Ontario Network of
Child and Adolescent Inpatient
Psychiatry Services

2015 ONCAIPS COLLABORATIVE PROVINCIAL

CHILD & ADOLESCENT INPATIENT MENTAL HEALTH STANDARDS

Recommended Citation: *ONCAIPS (2015) 2015 ONCAIPS Collaborative Provincial Child & Adolescent Inpatient Mental Health Standards. Ontario Network of Child and Adolescent Inpatient Psychiatry Services.*

TABLE OF CONTENTS

Introduction

CONTRIBUTORS

- Stacey Beaveridge, Social Worker, Lakeridge Health, Oshawa
- Erica Bickell, Registered Nurse, Sault Area Hospital, Sault Ste Marie
- Corine Carlissle, Clinical Head, Youth Addiction and Concurrent Disorders Service, CAMH, Toronto
- Lisa Cowan, Social Worker, St. Joseph's Health Centre, Toronto
- Monica Figueiredo, Registered Nurse, St. Joseph's Health Centre, Toronto
- Stephanie Greenham, Psychologist, Children's Hospital of Eastern Ontario, Ottawa
- Subaida Hanifa, Professional Practice Educator, Mental Health Program Joseph Brant Hospital, Burlington
- Laurie Horricks, Registered Nurse MN, McMaster Children's Hospital, Hamilton
- Mary Jago, Clinical Manager of the Child, Adolescent and Family Mental Health Program, Health Sciences North, Sudbury
- Krista Lemke, Child and Adolescent Psychiatrist, Toronto East General Hospital, Toronto
- Joe Persi, Psychologist, North Bay Regional Health Centre[1], North Bay
- Pam Roe, Coordinator, St.Joseph's Health Centre, London

BACKGROUND

A core group of inpatient units formed the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS) in November 2006 with the aim of reducing inter-unit isolation, facilitating knowledge exchange and exploring service improvement. In light of the lack of information about who was providing inpatient services in Ontario, the ONCAIPS community of

[1] *Primary contact joe,persi@nbrhc.on.ca for questions about the Standards document*

practice compiled the first provincial directory of inpatient programs in Ontario, their locations and characteristics. ONCAIPS currently comprises all general (units not restricted to admissions for a specific diagnosis such as eating disorders) units in Ontario

Soon after its inception, ONCAIPS began a process of annual provincial surveys and the scheduling of annual networking meetings where survey results are shared. Surveys since 2007 have indicated that inpatient units are highly utilized and provide important services in the continuum of mental health care. But surveys have also identified significant undesirable variations in access, resourcing, and service quality across inpatient units (Greenham & Persi, 2014). In response to these findings at the 2013 annual meeting, ONCAIPS members set out to develop a common set of standards to help improve consistency and quality of care.

PURPOSE OF STANDARDS

- To promote high quality care
- To promote safety
- To improve effectiveness
- To reduce unacceptable variations in care
- To improve efficiency
- To safeguard the rights and dignity of children, adolescents and families
- To integrate emerging best practices evidence
- To promote child and adolescent inpatient research
- To provide guidance for what should be measured and benchmarked
- To encourage comparison against standards identified in the literature and provincial benchmarks
- To encourage collaborative comparisons and learning across inpatient units
- To identify areas for improvement in inpatient clinical and managerial practices
- To inform children, adolescents, parents, and professionals about the types and quality of services to expect

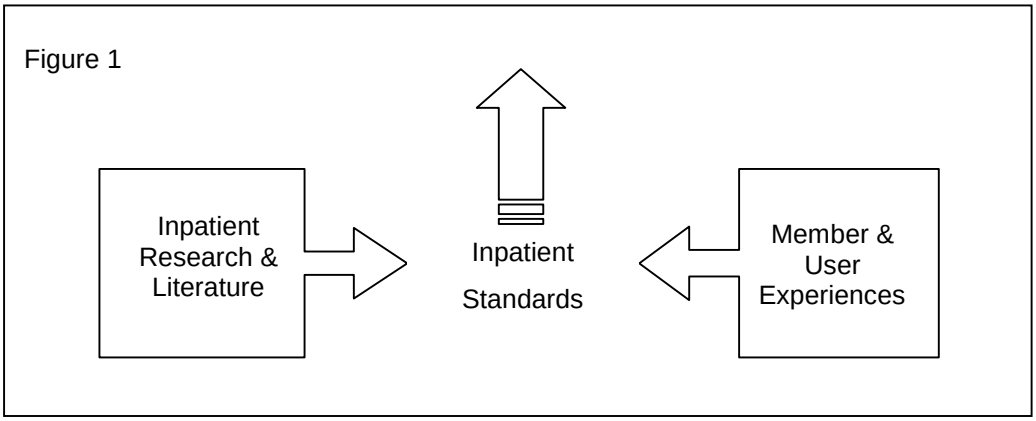
FOCUS

The present inpatient standards apply to crisis as well as assessment and treatment units that are "general" or "generic" in type (O'Herlihy et al., 2003). General types of units do not restrict admissions by diagnosis or problem type (e.g., eating disorder, forensic, developmental disabilities) but admit across diagnostic groups.

INFLUENCES

ONCAIPS chose the United Kingdom *Quality Network for Inpatient Child and Adolescent Mental Health Services 2011 Service Standards* (Sixth Edition) (Solomon, Thompson & Collins, 2011; McDougall & Thompson, 2014) as its starting point for the development of provincial standards, as these are the most comprehensive standards currently available for general child and adolescent inpatient units. The standards were not simply copied for a number of reasons. First, Ontario and Canadian units differ from those in the U.K. as Canadian units tend to provide briefer stays and have more of a crisis focus. Second, U.K. standards did not include explicit links to the literature and research upon which they were based. The ONCAIPS Standards Development working group thought it important to gather and disseminate information from the existing child and adolescent inpatient literature and research, and to explicitly link the literature to the development of standards (see Figure 1). Third, quantitative benchmarking was thought to be highly desirable and thought to require more objective indicators than provided by United

Figure 1



Kingdom standards. Finally, the Ontario process of collaborative development was judged as very important and simply adopting existing standards would not have engaged the membership in a reflective review. An Ontario-focused process would further engage member units in the identification of key issues and potential improvements. ONCAIPS is part of a national body which may permit opportunity to further expand the provincial initiatives on standardization to a national stage.

CRITERIA FOR STANDARDS SELECTION

The consensus was that ONCAIPS standards development should develop standards which are:

- Specific (i.e., specifically for child and adolescent inpatient psychiatry services)
- Distinct (i.e., enhance and not simply duplicate existing Hospital, Accreditation Canada, professional regulatory bodies etc.)
- Important (i.e., standards which ONCAIPS participatory surveys and member opinion felt were important to their unit and provincially)
- Acceptable & Brief (i.e., likely to be acceptable to the general membership in the first round of standards development)
- 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)
- Common & Shared (i.e., a standard that applies to all inpatient settings)
- 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)

DEFINITIONS & LANGUAGE

Standards in the present draft proposal define what different components of high quality care should look like (Brann, Walter & Coombs, 2011). Standards are similar to “practice parameters” and “guidelines” but differ from them by virtue of their capacity to be audited and evaluated in terms of degree of adherence or compliance. Standards are an inherent part of clinical pathways, but are not the same as clinical “maps” or “pathways” which describe the sequence of events and service contacts individuals make in the course of receiving health care. Standardization reduces unacceptable user variations and helps map out care processes so they follow most efficient and effective paths (Hazell, 2003).

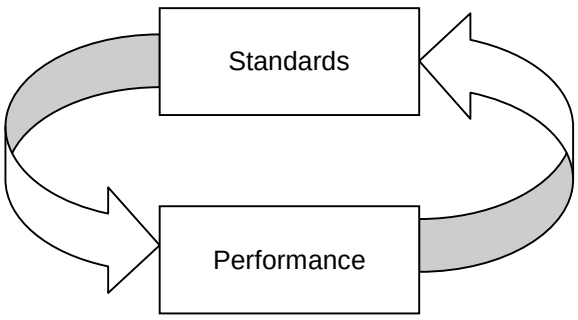
The term “child and adolescent inpatient units” refers to child and adolescent inpatient psychiatry and mental health services and settings. The term “patients” rather than clients was

chosen because it was more commonly used in inpatient care. The term “community partners” was used to refer to all community agencies including child welfare, children’s mental health, physicians, and school mental health services. The term “families/caregivers” refers to families or most responsible primary parenting figures.

PROCESS

The need for the development of provincial standards was recognized and supported by the consensus of all member units at the 2013 ONCAIPS Annual Meeting. It became apparent early on in the process that standards development and benchmarking of performance were both required and dynamically linked. Standards informed what should be benchmarked, benchmarking informed about how well the units were able to meet the standards they set, and what changes might be required to standards or performance. Early in the process it was agreed that the best way to proceed was in a nonjudgmental manner where the focus was on the entire provincial system of care and not upon unflattering comparisons across units or the use of data for purposes of competitive advantage of one unit at the expense of another.

Figure 2 - The Standards Development and Performance Benchmarking Cycle



At the end of the annual meeting, a working group (the Standards Development Working Group of ONCAIPS) was established with a view to starting the process of standards development prior to engaging the broader membership. The working group chose to position these standards as voluntary indicators for practice improvement, rather than as prescriptive demands. The intent was to engage the entire provincial inpatient community of practice in reviewing and optimizing the initial draft standards and to simultaneously provide a supportive literature base to inform the membership about key opinions and findings in the research literature.

Points of reference and criteria for selecting standards were identified, ten core standards were developed, a literature and research base was included, and the standards were reviewed at

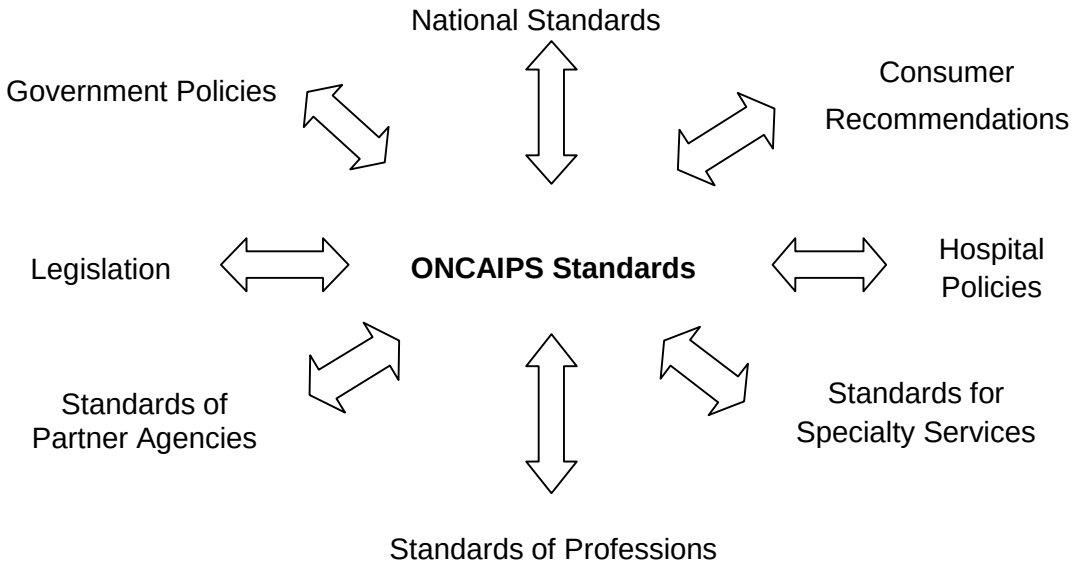
the 2014 ONCAIPS Annual Meeting. The membership offered recommendations for improvement and these recommendations were integrated into the draft standards.

From March to June 2015, the standards were integrated with the annual benchmarking survey and the work of the Benchmarking Survey Working Group of ONCAIPS. The present Standards document was aligned with the Benchmarking Survey document. ONCAIPS appreciates that this cycle of standards definition and performance benchmarking needs to recur annually and to serve as a focus of review, discussion, and improvements at the Annual ONCAIPS member conference.

CONTEXTUAL ASSUMPTIONS

The standards are meant to be sensitive to cultural and special needs of children and adolescents, their families, and their communities, 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 to be responsive to recommendations from consumers (see Figure 3). Provincial inpatient standards are expected to need updating across time as they reciprocally influence, and are influenced by their context.

Figure 3 ONCAIPS Provincial IP Standards in Context



THE TEN ONCAIPS STANDARDS

1. Safety - The unit provides a safe environment for staff, children, and adolescents.

1.1. The unit utilizes documented policies/ practice standards on safety-related practices

1.1.1. Assessment of medical stability on admission by a qualified health care provider

1.1.2. Clinical risk assessment to inform the plan of care

1.1.3. Regular mental status examination

1.1.4. Daily suicide risk assessment

1.1.5. Search of belongings

1.1.6. Personal searches

1.1.7. Environmental/room and unit safety checks/rounds and documentation

1.1.8. Restraint and seclusion procedures

1.1.9. Code White and crisis management (e.g., code white – pediatric vs generic, debrief and postvention)

1.1.10. Visitors

1.1.11. Passes, transfers, temporary leaves of absence, and discharges

1.1.12. Required staff competencies and training for safety and training on risk reduction and de-escalation

1.1.13. Medication error prevention (e.g., medication reconciliation)

1.2. The unit provides the patient and family/caregivers written information regarding safety and risk management

1.2.1. Unit expectations and responsibilities

1.2.2. Restricted items and associated procedures related to the search of belongings and persons

1.2.3. Items allowed on the unit and procedures governing the storage of belongings

1.3. The unit tracks, reports, reviews risks, incidents, and restrictive safety measures and makes improvements based upon the available information

1.3.1. Risks that precipitate referrals

1.3.2. Serious incidents/sentinel events

1.3.3. Safety occurrences/near misses

1.3.4. Percentage of youth admitted on an involuntary basis as a percentage of admissions

1.3.5. Percentage of youth that are certified as involuntary patients after admission

1.3.6. Percentage of patients and percentage of incidents per total admissions involving of physical, mechanical, environmental and chemical restraints

1.4. The unit endorses a least restraint model of care

1.4.1. Including staff training and education on restraint prevention

1.4.2. Patient validation and de-escalation strategies

1.4.3. Patient engagement in risk reduction, and preventive programming, and activities

Supporting Rationale in Literature & Research

The provision of a safe environment for children and adolescents is a fundamental expectation of inpatient services (Baren et al., 2008; Commonwealth of Australia, 2010; Solomon et al., 2011). Safety and security are essential for children and adolescents to be able to concentrate on recovery. Inpatient units need to be safe but also need to be mindful that the safety measures pose certain risks. Safety measures can also become excessively controlling to the point that they contribute to stigma, erode personal rights and dignity, and threaten recovery.

In the absence of clear and common standards, safety practices can significantly diverge from best practice expectations and be inconsistently applied across units. Standards increase the likelihood that the physical characteristics of units, patient orientation to the unit, staffing type and numbers, safety training, monitoring, and minimization of need for restrictive measures occurs in a consistent way that minimizes deviations that can lead some units to be less safe than others (Commonwealth of Australia, 2010; Solomon et al., 2011).

It is not possible to know which risks are more prevalent and which safety measures are in use, and how consistently in Ontario without provincial benchmarking. ONCAIPS standards expect all units to be aware of the risks involved in providing inpatient care to children and adolescents, to monitor and record risks that precipitate inpatient care and those that arise afterwards, to implement appropriate safety measures, and to report safety outcomes preferably in terms of quantitative performance benchmarks.

Because the most prevalent referral risk in Ontario is the possibility of suicide (Greenham & Persi, 2014) provincial information about numbers of completed child and adolescent suicides and suicide attempts in Ontario hospitals is important. So too is the ability to demonstrate that all units have inpatient interventions that focus upon prevention of suicide during inpatient stay and stabilization of risk so that the patient can be safely discharged. Similarly it important to survey prevalence of use of restrictive safety procedures as many of these pose their own safety concerns.

Mental health legislation internationally, and the Ontario Mental Health Act (1990) provincially, legitimize and strengthen capacity to use restrictive measures such as detention and restraint to assure safety when children and adolescents at imminent severe risk by virtue of a suspected or verified mental illness, and are unwilling, or unable, to engage in assuring their safety (Ellila et al., 2008). It has been suggested that such safety measures can be humane and therapeutic, provided they are the least restrictive option, predictable, transparent, monitored, understood by children and adolescents in the context of prevention and their treatment goals, involve collaborative debriefing with parents, youth and other observers, and are followed by rapid return to typical unit activities (Dean et al., 2007).

At the same time, because restrictive measures come with their own risks and costs, the ONCAIPS standards on safety strive to minimize excessive and unnecessary use of safety measures and associated undesirable outcomes. Minimizing seclusion and restraint is particularly important as its use can result in physical injury and distress youth who have been traumatized or who may be vulnerable to being traumatized by the use of such measures. Traumatized and vulnerable children and adolescents do not recover well in overly restrictive inpatient and residential settings (Bloom, 2005).

Similarly it is important to appreciate that youth who may have been inaccurately triaged and detained involuntarily as a result of overly sensitive but insufficiently specific assessments will experience restrictive measures, and loss of personal rights and freedoms, unnecessarily and without significant health care benefits. For example, excessive use of suicide risk factors to guess or estimate which patients are at high or low risk has been noted to result in very large numbers of identified patients. But the identification of higher numbers of patients has not altered rates of completed suicide and leads to considerable loss of autonomy for patients who likely may not have needed to be hospitalized, to increased potential of injury resulting from defiant reactions to detention, and to the loss of health care resources that may have been better utilized on equally if not more effective longer term community programs (Large, Ryan & Nielssen, 2011; Werry, 2009). There have been findings about involuntary detention and restraint pointing to overuse, culturally biased application, reactive emotional or angry applications by staff, excessive use with very young children, inappropriate use to bypass outpatient waiting lists, and highly variable inconsistent practices (Cassells, Paterson, Dowding, & Morrison, 2005; De Leo & Sveticic, 2010; Dein, Williams, & Dein, 2007; Ellila et al., 2008; Greenham & Persi, 2014; Kaltiaila-Heino, 2004, 2010; Molnar, 1997; Smith, 2004; Tolmac & Hodes, 2004; World Health Organization, 2005).

Restrictive measures can harm therapeutic alliances important for recovery (Mooney, (2013), but they are subject to inconsistencies in use and can cause physical injuries for youth and staff, and distress and traumatize both those being restrained and those observing (Prescott, 2000). For example, one study of comparable adult units found that one unit had 38 restraints whereas the other had around 3000 across the same the same period (Mind, 2013). Practices such as seclusion room use and restraint continue to

be challenges as being unnecessary, failing to be evidence-based, and being potentially harmful (e.g., Finke, 2001; Rydelius, 2007). Because of lack of consensus about the need for such restrictive measures and how often these should be used, ONCAIPS standards have taken as a starting point the expectation that all units monitor and report risk types, incidents, and changes in the degree of unit reliance upon restrictive safety measures.

Because findings indicate that reduction of restrictive practices is both desirable and possible (Delaney, 2001), the present standards additionally recommend that all units also have a process for reduction of the need for seclusion, restraint, and prn medication. No simple or unique way to do this has been identified as reduction of restraint and seclusion appears to be the result of a number of interacting variables and interventions (Berntsen et al., 2011). Interventions showing promise for reduction of the use of seclusion and restraint include unit and emergency care promotion of voluntary admissions, earlier detection and planning as a majority of risk management problems arise within the first seven days of admission (Dean, Duke, George, & Scott, 2007; Donovan et al.,2003; Swadi & Bobier, 2012), .changes to programming (Delaney, 2006), improved staff communication, increased consistency of behavioral contingency management (Dean et al., 2007), shift of focus to prevention and client strengths (LeBel et al., 2004), engagement of youth in collaborative problem solving (Greene et al., 2006), organizational prioritization of reduction and utilization of trauma-informed principles, use of data to inform progress, staff training, enhancing consumer participation, and vigorous debriefing with patients, family, and observers (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011).

Medication on a p.r.n. or, 'as needed' basis are often utilized by inpatient staff for chemical restraint or preventively (Baeza et al., 2013; Swart, Siman & Stewart, 2011). But although rapid acting medications can at times suppress agitation and aggression quickly and in a way that can provides distress relief for patients and staff, reliance on medication is also not without its problems. For example, some children and adolescents need to be physically restrained before involuntary injections can be used, thus making medication a part of a physical restraint and exposing patients to at least some of the risks involved in physical control. Similar to seclusion and physical restraint there are very high rates and significant variability among inpatient units in their use of medication for behavior control (Dean et al., 2006; Kaplan & Busner, 1997) and a lack of standards to improve consistency (Deshmukh, Kulkarni, & Barzman, 2010). Staff across units may require more training, clinical time, and opportunities to provide what are likelier to be slower acting but longer lasting inpatient family and behavioral interventions (Sparks & Duncan, 2008). It has been further recommended that children, adolescents and parents also be informed about the potential for significant adverse medication side-effects and events, the meaning of "off-label prescription", and the relative absence of research for combining psychotropic medications in the management of risky behaviors (Jerrell & McIntyre, 2008; Sparks & Duncan (2008).

It is important that patients, families/caregivers, and referral sources are adequately informed about how units manage risk, what risks may remain, and about the potential for exposure to violent or sexualized behaviors, bullying or aggression, from other patients. Younger children and families are often not made sufficiently aware about potential incidents involving co-patients such as potential for exposure to adolescents who are quite different from children in their level of aggression and sexuality. This expectation for better informing patients is also part of Standard 9 which expects potential patients and the public to be well informed about the possible costs and benefits of hospitalization on a child and adolescent inpatient unit.

2. Access & Discharge - Timely inpatient care is available to all who would benefit.

2.1. Numbers of beds, types, and access to these beds is sufficient to meet needs

2.1.1. Beds and admissions per 100, 000 are similar across geography

2.1.2. In an effort to assess and prevent bias, the units tracks demographic data including age, culture, gender and diagnosis

2.1.3. For crisis units, there are always open beds to accommodate emergency admissions and there are no significant delays as measured through their own data sources or nationally reporting bodies

2.2. When the unit does not admit the patient, it redirects patients to other programs in the continuum of care that would best serve them

2.3. Referral criteria distinguish appropriate and inappropriate referrals by

2.3.1. Age

2.3.2. Whether and under what conditions transitional age 16 and 17 year-old adolescents should be admitted to the unit as opposed to an adult mental health inpatient unit or a Psychiatric Intensive Care unit

2.3.3. Geography. Boundaries are well defined.

2.3.4. Primary Diagnosis Inclusion/Exclusions

2.3.4.1. Development Disorders

2.3.4.2. Eating Disorder

2.3.4.3. Conduct Disorder

2.3.5. Services. Whether and under what conditions should children and adolescents be admitted to child and adolescent inpatient unit versus psychiatric-intensive care, non-hospital residential, therapeutic foster care, specialized community programs and similar)

2.3.5.1. Emergent

2.3.5.2. Elective

2.3.6. Safety & Security.

2.3.6.1. Medical stability

2.3.6.2. Capacity to admit involuntary patients,

2.3.6.3. Crisis/emergency versus longer assessment treatment focus

2.3.6.4. Capacity/incapacity to address high risk safety situations

2.4. There are clear criteria and processes describing how the following are managed

2.4.1. Exclusions and redirections to more appropriate services

2.4.2. Delays because of unavailable inpatient beds

2.4.3. Overflow to and from other inpatient units, beds, programs, and facilities

2.4.4. Frequent readmissions

2.4.5. Discharge

Supporting Rationale in Literature & Research

Equitable and timely access is a well-accepted standard for inpatient care (Solomon et al., 2011). Although there is no commonly accepted or empirically supported benchmark for beds per population (Cotgrove, 2014), ONCAIPS recognizes the need to establish such benchmarks to guide planning and service development. In order to better understand quality of access and to identify potential access problems and develop ideal or median benchmarks, ONCAIPS has identified the need to survey bed availability and admissions, and appropriateness of utilization.

York and Lamb (2005) observed that there must be beds and capacity to admit both children and adolescents in need of 1) crisis/emergency admissions for high-risk including those subject to involuntary mental health legislation, as well as those in need of 2) long-term planned, elective, inpatient assessment, treatment, and rehabilitation. ONCAIPS surveys have noted that in Ontario the general inpatient units predominantly admit for crisis but that there is a very small proportion of planned elective admissions. This raises questions for Ontario about whether youth requiring 2 to 6 week types of assessment and treatment admissions are being seen in other types of residential treatment and other specialized community-based programs, or whether there are gaps in services for such needs. In the absence of international and provincial consensus about the best balance between crisis versus planned elective cases, ONCAIPS has deferred taking a similar position for the present. But ONCAIPS will continue to track crisis versus planned elective treatment stays and look to encourage and participate in research that can better establish best options for youth who require longer treatment that may not be possible at community care levels.

Standardization of a desirable or acceptable range of bed numbers per population is important for consumers as comparative within-country and within-province studies have generally found very high

disparities in bed availability across geography which has been difficult to explain on epidemiological grounds or service needs with some jurisdictions having no beds and others having very high numbers (Ellila, 2007; Greenham & Persi, 2014; O`Herlihy et al., 2003). Although not widely adopted, occasional recommendations have been made (Kurtz, 2009; O'Herlihy et al, 2001; Royal College of Psychiatry, 2006, 2010). Because recommendations vary depending upon local service cultures and uses of inpatient care, ONCAIPS made the decision to survey bed numbers and locations in Ontario and then to strive to tentatively define Ontario provincial benchmark range for bed numbers per health jurisdiction on that basis.

Understanding access to inpatient care requires appreciation that inpatient units do not dictate or control the frequency of referrals or utilization and that these processes are in part consequences of pressures and services available or not available in the broader mental health service continuum in which the unit finds itself. Bickman et al., (1996) observed admissions thresholds vary with what is available in the other parts of the continuum of care. This is to say that likelihood of admission to inpatient care for the same problem severity increases as quality and level of resources available in the other parts of the system of care decrease (Bickman et al., 1996). High numbers of admissions of children and adolescents to child and adolescent inpatient units and overflow to other less appropriate inpatient settings, such as adult units, can both be symptomatic of insufficient access in other parts of the continuum (Worral et al., 2004). Maskey (1998) further suggested that professionals with more direct access to inpatient admission routes through an affiliated inpatient program are more likely to use the more available service for their own patients than for the patients from other systems. ONCAIPS has therefore made a commitment to understanding how bed and admission numbers may be linked to alternatives to admission by surveying disparities in the availability and accessibility to alternatives to hospitalization

Although the issue is yet to be well researched, the possibility that too many beds may also be problematic is garnering at least some attention. McDougall & Cotgrove, 2014) cited an unpublished study by McDougall which found that admissions to the same setting quadrupled when a primarily treatment setting opened up services for crisis, suggesting that increasing numbers of bed in a geographic area may by itself lead to increased numbers of admissions and that such increases may be the result of higher proportions of lower risk patients and unnecessary admissions.

As is the case for number of beds per population, there is no evidence-supported benchmark for ideal numbers admissions per population. ONCAIPS is benchmarking admissions per population in order to compare utilization across geography, culture, race, age, gender, socioeconomic status, diagnosis, and other characteristics. Such a survey may help to define a standard range for admissions and also help clarify whether inpatient care is being accessed and utilized in a fair and unbiased manner.

Standardizing data reporting on beds and admissions as part of ONCAIPS standards development allows also for comparisons across time. A comparison of bed numbers in Ontario, for example, found that bed numbers, and therefore access in terms of service availability increased from 6/100, 000 in 2009-2010 (Greenham & Persi, 2014), to 7/100, 000 in 2013-2014 (DeRoche, Greenham, & Persi, 2014). Information from surveys in the U.K. suggests that Ontario bed numbers per 100, 000 are not grossly dissimilar to those in the U.K. (O`Herlihy et al., 2003) but markedly lower than in Finland (Ellila, 2007). Findings indicate that inpatient admissions are on the increase in a manner that is not explainable by corresponding changes in epidemiology (Canadian Institute For Health Care Information, 2015)

Reviewing admission rates in the context of changing availability of beds will be important to understand if beds are sufficient to meet demand, and whether bed availability is encouraging demand rather than meeting needs in the most efficient and least restrictive way possible. Reporting of beds and admissions can provide information that will be helpful in identification of median type benchmarks for both.

Knowledge of beds and admissions per age, geography and patient characteristics is not sufficient to assure that children who do not need the services are redirected to more appropriate levels of care. Children and adolescents with low risks who are unlikely to be helped, those who may be harmed, and those who can profit from equally effective, less costly, and less restrictive services are inappropriate for admission are sometimes admitted and should ideally be redirected the level of restrictiveness and intensity most appropriate for their need (Stroul & Friedman, 1986). Although government frameworks recurrently recommend that the level of service intensity and restrictiveness match level of needs with the intent of promoting stepped entry into the mental health system (Ministry of Children and Youth Services, 2006), a significant number of children and adolescents who should have been receiving services for significant periods of time prior to admission enter the mental health system without opportunity for appropriate stepped care and prevention (Akin et al., 2010; Gottlieb et al., 1990; Mental Health Commission of Canada, 2012).

Children and adolescents who would be better served by less costly and restrictive services can be misidentified as needing hospitalization when a less restrictive setting would have been more effective and appropriate, or are correctly identified as being better candidates for alternatives to admission but cannot find or access such alternatives (Cotgrove, 1997). Leon et al. (1999) found that 30% of hospitalized children and adolescents did not demonstrate severe levels of symptomatology or risk behaviors supporting the view that many could have been treated successfully in less restrictive community settings. Lyons et al., (1998) found that 20% of youth admitted to inpatient units did not meet criteria for a serious emotional disorder at admission, 13% the state's residential treatment population had no history of risk to self or others, and an additional 20% of cases had no recent assessment about their level of risk prior to presenting for hospitalization. Children and adolescents may bypass community alternatives for many reasons that are more related to beliefs about services, ease of access to inpatient care, and absence of alternatives rather than solely for clinical or service needs. For example, in a survey of units in Kansas, Jacobs et al., (2004) found that belief in the superiority of the "medical model" over a psychosocial model contributed to elevated inpatient referrals and admissions. Standard 8 discusses the relationship between the availability of a complete continuum of care and admission rates in greater detail.

Standardization of referral and admission criteria has been suggested as a way to improve accuracy and consistency of decisions about whether to hospitalize (Cotgrove, 2014; Leon, Lyons, & Uzel-Miller, 2000; Mabe et al., 1989). Cotgrove (2014) recommended criteria be based upon risk and complexity. After finding significant variability in admission criteria across units and the use of open ended criteria such as "at the discretion of the attending", Mabe et al., (1989) recommended that criteria for admission should include 1) severe problems, 2) problems that cannot be addressed as well by less restrictive services, 3) inability of a family to cope and 4) complications or needs requiring hospital-based medical as opposed to non-medical intervention. Blanz & Schmidt (2000) compiled a list of criteria for admission which included expectations that referrals should be for 1) diagnostic work that is unavailable in the community, 2) severe psychiatric disorder which is best addressed by an inpatient multidisciplinary and inpatient team, and/or 3)

adverse environmental circumstances that preclude the child's improvement within the home including continuing or progressive interference by parents with the child's development or recovery.

Criteria typically specify not only which types of referrals are appropriate but also which types are not. For example, it is commonly accepted that referrals to inpatient care should not be for the purpose of helping place hard to serve youth until they find a home or residential placement elsewhere (Hawaii Child and Adolescent. Mental Health Performance Standards, 2012; James et al., 2006; Southwestern Ontario Highly Specialized Services and Supports Advisory Group, 2003). Muller, and Forman (1989) proposed a number of criteria to assist with decisions about non-admission including likelihood that admission will result in 1) excessive disruption of the child's family and community relationships, 2) excessive reinforcement of parental denial or guilt, 3) likelihood of further contributing to child or adolescent term exclusion from the community and the education system, 4) likelihood of cultural stigmata and labeling, 5) unresolved transference and dependency and 6) excessive attachments to the institution. Cotgrove and Gowers (1999) considered the following as important reasons for non-admission: 1) treatment likely to be ineffective, 2) extreme risk of violence dangerousness, 3) specific expertise treatments not available, and 4) problems with incompatible dangerous case mix.

Criteria should help direct children and adolescents to access not only inpatient care but also to access the most appropriate option among highly specialized residential and non-residential alternatives. Leon, Lyons, Uzel-Miller, Rawal, Tracy, & Williams (2000) suggested that youth at acute severe risk who require brief stay should be directed to inpatient care, whereas moderate to severe but non-acute impairment of functioning, affect, behavior or thinking with the potential of danger to self or others which requires the need for longer term multi-month continuous, comprehensive, holistic treatment should be directed to non-hospital residential services. Leon, Lyons, & Uzel-Miller, (2000) also recommended the use of a standardized measure of severity help improve accuracy of admissions decisions by better distinguishing youth with low risk and problem severity from those with high risk and problem severity. ONCAIPS is beginning its work on access by standardizing the expectation all units have publicly available criteria for referral and admission, before looking for commonalities in these criteria, that may lead to adoption province wide components.

Because of the very limited numbers of beds in inpatient care it is important to appreciate that access to inpatient services depends upon ability of unoccupied beds for new admission. With this need in mind, York and Lamb (2005) recommend that bed occupancy not exceed 85% to ensure availability ofof beds for emergency needs. When children and adolescents cannot return to the community after their clinical services are complete because of community obstacles to discharge, access is compromised for new admissions. When this occurs children and adolescents may "overflow" to adult units, pediatric units, off-service beds, distant hospitals where they are disconnected from their families and community support systems or experience extended stays in emergency departments. It is important from multiple perspectives that overflow process and criteria be clearly identified and numbers experiencing overflow tracked. In order to assure access and open beds it is also clear to see that criteria for discharge that facilitate timely patient flow back to community settings are as important as criteria for admission.

3. Environment & Dignity - Units are designed and managed so that child and adolescent rights, privacy and dignity are respected.

3.1. The child and adolescent unit should be separate from the adult unit

3.1.1. Ideally children should receive inpatient services on child units, and adolescents on separate adolescent units rather than adult units

3.2. The unit provides culturally responsive services

3.3. There is a formalized process for patients and their families/caregivers to provide their feedback and input into the unit design, programming and evaluation

Supporting Rationale in Literature & Research

The physical design of inpatient unit needs to assure safety while at the same time promoting recovery and developing resilience. Poorly designed inpatient environments can also increase probability of harmful and traumatizing events particularly for children and adolescents with particular vulnerabilities and histories (Bloom, 2005). Suicide attempts and completed suicide are possibilities that can be partly mitigated by unit designs. One area of focus has been the reduction of suicide by reducing ligature attachment points or placing protective boxes around support bars ("grab bars"), kitchen drains, bed posts, high mounted door stops, and plumbing fixtures in showers and bathrooms that pose a hanging risk from a sitting or kneeling position and twist risks (Yeager et al., 2005).

Beyond designs for safety, the Solomon et al., (2011) UK standards specify the need for a clean well-maintained environment that is separate from adult units, which also has a space for privacy, a low-stimulus area, schooling, indoor and outdoor space for recreation and exercise, places for socialization, capacity for food preparation and meals, access to computer and telephone, capacity to personalize bedrooms, an area to visit with family, and availability of age-appropriate reading, art, and play materials. Cotton and Geraty (1984) recommended that physical environments should 1) provide patients and families with a friendly, warm, adaptive setting that conveys a willingness to tolerate problems without judgment, panic, despair, or avoidance, 2) provide design spaces that promote rather than erodes opportunities for autonomy and self- control, 3) support integration for patients at all levels of functioning, 4) provide opportunities for constructive peer relations and private times, and 5) support formation of more adaptive alternatives to maladaptive behaviours.

Locked doors, confinement, one-to-one security, and constant observation through close captioned TV, can all reduce immediate likelihood of harm to self, reduce opportunity for absconding, and prevent dangerous individuals and illegal substances from entering the unit but there are some costs (Desai, 2009; Van der Merwe, Bowers, Jones, Simpson, & Haglund (2009). Excessive reliance on closed doors, confinement, and control, can create a barren demoralizing institutional type of environment increase patient aggression, disatisfaction with treatment ,and risks and symptoms (Muller, Schlosser, Kapp-Steen, Schanz, & Benkert (2002); Van der Merwe, et al., 2009). Biering et al (2011) found that while adolescents' appreciate safety and security, they also value socialization with peers, ability to safely express who they

are, and being treated as a person rather than patients. One study reported that inpatient children particularly disliked the heat, noise levels and bright lights which are prominent in some hospital settings (Battrick & Glasper, 2004). Environments that excessively focus on safety and security can inadvertently create a stigmatizing and anti-therapeutic institutional type of climate that can compromise the dignity and recovery of patients (Cotton & Geraty, 1984; Solomon et al., 2011).

The use of quiet rooms and seclusion rooms is a part of most unit designs, but costs and benefits of seclusion practice and availability of such rooms continue to be debated (e.g., Finke, 2001) and are not used in certain countries (e.g., Rydelius, 2007). Regardless of the debate, such rooms are present almost all hospitals in Ontario, and there is evidence that their design, like unit design itself can affect patient experiences and may affect outcomes. Glod et al (1994) reported that changing the quiet room from bare white walls and cold hard floors, to warmer paint tones, visually interesting mural, and more comfortable floor material was associated with improvements in agitation and aggression.

Unit designs for children and adolescents must be founded upon a good understanding of developmental differences. Knowledge of the values and beliefs of importance at different periods of development is as important as knowledge about culture, language, and special needs. Mixed age settings that admit both children and adolescents have been criticized as lacking the ability to best address the differing developmental needs of children and adolescents. Adolescents have greater needs for autonomy than children, concerns about privacy and fears when going to the bathroom or having a shower, need for confidentiality, and needs for different types of peer support (Hutton, 2005). Adapting physical designs that work for both child and adolescent social cultures is challenging. In Ontario's typically mixed-age settings, hospitalized children are often without a peer group as they are admitted into a predominantly adolescent inpatient group whose emerging sexuality, aggression, and larger size can be intimidating. On mixed units it is very important parents of children be informed about potential problems stemming from children being hospitalized with older adolescents. It is essential that unit design allows for separation of children from sexually and physically acting-out adolescents that may harm younger children of make them feel bullied or threatened.

The size of a unit and its staffing are also important considerations in designing a unit. There is little empirical evidence around how many beds there should be per unit, although York and Lamb (2005) noted that it is generally accepted that the optimal maximum number of beds should be in the range of 10 to 12. This is to ensure that the unit can provide an integrated milieu and therapeutic services but also in order for it to be financially viable and efficient (York & Lamb, 2005). They point out that it is difficult for a stand-alone unit to be financially viable below 6–7 beds as the same number of staff is required to run a smaller unit and provide clinical input, as the number required to run a larger one. Greenham and Persi (2014) confirmed that the numbers of staff per bed tends to be significantly higher on smaller units, but also observed that smaller units may be required in rural and remote areas despite cost inefficiencies if youth are to receive services closer to their home.

Little is known about the relative benefits of single rooms compared to rooms that sleep two or more people. Tulloch et al., (2008) in their study reported 59% of beds) were located in single bedrooms and 41% of beds slept two or more people. Miller, Friedman, & Coupey, (1998) recommended asking patients about preferences when allocating single or shared bedrooms.

It is generally accepted that units must be respectful and inclusive in their design and operation. This seems to be a work in progress. Lefrancois (2013), describes numerous incidents where young people with non-mainstream sexual preferences or orientation reported experiencing institutionally-based shaming and devaluation. This feeling of exclusion can come from numerous sources such as the type of art on the walls and reading materials as well as expressed or implied staff and inpatient peer attitudes. Pumariega et al.'s (2013) practice parameters include expectations that units monitor, identify, and address of problems that arise when staff do not share the same language or culture as patients. According to Pumariega et al., (2013) staffing practices should include identifying and addressing professional beliefs and personal cultural biases which might interfere with clinical judgment.

When it comes to physical design it m,ay be commonly presumed that all inpatient units should be or need to be within the walls of a hospital. But this is not always the case. In Ontario there is at least one inpatient setting which is part of a hospital but is not within a hospital building but in the community (Greenham & Persi, 2014). The operation of an inpatient unit raises obvious questions about the difference and relative advantages and disadvantages of the locations of inpatient units from safety and recovery viewpoints.

Encouragement for patients and users to express themselves about whether they are being treated in a dignified manner is important and requires access to a complaints process. Units should solicit client feedback about the patient experience as indicated in Standard 4 and demonstrate that they have sued the feedback to make improvements. Additionally, children and adolescents must have access to a complaints procedure on the unit (Solomon et al., 2011), and process to engage them as environmental consultants (Hutton, 2005).

4. Engagement - Children, adolescents, and their families/caregivers are effectively engaged partners in the process of care from referral to follow-up.

4.1. An orientation process prior to or upon admission (also in Standard 1 for safety) informs children and adolescents and their families/caregivers about inpatient care to be provided. Orientation topics include

4.1.1. Confidentiality

4.1.2. Visits

4.1.3. Opportunities and expectations for participation in care

4.1.4. Typical inpatient care process

4.1.5. Availability of peer support for youth and families

4.1.6. Outcomes of care (See also Standard 6)

4.2. An integrated care plan is available to guide care throughout the admission.

4.2.1. The care plan includes a description of the problem precipitating the referral and services to be provided

4.2.2. Patients, families/caregivers and community partners are provided opportunity to participate in, and contribute to care planning (with appropriate consent)

4.3. An integrated discharge summary with recommendations is available at point of discharge

4.3.1. The discharge summary and plan summarizes services provided and outcomes, and recommendations for continuity of care

4.3.2. Patients, families/caregivers and community partners are invited to participate (ideally at a discharge and planning session), as appropriate and with consent.

4.3.3. The discharge summary and plan and a print copy is available to be shared with patients, families/caregivers and community partners

4.4. Patients, families/caregivers and community partners are provided the opportunity to provide feedback about the quality of care received.

4.4.1. The unit provides youth and caregivers with the opportunity to complete satisfaction & feedback measures

Supporting Rationale in Literature & Research

The importance of engaging children, adolescents and their families in inpatient care decisions has long been recognized as a core component of inpatient care and has become a standard in the UK (Mental Health Commission of Canada, 2012; Solomon et al. 2011;). Engagement and active participation should begin as early as possible in the process of admission and no later than orientation. Orientation should permit open discussions about presenting problems, needs, and service expectations and allow the opportunity for parents, patients, and professional providers to clarify misunderstandings and identify common goals.

Engagement includes being adequately informed, being empowered to participate in decisions, and having an opportunity to work on recovery within a therapeutic alliance with providers within a context of respect for cultural characteristics (Singh, Curtis, Wechsler, Ellis, & Cohen, 1997). Engagement is founded upon accurate mutual understanding. It is important to take the time to know children and adolescents as people, and families, to discuss their fears and preferences, and to provide some normalizing anxiety-reducing and motivating control over events in hospital (Coyne, 2006). ONCAIPS has recognized the need to promote engagement and to benchmark performance in light of inconsistencies and shortcomings in the extent of focus and implementation that have been reported by different units across Ontario.

Engagement, as an ideal, is well supported by inpatient staff. Inpatient mental health nurses identified that nurses supported need for service users to be engage in their own care and to be able to affect service process and directions and clinical time (Brimblecombe, Tingle, & Murrells, 2007).

Inpatient engagement requires the adoption of a broader perspective that balances client and parent expressions of needs and goals (Kroll & Green, 1997) and that avoids and improves Involvement of youth and parents in treatment planning is very important to identify and alter unrealistic expectations about the process and effectiveness of inpatient care (Akin et al., 2010). For example, children often erroneously assume that they are to be passive recipients rather than active partners in change (Hepper, Weaver, & Rose, 2005). Developing more realistic expectations as early as possible in the referral process would be ideal. The need for units to take more time to effectively engage youth and families, is reflected in studies reporting that numerous youth and families feel excluded despite the importance of their motivated involvement and collaborative goal setting (Hepper, Weaver, & Rose, 2005; Ronzoni & Dogra, 2012)

Empowered engagement should begin at referral, and proceed throughout care planning, assessment, stabilization, treatment, discharge planning, and service evaluation (Singh, Wechsler & Curtis, 200). Having a schedule for engagement and development of collaborative work is essential for assuring that this will occur. Sourander & Piha (2000) proposed that at the very least, two meetings should minimally occur. The first of these sessions should occur at referral or admission and focus upon integrating the knowledge, strengths, and opinions of youth, families, and past providers into the inpatient care plan. The second session should occur at discharge and focus upon integrating the findings of inpatient staff

and experiences and opinions of youth, families, and community mental health providers into a post-discharge plan.

The preadmission meeting for contracting and planning is a commonly required standard for inpatient care (e.g., Hawaii Department of Health's Child and Adolescent Mental Health Division, 2012) but as Greenwald et al., (2007), noted discharge is equally important for youth and family engagement because this period contains risks that can result in medical errors and an array of post-discharge adverse events. Discharge needs to start at admission in the form of planning and engage patients, families, and partners in the process which should end with recommendations, reinforcement of patient education, reliable exchanges of information, delineation of post-discharge roles and responsibilities, and provision of a discharge summary report (Greenwald et al., 2007). It is possible to go even further to promote integrated engagement that can reduce likelihood of rapid readmission, for example, by locating discharge sessions in the agency most responsible for discharge services rather than in the hospital (Jensen et al., 2009).

The written discharge summary report is important as a permanent record and initial guide for next steps. Consequently it should be written in a language and literacy level appropriate for the patient and family includes recommendations about medications and therapy, dietary and other lifestyle modifications, patient education and health literacy needs, recommendations for post-discharge care, and instructions about what to do if the child or adolescent's condition changes in order to re-access and/or prevent re-hospitalization (Greenwald et al., 2007). Solomon et al., (2011) set the standard for availability of the discharge report as within a week of discharge but the target population in the U.K. is more of an elective one where post-discharge need for immediate crisis management is lower. According to Greenwald et al., (2007) the discharge report should be available at discharge, and units should be able to make discharge available around the clock if possible and not just daytime office hours. Greenwald et al., (2007) also recommended that the discharge process be subject to benchmarking measurement and continuous quality improvement.

ONCAIPS has made the expectation that units collect and report client feedback a component of the engagement standard. Ortiz & Schacht (2012) noted that measurement of consumers' satisfaction in psychiatric settings is important because it has been correlated with improved clinical outcomes and administrative measures of high-quality care. Solomon et al., (2011) set a standard that information from young people and parents/caregivers is routinely collected to evaluate the unit through a number of means and action plans are developed, and that this can include standardized satisfaction surveys. Information from such surveys can also inform the public, providers, funders and funders about different aspects of care across settings, particularly if these utilize a common satisfaction measure (See also Standard 10. Accountability). Youth and families need to have an opportunity to share their inpatient experience and a voice in evaluating services. Numerous methods and survey measures for describing client satisfaction on inpatient units have been utilized in child and adolescent inpatient research (Biering & Jensen, 2011; Blader, 2007; Brinkmeyer, Eyberg, Nguyen, & Adams, 2004; Kaplan, Busner, Chibnall, & Kang, 2001; Marriage, Petrie, & Worling, 2001; Tas, Guvenir, & Cevrim, 2010).). The use of the same measure would in be ideal, but until such a common method or measure is better identified or developed through literature review and research, ONCAIPS has limited its standardization to a requirement that all units utilize a client feedback mechanism whether qualitative or quantitative, at discharge. It is the ONCAIPS hope that client feedback can help to identify at a provincial level what is working well and what needs improvement.

Although much of the work on engagement speaks to children and their families, without effectively engaging community agencies it is not possible to plan collaboratively or to address community professional lack of confidence or fears of liability that may have precipitated admission, may get in the way of discharge, and may trigger rapid readmission (Bowles & Jones 2005). Collaboration and alliances involving the inpatient unit and other agencies are separately and further detailed in Standard 8.

5. Assessment & Treatment - The unit provides assessments and treatments that have the best evidence and research support.

5.1. The unit uses one or more useful, standardized, developmentally appropriate, reliable, and valid measures or indicators of risk, functioning and/or symptom severity for all patients

5.1.1. For treatment selection and planning

5.1.2. For outcome evaluation (changes in functioning or symptoms from admission to discharge)

5.1.3. If the unit delivers specific treatment modalities for specific symptoms and/or diagnoses, it uses additional measures specific for this task.

5.1.4. 30 day admission rates

5.1.5. Diagnosis

5.2. The unit distinguishes whether it is providing interventions aimed at 1) crisis stabilization and rapid return to the community for treatment, or 2) longer complete course of treatment (e.g., some medications and most manual based therapies may require 6 weeks or longer for completion)

5.3. The unit informs and educates patients, families/caregivers and community partners about the process, costs, and benefits of the inpatient treatments/interventions

5.3.1. The unit identifies the primary presenting problems, symptoms, and diagnoses responsible for the admission and describes the costs and benefits of different medication and psychosocial treatment/intervention option

5.3.2. The unit describes the expected outcomes of inpatient stay for the reasons for admission and inpatient services to be provided (e.g., typically for this problem and service the length of stay is about… or ranges from…to…)

5.3.3. The unit describes the expected outcomes of inpatient stay for the reasons for admission and inpatient services to be provided

5.4. The unit provides evidence-supported treatments/interventions including

5.4.1. Interventions targeting factors important for change that are common across most admissions. These include

5.4.1.1. therapeutic alliance

5.4.1.2. motivation

5.4.1.3. distress tolerance and emotional self-regulation

5.4.1.4. mindfulness

5.4.2. Interventions targeting symptoms, problems, or diagnoses that differ from individual to individual, and which require specific treatment process

5.4.3. Treatment modalities which are offered include individual, family, and group psychotherapy, milieu therapy, and medication

5.5. Length of stay is appropriate for the required and contracted assessment and treatment/interventions (not too brief and not beyond the point where benefits plateau)

Supporting Rationale in Literature & Research

Standardized information gathering and measurement are integral to evidence-based care. Standardization of measurement across units and patients allows for differentiation of problem severity, identification of symptoms, treatment selection, and outcome evaluation. ONCAIPS has identified that there a lack of common measurement in Ontario, and lack of common treatments, which makes it impossible to compare units in terms of needs of clients and performance (Greenham & Persi, 2014). Adding to the lack of clarity is lack of common understanding about whether crisis stabilization can be considered treatment or is better considered as stabilization designed to return a patient to typical functioning. Gowers & Rowlands (2005) noted that there are three typical inpatient service lines 1) risk management including stabilization, 2) assessment of complex problems that cannot be better evaluated elsewhere, and 3) treatment including pharmacotherapy that cannot be better provided elsewhere. In Ontario the role of hospitals has clearly been to provide risk management and stabilization with only a very small proportion of patients receiving longer stay assessment and treatment (Greenham & Persi, 2014).

The ONCAIPS findings raise the question of whether it is desirable for similar units to be using so many different types of assessments and treatment models while presumably providing similar services to similar clients (Greenham & Persi, 2014). ONCAIPS has therefore taken on the task of exploring willingness to adopt common assessment methods and treatments with the best evidence-support in a bid to reduce variability. ONCAIPS further has committed to exploring which assessment methods and treatments might be amenable to standardization provincially.

ONCAIPS appreciates that there are many indicators of client status and progress, including measures specific for certain problems and diagnoses, measures of satisfaction with services, and physical examination with 24 hours of admission, diagnostic assessment and changes to diagnostic status across time, need for out-of-home placement at discharge, and readmissions rates. Certain measures are better suited for pre-post evaluation and others for treatment selection, monitoring of risk or tacking specific

symptoms. Given the crisis orientation of Ontario inpatient units, ONCAIPS has started with exploring willingness to adopt a standardized measure of acuity which is completed at admission and discharge. Such measurement requires that units make the time to complete outcome measurement, to discuss results with families and youth, and to use findings to help shape discharge recommendations (Solomon et al., 2011). Greenham and Persi (2014) found that few settings in Ontario were using pre-post outcome measures and those that did measure outcomes generally used different measures which made comparisons across units impossible.

Provincial adoption of a standardized measure that can reliably and validly track acuity across days (versus across months) is under consideration by ONCAIPS (e.g., Childhood Acuity of Psychiatric Illness scale; access at www.canstraining.com). In the UK the Quality Network for Inpatient CAMHS has organized an Outcome Research Consortium (McDougall & Thompson, 2014) which collects and allows units to compare themselves on the basis of a standard set of measures including 1) the Health of the Nation Outcome Scales (for Child and Adolescent Mental Health -Self and parent rated versions) (Gowers et al., 1999), 2) the Children's Global Assessment Scale of Functioning (CGAS)(Shaffer et al., 1983) and 3) the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) but the UK units have more longer term assessment and treatment patients and therefore less need to track acuity on a daily or brief admission basis. The eventual choice of measure will need to be sensitive to need for cross-system portability across Emergency Departments and community care, and capacity to guide health jurisdiction decisions.

Another common indicator of performance in wide use is rapid readmissions under 28 to 30 days (Brown & Pirkis, 2009). Although readmissions are typically undesirable, those that occur most rapidly and within 30 days have been seen to be the most concerning as these may signal that inpatient care may have discharged prematurely, that follow-up services failed to engage, or that neither inpatient care nor follow-up community services have the components to be effective in preventing rapid readmissions for certain problems and groups of individuals. Fontanella, Zuravin & Burry (2006) found that the highest risk period for readmission was within the first 15–30 days post-discharge and questioned whether the high rate of early readmissions reflect a lack of quality and adequacy of both inpatient and community based services. ONCAIPS does not presume to conclude that a rapid readmission is necessarily preventable, but rather that it is a common indicator worth standardizing across units and exploring for its potential information value. This indicator is also discussed further in Standard 10. Accountability.

Although extensive research has shown low agreement between clinician-generated diagnoses in routine practice, diagnoses nevertheless provide certain information not obtainable by questionnaire and play an important role in treatment planning and subsequent outcome monitoring (Jensen-Doss et al., 2014). Findings of high variability among diagnostic practices across settings in geographic proximity as well as across countries (e.g., James et al., 2014 reported there was a 72.1-fold difference in discharge rates for Pediatric Bipolar Disorder in youth between the United States and England) support the need for understanding of practice differences and routine tracking of inpatient diagnoses for reliability.

Although there is a general expectation on all fronts that inpatient units provide services that are effective and helpful, the assessment and treatment variations found between units present a concerning level of possible variation from best practice (Greenham & Persi, 2014). Government frameworks and standards expect that a range of treatments/interventions including medication, individual and group therapies, and

family support are to be provided on inpatient units, and equally clear that these treatments/interventions should be supported by research trials and findings (Ontario Ministry of Child and Youth Services, 2008; Solomon et al., 2011).

Very little is known about the consistency or adherence to best practice standards for pharmacotherapy across units. What is known suggests there have been increases in medication use for children and adolescents in Canada that have accompanied increasing rates of presentations to emergency care and inpatient care (Canadian Institute for Health Care research, 2015). Both increasing presentations to hospitals and increasing reliance on medication may signal some reduction in the ability of non-hospital psychosocial services to respond to mental health care needs and possibly increasing inabilities of families and natural support systems to cope as well as they have in past. ONCAIPS anticipates that future benchmarking will help provide a better picture of inter-unit consistency in use of medication for similar disorders with a view to improving benchmarking in these areas.

There is insufficient research comparing different treatments for their applicability, and effectiveness on inpatient units. Most of the treatments provided on inpatient units have been adapted, typically in briefer form, from manualized therapies found to be promising or efficacious in outpatient systems of care (e.g., Fonagy, Cottrel, Phillips, Bevington, Glaser, & Allison, 2015). Outpatient trials have resulted in a vast array of evidence-based practice recommendations that are widely disseminated (e.g., Hawaii CAMHD http://health.hawaii.gov/camhd/resource-library/research-and-evaluation, research effectiveness (e.g., the Cochrane reviews which are published in the Cochrane Library at http://www.cochrane.org/cochrane-reviews) and guidelines for the implementation of evidence supported psychosocial treatments and pharmacotherapy (NICE guidelines https://www.nice.org.uk/guidance, NICE clinical pathways http://pathways.nice.org.uk/ the CAMHD Biennial Report, http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs013.pdf and the evidence-based child and adolescent psychosocial intervention matrix from the American Academy of Pediatrics http://coe.csusb.edu/documents/CRPsychosocialInterventions.pdf).

Because almost all of the outcome research has been validated on non-inpatient populations, it is not clear which treatments, medications, or treatment components are best suited for inpatient care across the varied lengths of stay for different problems and groups. Delaney (2002) pointed out, the literature contains many behavioral and cognitive therapies designed for psychiatric disorders, but literature only very rarely addresses if and how these therapies transfer to inpatient treatment and brief inpatient lengths of stay that are numbered in days rather than weeks or months. Process and outcome studies specific to inpatient care which evaluate different interventions across age groups, problems, lengths of stay and problem types are badly needed. One of the only ways to assure that what has been studied in other contexts works within the constraints of inpatient care is to directly measure it. Solomon et al., (2011) has proposed a standard that the outcome of treatments/interventions be directly measured, and that these measurements be shared with children and adolescents and their families as well as with the larger system for accountability (see also Standard 10).

There is very little need to continue to promote research that demonstrates that inpatient care is generally beneficial as this has been well established, but there is a pressing need to demonstrate that the benefits of inpatient care relative to less costly and less restrictive setting (Barwick & Boydell, 2005),and an equally pressing need to identify which components of care are most effective. Studies since the 1980s

have generally reported rapid and relatively lasting improvements in child and adolescent functioning from admission to discharge across most age groups, measures, setting types, treatment approaches, models, lengths of stay, countries, and problems (e.g., Gavidia-Payne, Littlefield, Hallgren, Jenkins, & Coventry, 2003; Green et al., 2001; Hanssen-Bauer et al., 2011; Hengeller et al., 2003; Setoya et al., 201). The likelihood that these changes are the result of inpatient treatment is supported by findings that significant and meaningful" improvements are rapid and tend to occur shortly after admission, and not before (Green et al., 2001). Common factors such as therapeutic alliance, respite from stress, and attachment supports provided by staff , rather than specific therapies or medications may be the most responsible for the observed outcomes (Green et al., 2006; 2007).

There are no RCT studies, meta-analyses, or comparative head-to-head outcome evaluations of different therapies or therapeutic components on inpatient units (Kurth, 2009). The lack of research to guide which inpatient therapies or components to preferentially use may explain findings including the Ontario ones where no two units shared the same treatment models (Greenham & Persi, 2014). Without additional research and standardizations units will continue to utilize their own models of care. Children and adolescents admitted to one unit will receive very different care than those admitted to another unit. Although ONCAIPS has identified the need for common assessment and treatment pathways it accepts that such standardization is a longer term aspiration and that getting there will require improvements in our understanding of inpatient treatment component processes and outcomes.

It is also important for inpatient units and their community supports to appreciate that while most children and adolescents improve, and although improvements last up to a year or more, that as many as 45% of children and adolescents are eventually readmitted suggesting that inpatient children and adolescents are a highly vulnerable group with a significant proportion continuing to have unmet treatment needs that will require a better system of follow-up and prevention than currently available (Arnold, Goldston, Ruggiero, Reboussin, Daniel, & Hickman, 2003; Pedersen & Aakrog, 2001). Better studies will be required that can identify the particular costs and benefits of hospitalization relative to alternatives.

The prominence suicide risk in precipitating referrals makes it important to ask whether units are in fact the best option for assessment and treatment suicide risk. Do inpatient unit assessments and treatments actually reduce completed suicides or suicidal behaviors. Or are admissions more reassuring than effective change agents. Certainly not everyone agrees that suicide prevention should be the primary role of inpatient units (e.g., Werry, 2009). Engquist and Rydelius (2006) point out that most individuals who completed suicide in their study were not protected by services and were receiving either inpatient or outpatient treatment at the time of their suicide. McShane, Mihalic, Walter, & Rey (2006) in their Australian inpatient sample found that suicide attempts and suicidal thoughts were as prevalent at 2.5 year follow up as at the time of initial inpatient assessment. Greenfield, Larson, Hechtman, Rousseau, and Platt (2002) found that inpatient care did not confer advantages over a rapid-response outpatient model for suicide risk intervention.

But such rapid-response outreach programs are rare and referrals for management of suicide appear to be well established reasons for admission (Greenham& Persi, 2014). Reports suggest that around a half of inpatient admissions are for suicide risk (Arnold et al., 2003; Larsson and Ivarsson, 1998; Pottick, Warner, Isaacs, Henderson, Milazzo-Sayre & Manderscheid, 2004), that reduction of suicidal behaviors occurs within several weeks (Shaffer & Pfeffer, 2001), that briefer length of stay correlate with increased

likelihood of re-attempt (Brent et al., 2013; Christiansen & Larsen, 2012), and that completed suicides are statistically very infrequent (i.e., 19 of 1400 according to Engquist & Rydelius, 2006) though admittedly publicly intolerable at any number. Many youth continue to experience suicidal ideation and engage in repeated suicidal behavior after discharge from outpatient, emergency departments, and inpatient units (Christiansen & Larsen, 2012; Goldston et al., 1999; King et al., 1995; Prinstein et al., 2008). After many decades of research and clinical trials, it has been argued that there are still no empirically validated psychosocial or pharmacological treatments that effectively prevent child and adolescent suicide raising a need for new improved interventions and acceptance that a zero-suicide rate is not yet imminent (Brent et al., 2013; Dubicka et al., 2010; Nock et al., 2013).

It is important to also important to consider potential adverse events of hospitalization on suicidal behaviour. Admission may result in first-time, or increased, exposure to peer suicidal behavior something which may increase rather decrease risk for suicidal thoughts and behavior (Crepeau-Hobson & Leech, 2014; Gould, Kleinman, Lake, Forman, & Middle (2014). Furthermore perhaps as low as 1 in 5 of those at risk for suicide come to the attention of hospitals despite similar clinical needs and presentation which raises the question about the need to consider the relative advantages or rapid response community-based crisis intervention as opposed to hospital-based crisis intervention (Pages, Arvers, Hassler, & Choquet 2004; Gex, Narring, Ferron, & Michaud, 1998).

Regardless of whether inpatient care represents the only perceived option or the most effective option, it seems likely that inpatient units will continue to be utilized for this purpose. So long as inpatient units play such a prominent suicide risk management role, it will be important to assure that inpatient units complete this task as helpfully as possible. Although there are no common evidence supported standards internationally for the inpatient treatment of suicidal adolescent patients, or for optimal follow-up (Grossman & Kruesi, 2000), there is a need for such guidelines and for the evaluation of whether such guidelines can make an appreciable difference. Some standardization may be able to be explored by partnerships which may evolve out of ONCAIPS collaborations. Child and adolescent inpatient standards for the management of suicide may be one component of broader risk management standards across different services and age groups, risk types (e.g., suicide ideation only versus frequent attempts) and diagnostic groups (e.g., obsessive, depressive, bipolar, adjustment reactions, and borderline traits).

6. Health Promotion Activities - Activities that help maintain and improve mental health are available to all patients.

6.1. The unit provides a weekly activity schedule that includes opportunities to learn about and to practice habits of healthy lifestyle. Opportunities include

6.1.1. Exercise

6.1.2. Nutrition

6.1.3. Sleep hygiene

6.1.4. Personal care

6.1.5. Socialization with peers on the unit

6.1.6. Socialization with families and relevant others

6.1.7. School Work

6.1.8. Recreation & Arts (e.g., music, dance, art)

6.1.9. Relaxation (e.g., breathing, muscle relaxation, yoga)

6.1.10. Work (e.g., gardening, food preparation)

6.1.11. Free time

6.2. The weekly schedule is available to patients, families/caregivers and community partners.

Supporting Rationale in Literature & Research

It is important to not confuse 1) specific therapies with defined steps known outcomes for the treatment of specific problems or diagnoses from 2) activities of daily living that can be therapeutic. As Bloom (2005) points out "therapy" in residential settings does not occur around the clock and formal therapeutic intervention (as opposed to milieu activities) do not constitute a significant part of the child's day from a time perspective. Most of the time is occupied in normalizing, stabilizing, and health promoting schoolwork, meals, socialization, recreation and other activities many of which are supervised and supported by nurses and child and youth workers (Bloom, 2005) Such activities need to distinguished from those more specific formal sessions that target specific presenting problems and symptoms.

Activities have therapeutic value for restoring and improving functioning and are core components of recovery and can be as valuable as therapy for their roles in normalizing, stabilizing and de-stigmatizing. Absent or insufficient activities and scheduling can fail to provide required supports for recovery.

Furthermore inactivity and under stimulating inpatient mental health can also be harmful (Wing & Brown, 1970). Various studies on adult inpatient units have observed widespread problem of patient inactivity (e.g., Sundram 1987, Smith et al. 1996). The need for individuals to be involved and active is well recognized (Radcliffe, & Smith, 2007). Not only is activity important for recovery but it is also generally welcomed children and adolescents who when surveyed reported that they much prefer to be active and occupied rather than resting alone with "nothing to do" (Jacobs et al., 2004). Solomon et al., (2011) provide standards that expect units to provide opportunities for children and adolescents, to participate in activities such as schoolwork, exercise, relaxation, recreation, meals, outings, socialization, and sleep routines, with many activities preferably being off the unit and in the community whenever possible.

Staff involvement is important (Faulkner & Biddle, 2002). Unfortunately, staff who adopt a custodial and observational role rather than seeing themselves as active engaged partners fail to optimize their own participation and patient involvement in activities (Mullen, 2009). It has also been pointed out that overcoming one of the more challenging obstacles may involve assuring protected time to allow staff to engage with patients in exercise and similar activities (Brimblecombe, Tingle, & Murrells, 2007). Cromwell & Maier (2006) reported data from adult psychiatric facilities show considerable variation across settings in average daily direct staffing time per patient. Standardization of expectations for minimal and optimal direct time may encourage a more desirable level of staff and patient engagement in health promotion activities.

One of the ways in which children and adolescents differ from hospitalized adults is in terms of their need to stay connected with regular academic activities and receive support for accommodations that they and schools will need to make because of mental illness. Attending school and participating in learning reduces likelihood of difficulties during school re-entry and further provides children with a sense of normalcy and sometimes additional hope. Models of involvement include one-on-one teaching either in a hospital classroom or at the bedside as well as help with course selection or reduction, rearranging timetables, work completion, test examination, identification of new special needs, and involvement in support for the work of Identification, Placement, and Review Committees (Ratnapalan, Rayar, & Crawley, 2009).

The World Federation for Mental Health recognizes the importance of physical exercise and other stress reducing activities for mental health (e.g., World Federation for Mental Health, 2004). Mindfulness, progressive muscle relaxation, mental imagery, drama, and art show promising health benefits as well as specific impacts on reduction of aggression on inpatient units (e.g., Bornmann, Mitelman, & Beer, 2007).

Tas, Guvenir, & Cevrim (2010) considered it important to understand the importance of meals on child and adolescent inpatient units not only in terms of nutrition but in terms of social and symbolic benefits.

Similarly healthy sleep routines can help with common inpatient problems like insomnia as well as with development of good personal self-care habits and comforting attachment routines prior to sleep (Collier, Skitt, & Cutts, 2003). Not only do changes from sleeping at home to sleeping in typically well lighted and occasionally noisy units have the potential for short term sleep disruption, but inpatient children and adolescents may have also been found through sleep study to have a high prevalence of sleep disturbance and altered sleep architecture that appear linked to the severity of psychopathology (Shahid, Khairandish, Gladanac, & Shapiro, 2012). Unit lightning, noise, and routines may help promote or

disturb sleep and are important to standardize and to work hand in hand with more focused treatments such as cognitive behavioral therapy for insomnia (e.g., Harvey et al., 2015).

Weekly schedules to assure activities are in place on many units and activity scheduling may have particular value as a part of behavioral activation for individuals with depression (Iqbal & Bassett, 2008). Although much more research is required to identify the best blend of activities generally and for different presenting problems, ONCAIPS has proposed a starting point which is the expectation that that all children and adolescents have opportunity and encouragement to participate in activities that promote their recovery and resilience. The hope is that introduction to, and practice of healthy lifestyle habits will result in some continuity with school and community activites before admission and after discharge.

7. Staffing & Training - Staff are appropriate in number and type to provide safety and care, well trained, and function within an interdisciplinary model.

7.1. Numbers and types of staff and disciplines are appropriate to ensure the safety and care needs of inpatients

7.1.1. Staffing models are formally identified and evaluated on an ongoing basis

7.1.2. The common tasks and distinct roles of each discipline in the model of care are available to all staff

7.2. Competencies are formally identified, needs evaluated, and training is available and provided

7.2.1. For roles and skills common to all staff around safety and care

7.2.2. For roles and skills specific for each discipline

7.3. The unit has formalized processes for addressing, optimizing and evaluating team interdisciplinary functioning and development

Supporting Rationale in Literature & Research

Units need to have capable, qualified, and effective staffing. This includes sufficient numbers and types of disciplines to assure safety, to lead activities, to complete and integrate specialized interdisciplinary assessments and treatments, to provide ongoing training and supervision, and to engage in process and outcome evaluation (Solomon et al., 2011).

The interdisciplinary model of care is currently a standard, and measures of interdisciplinary diversity have been developed which can help differentiate units with one or two disciplines from those with a more diverse specialized complement (O'Herlihy et al., 2001). Units should minimally be able to demonstrate that they have qualified staff with the necessary skills to provide a repertoire of basic psychological interventions in line with recommendations such as those provided by the National Institute of Clinical Excellence best practice guidelines (Baskind et al., 2010).

In the absence of better empirical data that define a team composition which is most effective and efficient, one is left to be guided by current and past staffing models, opinions from professional bodies and feedback from consumers. Reviews of the adequacy of staffing internationally tend to focus upon the presence or absence of an interdisciplinary team that minimally includes psychiatrists, nurses, psychologists, social workers and occupational therapists (Miller, Siggins, Ferguson & Fowler, 20110). But the preceding list is not exhaustive as there are many other potential profession types which may be important. Roles for aboriginal teams as parts of mainstream mental health services (Fielke, Cord-Udy, Buckskin, Lattanzio, 2009) as well as roles for traditional healers as part of the healing process in some

communities (Jones & Brideson 2009) are being explored for the broader mental health system and also pose some potential advantages for inpatient care.

Greenham and Persi (2014) reported that Ontario differs from the U.K. in its greater use of child and youth workers who after nursing represent the most frequently employed group on inpatient units. Child and youth workers provide a level of behavioral management competencies that complement the medical and health care skills of nurses. One of the similarities that both Ontario and the UK share is that like all other systems of inpatient care internationally, units are subject to fiscal pressures and problems with retention of skilled staff that can result in understaffed and under-specialized units. Hence there is a need for standards to help protect staffing numbers and types in a way that helps preserve the quality of care for admitted children and adolescents.

Solomon et al., (2011) provide standards for both numbers and types of staff and training. Numbers suggested for direct care are 1:1 in high risk and 3:1 in low risk staff to patient ratios, with a minimum of 2 staff on at all times and at night. The standards for what has been described as an ideally sized unit of 10-12 beds are for a minimum of 2 FTE nurses, 1 FTE manager, 1 FTE psychiatrist (can be split into 2 half time positions for back-up needs), 1FTE psychologist and 1 FTE occupational therapist with access to dietitians, recreation therapist, speech and language therapist, and other specialized supports if required.

Unfortunately financial constraints and problems with recruitment and retention have resulted in some units having much lower staff per bed per shift than others, some units lacking core key interdisciplinary components such as psychiatry, psychology, and social workers, some units employing staff whose credentials and training are fall short of capacity for the inpatient tasks expected of them, and some units lack an interdisciplinary team altogether (Ellila, Sourander, Valimaki, & Piha, 2005; Foulkes, 2014; Greenham & Persi, 2014; Jaffa, Lelliott, O'Herlihy, Worrall, Hill, & Banerjee, 2004; Miller et al., 2011).

Not only do the right numbers and types of staff have to be in place on inpatient units but they need to be supported by supervision and training. In Ontario, Foulkes (2014) surveyed whether front line staff (nurses & child and youth workers & allied health but not physicians) receive the kind of standardized training (beyond hospital basic requirements) that would assure the most consistent high quality specialized inpatient work with children and adolescents. The survey findings indicated that over half of the units surveyed required non-violent crisis intervention training because of concerns about risks to patients and hospital liability but most sites did not require mandatory specialized inpatient education for their staff on most other aspects of child and adolescent inpatient assessment or intervention. Although there are no models of staffing that are currently supported by research as a gold standard, staffing models nevertheless need to be explicitly stated in order to guide unit functioning, to inform consumers and planners, and to permit evaluation.

It is generally accepted that staff have tasks in common and some tasks that are more (but typically not entirely) discipline-specific. Some roles in common include contributions to observational assessments, and building a therapeutic alliance. Although all professions can take part in most inpatient activities, there are some activities which have tended to fall more so to particular disciplines because of their training. Nursing care has been placed to provide ongoing monitoring of the milieu, daily management of symptoms and side effects, and providing supportive interactions to help a young person through crisis and then engage t in recovery (Delaney, 2002; Delaney & Lynch, 2008). Child and youth workers may

take lead in patient activity scheduling and help establish limits and consequences. Psychiatrists are typically tasked with leadership of the inpatient interdisciplinary team, admission and discharge decisions, application of involuntary certification, as well as providing diagnosis and medication. Psychologists can provide direct therapy, assessment of the functions of problematic behaviors, case formulation and recommendations from a psychological perspective as well as supervision, training, and research (Christofides, Johnstone, & Musa, 2012). Inpatient social workers may be best able to lead in areas where they can use social work theory and practice to help understand and help the team better understand the relationship of family roles and structure to adolescent problems that precipitated the admission, to provide case family and larger system case management, and to help the youth and family consider and access aftercare services and alternatives to hospitalization (Specht & Glasser, 1963). The ONCAIPS task going forward will include consideration of how best to provide some standards that take into account both different disciplines and different activities, and how to cope when a unit is missing a key component such as an on-unit psychiatrist.

The lack of identified training programs specific for child and adolescent inpatient mental health is concerning as the youth who are admitted represent a group of youth requiring very specialized and intensive interventions. Puntil, York, Limandri, Greene, Arauz, & Hobbs, (2013) noted that there are also serious gaps in nursing training across high prevalence areas such as suicide risk and that despite the development of frameworks, competencies, guidelines, and standards that none of these provide the specificity required for provision of services on inpatient mental health units. Inoue, Del Fabbro, & Mitchell (2012) identified the top 2 educational priorities for nurses on child and adolescent inpatient units as improved knowledge of normal development, mental illness, and disorders in childhood and adolescence, and understanding how to work with the parents and families of children with mental illness. Sargeant (2009) wrote a handbook describing the core skills and competencies required to work as a part of an inpatient child and adolescent team. Sargeant (2009) recommended providing all staff with learning about families and child development, behavioural skills including therapeutic alliance development, self-care skills and teamwork, risk management, and understanding and facilitating service pathways (including consent and transitions to other services).

In terms of actual best training methods, Delamater et al (1984) found that in-service training had little effect upon inpatient staff behaviour and that direct feedback in actual care situations and role playing simulation led to the greatest staff improvements. Conjoint work involving novice-expert pairs may provide additional benefits.

Finally it is important that unit staff function in a collaborative integrated interdisciplinary manner that improves effectiveness and efficiency. The need to avoid territoriality and explore common functions that can be supported by all staff (e.g., medication, individual psychotherapy, family therapy) has been recognized as important for interdisciplinary functioning (Armstrong,2000) as has the need to accept that in the face of recurring psychiatric shortages other disciplines may have to do more (Niller et al., 2011).

ONCAIPS could have gone further than it did in recommending minimal staff numbers, types of disciplines, and required competencies, but a decision was made for additional study and consensus building prior to defining more detailed benchmarks for staffing.

8. Inter-System Collaboration - The unit has a well-defined distinct valuable role within a complete continuum of care, collaboration with other partner mental health services, and mechanisms to assure good transitions and continuity of care.

8.1. The unit identifies and addresses gaps in its continuum of care with its consumers and partners

8.2. The unit works with the continuum of care and consumers to

8.2.1. Improve access and prevent unnecessary inpatient admissions

8.2.2. Redirect admissions that should be seen at higher (e.g., specialized provincial resources) or lower levels of care

8.2.3. Eliminate obstacles that delay or block discharge (e.g., non-psychiatric residential, housing, wraparound, intensive services at home, family preservation, outpatient psychiatry)

8.3. The unit reviews criteria, processes, and protocols in place with service partners to assure ease of transitions and continuity of care

8.3.1. The unit has at least one annual meeting with key partners where barriers to admission and discharge, assessment and therapeutic approaches are discussed and services are better aligned

8.3.2. Referral and post-discharge partners are engaged in collaborative care with the unit across referral, care, and discharge processes

8.3.3. Partners-in-care are routinely invited to sessions and participate in planning and contracting plans for inpatient care and discharge plans

8.4. The unit is engaged in provincial and national collaborations that aim to improve and standardize best practices for child and adolescent inpatient and mental health services for children, adolescents, and their families

8.4.1. ONCAIPS & its national partners

8.4.2. Provincial Council for Maternal Child Health

8.4.3. LHIN initiatives

Supporting Rationale in Literature & Research

Units are expected to collaborate with other components in the larger system of care, and to remove obstacles to effective collaboration. The hospital-centric view of services where the hospital was seen to be the HUB of mental health services has transformed into a very different view where hospitalization is seen to be a brief episode in a significantly longer course of services that occur in the community. Systems of care models have shifted the philosophy of inpatient care away from a professionally-centred medical one, to one which is increasingly child- and family-centered and a part the community and its culture (Sondheimer & Evans, 1995). Although inpatient units are valuable components in the system of care for numerous reasons, including ease of access and availability, neither emergency departments nor inpatient services are, or should be, the end- or the start-point for services. Emergency care and inpatient services are way-stations on a journey where individuals engage in a process of recovery, resilience, inclusion/participation, and activities that will improve quality of life, flexibly accessing a variety of services from the continuum of care.

This continuum of care has been described as a series of levels or steps, at times as an array of increasingly intensive and restrictive generic components of care, and at times as involving different levels of problem and diagnosis-specific services (e.g., services including specialized inpatient and community services for youth with substance abuse and concurrent disorders; eating disorders, first episode psychosis and schizophrenia), youth forensic programs, autism and developmental disorders, mood and anxiety disorders, and personality disorders)

The Ontario Ministry of Child and Youth Services (2006) conceptualized four levels of care resembling the Tier 1 to Tier 4 levels of services defined in the UK. The first level of care is for Ontario youth in good mental health, the second for those at risk of experiencing mental health problems, the third for those experiencing significant mental health problems, and the fourth for children likely to have severe, complex, rare or persistent mental illness (Ministry of Child and Youth Services, (2006). The Highly Specialized Services and Supports Advisory Group (2003, p.17) who contributed to the conceptualization of the South West Ontario ideal model of care used the term "highly specialized services and supports" to describe the services which can be provided to children/youth needs at Level 4 whose problems are severe, complex and determined to be refractory to primary and secondary care. The highly specialized services and supports comprised a residential treatment for youth with co-morbid developmental disorders, a regional specialized inpatient care setting which provided primarily assessment and treatment rather than crisis, an eating disorder program and an autism program. In this model access to the regional assessment and treatment setting occur by way of a coordinated service mechanism case manager, or directly from an inpatient crisis setting. It is not clear in the absence of further study on how well the model was implemented and with what results whether the approach proved to be a viable one. What the conceptual model does, however, clearly show, is an attempt by the model developers to encourage a stepped care approach.

The ideal system of care has also been described as an array of services including office or outpatient clinic, intensive case management, home-based treatment services, family support services, day treatment programs, partial hospitalization or day hospital, emergency/crisis services, respite care, therapeutic group home or residence, crisis residence, non-hospital residential treatment services, and inpatient services (American Academy of Child and Adolescent Psychiatry, 2008).

Although there is a broad-based expectation that communities provide access to the right combination of services, treatments and supports, when and where people need them (Mental Health Commission of Canada, 2012) it is also widely recognized that there are very significant geographic variations not only in inpatient services but also in the availability of other services to support inpatient care. Kutcher, & McLuckie, (2011), reported that the Canadian youth and family point of view indicates that they face serious difficulties trying to access mental health services because of a combination of factors such as lack of integration in services, funding cuts causing service reductions, excessively long wait times, lack of availability outside office hours, and a poor system design for user need. Street (2006) identified gaps in the UK system of care concluding that the absence of long-term therapeutic provision and post-discharge support services results in over-dependence on inpatient care. Bickman et al., (1996), in the US, similarly found a relationship between the absence of community services and the greater likelihood of inpatient service utilization. As mentioned previously, Greenfield, et al. (2002) found that inpatient care did not confer advantages over a rapid-response outpatient model for managing suicide risk, but in the absence of such rapid response models consumers and emergency care may not have options beyond the inpatient one.

The increasing reliance upon inpatient care may be in part due to absent centralized monitoring, and planning bodies at provincial and national levels. In response to findings of inconsistency and variability in access and levels of care, Crofts and Hipkiss (2015) emphasized the need for an integrative process across jurisdictional, government, and privately provided services that identifies, secures, and monitors the ability of services to meet people's needs in a timely fashion. Unfortunately a commissioning process such as is available in the UK (Crofts & Hipkiss, 2015) is missing at provincial levels, leaving voluntary communities of practice such as ONCAIPS to help provide data and processes for more broad-based integrative provincial monitoring and planning.

As a way of appreciating the interdependence of inpatient units with other systems of care, ONCAIPS has endorsed an initial standard that expect inpatient units to well define their role and relationships with other services in their geographic area, to identify gaps in supportive services, and to facilitate transitions from community to hospital and back. ONCAIPS further recognizes that innpatient services should be developed, operated, and evaluated as a part of the larger mental health system continuum of care and not in isolation (Stroul & Friedman, 1986), and that there is a need for units to work beyond their local hospital and to engage in provincial and national collaborations to rectify gaps in services. See also Standard 2 which specifically discusses access to, and discharge from, inpatient units, and Standard 10 which discusses the importance of reliable data for system-of-care management.

9. Consumer & Public Information - Information about the unit and its services are easily available to children, adolescents, families/caregivers, community partners and the general public.

9.1. Children and adolescents, families/caregivers, community partners and other referral sources can access information about the unit prior to admission

9.2. Appropriate information (electronic or print) is available in the emergency department and in other referral settings

9.3. The unit has a user-friendly public website that provides accurate, up to date information. Information on the public website should include at least the following:

9.3.1. The range of services provided

9.3.2. How to access inpatient services and alternatives

9.3.3. Admission and exclusion criteria (see also Standard 1)

9.3.4. Typical length of stay and outcomes

9.3.5. When the information was last written or updated

Supporting Rationale in Literature & Research

Research indicates that a majority of youth and parents do not have an accurate or informed view about what inpatient admissions can and cannot provide prior to admission (Akin et al., 2006). There are also significant difference of opinions between referring professionals and inpatient staff about what youth should be admitted and for what risks and services which reflect the higher expectations of the public and the more humble expectations of unit staff (e.g., Cotgrove, 1997). Inpatient units often market their services in ways that emphasize the positives in services and that can mislead the public and patients about effectiveness and resources. This leads to unrealistic expectations, disappointment, and frustration with services (Akin et al., 2006).

Solomon et al., (2011) have a number of standards to address this problem including expectations that information about the unit and its services be made available to youth and families prior to admission. This includes expectations for a website with accurate information about inpatient services (Solomon et al., 2011). Accuracy is important as anxiety-promoting but one-sided statements about what would happen in the absence of treatment and exaggerated claims about outcomes of inpatient care can erode public and consumer confidence in mental health providers and their services.

Pollock, Grime, Baker, & Mantala (2004) noted that although informing patients is generally accepted to be a core component of quality care that the actual practice of informing patients is lagging. This is reflected by consumer complaints about incomplete or misleading information about services.

In order to narrow the gap between what users and providers of inpatient care believe about inpatient services, the ONCAIPS membership endorsed the need for units make available accurate information about how to access services, who can refer, who can be referred, process of care, risks and benefits, typical length of stay, discharge process, and the role of community follow-up. The current initial proposed ONCAIPS standards includes a Standard and components that aim to improve accuracy of expectations, and better informed admission, care, and discharge planning. See also Standard 2.

10. **Accountability** - Information about utilization and performance is publicly available to users, providers, funders, and communities of practice.

10.1. The unit collects, retains, and reports reliable and valid information about its services. Utilization and performance measures include

10.1.1. Numbers of beds, types of beds, and locations

10.1.2. Precipitating Problem

10.1.3. Gender, Age

10.1.4. Primary (Most Responsible) Diagnosis

10.1.5. Setting Discharged To (i.e., home versus out of home placements)

10.1.6. Occupancy By Month (could also do admissions by month)

10.1.7. 30 day re-admission rates

10.1.8. Delays in accessing a bed

10.1.9. Implementation of Standards

10.2. The unit participates in providing information and making use of existing data bases to monitor its services

10.2.1. Own hospital data bases

10.2.2. ONCAIPS membership, website, and annual survey data

10.2.3. CIHI data including Discharge Abstracts Database, and data in the National Ambulatory Care Reporting System (NACRS)

10.2.4. The Provincial Council for Maternal and Child Health

10.3. The unit provides information and participates in cross sector Performance Benchmarking and Standards Development including but not limited to ONCAIPS

10.4. ONCAIPS collaborates in benchmarking and standardizing best practices for mental health, and advocating for changes and improvements to the mental health system with key partners such as

10.4.1. Canadian Child and Adolescent Inpatient Psychiatry Services

10.4.2. Provincial Council for Maternal Child Health

10.4.3. Children's Mental Health Ontario

10.4.4. Ontario Hospital Association

Supporting Rationale in Literature & Research

Accountability is a guiding principle of government child and adolescent mental health frameworks (e.g., Ontario Ministry of Child and Youth Services, 2008). Accountability requires accurate, current, and relevant information about services and users of the system. This information can then be utilized to evaluate the state of the child and adolescent inpatient system of care, its role in the continuum of care, and its needs for improvement. Without reliable and valid information, societal resources can be inappropriately used to fund ineffective and inefficient services.

Solomon et al., (2011) articulated the expectation that units collect unit-specific information and then act upon this information in a way that reduces risks and improve services and outcome. The Solomon et al., (2011) standard unfortunately lack a comprehensive benchmarking system which is important for cross-unit comparisons (Brann et al., 2011) and comparison against ideal benchmarks. Benchmarking data and not only indication of adherence to standards is required in order to track inpatient unit performance across time and against similar settings in a way that can better identify promising practices and potential for improvement.

Standardized benchmarks specific for accountability to funders, consumers, and stakeholder have been developed for broader systems of care (e.g., Brann et al., 2011; Hawaii Department of Health's Child and Adolescent Mental Health Division, 2012). The Provincial Council for Maternal and Child Health Benchmarking Report (2012) in Ontario also gathers and makes available comparative data across hospitals with the aim of helping participating organizations identify potential opportunities for improving clinical and operational efficiency and quality and utilization management processes. These broader reports are essential for larger health and mental health system monitoring but lack the degree of detail and specificity required by child and adolescent inpatient mental health providers and planners. Numbers of beds, locations, utilization by geography, age, gender, and diagnosis are important to understand who is using inpatient care and why. Delays in accessing a bed also important as stated in Standard 2 on access which explicitly sets a standard that no child who needs the safety and services of an inpatient unit shall be unable to access one.

Accountability to patients and their families is also essential. In order to understand the needs and expectations of referral source, patients, and parents, reasons for the admission in the form of precipitating problems and not just diagnoses be collected. Currently there is a lack of information in national and provincial databases to clarify the reason for referral in terms of the problems and needs that actually and proximally precipitated the referral (Cotgrove & Gowers, 1999). Gowers and Rowlands (2005) defined precipitating problems along a single continuum of three services types, 1) high risk (generally to self as a result of self-harm/suicidal thoughts/self-neglect/abuse); need for intensive assessment, (e.g. where diagnostic uncertainty exists); and need for intensive treatment (including trials of medication), but this confuses actual patient problems with potential solutions such as further assessment and treatment. Ideally, diagnostic uncertainty and medication reviews on their own would

typically be better addressed by longer term outpatient assessment and treatment in the home and school environment. But unfortunately this may not be possible if specialized community services are unavailable, inaccessible, or not sufficiently trusted.

Greenham and Persi (2014) found that perceived suicide risk was the most frequent driver of admissions in Ontario. As mentioned earlier, this may be the result of growing lack of acceptability on the part of community systems to expose themselves to risks of complete suicide, despite the evidence suggesting that community programs are likely as effective in reducing risk (Greenfield, et al., 2002) albeit not as immediately reassuring. If we are to address the most common risk or fear that precipitates admission it will be difficult to do so without better information about inpatient unit performance and outcomes particularly relative to community programs.

Rapid unplanned readmission to inpatient care is an undesirable outcome and a common indicator of quality care. From this viewpoint alone a 28-day or 30-day readmission rate is worth tracking. Its validity as an indicator of the quality of inpatient care is more tenuous as rapid relapse may be the result of other factors including problems with the accessibility and quality of community follow up. Some findings do suggest modest support that attending to stability of clinical condition and preparing patients for discharge can protect against early readmission (Durbin, Lin, Layne, & Teed, 2007). The Mental Health Commission of Canada (2012) has also identified hospital readmission rates for mental illness within seven and 30 days as benchmark indicators. The one month readmission indicator was also part of the Australian National Mental Health Benchmarking Project (Callaly, Hyland, Trauer, Dodd, & Berk, 2010).

Ontario does not currently have an integrated centralized performance monitoring system with benchmarks specific for child and adolescent inpatient mental health units. But ONCAIPS with its annual membership updates, its currently proposed standards, and year-end benchmarking surveys is helping the community of Ontario child and adolescent inpatient mental health units to move in this direction by providing median performance benchmarks and opportunities for comparison (Greenham & Persi, 2014). Ideally the ONCAIPS information should be contextualized performance monitoring for the broader mental health system.

REFERENCES

Akin, B., Bryson, S., Gomi, S., Moore, T., Parkinson-Arnold, E & Tullis, L. (2010) *Inpatient psychiatric care for children and youth: Precipitants, and predictors of admissions and readmissions.* Lawrence, Kansas: Office of Child Welfare and Children's Mental Health.

American Academy of Child and Adolescent Psychiatry (2008). The Continuum of Care. Facts for Families. Number 42. New York: American Academy of Child and Adolescent Psychiatry, www.aacap.org.

Armstrong F (2000) Dope 'em up and ship 'em out: Issues in mental health care. *Australian Nursing Journal, 8(5),* 26.

Arnold, E., Goldston, D., Ruggiero, A., Reboussin, B., Daniel, S., & Hickman, E. (2003) Rates and predictors of rehospitalization among formerly hospitalized adolescents. *Psychiatric Services, 54,* 994–998.

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R.B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 24,* 11-15.

Baeza, I., Correll, C.U., Saito, E., Amanbekova, D., Ramani, M., Kapoor, S., Chekuri, R., De Hert, M., & Carbon, M. (203). Frequency, characteristics and management of adolescent inpatient aggression. *Journal of Child and Adolescent Psychopharmacology, 23,* 271–281.

Baren, J.M., Mace, S.E., Hendry, P.L., Dietrich, A.M., Grupp-Phelan, J., & Mullin, J. (2008). Children's mental health emergencies: Part 1 - Challenges in care: definition of the problem, barriers to care, screening, advocacy, and resources. *Pediatric Emergency Care, 24,* 399-408.

Barwick, M., & Boydell, K. (2005). *A review of acute child and adolescent mental health services.* Toronto, ON: Ministry of Children and Youth Services.

Battrick, C., & Glasper, E.A. (2004) 'The Views of Children and Their Families on Being in Hospital', *British Journal of Nursing, 13(6),* 328–38.

Bickman, L., Foster, E. M., & Lambert, E. W. (1996). Who gets hospitalized in a continuum of Care? *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(1), 74-80.

Berntsen, E., Starling, J., Durheim, E., Hainsworth, C., de Kloet, L., Chapman, L., & Hancock, K. (2011).Temporal Trends in Self Harm and Aggression On a Paediatric Mental Health Ward. *Australasian Psychiatry, 19,* 64-69.

Biering, P., & Jensen, V.H. (2011). The concept of patient satisfaction in adolescent psychiatric care: a qualitative study. *Journal of Child and Adolescent Psychiatric Nursing, 24*, 3-10.

Blader, J. C. (2007). Longitudinal assessment of parental satisfaction with children's psychiatric hospitalization. *Administration and Policy in Mental Health and Mental Health Services Research, 34(2),* 108-115.

Blantz, B., & Schmidt, M. H. (2000). Practitioner review: Preconditions and outcome of inpatient treatment in child and adolescent psychiatry. *Journal of Child Psychology and Psychiatry, 41,* 703–712.

Bloom, S. L. (2005) The Sanctuary Model of Organizational Change for Children's Residential Treatment. Therapeutic Community: *The International Journal for Therapeutic and Supportive Organizations, 26(1),* 65-81.

Bornmann, B. A., Mitelman, S. A., & Beer, D. A. (2007). Psychotherapeutic relaxation: How it relates to levels of aggression in a school within inpatient child psychiatry: A pilot study. *The Arts in psychotherapy, 34(3),* 216-222.

Bowles N. & Jones A. (2005) Whole systems working and acute inpatient psychiatry: an exploratory study. *Journal of Psychiatric and Mental Health Nursing, 12,* 283–289.

Brann, P., Walter, G., & Coombs, T. (2011). Benchmarking child and adolescent mental health organizations. *Australasian Psychiatry, 19,* 125-132.

Brent, D.A., McMakin, D.L., Kennard, B.D., Goldstein, T.R., Mayes, T.L., & Douaihy, A.B. (2013). Protecting adolescents from self-harm: a critical review of intervention studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 1260–1271.

Brimblecombe, N., Tingle, A., & Murrells, T. (2007). How mental health nursing can best improve service users' experiences and outcomes in inpatient settings: responses to a national consultation. *Journal of Psychiatric and Mental Health Nursing, 14(5),* 503-509.

Brinkmeyer, M. Y., Eyberg, S. M., Nguyen, M. L., & Adams, R. W. (2004). Family engagement, consumer satisfaction and treatment outcome in the new era of child and adolescent in-patient psychiatric care. *Clinical Child Psychology and Psychiatry, 9(4),* 553-566.

Brown, P., & Pirkis, J. (2009). Mental health quality and outcome measurement and improvement in Australia. *Current Opinion in Psychiatry, 22,* 610–618.

Callaly, T., Hyland, M., Trauer, T., Dodd, S., & Berk, M. (2010). Readmission to an acute psychiatric unit within 28 days of discharge: identifying those at risk. *Australian health review, 34(3),* 282-285.

Canadian Institute For Health Care Information (2015). *Care for children and youth with mental disorders.* Downloaded June 5 2015 from:*https://secure.cihi.ca/free_products/CIHI%20CYMH%20Final%20for%20pubs_EN_web.pdf*

Cassells, C., Paterson, B., Dowding, D., & Morrison, R. (2005.) Long- and short-term risk factors in the prediction of inpatient suicide: A review of the literature. *Crisis, 26,* 53–63.

Christiansen, E., & Larsen, K.J. (2012). Young people's risk of suicide attempts after contact with a psychiatric department – a nested case-control design using Danish register data. *Journal of Child Psychology and Psychiatry, 53,* 16–25.

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice, 85(4),* 424-435.

Collier, E., Skitt, G, & Cutts, H. (2003). A study on the experience of insomnia in a psychiatric inpatient population. *Journal of Psychiatric and Mental Health Nursing,10,* 697–704.

Commonwealth of Australia (2010). National standards for mental health services 2010. Canberra, Australia. Downloaded Dec. 30 2014 from:*http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubsn-servst10*

Cotgrove, A. (1997). Emergency admissions to a regional adolescent unit: Piloting a new service. *Psychiatric Bulletin, 21,* 604-608.

Cotgrove, A. (2014). Inpatient services. In T.McDougall & A.Cotgrove (Eds) *Specialist mental healthcare for children and adolescents. Hospital, intensive community, and home based services.* New York: Routledge.

Cotgrove, A. J., & Cowers, S. G. (1999). Use of an adolescent in-patient unit. *Advances in Psychiatric Treatment, 5(3),* 192-199.

Cotton, N.S., & Geraty, R.G. (1984) Therapeutic space design: Planning an inpatient children's unit. *American Journal of Orthopsychiatry, 54*, 624-636.

Coyne, I. (2006). Children's experiences of hospitalization. *Journal of Child Health Care, 10,* 326-336.

Crepeau-Hobson, M.F., & Leech, N.L. (2014). The Impact of Exposure to Peer Suicidal Self-Directed Violence on Youth Suicidal Behavior: A Critical Review of the Literature. *Suicide and Life-Threatening Behavior, 44,* 58-77.

Crofts, M., & Hipkiss, H. (2014). Commissioning. In T.McDougall & A.Cotgrove (Eds) *Specialist mental healthcare for children and adolescents. Hospital, intensive community, and home based services.* New York: Routledge.

Cromwell, J., Maier, J. (2006). Economic grand rounds: variation in staffing and activities in psychiatric inpatient units. *Psychiatric Services, 57(6),* 772–774.

Dalton, R., Forman, M.A., Daul, G.C., & Bolding, D. (1987). Psychiatric hospitalization of preschool children: Admission factors and discharge implications. *Journal of the American Academy of Child and Adolescent Psychiatry, 26*, 308-312.

De Leo, D., & Sveticic, J. (2010). Suicides in psychiatric in-patients: what are we doing wrong? *Epidemiologia e Psichiatria Sociale,1,* 8-15.

Dean, A.J., Duke, S.G., George, M., & Scott,J. (2007). Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of the American Academy of Child and Adolescent Psychiatry, 46,* 711-720.

Dean A, Scott J, McDermott BM: (2009). Changing utilization of pro re nata (as needed) sedation in a child and adolescent psychiatric inpatient unit. *Australian and New Zealand Journal of Psychiatry, 43,* 360–365.

Dein, K., Williams, P. & Dein, S. (2007). Ethnic bias in the application of the Mental Health Act 1983. *Advances in Psychiatric Treatment, 13,* 350–357.

Delamater, A., Conners, C.K., & Wells, K.C. (1984). A comparison of staff training procedures: Behavioral applications in the child psychiatric inpatient setting. *Behavior Modification, 8,* 39-58.

Delaney, K.R. (2001) Developing a restraint-reduction program for child/adolescent inpatient treatment. *Journal of Child and Adolescent Psychiatric Nursing, 14,* 128-140.

Delaney, K.R. (2002) Inpatient Psychiatric Nursing: Set Up to Stagnate? *Journal of the American Psychiatric Nurses Association, 8,* 130-134.

Delaney, K. R., & Lynch, P. (2008). Magnet forces: A structure for a transformation in inpatient psychiatric nursing. *Journal of the American Psychiatric Nurses Association, 14(5),* 346-352.

DeRoche, C., Greenham, S. & Persi, J. (2014). Ontario Network of Child and Adolescent Psychiatry Services, Annual Benchmarking 2013-2014, Presentation at the Annual ONCAIPS Conference Oct 3, 2014.

Desai, S. (2009). The new stars of CCTV: What is the purpose of monitoring patients in communal areas of psychiatric hospital wards, bedrooms and seclusion rooms*? Diversity in Health and Care, 6 (1),* 45-53.

Deshmukh, P., Kulkarni, G., & Barzman, D. (2010) Recommendations for Pharmacological Management of Inpatient Aggression in Children and Adolescents Psychiatry (Edgmont), 7(2), 32–40. Published online Feb 2010. PMCID: PMC2848469

Donovan A, Plant R, Peller A, Siegel L, & Martin A. (2003) Two year trends in the use of seclusion and restraint among psychiatrically hospitalized youths. *Psychiatric Services 54,* 987–993.

Dubicka, B., Elvins, R., Roberts, C., Chick, G., Wilkinson, P., & Goodyer, I.M. (2010). Combined treatment with cognitive-behavioural therapy in adolescent depression: meta-analysis. *British Journal of Psychiatry,197,* 433-440.

Durbin, J., Lin, E., Layne, C., & Teed, M. (2007). Is readmission a valid indicator of the quality of inpatient psychiatric care?. *The journal of behavioral health services & research, 34(2),* 137-150.

Ellila, H. (2007). Child and adolescent psychiatric inpatient care in Finland. In *ANNALES-UNIVERSITATIS TURKUENSIS SERIES D* (Vol. 758). Turun Yliopisto.

Ellila, H., Sourander, A., Valimaki, M., & Piha, J. (2005). Characteristics and staff resources of child and adolescent psychiatric hospital wards in Finland. *Journal of Psychiatric and Mental Health Nursing, 12,* 209–214.

Ellila, H. T., Sourander, A., Välimäki, M., Warne, T. & Kaivosoja, M. (2008). The involuntary treatment of adolescent psychiatric inpatients - A nation-wide survey from Finland. *Journal of Adolescence, 31,* 407-419.

Engqvist, U., & Rydelius, P. A. (2006). Death and suicide among former child and adolescent psychiatric patients. *BMC psychiatry, 6(1),* 51.

Faulkner, G., & Biddle, S. (2002). Mental health nursing and the promotion of physical activity. *Journal of Psychiatric and Mental Health Nursing, 9(6),* 659-665.

Fielke, K., Cord-Udy, N., Buckskin, J., Lattanzio, A. (2009) The development of an 'Indigenous team' in a mainstream mental health service in South Australia. *Australasian Psychiatry, 17(1),* S75–S78.

Finke, L. M. (2001). The Use of Seclusion Is Not Evidence-Based Practice. *Journal of Child and Adolescent Psychiatric Nursing, 14(4),* 186-190.

Fonagy, P., Target, M., Cottrell, D., Phillips, J. & Kurtz, Z. (eds.) *What works for whom? A critical review of treatment for children and adolescents.* New York/London: The Guilford Press.

Gavidia-Payne, S, Littlefield,L., Hallgren, M., Jenkins, P.,& Coventry, N. (2003). Outcome evaluation of a statewide child inpatient mental health unit. *Australian and New Zealand Journal of Psychiatry, 37,* 204–211.

Gex, C. R., Narring, F., Ferron, C., & Michaud, P. A. (1998). Suicide attempts among adolescents in Switzerland: prevalence, associated factors and comorbidity. *Acta Psychiatrica Scandinavica, 98(1),* 28-33.

Glod, C. A., Teicher, M. H., Butler, M., Savino, M., Harper, D., Magnus, E., & Pahlavan, K. (1994). Modifying quiet room design enhances calming of children and adolescents. J*ournal of the American Academy of Child & Adolescent Psychiatry, 33(4),* 558-566.

Goldston, D. B., Daniel, S. S., Reboussin, D. M., Reboussin, B. A., Frazier, P. H., & Kelley, A. E. (1999). Suicide attempts among formerly hospitalized adolescents: A prospective naturalistic study of risk during the first 5 years after discharge. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 660–671.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38,* 581–586.

Gottlieb S.J., Reid, S., Fortune, A.E., & Walters, D.C. (1990). Child/Adolescent Psychiatric Inpatient Admissions - Is the "Least Restrictive Treatment" Philosophy a Reality? *Residential Treatment for Children & Youth, 7*, 29-39.

Gould, M.S., Kleinman, M.H., Lake, A.M., Forman, J., & Midle, J.B. (2014). Newspaper coverage of suicide and initiation of suicide clusters in teenagers in the USA, 1988–96: a retrospective, population-based, case-control study. *The Lancet,* www.thelancet.com/psychiatry Published online May 2, 2014.

Gowers, S. G., Harrington, R. C., Whitton, A., Lelliott, P., Beevor, A., Wing, J., & Jezzard, R. (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for children and Adolescents (HoNOSCA). *The British Journal of Psychiatry, 174(5),* 413-416.

Gowers, S. G., & Rowlands, L. (2005). Inpatient services. *Current opinion in psychiatry, 18(4),* 445-448.

Green, J., Kroll, L., Imrie, D., Frances, F.M., Begum, K., Harrison, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 325-332

Green, J., Jacobs, B., Beecham, J., Dunn, G., Kroll, L., Tobias, C., Briskman, J. (2007) Inpatient treatment in child and adolescent psychiatry—a prospective study of health gain and costs. *Journal of Child Psychology & Psychiatry, 48(12*), 1259–1267.

Greene, R.S., Ablon, J.S.,Regan, K.M., & Martin, A. (2006) Innovations: child & adolescent psychiatry: use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. *Psychiatric Services, 57,* 610-612.

Greenfield, B., Larson, C., Hechtman, L., Rousseau, C., & Platt, R. (2002). A rapid-response outpatient model for reducing hospitalization rates among suicidal adolescents. *Psychiatric Services, 53(12),* 1574-1579.

Greenham, S.L., & Bisnaire, L. (2008). An outcome of an inpatient crisis stabilization and assessment program for youth. *Residential Treatment for Children and Youth, 25,* 123-143.

Greenham, S.L., & Persi, J. (2014). The state of inpatient psychiatry for youth in Ontario: Results of the ONCAIPS benchmarking survey. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 23(1),* 31-7.

Greenwald, Denham, & Jack (2006). The hospital discharge: A review of a high risk care transition with highlights of a reengineered discharge process, *Journal of Patient Safety, 3,* 97-106.

Grossman, J. A., & Kruesi, M. J. (2000). Innovative approaches to youth suicide prevention: An update of issues and research findings. In American Association of Suicidology Annual Preconference Workshop: Suicide Update, 1997, Apr, 1997, Memphis, TN, US. Guilford Press.

Hanssen-Bauer, K., Heyerdahl, S., Hatling, T., Jensen, G., Olstad, P.M., Stangeland , T & Tinderholt , T. (2011). Admissions to acute adolescent psychiatric units: a prospective study of clinical severity and outcome. *International Journal of Mental Health Systems, 5. Downloaded from http://www.ijmhs.com/content/5/1/1*.

Harvey, A. G., Soehner, A. M., Kaplan, K. A., Hein, K., Lee, J., Kanady, J., ... & Buysse, D. J. (2015). Treating insomnia improves mood state, sleep, and functioning in bipolar disorder: A pilot randomized controlled trial. *Journal of consulting and clinical psychology, 83(3),* 564.

Hawaii Department of Health's Child and Adolescent Mental Health Division (2012). *Child and Adolescent Mental Health Performance Standards,* Hawaii Department of Health's Child and Adolescent Mental Health Division. Clinical Services Office and Performance Manage Office, Child and Adolescent Mental Health Division, Department of Health State of Hawaii.

Hazell, P. (2003). Establishment and evaluation of a clinical pathway for young suicide attempters and ideators. *Australasian Psychiatry, 11,* 54-58.

Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C, et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 543-551.

Hepper, F., Weaver, T., & Rose, G. (2005). Children's understanding of a psychiatric in-patient admission. *Clinical child psychology and psychiatry, 10(4),* 557-573.

Highly Specialized Services and Supports Advisory Group (2003). An Ideal Model for Children's Mental Health Services in South West Region Year 1 Implementation. Highly specialized services and supports.

Hutton, A. (2005) Consumer perspectives in adolescent ward design. *Journal of Clinical Nursing, 14,* 537–545.

Inoue, M., Del Fabbro, L., & Mitchell, M. (2012). Assessing the educational needs of mental health nurses: Working in an adolescent inpatient psychiatric ward in Japan*. Journal of Child and Adolescent Psychiatric Nursing, 25*,124–129,

Iqbal, S. & Bassett, M. (2008). Evaluation of perceived usefulness of activity scheduling in an inpatient depression group*. Journal of Psychiatric and Mental Health Nursing, 15,* 393–398.

Jacobs, B., Green, J., Beecham, J., et al (2004). CHYPIE – Two and a Half ThousandHours. The Children and Young Person's Inpatient Evaluation Study into Process and Outcome of Inpatient Child and Adolescent Psychiatric Care. Report for the Department of Health. (downloaded on September 1 2013 from *http://kc.nimhe.org.uk/upload/CHYPIE%20final%20report%20short%20version1.doc*

Jaffa, T, Lelliott, P., O'Herlihy, A., Worrall, A., Hill, P., & Banerjee, S. (2004). The staffing of inpatient child and adolescent mental health services. *Child and Adolescent Mental Health 9,* 84–87

James, S., Leslie, L.K. Hurlburt, M.S., Slymen, D.S., Landsverk, J., Davis, I., Mathiesen, S.G., & Zhang, J. (2006) Children in out-of-home care: Entry into intensive or restrictive mental health and residential care placements. *Journal of Emotional and Behavioral Disorders, 14,* 196-208.

Jensen, E., Forchuk, C., Seymour, B., Chapman, P., Witcher, P., & Davis, A. (2009). An evaluation of community based discharge planning–final report. Toronto: York University and Systems

Enhancement Evaluation Initiative. Retrieved from https://www.ehealthontario.ca/portal/server.pt/community/seei_final_reports/2182.

Jerrell, J.M., & Roger S. McIntyre, R.S. (2008). Adverse events in children and adolescents treated with antipsychotic medications. *Human Psychopharmacology: Clinical and Experimental, 23,* 283–290.

Jones, C., & Brideson, T. (2009) Using policy and workforce development to address Aboriginal mental health and wellbeing. *Australasian Psychiatry, 17(S1),* S72–S74.

Kaltiaila-Heino, R. (2004). Increase in involuntary psychiatric admissions of minors: A register study. Social Psychiatry & Psychiatric Epidemiology, 39, 53-59.

Kaltiala-Heino, R. (2010). Involuntary commitment and detainment in adolescent psychiatric inpatient care. Social Psychiatry & Psychiatric Epidemiology, 45, 785-793.

Kaplan, S.L., & Busner, J. (1997) The use of prn and stat medication in three child psychiatric inpatient settings. *Psychopharmacological Bulletin, 33,* 161–164.

Kaplan, S., Busner, J., Chibnall, J., & Kang, G. (2001). Consumer satisfaction at a child and adolescent state psychiatric hospital. *Psychiatric Services, 52(2),* 202-206.

King, C. A., Segal, H. G., Kaminski, K., Naylor, M. W., Ghaziuddin, N., & Radpour, L. (1995). A prospective study of adolescent suicidal behavior following hospitalization. *Suicidal and Life-Threatening Behavior, 25,* 327–338.

Kroll, L., & Green, J. (1997). The therapeutic alliance in child inpatient treatment: Development and initial validation of a family engagement questionnaire. *Clinical Child Psychology and Psychiatry,* 2(3), 431-447.

Kurth, J. (2009). Introducing evidence-based practice to an inpatient child and adolescent psychiatry unit. *Academic Psychiatry, 33*, 400-403.

Kutcher, S., & McLuckie, A. (2011). Evergreen: A child and youth mental health framework for Canada. *Paediatrics & child health, 16(7),* 388.

Large, M., Ryan, C. & Nielssen, O. (2011). The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry, 19,* 507-512.

Larsson, B., & Ivarsson, T. (1998). Clinical characteristics of adolescent psychiatric inpatients who have attempted suicide. *European child & adolescent psychiatry, 7(4),* 201-208.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper,, G., LaFlair, L., & Sudders, M. (2004) Child and Adolescent Inpatient Restraint Reduction: A state initiative to promote strength-based care, *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 37-45.

Lefrancois, B.A. (2013) Queering child and adolescent mental health services: The subversion of heteronormativity in practice. *Children & Society, 27,* 1–12

Leon, S. C., Lyons, J. S., Uziel-Miller, N. D., & Tracy, P. (1999). Psychiatric hospital utilization of children and adolescents in state custody. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 305–310

Leon, S.C., Lyons, J.S., Uzel-Miller, D.D.., Rawal, P., Tracy, P., & Williams, J. (2000). Evaluating the Use of Psychiatric Hospitalization by Residential Treatment Centers. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 1496–1501.

Leon, S.C., Lyons, J.S., & Uzel-Miller, D.D.., (2000). Variations in the Clinical Presentations of Children and Adolescents at Eight Psychiatric Hospitals. *Psychiatric Services, 51,*786–790.

Lyons, J., Libman-Mintzer, L., Kisiel, C. & Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential treatment*. Professional Psychology, Research and Practice, 29,* 582–587.

Mabe, P.A., Riley, W.T., & Sunde, E.R. (1989). Survey of admission policies for child and adolescent inpatient services: A national sample. *Child Psychiatry & Human Development, 20,* 99-111.

Maskey, S. (1998). The process of admission. In J. Green & B.Jacobs (Eds.), *In-patient child psychiatry. Modern practice, research and the future* (pp. 39-50). London: Routledge.

McDougall, T., & Cotgrove, P. (2014). Referral pathways into hospital intensive community and home-based services. In T.McDougall & A.Cotgrove (Eds) *Specialist mental healthcare for children and adolescents. Hospital, intensive community, and home based services.* New York: Routledge.

McDougall, T., & Thompson, P. (2014). Quality standards for specialty mental health services.. In T.McDougall & A.Cotgrove (Eds) *Specialist mental healthcare for children and adolescents. Hospital, intensive community, and home based services.* New York: Routledge.

McShane, G., Mihalic, M., Walter, G., & Rey, J. (2006). Outcome of patients with unipolar, bipolar and psychotic disorders admitted to a specialist child and adolescent mental health service. *Australasian Psychiatry, 14,* 198-201.

Marriage, K., Petrie, J., & Worling, D. (2001). Consumer satisfaction with an adolescent inpatient psychiatric unit. *Canadian journal of psychiatry. Revue canadienne de psychiatrie, 46(10),* 969-975.

Mental Health Commission of Canada (2012). Changing directions, changing lives The mental health strategy for Canada. Downloaded May 6 2015 from *http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf*

Miller, N.O., Friedman, S.B., & Coupey, S.M. (1998). Adolescent preferences for rooming during hospitalization. *Journal of Adolescent Health,23,* 89–93.

Miller, M.E., Siggins, I., Ferguson, M. & Fowler, G. (2011) *National mental health workforce literature review,* Melbourne, Department of Health.

MIND (2013) Mental health crisis care: physical restraint in crisis – A report on physical restraint in hospital settings in England. Downloaded April 2, 2015 from http://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

Ministry of Children and Youth Services (2006). *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health.* Toronto: Government of Ontario.

Molnar, (1997). Juveniles and psychiatric institutionalization: toward better due process and treatment review in the United States. *Health and Human Rights, 2,* 98-116.

Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing, 18,* 83–90.

Muller, M.J., Schlosser, R., Kapp-Steen, G., Schanz, B., & Benkert, O. (2002). Patients' satisfaction with psychiatric treatment: comparison between an open and a closed ward. *Psychiatric Quarterly, 73,* 93-107.

Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. *JAMA psychiatry, 70(3),* 300-310.

O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V., & Lelliott, P. (2001). *National In-patient Child and Adolescent Psychiatry Study. Final Report to the Department of Health.* London: Royal College of Psychiatrists' Research Unit. Downloaded December 1, 2014 from http://www.rcpsych.ac.uk/PDF/NICAPS%20report%20full.pdf

O'Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Hill, P., & Banerjee, S. (2003). Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales. The British Journal of Psychiatry, 183(6), 547-551.

Ontario Mental Health Act (1990). Ontario Ministry of Health and Long Term Care web site; http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm; accessed December 12, 2014.

Ontario Ministry of Children and Youth Services (2006). A shared framework. Ontario's policy framework for child and youth mental health. Downloaded November 27, 2014 http://www.children.gov.on.ca/htdocs/English/topics/specialneeds/mentalhealth/index.aspx

Ontario Ministry of Child and Youth Services (2008). A shared responsibility. Ontario's policy framework for child and youth mental health. Toronto: Ministry of Children and Youth Services. Downloaded November 27, 2014 http://www.children.gov.on.ca/htdocs/English/topics/specialneeds/mentalhealth/index.aspx

Ortiz, G., & Schacht, L. (2012). Psychometric evaluation of an inpatient consumer survey measuring satisfaction with psychiatric care. *The Patient, 5*, 163-173.

Pages, F., Arvers, P., Hassler, C., & Choquet, M. (2004). What are the characteristics of adolescent hospitalized suicide attempters?. *European child & adolescent psychiatry, 13(3),* 151-158.

Pedersen, J., & Aarkrog, T. (2001). A 10-year follow-up study of an adolescent psychiatric clientele and early predictors of readmission. *Nordic Journal of Psychiatry, 55,* 11-16.

Persi, J., & Pasquali, B. (1999).The Use of Seclusions and Physical Restraints: Just How Consistent Are We? *Child and Youth Care Forum, 28,* 87-103.

Pollock, K.; Grime, J., Baker, E., & Manatla, K. (2004) Meeting the information needs of psychiatric inpatients: Staff and patient perspectives. *Journal of Mental Health, 13,* 389-401.

Pottick, K., Warner, L., Isaacs, M., Henderson, M.J., Milazzo-Sayre, L., & Manderscheid, R. (2004). Children and adolescents admitted to specialty mental health programs in the United States, 1986 and 1997. In: R.W. Mandersheid and M.J. Henderson (Eds) *Mental health, United States, 2002*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 322-334.

Prescott, L, (2000), Veterans of abuse and daughters of the dark: the politics of naming and risk of transformation in building partnerships for change. *Perspectives on Psychiatric Care, 34,* 95-100.

Prinstein, M. J., Nock, M. K., Simon, V., Aikins, J. W., Cheah, C. S.L., & Spirito, A. (2008). Longitudinal trajectories and predictors of adolescent suicidal ideation and attempts following inpatient hospitalization. *Journal of Consulting and Clinical Psychology, 76,* 92–103.

Provincial Council for Maternal Child Health. (2012). Ontario Hospitals Maternal-Child Benchmarking Report. Add website.

Pumariega, A. J., Rothe, E., Mian, A., Carlisle, L., Toppelberg, C., Harris, T., & Smith, J. (2013). Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice. *Journal of the American Academy of Child & Adolescent Psychiatry, 52(10),* 1101-1115.

Puntil, C., York, J., Limandri, B., Greene, P. Arauz, E., & Hobbs, D. (2013). Competency-based training for PMH nurse generalists: Inpatient intervention and prevention of suicide. *Journal of the American Psychiatric Nurses Association, 19,* 205–210.

Radcliffe, J., & Smith, R. (2007). Acute in-patient psychiatry: how patients spend their time on acute psychiatric wards. *Psychiatric Bulletin, 31(5),* 167-170.

Ratnapalan, S., Rayar, M. S., & Crawley, M. (2009). Educational services for hospitalized children. *Paediatrics & child health, 14(7),* 433.

Ronzoni, P., & Dogra, N. (2012). Children, adolescents and their carers' expectations of child and adolescent mental health services (CAMHS*). International Journal of Social Psychiatry, 58(3),* 328-336.

Royal College of Psychiatrists (2006). *Building and sustaining specialist child and adolescent mental health services* (Council Report CR137). Royal College of Psychiatrists.

Rydelius, P. A. (2007). Inpatient and emergency child and adolescent psychiatry units in Sweden do not use restraint and seclusion: what we have learned. *BMC Psychiatry, 7(Suppl 1),* 1-1.

Sargeant, A. (2009). *Working with child and adolescent inpatient mental health services.* National Workforce Program: National CAMHS Service.

Setoya, Y., Saito, K., Kasahara, M., Watanabe, K., Kodaira, M., & Usami, M. (2011). Evaluating outcomes of the child and adolescent psychiatric unit: A prospective study. *International Journal of Mental Health Systems, 5:7*

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General psychiatry, 40(11),* 1228-1231.

Shaffer, D., & Pfeffer, C. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent, Psychiatry, 40 (Suppl) 7.*

Shahid, A., Khairandish, A., Gladanac, B., & Shapiro, C. (2012). Peeking into the minds of troubled adolescents: the utility of polysomnography sleep studies in an inpatient psychiatric unit. *Journal of Affective Disorders, 139(1),* 66-74.

Singh, N.N., Wechsler, H.A., & Curtis, W.J. (2000). Family friendliness of inpatient services for children and adolescents with EBD and their families: Observational study of the treatment team process. *Journal of Emotional and Behavioral Disorders, 8,* 19-26.

Solomon, J., Thompson, P., & Collins, E. (Eds.) (2011). *Service Standards (6th edition).* College Quality Network for Inpatience Child and Adolescent Mental Health Services, Royal College of Psychiatrists. Downloaded Saturday, March 29, 2014 from https://www.rcpsych.ac.uk/quality/qualityandaccreditation/childandadolescent/inpatientcamhsqnic/membersarea/usefuldownloads.aspx.

Sondheimer, D. L., & Evans, M. E. (1995). Developments in children's mental health services research: An overview of current and future demonstration directions. In L. Bickman & D. J. Rog (Eds.), *Children's mental health services: Research, policy, and evaluation* (pp. 64–84). Thousand Oaks, CA: Sage.

Sourander, A., & Piha, J. (2000). A model for change at the outpatient–inpatient interface in child psychiatry. *Clinical Child Psychology and Psychiatry, 5,* 97–103.

Southwestern Ontario Highly Specialized Services and Supports Advisory Group (2003). An Ideal Model for Children's Mental Health Services in South West Region Year 1 Implementation.

Sparks, J.L., & Duncan, B.L. (2008). Do no harm: A critical risk/benefit analysis of child psychotropic medication. *Journal of Family Psychotherapy, 19,* 1-19.

Specht, R., & Glasser, B. (1963). A Review of the Literature on Social Work with Hospitalized Adolescents and Their Families. *The Social Service Review, 37(3),* 295-306.

Street, C. (2000). *Whose crisis? Meeting the needs of children and young people with mental problems.* London: Young Minds.

Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Sundram, C. J. (1987). Patient idleness in public mental hospitals. *Psychiatric Quarterly, 58(4),* 243-254.

Swadi, H. & Bobier, C. (2012). Lessons from an investigation of seclusion at an older adolescent inpatient unit. *Australasian Psychiatry, 20,* 98-101.

Swart, G., Siman, E., & Stewart, S. (2011). The use of pro re nata or statim medications for behavioral control: a summary of experience at a tertiary care children's mental health center. *Journal of Child and Adolescent Psychopharmacology, 21,* 67-77.

Tas, F. V., Guvenir, T., & Cevrim, E. (2010). Patients' and their parents' satisfaction levels about the treatment in a child and adolescent mental health inpatient unit. *Journal of psychiatric and mental health nursing,* 17(9), 769-774.

Thomas, K. & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: A systematic review*. Psychiatric Services, 64,* 1140–1149.

Tolmac, J. & Hodes, M. (2004). Ethnic variation among adolescent psychiatric inpatients with psychotic disorders. *British Journal of Psychiatry, 184*, 428–431.

Tulloch S, Lelliott P, Bannister D et al. (2008) *The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study*. NCCSDO Downloaded November 25 2013 from *http://www.rcpsych.ac.uk/clinicalservicestandards/centreforappliedresearch/cosicaps.aspx*

Van der Merwe, M., Bowers l., Jones, J., Simpson, A., & Haglund, K. (2009). Locked doors in acute inpatient psychiatry: a literature review*. Journal of Psychiatric and Mental Health Nursing 16*, 293–299.

Werry, J. (2007). Predicting completed suicides. Letter to the editor. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 425–33.

Wing, J.K., & Brown, G.W. (1970). *Institutionalism and Schizophrenia*. Cambridge: Cambridge University Press.

World Federation for Mental Health (2004). The relationship between physical and mental health. Co-occurring disorders. Downloaded *http://wfmh.com/world-mental-health-day/wfmhd-archives/*

World Health Organization (2005). *WHO Resource book on mental health, human rights and legislation.* Geneva, Switzerland. World Health Organization. Retrieved August, 2012 from: *http://www.who.int/mental_health/policy/legislation/Resource%20Book_Eng2_WEB_07%20(2).pdf*

Worral, A., O'Herlihy, A., Banerjee, S., Jaffa, T., Lelliott, P., Hill, P., Scott, A., & Brook, H. (2004). Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: Cross sectional study of six months' activity. *British Medical Journal,* doi:10.1136/bmj.38058.605787.AE (published 5 April 2004). Retrieved May 19, 2014.

Yeager, K. R., Saveanu, R., Roberts, A. R., Reissland, G., Mertz, D., Cirpili, A., & Makovich, R. (2005). Measured response to identified suicide risk and violence: What you need to know about psychiatric patient safety. *Brief Treatment and Crisis Intervention, 5(2),* 121-141.

York, A., & Lamb, C. (2005). *Building and sustaining specialist CAMHS: a consultation paper on workforce, capacity and functions of tiers 2, 3 and 4 Child and adolescent mental health services.* London: Child and Adolescent Faculty: Royal College of Psychiatrists.