NOVA SCOTIA

Standards for Mental Health Services in Nova Scotia

Revised and Approved March 22, 2004

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

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I. Introduction

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

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

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

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

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

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

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

II Generic Mental Health Standards

1. Standards

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

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

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

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

2. Access

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

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

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

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

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

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

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

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

2.9 services are sensitive to accommodating individuals with special needs

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

3.0 Service Delivery:

3.1 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 accompished 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 assessment

- professional staff identified as providing mental health services within a speciality 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.

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

Context & Issues:

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

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

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

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

Core Program Description:

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

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

Goal Statement:

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

The risk factors associated with mental illness are reduced.

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

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

Core Program: Outpatient and Outreach Services: (B)

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

Early Identification/Intervention Services:

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

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

Assessment and Treatment Services:

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

Intensive Community Based Acute Treatment Services:

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

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

The standards that follow focus only on Assessment/Treatment Services.

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

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

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

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

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

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

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

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

Goal Statement: Residents of each district have access to a twenty-four (24) hour crisis response service.

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

Core Program Description: Early Identification Services (B2)

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

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

Goal Statement:

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

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

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

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

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

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

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

Core Program Description: Consultation Service (B4)

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

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

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

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

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

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

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

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

Core Program: Community Mental Health Supports (C)

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

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

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

Core Program Description:

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

Community Supports include:

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

Goal Statement: Individuals with severe and persistent mental health problems, and who experience difficulty living in the community with a quality of life acceptable to them, have access to a network of community supports consistent with services based on best practice evidence.		
Domains (CCHSA)	**Standards Statements**	**Nature of Evidence**
Appropriateness	C.1. Cases assessed as meeting the eligibility criteria for community supports are referred to the appropriate service. Admission criteria are: • severe and persistent mental illness and/or severe disruptive behavior with significant impairment in activities of daily living and, • effective support can not be provided in a less intensive service and, • the individual will benefit from the community supports program supported by best practice evidence	II
Acceptability	C.2. Referrals to community supports are accepted from multiple sources including professionals, non-profit and other service agencies, homeless shelters, employment services and self-referrals. Pro-active outreach/referral finding is part of this process.	II
Appropriateness	C.3. Standardized, validated intake assessment is initiated within ten (10) working days of the referral.	II
Effectiveness	C.4. A comprehensive assessment, intervention plan, and individual progress review is undertaken that considers all domains in the individual's life and his/her support network. For youth and adults this is consistent with PSR best practices.	II
Effectiveness	C.5. The community supports plan outlines mutually established goals and/or outcomes expected for the individual and/or support network, where appropriate, as well as a time frame for treatment or goal attainment.	II
Continuity	C.6. The community supports plan includes, where appropriate, linkage and coordination with all relevant professional and community resources.	II

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

Inpatient Services - Adults, Children and Youth (D)

Context & Issues:

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

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

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

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

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

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

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

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

Core Program Description: Acute Inpatient Services (D1)

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

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

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

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

Goal Statement: All Nova Scotians have timely access to inpatient services**.** Inpatient services, which are the most intrusive for the patients, and the most costly to the system, are used appropriately.

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

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

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	D1.11. The inpatient mental health team engages in collaborative planning to ensure that at discharge: a) the objectives of the admission have been met or, if not, the specific reasons for failure to meet those objectives are documented b) the patient may be managed in a less restrictive/intrusive setting c) continuity and consistency are maximized by: 1. giving advanced notice of the discharge date to relevant community-based care providers and where appropriate, family members 2. developing a discharge plan in collaboration with mental health community teams to whom the patient is being referred at discharge - faxing interim discharge summaries and other pertinent forms/information to all relevant care providers, including the family physician, outpatient primary therapist and/or continuing care facility within seventy-two (72) hours of the discharge - disseminating full written discharge reports to the primary therapist, family physician and other relevant care providers within four (4) weeks of discharge	IV

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

Core Program Description:
The Short Stay Units, provide stabilization and intensive assessment service of less 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 inpatient services and minimizes disruption to children, youth and support networks.
The Short Stay Units will provide:
a) crisis stabilization
b) assessment
c) timely disposition.
These standards apply to hospital-based short stay units . It is expected that there will be regional cooperation in managing bed availability.

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

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

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

Core Program Description:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Goal Statement:

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

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	E1.1. Each district identifies personnel to assess and either treat or arrange referral for individuals seeking care for eating disorders.	III
Competence	E1.2. These personnel are responsible to: a) Be a liaison with community agencies (schools, clubs etc) within their area b) Link to primary care clinicians c) Triage cases to appropriate level care at either local or provincial level for child/adolescent and adults d) Participate in the provincial network (referred to in context and issues section)	III
Efficiency	E1.3. A standardized initial assessment for eating disorders is used in each district. Standards for triage and initiation for service is as described in Section 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

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

Context & Issues:

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

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

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

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

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

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

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

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

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

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

Goal Statement:

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

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

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

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

Core Program Title: **Specialty Programs - 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).

Context & Issues contd:

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 which 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 reoffending, 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 Appendix E3-e).	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-f)	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

Core Program Title: 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
Continuity	E4.9 Collaborative partnerships are developed to facilitate a comprehensive range of local resources to support individuals, families and support systems.	11

Domains (CCHSA)	Standards Statements	Nature of Evidence
Effectiveness	E4.10 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

Core Program Title: Speciality Program - Seniors Mental Health (E5)

Context & Issues:

People aged 65 and over comprise 12.5% of the population. Statistics Canada has projected that by 2021 seniors will represent 18.9% of the total population and that by 2041 they will represent 24.9% of the population (Statistics Canada, 2002). The most significant increase will be in the over 85 years group (1).This increase in the elderly population over the next 30 years will lead to an unprecedented increase in the number of seniors experiencing mental health problems and will place more demand on the system's capacity to address seniors mental health needs.

The majority of seniors cope well with physical limitation, cognitive changes and loss. Mental disorders are not part of "normal aging". Some mental health disorders such as Schizophrenia are no more common in seniors – but disorders, such as dementia and delirium, and depressive symptomatology, are more common. When mental health problems do occur with seniors, these problems are often unrecognized and untreated. If left untreated, these problems are often associated with increased mortality, increased physician visits and worsening prognosis for medical problems.

Mental llness effects 12-20% of seniors living in the community. This number rises drastically to 70-94% of seniors living in long term care facilities. In 1994, 364,000 Canadians over age 65 had dementia (5). This number is expected to increase to 750,000 by 2031. Mental illness and dementia lead to decreased quality of life for the senior and caregiver, premature institutionalization and caregiver distress (6). The suicide rate is much higher in seniors, especially for men over 80 years (4).

There are challenges in managing mental illness in seniors. Their symptoms often differ from younger adults, making diagnosis more difficult. There is 'ageism' and 'stigma' associated with service access and transportation limitations impact service availability. Lack of services and supports in rural areas makes access and availability even more difficult. Current service delivery models do not reflect the complex and changing mental health needs of seniors. There is lack of coordination between service modalities such as geriatric medicine, emergency health services, home care, continuing care and mental health services. There is also a lack of support for caregivers.

Family or unpaid caregivers are providing the majority of care for seniors. Seventy percent of caregivers are women (13) and 36 percent of these caregivers are over 70 years old. These unpaid caregivers save the public health services system over $5 billion per year in Canada (12). Unfortunately, these unpaid caregivers have not been given the attention they deserve. Up to 46 percent of them are depressed themselves (15). They lack meaningful mental health information or knowledge of local support groups, public health services (Home Care Nova Scotia) or availability of respite services.

It is possible to prevent deterioration in mental health as well as restore health and enhance quality of life by recognizing these mental health problems. Access to specialized seniors services should be 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.

Context & Issues contd.:

Family or unpaid caregivers are providing the majority of care for seniors. Seventy percent of caregivers are women (13) and 36 percent of these caregivers are over 70 years old. These unpaid caregivers save the public health services system over $5 billion per year in Canada (12). Unfortunately, these unpaid caregivers have not been given the attention they deserve. Up to 46 percent of them are depressed themselves (15). They lack meaningful mental health information or knowledge of local support groups, public health services (Home Care Nova Scotia) or availability of respite services.

It is possible to prevent deterioration in mental health as well as restore health and enhance quality of life by recognizing these mental health problems. Access to specialized seniors services should be 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: Specialty Program - Seniors Mental Health (E5)

The seniors mental health program is a client and family-centred, community based, outreach/out-patient/inpatient service which provides:

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

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

Goal Statement:

All Nova Scotians have access to an integrated, comprehensive program for the management of <u>seniors' mental health:</u>

- to ensure the mental health needs of seniors are understood, identified and responded to at the appropriate service level;
- to ensure health promotion, early intervention and education in seniors' mental health are key elements available across the continuum of care;
- to establish an integrated service delivery model that will facilitate access to appropriate care in a timely manner with direct links to Continuing Care (Home Care, Adult Protection and Long Term Care), Emergency Health Services, Speciality Medical Services (Geriatric Medicine, Family Medicine, etc.);
- to support and participate in research initiatives directed at improved care for seniors.

Domains (CCHSA)	Standards Statements	Nature of Evidence
Efficiency	E5.1 Each district identifies clinician(s) to assess and treat/refer individuals seeking seniors mental health services.	III
Continuity	E5.2 The clinician(s) provide: a) liaison with other service providers including: Continuing Care (Home Care, Adult Protection and Long Term Care); Emergency Health Services; Speciality Medical Services (Geriatric Medicine, Family Medicine); and non-government agencies/organizations, etc. b) linkage to primary care clinicians c) triage to appropriate level care at either local or provincial level for seniors services d) participation in the provincial network (referred to in context and issues section)	IV
Acceptability	E5.3 Services are client and family centred; client and/or family members participate in decisions regarding treatment, goal setting and evaluation, to the degree warranted.	II
Competence	E5.4 Outreach services in each district/shared district consists of at least one clinician and one physician (generalist or specialist) with knowledge in seniors mental health.	III
Accessibility	E5.5 Referral protocol for service and consultation is clearly defined, widely distributed and routinely revised, incorporating user input.	IV
Accessibility	E5.6 Access to speciality service • is made by the family physician (accepted from other sources as necessary) • in cases where a client presents without a family physician referral, contact with the family physician is made as soon as is practical. • in cases where there is no family physician a medical screening is obtained.	III
Appropriateness	E5.7 A comprehensive seniors mental health assessment is conducted. (see Section B3).	II

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	E5.8 Referral criteria (a) for outpatient/outreach service are: • 65 years of age or older • first onset of psychiatric disorder • new onset or exacerbation of existing psychiatric disorder complicated by aging process • dementia under or over age 65 • community based services unable to assess, stabilize and treat E5.8 (b) for admission to general service beds (medicine or psychiatry) at district/shared district is subject to admission criteria for those services. E5.8(c) for admission to speciality beds : • complex mental health problem associated with aging process or medical complications requiring 24 hour nursing care for specialty assessment, diagnosis and treatment • referral by public practice psychiatrist (where feasible) from district hospital unit • all admissions require return of patient to referring hospital unit	III
Acceptability	E5.9 DHAs seniors service planning process includes recognized agencies and organizations providing care, treatment, and/or support to seniors and their families.	II
Competence	E5.10 Seniors mental health clinicians collaborate in the development of core curriculum for clinical training with secondary education organizations.	II
Acceptability	E5.11 Each district has available information to assist the public, individuals, family, community groups and other community agencies in understanding and accessing services. This includes: *a)* An outline of the features of seniors mental health issues *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

Domains (CCHSA)	Standards Statements	Nature of Evidence
Continuity	E5.12 At admission and throughout the patient's treatment, the treatment team involves the patient's family, referring service and other relevant agencies/services in discharge planning as appropriate.	II
Competence	E5.13 Clinicians have access to continuing education in seniors mental health.	II
Competence	E5.14 Client/patient consultation to district generic mental health services is available from specialty seniors service upon request.	III
Competence	E5.15 Services with university affiliation serve as centres of clinical expertise accessible from across province in assisting seniors mental health program development, clinical case consultation, research/academic pursuits, advice on medico-legal issues, and education of health care professionals.	II
Accessibility	E5.16 Promotion, prevention and advocacy activities associated with depression and dementia occur at provincial, district and local levels and in collaboration with relevant agencies as appropriate.	II

Core Program: Speciality:
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 individuals needs. 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.

Standards Statements

E6.1. A structured integrated model between Mental Health Services and Addictions Services is established to facilitate the provision of services at the local level.

E6.2. Guidelines and policies are established to support integrated treatment.

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.

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.

E6.5. Clinical treatments for individuals with concurrent disorders including:

- acute stabilization
- motivational enhancement
- active treatment
- relapse prevention
- rehabilitation and recovery (Appendix C: Community Mental Health Supports)

are based on current best practices, evidence based research and expert consultations.
(See Glossary)
(Minkoff, *Service Planning Guidelines, April 2001, page 5)*

E6.6. Outcome measures are established to evaluate integrated treatment.

E6.7. Retention and follow-up strategies are in place to support continuity of care.

E6.8. Core and speciality competencies are established and maintained.
Elements of a Dual-Diagnosis Program, August, 2003 (See Appendix D)

E6.9. Staff training and education forms the foundation for development of an Integrated Concurrent Disorders service includes cross-training and continuing education.

E6.10. Province wide best practices are built and maintained on evaluation, shared experience and research.

Core Program Title: **Speciality 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).

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 collaborate 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 include:

- assessment, diagnosis, treatment, consultation, collaboration and case co-ordination to meet the individual and family needs. Access is available across the life span as required. Service is provided 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 A)	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. Teams members providing intensive behavioural intervention must complete intensive training and receive ongoing supervision by appropriately trained clinical staff. See Appendix A	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

APPENDIX A
Prevention, Promotion and Advocacy (A1)

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

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

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

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

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

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

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

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

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

Public Health Approach on Mental Health in Europe p. 116

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

Public Health Approach on Mental Health in Europe p. 116

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

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

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

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

APPENDIX B
Outpatient and Outreach: (B)

Crises and Response Services:

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

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

APPENDIX C
Community Mental Health Supports (C)

(A) Psychosocial Rehabilitation

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

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

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

(B) Psychosocial Rehabilitation Best Practices

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

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

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

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

(C) Case Management

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

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

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

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

(E) Psychosocial Rehabilitation Training/ Education

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

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

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

(F) Community Supports versus Outpatient Services

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

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

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

Inpatient Unit Design:

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

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

APPENDIX E
Specialty Programs-Eating Disorders (E1)

Specialty Programs
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

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.

- 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.

- 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).

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

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

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

- After verification, file in appropriate file.

- IWK will fax the assessment 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.

- 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.

- 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

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

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

l) 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):
    1. Notice to Review Board
    2. Warrant of Committal
    3. 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:**
    1. Warrant or Committal
    2. Treatment Order
    3. Disposition Order
    4. Notice to Review Board
    5. 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):
  1. Notice to Review Board
  2. 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 Deouty Sheriff to be taken to the identified facility along with the accused.
- Send a copy of the Warrant of Committal and orginal 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 orginial 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

NOTE: NCR and fitness hearings are covered under Chapter 15

Cross-Reference

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 follw 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 yong 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 practionners on the types of intervention strategies that will reduce criminal recidivism. The goal of the mental health practioner 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 reoffending 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 neighborhood

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 Behavior 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 Behavior 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 a 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 assesses 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, 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 clinicul 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 behavior 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 defense. 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 wether 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 wether 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 are 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 laboring 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 defendants'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's 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 practionner 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:
    a. Cognitive perception of offense
    b. Emotional response
2. Detailed account of offense
    a. Evidence of intrapsychic stressors - for example delusions or hallucinations
    b. Evidence of external stressors - for example, provoking events or fear or panic triggers
    c. Evidence of altered state of consciousness - for example, alcohol-induced or drug-induced
    d. Claimed amnesia - partial or complete
3. Events leading up to the offense
    a. Evidence of major changes in environment - for example, change in job status or change in family status
    b. Relationship with victim
    c. Preparation for the offense
4. Post offense response
    a. Behaviour following act
    b. Emotional response to the act
    c. 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 skeptical 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
Standards: Sex Offender Treatment (Children and Youth)

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

Appendix E3-f

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**

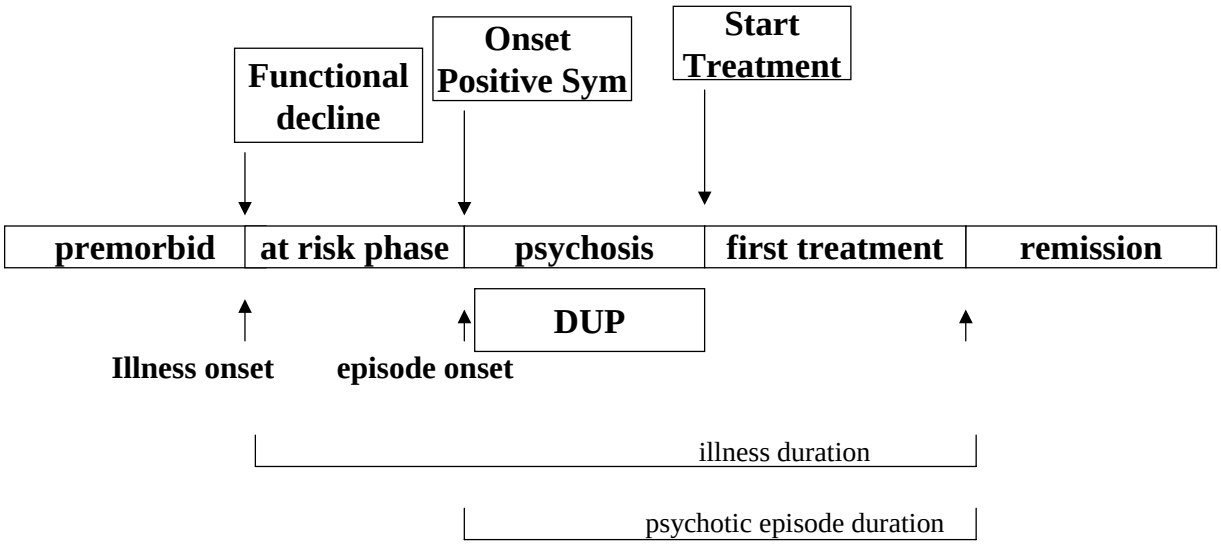
6. **THAT**

PREPARED BY:

(Name)
(discipline)
(registration #)

Early Course of Psychotic Disorders

(adapted from Larsen 1996**)**



(Adapted from Larson 1996)

Speciality Programs
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

Speciality Programs
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 judgement

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)]

Speciality 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)

Speciality Programs: Concurrent Disorders (E6)
Appendix E6 - C
Community Supports Standard Statements

C.1. Cases assessed as meeting the eligibility criteria for community supports are referred to the appropriate service. Admission criteria are:

- severe and persistent mental illness and/or severe disruptive behavior with significant impairment in activities of daily living and,
- effective support can not be provided in a less intensive service and,
- the individual will benefit from the community supports program supported by best practice evidence

C.2. Referrals to community supports are accepted from multiple sources including professionals, non-profit and other service agencies, homeless shelters, employment services and self-referrals. Pro-active outreach/referral finding is part of this process.

C.3. Standardized, validated intake assessment is initiated within ten (10) working days of the referral.

C.4. A comprehensive assessment, intervention plan, and individual progress review is undertaken that considers all domains in the individual's life and his/her support network. For youth and adults this is consistent with PSR best practices.

C.5. The community supports plan outlines mutually established goals and/or outcomes expected for the individual and/or support network, where appropriate, as well as a time frame for treatment or goal attainment.

C.6. The community supports plan includes, where appropriate, linkage and coordination with all relevant professional and community resources.

C.7. Individual plans and interventions for youth and adults are developed to support quality, safe and affordable housing goals consistent with best practice.

C.8. Individual plans and interventions for children, youth and adults are developed to support / facilitate ongoing social/recreational networks consistent with best practice.

C.9. Individual plans and interventions for children, youth and adults are developed to support / facilitate ongoing individual educational and employment goals consistent with best practice.

C.10. Case loads are managed according to case mix, intensity, and individual needs/outcomes; and within the context of geography , population and available service system.

C.11. Case managers/youth workers who are employed by the mental health program are supervised by mental health professionals and work in multi disciplinary teams which provide clinical supervision and back up.

Speciality Programs
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 (EIlSS) 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 EIlS 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 EIlSS (EIlSS 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 Analyses of Autism Intervention Research, 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 EllS 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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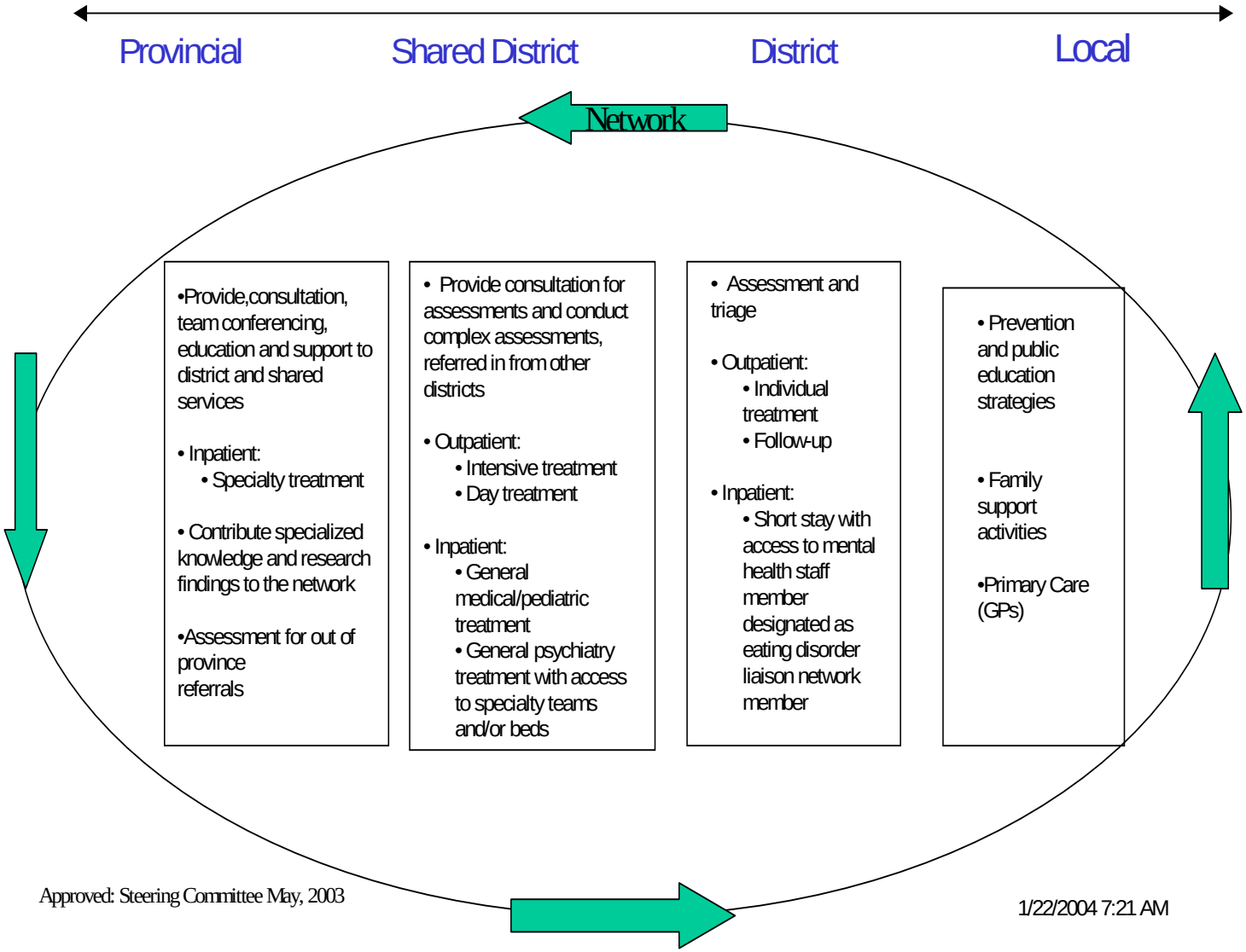
SERVICE DELIVERY MODELS
FOR
PROVINCIAL SPECIALITY SERVICES

Provincial Eating Disorder Services Model



Approved: Steering Committee May, 2003

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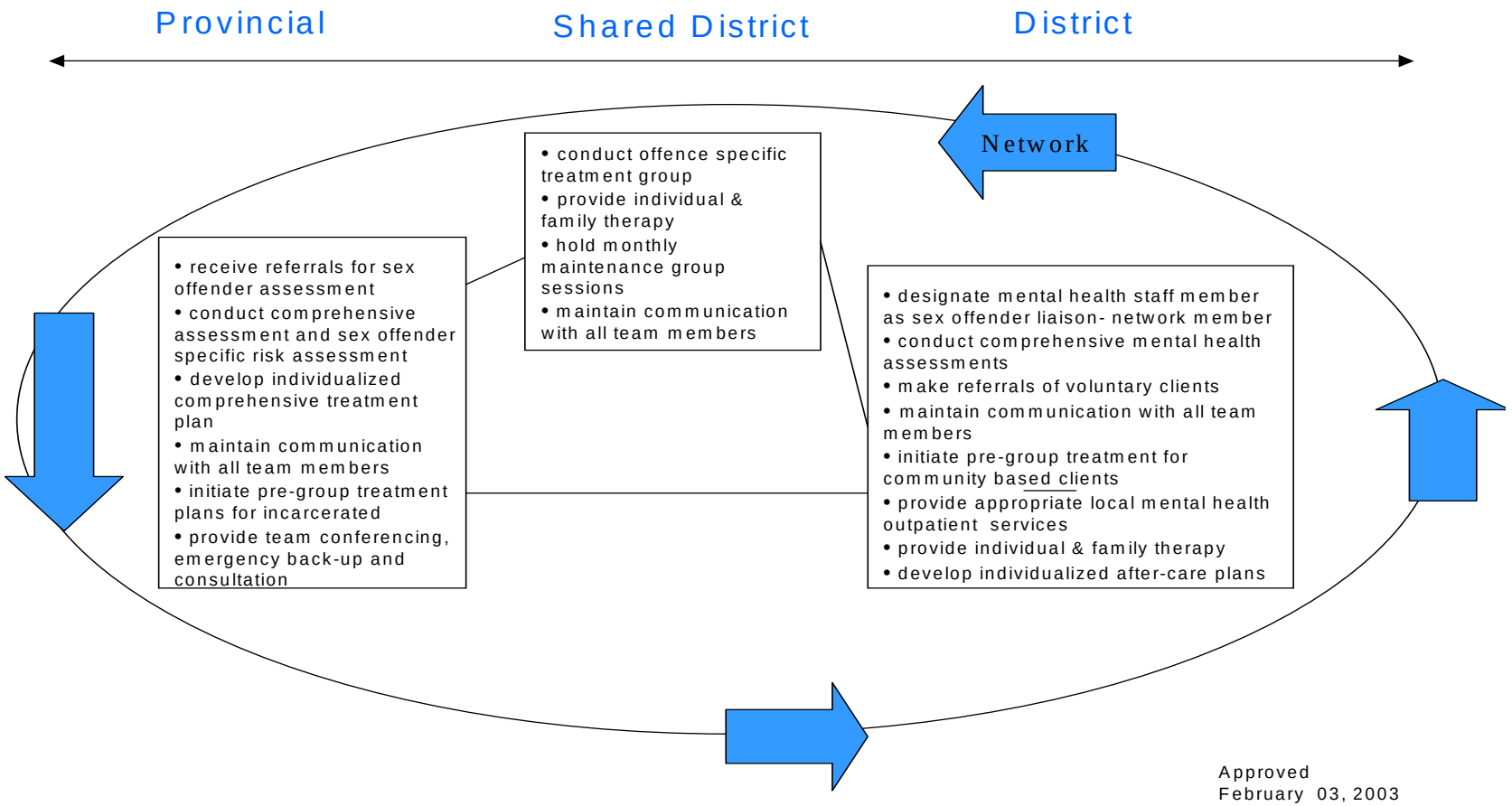
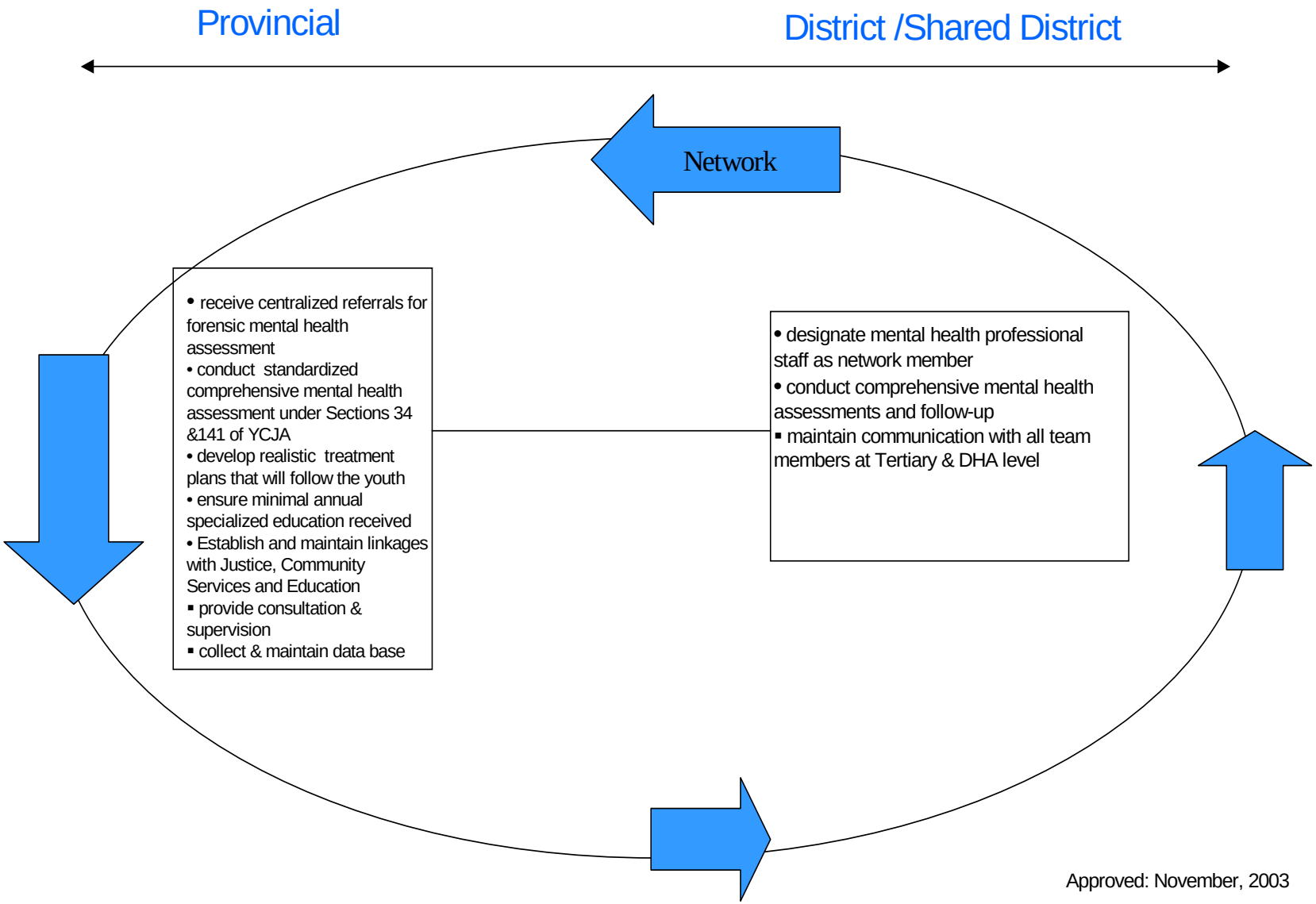
Sexually Aggressive Youth Program



Approved
February 03, 2003

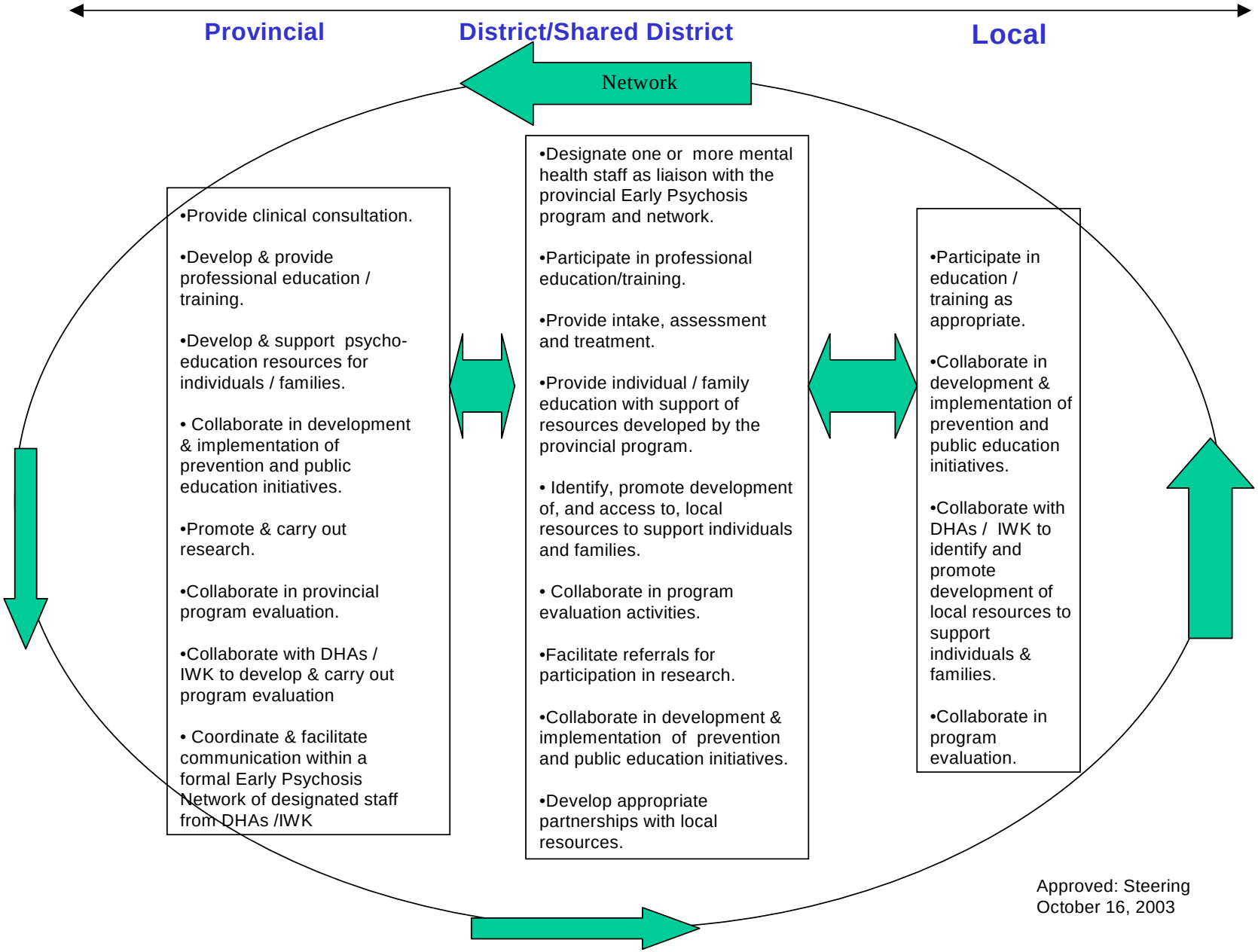
Youth Court Assessment System Model - Nova Scotia



Approved: November, 2003

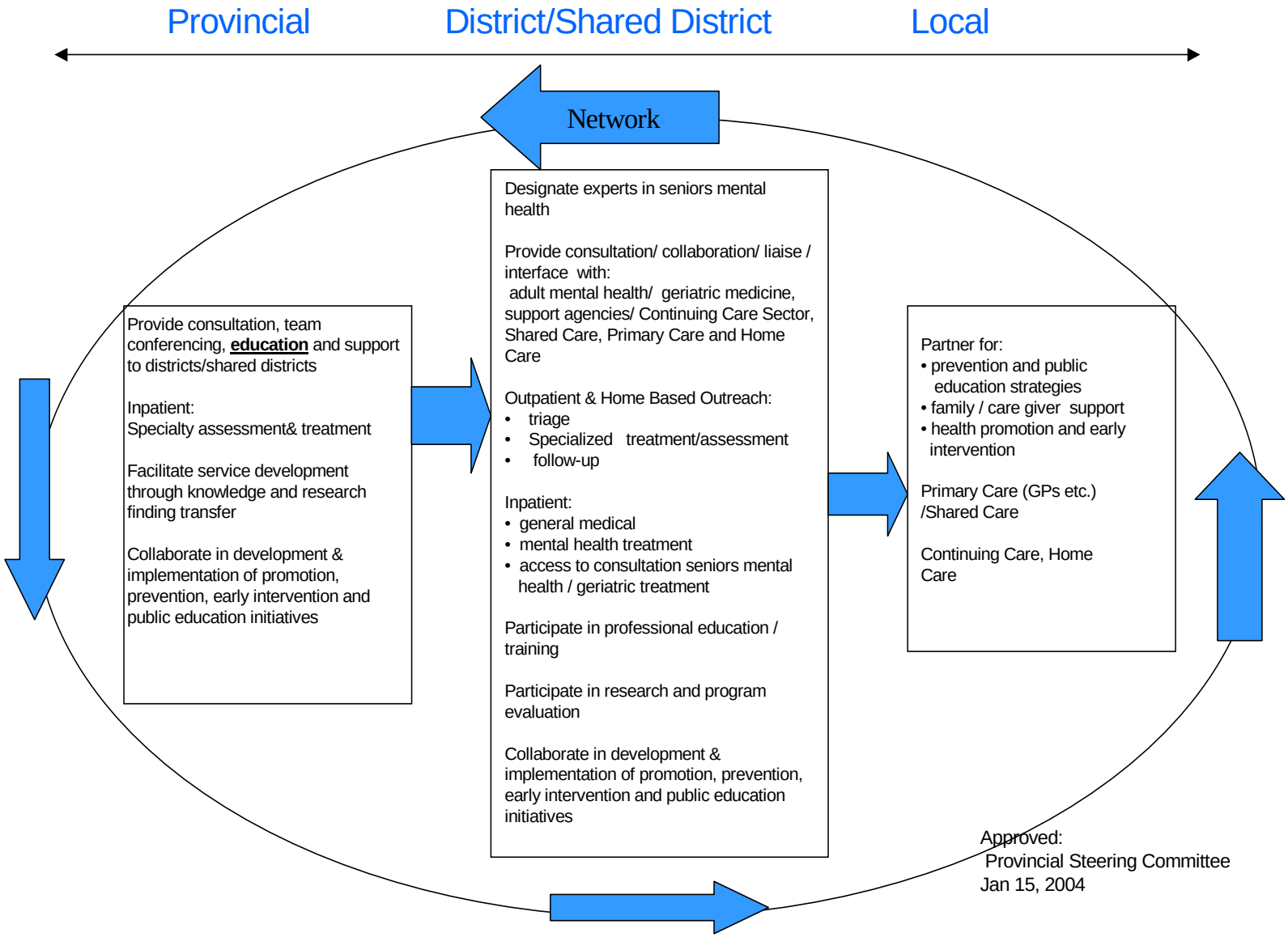
Provincial Early Psychosis Services Model

Children, Youth and Adults



Approved: Steering
October 16, 2003

Seniors Mental Health Services Model - Nova Scotia

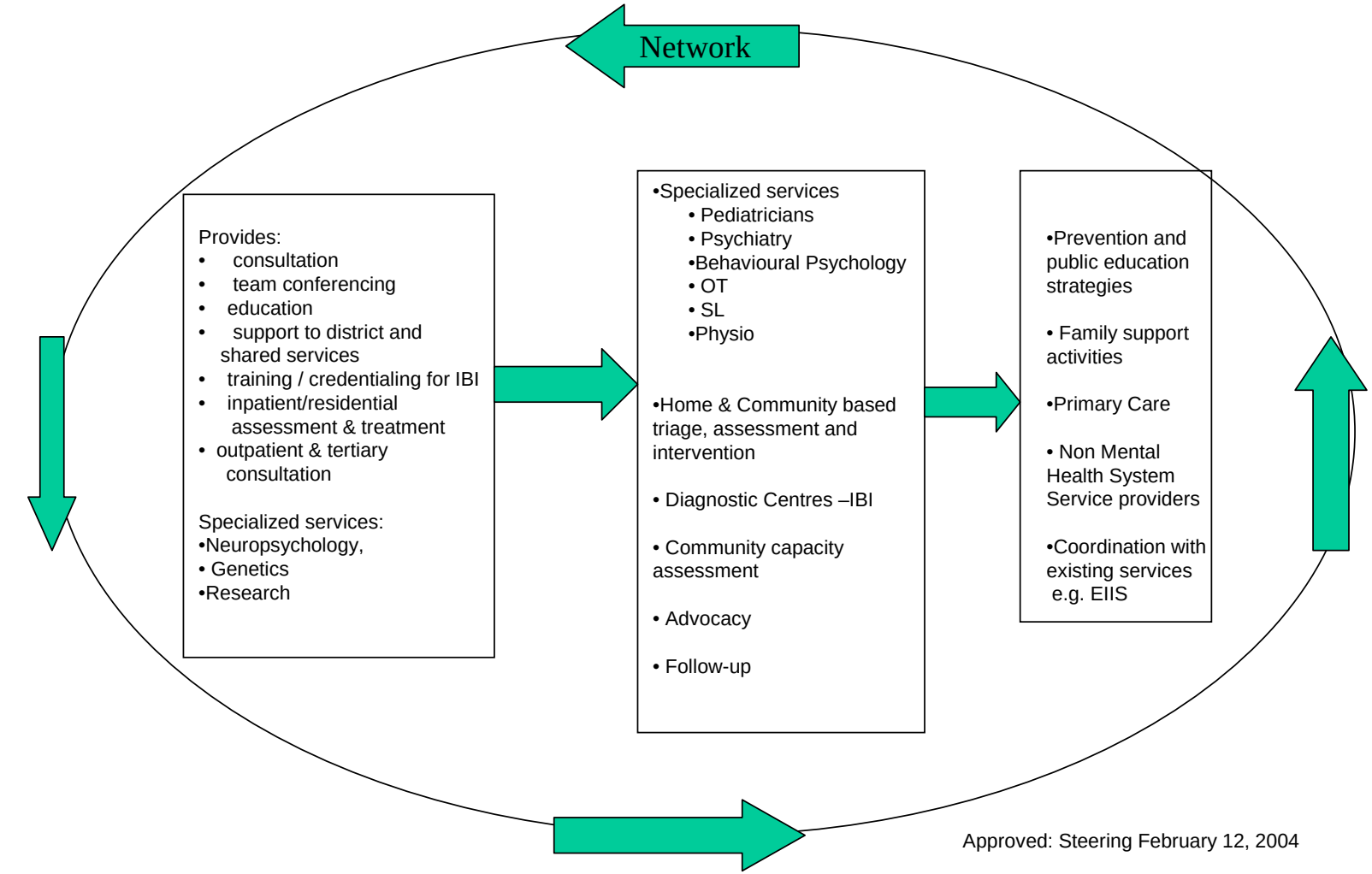


Approved:
Provincial Steering Committee
Jan 15, 2004

Service Model: Neurodevelopmental Disorders for Children and Youth

(includes: Autistic Spectrum Disorders)

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



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Use of Secretin to Treat Autism. NIH News Alert. October 16, 1998. http://www/nichd.nih.gov

Glossary

ABC Observation:

A functional assessment method involving direct observation of the antecedents, the target behavior, and the consequences of the behavior. Typically conducted in the natural environment where the target behavior occurs.

Advocacy:

is the act of speaking in support of human concerns or needs. When people have their own voice, advocacy means making sure they are heard; when they have difficulty in speaking, it means providing help; where they have no voice; it means speaking for them. Making Change: A Place to Start. Ministry for Children and Families; Advocacy Centre, Nelson; the BC Association for Community Living; The Office of Child, Youth and Family Advocate and the Penticton Advocacy Network.

Antecedent:

A stimulus or event that precedes the target behavior.

Applied behavior analysis:

A term often used interchangeably with the term behavior modification; it involves analyzing and modifying human behavior.

Behavior:

The subject matter of behavior modification. Behavior is what a person says or does; it involves a person's actions.

Behavioral assessment:

Measurement of the target behavior (or behaviors) in behavior modification. May also refer to measurement of antecedents and consequences of the target behavior.

Behavioral deficit : A desirable target behavior that a person seeks to increase in frequency, duration, or intensity.

Behavioral excess: An undesirable target behavior that a person seeks to decrease in frequency, duration, or intensity.

Behavior modification:

The field of psychology concerned with analyzing and modifying human behavior.

Community Support Services includes:

1. Case management: a collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost- effective outcomes. This is usually long-term in nature and may be provided outside four walls. (See appendix for differentiation from outpatient services).

2. Community or Home based interventions: clinical treatment or procedures and psychosocial rehabilitation in the home or where the consumer requests service. For

children and youth, this is time limited in nature.

3. Consultation/liaison: mental health care advice and recommendations to service providers outside the formal mental health system

4. Proactive outreach/case finding: interventions that will increase help-seeking behaviour and find those who are at risk/hard to find/hard to serve.

Contingency :

A relationship between a response and a consequence in which the consequence is presented if and only if the response occurs. When such a relationship exists, the consequence is said to be contingent on the response.

Dimension of behavior:

Am aspect of the behavior that can be measured and modified. Relevant dimensions may include frequency, duration, intensity, and latency.

Direct assessment:

Behavioral assessment involving direct observation and recording of the behavior as it occurs. Direct assessment may also refer to direct observation and recording of the antecedents and consequences of the behavior**.**

Discrimination:

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

Emergency cases:

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

Employment and education:

help consumers to prepare for, gain, and keep productive roles in the community.
(CMHSA Document, 2000. Page 16)

Escape behavior:

Behavior that results in the termination of an aversive stimulus. The termination of the aversive stimulus negatively reinforces the behavior.

Fading:

The gradual removal of prompts as the behavior continues to occur in the presence of the $S^{D.}$

Frequency :

The dimension of behavior, specifically, the number of times a behavior occurs in a specific time period. The number of responses (frequency) divided by the time equals

the rate of the behavior.

Functional analysis:

A functional assessment method in which environmental events (antecedents and consequences of the behavior) are manipulated to demonstrate a functional relationship between the environmental events and the behavior.

Functional assessment:

The process of generating information on the events preceding and following the behavior in an attempt to determine which antecedents and consequences are reliably associated with the occurrence of the behavior. Includes indirect assessment through interviews and questionnaires, direct observation of the antecedents and consequences in the natural environment, and functional analysis methods involving the manipulation of environmental events.

Generalization:

A process in which the behavior occurs in the presence of antecedent stimuli that are similar in some way to the discriminative stimulus present when the behavior was reinforced. Generalization is also defined as the occurrence of a target behavior in a nontraining situation after training.

Gestural prompt:

A physical movement of gesture of another person that leads to the correct behavior in the presence of the discriminative stimulus.

Goal setting:

A self-management strategy in which the person decides on and writes down the desired level of the target behavior he or she hopes to achieve as a result of self-management procedures.

Individuals at Risk:

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

Individual community support/case management:

is designed to help consumers with severe and persistent mental illnesses to manage the expectations of daily living related to housing, income, social and recreational activities, self-care, and physical and mental health care. Community support workers collaborate with consumers, providing continuous outreach support, even when a consumer's needs change and cross service setting.

(CMHSA Document, 2000, page 15[1])

Individual housing supports:

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

Intensity:

A dimension of behavior, specifically the physical force or magnitude of the behavior. Often measured with a recording instrument or on a rating scale.

Maintenance:

Continuation of the behavior change for a long period after the termination of a behavior modification program. Also, continuation of an operant behavior with intermittent reinforcement.

Respite:

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

Intensive housing supports:

include small residence facilities integrate within existing communities that provide specialized tertiary treatment, active rehabilitation, and supports for adults with severe disabilities and very challenging behaviors.

(*CMHSA Document, 2000, Page 16)*

Paraphilia:

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

Physical prompt:

A type of prompt in which the trainer physically assists the learner to engage in the correct behavior at the correct time. Most often involves hand-over-hand guidance of the behavior.

Picture prompts:

A type of prompt in which the client is presented with a picture of a person engaging in the target behavior. The picture acts as a prompt for the client to engage in the correct behavior at the correct time. Often, a sequence of pictures is presented to prompt a client to engage in a chain of behaviors.

Positive reinforcement:

A type of reinforcement in which contingent on the behavior, a stimulus or event is presented and the probability of the behavior increases in the future.

Prevention:

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

Promotion:

Process of actively supporting and enabling people to increase control over and improve their health.

(World Health Organization [WHO]) AIM Accreditation Program. 2001. Glossary. p.15

Prompt:
A prompt is used to increase the likelihood that a person will engage in the correct behavior at the correct time. A prompt may involve the behavior of the trainer (response prompts) or supplemental environmental stimuli (stimulus prompts).

PSR Practices: Housing.

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

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

Examples of housing options:

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

Psycho social Interventions:

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

(IAPSRS Guidelines, 1997. Page 10)

Rehearsal:

Practice of the behavior in a role-play situation after instructions and modeling. Rehearsal is followed by feedback on the performance.

Reinforcement:

The process in which the occurrence of a behavior is followed by a consequence that results in an increase in the future probability of the behavior.

Resilience:

In 1984, Garmezy, Masten, and Tellegen operationalized resilience in one of their

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

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

Self-instructional training:

A type of cognitive behavior modification procedure in which the client learns to make specific self-statements that increase the likelihood that a target behavior will occur in a specific situation.

Self-management:

Behavior modification procedures used by a person to change his or her own behavior that alters and antecedent or consequence of the target behavior or alternative behavior.

Shaping:

The reinforcement of successive approximations to a target behavior. Used to establish a novel topography or dimension of a behavior.

Social Recreation Networks:

Community based opportunities for interpersonal contact and play throughout the lifespan. (*IAPSRS Guidelines, 1997. Page 11)*

Stigma (Psychiatric):

is the false and unjustified association of individuals who have mental illness, their families, friends and service providers with something shameful. It is often deeply hurtful. fosters hostility in the community and negative discrimination by services and employers. Stigma stirs up fears and discourages people who suspect they may have a mental illness from seeking appropriate timely help.
Rosen, A., Walter, G., Casey, D., Hocking, B. Combating Psychiatric Stigma: An overview of contemporary initiatives. Australasian Psychiatry. Vol 8, No 1. March 2000.

Supported Housing:

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

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

Target behavior:

In behavior modification, the behavior to be modified.

Task analysis:

Identification of the discriminative stimulus and response for each component of a behavior chain.

Tolerance:

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

Transitional Housing:

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

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

Urgent cases:

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

Verbal prompt:

A type of prompt in which the verbal behavior of another person results in the correct behavior of the trainee in the presence of the discriminative stimulus.

Vulnerable People:

vulnerable populations are those groups of people "made vulnerable by their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively...[and] personal characteristics, such as race, ethnicity, and sex." **http://www.ahcpr.gov/research/dec98/ra4.htm**

Vulnerable people includes: children, victims of domestic violence, homeless, minorities, people with addictions, sexual abuse victims.

Youth:

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

FRAMEWORK INDICATORS
OF
MENTAL HEALTH SYSTEM PERFORMANCE

Approved: Senior Leadership March 22, 2004

			Type		Responsibility			
Domain	**Standard**		**Process**	**Outcome**	**DHA**	**DOH**	**Data Source**	**Reporting Frequency**
Accessibility	D1.4	**1.0 Inpatient (D): <u>Wait Times for Admission</u>** 1.1 Elective admissions: Average wait time (median/ range) from referral for admission to acceptance by age category* 1.2 Elective admissions: Average wait time (median/range) from acceptance to admission by age category 1.3 Emergency admissions: Proportion of emergency patients admitted within 24 hours of acceptance by age category 1.4 Proportion of cases referred for emergency admission to the IWK in which a telephone response related to the suitability of the admission occurs within one hour of the referral.	x x x x		x x x x		1.1 and 1.2 are not indicators but will be useful to eventually set standards. Retrospective audits (charts/logs)	Quarterly
	B3.4, B3.6, B3.7, B3.8, B3.9, B3.10	**2.0 Outpatient (B): <u>Wait Times for Services:</u>** 2.1 Proportion of referrals reviewed by a clinician within one (1) working day of the referral by age category to determine status of referral (emergent, urgent, non-urgent, inappropriate) 2.2 Proportion of emergency cases assessed by a mental health clinician within twenty-four (24) hours by age category 2.3 Proportion of urgent cases assessed by a mental health clinician within five (5) working of the referral by age category 2.4 Proportion of non-urgent cases assigned to a mental health clinician within ten (10) working days of the referral by age category 2.5 Proportion of discharged inpatients (non-urgent) receiving ambulatory follow-up within ten (10) days of discharge by age category 2.6 Proportion of non-urgent cases receiving the initial mental health assessment, including a recorded diagnosis or diagnostic impression within ninety (90) days of the decision on disposition by age category	x x x x x x		x x x x x x		Retrospective audits (charts/logs)	Quarterly
	C3	**3.0 Community Supports(C): <u>Wait times for Assessment</u>** 3.1 Proportion of cases receiving an intake assessment within ten (10) working days of the referral by age category	x		x		Retrospective audits (charts/logs)	Quarterly
	Generic 5.1	**4.0 Generic: <u>Access to Psychiatrists:</u>** 4.1 Clinical hours per 10,000 population by District by age category	x		x	x	This is not an indicator but will be recorded/reported for planning purposes.	Annual
Appropriateness	D1.1 D2.1 D3.1 D2.1 D1.2 D1.7	**1.0 Inpatient (D): <u>Appropriate Admissions</u>** 1.1 Proportion of admissions meeting admission criteria by age category 1.2 Ambulatory Sensitivity Rate by age category 1.3 Proportion of MNRH admissions (C&Y only) 1.4 Proportion of inpatient days for patients in hospital beyond the documented “medically ready for discharge” date by age category 1.5 Proportion of admissions readmitted within seven (7) and twenty-eight (28) days of discharge by age category 1.6 Proportion of patients admitted to identified short-stay beds for children and youth with lengths of stay exceeding five (5) working days 1.7 Proportion of admissions with a preadmission mental health assessment by a member of a mental health team by age category 1.8 Proportion of admissions with care plans reviewed by a psychiatrist by age category	x		x		Either the chart or a yet to be developed audit tool (“transit form”)	Quarterly

			Type		Responsibility			
Domain	**Standard**		**Process**	**Outcome**	**DHA**	**DOH**	**Data Source**	**Reporting Frequency**
Appropriateness	B3.2, B3.3 B3.9?	**2.0 Outpatient (B): <u>Appropriate Admissions</u>** 2.1 Proportion of accepted cases meeting admission criteria by age category 2.2 Average number of contacts per year x diagnosis x district by age category 2.3 Proportion of cases without a diagnosis (in MHOIS) following the third appointment by age category	**x** **x** **x**		**x** **x** **x**		2.1 Retrospective audits 2.2 This is not an indicator but should be monitored and reported for planning purposes. 2.3 MHOIS - audit process to be developed	Annual Annual Annual
	C1	**3.0 Community Supports: <u>Appropriate Admissions</u>** 3.1 Proportion of accepted cases meeting admission criteria by age category	**x**		**x**		Adults: Retrospective audits MHOIS C&Y: In development	Annual
Acceptability		**1.0 Inpatients (D):** <u>Satisfaction</u> 1.1 Proportion of inpatients satisfied with services by age category 1.2 Proportion of family members satisfied with services ? by age category	**X** **x**		**x** **x**		Measure to be determined	Annual
		2.0 Outpatients: <u>Satisfaction</u> 2.1 Proportion of patients satisfied with services by age category 1.2 Proportion of family members satisfied with services ? by age category	**X** **x**		**x** **x**		Measure to be determined	Annual
		3.0 Community Supports: <u>Satisfaction</u> 3.1 Proportion of patients satisfied with services by age category 3.2 Proportion of family members satisfied with services	**x** **x**		**x** **x**		Measure to be determined	Annual
Effectiveness	Generic 3.1	**1.0 Inpatient (D): <u>Outcomes</u>** 1.1 Monday Dec.8 of discharged children/youth successfully reintegrated into home/school 1.2 Proportion of discharged patients with improvement in overall mental health functioning		**x** **x**	**x** **x**		? HoNOS HoNOS	**Annual**
	Generic 3.1	**2.0 Outpatient and Community Supports: <u>Outcomes</u>** **2.1** Proportion of clients with improved functioning, decreased symptomatology and improved quality of life by age category		**x**	**x**		**HoNOS**	**Annual**
Efficiency		**1.0 Generic: <u>Mental Health Spending</u>** 1.3 Total mental health spending by core program by district by age category	**x**		**x**	**x**	Financial reports	Annual
		2.0 Outpatient (B): <u>Costs</u> 2.1 Cost per patient visit x district	**x**			**x**	Financial reports MHOIS	
		3.0 Inpatient (D): <u>Costs</u> 3.1 Cost per patient day x district	**x**			**x**	Financial reports CIHI	

			Type		Responsibility			
Domain	**Standard**		**Process**	**Outcome**	**DHA**	**DOH**	**Data Source**	**Reporting Frequency**
Competence	Generic	**1.0 Generic: Competence of Staff** 1.1 Proportion of targeted staff with initial or refresher training (if required) completed: ■ Proportion of staff in areas at high risk for violence (based on incident reporting) competent in non-violent crisis intervention ■ Proportion of staff carrying out home visits competent in non-violent crisis intervention ■ Proportion of staff responsible for establishing a diagnosis or a diagnostic impression competent in DSM-IV diagnosis ■ Proportion of staff working within Community Supports competent in psychosocial rehabilitation ■ Proportion of all clinical mental health staff competent in suicide risk assessment	**x**		**x**		Records of attendance or certification only. A mechanism to measure competence with mental health staff competence has yet to be developed.	Annual
Multiple Domains	Generic 4.1	**1.0 All Services** 1.1 Percentage full compliance with all standards for each district for each core program and specialty service by age category	**X**		**x**		Compliance reports by Directors	Annual
	Generic 5.1	**2.0 All Services** 2.1 Number of unfilled vacancies by district by profession	**x**		**x**		Financial reports/budget sheets	Annual
	Generic 6.2	**3.0 All Services** 3.1 Proportion of districts and IWK compliant with MIS guidelines	**x**			**x**	Financial reports	Annual

There are two age categories:: 0 up to the 19th birthday
19 years of age and over.