CONDUCTING ASSESSMENTS IN FIRST NATIONS AND INUIT COMMUNITIES

A TRAINING AND REFERENCE GUIDE FOR FRONT LINE WORKERS

NATIONAL NATIVE
ADDICTIONS PARTNERSHIP
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in
First Nation and Inuit Communities

A Training and Reference Guide for:

Front Line Workers
In
First Nations and Inuit
Mental Health and Addiction Services

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INTRODUCTION

Over the years a great deal of attention has been paid, both in the media and in the literature, to the poor health and social conditions faced by the First Nations and Inuit peoples of Canada. An examination of the early literature identified alcoholism as the primary problem facing First Nations and Inuit peoples.

A variety of programs were developed to combat the problem of addictions, the most notable being the National Native Alcohol and Drug Abuse Program (NNADAP). At its inception in the 1980s, the intent of NNADAP was to provide culturally-based treatment facilities for First Nations and Inuit peoples facing addictions issues while community programs were designed to prevent the development of addictions issues, especially in the younger population, by encouraging and promoting healthy lifestyles. It would appear that the ideals of this initiative were to improve the quality of life for the individual with the perception that this would improve the overall quality of life in First Nations and Inuit communities. Based on quantitative and observational assessments of NNADAP, usually through personal testament, it appears that this program has had some impact on reducing alcoholism rates in the communities.

This is not to say that alcoholism or addictions issues are no longer a concern in the communities. It is estimated that 50-80% of the adult population suffer from alcohol and addiction-related problems *(Warry, 1990)*, including substance abuse and gambling addictions. It has not, however, made a significant impact on improving the quality of life in First Nations and Inuit communities, suggesting that addictions is a symptom of deeper underlying and unresolved issues.

Mental health issues of First Nations and Inuit peoples have become more widely acknowledged in the last 10 years due, in part, to the fact that individuals who became sober continued to experience difficulty functioning with daily life issues. These people displayed symptoms suggestive of such mental health problems as suicide, depression, violence, sexual abuse, elder abuse, child neglect and abuse, and relationship difficulties *(Brant, 1994; Duran & Duran, 1995; Elliot & Foster, 1995; Mussell, 1993; RCAP, 1996; Waldram et al., 1995; Warry, 1998)*. This is not to say that First Nations and Inuit people do not suffer from serious mental illness such as schizophrenia, bipolar disorder, major affective disorders and personality disorders. According to Brant *(1994)*, little is known about the exact prevalence rates of these mental illnesses in First Nations and Inuit population. It is known that these illnesses occur, and are a concern, in First Nations and Inuit communities, but it is the mental health problems that appear to threaten the quality of life of the individual, family and community.

Compounding mental health problems are a variety of social and economic factors found in most First Nations and Inuit communities, such as:

- poor nutrition,
- inadequate housing conditions
- poor water and sewage conditions
- high unemployment rates
- low income levels
- high number of single parent families
- high teen pregnancy rates
- high level dependancy on social assistance programs
- disproportionate number of children in care
- high number of Aboriginal incarceration
- low levels of education and training

(Native Mental Health Association of Canada, 2002)

Since many First Nations and Inuit people suffer from a variety of addictions, mental health and/or social and economic difficulties, there have been a number of community and government initiatives to offer assistance. These initiatives have taken the form of prevention and promotion, intervention or treatment, and aftercare programs. To ensure that individuals, families or communities receive the best quality care, it is important to conduct a thorough assessment. The usefulness of an assessment will be determined by the skills and training of the worker, the mandate of the program or organization, the resources available, and the needs of the person being assessed.

Generally, an assessment provides an overall evaluation of a person by examining his or her abilities and skills, or lack thereof, in all areas of his or her life. An assessment will gather information regarding the presenting difficulty or problem that has led the person to seek assistance, strategies that were attempted, the success of previous attempts to solve the problem and how other areas of his or

her life may be impacting on the problem. When assessing a First Nations or Inuit person, it is important to gather information in a holistic manner by examining its effect on the physical, emotional, mental and spiritual aspects of his or her life. In gathering this information the assessor should always be sure to understand the person's functioning as a single component of the larger context, family and community issues, historically and in the existing context. A thorough assessment provides the assessor with valuable information about past issues that may be impacting on present functioning, abilities and resources available to the person, and areas that require enhancement or skills development.

The ultimate goal of an assessment is the development of a treatment goal and plan of care to assist the person in alleviating his/her distress regarding the presenting problem or difficulty. An assessment also assists the assessor or therapist in developing rapport with the person seeking help, as the assessor must utilize effective listening and communication skills during the course of the assessment to gather all of the necessary information. Occasionally, people who seek help experience difficulty in describing the type of help s/he needs and an assessment provides a structure to gather information that can determine the nature of the problem and how best to intervene. Assessments have been used with children, adolescents, adults, families, groups and communities in a variety of settings (i.e., hospital, community organizations). Any front line worker who has contact with people experiencing distress or difficulty functioning should conduct an assessment as a way to begin assisting the person in moving towards improved health and wellness.

There are a variety of situations in which a front line worker may find him or herself in need of conducting an assessment. This manual will provide general guidelines on how to conduct various types of assessments for individuals, families and communities and how to utilize the information to assist community members to move towards improved health and wellness. Special attention will be given to conducting a suicide risk assessment, the responsibility of the worker, and what to do with the information gathered.
The manual will also include a component on confidentiality, what constitutes a breach of confidentiality, how to make clients aware of confidentiality and legal issues concerning this topic. The manual will end with some strategies on how to set up records, store and maintain records, and obligations regarding record keeping.

INDIVIDUAL OR CLIENT-BASED ASSESSMENT

The most common type of assessment a front line worker will conduct is known as an **individual** or **client-based** assessment, that is introduced in the early stages of the client-therapist relationship. A client-based or individual assessment is used for a variety of reasons.

The main purpose of an individual assessment is to gather information on the client that will assist the worker or therapist in planning how to meet the needs of the client. There is a common perception that individual assessments should only be completed by workers or therapists whose intentions are to provide intervention or treatment services to clients, since the information is usually used to plan treatment. However, in First Nations and Inuit communities, front line workers, regardless of their focus or mandate, are often expected to offer a wide variety of services to community members. Community workers who conduct individual assessments will find the information helpful for assisting clients who require support, advocacy, training or skills enhancement, as well as treatment planning.

Depending on the program or organization, the individual assessment may also be used to evaluate whether the client meets eligibility criteria. These types of assessments are an integral part of the success of the program, as it is used as a screening tool to ensure there is a match between the client and program. Treatment centers are a good example of criteria-based assessments where the client must meet a certain criteria standard in order to enter the program. Conducting an individual assessment also affords an additional reward, developing rapport and trust with the client. In conducting an assessment, the worker must be attentive to the needs of the client which is reflected in his or her listening skills, when and how questions are posed, and in how information is understood and clarified. Since assessments have specific sets of questions to ask, this provides opportunities for the client to share information s/he may not have divulged if the questions were not asked. This information could be important for the worker in developing a complete and accurate description of the client, nature and severity of the presenting problem, and overall effects to daily functioning.

Introducing the Assessment

Appendix 1 is an example of an individual assessment commonly found in mental health clinics. The individual or psychosocial assessment is introduced to the client in the first or second face-to-face interview. When introducing the psychosocial assessment the worker should take time to explain that some time will be spent gathering information about the client. To gather this information the worker should explain that s/he will ask a series of questions that will help frame a general idea of the nature and extent of the client's problem to assist in the a plan of care, which may include a treatment goal and plan. The client should be encouraged to be as honest as possible in answering the questions so an appropriate plan of care can be developed. When conducting the assessment the worker should keep in mind that the questions are a general framework to elicit information and asking open-ended questions will encourage active participation of the client in this process. Therefore, the worker should attempt to ask a limited amount of closed-ended questions that elicit only yes, no or one word answers while asking more open-ended questions that promote dialogue with the client.

Components of the Assessment

Presenting Problem: In beginning an individual assessment, it is usually best to begin with why the person has sought services or assistance in the first place. This gives the client an opportunity to speak openly about his/her issue or problem, it allows the client to take an active role in the interview and, it gives a message that the client is important.

When asking about the presenting problem an open-ended question such as *What brings you here today?* can often elicit an open discussion with the client. Once the client begins to discuss his/her problem the worker should ask more detailed questions to ensure a complete understanding of how this problem is affecting the client. It is important to find out how long this problem has been happening, how s/he has attempted to solve the problem, have any strategies helped to make the situation better, and the client's understanding about the cause of the problem.

Provide as much opportunity as needed for the client to give a detailed description of his/her problem by asking such open-ended questions as

Is there anything else you can tell me about this? or *Is there anything else I need to know about this problem?* Once the worker and client agree that they have gathered sufficient information to understand the problem, the worker should frame the remainder of the assessment as an opportunity to learn more about the client and understand more about his or her life.

Presenting Strengths: Since the initial question often discusses problems and probes at negative thinking or behaviors, asking the client to describe some strengths or positive qualities about him/herself brings some balance to the interview by encouraging some positive self or other (if the identified client is a child) statements. This question gives the worker some insightful information about whether the client can identify any positive qualities about him/erself or the child (if the identified client). Sometimes the client has difficulty answering this question in the interview since s/he has focused on negative qualities of the situation or self for a long period of time. Therefore, it is important for the worker to encourage the client to share any strengths s/he (or the child) may have, which may or may not be related to the presenting problem.

Personal History: Gathering facts about the client's personal history may also offer valuable information about how the client functions on a daily basis, especially as it relates to family relationships. Conducting a genogram which is a pictorial arrangement of family membership provides a good basis for gathering familial information *(see Appendix 2)*. It is usually best to frame the genogram as an opportunity to get to know who is in the client's family and how the client grew up. When constructing a genogram, male family members are signified by a square [□] while female family members are signified by circles [○]. To signify unions (common law or marriage) two people are connected by a straight vertical line [▌], separations are signified by a single horizontal line [▬] to show a break in the union, while a divorce is signified by 2 horizontal lines [〓] to show a break in the union.

Depending on the worker's preference, the genogram can start as far back as the grandparents of the client, or at the parents. Sufficient information is often provided by starting at the parents' level and asking if there are significant family members, not located in the genogram, that should be included (i.e., grandparents, aunts, uncles, cousins, etc). The siblings of the client should be placed in birth order and include their unions and children. As part of the genogram, the client may be asked the age of all identified family members, as well as where each person lives. If the person has died, an [**X**] should be placed over the circle or square that signifies that person.

Gathering information about the year the person died and how, may also be important. It is now common to find that there may be multiple unions for a single person and they should all be clearly defined, including any children that may have resulted. Once the general picture of the family has been established, some specific questions can be asked about the client's relationship with family members; getting a description of what it was like growing up in his/her family; exposure to alcohol, drugs, parties, abuses, family violence; spiritual involvement; separation from family; involvement of Children's Aid Society or legal system, etc.

Previous Treatment: This section begins by asking a variety of closed-ended questions about any previous therapy or treatment the client has received. If the client identifies receiving any type of services the worker can then ask more open-ended questions to determine reasons for engaging services and how helpful it was for the client.

Traumatic Experiences: This section is meant to identify any past or present trauma the client may have experienced. Areas of trauma the worker may attempt to learn more about can include disruptions in family relationships (separation through Residential School, C.A.S., etc.); medical, psychiatric or substance abuse problems within the family; emotional, physical, sexual or mental abuse; family violence; and suicidal ideation or behavior within the family.

If the client acknowledges trauma, the worker should attempt to learn about the nature of the trauma, if it was dealt with legally (if applicable), had the client disclosed this before and had they sought services for the disclosure? If the worker has concerns about the trauma, one can always ask how the client perceives the trauma as impacting on his or her life, if at all.

Developmental History: This section is meant to gather information regarding the client's educational and work history, including any difficulties or

successes s/he may have experienced. This section may provide information on the client's reading and writing abilities, which may effect how therapy is provided. It may also indicate how the client's issue is affecting his/her functioning in the school or work environment.

Spiritual Involvement: This section provides information on the type of spiritual involvement the client participates in, how the client identifies him or herself spiritually as well as the level of involvement in spiritual activity. This may elicit information on a support system, client's beliefs and, his/her interest in utilizing spirituality to assist in mediating the presenting problem.

Other Information: This is an open section for other types of information that may not have been gathered in the previous sections. Information that may be relevant includes challenges in meeting developmental milestones, addictions issues, health and medical issues, legal issues, and resources.

Questions and Concerns: This section is meant as a reminder to the worker to ensure they have explained confidentiality and its limits to the client. Ideally, it should be shared prior to beginning the assessment but, at the least, should be shared prior to completing the assessment. This is also an opportunity to ask the client if s/he has any questions or concerns before proceeding to developing a plan of care. The worker can also spend some time discussing his/her expectations of the client and allow the client to respond to whether s/he feels these can be met (doing homework, meeting with a doctor or psychiatrist, engaging family in supporting client, etc.).

Developing a Plan of Care

In developing a plan of care, the worker must make use of the information the client has shared along with observations made throughout the assessment period. The worker should frame the assessment in terms of their understanding of the problem and its causes, their perception of the client's level of functioning and any identified strengths the client has presented. A summary or diagnosis of the problem is the worker's opportunity to make suggestions to the client about how the worker would describe the problem (relationship problem, parenting, abuse history, mood, anxiety, etc.). There is an opportunity for the client to make comments about his/her agreement or disagreement with the worker's assessment and ensures that the worker has gathered all of the information needed to make an accurate assessment.

Once the worker and client have agreed on a general description of the problem, the client should be encouraged to think about a goal for treatment. This goal of treatment is based on what the client and worker see as the most important or critical issue affecting the client's level of functioning. The goal should be developed using the **SMART** format. The SMART format means the goals should be **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime specific. The goals should be worded in such a way as to promote thinking and behaviors that encourage the client to move towards wellness.

For example, to improve the client's relationship with his/her spouse, or to enhance parenting skills, include the specific, achievable and realistic components of a plan. It would not be realistic or achievable to set up goals that focus on making change in someone other than the client, such as a spouse or family member.

The measurable component of the goal is located in the discharge goals section of the assessment. In this section it is the worker's responsibility to identify what area of the person's life change should occur. In using the previous example, the discharge goal for improving the client's relationship with his/her spouse the measurable component or discharge goal might be that the client self-reports increased resolution to disagreements or increased time spent in mutually pleasurable activity. The time specific component of the goal is located in the estimated duration of treatment section of the assessment. In this section the worker must identify an approximate number of sessions that will be required to achieve the goal, how long the sessions will be (one hour in length) and how often the client and worker will meet (once a week). The worker should keep in mind that the number of sessions suggested is an estimation and can be shortened or lengthened depending on how the client progresses in his/her plan of care.

Deciding on the duration of treatment is not an accurate science. This usually comes with some experience and practice on the part of the worker. As a general rule of thumb, complex and chronic

issues often require a longer duration of treatment (i.e. 15 or more sessions), while situational or simple issues usually require a shorter duration of treatment (i.e. six to eight sessions). The worker should also consider the client's abilities, skills, resources and supports in deciding on the duration of treatment.

Much of the information located in this section is not only contingent on the goal but also on the modality of treatment. This section of the assessment requires the worker to share how s/he will assist the client in meeting the treatment goal. The type of services offered will vary by worker depending on training, skill level and resources. In this section the worker must identify if s/he will be providing counseling (i.e., individual, family, group), support, advocacy, skills teaching, aftercare, promotion/ prevention education or referral for medication management.

The final section of the assessment is the evaluation plan, which includes date of review and scheduled next session. As a rule of thumb, the worker can suggest a review of goals and progress at the identified number of sessions noted in the duration of treatment section. For example, if the worker has identified 10 sessions for assisting the client to improve marital relationship, the 10th session can be the review session. At the time of review, the main goal is for the worker and client to review their assessment of progress towards the goal. If progress is satisfactory, but the goal is not yet met, additional sessions may be contracted. However, if progress is not satisfactory, it would be important to review reasons for this.

Examining the client's participation and motivation in sessions (i.e., is she completing homework or showing up for regularly scheduled appointments), do sessions need to occur more regularly, has the nature of the problem changed for the client, are there barriers to making change, etc.? All of these must be explored in order to comprehend why progress is not occurring and what can be done to keep the client from becoming frustrated and on track towards wellness. Once this has been determined, the duration of treatment may need to be altered to meet any changes made to the treatment plan or goal.

Assessing Therapeutic Gains

In this section, the worker may also want to make note of how the goal will be evaluated. Assessing gains or progress in the therapeutic setting is an important tool for worker. It helps to determine if there are any changes in the presenting problem, how to maintain any changes made, how to encourage continued change, and when it may be necessary to change the treatment goal if no change is occurring. Depending on the presenting problem, assessing for progress or gains can be made during each contact with the client. This may occur for more transient stages or emotions, such as risk for self-harm. Other types of presenting problems, such as mood, stress and psychiatric illnesses would require less frequent assessment of change, since the emotion or situation is less likely to be transient.

Workers may choose to assess for treatment gains at regular intervals, such as after every eight to 10 sessions, or every three months. Other presenting problems that require skills enhancement or training may be assessed more frequently. Checking with the client if they have utilized or practiced the acquired skill between sessions is important to ensure mastery of the skill, and offering assistance if the client is experiencing difficulty using the skill effectively and appropriately. Checking for mastery of the acquired skills should be done periodically, for example every fourth session, or every month.

In most cases, gathering a self-report along with observations by the worker is sufficient to monitor progress. Workers can ask such questions as *Did you have an opportunity to use self-talk to keep from being too anxious or worrying too much?* If the client reports use of the new skill learned or positive change in his/her situation or mood, the worker can surmise that the client has made some gains in treatment. In dealing with such concerns as mood, anxiety or other psychiatric illnesses sometimes it is valuable to get a rating, using a **Likert scale**, of how the client is feeling, and assess whether there is a change in the rating during the course of treatment.

In this case, the worker might ask the client at the beginning of treatment, *on a scale of one to 10, with one meaning extremely sad and 10 meaning really happy, tell me how sad you are feeling today.* The worker can ask this question at regular intervals to learn if there is a positive change in the rating. Other means of evaluation may include reports by

others, attendance records, increase in grades or performance levels, decrease in suspensions from school, and will depend largely on the treatment goal. All of these evaluative measures must be consented to by the client.

Workers can also use their own skills to assess the treatment gains of their clients. Gathering information on how the client handles situations, how s/he presents him/herself in sessions, and how s/he looks, may all be used as indicators of possible gains in treatment. The worker should not rely on observation alone, but should check with the client to learn if s/he would agree with the observations. The worker can ask, *When I saw you yesterday at the community feast, it looked like you were feeling happy and excited, as noted by the smile on your face. Would you agree that you were feeling this way yesterday? And how are you feeling today?* Ongoing assessment of the client throughout the treatment is just as important as gathering an accurate individual assessment as it allows for monitoring of what is working in treatment, what is not and how to proceed.

It is common for an assessment to take 1.5 to two hours to complete, depending on the amount of information to be gathered to make an accurate plan of care. It is important for the worker to review the completed assessment with the client, and receive agreement on the treatment plan. Once this has been done, obtaining the client's signature at the end of assessment indicates his/her agreement with the overall assessment, treatment goal, and plan of care.

Supporting Documents

Although the individual or psychosocial assessment is the primary tool required to make an assessment of the client's functioning and develop a plan of care, there are other supporting documents which can be helpful to this process.What follows is a brief description of each of these documents with the sample documents found in **Appendix 3 through** 7.

Referral and Intake Form: This form is the initial document used when a client seeks services from a worker or agency. This document ensures that the potential client receives timely and consistent access to services. The form assists in gathering all necessary demographic information on the potential client, the reason for referral (also known as *presenting problem*) and an assessment regarding the urgency of the case. All of this information is gathered to make a judgement regarding whether the potential client meets eligibility criteria (i.e., is s/he a band member, is s/he proper age, does the presenting problem meet the program's mandate criteria?), assigning the worker to best meet the needs of the client and scheduling a follow-up appointment if the presenting problem is of an urgent or crisis basis. This form also provides statistics that may be needed for ongoing reporting to the funding agency. This form is filled in by the *intake worker* with the client, in person or over the phone, or with a referring agent (another agency, family member, school, probation, C.A.S., etc).

General Information and Screening: This form is a secondary form to completing a more comprehensive individual or psychosocial assessment and is often completed prior to the psychosocial assessment. The GIS is used to explain the services available to the client along with collecting preliminary information about the client's presenting problem and other related data.

During this component of the assessment, the client is also assessed for suitability for admission based on the criteria of the program. Clients who are not considered suitable for the program are referred to other community programs and services. This information can be collected in person or over the phone with the potential client.

When providing information about the service to the client, the worker must make reference to the program mandate or goals, population served (i.e., band membership), availability of openings or waiting list (if applicable), and scope of services (counseling, life skills training, support and advocacy, etc.). The client's suitability is assessed using the predefined program criteria and must be outlined to the client if s/he does not qualify for admission. Documentation of client-specific information should consist of demographic information, presenting problem and services needed, severity of the problem, and whether the problem is chronic or acute.

Consent to Receive Services: Clients should be told about the nature of the services, any agreements or affiliations with other agencies or programs, the types of services offered, criteria for admission into the program and, guidelines or regulations required of the program (i.e., confidentiality). Some services find it advantageous to have a Client Information Sheet or program brochure that outlines all of this information which the client can take away for future reference.

If the client is accepting of this information, the worker will request the client to sign this form consenting to receive services from the program. Some services choose not to have such a form, and when the client discloses information or agrees to the treatment plan this is legally considered a client's consent to receive services. This form does not bind the client from choosing to terminate, drop out or refuse additional services.

History Update Form: Occasionally previous clients of a service may choose to re-engage services regarding the same or new problem. As a comprehensive psychosocial assessment was already completed, it is redundant to redo such an assessment. A *History Update Form* is used for clients designated as *re-admissions* to the program. The main purpose of this form is to define any significant changes in the client's life since completion of the original psychosocial assessment. Information is again collected on the presenting problem, a summary assessment of the client's problem, an assessment of the client's functioning, and a treatment plan for the newly identified presenting problem.

Admission/Closure Summary: When keeping clinical records of clients, a summary sheet located at the front of the clinical document allows for quick reference of information located in the document. Information included in the summary sheet consists of demographic data of the client, description of the problem, types of services accessed, date of admission and discharge, length of time in the program, outstanding problems at time of discharge and, basis for client separation. This form can be colour-coded for quick access and should be completed each time new services are accessed by the client.

Cultural Considerations

Although it is recognized that this manual is intended for front line workers from First Nations and Inuit communities, it is important to stress that one must be aware of cultural differences. Should a front line worker request or access an assessment from non-Aboriginal professionals, it is important that these individuals have an awareness of First Nations and Inuit culture. Non-Aboriginal professionals conducting assessments who have no knowledge or background regarding cultural issues may risk misdiagnosing normal cultural behavior patterns and beliefs as mistaken pathological symptoms of psychiatric illness.

According to *A Gathering of Wisdoms (1995)* different symptom patterns among First Nations and Inuit clients may also complicate assessments. Whereas the underlying causes and basic symptoms of major mental illnesses are universal across cultures, the content of delusions, hallucinations and abnormal conduct differ between cultures. These *symptoms* also run the risk of misdiagnosis since a non-Aboriginal professional may categorize these as symptoms of major mental illness when they may in fact be related to a client's traditional orientation and belief system (i.e., the acknowledgment of spirits). First Nations and Inuit clients may present with uncommon symptoms that are not readily recognizable within the *Diagnostic and Statistic Manual - Third Edition (DSM-III)*.

For example, First Nations and Inuit peoples may mask depression through such symptoms as substance abuse, vocational issues, or domestic violence. Other diagnostic categories within the DSM-III are weighted heavily on socio-cultural norms and can be culture specific, which may not apply to First Nations and Inuit peoples, resulting in misdiagnosis (i.e., personality disorders).

From the sample psychosocial assessment and supporting documents it is clear there is importance in establishing a clients' connection with his/her culture. This should be done by investigating a client's:

- identification with his/her Aboriginal culture
- degree of traditional orientation
- status, role and obligations in the extended family
- familiarity and comfort dealing with mainstream resources

- appropriateness of involving family members in treatment
- spiritual needs
- family and community resources

Family and Community Assessments

There are a variety of theories on the most effective way of conducting family-based assessments. One theory states that each individual member should be assessed individually allowing each member to define his/her issue or problem which may provide the best possible description of the entire family. Another theory suggests that the entire family should be assessed as a group in order to see some of the complexities and dynamics which occur within this group. While other theories promote a combination of individual and group assessment as the most effective course of action.

Although conducting a combined individual and group assessment may be time-consuming it may offer the worker or assessor the richest description of the family, roles, areas of abilities and deficits, and issues, to name a few. As part of family therapy, it is often important to break the family structure into coherent groupings that promote progress within the family structure. To this end, an assessment utilizing individual and family constellations may be the most comprehensive and yield the greatest outcomes.

When assessing the family within the larger constellation, the structure is somewhat less formalized. The worker must be adept at observing interactional and relationship patterns between family members. It will also be important for the worker to have a well-defined set of interview skills that promotes dialogue and discussion allowing all family members an opportunity to contribute. Through this process the worker will be developing an evaluation of the family.

There are a variety of questions the worker may consider when carrying out a family-based assessment. These may include:

- is the *identified* client's symptoms a reflection of difficulties in the larger family relationships?
- what kind of boundaries exist between individuals and subsystems (i.e., parents)?
- are boundaries within the family rigid or diffuse?
- what are the roles and relationships within the family?
- are roles and responsibilities age and generation-appropriate?
- are children being *parentified*?
- who is scapegoated?
- do family members take turns as the symptomatic or scapegoated one?
- does triangulation occur, and where?
- what type of communication exists within the family?
- what messages are given through non-verbal communication?
- will family supports promote individual growth?
- are family members enmeshed or estranged?
- is there resistance to change, and how strong is it?
- what kind of defenses does the family use to maintain dysfunctional balance?
- are there myths and secrets?
- how are family rules enforced?
- what is the emotional climate of the family?
- are expressions of anger taboo?
- are feelings of tenderness, sadness and disappointment discouraged?
- does the family tolerate differences of opinions, and feelings among members?
- what is the family's cultural values and belief systems?
- do cultural belief systems differ among family members, and is this tolerated?
- what is each members role, expectations and obligations within the family?
- how does extended family affect the immediate family structure?

The types of questions asked in the family assessment may be based partially on the information the assessor or worker has garnered through the previously conducted individual assessments and theories the worker may be investigating.

Another strategy that could assist in the development of the family evaluation is known as an *eco-map*. An eco-map is a diagram of the family within the community setting. Its purpose is to organize and clarify information on supports and stresses within the family context.

Within the eco-map, it is important to identify any supports, systems or resources within the community which may be impacting on the family system. The immediate family genogram is placed in the center of the eco-map with all identified groups placed around the family. To signify the

type of relationship, if any, that these various groups have with the family, a strong relationship is signified with a straight line with two-way arrows [<---->], a stressful relationship is signified by a straight line with intersecting horizontal lines [-/-/-/-/-], a tenuous relationship is signified by a broken vertical line [-----] and no relationship is signified by no line (*see Appendix 2B*).

Not only does the eco-map identify supports, resources and stresses in the family's life, but it also assists with defining groups that the family should become involved with to improve their functioning, a major task of treatment.

An eco-map may also provide information on how well-connected the family is to the community (i.e., have they always lived in a First Nations or Inuit community?), who or what they are most aligned with (i.e., spiritual groups, other family systems, etc.) and perhaps, the family's status within the community. Gathering all of this information provides the worker with identifiable treatment goals through the acknowledgment of areas of family stress and the source of such stress.

The eco-map is not only a good tool for conducting a family-based assessment, but it also provides information on what resources are in the community and how the community responds in times of crises and celebration. This is particularly important if the worker is not a member of the community s/he services. There are certain community issues workers should be familiar with so they can offer clients the best services possible. It is important to be aware of the cultural values and beliefs of the community, how tolerant the community is to individual differences (i.e., sexuality, spirituality, etc.), the political atmosphere of the community, how the community responds to crises and celebrations, relationships between extended families, identifying influential individuals and families in the community, the needs of the community (i.e., housing, health care, education, etc.), and important historical information about the community (i.e., residential school experience, maintenance of language, traditional activities, etc.). This information could provide valuable suggestions about challenges that an individual or family may be facing within the community, and the likelihood of accessing various supports within the community setting.

RISK ASSESSMENT

Suicidal ideation and behavior is a serious concern throughout the Canadian population, with approximately one in seven Canadians admitting to seriously considering suicide. Statistics show that for every completed suicide, there are 100 attempts. The rate of suicide in Canada is reportedly higher than that of the United States with the Canadian Mental Health Association estimating that 8% of Canadians are directly affected by suicide attempts and completions. In the last 45 years, suicide rates have increased by 60% worldwide. This has particular urgency for First Nations and Inuit populations as the leading cause of death is injury, with suicide making up 24% of those deaths, second only to motor vehicle accidents. A conservative estimate by the Canadian Mental Health Association suggests that First Nation and Inuit people of all ages completed suicide two to three times more often than non-Aboriginal people. These statistics increase significantly for adolescent males, who are more likely to use lethal means.

Based on the high rates of suicide attempts and completions for First Nations and Inuit people, it is important for front line workers to have a good suicide risk assessment tool. Such a tool relies on self-report data of the client, since there are no good psychometric tools that can accurately predict a person's level of risk to him/herself. Self-reports are considered a valuable tool since clinicians and researchers who are experts in the area of suicide agree that a suicidal individual may admit his/her suicidal thoughts or plans. If the suicidal person admits to suicidal ideation or behavior, it is important to take this information seriously and act on it immediately! The likelihood of a non-suicidal person admitting to suicidal ideation or behavior is highly unlikely. Any person who discloses suicidal ideation or behavior should be taken seriously.

Regardless of a worker's training, it is important to have standard procedures on how to act when a client presents as suicidal. In this section of the manual, information will be offered on:

- characteristics and warning signs of suicidal ideation and behavior
- how to respond to an individual who reports as suicidal
- how to assess for risk of self-harm
- what to do with a client who presents as moderate to severe risk of suicide or self-harm

When attempting to assess a client for risk of self-harm, having some knowledge of common warning signs and characteristics of a suicidal person can assist in carrying out an effective suicide risk assessment. It is important to remember that when gathering information on a person's level of risk, these are signs that may suggest imminent risk of self-harm. Should a person have a preoccupation with death or make death threats, these are a serious indicator of risk. Some signs suggested below, however, do not alone suggest risk (i.e., moodiness), but when considered with other risk factors or signs, may increase a person's level of risk. **Appendix 9** offers some common characteristics of suicide, including some suggestions on ways of reducing a person's risk level of self-harm.

COMMON WARNING SIGNS

Suicidal threats:

- writing about suicide
- direct threats (*I'm going to kill myself*)
- indirect threats (*I might as well be dead*)

Preoccupation with death:

- making final (death) arrangements
- giving away prized possessions
- talking about death
- reading or writing about death
- creating artwork about death
- obsessing about a dead person

Changes in a person's behavior, physical condition, thoughts or feelings:

- social withdrawal, isolation
- loss of resources
- less involvement in interests and activities
- increased risk taking behaviors
- heavy use of alcohol and/or drugs
- decreased work or academic performance
- frequent lateness
- unexplained absences
- crying easily
- abrupt changes in appearance
- recent weight or appetite changes
- sleeplessness or sleepiness
- lethargy or exhaustion
- increased absences due to unexplained or minor illnesses
- inability to concentrate or think rationally
- exaggerated fears of disease
- low self-esteem
- hopelessness or helplessness (*I'm tired of it all!*)

- increased irritability or anger
- moodiness
- not communicating
- extreme anxiety

Stress:

- loss of significant person, job or financial resources, friend, child, sibling, etc.
- breakdown in a significant relationship
- threats of incarceration
- past trauma

Procedures for Dealing with Suicidal Individuals

There may be occasions when a staff member who has no clinical training, such as a receptionist, may encounter a suicidal individual and must make quick decisions to ensure the safety of the client. If a non-clinical staff member is alone in the clinic and receives a phone call from an individual who reports being suicidal, the following steps should be taken:

1. If the individual is on the phone, get as much information as possible (i.e., name, address, phone number, etc).
2. If s/he is alone in the home, can s/he call someone to be with them? Has s/he attempted suicide before and does s/he have a plan and necessary equipment to carry it out (i.e., rope, gun, pills, etc.)
3. Try to persuade him/her to go to the nearest emergency department. If s/he hangs up and the worker has at least the name and address, call the police and request them to investigate.
4. Notify the manager or supervisor as soon as possible. Completing a report may be beneficial.

If a non-clinical staff member encounters an individual, either in person or on the phone, who reports being suicidal and there are other workers in the office, the non-clinical staff member should attempt to gather as much information as possible (i.e., name, address, phone number, etc) and then transfer the call or refer the client to a worker as quickly as possible.

If a non-clinical staff member is working alone in the clinic and an individual walks into the clinic reporting s/he is suicidal, the following steps should be taken:

1. Remain calm. Gather information, then call the designated person *on call* for consultation, if available or applicable.
2. Call the individual's family doctor to arrange to have him/her see his/her family doctor or arrange to send the individual to the local hospital's emergency department.
3. If the individual refuses to go to the doctor or local emergency department, call the police to have the individual escorted to the emergency department.
4. Notify the manager or supervisor to arrange follow-up with the individual to be seen either at home or in office.

In most cases, there will hopefully be a worker trained in suicide risk assessment available if and when a suicidal person presents, in person or by phone, to the clinic. The primary objective of a front line worker is to complete a suicide risk assessment to determine the level of risk for self-harm of the identified individual. The reader is referred to **Appendix 8** for a sample of a *Suicide Assessment Tool*. Generally, if the person is assessed as low risk for self-harm, a follow-up appointment should be conducted. If the person is assessed at moderate to high risk for self-harm, a safety contract and/or visit to the local emergency department is recommended, along with a follow-up visit for ongoing assessment and monitoring.

Along with conducting a suicide risk assessment the worker should carry out the following procedure if an individual, on the phone, reports being suicidal:

1. Engage the individual. Gather demographic information (i.e., name, address, phone number, age, etc.) and complete the Suicide Assessment Tool if possible.
2. Encourage the individual to come to the clinic or go to his or her family doctor or local emergency department.
3. Discuss the case with the manager or supervisor or consultant (if applicable). If considered low risk, make arrangements to see the individual at home or in the office. If considered moderate to high risk, staff will be dispatched from the clinic along with the police to the home or wherever the call came from. Police may be requested to visit the individual at home or transport, if necessary.

4. Arrange to see the individual for follow-up. A home visit allows for a face-to-face assessment to ensure that support systems are in place and to monitor the individual.

If a suicidal individual walks into the clinic the worker should take the following steps:

1. Assess level of risk by completing the Suicide Assessment Tool.
2. Consult with the manager or supervisor or peer clinician when possible.
3. Send the individual to his or her family doctor or nearest emergency department if risk is high. If individual refuses to go to either, allow him or her to leave and call the police. Police may be requested to visit the individual at home or transport, if necessary.
4. If risk is moderate or low, as a result of the completed Suicide Assessment Tool, arrange frequent follow-up appointments for reassessment. Apprise the manager or supervisor of the individual's progress (or lack of) after each appointment while the client remains at risk.
5. Arrange consult with family doctor or psychiatrist, if appropriate.

Caring for a Suicidal Individual

A suicide risk assessment should always be used if a client reports experiencing suicidal ideation or behavior. Should a worker be concerned that a client is experiencing low mood or depression, part of the ongoing evaluation of the mood is to conduct an assessment of symptoms, including asking if the client is suicidal or has had recent thoughts or plans of self-harm.

If a worker is unsure about a client's risk level, ask the client if s/he has experienced suicidal thoughts or behaviors recently. This question will not cause someone to become suicidal. As stated previously, clients who present as low risk for self-harm require ongoing follow-up for monitoring of feelings and thoughts so his/her risk level does not increase. These follow-up appointments should always be done in person so that a worker can observe for any signs of suicide, including any physical changes in the client, and to re-assess the client's risk level. If a client is evaluated as being at moderate risk for self-harm, a safety contract should be established which includes identifying formal and informal support systems for the individual, making an agreement to not engage in any suicidal behavior, and activities for the client and worker that would decrease the client's risk level (i.e. phoning a friend, going for a walk, agreeing to meet in two days, doing phone check-ins, etc). This safety contract should be a part of the ongoing monitoring and follow-up the worker will engage in until such a time that the client's risk level has reduced.

If a client presents at high risk for self-harm, encourage the client to go voluntarily to the local emergency department. If s/he refuses, it is important to ensure his/her safety and the worker should notify the client that s/he has an obligation to keep the client safe, and should the client refuse to seek medical attention the worker will notify the police to escort him/her to the hospital.

Ongoing follow-up with the client is also necessary to monitor risk level and assist in defining ways to reduce risk. Strategies to reduce a client's risk level may include:

- reducing feelings of isolation
- defining a support system
- becoming involved in interesting activities
- increasing energy by engaging in exercise
- finding something meaningful in his/ her life
- developing positive thoughts
- reducing his or her feelings of extreme stress

Usually a small behavior, thought or feeling can reduce a person's level of risk for self-harm, and it is finding this key factor, which is unique for each individual, that can save a person's life.

ABUSE DISCLOSURES

When conducting an assessment (individual or risk) or therapy with clients it is possible that the client will disclose an experience of trauma or abuse. This disclosure signifies a client's level of trust in the therapeutic relationship and it is important that the client knows your boundaries and limitations. For this reason, it is important to qualify confidentiality and its limits prior to beginning the individual assessment. As noted later in this manual, it is also important workers not agree to keep a secret. as it may not be ethically possible and could irrevocably damage the client-therapist relationship.

When a client discloses abuse there are certain measures that need to be taken, depending on the age of the client. If the client is an adult reporting past abuse, workers must inform the client that they are under no obligation to report this to the police or child protection services. The only exception to this rule is if an adult discloses being abused by a Registered Health Professional (i.e., doctor, nurse, psychologist, optometrist) to another Registered Health Professional. In this case the RHPA must report this disclosure to the appropriate licensing body.

Once a person is over the age of 16 it is the client's choice and responsibility to have this matter investigated and lay charges, if applicable. In most cases, adult survivors of abuse are usually most concerned with telling their story and working through their issues first. Should an adult survivor choose, at any point, to formally lay charges, it is the responsibility of the worker to offer support in making decisions and working through any emotions they may experience as part of this process.

However, when a disclosure of abuse occurs, it is always important to ask questions about the perpetrator. Workers should ask if the alleged perpetrator is still alive and what kind of contact s/he may have with children. If there is a concern that the alleged perpetrator has unsupervised access with children and there is concern for the safety of a child, it is the worker's responsibility to contact the child protection services or Children's Aid Society (CAS). This is also the case when an abuse disclosure is made by a child under the age of 16. A report must be made by the worker to child protection services or CAS. Outlined below are some general guidelines regarding duty to report suspicions of child abuse.

Reporting Suspicions of Child Abuse

According to the Child and Family Services Act *(March 31, 2000)*, anyone making a report in good faith will be protected from civil and criminal liability for reporting, unless it is determined that the person has acted maliciously or without reasonable grounds for the suspicion.

Under this Act, *Section 72*, staff, volunteers and students have a duty to report when they have reasonable grounds to suspect that a child is or may be in need of protection as set out immediately as follows:

S72.(1) Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

1) The **child has suffered physical harm**, inflicted by the person having charge of the child or caused by or resulting from that person.
    1) Failure to adequately care for, provide for, supervise or protect the child, or
    2) Pattern of neglect in caring for, providing for, supervising or protecting the child.
2) There is a **risk that the child is likely to suffer physical harm** inflicted by the person having charge of the child or caused by or resulting from that person's,
    1) failure to adequately care for, provide for, supervise or protect the child, or
    2) pattern of neglect in caring for, providing for, supervising or protecting the child.
3) The child has been **sexually molested or sexually exploited** by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.
4) There is a **risk that the child is likely to be sexually molested or sexually exploited** as described in paragraph (c).
5) The child **requires medical treatment** to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to the treatment.

6) The child has **suffered emotional harm**, demonstrated by serious
   1) anxiety
   2) depression
   3) withdrawal
   4) self-destructive or aggressive behavior, or
   5) delayed development,

   and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

7) **The child has suffered emotional harm** of the kind described in sub-clause (f) i, ii, iii, iv, or v and the child's parent or the person having charge of the child does not provide, or refuses or unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

8) There is a **risk that the child is likely to suffer emotional harm** of the kind described in sub-clause (f) i, ii, iii, iv, or v resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

9) There is a **risk that the child is likely to suffer emotional harm** of the kind described in subparagraph (f) i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

10) The **child suffers from a mental, emotional or developmental condition** that, if not remedied, could seriously impair the child's development and the child's parent(s) or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to treatment to remedy or alleviate the condition.

11) The **child has been abandoned, the child's parents have died or are unavailable to exercise his or her custodial rights** over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.

12) The **child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property**, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to those services or treatment.

13) The **child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property**, with the encouragement of the person having charge of the child or because of the person's failure or inability to supervise the child adequately.

S72.(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) shall make a further report under subsection (1) even if he or she has made previous reports with respect to the same child.

S72.(3) A person who has a duty to report a matter under subsection (1) or (2) shall make the report directly to the society and shall not rely on any other person to report on his or her behalf.

S72.(4) A person referred to in subsection (5) is guilty of an offence if,
1) he or she contravenes subsection (1) or (2) by not reporting a suspicion, and
2) the information on which it was based was obtained in the course of his or her professional or official duties.

S72.(5) Subsection (4) applies to every person who performs professional or official duties with respect to children including,
1) health care professionals, including physicians, nurse, dentist, pharmacist and psychologist;
2) a teacher, school principal, social worker, family counselor, priest, rabbi, member of the clergy, operator or employee of a day nursery and youth and recreation workers;
3) a peace officer and a coroner;
4) a solicitor; and
5) a service provider and an employee of a service provider.

If, at any time, workers are unsure of whether or not they should report a suspicion that a child is or may be in need of protection, they should call the Children's Aid Society Intake Worker and consult regarding their suspicion by sharing the facts to determine whether there is a duty to report.

When the CAS Intake Worker determines that there is a duty to report, the worker making the referral must immediately disclose all identifying information, as well as all of the facts upon which the suspicion that a child is or may be in need of protection is based. The CAS must then conduct a protection investigation in relation to the referral. Regardless of the outcome of the call the worker must record in the client's chart that a call was placed to CAS.

Procedure for Reporting Suspicion of Child Abuse

Steps to follow in reporting that a child is or may be in need of protection whether the information has been disclosed to you directly or by a third party.

1. Call the Children's Aid Society (CAS) and speak with an intake worker.
2. Identify who you are and where you work.
3. Give the CAS the information provided to you by the child or other person which caused you to have reasonable grounds to suspect that a child is or may be in need of protection as identified in S.72(1), including (if available):
   - the name of the child, date of birth and address;
   - the name of the parent(s), their address and telephone number;
   - explain the suspicion that a child is or may be in need of protection and the information upon which it is based (e.g., child has been sexually molested; see grounds upon which a child is or may be in need of protection, where a duty to report applies as listed in S.72(1));
   - when the event happened, or when you became aware of it;
   - details and facts of the event as described by the child or other person; use the child or other person's words when possible;
   - whatever additional information as requested verbally by the CAS so that they can proceed with their initial investigation.
4. Write a note in the chart that a report has been made to the CAS about a child who is or may be in need of protection, whether for a formal report or a consultation.
5. Notify your supervisor that you have reported that a child is or may be in need of protection by CAS.
6. Within two or three working days, provide a written letter to CAS, restating the same information that was reported verbally.
7. A copy of the letter to the CAS must go in the child's chart and another copy sent to the staff's immediate supervisor. (Do not send copies to directors or managers unless specifically requested by them.)
8. Given the provisions for confidentiality in the legislation, the CAS cannot disclose to staff the outcome of the investigation conducted in relation to any referral made by staff. The CAS will provide acknowledgment or receipt of the referral within 30 days, or upon completion of the investigation.

   Where staff have not received any feedback, from the CAS about a referral, the staff having made the initial referral shall contact the CAS verbally to inquire about the status of the case. The staff will also document on the chart that a call was made to inquire about the status of the investigation.

Reporting Suspicions of Abuse When Disclosure Occurs to Several Professionals Simultaneously.

1. When disclosure occurs to several staff simultaneously, place a single call to CAS; identify the names of each staff that were present is sufficient. The names of EACH of the professionals must be reported in the call to CAS.
2. Follow-up with a single group letter to the CAS containing the signatures of each of the staff present or separate letters from each of the staff who were party to the disclosure.
3. If disclosure occurs when professionals from other agencies are present, each agency should write a separate letter. Group letters within agencies are acceptable as long as they contain each of the signatures.
4. If you receive information about a report from

somebody else (internal or external) made in the past (i.e., more than several weeks ago), and you know the other professional reported it, you do not have to report this to the CAS. If you receive additional information that was not originally reported, or are unaware if the additional information was reported, you must report it to the CAS.

5 If you are unsure if somebody else has reported the abuse, call the CAS.

See **Appendix 14** for a sample letter to send to CAS regarding reported suspicion of child abuse. As front line workers in First Nations and Inuit communities there is a strong likelihood that a worker will be faced with not only reporting, but also providing therapy on trauma and abuse. Workers are encouraged to seek appropriate training on this important and sensitive issue, which is beyond the scope of this manual.

CONFIDENTIALITY

Confidentiality is *the safe keeping and management of private, personal and intimate information.* It refers to something that is *told or communicated in privacy.* Clients have a fundamental right to privacy and confidentiality.

It is a worker's principal and primary responsibility to protect client privacy and confidentiality. Privacy and confidentiality are privileges of clients and only clients may waive these rights. Therefore, those who work in the area of social service delivery, and who receive these communications, have a serious responsibility to keep the concerns of their clients private. Confidentiality is a key component of all community services that handles personal and sensitive information about individuals. When providing mental health or addictions services to vulnerable individuals, it is especially important that clients be aware that confidentiality is a primary goal of the services. Providing clients with assurances of confidentiality can promote worker credibility and a sense of trust in this client population which is a prerequisite for disclosing personal and private information, all needed for effective service delivery.

Challenges to Confidentiality

As noted in *A Gathering of Wisdoms (1995)*, ensuring the confidentiality of all client information is both extremely important and extremely difficult for front line workers in small First Nations and Inuit communities.

Maintaining confidentiality in a First Nations and Inuit community is more complicated than in most mainstream services. In small First Nations and Inuit communities everyone knows a great deal about everyone else and their family.

There is considerable curiosity and gossip that reflects both genuine concerns for other community members and acts as a form of social pressure. It is common for potential clients to be hesitant to seek mental health and addiction services for fear they will be seen speaking with these workers and defined as *crazy* or *drunk*. This fear is two-fold, first regarding the stigma attached to seeking mental health and addictions services, and second, regarding confusion between confidentiality and anonymity.

In regards to the stigma associated with seeking mental health and addictions services, it appears the best way to demystify the services is to provide education on what these services offer and to publicize the services through newsletters, workshops, lectures and other community activities that promote the services. Since some community members are unable to distinguish the difference between anonymity and confidentiality, it is the responsibility of the worker and the Health Centre to offer education on the differences. Anonymity means that the worker and/or Health Centre can guarantee potential and existing clients that they will not be seen accessing services at the clinic or Health Centre. This is usually impossible to guarantee since First Nations and Inuit clinics and Health Centres are centrally located in the community and accessed by most community members.

Confidentiality, on the other hand, means that the worker and/or Health Center can guarantee potential and existing clients that information will not be made public regarding types of services accessed, reason for accessing services, or release of any personal information. This is a guarantee that can be realistically made with the proper procedures and education.

Educating the community, other community agencies and workers, administration, and Chief and Council regarding confidential services is an important and necessary task of all community services who provide assistance to community members on personal and sensitive information. Education can be done at a variety of levels. Providing descriptions of what it means to access a confidential service through newsletters, television, radio and community information sessions are valuable strategies. Developing policies and procedures regarding what it means to offer confidential services, how to maintain confidentiality, and what are the limits or boundaries to confidentiality will also assist in educating administration, community workers, and Chief and Council.

Oath of Confidentiality

Regardless of a workers training, there is an ethical and moral responsibility to maintaining confidentiality with clients personal information. New and existing workers can be asked to sign an oath of confidentiality which simply states that they *will not share or discuss any personal information about clients at any time, except in the performance of their work assignments and with the permission of the*

client. As part of the oath, workers also acknowledge ethical and moral responsibility to breach confidentiality or disclose personal information with a client's consent only in the following conditions:

1. The information involves a threat or risk of harm to self or others
2. When there is a risk or suspicion of abuse or neglect of a minor child under the age of 16 years
3. When ordered by a court having jurisdiction
4. When there is a suspicion of abuse by a Registered Health Professional or Social Worker *(applies to RHPA or Social Workers only)*.

As part of the oath or policy there is recognition that any breach of confidentiality that falls outside of these parameters may be considered a cause for dismissal. A procedure on how to handle and investigate complaints of breach of confidentiality should also be included within this policy.

Confidentiality Agreements

For community members who access confidential services it is a good idea to set out the parameters and expectations of a confidential service, as well as define the boundaries or limitation to confidentiality. **Appendix 10** provides a sample letter that can be shared with new and potential clients regarding how a confidential service is maintained, limits to confidentiality and what to do when a client is concerned about a breach of confidentiality. Similar to a *Consent to Receive Services Form*, some organizations find it useful to expand on this concept and require clients to enter Service Agreements. These agreements may vary in form and format but usually include the following elements:

- what records will be kept;
- how long records will be kept;
- confirmation that they will be maintained securely;
- any necessary acknowledgment that information may be discussed among professionals to ensure the best service to clients;
- the fact that information contained in client records will not be revealed without the signed and informed consent of clients (excluding legal and professionals expectations regarding limits); and
- the method by which clients can access their own records.

Service Agreements can be an important part of service delivery. It promotes a cooperative relationship between the client and the worker by letting clients know that their information is considered valuable and important. The client also understands that they have control of their personal information, including who accesses their records. **Appendix 11** offers a sample of a *Service Agreement*.

Procedures for Maintaining Confidential Files

Management or administration plays a significant role in the area of confidentiality. It is ultimately the responsibility of management to ensure that client information is kept confidential. This responsibility is best met in the development of policies and procedures regarding the development and maintenance of confidential records. The maintenance of confidential files requires the following:

1. Complete name, address, telephone number or any other identifying information of anyone other than the client in question is not to be recorded in a case file.

   Exceptions:
   a. Referring agent: family member, agency worker, teacher, etc.
   b. Informant: the person who provides important or essential information that in the clinician's opinion is pertinent to the management or well-being of the client.
2. Under no circumstances should the chart number of a client be recorded in the clinical record of another client.
3. Do not release any information without an originally signed, witnessed, and dated Consent to Release of Information Form specifying validation dates.
4. All files must be returned at the end of the day. Files must not be kept in the therapist's office *(unless policy dictates that clients who are family members of staff will be kept separate to ensure confidentiality. These records will also be kept in a locked cabinet)*.
5. Do not remove any files from the property. If they have to be transported to a sub-office they must be carried in a locked container.
6. In accordance with the Ministry of Health, the following persons may review information without written consent:

- Attending physician
- Court order or subpoena
- Nursing, social work or psychology student on placement
- Clinical supervisor
- Audit committee or auditor

Access to Clinical Files

Once workers and managers have developed a system to maintain confidential client information it is important to monitor access to these files. Often, this client population is involved with various community agencies who require access to information. Accessing this information may be important to a client's overall plan of care, however, it is the worker and manager's responsibility to ensure that those who request access to the information have legal permission to do so.

As noted earlier, an integral component of confidentiality is the client's awareness that s/he has control of his/her personal and private information, including who has access. Information from a client's file may only be released with the client's voluntary, written informed consent. If the client is a minor, the legal guardian of the client must consent to the release of information. For information being requested from the chart of a deceased client, the next of kin or executor of the estate will consent to the release of information. Only the following supercedes the above:

- a subpoena
- a search warrant
- a coroner's warrant
- a summons
- the Registrar of the College of Physicians and Surgeons
- a designated individual from the Deputy Minister of Veteran's Affairs where the client is a member of the Canadian Forces or an ex-member of Her Majesty's military, naval or air force of Canada
- when a written request has been received by the Health Board or Manager for information to assist in research
- the Medical Officer of Health regarding a reportable disease

Procedure for Disclosure or Release of Information

1. Requests for information must be accompanied by a properly dated, signed and witnessed *Consent for Release of Information Form*. Photocopies of signatures and faxed signatures are unacceptable.
2. The manager or director must ensure that a properly dated, signed and witnessed consent form accompanies the request.
3. The manager or director will handle all requests for information, including requests from insurance companies, unions, clients and their families, lawyers, police, members of parliament, band councils, etc. It will be the responsibility of the manager or director to consult with the executive director when in doubt.
4. The manager or director will review and determine what information is being requested and what information will be sent.
5. Photocopies of the information must be made and stamped to indicate that they are copies and stamped to indicate that these photocopies must not be copied.
6. When appropriate, an invoice for services will be sent.
7. A covering letter, written and signed by the manager or director, indicating what information has been provided will be sent and a copy of this letter will be placed on the client's file.
8. When a subpoena, search warrant or coroner's warrant is received, a copy of the client's entire file is made.
9. In all cases, documentation should be written on the request as to what information was provided.

When disclosing or releasing personal information from client files it is important to have a voluntary, written informed consent form from the client. **Appendix 12** provides a sample of a *Consent to Release Information Form*.

The confidential client file, when developed, is considered the property of the service, program or clinic. In this regard, staff members who work in this area have access to client files. To ensure that access is not abused it is important that files be stored in a central location that is locked and monitored by a designate such as a file room clerk or receptionist. It is the designate's responsibility to ensure that client files are returned to the central

location at the end of the day or when not in use, they are not removed from the general program area or clinic, and they are stored in a locked storage unit.

Although files are the property of the program or clinic, clients and/or legal guardians have a right to access their information. Clients who are over the age of 16 years or legal guardians (for those under the age of 16) have the right to make a request to access their information. When doing so, the client or legal guardian must make a request in writing to the manager or director to examine his or her (or child's) records.

Procedure for Client/Relative Access to Client Files

1. All requests for access by a client to their clinical records must be in writing and must contain the following:
   - full name, address and date of birth of the person whose information is being requested
   - purpose or need for the information
   - specific definition of the type and extent of the information being requested
   - relevant treatment dates
2. Upon receipt of the request, the manager will meet with the staff involved to determine whether the client's access to their clinical records will result in *harm to the treatment or recovery of the individual, injury to the mental condition of another individual or bodily harm to another individual or if access could reasonably be expected to constitute an unjustified invasion of another individual's personal privacy (Personal Health Information Privacy Act)*.
3. Care must be taken to ensure that the person requesting the information is entitled to receive it, ensuring appropriate consent from the appropriate person was obtained and that legislative and regulative requirements were followed; where appropriate, the attending physician is notified.
4. Should the request be granted, a meeting must be arranged by the manager for him/her to review it in the presence of the staff member attached to the case.
5. All questions and concerns raised by the client during the meeting will be documented and dealt with by the appropriate staff member.
6. If the client requests copies of his/her clinical record, copies will be provided. A list of all documents copied for the client will be made and maintained on the client's file.
7. If the request for access is refused in whole or in part, the individual is entitled to make a complaint to the Information and Privacy Commissioner.
8. An individual who believes there has been an error or omission in a record of personal health information relating to the individual may request in writing that the record be amended. The record is either amended as requested or a statement of disagreement will be attached to the record stating that the amendment requested has not been made.

Procedure for Telefaxing Client Information

There are occasions where it may be necessary to telefax client information. Although this is NOT totally confidential, certain procedures can be enforced to meet the needs of our health care agencies.

1. Client information should not be faxed unless it is medically imperative that the information be received immediately. The preferred method is still by regular mail or courier.
2. Client information includes documents that identifies the person as being a client of the _____ service.
3. Use a standard *Consent for Release of Information Form* when telefaxing client information.
4. With original *Consent to Release of Information Form* information may be faxed to:
   - other mental health services
   - other hospitals
   - other doctor's offices
5. When telefaxing information, you should telephone the receiving services to inform them when the information is being sent. It is preferable that the information is telefaxed to a specific area and not a general mailroom.
6. If deemed necessary to telefax information, client consent will be obtained.
7. Client information may NOT be faxed to the following:
   - insurance companies
   - lawyers
   - workplace safety and insurance boards
   - probation and parole

A Gathering of Wisdoms (1995) offers some valuable guidelines to assist front line workers in maintaining and respecting confidentiality.

1. Each client has a right to privacy.
2. Never repeat things you are told by clients, even to members of your family or the client's family.
3. Do not discuss a client's problem with anyone who doesn't have a job-related *need to know*. Don't allow yourself to get drawn into community gossip, no matter how interesting or harmless it may seem.
4. Explain to clients that your services are confidential, but be very careful not to promise more confidentiality than you can legally keep. Be sure you understand the limits of confidentiality: Learn what things you must tell someone else about (child abuse, suicide threats, and other situations where clients are a danger to someone else). Also learn who you should tell in these situations (usually your supervisor and/or the police, child protective services). Situations like these where law requires you to report information in order to protect your client or someone else are rare, however, it is very important that you understand and explain these confidentiality limits to your clients. Don't promise to keep secrets, especially before you know what they are.
5. Learn your mental health clinic policies about information-sharing among staff. Know when you need to talk with other workers, and when to not. It is often appropriate to share some but not all information about a client with other staff. It is important to explain these policies to clients so that they will feel comfortable that their privacy is protected.
6. Become familiar with the laws surrounding confidentiality. You should discuss questions or difficult situations with your supervisor.
7. When you want to discuss a case with an *outside* person (i.e., worker at another agency, lawyer, family member), you must first get written permission from your client. This is true even if the client has asked you to talk to the other person. The permission form must spell out with whom you will talk, the agency involved, why, and what information you can share. Without this written permission, you must not share anything about a client, even whether or not a certain person is your client. The signed release form is kept in the client's chart and must be dated as to when it was signed, and the date when permission to share information expires.

Appendix 13 offers front line workers a list of expectations regarding professional conduct that promotes such ideas as confidentiality and consent for release of information. This professional code of conduct should serve as a guide in providing professional and ethical services to community members.

RECORD KEEPING

Record keeping is a term used for the secure storage and maintenance of client files or charts. It is a set of professional practices by which a private client documentation is preserved and protected. *Record* is a term used for any documentation that is stored in client files within organizations. This includes such things as forms, notes, reports, summaries and any other written information about clients. In general, records have sufficient identifying information within them to recognize who that client may be. The important activity of making and keeping records is an essential and integral part of treatment.

Records have been kept for as long as services have been provided to community members. Records help provide information that enables service providers to:

1. Determine client eligibility for services.
2. Determine the need for further investigation or assessment.
3. Contribute to the assessment of client needs and expectations.
4. Assign clients to the most appropriate service provider.
5. Record events and impressions for later reference.
6. Record events and related facts for later investigation.
7. Provide a form of written communication among staff who work on different shifts and have a genuine need for crossover exchanges of information about clients.
8. Record information and observations about the client.
9. Offer an account of problems that arise and any action taken.
10. Furnish information on treatment required, any intervention by staff and client response to staff intervention.
11. Give data on significant factors (physical, psychological, or social) that affect the client.
12. Provide a record of the chronology of events and reasons for any decisions made by service providers or clients.
13. Establish a baseline against which progress and change may be appropriately evaluated.

There is, however, substantial experience to indicate that inadequate and inappropriate record keeping concerning services provided to clients disregards their interests through:

- Interfering with continuity of care.
- Diminishing communication between staff.
- Creating the risk of treatment being duplicated or overlooked.
- Failing to focus attention on early signs of problems.
- Failing to place on record significant observations and conclusions.

Basic Rules and Functions of Record Keeping

A correctly made record demonstrates the ethical concepts on which good practice is based and supports professional and clinical decisions. A basic rule of record keeping is that those who make, access and use the records understand the ethical concepts of professional practice that relates to records. This includes the need to protect confidentiality, to ensure true informed consent and to assist all clients in making informed decisions. Record keepers must also ensure that entries in a record are accurate and complete. Records must:

- Be written legibly and in ink
- Be clear and unambiguous
- Include dates and time
- Ensure that any alterations are clearly noted
- Ensure additions are dated and signed
- Avoid abbreviations and ambiguous phrases

There are seven principle functions to the development and maintenance of good clinical records. They are as follows:

1. To maintain a system of identification and filing that facilitates the prompt location of client information for continuity of services.
2. To ensure continuity of services through support of clinical evaluation studies, requests for statistical research, educational material and if applicable, requests for additional human and financial resources.
3. To ensure that the clinical record shall be confidential, current, complete, accurate, legible and readily available and shall be stored securely, as per the Client Confidentiality Act.
4. To maintain confidentiality and security of client information.
5. To channel and control all release of information from the clinical record, ensuring the safeguard of the record through authorized consent and proper documentation of the released information.
6. To maintain strict confidentiality.
7. To ensure compliance with government regulations as well as community applicable policies and procedures.

Goals and Objectives of Clinical Records

1. To maintain an adequate clinical record for every person admitted as a client.
2. To facilitate the accurate processing, checking, indexing, filing and prompt retrieval of all client information which ensures that a process contains sufficient information to:
   - accurately identify the client
   - justify treatment
   - document all results (includes intake, treatment plan and progress notes)
3. To ensure that the clinical record shall be confidential, current, complete, accurate, legible and readily accessible.
4. To maintain a system of identification and filing to facilitate the prompt location of client information.
5. To ensure that Management Information System data stored in an automated computer system shall be confidential, secure and accurate, as applicable.

As organizations and individual service providers move in greater numbers toward the use of computerized records, the issues surrounding the confidentiality and security of client information will grow. As with a paper record, it is the duty of the management team in the organization to assure the confidentiality of client information. There may be some who question the need for extra security measures, but organizations have the same responsibility (and client expectation) for the security and privacy of information. It is important to assign passwords to all confidential files and make certain these passwords are effective.

Policies Related to Record Keeping

Records, and their confidentiality, are dictated and maintained through the application of organizational policies related to record keeping. Simply put, a policy is a short, simple and clear statement of a behavior that is expected from all individuals who are governed by it. It describes a behavior, or set of behaviors, that shall be complied with by members of the organization who work under its cover. Many organizations have established *policies* which are not policies. They are procedures, guidelines, standards or practices that masquerade as policies, but are not in and of themselves policies. The role of policies is to create rules that are an essential part of service delivery, are relevant, and ensure professional practice.

There are several advantages of policy and procedure development which include:

- Resolving disputes. In situations in which there is disagreement about action to be taken or procedures to be followed, properly written policies can resolve the dispute.
- Providing orientation to new staff. When new staff are hired an initial review of the organization's policy manual can indicate the way the organization works, the values it supports and the behaviors that are expected.
- Offer a foundation for continuous training. Policy driven staff behavior is a reflection of basic performance expectations. As such, the issues dealt with through policies are also issues that most often require review and training for organizational staff.
- Providing key performance indicators. KPIs are indicators that the organization is emphasizing important values and can be a basis for both performance reviews and program evaluation. Policies reflect the intended outcomes of service delivery and as such, highlight such key performance indicators.

Proposed Process for Developing Policies and Procedures

Policy Proposal: Individuals, groups or departments propose a policy based on clearly identified needs. They sponsor the proposal into the development process within the organization.

Validation of Need: An organization should develop only those policies that are essential to the efficient and *best practice* operation of the organization. The proposal must make a compelling case for policy development.

Preparation of a Draft: A draft policy is developed based on the sponsored proposal. This is a management responsibility, although other staff members, stakeholders or governance members may be involved in preparing the draft.

Review of Draft by Staff: The draft is distributed to staff and to any external stakeholders (or representatives) who may be affected by the establishment of the policy. They return comments, concerns and suggestions to management.

Modification to the Draft: The comments, concerns and suggestions for policy modification are reviewed by management and appropriate modifications are completed.

Review by the Governance Body: The draft policy is presented to and evaluated by the organization's governance body. If necessary, any additional modifications can be made during this review.

Development of policies and procedures is a valuable component to any new or existing programs, services or organizations as it ensures the ongoing day to day operations of the program in an efficient manner. Without policies and procedures programs, services and organizations daily operations, goals, mandate, and the overall integrity may be jeopardized by any transitions that may occur at the staff or administration levels. This will ensure that staff and administrative transitions or turnover do not affect a dramatic change in the service that is being offered to the community. Further to this, policies also ensure that the training, skills and abilities of staff are maintained and quality assurance measures are incorporated into the program to promote effective client care.

Perhaps the most important reason to establish a formal set of policies and procedures is to protect the client. It is a task that requires ongoing review to ensure the applicability and appropriateness of the policy as the program, service or organization grows, but it also ensures continuity in client care at all times.

SUMMARY

There are a variety of issues that must be considered when conducting assessments in First Nations and Inuit communities. Attempts to consider such cultural issues as spirituality, cultural identity, role of the extended family and role of the community are just some of the areas that warrant special attention. Assessments can offer a wide array of information that can assist a worker in developing a plan of care, whether for an individual, a family or the entire community. For this reason, any front line worker from First Nations and Inuit communities have a stake in learning how to conduct effective assessments since it can assist in defining strategies that can improve the health and wellness of all community members. Each worker will develop their own unique style in gathering the information s/he needs for the development of the plan of care. This manual's goals is to provide sample forms that can assist workers in conducting assessments and how to use the information to provide quality client care.

When conducting assessments there is a likelihood that the worker may encounter situations in which s/he must have the skills to carry out more specialized assessments, particularly in the area of assessments regarding risk for self-harm or suicide. These assessments, upon first inspection, are less well-defined than the individual assessments offered in the manual. Rather, the manual attempted to provide the worker with knowledge about certain areas that must be explored with an individual who may be at risk for self-harm or suicide. Once again, how the assessment is carried out is defined by the skills of the worker and also by the responsiveness of the client in sharing information.

As it appears that many First Nations and Inuit people have dealt with some kind of trauma in their past, front line workers must be skilled at handling abuse disclosures and how to process the information. This is a particularly sensitive topic and workers must be aware of the issues of confidentiality as it relates to abuse, harm to self or others and personal information. To maintain confidentiality the worker should be aware of legal obligations and the necessity of informing clients of the responsibilities. The maintenance of confidential information is the responsibility of both management and staff. It is managements duty to set up an effective system for maintaining records or files which must often be supported by a well-developed set of policies and procedures that governs the daily functioning of a program or service.

It is hoped that this manual offers staff and management guidelines on how to conduct various types of assessments, providing education and procedures to maintaining confidentiality, and guidelines to assist in the development of policies and procedures for effective record keeping. All are forms of quality assurance measures to ensure that high quality service is being delivered to the community, and ultimately, that it protects the client, whether an individual, family or the entire community.

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APPENDIX I

CLIENT ASSESSMENT

WORKER: _____ **DATE:** _____

CLIENT NAME: _____ **DATE OF BIRTH:** _____

Presenting Issues/Diagnosis: *(Why is the client here?)*
Include client's view of the problem and their causes, previous attempts at dealing with the issue.

_____

_____

_____

_____

Presenting Strengths:

_____

_____

_____

_____

Relevant History: *(family, marriage, support system, traditional orientation, genogram, etc)*

_____

_____

_____

_____

Previous Treatment: *(include counseling, self-help, hospitalizations, spiritual help, etc.)*

- ☐ ADDICTION TREATMENT
- ☐ PSYCHIATRIST/PSYCHOLOGIST
- ☐ FAMILY COUNSELING
- ☐ SEXUAL ASSAULT SERVICES
- ☐ MEDICAL TREATMENT
- ☐ ADDICTION COUNSELING
- ☐ MENTAL HEALTH COUNSELING
- ☐ LEGAL SERVICES
- ☐ TRADITIONAL SERVICES
- ☐ SELF-HELP GROUP
- ☐ OTHER: _____

Details:

Traumatic Experiences: *(disruption of family relationships; medical, psychiatric or substance abuse problems within the family; emotional, physical, mental or sexual abuse; suicidal ideation or behavior within the family)*

Developmental/Educational History:

Education Completed:

- ☐ ELEMENTARY SCHOOL
- ☐ GRADE 9
- ☐ GRADE 10
- ☐ GRADE 11
- ☐ GRADE 12
- ☐ GRADE 13/ OAC
- ☐ NO FORMAL EDUCATION
- ☐ SOME COLLEGE
- ☐ COLLEGE CERTIFICATE
- ☐ COLLEGE DIPLOMA
- ☐ SOME UNIVERSITY
- ☐ UNIVERSITY DEGREE
  - ☐ BACHELORS
  - ☐ MASTERS
  - ☐ DOCTORATE

Did you attend Residential School? ☐ YES ☐ NO

Problems in: ☐ READING ☐ WRITING

Details:

Work History:

- ☐ HOMEMAKER
- ☐ SEASONAL EMPLOYMENT
- ☐ UNEMPLOYED
- ☐ EMPLOYED FULL-TIME
- ☐ EMPLOYED PART-TIME
- ☐ ATTENDING SCHOOL
- ☐ OTHER: _____

Details:

Spiritual Involvement:

☐ TRADITIONAL ☐ CATHOLIC ☐ OTHER: _____

Details of traditional activities and level of involvement: *(sweat lodge, healing circles, etc.)*

Other Relevant Information: *(developmental history, social history, history of substance abuse, health and medical issues, legal issues, resources, etc.)*

Client Questions or Concerns: *(explain limits of confidentiality and boundaries, inquire about client concerns)*

Other: *(other applicable session content)*

TREATMENT PLAN

Worker's Observations and Assessment: *(describe current level of functioning, strengths, problems and needs)*

Summary of Problem and Diagnosis:

Goals of Treatment: *(Goals should be SMART - Specific, Measurable, Achievable, Realistic and Time Specific)*

Mode of Intervention: *(counseling, therapy type, medication management, support/advocacy, skills teaching, etc.)*

Evaluation Plan: *(include reviews, date of next session, etc.)*

Discharge Goals: *(reduction of symptom, acquisition of new skills, follow-up plans, etc.)*

Estimated Duration of Treatment: *(number of sessions, length of sessions, etc.)*

_____

_____

_____

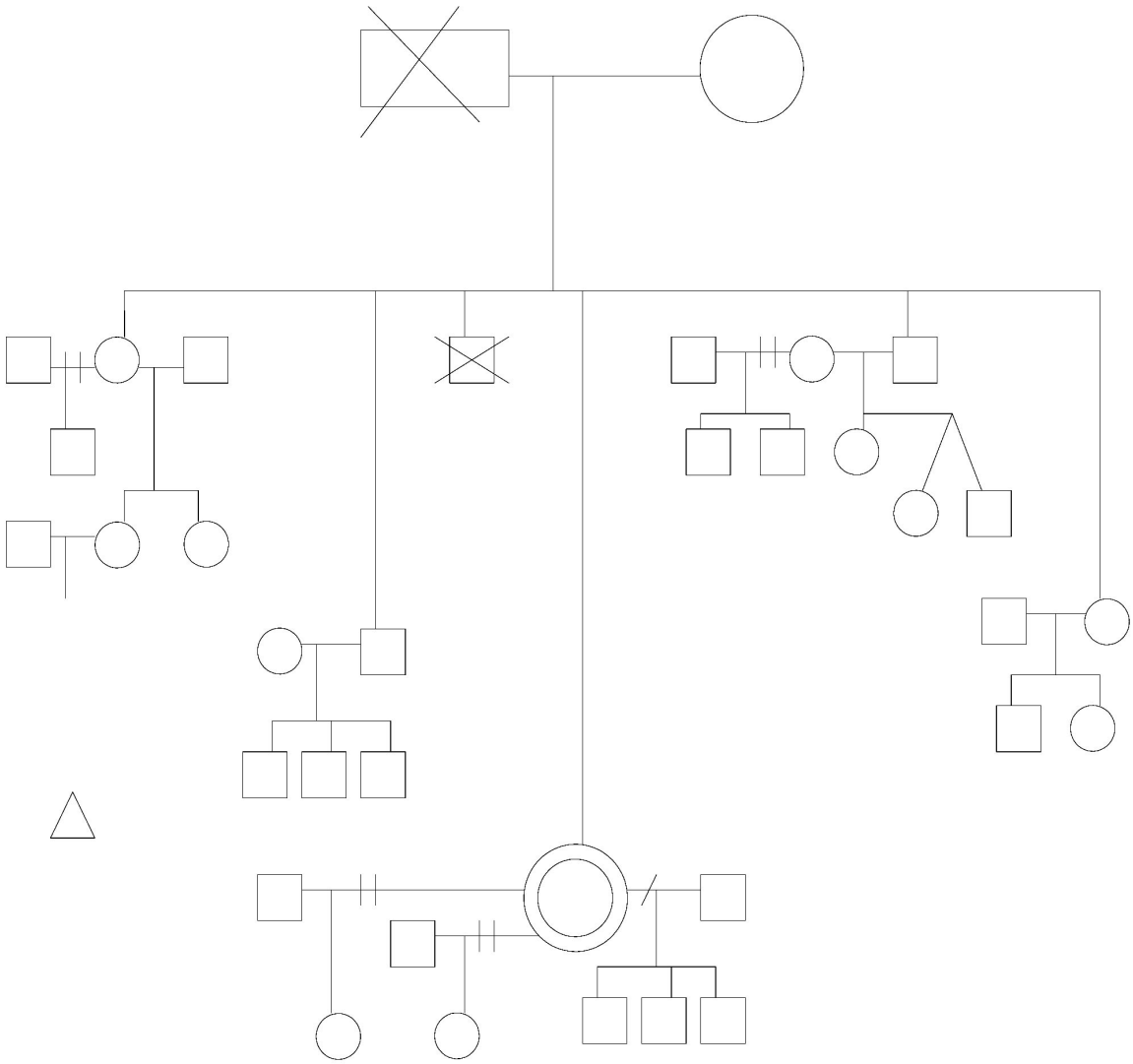
_____

WORKER SIGNATURE: _____ **DATE:** _____

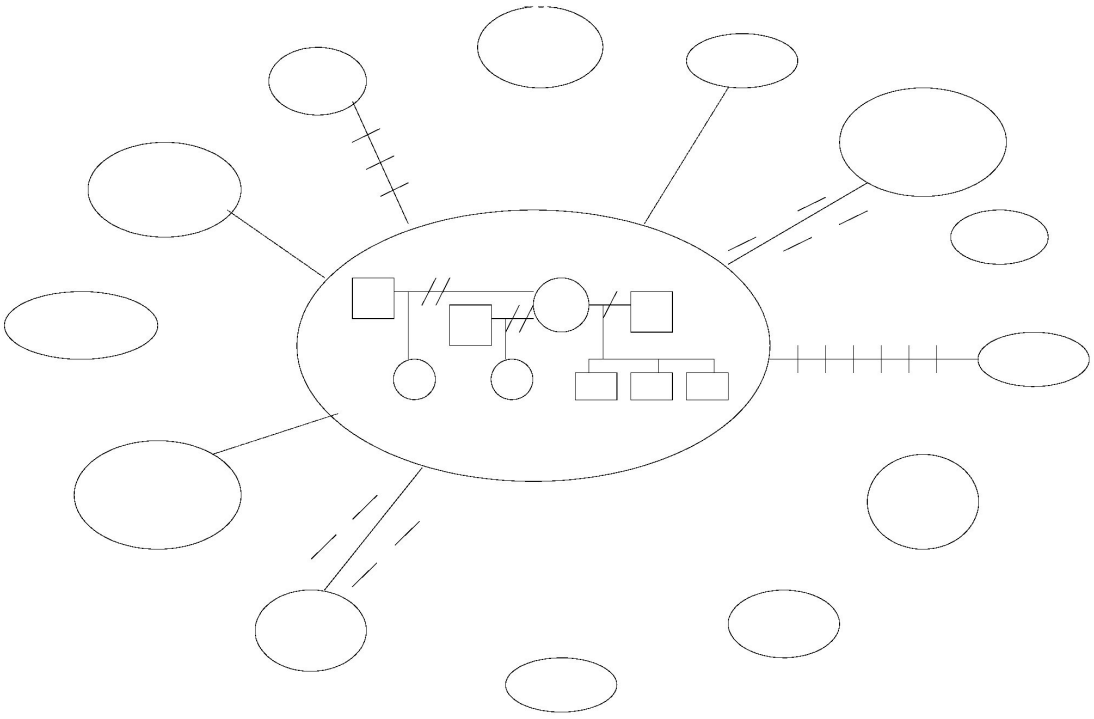
CLIENT SIGNATURE: _____ **DATE:** _____

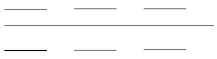
APPENDIX II

GENOGRAM



E C O M A P





APPENDIX III

REFERRAL/INTAKE FORM

WORKER: _____ **DATE:** _____

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

ADDRESS: _____ **TEL (HOME):** _____

_____ **TEL (WORK):** _____

_____

Referral Source:

☐ SELF ☐ FAMILY MEMBER ☐ OTHER: _____

Client: ☐ NEW ☐ REPEAT

Chart # _____

Reason for Referral:

_____

_____

_____

_____

Seriousness of Issue:

☐ CRISIS ☐ HIGH ☐ MEDIUM ☐ LOW

Does the person need to speak with someone right away? ☐ YES ☐ NO

Does the person consent to counseling/services? ☐ YES ☐ NO

Appointment Given: _____

FOR INTAKE USE ONLY *(Please complete after contact)*

☐ ADMISSION ☐ REFERRED OUT

☐ REFERRAL ACCEPTED BUT DECLINED SERVICES ☐ BRIEF SERVICES

WORKER SIGNATURE: _____ **DATE:** _____

APPENDIX IV

GENERAL INFORMATION AND SCREENING FORM

CLIENT NAME: _____ **DATE:** _____

Presenting Problem: *(reason for referral - use client's own words or referral source information)*

_____

_____

_____

_____

Is this a crisis? *(Use client's own words)*

_____

_____

_____

_____

Medication use: *(current prescription medications/over the counter medications; traditional, natural or herbal medications.)*

Medication/Dosage	Frequency	Last Taken	Duration of Use

Medical or Physical Problems: _____

Family Physician or Healer: _____

Substance Use:

Are you presently using any of the following substances:

Alcohol: ☐ YES ☐ NO

If yes, amount last drank and pattern of use:

_____

_____

Street Drugs: ☐ YES ☐ NO

If yes, amount last used, type and pattern of use:

_____

_____

Tobacco: ☐ YES ☐ NO

If yes, amount of use and pattern of use:

_____

_____

Support System: *(describe)*

_____

_____

_____

_____

Other Services Being Received: *(list and indicate if helpful)*

_____

_____

_____

_____

Client's expectations of this service or program: *(what kind of help is the client looking for?)*

_____

_____

_____

_____

Intake Worker's Plan: *(next steps, internal admission, referral out, etc.)*

_____

_____

_____

_____

INTAKE WORKER: _____ **DATE:** _____

ASSIGNED WORKER: _____ **DATE:** _____

APPENDIX V

CONSENT TO RECEIVE SERVICES

I certify that all aspects of the program have been explained to me, including its affiliation with other programs or organizations, composition of the staff or team and the restrictions or limitations of the program and its workers. I understand that the services are completely voluntary and confidential and I have provided my fully informed and voluntary verbal consent to receive services. The information I provide is considered strictly confidential. As such, information shared during our sessions will not be disclosed unless mutually agreed upon.

WORKER SIGNATURE: _____ **DATE:** _____

CLIENT SIGNATURE: _____ **DATE:** _____

APPENDIX VI

HISTORY UPDATE FORM

NAME: _____ **CHART #:** _____

DATE: _____

Presenting Problem: *(why is the client here? Include client's view of the problems and their causes, previous attempts at dealing with the issue.)*

_____

_____

_____

_____

History Update: *(any changes in client's life since last contact)*

_____

_____

_____

_____

Current Functioning: *(client's abilities, challenges and resources)*

_____

_____

_____

_____

Summary: *(formulation of the problem)*

_____

_____

_____

_____

Treatment Plan: *(include goals, discharge goals, next session, evaluation plan)*

_____

_____

_____

_____

WORKER: _____ **DATE:** _____

APPENDIX VII

ADMISSION AND CLOSURE SUMMARY FORM

WORKER/CLINICIAN/THERAPIST: _____ **CHART #:** _____

NAME: _____ **GENDER:** ☐ M ☐ F

DATE OF BIRTH: _____ **AGE:** _____

ADDRESS: _____ **TEL (HOME):** _____

_____ **TEL (WORK):** _____

MARITAL STATUS: ☐ SINGLE ☐ COMMON LAW ☐ MARRIED
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

RELIGION/SPIRITUALITY: ☐ TRADITIONAL ☐ CATHOLIC ☐ OTHER

HEALTH CARD #: _____ **FAMILY PHYSICIAN:** _____

NEXT OF KIN _____ **RELATIONSHIP:** _____

ADDRESS: _____ **TEL (HOME):** _____

_____ **TEL (WORK):** _____

_____

PREVIOUS TREATMENT: ☐ YES ☐ NO

PLACE: _____ **DATE:** _____

☐ NEW CLIENT ☐ REPEAT CLIENT

BAND NUMBER: _____ **COMMUNITY:** _____ **PLACE OF BIRTH:** _____

NATIVE: ☐ YES ☐ NO

EDUCATION: ☐ NONE ☐ ELEMENTARY ☐ COLLEGE
☐ UNIVERSITY ☐ UNKNOWN

SCHOOL ATTENDING: _____

OCCUPATION AND EMPLOYMENT STATUS: _____

SOURCE OF INCOME: _____

LANGUAGE PREFERRED: ☐ NATIVE ☐ ENGLISH ☐ OTHER
MOTHER TONGUE: ☐ NATIVE ☐ ENGLISH ☐ OTHER

LIVING ARRANGEMENTS: _____ **TYPE OF ACCOMODATION:** _____

PROBLEM (PRIMARY):

_____

_____

_____

_____

PROBLEM (SECONDARY):

_____

_____

_____

_____

DATE OF ADMISSION: _____ **DATE OF CLOSURE:** _____

SERVICE TYPES: _____ **LENGTH IN PROGRAM:** _____

PROBLEMS OUTSTANDING: _____

REFERRAL TO SERVICE PROVIDER: _____

BASIS OF CLIENT SEPARATION: _____

_____

SIGNATURE OF WORKER/CLIENT/THERAPIST: _____

PRESENTING PROBLEM/OUTSTANDING PROBLEM

1 **Relationship Breakdown/Difficulty:** Problems arising in a previously functioning relationship causing the relationship to deteriorate and become dysfunctional.

2 **Separation Adjustment:** Assisting a client with coping activities leading to and following a separation from a significant other.

3 **Family Discord:** Disharmony and distress within a family context experienced by one or more family members.

4 **Adjustment Reaction:** Failure from the individual's or couple's efforts to deal with stresses and meet their needs.

5 **Physical/Emotional Abuse:** Emotional distress resulting in inflicted trauma, either physical or emotional.

6 **Sexual Difficulties:** Difficulties encountered by individuals and couples in terms of their sexuality.

7 **Sexual Trauma:** Emotional difficulties arising from past sexual abuse that may limit present sexual functioning.

8 **Anxiety:** Fear and/or worry interfering with a person's ability to function.

9 **Depression:** An intense feeling of hopelessness, worthlessness and dejection that may be experienced by a person undergoing emotional trauma.

10 **Phobia:** Uncontrollable, irrational fear experienced by a person.

11 **Anger:** Strong emotional reactions resulting in negative behaviors in interpersonal situations.

12 **Stress:** A change in internal or external factors resulting in a person becoming distressed.

13 **Unresolved Grief:** Emotional distress caused from an inadequate grieving process after a loss *(through death or separation)*.

14 **Behavior Problem:** Difficulties in interpersonal relationships resulting from inappropriate or unacceptable behavior patterns.

15 **Physiological Related (Psychosocial) Difficulties:** Mental health difficulties as a result of or associated with physical health problems *(Acquired Brain Injury, Loss of Health)*.

16 **Long Term Mental Disorder:** A person having a psychiatric diagnosis and/or longstanding psychoemotional disturbance.

17 **Suicide Risk:** The person, through verbalization of suicide intent and/or suicidal plan and/or means to carry out such a plan, presents some degree of risk of suicidal behavior.

18 **Eating Disorder:** A person diagnosed with having either anorexia or bulimia.

19 **Other:** Specify

20 **Incest**

21 **None**

SECONDARY PROBLEMS

1 None
2 Alcohol
3 Drug Only
4 Drug/Alcohol
5 Developmental Delay
6 Physical Impairment
7 Other Combinations
8 Unknown

TYPES OF ACCOMMODATION

1 Private House
2 Private Apartment
3 Private Room
4 Boarding House
5 Hostel/Temporary Shelter
6 Nursing Home
7 Supported Independent Living
8 Co-op Home/Apartment
9 Group Home
10 Halfway House
11 Correctional Facility
12 Treatment Center
13 No Fixed Address
14 Other *(i.e., tipi, car, trailer)*
15 Unknown

LIVING ARRANGEMENTS

1 Lives Alone
2 Single Parent
3 Spouse/Common Law
4 With Family Members
5 With Friends
6 Institutional
7 Residential
8 Other
9 Unknown

REFERRAL SOURCES/ REFERRALS TO SERVICE PROVIDERS

1 Self
2 Family
3 Friends
4 Psychiatric: In-Patient
5 Psychiatric: Out-Patient
6 Hospital Emergency Department
7 Self-Help Groups *(i.e., AA, NA)*
8 Long Term Care
9 Detoxification Center
10 Addiction Program
11 Withdrawal Management Program
12 Treatment Program
13 NNADAP/Alternatives Program
14 Prevention Programs
(child, youth, adult, cultural resource teams)
15 Psychiatrist
16 Psychologist
17 Public Health Nurse/Community Health Nurse/Nurse Practitioner
18 Physician
19 Assertive Community Treatment Program
20 Social Assistance/Ontario Works
21 Housing
22 Crisis Shelter
23 Food Bank
24 Family Violence Programs
25 Supported Independent Living (SIL) Programs
26 Children's Aid Society
27 Native Child Welfare Program
28 Child and Family Services
29 Band Representative
30 Legal/Court/Police
31 Legal Aid
32 Tribal Police
33 Probation/Parole

34 Alternative Justice Program

35 Court Outreach Programs/Court Worker

36 Native Friendship Center

37 Other Institutional/Residential Program *(i.e., Healing Lodges)*

38 Training/Education *(i.e., teacher, principal, vice principal, education counselor, special education)*

39 YWCA - Service Coordination

40 Employer

41 Other

42 Unknown

SERVICE TYPES/ACTIVITIES

1 **Assessment:** To gather information to assess the needs of the client and to provide a triage function regarding appropriate referral, urgency and extent of treatment.

2 **Individual Therapy:** A variety of therapeutic approaches used to assist individual clients to achieve good mental health.

3 **Couple Therapy:** A variety of therapeutic approaches used to increase healthy relationship between couples.

4 **Family Therapy:** A variety of therapeutic approaches used to enhance family relationships where a child is not the identified client.

5 Group Therapy: A variety of therapeutic approaches offered within a group forum to enhance client coping mechanisms, maximize relationships and improve communication skills.

6 **Long Term Support Program:** Assessment and ongoing emotional support carried out with clients experiencing long-term psycho-emotional disturbances.

7 **Psychological Assessment:** An assessment using psychometric tests to provide information regarding psychological status and provision of recommendations for treatment.

8 **Family Support:** The provision of support/education to family members or friends of registered clients.

9 **Agency Collaboration:** Joint case management activities with community organizations who have contact with the client.

10 **Off-site Visits:** A variety of therapeutic interventions provided to clients in a mutually agreed confidential site, other than the clinic site.

11 **Walk-in:** All new and registered clients who are seeking assistance without having a scheduled appointment.

12 **Planning for Closure:** Coordination and referral of client cases from in-patient services to community services to provide continuity of care and ongoing assessment of clients in the community.

13 **Psychiatric Consultation:** An assessment by a psychiatrist after completion of the therapist's assessment for the purpose of obtaining a psychiatric opinion and recommendations for treatment. Notation from the consultation must be documented on the client's chart.

14 **Internal Referrals:** Referrals to other departments based on the specific needs of the client. Referrals are followed up with a notation on the client's chart.

15 **Interagency Referrals:** If the clinic is unable to meet the client's needs, then referrals to other agencies may be necessary. A telephone call or letter must accompany all referrals and must be followed up with a notation on the client's chart indicating that such a referral was made.

16 **Consultation/Supervision:** Service provided by outside consultation to clinicians to assist in case management/therapy.

17 **Significant Other:** Family members, friends and other individuals who are involved in the treatment plan of the identified client.

18 **Advocacy:** Advocating on behalf of the client or family members of the client in order to improve living conditions and/or create opportunities for the client to become independent.

19 **Traditional Medicine:** Referral to Traditional Health Practitioner for the purpose of obtaining an opinion and recommendations for treatment and/or to assist in the treatment of the client. Notation from the consultation must be documented on the client's chart.

20 **Traditional Support:** Providing support to the clients and/or family members in accessing traditional therapeutic approaches and where possible accompanying the client/family to traditional activities (*circles, sweats, naming ceremonies, fasts, etc.)*.

21 **None**

BASIS OF CLIENT SEPARATION

1 **Hospitalization**

2 **Mutually Agreed**

3 **Against Program Advice**

4 **Against Client's Wishes**

5 **Drop-out**

6 **Treatment Completed**

7 **Relocation**

8 **Referred Out**

9 **Suicide**

10 **Other Deaths**

11 **Other**

12 **Unknown**

APPENDIX VIII

SUICIDE ASSESSMENT TOOL

INDICATORS OF RISK:

Three major factors indicating the possibility of suicide risk are: *stress, symptoms, and thoughts of suicide.*

STRESS

Personal reactions to disruptive life events when experienced as Aan intolerable loss@ are important indicators of the potential for suicide. Some examples include rape or sexual abuse, suicide or other death of a loved one (i.e., parent, child, spouse, sibling, etc.), separation or divorce, or serious illness.

Because responses are highly individualized, it is important to determine how the person perceives the event. A loss that seems trivial to an adult may be a life threatening crisis to an adolescent. To do this, ask direct questions.

Ask: How are you feeling about the things that have happened to you?

SYMPTOMS

Most of the common warning signs indicating symptoms of stress and disruption can be organized into four categories: 1) behaviours, 2) physical changes, 3) thoughts, and 4) emotions. Overall symptoms that indicate a theme of helplessness and hopelessness are more likely to be indicators of suicide risk.

Ask: Sounds like you might be feeling really helpless and hopeless right now. Is that correct?

THOUGHTS OF SUICIDE

Thoughts of suicide are especially strong indicators of suicide risk. Frequently, these thoughts are not directly or openly expressed. To find out if a person is thinking about suicide, ask directly.

Ask: Are you thinking about suicide? Are you thinking about killing yourself?

ASSESSMENT OF RISK:

If the person has thoughts of suicide, gather more information about the following factors likely to predict risk: *current plan, prior suicide behaviour* and *resources.*

CURRENT SUICIDE PLAN

The more detailed the plan, the greater the risk the plan may be carried out.

Ask: Have you thought about how you would do it? What have you done about carrying out your plan?

PRIOR SUICIDE BEHAVIOUR

The risk of suicide is 40 times greater for people who have previously tried to kill themselves than for someone who has never tried before. Get more information about prior suicide behaviour by asking directly about how and when it happened and about others close to them (i.e., family, friends) who have engaged in suicidal behaviour.

Ask: Have you ever tried to harm yourself before? What happened? Do you know others who have tried to kill themselves?

RESOURCES

The person most at risk is someone who is feeling alone ad unconnected to others. Supportive resources (i.e., caring family or friends, traditional support systems, other service providers, membership in churches or clubs) and basic needs (i.e., adequate job, a place to live, access to medical help, etc.) can effectively lower the risk of suicidal behaviour.

On the other hand, the absence or >perceived= absence of supportive resources and basic needs can greatly increase the risk of suicide. To determine whether the absence of resources is increasing the risk of suicide, ask directly about feelings of being alone. Determine if there are resources, including yourself, that they find acceptable to connect with to satisfy social or basic needs.

Ask: Are you feeling alone with these thoughts of suicide? Are you getting support from anyone? Is there anyone you might turn to for help?

Share your assessment of the risk level for suicide with the person to see if s/he agrees with you.

Ask: I see the risk of harming yourself as _____ *(high, medium, low)* right now. Does this fit with how you are feeling?

CONTRACT

Develop a plan of action with the person to reduce immediate risk of suicide. The plan should include a no self-harm contract.

- Details about the things to be done must be clearly understood
- Both the worker and the person at risk have some things to do
- The person must agree not to engage in any self-harm for a specific period of time
- Ask the person to repeat the agreement, or if necessary, have it written down and signed

Ask: Are we agreed then that you will do A, B and C and I will do X and Y to prevent the immediate risk of harming yourself?

CRISIS SUPPORT

If you cannot contract or the steps of the plan cannot be carried out until follow-up, emergency support must be arranged with available emergency support systems.

FOLLOW-UP

Set a follow-up meeting between the worker and the person at risk or between the person at risk and the follow-up resources that were agreed to as part of the intervention plan.

This assessment tool was adapted from information provided in The Living Works Suicide Intervention Handbook 1994

APPENDIX IX

COMMON CHARACTERISTICS OF SUICIDE

The common purpose of suicide is to seek a solution. Suicide is not a random act. It is a way out of a problem, dilemma or crisis. It is the answer, seemingly the only answer, to a real puzzler. How to get out of this? It is important to view each suicidal act as an urgently felt effort to answer a question, to resolve an issue, or to solve a problem.

The common goal of suicide is the cessation of consciousness. Suicide can be seen as both a *moving away* and *moving toward* something. Suicide is a moving away from unendurable pain and a moving toward a cessation of consciousness. The core ambivalence in suicide reflects the conflict between survival and unbearable stress.

The common stimulus for suicide is intolerable psychological pain. There is a movement away from intolerable emotion, unacceptable anguish to a cessation of consciousness. The main clinical rule is: Reduce the level of suffering, often just a little bit and the person will choose to live.

The common stressor in suicide is frustrated psychological needs. Suicides are born, negatively, out of needs. Most suicides probably represent combinations of various needs. The clinical rule is: Address the frustrated needs and the suicide will not occur.

The common emotion in suicide is hopelessness and helplessness. Often times, persons literally on the ledge of attempting suicide would be willing to live if things or life were only a little bit better, a just noticeable difference. The common fear is that the inferno is bottomless and that we have to draw the line on human suffering somewhere.

The common cognitive state is ambivalence. Something can be both A and non-A. We can both love and hate the same person. We can now assert that the prototypical suicidal state is one in which the individual feels that s/he had to do it and simultaneously yearns and even plans for rescue and intervention.

The common perceptual state in suicide is constriction or *tunnel vision*. Suicide cannot be understood as a psychosis, a neurosis or a character disorder. It is a transient psychological constriction of affect and intellect. It is a narrowing of the range of options, which leads to either/or thinking.

The common interpersonal act in suicide is egression or escape. The action is the communication itself that is purposeful. In suicide, the action is meant to end life.

The common consistency in suicide is with life-long coping patterns. *You can't fire me, I quit* and *I'll leave her before she leaves me* are common examples of such patterns. Suicide is not a random act, and in some cases it is reasonably predictable.

The single psychological mechanism in all suicide is psycheache. This refers to the hurt, anguish, soreness, aching and psychological pain in the psyche, the mind. The pain is undeniably real. It involves excessive shame, fear, guilt, humiliation, loneliness, dread of growing old or dying badly and it is UNBEARABLE.

APPENDIX X

CONFIDENTIALITY

This program is a voluntary and confidential service. To ensure confidentiality a number of precautions are taken.

All staff members sign an oath of confidentiality when hired.

A case file will be started. Each case file is assigned a number that is written on the outside of the file with all confidential information located only on the inside of the file.

If you are over the age of 12 (in Ontario) or age of 14 (in Western provinces) you must provide expressed written permission (using a special form known as a Release of Information form) should yo wish for anyone else to have access to information about you.

If you are under the age of 12 your parents or guardian has legal access to the file. Without expressed written permission we are not able to release any information about you, including whether or not you are a client of this program, when you were last seen, who your worker is, etc. This includes releasing information to the referring agency.

Files are only accessible to staff members working in this program. Staff members will only access your file if they are your primary worker or if the staff member has had contact with you and needs to document it in your file. **If you have a family member working in this program, the file is kept with your primary worker at all times.**

Files are stored in a secure area. In this area, all files are housed in a central filing system which is locked when no one is in the area and/or at the end of the day. The file room and outside doors are locked at the end of the working day. Only the staff have access to keys to open these areas and the file cabinet.

Limits of Confidentiality: There are instances where we are ethically, morally and legally obligated to breach confidentiality without your permission. Failure to do so may result in our dismissal and, where applicable, loss of licensing to a professional college. These instances include:

If you are suicidal and we cannot come up with a plan to keep you safe, we are obligated to ensure your safety by notifying your next of kin or the police and/or get you to the nearest emergency room at the local hospital.

If you threaten to seriously harm another person, we are obligated to ensure this person's safety by notifying that person of possible danger to him or her and notify the police.

If we receive information of risk of abuse to a minor child under the age of 16 we are obligated to report it to the Children's Aid Society. It is not our responsibility to determine whether or not the situation or act is abusive, simply to report any risk for the CAS to investigate.

If, for some reason, you are involved in court proceedings and your involvement with our program is of interest to the courts we are obligated to release your records when they are subpoenaed by the courts.

If you report abuse by a Registered Health Professional *(dentist, doctor, nurse, optometrist, psychologist, etc.)* we are obligated to report this to their professional licensing body where the professional faces the risk of losing his or her license to practice. **This limit to confidentiality is applicable to Registered Health Professionals only. A similar obligation may occur for social workers with their college/professional licensing body**.

If at any time, you are concerned that there has been a breach of confidentiality (outside the limits specified above) or inappropriate conduct by any worker in this program there are a number of options available to you.

1. You may report this suspected breach of confidentiality in writing to the clinic manager or supervisor. This will result in an investigation into the allegations where the worker faces the risk of suspension or dismissal.
2. If you are not satisfied you may take your complaint, in writing, to the Health Director (or other designated authority). Further investigation will occur where the worker faces the risk of suspension or dismissal.
3. If the worker belongs to a professional licensing body (i.e, The College of Psychologists of Ontario, College of Social Workers) you may contact the College directly to make a complaint. An investigation will be launched and may result in limitations or removal of license to practice.

Should you wish to contact any of the following individuals concerning a breach of confidentiality or inappropriate conduct contact numbers are provided below.

Clinic Manager/Supervisor

Health Director (or other designated authority)

The College of Psychologists of Ontario	**1-800-489-8388**
The College of Social Workers (Ontario)	**1-877-828-9380**

APPENDIX XI

SERVICE AGREEMENT

I/We, _____

agree to accept services from _____ .

In agreeing to accept these services, I/we understand and accept the information below:

Records about the services I have received will be maintained for a period of _____ years.

All information in my file is treated as private and confidential. No information will be released without my voluntary, written and informed consent, unless required by law or professional guidelines. This information may be discussed with colleagues for the sole purpose of ensuring the best service is provided to me.

I may request access to your records and upon request a process for requesting this access will be explained to me; and

I am expected to attend scheduled sessions. If I cannot attend, I will provide 24 hours advance notice.

CLIENT'S SIGNATURE: _____ **DATE:** _____

APPENDIX XII

CONSENT FOR RELEASE OF INFORMATION

TO: _____ **FROM:** _____

I, _____ give permission for release, disclosure or transmittal of

information concerning _____ , *(Date of Birth)* _____

to/from _____ for the purpose of

_____

_____

_____ .

This consent is valid from _____ to _____

CLIENT'S SIGNATURE: _____ **RELATIONSHIP TO CLIENT:** _____

WITNESS: _____ **DATE:** _____

TO RECIPIENT: This information has been given to you from confidential records. Any further disclosure of it without specific written consent of the person to whom it pertains is prohibited by law.

APPENDIX XIII

PROFESSIONAL CONDUCT

1 Maintain confidentiality at all times.

2 Share information according to the policies and procedures.

3 Respond properly to questions dealing with confidential matters.

4 Report information regarding suicidal/homicidal intent or risk of child abuse.

5 Provide accurate and complete information.

6 Monitor professional performance.

7 Admit and correct mistakes.

8 Maintain objectivity. Identify personal biases and beliefs.

9 Focus on communication with clients.

10 Do not bring up personal issues, beliefs, opinions or biases.

11 Refrain from counseling or advising where this is not appropriate.

12 Respect client's physical and personal and emotional rights to privacy.

13 Maintain professional distance and respect boundaries.

14 Help clients use appropriate resources.

15 Avoid creating expectations you cannot fulfill in this role.

16 Promote client self-sufficiency.

17 Monitor your personal wants and needs.

18 Maintain professional principles.

19 Refrain from fulfilling any functions/services that are not part of the role.

20 Know the limits of professional skills and do not go beyond.

21 Ensure limitations to practice are fully understood by the client.

22 Refrain from situations where there may be a conflict of interest.

23 Take responsibility for your professional development.

24 Recognize and respond to discrimination.

APPENDIX XIV

REPORTING SUSPICION OF CHILD ABUSE

SAMPLE LETTER 1

Date

The Children's Aid Society of _____
(Address)

RE: *Child's name, date of birth, address*
Present location of child if different from above address
Parent's name, address, telephone number

Dear Sir/Madame:

This letter confirms the report I made by telephone on *(date)* at *(time)* to *(name of CAS staff)* notifying your agency of a suspicion that a child may be in need of protection. With this letter I am complying with the Child & Family Services Act.

My reasonable grounds for suspecting that the child is or may be in need of protection is (are) that on *(date*, *(child's name)* disclosed that...

Describe when the event happened, or when you became aware of it.

Provide details and facts of the event using the words of the child or other person when possible

If necessary, refer to the policy to explain the specific grounds for finding that the child is or may be in need of protection.

We look forward to receiving acknowledgment of this referral within 30 days or upon completion of the investigation.

Sincerely,

Your Name, Credentials
Title

cc. Chart

** this letter to be used when information has been disclosed directly to you.*

REPORTING SUSPICION OF CHILD ABUSE

SAMPLE LETTER 2

Date

The Children's Aid Society of _____
(Address)

RE: *Child's name, date of birth, address*
Present location of child if different from above address
Parent's name, address, telephone number

Dear Sir/Madame:

This letter confirms the report I made by telephone on *(date)* at *(time)* to *(name of CAS staff)* regarding the safety of a child. This is information that was reported to me as a third party.

My reasonable grounds for suspecting that a child is or may be in need of protection is (are) that...

Describe when the event happened, or when you became aware of it.

Provide details and facts of the event using the words of the child or other person when possible

If necessary, refer to the policy to explain the specific grounds for finding that the child is or may be in need of protection.

We look forward to receiving acknowledgment of this referral within 30 days or upon completion of the investigation.

Sincerely,

Your Name, Credentials
Title

cc. Chart

** this letter to be used when the information has been disclosed to you by a third party (i.e., school, teacher, friends or relatives of the child)*

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N A T I O N A L N A T I V E
A D D I C T I O N S P A R T N E R S H I P
F O U N D A T I O N

BOX 183
MUSKODY, SASKATCHEWAN
S0J 3H0

Phone: 306.763-4714
Toll free: 866.763.4714
Fax: 306.764-7272
E-mail: info@nnapf.org