YOUTH MENTAL HEALTH TRANSITION PROTOCOL AGREEMENT

between

Ministry for Children and Family Development
and
Ministry of Health and Health Authorities

An agreement between the Ministry for Children and Family Development (MCFD) and the Ministry of Health, through the Health Authorities, to facilitate a collaborative approach to transitioning youth/young adults from Child and Youth Mental Health Services to Adult Mental Health and Substance Use Services.

Protocol Date: June 11, 2015

PURPOSE

The purpose of this protocol is to support positive mental health service experiences and improve mental health outcomes of youth[1] in the transition years (from 17 years of age until the 21st birthday), and their families[2] by promoting coordinated, continuous, and responsive service planning and support. This will be achieved by:

- Providing MCFD Child and Youth Mental Health (CYMH), Aboriginal CYMH (ACYMH), health authority tertiary child and adolescent outpatient services[3] and Health Authority Adult Mental Health and Substance Use (AMHSU) practitioners and other relevant service providers across the province with a consistent approach to transitioning youth;

- Outlining the collaborative relationships required of CYMH and AMHSU practitioners and community partners, and other essential processes and elements required for promoting effective transitions;

- Providing a mechanism for ongoing review and monitoring of transition related issues and stewardship of the *Youth Mental Health Transition Protocol Agreement* via the Joint Management Tables, which are outlined later in these protocols;

- Promoting service planning that focuses on the individual needs of transitioning youth;

- Promoting positive engagement of youth and their families throughout the process; and

- Supporting culturally safe transition practices.

POPULATION

- These protocols apply to MCFD Child and Youth Mental Health services, including MCFD Aboriginal Child and Youth Mental Health services; health authority child and adolescent tertiary outpatient services; and Health Authority Adult Mental Health and Substance Use outpatient services delivered by health authorities. Other service providers and agencies will be encouraged to align their practice with these protocols as appropriate.
- Children, youth and families transitioning to adult services may follow one of three pathways:
    - MCFD services to health authority services

[1] The term youth refers to persons in the transition years between 17 and 21 years of age. In this document the terms youth, young person and adolescent are used interchangeably.

[2] Families include extended family, caregivers/guardians, and identified key supports.

[3] Tertiary child and adolescent outpatient services are specialized clinical services provided by some regional health authorities and the Provincial Health Services Authority (PHSA). For the purposes of this document all child, youth and adolescent mental health services will be represented by the CYMH/ACYMH acronym to promote readability while acknowledging the unique strengths and needs of Aboriginal CYMH.

    - regional health authority child and youth services to regional health authority adult services
    - PHSA tertiary child and adolescent services to regional health authority adult services
- This protocol supersedes the regional youth mental health transition protocols signed by MCFD and regional health authorities in 2002.

- This protocol does not supersede existing protocols/agreements that support youth being transitioned to adult mental health services from youth services, such as the Early Psychosis Intervention Program or community eating disorders programs.

- This protocol applies to youth receiving CYMH/ACYMH services planning for or transitioning to Adult Mental Health and Substance Use Services, who are between 17 years of age and their 21st birthday, and have a mental disorder(s)[4] or provisional diagnosis with challenges that:
    - are predicted to continue into adulthood; and
    - impair their ability to perform basic activities of daily living and/or social/academic/vocational functioning, and/or their ability to maintain housing, without significant and ongoing mental health support.

ASSUMPTIONS

The Ministry of Children and Family Development, Ministry of Health and the Health Authorities agree, based on relevant research, practice evidence and youth and family experiences that:

- Youth and families who are transitioning between service systems benefit from effective transition processes that are:
    - youth and family centred;
    - coordinated, continuous, and responsive;
    - planned and supported over an adequate period of time; and
    - monitored and evaluated.

- Many youth benefit from having their family and/or other natural supports involved in their care.

- High quality care during the mental health/substance use service transition period supports positive health and social outcomes for youth and families and has the potential to reduce the overall need for long-term intensive mental health/substance use services and supports.

- Youth experiencing a mental health/substance use service transition:

[4] Mental disorder(s) refers to refers to psychiatric disorders including substance use disorders, but does not include developmental or intellectual disability disorders.

- are particularly vulnerable to challenges with relationships, school, employment, housing, substance use, and the legal system;
- have diverse and variable needs in relation to the level of support and independence they require; and
- require opportunities to build skills for daily living and other developmental support.

- Youth experiencing a mental health/substance use service transition and their families require:
  - information about the mental disorder(s) or illness(es) and how to support health and wellness;
  - time to develop relationships and trust with new service providers; and
  - assistance to navigate the mental health and substance use system of services.

- As a result of the enduring effects of colonization, Aboriginal youth experience significant and unique risk factors that may contribute to mental health and substance use problems. Aboriginal youth have unique strengths and resiliencies that can support their recovery from mental health and substance use problems.

- Culturally specific and safe services better meet the needs of those from non-dominate cultures such as Aboriginal youth, youth from immigrant and refugee families; lesbian, gay, bisexual and transgender (LGBT) youth, youth in care and others.

SERVICE PRINCIPLES

Coordinated, continuous, and responsive mental health transition planning services and supports must include:

- A collaborative planning process[5] that includes active engagement and involvement of:
  - the young person, their family and others the youth designates as supports;
  - CYMH and AMHSU services; and
  - related services and supports.

- Flexibility and commitment on the part of all professionals to address the unique strengths and needs of each youth during the transition process.

- The commitment of both CYMH/ACYMH and AMHSU services to continue the collaborative planning process until the mental health and substance use transition needs of the youth and their family have been effectively addressed, recognizing that transition may occur from CYMH/ACYMH to:
  - AMHSU services only;
  - AMHSU services and other community services and supports; or,

[5] There are various collaborative planning models used in BC such as integrated case management, wrap around services, integrated service provision. These models put the client at the centre and involve all the client's relevant professionals and natural supports in service planning and provision. More details and examples can be found in section 2 of Appendix A.

- other community services and supports only.

- The provision of services provided to the youth and their family by the most appropriate service provider or program, should use the principle of "best fit" rather than chronological age alone.

- Consideration of the need for concurrent, complementary services from CYMH/ACYMH and/or AMHSU based on the principle of "best fit" for youth/young adults 17 years of age and up to the 21st birthday.

- Collaborative planning and therapeutic services that are informed by best practices for transition aged youth and address symptom management, the assets of being mentally well, and the broad aspects of daily living/functionality.

- Services that involve families or other natural supports the youth identifies in the transition process[6]. Depending on individual circumstances, it is sometimes appropriate to further engage youth who indicate they do not wish their family to be part of their service provision, as the evidence indicates family involvement promotes positive outcomes for youth with mental health and substance use problems.

- Service planning and treatment that adaptively responds to youth's changing needs for support and independence.

- Services that are culturally safe and, where possible, utilize culturally specific or culturally relevant treatment modalities and supports.

Guidelines to Support Youth Transitions

- Establish and maintain Joint Management Tables at the local geographic area[7] to support the roles of stewardship and conflict resolution related to the protocols.

- Members of the CYMH/ACYMH team, in collaboration with the youth, their family, physicians and other professionals when possible, will identify the need for transition to adult mental health and/or substance use services or other community services. This will be based on the severity of impact the youth's mental health challenges have on their ability to function, as well as their developmental strengths and needs.

- When the need for transition services is determined, CYMH/ACYMH and AMHSU practitioners, the youth, their family, other supports and service providers identified by the youth, will engage in a collaborative planning process to agree on what services will best meet the strengths, needs and preferences of the youth.

6 The level of family/natural supports involvement is based on the youth's informed consent and the family's desire and capacity to be involved. Informed consent must be revisited on a regular basis as the youth's circumstances and preferences change.

7 The geographic area for each Joint Management Table (JMT) will be determined at the local level. The JMT may relate to one CYMH agency and one AMHSU agency or it could represent a broader area and include several CYMH and AMHSU agencies. Additionally, other community partners may be invited to be members of the Joint Management Table, depending on local context, needs, strengths and preferences.

- Youth who remain with CYMH/ACYMH past their 19 birthday, and for whom a transition plan to AMHSU is not yet in place, will have their suitability and readiness for discharge and/or readiness for transition to AMHSU reviewed at least once every 6 months.

- Collaborative planning processes are described in more detail in Appendix A, Section 2. A collaborative planning process must be used when providing transition services and must include at a minimum the youth and their family, a CYMH/ACYMH practitioner and an AMHSU practitioner. A collaboratively developed, written transition service plan must be used to support transition services.

- A collaborative planning process will not always result in the admittance of the youth to AMHSU. In some situations, other community resources will be determined to better meet the strengths, needs and preferences of the young person. Examples of other services include: family physician, youth transition programs such as Connect by 25, support workers employed at community non-profit organizations, peer support workers, mutual aid groups, and primary care homes[8].

- Effective collaborative planning requires information sharing between service providers and service systems. The youth's and families' personal information must be protected and shared in adherence to the *Freedom of Information and Protection of Privacy Act*[9] and organizational policies relating to obtaining and releasing personal information.

- When the youth's transition plan includes admittance to AMHSU services, the practitioner from AMHSU services will work to ensure a smooth process for the young person and their family by:
    - minimizing access barriers related to intake procedures;
    - minimizing the need for the youth to provide information already provided to other involved professionals;
    - preparing the youth for the differences in the adult service environment; and
    - welcoming the youth to their care and, where possible, providing additional support to respond to the developmental needs of the youth.

- While there are age-based criteria for CYMH/ACYMH and AMHSU services, youth aged 17 years and up to their 21st birthday, may be served by either or both services based on the principle of "best fit". This requires that the needs of the youth are considered throughout the transition process and that each system be flexible and youth and family centred.

The following considerations are used to determine "<u>best fit</u>":

[8] Primary care home is a primary care model where patients have a personal family physician, care is holistic and person centred and supported by inter-professional teams.
[9] It is important to note that the *Freedom of Information and Protection of Privacy Act* does not prevent the sharing of information in the provision of care.

1. Youth between the ages of 17 and 19 will be given access to AMHSU services if:
   - the youth is functioning at a developmental level that matches or exceeds chronological age, considering physical, cognitive, social, and emotional development; and
   - the primary treatment team, youth, and their family, agree that AMSHU services would better meet the needs of the youth.

2. A young adult will remain with CYMH/ACYMH beyond 19 (but not beyond the 21st birthday) if:
   - the youth is functioning at a developmental level younger than chronological age, considering physical, cognitive, social, and emotional development;
   - the primary treatment team, youth, and family as appropriate, agree that CYMH/ACYMH services are a better fit for the youth; and
   - the current treatment plan includes clear goals designed to prepare the youth for adulthood and an eventual transition to AMHSU and/or other community services.

3. New referrals to CYMH/ACYMH, for youth that are within 6 months of their 19th birthday and are predicted to require AMHSU services, will be referred to an expedited collaborative planning process for planning of best-fit services. The age of the youth will not delay the CYMH intake process, or provision of therapeutic services and planning.

JOINT MANAGEMENT TABLES

A draft Terms of Reference for Joint Management Tables10 is provided in Appendix B. This draft Terms of Reference can be adapted to the reflect strengths, needs and preferences of the local geographic area. Joint Management Tables must be established and implemented at the local level to support stewardship and conflict resolution related to the protocols.

Members of each local Joint Management Table will:

- Ensure membership includes, at minimum, management level representatives from CYMH/ACYMH and AMHSU services.

- Provide stewardship for the *Youth Mental Health Transition Protocol Agreement*.

- Ensure the provincial monitoring framework is implemented and the results are reported to the appropriate position for provincial reporting on an annual basis.

- Facilitate issue and conflict resolution processes for transition planning, identify and resolve complex issues related to transitions if possible, and/or bring forward significant issues to their respective organizations.

[10] Joint Management Tables may be new or developed from pre-existing structures and processes.

- Seek input from youth-serving clinicians, youth, families, and other ministries, services, partners and consumer groups as appropriate.

- Promote positive relationships between the respective staff of the child and youth and adult service systems to support effective transitions for youth and their families.

- Ensure the *Youth Mental Health Transition Protocol Agreement* is consistently implemented in a manner that also incorporates local operational strengths, needs and preferences as appropriate.

- Track transition related issues, adherence to the transition protocol, and service gaps to support future local, regional and provincial review processes.

Joint Management Tables have two core functions:

1. Quality Improvement Process

   Each Joint Management Table will:

   - Ensure staff, clinicians and managers within their service area, have access to and are orientated to the *Youth Mental Health Transition Protocol Agreement*. Electronic access is suggested. Orientation should be completed when a staff person is hired and for all staff on an annual basis.

   - Collect quantitative and qualitative information to inform regular (annually at minimum) reviews and implementation monitoring of their local Mental Health Transition Protocol Agreement and associated CYMH/ACYMH to AMHSU transition processes and report results to their respective Ministries.

   - Make their respective Ministries and/or health authority aware of system level issues that require provincial or health authority system supports for resolution.

2. Issue Resolution Process

If a youth or their family's transition needs cannot be adequately addressed, or there is a disagreement about how to proceed with the transition process:

1. Practitioners will review and confirm their understanding of the *Youth Mental Health Transition Protocol Agreement* to support resolution.

2. If the issue cannot be resolved between practitioners, respective supervisors will be included in the process.

3. If the issue cannot be resolved with involvement of supervisors, it will be referred to the local Joint Management Table within 30 days. Members of the Joint Management Table will make decisions necessary to resolve the issue based on the best interests of the youth and their family.

4. If the youth and family are not satisfied with the resolution identified by the Joint Management Table they will be made aware that they may choose to make a complaint to: Patient Care Quality Review Board for services provided by health authorities; any MCFD staff member, who will help them navigate the Ministry's complaint process; or to the Representative for Children and Youth.

TERMS OF AGREEMENT AND PROVINCIAL SIGN OFF

The terms of this agreement commences on the date this protocol agreement is signed by the parties and remains in force until terminated by a signatories' Administrator of this protocol agreement, upon 30 days prior written notice. The protocol will be reviewed every five years or sooner if required.

Signed on the _____ day of _____, 2015.

Ministry of Children and Family Development Administrator

_____

Mark Sieben, Deputy Minister
Ministry of Children and Family Development

Ministry of Health Administrator

_____

Stephen Brown, Deputy Minister
Ministry of Health

Supplementary Information

This section includes a definition of transition; more detailed information on collaborative planning; highlights from the *Youth Mental Health Transition Protocol Review Summary Report*, and links to transition related resource tools.

Section 1: Transition vs. Transfer

During the 2012 review of the *Regional Youth Mental Health Transition Protocols* and the broad consultation conducted during the development of these protocols, service providers indicated it is important to clearly identify the difference between a transition and a transfer. A description related to youth mental health services is offered below.

Transfer is considered "the termination of care by a children's healthcare provider and its re-establishment with an adult provider,"[11] whereas **transition** "is a process requiring therapeutic intent, which may be expressed by the young person's preparation for transition, a period of handover or joint care, transition planning meetings (involving the young person [and their parent or care provider][12], and key [youth] and [adult] mental health service professionals) and transfer of case notes or information summaries. **Transition** ultimately results in established engagement of the young person with adult services and therefore includes vital aspects of continuity of care"[13]

Section 2: Collaborative Planning Process

In support of positive and effective transitions for youth and families, these protocols strongly promote a collaborative planning process as evidence based transition practice. Currently many mental health and substance use practitioners engage their clients in a strength-based, collaborative planning process, using various models such as Integrated Case Management or Wrap Around Services. Below is a detailed description of how collaborative planning for transitioning youth and families can be operationalized recognizing that implementation of these protocols, including the collaborative planning process, will vary by community, depending on the nature of resources, and needs.

[11] Paul M, Ford T, Kramer T et al. Transfers and transitions between child and adult mental health services. *British Journal of Psychiatry*. 2013; 202(s54): s36-s40.
[12] Added
13 Paul M, Ford T, Kramer T et al. Transfers and transitions between child and adult mental health services. *British Journal of Psychiatry*. 2013; 202(s54): s36-s40.

Phase one – Initial Identification of Youth in Need of Transition Services

CYMH practitioners will:

a) Identify predicted mental health and/or substance use service needs into adulthood as soon as possible to ensure appropriate planning for all children and youth. When identified as a need, the transition process should be initiated when the youth is 17 years of age. Identification of the need for transition is based on the severity of impact that the youth's mental health challenges have on their ability to function and their developmental strengths and needs, and occurs in collaboration with the youth, their family, physicians and other professionals whenever possible. Negative impacts on functionality include impairments in the ability to manage basic activities in daily living and/or meet developmentally appropriate social, academic and vocational goals, and/or maintain housing, without significant and ongoing support to meet their mental health needs.

b) Assess the youth's specific needs for AMHSU services, through collaboration with physicians, the youth and other family and community supports as appropriate, by considering:
    1. the severity, complexity, and predicted prognosis of the youth's mental illness; and
    2. the developmental capacity of the youth to transition to AMHSU services.

c) Engage in the above process until it is determined that:
    1. the youth no longer requires CYMH/ACYMH services;
    2. future need for AMHSU services is not anticipated; or
    3. adult mental health services are required and the youth demonstrates the developmental capacity to begin the transition process between services.

Phase 2 – Collaborative Planning

Step 1: Collaboration between CYMH/ACYMH and AMHSU Services

1. Mental health transition planning begins early, whenever possible, and at least 6 months before a youth is predicted to transition to AMHSU services.

2. Youth, their families (where applicable), CYMH/ACYMH staff and AMHSU staff (i.e., clinician, team leader, or designate) meet to collaboratively identify:
    - other community services and supports that may assist in providing coordinated care to meet the young person's mental health needs;
    - the roles and responsibilities of each service provider in the transition process; and
    - the roles and responsibilities of the youth and family.

3. Consent for information sharing is obtained, as appropriate and required.

Step 2: Collaborative Planning Meeting(s)

The following individuals meet in person, when possible, for a collaborative planning meeting(s):

- CYMH/ACYMH and AMSHU practitioners (team leaders/coordinators and/or clinicians);
- the youth, and their family as appropriate; and
- other involved and relevant service providers (e.g., GPs, O/Ts, outreach workers)

The Collaborative Planning Meeting is designed to:

- identify the transition needs and goals of the youth, and their family as appropriate;
- coordinate ministry, health authority, and community planning services and supports; and
- develop and document an agreed upon transition service plan for the youth and family that clearly identifies the roles and responsibilities of all those involved in the plan.

Step 3: Collaborative Intake Process to AMHSU Services

- If there is a determination that the youth will be admitted into AMHSU services, smooth transitioning will be supported by sign-off on the admittance by the AMHSU clinician assigned to serve the youth and family. Sign-off on admittance should minimize the formal requirements of the youth to receive services. Further, the youth, and their family where appropriate, will receive an orientation to AMHSU services.
- Following the admittance to AMHSU services, CYMH/ACYMH and AMHSU services may continue to work collaboratively, to provide services such as collaborative case planning, groups, or program or client specific consultation, to ensure the youth and their family feel safe and supported throughout the transition process.

Section 3: Highlights from the *Youth Mental Health Transition Protocol Review Summary Report*

In 2002, the Ministry of Children and Family Development (MCFD) and the Ministry of Health developed the regional Mental Health Transition Protocol agreements in order to facilitate successful transitions for youth moving from the child and youth mental health system in MCFD to the adult mental health system, a component of the health authorities. These protocols outline the principles and procedures for staff of both systems to follow, to ensure that youth transitioning to adult services are served according to their needs. In alignment with quality improvement practices, the ministries collaboratively conducted an internal systems review of the protocols to discover if and how they are being used, and how they may be improved.

By conducting a literature review, staff surveys, key informant interviews and engagement sessions with youth and families, the review sought to understand:

1. The current status of the Mental Health Transition Protocol (MHTP) agreements,
2. What is working and not working with the MHTP agreements, and
3. Potential improvements for the MHTP agreements.

Below are the recommendations from the review:

Recommendation	Purpose of recommendation
1. ***Promote staff awareness/understanding of the MHTP agreements***	Continuing to raise staff and leadership's understanding of and awareness about the MHTP agreements through regular orientation and accessibility to the protocols is an integral component of regional implementation.
2. ***Implement local joint planning groups as outlined in the agreements***	Local joint planning groups are an essential factor in making youth transitions effective by promoting positive relationships between youth and staff, and between staff across services. Where communities have implemented the groups, positive outcomes were reported. This ensures that local dispute resolution mechanisms identified in the MHTP agreements are available and utilized.
3. ***Consider the most appropriate time to transition youth***	The MHTP agreements outline the principle of best fit, which promotes services that are flexible, adaptive, and based on the needs of the youth rather than age. The protocols currently have the flexibility to allow transition discussions/planning to occur according to the developmental readiness and therapeutic progress of the youth. Staff need to be aware of, and supported by management to become involved in transitioning youth accordingly.
4. ***Build relationships between staff in each service system***	Having positive relationships between staff in child and youth, and adult mental health and/or substance use systems is one of the most important factors in determining a successful transition experience. Examples of positive outcomes through collaborative service delivery were noted in a few areas such as the Early Psychosis Intervention program. Efforts to develop a shared culture between child and youth and adult mental health services through activities such as joint educational or networking events, joint planning groups, and team building events may further assist in effective collaboration and relationship building between systems.
5. ***Adapt and/or develop tools that will support transition***	Transition tools are designed to ensure that the complex mental health related needs of youth are met throughout the transition process and may include process checklists and/or youth learning needs checklists that specifically outline the steps for professionals, youth, family/caregivers, and the

Recommendation	Purpose of recommendation
	community during transition. A guide for youth in transition and their parents describing the roles and responsibilities for everyone involved may also assist families to remain central to the transition process.
6. Learn from the role of aboriginal mental health liaison workers	Staff interviews in the child and youth system revealed that even though there is room to improve the MHTP agreements and service structure for transitioning aboriginal youth, aboriginal mental health liaison workers promote more effective transitions. The role of aboriginal mental health liaison workers (in both child and youth and adult mental health) and how they contribute to cultural safety and promote successful transitions may be an area to strengthen in the MHTP agreements.
7. Include engaging youth and families in the MHTP agreements	Parents, families and caregivers have a central role in the transition process for their youth. Parents may need information about their child's mental health treatment, when appropriate, and regular support around the care of their young adult. Aboriginal families must also experience a sense of cultural safety throughout the process of supporting their youth in order to remain engaged and effective. The role of youth and family members should be strengthened in the MHTP agreements as it relates to planning discussions and decisions regarding service choices and transition time frames as appropriate.
8. Reference the need for culturally safe practices	Culturally safe transition planning needs to be available to all youth, including aboriginal youth and youth from different cultures. The MHTP agreements should include reference to/considerations for establishing cultural safety with youth and their family members.
9. Monitor and report on implementation of the MHTP agreements	The MHTP agreements have not been fully implemented throughout British Columbia. Formalized education, monitoring, and reporting on the use of the protocols and related Local joint planning groups may provide an increased level of accountability for implementation.

Section 4: Links to transition related resources

Below is a link to a toolkit for youth, families and professionals which has been developed by the ON TRAC (Transitioning Responsibly to Adult Care) initiative to help youth, young adults, families, and health care providers work together to ensure a smooth, safe, continuous, developmentally-appropriate transition from pediatric to adult care. To access the tool kit follow this link http://ontracbc.ca/toolbox/

Youth and Family Mental Health Joint Management Tables
Draft Terms of Reference

Name	Youth and Family Mental Health Joint Management Tables
Purpose	Joint Management Tables will be established, or supported where they are already established in all local geographic areas to facilitate positive service transition experiences and outcomes for youth, and their families through: • development of strong working relationships built on trust, commitment to collaboration and familiarity with roles and mandates of participating organizations and involved professionals; • ensuring the *Youth Mental Health Transition Protocol Agreements* are enhanced to meet local needs and implemented consistently; • collecting and reporting data as identified in the provincial monitoring and evaluation frame work; • mediating significant transition conflicts between systems and services; and • identifying and informing their Executive Leadership and Ministries of youth to adult transition service gaps and needs.
Deliverable	Effective transitions between child and youth mental health services and adult mental health and substance use services.
Membership	Joint Management Table membership must include: • MCFD Community Services Manager(s) responsible for CYMH/Aboriginal CYMH services; and • Health Authority manager(s) responsible for Adult MHSU services. Additional participants, determined locally, may include: • CYMH and/or Aboriginal CYMH and AMHSU Team Leaders; • Representatives of the First Nations Health Authority as appropriate; • Front-line coordinators in health authorities representing mental health and substance use, including adult mental health; • School district principals representing school counsellors; • Physician representatives such as general practitioner, child & adolescent and/or adult psychiatrists and/or paediatrics; • Community agency and/or First Nations Band mental health leaders; • Child Welfare Team Leader representation; • FORCE (Families Organized for Care Equality in CYMH) representation; • CYSN/CLBC representation; • Adult mental health agencies and partners such as advanced education, housing, and others.
Reporting and "Linkages"	• Reporting to MCFD, HA, and MoH Executive. • Linkages to: o Executive from other Ministries, such as Ministry of Education, Ministry of Social Development and Social Innovation. o School district leadership (i.e. Superintendent) . o Front-line clinicians, consumers, and advocacy groups such as the FORCE, as needed.
Communication	Agenda and materials that require review before meeting date will be circulated

Name	Youth and Family Mental Health Joint Management Tables
	prior to meeting.
Meeting Frequency	Meeting frequency will be agreed upon by the managers of both service systems, and should meet regularly enough to meet the transition needs of youth and families in their communities.
Membership Responsibilities	Members are expected to: • Review, understand and adhere to the *Youth Mental Health Transition Protocol Agreement*, • Mediate difficulties that may arise in relation to implementation. • Make a commitment to the Joint Management Table's purpose and communicate honestly and respectfully with all involved. • Involve additional partners as needed to ensure seamless, positive transitions.

Template for Local Sign Off

The terms of this agreement commence on the date this protocol agreement is signed by the parties and remains in force until terminated by a signatories' Administrator of this protocol agreement, upon 30 days prior written notice. The protocol will be reviewed every five years or sooner if required.

By signing this protocol, all parties agree to practice in accordance with the protocol, specifically in alignment with the principal of "best-fit" and provision of services to youth based on developmental needs and functional ability, rather than chronological age.

By signing this protocol, all parties agree to implement the protocol as per the Youth to Adult MHSU Provincial Transition Protocol: MCFD/Health Authority Shared Implementation Work Plan. Specifically, all signatories will:

- Establish a Joint Management Table or use the existing _____ committee to carry out the functions of the Joint Management Table as per the terms of reference in Appendix B of this document.
- Develop local procedures and processes that are required to support the implementation of the provincial protocol as per the shared implementation work plan.
- Develop and implement a system to collect and report data to support sustained implementation of the protocol through monitoring and evaluation.

Signed on behalf of _____ MCFD Service Delivery Area

_____
Name

_____
Title

_____
Date

Signed on behalf of _____ Health Authority Area

Name

_____
Title

_____
Date

Signed on behalf of _____ Community Agency (optional)

Name

_____
Title

_____
Date

Signed on behalf of _____ Community Agency (optional)

Name

_____
Title

_____
Date