Guide, Standards, Benchmarks & Literature Review:

Introduction

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There will be ongoing updates in response to feedback and new research. Future updates and a brief self-audit form will be available for review at www.oncaips.ca

EXECUTIVE SUMMARY

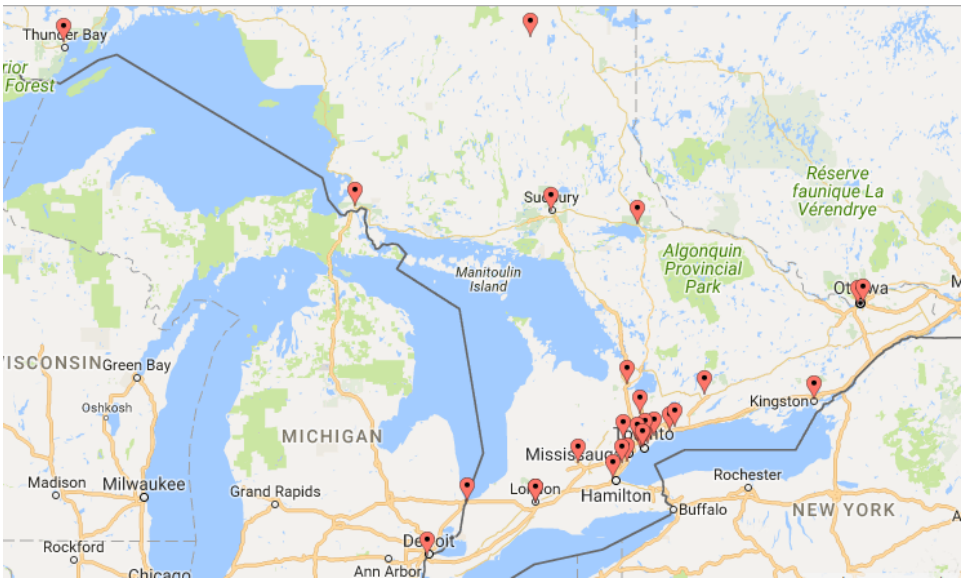
The provision of inpatient care is both rewarding and challenging. It is very rewarding to be part of a crisis unit that is in high demand and that provides rapid safety, reduction of stress, and stabilization for children, adolescents, and their families. It is similarly rewarding to be part of a treatment unit that provides some of the most specialized and intensive types of treatment in a safe environment. The work, however, can also be challenging. Doing good work depends upon keeping up with the literature, evaluating process and outcomes, and being open to learning and collaborating with other units and services. The Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS) evolved out of the recognition that Ontario inpatient unit providers needed to reduce their isolation, increase collaboration, standardize common best practices, and develop new ways to meet new and recurring challenges. The present *Ontario Child & Adolescent Inpatient Psychiatry Services: Guide, Standards, Benchmarks & Literature Review* is one small part of the ONCAIPS effort to help units evaluate their performances and align best practices.

Some of the information provided in the ONCAIPS *Guide* is based upon information gathered from ONCAIPS surveys of Ontario units. These surveys indicate that Ontario inpatient care is predominantly a crisis one, with a few important treatment units. Crisis units receive their patients from Emergency Departments of hospitals and provide brief assessment and stabilization primarily of suicide risk, whereas treatment units focus on providing somewhat longer stays for treatment. The lack of specialized units focusing upon families, children, and certain subspecialty diagnostic groups has been noted to be problematic at times.

The challenges involved in meeting increasing demands for services have increased over time. Increase in demand provincially has outpaced increases in the resources of crisis units leading to occasional bed blockages. These blockages cause delays in admissions and transfers of patients away from their home community to units with open beds. Problems of surging demand are compounded by community service gaps and insufficient community-hospital service integration. Lack of integration is reflected in a lack of a common plan and continuity of care across services for the patient. Fiscal restraints and reductions have caused additional concerns by eroding the ability of units to provide the interdisciplinary diversity and the previously high degree of specialization the public had come to expect from psychiatric child and adolescent inpatient care. Staff are increasingly likely to be part time and contracted, and not specialized for child and adolescent inpatient care. The relative absence of provincial and national oversight mechanisms and of applied research makes it difficult to know if these trends are cost-effective or helpful.

With a view to promoting improved oversight, protection of best practices, and development of new and more effective inpatient care, ONCAIPS has elaborated its 2015 Standards and published the following *Guide, Standards, Benchmarks & Literature Review* on its website (www.oncaips.ca). The plan is to release the *Guide* in sections in 2020. We encourage feedback and involvement in the work of further developing the *Guide.*

ONCAIPS MEMBER UNITS (2020)



Bluewater Health	Sarnia
Centre for Addictions and Mental Health	Toronto
Children's Hospital of Eastern Ontario	Ottawa
Grand River Hospital	Kitchener
Health Sciences North	Sudbury
Humber River Regional Hospital	Toronto
Kingston General Hospital	Kingston
Lakeridge Health Oshawa	Oshawa
London Health Sciences Centre- Children's Hospital	London
Maryvale (Windsor Regional Hospital)	Windsor
McMaster Children's Hospital	Hamilton
Michael Garron Hospital/Toronto East Health Network	Toronto
North Bay Regional Health Centre	North Bay
North York General Hospital	Toronto
Oakville Trafalgar Memorial Hospital	Oakville
Ontario Shores Centre for Mental Health Sciences	Whitby
Peterborough Regional Health Centre	Peterborough
Regional Mental Health Care	London
Rouge Valley Centenary Hospital	Scarborough
Royal Victoria Hospital	Barrie
Royal Ottawa Mental Health Centre	Ottawa
Sault Area Hospital	Sault Ste. Marie
Sick Kids	Toronto
Southlake Regional Health Centre	Newmarket
St. Joseph's Health Centre	Toronto
Sunnybrook Health Sciences Centre	Toronto
Syl Apps Youth Centre	Oakville
Thunder Bay Regional Health Sciences Centre	Thunder Bay
Timmins and District Hospital	Timmins
William Osler Health Centre	Brampton

INTRODUCTION

In November 2006, existing inpatient units with dedicated mental health beds for children and adolescents in Ontario came together to form the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS). Like many similar networks, ONCAIPS evolved out of a communal interest and willingness to engage in informal and flexible specialized knowledge exchange and translation (Short et al., 2014). The founding members recognized that child and adolescent inpatient care is a distinct service type, and that successful operation requires specialized knowledge exchange beyond what could be fully provided by existing structures such as meetings of Schedule 1 facilities, academic settings, general hospitals, discipline-specific groups, or broader-based accreditation mechanisms. The Network started with questions like "What services should my unit provide? How should our unit maintain safety? and, How should it be staffed?" and proceeded to questions like "What services should inpatient care provide? What is being provided provincially? How should units maintain safety? and, What should be the minimal staffing and process standards for similar types of units provincially?"

Driven by a need to know how services were being provided and how services should best be provided in Ontario, ONCAIPS started a journey of inquiry, knowledge exchange, and standards development. Since its inception, ONCAIPS has grown in size and scope and has supported applied clinical child and adolescent inpatient research and child and adolescent mental health services reform. ONCAIPS has also supported advocacy for the resourcing of a complete system of mental health care, implementation of best practices and increased responsibility for appropriate and cost-efficient service use. As of 2019, ONCAIPS included all general child and adolescent inpatient psychiatry units in Ontario (i.e., 29 units not restricted to admissions for a specific diagnosis or problem type such as eating disorders) and one specialized unit for concurrent disorders. It has since opened up invitations for affiliate membership to other types of settings (e.g., eating disorders units, residential treatment settings).

ONCAIPS developed the first provincial directory of child and adolescent inpatient mental health programs in Ontario which provides details about locations and characteristics of the units. ONCAIPS also utilizes surveys and available data to describe the changing state of inpatient care, and has a website (www.oncaips.ca) which contains the directory and opportunities through a Google Group for member units to discuss and problem solve as a community of practice. ONCAIPS continues to facilitate a yearly networking conference which rotates across member sites. Results of surveys, standards, and literature review are disseminated and discussed at the ONCAIPS conference every year and are available to members on the ONCAIPS website.

ONCAIPS surveys have consistently supported the view that inpatient units are in high demand, and that they provide an important component in the broader mental health services system, particularly for adolescents screened to be at risk for suicide. But surveys have also found significant undesirable variation in access, resourcing, and service quality across units in Ontario (Greenham & Persi, 2014). The finding of significant variation among units in their resources, quality of care, and reported outcomes in Ontario resembles findings in other jurisdictions such as the UK (O'Herlihy et al, 2001) and Norway (Hansen-Bauer et al., 2011). Understanding that variation from best practice is not uncommon prompted the ONCAIPS membership to look to standards as having the potential to help reduce undesirable variation. There are similar disparities internationally and needs to reduce geographical inequalities, improve standardization of best practices, and advocate for improved funding to support best staffing models and practices (Tulloch et al., 2008). Considering the findings of inconsistencies and underdeveloped aspects of best practice in Ontario, the ONCAIPS membership at the 2013 annual meeting set out to

develop a common set of inpatient standards. The intent of standards was to identify aspirational and potentially achievable targets for Ontario units.

The present edition of the ONCAIPS *Guide* is an expanded 2020 revision of the initial 2015 Standards, and represents a commitment ONCAIPS made to review and improve standards and supporting literature every several years. The 2020 Standards include more detailed indicators and the beginning of benchmarking by including typical average and median performance benchmarks at the provincial and, at times, international levels when these are available. The 2020 Standards continue to focus on standards not elsewhere available, those available elsewhere but insufficiently detailed, and those of greatest interest and concern for member sites. ONCAIPS has sought to avoid duplicating existing standards. Nevertheless, the ONCAIPS Standards have made the effort to be consistent with broader hospital and accreditation standards as well as common organizational expectations and efforts to use existing standards and indicators for specific components of care when these are available.

ONCAIPS also began to appreciate the impact of ongoing changes in the managers, clinicians and national leadership advocating for mental health reform. These changes created some risk that the history and needs for change would be forgotten or have to be relearned by new arrivals to inpatient and mental health care. It was also possible that ONCAIPS itself might not be able to sustain itself in the longer term. Given these concerns, the decision was made to develop a more comprehensive guide that included recommended standards and literature review to inform future providers, many of whom could be new to the inpatient service field.

HISTORY OF STANDARDS DEVELOPMENT

ONCAIPS was inspired, and to a significant extent guided, by the work on standards completed by the Quality Network for Inpatient Care (QNIC), an initiative supported by the Centre for Quality and Improvement (CCQI) of the Royal College of Psychiatrists in the UK. The QNIC UK standards were the first comprehensive standards for general child and adolescent inpatient units, and their revisions continue to provide a model for standardization and audit (Thompson & Clarke, 2016). ONCAIPS continues to consider and refer to these and other standards whenever appropriate with a view to best fit for Ontario's inpatient needs.

QNIC has identified three different levels of standards referred to as Type 1, 2, or 3. Type 1 standards are considered essential as they have the potential to cause significant threat to patient safety, rights or dignity and/or breaches to the law. Type 2 are standards that an inpatient unit should be expected to meet, and Type 3 are standards that an excellent inpatient unit should meet or standards that are not the direct responsibility of the inpatient unit. ONCAIPS is considering eventually utilizing different levels for Ontario standards in future revision and enhancement.

The QNIC standards were not simply adopted by ONCAIPS as published in the UK for several reasons. First, Ontario inpatient units differ from those in the UK. Ontario units operate under different legislation, tend to have more of a crisis and less of a treatment focus, have large catchment areas with more thinly dispersed and remote populations, and include different cultural and language groups. Second, ONCAIPS wanted to include the literature alongside the standards for improved transparency, comment, and criticism (see Figure 1). There was no literature review with the QNIC standards. Third, ONCAIPS wanted to link standards to benchmark indicators using, not only quantitative data as QNIC does, but also qualitative data. Fourth, the process of collaboration among Ontario units in the process of developing standards

was judged to be essential for engagement and support, shared learning, and implementation. Nevertheless, ONCAIPS continues to be inspired by the same vision as QNIC which is of a psychiatric clinical network in a comprehensive system of care, both guided by unifying clinical standards that include a set for inpatient units (e.g., Scottish Executive, 2005).

OBJECTIVES OF THE STANDARDS

- Promote critical discussion and review
- Help guide existing and developing inpatient units
- Provide a means of self-audit
- Integrate and disseminate inpatient literature and research information
- Promote safety, rights, and dignity for children and adolescents and their parents/caregivers
- Promote evidence supported best practices
- Support development of a complete system of care, service integration, sharing of resources, and continuity of care across agencies, providers, and sectors
- Protect appropriate resourcing of inpatient care
- Encourage development of capacity for evaluation of effectiveness and efficiency
- Disseminate information about differing types of inpatient services, and their access, utilization, and outcomes
- Guide the ONCAIPS benchmarking survey
- Allow comparisons to provincial, international, and ideal benchmarks when these are available
- Encourage research

GUIDING PRINCIPLES

The ONCAIPS consensus was that standards should be:

- Specific (i.e., specifically for child and adolescent inpatient psychiatry services)
- Applicable provincially and eventually nationally
- Common & Shared (i.e., a standard that applies to all inpatient settings)
- Distinct (i.e., enhance and not simply duplicate existing Hospital, Accreditation Canada, professional regulatory bodies, etc.)

- Relevant (i.e., standards which ONCAIPS and units felt were important for their unit to attend to and not as well addressed elsewhere)
- Acceptable (i.e., likely to be acceptable to the general)
- Succinct
- Supported by Evidence (i.e., supported by the best available research evidence ranging from expert observation, descriptive surveys, and opinion to randomized controlled trials when these were available)
- Measurable (i.e., capable of being quantified or measured in a way that can lead to quality improvement)
- Sustainable (i.e., able to be tracked and likely to continue to be relevant across time)
- Flexible & Dynamic (i.e., able to change and improve in response to research and practice changes)
- Inspirational & Aspirational
- Collaborative (i.e., not critical of certain units or able to be used to foster competitive advantage of one unit at the expense of another)
- Realistic (i.e., considering funding, public opinion, and other constraints)

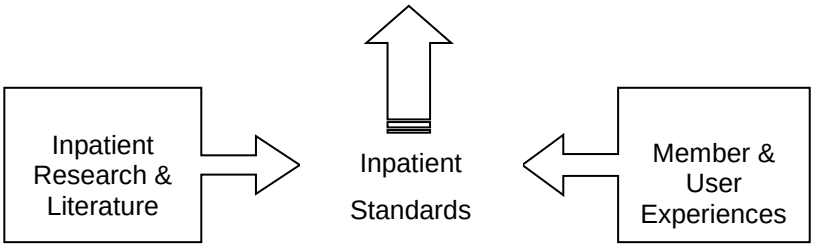
PROCESS

The need for the development of provincial standards was recognized and supported by the consensus of all member inpatient units at the 2013 ONCAIPS Annual Meeting, and a Benchmarking and Standards Development Survey working group was convened.

The working group made the decision to position the ONCAIPS standards as voluntary guiding ones, rather than as prescriptive demands. The working group sent out e-mails and promoted discussions intended to engage the entire provincial inpatient community of practice in developing, reviewing and improving standards as a medium for improving care. The working group integrated information from the research, literature reviews, and standards from other parts of the world with their professional experiences to help inform the decision-making process. Ten core standards were initially identified, and a literature review was included. These standards were reviewed at the 2014 ONCAIPS Annual Meeting where the membership offered recommendations for improvement which were integrated into the final 2015 Standards.

From March to June 2015, the standards began to be aligned with the annual benchmarking survey. ONCAIPS appreciated that a cycle of standards definition and performance benchmarking needed to recur at least every several years to serve as a focus of review, discussion, and improvements at the ONCAIPS Annual Meeting.

Figure 1: Integration of Evidence



The hope is that standards for all mental health services for all age groups, and not just child and adolescent inpatient care, will be developed collaboratively at provincial, national, and international levels, and that the present standards can become a small part of this collaboration. Mental health standards, which include child and adolescent inpatient care, need to be aligned and integrated with standards for all mental health services if performance is to be better monitored and integrated around common best evidence-based practices (e.g., Child and Adolescent Mental Health Performance Standards developed by the Hawaii Department of Health's Child and Adolescent Mental Health Division, 2012). ONCAIPS continues to look for opportunities to collaborate on common standards for residential treatment services, therapeutic group homes, and outpatient mental health services. Collaboration on common standards would encourage common best practices and help reduce 'silo' type thinking and unhelpful practice variations that are part of current mental health services. ONCAIPS is part of the Canadian Child and Adolescent Psychiatry Inpatient Network (CCAPINet) which may be a group that can help expand the provincial initiative to a national one.

INTENDED APPLICATION OF THE STANDARDS

The present standards are intended to guide, and the literature to help inform, all inpatient units in Ontario. It is hoped in the future there will be specialized additions to the standards. These more specialized additions will address provision of care beyond a generic level. An example is the UK draft standards for its eating disorders services which are a specialized companion to the UK generic standards. The standards described in the Quality Network for Eating Disorders & Quality Network for Inpatient Care in the UK (Thompson & Clarke, 2016) and the integrated care pathways for children and adolescents with eating disorders described by the NHS Lanarkshire Eating Disorders Services (2017) are examples of these specialized companions.

INDICATORS & BENCHMARKING

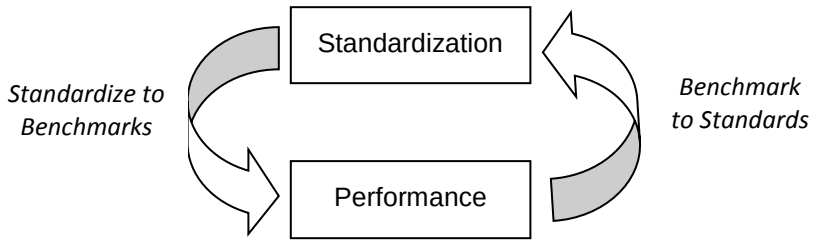
Standards should inform what data should be collected and what benchmarks should be developed. Benchmarks, in turn, help to inform the development of standards. Benchmarking can inform how well units are able to meet the standards they set, and what changes might be required to meet desired unit performance (see Figure 2).

In 2015 and 2016, ONCAIPS used the standards to guide the survey design for the provincial benchmarking process. The information obtained began to form a clearer picture of the state of child and adolescent inpatient care in Ontario and to better highlight areas for improvement.

In 2020, the standards were improved based upon information from the 2015 and 2016 benchmarking surveys. In addition, indicators were formally defined with the intention of better linking standards and survey. A second addition was the inclusion of 1) provincial benchmarks which were averages or medians, and 2) international benchmarks which could be a) average or median benchmarks reported by other jurisdictions, and b) ideal benchmarks recommended in the literature.

In accordance with the guiding principles for development, standards continue to be improved with a view to increasing reliability of measurement. A self-audit tool using categorical "yes/no" indicators or Likert scale type (e.g., "Most of the time, some of the time, seldom, never") which also included quantitative benchmarks was developed and a first draft was published on the ONCAIPS website.

Figure 2: Standardization and Performance Cycles



ALIGNMENT WITH OTHER STANDARDS

The standards are meant a) to be sensitive to cultural and special needs of children and adolescents, their families, and their communities, b) to be consistent with existing government legislation, hospital, professional, and partner standards and policies (e.g., Mental Health Act, Heath Care Consent Act, PHIPPA, PIPEDA, and all other pertinent acts, professional practice standards, hospital policies and procedures, government policies, standards of partner agencies and services), and c) to be responsive to recommendations from consumers. Provincial inpatient standards are expected to need updating across time as they influence, and are influenced by, changes in health care. Many different standards that have developed internationally have informed the present initiative (e.g., Delaney, 2007; Hawaii Department of Health's Child and Adolescent Mental Health Division, 2012; Thompson & Clarke, 2016).

THE CURRENT GUIDE, STANDARDS, & BENCHMARKS

The standards are divided into 16 broad categories/areas of importance to inpatient care. Each of the 16 standards and related benchmarks, and literature review is discussed in its own separate section. These sections are, 1. Physical Safety (including sexual safety), 2. Psychological Safety, Dignity, & Rights, 3. Physical Environment, 4. Staffing, 5. Mental Health System, 6. Beds & Unit Types, 7. Access & Admissions, 8. Care Planning, 9. Milieu & Activities, 10. Assessment, 11. Stabilization & Therapy, 12. Medication, 13. Discharge, 14. Utilization, 15. Outcomes, and 16. Public Information. Each section has its own checklist for compliance to standards which, whenever possible, includes established performance benchmarks and suggested survey questions to establish benchmarks.

THE LITERATURE REVIEW

The literature review includes not only international research and opinions but also recent ONCAIPS survey findings. The review of the literature was not intended to provide final conclusions or interpretations, but rather be a starting point for discussions and for the development of continuously improving standards of practice. The literature review was provided to promote understanding of the many varied past and current different models of care. The review includes consideration of the history of inpatient units, changing models, concepts, diagnosis, medication, therapy, milieu programming, staffing, system of care roles, and differences in models of care across regions, provinces and nations. The review was intended to encourage discussions about the relative value of inpatient care and different practices based upon a broader view of the evidence and professional opinions. Inclusion of articles in the literature is not restricted to judgments of its quality but is presented as published with a hope that readers will read the information, whether opinion or research, with an open mind and a critical eye. Some of the most poorly designed studies have generated hypotheses that turned out to be quite valuable and valid. The intent was to provide a reference list of articles related to the standards that users and providers of inpatient care can directly consult to come to their own conclusions or to aggregate in different ways for different analyses. The hope is that readers will criticize and challenge, but also not stop there, and continue to add knowledge, to improve what we as an inpatient community know, so we can improve our services.

DEFINITIONS

The following definitions are provided to illustrate how the terms are intended to be understood in the context of the present document. They are not intended to be definitive statements of how the terms should be used in other contexts.

Academic Health Sciences Centres: These are units which have a working relationship with medical schools and universities. Such units can be general crisis units and operate similarly to units that are not part of academic centres. Academic health sciences centres have a reputation for having highly specialized staff, but survey information suggests that they often have similar staffing or care models as units that are not academic centres.

Actual versus Ideal or Evidence-Based: These terms are utilized to distinguish actual practice from ideal practice, as in the ideal evidence-supported system of care versus the actual

system of care, and the ideal or evidence-based pathway versus the actual pathway a patient or group of patients follow.

Behaviour: The term behaviour is used in a broad way to allude to any observable behaviour, as well as mental behaviour, which includes reported thoughts, beliefs, ruminations, obsessions, sensations, physical pain, and emotions.

Clinical Maps and Pathways: Standards are an inherent part of clinical pathways but are not the same as clinical "maps" or "pathways" which describe the sequence of events in providing assessment and treatments for different problems and disorders. Standards help reduce unacceptable user variations and are integral parts of clinical pathways working to ensure that the most efficient and effective service paths are followed (Hazell, 2003).

Community Partners: The term "community partners" is used to refer to all community agencies including child welfare, children's mental health, primary care providers, and school mental health services.

Crisis (aka Acute Care and Emergency Care) Units: These units, which are also known as emergency mental health units and acute care units, admit youth at suspected or demonstrated imminent risk of severe harm to self and others for the provision of rapid assessment and stabilization of risk if required. Rather than providing longer inpatient stay for treatment, the goal of such units is to return the young person back to their communities as rapidly as possible for treatment in community offices, homes, and classrooms.

Delays in Admission: Delays in admission are delays that result in waiting in a setting that is not appropriate for addressing the crisis or treatment needs of a patient. This does not imply that inpatient care is always necessarily the right or best choice, only that individuals experience a delay in accessing the service.

Delays in Discharge: Delays in discharge are intended to describe a situation where a patient stays in a bed after a determination is made that they can be discharged because of the lack of health care benefit of continued hospitalization relative to community care. Delays in discharge block beds, but additional assessment is required to identify if a delay in discharge was for a youth accurately or inaccurately identified as needing inpatient care.

General Units: Units which admit all or almost all disorders and problem types.

Patient: The term "patient" rather than client was chosen because it is more commonly used in inpatient care. The term patient is used interchangeably with "children and adolescents" and "youth".

Parents/Caregivers: The term "parents/caregivers" refers to the most responsible primary caregiving figures. The term "caregiver" was included to respect the reality that a high number of young people who are admitted to inpatient care are residing with caregivers who are not biological parents.

Planned/Elective Admissions: These are admissions of children and adolescents who are not in a crisis or suspected to be in a crisis that requires emergency care. Planned elective admissions which occur under voluntary or parental authority are usually preceded by preadmission contracting and informed consent for treatment. Ontario units provide

predominantly crisis/emergency/emergency services, but most provide small numbers of planned admissions.

Professional Partners: Community agencies and providers who are engaged in helping a youth and family address mental health needs, prior to, during, and after admission to an inpatient unit.

Service Access and Transition Pathways: These pathways describe the steps, criteria, and processes involved in accessing different services, such as inpatient care, and in transitioning across services. An inpatient access pathway would describe how the unit's beds and services can be accessed, criteria for decisions, steps in the path, and who is responsible for completing the tasks.

Diagnosis or Problem-Specific Units (aka by some as Tertiary Units or Sub-Specialty Units): Inpatient units which focus or limit admission to a particular problem (e.g., a forensic unit) or diagnostic type (e.g., an eating disorders unit). When inpatient care for children and adolescents was in its developmental years, the term specialized referred to psychiatric settings for children and adolescents to distinguish these units from adult ones. Subsequently, the term specialized was used to describe mental health units in specialized psychiatric hospitals rather than those in general hospitals. More recently the term sub-specialty units or diagnosis-specific units help to distinguish general units which admit all youth with mental health problems from those limited to assessing a target problem or diagnosis. Examples of sub-specialty units include eating disorders units, forensic units, concurrent disorders units, and developmental units that specialize in providing inpatient care to youth with disorders like autism.

Stabilization: Return to pre-crisis level of a mental health related risk (e.g., as in stabilizing risk of suicide, aggression, possibility of harming self or others inadvertently because of impaired judgment). This involves application of treatment, but it is not the same as treatment directed at affecting longer term and more permanent improvement in functioning and reduction of vulnerability.

Standards: Standards typically define what different components of quality care <u>should</u> look like (Brann, Walter & Coombs, 2011). The word "standards" in this document refers to aspirational goals which are supported by (preferably) research-supported objective indicators to assist evaluation of process and performance against those goals.

Systemically Inappropriate Admissions: These are admissions which may be appropriate or the best or only choice for parents and providers, but are low value, harmful, or unnecessarily restrictive admissions that result from gaps in services, waiting lists, lack of knowledge of services, unfamiliarity with cultural needs, bias and prejudice, faulty assessment, and other systemic problems.

Tertiary Care Units: The term "tertiary care" has been used to mean many different things to different users and providers and has changed across time. Arguments could be made that all inpatient units are tertiary care units if they provide specialized psychiatric care. The term 'tertiary care' has been used indiscriminately in Ontario. Sometimes it is used to refer to the work of a crisis/emergency unit. Sometimes it is used to refer to extended stays for treatment or extended stay after stabilization on a crisis/emergency unit. Sometimes it is used to refer to the work completed by longer stay units that receive referrals from crisis units. Sometimes it is used to refer to treatment units which do not accept crisis but provide longer term treatment of either

generic or sub-specialty type. Occasionally it is also applied to academic health sciences centres because of the assumptions that affiliation with a university or medical school implies a higher level of knowledge than is available in non-affiliated units. In the hierarchical view, tertiary care units are specialized enough to provide sub-specialty care (e.g., specialized eating disorders units) in support of secondary care crisis and treatment units. The present document views tertiary care and sub-specialty care as similar. The term "tertiary care" is generally avoided and phrases such as "units specialized by diagnosis or problem type" are used.

Treatment: The term refers to pharmacotherapy, psychotherapy, and other family, school, or environmental interventions that are applied with the intention of making lasting improvements to a young person's health and functioning beyond what can be achieved through stabilization.

Treatment Units: Treatment units include those which are general (i.e., accept all or most mental health problems and diagnoses) and those which are specialized by diagnosis or problem types. Treatment units typically provide more in-depth, longer assessment and treatment unlike the very brief stay crisis/emergency units.

Units: The term child and adolescent inpatient "unit" is similar in meaning to "ward" or "setting". These terms refer to the setting which has the beds for the care of patients with similar problems, disorders, and/or service needs.

Users: The term is used for purpose of brevity to describe patients, community partners, and families/caregivers who have utilized or collaborated in inpatient admissions and care.

THE 2020 ONCAIPS STANDARDS

1. **Physical Safety.** **The unit assures the physical safety of patients, visitors, and staff.**
2. **Psychological Safety, Dignity, & Rights.** **The unit assures psychological safety and promotes psychological safety, dignity, rights, inclusion, and participation in care.**
3. **Physical Environment.** **The unit physical environment is not only safe but also meets the therapeutic, cultural, developmental, and special needs of patients.**
4. **Staffing.** **The unit has the staff numbers, disciplines, processes, training, and morale to provide the best possible inpatient care.**
5. **Mental Health System.** **The unit works with its community partners to develop and maintain a complete, integrated, cost-effective mental health system that ensures children and adolescents receive the services and supports they need when they need them.**
6. **Beds & Unit Types.** **The system of care has the right numbers and types of beds and units to best meet the needs of children and adolescents.**
7. **Access & Admissions.** **The unit and community services use joint admission criteria and processes to assure timely access for children and adolescents best helped by inpatient care.**

8. **Care Planning.** **Care is guided by a single interdisciplinary plan of care and integrating planning process that addresses the reason for admission.**

9. **Milieu & Activities.** **The unit milieu provides patients with the health promotion activities that can best support stabilization and/or longer-term change.**

10. **Assessment.** **The unit provides reliable and valid assessments that inform stabilization and/or treatment and improve outcomes.**

11. **Stabilization & Therapy.** **The unit provides stabilization and therapy interventions which are supported by the best current evidence.**

12. **Medication.** **The unit assesses medication needs and provides pharmacotherapy that is supported by the best current evidence.**

13. **Discharge.** **The unit and partner services employ a commonly developed, efficient and effective discharge process that facilitates successful transition back to home, community, and school.**

14. **Utilization.** **The unit monitors and ensures helpful, fair, and cost-effective utilization of inpatient resources.**

15. **Outcomes.** **The unit monitors, reports, and evaluates youth, family, and system outcomes.**

16. **Public Information.** **The unit accurately and helpfully communicates information about its staffing, care process, utilization, and outcomes.**