Thompson Region
Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients

# Child and Youth Mental Health and Substance Use

# Thompson Region's Local Action Team

## Physician Information

July 2016

Thompson Region Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients

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# CRISIS RESPONSE at Family Physician Office

## (up to 18 years old)

## 1 Call for an Urgent Assessment:

- Call Child and Youth Mental Health: **Weekdays, 9:00 am – 12:00 pm, 1:00 pm – 4:00 pm**
  **North shore:** 250-554-5800 — 905 Southill Street, Kamloops
  **South shore:** 250-371-3648 — 1165 Battle Street, Kamloops
- To access initial assessment youth/family will visit CYMH (North Shore, or South Shore locations, depending on individual's residence). Following an initial assessment by the Clinician, the Clinician will determine whether referral to hospital is required. If they feel a referral to hospital is required, they will contact Parkview Child and Adolescent Mental Health or KMHART to discuss the case.
- If referral to hospital is required, the CYMH clinician, in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

## 2 Call for an Urgent Psychiatrist Assessment:

- Call **Parkview: 250-314-5629 — Weekdays: 8:00 am – 6:00 pm** to connect with child psychiatrist.
  Note: *Admission to Parkview for Crisis Stablization: Important for FP to be aware that the youth's care will be managed through Parkview until the crisis is over and they are transitioned to community resources for long term support.*

## 3 Send Patient to the Emergency Department/Parkview on Their Own:

- Physician to call Parkview to decide if patient should go directly to Emergency Department or sent directly to Parkview.
  Call **Parkview: 250-314-5629 — Weekdays: 8:00 am – 6:00 pm** to connect with child psychiatrist.
- Physician will prepare/collate information for family. Will send information electronically to the Emergency Department/Parkview. Ensuring that a warm handover occurs, where there is a conversation between the FP and Emergency Department Doctor/Parkview manager.
- Arrange transportation for patient and their family to the hospital in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

## 4 Call for Escort to Hospital Via RCMP:

- For non-emergency call: **250-828-3000**
- For emergency call **911**

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# KAMLOOPS
# CHILD AND YOUTH MENTAL HEALTH
# CRISIS RESPONSE PROTOCOL

**A Collaborative Approach between the Ministry for Children and Family Development, Interior Health, Aboriginal Child and Youth Mental Health Services, Community Partners and Family Physicians**

**PROTOCOL**
**DATE:**
**May 1, 2016**

## Context and Purpose

The purpose of this protocol is to promote safe and effective care for youth in crisis under 19 by ensuring timely and appropriate referrals are made to community service providers. This protocol outlines the role of various community partners in a crisis situation, identifies the appropriate agency to contact depending on the day and time. The protocol is also meant to ensure a collaborative approach to treatment planning considerations, discharge decisions, and referral guidelines to community-based treatment services for youth who are presenting at hospital in a crisis.

## Background

Under the Thompson Region Child and Youth Mental Health and Substance Use Local Action Team representatives from Interior Health Authority, Ministry for Children and Family Development (MCFD), and MCFD contracted Aboriginal Child and Youth Mental Health service providers (White Buffalo Aboriginal and Métis Health Society and Secwepemc Child and Family Services), Royal Canadian Mounted Police (RCMP), Family Physicians, and School District 73 met to review and update the child/youth mental health crisis response protocol for the Kamloops area. Original proposal was implemented on January 16, 2013.

## Key Partners

- Family Physicians
- Interior Health: Community Services, Parkview Child and Adolescence Mental Health Centre, Royal Inland Hospital
- Ministry for Children and Family Development, Child and Youth Mental Health
- Royal Canadian Mounted Police
- Secwepemc Child and Family Services
- School District 73
- White Buffalo Aboriginal and Métis Health Society
- Youth Forensics

## Review

This Crisis Response Protocol will be reviewed annually from the date of this protocol to ensure that it remains current and meets the needs of committee and community members.

# Crisis Response Protocol

## A. INITIAL COMMUNITY PRESENTATION

**School Setting –** when a child or youth presents with active suicide ideation in the school setting:

1. Trained school personnel will follow applicable School District 73 Protocols. See Appendix for Suicide Risk Assessment Protocol.

2. With the involvement of the students' parent/guardian, a safety plan will be collaboratively developed for the child/youth with a designated community resource (MCFD, Child and Youth Mental Health, Interior Health, Parkview Child and Adolescent Mental Health, Secwepemc Wellness, White Buffalo Wellness).

Note: Other SD 73 protocols that may apply in other crisis areas may include The VTRA (Violence Threat Risk Assessment) Protocol/Worrisome Behavior and the Critical Incident Response Plan.

### Child and Youth Mental Health (CYMH)

On **weekdays, between 9:00 am – 12:00 pm, 1:00 pm - 4:00 pm**, CYMH provides crisis response to child, youth, family or community referrals.

1. Following an initial suicide risk assessment by assigned Clinician on urgent response, the Clinician will determine whether referral to hospital is required.

2. If referral to hospital is required, the CYMH Team Leader or Clinician will contact Parkview Team Leader or Parkview On-Call Clinician to consult and provide some back ground information. The CYMH Clinician, in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

Note: If the child or youth is in the care of either the Ministry of Children and Family Development or Secwepemc Child and Family Services, the Social Worker may be required to transport the child or youth to Royal Inland Hospital for an assessment. ***If so, the Social Worker may transport the youth to the hospital and remain at the hospital until care is transferred to another health care clinician, the youth is admitted or discharged.***

## Aboriginal Child and Youth Mental Health (ACYMH)

### White Buffalo Aboriginal and Métis Health Society

1. The Aboriginal Child and Youth Mental Health Clinician, when available, will provide crisis response for clients with whom the Clinician holds open, active files.

2. Office Hours are 8:30 AM to 4:30 PM Monday to Friday, with a daily office closure between 12:00 PM and 1:00 PM. Please contact the agency's main land line: 250.554.1176.

3. When the Aboriginal Child and Youth Mental Health Clinician is unavailable to provide crisis response, please contact mainstream CYMH to provide assistance: 250.554.5800 (North Shore residents) and 250.371.3648 (South Shore residents).

### Secwepemc Child and Family Services (SCFS)

1. The Wellness Team Leader/Aboriginal Development Clinician, when available, provides crisis response in the community to those families who are actively involved with SCFS.

2. Parkview or Kamloops Mental Health Afterhours Response Team provides the crisis service in the ER and then collaborates with SCFS regarding follow-up services.

3. New referrals for Aboriginal families are accepted through the hospital and are seen as a priority, however if there is a capacity issue SCFS, Parkview and CYMH will collaborate and determine the most immediate service provision available.

## RCMP Involvement

### Community to Royal Inland Hospital Emergency Room:

1. A child/youth may be brought by the RCMP to Royal Inland Hospital (RIH) for an assessment if they meet the criteria for apprehension under section 28 (1) of the Mental Health Act (MHA).

2. Parkview will be called by ED physicians and will follow Pediatric Algorithm. See Appendix B for Algorithm.

3. RCMP staff will remain with the youth until assessment is completed by a physician and the youth is admitted or discharged.

4. RIH ED will prioritize the patient to support prompt discontinuation of RCMP attendance.

5. The RCMP member's decision to transport to RIH under the MHA is dependent on the seriousness of the offence that brought the youth to cells, consideration for public safety and that of the youth as well.

**In RCMP City Cells:**

**Weekdays, between 8:30am – 4:30 pm**

1. CYMH will respond to a youth presenting in crisis in RCMP City Cells.

2. If the RCMP are aware that the child or youth has an open file with Secwepemc Child and Family Services, the Secwepemc Aboriginal Development Clinician will be contacted to respond.

3. If the CYMH or Secwepemc Family Services Clinician determines the youth needs to be referred to the hospital, the RCMP will transport the client to RIH ED if the youth meets the criteria for apprehension under section 28 (1) of the MHA.

4. The RCMP member's decision to transport to RIH under the MHA is dependant on the seriousness of the offence that brought the youth to cells and considerations for public safety.

5. If the youth has a current probation order, the RCMP will contact the Probation Officer.

**After 4:30pm on Weekdays and Weekends**

1. Kamloops Mental Health Afterhours Response Team (KMHART) will assess in cells, unless an Aboriginal youth specifically requests the assessment be done by the Secwepemc Child and Family Services clinician depending on availability.

2. If KMHART determines that a child needs to be transported to hospital, RCMP will take the child or youth to hospital, if the youth meets the criteria for apprehension under section 28 (1) of the MHA, and remain with the youth until assessment is completed by a physician and the youth is admitted or discharged.

3. If the youth has a current probation order, the RCMP will contact the Probation Officer.

## B. INITIAL HOSPITAL PRESENTATION

Client presents at the RIH ER, ER provides triage and registration.[1] Please see Appendix B for RIH Pediatric Psychiatry Access and Flow Chart for details.

**Weekdays 8:30 am – 6:00 pm**

1. ER Physician personnel will contact Parkview (250-314-5629) if client is presenting in crisis.

2. Parkview will assess client in ER and consult with attending ER physician. Clinician review chart/ensures safety/able to engage in assessment.

3. Parkview will contact the agency to participate or consult if child is involved with Youth Forensic Services (YFS), CYMH, White Buffalo Aboriginal and Métis Health Society, or Secwepemc Child and Family Services, - if available.

4. ER personnel can involve the Aboriginal Patient Navigator (APN) at RIH to provide support to the patient, family and staff. APN services are available 7 days a week (except stat holidays) from 7:00 am – 4:00 pm.

5. ER physician consults with Parkview or to determine if the patient will be admitted to:
    a. Pediatric psychiatry unit
    b. Remain in secure room in ER
    c. Adult psychiatry unit with support

If not admitted to hospital, REFER TO P.7 “NO ADMISSION TO HOSPITAL” SECTION.

**Monday-Friday 6:00 pm -11:00 pm, Saturday-Sunday 8:00 am -10:00 pm**

1. ER physician contacts KMHART (250-377-0088) if client is presenting in crisis.

2. KMHART assess client presentation and consults with attending ER physician.

3. The ER physician completes assessment and will make the arrangements for admission, if appropriate.

[1] Screening for domestic violence and parental mental health issues, and coordinating referrals to appropriate services will be a consideration in future reviews of this protocol.

4. If discharge is recommended, and if appropriate, the ER physician will send a referral for Parkview for crisis stabilization.

## C. NO ADMISSION TO HOSPITAL AND TRANSITION TO COMMUNITY (i.e. Health care clinician completes assessment and recommends return to community):

Definition: Health Care Clinician: Any health care provider from acute that is responsible for the assessment, care and/or treatment of children/youth in Kamloops and noted in this protocol.

### Transition to Community Mental Health Services

1. The appropriate health care clinician will facilitate a transitional safety plan back into the community. ER Social Worker to support transition process if needed and appropriate.

2. Discharge summary and assessment record will be sent to Family Physicians/Pediatrician/Psychiatrist and appropriate agency for follow up.

3. The health care clinician consults with the parent/legal guardian and all appropriate community services and resources of the child/youth to create a safe and appropriate transition plan.

4. For those requiring crisis intervention, the health care clinician will refer to Parkview clinician.

5. If there are child protection concerns (as per Section 13 CFCSA), the ER personnel contacts MCFD – Child Protection, Secwepemc Child and Family Services – Child Protection, or After Hours 250-310-1234.

6. The health care clinician obtains the client's consent to refer to CYMH/ACYMH and, with consent, makes the referral within one business day (Monday to Friday).

   * If YFS is involved, the health care clinician will notify YFS prior to discharge (2).

7. CYMH receives referral. Referral will be triaged. CYMH completes an intake if required within two business days. If the client is Aboriginal, Parkview will contact the appropriate ACYMH service and co-ordinate a collaborative intake process.

8. Upon completion of an intake and acceptance of service, CYMH/ACYMH assigned clinician participates in the ongoing care and discharge planning with the client/guardian (note: Child might already be on CYMH/ACYMH caseload).

[2] YFS is not a voluntary mental health service – it is a Youth Court mandated mental health program.

**Admission to Parkview for Crisis Stabilization**

The Parkview Clinician will book a follow-up appointment through the Parkview Crisis Program and child/youth will be assigned a case manager. The youth's care will be managed through Parkview until the crisis is over and they are transitioned to community resources.

## D. CRISIS REPONSE AT FAMILY PHYSICIAN OFFICE

Following an initial assessment by Family Physician and child/youth is in a crisis and Physician may choose to:

### 1) Call for an urgent assessment:

- Call Child and Youth Mental Health**:** Weekdays, between 9:00 am – 12:00 pm, 1:00 pm - 4:00 pm (hours to be determined)
    - North shore: 250-554-5800
        - 905 Southill St. Kamloops
    - South shore:250-371-3648
        - 1165 Battle St. Kamloops

- To access initial assessment youth/family will visit CYMH (North Shore, or South Shore locations, depending on individual's residence). Following an initial assessment by the Clinician, the Clinician will determine whether referral to hospital is required. If they feel a referral to hospital is required, they will contact Parkview Child and Adolescent Mental Health, Monday to Friday 8:30 am -6:00 pm, (250-314-5629) and or KMHART to discuss the case.

- If referral to hospital is required, the CYMH clinician, in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

### 2) Call for an urgent psychiatrist assessment:

- Call Parkview (250-314-5629) Mon – Fri 8:00 am – 6:00 pm to connect with child psychiatrist.
- Or call KMHART (250-377-0088) Mon-Fri 6:00 pm -11:00 pm Sat-Sun 8:00 am -10:00 pm.

*Note: Admission to Parkview for Crisis Stabilization*
*Important for FP to be aware that the youth's care will be managed through Parkview until the crisis is over and they are transitioned to community resources for long term support.*

**3) Send Patient to the Emergency Department/Parkview on their own**

- Physician to call Parkview to decide if patient should go directly to Emergency Department or sent directly to Parkview.
- Physician will prepare/collate information for family. Will send information electronically to the Emergency Department/Parkview. Ensuring that a warm handover occurs, where there is a conversation between the FP and Emergency Department Doctor/Parkview manager.
- Arrange transportation for patient and their family to the hospital in consultation with parent/guardian, will make a decision regarding the transportation of the client to the hospital (i.e, parent/guardian or RCMP).

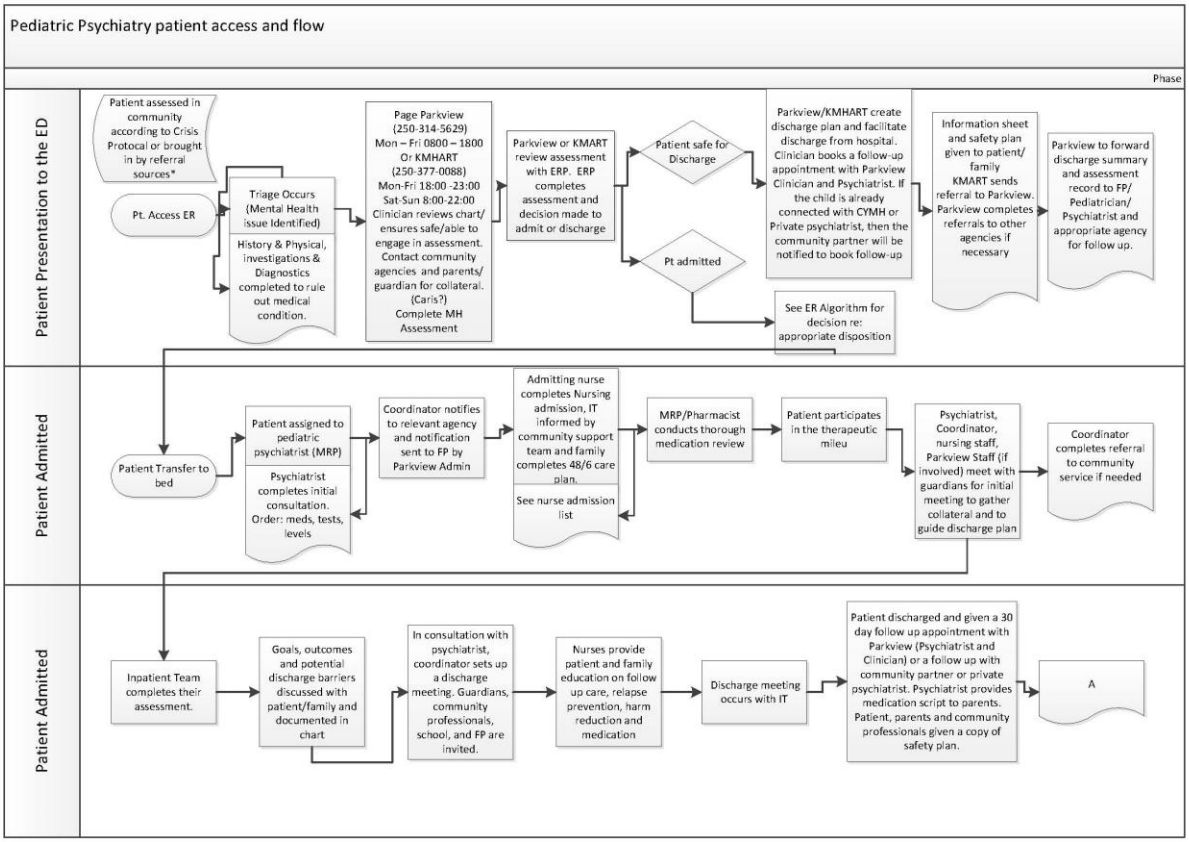
**4) Call for Escort To Hospital via RCMP**

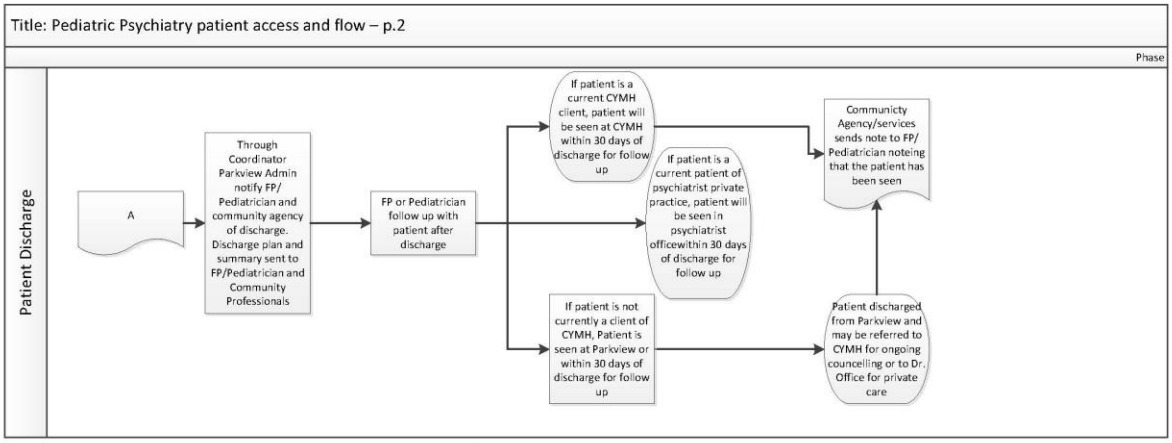
- For non-emergency call (250)-828-3000
- For emergency call 911

## Appendix A: Crisis Response Working Group Participants

| | |
|---|---|
| Family Physicians | |
| Interior Health Authority: Community Services, Parkview Child and Adolescence Mental Health Centre, Royal Inland Hospital | Raj Chahal, Rae Sampson, |
| Ministry for Children and Family Development, Child and Youth Mental Health | Manon LeBlanc<br>Katherine Gulley |
| Royal Canadian Mounted Police | Kim Lucas |
| Secwepemc Child and Family Services | Kathie McKinnon |
| School District 73 | Bill Hamblett |
| White Buffalo Aboriginal and Métis Health Society | Leilah Stella |
| Youth Forensics | Rob Brooks |

## Appendix B: RIH Pediatric Psychiatry Access and Flow Chart






## Nursing Admission

- Admission assessment (includes 48/6, HoNOS/MRR, MSE etc.)
- BPMH
- Rating scales
- Behavioural expectations and strategies
- Identifies pre-hospital functions,
- Supports in place and
- Informed consent
- MHA forms

## Elements of Discharge

- Patient must be safe to discharge home (discharged to an environment in which there are resources adequate to address the patients medical/psychiatric needs)
- All referrals, equipment, safety , social services, counselling, medications are coordinated and confirmed prior to discharge
- Medication ordered, medication reconciliation and /or medication review completed
- Education literature given to family/patient
- Receiving is arranged during day time hours (if possible)
- Care providers, Food and housing is confirmed
- Potential discharge barriers are resolved

## Referral Source:

- CYMH
- School
- Community agencies (ddmh, eating disorders)
- Self referral
- RCMP
- Forensics
- Aboriginal Agencies
- Expectation: TL or clinician contact parkview coordinator or on-call clinician for continuity of information.

## Glossary

- FP – Family Physician
- Family – Includes caregivers
- IT – Interdisciplinary team
- CYMH – Child and Youth Mental Health
- MRP – Most Responsible Physician
- ERP – Emergency Room Physician
- BPMH – Best Possible Medication History
- SU – Substance Use

## Appendix C: Suicide Protocol

**Protocol Agreement Between**
**School District #73, MCFD - Child and Youth Mental Health,** Interior **Health and FN Wellness Services**

**Responding to Students Who Present At Risk for Suicide**

**PURPOSE:**
The purpose of this protocol is threefold:

1. To ensure that students identified as potentially suicidal by school personnel are adequately screened and further help is provided in an effective and coordinated manner with community partners.
2. To clarify the roles and responsibilities of school personnel with respect to assisting students with suicidal thoughts.
3. To provide guidelines that aid in appropriate screening, response, and follow up to suicidal students and, if needed, to facilitate the transport of students to ensure their personal safety and immediate intervention.

**GUIDING PRINCIPLES:**

1. The safety and well-being of children and youth is always the primary consideration.
2. There are times children and youth may need protection from themselves.
3. All confidentiality is waived with a student's disclosure of suicidal thoughts, plans, or actions.
4. Information related to suicidal disclosure should be shared by all involved helpers and parents/guardians for the sole purpose of ensuring the life and safety of the student.
5. Collaboration and creation of a safeplan strategy between the child/youth and their resource team, which could include varied formal and informal supports such as school personnel, CYMH, Interior Health, FN Wellness Services, social workers and other community resources, family, etc. is a key factor in effectively reducing suicidal behavior.

**At a school site, only designated school personnel who have been instructed through the current SD73 Suicide Response Training are allowed to screen for the child/youth's suicide risk and contract an interim safeplan.**

**SD73 Suicide Response Trained personnel should assess any child or youth presenting with suicidal thoughts. If this is not possible, the child/youth is to be referred to the CYMH Urgent Response Clinician** (contact North or South shore depending on home address) **for immediate consultation regarding assessment and planning.**

## SD73 PROCEDURE FOR INTERVENING WITH SUICIDAL CHILDREN/YOUTH

**Always make certain that a suicidal student is never left alone.**

If a student presents with current suicidal thoughts or ideation, only SD73 Suicide Response trained personnel are to initiate this process with the child/youth present.

☐ School personnel must ensure the youth's legal guardian/parent/caregiver is contacted and that a responsible adult comes to the school site

☐ Complete the **Suicide Risk Screening and Interim Safeplan** document (best if done in collaboration with the student)

- With student's knowledge, ensure safeplan includes involvement of parent(s)/guardian(s)
- With student's knowledge, ensure safeplan includes informing principal or vice-principal
- With the student's and parent(s)/guardian(s) knowledge ensure that everyone knows the Suicide Risk Screening and Interim will be shared with involved community agencies

☐ With the Suicide Risk Screening and Interim Safeplan document completed and while still in the presence of the child/youth and parent/guardian, call the applicable agency

When you call, be sure to clearly state the purpose of your call**…"I am calling from the school district with a suicide risk screening. Could I please speak directly to your urgent response mental health clinician"**

1. If the child/youth is a ***current client*** of Parkview, Secwepemc or White Buffalo, your first point of contact will be that agency
2. Should contact with Parkview, Secwepemc or White Buffalo not occur, make contact with the respective CYMH Urgent Response Team (North Shore or South Shore Team)
3. All other Suicide Risk Screenings will be processed through CYMH North Shore or South Shore Urgent Response Teams

| | |
|---|---|
| **CYMH – North Shore residents** | **250.554.5800** |
| **CYMH – South Shore residents** | **250.371.3648** |
| **Parkview** | **250.314.2122 (pager)** |
| **Secwepemc (not between 12-1)** | **250.314.9669** |
| **White Buffalo (not between 12-1)** | **250.554.1176** |

An immediate discussion will occur with the designated community agency urgent response clinician regarding the information received through the screening and the best plan of action will be collaboratively determined

- ☐ Ensure child/youth and parent(s)/guardian(s) have been provided with all key contact phone numbers - current local resource card

- ☐ Only allow the child/youth to leave under the care of their parent(s)/guardian(s)/designated adult(s) who can/will ensure the safeplan will be followed

- ☐ Once a plan of action is determined and initiated, the completed Suicide Risk Screening and Interim Safeplans must be immediately faxed to involved agencies using the provided fax cover sheet

| | |
|---|---|
| **CYMH North Shore** | **250.554.5849 (fax)** |
| **CYMH South Shore** | **250.371.3611 (fax)** |
| **Parkview** | **250.314.2281 (fax)** |
| **Secwepemc** | **250.314.9609 (fax)** |
| **White Buffalo** | **250.554.1157 (fax)** |

- ☐ Within the school day fax a copy of the completed Suicide Risk Screening and Interim Safeplan to the School Board Office using the provided fax cover sheet

| | |
|---|---|
| **School Board Office** | **250.372.1183 (fax)** |

- ☐ Keep the initial/hard copy of the Suicide Risk Screening and Interim Safeplan as part of your restricted client documents (do not place any information in the student's permanent student file or on data systems)

If the child/youth cannot agree to a safeplan, *immediate* measures must be taken to ensure safety.

- ☐ Contact the appropriate community agency and one of two actions will occur

1. The child/youth will be transported to the appropriate agency for a comprehensive Suicide Risk Assessment.

or

2. The community agency will immediately consult Parkview staff to develop an emergency response plan. In this case the SD73 staff will follow the recommendations of the community agency/Parkview

When you call, be sure to clearly state the purpose of your call**…"I am calling from the school district with a suicide risk screening. Could I please speak to your urgent response mental health clinician"**

1. If the child/youth is a ***current client*** of Parkview, Secwepemc or White Buffalo, your first point of contact will be that agency.
2. Should contact with Parkview, Secwepemc or White Buffalo not occur, make contact with the respective CYMH Urgent Response Team (North Shore or South Shore team)
3. All other Suicide Risk Screenings will be processed through CYMH North Shore or South Shore Urgent Response Teams

| | |
|---|---|
| **CYMH – North Shore residents** | **250.554.5800** |
| **CYMH – South Shore residents** | **250.371.3648** |
| **Parkview** | **250.314.2122** **(pager)** |
| **Secwepemc (not between 12-1)** | **250.314.9669** |
| **White Buffalo (not between 12 - 1)** | **250.554.1176** |

Should the child/youth need transport to a community agency or ER and parents/guardians are not available, school district personnel can do so if deemed safe. If it is not safe to transport the child/youth to ER emergency services will need to be called (911). No matter the means of transport, SD73 personnel are to remain with the child/youth at the agency site or in ER until staff/parent/guardian assume responsibility

☐ Once a plan of action is determined and initiated, completed Suicide Risk Screening and Interim Safeplans must be immediately faxed to involved agencies

| | |
|---|---|
| **CYMH North Shore** | **250.554.5849 (fax)** |
| **CYMH South Shore** | **250.371.3611 (fax)** |
| **Parkview** | **250.314.2281 (fax)** |
| **Secwepemc** | **250.314.9609 (fax)** |
| **White Buffalo** | **250.554.1157 (fax)** |

☐ Within the school day fax a copy of the completed Suicide Risk Screening and Interim Safeplan to the School Board Office

| | |
|---|---|
| **School Board Office** | **250.372.1183 (fax)** |

☐ Keep the initial/hard copy of the Suicide Risk Screening and Interim Safeplan as part of your restricted client documents (do not place any information in the student's permanent student file or on data systems)

# FIVE-STEP REFERRAL PATHWAY:
## Children Birth-6
## Behavioural and Social-Emotional Development

DRAFT COPY

### Basic Needs
**1**

**Are your basic needs being met?**

- Housing – Ministry of Housing and Social Development, ASK Wellness
- Nutrition – community kitchens, Food Bank
- Safety – Ministry for Children and Family Development
- Other – community agencies

For more information, refer to **www.ewaykamloops.ca**

### Prevention & Promotion
**2**

**Do you need support in your role as a parent?**

**Are you connected with community supports?**

**Has your child had developmental screening?**

Possible referrals:
- Early Years Centre
- Strong Start Programs
- Drop-in groups
- Aboriginal agencies
- Free low-cost activities

### Early Intervention
**3**

**Do you have concerns about your child's social-emotional development and/or behaviour?**

Refer to:
1. Community Groups
2. IDP (0 to 3)
3. ICS Early Connections (3-5)
4. Aboriginal Early Childhood Agencies (0-5)
5. CTFRC Supported Child Development for children in daycare/preschool

### Identified Intervention
**4**

**Is your child able to communicate his/her needs?**

**Is your child sensory seeking or avoiding?**

**Is your child having difficulties with eating, dressing, toileting or sleeping?**

**Is your child having difficulties interacting with others?**

**Do you find your child difficult to parent?**

Refer to:
- Communication/Social Skills/Sensory Processing/Self-Care – CTFRC (OT and SLP), Interior Health (SLP)
- Parent-Child Relationship Difficulties – ICS (Early Connections) and CYMH
- Pediatricians (including sleep concerns)

### Treatment
**5**

**Does the child show symptoms of mental health disorder or neurological impairment?**

**Has the child witnessed or experienced trauma?**

Refer to:
- Mental health disorders (Anxiety, Depression, ADHD, ODD, PTSD): CYMH, child psychiatrist, private counselling, Secwepemc Child and Family Services
- Neurological Impairments: (FASD/ASD) – CTFRC, Insight Support Services, Behaviour Consultants
- Trauma/Abuse: CYMH, Sexual Assault Centre, YMCA (Children Who Witness Abuse), private counsellors, Secwepemc Child and Family Services

### Community Groups

1. **Circle of Security** – Early Years Centre
2. **Incredible Years** – Boys and Girls Club
3. **Nobody's Perfect** – Early Years Centre
4. **Pathways to Competence** – Interior Community Services

### Community Therapy Groups

1. **REST** – CTFRC
2. **Circle of Security** – Early Years Centre
3. **Worry Bugs** – School District
4. **Children Who Witness Abuse** – YMCA

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# Community groups information:

**Circle of security (COS)** is an attachment based 8 week parenting program for parents of children birth to 8 years of age that teaches parents how to better understand children's needs underneath their behaviours, reflect on their responses, and be more attuned and sensitive in their responses to children. Snacks and child-minding is provided. Registration is through the Early Years Centre.

**Incredible Years** is an attachment-focused parenting program for parents of children 4 to 8 years old that promotes children's social-emotional competence and reduces behaviour problems. Registration is through the Boys and Girls Club.

**Nobody's Perfect** is a free program for parents of children 0-5 years of age. Facilitators will cover a range of topics and guide discussions on concerns that parents may have. Food, child-minding and transportation are provided. Registration is through the Early Years Centre.

**Pathways to Competence** is a program for parents of children birth to 7 years of age that helps parents to understand and manage their child's behavior and take an active, positive role in guiding their children's social-emotional development. Registration is through Early Connections Program at Interior Community Services.

**Regulation of Emotions, Sensations and Thinking (REST)** is a 4 week group for parents of preschool to primary age children that offers parents tools to help their children be calmer and more focused, and to help them manage everyday emotions and activity level. Registration is through the Children's Therapy and Family Resource Centre. Cost: $30 total for all 4 groups.

**Worry Bugs** is a group for children in Kindergarten and grade 1 who have anxieties and worries. It includes a parent component. Children and parents learn cognitive behavioural strategies to manage anxiety. Registration is through the Henry Grube, SD 73.

# Contact Information for Referral Pathway

Aboriginal Agencies

- Interior Indian Friendship Society – 250-376-1617
- Lii Mischif Otipemisiwak Family and Community Services (Interior Metis) – 250-554-9486
- Secwepemc Child and Family Services – 250-314-9669
- White Buffalo Aboriginal Health Society and Resource Centre – 250-554-1176

ASK Wellness – 250-376-7558

Behaviour Consultants – see R.A.S.P. list through ACT-BC

Boys and Girls Club – 250-554-5437

Child and Youth Mental Health – 250-371-3648

Child Psychiatrist (Dr. Olabiyi) 778-471-5874

Children Who Witness Abuse Program – 250-376-7800

Children's Therapy and Family Resource Centre – 250-371-4100

Early Years Centre – 250-376-4771

Kamloops Food Bank – 250-376-2252

Insight Support Services – 250-554-0085

Interior Community Services (Early Connections Program) – 250-554-3134

Interior Health – Speech and Language Services – 250-851-7300

Kamloops Infant Development Society – 250-371-4140

Ministry of Children and Family Development

- South Shore – 250-371-3600
- North Shore – 250-554-5800

Ministry of Social Development and Social Innovation – 1-866-866-0800

School District 73 – 250-376-2266

Sexual Assault Centre – 250-372-0179

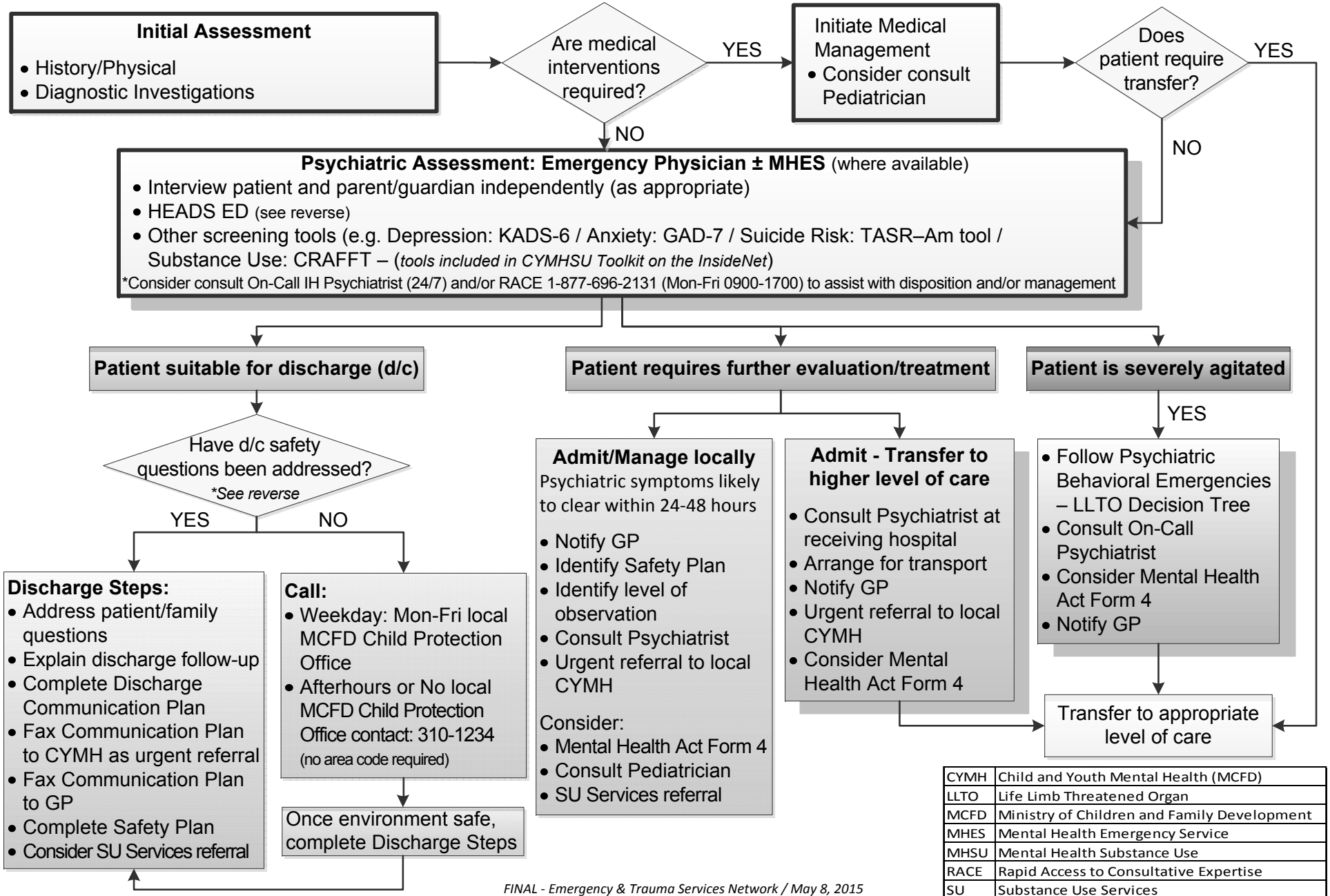
Strong Start Programs (SD 73) – 250-376-2266

Interior Health

# Child/Youth Mental Health and Substance Use (CYMHSU) Emergency Department Guidelines

Less than 19 years old

On-Call IH psychiatrist advice available 24/7 at referral facilities




| | |
|---|---|
| CYMH | Child and Youth Mental Health (MCFD) |
| LLTO | Life Limb Threatened Organ |
| MCFD | Ministry of Children and Family Development |
| MHES | Mental Health Emergency Service |
| MHSU | Mental Health Substance Use |
| RACE | Rapid Access to Consultative Expertise |
| SU | Substance Use Services |

# HEADS-ED Tool

| **The HEADS-ED©** is a tool that enables physicians to take a psychosocial history which aids in decisions regarding patient disposition. Seven variables are incorporated into the use of the HEADS-ED tool: **H**ome, **E**ducation, **A**ctivities and peers, **D**rugs and alcohol, **S**uicidality, **E**motions, behaviours and thought disturbance, **D**ischarge resources | **0**<br>**No action needed** | **1**<br>**Needs action but not immediate** | **2**<br>**Needs immediate action** |
|---|---|---|---|
| **H**ome<br>*Sample Questions*<br>*How does your family get along with each other?*<br>*Optional probes: Child Protection Issues, Family Violence* | o Supportive | o Conflicts | o Chaotic / dysfunctional |
| **E**ducation<br>*Sample Questions*<br>*How is your school attendance?*<br>*How are your grades?* | o On track | o Grades dropping / absenteeism | o Failing / not attending school |
| **A**ctivities & peers<br>*Sample Questions*<br>*What are your relationships like with your friends?*<br>*What do you do for fun?*<br>*Optional probe: Bullying* | o No change | o Reduced / peer conflicts | o Fully withdrawn / significant peer conflicts |
| **D**rugs & alcohol<br>*Sample Questions*<br>*How often are you using drugs or alcohol?* | o No or infrequent | o Occasional | o Frequent / daily |
| **S**uicidality<br>*Sample Questions*<br>*Do you have any thoughts of wanting to kill yourself?*<br>*How would you do it? When would you do it?*<br>*Have your thoughts of suicide changed?* | o No thoughts | o Ideation | o Plan or gesture |
| **E**motions, behaviours, thought disturbance<br>*Sample Questions*<br>*How have you been feeling lately?*<br>*Do you ever get any bad thoughts that you can't get out of your head?*<br>*Do you get into any trouble with parents, police, school etc.?* | o Mildly anxious / sad / acting out | o Moderately anxious / sad / acting out | o Significantly distressed / unable to function / out of control / bizarre thoughts |
| **D**ischarge resources<br>*Sample Questions*<br>*Do you have any help or are you waiting to receive help (counselling etc)?* | o Ongoing / well connected | o Some / not meeting needs | o None / on wait list / non-compliant |

**Discharge Safety Questions**

1. Does anyone at home experience a MH challenge that interferes with their ability to function?
2. Have drugs or alcohol been a problem for anyone in the home?
3. Do you have any concerns about going home today?
4. Is your parent/caregiver able to play a supportive role?
5. Does the patient have access to resources? (e.g. distraction activities, school, relationships)

***Any adverse responses to Discharge Safety questions should prompt consultation to MCFD for guidance***

The HEADS-ED is a screening tool and is not intended to replace clinical judgment

# Thompson Region Integrated Case Management Learnings

## Family Background:

**BIOLOGICAL DAD**
- Diagnosed with PTSD
- Biological son 3 years old
- Has sole custody

**STEP MOM**
- Diagnosed with PTSD
- Biological daughter 6 years old
- Pregnant

**3 YEAR OLD CHILD**
- Experienced trauma
- Behavioral issues

***Family is currently living in a home they cannot afford to rent because dad had to switch jobs.***

**BIOLOGICAL MOM**
- History of substance use
- Does not have custody of biological son

## Identification:

**PEDIATRICIAN**
- Identifies a complex family
- Works with family as three year old is having behavioral issues
- Approaches LAT to support an integrated case management session with family to develop integrated care plan

## The Team:

**PEDIATRICIAN**

**ADULT PSYCHIATRIST**
- Previously worked with parents

**SOCIAL WORKER**
Ministry of Child and Family Development

**2 FAMILY PHYSICIANS**
- Obstetrics
- GP

**EARLY CONNECTIONS**
Interior Community Services

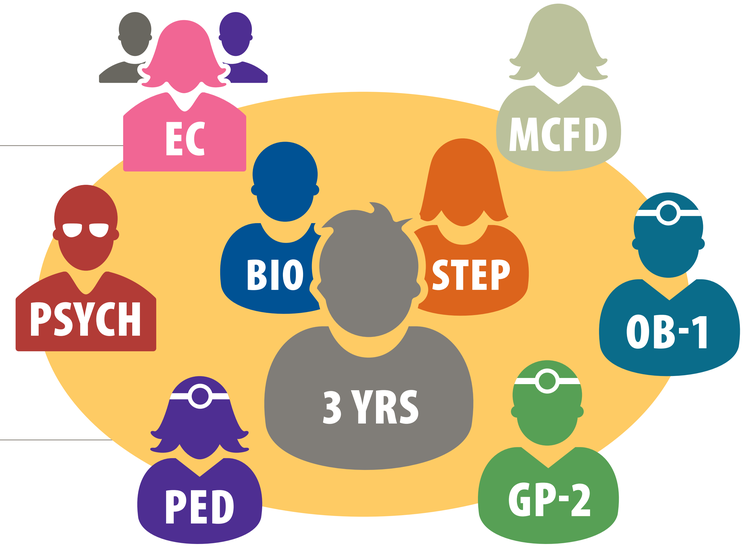
**BIO DAD, STEP MOM, 3 YR OLD**

**Case Management Definition:**

*A collaborative, client-driven process that supports the clients' achievement of safe, realistic and reasonable goals within a complex health, social and fiscal environments.*

(Canadian Standards for Practice for Case Management, 2009)

**GOAL:**
To provide coordinated wrap around care for a complex family in need




## Team Participated in an Integrated Case Management Session November 2015

| TEAM MEMBERS | ACTION ITEMS | COMPLETION DEC 2015 | COMPLETION JAN 2016 |
|---|---|---|---|
| Pediatrician | • Referral for IHCAN Assessment | ✔ | |
| | • Connect with Adult Psychiatry | ✔ | |
| | • Letter to support child care subsidy | ✔ | |
| | • Stay connected with GP (obstetrics) | ✔ | ✔ |
| | • Continue to support 3 year old | ✔ | ✔ |
| Adult Psychiatrist | • Continue to provide help for parents | | ✔ |
| Family Physician #1 | • Continue providing obstetrics care, pre and post delivery | ✔ | ✔ |
| Family Physician #2 | • Continue to support family | ✔ | ✔ |
| MCFD Social Worker | • Continue to support family | ✔ | ✔ |
| | • Register family for child care subsidy | ✘ | ✔ |
| Interior Community Services | • Regular connection: Weekly home visits with family | ✔ | ✔ |

**OVERALL ACTION ITEMS:**
- Pediatrician organized team of professional to support family
- Immediate short term plan in place
- Long term plan discussed with family

**CHALLENGES:**
- Lack of clarity around roles for case management
- Challenging referral process to services
- Lack of respect for collaborating between professionals
- Historical tensions between organizations
- Action items not being followed through in a timely manner

**STRENGTHS:**
- Initially increased relationships and trust between providers
- Increased relationships and trust between family and providers
- Health care providers being able to put a face to a name

## Family's Current Situation:

- Family moved and living in a home they can afford
- Decreased financial stress
- Increased energy, and commitment to working on adult relationships
- Biological mom is no longer abusing substances and has supervised visits with son
- All three parents taking Circle of Security training
- 3 year old no longer having nightmares

## Next Steps:

- Schedule another session with team and family
- Clearly outline roles and responsibilities of the professional team members to each other and to family

## Done Differently Next time:

- Clearly identifying the roles of each provider for the family, including the responsibilities of a case manager. The case manager could then follow up with the professionals ensuring action items were completed before the next meeting with the team.

## Learnings:

- Any person in the care of a complex family can take steps to pull an integrated case management session together
- The benefits of working together have the possibility to outweigh the cons
- To clearly define roles of each provider, including the responsibilities of a case manager. Case manager is critical for both the youth/family as well as the professionals

# Thompson Region: How to Start an Integrated Case Management Session

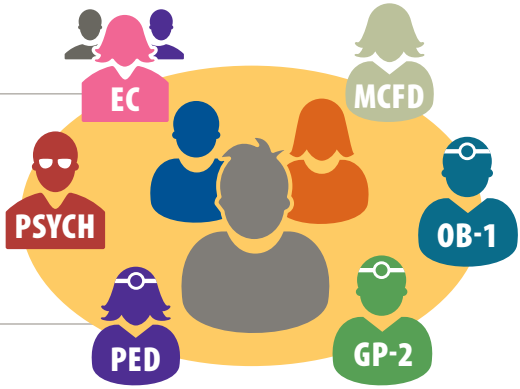
**Case Management Definition:**

*A collaborative, client-driven process that supports the clients' achievement of safe, realistic and reasonable goals within a complex health, social and fiscal environments.*

(Canadian Standards for Practice for Case Management, 2009)

## GOAL:

To provide coordinated wrap around care for a complex family in need




## An Integrated Case Management Process:

1. Identify a complex family
2. Assess family's readiness
3. Identify a case manager
4. Case manager approaches appropriate team members
5. Case manager organizes session with family and team
6. Family and team members come together
7. Co-develop wrap around care plan and assign action items
8. Case manager follows up to ensure action items are complete

Thompson Region Division of Family Practice
SharedCare Partners for Patients
BRITISH COLUMBIA
doctors of bc

BILLING CODES

SGP
Society of General Practitioners of BC

# Kamloops - Service Elements and Billing Codes for Mental Health Team

| PROVIDER | PATIENT SERVICES | | | | | PROVIDER SERVICES | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Planning Visit | Follow-up | | | | Specialist giving advice to GP | | | | GP requesting advice from Specialist | | | | GP providing advice to allied Provider | | | | GP providing advice to GP or Specialist | Case Conference | | |
| | In-per | In-per | Vid | Tel | Email | In-per | Vid | Tel | Email | In-per | Vid | Tel | Email | In-per | Vid | Tel | Email Fax | | In-per | Vid | Tel |
| Specialist | | | 10003 | 10003 | 10006 | 10002 | 10002 | 10002 | 10005 | | | | | | | | | | | 10004 | 10004 |
| GP-MRP | 14043 Mental Health Planning | | | 14076 | 14079 | | | | | | | 14077<br>14016<br>14018 | | | | 13005 if requested | 13005 if requested | | 14077 | 14077 | 14077 |
| GP-OB If in maternity network | | | | 14076 | | | | | | | | | | | | | | | 14077 | 14077 | 14077 |
| GP providing consultative expertise to NP about NP'S own patient | | | | | | | | | | | | | | | | 14019 | | | | | |
| GP with specialty training & working in focussed HA program for (e.g. addictions) | | | | 14023 | | | | | | | | | | | | 14022 | | 14021<br>14022 | | | |

** In order to access billing fee code hyperlinks, please log into the Society of General Practitioners of BC website at www.sgp.bc.ca* *June 2016*

For case conference with pediatrician, allied providers and GP- MRP and GP- OB 14077 billable for both the GP OB and the GP FP

- The GP OB could bill up to two sessions on the mom, and the other GP could bill up to 2 sessions on the child.
- If the GP is FP for both mom & dad it would not be appropriate to bill for both for concurrent times, but if meeting > than ½ hr, then the GP could bill the rest of the time as 14077 under the dad.
- If the GP MRP and GP OB case conference with each other about the same patient, each can bill 1 unit of 14077.

Follow up phone calls are 14076 (talking to patient) or 14077 (talking to allied provider or specialist ) or 13005 (talking to allied provider when requested), ensuring that the conversations meet the planning elements, time elements and other fee requirements for case conference (14077) or meet the fee requirement for brief advice when requested (13005).

If the patient has had a 14043 mental health planning visit billed by FP, then they can use 14079 to communicate with the patient. Depending on situation, 13005 could be used for some communications, if these patients are considered to be in "community care," and advice from an MSP defined allied provider caring for the patient was requested.

**All of the information above should be interpreted in the context of reading the FULL fee details in the SGP Simplified Guide to Fees at www.sgp.bc.ca or other billing reference.**

Thompson Local Action Team Bus Tour of
Child and Youth Mental Health and Substance Use Services

NATIONAL CHILD AND YOUTH MENTAL HEALTH WEEK • MAY 2–8, 2016

# Take a Journey With Us


**Stops** and **Location Tours**

1. **Henry Grube Education Centre**, 245 Kitchener Cres. (tour start & finish)
2. **John Tod Center Y/Boy and Girls Club of Kamloops,** 435 McGowan Ave.
3. **Interior Community Services**, 396 Tranquille Rd.
4. **White Buffalo Aboriginal and Metis Health Society**, 517A Tranquille Rd.
5. **Insight Support Services**, 624 Tranquille Rd.
6. **Lii Michif Otipemisiwak Family and Community Services**, 707 Tranquille Rd.
7. **Secwepemc Child and Family Services**, 2-726A Sydney Ave.
8. **Interior Community Services**, 765 Tranquille Rd.
9. **Chris Rose Therapy Centre for Autism**, 1111 Tranquille Rd.
10. **Child and Youth Mental Health North Shore**, 201–905 Southill St.
11. **Kamloops Aboriginal Friendship Society**, 2355 Parkcrest Ave.
12. **First Steps**, 750 Cottonwood Ave.
13. **Interior Community Services Youth Shelter**
14. **Kamloops Mental Health and Substance Use**, 126 King St.
15. **Kamloops Aboriginal Friendship Society**, 119 Palm St.
16. **Children Therapy & Family Resource Centre**, 801 McGill Rd.
17. **Youth Forensic Psychiatric Services**, #8 Tudor Village, 1315 Summit Dr.
18. **Phoenix Centre**, 922 Third Ave.
19. **Parkview Child and Adolescent Mental Health Centre,** 311 Columbia St.
20. **Interior Community Services Youth Outreach**, 408 Seymour St.
21. **Interior Community Services Safe Spaces**, 540 Seymour St.
22. **Canadian Mental Health Association Kamloops Branch**, 857 Seymour St.
23. **Child and Youth Mental Health South Shore**, 1165 Battle St.
24. **Kamloops Adult Mental Health & Substance Use**, 235 Lansdowne St.
25. **Kamloops Sexual Assault Counselling Centre**, 235 First Ave.

# Pediatric Psychiatry patient access and flow

Phase

## Patient Presentation to the ED

Patient assessed in community according to Crisis Protocal or brought in by referral sources*

Pt. Access ER

Triage Occurs (Mental Health issue Identified)

History & Physical, investigations & Diagnostics completed to rule out medical condition.

Page Parkview (250-314-5629) Mon – Fri 0800 – 1800 Or KMHART (250-377-0088) Mon-Fri 18:00 -23:00 Sat-Sun 8:00-22:00 Clinician reviews chart/ ensures safe/able to engage in assessment. Contact community agencies and parents/ guardian for collateral. (Caris?) Complete MH Assessment

Parkview or KMART review assessment with ERP. ERP completes assessment and decision made to admit or discharge

Patient safe for Discharge

Pt admitted

See ER Algorithm for decision re: appropriate disposition

Parkview/KMHART create discharge plan and facilitate discharge from hospital. Clinician books a follow-up appointment with Parkview Clinician and Psychiatrist. If the child is already connected with CYMH or Private psychiatrist, then the community partner will be notified to book follow-up

Information sheet and safety plan given to patient/ family KMART sends referral to Parkview. Parkview completes referrals to other agencies if necessary

Parkview to forward discharge summary and assessment record to FP/ Pediatrician/ Psychiatrist and appropriate agency for follow up.

## Patient Admitted

Patient Transfer to bed

Patient assigned to pediatric psychiatrist (MRP)

Psychiatrist completes initial consultation. Order: meds, tests, levels

Coordinator notifies to relevant agency and notification sent to FP by Parkview Admin

Admitting nurse completes Nursing admission, IT informed by community support team and family completes 48/6 care plan.

See nurse admission list

MRP/Pharmacist conducts thorough medication review

Patient participates in the therapeutic mileu

Psychiatrist, Coordinator, nursing staff, Parkview Staff (if involved) meet with guardians for initial meeting to gather collateral and to guide discharge plan

Coordinator completes referral to community service if needed

## Patient Admitted

Inpatient Team completes their assessment.

Goals, outcomes and potential discharge barriers discussed with patient/family and documented in chart

In consultation with psychiatrist, coordinator sets up a discharge meeting. Guardians, community professionals, school, and FP are invited.

Nurses provide patient and family education on follow up care, relapse prevention, harm reduction and medication

Discharge meeting occurs with IT

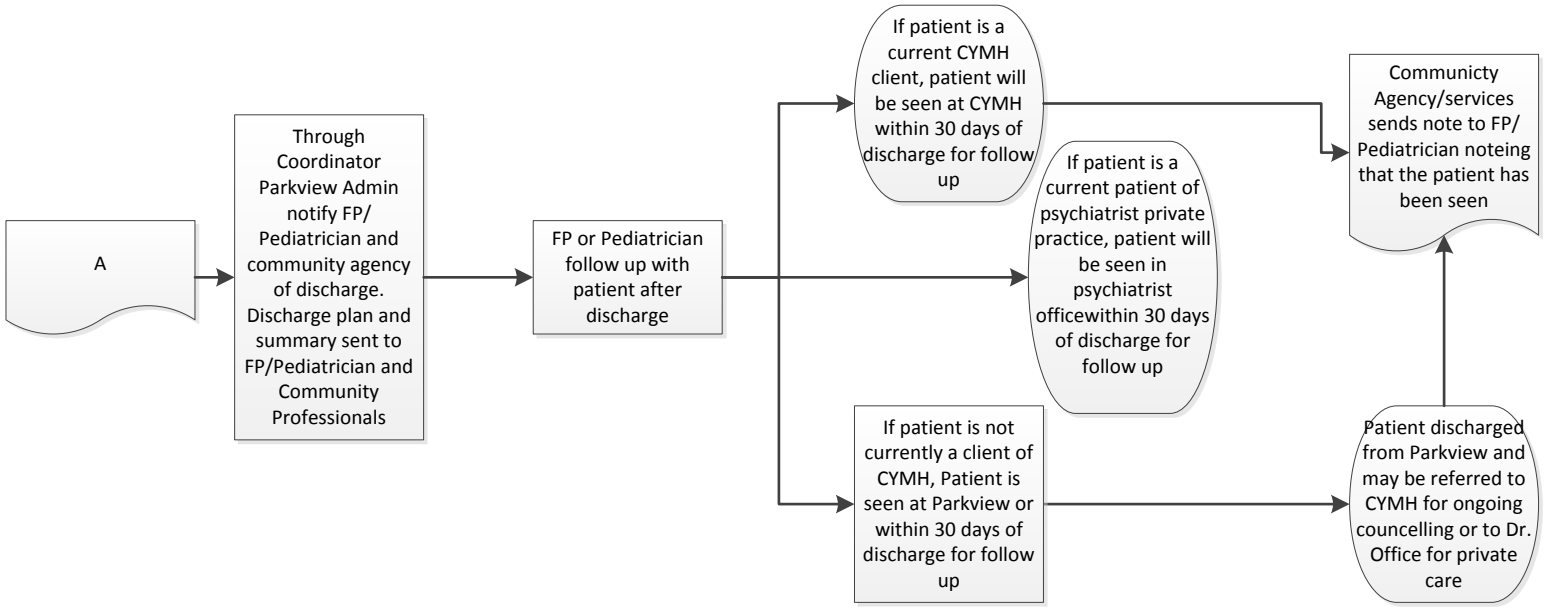
Patient discharged and given a 30 day follow up appointment with Parkview (Psychiatrist and Clinician) or a follow up with community partner or private psychiatrist. Psychiatrist provides medication script to parents. Patient, parents and community professionals given a copy of safety plan.

A

# Title: Pediatric Psychiatry patient access and flow – p.2

Phase

Patient Discharge




## Nursing Admission

- Admission assessment (includes 48/6, HoNOS/MRR, MSE etc.)
- BPMH
- Rating scales
- Behavioural expectations and strategies
- Identifies pre-hospital functions,
- Supports in place and
- Informed consent
- MHA forms

## Elements of Discharge

- Patient must be safe to discharge home (discharged to an environment in which there are resources adequate to address the patients medical/psychiatric needs)
- All referrals, equipment, safety , social services, counselling, medications are coordinated and confirmed prior to discharge
- Medication ordered, medication reconciliation and /or medication review completed
- Education literature given to family/patient
- Receiving is arranged during day time hours (if possible)
- Care providers, Food and housing is confirmed
- Potential discharge barriers are resolved

## Referral Source:

- CYMH
- School
- Community agencies (ddmh, eating disordes)
- Self referral
- RCMP
- Forensics
- Aboriginal Agencies
- Expectation: TL or clinician contact parkview coordinator or on-call clinician for continuity of information.

## Glossary

- FP – Family Physician
- Family – Includes caregivers
- IT – Interdisciplinary team
- CYMH – Child and Youth Mental Health
- MRP – Most Responsible Physician
- ERP – Emergency Room Physician
- BPMH – Best Possible Medication History
- SU – Substance Use

# BEST PRACTICES FOR SERVICE PROVIDERS: PRIVACY AND INFORMATION SHARING

Canadian Mental Health Association
British Columbia
*Mental health for all*

While the legislation provides the absolute rules, best practices can be useful supplemental information in situations where judgment and interpretation is required. Best practices can also be useful to help shape procedures, guidelines, policies or standards at the organizational or professional level. In the absence of guidelines to support a deeper understanding of the legislation, service providers may default to interpret application of the legislation in its strictest form.

The following principles are derived from best practices and recommendations from a scan of relevant Canadian and international literature.

## Knowledge

- Understand and comply with the law.
- Know standards and ethical codes of professional bodies and the information-sharing policies and procedures of your organization.
- Policies should be clear, practical and accessible and be accompanied by practical guidance and education. This should fit within systems, which help ensure that rules are followed.
- Know whom to approach within your organization or area for guidance.
- Know your responsibilities with respect to privacy and information sharing.
- Differentiate between general and personal information. For example, it may be possible to still give general information without consent if diagnosis is known and information on available supports, services, or programs—this is a judgment call on a case-by-case basis.

## Responsibility

- Treat personal information confidentially and respectfully.
- In addition to the responsibility to protect patient privacy, there is also a responsibility to share information in certain cases. Know when information must be disclosed. Do not let privacy get in the way of health or safety.
- Keep within your scope of practice.
- Exercise sound clinical judgment and consult with colleagues or supervisors when in doubt.

## Purpose

- Identify the purpose of and rationale for sharing information. The purpose should be broad enough to capture everything you intend to do, but not so broad that it is meaningless.
- Access to personal confidential data should be on a strict need-to-know basis, meaning that essential information is shared, but nothing more. In other words, information should be shared for the purpose of providing safe and effective care.
- Use caution when disclosing information that is not for the purposes of providing care (the purpose for which the information was collected)—using personal information for secondary purposes requires consent.

## Communication

- Maintain open communication between individuals, family/families, and service providers.
- Communicate with individuals about how their information may be collected, used and disclosed, and inform them of their right to request their own information.
- Encourage individuals to understand the value of collaboration and information sharing between service providers.
- Be honest and up front with individuals and their families about limits to privacy and confidentiality.
- Maintain open communication at key milestones for individuals, including service entry, treatment planning, team review, exit planning and relapse response.

## Consent

- Seek the consent of the individual to share their information, and, with some exceptions, respect an individual's right to object.
- Use plain language to ensure the individual understands information sharing.
- Explain the purpose and benefits of sharing information.
- Let the individual know they can withdraw consent at any time.
- Document verbal consent in the individual's file, specific to named agencies rather than staff members.
- Seek consent early on in the care relationship (e.g., at intake) and have a conversation about how their information may be used, who should be involved in their care (e.g., family and other service providers), and document the decisions made. Consent should be sought when it is easy to explain what information is being collected, why, how it will be used and to whom it may be disclosed.
- Differentiate between specific consent (sharing a particular piece of information) and general consent (may share all personal or care information with family).
- Where appropriate, review consent at key milestones (e.g., release planning) and on an ongoing basis.
- For best practices on making disclosure decisions situations when there is no consent, see Appendix 4.
- For youth, seek consent of a parent or guardian, unless the youth is able to consent themselves (Infants Act, section 17).
- If an individual is unable to provide consent, make an attempt to seek consent when their mental state has improved.
- If an individual doesn't want information shared with family, have a conversation to understand their concerns. Ask: are they refusing consent because they are concerned about a particularly personal or sensitive piece of information? Without a discussion initiated by the service provider, "no consent" may be recorded and an opportunity may be missed.
- Revisit consent on an ongoing basis.
- Seeking consent for disclosure or being open about how an individuals' information may be shared, even when consent is not required, can help build trust.
- Conversations about who to share information with (e.g., seeking consent from the individual to share with family) can help encourage individuals to build their support network.

*This project has been initiated and funded by the Province of British Columbia*

BRITISH COLUMBIA

# Supporting Our Families: **Family Navigator**

**Are you caring for a child/youth or dependent adult up to age 25? Are you feeling overwhelmed as a result of mental health and/or substance use issues of your loved one?**

CMHA's Interior Region Family Navigator works collaboratively with partners **in your community** to help Parents/Caregivers access relevant programs and services based on their individual needs.

**Contact the Interior Region Family Navigator to Get Started:**

**Telephone:** 1-844-234-6663
**Email:** family.navigator@cmha.bc.ca
**www.BCFamilyNavigator.com**

Canadian Mental Health Association
*Mental health for all*

With support from:
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With support from:
Interior Health

# SPECIALIST PRACTICE MODULES (SPM)

BC Mental Health and Substance Use Services received two-year funding from the Doctors of BC and Ministry of Health's Shared Care Committee, with a contribution from the Specialist Services Committee, to support the development of enhanced learning modules in child and adolescent psychiatry for paediatricians and general psychiatrists. The Specialist Practice Modules will serve the whole province, with a special focus on rural and remote areas with limited access to child psychiatry services. CME credits for module completion will be available.

## Project Timeline:

**Year 1** (April 2014-March 2015)

- The focus for Year 1 was on gathering the background information to inform the development of the resource and the development of the draft content for the modules. Master clinician videos were filmed in Year 1.

**Year 2** (April 2015-March 2016)

- Year 2 is focused on resource development, including finalizing the resource content and creation of the online learning environment, dissemination and evaluation. The modules will be pilot tested in the winter of 2015 prior to final rollout in 2016.

## Module Topics:

1) **Anxiety Disorders**
   - Generalized Anxiety
   - Social Anxiety
   - Separation Anxiety
   - Panic Disorder
   - Selective Mutism
2) **Attachment Disorders**
   - Attachment Disorder/behaviour
3) **Building Rapport with Children and Youth**
4) **Depressive & Mood Disorders**
   - Depression (Major and Minor)
   - Dysthymia
   - Disruptive Dysregulation
   - Bi-polar Disorder
5) **Disruptive, Impulse-Control & Conduct Disorders**
   - Oppositional Defiant Disorder
   - Conduct Disorder
6) **Emergent Presentations**
   - Self-Harm/Dysregulation
   - Suicide Risk Assessment
7) **Feeding & Eating Disorders**
   - Eating Disorders
8) **Neurodevelopmental Disorders**
   - ADHD
   - Tic Disorders
9) **Obsessive Compulsive & Related Disorders**
   - OCD
10) **Psychotic Disorders**
   - Early Psychosis
11) **Sexual and Gender Identity**
12) **Sleep Disorders**
13) **Somatization Disorders**
14) **Substance Related & Addictive Disorders**
   - Substance Use Disorders
   - Concurrent Disorders
15) **Trauma & Stressor Related Disorders**
   - PTSD
   - Other Trauma (Adverse Child Experience)

**For any questions about the Specialist Practice Modules please contact Meagan Colenutt at**
**meagan.colenutt@bcmhs.bc.ca**

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
An agency of the Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

BRITISH COLUMBIA

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Better. Together.

SharedCare
Partners for Patients