TIERS
IN FULL

MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH

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APRIL 2019

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Mental Health Services for Children and Youth: Tiers in Full to Support Operational Planning

Contents

HOW TO CITE THE MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH MODULE:

We encourage you to share these documents with others & we welcome their use as a reference. Please cite each document in the module in keeping with the citation on the table of contents of each of the three documents. If referencing the full module, please cite as:

Child Health BC. *Mental Health Services for Children and Youth.* Vancouver, BC: Child Health BC, DRAFT Apr 1, 2019.

Child Health BC acknowledges the principle authors, Olsen A, O'Donnell M, Davidson J, Thomas-Peter K, Williams, J & the contributions of the following groups: MH Module Development Advisory Group, Provincial MH Module Development Working Group, Task-Specific Working Groups, Provincial MH & Substance Use Working Group and the Child Health BC Steering Committee. We would also like to thank Keli Anderson from FamilySmart for her valuable input. Appendix 1 lists the participants on each group.

Mental Health Services for Children and Youth: Tiers in Full to Support Operational Planning

1.0 Tiers of Service

1.1 Tiers of Service Framework and Approach

Planning and coordinating children and youth health services is a major area of focus for Child Health BC and its collaborators (health authorities, ministries, non-profit organizations, school boards, etc). The Tiers of Service framework provides a tool to define and plan such services.

Utilizing a common language and methodology, the Tiers of Service framework:

- Recognizes that health services are one of several factors that contribute to child and youth well-being overall.
- Is informed by a review of frameworks/tools in other world-wide jurisdictions.
- Facilitates system planning for clinical services, knowledge sharing/training and quality improvement/research. The responsibilities and requirements for each of these three areas are defined within the Tiers framework.

Child Health BC is leading the use of the Tiers of Service approach to system planning for children's services. This is being done through:

Creation of a series of modules: For each of the major areas of health services - such as children's medicine, children's surgery, children's emergency care, children & critical care services and mental health services for children and youth - a Tiers of Service module has or is being created.

Self-assessment based on the modules: Once a module is finalized and accepted by key partners in the province, a self-assessment is completed. Child Health BC works with ministries, health authorities and other partners as necessary to complete this.

System planning and service planning based on self-assessment results: Using the self-assessment analysis, CHBC is committed to supporting provincial, regional and local planning in collaboration with other entities.

1.2 BC's Child Health Tiers of Service Modules

Below are the Tiers of Service modules. Some have been completed and some are in development.

Clinical Services modules:

- Children's Medicine
- Children's Surgery
- Children's Emergency Department
- Children & Critical Care Services
- Child Development, Habilitation & Rehabilitation
- Children's Home-based Services (future)
- **Mental Health Services for Children and Youth**
- Substance Use Services for Children and Youth (future)

Clinical Diagnostic & Therapeutic Service modules:

- Children's Laboratory, Pathology & Transfusion Medicine
- Children's Medical Imaging (future)
- Children's Pharmacy Services (future)

Collectively, the modules and their components provide the foundation for provincial and regional/health authority planning of children's health services.

2.0 Mental Health Tiers of Service: Introduction

2.1 Module Development

The Mental Health (MH) Services for Children and Youth module is made up of three components:

- Setting the Stage for Tiers Development: Summarizes the data and literature used to create the module.
- Tiers in Brief to Support System Planning: Provides a high-level description of the tiers, including responsibilities and requirements.
- Tiers in Full to Support Operational Planning: Provides detailed description of the responsibilities and requirements at each tier ***(this document)*.**

The MH Services for Children and Youth module was developed by a provincial interdisciplinary working group and topic-specific working groups comprised of a representative(s) from:

- Each of BC's regional HAs, child and youth psychiatrists, adult psychiatrists, pediatricians, a general practitioner, managers/leaders, social workers and registered nurses
- First Nations HA (FNHA)
- Ministry of Health (MOH)
- Ministry of Children and Family Development (MCFD)
- Child & Youth MH Teams (community-based)
- Patient/family representative (FamilySmart)
- Child Health BC (CHBC)

The document was informed by work done in other jurisdictions, mostly notably Queensland[1] and New South Wales.[2,3] B.C. data was used where it was available, as were relevant BC, Canadian and International standards, guidelines and reports (e.g., Accreditation Canada standards,[4] Provincial Privileging documents,[5] Royal College of Physicians and Surgeons of Canada Objectives of Training documents for Psychiatry[6] and Pediatric Psychiatry,[7] BC Representative for Children and Youth reports [8-10] and a variety of other service standards documents[11-19]).

In addition to the MH Module Advisory Committee and the Provincial MH Module Development Working Group, feedback on the draft was provided by representatives from BC HAs, MCFD and other stakeholder groups. The final version was submitted to the Provincial MH & SU Working Group and the CHBC Steering Committee for acceptance.

2.2 Module Scope

This module focuses on clinical services provided to children and youth with mental health conditions +/- behavioural issues. While some health promotion and prevention activities are identified in the module to acknowledge the continuum of services, it is recognized that the scope of activities required to support the health and well-being of children and youth goes far beyond what is in this module. Further discussion of the needs and subsequent planning and action in this area is strongly supported.

For the purposes of this document, the term "mental health" includes concurrent disorders, as the interplay of MH and substance use (SU) is important in the continuum of MH services. A separate module with a substance-use specific focus will be developed.

Services are divided into 3 categories:

1. Hospital Inpatient Services (focus of this section is on the care provided after admission to an inpatient bed)
2. Community-Based & Ambulatory Services
3. Residential Services

The following services are not included in this document:

- Services provided to children who are incarcerated (beyond the scope of influence of the tiers of service initiative).
- Services provided in Emergency Departments (EDs) (discussed in Children's ED Services module).
- Services provided in Critical Care Units (discussed in Children's Critical Care Services module).
- Medical/surgical services provided to children who are on general inpatient or pediatric units (discussed in Children's Medicine and Surgery modules).

Mental Health services provided to children and youth who are on general inpatient or pediatric units are included in the current module.

2.3 Recognition of the Tiers

The *Child Health Tiers of Service Framework* includes 6 tiers of service. The Children's MH module recognizes 5 of the 6 tiers (refer to Table 1):

1. Hospital Inpatient Services: T2 - T6
2. Community-Based & Ambulatory Services: T3 - T6
3. Residential Services: T4-T6

Table 1: Overview of Child Health Tiers of Service & Child & Youth MH Tiers of Service

Tier	Child Health Framework Tiers of Service	Child & Youth MH Tiers of Service
T1	Prevention, Primary & Emergent MH Service	Health Promotion & Prevention Service
T2	General Health Service	General Health Service
T3	Child-Focused Health Service	Child-Focused MH Service
T4	Children's Comprehensive Health Service	Children's Comprehensive MH Service
T5	Children's Enhanced & Regional Subspecialty Health Service	Children's Regional Subspecialty MH Service
T6	Children's Provincial Subspecialty MH Service	Children's Provincial Subspecialty MH Service

Note re Table 1: T1 & T2 services are *general* child/youth health services and not specific to mental health (MH). They are included to show the continuum of services but are grayed out to show the distinction.

2.4 Differentiation of the Tiers

"Acuity" and "complexity" with respect to mental health conditions are terms used to differentiate the tiers from each other.

- "Acuity" considers level of observation required, risk of harm/safety risk, functional status, recovery environment and engagement/understanding/awareness of condition.
- "Complexity" considers single vs multiple mental health and/or medical diagnoses, availability of care algorithms/protocols to direct treatment, predictability of condition, range of interventions required and functional limitations specific to mental health conditions.

Table 2 provides a summary of the relationship between "acuity," "complexity," relative frequency and tier of service. The hatched areas indicate active involvement and the white areas indicate limited or no involvement.

Table 2: Children & Youth Appropriate to Receive Services at Each Tier (Acuity, Complexity & Relative Frequency)

		General Health Service			Child-Focused MH Service			Children's Comprehensive MH Service			Children's Regional Subspecialty MH Service			Children's Provincial Subspecialty MH Service		
		T2			T3			T4			T5			T6		
Underlying Condition		**Acuity of Presenting Complaint**														
Complexity	**Relative Frequency**	Low	Mod	High	Low	Mod	High	Low	Mod	High	Low	Mod	High	Low	Mod	High
Low																
Mod	Common															
Mod	Uncommon															
High	Common															
High	Uncommon															

3.0 Mental Health Tiers of Service: Tiers in Full

This section describes the **responsibilities** and **requirements** at each tier to provide a **safe, sustainable** and **appropriate** level of service.

Responsibilities and requirements are divided into the following sections:

3.1 Clinical Service
- 3.1.1 Service Reach & Focus (all settings)
- 3.1.2 Hospital Inpatient Services
- 3.1.3 Community-Based & Ambulatory Services
- 3.1.4 Residential Services

3.2 Knowledge Sharing & Transfer/Training

3.3 Quality Improvement & Research

Note:

1. The tier identified for a given service represents the highest tier of that service which is available at a site or for a designated geographic area under usual circumstances. While the expectation is that the requirements at each tier will align with the responsibilities, occasional exceptions may occur, usually due to geography and transportation, in which children/youth may be managed and/or interventions performed on a case-by-case basis by services that would not normally care for such children/youth. This scenario is usually for unplanned/emergent events and such events are not the focus of this document.
2. Throughout this document, the word *family* is meant to capture biological relatives including parents and siblings, and/or those who are identified as significant individuals in the child/youth's life.
3. Services common to all aspects of mental health service delivery include: Evidence-informed & Wise Practice, Trauma Informed Practice, Culturally Competent & Culturally Safe Practice, Person & Family Centered Care, Harm Reduction and Recovery & Strengths Based Care.

3.1 Clinical Services

T1 & T2 services are *general* child/youth health services and not specific to mental health (MH). They are included on this table to show the continuum of services but are grayed out to show the distinction.

3.1.1 Service Reach and Focus (all settings)

	Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
	T1	**T2**	**T3**	**T4**	**T5**	**T6**
Service reach[i]	Local community	Local service area / local health area.	Multiple local service areas / multiple local health areas.	Service delivery area (s)/ health service delivery area(s)	Region / health authority.	Province.
Service focus (target population)	Supports the health (including mental health) & well-being of infants, children, youth & their families. Refers as required.	Identifies children & youth with potential MH +/- behavioural concerns. Refers as required. In addition, Primary Care Providers (PCPs) diagnose & provide treatment for children & youth with common, low acuity/complexity MH conditions +/- behavioural concerns.	Diagnoses & provides treatment for children & youth with *relatively common, low to moderate acuity/complexity* MH conditions +/- behavioural concerns. Stabilizes & refers as required.	Diagnoses & provides treatment for children & youth with a *broad range* of *moderate acuity/complexity* MH conditions +/- behavioural concerns. Stabilizes & refers as required.	Diagnoses & provides treatment for children & youth with *relatively common high acuity &/or high complexity* MH conditions +/- behavioural concerns. Stabilizes & refers as required.	Diagnoses & provides treatment for children & youth with a *broad range* of *high acuity &/or high complexity* MH conditions +/- behavioural concerns. Focuses on children & youth with severe, complex &/or persistent MH conditions.

[i] "Service area" refers to MCFD geographical boundaries while "health areas" refer to MOH geographical boundaries

3.1.2 Hospital Inpatient Services

Notes:

1. T1 services are not included on the charts in this section because T1 refers to community-based services only.
2. T2 services apply only to rural and remote sites (in urban sites, "best practice" is to admit children and youth with MH conditions to a site which has pediatric &/or specialty child & adolescent psychiatry inpatient beds).
3. T2, T3 & T4 services are provided on general medical/surgical inpatient units or pediatric-specific inpatient units. T5 & T6 services are provided on specialty child & adolescent psychiatry inpatient units.
4. Refer to Appendix 2 for Referral Algorithms:
   (1) Children under Age 12 (1A - Non-certifiable; 1B - Certifiable); and
   (2) Youth Ages 12 to 18.9 Yrs (2A - Non-certifiable; 2B - Certifiable)

A. Service Description

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.0	**Children 0 - 11.9 yrs old**					
1.1	Stabilization & crisis intervention	Provides stabilization & crisis intervention for children living *locally*. Consults with T5 (if available within the HA) or T6, as needed. Anticipated length of stay is <72 hrs. If severe, complex &/or persistent MH condition &/or if discharge not anticipated within 72 hrs, consults with T6 re ongoing treatment. Arranges transfer as required.	Same as T2.	Where no T5 specialized child & adolescent psychiatry unit exists *locally* (i.e., within the same community), provides stabilization & crisis intervention for children living *locally*. Where T5 specialized child & adolescent psychiatry unit exists *locally*, arranges admission to the specialized unit.	Provides stabilization & crisis intervention for children living *locally*. Stabilization is provided in a specialized child psychiatry stabilization bed which is located on a child & adolescent psychiatry unit. Anticipated length of stay may be longer than 72 hrs. Consults with T6 re treatment of children with severe, complex &/or persistent MH conditions as needed. Arranges transfer as required.	Provides stabilization & crisis intervention for children from *across the province*. Focuses on children with severe, complex &/or persistent MH conditions &/or children requiring services from multiple medical subspecialties. Stabilization is provided on one of several subspecialty units. (child psychiatry unit, child/adolescent psychiatric intensive care unit or child/adolescent eating disorders unit).

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
	Stabilization & crisis intervention cont'd	Clearly describable process exists for reevaluating the "best & safest" location given local resources to provide treatment for children who are (1) physically aggressive; (2) at high risk of elopement; &/or (3) acutely suicidal.				
1.2	Ongoing treatment					Provides ongoing treatment for children from *across the province* for all types of MH conditions. Location of treatment is as above.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
2.0	**Youth 12 - 18.9 yrs old**					
2.1	Stabilization & crisis intervention	Provides stabilization & crisis intervention for youth living *locally*. Consults with T5/T6 as needed. Anticipated length of stay is <72 hrs. If severe, complex &/or persistent MH condition &/or if discharge not anticipated within 72 hrs, consults with T5/T6 re treatment. Arranges transfer as required Clearly describable process exists for reevaluating the "best & safest location" given local resources for youth who are (1) physically aggressive; (2) at high risk of elopement; (3) acutely suicidal &/or (4) aged 17 – 18.9 yrs.	Same as T2.	Where no T5 specialized child & adolescent psychiatry unit exists *locally* (i.e., within the same community), provides stabilization & crisis intervention for youth living *locally*. Consults with T5/T6 as needed. Anticipated length of stay is <72 hrs. Where T5 specialized child & adolescent psychiatry unit exists *locally*, arranges admission to the specialized unit.	Provides stabilization & crisis intervention for youth living *locally.* Stabilization is provided in a specialized child & adolescent psychiatry unit. Anticipated length of stay may be longer than 72 hrs. Consults as needed with T6 re youth with severe, complex &/or persistent MH conditions. Arranges transfer as required.	Provides stabilization & crisis intervention for youth from *across the province*. Focuses on youth with severe, complex &/or persistent MH conditions &/or youth requiring care from multiple medical/surgical subspecialties. Stabilization is provided on one of several subspecialty child & adolescent psychiatry inpatient units (adolescent psychiatry unit, child/adolescent psychiatric intensive care unit or child/adolescent eating disorders unit).
2.2	Ongoing treatment				Provides ongoing treatment to youth from *within the HA* for a broad range of MH conditions. Consults as needed with T6 for youth with severe, complex &/or persistent MH conditions. Arranges transfer as required.	Provides ongoing treatment to youth from *across the province* for their MH condition. Focuses on youth with severe, complex &/or persistent MH conditions. Location of treatment is as above.

B. Responsibilities

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.0	Intake[ii]	Consults with T5/T6 as needed re: decision to admit & treatment plan.	Same as T2.	Same as T3.	Triages referrals to appropriate service. If service is at capacity, facilitates development of interim plan. Admits children & youth living *locally* for stabilization & crisis intervention. Admits youth from *within the HA* for ongoing treatment.	Triages referrals to appropriate service. If service is at capacity, facilitates development of interim plan. Admits children & youth from across the province for stabilization & crisis intervention & ongoing treatment.
2.0	Assessment & diagnostics	Utilizes standardized & validated tools available through the Practice Support Program[iii] & Kelty Mental Health Resource Centre[iv] to facilitate screening, assessment & diagnostics. Consults/refers & arranges transfer to T5/T6 as required. Utilizes procedures to mitigate safety risks during transfer.	Same as T2 plus: Acuity/complexity is higher & medical issues are more likely to be present & require assessment/monitoring/ treatment.	Same as T3.	Utilizes standardized & validated tools to assess & determine diagnoses. Provides psychometric testing as clinically required. Collaborates with &/or refers medical issues to pediatrician &/or appropriate pediatric subspecialist(s), as available (e.g., cardiology, neurology). Consults/refers & arranges transfer to T5/T6 as required. Utilizes procedures to mitigate safety risks during transfer.	Utilizes standardized & validated tools to assess & determine diagnoses. Provides psychometric testing as clinically required. Collaborates with &/or refers medical issues to on-site medical/surgical pediatric subspecialist(s) (e.g., cardiology, neurology, endocrinology & genetics).

[ii] Intake occurs when a person first comes to seek help from a service provider, or comes to the attention of a service via referral.
[iii] Practice Support Program: http://www.gpscbc.ca/what-we-do/professional-development/psp/modules/child-and-youth-mental-health/tools-resources
[iv] Kelty Mental Health Resource Centre: http://keltymentalhealth.ca

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
3.0	Stabilization, crisis intervention & safety planning	Provides stabilization & crisis intervention & develops safety plan (see glossary). Utilizes clearly describable process to admit/transfer children/youth to an appropriate designated facility[v] involuntarily under the MH Act (see glossary). Initiates psycho-pharmacology. Consults with T5/T6 as required.	Same as T2.	Same as T3.	Provides supportive inpatient environment to facilitate stabilization, crisis intervention & development of a safety plan. Utilizes clearly describable process to admit children/youth involuntarily under the MH Act (see glossary). Initiates psycho-pharmacology. Provides short-term interventions that are 1:1 &/or family-based, focused on safety & building coping strategies.	Same as T5.

[v] www.health.gov.bc.ca/library/publications/year/2018/facilities-designated-mental-health-act.pdf

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	**T3**	**T4**	**T5**	**T6**
		ED or General Inpt Bed	**Pediatric Inpt Bed**	**Pediatric Inpt Unit**	**Child & Adolescent Psychiatry Unit** **Child Psychiatry Beds are for Stabilization Only**	**Child & Adolescent Psychiatry Subspecialty Units**
4.0	On-going treatment[vi]				*Children ages 12 – 18.9 yrs:* Provides group & 1:1 therapy, including: • Art or play therapy • Cognitive Behaviour Therapy (CBT) • Dialectical Behaviour Therapy (DBT) • Family Therapeutic Interventions. e.g., Family Therapy & coaching (see glossary) • Interpersonal Therapy • Motivational Interviewing. Initiates psycho-pharmacology. Facilitates transition to home & school with activities such as: • Participation in "typical activities" (e.g., self-care, school, peer socialization) • Safe & supervised outdoor play & recreational activities • Supervised off-unit time in the community (e.g., visit to beach/park, grocery store) • Connection with community resources.	Same as T5 except service is provided to all ages of children & youth (0 - 18.9 yrs), plus: Provides specialized therapies such as: • Emotion Focused Family Therapy • Trauma Focused CBT • Parent Child Relational Therapy. Arranges for electroconvulsive therapy (ECT).

[vi] An integrated approach to treatment is recommended by best current evidence to address concurrent issues of MH & substance use.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
5.0	Treatment planning & care-coordination	In collaboration with child/youth/family, creates a short-term treatment plan to address identified admission issues. With consent collaborates with schools and community providers.	Same as T2.	Same as T3.	In collaboration with child/youth/family, creates a comprehensive treatment plan linked to MH issues & identified goals. Includes timeline for review/revision. With consent, collaborates with schools & community providers.	Same as T5 plus: Coordinates care for highly complex cases with multiple subspecialty teams (e.g., neurology, endocrinology).
6.0	Support provided to family / family intervention	Provides information to families on community resources such as: • Local MH resources (e.g., child/youth MH teams) & emergency services (e.g., child safety, domestic violence, immigration services, financial assistance programs) • Peer support resources • Provincial eHealth resources (i.e., Healthlink, FamilySmart[vii], Kelty Mental Health[viii], e Foundry).	Same as T2 plus: Facilitates access to appropriate community resources	Same as T3 plus: Provides short-term supportive counseling (e.g., coping with trauma or illness) & psychoeducation [ix] to families.	Provides ongoing support to families during inpatient stay. Provides: • Psychoeducation, including crises intervention skills & skills to support recovery/coping • Family Therapeutic Interventions. e.g., including Family Therapy & coaching (see glossary) • Assistance in accessing follow-up for MH +/- medical conditions. Offers peer support programs for: • Parents (i.e., Parent-In-Residence, Kelty MH Resource Centre) & • Youth (i.e., Youth-In-Residence, Kelty MH Resource Centre). Support may be provided either on-site or virtually. Facilitates access to community resources (refer to T2).	Same as T5 plus: Provides specialized therapeutic parent groups, parent education & parent support groups specific to MH condition of the child/youth.

[vii] FamilySmart: *http://www.familysmart.ca/programs/familysmart*
[viii] Kelty Mental Health Resource Centre: *http://keltymentalhealth.ca*
[ix] Psychoeducation refers to a therapeutic intervention for children/youth/families that provides information & support to better understand and cope with a MH condition.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
7.0	Observation level	Provides low level monitoring (i.e., same staff/patient ratio as other patients on the unit). Provides time-limited periods of constant visual observation (i.e., 1:1 staff/child ratio) for children/youth expected to improve quickly (i.e., require 1:1 <72 hrs) &/or awaiting transfer to higher tier.	Same as T2.	Same as T3.	Provides full range of observation levels, including arm's reach observation for extended periods.	Same as T5.
8.0	Support for mobility & independence	Provides assistance with activities of daily living (ADLs) & transfers/mobility, as required.	Same as T2.	Same as T3.	Same as T4.	Same as T5.
9.0	Managing substance intoxication &/or withdrawal (substance use (SU))	Provides medical treatment to children & youth who are experiencing acute substance intoxication &/or withdrawal. Provides information about appropriate community-based substance use services (e.g., SU team). Consults/refers/transfer to higher tier as required.	Same as T2.	Same as T3 plus: Provides medical treatment to children & youth who are medically unstable/complex due to acute substance intoxication &/or withdrawal. Arranges transfer to an ICU if monitoring/treatment requirements are beyond that provided on a pediatric unit.	Provides MH treatment for children & youth who are concurrently experiencing acute substance intoxication &/or substance withdrawal. Must be medically stable. For children & youth who are not medically stable, arranges transfer to appropriate unit (pediatric or ICU). Consults/refers/transfers to T6 as required.	Provides MH treatment to children & youth who are concurrently experiencing acute substance intoxication &/or substance withdrawal. Must be medically stable. For children & youth who are not medically stable, arranges transfer to appropriate *on-site* inpatient unit (pediatric or ICU).

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
10.0	Deteriorating/ emergency medical situations	Uses BC Pediatric Early Warning System (PEWS) to identify, communicate, mitigate & escalate signs of clinical deterioration. Stabilizes and maintains critically ill children in most appropriate location within facility while arranging & awaiting transfer to higher tier.	Same as T2.	Same as T3. Refer to Children's Critical Care Module for availability of critical care services.	Utilizes clearly describable process to identify & transfer medically unstable children & youth to appropriate inpatient unit (pediatric unit or ICU). Consults/refers/transfers to T6 as required.	Utilizes clearly describable process to identify & transfer medically unstable children & youth to appropriate *on-site* inpatient unit (pediatric unit or ICU).
11.0	School / educational support			Provides opportunities for on-site school board teacher visits to support/maintain connection with school & studies. Facilitates transition back to community school.	Provides on-site individualized educational curriculum taught by school board teacher. Facilitates transition back to community school.	Same as T5.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
12.0	Child maltreatment (neglect & physical, sexual & emotional abuse)	Recognizes suspected cases of child maltreatment. Takes action to ensure immediate medical & safety needs are met, findings documented & appropriate cases reported to MCFD[x] as per the Child, Family & Community Service Act. Works collaboratively with MCFD child protection services to create a plan that meets the child/youth's safety needs. Refers to pediatrician or local/regional/provincial child maltreatment team if required.	Same as T2 plus: Provides consultation & follow-up for children/youth referred for suspected maltreatment.	Same as T3.	Same as T4.	Same as T5.

[x] Provincial MCFD Child Protection Centralized Screening Team can be contacted at: 1-800-663-9122.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
13.0	Discharge/ Transition planning	Provides child/youth/family with written discharge recommendations that address issues & goals identified by child/youth/family & provider during admission.	Same as T2.	Same as T3.	Same as T4 plus: Coordinates discharge planning between hospital services, child/youth/family & community service providers. Includes agreement on responsibility for on-going support. Provides post-discharge consultation to child/youth/family & community service providers for questions & support relevant to child/youth's stay.	Same as T5 plus: Proactively contacts children/youth/families post-discharge to assess/support transition back to community & adherence to treatment plan.
14.0	HA/provincial resource				Provides virtual consultations (e.g., telephone/telehealth) to T2, T3 & T4 providers *across the HA* to support the care of children/youth/families with MH conditions, ***in their local communities***. Available M-F days.	Provides 24/7 virtual consultations (telephone/telehealth) to providers *across the province* to support the care of children/youth/families with MH conditions ***in their local communities***.

C. Requirements

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.0	**Providers**					
1.1	Team support	Physicians, nurses & psychosocial, allied health & Indigenous providers (as available) come together over the *care of an individual child/youth*.	Same as T2.	Physicians, nurses & psychosocial, allied health & Indigenous providers work consistently together as a *pediatric interdisciplinary team.* Focus on children & youth with a broad range of pediatric conditions, including MH conditions.	Physicians, nurses & psychosocial, allied health & Indigenous providers work together as a *child & youth MH interdisciplinary subspecialty team*. Focus on children & youth with MH conditions. Member of team designated to provide clinical supervision (e.g., de-briefing critical incidents, addressing ethical dilemmas, resource for staff).	*Multiple child & youth MH interdisciplinary subspecialty teams* are population &/or condition-specific (e.g., child, youth, eating disorders) and consistently work together. Teams have critical interdependencies with pediatric medical & surgical subspecialists. Member of each team designated to provide clinical supervision (e.g., de-briefing critical incidents, addressing ethical dilemmas, resource for staff).
1.2	Most responsible physician (MRP)	If child/youth in hospital, family physician/NP on-call & available on-site as needed 24/7.	Pediatrician on-call & available on-site as needed 24/7.	Where no T5 child & adolescent psychiatry beds exist locally (i.e., in the same community), MRP is pediatrician on-call & available on-site as needed 24/7.	Child & adolescent psychiatrist on-call & available on-site as needed, M-F days. Outside these hours, child & adolescent psychiatrist OR general psychiatrist on-call & available on-site as needed.	Child & adolescent psychiatrist on-call & available on-site 24/7.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.3	Consulting MD	Pediatrician & general psychiatrist from *within the HA* available to discuss cases & provide advice by telephone 24/7. Child & adolescent psychiatrist available by telephone from *within the HA* or via the Compass line[xi] days M-F. T6 child & adolescent psychiatrist available by telephone outside these hours.	General psychiatrist on-call for consultation & available on-site as needed 24/7. Child & adolescent psychiatrist available by telephone from *within the HA* or via the Compass line days M-F. T6 child & adolescent psychiatrist available by telephone outside these hours.	Where no T5 child & adolescent psychiatry beds exist locally, general psychiatrist or child & adolescent psychiatrist is on-call for consultation & available on-site as needed 24/7.	Pediatrician/Internal Medicine specialist on-call & available as needed 24/7 for medical issues. Clearly describable process exists to access acute pediatric services 24/7.	Pediatric medical & surgical subspecialist MDs on-call 24/7 & available on-site as needed.
1.4	Nurses	RNs have general "pediatric skills" (see glossary). Practice is predominantly with adults. RNs have received general MH education including information on MH resources & the MH Act. .	Same as T2 except RNs practice, although predominantly with adults, includes some children.	Where no T5 child or adolescent psychiatry beds exist *locally*, RNs have "pediatric skills" (see glossary). RN practice is exclusively or primarily with children. RNs assigned to children/youth with MH conditions have received MH-specific education such as:	RNs/RPNs have "child & youth MH skills" (see glossary). Practice is exclusively or primarily in child & youth psychiatry. Additional training (all team members): • Indigenous Cultural Safety program. • Accredited de-escalation & physical behaviour management program.	Same as T5 plus: RNs/RPNs have "enhanced child & youth MH skills" in relevant specialty area (see glossary). Practice is exclusively or primarily in specialty child & youth MH area.

[xi] Compass 1-855-702-7272. www.bcchildrens.ca/health-professionals/clinical-resources/mental-health/compass

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
	Nurses cont'd			• Key concepts of MH service delivery (e.g., recovery orientation, early intervention/relapse prevention, engagement) • MH assessment • Safety planning • Engaging & collaborating with families • Observation & documentation of patterns of behaviour, shifts in affect/mood & significant information shared by child/youth/family • Strategies to support dysregulated children/youth • Role & boundaries • MH resources • MH Act. All team members are trained in an Indigenous Cultural Safety program.		

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.5	Psychosocial providers	Generalist social worker (SW) & spiritual care practitioner available on request, M-F days, for individual cases. Practice is predominantly with adults. Clearly describable process exists for accessing telephone consultation from a MH clinician[xii] *from within the HA* on M-F days. Examples: Local CYMH clinician, T5 child/youth MH clinician, MH clinician from adult psychiatry service (if exists).	SW with *general pediatric* knowledge & skills available on request, M-F days, for individual cases. Practice may be predominantly adults but includes some children. Clearly describable process exists for accessing *telephone consultation from a MH clinician from within the HA* on M-F days. Examples: Local CYMH clinician, T5 child/youth MH clinician, MH clinician from adult psychiatry service (if exists). Spiritual care practitioner with *general pediatric* knowledge & skills on-call 24/7 & available on-site as needed.	Where no T5 child or adolescent psychiatry beds exist locally: • SW(s) with *general pediatric* knowledge & skills available, M-F days. Practice may include both adults & children. • Spiritual care practitioner with *general pediatric* knowledge & skills on-call 24/7 & available on-site as needed. • Clearly describable process exists for accessing on-site consultation from a MH clinician *from within the HA* on days, M-F. Examples: Local CYMH clinician, T5 child/youth MH clinician, MH clinician from adult psychiatry service (if exists). Child life specialist available on days, M-F.	Youth & family counsellor(s), SW clinician(s)[xiii] & registered clinical psychologist(s) available days, M-F. Practice is primarily child & youth MH or, if not, team members have significant exposure to facilitate development of required skills. Clearly defined process to access art/play therapy for individual cases. Child life specialist available, M-F days. Spiritual care practitioner with *general pediatric* knowledge & skills available on request for individual cases. Additional training (all team members except spiritual care practitioner): • Indigenous Cultural Safety program. • Accredited de-escalation & physical behaviour management program.	Same as T5 plus: Team members have "enhanced child & youth MH skills" in relevant specialty area (see glossary). Practice is exclusively or primarily in specialty child & youth MH area.

[xii] MH Clinician may include: Team Leader/Clinical Director, SW Clinician, RPN/RN, Registered Clinical Psychologist or Clinical Counselor.
[xiii] SW clinician refers to SWer(s) whose clinical practice involves the professional application of social work theory & methods of treatment & prevention of psychosocial dysfunction, disability or impairment, including but not limited to MH conditions.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
	Psychosocial providers cont'd		All team members are trained in an Indigenous Cultural Safety program.	All team members are trained in an Indigenous Cultural Safety program.		
1.6	Allied health	Generalist PT, OT & dietitian available on request, M-F days, for individual cases. Practice predominantly with adults. Generalist pharmacist available as per Accreditation Canada standards, including on-call service (not specific to pediatrics).	Same as T2.	Where no T5 child or adolescent psychiatry beds exist locally: • PT, OT & dietitian with general pediatric knowledge & skills available M-F days. Practice may include adults & children. • Pharmacist with pediatric expertise[xiv] available on-site M-F days. Outside these hours, general pharmacist available on-call for telephone consultation. Access to T6 clinical pharmacy specialist[xv] in pediatric MH for telephone consultation M-F days.	OT available, M-F days. Practice primarily child & youth MH or, if not, team members have significant exposure to facilitate development of required skills. Pharmacist with pediatric expertise available on-site M-F days. Outside these hours, general pharmacist available on-call for telephone consultation. Access to T6 clinical pharmacy specialist in pediatric MH for telephone consultation M-F days. PT & dietitian available on request, M-F days for individual cases. Additional training (OT only): • Indigenous Cultural Safety program. • Accredited de-escalation & physical behaviour management program.	Same as T5 plus: Team members have "enhanced child & youth MH skills" in relevant specialty area (see glossary). Practice is exclusively or primarily in specialty child & youth MH area. Dietitian available on request, M-F days for Eating Disorders cases. Clinical pharmacy specialist(s) in pediatric MH available on-site, M-F days. Also available to T5 services for consultation during this time.

[xiv] Pharmacist with pediatric expertise: Pharmacist that has completed a Pharmacy Practice Residency Program & has a demonstrated special interest, knowledge & skills in pediatric pharmacy. Pediatric knowledge & skills are acquired & maintained through clinical experience & special pediatric-focused continuing pharmacy education.
[xv] Clinical pharmacy specialist: Same as pharmacist with pediatric expertise except practice is exclusively or almost exclusively with children.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
1.7	Indigenous providers[xvi]	Clearly describable process to access Indigenous Patient Liaison/Navigator.	Same as T2.	Indigenous Patient Liaison/Navigator on-site & available on request for individual cases.	Same as T4.	Same as T5.
1.8	Concurrent disorders specialist				Clearly describable process to access *telephone* consultation from concurrent disorders specialist on M-F days (MD, SW, RN &/or counsellor).	Access to *on-site* consultation from concurrent disorders specialist on, M-F days (MD, SW, RN &/or counsellor).
2.0	**Facilities**					
2.1	Inpatient bed/unit	"Safe pediatric bed(s)" (see glossary) available within the facility (ED or general inpatient bed). No dedicated pediatric inpatient resources/beds.	Dedicated pediatric inpatient bed(s) on a general inpatient unit. Bed meets criteria for "safe pediatric bed(s)" (see glossary). Physical space separate from adults is recommended.	Pediatric inpatient unit. Unit meets criteria for "safe pediatric unit" (see glossary).	Child & adolescent psychiatry unit which includes a child psychiatry stabilization bed(s). Unit is child & youth friendly, provides a safe & secure environment as per ONCAIPS standards[xvii] & includes a lounge(s), recreation area(s), dedicated space for family use, classroom & safe de-escalation space (e.g., calm down room).	Same as T5 plus: Dedicated inpatient child & adolescent psychiatry units, grouped by specialty/subspecialty (i.e., child psychiatry unit, adolescent psychiatry unit, child/adolescent psychiatric intensive care unit or child/adolescent eating disorders unit). Units include additional specialty spaces such as a sensory room & healing room. Dedicated space & infrastructure for C&Y MH academic education.

[xvi] Tiers 2-6 welcome participation of Indigenous providers (including Elders & Traditional Healers) from the community, with child/youth/family consent.
[xvii] Ontario Network of Child and Adolescent Inpatient Psychiatry Services. ONCAIPS collaborative provincial child & adolescent inpatient mental health standards. http://ONCAIPS.ca/ONCAIPS_Standards_June_2015.pdf. 2015:1-58.

		General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T2 Rural & Remote Only	T3	T4	T5	T6
		ED or General Inpt Bed	Pediatric Inpt Bed	Pediatric Inpt Unit	Child & Adolescent Psychiatry Unit *Child Psychiatry Beds are for Stabilization Only	Child & Adolescent Psychiatry Subspecialty Units
2.2	MH Act Designation, Section 3(2)[xviii]	May be designated as a psychiatric facility or observation unit under the MH Act. If a designated facility, secure room exists in ED &/or on an inpatient unit. Clearly describable process in place to admit/transfer children/youth involuntarily under the MH Act (see glossary).	Same as T2.	Designated as a psychiatric facility under the MH Act. Secure room exists in ED &/or on an inpatient unit. Clearly describable process in place to admit children/youth involuntarily under the MH Act (see glossary).	Same as T4 plus: Secure room exists on the C&Y psychiatric inpatient unit.	Same as T5 plus: Secure room exists on each of the C&Y psychiatric inpatient units.
3.0	**Volumes per year**					
3.1				Based on a 3 year average, children/youth ages 0 - 18.9 yrs with a MH diagnosis: 50 inpatient discharges/yr AND 300 patient days/yr	Based on a 3 year average, children/youth ages 0 - 18.9 yrs with a MH diagnosis: 100 inpatient discharges/yr AND 2,000 patient days/yr	Based on a 3 year average, children/youth ages 0 - 18.9 yrs with a MH diagnosis: 450 inpatient discharges/yr AND 9,000 patient days/yr

[xviii] www.health.gov.bc.ca/library/publications/year/2016/facilities-designated-mental-health-act.pdf.

3.1.3 Community-Based & Ambulatory Services

Notes:

1. T1 & T2 services are general child/youth health services and not specific to mental health (MH). They are included on this table to show the continuum of services but are grayed out to show the distinction.
2. T3 & T4 MH services are community-based, T5 services may be community or hospital outpatient-based and T6 services are hospital outpatient-based.

A. Service Description

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
1.0	Service description	*Individual providers* promote positive MH & well-being in all children & youth. Focus is on health promotion & prevention.	*Individual providers* identify children/youth with potential MH +/- behavioural concerns & offer education about managing symptoms. Provide general parenting support & assistance in accessing MH services.	*Community-based providers* assess, diagnose & treat children/youth with *relatively common, low to moderate acuity/complexity* MH conditions +/- behavioural concerns. Provide psychoeducation[xix], skill building & coaching to support recovery/ coping.	*Community-based interdisciplinary Child & Youth MH (CYMH) Teams* assess, diagnose & treat children/youth with a *broad range of moderate acuity/complexity* MH conditions/ concurrent disorders +/- behavioural concerns.	*Community or hospital outpatient-based, interdisciplinary teams of subspecialty MH providers* assess, diagnose & treat children/youth with *relatively common high acuity &/or high complexity* MH conditions/concurrent disorders +/- behavioural concerns.. Medical co-morbidities may be present but are stable & can be managed by a pediatrician.	*Hospital outpatient-based, interdisciplinary, subspecialty MH teams* assess, diagnose & treat children/youth with a *broad range of high acuity &/or high complexity* MH conditions/concurrent disorders +/- behavioural concerns. Focus is on children & youth with severe, complex &/or persistent MH conditions. Medical co-morbidities often present & require monitoring/ treatment by one or more medical/surgical pediatric subspecialists.

[xix] Psychoeducation refers to a therapeutic intervention for children/youth/families that provides information & support to better understand & cope with a MH condition.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
	Service description cont'd		In addition, Primary Care Providers (PCPs) diagnose & provide treatment for children & youth with common, low acuity/complexity MH conditions +/- behavioural concerns.	Support access to follow-up care for MH &/or medical condition(s).	Treatment includes therapeutic MH interventions with families. Teams provide case management & service coordination for children/youth involved with the service.	Available treatments include Family Therapeutic Interventions. e.g., Family Therapy & coaching (see glossary). Subspecialty MH teams/clinics must include but are not limited to: • Infant psychiatry (5 yrs old & younger) • Eating disorders • Externalizing behavioural disorders • Mood/anxiety • Neurodevelopmental disorders with co-morbid MH condition(s). Most children/youth/ families will return to T4 for ongoing follow-up after initial treatment. Case management & service coordination is provided by the T5 team for highly complex cases.	Available treatments include Family Therapeutic Interventions. e.g., Family Therapy & coaching (see glossary). Most children/youth/ families will return to T4 or T5 for ongoing follow-up after initial treatment. Case management & service coordination is provided by the T6 team for highly complex cases.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
2.0	Service setting			Services may be provided in a range of settings such as child/youth's home, school or an office in the community.	Same as T3 plus: Where sufficient volumes exist within a geographical area (i.e., urban settings), dedicated MH teams provide short-term, assessment & crises intervention outreach services for children & youth (e.g., in home or in community settings). Where volumes are *insufficient*, a clearly describable process exists for providing short-term assessment & crises intervention services (e.g., virtual services from another geographic area, direct patients to go to local ED).	Services are provided in 3 settings: 1. Office or hospital outpatient-clinic(s): Team provides service from a common location. Service may be provided in-person or virtually. Appointments are pre-scheduled. 2. Home-based (where sufficient volumes exist): Team travels to the child/youth/family. 3. Day treatment (where sufficient volumes exist): Team provides service from a common location to a consistent group of children/youth/families. Service includes educational programming.	Services are provided in a broad range of hospital outpatient-based MH-focused subspecialty clinics. Appointments are scheduled & the team provides service from a common location (service may be provided in-person or virtually to the child/youth/family).

B. Responsibilities

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
1.0	Intake[xx]			Receives referrals from self/family/local service providers within health area(s). Determines suitability for service & assesses for immediate safety risk. Takes action as required. Re-directs to alternative community, hospital or residential resource(s) as necessary.	Same as T3 plus: • Referrals are received from broader service delivery/health service delivery area. • Standardized clinical screening tools are utilized to determine suitability for service.	Receives referrals from providers *across the region/HA*. Determines suitability for subspecialty service(s) & assesses for immediate safety risk. Takes action as required. Re-directs to alternative community, hospital or residential resource(s) as necessary.	Same as T5 except: • Requests for service are received from providers *across the province.*

[xx] Intake occurs when a person first comes to seek help from a service provider, or comes to the attention of a service via referral.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
2.0	Assessment & diagnostics		Identifies children/youth with potential MH +/- behavioural concerns. Refers as required. PCPs: Utilize standardized & validated tools such as those available through the Practice Support Program[xxi] & Kelty Mental Health Resource Centre[xxii] to facilitate screening, assessment & diagnostics.	Same as T2 plus: Diagnoses or accesses diagnoses as needed via PCP, psychologist or Registered Clinical Social Worker (RCSW). Refers as required.	Provides MH assessment using standardized & validated tools that are clinically appropriate. Makes diagnosis & refers as required. Refers complex comorbid medical issues to pediatrician &/or appropriate pediatric subspecialist(s).	Same as T4 plus: Provides MH assessment using additional standardized & validated tools in keeping with subspecialty service.	Same as T5 plus: Collaborates with on-site medical/surgical pediatric subspecialist(s) re assessment of medical co-morbidity(ies) (e.g., cardiology, neurology, endocrinology & genetics).
3.0	Stabilization, crisis intervention & safety planning	Recognizes potential MH crises, including risk of harm to self (suicide) or others. Takes action to meet immediate safety needs. Examples of actions include: • Removing items such as sharp objects, medication • Contacting family	Same as T1 plus: Creates immediate safety plan (see glossary) with child/youth/ family. Consults MH professional &/or PCP (usually child's PCP). Makes follow-up arrangements &/or refers to higher tier.	Same as T2 plus: Refers to a community based suicide prevention, intervention & post-intervention program from *within the service delivery area* as required.	Same as T3 plus: Provides comprehensive safety assessment & plan. Involves consultation with child & adolescent psychiatrist. Includes child/youth/family in plan development.	Same as T4.	Recognizes potential MH crises, including risk of harm to self (suicide) or others. Takes action to meet immediate safety needs. Examples of actions include: • Removing items such as sharp objects, medication

[xxi] Practice Support Program: *http://www.gpscbc.ca/what-we-do/professional-development/psp/modules/child-and-youth-mental-health/tools-resources*
[xxii] Kelty Mental Health Resource Centre: *http://keltymentalhealth.ca*

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
	Stabilization, crisis intervention & safety planning cont'd	• Taking child to quiet area • Arranging transfer to local ED. Directs child/youth/family to crisis supports (e.g. crisis line) & relevant community services. As required, arranges transfer to nearest ED.	PCPs: • Collaborates with child & adolescent psychiatrist via Compass line as required.[xxiii] T6 child & adolescent psychiatrist available by telephone outside these hours. • Initiates psycho-pharmacology as required. • Utilizes clearly describable process to admit/transfer children/youth involuntarily under the MH Act (see glossary). Provides psychoeducation, supportive counselling (e.g., brief solution focused therapy, coping with grief, bullying), & facilitates access to: • Indigenous services (e.g., Land-based interventions (see glossary) • Peer support (e.g., Kelty Mental Health).		Provides crisis intervention as required. Utilizes clearly describable process to admit/transfer children/youth involuntarily under the MH Act (see glossary). Where sufficient volumes exist, C&Y MH outreach teams provide short-term MH assessment & crises intervention. Where volumes are *insufficient*, a clearly describable process exists for providing short-term assessment & crises intervention services (e.g., virtual services from another geographic area, direct patients to go to local ED).		• Contacting family • Taking child to quiet area. • Arranging transfer to local ED. Provides comprehensive safety assessment & plan that involves consultation with child & adolescent psychiatrist. Includes child/youth/family in plan development. Provides crisis intervention as required. Initiates psycho-pharmacology. . Makes follow-up arrangements. Utilizes clearly describable process to admit children/youth involuntarily to an on-site child/youth inpatient psychiatry unit under the MH Act.

[xxiii] Compass 1-855-702-7272. www.bcchildrens.ca/health-professionals/clinical-resources/mental-health/compass.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
4.0	On-going treatment[xxiv]			Provides treatment (group &/or 1:1) interventions: • Helping families/caregivers to understand & manage the unique needs of their child/youth • Promoting resilience & healing. Examples: • Cognitive Behaviour Therapy (CBT) • Motivational interviewing • Art or play therapy • Sexual Abuse Intervention Program (SAIP) • Connect Parent Group (adaptations for culturally safe & unique populations exist) • Traditional wellness (see glossary). Initiates psycho-pharmacology as clinically indicated.	Same as T3 plus: Provides more intensive treatment interventions such as: • Dialectical Behaviour Therapy (DBT) • Trauma-focused CBT • Interpersonal Therapy • Family Therapeutic Interventions. e.g., Family Therapy & coaching (see glossary). Provides support *within* child/youth's school/education program to help child/youth *return to* school/education. Provides social/network enhancement & access to leisure activities. Supports admissions/discharges to/from hospital as required.	Same as T4 plus: Where sufficient volumes exist, interdisciplinary, subspecialty team(s) offers day treatment & educational programming for children/youth with high complexity MH conditions. If volumes are insufficient to maintain this service, the service need is met through collaboration with other T5 services.	Same as T5 plus: Collaborates with on-site medical/surgical pediatric subspecialist(s) re assessment of medical co-morbidity(ies) (e.g., cardiology, neurology, endocrinology & genetics). Provides treatment support to T2-T5 providers to facilitate specialized MH care closer to home.

[xxiv] An integrated approach to treatment is recommended by best current evidence to address concurrent issues of MH & substance use.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
5.0	Treatment planning & care-coordination		In collaboration with children/youth/families, creates a treatment plan to address identified intake issues. With consent, collaborates with schools & community providers.	Same as T2 plus: Individual providers coordinate the care of children/youth/ families to ensure goals & treatment plans are congruent & manageable. If multiple providers, a key contact is identified that considers family choice, expressed needs & collaborative input.	Same as T3 plus: Interdisciplinary teams provide case management services. Work with children/youth/families to coordinate services between different providers & tiers.	In collaboration with child/youth/family, creates a clear, comprehensive treatment plan linked to goals. Includes timeline for review/revision. With consent, collaborates with schools & community providers. . Provides case management & service coordination for highly complex T5 cases.	Same as T5 except: Provides case management & service coordination for highly complex T6 cases. May involve coordination with multiple subspecialty teams (e.g., neurology, endocrinology).

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
6.0	Support provided to families / family intervention	Provides information to families on community resources such as: Local MH resources (e.g., child/youth MH teams) & emergency services (e.g., child safety, domestic violence, immigration services, financial assistance programs), Peer support resources Provincial eHealth resources (i.e., Healthlink, FamilySmart, Kelty MH Resource Centre, e Foundry). Educates children/youth/families on ways to promote positive mental health & well-being. Includes teaching in areas such as: • Self-regulation • Positive behavioural interventions & supports • Mindfulness • Community connectedness • Cultural engagement • MH literacy • Social & emotional learning.	Same as T1 plus: Provides general parenting education.	Same as T2 plus: Provides targeted parenting support such as: • Psychoeducation (e.g., ways to manage MH symptoms) • Coaching on handling parenting challenges, i.e. parent/teen conflict, behavioural issues. • Supportive counseling.	Same as T3 plus: Engages families as partners in all aspects of child/youth's MH care. Assesses family's needs & provides therapeutic MH interventions. Facilitates access to psychosocial support for families impacted by barriers (e.g. economic or food insecurity). Liaises & facilitates access to resources in the community to address psychosocial issues (e.g., child safety, domestic violence).	Same at T4 plus: Family Therapeutic Interventions . e.g., Family Therapy & coaching (see glossary).	Same as T5 plus: Provides therapeutic parent groups, parent education groups & parent support groups which are specific to the MH condition of the child/youth.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
7.0	Managing substance intoxication &/or withdrawal (substance use (SU))	Refers/arranges transfer of child/youth to nearest ED for acute medical concerns related to SU. Provides information about relevant community-based services (e.g., SU team).	Same as T1.	Same as T2.	Same as T3 plus: Provides MH treatment for children/youth with concurrent MH & SU issues. Consults with T5 or T6 as needed. Collaborates/consults with SU providers & refers to detox &/or SU residential services as required.	Same as T4.	Same as T4.
8.0	Deteriorating / emergency medical situation	Recognizes potential medical crisis. Takes action to meet immediate safety needs. As required, arranges transfer to nearest ED.	Same as T1 plus: Consults PCP (usually child's PCP) from *within the local service/health area*.	Same as T2.	Same as T3.	Recognizes potential medical crisis. Takes action to meet immediate safety needs. As required, arranges transfer/admission to pediatric medical/surgical inpatient unit or nearest ED.	Recognizes potential medical crisis. Takes action to meet immediate safety needs. As required, arranges transfer/admission to *on-site* pediatric medical/surgical inpatient unit or ED.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
9.0	School / educational support			Collaborates with child/youth's school administration as per treatment plan.	Same as T3 plus: Liaises with local school program to facilitate transition planning & implementation of treatment recommendations.	Same as T4 plus: Where day treatment & educational programming is offered programming includes an individualized education curriculum provided within the context of assessment & therapeutic intervention. Program taught by school board teacher.	Same as T4.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
10.0	Child maltreatment (neglect & physical, sexual & emotional abuse)	Recognizes suspected cases of child maltreatment. Takes action to ensure immediate medical & safety needs are met, findings documented & appropriate cases reported to MCFD[xxv] as per the Child, Family & Community Service Act. Refers to pediatrician or local/regional/ provincial child maltreatment team if required.	Same as T1.	Same as T2 plus: Works collaboratively with child protection services to create a plan that meets the child/youth's needs for safety & well-being (including MH care).	Same as T3.	Same as T4.	Same as T5.
11.0	Discharge / transition planning			Collaborates with child/youth/family to create documented transition plan (copy provided to child/youth/family & providers) to another tier, adult services &/or discharge from service.	Interdisciplinary team collaborates with child/youth/family & other service providers involved in child/youth's care to create documented transition plan (copy provided to child/youth/family & providers) to another tier, adult services &/or discharge from service. Plan includes responsibility for on-going support & treatment.	Same as T4. Most children/youth/ families will return to T4 for ongoing follow-up after initial treatment.	Same as T5.

[xxv] Provincial MCFD Child Protection Centralized Screening Team can be contacted at: 1-800-663-9122.

		MH Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
12.0	HA/ provincial resource					Provides virtual consultations (e.g., telephone, telehealth) to providers *across the region/HA* to support the care of children/families with MH conditions, ***in their local communities***.	Provides virtual consultations (e.g., telephone, telehealth) to providers *across the province* to support the care of children/families with MH conditions, ***in their local communities***.

B. Requirements

		Prevention, Primary & Emergent MH Service	General MH Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Enhanced & Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
1.0	**Providers**						
1.1		Staff working in: • Public health units • Community health centres • Nursing stations • Schools & school-based programs • Early years centre staff • eHealth • HealthLink • Friendship centres • Indigenous Wellness centres	• Primary care providers • Teachers • School counsellors • Family & community services society staff • Indigenous providers • Service / family navigators	• Community-based pediatricians, psychiatrists, psychologists, clinical social workers, & clinical counsellors • Youth-specific health services (e.g., Foundry staff, drop-in youth clinic staff) • Specialized contracted family & community services society staff. Staff at community agencies may include SW/clinical SW, psychologist, clinical counselor, RN/RPN, & child & youth care worker.	Interdisciplinary teams that include: • Team Leader[xxvi] • SW Clinician • RPN/RN • Registered Clinical Psychologist • Clinical Counselor • Consistent child & adolescent psychiatrist or physician with special interest & expertise in MH integrated as part of the team. Some team members may be in virtual locations. Practice is exclusively or primarily in child & youth MH or, if not, team members have significant exposure to facilitate development of child & youth MH-specific expertise.	Interdisciplinary subspecialty teams that include: • Team Leader / Clinical Director • Child & Adolescent Psychiatrist (s) • SW Clinician • Other professionals as relevant to the type of MH service provided (e.g., pediatrician, nutritionist, OT). • See Appendix 4 for staffing requirements for T5 clinics. Team members have "enhanced skills" (see glossary) in relevant specialty area(s) (e.g., infant psychiatry, eating disorders). Trained in an Indigenous Cultural Safety program.	Same as T5 except the range of subspecialty services is broader.

[xxvi] Individual delegated to provide "clinical supervision" and team support in order to provide MH services within the community. Examples of activities include: creating opportunities for clinical skill building, integrating theory & practice, de-briefing critical incidents, addressing confidentiality issues & ethical dilemmas and enhancing self-reflection skills.

		Prevention, Primary & Emergent MH Service	General MH Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Enhanced & Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
		Community-Based	Community-Based	Community-Based	Community-Based	Community or Hospital Outpatient-Based	Hospital Outpatient-Based
					Providers are members of an *interdisciplinary team* & the team works together to serve a defined population of children/youth/families. All team members are trained in an Indigenous Cultural Safety program.		
2.0	**Treatment space**						
2.1				Services may be provided in a range of settings such as child/youth's home, school or an office in the community.	Services may be provided in a range of settings such as child/youth's home, school or an office in the community. Out-of-home treatment space is child & youth friendly & enabled to provide care by virtual means (e.g., telephone, telehealth).	Same as T4 except treatment is provided in a child & youth specific, & accessible office/clinic space. Space may have a shared function but is dedicated to children/youth during clinic times.	Same as T5 except space accommodates multiple child & youth MH subspecialty clinics. Space is dedicated exclusively to children/youth.

3.1.4 Residential Services

Tiers 1 to 3 are not shown as they do not apply to residential services.

A. Service Description

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
1.0	Service description	*Residential placement* in a foster family, kinship or group home for children and youth in Ministry of Children & Family Development (MCFD) care. Placements are not specific to children/youth with MH conditions +/- behavioural concerns. Placement examples: • MCFD-contracted specialized foster family placement • MCFD contracted agency-based & staffed residential resource (e.g., group home) • MCFD-contracted family-based home with agency contracted to provide support MH assessment & treatment services required while in T4 residential placement are provided through community-based & ambulatory services (see Community-Based & Ambulatory Services section).	*Residential assessment & treatment* service provided in a specialized, staffed group home. i.e., MCFD-contracted Complex Care Community Residential Resource. Service focuses on behaviour stabilization & on teaching children/youth/families about techniques for managing challenging behaviours at home.	*Residential assessment & treatment service* provided in a community-based, facility setting. Includes a *step-up/step-down unit.* Service is provided to children & youth with: • Complex MH presentations with a behavioural component (e.g., Crossroads Unit at the Maples) • Complex MH presentations without a behavioural component (e.g., Dala Unit at the Maples) • Complex neurodevelopmental disorders with co-morbid MH condition(s) (e.g., Provincial Assessment Centre) • Eating disorders (e.g., Looking Glass) • Complex & severe co-occurring emotional, MH, developmental &/or behavioural needs (e.g., Complex Care Unit at the Maples) • Complex & severe co-occurring emotional, MH, developmental &/or behavioural needs who are transitioning out of hospital care & requiring additional support before returning to their family ("step-down" service). May also be utilized by children experiencing an escalation in symptoms as a way to avoid hospitalization ("step-up" service). Provides case consultation to T4 - T6 residential service providers for complex cases (i.e., Provincial Outreach Service).
2.0	Service settings	Foster family, kinship, or group home.	Specialized group home.	Facility.

B. Responsibilities

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
1.0	Intake[xxvii]	MCFD Social Worker (SW): • Matches child/youth with appropriate placement. • Refers for community-based & ambulatory MH assessment & treatment services. Child & Youth Mental Health (CYMH) Team (see *Community-Based & Ambulatory Services):* • Determines appropriate MH service for child/youth/family needs & re-directs to alternative resources as needed.	Receives referrals from hospitals, CYMH &/or MCFD SW for planned admissions. Determines suitability for service(s). If service is at capacity, facilitates development of an interim plan.	Receives referrals from providers for planned admissions. Determines appropriate service for child/youth/family & re-directs to alternative resources, if appropriate.
2.0	Assessment & diagnostics	Foster care provider / Group home staff: • Provides input into child/youth's MH assessment (e.g., assessment of behaviour & daily functioning). CYMH Team (see *Community-Based & Ambulatory Services):* • Performs MH assessment & diagnostics. MCFD SW: • Provides input into child/youth's MH assessment (e.g., developmental/social history of child/youth, medical information).	Performs MH assessment using standardized & validated tools that are clinically appropriate & in keeping with the nature of the service. Refers medical issues to PCP.	Performs MH assessment & diagnostics. Includes psychometric testing as clinically relevant. Collaborates with medical/surgical pediatric subspecialist(s) regarding treatment of medical co-morbidity(ies) (e.g., cardiology, neurology, endocrinology & genetics).

[xxvii] Intake occurs when a person first comes to seek help from a service provider, or comes to the attention of a service via referral.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
3.0	Stabilization, crisis intervention & safety planning	Foster care provider / Group home staff: • Assesses & takes action to meet immediate safety needs, including risk of harm to self (suicide) & others. • Follows safety plan (see glossary). • Collaborates with involved MH professionals. • As required, arranges for assessment of MH crisis at the nearest ED. • Reports incident(s) to MCFD SW. CYMH Team (see *Community-Based & Ambulatory Services):* • Leads the development of a MH safety plan. • Provides crisis intervention as required. • As required, arranges for assessment of MH crisis at the nearest ED, hospital inpatient unit or higher tier residential service. MCFD SW: • Collaborates with MH providers & child/youth/family to address MH crisis.	Assesses & takes action to meet immediate safety needs, including risk of harm to self (suicide) & others. Develops a MH safety plan. Includes child/youth/family in development of the plan. As required, arranges for assessment of MH crisis at the nearest ED. Reports incident(s) to MCFD SW.	Same as T5 plus: Utilizes clearly describable process to admit/transfer children/youth to an appropriate designated facility involuntarily under the MH Act. [xxviii]

[xxviii] www.health.gov.bc.ca/library/publications/year/2018/facilities-designated-mental-health-act.pdf.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
4.0	On-going treatment[xxix]	Foster care provider / Group home staff: • Provides input into the development of the MH treatment plan. • Provides specific aspects of treatment as per the treatment plan. • Supports cultural engagement & connection with community resources. CYMH Team (see *Community-Based & Ambulatory Services):* • Leads the development of the MH treatment plan in collaboration with foster care provider/group home staff, other MH providers & child/youth/family. • Provides treatment for MH condition. MCFD SW: • Leads the development of a comprehensive plan of care (broader than the MH plan) in collaboration with foster care provider/group home staff, MH providers & child/youth/family. • Authorizes/arranges additional support for foster care provider/group home staff (e.g., respite, extra staffing).	Develops treatment plan in collaboration other MH providers & child/youth/family. Supports cultural engagement. Provides 1:1 &/or group therapy.	Develops treatment plan & provides supportive residential environment to facilitate treatment of MH condition. Provides 1:1 &/or group therapy. Examples: • Art or play therapy • Cognitive Behavioural Therapy (CBT) / Trauma-focused CBT • Dialectical Behaviour Therapy (DBT) • Family Therapeutic Interventions. e.g., Famil Therapy and coaching (see glossary) Arranges for electroconvulsive therapy (ECT) as necessary. Facilitates transition to home & school with activities such as: • Participation in "typical activities" (e.g., self-care, school, peer socialization). • Safe & supervised outdoor play & recreational activities. • Supervised off-unit time in the community (e.g., visit to beach/park, grocery store). • Opportunities for cultural engagement. • Connections with community-based or ambulatory MH resources.

[xxix] An integrated approach to treatment is recommended by best current evidence to address concurrent issues of MH & substance use.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
5.0	Care planning & care coordination[xxx]	Foster care provider / Group home staff: • If assigned by the treatment team, provides administrative coordination to implement the plan of care (e.g., organizing meetings). CYMH Team (see *Community-Based & Ambulatory Services):* • Provides supportive coordination for implementing the plan of care (e.g., organizing meetings, maintaining contact with all members, reviewing progress, providing support to child/youth/family in accessing services) (this function may be done by CYMH or the MCFD SW and is decided on a case-by-case basis). MCFD SW: • Provides supportive coordination for implementing the plan of care (e.g., organizing meetings, maintaining contact with all members, reviewing progress, providing support to child/youth/family in accessing services) (this function may be done by CYMH or the MCFD SW and is decided on a case-by-case basis).	Develops meaningful, contextually relevant goals. Goals are aimed at supporting child/youth to achieve their highest potential at home, school & in their community. Partners with child/youth/family to develop a clear, comprehensive plan of care linked to goals. With appropriate consent, collaborates with providers, including schools, to ensure continuity of care & coordination across tiers of service.	Same as T5 plus: Contributes complex specialized MH input into goal setting & care planning initiated in T4-T5.

[xxx] MCFD Integrated Case Management: A User's Guide (2006).

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
6.0	Support provided to family / family intervention	Foster care provider / Group home staff: • Provides teaching & role-modeling for family to manage child/youth's behaviours. CYMH Team (see *Community-Based & Ambulatory Services):* • Assesses family's needs & provides therapeutic MH interventions. Provides crisis intervention as required. MCFD SW: • Assists family with service navigation & access to appropriate community resources such as local emergency services, relevant cultural services, youth peer support services & eHealth resources (e.g., FamilySmart,[xxxi] Kelty Mental Health[xxxii]) • Facilitates access to psychosocial support for families impacted by barriers (e.g. economic or food insecurity).	Same as T4.	Same as T4 plus: Provides (where relevant) Family Therapy specific to MH condition of child/youth. Provides access to parent peer support (i.e., Parent-In-Residence) &/or youth peer support (i.e., Youth-In-Residence). Provides specialized therapeutic parent groups, parent education groups & parent support groups specific to MH condition of the child/youth.
7.0	Observation level	Foster care provider / Group home staff: • Provides low level monitoring. CYMH Team (see *Community-Based & Ambulatory Services):* • Arranges transfer to hospital inpatient or residential services when care/monitoring needs to intensify. MCFD SW: Same as CYMH plus: • Authorizes/arranges additional support for foster care provider/group home staff (e.g., respite, extra staffing).	Provides low level monitoring. Provides time-limited periods of constant visual observation (i.e., 1:1 staff/child ratio) for children/youth expected to improve quickly (i.e., require 1:1 <48 hrs) &/or awaiting transfer to hospital inpatient or T6 residential services.	Provides the full range of observation levels, including arm's reach observation as required. Arranges for transfer to hospital inpatient service when care indicates a need for more intensive level of medical monitoring.

[xxxi] FamilySmart: *http://www.familysmart.ca/programs/familysmart.*
[xxxii] Kelty Mental Health Resource Centre: *http://keltymentalhealth.ca.*

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
8.0	Support for mobility & independence	Foster care provider / Group home staff: • Provides assistance with activities of daily living (ADLs) & transfers/mobility, as required.	Provides assistance with activities of daily living (ADLs) & transfers/mobility, as required.	Same as T5.
9.0	Managing substance intoxication &/or withdrawal (substance use (SU)	Foster care provider / Group home staff: • Provides care to children & youth who are experiencing acute substance intoxication &/or withdrawal. • Takes action to meet immediate safety needs, which may include administering naloxone. • Arranges for assessment of medically unstable children/youth at the nearest ED. • Reports incident to MCFD SW. CYMH Team (see *Community-Based & Ambulatory Services):* • Provides treatment that addresses MH & SU concerns concurrently. • Provides child/youth/family with assistance in accessing SU resources, which may include completing applications to residential SU services. MCFD SW: • Provides child/youth/family with assistance in accessing SU resources, which may include completing applications to residential SU services.	Provides care to children & youth who are experiencing acute substance intoxication &/or withdrawal. Must be medically stable. Provides child/youth/family with assistance in accessing SU resources, which may include completing applications to residential SU services. For children & youth who are not medically stable, arranges transfer to nearest emergency department (ED).	Same as T5.
10.0	Deteriorating / emergency medical situation	Foster care provider / Group home staff: • Recognizes potential medical crisis & takes action to meet immediate safety needs. • As required, arranges for transfer to nearest ED. • Reports incident(s) to MCFD SW	Recognizes potential medical crisis & takes action to meet immediate safety needs. As required, arranges for transfer to nearest ED. Involves the child/youth's physician/NP as available. Reports incident(s) to MCFD SW.	Transfers medically unstable children & youth to nearest ED. Involves the child/youth's physician/NP as available.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
11.0	School / educational support	Foster care provider / Group home staff: • Supports child/youth's involvement in a school program, according to child/youth's abilities. • Provides educational curriculum for children/youth not able to attend school. CYMH Team (see *Community-Based & Ambulatory Services):* • Collaborates with school board/regional school counselor to support implementation of the MH treatment plan. MCFD SW: • Same as CYMH.	Supports child/youth's involvement in a school program, according to child/youth's abilities. Provides educational curriculum for children/youth not able to attend school. May provide opportunities for on-site school board teacher visits to support/maintain connection with school & studies. Facilitates transition back to community school.	Creates a learning environment according to child/youth's individual needs. May include individualized educational curriculum taught by school board teacher in the context of assessment & therapeutic intervention. Facilitates transition back to community school.
12.0	Child mal-treatment (neglect & physical, sexual & emotional abuse)	Foster care provider / Group home staff: • Recognizes suspected cases of child maltreatment. • **Takes action** to ensure immediate medical & safety needs are met, findings documented & appropriate cases reported to MCFD as per the Child, Family & Community Service Act. • Works collaboratively with child protection services to create a plan that meets the child/youth's safety needs. CYMH Team: • Same as Foster care provider / Group home staff. MCFD SW: • Recognizes suspected cases of child maltreatment & follows protocols for addressing concerns. • Works collaboratively with family, CYMH & care-providers to create a plan that meets the child/youth's needs for safety & well-being (including MH care).	Recognizes suspected cases of child maltreatment. **Takes action** to ensure immediate medical & safety needs are met, findings are documented & appropriate cases reported to MCFD as per the Child, Family & Community Service Act. Refers cases to pediatrician, if required. Works collaboratively with child protection services to create a plan that meets the child/youth's safety needs.	Same as T5.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
13.0	Discharge / transition planning	Foster care provider / Group home staff: • Prepares & supports the child/youth to successfully transition (e.g., to another tier, adult services, new school, alternative services, or back to family home or another home). CYMH Team (see *Community-Based & Ambulatory Services):* • Collaborates with child/youth/family & service providers to create a documented MH transition plan to another tier, adult services &/or discharge from service (copy provided to child/youth/family & providers). • Plan includes responsibility for on-going support & treatment. MCFD SW: • Collaborates with child/youth/family & service providers to ensure a transition plan is made (broader than the MH plan). • Supports child/youth/family in making decisions, completing referrals, making linkages with services, & emotionally preparing for change.	Same as T4 plus: Residential staff available to child/youth/family & community service providers post-discharge for follow-up questions & support relevant to the child/youth's stay.	Provides child/youth/family with written discharge recommendations that address issues identified during admission. Treatment team coordinates discharge planning between residential services, child/youth/family, & community service providers. Includes agreement on responsibility for on-going support. Provides consultation to service providers post-discharge for follow-up questions & support relevant to the child/youth's stay. May also include limited planned respite services for child/youth to promote healthy relationship attachments & re-integration into community.
14.0	Regional/ provincial resource			Provides virtual consultations (e.g., telephone, telehealth) to T4-T6 residential care providers *across the province* to support the care of children/youth with MH conditions +/- behavioural concerns, **in their local communities.**

C. Requirements

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
1.0	**Providers**	See *Community-Based & Ambulatory Services* for MH-specific requirements		
1.1	Team support	Foster care providers/group home staff provide 24/7 care to an individual child/youth or a group of children/youth. Caregivers have specialized training & experience.	Specialized group home staff work together consistently to provide care to a group of children/youth living in residence. Staff have access to an *interdisciplinary, subspecialty MH team.*	Physicians, nurses & psychosocial, allied health & & Indigenous providers work together consistently as a *child & youth MH interdisciplinary subspecialty or population specific team* (e.g., complex MH presentations, neurodevelopmental disorders, eating disorders). Member of team designated to provide clinical supervision (e.g., de-briefing critical incidents, addressing ethical dilemmas, resource for staff).
1.2	Physicians/ nurse practitioners (NPs)	Makes appointment with child/youth's PCP or accesses local PCP. For access to child & adolescent psychiatrist or general psychiatrist, refer to Community-Based & Ambulatory Services section.	Physician or NP available by phone 24/7. Access to child & adolescent psychiatrist or general psychiatrist from within the region/HA for on-site or virtual consultation[xxxiii] M-F days.	Physician or NP on-call & available for on-site consultation as needed days M-F. Physician or NP on-call for on-site or virtual consultation outside these hours. Clearly describable process in place to manage acute situations when physician or NP not on-site. Child & adolescent psychiatrist or general psychiatrist available on-site for regularly occurring consultation sessions a (minimum one session per week). Additional physicians available as relevant to the subspecialty service (e.g., pediatrician, internist, endocrinologist, geneticist).
1.3	Nurses			RNs/RPNs on-site 24/7. RNs/RPNs have "enhanced child & youth MH skills" (see glossary) in relevant subspecialty area. Practice is exclusively or primarily in child & youth subspecialty area (e.g., complex MH presentations, neurodevelopmental disorders, eating disorders

[xxxiii] Virtual consultation involves the use of digital technology to provide enhanced access to specialty & subspecialty pediatric care across BC, for example telehealth.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	T5	T6
	Nurses cont'd			All RNs/RPNs are trained in: • an Indigenous Cultural Safety program • an accredited de-escalation & physical behaviour management program that minimizes trauma & keeps residents & staff safe from harm.
1.4	Psychosocial professionals		Group home staff (e.g., Child & Youth Care Worker, Social Worker &/or Indigenous Support Worker) on-site 24/7. Staff have "enhanced child & youth MH skills" in managing complex behaviour. All group home staff are trained in: • an Indigenous Cultural Safety program • an accredited de-escalation & physical behaviour management program that minimizes trauma & keeps residents & staff safe from harm.	MH clinician(s) (may be a SW Clinician, an Indigenous Outreach Clinician, Registered Clinical Psychologist, or Clinical Counselor) available on-site M-F days. Staff has "enhanced child & youth MH skills" (see glossary) in relevant subspecialty area. Practice is exclusively or primarily in child & youth subspecialty area (e.g., complex MH presentations, neurodevelopmental disorders, eating disorders). All MH clinicians are trained in: • an Indigenous Cultural Safety program • an accredited de-escalation & physical behaviour management program that minimizes trauma & keeps residents & staff safe from harm.
1.5	Indigenous providers	A clearly describable process exists to access Indigenous community providers (healer, elder, knowledge keeper, band council member/liaison).	Same as T4.	Same as T5.
1.6	Allied health			Allied health professionals available M-F days as relevant to the subspecialty service. e.g., occupational therapist, physiotherapist, behavioural interventionist, behavioural consultant, dietician, speech language pathologist (SLP), geneticist, art/music therapist. Allied health professionals have "enhanced child & youth MH skills" (see glossary) in relevant subspecialty area. Practice is exclusively or primarily in child & youth subspecialty area (e.g., complex MH presentations, neurodevelopmental disorders, eating disorders) or, if not, staff has significant exposure to facilitate development of required skills.

		Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T4	**T5**	**T6**
	Allied health cont'd			Clinical pharmacist available by telephone, M-F, working hours. Allied health professionals working on-site as regular members of the team are trained in: • an Indigenous Cultural Safety program • an accredited de-escalation & physical behaviour management program that minimizes trauma & keeps residents & staff safe from harm.
1.7	Other	Foster care providers / group home staff available on-site 24/7 & are trained in: • an Indigenous Cultural Safety program • an accredited de-escalation & physical behaviour management program that minimizes trauma & keeps residents & staff safe from harm.		
2.0	**Facilities**			
2.1		Child & youth friendly & appropriate home for the care of children/youth with MH conditions +/- behavioural concerns.	Same as T4.	Space is child & youth friendly, environments are safe & all units include a lounge(s), recreation area(s), space dedicated for family use, safe space to de-escalate situations (e.g., calm down room, healing room). Units are dedicated for children & youth. Units are grouped according to specialty/subspecialty (e.g., eating disorders, complex neurodevelopment disorders).
2.2	MH Act Designation, Section 3(2)[xxxiv]			May be designated as a psychiatric facility under the MH Act. Secure room exists on-site if designated.

[xxxiv] www.health.gov.bc.ca/library/publications/year/2016/facilities-designated-mental-health-act.pdf.

3.2 Knowledge Sharing & Transfer/Training

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
1.0	**Student learning**						
1.1	Medical students, residents & fellows						
a.	Hospital inpatient					May be designated by UBC as a training site: • Undergraduate medical students • Pediatric residents • Family medicine residents • General psychiatry residents • Child & adolescent psychiatry subspecialty residents.	Designated by UBC as a training site in child & adolescent psychiatry for: • General psychiatry residents • Child & adolescent psychiatry subspecialty residents & fellows • In conjunction with UBC, develops model for training child & adolescent psychiatry residents & fellows in BC.
b.	Community-based & ambulatory				*Community-based:* May provide placements in child & youth MH for: • Undergraduate medical students • General psychiatry residents • Child & adolescent psychiatry subspecialty residents	*Community-based*: Same as T4 community-based. *Hospital-based ambulatory*: Same as T5 hospital inpatient.	*Hospital-based ambulatory services*: Same as T6 hospital inpatient.

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
1.2	Nursing, allied health & other students						
	Hospital inpatient					Provides child & youth MH educational experiences/placements for a broad range of undergraduate, graduate & post-graduate students. Specific experiences are negotiated between the site & applicable learning institution.	Same as T5.
	Community-based & ambulatory				Provides child & youth MH educational experiences/placements for a broad range of undergraduate, graduate & post-graduate students. Specific experiences are negotiated between the MH team & applicable learning institution.	Provides child & youth MH educational experiences/placements for a broad range of undergraduate, graduate & post-graduate students. Specific experiences are negotiated between the MH team & applicable learning institution.	Same as T5.

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
2.0	**Continuing education (physicians and staff)**						
		Facilitates access to learning activities that support the maintenance of physician/staff competencies in health promotion (including MH) for children/youth/ families.	Same as T1.	Same as T2.	Facilitates access to regional & provincial learning activities that support the maintenance of physician/staff competencies in child & youth MH relevant to the setting & population served.	Same as T4 plus: • Organizes regional/HA learning activities that support the maintenance of physician/staff competencies in child & youth MH relevant to the setting & population served. e.g., rounds. • Mechanisms in place to regularly review physician/staff education needs related to the maintenance of child & youth MH competencies. • Facilitates access to learning activities based on identified practice gaps. •	Same as T5 plus: • Organizes *provincial* learning activities that support the maintenance of physician/staff competencies in child & youth MH relevant to the setting & population served. e.g., workshops & conferences, on-line best practice guidelines/courses, topic-based consultation on the management of low frequency, high complexity MH conditions.

3.3 Quality Improvement & Research

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
1.0	**Quality improvement**						
1.1	QI structures & case reviews	Participates in relevant regional & provincial MH improvement initiatives.	Same as T1 plus: Clearly describable processes in place to appropriately refer cases involving children & youth with MH conditions +/- behavioural issues for quality & safety review. Physicians & staff with child & youth MH expertise & others as appropriate (e.g., young people & families) are included in the review.	Same as T2.	*Hospital inpatient services:* • Same as T3. *Community-based services (CYMH):* Same as T3 plus: • QI structures & processes in place to specifically review & improve the quality & safety of child & youth MH, including case reviews. • Establishes structures & processes to track child & youth specific MH quality indicators at a regional & provincial level. *Residential services:* • Same as T3.	*Hospital inpatient & community-based & ambulatory services:* • QI structures & processes in place to specifically review & improve the quality & safety of child & youth MH, including case reviews. • In collaboration with T6, structures & processes are in place to track regional/provincial child & youth specific MH quality indicators. Indicators are relevant to the setting (e.g., hospital inpatient, community-based, ambulatory). *Residential services:* • QI structures & processes in place to specifically review & improve the quality & safety of child & youth MH, including case reviews. • Structures & processes in place to track regional/provincial child & youth specific MH quality indicators.	*Hospital inpatient & community-based & ambulatory services:* • QI structures & processes in place to specifically review & improve the quality & safety of child & youth MH, including case reviews. • In collaboration with T5, structures & processes are in place to track regional/provincial child & youth specific MH quality indicators. • Provides subspecialty child & youth expertise for T2-T5 case reviews, as requested. *Residential services:* • QI structures & processes in place to specifically review & improve the quality & safety of child & youth MH, including case reviews. • Structures & processes in place to track provincial child & youth specific MH quality indicators.

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	**T2**	**T3**	**T4**	**T5**	**T6**
1.2	QI initiatives	Participates in regional & provincial MH improvement initiatives relevant to the setting.	Same as T1.	Same as T2.	Same as T3.	*Hospital inpatient & community-based & ambulatory services:* • Leads/participates in regional child & youth MH improvement initiatives. • Participates in provincial child & youth MH improvement initiatives. *Residential services:* • Participates in regional/provincial child & youth MH improvement initiatives.	*Hospital inpatient & community-based & ambulatory services:* • Leads/participates in regional child & youth MH improvement initiatives. • Leads/participates in provincial child & youth MH improvement initiatives. *Residential services:* • Leads provincial child & youth MH improvement initiatives.
1.3	Child/youth/ family feedback	Organizational mechanisms are in place to obtain child/youth/family feedback on services provided. Incorporates feedback as appropriate.	Same as T1.	Same as T2.	Same as T3.	Same as T4.	Same as T5.
1.4	Evidence-informed care & wise practices	Systems are in place to support dissemination & use of guidelines on existing, new & emerging evidence-informed care & wise practices.	Same as T1.	Same as T2.	Same as T3.	Same as T4. Participates in the development & regional dissemination of evidence-informed guidelines related to child & youth MH. Participates in the regional dissemination of wise practices.	Same as T5 plus: In collaboration with CHBC & relevant ministries/HAs/ regions & providers, develops & disseminates evidence- informed guidelines related to child & youth MH. Participates in the provincial dissemination of wise practices.

		Health Promotion & Prevention Service	General Health Service	Child-Focused MH Service	Children's Comprehensive MH Service	Children's Regional Subspecialty MH Service	Children's Provincial Subspecialty MH Service
		T1	T2	T3	T4	T5	T6
2.0	**Research**						
2.1						Participates in research related to child & youth MH care. Research is relevant to the setting.	Leads & supports others to conduct child & youth MH-related research.

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Appendix 1: Groups/Individuals Contributing to Development of the Module

Child Health BC would like to acknowledge the many health care professionals and service providers who contributed to the development of this module by sharing their expert opinion and by acting as reviewers.

MH Module Development Advisory Group[xxxv]

Child Health BC

- Dr. Maureen O'Donnell (Executive Director)
- Janet Williams (Project Lead)
- Angela Olsen (Project Coordinator, seconded from BCCH MH Programs)

BC Children's Hospital/PHSA

- Sarah Bell (Executive Director of MH Programs)
- Dr. Jana Davidson (Chief of Psychiatry, MH programs)
- Kate Thomas-Peter (Program Director of Projects, Quality Improvement & Evaluation)

Ministry of Children & Family Development

- Joanne White (Prov Director of Practice)
- Martin Bartel (Director of Operations CYMH - Service Delivery Branch)
- Janet Campbell (Coast Fraser Regional CYMH Co-Ordinator – Practice Branch)

Provincial MH Module Development Working Group[xxxvi]

Interior Health

- Carla Mantie – Manager, Practice Lead for MH & SU
- Dr. David Smith – Medical Director, Child & Adolescent Psychiatrist
- Dr. Jeff Peimer – Emergency Physician

Fraser Health

- Stan Kuperis - Director, MH & SU Services,
- Dr. Shruthi Eswar – Child & Adolescent Psychiatrist, Division Lead, Child, Youth, Young Adult
- Dr. Aven Poynter – Pediatrician, Doctors of BC

Vancouver Island Health

- Shannon Moffat – CHBC Regional Coordinator
- Dr. Carol-Ann Saari – Child & Adolescent Psychiatrist (previously FHA) & Past President of the BC Psychiatric Association
- Dr. Wilma Arruda – Pediatrician
- Dr. Fawad Elahi – Child & Adolescent Psychiatrist, North Island
- Elaine Halsall - Manager Child, Youth & Family MH (retired end of January 2018)
- Susan Gmitroski - Manager Child, Youth & Family MH (took over from Elaine Halsall Jan 2018)

[xxxv] 10 meetings, June - December 2017.
[xxxvi] 6 meetings, including 2 full day meetings, March - December 2017

Vancouver Coastal Health

- Lizzy Ambler – Operations Director, CYMH & SU
- Dale Handley – Clinical Planner, Youth MH & SU Services, Carlile Centre

PHSA

- Kristen Catton – BCCH – SW Professional Practice Leader
- Cynara Radley –BCCH – Senior Practice Leader

First Nations Health Authority

- Erika Mundel - Snr Policy Analyst, MH & Wellness
- Pam Watson – Program Consultant

Child Health BC

- Yasmin Tuff – Project Lead

Other Key Stakeholders

- Keli Anderson – FamilySmart
- Karen Tee – Director, Operations & Planning, Foundry (previously FHA)

Plus members of the MH Module Development Advisory Group.

Northern Health

- Jennifer Begg – Executive Lead, Child & Youth Health
- Mary Morrison – Manager, Youth Services & Eating Disorders
- Dr. Dmitri Zanozin – Psychiatrist
- Dr. Bill Abelson – Pediatrician
- Michelle Lawrence – Executive Lead, MH & SU (joined Nov 2017)
- Dr. Rachel Boulding – Child & Adolescent Psychiatrist, Medical Director of APU

Ministry of Health

- Kelly Veillette – Manager, MH & SU (until May 2017)
- Michelle Wong – Director of Community SU & Child & Youth (as of May 2017)

Ministry of Children & Family Development

- Sandy Wiens –Prov Director of Policy (retired summer 2017)
- Rob Lampard - Prov Director of Policy (from Sept 2017 to replace Sandy Wiens)
- Jody Al-Molky –Maples, Director of Nursing, Quality Assurance & Training
- Lise Erikson – ED Service Branch, South Vancouver Island
- Louise Rogers –Team Leader CYMH Northeast Service Delivery Area

<u>Task-Specific Working Groups</u>

For those who were also on the Provincial MH Module Development Working Group, titles are not repeated below.

1. Community-based & Ambulatory Services[xxxvii]

- Karen Tee
- Dr. Carol-Ann Saari
- Dr. Aven Poynter
- Carla Mantie
- Dr. Jeff Peimer
- Dr. Jana Davidson
- Martin Bartel
- Janet Campbell
- Louise Rogers
- Janet Williams
- Angela Olsen
- Kate Thomas-Peter

[xxxvii] 2 meetings, April-May 2017.

2. Residential Services[xxxviii]

- Jody Al-Molky
- Lise Erikson
- Mary Morrison
- Kim Williams (Clinical Operations Manager, Looking Glass Residence)
- Shannon Gillin (MCFD Child & Youth with Special Needs Consultant for Van Coastal)
- Kate Thomas-Peter
- Janet Williams
- Angela Olsen

3. Inpatient Services for Children & Youth With Acute MH Needs[xxxix]

- Dr. Wilma Arruda
- Jennifer Begg
- Dr. Aven Poynter
- Dr. Bill Abelson
- Susan Gmitroski
- Dr. Carol-Ann Saari
- Dr. Jeff Peimer
- Dr. Jana Davidson
- Deb Chaplain – Director Child, Youth & Family, VIHA
- Dr. Crosbie Watler – Psychiatrist, VIHA
- Dr. Rodney Drabkin – Child & Adolescent Psychiatrist, VIHA
- Dr. Paul Dagg – Psychiatrist, Medical Director MH & SU, Interior Health
- Dr. Tom Warshawski – Pediatrician, Pediatric Medical Director, Interior Health
- Dr. Rummy Dosanjh – Physician, Doctors of BC
- Dr. Maureen O'Donnell
- Janet Williams
- Angela Olsen
- Kate Thomas-Peter

Presentations of module drafts for introduction/feedback

June 20, 2017 - Ministry of Children & Family Development (ministry representatives):

- Dr. Maureen O'Donnell (presented in conjunction with the Child Development, Habilitation & Rehabilitation module)

Dec 1, 2017 - Child Health BC Steering Committee:

- Drs. Maureen O'Donnell and Jana Davidson, and Janet Williams
- Membership includes pediatric operational and medical leads from all regional health authorities and representatives from PHSA (BC Children's Hospital, Sunny Hill Health Centre, Perinatal Services BC, Population & Public Health), First Nations Health Authority, Ministry of Health, Ministry of Children and Family Development, Ministry of Social Development and Poverty Reduction, Principals Association, Canadian Child and Youth Health Coalition, Child and Family Research Institute, Society of General Practitioners of BC, BC Pediatric Society, and, the University of British Columbia.

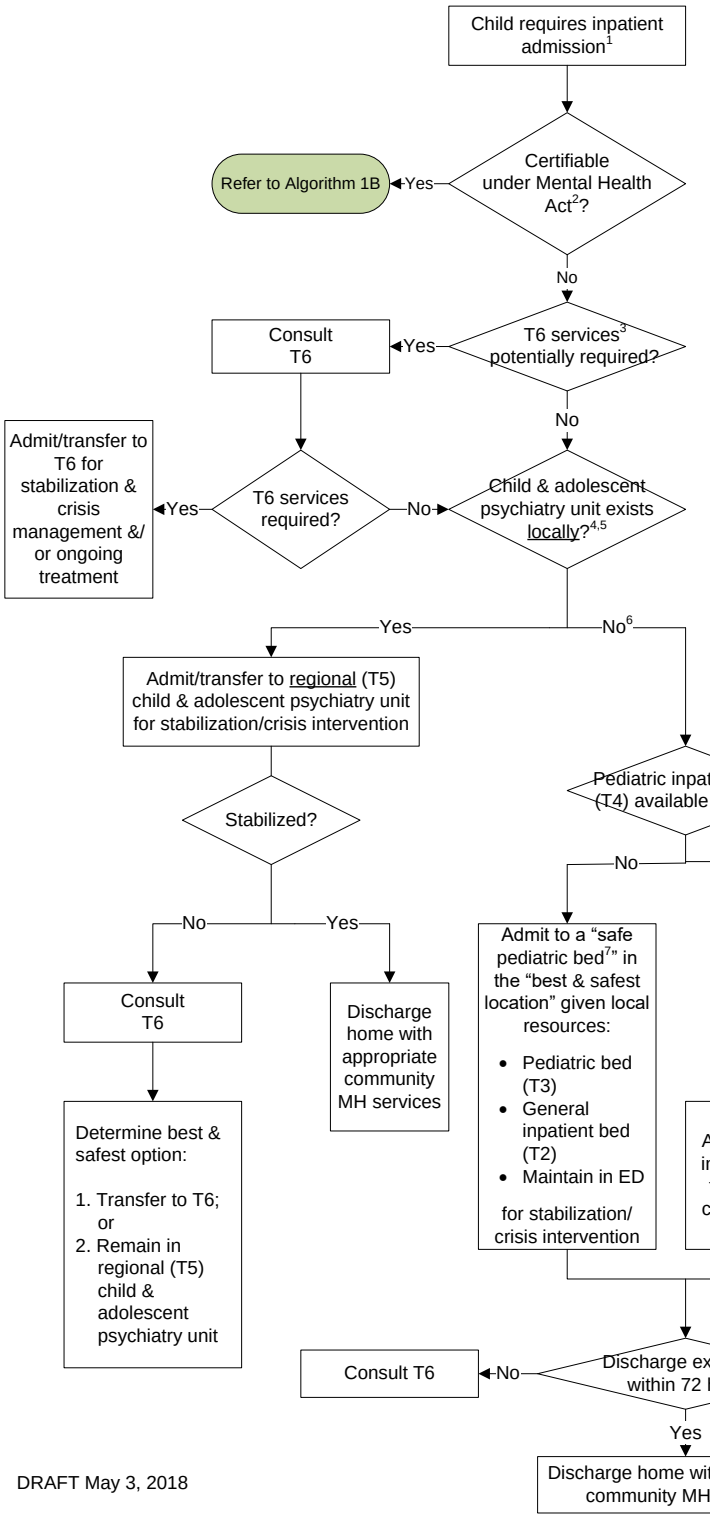
Dec 6, 2017 - Provincial MH and Substance Use Collaborative Working Group:

- Drs. Maureen O'Donnell and Jana Davidson
- Membership includes mental health operational and medical leads from all regional health authorities and representatives from PHSA (BC Children's Hospital & BC Mental Health & Substance Use Services), First Nations Health Authority, Ministry of Health, Ministry of Mental Health & Addictions and Ministry of Children and Family Development.

[xxxviii] 2 meetings, April-May 2017.
[xxxix] 2 meetings, January-February 2018.

Appendix 2: Desired Future State Referral Algorithms

Children Under Age 12 with MH Conditions Requiring Inpatient Admission: 1A - Not Certifiable



[1]Assumes all other community-based/ambulatory treatment options have been exhausted.

[2]Certifiable:

- Suffers from a mental disorder that seriously impairs his or her ability to react appropriately to his or her environment or to associate with others;
- Requires psychiatry treatment in or through a designated facility;
- Requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or for the protection of others, and
- Cannot be suitably admitted as a voluntary patient.

[3]Focus of T6 services:

- Severe, complex &/or persistent MH conditions; &/or
- Services required from multiple medical subspecialties.

[4]Locally = Service exists in the same community.

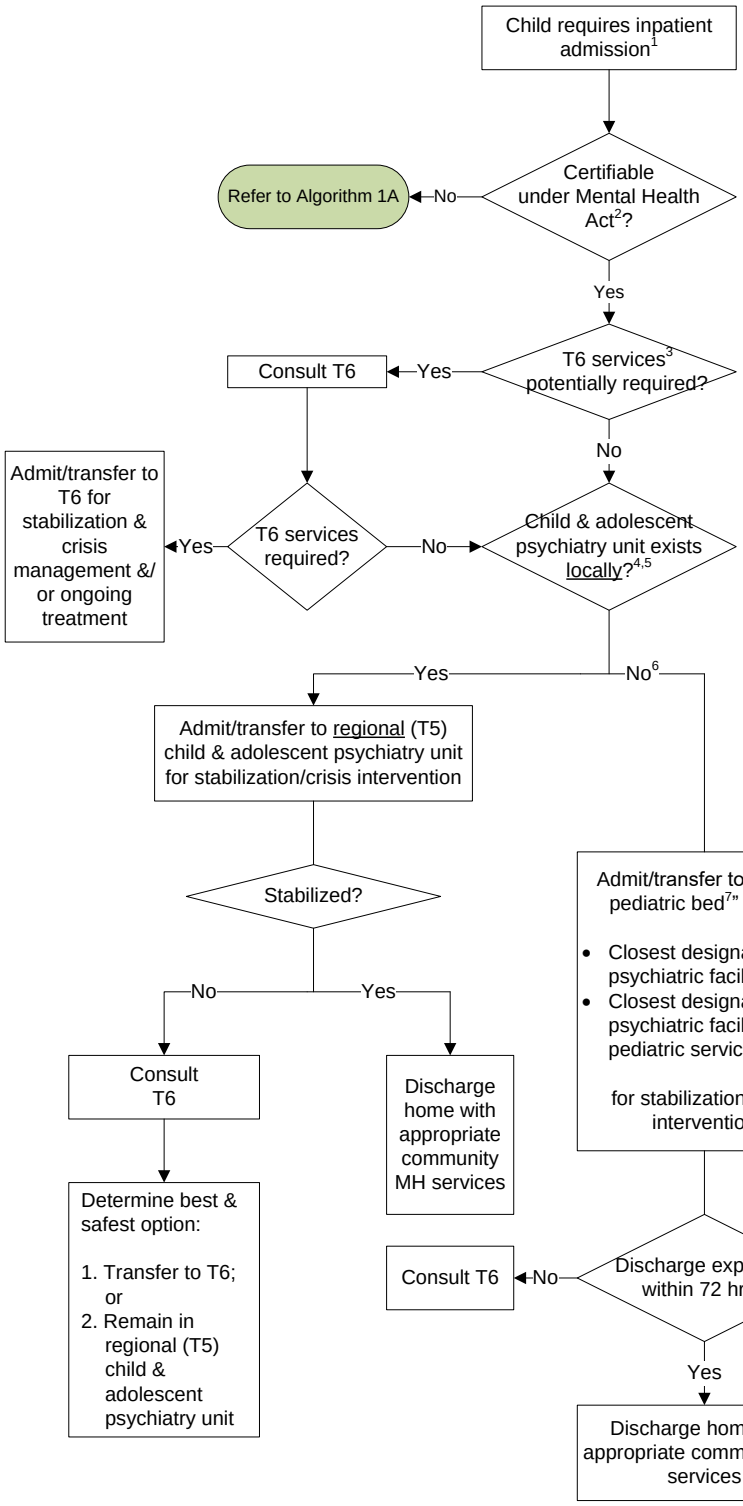
[5]Child psychiatry beds are intended for stabilization only.

[6]Telephone consultation with a child & adolescent psychiatrist (CAP) is encouraged when considering inpatient admission. Consultation is available 24/7: (a) RACE line (days M-F); & (b) T6 (outside these hours).

[7]"Safe pediatric bed:" All hospitals that admit children must take steps to ensure the environment is as safe as possible for children & youth. This includes a physically safe and psychologically comfortable environment & having staff available with skills relevant to the age and needs of children/youth. See "glossary" in the Tiers modules for specifics.

DRAFT May 3, 2018

Children Under Age 12 with MH Conditions Requiring Inpatient Admission: 1B - Certifiable



[1]Assumes all other community-based/ambulatory treatment options have been exhausted.

[2]Certifiable:

- Suffers from a mental disorder that seriously impairs his or her ability to react appropriately to his or her environment or to associate with others;
- Requires psychiatry treatment in or through a designated facility;
- Requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or for the protection of others, and
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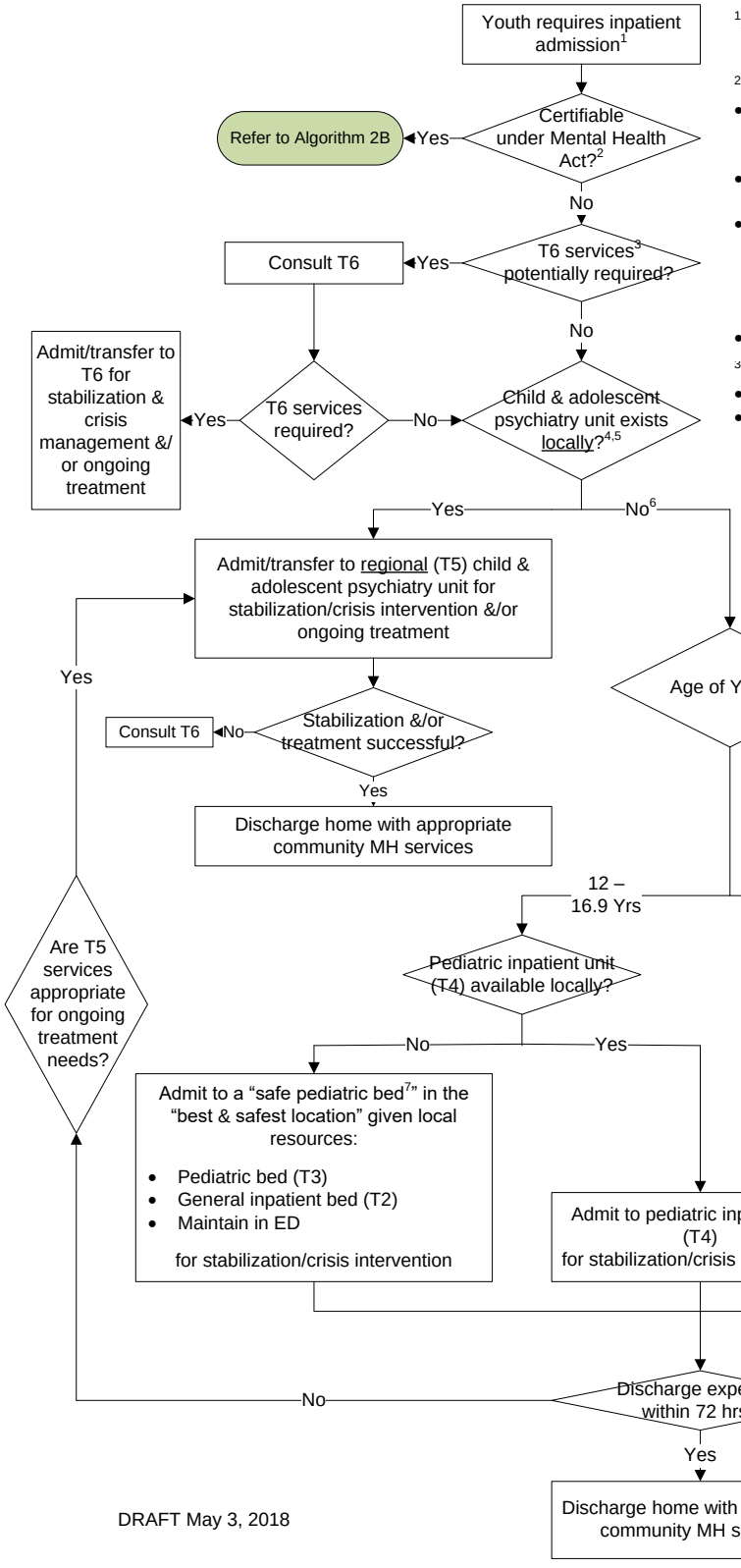
[7]"Safe pediatric bed:" All hospitals that admit children must take steps to ensure the environment is as safe as possible for children & youth. This includes a physically safe and psychologically comfortable environment & having staff available with skills relevant to the age and needs of children/youth. See "glossary" in the Tiers modules for specifics.

DRAFT May 3, 2018

Youth Ages 12 to 18.9 Yrs with MH Conditions Requiring Inpatient Admission: 2A - Not Certifiable



[1]Assumes all other community-based/ambulatory treatment options have been exhausted.

[2]Certifiable:

- Suffers from a mental disorder that seriously impairs his or her ability to react appropriately to his or her environment or to associate with others;
- Requires psychiatry treatment in or through a designated facility;
- Requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or for the protection of others, and
- Cannot be suitably admitted as a voluntary patient.

[3]Focus of T6 services:

- Severe, complex &/or persistent MH conditions; &/or
- Services required from multiple medical subspecialties.

[4]Locally = Service exists in the same community.

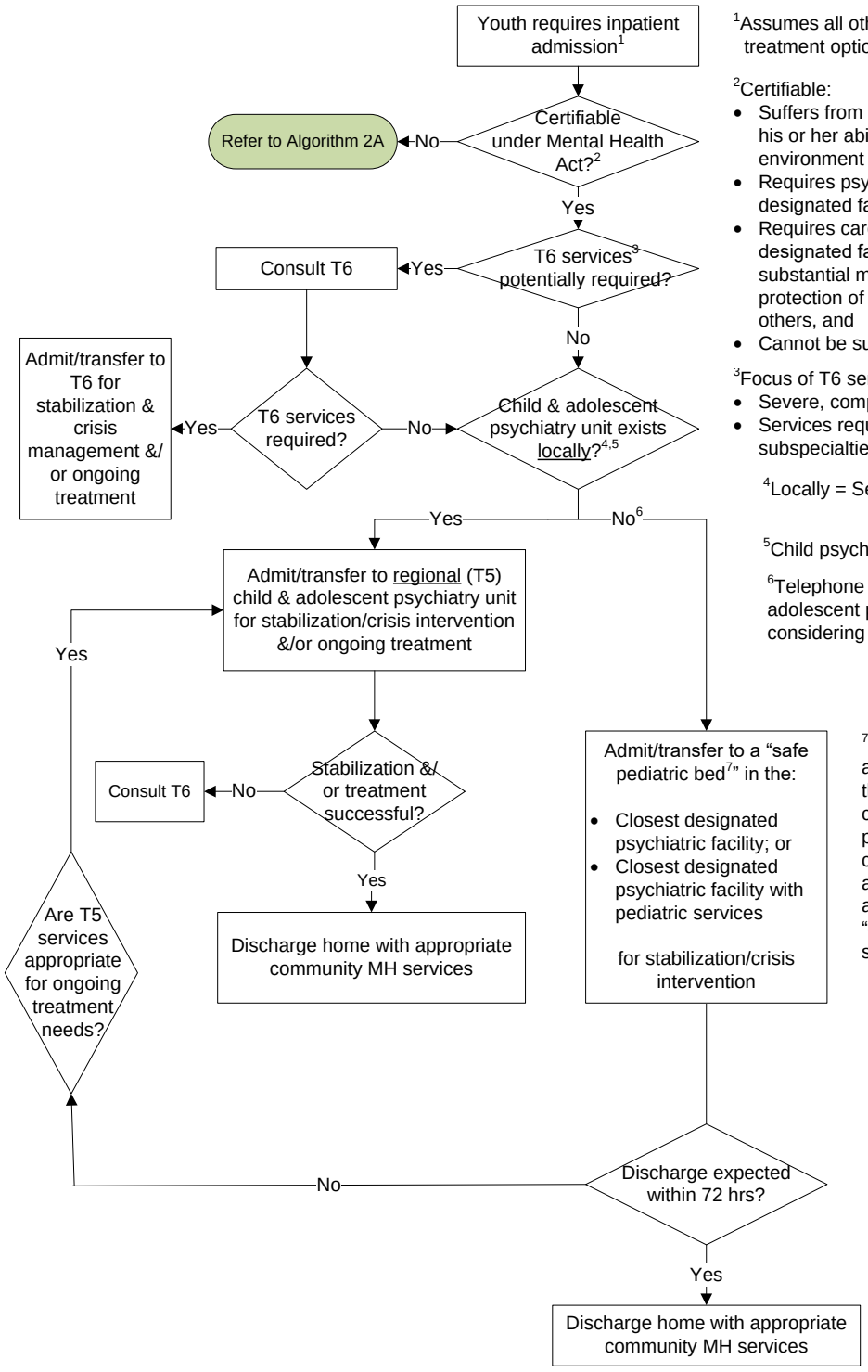
[5]Child psychiatry beds are for stabilization only.

[6]Telephone consultation with a T5/T6 child & adolescent psychiatrist (CAP) is encouraged when considering inpatient admission.

[7]"Safe pediatric bed:" All hospitals that admit children must take steps to ensure the environment is as safe as possible for children & youth. This includes a physically safe and psychologically comfortable environment & having staff available with skills relevant to the age and needs of children/youth. See "glossary" in the Tiers modules for specifics.

DRAFT May 3, 2018

Youth Ages 12 to 18.9 Yrs with MH Conditions Requiring Inpatient Admission: 2B - Certifiable



[1]Assumes all other community-based/ambulatory treatment options have been exhausted.

[2]Certifiable:

- Suffers from a mental disorder that seriously impairs his or her ability to react appropriately to his or her environment or to associate with others;
- Requires psychiatry treatment in or through a designated facility;
- Requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or for the protection of others, and
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[7]"Safe pediatric bed:" All hospitals that admit children must take steps to ensure the environment is as safe as possible for children & youth. This includes a physically safe and psychologically comfortable environment & having staff available with skills relevant to the age and needs of children/youth. See "glossary" in the Tiers modules for specifics.

DRAFT May 3, 2018

Appendix 3: Differentiation of the Tiers

"Acuity" and "complexity" are the terms used in this module to differentiate the populations of children and youth served at each tier. Definitions are provided in Tables 3 and 4.

Table 3: Levels of Complexity

	Low	Moderate	High
Relative frequency	Common. AND	Common or uncommon. AND	Common or uncommon. AND
Medical & mental health comorbidity	Single mental health diagnosis without medical comorbidity. OR	Single or comorbid medical *AND* mental health diagnoses or problems. OR	Multiple medical *AND* mental health diagnoses &/or unclear diagnoses. OR
Mental health comorbidity	Single diagnosis or problem. AND	Single or comorbid diagnoses or problems. AND	Multiple diagnoses &/or unclear diagnoses. AND
Course of mental health condition	Predictable. AND	Predictable with some ambiguity or may be poor response to treatment. AND	Unpredictable or non-responsive to traditional treatment. AND/OR
Availability of care algorithms /protocols	Yes. AND	Some conditions. AND	Possibly. AND
Escalation of condition	Escalation of condition, if present, does not require emergent intervention. Escalations are predictable & not life threatening. AND	Escalation of condition may require emergent intervention. Escalations are predictable & not life threatening. AND	Escalations of condition are frequent & often linked to threat to safety of self or others. AND/OR
Range of interventions required	Standard range. Outcomes to the intervention are predictable. AND	Standard range. Outcomes to the intervention are mostly predictable or mostly respond to intervention. AND	Extensive & innovative range of interventions may be required. Interventions may be associated with significant risk or side effects. AND
Functional limitations specific to mental health condition & its management	Functional impairments, if present, are short-lived & expected to resolve without impact on developmental milestones	Regular monitoring & proactive planning is required to manage functional impairments & impact on developmental milestones	Significant functional impairments may be present despite on-going intervention(s), & are impacting developmental milestones
Examples	*13 yr old diagnosed with first episode of depression.* *8 yr old with question of ADHD.*	*Common Conditions:* *10 yr old diagnosed with ADHD & anxiety. Challenges are present at school (attendance, bullying), & there is a recent family breakup with MCFD involvement due to family*	*Common Conditions:* *13 yr old diagnosed with depression, ADHD, complex developmental trauma, poly-substance use, self- harm, & unstable diabetes. One previous suicide attempt & several inpatient stays due to mental health issues.*

	Low	Moderate	High
		violence. *Uncommon Conditions:* *6 yr old diagnosed with Autism & anxiety. Recently lost a parent due to cancer.*	*Suffers from chronic stomach pain & GI symptoms. Lives in an MCFD group home.* *Uncommon Conditions:* *16 yr old diagnosed with Fragile X syndrome & depression. Currently experiencing hallucinations & persecutory delusions.*

Table 4: Levels of Acuity

	Low	Moderate	High
Observation level	Requires non-urgent standard level of observation &/or standard level of care that might focus on monitoring.	Requires visual proximity &/or regular clinician contact.	Requires one or more clinicians in immediate proximity. Typically requires in-patient stay.
Risk of harm /safety risks present	No current suicidal / homicidal ideation, plan or intentions. Low likelihood for harmful behaviour. Ability to care for self with support. Intact impulse control. AND	Current suicidal or homicidal ideation without intent, plan or past history. Potential for harmful behaviour. Evidence of self-neglect. Impaired impulse control. AND	Current suicidal or homicidal intentions with a plan. Episodes of harmful behaviour to self or others, or high likelihood for this to occur. Extreme compromise of self-care. Markedly impaired impulse control. AND
Functional status	Transient impairment in functioning, but able to maintain some meaningful relationships. Minor or intermittent disruption/s to usual developmental activities. AND	Becoming conflicted, withdrawn, alienated or troubled in most significant relationships. Maintains control over impulsive or harmful behaviour. Deterioration in ability to reach developmental milestones &/or engage with environment (family friends, school, community). AND	Extreme deterioration in social interactions. Minimal control over impulsive or harmful behaviour. Disruption in development noted (physical, cognitive, emotional). Complete inability to function in community. AND
Recovery environment	Life circumstances are predominantly stable. At least one source of support is accessible. AND	Significant discord or difficulties in family or other important relationships. Recent important loss or deterioration of home environment. Exposure to danger. Pressure to perform surpasses ability to do so in significant area. Limited support resources accessible. AND	Serious disruption of family/social environment or life circumstances. Episodes of trauma or violence. Overwhelming demands. No support resources accessible. AND

	Low	Moderate	High
Engagement	Potential to understand & accept mental health condition & its effects (with support & psychoeducation).	Some variability in understanding or accepting mental health condition, associated impact &/or comorbidities. Limited commitment to change & participate in treatment.	No understanding or awareness of mental health condition, associated impact or comorbidities. Unable to actively engage in treatment. Avoidant, frightened or guarded.
Examples	*8 year old struggling academically at school, has some worries, some trouble sleeping, parents have sought tutors &are reading books on anxiety in children.*	*16 yr old with recent suicide attempt (took 10 Tylenol with alcohol) after fight with boyfriend, conflict with parents due to cannabis use, uses cannabis to cope with anxiety, infrequently attending alternative education program.*	*12 yr old with diagnoses including depression, ADHD, FASD & complex developmental PTSD. Currently uses alcohol, previous physical/ sexual abuse by father, 4th foster placement this year, recent escalating pattern of substance use & cutting, sexually active, running away to DTES, current plan to suicide before upcoming court date.*

Table 5 provides an overview of the relationship between medical complexity, relative frequency, acuity and the appropriate tier of service provision.

Table 5: Children Appropriate to Receive Services at Each Tier (Acuity, Complexity, & Relative Frequency)

		General Health Service			Child-Focused MH Service			Children's Comprehensive MH Service			Children's Regional Subspecialty MH Service			Children's Provincial Subspecialty MH Service		
		T2			T3			T4			T5			T6		
Underlying Condition		**Acuity of Presenting Complaint**														
Complexity	**Relative Frequency**	Low	Mod	High	Low	Mod	High	Low	Mod	High	Low	Mod	High	Low	Mod	High
Low		Eg1							Eg3				Eg9			
Mod	Common				Eg2				Eg4				Eg10			
Mod	Uncommon							Eg5	Eg6				Eg11			
High	Common										Eg7	Eg8				Eg14
High	Uncommon													Eg12	Eg13	Eg15

Table 6 provides examples of children who would be expected to receive services at each tier.

Table 6: Examples of Children Appropriate to Receive Services at Each Tier (application of the principles in Tables 3, 4 & 5)

#	Level of Complexity	Relative Frequency	Level of Acuity	Example	Tier of Service Required
1	Low		Low	Child diagnosed with ADHD presenting with stomach aches.	T2
2	Moderate	Common	Low	Child diagnosed with depression & anxiety, prescribed Prozac & now presenting with insomnia.	T3

#	Level of Complexity	Relative Frequency	Level of Acuity	Example	Tier of Service Required
				Has been unable to attend school the past 2 weeks. Father recently diagnosed with terminal CA.	
3	Low		Moderate	Child with 2 yr history of depression presenting with worsening symptoms which include passive thoughts of wanting to die. Has been unable to attend school the past 4 weeks, irritable with parents, difficult to get out of the house for appointments.	T4
4	Moderate	Common	Moderate	Child diagnosed with anxiety, ADHD & learning disabilities has become more isolative, refusing to attend school or attend to personal hygiene, allegedly addicted to video games. Got into a fight with mother & police were called.	T4
5	Moderate	Uncommon	Low	Child diagnosed with Autism, now presenting with anxiety symptoms.	T4
6	Moderate	Uncommon	Moderate	Child diagnosed with diabetes & depression, now presenting with increased alcohol use & self-harm after best friend committed suicide.	T4
7	High	Common	Low	Child diagnosed with FASD, ADHD, depression, moderate developmental delay, self-harm with a previous suicide attempt requiring hospitalization, now presenting with alcohol intoxication. Foster parents (of 5 years) advise this is child's first experience with substances yet are concerned about child's recent change in peer group, & behavioural concerns such as running away.	T5
8	High	Common	Moderate	Child diagnosed with bipolar disorder & anxiety, treated previously with Lithium, now presenting with psychotic symptoms.	T5
9	Low		High	Child diagnosed with depression now presenting with plan to kill self. Parents are appropriately concerned & unsure if they can keep child safe at home.	T5
10	Moderate	Common	High	Child diagnosed with anxiety & PTSD, living in MCFD care. Now presenting with increased self-harm, suicidal thoughts & behavioural concerns including running away, violence towards foster parents, & refusing to attend school.	T5
11	Moderate	Uncommon	High	Child with increasing weight loss & over exercise in the context of bullying & family conflict. Child is hypothermic & bradycardic with episodes of syncope. Child is motivated to gain weight & working well with unit staff.	T5
12	High	Uncommon	Low	Child diagnosed with Fragile X Syndrome, depression, benign brain tumor & partial blindness. Child now presenting with insomnia, lack of appetite, & withdrawal from family.	T6
13	High	Uncommon	Moderate	Child diagnosed with unstable diabetes & gender dysphoria who is now presenting with increased alcohol use, not taking insulin post friend's suicide, & passive thoughts of wanting to join friend. Child's	T6

#	Level of Complexity	Relative Frequency	Level of Acuity	Example	Tier of Service Required
				parents still having difficulty accepting gender issues.	
14	High	Common	High	Child diagnosed with anxiety, neonatal exposure to substances, unspecified learning difficulties & extreme behavioural issues including fire-setting & sexual intrusiveness. Child has been expelled from school & the foster placement has broken down. Police were called after altercation with current caregiver. CYMH & MCFD are requesting a consult.	T6
15	High	Uncommon	High	Child diagnosed with early on-set schizophrenia & has been hospitalized several times for psychosis. Child is now presenting with catatonic symptoms. Many medications trials have been unsuccessful. child has been home-bound for the past year. Parents do not speak English & cultural issues make it challenging for them to accept the diagnosis & engage in treatment.	T6

Appendix 4: Glossary

Types of Beds/Units

Regional child & adolescent psychiatry unit

Programming focuses on (1) stabilization and crisis intervention for children & youth up to age 18.9 years; (2) ongoing treatment and discharge planning for youth ages 12 - 18.9 yrs; Anticipated length of stay for children up to 11.9 years old is <72 hrs although may be longer in specific situations. Anticipated length of stay for youth may be several weeks.

Child psychiatry stabilization bed

Programming focuses on stabilization and crisis intervention for children up to age 11.9 years. Anticipated length of stay is <72 hrs. Bed is located on a regional child & adolescent psychiatry unit or on a provincial child psychiatry unit.

Provincial child psychiatry unit

Programming focuses on (1) stabilization and crisis intervention; (2) ongoing treatment & discharge planning for children up to age 11.9 years. Anticipated length of stay may be several weeks.

Provincial adolescent psychiatry unit

Programming focuses on (1) stabilization and crisis intervention; (2) ongoing treatment & discharge planning for youth ages 12 - 18.9 years. Anticipated length of stay may be several weeks.

Safe pediatric bed (extracted from CHBC Children's Medicine module)

All hospitals that admit children must take steps to ensure the environment is as safe as possible for children & youth (<16.9 yrs). For a T2 service, this includes:

- Physical safety:
  - Area is physically safe for children & youth with any potentially dangerous equipment or sharps, ligature risks, medications, chemicals or fluids out of reach or in locked cupboards. Windows, if present, must have safe guards to allow for minimal opening.
  - Ability to position bed near the nursing station for appropriate level of observation, as required (e.g., children/youth with mental health conditions).
  - Physical separation of children & youth from adult patients is recommended. If physical separation is not possible, children & youth are not in the same area/unit as adults who are under the influence of, or withdrawing from alcohol or chemical substances, known sex offenders, a danger to themselves or others and/or are confused and/or wandering.
  - Furniture meets appropriate safety standards for children & youth, with appropriate size of beds for smaller children.
- Psychological comfort:
  - Parents/primary caregivers are able to stay with their children & youth 24/7 during hospitalization.

- Self-served food and drink is in close proximity.
- Knowledgeable staff:
  - Sufficient “RNs with pediatric skills” are allocated each shift to ensure adequate supervision and care (includes adhering to a daily routine) relevant to the age and nursing needs of child.
  - Criminal record checks are required as part of the credentialing and/or hiring process for all staff and physicians (as per legislation).
- Equipment and supplies:
  - Pediatric emergency equipment and supplies are in close proximity (refer to Appendix 1 in the Medical Tiers in Full document for a non-exhaustive list of equipment and supplies).

Additional requirements for a T3/T4 service:

- Psychological comfort:
  - Access to child-friendly bathrooms.
  - Space for changing diapers (if appropriate to the clinical specialty).
  - Facilities for breastfeeding and breast milk storage (if appropriate to the clinical specialty).
  - Safe space(s) and age-appropriate facilities/equipment for children and youth to play/be entertained/have exercise. e.g., age appropriate media, arts/crafts books and board games, supervised use of courtyard, if available.

Safe pediatric unit (extracted from CHBC Children's Medicine module)

In addition to the requirements for a safe bed, a "safe pediatric unit" includes:

- Physical safety:
  - Children & youth are cared for on a dedicated pediatric inpatient unit(s).
  - Pediatric unit is functionally separate from adult patients, preferably with a door that can be closed (but not locked) and not opened by young children.
  - Regulated hot water temperature and secure electrical outlets are present on the unit.
- Psychological comfort:
  - Bedside sleeping facilities and ideally a kitchenette with fridge and microwave are available for parents/primary care givers.
  - Youth-friendly facilities/activities are available.

Staff Competencies

Registered Nurse (RN) with "pediatric skills"

- Demonstrates a broad understanding of growth & development. Distinguishes between normal & abnormal growth & development of infants, toddlers, children & youth.
- Understands the psychological impacts of care provision (including hospitalization) at different developmental stages (infant, toddler, preschooler, school aged & youth).
- Understands how to provide a physically & psychologically safe environment appropriate to the age & condition of the child.

- Demonstrates understanding of the physiological differences between infants, children & adults & implications for assessment & care.
- Assesses a child's normal parameters, recognizes the deviations from the normal & acts appropriately on the findings.
- Demonstrates knowledge of common pediatric conditions & their management.
- Demonstrates understanding of fluid management in an infant & child.
- Calculates & administers medications & other preparations based on weight based dosages.
- Assesses child & family's knowledge & provides teaching specific to the plan of care & condition or procedure.
- Communicates effectively & works in partnership with children & families (children & family-centered care).
- Aware of & accesses pediatric-specific clinical guidelines & protocols.
- Responds to patient deterioration/acute urgent situations in an appropriate & timely manner.
- Commences & maintains effective basic pediatric life support, including 1 & 2-rescuer infant & child CPR, AED use & management of airway obstructions.
- Provides referrals to public health nursing, nutrition & utilizes contact with the child & family to promote child health. e.g., immunization, child safety.
- Assesses pain & intervenes as appropriate.
- Initiates & manages peripheral IV infusions on children. Consults expert clinicians as necessary. Identifies & manages complications of IV therapy.

References:

- NSW's Guidelines for Care in Acute Care Settings[20]
- BC Children's Pediatric Foundational Competencies on-line course[21]
- BC Children's CAPE tools (2008-2010)[22]

RN/Registered Psychiatric Nurse (RPN) with "child & youth MH skills"

- Demonstrates in-depth knowledge of diagnosis & treatment of child & youth MH conditions, including concurrent disorders.
- Perform comprehensive MH nursing assessment which includes Mental Status Exam
- Ability to identify risks & create care-plans to mitigate/avoid risk (i.e. harm to self/other, running away, self-neglect & violence).
- Includes families in all aspects of service delivery & treatment of their child/youth.
- Knowledge of common medications used in pediatric MH, side effects & their use in treatment of pediatric MH conditions.
- Ability to respond to acute or emergent MH &/or medical situations in an appropriate & timely manner. Includes CODE procedures, use of crash cart, conflict resolution & use of physical behaviour management skills.
- Ability to provide milieu management/engagement, de-escalation, relationship building, collaborative problem solving & culturally sensitive & respectful care.
- Knowledge of guidelines for the use of seclusion & restraint & utilizes it appropriately.

- Knowledge of relevant legislation regarding consent, confidentiality, rights, duty to report (Infants Act, MH Act, FOIPA Act, CF&CS Act), its implications for nursing practice, & utilizes it appropriately.
- Supports & helps to mentor & coach newly graduated nurses.

References:

- ONCAIPS (2015) Collaborative Provincial Child & Adolescent Inpatient Mental Health Standards[18]
- NSW Child & Adolescent Mental Health Services Competency Framework (2011)[3]
- Canadian Standards for Psychiatric Mental Health Nursing (2014)[23]

"Enhanced child & youth MH skills" (refers to RNs/RPNs & other health professionals on the interdisciplinary team)

- Demonstrates in-depth expert knowledge in assessment, diagnosis & treatment in a specific area of clinical care (e.g., children, youth, eating disorders, complex neurodevelopmental disorders).
- Provides supervision and/or education & training for less experienced staff and peers in the delivery of care.

References:

- ONCAIPS Collaborative Provincial Child & Adolescent Inpatient Mental Health Standards(2015)[18]
- NSW Child & Adolescent Mental Health Services Competency Framework (2011)[3]

Therapeutic interventions

Family therapeutic Interventions

- Evidenced based interventions that seek to change the system of interactions between family members, parent/child or an intimate couple. e.g., Family Therapy, coaching.
- Family Therapy is generally used when the family system is seen as contributing to one family member's difficulties (such as a child/youth). There are many different approaches. A therapist attempts to match the approach(s) with the type of MH issue identified & family situation. Examples: Systemic Family Therapy, Emotion-Focused Therapy, Solution-Focused Therapy, Experiential Family Therapy.
- The number of sessions varies. May only occur during a time of crisis, or, may continue until the family reports improved wellness and improvements in relationships &/or family functioning.

References:

- Calgary Family Therapy Centre website[24]
- Centre for Addiction & Mental Health website, About Therapy section[25]

Land-based Interventions

- Treatment services, typically provided to clients within their own traditional territories & communities, which predominantly take place in wilderness environments.
- Services are provided via integrated teams of health professionals which include Elders & traditional healers.
- Examples: Land-based seasonal activities, cultural art & teachings, language, & storytelling.

Reference:

- Land-based Healing Program (2014)[26]

Traditional Wellness & Healing

- Encompasses medicines, ceremonies, practices, & knowledge inherent to First Nation peoples, found worldwide in Indigenous communities.
- Traditional healing practices are understood to lead to better long term wellness.
- First Nations Health Authority (FNHA) has a Traditional Wellness Strategic Framework & suggests that integrated approaches to health care (i.e. combined traditional & mainstream approaches) can result in more favorable outcomes.

References:

- First Nations Health Authority Summary Service Plan (2016/17)[27]
- First Nations Health Authority Traditional Wellness Strategic Framework (2014)[28]

Other

Certifiable/certification

- When a child/youth requires immediate treatment necessary to avert serious health consequences & risk of death, the patient can be admitted involuntarily to a designated facility[xl] & treated under the Mental Health Act (MHA) if they meet specific criteria.
- The MHA authorizes involuntary psychiatric admission to a designated facility for people who meet the following criteria:
  - The patient is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
  - The patient requires psychiatric treatment in or through a designated facility;
  - The patient requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or for the protection of others, and
  - The patient cannot be suitably admitted as a voluntary patient.
- Involuntary detainment & psychiatric treatment can occur as a life-saving measure if voluntary admission & consent to treatment is not possible. One Medical Certificate (Form 4) is required to provide legal authority for an involuntary admission for a 48-hour

[xl] A designated facility is a provincial mental health facility designated under the *Mental Health Act*, a public hospital or part of it, designated by the Minister of Health.

period. A Medical Certificate is completed by a physician who examines a person & finds that the person meets the involuntary admission criteria of the MHA. http://www2.gov.bc.ca/gov/content/health/health-forms/mental-healthforms

- For further guidance, refer to the Guide to the Mental Health Act: http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

Reference:

- Guide to the Mental Health Act, April 4, 2005[29]

Safety Plan

- A plan that is completed in collaboration between service provider(s) & the child/youth/family with a focus on keeping (selves & others) safe.
- This process is frequently used in outpatient & community settings, but may also be implemented in inpatient/residential environments, particularly when granting privileges & passes.
- Includes description of warning signs that indicate worsening mental status &/or increasing behavioural issues (i.e., things child/youth says or does, increased isolation, increased conflict, decreased self-care), coping skills unique to child/youth &/or actions to prevent escalation (i.e., going for a walk, creating art, listening to music, phoning a friend, having a snack, having a rest), who social supports are (i.e., friends, family member, spiritual/cultural community), & identified professional supports to contact (i.e., MH clinician, school counselor, PCP, 911, crisis lines).
- Also identifies potential risks in the home/residential environment such as medications & sharp objects, &, plans to eliminate the risks.

References:

- CAMH Suicide Prevention & Assessment Handbook (2015)[30]
- Kelty Mental Health: Pinwheel Education Series – Suicide & Safety Planning (2014)[31]