External Review

Child and Adolescent Mental Health and Addiction Services in the Halifax Regional Municipality

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NOVA SCOTIA

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Child and Adolescent Mental Health and Addiction Services in the Halifax Regional Municipality (External Review)
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Introduction

On June 14, 2013 the Government of Nova Scotia received an external review of the Halifax Regional School Board's support of Rehtaeh Parsons. Recommendations from this review were accepted by the Minister Responsible for the Advisory Council on the Status of Women, including commissioning an expert independent review of the mental health and addiction (MHA) programs and services of the IWK Health Centre (IWK) and the Capital District Health Authority (CDHA).

An independent review was subsequently undertaken by the authors, with the agreement of the appropriate departments, to focus on the continuum of mental health services available to children and youth within the IWK and CDHA, and on the flow of children and youth into, through, and out of these services.

Five key questions, outlined in the Terms of Reference provided by the Department of Health and Wellness, provided a focus for the review. To summarize, the intent of the review was to examine current IWK and CDHA treatments and counseling services and policies, procedures, and guidelines as they relate to accepted/national best practices for the needs of youth in areas of assessment, triage, referral, treatment, and follow-up care. Policies, procedures, and guidelines were considered in a context of best practices regarding follow-up for youth assessed at risk of self-harm or suicide at a level not requiring hospitalization. In addition, the educational and support needs of families/care providers were examined. Finally, IWK and CDHA policies were examined for evidence of collaboration in providing mental health and substance-use services to youth.

A multi-method approach was utilized, including a review of relevant strategic documents, policies, and procedures, and interviews with IWK and CDHA clinical and administrative managers, directors, chiefs, and vice presidents responsible for program, service, and policy decisions in the mental health and addictions program. The review also included an environmental scan of relevant literature, including national or best practices for treatment and counseling services for youth who have experienced bullying, cyberbullying, or sexual assault. A summary of current research on youth concurrent disorders and trauma-informed care was also provided.

The review highlighted critical facilitators and challenges for the IWK and CDHA and provided fourteen recommendations. The recommendations addressed the following themes:

- Trauma Treatment and Trauma-Informed Care
- Ensuring Continuity of Care
- Youth and Family Engagement
- Human Capital

Recommendations

Trauma Treatment and Trauma-Informed Care

1. Fully implement trauma-informed care (TIC) across the IWK MHA program and in the CDHA Mobile Crisis Response Team. The immediate priority for TIC at the IWK is the Acute Psychiatric Inpatient Unit (4S), as this is the service that provides the highest level of care within the IWK MHA programs.

2. Establish clear pathways into care for the treatment of trauma across the IWK MHA program. Capacity can be facilitated by integrating and building upon existing pockets of excellence in trauma treatment (SeaStar, Avalon, IWK MHA experts). Existing expertise in trauma-focused CBT can be leveraged to increase community-based treatment. Fully explore implementation of early parenting interventions, such as PCIT, alongside the existing Incredible Years program with a view to the prevention of family based trauma.

3. Introduce mental health screening to facilitate early identification of mental health and addiction issues for children and youth diverted from the courts to programs such as restorative justice. Ensure timely prevention and early intervention for youth by examining and reallocating mental health and addiction treatment resources across the continuum of care.

Ensuring Continuity of Care

4. Despite the significant efforts undertaken so far, the impact of silos on the delivery of MHA care and on the implementation of changes associated with recent reviews remains a frustration for many of those we interviewed. A possible approach for facilitating meaningful cross-jurisdictional collaboration is patient and family journey mapping, a process utilizing exemplar cases as a method for identifying and reducing systemic barriers and integrating service delivery. This should be undertaken in collaboration with youth, families, and personnel from across the system of care – in Education, Health, Community Services, and Justice.

5. Integrate all health care for children and youth up to age 19 at the IWK. For youth who have experienced physical and/or sexual assault or abuse and the associated mental health sequelae, the current divide creates serious barriers to care, including discontinuity of care and unnecessary delays in receiving timely and appropriate treatment.

6. Fully implement SchoolsPlus across Nova Scotia and integrate SchoolsPlus, Youth Health Centres, guidance counselors, and mental health clinicians, using a "Wellness Hub" model in schools. Problems associated with providing services during times of school closure need to be addressed creatively to ensure continuity of care. This could be accomplished through partnerships with community health services.

7. Consolidate existing mental health clinician resources that are currently available in limited degrees across service areas, such as in shared care in the community (e.g., 0.2 FTE distributed across programs), to maximize access and improve system efficiency. Further increase the number of mental health clinicians available in schools beyond the current estimated allocation of one per 10 schools*, to prevent excessive caseloads and facilitate ease of access to MHA care. **This is approximate based on current commitments to increase the number of mental health clinicians available to work in schools by ~40.*

8. Establish a formalized method for standardized communication of suicide risk. The Nova Scotia tool for suicide risk assessment (quantitative) assists in a determination of risk. However, a standardized risk assessment documentation tool is recommended (e.g., ASARI, www.asari.ca). Clearly identified communication pathways to appropriate care providers within the system, for the dissemination of documented risk, together with recommendations for managing that risk for non-hospitalized patients, are necessary.

9. Prioritize the development of the provincial electronic medical record (clinical information system, or CIS) to allow for continuity of care for children and youth with mental health and addictions problems across the continuum of care. A Healthcare Information and Management Systems Society (HIMSS), level 6-7 CIS, would allow programs to undertake analytics and evaluation in a systematic way.

With appropriate consent, the Tynet database used in Education can allow for communication across schools for children and youth previously connected to MHA services either in or outside the school and will significantly improve continuity of service provision when children and youth change schools.

10. Expand usage of the multisectoral single consent form ("Joint Consent Form") currently utilized by some services to facilitate communication across jurisdictions, including Health, Education, Community Services, and Justice.

Youth and Family Engagement

11. Establish a formalized process to build sustainable youth and family engagement into the program/protocol/policy development and evaluation framework across the IWK MHA programs.

12. The Choice and Partnership Approach (CAPA) approach provides an opportunity for the collaborative development of care plans for children, youth, and families involved in IWK MHA programs, in particular outpatient services. Translation of this approach into the development of collaborative care plans for children and youth admitted to acute psychiatric inpatient services is recommended. Formalized supports and education for families of children and adolescents admitted to the acute psychiatric inpatient unit are also recommended.

13. Introduce youth and family member "Systems Navigators" into the MHA system of care to further enhance child, youth, and family support. Several jurisdictions in Canada are piloting this approach and can be used as resources (e.g., in British Columbia, the FORCE Society for Child and Youth Mental Health has created two new roles, the Parent-in-Residence and Youth-in-Residence positions).

Human Capital

14. Reconsider the recommendation of the Nova Scotia physician resource plan to reduce the number of psychiatrists for children and adolescents in Nova Scotia. A reduction in the number of psychiatrists will adversely affect access to child and adolescent MHA care throughout Nova Scotia and will overwhelm the IWK MHA program's ability to deliver MHA services either directly or by telehealth and videoconferencing. Development of a clinical services plan is a necessary companion to the physician resource plan generally, as well as specifically as it relates to child and adolescent mental health.

In Summary

Tremendous efforts have been undertaken to improve access and quality of MHA care for children, youth, and families in Nova Scotia. The passion, commitment, and energy to undertake progressive, evidence informed improvement is apparent in those working across the system of care. Moreover, a strong philosophy of continuous improvement exists, and the necessary mechanisms are in place at the highest levels of government to facilitate ongoing integration and the implementation of sustainable changes across sectors involved in the delivery of MHA care in the province of Nova Scotia.

Introduction

On June 14, 2013 the Government of Nova Scotia received an external review of the Halifax Regional School Board's support of Rehtaeh Parsons. Recommendations from this review were accepted by the Minister Responsible for the Advisory Council on the Status of Women, including commissioning an expert independent review of the mental health and addiction programs and services of the IWK Health Centre (IWK) and the Capital District Health Authority (CDHA).

It was determined that an independent review would be undertaken with a focus on IWK and CDHA policies, procedures, and guidelines with respect to assessment, triage, referral, treatment, and follow-up care for inpatient and community based programs related to mental health and addiction services available to youth. A specific focus of the review included the care available to youth who experience difficulties with addictions, peer relationships, bullying, cyberbullying, sexuality, and sexual assault. Following discussion with the appropriate departments, the scope of the review was expanded to include the continuum of mental health services available to children and youth within the IWK and CDHA and the flow of children and youth into, through, and out of these services.

Five key questions were determined to provide the scope for the review, as follows:

1. Are current treatment and counseling services for victims of bullying, cyberbullying, or sexual assault and resulting issues, in relation to the subject of this review, in keeping with accepted/national or best practices to meet the needs of youth?

2. Are existing IWK policies, procedures, and guidelines in relation to the subject of this review in keeping with accepted national or best practices with respect to assessment, triage, referral, treatment, and follow-up care?

3. Are current IWK policies, procedures, and guidelines in relation to the subject of this review in keeping with accepted national or best practices regarding follow-up in cases where youth are assessed to be at risk of self-harm or suicide, when this risk is not at a level that requires hospitalization?

4. What policies, procedures, and guidelines in relation to the subject of this review are in place to educate and support families and care providers and to ensure their concerns are given appropriate consideration during the triage, assessment, and treatment phases of children and youth engaged with mental health services at the IWK?

5. Do current IWK and CDHA policies in relation to the subject of this review promote effective collaboration between the IWK, the CDHA, and other agencies involved in providing mental health and addiction services to youth?

Methodology

A multi-method approach was utilized to inform this work, including a review of relevant strategic documents, policies, and procedures and interviews with IWK and CDHA clinical and administrative managers, directors, chiefs, and vice presidents responsible for program, service, and policy decisions in the mental health and addictions program.

To help inform the review, an environmental scan was conducted to identify accepted national or best practices for treatment and counseling services for youth who have experienced bullying, cyberbullying, or sexual assault.

The environmental scan included a review of journals accessed through a range of databases, including CINAHL, PubMed, Medline, PsychInfo, PsychTests, and PsychArticles. In addition, a manual search for relevant reports, websites and articles from grey literature was conducted, including PrevNet and the Canadian Best Practices Portal. A search of relevant databases was undertaken using the search terms "bullying," "cyberbullying," "sexual assault," "youth," "adolescent,*" "evidence-based practice,*" "evidence-based intervention,*" "evidence-based therapy,*" "best practice,*" "counseling," "treatment," "clinical treatment,*" "medical treatment,*" "psychological treatment,*" and "guideline.*" The search was limited to articles from Canada, United States, Australia, United Kingdom, and the Netherlands. Abstracts from 2004 to 2013 were reviewed to determine if sources met inclusion and exclusion criteria.

A targeted review of research into concurrent disorders in youth was also completed, and a comprehensive trauma-informed care literature review was carried out for this project.

Summary of the Literature Review

Bullying and Cyberbullying

Most of the literature regarding bullying or cyberbullying and youth focuses on supporting coordinated efforts to develop strategies for the prevention of bullying. Within this literature, interventions for bullying typically focus on school or community-based programs or initiatives. Research and assessment tools for measuring the range of bullying experiences (perpetration, victimization, bully-victim experiences, etc.) also exist, but these tools are mainly for helping researchers, prevention specialists, and health educators make informed decisions when selecting measures for their work (see http://www.cbc.gov/violenceprevention/pdf/bullycompendium-a.pdf).

Limited literature exists on best practices for individual counseling or treatment interventions for youth who have experienced bullying or cyberbullying. However, the importance of addressing the negative emotional, mental, physical, and academic consequences of victimized youth was frequently noted in the literature review. The important role primary care providers can play in screening for victimization during wellness visits or other appointments with youth is emphasized in the literature. Supporting victimized youth, making appropriate referrals, and working in a coordinated approach with families, schools, and communities are key functions primary care providers can offer.

Regarding the literature on treatment and counseling for youth who have experienced sexual assault, the most commonly evaluated therapy supported by evidence is Trauma-Focused Cognitive Behavioural Therapy (TF–CBT). While there is more extensive literature available on guidelines and best practices regarding the efficacy of TF–CBT for children and adolescents who have been sexually abused, the more limited literature on the treatment of adolescents who have experienced sexual assault also supports the use of TF–CBT. The importance of routine screening by health professionals for violence victimization among adolescents was also frequently noted in the literature.

Youth Concurrent Disorders

Concurrent disorders are highly prevalent in adolescent populations (Hawkins, 2009). These youth are at high risk for violence exposure and initiation of drug use (Suarez, et al., 2011), and research has demonstrated an association between concurrent substance use and trauma exposure. An integrated, holistic approach to treatment is critical, with a focus on effective interventions addressing both mental health and substance-use issues to prevent the very serious risks for medical and legal problems, incarceration, suicide, school difficulties and drop out, unemployment, and poor interpersonal relationships (Hawkins, 2009). Shared vision, a strong foundation, capable clinicians, ongoing financial support, and capable leaders are key components of an integrated approach to treatment (Winston et al., 2012). Partnerships are emphasized to ensure establishment of strategic relationships with appropriate youth-serving organizations in order to overcome barriers to care (Winston, 2012). The integration of substance-use treatment and adolescent health care is encouraged, with a focus on screening, brief intervention, and referral to treatment in emergency departments and primary care facilities, as well as in school and college based health centres. School health centres are considered accessible settings for addressing the complex needs of adolescents (Sterling, 2012).

Trauma-Informed Practice

The Mental Health and Substance Use (MHSU) sector is increasingly aware of the need for a continuum of services that includes both specialized and non-specialized MHSU services and involves multidisciplinary and multisectoral approaches, to better respond to the acuity and chronicity of issues experienced by individuals seeking help. Trauma-informed practice builds on this by recognizing the need to respond to the individual's intersecting experiences of trauma, mental health, and substance use. Trauma-informed practice acknowledges that this is achieved not only in specialized services that specifically treat trauma, but also in practical ways at all levels of care across multiple settings. For children and youth, developmentally appropriate options need to be considered in collaboration with families and caregivers.

Trauma-informed services consider an understanding of trauma in all aspects of service delivery and place priority on the individual's safety, choice, and control. These services engender a culture of nonviolence, learning, and collaboration. Services are provided in a way that recognizes the need for physical and emotional safety, as well as choice and control in decisions affecting treatment. Trauma-informed practice is more about the overall essence of the approach, or way of being in the relationship, rather than a specific treatment strategy or method.

In trauma-informed services, safety and empowerment for the patient and family are a priority, and are embedded in policies, practices and staff approaches to care. Service providers cultivate safety in every interaction and avoid confrontational approaches. A key aspect of trauma-informed care is to create an environment in which patients do not experience further traumatization or re-traumatization and can make decisions about their treatment needs at a pace that feels safe to them.

Trauma-informed practice has been implemented in several child and adolescent mental health programs in Canada, including the Ontario Shores Centre for Mental Health Sciences and the St. Boniface Hospital in Winnipeg, Manitoba. The Mental Health and Substance Use Programs at the Children and Women's Health Centre of British Columbia have recently undertaken a process of implementing trauma-informed care. As part of this work, an extensive trauma-informed literature review was completed and is available by request from BC Mental Health and Addiction Services. In addition, the Ministry of Health in British Columbia recently published its Trauma-Informed Care Guide as part of a review of seclusion and restraint standards and guidelines in the province. The guidelines recommended are available upon request.

Program and Policy Review

In-person interviews were held in Halifax, Nova Scotia on September 12, 13, 26, and 27. Telehealth and teleconference options were made available for those who were unavailable on those dates. A total of 34 individuals were interviewed, including Deputy Ministers, clinical and administrative managers, directors, chiefs, and vice presidents responsible for program, service, and policy decisions in departments and in mental health and addictions programs related to the Terms of Reference for the review. The parents of Rehtaeh Parsons were also interviewed. We would like to acknowledge the openness and transparency of all those who were interviewed as part of this process. In addition to making themselves available for the face-to-face interviews, participants' willingness to provide additional information and reports was greatly appreciated.

Interviews with senior department representatives and IWK leadership provided invaluable insight into the considerable efforts dedicated to facilitating change in relation to the concerns that led to this review. In particular, the collaborative, cross-department Better Healthcare Committee will ensure ongoing implementation of recommendations related to the Rehteah Parsons case.

IWK Policies, Procedures, and Quality Assurance in the MHA Programs

A review of IWK quality assurance policies and procedures indicated that appropriate mechanisms are in place for reporting adverse patient-related events and that a rigorous process exists for reviewing these events. The IWK utilizes the AEMS incident management system for reporting adverse patient related events. There are eight mental health and addiction Morbidity and Mortality (MOM) committees undertaking critical event reviews for serious patient-related adverse events, including death by suicide. Recommendations that arise from these MOM reviews are reported to the Mental Health and Addictions Leadership Team (MHALT) and the senior MOM Committee, and are tracked on a quarterly basis by senior leadership to ensure that implementation of the recommendations occurs.

The leadership team is interested in establishing the participation of family representatives on MOM committees; however, legislative changes are required to facilitate this.

An inventory of IWK documents, including policies and procedures considered in the review, can be found in Appendix 1. We were impressed with the commitment of IWK leadership to ensuring the completeness and appropriateness of mental health and addiction policies and procedures with respect to national standards and best practices. Where improvements in policies and procedures are recommended, they are addressed in this review.

The MHA Continuum of Care for Children and Adolescents in the Halifax Regional Municipality (HRM)

Notably, the components of a potentially seamless continuum of mental health and addictions care currently exists for children, youth, and families in the HRM (Figure 1). At present, however, these components are not fully integrated, creating the potential for gaps in service. At the systems level significant efforts have been made to improve integration and access to MHA care within the HRM.

Child and adolescent mental health and addiction services in the HRM are provided primarily by the IWK Health Centre, in partnership with the Capital District Health Authority (CDHA), Education, and Justice. Community NGOs also provide components of care.

The IWK Health Centre is responsible for the provision of secondary (Halifax), tertiary (Nova Scotia) and quaternary (Maritime Provinces) child and adolescent mental health and addiction services, including emergency psychiatry, acute psychiatric inpatient treatment, psychiatric day treatment, residential treatment, concurrent disorders and addiction treatment, community mental health outpatient services, and forensic psychiatric services. Over 4,500 children and youth per year receive assessment and/or treatment from the mental health and addiction programs provided by the IWK.

In 2011, IWK Child and Youth MHA leadership undertook a substantial stakeholder engagement process to develop the current strategic plan (2011–2016). This process included focus groups with youth and families. The primary goals of the strategic plan are ambitious and will result in significant program improvements, once the plan is fully implemented.

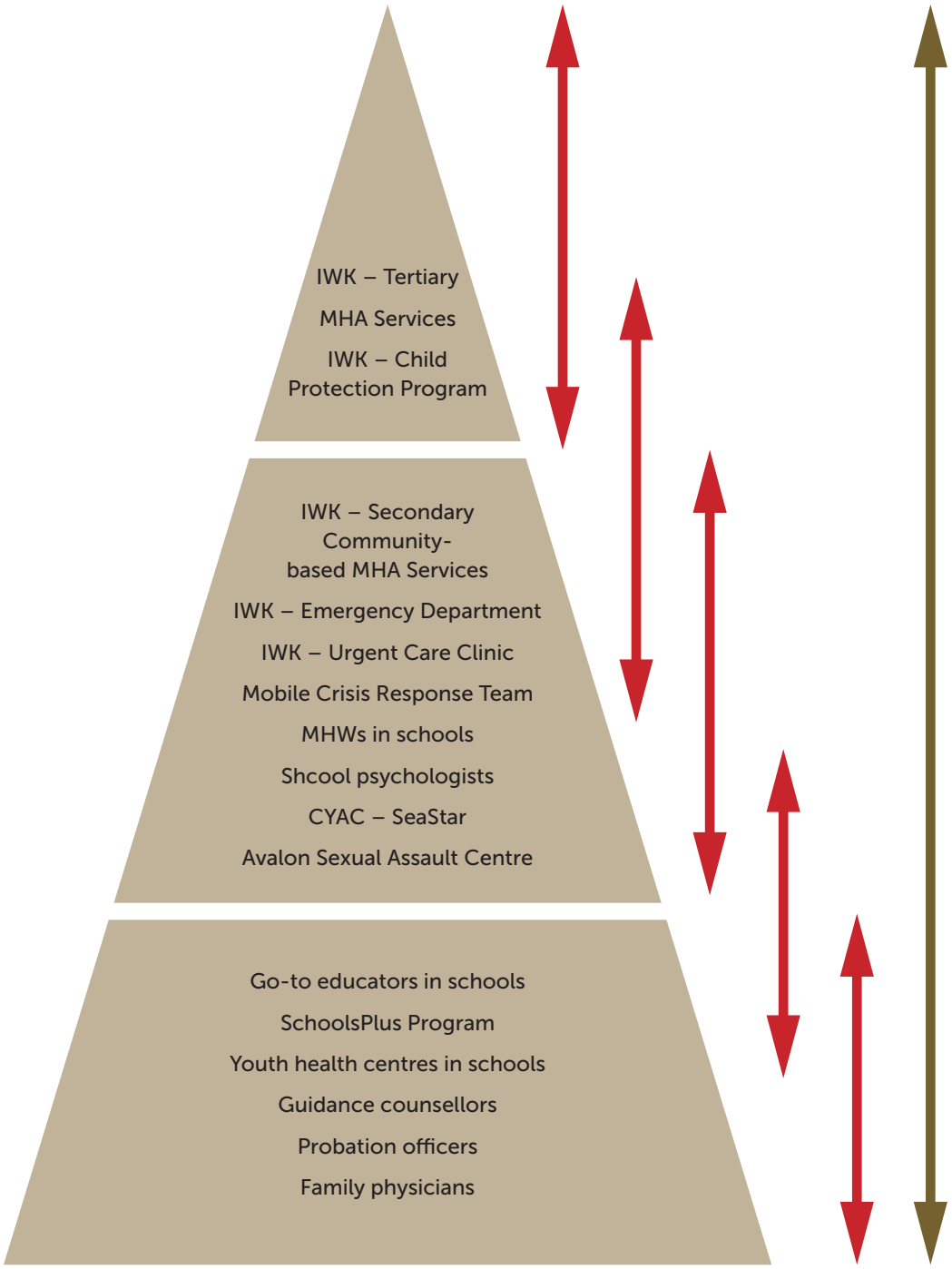

Figure 1
Continuum of Child and Adolescent MHA Services in the HRM

The strategic plan required a comprehensive clinical review of MHA services, which was completed in 2012. This review, together with recommendations from previous critical event reviews and the application of Program Based Marginal Analysis (PBMA), resulted in a significant redesign of clinical services with a goal of improving not only the quality of care but also the efficiency with which it is delivered. As a result, ambulatory services were integrated, residential and day treatment programs pertaining to children (12 years and younger) were amalgamated, and the residential and day treatment programs and the addictions program for youth will be restructured and amalgamated by January, 2014. These changes allow for the reallocation of critical resources to increase the capacity of community based mental health programs while enhancing service delivery.

A feature of the redesign was the introduction of the Choice and Partnership Approach (CAPA) model, a methodology based on LEAN principles and Q theory (capa.co.uk). The CAPA model provides an opportunity for collaborative service planning with children, youth, and families. During the "Choice" appointment, the service plan is developed and families are provided with access to customized options for care and appropriate resources. This is followed by the "Partnership" appointment when indicated, and specific treatment is initiated. The CAPA model is designed to improve engagement and better involve children, youth, and families in treatment planning. This works well in outpatient settings; however, similar opportunities for collaborative service planning are necessary for youth admitted to acute psychiatric inpatient care, and for their families.

Introduction of CAPA has already resulted in significant improvement in wait times from a baseline of thirteen to twenty-four months (depending on the program) to three months for a "Choice" appointment and a further three months for a "Partnership" appointment. The ultimate goal is to reduce wait times to four weeks for a "Choice" appointment and two to three weeks for a "Partnership" appointment. MHA leaders assert that new resources are not required to attain these targets. However, all vacant staff positions within the IWK MHA programs must be filled in order to achieve this goal.

Another element of the redesign was the streamlining of internal program referrals to eliminate unnecessary reassessment and address delays in the transition of care between program areas.

The wait time for initiation and completion of MHA assessment in the Emergency Department was identified as an ongoing concern; steps have already been taken to address this issue. Efforts have been made to reduce the length of the MHA assessment from eight to four hours. The establishment of an Urgent Care Clinic will

ensure timely access to follow-up care for children and youth presenting emergently at the IWK who are not admitted but require timely access to follow-up in the context of a crisis.

The delivery of evidence-based care to meet the needs of children, youth, and families referred to the IWK MHA were deemed priorities of the redesign. Four core psychotherapeutic treatment modalities were identified: Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Family-Based Therapy (FBT/Maudsley), and Family Therapy. Clinical expertise exists within the program for the delivery of various forms of CBT, and funding was obtained to increase capacity for the delivery of DBT. Eating Disorder Team members have been trained in the Maudsley approach.

Implementation of the strategic plan is closely monitored, with clear progress reporting and accountabilities. Resources have been allocated to support this work. Unfortunately, quality assurance evaluation of these significant changes is impeded by the lack of a comprehensive clinical information system. Health Information Technology Services intends to introduce a provincial clinical information system. The expected date of implementation is unknown, and so at present any quality assurance or evaluation work requires manual data gathering and analysis.
The IWK MHA clinical program review is robust. The only criticism of this review is the lack of engagement of youth and families and other service providers both inside and outside of the IWK. Opportunities exist, however, to promote this engagement in the future.

A Mobile Crisis Response Team (MCRT) that provides crisis intervention services for children, youth and adults operates in the Capital District Health Authority. The MCRT is comprised of a police officer from the Halifax Regional Police Department (HRP) and a Mental Health Worker. Memorandums of Understanding (MOUs) between police departments (HRP and RCMP), CDHA, IWK, and the Department of Health Services facilitate the operation of this team. The MCRT provides 24/7 crisis-line telephone coverage for the province and twelve hours of mobile crisis-response coverage in the CDHA (1300–0100 h), 7 days per week. Both the 911 and 811 emergency lines in Nova Scotia have "hot patches" directly to the Crisis Line.

Police officers who become members of the MCRT undergo significant training in mental health through a tiered training process. All police officers undergo 3.5 days of core training in mental health, followed by three additional days of online training; this is followed by continuing professional development. Officers directly involved with the MCRT undergo an additional forty hours of training in the "Memphis" Crisis Intervention Training (CIT) model and participate in ride-alongs with the team prior

to joining the MCRT. The "Memphis" CIT is a police-based first responder program focused on pre-arrest jail diversion for those in a mental health crisis.

Statistics indicate that 20 to 25 % of MCRT contacts are with children, youth, and families. MCRT routinely completes a standardized clinical assessment in the field. Children and youth requiring emergency psychiatric evaluation are taken by the MCRT to the IWK Emergency Department, where another assessment is completed by the MHA Crisis Team. The rework in the form of reassessment was noted as a source of frustration by a number of interviewees. For those seen by members of the MCRT who do not visit the IWK Emergency Room, a contact form is completed and forwarded by the MCRT to the IWK MHA. Trigger points for sending the contact form following crisis-line intervention are inconsistent, although forms are sent when matters of clinical significance are identified. Transparent criteria for initiating the contact form for crisis-line calls do not exist. To ensure safety during transitions in care, the IWK MHA acute inpatient unit encourages patients and families to utilize MCRT services as part of their discharge plan, and discharge summaries and protocols guiding crisis intervention are shared in advance.

The integration and provision of physical and mental health care for adolescents up to the age of 19 at the IWK was noted by several interviewees as a significant need. At present, physical health care for youths 17 years of age and older is managed by CDHA at the Queen Elizabeth II Hospital, while mental health is managed at IWK for youth up to age 19. For youth experiencing concurrent physical and mental health problems, this creates barriers and ultimately leads to discontinuity of care, including delays in receiving appropriate and timely treatment. This issue is of particular importance for youth who have experienced acute physical or sexual trauma, a focus of this review.

To ensure continuity of mental health and substance-use care and create a bridge to appropriate and timely services following emergency psychiatric assessment, a new urgent care clinic will begin offering services in the fall of 2013. The urgent care clinic is intended to provide follow-up care for children and youth seen emergently at the IWK.

For children and youth admitted emergently to the acute psychiatric inpatient unit, a transition worker provides short-term follow-up care after discharge, including outreach as needed. As per provincial mental health standards, community mental health provides follow-up appointments for priority patients within two weeks of discharge from hospital. From time to time, the acute inpatient psychiatrist and social worker provide post-discharge bridging care until this appointment. The clinical redesign has also led to the establishment of a new school liaison position, and it

is anticipated that this role will assist with the transition of care from hospital to community. The school liaison will also serve as a link to the SchoolsPlus program.

Standardized approaches to the communication of suicide risk are critical and can facilitate improved safety and continuity of care across services involved with high-risk children and youth. The Nova Scotia Tool for Suicide Risk Assessment (IWK MHA Program) could be enhanced through the development of an additional tool for the documentation and communication of the identified suicide risk. ASARI, the Assessment of Suicide and Risk Inventory (www.asari.ca), is an example of such a tool.

Trauma Treatment

A specific focus of this review was the treatment of sequelae of various forms of trauma, including bullying, cyberbullying, and sexual assault and relational violence. Clinical expertise in the evidence-based treatment of trauma exists at various levels within the IWK. Following the clinical redesign, the "trauma treatment team" was distributed across the community mental health teams, with a goal of increasing capacity for the delivery of this specialized treatment. To provide adequate trauma treatment, further capacity building is required, as only a limited number of staff have expertise in trauma-focused CBT, a well-supported, evidence-based treatment for trauma. At present, referrals for the treatment of trauma within the IWK are ad hoc, as there is no visible pathway to this treatment for those who need it.

Within the IWK, the CYAC SeaStar program, under the umbrella of the Child Protection Team, is a provincial demonstration project for children and youth who have been physically and/or sexually assaulted or abused. The program is based on the "Children's Advocacy Centre" and is meant to function as a "one stop" for anyone with concerns about abuse or neglect. A full-time masters-level social worker from the Child Protection Team provides trauma-informed CBT for children and youth who have symptoms of either current or historical trauma (abuse or neglect); current clinical demands indicate the need for an additional therapist in the program. Opportunities exist for improving linkages between the SeaStar program and the trauma treatment experts within the IWK MHA programs to support increased capacity. Importantly, the patient flow sheet for the SeaStar program requires that MHA Services be alerted regarding a child or youth who presents with acute or historical trauma.

The Avalon Sexual Assault Centre provides two clinical services: the sexual assault nurse examiner program, staffed by 12 to 14 nurses with 24/7 coverage to four health-

care facilities in the HRM, including the IWK; and a counseling program for women 16 years of age and older who have experienced relational trauma. The counseling program provides treatment for trauma in a phased approach that includes individual therapy and options for subsequent group interventions.

Opportunities exist to develop a strong network of services for the evidence-based treatment of trauma. The essential components exist, but improved integration is essential and visible pathways into care are required. Pockets of excellence that exist within the IWK MHA, SeaStar, and the Avalon Women's Centre are notable.

As noted in Goal 5 of the IWK Strategic Plan (Health Promotion and Prevention), expansion of capacity to provide parenting interventions in the early years is a focus. Development of expertise in interventions, such as "Parent Child Interaction Therapy" for early coercive parenting, would further enhance the continuum of trauma treatment at the IWK and complement existing early intervention parenting programs, such as the Incredible Years. Increased collaboration between MHA Services and the Department of Community Services (DCS) is also required to better support children and youth who have experienced trauma. Formalized pathways into trauma care are necessary to facilitate this linkage.

Youth Concurrent Disorders and Addiction Treatment

The continuum of services available for youth with concurrent disorders or addictions is well established. Youth Health Centres located in schools provide health promotion and alcohol and drug-use awareness to students, and the IWK MHA provides a substantial set of services, including outpatient, day treatment and residential care for youth. It is important to note that a very high percentage of youth with concurrent disorders have experienced some form of trauma and are at high risk for negative outcomes. Improved early identification of trauma and clear, formalized pathways into evidence-based treatments are absolute necessities for this population. Trauma is a common experience in the lives of children and youth who present with mental health and addictions concerns. The care provided for children, youth, and families must take this into consideration. Philosophically, trauma-informed services consider an understanding of trauma in all aspects of service delivery, and place priority on the individual and family's safety, choice, and control. Efforts to incorporate trauma-informed practice have been undertaken, particularly in the child and youth residential and the youth concurrent disorder/addiction programs at IWK MHA. Expansion of trauma-informed practices across all MHA programs is required. A particular emphasis should be placed on priorizing implementation of trauma-informed practice on the acute psychiatry inpatient unit (4S).

Physician Resource Plan

The proposed reduction in the number of child and adolescent psychiatrists in the province of Nova Scotia as part of the Physician Resource Plan is of grave concern. It is unclear how the psychiatric needs of children and adolescents outside the HRM will be met without ongoing recruitment of psychiatrists to provide care in outlying communities. At present, expansion of telehealth services at the IWK to meet the secondary MHA treatment needs of children and youth outside the HRM will overwhelm the current capacity of the IWK to deliver these services. Moreover, the Physician Resource Plan has not been accompanied by a parallel clinical services plan. For this reason, although the Physician Resource Plan necessitates increasing responsibility on the part of primary care to deliver services currently provided by specialists, the mechanisms by which this will occur is not clear.

Education

A number of exciting initiatives are underway to provide increased school-based MHA services, including entry points to clinical care for students within the education system in Nova Scotia.

Recently, a number of educators and staff within the Nova Scotia school system received "Go-To" training to assist in identifying adolescents at risk of developing mental health problems. The premise of Go-To training is that students will naturally gravitate towards certain staff and teachers for help at school. Additional pathways to care are provided by equipping staff and teachers with the necessary skills to recognize youth at risk. Once a youth is identified, Go-To educators will link the youth to appropriate supports, provide ongoing assistance, and liaise with the parents. Go-To training has yet to be delivered to school personnel in all school districts across the province. Full implementation is necessary and should be supported.

SchoolsPlus is an innovative interagency collaborative led by the Department of Education with a mandate to promote and facilitate the delivery of supports and services in schools by Community Services, Justice, and Mental Health and Addiction Services. Regional advisory committees, including community stakeholders, assist in identifying gaps in service delivery, opportunities for collaboration, and barriers that impede disenfranchised students from returning to school. In communities outside Halifax, each SchoolsPlus Facilitator and Community Outreach Worker works with a family of schools that includes elementary schools, middle/junior high schools, and a high school. In Halifax, the SchoolsPlus Program has been implemented in elementary and junior high schools only. SchoolsPlus has not been introduced to high schools because of the availability of Youth Health Centres in Halifax. Community Outreach Workers facilitate the delivery of after-school programs that meet community-identified needs and work directly with individuals and families. Each outreach worker carries a caseload of between 20 and 30 children and youth. SchoolsPlus is not present in every school in Nova Scotia; a commitment has been made to continue adding four to five "families" of schools per year.

The SchoolsPlus Program provides an additional and much needed entry point into mental health and addiction services for children, youth and families. Recently, Mental Health Clinicians were placed in some schools. The stated commitment to increase the complement of Mental Health Clinicians in schools is positive. However, the stated commitment is equivalent to approximately one Mental Health Clinician for every ten schools in Nova Scotia, and it is anticipated that clinician caseloads will quickly become overwhelming. To ensure the effectiveness and sustainability of this initiative, a greater resource commitment is necessary.

Youth Heath Centres (YHCs) are located in all high schools in Halifax but have not been fully implemented across the province of Nova Scotia. Administratively, they are under the jurisdiction of District Health Authorities. Youth Health Centres provide information on general health, sexual health, and drugs and alcohol to students. Although Youth Health Centre Managers participate as members of SchoolsPlus Advisory Committees, there have been no formal attempts to better integrate these programs either administratively or at the program level. A unique opportunity exists in Nova Scotia to develop school "wellness hubs," centres of activity or focal points in school communities featuring integrated Youth Health and SchoolsPlus services in close collaboration with guidance counselors and mental health clinicians. Go-To trained staff could also play a key role in this hub concept. Examples of co-location already exist in the province and could serve as a basis for integration. Implementation of a hub model would eliminate the potential for gaps in identification and early intervention and could reduce the stigma associated with seeking help concerning mental health and addictions in school environments.

Youth Justice

Prevalence rates of mental disorders among incarcerated youth are high. A recent study of juvenile offenders in the US highlighted that five years after baseline, more than 45% of males and nearly 30% of females had one or more psychiatric disorders, with associated impairment (Teplin et al, 2012). This population of youth within the HRM require access to services within the continuum of mental health and addiction services discussed in this review.

In 2006, as a result of the Nunn Inquiry, the Halifax Youth Attendance Centre was created. The program model necessitated collaboration between Justice, Education, Health, and Community Services. The program was targeted at ultra-high risk youth. Early evaluation of the program indicated that a low number of youth were served, and changes were implemented to increase service delivery further upstream. As a result, dedicated youth probation officer positions were established in the community. Youth forensic psychiatric services were expanded in 2012 with the opening of six youth psychiatric forensic beds at the Waterville facility. The goal of this expansion was to better meet the unique mental health needs of this population. There is potential capacity available within existing mental health resources at the Waterville facility that could be utilized to better meet the needs of the general youth forensic population as well, not just those youth who are deemed Not Criminally Responsible due to a Mental Disorder (NCRMD). Additional exploration in this area is recommended.

Youth who have experienced trauma and find themselves in the justice system are frequently identified in presentencing reports. These individuals do not have easy access to evidence-based trauma treatment. Within the HRM, the ratio of clients to youth probation officers is good, and opportunities exist for strong engagement and support. Probation officers working with these youth receive some mental health and addictions training through a train-the-trainer approach, but such training could be strengthened. Comprehensive training is essential for youth probation officers to assist in identifying their clients' mental health and addictions issues and in making referrals to appropriate and timely care.

For youth diverted into programs such as restorative justice, invaluable opportunities for early identification and intervention for mental health and addictions concerns are missed, since screening this group for such concerns does not occur. As a result, the best MHA services available remain significantly downstream for the youth forensic population and are expensive to deliver. At present, limited resources are available to support prevention and early identification in this population of youth.

Key Findings

Facilitators

- Provincial leadership through the Better Healthcare Council
- Strong leadership at the IWK MHA program level
- Protected resources for MHA and public health in Nova Scotia
- An IWK MHA strategic plan, including dedicated resources
- An IWK MHA clinical services redesign
- Examples of excellence in clinical care
- Some expertise in trauma-informed care
- IWK Partners in Care Providing a Youth and Family Lens
- Volunteer partners-in-care committees within two IWK MHA programs
- Innovative school-based mental health programs
- Establishment of the IWK School Liaison Position
- Development of a joint-consent form (SchoolsPlus, SeaStar)

Challenges

- Recruitment of clinical staff and physicians
- The recommendation of the Physician Resource Plan to reduce the number of child and adolescent psychiatrists in Nova Scotia
- Delays in the development and implementation of a provincial clinical information system for the health sector
- Limits to provision of physical health care at the IWK for youths 17 to 19 years old
- Perceived silos in service delivery, reviews, and implementation of changes

Recommendations

Trauma Treatment and Trauma-Informed Care

1. Fully implement trauma-informed care (TIC) across the IWK MHA program and in the CDHA Mobile Crisis Response Team. The immediate priority for TIC at the IWK is the Acute Psychiatric Inpatient Unit (4S), as this is the service that provides the highest level of care within the IWK MHA programs.

2. Establish clear pathways into care for the treatment of trauma across the IWK MHA program. Capacity can be facilitated by integrating and building upon existing pockets of excellence in trauma treatment (SeaStar, Avalon, IWK MHA experts). Existing expertise in trauma-focused CBT can be leveraged to increase community based treatment. Fully explore implementation of early parenting interventions such as PCIT, alongside the existing Incredible Years program with a view to the prevention of family based trauma.

3. Introduce mental health screening to facilitate early identification of mental health and addiction issues for children and youth diverted from the courts to programs such as restorative justice. Ensure timely prevention and early intervention for youth by examining and reallocating mental health and addiction treatment resources across the continuum of care.

Ensuring Continuity of Care

4. Despite the significant efforts undertaken so far, the impact of silos on the delivery of MHA care and on the implementation of changes associated with recent reviews remains a frustration for many of those we interviewed. A possible approach for facilitating meaningful cross-jurisdictional collaboration is patient and family journey mapping, a process utilizing exemplar cases as a method for identifying and reducing systemic barriers and integrating service delivery. This should be undertaken in collaboration with youth, families, and personnel from across the system of care – Education, Health, Community Services, and Justice.

5. Integrate all health care for children and youth up to age 19 at the IWK. For youth who have experienced physical and/or sexual assault or abuse and the associated mental health sequelae, the current divide creates serious barriers to care, including discontinuity of care and unnecessary delays in receiving timely and appropriate treatment.

6. Fully implement SchoolsPlus across Nova Scotia and integrate SchoolsPlus, Youth Health Centres, guidance counselors, and mental health clinicians, using a "Wellness Hub" model in schools. Problems associated with providing services during times of school closure need to be addressed creatively to ensure continuity of care, and provision could be accomplished through partnerships with community health services.

7. Consolidate existing mental health clinician resources that are currently available in limited degrees across service areas, such as shared care in the community (e.g. 0.2 fte distributed across programs) to maximize access and improve system efficiency. Further increase the number of mental health clinicians available in schools beyond the current allocation of one per 10 schools, to prevent excessive caseloads and facilitate ease of access to MHA care.

8. Establish a formalized method for standardized communication of suicide risk. The Nova Scotia tool for suicide risk assessment (quantitative) assists in a determination of risk. However, a standardized risk assessment documentation tool is recommended (e.g., ASARI, www.asari.ca). Clearly identified communication pathways are required for appropriate care providers within the system, for the dissemination of documented risk, together with recommendations for managing risk for non-hospitalized patients.

9. Prioritize the development of the provincial electronic medical record (clinical information system; or CIS) to allow for continuity of care for children and youth with mental health and addictions problems across the continuum of care. A Healthcare Information and Management Systems Society (HIMSS), level 6-7 CIS, would allow programs to undertake analytics and evaluation in a systematic way.

   With appropriate consent, the Tynet database used in Education can allow for communication across schools for children and youth previously connected to MHA services either in or outside the school and will significantly improve continuity of service provision when children and youth change schools.

10. Expand usage of the multisectoral single consent form ("Joint Consent Form") currently utilized by some services to facilitate communication across jurisdictions, including Health, Education, Community Services, and Justice.

Youth and Family Engagement

11. Establish a formalized process to build sustainable youth and family engagement into the program/protocol/policy development and evaluation framework across the IWK MHA programs.

12. The CAPA approach provides an opportunity for the collaborative development of care plans for children, youth, and families involved in IWK MHA programs, in particular outpatient services. Translation of this approach into the development of collaborative care plans for children and youth admitted to acute psychiatric inpatient services is recommended. Formalized supports and education for families of children and adolescents admitted to the acute psychiatric inpatient unit are also recommended.

13. Introduce youth and family member "Systems Navigators" into the MHA system of care to further enhance child, youth, and family support. Several jurisdictions in Canada are piloting this approach and can be used as resources (e.g., in British Columbia, the FORCE Society for Child and Youth Mental Health has created two new roles, the Parent-in-Residence and Youth-in-Residence positions).

Human Capital

14. Reconsider the recommendation of the Nova Scotia physician resource plan to reduce the number of psychiatrists for children and adolescents in Nova Scotia. A reduction in the number of psychiatrists will adversely affect access to child and adolescent MHA care throughout Nova Scotia and will overwhelm the IWK MHA program's ability to deliver MHA services either directly or by telehealth and videoconferencing. Development of a clinical services plan is a necessary companion to the physician resource plan generally, as well as specifically as it relates to child and adolescent mental health.

Conclusion

Tremendous efforts have been undertaken to improve access and quality of MHA care for children, youth, and families in Nova Scotia. The passion, commitment, and energy to undertake progressive, evidence informed improvement is apparent in those working across the system of care. Moreover, a strong philosophy of continuous improvement exists, and the necessary mechanisms are in place at the highest levels of government to facilitate ongoing integration and the implementation of sustainable changes across sectors involved in the delivery of MHA care in the province of Nova Scotia.

Appendix 1

Documents Reviewed

Nova Scotia Government

Bill 203, Involuntary Psychiatric Treatment Act, 2005.

Building Bridges: Improving Care in Custody for People Living with Mental Illness. Update, December, 2012.

Changing the Culture of Alcohol Use in Nova Scotia. An Alcohol Strategy to Prevent and Reduce the Burden of Alcohol-Related Harm in Nova Scotia. 2007.

Changing the Culture of Alcohol Use in Nova Scotia. Responding to the Nova Scotia Alcohol Strategy: Provincial Initiatives led by the Department of Health Promotion and Protection.

Come Together. Report and Recommendations of the Mental Health and Addictions Strategy Advisory Committee, March, 2012.

Government of Nova Scotia Physician Resource Plan

Involuntary Psychiatric Treatment Regulations made under Section 83 of the Involuntary Psychiatric Treatment Act, 2007.

Involuntary Psychiatric Treatment Act – Fact Sheet.

Involuntary Psychiatric Treatment Act – Fact Sheet for Law Enforcement.

Nova Scotia Standards for Mental Health Services. July, 2009.

Report of the Fatality Enquiry into the Death of Howard Hyde. 2010.

Report of the Nunn Commission of Inquiry. Spiralling out of Control: Lessons Learned from a Boy in Trouble. December, 2006.

Terms of Reference: Nova Scotia Department of Health and Wellness, the IWK Health Centre, and Capital District Health Authority. Independent Review of Policies and Practices that Impact Youth Living with Mental Health and Addictions Issues Who May Have Been Victimized by Bullying, Cyber-Bullying, or Sexual Assault. 25 June, 2013.

Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians. Government of Nova Scotia, Department of Health and Wellness, 2012.

IWK

Admission Criteria, Adolescent Day Treatment Program.

Adverse Events Process – Care Team Level, June, 2013.

Adverse Event and Good Catch (Near Miss) Reporting Policy, IWK Health Centre, March, 2012.

Child and Youth Advocacy Centre Demonstration Program. Six-Month Report. June, 2013.

Child and Youth Advocacy Centre Demonstration Program. Reference Guide. December, 2012.

Developing a Child and Youth Advocacy Centre in Nova Scotia, April, 2013.

Disclosure of Adverse Events Policy, IWK Health Centre, April, 2008.

IWK Health Centre Consultations, June, 2012.

IWK–MHA Strategic Plan Progress Report, April, 2013.

IWK Mental Health and Addictions Clinical Services Review. A way forward: Using resources wisely through integration of services. Emberly, Debbie. March, 2012.

IWK Adverse Event and Good Catch (Near Miss) Reporting, March, 2012.

IWK Health Centre Child Protection Team Therapy Guidelines and Information

IWK Emergency Department Tools, July, 2013.

IWK Health Centre Risk and Safety Plan, November, 2012.

IWK Health Centre, Project Charter, Integration of Children's Services.

IWK Health Centre, Project Charter, Integration of Adolescent Services.

Memorandum of Understanding, IWK/CDHA Staff in home support services for children and youth in the Windsor East-Hants area, 2013–2016.

Memorandum of Understanding, IWK/CDHA, Mental Health Mobile Crisis Team, May, 2011.

Nova Scotia Tool for Suicide Risk Assessment, Mental Health and Addictions Program, IWK/CDHA, 07/12.

Quality Review: MOM Process at the IWK. Comeau, Karen. June, 2013.

Quality Review: MOM Process at the IWK. Karen Comeau Improvement Consultant PPT, June 10, 2013.

Suicide Risk Assessment, Monitoring and Management, IWK Health Centre, February, 2013.

Suicide Risk Assessment and Monitoring Policy, Suicide Task Force, Spring, 2012 PPT.

Terms of Reference, Mental Health Community Morbidity, Occurrence and Mortality Subcommittee, November, 2010.

Transition of Youth to Adult Mental Health and Addiction Services, IWK to CDHA, February 2011.

Trauma Intervention Program, Parent's Workbook. Steele, William, 2009.

Triage Assessment, Mental Health, and Addictions Emergency, November, 2007.

Understanding Our Teams, IWK Health Centre, Adolescent Day Treatment.

Capital District Health Authority

Capital District Health Authority 2010 Accreditation Results

Department of Education

Child and Youth Strategy. Evaluation of the SchoolsPlus Model. Year 3 Evaluation. Final Report, September 24, 2012.

Examples of SchoolsPlus Initiatives: Halifax Regional School Board, Digby SchoolsPlus, Amherst SchoolsPlus.

External Review of the Halifax Regional School Board's Support of Rehtaeh Parsons. Final Report. Debra Peplar and Penny Milton, June 14, 2013.

External Review of the Halifax Regional School Board's Support of Rehtaeh Parsons, Interim Report. Debra Peplar and Penny Milton, May 10, 2013.

SchoolsPlus Individual Gap Analysis Sheets

SchoolsPlus Newsletter, September, 2013.

Summary of Public Feedback to the Review of Halifax Regional School Board's Support of Rehtaeh Parsons. Nova Scotia Department of Education and Early Childhood Development. June 8, 2013.

External

Assessing Emotional Neglect in Infants, Centres of Exccellence for Children's Well Being, Wotherspoon, E. and Gough, P. (2008).

Canadian Centre for Child Protection (2013). Response and Recommendations to the External Review of Halifax Regional School Board's Support of Rehtaeh Parsons.

Champagne, T., & Stromberg, N. (2004). Sensory Approaches in Inpatient Psychiatric Settings. Innovative Alternatives to Seclusion and Restraint, *Journal of Psychosocial Nursing*, Vol 42 (9), 35–44.

Crosscurrents, The Journal of Addiction and Mental Health, Spring 2009, Volume 12 #3.

Dr. Lori Haskell, Essentials of Trauma-Informed Practice, September, 2013 (workshop outline)

Emotional Trauma in Infancy, Centres of Excellence for Children's Well Being, Wotherspoon, E., and Gough, P. 2009.

Facing the Challenge of Care for Child and Youth Mental Health in Canada: A Critical Commentary, Five Suggestions and a Call to Action, Kutcher, S. *Healthcare Quarterly*, 14, April, 2011.

Focus on Complex Trauma – Workshop information, October, 2013.

Restraint Minimization Taskforce. Final Report, May 30, 2008. Centre for Addiction and Mental Health.

Strengthening the Safety Net. A Summary on the Suicide Prevention, Intervention and Postvention Initiative for BC.Suicide PIP Initiative. October, 2009.

Trauma-Informed Practice Guide, BC Provincial Mental Health and Substance Use Planning Council, 2013.

When Mental Health and Substance Abuse Problems Collide: Understanding, Preventing, Identifying and Addressing Mental Health Disorders and Substance Abuse Issues in Youth. Canadian Centre on Substance Abuse, 2013.

Appendix 2

Interviews

Mr. Kevin McNamara, Deputy Minister of Health and Wellness
Ms. Lynn Hartwell, Deputy Minister, Community Services
Ms. Carole Olsen, Deputy Minister, Education and Early Development
Ms. Marilyn More, Minister, Public Service Commission
Dr. Shannon MacPhee, IWK Emergency
Ms. Barbara Stonehouse, IWK Emergency Director
Ms. Barbara Bergeron, IWK Emergency Manager
Dr. Ruth Carter, IWK Mental Health and Addictions
Dr. Kathy Pajer, Chief, IWK Department of Psychiatry
Mr. Andy Cox, IWK Mental Health Advocate
Ms. Kristi Kempton, Manager, Acute Psychiatry Inpatient Unit, IWk
Dr. Gerald Gray, Medical Director, Acute Psychiatry Inpatient Unit, IWK
Dr. Alexa Bagnall, Associate Chief, IWK Department of Psychiatry
Ms. Barbara Casey, IWK Mental Health Strategic Plan Implementation Team
Ms. Patricia Murray, Lead CYMH, Department of Health and Wellness
Ms. Anne Cogdon, SchoolsPlus Advisory Committee
Ms. Judy Elliott, SchoolsPlus Liaison
Ms. Mary Pyche, Lead, Mobile Crisis Unit, Capital Health District
Dr. Amy Ornstein, Pediatrician, CYAC SeaStar/Child Protection
Ms. Karen Carter, Manager, Pediatric Ambulatory Care/Child Protection
Mr. Glen Canning, Parent
Ms. Leah Parsons, Parent
Ms. Irene Smith, Executive Director, Avalon Sexual Assault Centre
Ms. Glenda Hayden, Lead Counsellor, Avalon Sexual Assault Centre
Ms. Tara Moore, SchoolsPlus Lead
Ms. Anne McGuire, President and CEO, IWK
Ms. Jocelyn Vine, Vice-President, Patient Care, IWK
Dr. Vicki Wolfe, Psychologist, IWK Mental Health and Addictions
Mr. Doug Leck, Senior Parole Officer, Youth PO Team Metro
Ms. Maureen Brennan, Manager, Choices
Dr. Stan Kutcher, SunLife Financial Chair in Adolescent Mental Health, Dalhousie University
Dr. Sabina Abidi, Physician Leader, Community Mental Health
Ms. Darlene Boliver, Director of Quality and Patient Safety, IWK
Ms. Karen Comeau, Improvement Consultant, IWK

Appendix 3

Environmental Scan – Relevant Literature

The articles or papers below form the list of the most relevant literature identified for the focus of this environmental scan. They have been organized under the following topic headings:

- Cyberbullying
- Bullying – Role of the Primary Care Provider
- Bullying – Treatment Considerations
- Hospital-Based Anti-Bullying Program
- Sexual Assault – Treatment Considerations
- Sexual Assault – Role of the Primary Care Provider
- Youth Concurrent Disorders
- Trauma-Informed Care

1. Cyberbullying

Campbell, M. A. (2007). Cyberbullying and young people: Treatment principles not simplistic advice. In www.scientist-practitioner.com, paper of the week of 23rd February 2007. QUT Digital Repository, http://eprints.qut.edu.au/14903/1/14903.pdf

According to the Marilyn A. Campbell, there is no evidenced-based treatment for cyberbullying. Despite the lack of evidence-based treatments, Campbell outlines within this article four principles that psychologists can apply when working with young persons who have been cyber bullied.

- Principle 1: Ask the young person how they would like to be helped. It is important to individualize the solution.
- Principle 2: Continuously reinforce that it isn't their fault and that they don't need to change.
- Principle 3: Carefully ascertain whether bullying is the main problem, if the bullying has brought on a psychological problem, or whether a pre-existing psychological disorder has been exacerbated.
- Principle 4: Provide the client with positive peer relations and social cohesion, when peers and friends can support them.

The article also emphasizes the importance of working with parents to develop good relationships between parents and children, as well as working with the young person's community (school, police, and technological/internet service providers) to help address the issue.

2. Bullying – Role of the Primary Care Provider

Carr-Gregg, M., & Manocha, R. (2011). Bullying: effects, prevalence and strategies for detection. *Australian Family Physician*, 40 (3), 98–102. http://www.racgp.org.au/download/documents/AFP/2011/March/201103carrgregg.pdf

Carr-Gregg and Manocha discuss how assessment for bullying should be incorporated into standard psychosocial screening during primary care visits with adolescents. They note that general practitioners play an important role in identifying at-risk patients, screening for psychiatric comorbidities, counselling families, and advocating for bullying prevention within their communities. Common clinical indicators for bullying are included.

Lamb, J., Pepler, D. J., & Craig, W. (2009). Approach to bullying and victimization. *Canadian Family Physician*, 55 (4), 356–60. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669002/pdf/0550356.pdf

Lamb et al. discuss the role primary care providers can play in identifying children and youth involved in bullying and in providing them the support they need. The peer-reviewed paper presents an outline of symptoms of bullying, a tool for assessing bullying involvement, and an overview of intervention and management strategies. In the absence of clinical practice guidelines, the paper puts forward a potential strategy for screening and management of bullying within the primary care setting. While noting that the management of bullying requires a multidisciplinary effort, involving parents, educators, primary care physicians, and mental health specialists, the article outlines several roles physicians can play to support a child or youth who bullies or who is being bullied, including recognizing symptoms, providing referrals to treatment as appropriate, and advocating on behalf of children to school officials or other community agencies.

Lyznicki, M. S., McCaffree, M., & Robinowitz, C. B. (2004). Childhood bullying: Implications for physicians. *American Family Physician*, 70 (9), 1723–28. Retrieved from http://www.aafp.org/afp/2004/1101/p1723.html

This article outlines the role physicians can play in identifying at-risk patients, counselling families, screening for psychiatric comorbidities, and advocating for bullying prevention in their communities.

PrevNet (Promoting Relationships & Eliminating Violence Network) http://www.prevnet.ca/sites/prevnet.ca/files/Family_Doctors_and_Primary_Care-Bullying_Tip_Sheet.pdf

PrevNet has created a two-page information sheet on bullying for primary care providers. The information sheet includes information on bullying, suggestions as to what primary care providers can do about it, questions to ask patients if primary care providers suspect bullying, and a list of indicators that children who bully or are bullied might exhibit.

3. Bullying – Treatment Considerations

Herba, C. M., Ferdinand, R. F., Stijnen, T., Veenstra, R., Oldehinkel, A. J., Ormel, J., & Verhulst, F. C. (2008). Victimization and suicide ideation in the TRAILS study: specific vulnerabilities of victims. *Journal of Psychology and Psychiatry*, 49 (8), 867–76.

Using data from a population-based cohort study of children and adolescents in the Netherlands, Herba et al. examined whether parental psychopathology and feelings of rejection (at home and at school) exacerbate vulnerability to suicide ideation in victims of bullying. Results of the study found that victims of bullying (but not bully-victims) with parents with internalizing disorders reported elevated levels of suicide ideation compared to children who had not been victimized by bullying. Victims who felt rejected at home also reported more suicide ideation. The authors conclude that the findings from this study strongly suggest that health-care professionals should consider the influence of family factors, such as parental psychopathology and home environment, when examining the consequences of bullying among children and youth.

4. Hospital-Based Anti-Bullying Program

Boston Children's Hospital: http://childrenshospital.org/az/Site2912/mainpageS2912P0.html

Boston Children's Hospital uses a multidisciplinary approach to support children and families affected by bullying. The Hospital has established the BACPAC (Bullying and Cyberbullying Prevention and Advocacy Collaborative), a multidisciplinary anti-bullying collaborative, the first hospital-based program of its kind in the United States. According to the Boston Children's Hospital website, the BACPAC "serves as a source of expert information on bullying for schools, families and other health-care providers; operates a clinic that performs comprehensive evaluations of children with neurodevelopmental disorders (like ADHD, Tourette's disorder, intellectual disabilities, Asperger's syndrome and autism) who are affected by bullying, either as victims or perpetrators; provides customized guidance and recommendations to meet the needs of the individual child; [and] works in partnership with each child's family, school and primary care provider to resolve the issue." Boston Children's Hospital is currently working on several research projects related to bullying prevention and intervention. Most notably they are working with the Massachusetts Aggression Reduction Center to pilot a questionnaire that will ensure primary care providers ask their patients appropriate questions to identify bullying.

5. Sexual Assault – Treatment Considerations

Allnock, D. & Hynes, P. (2011).Therapeutic services for sexually abused children and young people: Scoping the Evidence Base. Summary report. National Society for the Prevention of Cruelty to Children. http://www.nspcc.org.uk/inform/resourcesforprofessionals/sexualabuse/therapeutic-services-evidence-pdf_wdf88612.pdf

Aiming to identify what types of therapy are effective, Allnock and Hynes's report provides a review of existing research on therapeutic services for children and youth who have been sexually abused. The paper determines that the most commonly-evaluated therapy to date is cognitive behavioural therapy (CBT), and there is a growing body of evidence that has documented its positive effects. While the authors noted that current evidence supports CBT, they suggested that this might be because CBT is easier to study in trials than other types of therapy.

The authors note that while there is a lack of literature about the effectiveness of different types of therapy, there does seem to be a range of factors described within the literature that may be relevant to outcomes, regardless of the type of therapy used. The key factors include

- the therapeutic alliance between client and therapist
- the role of a 'safe carer' parent or caregiver
- specialized practitioner training and supervision
- inter- or multi-agency collaboration, involving schools, teachers, and social workers
- treatment manuals

The report concludes with recommendations for components of a therapeutic intervention guide for sexually abused children and youth. The guide would be based on the evidence reviewed (p. 40).

Behnken, M. P., Le, Y. L., Temple, J. R., & Berenson, A. B. (2010). Forced sexual intercourse, suicidality, and binge drinking among adolescent girls. *Addictive Behaviors*, 35 (5), 507–09.

Behnken et al. discuss results of a study which examined whether binge drinking mediates the relationship between forced sexual intercourse and suicidality among a sample of adolescent females in the United States. Generally, the study found that engaging in binge drinking could help to explain why some adolescent victims of sexual assault become suicidal, while others without a history of binge drinking do not. Despite some of the limitations noted in the article, the study's findings suggest

that suicide prevention and intervention programs may benefit from addressing the drinking behaviours of adolescent female victims of sexual assault.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43 (4), 393–402.

This study by Cohen et al. in 2004 examines the difference in efficacy of trauma-focused cognitive-behavioral therapy (TF–CBT) and child-centred therapy (CCT) for treating PTSD and related emotional and behavioral problems in children who have suffered sexual abuse. The results of the study indicate that children assigned to TF–CBT, compared to those assigned to child-centred therapy, demonstrated significantly more improvement with regard to PTSD, depression, behaviour problems, shame, and abuse-related attributions. The study supports the evidence around the effectiveness of TF–CBT with children suffering PTSD and related difficulties as a result of sexual abuse. The authors note that the TF–CBT approach evaluated within the study also appears to be superior to CCT in reducing abuse-related attributions and shame.

Danielson, C. K., McCart, M. R., Walsh, K., de Arellano, M. A., White, D., & Resnick, H. S. (2012). Reducing substance use risk and mental health problems among sexually assaulted adolescents: A pilot randomized controlled trial. *Journal of Family Psychology*, 26 (4), 628–35.

Danielson et al. report results from a pilot randomized controlled trial evaluating the feasibility and efficacy of Risk Reduction through Family Therapy (RRFT) for reducing substance use risk and trauma-related mental health problems among sexually assaulted adolescents. Trauma-focused psychotherapies have been developed and rigorously evaluated for victims of childhood sexual assault (e.g., Trauma-Focused Cognitive Behavioral Therapy, or TF–CBT), yielding significant reductions in PTSD and other symptoms among youth. However, the authors note that existing models do not typically target some of the other clinical problems commonly experienced by this population, namely substance use and risky sexual behavior.

The current study compared RRFT to the 'treatment as usual' approach to determine whether RRFT can be efficacious in reducing risk for substance use problems, PTSD, and other related outcomes. The study found that adolescents who received RRFT reported reduced substance use and improvements in substance use risk factors (e.g., increased family cohesion). While participants in both RRFT and the treatment-as-usual therapy experienced reductions in PTSD and depression symptoms, greater

reductions were found for adolescents in RRFT with regard to parent-reported PTSD, as well as adolescent-reported depression and internalized symptoms.

The primary limitation to this study was that baseline differences existed between the RRFT and the treatment-as-usual groups across most variables (despite rigorous randomization procedures), so the authors note that caution should be made when interpreting differences between the two groups. In conclusion, the authors note that "if further support is found for its efficacy, RRFT could improve clinical practice by offering families a more efficient alternative to the current compartmentalized approach to treatment of this population, as well as a risk-reduction option for youth at elevated risk for developing substance abuse and related mental health problems in the future, but who are not currently meeting diagnostic thresholds" (p. 634).

Kaufman, M., & the Committee on Adolescence. (2008). Care of the adolescent sexual assault victim. *Pediatrics*, 122 (2), 462–70.

This 2008 report by the American Academy of Pediatrics provides evidenced-based information for physicians on assessment and care of sexual assault victims in the adolescent population. While many other reports focus on treatment of children who have experienced chronic sexual abuse, this report addresses acute sexual assault in the adolescent age group. The article includes information on substances and sexual assault, adolescent perceptions, attitudes, and reactions to sexual assault, investigation related information, and acute and follow-up care. Effective screening, referral, and follow-up allow for support of the adolescent victim and appropriate delivery of health-care services.

Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center. http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf

The Child Physical and Sexual Abuse: Guidelines for Treatment report was developed in 2003 (revised in 2004) to encourage the use of mental health treatment protocols and procedures that have a sound theoretical basis, a good clinical-anecdotal literature, high acceptance among practitioners in the child abuse field, a low chance for causing harm, and empirical support for their utility in treating victims of abuse. The Guidelines provide criteria for judging the quality of mental health treatments, a base of information describing available treatments, and a set of general guidelines for treatment based upon the best scientific literature.

Within the individual focused interventions, Trauma-Focused Cognitive Behavioral Therapy achieved the highest classification rating, with the highest level of empirical support (p.49). An overview of Trauma-Focused Cognitive Behavioral Therapy can be found here: http://academicdepartments.musc.edu/projectbest/tfcbt/tfcbt.htm

6. Sexual Assault – Role of Primary Care Providers

The following two articles emphasize the importance of routinely screening for violence victimization among adolescents:

Bonomi, A. E., & Kelleher, K. (2007). Dating violence, sexual assault, and suicide attempts among minority adolescents: ending the silence. *Archives of Pediatrics & Adolescent Medicine*, 161 (6), 609–10.

Olshen, E., McVeigh, K. H., Wunsch-Hitzig, R. A., & Vaughn, I. R. (2007). Dating violence, sexual assault, and suicide attempts among urban teenagers. *Archives of Pediatrics & Adolescent Medicine*, 161 (6), 539–45.

7. Youth Concurrent Disorders

Hawkins, E.H. (2009). A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology*, 60, 197–227.

This research article discusses the serious challenges presented by co-occurring disorders to traditional mental health and substance use treatment systems. Among adolescents who require assistance, co-occurring disorders are highly prevalent and difficult to treat. Without effective intervention, these youth are at increased risk of serious medical and legal problems, incarceration, suicide, school difficulties and drop out, unemployment, and poor interpersonal relationships. Current service systems are generally inadequately prepared to meet this need due to a variety of clinical, administrative, financial, and policy barriers. The article provides an overview of co-occurring disorders among adolescents and discusses general considerations for treatment, reviews selected treatment models and outcomes, and discusses recommendations and best practice strategies. To summarize, co-occurring disorders are highly prevalent and occur in all adolescent service settings. There is wide variability on the subtypes, severity, and treatment needs of adolescents with co-

occurring disorders. A comprehensive integrated service system is the most promising method for effectively treating this population, and systemic changes are required to adequately provide services for these youth.

Koegl, C. J., & Rush, B. R. (2012). Need and use of services by persons with co-occurring substance use and mental disorders within a community mental health system. *Mental Health and Substance Use*, 5 (1), 4–19.

Persons with co-occurring mental and substance use disorders are known to have high needs. This research article compared persons with and without co-occurring disorders regarding their current and recommended levels of care and their need for specific supports within a provincial community mental health system. Without exception, persons with co-occurring disorders and in particular those with more severe substance use problems demonstrated significantly more need and had greater unmet need across a range of service categories. Findings of this study highlight the critical necessity for integrated care to address the needs of this vulnerable population.

Sterling, S., Valkanoff, T., Hinman, A., & Weisner, C. (2012). Integrating substance use treatment into adolescent health care. *Current Psychiatry Report*, 14 (5), 453–61. Published online October, 2012. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638945/

Substance use problems are common among adolescents, and as the authors discuss in this article, they are a serious risk factor and a major public health problem that is not adequately addressed in pediatric settings. The literature on the integration of substance use treatment and adolescent health care is reviewed with a focus on two areas: Screening, Brief Intervention, and Referral to treatment in Emergency Department and Primary Care; and School- and College-Based Health Centres. The authors conclude that primary care offers an excellent environment for substance use assessment and treatment for adolescents and their families, offering better access and a less stigmatizing environment for receiving treatment than in speciality programs. School health centres are discussed as a place where the complex behaviour health needs of adolescents can be met in an accessible setting. These population-based health services provide an approach to breaking down the barriers faced in traditional medical settings, such as those surrounding confidentiality, funding, culture, and stigma. The authors suggest that school-based health centres are uniquely positioned to integrate public health interventions and environmental strategies, and their proximity to adolescents enables effective follow-up and case management, creating multiple opportunities for brief interventions and preventative care. Key components of effective school-based interventions are discussed.

Suarez, L. M., Belcher, H., Briggs, E. C., & Titus, J. C. (2011). Supporting the need for an integrated system of care for youth with co-occurring traumatic stress and substance abuse problems. Society for community Research and Action. Published online 12 August, 2011. http://link.springer.com/article/10.1007/s10464-011-9464-8#page-1

This research article discusses the high risk for violence exposure and initiation of drug use among adolescents, as well as the association between co-occurring substance use and trauma exposure. Adolescents with this profile are at increased risk of mental health disorders, school underachievement, and involvement with multiple systems of care. The critical importance of coordination and integration of systems of care for these youth is emphasized, and the negative sequelae and increased service utilization patterns of adolescents with a history of trauma, substance abuse, and co-occurring trauma and substance use are examined to support the need for integrated services for youth. The authors recommend an integrated system of care that includes trauma-informed mental health treatment and substance abuse services aimed at reducing the morbidity and relapse probability of this high-risk group.

Winston, S., Winther, T., & Smith, C. (2012). Building integrated treatment for dually diagnosed youth. *Behavioural Healthcare*, 32 (6), 12-15. http://www.behavioral.net/article/building-integrated-treatment-dually-diagnosed-youth

This article references the 2002 SAMHSA report, noting that children with serious emotional disturbances are at greater risk for substance use, while youth who experience major depressive episodes are twice as likely to use alcohol as youth who do not. Integrated treatment for co-occurring disorders is advocated as more effective, because both problems are treated at the same time, in an inclusive and holistic manner. This requires clinicians who are dually credentialed or working in an environment where clinical and assessment information is shared freely among all treatment team members, who work jointly to develop consultation and care plans. Key components of an integrated approach are described, including shared vision, strong foundation, capable clinicians, ongoing financial support, and capable leaders. The importance of partnerships is also emphasized to ensure the development of strategic relationships with appropriate youth-serving organizations, with an ultimate goal of overcoming barriers to care.

8. Trauma-Informed Care

As indicated in the body of the review, two key documents are recommended. First, the British Columbia Trauma-Informed Care Guide (2013) is an excellent resource, providing a framework for the translation of trauma-informed principles into practice. The guide includes concrete strategies to facilitate the professional work of practitioners assisting clients with mental health and substance use concerns, and is based on findings from current literature, lessons learned from implementation in other jurisdictions, and ideas offered by practitioners who participated in focus groups and interviews across the province of British Columbia.

Secondly, a comprehensive trauma-informed care literature review was undertaken by BC Mental Health and Addiction Services in 2013. It is available upon request.