatment, and management of imminent risk (i.e., violence likely to occur with hours or days) is qualitatively different and may requires a qualitatively different risk management approach
- ➢ Clinicians concerned with risk management should recognize that not all risk factors need to be addressed in order for risk to be managed – risk management must be weighed against infringement on a person's autonomy and freedom

*Violence Risk here refers to non-imminent risk (not immediate), but to future potential risk of
violence within the rehabilitation period

Model of Treatment:

One of the main models of treatment/management of violence risk is Relapse Prevention. The following reasons have been suggested for why this is the most appropriate model[1]:

1) The model targets personal and environmental variables associated with individual patterns of behaviour
2) The model is based on a cognitive behavioural approach which is a well-researched and common therapeutic approach
3) The model is designed to maintain prosocial behaviour in the long term rather than simply stop antisocial behaviour in the short term
4) The model is a promising tool for use in substance abuse (an important factor in violence risk)

Treatment Approaches

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Violence Risk Assessment: (identification of salient risk factors)

↙   ↘

</div>

Reduction of Risk-Related Factors   Increase of Pro-social / Protective Factors

Guidelines for Community Risk Management

1. Risk management in the community should include, but is not limited to, regular follow-up on items considered to be critical for that patient (i.e., critical factors identified in the violence risk assessment).
   - Fluctuation in the management of any one factor may or may not indicate that a person's risk has become unmanageable and thus should be discussed with the rehabilitation team prior to decision-making around reducing privileges.
   - Whenever appropriate, specific risk factors can be designated as "critical", and if that risk factor fails to be successfully managed in the community, the patient's overall risk is immediately judged to be unmanageable, resulting in an immediate reduction in community privileges.
   - Enhancement of pro-social and protective factors (such as positive

supportive relationships) can reduce the risk level and may lead to changes in the risk management plan.

2. Management strategies identified in risk assessment should include specific recommendations about direct follow-up (e.g., frequency of face-to-face visits by forensic community staff, drug screening) and recommendations about how, if possible, the intensity of supervision and treatment can be reduced over time (and through success in services) to move towards full community reintegration.

3. The use of a Patient Journal (e.g., see attached) to document fluctuations in risk factors is recommended as a useful way to encourage self-monitoring and assist in communication with key support people (e.g., forensic community staff).

Manage Your Risk (MYR)
Daily Journal

Name: _____   **Date:** _____

Risk Factors: **Highest Level   Reached Today (1-10)**

1.	
2.	
3.	
4.	
5.	
6.	
7.	

Green Interventions used today (circle all that apply)
- ❑ talking with friends
- ❑ practiced deep breathing
- ❑ exercise
- ❑ monitored symptoms
- ❑ adequate nutrition
- ❑ planning ahead: _____
- ❑ spiritual activities
- ❑ practiced mental imagery
- ❑ hobby or can-do project
- ❑ sleep _____hrs
- ❑ work / groups / routine: _____
- ❑ self-reward, pat on the back
- ❑ entertainment / humour: _____
- ❑ other activities: _____

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Appendix E9 - D
Rehabilitation/Discharge Management Guidelines

Individuals who have been found unfit to stand trial or who have been found not criminally responsible and who are being treated under the provincial forensic services mandate will have a client-centred, assessment, treatment and rehabilitation plan. Assessment, treatment and rehabilitation will take place in the least restrictive environment, will due consideration to the safety of the public, the direction of the CCRB and PSR principles.

The assessment process is initiated as soon as the recommendation for "not criminally responsible" or "unfit" is made. For all inpatients, an intake meeting is set up within one week of the recommendation to brief the clinical team and to make preliminary assessment plans.

Each discipline meets with the client to develop client directed goals. These goals form the basis of the treatment plan.

The treatment plan is based on client-centered goals, the principles of psychosocial rehabilitation and is balanced with the mandate of security. The treatment plan is developed in partnership with the client.

In cases where the client is unfit to stand trial, primary focus will include resolution of the fitness issue along with rehabilitation and treatment.

Interventions are to be provided in the least restrictive environment considering client need, risk management and current best practices.

A written treatment plan is provided to the client and placed on the medical record within 4 weeks of the legal finding of "not criminally responsible" or "unfit".

The treatment plan is reviewed and updated by the team and the client every 8 weeks.

Successful community reintegration is the goal of the treatment plan. Reintegration is based on the ability of the treatment team, community and client to manage risk.

The movement of the client from the inpatient unit to community living is based on recommendations of the treating team to the Nova Scotia Criminal Code Review Board (CCRB). The CCRB will render a disposition based on those recommendation and perceived risk.

The assessment and treatment process continues until an absolute discharge is granted to the client from the CCRB. When an absolute discharge is granted the

forensic service will advise the involved community supports of absolute discharge status and ensure a smooth transition to mental health services if appropriate and advocate for other supports as required.

SERVICE DELIVERY MODELS
FOR
PROVINCIAL SPECIALITY SERVICES

Provincial Early Psychosis Services Model   Children, Youth and Adults

Provincial   **District/Shared District**   **Local**

Network

Provincial
•Provide clinical consultation.

•Develop & provide professional education / training.

•Develop & support psycho-education resources for individuals / families.

• Collaborate in development & implementation of prevention and public education initiatives.

•Promote & carry out research.

•Collaborate in provincial program evaluation.

•Collaborate with DHAs/ IWK to develop & carry out program evaluation

• Coordinate & facilitate communication within a formal Early Psychosis Network of designated staff fromDHAs/IWK

District/Shared District
•Designate one or more mental health staff as liaison with the provincial Early Psychosis program and network.

•Participate in professional education/training.

•Provide intake, assessment and treatment.

•Provide individual / family education with support of resources developed by the provincial program.

• Identify, promote development of, and access to, local resources to support individuals and families.

• Collaborate in program evaluation activities.

•Facilitate referrals for participation in research.

•Collaborate in development & implementation of prevention and public education initiatives.

•Develop appropriate partnerships with local resources.

Local
•Participate in education / training as appropriate.

•Collaborate in development & implementation of prevention and public education initiatives.

•Collaborate with DHAs/ IWK to identify and promote development of local resources to support individuals & families.

•Collaborate in program evaluation.

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Approved: Steering
October 16, 2003

Seniors Mental Health Services Model- Nova Scotia

Provincial   District/Shared District   Local

Network

Provide consultation, team conferencing, **education** and support to districts/shared districts

Inpatient:
Specialty assessment& treatment

Facilitate service development through knowledge and research finding transfer

Collaborate in development & implementation of promotion, prevention, early intervention and public education initiatives

Designate experts in seniors mental health

Provide consultation/ collaboration/ liaise / interface with:
 adult mental health/ geriatric medicine, support agencies/ Continuing Care Sector, Shared Care, Primary Care and Home Care

Outpatient & Home Based Outreach:
•   triage
•   Specialized   treatment/assessment
•   follow -up

Inpatient:
• general medical
• mental health treatment
• access to consultation seniors mental
  health / geriatric treatment

Participate in professional education / training

Participate in research and program evaluation

Collaborate in development & implementation of promotion, prevention, early intervention and public education initiatives

Partner for:
• prevention and public
  education strategies
• family / care giver support
• health promotion and early
  intervention

Primary Care (GPs etc.)
/Shared Care

Continuing Care, Home Care

Approved:
 Provincial Steering Committee
Jan 15, 2004

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Service Model: Neurodevelopmental Disorders for Children and Youth

(includes: Autistic Spectrum Disorders)

Provincial   District/Shared District   Local

Network

Provincial:

Provides:
- consultation
- team conferencing
- education
- support to district and shared services
- training / credentialing for IBI
- inpatient/residential assessment & treatment
- outpatient & tertiary consultation

Specialized services:
- Neuropsychology,
- Genetics
- Research

District/Shared District:

- Specialized services
  - Pediatricians
  - Psychiatry
  - Behavioural Psychology
  - OT
  - SL
  - Physio

- Home & Community based triage, assessment and intervention

- Diagnostic Centres – IBI

- Community capacity assessment

- Advocacy

- Follow -up

Local:

- Prevention and public education strategies

- Family support activities

- Primary Care

- Non Mental Health System Service providers

- Coordination with existing services e.g. EIIS

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Provincial Neurodevelopmental Disorder Services Model for Adults
Dual Disorders - Developmental Disability and Mental Illness

Provincial　　**District/Shared District**　　　**Local**

Network

•Provide specialized consultation,
to the District /
Shared District level

•Provide specialized inpatient care

• Enhance interdisciplinary expertise
across disciplines including
psychiatry, psychology, medicine
OT SW Nsg. Rec, Speech

• Education, support for developing clinical expertise within the province

• Coordination of Network Development for the implementation of best practice

•Provide access to Mental Health Services.
•Clinicians identified at the District / Shared District level with interest/ expertise in dual disorder.
•Multidisciplinary representation
•Support collaborative approach to service delivery across Health and Community Services.
• Provide home / community based outreach consultation, assessment,& treatment.
• Access to acute inpatient treatment (general medicine/ psychiatric beds)
•Support, Education to family, care

•Health promotion, prevention, and public education

• Informed family, care givers and health care providers

• Early intervention at the primary care level

• Family and care giver support

• Support collaboration between Health and Community Services

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