ED Clinical Pathway for Children and Youth with Mental Health Conditions

Part Two

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Supporting documents are available at: http://www.pcmch.on.ca/

Latest News

June 18th, 2013
Emergency Department Pathway for Children and Youth with Mental Health Conditions, Part Two. If you will be attending the webinar please click on the link below to download the document for your reference during the webinars on June 18th and June 21st:

ED Pathway for Children and Youth with Mental Health Conditions
Webinar Overview

1. Clinical Pathway Review
   i. Pathway Details and Tools
   ii. Process

2. Implementation

3. Discussion
Clinical Pathway: Purpose

To guide and support care of children and youth, 17 years of age and younger, presenting to EDs with mental health concerns.

To ensure seamless transition to follow-up services with relevant community mental health agencies and providers.
1. Regarding the ED MH Clinical Pathway, I am …

1) … first learning about it
2) … familiar but still shopping
3) … ready to implement in my community
4) … pursuing implementation independently as an ED or community agency
5) … pursuing implementation collaboratively as an ED and community agency
Area of Interest

2. What is your primary interest?
   1) The Pathway Specifics and Tools
   2) The Implementation Process
   3) Both 1 and 2
ED Clinical Pathway for MHC

Clinical Pathway
Clinical Pathway Algorithm

ED Triage

Triage

Resuscitation/Emergent Care Required?

Yes

ED Treatment

No

MH/A Screening

C/YPS

RSQ-4

PSC <12 yrs

GAIN-SS > 12 yrs

Clinical Assessment

Child/Youth Mental Health Clinician

ED Physician

Disposition

Inpatient Admission

Community MH Services

Follow-up with Primary Care

Admission to Inpatient Bed

24 Hour Response

7 Day Response

Home with Resources

PPO
The following standards of care are required to ensure effective implementation of the ED CP:

1. Access to child and youth mental health clinician (CY MH clinician)
2. Use of standardized triage screening tools
3. Memorandum of agreement between EDs and community providers and agencies
1. CY MH Clinician

Recommendation:

• Every accredited hospital ED should have **24/7 access** to child and youth mental health clinician
  • Not limited to in-person/on-site consultation
  • Community/mobile service, telephone or video access
• Roles, qualifications and required competencies defined
3. What is your current access to a CH MH Clinician?

1) 24/7 coverage
2) Weekdays/weekends days and evenings only
3) Weekdays/weekends days only
4) On call access only
5) No coverage
4. Where is your CY MHC based?

1) The hospital ED

2) The hospital MH unit

3) A community MH agency

4) Mobile community MH service

5) Not available in our community
5. How challenging will 24/7 CYMHC coverage be for your site?

1) Very little problem
2) Will have difficulty to get weekend coverage
3) Will have difficulty to get evening coverage
4) Will have difficulty to get overnight coverage
5) Some combination of 2, 3 and 4
## 2. MHC Screening Tools for C&Y

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>All CY MH/A patients</th>
<th>All CY MH/A patients &lt; 12 years</th>
<th>All CY MH/A patients ≥12 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Suicide Questionnaire (RSQ-4)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric Symptom Checklist (PSC)</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Global Appraisal of Individual Needs – Short Screener (GAIN-SS)</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>HEADS-ED Tool</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MHC Screening Tools for C&Y

- Initial Screen:
  - CHEO Youth/Caregiver Perception Survey (Y/CPS)
  - Risk of Suicide Questionnaire (RSQ-4)

- In-Depth Screen:
  - Paediatric Symptom Checklist (PSC)
  - GAIN Short Screener (GAIN-SS)
Youth/Caregiver Perception Survey

Validation Information

• Difficult to evaluate using traditional psychometric techniques

• Have face and content validity from both the clinician and patient/caregiver perspectives
Risk of Suicide Questionnaire (RSQ-4)

Validation Information

• Moderate reliability and only after modification (using only 2 items) high sensitivity

• However specificity is low
Paediatric Symptom Checklist

Validation Information

• Well validated across several studies
• Sensitivity of 0.95 and Specificity of 0.68
• High internal consistency, high reliability
Global Appraisal of Individual Needs—Short Screener (GAIN–SS)

Validation Information

- Well validated across several studies
- Sensitivity of 0.91 and Specificity of 0.90
- High internal consistency when compared with the full GAIN
Optimal MH Risk Assessment Tool

- Very Brief
- Very Easy to complete
- Very Easy to score
- Clinically intuitive
- Help guide clinical decisions in assessment and disposition recommendations
The HEADS-ED Tool

- Guides psychosocial history by clinicians
- 7 variables rated on a 3-point scale based on need for action
<table>
<thead>
<tr>
<th></th>
<th>0 No action needed</th>
<th>1 Needs action but not immediate</th>
<th>2 Needs immediate action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home</strong></td>
<td>○ Supportive</td>
<td>○ Conflicts</td>
<td>○ Chaotic / dysfunctional</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>○ On track</td>
<td>○ Grades dropping / absenteeism</td>
<td>○ Failing / not attending school</td>
</tr>
<tr>
<td><strong>Activities &amp; peers</strong></td>
<td>○ No change</td>
<td>○ Reduced / peer conflicts</td>
<td>○ Fully withdrawn / significant peer conflicts</td>
</tr>
<tr>
<td><strong>Drugs &amp; alcohol</strong></td>
<td>○ No or infrequent</td>
<td>○ Occasional</td>
<td>○ Frequent / daily</td>
</tr>
<tr>
<td><strong>Suicidality</strong></td>
<td>○ No thoughts</td>
<td>○ Ideation</td>
<td>○ Plan or gesture</td>
</tr>
<tr>
<td><strong>Emotions, behaviours, thought disturbance</strong></td>
<td>○ Mildly anxious / sad / acting out</td>
<td>○ Moderately anxious / sad / acting out</td>
<td>○ Significantly distressed / unable to function / out of control / bizarre thoughts</td>
</tr>
<tr>
<td><strong>Discharge resources</strong></td>
<td>○ Ongoing / well connected</td>
<td>○ Some / not meeting needs</td>
<td>○ None / on wait list / non-compliant</td>
</tr>
</tbody>
</table>
Evidence for HEADS-ED

CHEO study with the HEADS-ED

• Crisis workers completed the HEADS-ED and CANS tools
• Youth completed the Children’s Depression Inventory
  • Evidence of inter-rater reliability, and criterion, concurrent and predictive validity for HEADS-ED
  • The HEADS-ED is correlated with youth’s ratings of depression and a more comprehensive clinician rating of mental health strengths and needs.
  • The tool had good detection of indicators of admission to inpatient psychiatry.

**HEADS-ED tool does not replace best clinical judgement; should be used to assist in clinical decision making.**
HEADS-ED Capability

- HEADS-ED Website: [www.heads-ed.com](http://www.heads-ed.com)
- Simple interface to enter HEADS-ED scores
- Generates list of community resources based on patient’s age, language, and needs according to the HEADS-ED
- Can produce customized printout of resources for patients/families, including personalized discharge instructions and HEADS-ED score summary
3. Memorandum of Agreement

Between

Emergency Department

And

Community Mental Health Agencies
MOA: Purpose

Recommendation:

• Implementation of an MOA between all parties involved to ensure collaboration and adherence to ED MH CP among ED & Community Agencies

• Comprehensive understanding of pathway and expected roles

• Key components and template described
Memorandum of Agreement

Formalizes the pathway—one MOA / community

• Purpose
• Principles
  • To direct the purpose of partnership/relationship
• Disposition
• Information and Privacy
  • HIC
Memorandum of Agreement cont.

Leadership
• Senior
  • 3x/yr
  • agreement level
  • metrics

• Operational
  • management and CQI
Standardized Assessment

Recommendation:

• Standardized assessment form that is shared with the MH community agency upon discharge
  • Follows the patient
  • Shared branding
  • Confidentiality—HIC inclusive
### ED MH Clinical Pathway

**Standardized Assessment Form**

#### ASPECT OF CARE

<table>
<thead>
<tr>
<th>DATE:</th>
<th>START TIME:</th>
<th>INITIALS:</th>
<th>PT WEIGHT: Kg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

#### ASSESSMENT

1. **Assessment**
   - RR, HR and BP, then as indicated
   - Review of presenting complaint

2. **Screening Tests Given**
   - Youth Perception Survey (YPS)
   - Caregiver Perception Survey (CPS)
   - Risk of Suicide Questionnaire (RSQ-4)

3. **Treatment / Medications**
   - Medications as per Pre-Printed Order set
   - Need for physical restraints

4. **Activity**
   - Activity as Tolerated
   - Security Watch
   - Section 17
   - Form 1
   - Form 42 given

5. **Education**
   - Discussion of web-based resources
   - Discussion of community resources
   - Written information provided

6. **Consults**
   - MH Crisis Worker
   - Psychiatry or Pediatrics
   - Other

7. **Disposition Planning**
   - Community Agency Referral
   - Good understanding of education
   - Resources Provided

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#### Screening Tool Summaries

<table>
<thead>
<tr>
<th>Screening Tool Summaries</th>
<th>High Risk Findings</th>
<th>Low Risk Findings</th>
<th>Non-Reliable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a) Youth Perception Survey (YPS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.b) Caregiver Perception Survey (YPS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Risk of Suicide Questionnaire (RSQ)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pediatric Symptom Checklist (PSC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Parent Completed Version (PSC)</td>
<td>Score &gt; or = 28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Youth Self-Report (Y-PSC)</td>
<td>Score &gt; or = 30</td>
<td></td>
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</tbody>
</table>

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**A copy of this form to be forwarded to:**
1. The referred Community MH/A Agency
2. The patient's Primary Care provider
## ED MH Clinical Pathway

### Standardized Assessment Form – page 2

### HEADS-ED Rating

<table>
<thead>
<tr>
<th></th>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Initials</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Hrs of Care</th>
<th>Initials</th>
<th>Signature</th>
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<tbody>
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Practice Recommendations

Use of pre-printed order sets ensure standardized, evidence-based management practices.

Recommendation:
PPO for chemical restraint to be implemented within the ED MH Clinical Pathway, to be used as needed.
PPO: Chemical Restraint in the ED

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>Dose</th>
<th>Reason</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLANzapine</td>
<td>Rapid Dissolve ___ mg</td>
<td>Olanzapine is refused</td>
<td>Not for use with children &lt; 6 years of age</td>
</tr>
<tr>
<td>ChlorproMAZINE</td>
<td>___ mg</td>
<td></td>
<td>Use of chemical and/or physical restraint</td>
</tr>
<tr>
<td>DiphenhydRAMINE</td>
<td>___ mg</td>
<td></td>
<td>Begin first with non-medication treatment</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>___ mg</td>
<td></td>
<td>Medication should only be used as a second</td>
</tr>
<tr>
<td>Benztpine</td>
<td>___ mg</td>
<td></td>
<td>For agitated patients with suspected</td>
</tr>
<tr>
<td>DiphenhydRAMINE</td>
<td>___ mg</td>
<td></td>
<td>ingestions, only benzodiazepines should be</td>
</tr>
<tr>
<td>Nicotine resin</td>
<td>gum 2 mg piece (MAX 12</td>
<td></td>
<td>used; neuroleptics are contraindicated.</td>
</tr>
<tr>
<td></td>
<td>pieces/day)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- Not for use with children < 6 years of age
- Use of chemical and/or physical restraint should be consistent with hospital policy
- Begin first with non-medication treatment (calming, supportive measures) and evaluation
- Medication should only be used as a second option for anxious/agitated patients
- Always give medication by oral route where possible
- **For agitated patients with suspected ingestions, only benzodiazepines should be used; neuroleptics are contraindicated.**
Clinical Pathway Algorithm

Disposition

- Inpatient Admission
  - Admission to Inpatient Bed
- Community MH Services
  - 24 Hour Response
- Follow-up with Primary Care
  - 7 Day Response
  - Home with Resources
Disposition

- **Disposition A** - From a Hospital Admission
  - Best Practice – in-person follow-up prior to discharge.
  - Minimum is contact by telephone
  - Service delivery timing: at the discretion of the agency

- **Disposition B** – From ED – Expedited Community follow-up based on risk and level of supports
  - One business day follow-up at a minimum by telephone to assess urgency
Disposition cont.

• **Disposition C** – level of risk and supports allows timely follow-up
  • Minimum telephone follow-up within seven days to assess service continuity requirements

• **Disposition D** – Discharge with follow-up determined by patient and family
  • Feedback loop to ED for patient management and metrics by CYMH clinician
6. What do you see as key challenge to implementing the ED MH Clinical Pathway?

1) Forming the necessary partnerships
2) Completing the MOA for our community
3) Integrating the CYMH clinician role into the ED
4) Applying the screening tools
5) Meeting the Disposition timelines
Implementation Approach

1. Create Implementation Team
2. Assessment and Planning
3. Change Strategy
4. Implement
5. Monitor and Evaluate
7. What do you see as the key barriers to change?

1) Attitudes/beliefs about mental health concerns
2) Lack of expertise/comfort with this population
3) Lack of awareness re: expertise/services provided by community agency / ED
4) Lack of 24/7 CY mental health clinicians
Meetings are occurring with the Ministry to identify and design an evaluation strategy for this pathway.

We would appreciate input into this conversation from participants.

Are there metrics or evaluation considerations participants would like to propose?
Summary

The development of an ED clinical pathway for CY MH/A will promote integrated services for children and youth with mental health concerns by ensuring a stabilization plan and timely follow-up. This will provide better patient care and reduce unnecessary use of costly emergency services.

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