Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Mental Health Act**	**Policy Number:**	**A-1**

Policy Statement:

Child and youth mental health clinicians and their supervisors must be familiar with the current *Mental Heath Act* (1999) and its applications.

Background:

- The *Mental Health Act* provides authority, criteria and procedures for involuntary admission and treatment for those deemed to be in need of treatment and a danger to themselves or to others. The Act also provides protection to ensure these provisions are applied in an appropriate and lawful manner.
- Certification under the *Act* requires that the patient is examined by two physicians and found to meet the following committal criteria:
  -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;
  -requires psychiatric treatment in or through a designated facility;
  -requires care, supervision and 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 the protection of others; and
  -is not suitable as a voluntary patient.
- Children and youth of all ages can be certified under the *Mental Health Act* and treated as involuntary patients where appropriate.
- C&YMH clinicians may have occasion to be concerned about the safety of a client or the public and may need to facilitate the client's transport to hospital by police or family for examination.
- Under *Section 28 (1) of the Act "a police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and (b) is apparently a person with a mental disorder."*

Guidelines:

- Clinicians may call on police to assist with clients who may be a danger to themselves and others and who are refusing to see a physician or to voluntarily go to hospital.

- Children under the age of 16 years may be admitted to hospital by the parent or guardian as voluntary patients under the *Mental Health Act* if the admitting physician agrees. The parent or guardian must sign the *Consent to Treatment (Voluntary Patient).*
- Youth over the age of 16 years may receive treatment voluntarily with a signed *Consent to Treatment*, or involuntarily under the *Mental Health Act*.
- A *Proposed Patient Apprehension Request* form may be filled out by the mental health clinician and given to the police when the client is apprehended. This form is not a prescribed form and does not require the police to act.
- The *Mental Health Act* and its prescribed forms are available at http://www.healthservices.gov.bc.ca/mhd/publications.html

References: *Guide to the Mental Health Act, 1999.*

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Child and Youth Mental Health (CYMH) Service Delivery Policies

Policy A-2: Multidisciplinary Team

Effective Date of Policy:

2014

Amendment Date of Policy:

January 10, 2014

POLICY STATEMENT

CYMH[i] services are provided by teams of mental health professionals from several different disciplines whenever possible.

Outcomes

- Infants, children, and youth with mental health challenges and their families/caregivers, including those from Aboriginal communities and cultural groups, receive screening, comprehensive assessment and therapeutic services that are appropriate to their unique mental health needs.

i CYMH includes general and Aboriginal CYMH practitioners

Standards: Multidisciplinary Team Development and Function

1.1 CYMH team leaders work with MCFD regional managers and leadership to develop and maintain **multidisciplinary teams**[ii] through recruitment, hiring, and retention practices.

1.2 CYMH team members collaborate to ensure the infant, child, or youth and their family's/caregiver's needs are aligned with the skills and knowledge of the assigned **qualified professionals.**

Procedures

- Team leaders, in consultation with managers, strive to include a balance of relevant disciplines on the CYMH team when filling vacant or new positions, supporting the team's capacity to meet the varying mental health needs of infants, children, youth and their families/caregivers.
- CYMH team leaders facilitate a culture whereby multidisciplinary professionals have regular opportunities for **general mental health consultation** or **child specific consultation** to enhance assessment and therapeutic planning and delivery for infants, children, youth and their families/caregivers (See CYMH Policy C-1b: Consultation).
- CYMH practitioners are familiar with their team members' professional knowledge and scope of practice and demonstrate respect and appreciation[iii] for other professional perspectives.
- CYMH teams are organized according to a multidisciplinary team structure but may operate on a collaborative continuum ranging from **multidisciplinary collaboration** to **inter-disciplinary collaboration**, based on the needs of the infant, child, youth and their family/caregiver and the capacity of the team.
- When a discipline is missing from a team, team members will collaborate with offsite practitioners from that discipline, when appropriate, through means such as Telehealth Services (See Specialized Cross Program Policy: Telehealth).

ii Bolded words are defined in the glossary

iii Demonstrating *respect and appreciation* within a multidisciplinary team requires self reflection, the consequent awareness of power differences between different disciplines and the willingness to relinquish power to contribute to client and family-centered collaboration 2, 3.

Glossary

Child-specific mental health consultation: A form of consultation that involves a mental health consultant providing assistance in relation to a *specific* infant, child, youth and their family/caregiver. In this relationship the consultant has to possess sufficient knowledge/information about the particular child to support recommendations that are tailored to the specific child's needs.

Inter-disciplinary collaboration: Professionals from different disciplines work together for a common purpose such as the development of a therapeutic plan. Each professional contributes their knowledge and skills related to practice, education, research, and/or theory. [1, 4, 6, 7, 8]

General mental health consultation: The general term "**mental health consultation**" describes non-client specific capacity-building and problem-solving consultations that involve a relationship between a professional consultant with mental health expertise, and one or more professionals who possess different areas of expertise[1,5,6]. The consultation provides information on general mental health issues or topics (e.g., depression in adolescents, support strategies for children with anxiety), and is not provided in reference to a specific client. **General mental health consultation** can be provided as part of a formalised service to a representative or group from another program/agency[1] (i.e. **Program-centred**) or to members of the general public and to other professionals as part of universal promotion/prevention, capacity building, or professional development (i.e. **Topic-centred**).

Multidisciplinary collaboration: Professionals from different disciplines work independently or collaterally (side by side) on a client centered goal within their own discipline-specific parameters.[1] An example may include a psychologist conducting psychological testing and providing these results back to the lead practitioner.

Multidisciplinary team: A group of professionals from different disciplines that have distinct but complementary bodies of knowledge, skills, qualifications, practice expertise and experience. These disciplines usually include but are not limited to psychologists (clinical counselling, developmental), clinical social workers, nurses, physicians, and others such as occupational therapists, child and youth care professionals, and family therapists.

Qualified professional: A qualified professional within CYMH is an individual who is able to perform the job duties, demonstrate competency, and meet the educational and experience qualification requirements identified in a CYMH job description. The professional must meet his/her applicable professional standards, development, and regulations on an ongoing basis.

Legislation

- Child, Family and Community Service Act
- Freedom of Information and Protection of Privacy Act
- Health Professions Act
- Infants Act
- Mental Health Act
- Representative for Children and Youth Act
- Social Workers Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Clinical Process and CARIS

MCFD Disclosure and Document Management

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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2. Anonson, J. M., Ferguson, L., MacDonald, M.B., Murray, B.L., Fowler-Kerry, S., & Bally, J. M. (2009). The anatomy of interprofessional leadership: An investigation of leadership behaviours in team-based health care. *Journal of Leadership Studies,* 3(3), 17-25.
3. Kelley, M. (2009). Cultural competency. In R. Mullner (Ed.), *Encyclopedia of health services research.* (pp. 270-275). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412971942.
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Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Reporting of Child Abuse**	**Policy Number:**	**A-3**

Policy Statement:

A reasonable belief of child abuse or neglect or the likelihood of abuse or neglect must be reported immediately to Child Protection. The legal duty to report child abuse or neglect supersedes patient/ client confidentiality.

It is the responsibility of the child protection social worker to assess and investigate reports that a child may be in need of protection. This responsibility cannot be assumed by a mental health clinician.

Background:

Section 14 of the *Child, Family and Community Services Act (CFCSA)*
Duty to report need for protection (see attached appendix)

Section 13 of the *CFCSA*
When protection is needed (see attached appendix)

Guidelines:

Clinicians are obliged to contact a delegated social worker whenever there are reasonable grounds to believe that a child or youth is in need of protection.

Clinicians will consult with a delegated social worker, team leader or district supervisor in their region, whenever there is any doubt whether or not a report is required under CFCSA.

References: *Child, Family and Community Services Act*

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Appendix:

CFCSA, section 14 **Duty to report need for protection**

a person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

CFCSA, section 13 **When protection is needed**

a child is in need of protection under the following:

- if the child has been, or is likely to be, physically harmed by the child's parent
- if the child has been, or is likely to be, sexually abused or exploited by the parent
- if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child
- if the child has been, or is likely to be, physically harmed because of neglect by the child's parent
- if the child is emotionally harmed by the parent's conduct
- if the child's development is likely to be seriously impaired by a treatable condition and the parent refuses to provide or consent to treatment
- if the child is deprived of necessary health care
- if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care
- if the child is or has been absent from home in circumstances that endanger the child's care
- if the child's parent is dead and adequate provision has not been made for the child's care
- if the child has been abandoned and adequate provision has not been made for the child's care
- if the child is in care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.

CFCSA defines a child as a person under 19 years of age and includes a youth who is 16 years of age or over but under 19 years of age.

Child and Youth Mental Health (CYMH) Service Delivery Policies	
Policy B-1: Referral and Intake	
Effective Date of Policy: 2014	**Amendment Date of Policy:** October 7, 2014

Policy Statement

CYMH [i] practitioners provide competent and **culturally safe** [ii] **referral** and **intake** services that facilitate access for infants, children, youth with mental health challenges, and their family/caregivers and communities, to appropriate mental health services and supports.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal communities and cultural groups:
  - Experience reduced risk; and
  - Access culturally safe and appropriate information, supports and services in a timely manner.

i CYMH includes general and Aboriginal CYMH practitioners

ii Bolded words are defined in the glossary

Standard: Accessing Referral and Intake

1.1 CYMH practitioners provide accessible **referral** and **intake** services, in a manner consistent with the **Helping Relationships Framework** and the Aboriginal Practice Framework[iii].

Procedures

- CYMH practitioners review and **respond (see Response in Glossary)** to requests for mental health services for infants, children, and youth up to age 18 received from all referral sources.
- CYMH practitioners respond immediately to mental health **referrals** for infants, children, and youth, identified as **urgent** or within 2 business days for non-urgent referrals and document this action**.**
- CYMH clinicians or team leaders/clinical supervisors conduct the specialized clinical function of **referral and intake**, and maintain clinical competence related to this function. Mental health support workers, students, or interns may perform this function under close supervision from a CYMH clinician and/or Team Leader/Clinical Supervisor.
- CYMH practitioners conduct **referral** and **intake** using:
  - The CYMH **Intake Clinic Model**, when available (See Appendix 1); and/or,
  - Other referral and intake processes, including **telehealth**, office-based or outreach as appropriate.
- CYMH practitioners conduct **referral** and **intake** processes that promote connection, collaboration and opportunities for choice for the child, youth and families/caregivers, including decisions about responding to questions asked as part of the intake process.
- CYMH practitioners discuss youth, families'/caregivers' and professionals' expectations related to the request for services and provide them with explicit information about CYMH services, including what they can expect throughout the referral and intake process.
- CYMH practitioners obtain and document verbal consent from the guardian(s) and/or the referred **mature minor** to proceed with the **referral** and **intake** process, except when an **emergency response** is required (see Standard 1.2 Urgency).
- CYMH practitioners explain to the child, youth and/or the parent/guardian, at initial contact, the limits of confidentiality according to the Freedom of Information and

iii Under development

Protection of Privacy Act and document this discussion.

- CYMH practitioners consistently inquire about the ethnicity of the child or youth and complete either the Aboriginal Origin field to indicate the Aboriginal origin of children and youth, or the ethnocultural background field, in the CARIS Management System[iv].
- CYMH practitioners provide information about the MCFD Complaint Policy, the role of the Representative for Children and Youth and the Ombudsperson (see the Child Family Community Service Act) as part of the **referral** and **intake** process[v].
- CYMH practitioners are aware of the demographics, diverse populations, and relevant supports and services within their communities, including those that are culturally appropriate for Aboriginal children, youth and their families.

Standard: Urgency

2.1 CYMH practitioners evaluate urgency related to the severity of mental health concerns and other safety issues throughout the **referral** and **intake** process and intervene appropriately with the child/youth and/or family/caregiver to ensure safety.

Procedures

- CYMH Team Leaders/Clinical Supervisors establish clear processes to facilitate access to urgent or emergent services through contracted clinical services, health authorities or service agencies as appropriate in each community (see CYMH Policy B-5 Mental Health Crisis Response).
- Non-clinical staff receiving inquiries from a **referral** source are required to consistently ask if the reason for calling is urgent. If the caller states the **referral** is **urgent**, the non-clinical staff immediately contacts a CYMH practitioner.
- CYMH practitioners use clinical best practices[vi] to inform monitoring, evaluation, and responding to immediate safety risks.
- CYMH practitioners addressing potentially urgent or emergent requests for service engage in information gathering as necessary for evaluation of the immediate risks and to initiate appropriate responses to ensure safety. Completion of other components of the screening process may be deferred based on clinical judgement and consultation with Team Leaders/Clinical Supervisors, and is to be completed later as clinically appropriate.

iv See the resource Asking About Aboriginal Origin for additional guidance on this topic.

v See the resource "Child Rights in Practice" and the MCFD complaints brochure for additional guidance.

vi Some resources include Preventing Youth Suicide: A Guide for Practitioners, Practice Guidelines for Working with Children and Youth At-Risk for Suicide in Community Mental Health Settings, the *Guide to the Mental Health Act (2005)* and *The CYMH Referral and Intake Scale (link to be added when available).*

Standard: Referral and Intake Screening and Eligibility Determination

3.1 CYMH practitioners engage children, youth and/or their families/caregivers in referral and intake services in a timely manner and determine mental health needs, using a standardized mental health screening tool and the collection of other pertinent information, sufficient to determine whether the needs are best met through CYMH services and/or through other supports and services.

Procedures

- CYMH practitioners use the **Brief Child & Family Phone Interview** (BCFPI) as part of the **referral** and **intake** process for all referrals (also see cultural guidelines[vii]), unless clinically contraindicated or deferred for specific reasons that are determined in consultation with the CYMH Team Leader/Clinical Supervisor.
- CYMH practitioners ensure that all required Intake Screening Questions are reviewed as part of the **referral** and **intake** process (see Appendix 2: *CYMH Required Intake Screening Questions* and *CYMH Referral and Intake Scale*) and that additional questions are included as clinically indicated.
- CYMH practitioners collect and record narrative and collateral information about the referred infant, child or youth and their family/caregiver in the CARIS referral note related to the elements listed below:
    - Presence and severity of mental health challenges and problematic substance use for the child or youth and parent/caregiver;
    - Risk of harm to the infant, child or youth and/or others related to suicidal ideation, self-harm, risk-taking, and/or threatening behaviours; psychosis; and/or serious psychotropic medication side-effects;
    - Level of functioning in daily living at home, school, in the community or at work when appropriate; and with family members/caregivers and peers;
    - Presence of neglect, abuse and trauma experiences, including exposure to **domestic violence** (see The B.C. Handbook for Action on Child Abuse and Neglect, CYMH Policy A-3 Reporting Disclosure of Child Abuse and CYMH Policy B-18 Trauma Informed Practice); and
    - Presence o**f risk factors** and **protective factors**, including strengths of the child, youth, their family and community, and availability of family and community supports.

vii Under development

Standard: Prioritization and Intake Response

4.1 CYMH practitioners collaborate with **mature minors** and/or parents/caregivers and guardians to discuss the results of the **referral** and **intake** process, including the results of the BCFPI and/or other screening tools, and jointly develop a plan to address the identified needs[viii].

- As a component of the **referral** and **intake** response, CYMH practitioners:
  - Collaborate with MCFD program areas and community partners, and local parents in residence and youth in residence, where available;
  - Share information about services and resources relevant to the presenting needs of infants, children, youth and their families/caregivers, including the CYMH Information and Resources Toolkit and the online map of child and youth mental health supports and services (link will be added when available).
  - Engage in the next steps in service planning in partnership with those who are eligible for CYMH services and their families/caregivers:
    - Explore and discuss service options and recommendations with the **mature minor** and/or their families/caregivers, including potential **Initial Services** from CYMH, as well as other relevant community supports and services;
    - Develop an initial supports and services plan, informed by child, youth and parent/caregiver preferences (for example, the *Plan for Initial Supports and Services* form being used in Intake Clinics – link will be added when available), and share a copy with the **mature minor** and/or parent/caregiver and guardian (see CYMH Policy B-2 Waitlist Management).
  - Provide **active system navigation** for those who do not meet criteria for CYMH services.
  - Routinely advise referring professionals of the referral outcome using the *Plan for Initial Supports and Services* form, whenever possible, with the consent [ix] of the legal guardian(s) and the **mature minor**, when appropriate.
- CYMH practitioners follow up and verify access to community supports and services recommended during the **referral** and **intake** process by:
  - Asking the parent/caregiver to report back to the practitioner if they have

viii The CYMH Referral and Intake Scale provide criteria regarding eligibility, priority rankings and service responses. The CYMH Testing Policy (to be implemented fall 2014) provides standards and procedures regarding the use of screening measures.

ix Consent is to be documented using the Disclosure of Information Form (CF0609).

difficulty accessing a resource; and/or

- Making a follow-up telephone call to the parent/caregiver or **mature minor** in cases of urgency and as clinically indicated.

Glossary

Active System Navigation: Active systems navigation is support provided by CYMH practitioners to referred infants, children, youth and their families/caregivers to facilitate access to appropriate mental health services and supports across systems and settings by:

- Locating and accessing appropriate mental health supports and services in a timely and culturally safe manner;
- Providing information on mental health services and recommending next steps;
- Coordinating referrals and linkages to appropriate mental health services;
- Establishing processes for parents/caregivers to re-contact CYMH if they have difficulty accessing resources.

Brief Child & Family Phone Interview: Is a standardized CYMH screening tool used as part of the referral and intake process and administered by phone or in person with parents, teachers or adolescents. It may also be administered during treatment, at the completion of service, or as a follow-up measure.

Cultural safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

Domestic violence: "A pattern of intentionally coercive and violent behaviour toward an individual with whom there is or has been an intimate relationship. These behaviours can be used to establish control of an individual and can include physical and sexual abuse; psychological abuse with verbal intimidation, progressive social isolation, or deprivation; and economic control".[1]

Emergency response: Services that respond to people in a crisis, such as those accessed through 911 and are available 24 hours a day, 7 days a week, including the police, fire departments, BC Ambulance Services, and hospital emergency rooms.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles	Common Factors
□ Child, Youth and Adult-Centered □ Family-centered □ Strengths-based □ Rights- & Social Justice-based □ Inclusive & Culturally Safe □ Evidence-Informed □ Trauma-Informed □ Developmentally/ecologically-based	□ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Intake: A process initiated following a referral that includes gathering of information from relevant and sometimes multiple sources. The intake process involves a preliminary evaluation of the situation sufficient to determine the next appropriate action or actions.

Intake Clinic Model: The intake clinic model for CYMH uses a walk-in approach in which mature minors and/or parents/guardians can have a face-to-face meeting with a an intake clinician to complete the referral and intake process (See Appendix A).

Initial Services: Consist of an array of brief services that can be provided following appropriate intake screening. Initial services include consultation, group-based interventions (e.g., risk reduction, skills, psycho-educational, support), and brief individual therapy interventions (between 1-4 sessions).

Mature minor: Is defined in the *Infants Act***.** Children may be able to consent to therapy without parental consent if they understand the "nature and consequences and the reasonably foreseeable benefits and risks of the care" and the health care provider determines that they are competent to make the decision and the health care is in their best interests.

Parents-in-residence**:** Act as navigators and support for families accessing mental health services. They work with systems to enhance services and find solutions, promote the sharing of mental health information to families and promote early intervention and prevention of mental health challenges. [2]

Protective factors: Factors and experiences that may reduce risks for mental health challenges or suicide.[16]These can include genetic and neurobiological makeup, attitudinal and behavioural characteristics and environmental factors.[8] Additional contextual factors for Aboriginal youth include: cultural identity and engagement in cultural activities, respect for tradition and community self-determination. [3, 4, 5]

Referral: Any request for CYMH services from a mature minor, legal guardian, family

member, or community professional regarding an infant, child or youth with mental health challenges (up to and including age 18).

Response: Action taken by a practitioner in a considerate manner to a specific circumstance such as a clinical intervention, a telephone call, or written correspondence.

Risk factors: Refers to characteristics at the biological, psychological, family, community, or cultural level that are associated with a higher likelihood of mental health challenges and/or disorders.

Telehealth: The use of videoconferencing equipment and other electronic means (e.g. telephone) to support communication about health care services over distance. The health care services include direct clinical services to children and youth as well as intake, indirect consultation, educational sessions for practitioners and administrative meetings.

Urgent (response): Response provided to infants, children and youth who are experiencing suicidal thoughts and/or serious mental health concerns when the practitioner is concerned for their safety and well-being or the safety of those around the child or youth. An urgent response is provided as soon as is reasonably and feasibly possible within the hours of service of the local CYMH office.

Youth-in-residence: An internet search for the provincial Kelty Mental Health Resource Centre youth in residence provides information on how to access this resource. The youth in residence Act as navigators and support for youth accessing mental health services. They work with systems to enhance services and find solutions, promote the sharing of mental health information to families and promote early intervention and prevention of mental health challenges.

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

Literature

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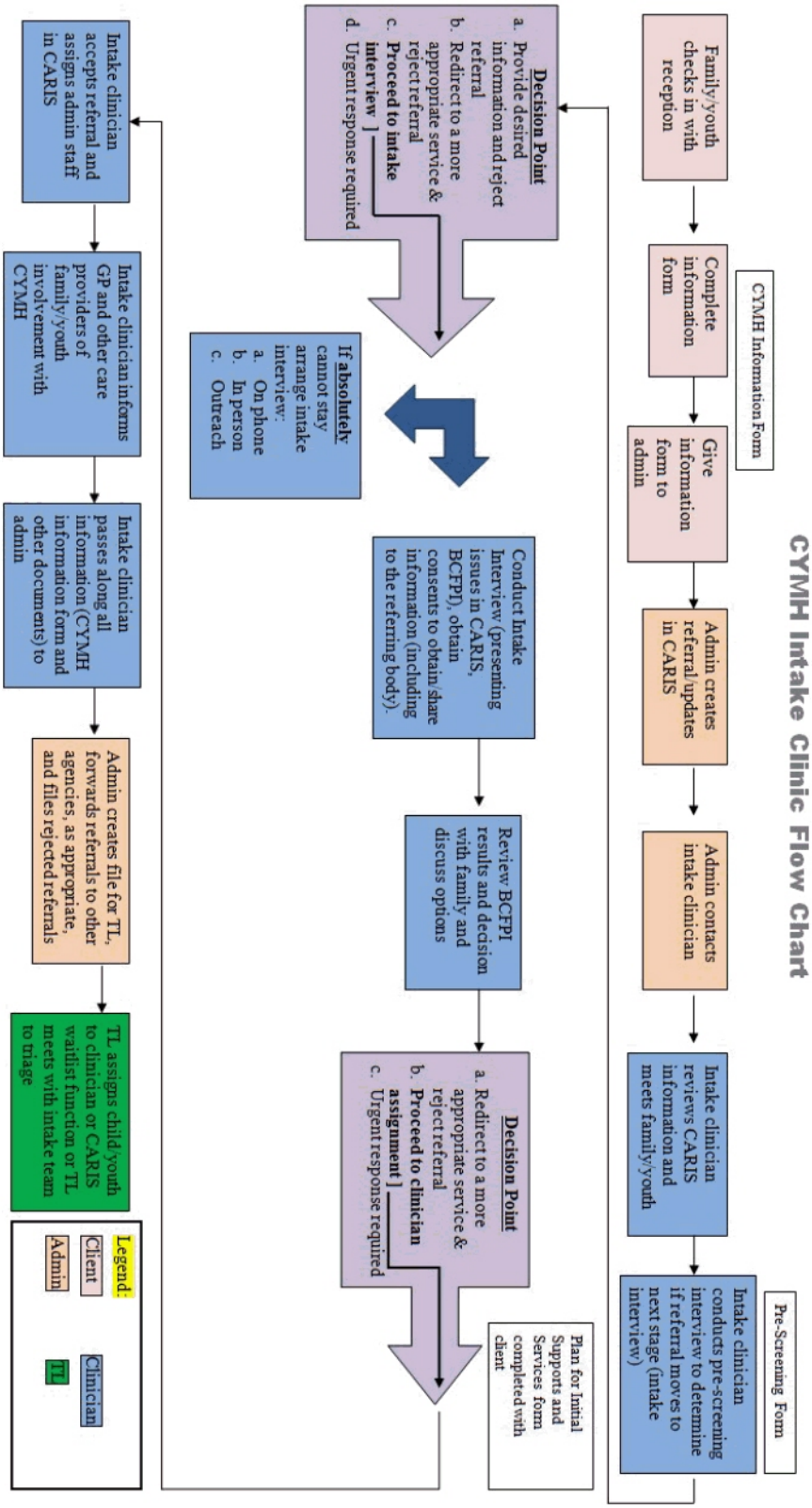
Appendix 1


CYMH Intake Clinic Flow Chart
CYMH Information Form
Pre-Screening Form
Family/youth checks in with reception
Complete information form
Give information form to admin
Admin creates referral/updates in CARIS
Admin contacts intake clinician
Intake clinician reviews CARIS information and meets family/youth
Intake clinician conducts pre-screening interview to determine if referral moves to next stage (intake interview)
Decision Point
a. Provide desired information and reject referral
b. Redirect to a more appropriate service & reject referral
c. Proceed to intake interview]
d. Urgent response required
If absolutely cannot stay arrange intake interview:
a. On phone
b. In person
c. Outreach
Conduct Intake Interview (presenting issues in CARIS, BCFPI), obtain consents to obtain/share information (including to the referring body).
Review BCFPI results and decision with family and discuss options
Decision Point
a. Redirect to a more appropriate service & reject referral
b. Proceed to clinician assignment]
c. Urgent response required
Plan for Initial Supports and Services form completed with client
Intake clinician accepts referral and assigns admin staff in CARIS
Intake clinician informs GP and other care providers of family/youth involvement with CYMH
Intake clinician passes along all information (CYMH information form and other documents) to admin
Admin creates file for TL, forwards referrals to other agencies, as appropriate, and files rejected referrals
TL assigns child/youth to clinician or CARIS waitlist function or TL meets with intake team to triage
Legend:
Client
Admin
Clinician
TL

Appendix 2: CYMH Intake Required Screening Questions

BCFPI Item	Required?	Comments	Type O=optional R=required S=standardized D=demographic
1 Basic Concerns *(1 item - Free text narrative)*	**Y**		**OD**
2 Basic demographics *(5 items)*	**Y**		**RD**
3 Behavior and Emotional Adjustment *(24-27 items)*		Items in this section are required for estimating symptom levels	
A. Regulation of Attention, Impulsivity & Activity (6 items)	**Y**		**RS**
B. Cooperativeness (6 items)	**Y**		**RS**
D. Conduct (6 items)	**Y**		**RS**
E. Separation from parents (6 items)	**Y**		**RS**
F. Managing Anxiety (6 items)	**Y**		**RS**
G. Managing mood (6 items + 3 if concern re: depression or self-harm)	**Y**		**RS**
4 Child Functioning & Impact on Family *(16 items)*		Items in this section are required for estimating impact on child functioning	
A. Child's Social Participation (3 items)	**Y**		**RS**
B. Quality of Child's Relationships (3 items)	**Y**		**RS**
C. Child's School Participation & Achievement (3 items)	**Y**		**RS**
D. Family Activities (4 items)	**Y**		**RS**
E. Family Comfort (3 items)	**Y**		**RS**
5 Other Items available for inquiry, if applicable	**N** **Y**	As per clinical judgment for all items *except for*: Substance Use ←	**OD except for RD**
6 Developmental Status – Not in current version of BCFPI.			
7 Risk Factors *(8 items)*			
A. Health- Parent (& Partner) (1 item)	**Y**		**RD**

BCFPI Item	Required?	Comments	Type O=optional R=required S=standardized D=demographic
B. Mood - Informant (6 items)	**Y**	*Links to Safe Relationships, Safe Children*	**RS**
B. Mood - partner (3 items)	**Y**	*Links to Safe Relationships, Safe Children*	**RD**
C. Alcohol-Parent (& partner) (1 item)	**Y**	*Links to Safe Relationships, Safe Children*	**RD**
D. Family functioning (2 items)	**Y**		**RD**
E. Couple relationship (1 item)	**Y**		**RD**
F. Discipline style (how often do you…)(5 items)	**Y**		**RD**
G. Abuse (4 items)	**Y**	*Links to Safe Relationships, Safe Children*	**RD**
8 Protective Factors			
A. Supervised activities (3 items)	**Y**	*These questions are linked to strength-based practices, and questions regarding strengths and resilience are consistent with the Helping Relationships Framework.*	**RD**
B. Skills (1 item)	**Y**		**RD**
C. Family Recreation (1 item)	**Y**		**RD**
D. Spiritual (1 item)	**Y**		**RD**
E. Child confidant (1 item)	**Y**		**RD**
F. Parent confidant (1 item)	**Y**		**RD**
9 Readiness, Barriers & Conclusion			
A. Readiness (6 items)	**Y**	*Required to support active system navigation and to inform initial service planning – links to CYMH Toolkit*	**RD**
B. Barriers (7 items)	**Y**	*Required to support effective engagement*	**RD**

Items In Current Intake Not Available In BCFPI[x]			
• Have you or another family member experienced a mental health challenge or concern that interferes with your happiness or ability to function?	**Y but see below**	See below	**RD**
• Have you ever felt you ought to cut down or stop using alcohol or other drugs or have others suggested that you need to cut down or stop? Have drugs or alcohol been a problem for anyone else at home?	**Y but see below**	See below	**RD**
• Have you ever been hurt, physically/psychologically by your current/former partner? Do you have any concerns about going home today?	**Y but see below**	See Abuse item 4	**RD**

x These draft questions are from Safe Relationships, Safe Children: A Guide to Enhance Practice (to be distributed when available). The draft questions, once finalized, will become a required component in interviews of adults in a parenting role after implementation of the Safe Relationships, Safe Children Project takes place.

These questions will complement Risk Factor Questions B 1-3, C 1 & G4. The questions require further review and discussion in relation to how to transition to the use of these questions, but they are required as part of an agreed to response to an RCY Report.

Child and Youth Mental Health (CYMH) Service Delivery Policies	
Policy B-2: Waitlist Management Policy (revision to 2002 Policy)	
Effective Date of Policy: 2014	**Amendment Date of Policy:** January 10, 2014

Policy Statement

CYMH[i] teams use a standardised approach to monitor and support infants, children and youth, and their families/caregivers waiting for mental health services.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal communities and cultural groups, receive information and resources to support their mental health and safety while awaiting service.
- MCFD CYMH teams and management at community and provincial levels use valid and reliable waitlist data to inform service and program planning.

i CYMH includes general and Aboriginal CYMH practitioners

Standard: Supporting Children, Youth and their Families/Caregivers when waiting for CYMH Services

1.1 CYMH team leaders/clinical supervisors and practitioners use a standardised approach to support the mental health of children, youth, and their families/caregivers waiting for mental health services, in a manner consistent with the **Helping Relationships Framework** and the Aboriginal Practice Framework[ii].

Procedures

- A standardised **intake** screening and prioritisation process (see Referral and Intake Policy) is used to inform initial decisions about whether children and youth are placed on a waitlist for mental health services.
- Infants, children and youth in crisis and in need of an **emergency or urgent response** are provided immediate support as appropriate to the situation (see CYMH Policy B-1: Referral and Intake, and CYMH Policy B-17: CYMH Suicide Prevention, Intervention and Postvention).
- CYMH practitioners seek informed consent from the legal guardian(s) and/or **mature minor**, to communicate and, if indicated, to collaborate with the referring professional and with other involved community supports as required to coordinate care during the wait for service (see CYMH Policy D-3: Informed Consent to Information Sharing).
- In consultation with legal guardians and/or mature minors, CYMH clinicians establish a plan for initial supports and services that will be in effect during the waiting period. The plan is informed by:
  - Child/parent/family/community needs and strengths identified during the intake interview; and
  - Parent's and/or youth's expressed preferences about the type of resource options (e.g., books, web resources, groups, workshops), they might find helpful during the waiting period.
- The initial support and service planning includes discussion with youth and/or parents/caregivers about the following, as relevant to the individual needs and circumstances of the child, youth and family:
  - A description of the CYMH service option(s) that they are waiting for;
  - An estimate of the anticipated range of time prior to the initiation of service(s);
  - Contacting their CYMH intake clinician (or other designated contact) if they

ii Under development

have questions or if their situation changes;

- Contact name(s), numbers and hours of availability for their designated CYMH contacts, and for emergency/crisis services;
- Agreement about how to monitor the child's or youth's mental health needs during the wait period. This may involve CYMH, parents/caregivers, family physicians, or others, when there are safety concerns and/or as part of assertive outreach (see CYMH Policy B-17: CYMH Suicide Prevention, Intervention and Postvention);
- Information, resources and recommended strategies, which may include:
  - Access to appropriate CYMH child/youth or parent/caregiver psychoeducational groups whilst the family is waiting for mental health services;
  - Psychoeducational material and self-help resources (e.g., books, booklists, handouts, online resources, and audiovisual material related to their identified concerns – see the CYMH website for a list of these resources); and
  - Information on other MCFD program areas, or other community-based services, in relation to their identified needs such as psychoeducational groups, parenting skills groups, support groups, and local parents in residence and **youth in residence**, where available.

➢ CYMH practitioners work to respond to identified changes in a child's or youth's mental health needs by collaborating with clinical supervisors/team leaders, parents/caregivers, youth, and other involved professionals to determine the best course of action, including making changes to the waitlist priority ranking.

➢ CYMH practitioners may follow-up about the usefulness of the initial plan for supports and services with children, youth, and their parents/caregivers, and suggest additional or alternative supports and services as required.

➢ CYMH practitioners document:

- The summary of the initial support planning discussion, using, for example, the Plan for Initial Supports and Services, which is placed on the clinical file and shared with the legal guardian and/or mature minor, and with other involved professionals with appropriate consent; and,
- Clinically relevant information related to contacts with those on the waitlist, and with other involved community professionals.

Standard: CYMH Waitlist Recording, Monitoring and Management

2.1 CYMH practitioners use the electronic information system[iii] waitlist to record and track information about **priority status**, wait times, and clinical notes for all infants, children and youth waiting for mental health services.

Procedures

➢ CYMH team leaders ensure that:

- All CYMH practitioners are oriented to the waitlist system.
- CYMH practitioners enter standardised waitlist data into the electronic waitlist management system and/or work with administrative authorised to act on their behalf.
- CYMH practitioners use a standardised system of prioritising the needs of infants, children, youth and their parents/caregivers at the point of adding their names to the electronic waitlist. The priority rankings include:

  1. Very High, 2. High, 3. Moderate

  (see Appendix 1 *CYMH Priority Ranking Tool* for more information); or

  "On Hold": Used when the parent/caregiver or youth has asked for a delay in starting a waitlisted CYMH service. Children and youth assigned "on hold" status are reviewed with the team leader/clinical supervisor as part of regularly scheduled waitlist monitoring. In addition, other involved professionals are informed about the delay in commencing service (with appropriate consent for information sharing) as appropriate to support collaborative care.
- A procedure or process for reviewing the needs of infants, children, and youth on the waitlist at regular intervals is in place.
- CYMH practitioners update the information on the electronic waitlist as needed to reflect changes in the needs of infants, children and youth.
- Aggregate waitlist information (e.g., numbers on waitlist, priority ratings, and average time on list) is reviewed as part of continuous quality improvement efforts to enhance access to CYMH services, and is routinely shared with the relevant Community Service Managers.

[iii] MCFD CYMH teams currently use the Community and Residential Information System (CARIS) and use the **CARIS waiting list and the aggregate reports** to record and monitor waitlist information.

Glossary

Assertive outreach: Practitioners use assertive outreach to actively engage with and reduce barriers to service for children and youth with mental health challenges and their families/caregivers through such means as arranging meetings in the home, at school, or community setting; offering flexible hours of service; and using email reminders about appointments.

CARIS waitlist management system: The Community and Residential Information System (CARIS) waitlist management system includes a means of adding individuals to a team location waitlist, and an aggregate team level waitlist report on all children and youth on the waitlist.

Cultural safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice[8].

Emergency response: Services that respond to people in a crisis, such as those accessed through 911 and are available 24 hours a day, 7 days a week, including the police, fire departments, BC Ambulance Services, and hospital emergency rooms.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles

- □ Child, Youth and Adult-Centered
- □ Family-centered
- □ Strengths-based
- □ Rights- & Social Justice-based
- □ Inclusive & Culturally Safe
- □ Evidence-Informed
- □ Trauma-Informed
- □Developmentally/ecologically-based

Common Factors

- □ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences
- □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach
- □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Intake: A process initiated following a referral that includes gathering of information from relevant and sometimes multiple sources. The intake process involves a preliminary evaluation of the situation sufficient to determine the next appropriate action or actions.

Mature minor: Is defined in the ***Infants Act.*** Children may be able to consent to therapy without parental consent if they understand the "nature and consequences and the reasonably foreseeable benefits and risks of the care" and the health care provider determines that they are competent to make the decision and the health care is in their best interests.

Parents-in-residence: An internet search for the provincial *Kelty Mental Health Resource Centre parents in residence* provides information on how to access this resource. The parents in residence act as navigators and support for families accessing mental health services. They work with systems to enhance services and find solutions, promote the sharing of mental health information to families and promote early intervention and prevention of mental health challenges.

Plan for Initial Services: A template plan that the parent/caregiver and child/youth can use during a wait for service. The plan is completed consistent with CYMH Policy B-3 Referral and Intake.

Priority Status: The CARIS Waitlist includes a numerical "1, 2, 3" ranking. See Appendix 1 for the *Waitlist Priority Ranking Tool*, which provides guidelines on priority ranking. The CARIS Waitlist priority rankings include:

1. Very High, 2. High, 3. Moderate, or **On Hold**

Referral: Any request for CYMH services from a mature minor, legal guardian, family member, or community professional regarding an infant, child or youth with mental health challenges (up to and including age 18).

Response: Action taken by a practitioner in a considerate manner to a specific circumstance such as a clinical intervention, a telephone call, or written correspondence.

Urgent response: Response provided to infants, children and youth who are experiencing suicidal thoughts and/or serious mental health concerns when the practitioner is concerned for their safety and well-being or the safety of those around the child or youth. An urgent response is provided as soon as is reasonably and feasibly possible within the hours of service of the local CYMH office.

Waitlist: A list of all referred child and youth clients who have been accepted for service but are waiting for the initiation of **mental health services.**

Youth-in-residence: An internet search for the provincial *Kelty Mental Health Resource Centre youth in residence* provides information on how to access this resource. The youth in residence Act as navigators and support for youth accessing mental health

services. They work with systems to enhance services and find solutions, promote the sharing of mental health information to families and promote early intervention and prevention of mental health challenges.

Legislation

- Child, Family and Community Service Act
- Freedom of Information and Protection of Privacy Act
- Health Professions Act
- Infants Act
- Mental Health Act
- Representative for Children and Youth Act
- Social Workers Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide (under development)

MCFD CYMH Clinical Process and CARIS, Version 1.0, June 2009

MCFD Disclosure and Document Management

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

References

1. The Canadian Association of Paediatric Health Centres, The National Infant, Child, and Youth Mental Health Consortium Advisory & The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (2010). *Access & Wait Times in Child and Youth Mental Health: A Background Paper*. Canadian Institutes of Health Research.

2. Alberta Health Services (2012). *Executive Summary: System Level Performance Report for Addiction and Mental Health Services in Alberta*.
3. UK Department for Children, Schools and Families and Department of Health, (2009). *Improving Access to Child and Adolescent Mental Health Services*.
4. Kowalski, K., McLennan, J. D. & McGrath, P. J. (2011). A Preliminary Investigation of Wait Times for Child and Adolescent Mental Health Services in Canada. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 20*(2), 112-119.
5. Smith, D. & Hadorn, D. (2002). Lining Up for Children's Mental Health Services: A Tool for Prioritizing Waiting Lists. *Journal of the American Academy of Child and Adolescent* Psychiatry, 41(4), 367-376.
6. Western Canada Waitlist Project (2011). *Child Mental Health Priority Rating Tool: User Manual*.
7. Cunningham, C.E., Deal, K., Rimas, H., Buchanan, D.H., Gold, M., Jarvie-Sdao, K., & Boyle, M. (2008). Modelling the Information Preferences of Parents of Children with Mental Health Problems: A Discrete Choice Conjoint Experiment. *Journal of Abnormal Child Psychology, 36,* p. 1123-1138.
8. National Aboriginal Health Organization (2009). Fact Sheet: *Cultural Competency and Safety in First Nations, Inuit and Metis Health Care*

Appendix 1: Child and Youth Mental Health Waitlist Priority Ranking Tool

Waitlist Priority Ranking	**Service Intensity Considerations while on Waiting for Service**	**Note: The following considerations are intended to guide decision-making and assignment of waitlist priority ranking, but in the end, clinical judgment that includes consideration of all relevant factors will inform the final ranking. Priority rankings will often reflect a *combined analysis* of individual child/youth distress and functioning and family/community capacity.**	
		Child & Youth Considerations	**Family/Community Considerations**
1 **Very High** **Moderate risk of harm to self or others and/or high levels of distress, complexity and functional impact, especially in absence of family and community support**	**In need of intensive action as soon as possible** • Safety plan may be required during wait period. • CYMH/ACYMH contact information and emergency contact information given to family as part of support planning. • Connecting parent/caregiver with supports during wait likely indicated (e.g. FORCE) • May require "wraparound" services - collaborative case planning with referring agent and/or community service to assist with stability and safety during wait for service • Active follow-up from CYMH/ACYMH may be required while on waitlist • Might require close monitoring by GP	**Risk of harm:** • Suicide risk – moderate, possibly including chronic as long as current risk is not severe or extreme, and safety plan is in place • Risk of harm to others – history of aggression to others where serious harm has taken place, recent escalation in behavioral outbursts that result in harm, or persistent aggression **Functional Status:** • Significant impact on function – Global Assessment of Functioning(GAF)/Child Global Assessment Scale (CGAS) approximately 40 and below; high BCFPI child functioning T-Score over 75-80+ • High levels of distress or dysfunction (high scores on BCFPI, Int, Ext – T score 75-80+) • Unstable clinical conditions with the potential to deteriorate quickly and result in emergency service or admission. **Complexity of Needs:** • Highly complex/comorbid mental health and other problems, including trauma (might result in high problems on multiple BCFPI scales). **Vulnerability/Developmental** • Recent/ significant trauma history • Significant recent loss (death of family member, peer suicide) **Protective Factors** (see BCFPI items): • Relative lack of individual protective factors or strengths that can mitigate current risks • Lacking insight into difficulties/not easily engaged	**Family (including extended) Risk Factors** • Presence of a severe family risk factor (or of multiple but less severe risk factors) – • Evidence that family/parent/caregivers have significant acute, complex or chronic needs that limit current capacity to provide support and/or require additional supports and services in addition to CYMH/ACYMH • High family functioning T-score on BCFPI/significant family distress **Protective Factors** • Identified family protective factors do not appear adequate to meet current needs of child/youth **Community Assets/Social Supports/Resources** • Significant lack of community supports for identified needs • Community factors are significant contributor to risk

Appendix 1: Child and Youth Mental Health Waitlist Priority Ranking Tool

<table>
<tr><th rowspan="2">Waitlist
Priority
Ranking</th><th rowspan="2">Service Intensity Considerations while on Waiting for Service</th><th colspan="2">Note: The following considerations are intended to guide decision-making and assignment of waitlist priority ranking, but in the end, clinical judgment that includes consideration of all relevant factors will inform the final ranking. Priority rankings will often reflect a combined analysis of individual child/youth distress and functioning and family/community capacity.</th></tr>
<tr><th>Child & Youth Considerations</th><th>Family/Community Considerations</th></tr>
<tr><td rowspan="5">2
High

Moderate risk of harm and/or significant distress that strains family and/or community capacity to support</td><td rowspan="5">• Needs that indicate individual assessment and therapy likely
• Support plan – including self-care options and list of other supports - likely required during wait period
• CYMH/ACYMH contact information and emergency contact information given to family as part of support planning.
• Might benefit from group psychoeducational sessions (parent and/or child/youth) during wait from service
• Shared care with GP and/or collaborative care (school counselor or similar) might be option</td><td>Risk of harm:
• Suicide risk – mild to moderate, possibly including chronic as long as current risk is not severe or extreme, and safety plan is in place
• Risk of harm to others – moderate risk due to frequent aggression or serious antisocial behavior</td><td rowspan="2">Family (including extended)
Risk Factors
• Presence of moderate family risk factor (or of multiple but less severe risk factors) – see risk factor items on BCFPI
• Moderate elevation of BCFPI family functioning scale
Protective Factors
• Parents/caregivers with parenting skills, social supports, or other protective factors that contribute to their coping and to their support of child/youth</td></tr>
<tr><td>Functional Status:
• Moderate impact on function - GAF/CGAS approximately 41-50 (but “bumps” to urgent if there is moderate suicide risk)
• Symptom domains surpassing clinical thresholds (t= ≥ 70) on BCFPI
• Functioning domains surpassing clinical thresholds (t= ≥ 70) on BCFPI</td></tr>
<tr><td>Complexity of Needs:
• May have single area of high elevation (e.g., T-score over 80) and impact or multiple problem areas of with moderate clinical elevation (number of BCFPI problem areas over T score of 70)</td><td rowspan="3">Community Assets/Social Supports/Resources
Risk Factors
• Community factors present mild to moderate risks
• Lack of educational, health, social service, other supports
Protective Factors
• Child/family connected to some community supports related to identified needs
• One or two peer friendships
• Positive connection to at least one adult outside of the home</td></tr>
<tr><td>Vulnerability/Developmental
• Significant loss
• History of multiple adverse experiences increases risk of physical and mental health challenges</td></tr>
<tr><td>Protective Factors (see BCFPI items):
• Presence of individual child protective factors or strengths that can mitigate current risks
• Some insight into difficulties and willing to engage in supports</td></tr>
</table>

Appendix 1: Child and Youth Mental Health Waitlist Priority Ranking Tool

Waitlist Priority Ranking	**Service Intensity Considerations while on Waiting for Service**	**Note: The following considerations are intended to guide decision-making and assignment of waitlist priority ranking, but in the end, clinical judgment that includes consideration of all relevant factors will inform the final ranking. Priority rankings will often reflect a *combined analysis* of individual child/youth distress and functioning and family/community capacity.**	
		Child & Youth Considerations	**Family/Community Considerations**
3 Moderate **Minimal or mild risk of harm to self but presence of clinically significant distress and dysfunction and related need for CYMH/ ACYMH services**	• Needs that might be addressed through group therapy, family support to parent, brief therapeutic interventions, general, child- or specific or program-based consultation • Support plan – including individualised self-care options and list of other supports – have potential as means of early intervention • CYMH/ACYMH contact information and emergency contact information given to family as part of support planning. • Potential candidate for support from GP if concerns are uncomplicated ADHD, anxiety, depression.	**Risk of harm:** • Suicide risk – minimal to mild • Risk of harm to others – no danger or infrequent/minor risk based on history **Functional Status:** • Mild/moderate single disorder or problem area • Limited impact on GAF/CGAS approximately 51-60 • Symptom domains surpassing clinical thresholds (t= ≥ 70) on BCFPI) • Stable symptoms, with need for intervention, but manageable short-term impacts on the child, youth and their family • Functioning domains surpassing clinical thresholds (t= ≥ 70) on BCFPI **Complexity of Needs:** • Single mental health problem/disorder or multiple mild mental health problem areas (on BCFPI) without negative impact from other disabilities/comorbidity **Vulnerability/Developmental** • Significant developmental transitions (e.g., move, change of school) **Protective Factors** (see BCFPI items): • Multiple strengths that support coping with current distress and symptoms • Good connections with a best friend, peers • Insight into difficulties • Capacity to engage in self-help with assistance	**Family (including extended)** **Risk Factors** • Low level of family risk factors **Protective Factors** • Family/extended family has presence of multiple protective factors/strengths to provide support during wait for service **Community Assets/Social Supports/Resources** **Risk Factors** • Community factors present mild risks **Protective Factors** • Child/family connected to some community supports related to identified needs • Positive peer relationships • Positive connection to adults outside of the home. • Has more than one effective community resource engaged or available that can provide support during wait for service

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Assessment**	**Policy Number:**	**B-4**

Policy Statement:

A written assessment will be completed for every client who has a face- to-face session with a CYMH clinician.

A "Brief Initial Assessment Report and Termination Summary" will be completed for each client who has been seen for five or fewer sessions and the case becomes closed. A regular "Assessment Report and Treatment Plan" will be completed within a reasonable time period after the sixth session. This assessment must include a multi-axial DSM IV-TR provisional diagnosis for the purposes of treatment planning.

Background:

Information gathered from an assessment assists the clinician/therapist and the client in developing a treatment plan.

Guidelines:

As a minimum the following information should be included in the assessment report:

- Identifying information
- Reasons for referral and presenting problems
- History of previous & current psychological & psychiatric problems
- Developmental history
- Social & family background
- Medical history including allergies and any serious medical condition
- Educational history
- Current functioning
- Mental Status Examination (MSE)
- Psychological test results and results of other assessment procedures if done
- Formulation and Impressions

A Brief Initial Assessment Report includes the following:

- Identifying information
- Presenting problem
- History of current problem
- Allergies

- Current functioning
- Mental Status Examination (MSE)
- Formulation and Impressions

Assessment information is retained on the client file in accordance with the *Document Disposal Act.*

References: *Management of Mental Disorders, Volumes I & II* ,Canadian Edition

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Mental health crisis response**	**Policy Number:**	B-5

Policy Statement:

Regions will have a policy in place that will ensure:

- Capacity to respond immediately to mental health emergencies
- Establishment of formal protocols for crisis response co-ordination both during office hours and after hours.

Background:

- A psychiatric crisis is an acute presentation of symptoms accompanied by extreme functional deterioration of behaviour. It can result in serious harm to self or others; therefore rapid, appropriate response is essential.
- Appropriate response to psychiatric crises often requires co-ordination of a variety of services including community mental health, crisis teams, hospital, and other community programs.
- The Joint Ministry Working Group has developed recommendations for responding to psychiatric crises.

Guidelines:

- Community mental health teams and /or contracted mental health services need to have the capacity to respond to mental health emergencies.
- The purpose of an emergency clinical intervention is crisis stabilization.
- When a crisis is not stabilized after a clinical intervention, a co-ordinated plan for further should be developed, including referral to hospital. Good co-ordination of services is essential for effective and efficient crisis response.
- Each community should develop a protocol for crisis response consistent with the recommendations of the Joint Ministry Working Group (See attached Appendix).

References:

Bridging Acute Care and Community Mental Health systems in British Columbia, MCFD & MOHS Joint Working Group Final report, Part II- Crisis/ Psychiatric response System: Recommendations, 2002

Authorized by:

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
Topic:	**Mental health crisis response**	**Amendment Date:**	
		Policy Number:	B-5

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Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
Topic:	**Mental health crisis response Appendix**	**Amendment Date:**	
		Policy Number:	**B-5 a**

Guidelines: Recommendations of the Joint Ministry Working Group:

1.That Regional Health Authorities and Regional MCFD Offices establish or strengthen a partnership structure or planning body for the delivery and evaluation of hospital and community based mental health services;

2.That regional and local program planners develop rationalized points of entry and service partnership agreements in accessing the Crisis Response System;

3.That Regional Health Authorities and Regional MCFD Offices establish case management and client-tracking mechanisms to ensure the delivery of continuous and accountable care;

4.That Regional Health Authorities and Regional MCFD Offices develop or strengthen community entry-level crisis response services with extended or flexible hours of operation (Level I Services);

5.That Regional MCFD Offices establish or strengthen home-based crisis services as an integral component of the Crisis Response System (Level II Services);

6.That crisis stablization and short-term assessment and treatment (STA) residential/hospital care be considered as essential secondary level services and as such, regional authorities establish their availability on a regional or sub-regional basis (Level III Services);

7.That Regional Health Authorities and regional hospitals with acute psychiatric care beds review the need for a response capacity for transition-age youth (Level III Services);

8.That the Regional Health Authorities and regional hospitals with general medical paediatric care beds review the need for a response capacity for children and younger youth with acute psychiatric/emotional disorder (Level III Services);

9.That Regional Health Authorities develop/augment non-hospital based crisis residential services through collaborative initiatives between Adult Mental Health Services and the MCFD network of residential resources (Level III Services);

10.That the Regional MCFD Offices establish or augment specialized personnel to improve the co-ordination and continuity of care between the regional hospital and community-based mental health service system (Level III Services);

11.That Regional Health Authorities and Regional MCFD Offices, working with tertiary facilities, establish referral priorities and procedures via a body or mechanism that reflects all stakeholder interests including schools, child & youth mental health, hospitals and private practitioners (Level IV Services);

12.That Regional Health Authorities and Regional MCFD Offices undertake an active public education program to promote high consumer and service provider awareness of the Crisis Response System including the appropriate entry points;

13.That Regional Health Authorities and Regional MCFD Offices ensure that designated staffs (including family practitioners and key hospital and community-based agents) have access to the specific evidence-based practices information and the clinical training needed for child and youth crisis work including decision options based on the relevant Acts;

14. That Regional Health Authorities and Regional MCFD Offices identify the service roles and contributions of the wide range of private practitioners and their linkages with the public service sector;

15.Given the absolute shortage and unbalanced distribution of specialist professional resources throughout the Province, that Regional Health Authorities and Regional MCFD Offices explore the use of video-conferencing technology and other creative approaches as a vehicle for consultation/backup to less resourced communities;

16.That, as part of the Provincial Child and Youth Network, the MOHS and MCFD establish a provincial body or mechanism to work with the regions to co-ordinate the planning of hospital-based services in order to achieve a coherent and efficient distribution of primary, secondary and tertiary child psychiatric care. (Level III & IV Services);

17.That MOHS and MCFD, in collaboration with the regions, establish outcome indicators that are tied to best practices for specific crisis response services along the continuum of care;

18.That MOHS and MCFD, in collaboration with the regions, specifically monitor the implementation of regional crisis response services including provincial outcomes for children and youth over a three-year period of regional/provincial planning and regional service implementation.

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Mental health crisis response Appendix**	**Policy Number:**	**B-5 a**

References: *Bridging Acute Care and Community Mental Health Systems in British Columbia, MCFD &MOHS Joint Working Group Final Report, Part II- Crisis/Psychiatric Response System: Recommendations, 2002.t*

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Consultation with Child Psychiatrists/ Medical Practitioner**	**Policy Number:**	**B-6**

Policy Statement:

All MCFD mental health programs will have access to psychiatric consultation through a psychiatrist or a medical practitioner with mental health expertise.

Background:

There is a shortage of child psychiatrists in BC.
The use of Outreach psychiatry and medical practitioners with mental health expertise is an attempt to address this shortage.
Outreach psychiatry is co-ordinated through the Mental Health Evaluation & Community Consultation Unit (Mheccu) at the University of British Columbia (UBC). It provides clinical services to communities that need additional resources in psychiatry.
Telehealth and other technologies are options for providing clinical support.

Guidelines:

The need for consultation will be determined by an experienced mental health clinician through the assessment process.

The C&YMH team will determine the order of priority for children/youth to be seen by the psychiatrist. Regions will have criteria in place for determining priority levels.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Provision of consultation by CYMH clinicians**	**Policy Number:**	**B-7**

Policy Statement:

CYMH clinicians provide education and consultation to other ministerial staff, community partners, and other professionals for the purposes of :

- Providing information and education about mental health issues,
- Helping in the prevention of mental disorders,
- Helping to identify mental health disorders early,
- Helping to understand the impact of mental disorders, and
- Assisting to intervene in cases of mental problems
- Helping to have realistic expectations of children and youth with mental health disorders.

Background:

- The large number of children and youth with mental problems and disorders exceeds the capacity of current governmental services to provide individual/intense intervention.
- Not all children and youth with mental problems and disorders need specialized individual mental health treatment.
- The expertise within each CYMH team is more efficiently utilized by providing information, education and consultation to other professionals and services in addition to the more intense, individual interventions for clients with severe mental disorders.
- Improved community knowledge of mental health issues can help to prevent the development of some mental disorders, or mitigate their effects.
- Early identification and intervention is a proven strategy that results in better prognosis for mental health disorders.

Guidelines:

- Mental health education can be formal (presentation, workshop) or informal (casual, informative conversations, lending of reference materials, etc.). In neither case is the information client-specific.
- Clinical consultation is a formal process that follows sound guidelines:
  - When client is known to the clinician being consulted, consent to the consultation by the client should be considered first.
  - The consultation is for a clear purpose that is relevant to a successful helping intervention with the client.

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Provision of consultation by CYMH clinicians**	**Policy Number:**	**B-7**

- A clinical consultation needs to be recorded in the client's file.
- Appropriate interventions should follow a clinical consultation.
- An integrated case management approach should be the consultation venue when several services are involved.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Treatment plan development and implementation**	**Policy Number:**	**B-8**

Policy Statement:	Treatment plans will be based on sound clinical diagnostic assessments covering the bio-psycho-social context of the specific client. Therapeutic interventions used in CYMHS will be based in credible theoretical and evidence-based clinical research literature and will be supported by clinical supervision provided by those with expertise in CYMH.
Background:	• Evidence-based practice is the implementation of evidence-based decision-making. • Evidence is information based on scientific evaluation of a practice. The types of evidence include: -quantitative and qualitative research; -practice guidelines, sound theoretical literature, consensus statements, dissertations and conference proceedings.
Guidelines:	• Treatment plans will be based on a comprehensive mental health assessment of the client that will include a multi-axial DSM IV TR provisional diagnosis. • Treatment plans will be developed in the context of multidisciplinary feedback within each clinical team and with input from the client and or the client's family. • The treatments best supported in the literature for the assessed problem will be provided first. • Outcome evaluations of individual treatment will be done at regular intervals and adjustments made as necessary. • Treatment plans will be consistent with integrated case management approaches when several service providers are involved. Planned termination takes place when the course of treatment has been implemented and desirable functional changes in the client have been achieved.
References:	
Authorized by:	Alan Markwart Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Documentation**	**Policy Number:**	**B-9**

Policy Statement:

Documentation will be completed for each client receiving service from CYMH clinicians.

Background:

- Documentation is any written or computer generated information about a client and describes the service provided to that client.
- Requirements for documentation result from legislation, case law and professional standards for practice.
- Documentation serves the following purposes:
  - to provide a record of treatment
  - to guide treatment
  - to facilitate good communication
  - to promote good practice
  - to meet legal and professional standards
  - to protect client's interests

Documentation is considered evidence and may be used in a court of law.

Guidelines:

- Documentation will be done in a timely manner according to applicable standards and policies.
- The client file is the property of MCFD and as such, is subject to ministry guidelines for file retention, the *Document Disposal Act* and *Freedom of Information and Protection of Privacy Act*.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Child and Youth Mental Health (CYMH) Service Delivery Policies

Policy B-10/11: Testing

Effective Date of Policy:

2014

Amendment Date of Policy:

January 10, 2014

POLICY STATEMENT

Testing is provided by qualified and competent CYMH[i] practitioners as a component of child and youth mental health screening, assessment, intervention planning, or monitoring services as appropriate to individual child, youth and family/caregiver needs.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal and cultural groups:
    - Experience testing that draws on an enhanced understanding of their unique strengths and needs and receive appropriate, non-discriminating, individualized services.
    - Are protected from potential harms related to test misuse, misinterpretation or from inappropriate sharing of testing material.
    - Experience respect and safety during **culturally-safe**[ii] testing processes that are informed by an understanding of their cultural values, beliefs and practices.

i CYMH includes general and Aboriginal CYMH practitioners

ii Bolded words are defined in the glossary

Standard: Access to Testing

1.1 CYMH practitioners provide or facilitate access to testing as part of clinical services.

Procedures

- CYMH team leaders work with their teams to develop and/or maintain local procedures for providing and/or referring infants, children and youth for testing.
- Qualified CYMH practitioners utilise culturally-safe and linguistically-appropriate **tests** for screening, assessment, intervention planning, or monitoring purposes**.**[1,2,3,4].
- CYMH **test users** provide testing services in a manner consistent with the **MCFD Helping Relationships Framework** and the Aboriginal Practice Framework[iii].
- CYMH practitioners explicitly inquire about previous assessments/testing (e.g. Psychiatric, Psychological, Psychoeducational, Speech and Language, Occupational Therapy) and seek informed consent to obtain copies (Policy B-3 Referral and Intake; Policy D-3 Informed Consent to Information Sharing).
- CYMH practitioners review previous test results (intake/screening, previous assessment reports) to inform decisions about the need for any additional assessment testing or retesting.
- Qualified CYMH practitioners conduct testing within the scope of their practice (see standard 1.3) or refer for testing. Referral options include:
    - Internal referrals to other CYMH multidisciplinary team members (e.g., referral for psychological assessment); or,
    - External referrals for specialised assessment services that are not available through the CYMH multidisciplinary team (e.g., referrals for the assessment of Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder, learning disabilities, speech and language, and/or motor skills/coordination).

*The psychometric development process used for **standardized**, norm-referenced **tests** is often done without specific consideration of, or adaptation for, individuals from different cultural, racial, language, and ethnic groups. **Test users** working with individuals from diverse backgrounds maintain familiarity with literature on general*

iii Under development

*issues in cross-cultural assessment as well as with issues related to the specific test being considered for use. They also consider whether obtained results could be influenced by the linguistic and cultural background and experience of test takers, and incorporate this consideration into their interpretation of test results[1,2,3,4]. The Health and Human Services Library can assist with literature searches in relation to specific tests and/or in relation to cultural considerations in testing. The potential use of **tests** with Aboriginal infants, children and youth should be informed by **cultural competence** in relation to general issues involving Aboriginal views of mental health[5] and to specific issues in assessment and test use involving Aboriginal Canadians[4].*

Standard: Informed Consent, Support and Sharing of Results

2.1 CYMH **test users** demonstrate respect for the rights of infants, children, youth and their families/caregivers throughout all phases of the testing process[6].

Procedures

Informed consent for testing:

- CYMH **test users**:
  - Obtain informed consent for testing during their initial discussions with children, youth and/or guardians, consistent with CYMH policy (Policy D-2: Informed Consent for Treatment) and with any additional requirements of professional regulatory bodies. The need for significant additional testing (e.g., psychological evaluation) requires specific informed consent and is to be documented separately using a new consent form; and,
  - Provide developmentally appropriate explanations about what will take place during testing and about the benefits and risks of testing as part of the informed consent process.

Supportive testing procedures:

- CYMH **test users**:
  - Demonstrate awareness that testing procedures can be experienced as stressful by preparing participants and their families/caregivers for testing and providing emotional support to the test takers during and following testing; and,
  - Provide plain language explanations of testing procedures to participants prior to and throughout testing and communicate in a manner that is appropriate in terms of age, language, gender, disability status, culture, and ethnicity.

Documentation of test results:

- CYMH **test users**:
  - Document the verbal sharing of interpreted results of testing in the clinical file; and,
  - Integrate the results of testing with other clinical information and document the interpreted results in an appropriate format.

Documentation of some aspects of testing might take place in a session note recorded on the clinical file (e.g., initial screening, outcome measure) whereas other test results might be incorporated into a formal report that is added to the clinical file (e.g., Mental Health Assessment, Psychological Assessment).

Sharing the results of testing:

- CYMH **test users:**
  - Maintain responsibility for the sharing of results with children, youth and families/caregivers, and for obtaining informed consent for testing and for the release of information related to testing and do not delegate these responsibilities to **test administrator**s or testing assistants.
  - Share the interpreted results of testing with children, youth and their parents/guardians by:
    - Advising them about any potential limitations in the accuracy or validity of the results;
    - Using visual aids or other interpretive devices as necessary;
    - Offering brief written summaries, as clinically appropriate; and,
    - Providing an opportunity for questions.
  - Maintain confidentiality in relation to testing results and interpretations associated with them and any sharing of testing results is done consistent with legislation, policy and ethical guidelines on release of information (see Policy D-3: Informed Consent to Information Sharing).

Standard: Qualifications, Competence and Responsible Test Use

3.1 Testing activities are carried out by qualified and competent CYMH practitioners who use tests ethically and responsibly.

Procedures

Roles and responsibilities of CYMH team leaders/clinical supervisors:

- CYMH team leaders/clinical supervisors:
    - Maintain responsibility for team-level adherence to testing policy and procedures;
    - Engage with CYMH leads as required to develop procedures to support compliance with this testing policy, including identification of **tests** to be used, test purchasing, supervision, training/professional development and test security;
    - Seek consultation from registered psychologists on their team and/or from CYMH leads as necessary in relation to testing; and
    - CYMH team leaders work with **test users** and with CYMH leads to support professional development in relation to test use such as access to formal training, team-level educational presentations, and establishment of "qualified test user" groups/communities of practice.

Qualifications, roles and responsibilities

- CYMH practitioners engage in testing activities consistent with their job descriptions, professional scope of practice, and for which they have appropriate education, training and experience[7,8].
- CYMH practitioners' roles in testing, consistent with their qualifications, include: (1) **test user**, (2) **testing technician/psychometrician**, and/or (3) **test administrator**.
- CYMH **test users** retain responsibility for the appropriate selection, administration, scoring, and interpretation of **standardized tests**, whether they did the testing or relied on a **testing technician** or **test administrator**[9,10,11]. More specifically:
    - The use of **test administrators** or **testing technician**s is limited to test administration, scoring, documentation of observations during testing, and nonpsychometric data gathering (e.g., distribution, collection of developmental history forms, questionnaires); and,
    - CYMH test users remain available to **test administrators** or **testing technicians** during testing adminstration by phone or other means of easy access to assist with clinical issues that arise during testing.

- CYMH **test users:**
  - Utilise evidence-informed literature on assessment[12,13,14];
  - Maintain competence as part of clinical supervision, and seek additional training and/or consultation as required (Clinical Supervision Policy C-2; and,
  - Maintain awareness of the qualifications required for the use of different types of tests.

Test user qualifications are described in:

- *Best practice literature on **test user** qualifications[7,8];*
- *Test use qualification standards established by professional regulatory bodies/associations; and,*

Test distributor "three-tier test classification system" on test user qualifications. Based on this system:

- *Mental health practitioners with appropriate qualifications, competence, and training use Level A and B **tests** as part of their clinical practice.*
- *Registered psychologists with appropriate qualifications, competence, and training use Level A, B and C **tests** as part of formal Psychological Assessments and as part of their general clinical practice, and provide consultation about testing to other members of the multidisciplinary team.*

Standard: Security of Testing Material

4.1 CYMH practitioners maintain test integrity and security.

Procedures

- CYMH regions and teams establish procedures to maintain the security and integrity of test materials kept in their offices, including software, test forms, test manuals, and any electronically stored material on their office computer drives (including local area network drives).
- CYMH Policy team works with CYMH regional leads and others as necessary to develop procedures to restrict access such that only authorised **test users** have access to **tests** located on provincially shared network drives.

- CYMH team leaders and **test users** develop contingency plans in the event that the sole qualified user for specific **tests** leaves a team to (a) ensure the security of test materials (e.g., intelligence **tests**, academic achievement **tests**, personality inventories), and/or (b) allow for the transfer of test materials to another qualified colleague who can make use of the material.
- CYMH **test users:**
  - Develop an inventory of test forms and materials that are used within their local team (including software on local computers used for scoring of **tests**);
  - Store all test forms and material securely (in locked cupboards or file cabinets) so the material is not accessible to unqualified users and develop a "sign-out" procedure for shared **tests,** especially for **standardized tests** where widespread availability of the material might invalidate the use of the test (e.g., intelligence **tests**, academic achievement **tests**, personality **tests**);
  - Ensure that security of copyrighted material is protected and contractual obligations to test publishers are maintained including prohibiting unauthorized reproduction or distribution of testing forms or material, and preventing public presentations involving test materials or practices that might impair the future validity and utility of **tests**;
  - Ensure that obsolete standardized test forms and/or material (including software stored on local or network drives) are disposed of in a secure manner. If test material/kits/software is identified by an asset tag, an Asset Disposal Report is to be completed indicating whether the material will be shredded or returned to the test publisher. Completion of this will serve as a record of appropriate disposal. Contact Asset Investment Recovery for additional information, including a link to the on-line asset disposal report form; and,
  - Work with information technology staff to ensure that testing software located on local hard drives is erased/destroyed if the equipment is no longer under control of CYMH **test users** (e.g., at times of computer "upgrades").

Standard: Security of Completed Test Records

5.1 CYMH test users ensure that completed test records are appropriately secured and that test security is protected in relation to requests for release of records.

Procedures

Storage of completed test protocols

- CYMH **test users** safely store completed test protocols:
    - In a locked drawer/secure fashion during the active stages of clinical work;
    - Separate from a common file where the raw data might be available to unqualified individuals. This applies to *any format* in which test material is stored, including electronic files stored on computer networks, and this also applies to the use of scoring services that might be obtained remotely from a commercial test publisher; and,
    - In the format specified by MCFD Disclosure and Document Management when a file is completed/"closed"*.

The MCFD CYMH Case File Guidelines allows for the separation of test material (and rough notes) from the common file. Standardized tests results/raw data are included in a sealed brown envelope at the back of the CYMH paper file. This includes an envelope for standardized tests/notes associated with a psychological report and an envelope for tests/notes used by other qualified* ***test users**.*

Release of records

- CYMH **test users** protect against the misinterpretation of test data (observations, notes) and test scores by:
    - Presenting test results in an interpreted form within a written summary or report;
    - Responding to any formal requests to share/release uninterpreted raw test data and/or test protocols by (1) notifying and consulting with team leaders or clinical supervisors; and, (2) if such sharing is required in exceptional circumstances by legislation/court order, by working with their team leaders or clinical supervisors to ensure the release of such material only to other qualified **test users** (e.g., release of information to a registered psychologist acting on behalf of a client rather than directly to a client or to a client's legal representative); and,
    - Working with team leaders/supervisors to establish contingency plans to ensure ethical oversight of infant, child and youth *test* results/release of records if the staff responsible for specialized assessments is no longer available at the site where the testing/assessment took place.

CYMH practitioners and their team leaders/clinical supervisors responding to requests to release raw test data/test protocols should refer to test disclosure/test security guidelines in material developed jointly by the Canadian Psychological Association and Canadian test publishers[15].

CYMH registered psychologists refer to the College of Psychologists of British Columbia Code of Conduct and Practice Advisories (especially in relation to release of psychology records) for additional information on this topic.

Glossary

Cultural safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities that they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles

□ Child, Youth and Adult-Centered
□ Family-centered
□ Strengths-based
□ Rights- & Social Justice-based
□ Inclusive & Culturally Safe
□ Evidence-Informed
□ Trauma-Informed
□ Developmentally/ecologically-based
ness, collaborative practices, allegiance to model/approach
□ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Common Factors

□ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences
□ Practitioner characteristics – Empathy, positive regard, genuine-

Standardized tests: Procedures that employ standard administration and scoring procedures. They go through a process of development that includes evaluation of psychometric properties such as reliability and validity.

Tests: Broadly defined as any systematic procedure used to sample the behaviour of an individual to allow for description, classification, prediction, tracking, monitoring, and intervention planning.

Test administrator: Someone who, *under the direction and supervision of a qualified* ***test user***, is occasionally involved in the administration and scoring of a subset of tests.

Testing technician/psychometrician: Assist with testing as the major component of their job description. They possess education, training and experience to be competent to administer and score **tests** and receive supervision from registered psychologists.

Test user: "The person or persons responsible for the selection, administration, and scoring of tests; for the analysis, interpretation, and communication of test results; and for any decisions or actions that are based, in part, on test scores" (p. 7)[15]. **Test users** must have education, training and experience sufficient to ensure competence for each standardized test that they use.

Three-tier test classification system: This three-tiered system (Levels A, B, C) was initially developed by the American Psychological Association in 1950[15], but "was dropped from the 1974 (and subsequent) *Standards* without a replacement" (p. 13). The system is still used by test distributors.

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide (in draft)

Child and Youth Mental Health Case File Guidelines

Clinical Process and CARIS

MCFD Records Management

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Prescription of Medication**	**Policy Number:**	**B-13**

Policy Statement:

Only licensed physicians will prescribe medications. Physicians will use the MCFD prescription form available at Office Products Centre order # 7530801065.

Background:

Guidelines:

- Renewal of medication is normally the responsibility of the assigned physician. Another physician may be requested to renew medication in the absence of the assigned physician. This is permissible at the discretion of the individual doctor and provided that a current medication review is documented. In the absence of a current medication review, the substituting physician must see the client.
- All changes in medication, including discontinued orders, require the written instruction of the physician. Changes in medication require that the physician see the client when possible. Changes in medication must be recorded in the progress notes, along with the reason for the change.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Closing a File**	**Policy Number:**	**B-14**

Policy Statement:

A client file must be closed within two weeks of mutually agreed upon closure.

Under exceptional circumstances and for clinical reasons a file may remain open for up to six months with no contact with the client. The file will to be signed off by the C&YMH clinical supervisor.

Background:

Guidelines:

A closing summary must be completed and contained in the client file.

This summary will contain the following minimum information:

- a summary of the presenting problem and treatment concern;
- diagnosis (if available) at assessment and at closure;
- treatment, interventions, processes;
- reason for closure;
- date of closure
- recommendations at closure.

The client file must also be closed on the CPIM system.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Child and Youth Mental Health (CYMH) Service Delivery Policies	
Policy B-17: CYMH Suicide Prevention, Intervention and Postvention	
Effective Date of Policy: 2014	**Amendment Date of Policy:** October 7, 2014

Policy Statement

CYMH[i] practitioners provide **culturally safe**[ii] and evidence-informed suicide prevention, intervention and postvention supports and services to children and youth at risk for suicide and their families/caregivers, in a manner consistent with the **Helping Relationships Framework** and the Aboriginal Practice Framework [iii].

Outcomes

- Children and youth at risk for suicide and their families/caregivers, including those from Aboriginal communities and cultural groups, experience:
  - Reduced risk for suicide and increased safety; and
  - Improved mental functioning and wellness.
- Children, youth and their families/caregivers impacted by a death from suicide:
  - Are supported in their grief process; and
  - Experience reduced risk for suicide contagion.

i CYMH includes general and Aboriginal CYMH practitioners.

ii Bolded words are defined in the glossary

iii Under development

Standard: Evaluating Suicide Risk

1.1 CYMH practitioners evaluate the risk for suicide in all children and youth referred to and involved with CYMH services.

Procedures

- CYMH practitioners develop and maintain clinical competence in suicide assessment, prevention, intervention and **postvention** through **clinical supervision** and consultation, experience, and appropriate education and training, including self-directed learning.
- CYMH practitioners screen for suicide risk in every child or youth referred to CYMH services, monitor them for risk throughout the therapeutic process, and document in the clinical file every query, disclosure and action taken (see Policy B-3: CYMH Referral and Intake).[1]
- CYMH practitioners ensure parents/caregivers are informed and involved with **safety planning** and treatment, where applicable, whenever a child or youth is at risk for suicide (see the Preventing Youth Suicide: A Guidebook for Practitioners – Crisis Response and Safety Planning; and the Practice Guidelines for Working with Children & Youth At-Risk for Suicide in Community Mental Health Settings – Planning for Safety).
- CYMH practitioners engage with children, youth, and their families, and communities, consistent with the **Helping Relationships Framework**, to facilitate the development of a therapeutic alliance.
- CYMH practitioners obtain and document informed consent from the legal guardian(s) and/or the referred **mature minor** to proceed with the suicide risk assessment (see Policy D-2: CYMH Informed Consent to Treatment).
- CYMH practitioners explain to children, youth and/or the parent/legal guardian the limits of confidentiality, in relation to promoting their safety as per the Freedom of Information and Protection of Privacy Act and document this discussion (see Policy B-3: CYMH Referral and Intake and Policy D-3: Informed Consent to Information Sharing).

Standard: Response to Children and Youth at Risk for Suicide

2.1 CYMH practitioners provide an urgent response involving the parent/caregiver and others as appropriate when a child or youth is identified at risk for suicide or facilitate immediate access to appropriate emeregency services when children or youth are at severe or extreme risk of suicide, and collaborate with hospitals and tertiary facilities to ensure continuity of care and follow-up (see Policy B-3: CYMH Referral and Intake).[2]

Procedures

- CYMH practitioners conduct a comprehensive suicide risk assessment as soon as possible within office hours following disclosure of suicidal intent.

  The assessment includes:

  - A clinical interview with the child or youth and their parent/caregiver and others as appropriate, that assesses **acute** and **chronic risk factors** and **protective factors**;
  - A mental status examination;
  - An assessment of the child or youth, and their family/caregiver's willingness and capacity to engage in **safety planning** and therapeutic interventions;
  - A clearly stated formulation of suicide risk including ideation, capability and/or intent (see the Practice Guidelines for Working with Children & Youth At-Risk for Suicide in Community Mental Health Settings - Planning for Safety);
  - CYMH practitioners use **promising practices** to classify the child or youth's level of suicide risk on the following continuum:
    - Minimal: absence of active suicidal thinking.
    - Mild: suicidal thinking with no specificity, low intensity of mental health symptoms and the presence of **protective factors**.
    - Moderate: specific suicidal thoughts including how, when and where they will die, increased frequency and duration of these thoughts, and the presence of **protective factors**.
    - Severe: specific suicidal thinking with intent (as above) and increase in intensity of mental health symptoms and a reduction in **protective factors**.
    - Extreme: as with "Severe" yet imminent with clear intention to die by suicide when there is an opportunity.
    - **Chronic**: as with "Moderate", "Severe" or "Extreme" with an overall vulnerability and susceptibility to suicidal behaviour (see Preventing Youth Suicide: A Guide for Practitioners – Risk and Protective Factors and Policy and Practice Considerations: Clinical Assessment of Suicide Risk and Clinical Documentation). [3, 5]

- A plan of intervention, safety and/or **urgent response** developed collaboratively and shared with the child or youth and their family/caregivers (see Preventing Youth Suicide: A Guide for Practitioners – Crisis Response and Safety Planning).[3, 4]

- The comprehensive assessment is documented in the clinical file and the safety plan is shared with other involved professionals as appropriate.
- CYMH practitioners re-evaluate the child or youth's level of risk for suicide on a regular basis and whenever the child or youth experiences a significant change in clinical symptoms or event that could affect risk.
- CYMH practitioners inform their team leader/clinical supervisor when a child or youth is identified as at risk for suicide and receive **clinical supervision** and consultation commensurate with their skills, knowledge and experience (see Policy C-1: CYMH Clinical Supervision).

Standard: Safety Planning and Collaborative Case Management

3.1 CYMH practitioners work collaboratively with children and youth at risk for suicide and their families/caregivers and other involved professionals, to implement a **safety plan**, provide appropriate mental health treatment and support, and facilitate and verify access to appropriate supports and services.

Procedures

- CYMH practitioners use a **collaborative case management** process to facilitate continuity of care of children or youth at risk for suicide and their families/caregivers by:
  - Sharing information related to suicide risk, **safety planning** and significant changes in a child or youth's situation, including repeated missed appointments, and changes in involved professionals, with appropriate family members and involved professionals in accordance with the Freedom of Information and Protection of Privacy Act (see Policy D-3: Informed Consent to Information Sharing);
  - Providing evidence-informed clinical interventions and follow-up, including **Aboriginal-specific** approaches, as appropriate (See Preventing Youth Suicide: A Guide for Practitioners – Indigenous Healing Practices and the Practice Guidelines for Working with Children & Youth At-Risk for Suicide in Community Mental Health Settings – Treatment and Support, and Providing Culturally Responsive Care);

- Facilitating access to other services, as appropriate;
- Ensuring an alternate practitioner will provide for their care in the event of the primary practitioner's planned or unplanned absence and communicate this plan to the family/caregivers and involved service providers; and
- Making every effort to contact and check the status of the child or youth and their family/caregivers as soon as possible and reschedule when a child or youth at risk for suicide misses a scheduled appointment.

➢ Documentation includes the recording of all child, youth and/or their family/caregiver contacts, collateral contacts, assessments, progress notes, decision making and therapeutic outcomes related to the comprehensive suicide risk assessment in the clinical file(s).

➢ CYMH practitioners complete a Reportable Circumstance form and follow MCFD notification processes according to policy if a child or youth is injured in a suicide attempt or if there is a death by suicide (see Policy B-15: Reportable Circumstance).

Standard: Mitigating Risk for Chronic and Acute Risk

4.1 CYMH practitioners actively engage children and youth at risk for suicide and their family/caregivers, using **assertive outreach when appropriate,** to mitigate risk and reduce barriers to services and supports (see the Practice Guidelines for Working with Children & Youth At-Risk for Suicide in Community Mental Health Settings – Engaging Hard to Reach Young People and Families).

Procedures

➢ When efforts to engage a child or youth who is at **acute** and/or **chronic** risk for suicide and/or their family/caregiver reveals challenges in engagement and barriers to service, CYMH practitioners consult with their team leader/clinical supervisor to explore options, such as:

- Providing services and supports in settings outside the office;
- Increasing the frequency and/or shortening the length of meetings;
- Collaborating with others who are engaged with the child, youth and/or their family/caregivers;
- Assessment and intervention under the Child, Family and Community Service Act; or

- Certification under the Mental Health Act of BC.

Standard: Postvention Support

5.1 CYMH practitioners collaborate with community partners to offer evidence-informed and culturally appropriate **postvention** responses to children, youth, their families/caregivers, and communities as appropriate, to facilitate the grief process and reduce risks for imitative suicidal behaviours following a death by suicide.

Procedures

- CYMH practitioners offer **postvention** strategies as a priority to peer survivors of a child or youth who died by suicide who may be at heightened risk for psychological distress and imitative suicidal behaviours (see Preventing Youth Suicide: Information for Professionals).
- CYMH practitioners provide education and support for family members and Aboriginal and cultural groups as appropriate, regarding suicidal behaviour, **safety planning** and **means restriction**, the role of social networking memorials as potential sites for pro-suicide messaging and the importance of being vigilant about fluctuating suicidal ideation and behaviour in vulnerable children or youth following another's death from suicide (see Preventing Youth Suicide: Information for Parents & Caregivers).[6, 7]
- CYMH practitioners affected by the death by suicide of a child or youth receive enhanced levels of support from their team leader/clinical supervisor and/or other MCFD staff and have access to **postvention** supports such as Employee Assistance Plan services, resources found in Preventing Youth Suicide: A Guide for Practitioners – Postvention and Bereavement, the American Association of Suicidology website or other evidence-informed supports.[8]

Glossary

Aboriginal–specific: A response incorporating an Aboriginal worldview that considers the child, youth, family and community in a holistic manner. This response would reflect the unique cultural heritage and rights of the Aboriginal child, youth and family and support access to a continuum of culturally sensitive/relevant and appropriate services and supports (see: Developing Respectful and Inclusive Relationships with Aboriginal Children, Youth and Families Policy).

Acute risk: The presence of current suicidal ideation exacerbated by prominent mental health symptoms, a current crisis, and significant stressors.[9]

Assertive outreach: Practitioners use assertive outreach to actively engage with and reduce barriers to service for children and youth with mental health challenges and their families/caregivers through such means as arranging meetings in the home, at school, or community setting; offering flexible hours of service; and using email reminders about appointments.

Chronic risk: Anyone experiencing recurrent and persistent suicidal ideation, intense mental health symptoms, and hopelessness for an extended period of time and particularly those who have made at least one previous suicide attempt.[3, 5, 9]Those at chronic high risk are more vulnerable to suicidal crises and tend to think of suicide in very specific ways and experience more enduring and severe symptoms relative to all others.[10]

Clinical supervision: A distinct professional practice whereby a supervisory practitioner supports and enhances the direct work of a practitioner to ensure quality service and the promotion of positive client development and well-being. This is achieved through the establishment of an intentioned and purposeful relationship where the supervisor provides feedback through a tutorial process that enhances the supervisee's professional competency, ensuring ethical and ecologically sensitive practice via role modelling and the building of a collaborative rapport between the supervisor and supervisee.[11] Clinical supervision is distinct from consultation in that a clinical supervisor is ultimately responsible for the actions of the person being supervised through direct liability11 or vicarious liability.[12]

Collaborative case management: Formal collaborative planning and appropriate information sharing among participating professionals/service providers, family members/caregivers and cultural community leaders, when appropriate, to plan, generate and execute solutions to identified challenges and offer a high level of support and coordinated services to the child or youth and their family/caregiver to promote their safety and mental functioning.[13, 14]

Cultural safety: A transformation of relationships where the needs and voice of the

child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

Emergency services: Services that respond to people in a crisis, such as those accessed through 911 and are available 24 hours a day, 7 days a week, including the police, fire departments, BC Ambulance Services, and hospital emergency rooms.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles	Common Factors
□ Child, Youth and Adult-Centered □ Family-centered □ Strengths-based □ Rights- & Social Justice-based □ Inclusive & Culturally Safe □ Evidence-Informed □ Trauma-Informed □Developmentally/ecologically-based	□ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration

Intake: A process initiated following a referral that includes gathering of information from relevant and sometimes multiple sources. The intake process involves a preliminary evaluation of the situation sufficient to determine the next appropriate action or actions.

Mature minor: Is defined in the Infants Act. Children and youth are deemed capable and competent to consent to health care services without parental consent if they understand the "nature and consequences and the reasonably foreseeable benefits and risks of the care" and the health care provider determines that the health care is in their best interests.

Means restriction: Limiting access to lethal methods of suicide including, though not limited to, reducing access to domestic gas, firearms, prescription and non-prescription medications.[6]

Postvention: Those activities and processes undertaken after a suicide has taken place. A coordinated and informed postvention response is designed to identify children and youth at potential risk for suicide, reduce risks for imitative suicidal behaviour and subsequent mental health problems, and facilitate healthy expressions of grief.[10,15]

Promising practices: Approaches considered by recognized experts to work especially well in a given context to respond to a particular problem or identified need. Some practices may be confirmed as being effective and evidence-based through rigorous research or evaluations. They are typically used to refer to an agreed upon set of procedures and practices for achieving desired outcomes that are grounded in the best available evidence, which can vary in terms of its stage of development, scientific rigour and other factors.

Protective factors: Factors and experiences that may reduce risks for mental health challenges or suicide.[16] These can include genetic and neurobiological makeup, attitudinal and behavioural characteristics and environmental factors.9 Additional contextual factors for Aboriginal youth include cultural identity and engagement in cultural activities, respect for tradition and community self-determination.[17, 18, 19]

Referral: Any request for CYMH services from a mature minor, legal guardian, family member, or community professional regarding an infant, child or youth with mental health challenges (up to and including age 18).

Risk factors: Refer to previous suicidal behaviour, current suicidal symptoms, precipitant stressors, general symptomatic presentation, multi-generational trauma, exposure to domestic violence, impulsivity and self-dysregulation, substance use, homicidal ideation and/or intent, predisposition to suicidal behaviour, and family history of mental health issues and suicidal behaviour, as well as known existence or lack of protective factors.[20]

Safety plan: A clinical tool used to proactively collaborate with the suicidal child or youth and their family/caregivers to identify strategies to increase safety. A safety plan is needed whenever the potential for suicide is identified.[22]

Tertiary facilities: Facilities that provide specialized care to meet the needs of individuals who have serious and persistent mental health challenges and who require more treatment options than are provided in the primary and secondary mental health system to achieve optimal functioning, including children and youth who have attempted suicide to prevent further attempts.[9, 23]

Urgent response: An urgent response involves evaluating children and youths' risk for suicide, safety planning and follow up. It is provided as soon as is reasonably and feasibly possible within the hours of service of the local CYMH office. Urgent response includes parents/caregivers and involved professionals as appropriate, when the practitioner is concerned for the safety and well-being of children and youth who are

experiencing suicidal thoughts and/or serious mental health concerns or the safety and well-being of those around them.

Legislation

Adoption Act

Child, Family and Community Service Act

Family Law Act

Freedom of Information and Protection of Privacy Act

Infants Act

Mental Health Act of BC

Youth Criminal Justice Act

Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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POLICY B-18: TRAUMA INFORMED PRACTICE

Effective Date of Policy:

2014

Amendment Date of Policy:

September 19, 2014

Policy Statement

CYMH[i] practitioners incorporate **trauma informed practice**[ii] that is **culturally safe,** including practices related to **domestic violence**, in all aspects of their work with infants, children, and youth with mental health challenges and their families /caregivers.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal communities and cultural groups:
  - Experience improved engagement and resiliency, reduced **trauma** symptoms, and reduced risk for additional **trauma**.

i CYMH includes general and Aboriginal CYMH practitioners

ii Bolded words are defined in the glossary

Standards: Incorporation of trauma informed practices

1.1 CYMH supervisors and practitioners ensure that intake, assessment and treatment plans incorporate **trauma informed practices**, and other components of the **Helping Relationships Framework** and Aboriginal Practice Framework[iii], to support infants, children and youth, and their families /caregivers and communities as appropriate.

1.2 CYMH practitioners understand risk factors and routinely screen for the presence of **trauma** exposure, including **domestic violence**, as part of the assessment**.**

Procedures

- Screening for the presence of **trauma** occurs in the context of a therapeutic relationship and includes information gathered in the Brief Child and Family Phone Interview (BCFPI), and the attached trauma screening guide (see Appendix 1 Trauma Screen: Child and Youth).
- When **trauma** screening indicates a history of **trauma,** CYMH practitioners follow up with further assessment of the impact of **trauma,** while building and maintaining safety and engagement with the child or youth and their family, drawing on their strengths and coping skills, and offering validation and hope.
- CYMH practitioners who have "reason to believe a child has been or is likely to be abused or neglected, and that the parent is unwilling or unable to protect the child, must report the suspected abuse or neglect to a child welfare worker". [1]
- CYMH practitioners and their supervisors routinely discuss **trauma informed practice** including identifying and addressing any gaps in knowledge related to **trauma informed practice** and other components of helping relationships, and support required to minimize secondary traumatic stress.
- Culturally safe healing practices related to addressing **intergenerational trauma** and **historic trauma** are incorporated into practice when appropriate.
- CYMH supervisors develop and maintain an environment of support for practitioners that minimizes and addresses secondary traumatic stress.
- CYMH supervisors and practitioners develop and maintain a culture of nonviolence, learning, collaboration, and cultural safety through behavior, their use of language, consideration of environmental factors, and interactions with infants, children, youth, and their families and communities, and with other staff.

iii Under development

Standard: Incorporation of knowledge and skills related to domestic violence.

2.1 CYMH practitioners have the necessary knowledge and skills to recognize the signs of potential exposure to **domestic violence** and related **trauma,** and to support infants children, youth and their families/caregivers exposed to **domestic violence.**

Procedures

- Safety is always the primary consideration and questions related to exposure to **domestic violence** are not asked in the presence of individuals who may be perpetrators of **domestic violence.**
- CYMH practitioners collaborate with ministry and community partners to facilitate an effective, integrated and co-ordinated response, which may include development of protocols, to support infants, child and youth and families exposed to **domestic violence**, including access to resources to ensure safety.
- CYMH practitioners and their supervisors identify and address any gaps in knowledge and skills related to supporting infants, children, youth and families exposed to **domestic violence,** including knowledge and skills related to **cultural safety.**

Glossary

Cultural safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

Domestic Violence: A pattern of intentionally coercive and violent behaviour toward an individual with whom there is or has been an intimate relationship. These behaviours can be used to establish control of an individual and can include physical and sexual abuse; psychological abuse with verbal intimidation, progressive social isolation, or deprivation; and economic control.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles

- □ Child, Youth and Adult-Centered
- □ Family-centered
- □ Strengths-based
- □ Rights- & Social Justice-based
- □ Inclusive & Culturally Safe
- □ Evidence-Informed
- □ Trauma-Informed
- □ Developmentally/ecologically-based

Common Factors

- □ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences
- □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach
- □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Trauma: An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (Substance Use and Mental Health Services Administration [SAMSA] working definition).

Trauma Informed Practice: Includes an awareness and understanding of trauma in all aspects of service delivery, with appropriate developmental considerations and in collaboration with families/caregivers, and includes the following:

- Awareness of how trauma, during any stage of development including pregnancy, can impact an infant's, child's or youth's social, emotional and physical development;
- Emphasis on safety and trustworthiness;
- Opportunity for choice, collaboration and connection;
- Interventions are strengths based and skill building, and focused on enhancing social and emotional development.

Trauma Specific Services: Address the need for healing from traumatic life experiences and facilitate recovery through specialized clinical interventions which may include specific therapies such as Trauma Focused Cognitive Behavioural Therapy and other evidence informed and culturally appropriate interventions.

Intergenerational trauma: Definition under development.

Historic trauma: Definition under development.

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Clinical Process and CARIS

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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Appendix 1:

Trauma Screen – Child and Youth

This screen is used to guide questions related to the possible experience of trauma, and may be used verbally with a parent and/or an older child/youth. If screen indicates trauma exposure –a full assessment of trauma should be completed.

Name_____ Date_____

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen.

1. Serious natural disaster like a flood, tornado, earthquake, or fire ☐ Yes ☐ No

2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No

3. Robbed by threat, force or weapon. ☐ Yes ☐ No

4. Slapped, hit, or beat up in your family. ☐ Yes ☐ No

5. Slapped, hit, or beat up by someone not in your family. ☐ Yes ☐ No

6. Seeing someone in your family slapped, hit, or beat up. ☐ Yes ☐ No

7. Seeing someone in the community slapped, hit or beat up. ☐ Yes ☐ No

8. Someone older touching your private parts when they shouldn't. ☐ Yes ☐ No

9. Someone forcing or pressuring sexual activity, when you couldn't say no ☐ Yes ☐ No

10. Someone close to you dying suddenly or violently. ☐ Yes ☐ No

11. Attacked, stabbed, shot or hurt badly. ☐ Yes ☐ No

12. Seeing someone attacked, stabbed, shot, hurt badly or killed. ☐ Yes ☐ No

13. Stressful or scary medical procedure. ☐ Yes ☐ No

14. Being around war. ☐ Yes ☐ No

15. Other stressful or scary event? ☐ Yes ☐ No

Please describe:

If response is **YES** to any of the above questions:

- Which one is bothering you the most now? _____
- When the event happened, did you feel:
  - Afraid you would die or be hurt badly. ☐ Yes ☐ No
  - Afraid someone else would die or be hurt badly. ☐ Yes ☐ No
  - Helpless to do anything. ☐ Yes ☐ No
  - Ashamed or disgusted. ☐ Yes ☐ No

Adapted from:

Harbourview Center for Sexual Assault and Traumatic Stress

CPSS Foa, Johnson, Feeny, and Treadwell (2001)

Child and Youth Mental Health (CYMH) Service Delivery Policies

POLICY C-1.A CLINICAL SUPERVISION

Effective Date of Policy:
2014

Amendment Date of Policy:

January 10, 2014

Policy Statement

CYMH[i] practitioners receive **clinical supervision**[ii] with a designated clinical supervisor who has current mental health knowledge and practice expertise.

Outcomes

- MCFD practitioners receive supervision that supports competent practice across the range of mental health challenges.
- Infants, children, and youth with mental health challenges and their families, including those from Aboriginal communities and cultural groups, receive quality professional, culturally safe and competent care.

i CYMH includes general and Aboriginal CYMH Practitioners

ii Bolded terms are defined in glossary

Standards: CYMH Clinical Supervisor Knowledge and Expertise

1.1 CYMH clinical supervisors have mental health knowledge and expertise, in addition to foundational clinical supervision knowledge and expertise.

1.2 Clinical supervisors and practitioners schedule the frequency of supervision sessions in response to the level of knowledge and experience of practitioners, and the type of mental health problem(s), complexity and acuity of the clinical situations, and treatment needs they encounter.

Procedures

- CYMH clinical supervisors are supported to maintain clinical child and youth mental health knowledge and expertise, including: child and family development; the broad range of mental health challenges; mental health assessment, formulation, treatment planning; knowledge of evidence informed treatments such as cognitive behavioural therapy; implementation and evaluation; and clinical supervision skills, which are developed through appropriate education, training and experience, including self directed learning.

Standards: CYMH Clinical Competency

1.1 CYMH **clinical supervision** addresses the use of appropriate evidence-informed and best practice modalities, in addition to approaches common to Common Cross Program supervision and the **Helping Relationships Framework** and Aboriginal Practice Framework[iii]**.**

1.2 CYMH clinical supervisors and practitioners utilize a **competency-based approach, which includes cultural competency,** to identify training needs and build competencies in generalized and specialized areas of practice in mental health.

Procedures

- CYMH practitioners and clinical supervisors routinely use relevant competency documents, along with the Helping Relationships Framework and Aboriginal Practice Framework, to determine areas requiring enhanced competency development.

iii Underdevelopment

- Clinical supervisors support designated CYMH clinical staff to develop specialized knowledge and competence in specialized areas of clinical practice (e.g. infant mental health, eating disorders, early psychosis) across the range of mental health challenges, through education, training and access to external clinical consultation where appropriate (see Policy C-1.b CYMH Consultation).
- CYMH clinical supervisors and CYMH clinicians contribute to the development of practice based evidence and evaluation of new promising practices.
- Clinical supervision includes evaluation of client specific outcomes.
- CYMH clinical supervisors and practitioners recognize the unique cultural heritage and rights of the Aboriginal child, youth, family and community, and incorporate Indigenous world views into practice as appropriate.
- Clinical supervisors have access to education and tools to facilitate the supervision process (e.g. *Supervision Competencies Framework, Practices and Beliefs Questionnaire, Supervisory Feedback Exercise, Student Evaluation of Supervision, Aboriginal Behavioural Competencies*).

Glossary

Clinical supervision: A distinct professional practice whereby a supervisory practitioner supports and enhances the work of a practitioner to ensure quality service and the promotion of positive client development and well-being. This is achieved through the establishment of a purposeful, collaborative relationship where the supervisor provides feedback that enhances the supervisee's professional competency, ensuring ethical and ecologically sensitive practice. Clinical supervision is distinct from consultation in that a clinical supervisor is ultimately responsible for the actions of the person being supervised through direct liability or vicarious liability.

Competency-based approach: Emphasizes the use of identifiable competencies which can be learned and build on existing strengths. These are based on the integration and application of specific knowledge, skills, attitudes and values that are informed by theoretical knowledge, science-informed evidence and best practice.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities that they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles

□ Child, Youth and Adult-Centered
□ Family-centered
□ Strengths-based
□ Rights- & Social Justice-based
□ Inclusive & Culturally Safe
□ Evidence-Informed
□ Trauma-Informed
□ Developmentally/ecologically-based ness, collaborative practices, allegiance to model/approach
□ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Common Factors

□ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences
□ Practitioner characteristics – Empathy, positive regard, genuine-

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

MCFD Records Management

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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Child and Youth Mental Health (CYMH) Service Delivery Policies

Policy C-1.b: Consultation

Effective Date of Policy:

2014

Amendment Date of Policy:

January 10, 2014

POLICY STATEMENT

CYMH[i] practitioners provide and receive **mental health consultation**[ii] to enhance understanding, skills, and expertise in relation to providing supports and services for infants, children, youth, their families/caregivers and communities.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal communities and cultural groups, access appropriate supports and services informed by an enhanced understanding of their mental health needs and their unique cultural heritage, values and beliefs.
- Practitioners enhance their knowledge, skills, and practices in relation to working with infants, children, youth and their families/caregivers.

i CYMH includes general and Aboriginal CYMH practitioners

ii Bolded words are defined in the glossary

Standard: Development of Consultation Services

1.1 CYMH teams develop **culturally-safe mental health consultation** services[1,2,3] as part of the formal array of CYMH interventions, consistent with the MCFD Common Cross Program Consultation Policy, the **Helping Relationships Framework** and the Aboriginal Practice Framework[iii].

Procedures

- CYMH teams develop the capacity to provide **mental health consultation** services[1,2,3] that address mental health promotion, prevention and therapeutic services, including: (a) **child-specific consultation**, and/or (b) **general mental health consultation**.
- CYMH practitioners develop knowledge of **mental health consultation** models and engage in consultation work that is within the scope of their practice.
- CYMH team leaders, clinical supervisors and/or others with administrative authority ensure that appropriate terms, conditions, service agreements, or contracts are in place as needed to support **mental health consultation** activities.
- CYMH practitioners collaborate with representatives from Aboriginal communities/ agencies and cultural groups, as appropriate, as part of the process of establishing formal consultation services and agreements[2, 4].

Standard: Child-Specific Mental Health Consultation

2.1 CYMH practitioners provide **child-specific mental health consultation** to other professionals[5, 6].

Procedures

- CYMH practitioners arrange child-specific consultation:
  - As a clinical intervention in response to a documented request from a professional external to CYMH; or,

iii Under development

- As a clinical support to other members of CYMH multidisciplinary teams (e.g., psychology consultation, infant mental health consultation).

- CYMH practitioners receive a documented request for consultation and clarify the respective roles and responsibilities of the consultant and consultee when providing **child-specific consultation**:
  - CYMH consultants maintain responsibility for conducting an assessment and providing recommendations, within their scope of practice, in response to the consultee's consultation request.
  - Consultees maintain responsibility for the ongoing care of the infant, child, or youth, and for implementation of any actions arising from the consultation.
- CYMH practitioners obtain appropriate consents from the involved mature minor and/or legal guardian prior to engaging in **child-specific consultations** and use the Consent for Child and Youth Mental Health Services form (CF0663) to document the informed consent for service (See D-2: Consent to Treatment Policy; D-3: Informed Consent to Information Sharing) .
- CYMH practitioners conduct a direct evaluation of the infant, child or youth.

  Note: If this is not possible, practitioners limit their consultation to **general mental health consultation**, and advise the consultee of this limitation.
- CYMH teams provide **child-specific consultation** activities described in the MCFD Common Cross Program Consultation Policy, with additional specific CYMH components including:
  - The initial referral stage can include use of a standardised "request form" or similar process;
  - Consultation summary reports include Mental Health Assessments, specialist assessments (e.g., CYMH contracted sessional psychiatrist assessment/consultation, psychological assessment); and,
  - CYMH practitioners provide child-specific consultation reports to consultees and document **child-specific consultations** in the clinical file, consistent with clinical file policies and procedures.

Standard: General Mental Health Consultation

3.1 CYMH practitioners provide **general mental health consultation**, which can include **topic** or **program-centred consultations,** to parents/ caregivers, community members and other professionals.

Procedures

A. Topic-centred consultations:

- CYMH practitioners provide **topic-centred consultations** as a form of **general mental health consultation** to community members and other professionals when there is no formal, program-centred arrangement, and when:
  - General information on a topic related to infant, child and/or youth mental health is requested (e.g., mental health promotion/ prevention, suicide prevention); or,
  - Child-specific information is requested but it is not possible or appropriate for the consultant to provide child-specific comments and recommendations.

B. Program-centred consultations:

- CYMH practitioners provide **program-centred mental health consultation** as a form of **general mental health consultation** provided through a formalised arrangement with another program area, agency or organisation.
- CYMH team leaders/clinical supervisors coordinate with their regional CYMH lead, CYMH team, MCFD colleagues, and community stakeholders to establish priorities and plans for the provision of consultation services.
- Ensure that no identifying information that would identify specific children, parents, or families/caregivers is shared in the process of providing **program-centred mental health consultation.**
- Consultation includes collaboration with representatives of other program(s) (e.g., MCFD program area, school, health authority, community agency) to jointly identify problems/issues that will form the basis for the consultation, **including** gathering information and developing a written plan.

- CYMH team leaders and practitioners use CARIS "**Topic-Based Consultation**" data to document the provision of **general mental health consultations** (topic and program-centered) at the team level, and attach copies of the program-centred agreements, notes from meetings with the program staff, assessment results and plans, and similar content.

Standards: Receiving Consultation

4.1 CYMH clinical staff receive consultation from individuals with expertise external to MCFD CYMH if required.

4.2 CYMH practitioners and their clinical supervisors receiving **child-specific consultation** retain responsibility for clinical services and all related actions.

Procedures

- CYMH team leaders/clinical supervisors work with their CYMH teams, regional CYMH leads and others as necessary, to review the need for external consultation, arrange for and approve such consultation, and establish priorities and parameters for the consultation.
- CYMH practitioners receive **child-specific** and/or **program-centred** consultation from sessional psychiatrists or other medical practitioners with mental health expertise, who are part of the CYMH multidisciplinary team.
- CYMH practitioners receive **program-centred consultations** about specific areas of mental health practice from:
  - Contracted external consultants with specialised training, qualifications, knowledge and expertise (e.g., Interpersonal Psychotherapy, Dialectical Behavior Therapy, Suicide, and Infant Mental Health);
  - Consultants from other MCFD program areas; and,
  - Representatives from recognised community groups, such as mental health advocacy groups, parent and family organisations, Aboriginal organisations, cultural organisations, and similar community members who have specialised knowledge and expertise.
- CYMH practitioners engaging in **general mental health consultation** and/or professional development activities outside the agency maintain the privacy and confidentiality of CYMH clients by anonymizing client related information, and with the approval of their clinical supervisor.

Glossary

Child-specific mental health consultation: A form of consultation that involves a mental health consultant providing assistance in relation to a *specific* infant, child, youth and their family. In this relationship the consultant has to possess sufficient knowledge/information about the particular child to support recommendations that are tailored to the specific child's needs.

Cultural competence: An educational phase where one grows in competence in applying cultural understanding to one's work. The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes.

Culturally safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

General mental health consultation: The general term "**mental health consultation**" describes non-client specific capacity-building and problem-solving consultations that involve a relationship between a professional consultant with mental health expertise, and one or more professionals who possess different areas of expertise[1,5,6]. The consultation provides information on general mental health issues or topics (e.g., depression in adolescents, support strategies for children with anxiety), and is not provided in reference to a specific client. **General mental health consultation** can be provided as part of a formalised service to a representative or group from another program/agency[1] (i.e. **Program-centred**) or to members of the general public and to other professionals as part of universal promotion/prevention, capacity building, or professional development (i.e. **Topic-centred**).

Helping Relationships Framework: The features of helping relationships that are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families/caregivers and communities that they work with. The model describes the evidence-informed practices that contribute to effective helping relationships.

The model consists of two main components:

Practice Principles	Common Factors
□ Child, Youth and Adult-Centered □ Family-centered □ Strengths-based □ Rights- & Social Justice-based □ Inclusive & Culturally Safe □ Evidence-Informed □ Trauma-Informed □ Developmentally/ecologically-based	□ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Program-centred mental health consultation: Is a form of **general mental health consultation.** It involves consultation between a mental health consultant and a representative or group from another program/agency[1]. The intention of the consultation can be to (1) support an overall enhanced understanding of and management of mental health issues, and/or (2) assist with problem-solving on issues that involve more than one individual child, staff member, and family.

Topic-centred mental health consultation: Is a form of **general mental health consultation.** It is similar to **program-centred**, with the significant difference being that topic-centred consultation is provided to members of the general public and to other professionals who are not receiving consultation as part of an established program-centred consultation process. This can include parents/caregivers of infants, children and youth who are not registered with CYMH (e.g., parent calling to inquire about services).

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

Clinical Process and CARIS

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

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Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Conflict of Interest**	**Policy Number:**	**C-2**

Policy Statement:

Clinical Practitioners employed by the Ministry may be engaged in private practice outside government employment with their supervisor's approval and provided it does not:

- Interfere with the performance of their duties as a public servant;
- Represent a conflict of interest or create the reasonable perception of a conflict of interest;
- Involve the unauthorized use of work time or government premises, services, equipment or supplies to which they have access by virtue of their public service employment; and

  Gain an advantage such as a referral to their private practice gleaned as a result of their MCFD work.

Background:

- Conflicts of interest can include both financial and personal interests. In addition to actual conflict of interest, there can also be *apparent* or *potential* conflict of interest situations.

Guidelines:

An *apparent* conflict of interest occurs when the answer to the following question is "yes":

Would a reasonably informed person perceive that the performance of the public servant's duties and responsibilities could be influenced by their personal interest?

A potential conflict of interest is a situation that may develop into a real conflict of interest. Any time a public sector employee is also engaged in private sector work, there is a potential for a conflict of interest situation. The employee and employer must review all such instances as part of regular performance planning and appraisal.

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Conflict of Interest**	**Policy Number:**	**C-2**

The following principles direct all actions and decisions regarding potential and actual conflict of interest in employment situations:

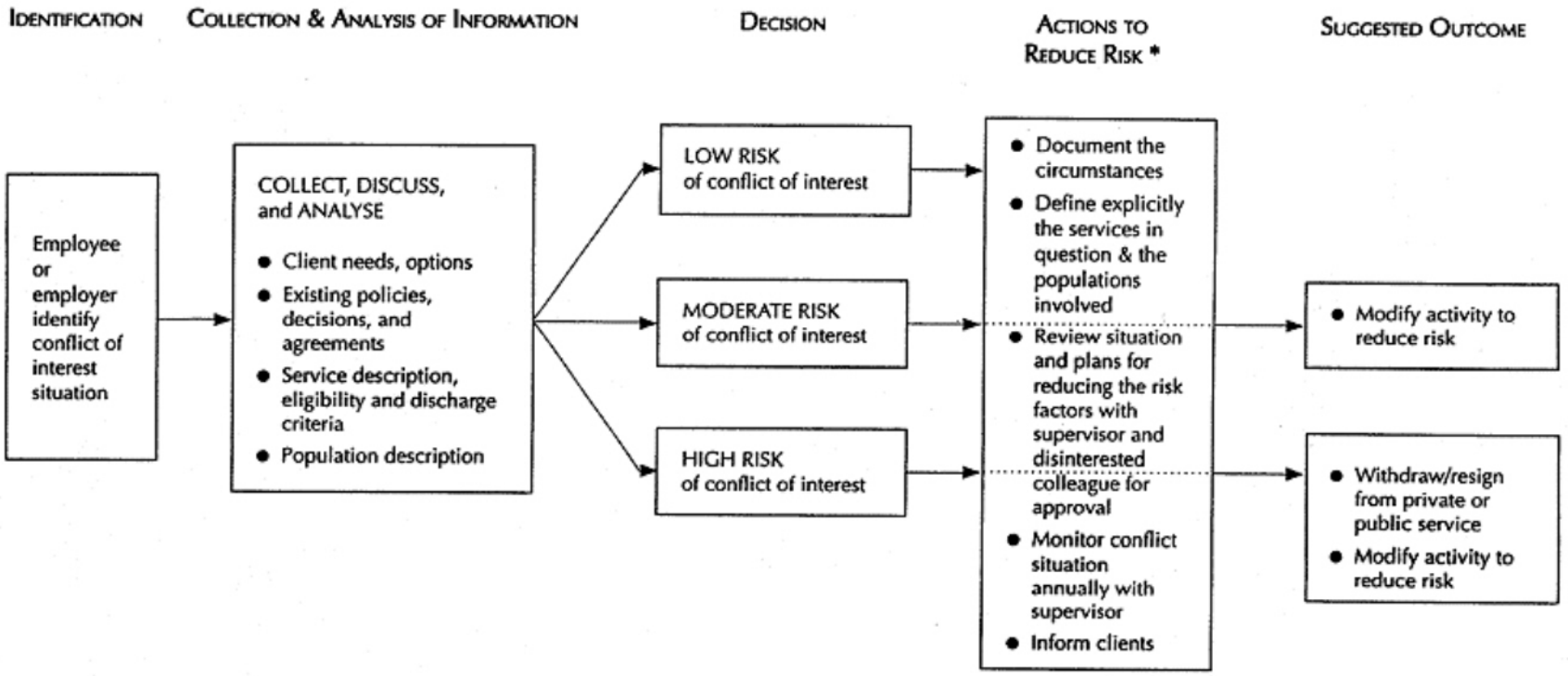
- The employer and employee act in the best interests of the client;
- All discussions, steps taken and decisions be documented and reviewed as appropriate;
- The employee not participate in decisions from which the employee benefit personally;
- The employee consider benefits accruing to a spouse, relative, business partner or close friend as if the employee were to benefit;
- The employee declares potential or actual conflict of interest situations to the employer and client;
- The employee not provide public and private service to the same client concurrently;
- The employee not refer clients from the employee's public sector job to the employee's private sector practice;
- The employee not operate his/her private practice while at work in public sector position;
- The employee not use the employee's position, or information obtained in the public sector job, to provide an unfair advantage to the employee;
- Co-workers not make referrals to the employee's private practice.

References: *Standards of Conduct for Public Service Employees (Province of British Columbia) 1996*

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

A Process for Managing Conflict of Interest

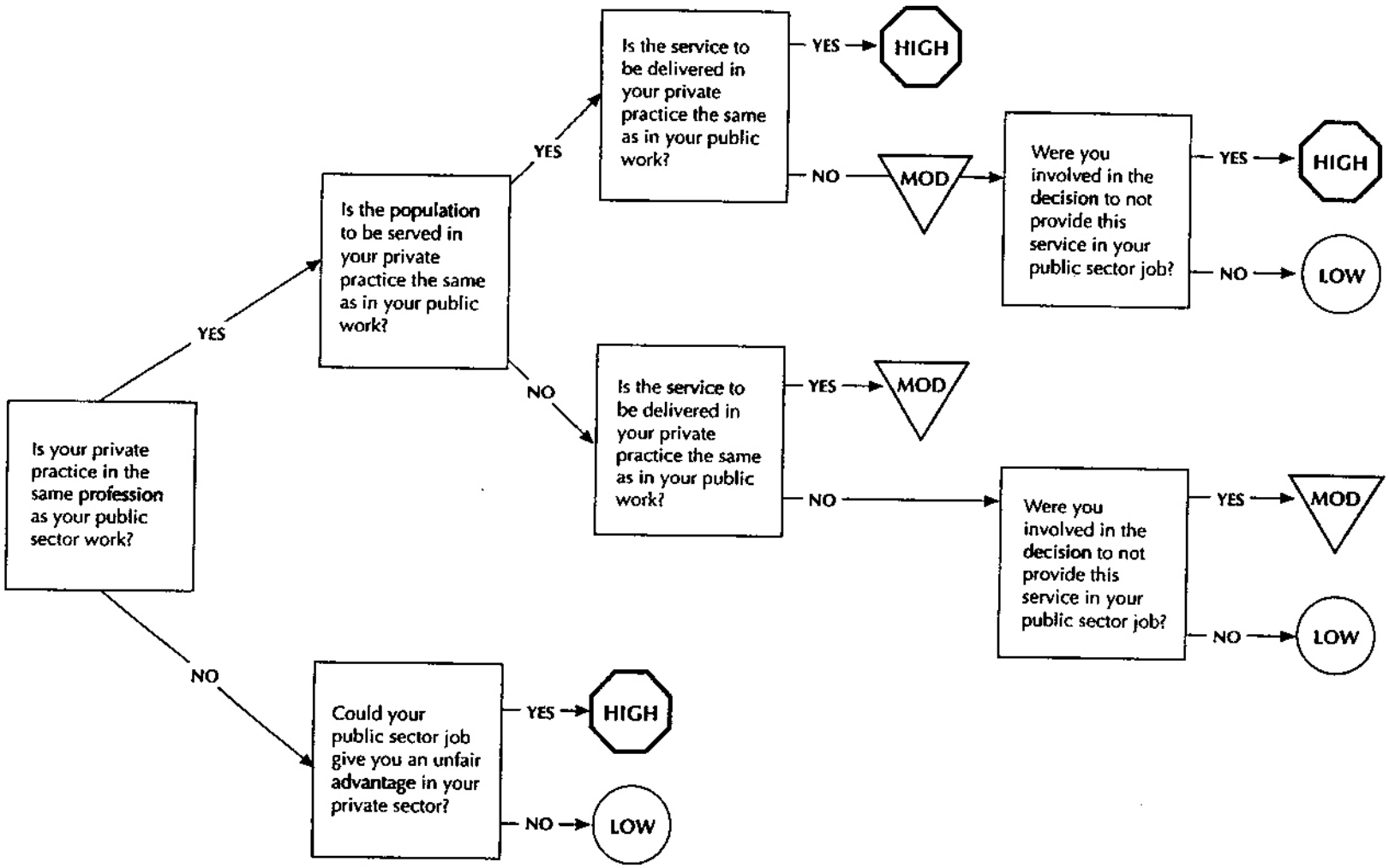
"A Process for Managing Conflict of Interest" describes the stages in the process from initial identification to suggested outcome. At all times, the intent of the recommended actions is to reduce the level of risk of a real, apparent or potential conflict of interest.



* *All actions and decisions regarding potential and actual conflict of interest situations must adhere to the Principles (see "Principles" page 1.)*

5a

A Process for Assessing Risk of Conflict of Interest



This flowchart is intended to assist employers and employees when it is necessary to assess the level of risk of Conflict of Interest. It identifies whether the employee's working circumstances constitute a high, moderate or low risk of conflict of interest. The higher the risk, the more necessary that appropriate actions be taken.

Ministry for Children and Families

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Discretionary fee/expenses**	**Policy Number:**	**C-3**

Policy Statement:

Discretionary fees/expenses will be used for the purchase of art and play therapy supplies and drinks and snacks for therapeutic purposes.

Background:

Guidelines:

Discretionary fees/expenses will be used in the following circumstances:

- Art and play therapy supplies required to provide expressive therapies to children and youth
- Drinks and snacks for therapeutic purposes e.g. outreach services for hard-to-reach children and youth where contact needs to be established in a community setting, group therapy and play therapy.
- Expenses will be coded to Service lines 14284, STOB 7956
- Spending authority outlined in the CYMHS Spending Matrix will be followed.
- Regions will determine spending authority access and levels.

Authorized by: Alan Markwart
Assistant Deputy Minister, MCF

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Clinical File**	**Policy Number:**	**D-1**

Policy Statement:

A complete and accurate file will be opened and maintained for each client/client group seen by a CYMH clinician.

Background:

Guidelines:

Clinical files will constitute detail relating to the following:

- Written assessment
- Treatment plan
- Progress of the client
- Related correspondence
- Consultation reports
- Alerts
- Consents
- Medication sheet
- Termination summary

Clinical files will be retained in accordance with the *Document Disposal Act* and ministry file management policy.

References:

Clinical Policies and Procedures Manual, Mental Health Division, Ministry of Health, 1996.

Document Disposal Act

Authorized by:

Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Informed Consent to Treatment**	**Policy Number:**	**D-2**

Policy Statement:

A mature child or young person can consent to their own health care in qualified circumstances, without the consent of their parent or guardian. (Health care means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.)

A request for or consent or agreement to treatment by the child or young person does not constitute consent to the health care unless the health care provider (health care provider includes a person licensed, certified or registered in British Columbia to provide health care):

(a) has explained to the young person and /or parent or legal guardian and has been satisfied that the young person and /or parent or legal guardian understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and

(b) has made reasonable efforts to determine and has concluded that the treatment is in the young person's best interests.

Children and youth who are determined to be mature minors, and /or the parent/legal guardian of children and youth who are determined to be unable to provide informed consent, must be provided with information concerning the treatment they will be receiving, the expected outcomes, the risks and the benefits.

The client's understanding of this information needs to be confirmed by the clinician.

The process should be documented on a consent form and in the clinical notes.

Background:

- The *Infants Act* does not define a minimum age at which a young person can consent to treatment. Young children may be able to consent to treatment without parental consent, if they understand the "nature and consequences and the reasonably foreseeable benefits and risks of the care" and the health care provider determines that the health care is in their best interests.
- According to section 29 of the *Child, Family and Community Services Act,* if a young person or parent refuses to give consent to treatment that, in the opinion of two medical practitioners, is necessary to preserve the young person's life or prevent serious or

permanent impairment of the young person's health, the Director of Child Protection may apply to court for an order authorizing treatment.

- Under section 13.1.f of the *Child, Family and Community Services Act,* a child is in need of protection if deprived of necessary health care.

Guidelines:

- In order to elicit consent properly, it is necessary to complete a consent process that involves a discussion of the following with the client:
  - a description of assessment and therapy;
  - a description of the specific recommended therapy, its risks and benefits;
  - a review of confidentiality and its limits.
- The clinician who will be providing the treatment should go through the consent process with the client, be identified on the consent form as having done so and witness the client's signature.
- The clinician will ask an unaccompanied young person if parents may be included in discussions and decisions about treatment. Where the young person declines such involvement, parents will be excluded.
- If the clinician believes that the young person's insistence on confidentiality will put them at risk, it will be necessary to break confidentiality. Disclosure will then be made to the parent/guardian or, where the young person is considered to be "a child in need of protection", to the Director of Child Protection.
- Questions about whether and when an application for court ordered treatment is necessary may be directed to regional child protection staff.
- Consent to Treatment form (cf0663)

References:

Infants Act Section 17

Child, Family and Community Services Act Section 13 & 29

Canadian Charter of Rights and Freedoms

Document Disposal Act

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**
Topic:	**Informed Consent to Treatment**
Issue Date:	September, 2002
Amendment Date:	
Policy Number:	**D-2**

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	May, 2003
Topic:	**Informed Consent to Information Sharing**	**Policy Number:**	**D-3**

Policy Statement:

When able, child and youth clients must give "informed consent" to the sharing of information about themselves. If the child or youth is not able to consent to the sharing of information, the parent or guardian must provide consent.

Where there are competing privacy interests between children and parents, the child's right to health, safety and well being is primary.

(A) Information sharing within a CYMH program area

Information can be shared to enable the provision of a given service. This information should be shared on a "need to know" basis with the responsibility being on the person requesting the information to demonstrate the "need toknow."

The sharing of should be maintained as a formal process.

Whenever possible and appropriate, consent of the individual the information is about will be obtained before their information is shared.

(B) Information sharing with other service partners

Information may be shared with service partners if **required** for the provision of a given service. This information must be shared on a "need to know" basis as above.

When sharing information with service partners, ministry staff must ensure that the service partners are aware that they are subject to the same privacy rules.

The *Child, Family and Community Service Act (*CFCSA) and the *Youth Criminal Justice Act (*YCJA) take precedence over the *Freedom of Information and Protection of Privacy Act (*FOIPPA) and place strict requirements on the sharing of information. Further, this legislation gives certain staff the right of access to information upon their request (CFCSA s.96)

Legislative requirements need to be known and followed when sharing information. Once legislative issues have been resolved, staff should be aware of the nature and quantity of the information to be shared.

Information to be shared is based on the "need to know" principle with the responsibility being on the requester to demonstrate this need. When the request is made under s.96 CFCSA, the director determines what is

necessary, not the person asked for the information.

(C) Information sharing with clients

Clients have a right to see any information the ministry and service partners have about them unless there are extenuating circumstances that prohibit it, such as health and safety or law enforcement matters. The "need to know" principle does **not** apply when sharing information with clients about themselves.

The sharing of information relates to clients' **own** information not that of their family members or a third party. Special consideration must be given to certain third party information that could reasonably be expected to reveal the identity of a person who has made a child protection report. Legislation requires that this information be kept confidential.

(D) Information sharing with client's family members

Whenever possible the consent of the individual the information is about will be obtained before sharing the information. Consideration should be given as to whether seeking consent is appropriate, based on the merits of each individual case. The parent's legal relationship with their child must also be reviewed when considering sharing the child's information with the parents. The age of a child, the nature of the information and the Act under which the information was collected all impact the ability of a service provider to share given information about a child. The key determination with respect to the child's ability to consent to the release of their information, is the child's capacity not age (see Appendix for Assessing Capacity).

(E) Information sharing for case planning

For the purposes of case planning, information may be shared on a case by case basis. When information is to be shared for reasons other than case planning, the legislative restrictions must be considered. The CFCSA, FOIPPA and YCJA all place restrictions on the sharing of information in such circumstances. If the information was collected under the CFCSA or YCJA the privacy requirements of those Acts take precedence over those contained in the FOIPPA when considering the sharing of information.

The YCJA does not permit young offenders to consent to the release of

their personal information, even to their parents.

Background:

The Ministry of Children and Family Development has a broad and complex mandate carried out via working partnerships between various individuals and agencies,in different program areas- both internal and external to the Ministry: the Ministry's service partners.

A Guide to the Privacy Charter was developed in 1999, to clarify what information about clients is necessary and appropriate to share.

Guidelines:

Personal information that is under the custody and control of the Mnistry of Children and Family Development is protected by distinct pieces of legislation- the *Freedom of Information and Protection of Privacy Act (FOIPPA),* the *Child, Family and Community Service Act* (CFCSA), the *Document Disposal Act* and the *Young Offenders Act (Canada).*

It is important to note that both the *Child, Family and Community Service Act* and the *Youth Criminal Justice Act (Canada)* **take precedence over the *Freedom of Information and Protection of Privacy Act.***
The *Child,Family and Service Act,* s.96, provides authority for the Director of Child Protection to have the right to access any information that is necessary to enable the director to exercise his powers or to perform the duties or functions under the CFCSA.

Personal information collected from and about clients can be divided as follows:

A. information that **must** be shared (see attached appendix)
B. information that **should** be shared (see attached appendix)
C. information that **should not** be shared (see attached appendix)

Child and youth clients have the same right to privacy as do adult clients.

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	May, 2003
Topic:	**Informed Consent to Information Sharing**	**Policy Number:**	**D-3**

Child and youth clients should be provided with the opportunity to provide their informed consent before their personal information is shared with anyone else. The appropriateness of seeking consent is based on the merits of each individual case.

The consent should be in writing and specify to whom personal information may be disclosed, how it may be used and a time limit to the consent.

Clients may not be denied service based on their refusal to provide consent to information sharing.

Child and youth clients should be made aware of those circumstances whereby information might be shared without their consent if necessary. If the clinician believes the young person's insistence on confidentiality will put them at risk, it is necessary to break confidentiality. Disclosure would then be made to the parent or, where the young person is considered to be "a child in need of protection", to the Director of Child Protection.

Note: The *Youth Criminal Justice Act* does not allow either young offenders or their parents to consent to the release of their personal information

Reference:

Freedom of Information and Protection of Privacy Act
Child, Family and Community Service Act
Youth Criminal Justice Act
Federal Privacy Act
Adoption Act
Document Disposal Act

Ministry of Children and Family Development
A Guide to the Privacy Charter

Ministry of Children and Family Development
Operational Records Classification System (ORCS)

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	May, 2003
Topic:	**Informed Consent to Information Sharing**	**Policy Number:**	**D-3**

Information and PrivacyCornmissioner
Fair Information Practices

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Appendix:

Assessing Capacity

In order to determine capacity to release information, the child/youth must be able to describe in their own words that will receive the information and for what purposes.

The clinician will have previously discussed the above with the child/youth.

Information Categories:

A. Must share:

Information **must** be shared when:

- **required** to share under law, by Court order or specific written policy that stems from relevant legislation
- it is one's **duty** to share information to protect the health, safety and well-being of clients or others

B. Should share:

Information should be shared to:

- facilitate effective integrated case management
- support continuity of care
- ensure consistent support to the child/youth at home and at school

C. Should not share:

Information that is not relevant to the case **should not** be shared.

Information **not needed** to assist clients should not be requested.

Fair information practices

The Ministry of Children and Family Development supports and complies with the following fair information practices:

1. Data collection by an agency of government should be explicitly authorized by law, with a responsible keeper for that information.

2. Personal information, when collected, should relate to, and be necessary for, an operating program or activity of the agency.

3. With limited exceptions, an agency collecting personal information should tell the data subject the purpose for collecting the information, the legal authority for collecting it, and provide detailed information as to who can answer any questions the person may have about the information collection.

4. Personal information should be collected directly from the person concerned, unless another method of collection is authorized by the person, or by law. The data subject should be provided with the information that will make informed consent possible and meaningful.

5. The existence of government data banks should be known; there should be no secret data banks.

6. Personal information collected and maintained should be as accurate as possible.

7. An individual has the right to request complete and unrestricted access to his or her personal information held by government (subject to limited exceptions) and be entitled to request correction of any information about him or her. Typically this is done through an FOI request.

8. Personal information should be used for the purpose for which it was collected, or for a reason consistent with the purpose of collection. It may be used for other purposes, if the subject of the information consents

9. Personal information may be disclosed by a government agency only as authorized by the data subject, by law, or to a law enforcement agency for a law enforcement purpose.

10. Child and youth case information is retained in accordance with the *Document Disposal Act.*

10. Reasonable security arrangements must be in place to protect all personal information from unauthorized collection, access and disclosure. (See GMOP 9.5 re security requirements)

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Use of Video and Audio Recording**	**Policy Number:**	**D-4**

Policy Statement:

Video and/or audio recording may be used for the purposes of treatment, supervision and teaching. A signed, informed consent must be obtained prior to taping.

Under FOIPPA, the video and /or audio tape is considered to be part of the client file and as such is subject to FOIPPA, MCFD Records and File Management policy and the *Document Disposal Act*.

Background:

Guidelines:

- An audio/video recording is considered to be part of the client file and must be stored in a safe and secure manner.
- The recording must be retained for the retention period of the file type and according to the *Document Disposal Act.*
- The recording may be requested by the client under FOIPPA.
- A file transferred to another jurisdiction must include the tape.
- A tape cannot be used for more than one client and must not be reused for multiple clients and sessions.

Consent form

References:

FOIPPA- section 26
MCFD File Management policy

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Data Reporting in Child & Youth Mental Health**	**Policy Number:**	D-5

Policy Statement:

Child and youth mental health client and service data must be entered in a Ministry approved information management system.

Child and youth mental health data entered must comply with the Provincial Minimum Data Set for mental health (to be implemented fall, 2002)

Background:

Guidelines:

- Appendix A refers to the current standard for entry of child and youth mental health data.
- Until the mental health Minimum Data Set for the province is in effect, minimum data to be entered into the provincial information management system must comply with Appendix A.

References:

Client/Patient Information Management (CPIM) Documentation Binder- Ministry of Health Services

Authorized by:

_____

Alan Markwart

Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**
Topic:	**Data Reporting in Child & Youth Mental Health- Appendix**
Issue Date:	September, 2002
Amendment Date:	
Policy Number:	**D-5 a**

Guidelines:

Ministry- Approved Information Management System for Child & Youth Mental Health Data:

Child and youth mental health data must currently be entered into the Client/Patient Information Management (CPIM) System This system is shared with and housed in the Ministry of Health Services (MOHS) and is accessible to all MCFD Child & Youth Mental Health (CYMH) service locations.

All CYMH clinicians and administrative staff must maintain access to the CPIM system, as outlined in the conditions set out in the individual CPIM User Agreement that each staff member must sign.

Procedures for entry of data in CPIM are found in the Client/Patient Information Management (CPIM) Documentation Binder (Ministry of Health Services).

Minimum Data for Entry:

Until further notice, minimum data fields for entry are captured on the Registration and Termination (HLTH 3579) Form. Data fields captured on the Service Utilization Record (HLTH 3573) Form and the Group/Family Counselling Record (HLTH 3574) Form may also be entered. All CPIM forms are available on the MARS site.

When the Mental Health Minimum Data Set comes into effect, data will be entered in CPIM based on this standard.

References: *Client/Patient Information Management (CPIM) Documentation Binder- Ministry of Health Services*

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Release of CPIM Information to Child Protection**	**Policy Number:**	**D-6**

Policy Statement:

Under s. 96 of the CFCSA, information from the Client/Patient Information Management System (CPIM) is provided to the Director of Child Protection or his designate, if requested by the Director or designate.

Background:

- CPIM is a data collection system in Corporate Shared Services, Ministry of Health Services (MOHS), which is shared with MCFD.
- The Memorandum of Understanding for Information Sharing between MOHS and MCFD for CPIM states :"The Ministry of Children and Family Development and the Ministry of Health will not use or disclose personal information collected by means of the CPIM system for any other purpose except in the case of child protection investigations where the information is accessible under the provisions within Child, Family and Community Services Act."

Guidelines:

- In order to fulfil their responsibilities, Child Protection Workers, delegated by the Director, may request information from the Mental Health CPIM system relating to the child/youth/family only.
- This request must be made in writing by the Director or a delegated child protection social worker, confirming that they are properly delegated by the Director and that they are requesting certain or specific information in order to carry out their responsibilities under the CFCSA.
- The determination of whether information is necessary or not is determined by the Director. This request must be complied with.
- A copy of the child protection social worker's delegation should be attached to the request.

References: *Child, Family and Community Service Act*
CPIM Memorandum of Understanding between MOH & MCFD

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**Caution/Alert**	**Policy Number:**	**D-7**

Policy Statement:

Caution/Alert sheets will be used to provide staff with information which potentially poses an immediate danger to a client or client's family, to the community, or to staff.

Background:

Guidelines:

- The Caution/Alert sheet (ministry form attached) will be used to identify clients who are suicidal, homicidal, or violent/aggressive.
- Team leaders will be notified of clients on Caution/Alert.
- Team leaders will maintain a list of current Caution/Alerts.
- Caution/Alert sheets will be kept on top left hand side of client's clinical record.
- The Caution/Alert sheet is a permanent document in the record.
- The Caution/Alert record is retained in the client file in accordance with the *Document Disposal Act.*

Caution/Alert form

References:

Ministry of Children and Family Development,
Document Disposal Act.

Freedom of Information and Protection of Privacy Act

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September,2002
		Amendment Date:	
Topic:	**Retention of CYMH File**	**Policy Number:**	**D-8**

Policy Statement:

MCFD CYMH client files are maintained in the care and custody of MCFD according to provincial guidelines and ministry guidelines.

Background:

Guidelines:

- The Ministry maintains CYMH client files for a period of 26 years following the closure of the file. (Currently this is a draft retention period).
- Copies of files of clients receiving service outside MCFD and/or transferring to the adult mental health system may be provided to said agency with the signed consent of the client. The original file remains the property of MCFD.
- It may be moved to offsite storage following the Ministry "Check-List" for transferring records to off-site storage guidelines.

References: MCFD Records and Forms Management

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Ministry of Children and Family Development

Policy

Program Area:	**Child and Youth Mental Health**	**Issue Date:**	September, 2002
		Amendment Date:	
Topic:	**File Audit**	**Policy Number:**	**D-9**

Policy Statement:

Regions will have in place a mechanism for regular audits of Child and Youth Mental Health files to ensure delivery of quality and consistent service. These audits will be done at a minimum, once a year.

Background:

- File audits are one form of quality improvement.

Guidelines:

- File audit tools will be consistent with *The Commission on Accreditation of Rehabilitation Facilities* (CARF) *Behavioural Health* or *Council on Accreditation* (COA) for *Behavioural Health Care Services and Community Support & Education Services*.
- Peer audits of files by senior or experienced clinicians are encouraged.

References:

Authorized by: Alan Markwart
Assistant Deputy Minister, MCFD

Common Cross Program (CCP) Policies

POLICY: CLINICAL SUPERVISION

Effective Date of Policy: 2014

Amendment Date of Policy: October 20, 2014

Policy Statement

MCFD practitioners receive clinical supervision provided by a designated supervisor with knowledge and expertise in their specialized area(s) of practice as well as cultural competence to work effectively with children, youth, and their families, including those from Aboriginal communities and cultural groups.

Outcomes

- Practitioners are supported to provide quality, professional, ethical practice.
- Children, youth and their families, including those from Aboriginal communities and cultural groups, receive services from practitioners who seek to understand and are respectful of their cultural identities, histories, approaches and strengths.

Standards: Determining supervision goals

1.1 Clinical supervisors and practitioners determine goals for supervision consistent with the Helping Relationships Framework, the Aboriginal Practice Framework[i], and role specific competencies.

1.2 Clinical supervisors and practitioners meet to engage in supervision on a regular basis according to the terms specified in a written supervision agreement that establishes the overall goals, methods, and schedule for supervision meetings. This agreement is reviewed and revised jointly once a year.

Procedures

- Clinical supervisors and practitioners determine the degree of focus on each of the three supervision elements (client centered, professional, and supportive) depending on the supervision needs of each practitioner relevant to their practice.
- Supervision sessions occur at scheduled times, and as needed at the following stages:
  - intake screening;
  - assessment, analysis, and child and family planning development phases;
  - implementation of child and family plan and review of progress;
  - termination; and,
  - when challenges or crises occur
- Supervisors increase the frequency of supervision sessions in relation to the complexity of the clinical situations and the experience of practitioners.
- Supervisors provide supervision either face-to-face or through various forms of distance technology (e.g. teleconferencing, telehealth or videoconferencing) depending on needs and available resources.

Standard: Competency and Professional Standards of Practice

2.1 MCFD managers support practitioners and clinical supervisors to develop practice expertise and competencies, including cultural competencies, through ongoing supervision and professional development, to inform sound professional judgments and practice decisions.

Procedures

- Clinical supervisors routinely use the Framework for Helping Relationships and Aboriginal Practice Framework, and role specific competencies, to guide supervision discussions and to review, acknowledge and strengthen practitioners' competencies.

- Clinical supervisors and practitioners identify and address specific knowledge gaps, areas for improvement, and learning opportunities, and develop goals and activities in a written plan for learning, support and supervision within an agreed upon timeframe.
- Clinical supervisors and practitioners recognize the unique cultural heritage and rights of the Aboriginal child, youth, family, and community, and incorporate Indigenous world views and perspectives into practice as appropriate.

Standards: Consistency with Policies, Standards and Legislation

3.1 Clinical supervisors and practitioners deliver services consistent with relevant policies, standards, legislation and existing federal and/or provincial agreements as required in supervision sessions.

3.2 Clinical supervisors ensure that new practitioners are oriented to MCFD organizational practices, policies, protocols, and services and relationships with Delegated Aboriginal Agencies and Aboriginal organizations and the community they work in and their particular area of practice.

Procedures

- Clinical supervisors and practitioners maintain current knowledge of policies, standards, protocols, legislation, and existing federal and/or provincial agreements with First Nations, Métis and urban Aboriginal organizations, Bands, Delegated Aboriginal Agencies, and Treaty Nations, relevant to their areas of practice.
- Clinical supervisors and practitioners are aware of the rights of children and youth pursuant to the UN Convention on the Rights of the Child, relevant legislation and conventions such as the Declaration on the Rights of Indigenous People and the Convention on the Rights of Persons with Disabilities, and the Representative for Children and Youth /MCFD Protocol, and their application in practice.
- Clinical supervisors ensure that teams have an orientation process in place for new staff taking their regional and community context into consideration, and a clear procedure to track orientation activities.

Standards: Documentation of Clinical Supervision

4.1 Clinical supervision sessions are documented to ensure accountability and quality assurance according to MCFD policies, standards of practice and professional codes of conduct/ethics. Documentation of clinical supervision sessions includes two separate components:

i. Child, youth and family information recorded in the clinical file; and

ii. Practitioner development and learning recorded in a separate file.

Procedures

- Clinical supervisors and practitioners ensure all notes are recorded in language that is objective, non-judgmental, and strength-based.
- Practitioners record child, youth and family information in the clinical file, including decisions and recommendations regarding specific issues(s) discussed in supervision, and these are reviewed in supervision sessions.
- Clinical supervisors ensure that supervision notes recorded in the clinical file do not include content related to the practitioner's development or learning.
- Clinical supervisors ensure that documentation of supervision sessions related to practitioner's development and learning includes supervision tools, such as the supervisory agreement, self assessment, a monitoring log and relevant documents required by regulatory bodies, and do not contain identifying information related to the child, youth or their family.
- Clinical supervisors ensure that documentation of practitioner development and learning is protected through restricted access and secure storage for a period of at least seven years following the last date of supervision.

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

References

1. Campbell, J.M. (2000). *Becoming an Effective Supervisor.* Ann Arbor, MI: Sheridan Books.
2. Falender, C.A. & Shafranske, E.P. (2004). *Clinical Supervision: A Competency-Based Approach.* Washington, DC: American Psychological Association.
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4. Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H. & Schoenwald, S.K. (2001). *Evidence-Based Practice in Child and Adolescent Mental Health Services*. *Psychiatric Services*, *52*(9), 1179-1189.
5. Morrison, Tony (2003). *Staff Supervision in Social Care*. Pavillion Publishing (Brighton) Ltd. Brighton, England.
6. Munro, Eileen (2011) *The Munro Review of Child Protection: Final Report.*
7. Waddell, C., Godderis, R., Wong, W., & Garland, O. (2005). *Implementing Evidence-Based Practice in Children's Mental Health.* Vancouver, British Columbia.

Reportable Circumstances Policy

Last Revised June 2018

Adoption, Quality Assurance and Policy Innovation

Reportable Circumstances Policy	
Policy 1: Fatalities	
Effective Date of Policy: June 1, 2015	**Amendment Date of Policy:** June 26, 2018

Policy Statement

1. A **fatality** of a child or youth, who has received or whose family has received a Ministry of Children and Family Development/Delegated Aboriginal Agency (MCFD/DAA)-provided reviewable service within the preceding 12 months, is reported to the Provincial Director of Child Welfare, the appropriate provincial director(s), the Representative for Children and Youth (RCY), and where applicable to the Public Guardian and Trustee (PGT), within 24 hours of MCFD and/or DAA having been informed of the fatality.

Outcomes

- Fatalities are reported in a timely manner, consistent with existing legislative requirements.
- Where applicable, the PGT is provided the necessary information to exercise their responsibilities.
- Affected children, youth, families and/or staff are offered support.
- Service delivery issues related to these fatalities are identified and addressed.

Standards

1.1 If a fatality occurs of a child or youth who has received or **whose family** has received an MCFD/DAA-provided reviewable service within the preceding 12 months, a reportable circumstance report is completed and provided to the Provincial Director of Child Welfare, the appropriate provincial director(s) and the RCY within 24 hours of MCFD and/or DAA having been informed of the fatality.

1.2 If a fatality occurs of an Indigenous child or youth who has received or **whose family** has received a DAA-provided reviewable service within the preceding 12 months, the reportable circumstance report is provided to the delegate of the director in DAA, within 24 hours of MCFD and/or DAA having been informed of the fatality.

1.3 If a fatality occurs of a child or youth when the director is the guardian and the PGT is the property guardian of the child or youth (as outlined in procedures) the reportable circumstance report is provided to the PGT within 24 hours of MCFD and/or DAA having been informed of the fatality.

1.4 If a fatality occurs of a person aged 19 or over who was receiving Youth Justice services at the time of the fatality, a reportable circumstance report is completed and provided to the appropriate Provincial Director within 24 hours of MCFD and/or DAA having been informed of the fatality.

Procedures

Reviewable Services

MCFD/DAA-provided reviewable services are:

- Services or programs under the *Child, Family and Community Service Act* (CFCSA) and the *Youth Justice Act*;
- Mental health services for children;
- Addiction services for children; and
- Additional designated services that are prescribed under section 29 (2) (b):
  - Services or programs under the *Youth Criminal Justice Act* (Canada);
  - The child in the home of a relative program, respecting which income assistance is provided under section 6 of the Employment and Assistance Regulation.

Responding to a Fatality

A fatality reportable circumstance (RC) report must be completed and submitted when:

- A child or youth who has received an MCFD/DAA-provided reviewable service within the previous 12 months has died.
- When a child or youth whose family has received an MCFD/DAA-provided reviewable service within the previous 12 months has died.

Who Creates/Sends the Fatality Reportable Circumstance Report

The Delegated Aboriginal Agency or MCFD practitioner who first learns of the fatality is the practitioner responsible for:

- Ensuring that the RC report template is completed; and
- Sending the RC report to the appropriate distribution list.

When a DAA is or has been involved within the previous 12 months, the notification goes to the delegate of the director in that DAA.

Direction

The Provincial Director of Child Welfare and other designated directors can require that a fatality RC report be created.

Completing the Fatality Reportable Circumstance Report

To complete the RC report, the practitioner responsible:

- Alerts the supervisor;
- Notifies by email all other involved MCFD and/or DAA program areas of the fatality and requests their input on the case facts and the plan for response;
- Completes the RC report template; and
- Receives supervisor approval to send the fatality RC report.

Sending the Fatality Reportable Circumstance Report

To send the RC report, the practitioner responsible emails the report to the appropriate distribution list.

The report is submitted within 24 hours, even if other program areas have not yet responded to requests for additional information.

Submitting a Report to the PGT

The PGT receives only those reports regarding a child or youth for whom the PGT is the property guardian, as follows:

- The director has continuing custody of a child [CFCSA s. 41(1)(d) or s. 49];
- The director is guardian of a child who has been relinquished for adoption (Adoption Act s.24);
- The director has temporary custody and an order making the PGT the temporary property guardian of a child (CFCSA s. 58);
- The director and the PGT are both guardians of a child (*Infants Act* s.51).

Supervision and Supports

After the practitioner responsible alerts the supervisor to the fatality, the supervisor identifies whether immediate supports are needed for affected families and/or staff.

- The supervisor approves the completed fatality RC report prior to its distribution.
- The Executive Director of Service or Executive Director of a Delegated Aboriginal Agency considers which supports, including financial, they will provide to the family, as detailed in the *Death of a Child in Care, in an Out of Care Placement Guideline or in an MCFD Financially Supported Placement*.

Fatality Reportable Circumstance Quality Assurance

The practice analyst for quality assurance:

- Reviews all fatality RC reports;
- Responds to practitioner, supervisor, provincial director and other inquiries;
- Forwards any concerns to the appropriate quality assurance supervisor;
- Screens all fatality RC reports to decide whether a Case Review should be considered (please refer to the Case Review Decision Process);
- Documents and sends the screening recommendation to the appropriate quality assurance supervisor.

Closing the Reportable Circumstance Report

- The practice analyst responsible for quality assurance closes the fatality RC report within 10 working days.

Reportable Circumstances Policy	
Policy 2: Critical Injuries	
Effective Date of Policy: June 1, 2015	**Amendment Date of Policy:** June 26, 2018

Policy Statement

2. A **critical injury** of a child or youth who has received or **whose family** has received an MCFD/DAA-provided reviewable service within the preceding 12 months is reported to the Provincial Director of Child Welfare, the appropriate provincial director(s), the RCY and where applicable to the PGT, within 24 hours of MCFD and/or DAA having been informed of the injury.

Outcomes

- Critical injuries are reported in a timely manner, consistent with existing legislative requirements.
- Where applicable, the PGT is provided the necessary information to exercise their responsibilities.
- Affected children, youth, families and/or staff are offered support.
- Service delivery issues related to these critical injuries are identified and addressed.

Standards

2.1 If a critical injury occurs of a child or youth who has received or whose family has received an MCFD/DAA-provided reviewable service within the preceding 12 months, a reportable circumstance report is completed and provided to the Provincial Director of Child Welfare, the appropriate provincial director(s) and the RCY within 24 hours of MCFD and/or DAA having been informed of the critical injury.

2.2 If a critical injury occurs of an Indigenous child or youth who has received or whose family has received a DAA-provided reviewable service within the preceding 12 months, the reportable circumstance report is provided to the delegate of the director in that DAA, within 24 hours of MCFD and/or DAA having been informed of the critical injury.

2.3 If a critical injury occurs of a child or youth when the director is the guardian and the PGT is the property guardian of the child or youth (as outlined in procedures) a reportable circumstance report is completed and provided to the PGT within 24 hours of MCFD and/or DAA having been informed of the critical injury.

2.4 If a critical injury occurs of a person aged 19 or over who was receiving Youth Justice services at the time of the injury, a reportable circumstance report is completed and provided to the appropriate Provincial Director within 24 hours of MCFD and/or DAA having been informed of the critical injury.

Procedures

Reviewable Services

MCFD/DAA-provided reviewable services are:

- Services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;
- Mental health services for children;
- Addiction services for children; and,
- Additional designated services that are prescribed under section 29 (2) (b):
- Services or programs under the *Youth Criminal Justice Act* (Canada);
- The child in the home of a relative program, respecting which income assistance is provided under section 6 of the Employment and Assistance Regulation.

Critical Injury Definition

A critical injury is an injury to a child or youth that has resulted in or which may in the future result in a serious impairment of the child or youth's health.
A serious impairment has occurred when a child or youth:

- Is unable to carry out their usual day-to-day activities on an ongoing basis, or,
- Requires considerable ongoing support to carry out their usual day-to-day activities.

The impairment may be physical and/or emotional in nature.

Reasonable Judgement

Reasonable judgement is used to determine whether a serious impairment has occurred or will occur in the future.

A medical or psychological assessment is not required to make a reportable circumstance report.

Responding to a Critical Injury Reportable Circumstance Report

A critical injury reportable circumstance (RC) report must be completed and submitted when:

- A child or youth who has received an MCFD/DAA-provided reviewable service within the previous 12 months has received a critical injury.
- When a child or youth **whose family** has received an MCFD/DAA-provided reviewable service within the previous 12 months has received a critical injury.

Who Creates/Sends the Critical Injury Reportable Circumstance Report

The practitioner who first learns of the critical injury is the practitioner responsible for:

- Ensuring that the RC report template is completed;
- Sending the RC to the appropriate distribution list.

When a DAA is or has been involved within the previous 12 months, the notification goes to the delegate of the director in that DAA.

Direction

The Provincial Director of Child Welfare and appropriate provincial directors can require that a critical injury RC report be created.

Completing the Critical Injury Reportable Circumstance Report

To complete the critical injury RC report, the practitioner responsible:

- Alerts the supervisor;
- Notifies by email all other involved MCFD and/or DAA program areas of the critical injury and requests their input on the case facts and the plan for response;
- Completes the RC report template; and
- Receives supervisor approval to send the critical injury RC report.

Sending the Critical Injury Reportable Circumstance Report

To send the RC report, the practitioner responsible emails the report to the appropriate distribution list.

The report is submitted within 24 hours, even if other program areas have not yet responded to requests for additional information.

Submitting a Report to the PGT

The PGT receives only those reports regarding a child or youth for whom the PGT is the property guardian, as follows:

- The director has continuing custody of a child [CFCSA s. 41(1)(d) or s. 49];
- The director is guardian of a child who has been relinquished for adoption (*Adoption Act* s. 24);
- The director has temporary custody and an order making the PGT the temporary property guardian of a child (CFCSA s. 58);
- The director and the PGT are both guardians of a child (*Infants Act* s.51).

Supervision

After the practitioner responsible alerts the supervisor to the critical injury, the supervisor identifies whether immediate supports are needed for affected families and/or staff.

The supervisor approves the completed critical injury RC report prior to its distribution.

Critical Injury Reportable Circumstance Quality Assurance

The practice analyst for quality assurance:

- Reviews all critical injury RC reports;
- Responds to practitioner, supervisor, provincial director and other inquiries;
- Forwards any concerns to the appropriate quality assurance supervisor;
- Screens all critical injury RC reports to decide whether a Case Review should be considered (please refer to the Case Review Decision Process);
- Documents and sends the screening recommendation to the appropriate quality assurance supervisor.

Closing the Critical Injury Reportable Circumstance Report

The practice analyst responsible for quality assurance closes the critical injury RC report within 10 working days.

Reportable Circumstances Policy	
Policy 3: Serious Incidents	
Effective Date of Policy: June 1, 2015	**Amendment Date of Policy:** June 26, 2018

Policy Statement

3. **A serious incident** is reported to the Provincial Director of Child Welfare, the appropriate provincial director(s), RCY and where applicable to the PGT within 24 hours of MCFD and/or DAA having been informed of a serious incident involving a child or youth who is receiving a reviewable service and:
   - Is in care under the CFCSA;
   - Is in care under the *Adoption Act*;
   - Is in an out-of-care placement including respite care under the CFCSA s. 5(2)(d)*;* s. 8; s. 35(2); or s. 41(1) ;
   - Is under a Youth Agreement under the CFSCA s. 12.2; and/or,
   - Is under the guardianship of the director and the PGT, as outlined in procedures.

Outcomes

- Serious incidents are reported in a timely manner to the Provincial Director of Child Welfare, appropriate provincial director(s) and RCY.
- Where applicable, the PGT is provided the necessary information to exercise their responsibilities.
- Affected children, youth, families and/or staff are offered support.
- Service delivery issues related to these serious incidents are identified and addressed.

Standards

3.1 If a serious incident occurs involving a child or youth who meets the criteria in policy, a reportable circumstance report is completed and provided to the to the Provincial Director of Child Welfare, appropriate provincial director(s), the RCY and where applicable to the PGT within 24 hours of MCFD and/or DAA having been informed of the serious incident.

3.2 If a serious incident occurs involving an Indigenous child or youth who meets the criteria in policy, the delegate of the director in that DAA is informed within 24 hours of MCFD and/or DAA having been informed of the serious incident.

Procedures

Reviewable Services

MCFD/DAA-provided reviewable services are:

- Services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;
- Mental health services for children;
- Addiction services for children; and,
- Additional designated services that are prescribed under section 29 (2) (b):
  - Services or programs under the *Youth Criminal Justice Act* (Canada);
  - The child in the home of a relative program, respecting which income assistance is provided under section 6 of the Employment and Assistance Regulation.

Serious Incident Definition

A serious incident occurs when the child or youth is:

- Lost or missing (age and developmental considerations are key);
- Witness to, or otherwise involved in, another person's critical injury or death;
- Diagnosed with a life-threatening illness;
- The subject of a report of abuse or neglect by a caregiver or in a care facility;
- Involved in high risk behaviour; and,

For a child or youth for whom the PGT is the property guardian and for whom MCFD or a DAA is also the guardian, the following are also reported to the PGT:

- Any motor vehicle accident involving the child or youth;
- Any event which may mean that the child or youth could be sued; charged with an offense; and/or entitled to compensation for a loss or an injury, either physical or emotional; and/or
- Involved in other circumstances of a similar, serious nature.

Reasonable Judgement

Reasonable judgement is used to determine whether a serious incident has occurred.

An event not included in procedures may, through supervisor approval, be appropriately reported as a serious incident.

Who Creates/Sends the Serious Incident Reportable Circumstance Report

The practitioner who first learns of the serious incident is the practitioner responsible for:

- Ensuring that the RC report template is completed;
- Sending the RC report to the appropriate distribution list.

When a DAA is or has been involved within the previous 12 months, the notification goes to the delegate of the director in that DAA.

Direction

The Provincial Director of Child Welfare and appropriate provincial directors can require that a serious incident RC report be created.

Completing the Serious Incident Reportable Circumstance Report

To complete the serious incident RC report, the practitioner responsible:

- Alerts the supervisor;
- Notifies by email all other involved MCFD and/or DAA program areas of the serious incident and requests their input on the case facts and the plan for response;
- Completes the RC report template; and
- Receives supervisor approval to send the serious incident RC report.

Sending the Serious Incident Reportable Circumstance Report

To send the RC report, the practitioner responsible emails the report to the appropriate distribution list.

The report is submitted within 24 hours, even if other program areas have not yet responded to requests for additional information.

Submitting a Report to the PGT

The PGT receives only those reports regarding a child or youth for whom the PGT is the property guardian, as follows:

- The director has continuing custody of a child (CFCSA s. 41(1)(d) or s. 49);
- The director is guardian of a child who has been relinquished for adoption (*Adoption Act* s.24);
- The director has temporary custody and an order making the PGT the temporary property guardian of a child (CFCSA s. 58);
- The director and the PGT are both guardians of a child (*Infants Act* s. 51).

Supervision

After the practitioner responsible alerts the supervisor to the serious incident, the supervisor identifies whether immediate supports are needed for affected families and/or staff.

The supervisor approves the completed serious incident RC report prior to its distribution.

Serious Incident Reportable Circumstance Quality Assurance

The practice analyst for quality assurance:

- Reviews all serious incident RC reports;
- Responds to practitioner, supervisor, provincial director and other inquiries;
- Forwards any concerns to the appropriate quality assurance supervisor;
- In exceptional circumstances, documents and sends a screening recommendation to the appropriate quality assurance supervisor.

Closing the Serious Incident Reportable Circumstance Report

The practice analyst responsible for quality assurance closes the serious incident RC report within 10 working days.

References (Relevant legislation, other policies, standards, literature)

Legislation Applicable to all Program Areas:
Freedom of Information and Privacy Protection Act
Representative for Children and Youth Act
Public Guardian and Trustee Act

Legislation and Selected Regulations Applicable to Specific Program Areas:
Child Welfare; Child/Youth Special Needs; Child/Youth Mental Health; Adoptions-
Child, Family, and Community Service Act
Child, Family, and Community Service Regulations
Adoption Act
Death of a Child in Care, in an Out of Care Placement or in an MCFD Financially Supported Placement Practice Guideline

Aboriginal Services
Aboriginal Operational Practice Standards and Indicators

Youth Justice
Youth Justice Act
Youth Criminal Justice Act
Youth Custody Regulation

Program Area: Youth Justice Services Ministry of Children and Family Development	Practice Directive
Effective Date: August 20, 2015	Practice Directive # 2015-02
Amendment Date:	

Reportable Circumstance Reports and Youth Justice Information

Directive Statement

Practitioners from Child and Family Services (CFS), Child and Youth Mental Health (CYMH), Child and Youth with Special Needs (CYSN), and Adoptions shall **not** enter information regarding youth justice involvement into any field or section of the Reportable Circumstance (RC) template.

Key Points

- The federal *Youth Criminal Justice Act* (*YCJA*) contains stringent provisions regarding the disclosure of information that identifies youth who are involved with Youth Justice Services under the Act. Contravention of these provisions is an offence.
- The RC template has a wide notification or distribution; including persons who do not have the legal right to information regarding youth justice involvement. This means youth justice information cannot be recorded in **any** section of the RC template.
- As authorized by the *YCJA*, youth justice practitioners may provide information to practitioners from other program areas about active orders and charges against a youth to assist in collaborative case planning. However, this information is not recorded in the RC template.
- If a youth justice practitioner is documenting a reportable circumstance, they will complete a separate RC template that specifies distribution in compliance with the *YCJA*.
- Specific questions about information sharing under the *YCJA* should be directed to the Youth Justice Consultant, the Regional Director of Youth Justice, the Youth Justice Practice Analyst or the Office of the Provincial Director of Youth Justice.

References

Policies:	Reportable Circumstance Policy
Legislation:	*Adoption Act* *Child, Family and Community Service Act* *Infants Act* *Mental Health Act* *Youth Justice Act* *Youth Criminal Justice Act*
Resources:	Reportable Circumstances Policy Practice Guidelines

Specialized Cross-Program (SCP) Policies	
Policy: Telehealth	
Effective Date of Policy: 2014	**Amendment Date of Policy:** January 10, 2014

Policy Statement

MCFD uses telehealth as a means of enhancing access to services for infants, children and youth and their families.

Outcomes

- Infants, children, and youth and their families/caregivers, including those from Aboriginal communities and cultural groups:
  - Experience timely and enhanced access to MCFD services.
  - Experience physical, emotional, and cultural safety when participating in **telehealth**[i].
  - Receive safe, secure, effective and appropriate telehealth services.

i Bolded words are defined in the glossary

Standard: Organisational Preparedness

1.1 MCFD program areas develop effective, efficient, and culturally safe **telehealth** services.

Procedures

- MCFD program areas develop their **telehealth** services to meet client and community needs, consistent with legislative and regulatory requirements and with government and ministry policies and procedures.
- MCFD program areas develop written agreements, memoranda of understanding or contracts when two or more organisations are involved in the delivery of **telehealth** services.
- MCFD program areas have organisational structures and procedures in place to support their use of **telehealth** services.
- MCFD program areas collaborate with Aboriginal people, agencies and communities in developing culturally-appropriate and **culturally-safe telehealth** services.
- When a MCFD site establishes an ongoing partnership with a consultant from a distant location it is recommended that the distant provider visit the MCFD site to gain familiarity with the staff and with the local community, including requirements for provision of culturally-appropriate services to that community. MCFD supports this whenever it is feasible within the terms of existing agreements.
- Organisational readiness for **telehealth** is established by program areas and/or teams prior to initiating use of **telehealth** at a local level through:
  - Review of the need for Privacy Impact Assessments[1] and Security Threat and Risk Analyses, and completion of these as required prior to the initiation of **telehealth** services.
  - Collaboration with communities and other service organizations to plan for the provision of **telehealth** services to meet the needs of children, youth, families and communities.
  - Identification of an organizational structure that outlines the roles and responsibilities of staff involved in the delivery of **telehealth** services.
  - Providing practitioners with a **telehealth** user guide and procedures for equipment use and **telehealth** service delivery.
  - MCFD team leaders ensuring that local sites meet privacy/security requirements and by obtaining local management endorsement prior to the use of **telehealth** for client-related purposes.

Standard: Rights and Safety

2.1 Telehealth services are provided in ways that protect the rights and safety of children, youth and their families.

Procedures

- Team leaders establish emergency safety procedures specific to the use of **telehealth**. These include: (a) an alternate means of communication, such as a telephone, in addition to the **telehealth** system to allow contact with distant sites in the event of a problem; and, (b) a pre-established procedure outlining when and how staff at one site can contact those at another site in case of emergency and/or technical difficulty.
- Practitioners:
  - Use practices consistent with the **Helping Relationships Framework** and the Aboriginal Practice Framework [ii] to support the physical, emotional, and **cultural safety** of infants, children, youth and families when providing **telehealth** services.
  - Engage in client-specific use of t**elehealth** only when all participating sites are based within BC due to privacy and liability issues.
  - Assess whether the **telehealth** service is appropriate to the participants' current stage of development, condition (e.g., physical and mental health status, risk for self-harm, risk for aggression), comfort, preferences and other relevant circumstances. When concerns exist, practitioners collaborate with the family and other involved professionals to address the concerns and/or identify alternatives to the use of **telehealth.**
  - Obtain informed consent for participation in telehealth. The informed consent process includes providing complete and accurate information about telehealth through the use of written handouts, videos or similar resources and advising children, youth and their family members/caregivers that consent can be withdrawn at any point (i.e., they can ask to cease a session).
  - Identify any additional procedures necessary to safeguard privacy and confidentiality when using telehealth (e.g., ensuring rooms are soundproof, windows open to public view are draped, approved and secure telehealth technology is used).
- Promote a climate of emotional safety by providing:
  - Clear and accurate information about the **telehealth** service ahead of time;

ii Under development

- Introductions of all persons in the **telehealth** rooms at all participating sites and explicit seeking of permission from children, youth and family participants for additional persons who are not mandatory participants;
- Adequate staff and (as appropriate) caregiver support for children and youth prior to, during, and after the **telehealth** service;
- Opportunity for debriefing and for questions about the experience after participation, and;
- Clarity about who is responsible for providing care between **telehealth** sessions.

➢ Promote **cultural safety** by considering and addressing the general circumstances related to service delivery to a specific community and/or individual. For example, they may establish a partnership with a liaison/support person from the community who can assist with **cultural safety** in the context of telehealth.

➢ Prohibit audiovisual recording of client-related telehealth sessions without (1) a review of privacy issues and completion of a Privacy Impact Assessment[1] specific to the planned uses of such recordings, (2) development of procedures for secure storage of any recordings, (3) appropriate management approvals, and (4) informed consent from telehealth service users.

Standard: Telehealth Service Delivery

3.1 Practitioners engage infants, children, youth and their families in effective and appropriate telehealth services.

Procedures

➢ Practitioners using **telehealth** to provide services directly to infants, children, youth and their families maintain consistency with existing policies, procedures and evidence-informed guidelines for **telehealth** service delivery [2,4,5,6,7,8].

➢ Practitioners use best practices in **telehealth** services that include:

- Using evidence-informed approaches for the delivery of **telehealth** services (e.g., telemental health best practice guidelines[5,6,7,8,10]).
- Developing procedures for client-related **telehealth** (e.g., collection/release of information, informed consent, referral, scheduling, documentation, structure of the **telehealth** session, support to children and youth before, during and after the session).
- Developing additional procedures or practice guidelines, as needed, for specific uses of **telehealth** (e.g., assessment, consultation, intervention, case

management meetings).

- Ensuring clarity of roles of involved professionals if **telehealth** consultation involves physicians who prescribe medication, including responsibility for the initial prescription and subsequent monitoring and follow-up care.
- Developing procedures for **telehealth** with specific guidance about *inclusion* and *exclusion* criteria for participation of children, youth and their families, including consideration of their emotional needs and safety (e.g., those at risk for self-harm) and the safety of staff (e.g., clients at risk of being aggressive).
- Establishing developmentally appropriate settings and procedures for the types of **telehealth** sessions used including, for example, the development of procedures to ensure safety in situations where a youth requests privacy (to be alone in the **telehealth** room at the local site) when speaking to a consultant or practitioner at a distant site.

Standard: Qualifications, Training & Competence

4.1 MCFD staff develop and maintain the necessary knowledge and skills appropriate to their role in telehealth.

Procedures

- Team leaders identify the specific roles and responsibilities for those involved in **telehealth** service delivery at their site.
- Practitioners and **site contacts** are appropriately educated, qualified, trained, and supervised in relation to their role in the delivery of **telehealth.**
- Practitioners engage in safe, competent and ethical use of **telehealth** that is within the scope of their role, training, and any regulatory requirements of their profession.

Foundational telehealth competencies

- Prior to using **telehealth** for service delivery, MCFD staff and service providers develop basic competency for their use of **telehealth**, including:
  - Orientation to policy and procedures specific to the use of **telehealth** technology.
  - Training/professional development in the use of **telehealth** facilities and equipment, including training on safety and emergency preparedness issues unique to the use of the **telehealth** as a means of communication.
  - Training/professional development as required in relation to the intended use(s) of the **telehealth** service (e.g., clinical, educational sessions, etc.).

Continuing professional development

- *Practitioners engage in professional development activities (e.g., reading journal articles, web-based material, attending educational presentations) as required to maintain competence for their involvement in **telehealth** service delivery.*
- *Team Leaders/Clinical Supervisors support staff development of the competencies required for their roles in **telehealth** as part of the supervisory process (see CFSP Clinical Supervision Policy and any related program-specific supervision policies).*

*Information on best practices in **telehealth** is available in publications[5,6,7,8] and online resources[9]. The Health and Human Services Library (https://gww.hhslibrary.gov.bc.ca/main.html) can assist with literature reviews on specific topics in **telehealth**, and an online resource provides a link to a literature review tool designed to assist practitioners engaged in telemental health with children and adolescents[10].*

Standard: Performance Monitoring & Quality Improvement

5.1 MCFD program areas evaluate their telehealth services to support continuous quality improvement of services.

Procedures

- Clinical issues and/or **telehealth** equipment problems that involve client care, safety or privacy are brought to the attention of team leaders and existing incident and complaint management processes are followed.
- **Telehealth** evaluation processes include any or all of the following as required in relation to the specific issues being addressed:
  - Child, youth, family and community stakeholder feedback about their involvement with **telehealth**.
  - Tracking of service utilisation data (e.g., number and types of clinical, educational, and administrative **telehealth** sessions).
  - Clinical/service effectiveness (i.e., measures of client-related outcomes of **telehealth** services).
  - Cost effectiveness of **telehealth**.
  - File reviews or other audit procedures to evaluate compliance with **telehealth** policy and procedures.

Standard: Technical

6.1 MCFD use of telehealth equipment meets or exceeds standards in relation to

technical issues related to quality of service, privacy, and safety[4].

Procedures

- Program areas work with MCFD information technology (IT) staff in relation to the purchase, routine maintenance, regular review, upgrading and replacing of **telehealth** equipment to:
    - Ensure that the equipment complies with all relevant safety and privacy laws, current industry standards for telehealth technology[4], and
    - Support adequate **quality of service** (i.e., high quality audio-video) and **interoperability** (i.e., ability to work effectively with equipment used by partners) required for client-related use of **telehealth.**
- Program areas work with IT staff to ensure that appropriate procedures are in place to ensure technical security of **telehealth** including procedures related to:
    - Secure access to **telehealth** equipment, devices and facilities/rooms;
    - Regular review and testing of network security; and,
    - Monitoring, reporting, and resolution of potential security risks encountered during **telehealth** sessions.

Telehealth technology and site readiness:

- Program areas/teams work with IT staff to:
    - Assess the technical readiness of **telehealth** sites/equipment;
    - Test equipment prior to using it for clinical service delivery to ensure adequate **quality of service**; and
    - Ensure that **telehealth** equipment is **interoperable** within and outside of MCFD and any other participating sites prior to any client-related use of **telehealth.**
- Team leaders ensure that their **telehealth** site/rooms are appropriate for client-related use of **telehealth** prior to initiating such use. They obtain appropriate approvals for any changes to room design or set-up. Telehealth rooms are set up to ensure that they[9]:
    - Protect privacy/confidentiality;
    - Are comfortable, age-appropriate, and safe for all participants;
    - Support good quality sound and vision through good lighting, location of cameras, room acoustics; and that,

Telehealth technological privacy safeguards:

- Team leaders establish procedures to control access to local **telehealth** facilities

and equipment to protect against damage, misuse, potential privacy breaches and other potential adverse outcomes arising from inadequate security.

- Team leaders and practitioners ensure that **telehealth** equipment (e.g., desktop applications, videoconference systems) protects privacy by ensuring that any "auto-answer" settings are set to "off" to protect against accidental privacy breaches.
    - When setting auto-answer to "off" for Polycom Videoconference equipment (check the MCFD Videoconference SharePoint site if you require additional assistance):
        - Review videoconference equipment administrative settings for "Auto Answer" and ensure that the Auto Answer is set to "No" to restrict distant callers from having immediate visual and auditory access to the local **telehealth** room when they initiate a call to the site. Note that when the videoconference system's Auto Answer is set to "No/Off", the system will function similarly to a telephone in that a call to the room will result in a ring and a display on the monitor that identifies who has initiated the call. As with a telephone call, a person will need to be in the room at the time of the call in order to answer it.
        - Post a notice in the videoconference room stating that Auto Answer is to be left set to No/Off *at all times,* as a basic privacy protection safeguard.
    - To set auto-answer to "off" if approved desktop computer applications are being used for **telehealth**, check the user guide if available, and/or contact the MCFD Help desk to request assistance in relation to auto-answer functions.

Telehealth technical problems:

- Program areas collaborate with IT staff and with **telehealth** partners, to develop:
    - "Troubleshooting" guides and procedures that specify the steps to be taken in event of technical problems (e.g., who to call, when to call, who initiates call if problems are encountered).
    - Local contingency plans in the event of equipment/network failures to allow for rescheduling or alternative means of conducting the clinical service (e.g., telephone consult).

Glossary

Cultural safety: A transformation of relationships where the needs and voice of the child, youth and family take a predominant role. Moves beyond cultural competence in that it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they relate to social policy and practice.

Helping Relationships Framework: The features of helping relationships are foundational to the work of all practitioners in MCFD. Helping relationships are the result of positive, collaborative partnerships between practitioners and the children, youth, families and communities that they work with. The model describes the evidence-informed practices that contribute to effective helping relationships. The model consists of two main components:

Practice Principles

- □ Child, Youth and Adult-Centered
- □ Family-centered
- □ Strengths-based
- □ Rights- & Social Justice-based
- □ Inclusive & Culturally Safe
- □ Evidence-Informed
- □ Trauma-Informed
- □ Developmentally/ecologically-based

Common Factors

- □ Child, Youth and Family characteristics – Preferences, hope/expectancy, coping style, culture, readiness/stage of change, religion/spirituality, strengths, adverse experiences
- □ Practitioner characteristics – Empathy, positive regard, genuine-ness, collaborative practices, allegiance to model/approach
- □ Alliance/Relationship Characteristics – The quality of the partnership that supports effective mutual collaboration.

Interoperability[4]: The ability of two or more systems to interact with one another and exchange information in order to achieve predictable results. The dimensions of interoperability include the technical components, the staff members, and the clinical procedures/protocols.

Quality of service[6]**:** The collective technical capacity of the telehealth system to deliver consistently high quality transmission of sound and video. For client-related telehealth, high quality audio and video is required to approximate face-to-face encounters. Quality of service can only be as good as the "weakest link" amongst components (e.g., internet bandwidth, cameras, microphones, display monitors, software).

Site contacts: The names of the primary and secondary contact at each MCFD site that has a videoconference system. These contacts are responsible for coordinating the use of the videoconference systems at their sites. Their names are listed on the MCFD Videoconference Site Information link on the MCFD Videoconference internet site[3].

Telehealth: The use of videoconferencing equipment and other electronic means to support communication about health care and social services over distance. This includes direct clinical services to children and youth as well as indirect consultation and educational sessions for practitioners and administrative meetings.

Legislation

- Adoption Act
- Child, Family and Community Service Act
- Family Law Act
- Freedom of Information and Protection of Privacy Act
- Infants Act
- Mental Health Act of BC
- Youth Criminal Justice Act
- Youth Justice Act

Other Relevant Documents

MCFD Framework for Helping Relationships Practice

MCFD Helping Relationships Competencies (under development)

MCFD Aboriginal Practice Framework (under development)

Trauma Informed Practice Guide

Jordan's Principle

UN Convention on the Rights of the Child

UN Convention on the Rights of Persons with Disabilities

UN Declaration on the Rights of Indigenous Peoples

Advocacy Protocol between the Ministry of Children and Family Development and The Representative for Children and Youth, April 4, 2011

Guidelines (numbers refer to references used in the policy)

1. MCFD Privacy Impact Assessment intranet site.
2. Telehealth User Guide: Under development – Link to be added when available.
3. MCFD Video Conferencing intranet site.

References

4. American Telemedicine Association. Core standards for telemedicine operations. Note that there are rapid changes in telehealth technology and associated changes in technical standards – check online for updates in relation to standards for telehealth equipment.
5. American Telemedicine Association. Evidence-based practice for telemental health.
6. American Telemedicine Association. Practice guidelines for videoconferencing-based telemental health.
7. American Academy of Child and Adolescent Psychiatry (2008). Practice parameters for telepsychiatry with children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(12), 1468-1483.
8. University of British Columbia. (2012). Telehealth for mental health and substance use: Literature review.
9. University of Colorado. Room setup and equipment issues. *Telemental Health Guide.*
10. University of Colorado. Literature review. *Telemental Health Guide.*