Provincial Council for Maternal and Child Health
building a brighter future

Implementation Toolkit

Emergency Department Clinical Pathway for Children and Youth with Mental Health Conditions

September 30, 2013

Implementation Toolkit
Emergency Department Clinical Pathway for Children and Youth with Mental Health Conditions

TABLE OF CONTENTS

Provincial Council for Maternal and Child Health
building a brighter future

Emergency Department Clinical Pathway for Children and Youth with Mental Health Conditions

Implementation Toolkit

Introduction

The hospital Emergency Department (ED) is a common and important entry point for children and youth (CY) into the mental health/addictions (MH/A) system. In addition to being an entry point, hospital EDs also serve as a point of interim care when children and youth are waiting for definitive mental health assessment and treatment either in hospital or, more frequently, in the community. Although EDs serve as an access point, many EDs across the province are challenged in managing CY with MH/A due to lack of clinical resources, standardized screening tools and/or training. This problem is compounded by the lack of defined, reliable, integrated and streamlined referral processes to appropriate resources in the community. Further, the mental health system itself in Ontario is complex, fragmented and limited.

The Provincial Council for Maternal and Child Health (PCMCH) established the Emergency Department Clinical Pathways for Children and Youth with Mental Health Conditions/Addictions Work Group in 2011. The goals of this work group have been two-fold:

1. Develop an evidence-informed clinical pathway with decision support tools to guide and support the care of children and youth presenting to EDs with MH/A problems;
2. To ensure seamless transition to follow-up services with relevant community MH/A agencies.

The development of an ED clinical pathway for CY mental health will enhance the capacity of the health system to provide integrated services for people with mental illness by developing protocols that ensure anyone discharged from an emergency department has a stabilization plan and, if necessary, receives timely follow-up resulting in reduced unnecessary use of costly emergency services. The pathway supports the Ontario Ministry of Health and Long-Term Care's Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy, Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy[1]

Work Process

Through a series of literature reviews, an environmental scan as well as expert consultation, a clinical pathway was developed that includes triage screening tools, a pre-printed order-set for the use of chemical restraints,

[1] Ontario Ministry of Health and Long-Term Care. (2010). Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy, Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy . Accessible at: http://www.health.gov.on.ca/en/public/publications/ministry_reports/mental_health/mentalhealth_rep.pdf

timely access to and minimum standards for child and youth mental health clinicians (CY MHC) and a draft Memorandum of Agreement for EDs, CY mental health agencies, and their respective community mental health partners. Although the intent of the work group was to address the needs of CY with mental health and addictions issues, it became clear that, due to the dearth of addiction services for children and youth, addictions could not be addressed at this time. As a result, this toolkit addresses the needs of CY with MH conditions only

The specific population addressed in this project includes children and youth aged 17 and younger. It was acknowledged that this clinical pathway could likely be extrapolated to young adults up to age 24, however further consultation with experts in young adult mental health would be required.

The facilitation of communication between EDs, community mental health providers, family physicians and other primary health care providers involved in the circle of care will optimize the successful implementation of the recommendations.

Clinical Pathway

Given the prevalence of children and youth suffering with mental health issues and the significance of EDs in their care, it is imperative that ED staff be supported to provide evidence-based approaches to the care of this population. In addition, successful referral and integration into community services is equally crucial. To address the issues of CY mental health as it pertains to hospital EDs, the clinical pathway is recommended to guide clinical care and optimize the system to ensure appropriate and timely referral into community mental health services.

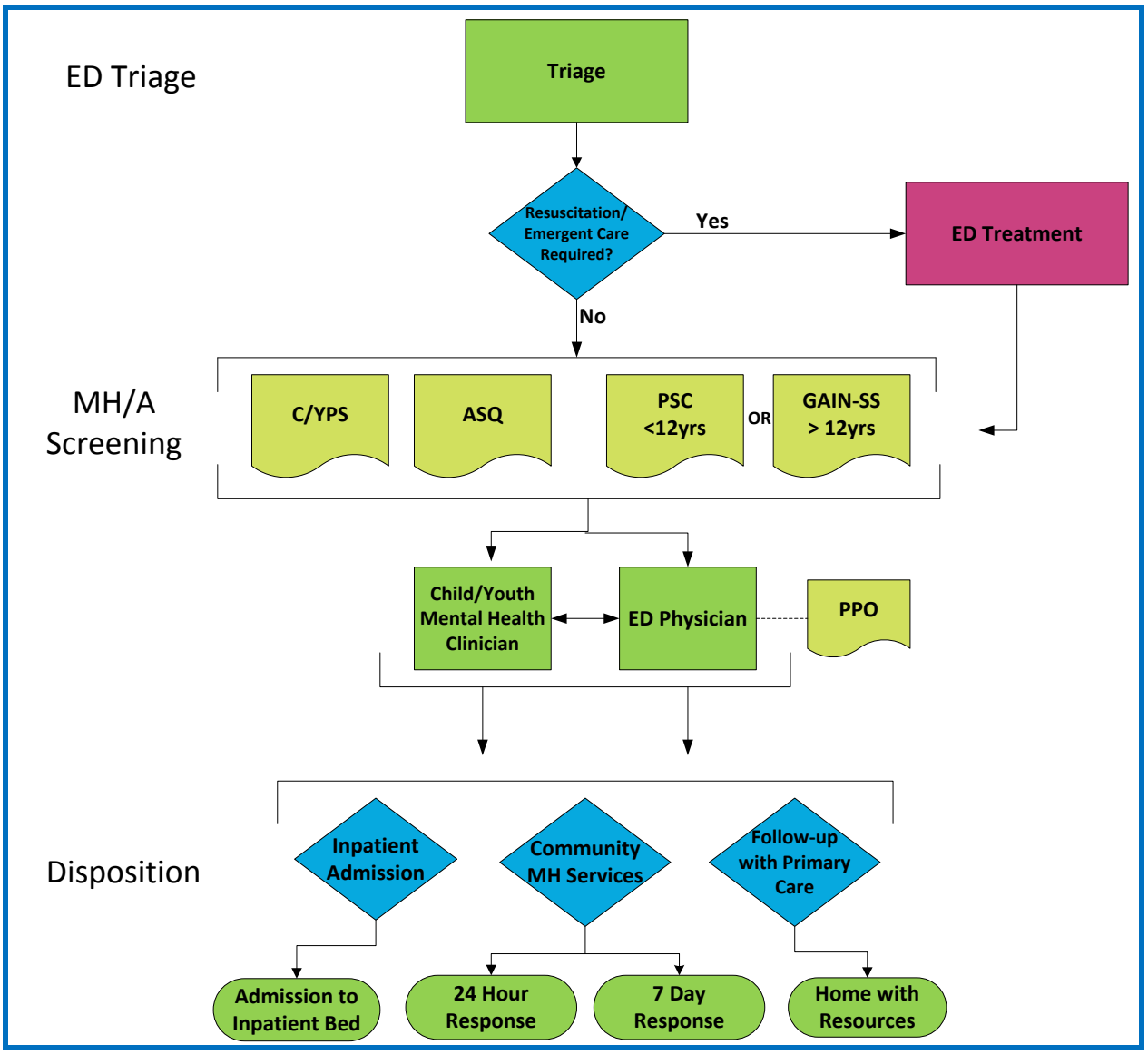
A clinical pathway is a tool that operationalizes best evidence recommendations and clinical practice guidelines in an accessible format for “point of care” management by multidisciplinary health teams. With evidence informed recommendations embedded into a pathway that is tailored for each patient, a well-designed pathway can lead to improved patient care and efficiency of care processes through standardized, multidisciplinary management plans that can be anticipated by an integrated healthcare team.

Benefits of the Clinical Pathway

- Supports decision making
- Supports team and inter-agency communication
- Supports delivery of high quality care
- Supports evidence informed practice
- Supports interdisciplinary care
- Supports seamless transition between the hospital, community agencies and primary healthcare providers
- Improves utilization of resources
- Potential improvement in outcomes

Emergency Department Clinical Pathway for Children and Youth with Mental Health Conditions

The following is an algorithm that describes key aspects of the flow, activities and community integration of the proposed ED Clinical Pathway.



Glossary:

ED: Emergency Department
PPO: Pre-printed order
C/YPS: Child / Youth Perception Survey
ASQ: Ask Suicide Screening Questions
PSC: Pediatric Symptom Checklist
Gain-SS: Global Appraisal of Individual Needs- Short Screener

Figure 1 Emergency department clinical pathway for children and youth with mental health conditions.

Description of Pathway Components

1. ED Triage: This pathway focuses on CY mental health presentations to the ED, thus the entry point for the algorithm is the ED triage. All patients are greeted at triage by an experienced ED nurse with special triage training and experience. The Canadian Triage Acuity Scale (CTAS) guidelines are used to assign each patient to the appropriate priority level for assessment. Specific mental health problems are addressed in the CTAS guidelines.

2. Resuscitative / Emergent Care Required: If the triage nurse identifies need for resuscitative or emergent care, the patient will be taken immediately to the appropriate area in the ED for assessment and management. When the patient is medically stable, the patient may then be directed for mental health assessment, if appropriate, as per the algorithm. Patients requiring this type of immediate care represent a small proportion of all children and youth with mental health presentations to the ED.

3. Mental Health Screening: After triage assessment, all medically stable children and youth with mental health presentations will be asked to complete a set of self-report surveys. All patients or caregivers will be asked to complete either the Caregiver or Youth Perception Survey (C/YPS). Patients 10-21 years of age will be asked to complete the Ask Suicide Screening Questions (ASQ). For children under 12 years of age, caregivers will be asked to complete the Pediatric Symptom Checklist (PSC), and youth over 12 years of age will be asked to complete the Global Appraisal of Individual Needs—Short Screener (GAIN-SS).

4. Clinical Assessment: Depending on the resources available in a particular ED, the patient will either be assessed directly by a Child and Youth Mental Health Clinician (CY MHC) or an ED physician. For the latter, depending on the physician's clinical assessment and responses to some of the self-report surveys, the patient may then be referred to a CY MHC for further assessment. The CY MHC is a specialized professional within the multidisciplinary team who can provide psychosocial/behavioural assessments and treatment planning for children/adolescents and their families presenting to the Emergency Department (ED) with acute psychiatric concerns. (*See role description on page 6*).

   Any patient who is deemed high risk by the CY MHC would be reviewed for potential admission with the Psychiatrist, Pediatrician or Family Physician on call, based on arrangements at that site. The ED is often an entry point or "gatekeeper" for children and youth with suicidal ideation. Education about suicide would be helpful in preparing clinicians for arranging appropriate disposition in order to mitigate the risk of post-stabilization follow through with suicidal thoughts.

5. Disposition: Based on the clinical assessment(s), one of the following three disposition decisions will be made:

   1. Immediate referral to a mental health specialist with potential admission **OR**
   2. Outpatient referral to a CY mental health community agency, with expected telephone follow - up in either 24 hours or telephone follow-up within 7 days **OR**
   3. Disposition home with a recommendation to follow-up with the Primary Care provider and provision of contact information for community mental health services to allow patient to follow-up should they choose to do so.

   For patients referred to a CY mental health agency the expectation for the telephone follow-up is to review the presenting concerns and referral information from the ED visit and to determine priority for

an in-person assessment at that agency. In the event that the child/youth revisits the ED with mental health concerns, the protocol specifies that the community agency inform the ED of the outcome of this follow-up for reference.

To achieve our collective goals and ensure optimal functioning of this pathway the following is strongly advised:

Minimum Standards

1. Access to Child and Youth Mental Health Clinician (CY MHC): At a minimum, every accredited hospital ED should have access to a CY MHC to assist with assessment, management and appropriate referral decisions for children and youth presenting acutely with mental health issues. In addition, it would be further recommended that the CY MHC use a standardized assessment form that could be shared with the mental health community agency upon discharge. These recommendations are not limited to in-person or on-site consultation, but could include involvement through community/mobile services and/or videoconference consultation. The CY MHC clinician can come from within the hospital or community based system.

2. Standardized Triage Screening Tools: For children/youth presenting with mental health concerns, patients and/or their caregivers will be asked, after triage, to complete three brief self-surveys to assist with determining risk and urgency. These are:
    - the Children's Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS) (Appendix Two)
    - the Ask Suicide Screening Questions (ASQ) for children aged 10-21 (Appendix Three)
    - either the Paediatric Symptom Checklist (PSC) for children under 12 years and/ or the Global Appraisal of Individual Needs- Short Screener (GAIN-SS) for children 12 years and over (Appendix Five)

3. Memorandum of Agreement: One Memorandum of Agreement (MOA) for each community between the ED and the local child and youth mental health service providers should be implemented to ensure implementation and adherence to the ED Clinical Pathway and referral processes. This will ultimately provide seamless integration for patients between the ED and Community mental health agencies. (Appendix Ten)

Recommended Practices

4. Use of Pre-Printed Order (PPO) Sets: Pre-Printed Order sets ensure standardized, evidence-based management practices and are a useful adjunct to clinical pathways. A PPO for chemical restraint has been developed for use with relevant patients within the ED Clinical Pathway. (Appendix Six)

Mental Health Screening Tools

Assessing CY mental health issues can be a challenge for EDs that do not have regular experience with these patients or for clinicians who are not comfortable with these patients. As such, an important component of the ED Clinical Pathway is the inclusion of screening tools early in the pathway to assist ED clinicians in decision-making. The completion of screening tools can also serve as an important communication tool during the disposition of these patients into CY mental health community services. As such the Work Group recommends the utilization of the following screening tools as part of the ED Clinical Pathway:

- The **Children's Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS)** – for all CY mental health patients
- The **Ask Suicide Screening Questions (ASQ)** – For CY aged 10-21 years
- The **Paediatric Symptom Checklist (PSC)** – For CY mental health patients under the age of 12 years
- The **Global Appraisal of Individual Needs – Short Screener (GAIN-SS)** – For CY mental health patients 12 years and over
- The HEADS-ED Tool

Screening Tool Selection and Descriptions

The Work Group undertook a comprehensive search in order to identify potential MH/A screening tools that could be incorporated into the ED Clinical Pathway.

Screening tools were identified via three methods:

- By members of the Work Group
- By review of the CAMH Report: Screening for Concurrent Substance Use and Mental Health Problems in Youth[2]
- By a literature review undertaken by Evidence In-Sight, Ontario Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario[3]

The search for screening tools resulted in 100 potential screening tools with the following categorization of MH/A conditions:

- 44 General MH/A screening tools
- 12 Depression screening tools
- 12 Suicide risk screening tools
- 11 Anxiety screening tools
- 21 Substance abuse screening tools

[2] Centre for Addiction and Mental Health. (2009). Screening for Concurrent Substance Use and Mental Health Problems in Youth. Accessible at: http://knowledgex.caMH/A.net/aMH/Aspecialists/Screening_Assessment/screening/screen_CD_youth/Pages/default.aspx

[3] Evidence In-Sight, Ontario Centre of Excellence for Child and Youth Mental Health: http://www.excellenceforchildandyouth.ca/about-learning-organizations/get-ready/support-services/evidence-sight

Given the large number of screening tools uncovered, three sub-groups were formed to review these tools with the lens of key populations who present to the ED with MH/A conditions: Children under 12 years, adolescents (12 years and over) with internalizing symptoms and adolescents (12 years and over) with externalizing symptoms. Each group reviewed the tools for relevance, feasibility and utility in the ED setting and potential efficacy in supporting decision-making related to acute MH/A conditions. The sub-groups selected many of the same tools and, after thorough discussion, decided on 4 potential tools for inclusion in the clinical pathway. Evidence-Insight was further engaged to do a literature review for validity data on these screening tools.

The screening tools selected are described below, with a summary of relevant validity data:

1. The **Children's Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS)** – A general mental health screening tool currently being used in the CHEO ED that addresses the main reason the child/youth is visiting the ED, main concerns and stress factors in the child/youth's life. This tool is difficult to evaluate using traditional psychometric techniques, however it does have face and content validity from both the clinician and patient/caregiver perspectives.[4,5]
2. The **Ask Suicide Screening Questions (ASQ)** – A four item questionnaire specifically indicated for use in the ED to detect children and youth, ages 10-21, at risk for suicide. The ASQ was shown to have high sensitivity at 0.97, meaning that the tool is very good at detecting suicide risk, and high specificity at .88 which means few false positive results.[6]
3. The **Paediatric Symptom Checklist (PSC)** – An in-depth psychosocial screen designed to facilitate the recognition of cognitive, emotional and behavioural problems. Questions include internalizing, attention and externalizing problems. The PSC demonstrates good validity across several studies, with a sensitivity of 0.95 and specificity of 0.68. It was also shown to have high internal consistency and high reliability.[7,8,9]
4. The **Global Appraisal of Individual Needs- Short Screener (GAIN-SS)** – An in-depth mental health screen targeted for adolescents. It identifies internalizing disorders, externalizing disorders, substance use and crime/violence. The GAIN-SS was shown to be well validated across several studies, with a sensitivity of 0.91 and a specificity of 0.90. It was also shown to have high internal consistency when compared with the full GAIN.[10]

Given these findings, the Work Group recommends these screening tools for use in the ED Clinical Pathway. Almost all the screening tools included in the pathway are available in the public domain for free use and

[4] Email correspondence with Paula Cloutier, July 7, 2011

[5] Cloutier, P. et al. (2010). Pediatric Mental Health Concerns in the Emergency Department: Caregiver and Youth Perceptions and Expectations. *Pediatric Emergency Care,* 26 (2):1-8

[6] Horowitz, L.M. et al. (2012). Ask Suicide-Screening Questions (ASQ). *Arch Pediatr Adolesc Med,* 166(12), 1170-1176

[7] Jellinek, M. S. et al. (1998). Pediatric Symptom Checklist: screening school-age children for psychosocial dysfunction. *Journal of Pediatrics.* 12(2): 201-209.

[8] Bothroyd, R.A. et al. (2001). An examination of the psychometric properties of the Pediatric Symptom Checklist with children enrolled in Medicaid. *Journal of Emotional and Behavioral Disorders,* 18(2): 113-126.

[9] Navon, M. et al. (2001). Use of the Pediatric Symptom Checklist in strategies to improve preventive behavioral health care. *Psychiatric Services,* 52(6): 800-804.

[10] Dennis, M. L. et al. (2006). Development and validation of the GAIN Short Screen (GSS) for internalizing, externalizing and substance use disorders and crime/violence problems among adolescents and adults. *American Journal on Addictions,* 15, 80-91.

will be downloadable from the PCMCH website. The GAIN-SS is the only tool that is not in the public domain. PCMCH plans to purchase the license so that the GAIN-SS can be made available for free use by Ontario hospitals and downloadable from the PCMCH website. Refer to Appendices Two, Three, Four and Five for a copy of the above-mentioned tools.

HEADS-ED Tool

In addition to the above screening tools, which are included to aid the assessment of children and youth with mental health concerns, the Work Group also identified the need for a guide, embedded into the Clinical Pathway, to ensure the ED physician assessment addresses key content areas. The HEADS-ED is a new tool that has been developed to assist ED physicians in taking a brief but essential psychosocial history that will aid in both the interview and clinical decision-making. This tool has been found to have very good correlation with the Childhood Depression Inventory, and early studies with MH Crisis Workers have demonstrated great potential for this tool in identifying the level of patient crisis in the ED setting. The HEADS-ED tool is currently being evaluated with ED physicians in single site and multi-centre trials. Ideally, these evaluations would have been completed prior to incorporation into the ED Clinical Pathway. However, as there is no other currently validated tool that will provide this function, the Work Group recommends use of this tool as a guide for ED physician assessment. It covers the key interview issues that are important to address, provides a simple scoring system, and is based on a mnemonic that will be familiar to many physicians. With 7 variables each rated on a 3-point scale based on need for action, the HEADS-ED tool fits well into the ED Clinical Pathway (page 2) and can be scored and recorded in the patient chart. Please see Appendix One for the ED Clinical Pathway documentation form which includes the HEADS-ED tool.

Pre-Printed Order Sets

Standardized, pre-printed order (PPO) sets are an important adjunct to clinical pathways and represent an opportunity to improve patient safety and quality of care. Developed for specific clinical conditions, PPOs typically include key management issues that are based on best evidence and practice recommendations. Because they are standardized and "pre-printed", the management plan can be anticipated by the health care team. PPOs have been shown to significantly reduce prescription errors.[11,12]

Because the ED Clinical Pathway is designed for use with any mental health presentation and not a specific condition per se, there is less need for PPO sets. However, a common management area for which a PPO will be useful relates to use of chemical restraints for agitated patients. A sample PPO for this indication can be found in Appendix Six. This PPO does not include descriptions for use of physical restraints but does refer to individual hospital policy and procedures. Standardized medication terminology and lettering, consistent with the Institute for Safe Medical Practices (ISMP) requirements have been used for this PPO. Specific notes are included to ensure safe practices and the selection of medications is intentionally limited. However practitioners are not restricted to the medications listed on the PPO and have flexibility to use

[11] O'Connor C, DeCaire K, Friedrich J. (2005) Improving patient care through the use of evidence based order sets. AMIA Annual Symposium Proceedings 1063.

[12] Kozer E, Scolnik D, MacPherson A, Rauchwerger D, Koren G. (2005). Using a preprinted order sheet to reduce prescription errors in a pediatric emergency department: a randomized, controlled trial. *Pediatrics*, 116, 1299-1302.

different treatments for a given patient based on their clinical judgment. Finally, while the use of chemical restraints would likely be anticipated for only a small percentage of CY mental health patients in the ED, availability of a clear PPO will promote safe, timely and effective care for those patients who truly need chemical restraint.

Emergency Department Crisis Services Minimum Standards

A key component to the ED Clinical Pathway is the involvement of crisis services. Crisis services are seen as the key link to appropriate and timely referral to community mental health services. The Work Group therefore recommends that every accredited hospital ED should have access to a Child and Youth Mental Health Clinician (CY MHC) 24-hours a day, 7-days a week. It is recommended that the CY MHC not be staffed directly by the ED but be housed under the mental health unit or department of the hospital or be provided by a community agency. Given the lack of availability of CY mental health services in some areas of the province it would not be feasible to restrict this to in-person/on-site consultation. Services of the CY MHC could also be made available by a community/mobile crisis service, via telephone or via videoconference.

Further it is also recommended that the CY MHC use a standardized assessment form that could be shared with the mental health community agency upon discharge. For an example of this form, see Appendix Seven.

In addition to performing a key role in the risk assessment of children/youth with MH presentations, the CY MHC would also:

- Conduct specific clinical interventions as required;
- Collaborate with the ED team in planning, implementing and evaluating treatment and discharge plans for specific patients;
- Collaborate with community mental health providers to have patients access appropriate and timely services;
- Serve a key role in relationship building with community mental health providers/organizations.

Child and Youth Mental Health Clinician Competencies

It is recommended that the CY MHC role be filled by an individual with one of the following:

- Bachelor of Social Work (BSW)
- Masters of Social Work (MSW)
- Psychologist/Psychological Associate (C.Psych. Assoc)
- Registered Nurse (RN)

In addition, individuals in these roles should be eligible for registration with their discipline-specific professional college.

Where a registered health professional is not available, a Child & Youth Worker Diploma (3 year program) or B.A. in Child & Youth Care could also be appropriate pending review of relevant experience. In this circumstance the CY MHC must be supervised by a registered health professional.

In addition, the CY MHC must have knowledge of psychiatric disorders in children and youth and a minimum of three years of mental health counseling experience with children, youth and families and would be required to work under the direction of a registered health professional.

Child and Youth Mental Health Clinician Scope of Practice

The scope of practice of the CY MHC should include the following:

- Providing psychosocial risk assessments and behavioural management, (including the ability to address suicidal ideation and injury) as well as counseling and support for children/youth and their families who present:
    - to the ED in an acute psychiatric crisis or
    - are being held in the ED overnight pending a mental health assessment in the morning
- Working with the multidisciplinary team to provide crisis de-escalation including application and monitoring of 5-point restraints, as needed.
- Liaising with ED and Psychiatry on-call services as well as hospital and community mental health services
- Preparing recommendations re: case disposition including admission to an Inpatient Psychiatry Unit or discharge home with timely and appropriate follow-up in the community.
- Planning crisis follow-up, including referrals, to collaborating agencies, as needed
- Preparing professional reports (both verbal and written) in a timely fashion.
- Documenting, including CBE (Charting by Exception), on all patient contacts.
- Monitoring of service utilization
- Participating in in-service training regarding the management of psychiatric crisis in children and youth
- Where applicable, providing follow-up services relative to referral to community services to ensure continuum for clients/families

For an example of a CY MHC worker job description, see Appendix Eight.

Memorandum of Agreement

The complexity and fragmentation of the current CY mental health system requires that extra vigilance be paid to ensure that children and youth do not fall through the system cracks once discharged from the ED.

A key component to the ED Clinical Pathway is the timely and appropriate referral for expeditious disposition to appropriate CY mental health services when required. Thus, for this clinical pathway to be successful effective integration with the community for the necessary mental health services is essential. This bridging of EDs and community CY mental health expands the boundaries of a clinical pathway into new territory outside of a hospital setting and requires a strategy for it to occur as a minimum standard.

The successful implementation of the ED Clinical Pathway is dependent on the ED, CY MHC and CY mental health community agency staff having a comprehensive understating of the clinical pathway, their roles within it, and a defined understanding about how they will integrate services.

To aid adherence to the ED Clinical Pathway and to ensure active collaboration between the ED, CY MHC and community agencies, the Work Group recommends implementing a Memorandum of Agreement (MOA) between all involved parties. An MOA template has been created to ensure the key issues are addressed, and this template could be tailored to the specific resources and requirements for each community. However, for consistency of practices and services delivered, there should be one common MOA for each community.

Key components to this MOA should include:

- Statement of purpose
- Governing principles
    - Principles agreed to by all parties involved regarding provision of treatment, collaboration, value added intent and outcomes.
- Details regarding the parties to the MOA
    - A brief description of all the parties involved and the services they provide. Where there is more than one community agency providing CY mental health services they will collaborate to have one access point and process for the ED to interact with defined in the MOA
- Details of the process to be followed
    - An overview of the ED Clinical Pathway, guidelines for decision making and definitions of risk and response times.
- Information sharing and privacy details
    - Details regarding information sharing between parties and privacy guidelines that will be followed.
- Leadership details
    - How the MOA will be governed and maintained

To review a sample MOA, including more details on the components outlined above, see Appendix Ten.

Implementation of the ED MENTAL HEALTH (MH) Clinical Pathway

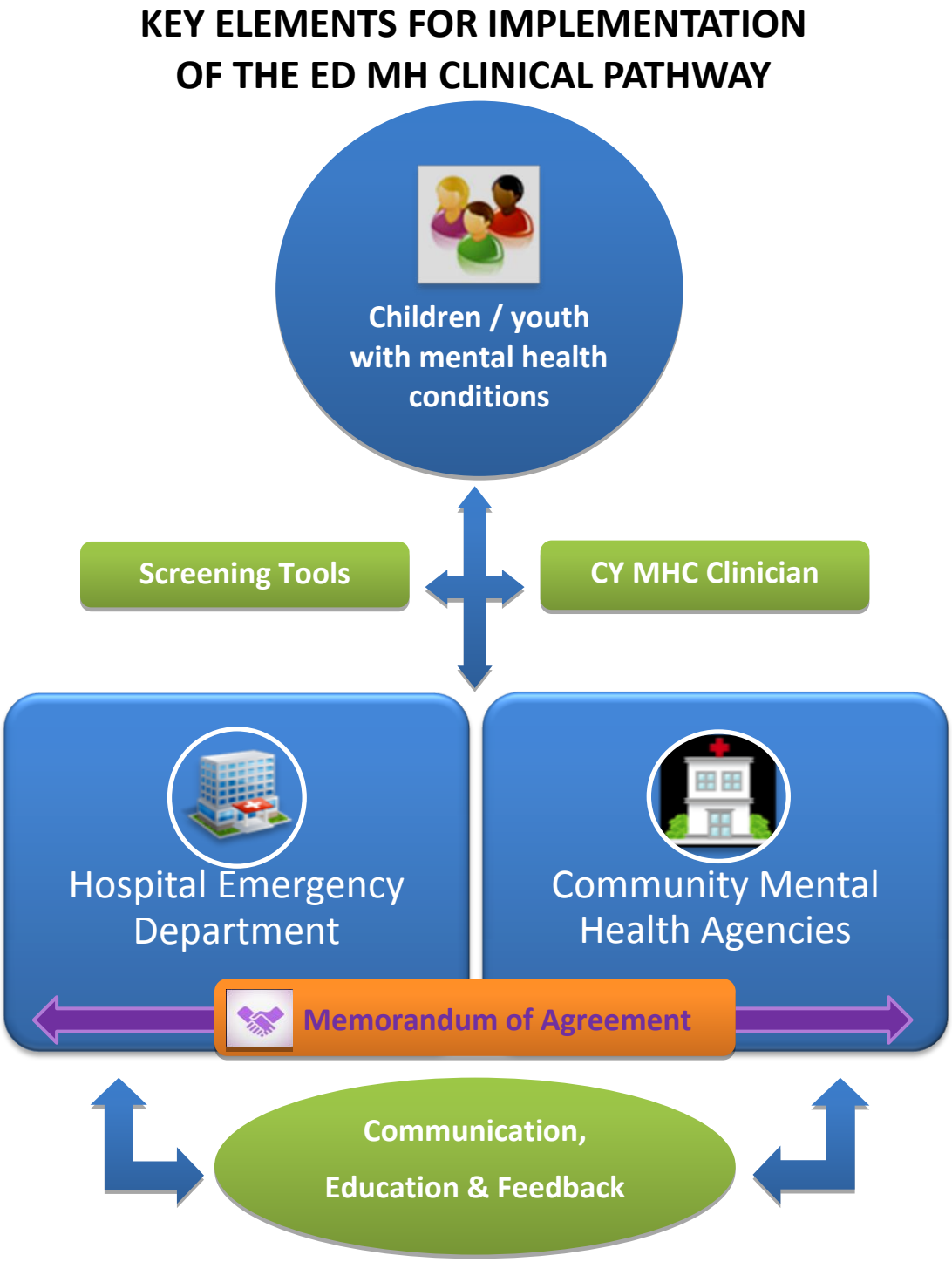


Figure 2 Key components of the Emergency Department Clinical Pathway for children and youth with mental health conditions.

IMPLEMENTATION PLAN

Successful implementation of this clinical pathway is dependent on a comprehensive implementation plan. This plan will assist organizations to implement the ED MH Clinical Pathway for children and youth in their communities. Given the goals of this pathway, it is critical that hospitals and community agencies work collaboratively to ensure seamless integration of care for children/youth and their families within that community.

An environmental assessment audit is recommended as part of the implementation plan to determine readiness for implementation by Emergency Departments and Community Providers (Appendix Nine)

A PowerPoint presentation is available as an educational resource to support implementation. It is available for download at www.pcmch.on.ca. A copy of the slide deck can also be found in Appendix Eleven.

IMPLEMENTATION PLAN

This guide will assist organizations to implement the ED MH Clinical Pathway for children and youth in their communities. Given the goals of this pathway, it is critical that hospitals and community agencies work collaboratively to ensure seamless integration of care for children/youth and their families within that community.

1. Create implementation team

a) Obtain support from senior leadership to implement the clinical pathway and formalize a collaborative partnership between hospital and community agencies required for successful implementation of the clinical pathway. Implement the Memorandum of Agreement between all parties. See Appendix Ten

b) Recruit and engage champions from stakeholder groups in both hospital and community agency settings.

Team members to consider:

- Clinicians
- Crisis intervention workers / CY MHCs
- Medical chiefs of the Emergency Department, Mental Health Services
- Managers
- Clinical Educators
- Nurse practitioners and nurses
- Primary care providers, family health teams
- Patients/families

c) Develop a working group to address clinical and operational issues for pathway implementation. Form a steering committee for each setting to provide oversight on implementation progress.

d) Establish meeting schedule

- Communicate meeting dates and times
- Discuss Implementation Toolkit

e) Establish project goals, including target dates.

2. Assessment

a) Review and discuss the clinical pathway and recommendations that support its implementation

b) Conduct an environmental assessment audit to identify the access to mental health services for C/Y within each setting. See Appendix Nine

c) Identify gaps between current practice and ED pathway recommendations

d) Identify practices & processes that require development or change in order to support the ED clinical pathway

e) Identify internal and external stakeholders who will be impacted by the pathway and therefore require education and support to implement it

f) Identify impact of infrastructure on goals. Consider: physical environment, resources, communication, relationship and linkages between EDs and community mental health providers, primary care providers, family health teams, services and supports.

g) Develop comprehensive implementation plan with timeline and benchmarks. Use of value stream mapping is recommended.

3. Plan strategy for change

a) Identify leadership support required for implementation phase.

b) Identify and engage influential clinical champions who will effectively drive change.

c) Revise or develop policies as needed.

d) Communicate with pathway partners about the clinical pathway, screening tools, and crisis services.

e) Develop a knowledge translation strategy to support practice change. Methodologies to consider:
- Shared staff meetings
- Educational rounds
- Intranet / on-line tutorial / self-learning module
- In-service
- Peer-to-peer mentoring
- Utilize implementation slide deck. Appendix Eleven.
- Meeting with ED and community agencies
- Communication with primary care providers and family health teams

f) Identify factors that will support practice change. For example:
- Engage all potential stakeholders early and often
- Schedule champions and clinicians to enable attendance at meetings and face -to-face education sessions
- Identify process and timelines for patient record forms approval
- Identify or create private space within the ED to screen/treat this population
- During and after implementation provide progress reports to staff, create opportunities for formal and informal discussions
- Facilitate the development of relationships between clinicians and mental health service providers within the hospital setting and with community providers/agencies.
- Conduct chart audits or monitor specific data indicators that will support practice change

g) Identify factors that may create a barrier for practice change in the Emergency Department. For example:
   - Attitudes and beliefs about mental health and addictions
   - Lack of awareness about community or hospital services that are available
   - Lack of awareness that some adult crisis teams have proficiency with children/youth
   - Lack of awareness of CY mental health services offered by the hospital
   - Lack of 24/7 CY mental health clinicians; lack of clinician expertise/comfort with this population
   - Need for additional resources to support this initiative, including development of education, revision of documentation, data collection and analysis

h) Identify factors that may create a barrier for practice change in community agencies. For example:
   - Lack of confidence that EDs are accessing crisis services consistently
   - Physician reluctance to call community agency if a face-to-face response is not possible
   - Capacity for community services/wait lists
   - Lack of protocols/MOUs between community agencies and hospitals

i) Develop strategies to manage barriers. For example, communication, education, opportunities to develop relationships within and between clinicians and service provider.

4. Implementation

a) Obtain screening tools and obtain approval for them to be incorporated into the patient record

b) Implement pre-printed orders

c) Deliver clinician education using implementation slide deck. Appendix Twelve

d) Encourage feedback from clinicians to overcome barriers and successfully change practice.

e) Develop audit tool to monitor progress. Include pre-implementation data indicators.

5. Monitor and evaluate progress

a) Conduct post-implementation audit.

b) Collect and analyze data and audit results on an ongoing basis.

c) Share results with stakeholders on a regular basis.

d) Create opportunities for frequent discussion of successes, challenges, and problem-solving.

e) Regular communication between hospital, community mental health providers/agencies, and primary care provides/family health teams to monitor progress

f) Review results and revise strategies to reach goal and sustain results.

g) Communicate progress to reinforce benefits of practice change for clinicians, patients & families.

h) Celebrate milestones!

APPENDIX ONE - ED CLINICAL PATHWAY FORM

ED Mental Health Clinical Pathway

Clinical pathways are not a substitute for sound professional judgement

INCLUSION	EXCLUSION	DOCUMENTATION CODES
Alert and oriented	CTAS 1	**N** = Within normal limits
Mental health presentation	Patient is not medically stable	**S** = Significant findings
	Age <6 years	**N/A** = Not applicable

Patient Identification

Date: **Start Time:** **Patient Weight:** **Kg**

ASPECT OF CARE		TIME	CODE	INITIALS
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)			
	Ask Suicide Screening Questions (ASQ)			
	Pediatric Symptom Checklist – Parent (PSC)			
	Pediatric Symptom Checklist – Youth Self Report (Y-PSC)			
	Global Appraisal of Individual Needs – Short Screener (GAIN-SS)			
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			

ASSESSMENT AND SCREENING TOOL SUMMARIES

	HIGH RISK FINDINGS	NON-RELIABLE
1. HEADS-ED tool	1 = Needs action but not immediate 2 = Needs immediate action	
2.a) Youth Perception Survey (YPS)		
b) Caregiver Perception Survey (YPS)		
3. Ask Suicide Screening Questions (ASQ)	"Yes" to any question	
4. Pediatric Symptom Checklist (PSC)		
a) Parent Completed Version (PSC)	Positive Score ≥ 28	
b) Youth Self-Report (Y-PSC)	Positive Score ≥ 30	
5. Global Appraisal of Individual Needs - Short Screener (GAIN - SS)	Moderate: 1-2 past year symptoms High: 3+ past year symptoms	

A copy of this form to be forwarded to:

1. The referred Community MH Agency ☐ Sent 2. The patient's Primary Care provider ☐ Sent

SIGNATURE	INITIALS	SIGNATURE	INITIALS

PROVINCIAL COUNCIL FOR MATERNAL AND CHILD HEALTH, ED MENTAL HEALTH CLINICAL PATHWAY SEPTEMBER 2013

The HEADS-ED

The HEADS-ED© is a tool that enables physicians to take a psychosocial history which aids in decisions regarding patient disposition. Seven variables are incorporated into the use of the HEADS-ED tool: **H**ome, **E**ducation, **A**ctivities and peers, **D**rugs and alcohol, **S**uicidality, **E**motions, behaviours and thought disturbance, **D**ischarge resources

	0 No action needed	1 Needs action but not immediate	2 Needs immediate action
Home	○ Supportive	○ Conflicts	○ Chaotic / dysfunctional
Education	○ On track	○ Grades dropping / absenteeism	○ Failing / not attending school
Activities & peers	○ No change	○ Reduced / peer conflicts	○ Fully withdrawn / significant peer conflicts
Drugs & alcohol	○ No or infrequent	○ Occasional	○ Frequent / daily
Suicidality	○ No thoughts	○ Ideation	○ Plan or gesture
Emotions, behaviours, thought disturbance	○ Mildly anxious / sad / acting out	○ Moderately anxious / sad / acting out	○ Significantly distressed / unable to function / out of control / bizarre thoughts
Discharge resources	○ Ongoing / well connected	○ Some / not meeting needs	○ None / on wait list / non-compliant

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

APPENDIX TWO - CHEO CAREGIVER AND YOUTH PERCEPTION SURVEYS

CHEO Caregiver Perception Survey (CPS)

CHEO
401 Smyth Rd, Ottawa, Ontario, K1H 8L1, 613-737-7600

CPS
(Caregiver's Perception Survey)

Patient ID#:

Today's Date:_____

Child/Youth's Name:_____
Date of Birth:_____

Home Address:_____
(Street)

_____
(City) (Postal code)
Child's School (name):_____ School Grade:____

Name of individual filling out survey: _____

Relationship to child/youth: _____

Name & relationship of any other individual(s) accompanying child/youth to CHEO:

_____

Who is currently living in the home with the child? (i.e.; mother, father, brother, sister…)

_____

Who recommended the child/youth come to the CHEO emergency department?

- ☐ Parent
- ☐ Family Doctor
- ☐ Another hospital: _____
- ☐ Child / Adolescent
- ☐ CAS
- ☐ School (name): _____
- ☐ Police
- ☐ Other: _____

Today: what is the main reason for bringing the child/youth to the CHEO Emergency department? (Choose 1 only)

- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Self-injury (physically hurts self on purpose)
- ☐ Depression / low mood / unstable mood
- ☐ Anxiety
- ☐ Bad temper / outbursts
- ☐ Violent behaviour
- ☐ Rule-breaking behaviour
- ☐ Drug and/or alcohol abuse: specify_____
- ☐ Psychosis (e.g. hearing voices, odd behaviour, seeing things)
- ☐ School issues
- ☐ Family conflicts
- ☐ Other_____

_____

Do you have any other concerns? (Choose a maximum of 3)

- ☐ No other concerns
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Self-injury (physically hurts self on purpose)
- ☐ Depression / low mood / unstable mood
- ☐ Anxiety
- ☐ Bad temper / outbursts
- ☐ Violent behaviour
- ☐ Rule-breaking behaviour
- ☐ Drug and/or alcohol abuse: specify_____
- ☐ Psychosis (e.g. hearing voices, odd behaviour, seeing things)
- ☐ School issues
- ☐ Family conflicts
- ☐ Other_____

_____

What do you think are the most significant or most important stresses in the child/youth's life that are contributing to this situation? (Choose a maximum of 3)

- ☐ School (grades, learning difficulties, problems with teachers, etc.)
- ☐ Friends/peers (no friends, not getting along with friends, dating issues, bullying, etc.)
- ☐ Issues with parents (fighting with parents, lack of communication, lack of involvement, etc.)
- ☐ Parent's marital issues (divorce, separation, fighting, etc.)
- ☐ Issues with siblings (brother/sister) (e.g. not getting along, jealousy, etc.)
- ☐ Blended family issues (step family issues)
- ☐ Family financial issues
- ☐ Parent's work/employment issues (working too much, working odd hours, no job, etc.)
- ☐ Traumatic/stressful event in family (death, accident, etc.)
- ☐ Child in care (group/foster home), CAS involvement
- ☐ Moving
- ☐ Illness in family (physical or mental)
- ☐ Other (please describe briefly): _____

_____

What are your child/youth's strengths?

1. _____
2. _____
3. _____

What are your expectations in coming to the CHEO Emergency Department?

_____
_____
_____

CHEO Youth Perception Survey (YPS)

CHEO
401 Smyth Rd, Ottawa, Ontario, K1H 8L1, 613-737-7600

YPS

(Youth's Perception Survey) – Age 12 and over

Patient ID#:

Today's Date:_____

Your Name:_____
Date of Birth:_____

Home Address:_____
(Street)

_____
(City) (Postal code)
School (name):_____ School Grade:____

Name and relationship of any people that came with you to CHEO today:

_____

Who is currently living with you in your home? (i.e.; mother, father, brother, sister…)

_____

Who recommended that you come to the CHEO emergency department?

- ☐ Parent
- ☐ You
- ☐ School (name): _____
- ☐ Family Doctor
- ☐ CAS
- ☐ Police
- ☐ Another hospital: _____
- ☐ Other: _____

Today: What do you think is the main reason that you came or were brought to the CHEO Emergency department? (Choose 1 only)

- ☐ Thoughts about killing myself
- ☐ Tried to kill myself
- ☐ Hurt myself on purpose (physically)
- ☐ Depression / low mood / mood swings
- ☐ Anxiety / worried feelings / scared feelings
- ☐ Angry / bad temper
- ☐ Violent behaviour
- ☐ Not respecting rules
- ☐ Problems with drugs and / or alcohol:
  Specify: _____
- ☐ Hearing or seeing things that are not really there
- ☐ School problems
- ☐ Family conflicts
- ☐ Family / friends / teachers thought I should come to CHEO
- ☐ Other (please describe briefly): _____
_____

Do you have any other concerns? (Choose a maximum of 3)

- ☐ No other concerns
- ☐ Thoughts about killing myself
- ☐ Tried to kill myself
- ☐ Hurt myself on purpose (physically)
- ☐ Depression / low mood / mood swings
- ☐ Anxiety / worried feelings / scared feelings
- ☐ Angry / bad temper
- ☐ Violent behaviour
- ☐ Not respecting rules
- ☐ Problems with drugs and / or alcohol:
  Specify: _____
- ☐ Hearing or seeing things that are not really there
- ☐ School problems
- ☐ Family conflicts
- ☐ Family / friends / teachers thought I should come to CHEO
- ☐ Other (please describe briefly): _____
_____

What do you think are the most significant or most important stresses in your life that are contributing to this situation? (Choose a maximum of 3)

- ☐ School problems (grades, learning difficulties, problems with teachers, etc.)
- ☐ Problems with friends / peers (no friends, not getting along with friends, dating issues, bullying, etc.)
- ☐ Problems with parents (fighting with parents, lack of communication, lack of involvement, etc.)
- ☐ Parents' marriage problems (divorce, separation, fighting, etc.)
- ☐ Problems with brothers and sisters (e.g. not getting along, jealousy, etc.)
- ☐ Problems with step family members
- ☐ Money problems in family
- ☐ Personal money problems
- ☐ Traumatic / stressful event in family (death, accident, etc.)
- ☐ CAS involvement
- ☐ Moving
- ☐ Illness in family (physical or mental)
- ☐ Other (please describe briefly): _____
_____

What are your strengths (e.g. what are the things that you like about yourself, what are the things that you are good at)?

1. _____
2. _____
3. _____

What do you expect in coming to the CHEO Emergency department?

_____
_____
_____

APPENDIX THREE – ASK SUICIDE SCREENING QUESTIONS (ASQ)

Ask Suicide-Screening Questions

Screening Youth for Suicide Risk in the Emergency Department

A rapid, psychometrically sound 4-item screening tool for all pediatric patients presenting to the emergency department.

BACKGROUND

- In 2010, suicide became the 2nd leading cause of death for youth ages 10-24.
- In the U.S., over 2 million young people attempt suicide each year, resulting in significant morbidity and increased use of emergency departments (EDs) and hospitals.
- Early identification and treatment of patients at elevated risk for suicide is a key suicide prevention strategy, yet high risk patients are often not recognized by healthcare providers.
- Recent studies show that the majority of individuals who die by suicide have had contact with a healthcare provider within three months prior to their death; nearly 40% visited an ED in the year before their death.
- Unfortunately, these patients often present solely with somatic complaints and infrequently discuss suicidal thoughts and plans ***unless asked directly.***

Hospital Setting

Suicide in the medical setting is one of the most frequent sentinel events reported to the Joint Commission (JC). In the past 17 years, over 1,000 patient deaths by suicide have been reported to the JC from hospitals nationwide.

- Notably, 25% of these suicides occurred in non-behavioral health settings such as general medical units and the emergency department.
- Root cause analyses reveal that the lack of proper "assessment" of suicide risk was the leading cause for 80% of the reported suicides.

National Institute of Mental Health

Emergency Department

The ED is a promising venue for identifying young people at risk for suicide.

- For over 1.5 million youth, the ED is their only point of contact with the healthcare system, creating an opportune time to screen for suicide risk.
- **Screening in the ED has been found to be feasible** (non-disruptive to workflow and acceptable to patients and their families).
- Several studies have refuted myths about iatrogenic risk of asking youth questions about suicide, such as the worry about "putting ideas into their heads."
- Screening positive for suicide risk on validated instruments may not only be predictive of future suicidal behavior, but may also be a proxy for other serious mental health concerns that require attention.
- Non-psychiatric clinicians in medical settings require brief validated instruments to help detect medical patients at risk for suicide.

Screening

- **2007** — The JC issued National Patient Safety Goal 15A, requiring suicide risk screening for all patients being treated for mental health concerns in all healthcare settings.
- **2010** — The JC issued a Sentinel Event Alert, recommending that all non-psychiatric patients in medical settings, including EDs, also be screened for suicide risk.
- **2011** — American Academy of Pediatrics (AAP): *"The ED has increasingly become the safety net for a fragmented mental health infrastructure in which the needs of children and adolescents, among the most vulnerable populations, have been insufficiently addressed... EDs can play a significant role in identifying and referring patients with previously undiagnosed and undetected conditions such as suicidal ideation..."*

Instrument Development Study

- 3 pediatric EDs associated with urban teaching hospitals:
  - Children's National Medical Center, Washington, DC
  - Nationwide Children's Hospital, Columbus, OH
  - Boston Children's Hospital, Boston, MA
- September 2008 to January 2011
- 524 pediatric ED patients
  - 344 medical/surgical, 180 psychiatric
  - 57% female, 50% white, 53% privately insured
  - 10 to 21 years (mean=15.2 years; SD = 2.6y)
- For use by non-psychiatric clinicians
- Takes 2 minutes to screen
- Positive screen: "yes" to any of the 4 items
- **Sound psychometrics**
  - Criterion standard: Suicidal Ideation Questionnaire (SIQ)
  - Sensitivity: 96.9% (95% CI, 91.3-99.4)
  - Specificity: 87.6% (95% CI, 84.0-90.5)
  - Negative predictive values:
    - Medical/surgical patients: 99.7% (95% CI, 98.2-99.9)
    - Psychiatric patients: 96.9% (95% CI, 89.3-99.6)
- **Available in the public domain, free of charge**

asQ

Ask Suicide-Screening Questions

1.	**In the past few weeks, have you wished you were dead?**	Yes	No	No response
2.	**In the past few weeks, have you felt that you or your family would be better off if you were dead?**	Yes	No	No response
3.	**In the past week, have you been having thoughts about killing yourself?**	Yes	No	No response
4.	**Have you ever tried to kill yourself?**	Yes	No	No response

If yes, how? _____

When? _____

Patient Name: Date:

Medical Record # (or Patient Label):

NIH National Institute of Mental Health

asQ

- **ED patients ages 10-21**
- **4 questions**
- **2 minutes to screen**
- **Positive screen: "Yes" to any question**
- **Public domain tool, free of charge**
- **Available in Spanish**

For more information contact:
Lisa M. Horowitz, Ph.D., M.P.H.
Intramural Research Program
National Institute of Mental Health, NIH
10 Center Drive, MSC 1276, Bethesda, MD 20892
Phone: 301-435-6052
E-mail: horowitzl@mail.nih.gov

Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P, Pao M. Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176.

Ask Suicide Screening Questions

Suicide Screening Questions for the Emergency Department

1. In the past few weeks, have you wished you were dead?

❍ Yes ❍ No ❍ No response

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?

❍ Yes ❍ No ❍ No response

3. In the past week, have you been having thoughts about killing yourself?

❍ Yes ❍ No ❍ No response

4. Have you ever tried to kill yourself?

❍ Yes ❍ No ❍ No response

If yes, how? _____

_____

_____

When? _____

_____

Patient Name: _____ **Date:** _____

Medical Record #:
(or Patient Label) _____

National Institute of Mental Health

APPENDIX FOUR - PAEDIATRIC SYMPTOM CHECKLIST (PSC)

BRIGHT FUTURES TOOL FOR PROFESSIONALS

INSTRUCTIONS FOR USE

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

INSTRUCTIONS FOR SCORING

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

REFERENCES

Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasability study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.

Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: http://psc.partners.org.

Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.

Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

BRIGHT FUTURES TOOL FOR PROFESSIONALS

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

www.brightfutures.org

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1	_____	_____	_____
2. Spend more time alone	2	_____	_____	_____
3. Tire easily, little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Have trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Act as if driven by motor	7	_____	_____	_____
8. Daydream too much	8	_____	_____	_____
9. Distract easily	9	_____	_____	_____
10. Are afraid of new situations	10	_____	_____	_____
11. Feel sad, unhappy	11	_____	_____	_____
12. Are irritable, angry	12	_____	_____	_____
13. Feel hopeless	13	_____	_____	_____
14. Have trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fight with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Down on yourself	19	_____	_____	_____
20. Visit doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Have trouble sleeping	21	_____	_____	_____
22. Worry a lot	22	_____	_____	_____
23. Want to be with parent more than before	23	_____	_____	_____
24. Feel that you are bad	24	_____	_____	_____
25. Take unnecessary risks	25	_____	_____	_____
26. Get hurt frequently	26	_____	_____	_____
27. Seem to be having less fun	27	_____	_____	_____
28. Act younger than children your age	28	_____	_____	_____
29. Do not listen to rules	29	_____	_____	_____
30. Do not show feelings	30	_____	_____	_____
31. Do not understand other people's feelings	31	_____	_____	_____
32. Tease others	32	_____	_____	_____
33. Blame others for your troubles	33	_____	_____	_____
34. Take things that do not belong to you	34	_____	_____	_____
35. Refuse to share	35	_____	_____	_____

APPENDIX FIVE – THE GLOBAL APPRAISAL OF INDIVIDUAL NEEDS-SHORT SCREENER (GAIN-SS) (SAMPLE)

A license is required to use the GAIN-SS assessment tool. PCMCH is in negotiations to purchase this license for use in Ontario.

The GAIN-SS Administration and Scoring Manual, Version 3 is available for download from:
http://www.gaincc.org/products-services/instruments-reports/gainss/

GAIN-SS

Global Appraisal of Individual Needs – Short Screener (GAIN-SS): Administration and Scoring Manual Version 3

July 2013

Michael L. Dennis, Ph.D.
Tim Feeney, M.A.
Janet C. Titus, Ph.D.
Chestnut Health Systems
448 Wylie Drive
Normal IL 61761
Phone: (309) 451-7700
Fax: (309) 451-7762
gaininfo@chestnut.org

Chestnut Health Systems

GAIN GLOBAL APPRAISAL OF INDIVIDUAL NEEDS Coordinating Center

GAIN Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS ver. 3.0

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: _____ Site name v. _____

9. Staff ID: _____ Staff name v. _____

10. Client ID: _____ Comment v. _____

11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____

15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

Appendix Six - Pre-Printed Order Set for Chemical Restraint in the Emergency Department

Hospital Logo PCMCH

PHYSICIAN ORDERS
FOR
CHEMICAL RESTRAINT IN THE EMERGENCY DEPARTMENT

Page 1 of 1

Patient Identification

Weight: _____ kg Height: _____ cm Allergies: _____

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.**

Use ONLY if chemical restraint is required. Do NOT use as an advanced or prn directive.

MEDICATION

____ ☐ **OLANzapine** Rapid Dissolve _____ mg (Children 1.25 – 5 mg/dose; Adolescents 5 – 10 mg/dose) PO
Reason: ☐ anixiety/agitation

____ ☐ **ChlorproMAZINE** _____mg (Children 0.5 – 1 mg/kg/dose, Adolescents 0.5 – 1.5mg/kg/dose) PO/IM
Reason: ☐ anixiety/agitation or ☐ Olanzapine is refused or ineffective

____ ☐ **DiphenhydrAMINE** (Benadryl®) _____mg (0.5 – 1 mg/kg/dose, MAX 50 mg/dose) PO/IM
Reason: ☐ extrapyramidal symptoms or allergic reaction

____ ☐ **LORazepam** _____ mg (0.02 - 0.03 mg/kg/dose, MAX 2 mg/dose) PO/SL/IM
Reason: ☐ anixiety/agitation

____ ☐ **Benztropine** _____mg (0.02 - 0.05 mg/kg/dose, MAX 2 mg/dose) PO/IM
Reason: ☐ extrapyramidal symptoms

____ ☐ **Nicotine resin gum** 2 mg piece (MAX 12 pieces/day) PO PRN for nicotine cravings

PHYSICIAN SIGNATURE	PRINT NAME OF PHYSICIAN	DATE & TIME
NURSE SIGNATURE	PRINT NAME OF NURSE	DATE & TIME

Form No. Date Original Copy – Chart Yellow Copy – Pharmacy

Appendix Seven - Child and Youth Mental Health Clinician Standardized Assessment Form

Hospital Logo PCMCH

PATIENT ID

CHILD AND YOUTH MENTAL HEALTH CLINICAN SCREENING FORM

HISTORY OBTAINED BY: _____ DATE/TIME: _____

1. **ID/REFERRAL:** source and reason for referral, who patient lives with, source of information

2. **CHIEF COMPLAINT/HPI:** time of onset, duration, predisposers, precipitators, perpetuators, severity

Screen For Mood Symptoms:

[ ] depressed/ irritable mood
[ ] reactivity
[ ] social isolation/withdrawal
[ ] less interest/ pleasure, anhedonia
[ ] changes in appetite or weight
[ ] sleep disturbance
[ ] agitation / retardation
[ ] loss of energy / fatigue
[ ] worthlessness, inappropriate guilt
[ ] poor concentration, indecisiveness
[ ] low self-esteem
[ ] feelings of hopelessness
[ ] mood elevation
[ ] grandiosity
[ ] pressured speech
[ ] other mania

Screen For Psychotic Symptoms:

[ ] circumstantiality
[ ] loosening of associations
[ ] delusions
[ ] auditory hallucinations
[ ] visual hallucinations
[ ] tactile hallucinations
[ ] communicating telepathically
[ ] thought broadcasting
[ ] thought insertion
[ ] thought withdrawal
[ ] catatonic behavior
[ ] flat/inappropriate/ incongruent affect

Screen For Anxiety Symptoms:

[ ] worries-generalized anxiety
[ ] phobias-age inappropriate
[ ] panic
[ ] obsessions - compulsions
[ ] dissociation
[ ] flashbacks
[ ] avoidance

Screen for Substance Use:

[ ] Alcohol
Frequency:

Amount:

[ ] Substance Use
Frequency:

Amount:

[ ] Cigarettes
Frequency:

Amount:

COPY OF THIS REPORT TO BE FORWARDED TO:
1) *Referred Community MH Agency*
2) *Patient's Primary Care Provider*

1

3. RISK OF SUICIDE:
Thoughts about death, dying or killing self/how long:

Plan for doing this:

Means available (e.g., pills, guns, knifes, poison, etc.):

Have you rehearsed or practiced:

Previous attempts, method, severity:

4. RISK OF HARM TO OTHERS:
Thoughts about hurting or killing others/who/how long:

Plan for doing this:

Are there means available (e.g., guns, knifes, poison, etc.)

Have you rehearsed or practiced:

Previous attempts, method, severity:

5.PAST PSYCHIATRIC HISTORY: diagnosis, medications, involvement with CAS/CCAS/JFCS/children's mental health agencies, counsellors (including guidance counsellor)

6.PERSONAL HISTORY: social, academic & behavioural functioning, sexual or physical abuse, substance abuse , aggression and violence, body image & eating problems, sexual preference/orientation

7. FAMILY HISTORY: relationships, psychiatric history (include medications), suicides in family including extended family

COPY OF THIS REPORT TO BE FORWARDED TO:
1) *Referred Community MH Agency*
2) *Patient's Primary Care Provider*

2

9. MENTAL STATUS: appearance and behaviour, speech and language, estimate level of intellectual functioning, affect and mood, frustration tolerance & impulsivity, task orientation, insight and locus of control

10. CURRENT SUPPORTS: what supports are available and do they currently have involvement with a community mental health agency

11. PARENT/CUSTODIAN willing to ensure supervision and safety of child?
(health teaching re: safety measures provided):

Yes [ ]
No [ ]

MANAGEMENT & DISPOSITION:

CY MHC Signature

MD Signature

Discussed with _____

COPY OF THIS REPORT TO BE FORWARDED TO:

1) *Referred Community MH Agency*
2) *Patient's Primary Care Provider*

3

APPENDIX EIGHT - CHILD AND YOUTH MENTAL HEALTH CLINICIAN

Child and Youth Mental Health Clinician

Position Summary:

The Child and Youth Mental Health Clinician (CY MHC) works with a multidisciplinary team providing psychosocial/behavioural assessments and treatment planning for children/adolescents and their families presenting to the Emergency Department (ED) with acute psychiatric concerns. S/he:

- Collaborates with the multidisciplinary team in planning, implementing and evaluating treatment and discharge plans;
- Collaborates with community mental health providers to refer patients to appropriate services;
- Conducts specific clinical interventions as directed by the multidisciplinary team members;
- Plays a key role in relationship building with community mental health/organizations;
- Models professional and organizational core competencies.

Scope of Practice:

- Provide psychosocial risk assessments, behavioural management, counseling and support for children/youth and their families who present 1) to the ED in an acute psychiatric crisis; 2) are being held in the ED overnight pending a mental health assessment in the morning.
- Work with multidisciplinary team to provide crisis de-escalation, including application and monitoring of 5-point restraints, as needed.
- Liaison with ED and Psychiatry on-call services as well as hospital and community mental health services.
- Prepare recommendations re: case disposition including admission to Inpatient Psychiatry Unit, discharge home with short-term follow-up in the community.
- Crisis follow up planning, including referrals to collaborating agencies, as needed.
- Follow up services with community agencies where applicable when referral made.
- Prepare professional reports (both verbal and written) in a timely fashion.
- Documentation, including CBE (Charting by Exception), on all patient contacts.
- Monitoring of service utilization
- Participate in in-service training regarding the management of psychiatric crisis in children and youth.
- Where applicable provide follow-up services relative to referral to community services to ensure continuum for clients/families

Competencies/Qualifications:

- Masters of Social Work (MSW), Bachelor of Social Work (BSW), Psychologist/Psychological Associate (C.Psych. Assoc), Registered Nurse (RN) and eligibility for registration with discipline-specific professional college (Preferred)
- OR, Child & Youth Worker Diploma (3 year program), or B.A. in Child & Youth Care will be considered based on relevant experience
- Police Record Check (PRC)
- Knowledge of psychiatric disorders in children and youth
- Knowledge regarding how to address suicidal ideation and injury

- Minimum of three years of mental health counseling experience with children, youth and families
- Ability to establish rapport with children, youth and families in crisis
- Non-violent crisis intervention (Preferred)
- Brief therapy training (Preferred)
- Ability to assess and prioritize needs
- Ability to work both collaboratively and independently
- Ability to collaborate with other disciplines in a medical setting
- Willing to work day/evening shifts including on-call crisis response to the Emergency Department
- Sound knowledge of community resources
- Bilingualism (Preferred)
- Ability/capacity to respond when on-call (required)

APPENDIX NINE – ENVIRONMENTAL ASSESSMENT FOR IMPLEMENTATION READINESS

A. Emergency Department

Conduct environmental audit to identify the accessibility of mental health services for children and youth within your emergency department.

1. What internal hospital resources does your ED draw upon when assessing/treating children and youth with mental health conditions?
    i. Do you have providers whose specific role is to provide care for children and youth with mental health conditions?
    ii. Are they part of the ED staff or are they provided from elsewhere? If elsewhere, what department(s) or community agencies provide this?
    iii. If yes, what professions/roles provide mental health services to children and youth in the ED? [i.e. adult psychiatrist, child psychiatrist, psychologist, RN, Nurse Practitioner, social worker, child and youth worker, none, other]
    iv. How many hours/day is your ED covered by mental health resources?
    v. Other resources?
2. Core competencies of mental health providers within your ED:
    i. What education background/level of training do they have?
    [i.e. MD, PhD, RN, RN-EC, PhD, MSW, Child and Youth Worker etc]
    ii. What, if any additional training do they receive?
    [i.e. mandatory hospital training, mandatory education package, none, other]
    iii. What is the supervisory structure for these providers (who do they report to)?
3. Are you currently using any mental health screening tools to assess children and youth? If yes,
    i. Which screening tools do you use? Are they helpful?
    ii. Do you use them in conjunction with community agencies to prioritize referrals?
    iii. If not using any tools, how would you feel about using a brief screening tool to assess risk in making disposition and referral decisions?
4. How are your physicians and staff kept aware of different types of services available in your community? What resources do you use to obtain this information?
5. Do you refer directly to a community agency or provide a phone number to the family when the patient is discharged? Do you have a triage process?
    i. How is information shared between your ED and community agencies?
    ii. Are there any confidentiality provisions in place? How is privacy dealt with?
6. Are there formal protocols or informal arrangements with community agencies? Please describe, including expectations regarding timelines.
    i. Who is responsible for facilitating the protocols/arrangements?
    ii. What works well in these protocols/arrangements?
    iii. How could they be improved?
    iv. What is your experience with schools and group homes? Do they attempt to access community services first?

7. What Role do Family Health Teams / Primary Care / private mental health providers play in your referrals or in follow-up care?
8. How are children and youth who enter your ED accompanied by police dealt with?
   - Is there a protocol in place for release to the ED service providers?
   - Is there a target wait time for assessment of the patient?
   - Is there a target wait time for police?
9. Do you feel that child and youth mental health conditions and/or addictions is/are addressed well in your ED?
   i. If not, what is lacking? What particular challenges do you face in addressing child and youth mental health concerns/addictions in your ED?
   ii. How would you improve the care of children and youth with mental health conditions in your ED?

B. Community Provider

Conduct environmental audit to identify the accessibility of mental health services for children and youth at your local hospital emergency department.

1. What linkages, if any, do you have with your local Emergency Department (ED) regarding child and youth mental health and/or addictions referrals?
   i. Are there formal protocols or informal arrangements? Please describe.
   ii. Do these protocols or arrangements vary depending on patient acuity/risk? If so, how?
   iii. Are there specific protocols in place for suspected suicidal patients?
   iv. What are your expected timelines for referrals from the ED? What are your expected timeline for dealing with other urgent referrals from other sectors? How are ED referrals dealt with in relation to these?
   v. Who is responsible for facilitating the protocols/arrangements?
   vi. What works well with these protocols/arrangements?
   vii. How could they be improved?
2. How do you receive/prioritize child/youth mental health referrals from the ED?
   i. What is the process?
   ii. What factors are considered in prioritization?
   iii. Do you also notify the patient's primary care provider?
3. What information is shared between the EDs and your organization/agency?
   i. How is information shared?
   ii. Are there any confidentiality provisions in place/how is privacy dealt with?
4. Are you currently using any child and youth mental health screening tools?
   i. What are they?
   ii. Are they helpful?
   iii. Do you use them in conjunction with EDs to screen the children and youth?
   iv. How would you respond to referral that was prioritized as "urgent" (i.e. within 48hrs or 5 days?) based on a screening tool used in the ED to assess risk?

5. What are the competencies of your staff regarding the provision of child and youth mental health services?
    i. Do they provide mental health services?
    ii. What education background/level do they have?
    [i.e. MD, PhD, RN, RN-EC, PhD, MSW, child youth worker etc]
    iii. What, if any additional training do they receive?
    [i.e. Mandatory organizational training, mandatory education package, none, other]
6. What do you see as the main obstacle/challenge in ensuring that children and youth with mental health conditions who visit the ED receive timely community services?
7. How would you like to see the ED-to-Community service provider process/system work?
8. How do you link/collaborate with Family Health Teams /Primary Care / private mental health providers?

APPENDIX TEN - MEMORANDUM OF AGREEMENT (SAMPLE)

Memorandum of Agreement

Between

<*Name of Hospital*> Emergency Department

And

Community Consortium Members

<Name of Community Agency>

And

<Name of Community Agency>

And

<Name of Community Agency>

<Date>

Purpose:

This Memorandum of Agreement (MOA) will:

- Promote fair and timely access to children's mental health and addictions (mental health) services for children and youth presenting at the Emergency Department (ED), including prioritization and response within the community.
- Ensure one common MOA between the ED and all community mental health agencies that service that ED.

- Prescribe the pathway of access and referral process on behalf of children and youth requesting mental health services from entry to the ED to disposition to child and youth mental health and addictions (CY mental health) services.
- To establish clear guidelines for the nature and timeliness of community response to children and youth discharged from the ED, based on evaluation of risk and urgency
- Establish processes whereby disposition decisions are regularly reviewed at the aggregate level to identify trends/patterns and ensure consistency with the protocol.

Governing Principles:

Response to youth with a mental illness or in acute emotional distress should be provided in the least restrictive and least intrusive means appropriate and in a manner that ensures the safety, privacy, dignity and self-respect of the youth, family and others.

Provision of prompt assessment and treatment for youth who are experiencing a mental health crisis is essential and timely follow-up may be required for many youth to ensure continued physical and psychological safety and wellbeing at home and in the community.

Inter-agency and cross-sectorial cooperation in assessment, intervention and coordination is essential to provide a comprehensive, efficient, and effective crisis resolution, as well as facilitation of ongoing service delivery.

Continuity in the relationships between children/youth and their health care providers allows for the most comprehensive and informed treatment planning and crisis management for children, youth, and their families. Where continuity in relationships may not be possible, information-sharing and coordination of services is essential.

To be effective, coordinated child- and family-centered care requires consideration of the unique needs of each child or youth, and his/her family and the community context.

Principles of the Partnership:

Appreciation of Diversity:

- The organizations appreciate the diversity of skills, perspectives, experience and knowledge brought to the partnership by the other(s). A partnership combines this diversity in a way that enables the partnership to think in new and better ways about how to service the community.

Valuing Relationship:

- Fundamental to the partnership success is the encouragement of relationships among leaders and staff from each organization. Relationship building opportunities are actively pursued among partner organizations at all levels.

Value Created:

- Partners do more than exchange resources – they create something new and valuable. This partnership will create value in that individuals will be served better across organizations/services.

Investment:

- Partnerships are relationships built over time and with shared experience. Partners show tangible signs of long-term and on-going commitment by devoting resources to the ongoing maintenance of the partnership.

Integrity:

- Partners behave towards each other in ways that justify and enhance mutual trust. Decisions will be made with the input of partners that will allow for compromise and consensus. Each partner has influence. Communication is open and constructive.

Collaboration:

- Inter-organization collaboration is aimed at producing and measuring better outcomes for people who use the service.

Excellence:

- Partners are strong in their commitment to this agreement and have something valuable to contribute. The motives for entering into this partnership are positive and of mutual benefit.

Parties to the Memorandum of Agreement:

The parties to this MOA are:

<*Name of Hospital*> Emergency Department

<Name of Community Agency>
<*Brief description of service rendered*>

<Name of Community Agency>
<*Brief description of service rendered*>

<Name of Community Agency>
<*Brief description of service rendered*>

Procedure/Process:

ED Clinical Pathway:
Please refer to the attached ED Clinical Pathway form and Algorithm.

Shared Documentation Between the ED and the Community Agency:

The ED will document the patient visit on a standardized clinical pathway form and the child and youth mental health clinician (CY MHC) will document their assessment on a standardized assessment form. In addition, the following screening tools will be used during the patient's ED visit – The Caregiver/Youth Perception Survey (C/YPS), the Ask Suicide Screening Questions (RSQ) and either the Paediatric Symptom

Checklist (PSC) for children under 12 years or the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for children 12 years and over. The clinical pathway form, standardized assessment, and the completed screening tools are to be shared with the community agency upon disposition and the patient's primary care provider where appropriate.

In the case of Disposition D, the community agency can request this documentation from the ED.

Guidelines for First Contact by Community Agencies Based on Disposition from ED:

Disposition A: Admission to hospital:

- As a best practice, it is recommended that the community agency will follow-up in person prior to the patient's discharge from a hospital admission. When an in person meeting is not possible, the minimum recommendation is contact via telephone.
- As a best practice, and where clinically appropriate, the community agency will follow-up in-person by next business day of receipt of discharge disposition information. Timing of service delivery is at the discretion of the community agency.

Disposition B: Discharge from ED with Expedited Follow-Up in the Community**:**
Where the ED disposition indicates that level of risk and available supports are such that expedited follow up in the community is required:

- The community agency will follow-up by telephone within one business day of receipt of ED documentation to discuss and make a determination regarding the urgency of community services required
- The community agency will keep the ED informed regarding follow-up response.

Disposition C: Discharge from ED with Follow-Up in the Community:
Where the ED disposition indicates that level of risk and available supports are such that timey follow up in the community is required:

- The community agency will follow-up by telephone within seven business days of receipt of ED documentation to discuss and make a determination regarding the urgency of community services required
- The community agency will keep the ED informed regarding follow-up response.

Disposition D: Discharge from ED with Follow-Up in the Community:

- The patient will be encouraged to follow-up with their Primary Care provider and will be provided with the contact information for mental health community services and may follow-up themselves if they choose to do so.
- If community agency receives the patient, they are to keep the ED informed of follow-up response.

Communication Protocol:

Reciprocal communication between the ED and the community agencies is of paramount importance in this ED Clinical Pathway. This communication includes but is not limited to the results of ED Clinical Pathway Form and screening tools, as well as community agency follow-up response. The communication mechanism and process will be left to the discretion of the parties involved however it is recommended that the CY MHC play the key role in ensuring this communication takes place.

Information Sharing and Privacy:

The parties of this MOA agree to comply with all relevant privacy-related legislation.
Where there is disclosure of personal information to a party of the MOA, they will ensure that:

- Informed consent to share personal information is obtained from the individual(s) and/or his/her guardian, where applicable.
- Personal information is disclosed in accordance with all applicable legislation pertaining to the personal information in question.

Where there is receipt of personal information to a party of the MOA and with respect to such personal information, they ensure that:

- All personal information received is used only in the manner and for the purposes for which the youth/guardian has consented;
- Appropriate security measures are in place to protect the delivery and storage of all personal information provided;
- They will comply with any reasonable recommendations made by governmental privacy authorities with respect to the protection of personal information provided.

Leadership:

Representatives from all organizations will meet at a minimum of 3 times per year to reaffirm the commitment to this agreement and provide future direction as well as discuss other related issues as they arise.

If trends emerge showing difficulty in responding to the needs of youth presenting in crisis, the partners will develop strategies and/or recommendations to address such trends.

Operational Lead:

Each partner will identify an operational lead who will be the primary contact for their organization/service for purpose of the MOA and who will have the authority to act on behalf of his/her organization.

<*Name of Hospital*> Emergency Department

Signature	Position	Date

<Name of Community Agency>

Signature	Position	Date

<Name of Community Agency>

Signature	Position	Date

<Name of Community Agency>

Signature	Position	Date

APPENDIX ELEVEN – IMPLEMENTATION SLIDE DECK

Visit the PCMCH website to download the slide deck. www.pcmch.on.ca

www.pcmch.on.ca

ED Clinical Pathway for Children and Youth with Mental Health Conditions

Implementation Toolkit

September 2013

Objective of this learning module

To educate physicians, clinicians and mental health service providers about:

1. The Emergency Department (ED) clinical pathway for children and youth with mental health conditions.
2. The assessment tools in the clinical pathway.
3. Use of a memorandum of agreement to support a seamless transition between hospital and community mental health providers.

Background I

- Estimated 14-21% of Canadian children / youth suffer from mental health and/or addiction (MH/A) disorders.
- Youth aged 15 to 24
  - 3 X more likely to have substance use problem than >24 years
  - More likely to experience mood disorders such as anxiety and depression.

Background II

High demand for *Emergency* Mental Health care

- ED is a frequent entry point for child & youth mental health/addictions (CY MH/A) services
- In 2009-2010, 19,582 ED visits by children and youth in Ontario had a MH/A diagnosis.

Limited ED capacity to respond to CY MH/A needs

- Organized chaos
- Acute care, diagnosis and management focus
- Mental health expertise …

Challenge of smooth and streamlined integration with community CY MH/A services

- Ministry of Health: ED care
- Ministry of Child & Youth Services: Mental Health Agencies

Currently, MH/A services in Ontario are funded or provided by at least **10** different ministries. Community care is delivered by **440** children's mental health agencies, **330** community mental health agencies, and **150** substance abuse treatment agencies.

Scope of the Clinical Pathway

Due to the limited resources currently available to support the needs of children and youth with addictions, this clinical pathway will focus only on the needs of children and youth with mental health concerns.

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.

Benefits of Clinical Pathways

- Support decision making
- Communication tool
- Support delivery of high quality care
- Support evidence informed practice
- Support interdisciplinary care
- Improve outcomes
- Improved utilization of resources

ED Clinical Pathway for MHC

Minimum Standards

Minimum Standards of Care

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. Memorandum of agreement between EDs and community providers and agencies
3. Use of standardized triage screening tools

ED Clinical Pathway for MHC

CY MH Clinician

CY MH Clinician

Child and Youth Mental Health Clinician

- Skills and focus to assess MH patients in ED
- Crisis services are main link to appropriate and timely referral to community MH services

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

CY MH Clinician: Roles

- Collaborate with ED team in assessment, treatment and discharge plans
- Provide specific clinical interventions as required
- Collaborate with Community MH agencies to ensure appropriate referrals and timely patient access
- Key role in ensuring integration of services:
  - ED and community MH agencies

CY MH Clinician: Competencies

- Masters of Social Work (MSW), Bachelor of Social Work (BSW), Psychological Associate (C.Psych. Assoc), or Registered Nurse (RN)
+ Registration/eligibility with their professional college.
- When this is not available:
  - Child & Youth Worker Diploma (3 year program), or B.A. in Child & Youth Care, if relevant experience.
  - Must have knowledge of child and youth psychiatric disorders and minimum 3 years counseling experience

ED Clinical Pathway for MHC

Memorandum of Agreement

Memorandum of Agreement (MOA)

Between
Emergency Department
And
Community Mental Health Agencies

MOA: Purpose

- Key component for pathway success
- Among ED & Community Agencies
  - Comprehensive understanding of pathway and roles within it.

Recommendation:
- Implementation of an MOA between all parties involved to ensure collaboration and adherence to ED MH CP

MOA: Key Components

- Statement of purpose
- Governing principals
- Details regarding the parties to the MOA
- Details of the process to be followed
- Information sharing and privacy details
- Leadership details

ED Clinical Pathway for MHC

Clinical Pathway (CP)

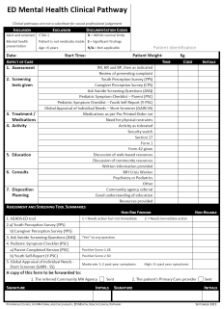
Standardized Assessment

Recommendation:

- Standardized assessment form that is shared with the MH community agency upon discharge
  - Follows the patient
  - Shared branding
  - Confidentiality—HIC inclusive
- Enables physicians to take a psychosocial history which aids in decisions regarding patient disposition. Includes 7 variables.

ED Mental Health Clinical Pathway

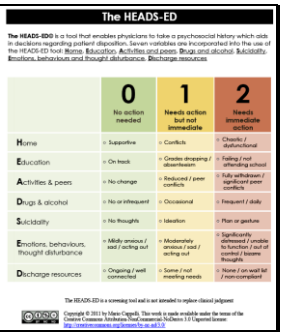
Standardized Assessment Form – page 1


ED Mental Health Clinical Pathway

ED Mental Health Clinical Pathway

Standardized assessment form – page 2

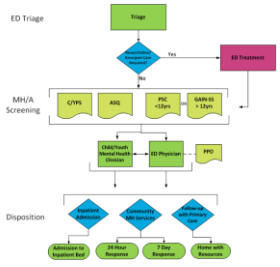
HEADS-ED Tool


The HEADS-ED

	0 No action needed	1 Needs action but not immediate	2 Needs immediate action
Home	Supportive	Conflicts	Chaotic / dysfunctional
Education	On track	Grades dropping / absenteeism	Failing / not attending school
Activities & peers	No change	Reduced / peer conflicts	Fully withdrawn / significant peer conflicts
Drugs & alcohol	No or infrequent	Occasional	Frequent / daily
Suicidality	No thoughts	Ideation	Plan or gesture
Emotions, behaviours, thought disturbance	Mildly anxious / sad / acting out	Moderately anxious / sad / acting out	Significantly distressed / unable to function / out of control / bizarre thoughts
Discharge resources	Ongoing / well connected	Some / not meeting needs	None / on wait list / non-compliant

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

Clinical Pathway (CP) Algorithm



CP Stage: *ED Triage*

- The entry point for the algorithm is the ED triage
- Initial assessment by an experienced ED nurse with special triage training and experience
- The Canadian Triage Acuity Scale (CTAS) guidelines are used to assign each patient to the appropriate priority level for assessment
- Specific MH problems are addressed in the CTAS guidelines

CP Stage: *Resuscitative / Emergent Care*

- The patient is taken immediately to appropriate ED area for assessment and management.
- If medically stable, the patient may then be directed for MH assessment, if appropriate, as per the algorithm. Only a small proportion of patients require this type of immediate care.

CP Stage: *Mental Health Screening*

All medically stable patients will be asked to complete a set of self-report surveys.

- All patients or caregivers: complete the Caregiver or Youth Perception Survey (C/YPS)
- Patients 10-21 years of age: complete the Ask Suicide Screening Questions (ASQ)
- Patients under 12 years: caregivers complete the Pediatric Symptom Checklist (PSC)
- Patients ≥ 12 years: complete the Global Appraisal of Individual Needs—Short Screener (GAIN-SS).

CP Stage: *Clinical Assessment*

- Depending on resources available, patients will either:
  - First be assessed by an ED physician, and then be referred to a Child and Youth Mental Health Clinician (CY MHC) for further assessment, or
  - Be assessed directly by a CY MHC
- Patients deemed high risk by the CY MHC would be reviewed for potential admission with the Psychiatrist, Pediatrician or Family Physician on call, as available based on arrangements at that site.

CP Stage: *Disposition*

Based on clinical assessment(s), one of three disposition decisions will be made:

1. Immediate referral to a mental health (MH) specialist with potential admission
2. Outpatient referral to a CY MH community agency
   - Telephone follow up in i) 24 hours or ii) within 7 days
3. Disposition home
   - Recommended follow-up with Primary Care provider
   - Provision of contact/resource information for relevant community MH services

CP Stage: *Disposition* *Continued*

Referrals to CY MH Community Agencies:

- Expectation for telephone follow-up is to review the presenting concerns and ED referral information and to determine priority for the in-person assessment at that agency.
- Expectation that the community agency inform the ED of this follow-up outcome, should the child/youth re-present to the ED.

ED Clinical Pathway for MHC

Screening Tools

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

MHC Screening Tools for C&Y

Screening Tool	All CY MH patients	CY MH patients aged:	Available in public domain free of charge
Children's Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS)	✓		Yes
Ask Suicide Screening Questions (ASQ)		10–21 years	Yes
Paediatric Symptom Checklist (PSC)		<12 years	Yes
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)		≥12 years	No PCMCH is purchasing the license
HEADS-ED Tool	✓		Yes

MHC Screening Tools for C&Y

- **Initial Screen:**
  - CHEO Youth/Caregiver Perception Survey (Y/CPS)
  - Ask Suicide Screening Questions (ASQ)
- **In-Depth Screen:**
  - Paediatric Symptom Checklist (PSC)
  - GAIN Short Screener (GAIN-SS)
- **Clinical Risk Assessment Tool:**
  - HEADS-ED

CHEO Youth / Caregiver Perception Survey (Y/CPS)

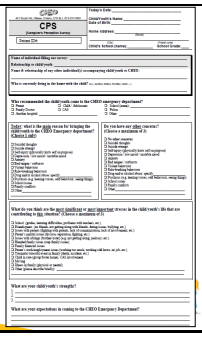
- A general MH/A screening tool used that addresses presenting concerns and stress factors in the child/youth's life.
- For use with all children/youth with MH concerns presenting to the ED

CHEO Y/CPS

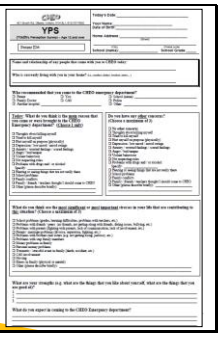
Validation Information

- Difficult to evaluate using traditional psychometric techniques
- Have face and content validity from both the clinician and patient/caregiver perspectives

Caregiver Perception Survey (CPS)


CPS

Youth Perception Survey (YPS)



Ask Suicide-Screening Questions (ASQ)

- A four item questionnaire specifically indicated for use in the ED to detect children and youth at risk for suicide
- For CY MH/A patients 10-21 years
- For use by non-psychiatric clinicians
- Positive screen: "Yes" to any question

ASQ

Validation Information

- Sensitivity of 0.97
- Specificity of 0.88
- Negative predictive value for psychiatric patients: 0.97

ASQ

Pediatric Symptom Checklist (PSC)

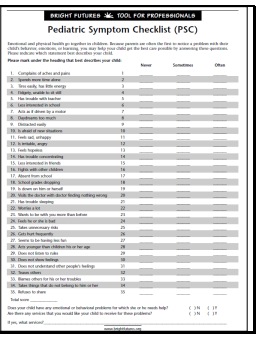
- An in-depth psychosocial screen designed to facilitate the recognition of cognitive, emotional and behavioural problems.
- Questions include internalizing, attention and externalizing problems.
- For all CY MH/A patients under 12 years

PSC

Validation Information

- Well validated across several studies
- Sensitivity of 0.95 and Specificity of 0.68
- High internal consistency, high reliability

Pediatric Symptom Checklist (PSC)


BRIGHT FUTURES TOOL FOR PROFESSIONALS

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child.

	Never	Sometimes	Often
1. Complains of aches and pains			
2. Spends more time alone			
3. Tires easily, has little energy			
4. Fidgety, unable to sit still			
5. Has trouble with teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interested in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on him or herself			
20. Visits the doctor with doctor finding nothing wrong			
21. Has trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feels he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

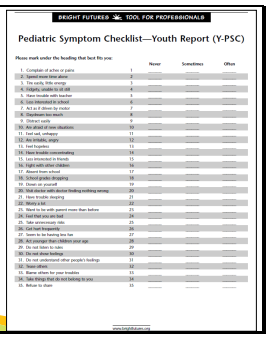
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? _____

www.brightfutures.org

43

Pediatric Symptom Checklist (PSC)


BRIGHT FUTURES TOOL FOR PROFESSIONALS

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Have less interest in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			

www.brightfutures.org

44

Global Appraisal of Individual Needs—Short Screener (GAIN-SS)

- An in-depth MH screen targeted for adolescents. It identifies internalizing disorders, externalizing disorders, substance use and crime/violence.
- For all CY MH patients 12 years or age and older
- Requires a user licence which PCMCH will obtain. The GAIN-SS will be available for download from the PCMCH website.

Provincial Council for Maternal and Child Health

Building a brighter future

45

GAIN-Short Screener

Validation Information

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

Findings

- Low risk: 0 past year symptoms
- Moderate risk: 1-2 past year symptoms
- High Risk: 3+ past year symptoms

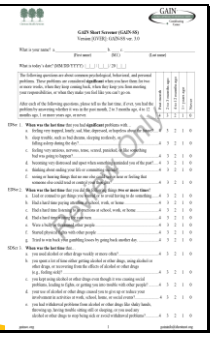
Provincial Council for Maternal and Child Health

Building a brighter future

46

Global Appraisal of Individual Needs– Short Screener (GAIN-SS)

PCMCH will purchase the license.

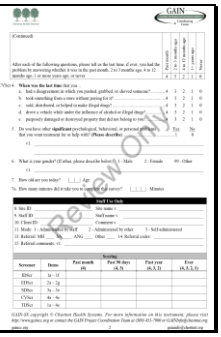

GAIN

GAIN Short Screener (GAIN-SS)
Version (GYOB): GAINSS-ver. 3.0

47

Global Appraisal of Individual Needs– Short Screener (GAIN-SS)

PCMCH will purchase the license.


GAIN

48

The HEADS-ED Tool

- Help guide clinical decisions in assessment and disposition recommendations
  - Very Brief
  - Very Easy to complete
  - Very Easy to score
  - Clinically intuitive
- 7 variables rated on a 3-point scale, based on need for action

Evidence for HEADS-ED

CHEO study with the HEADS-ED

- Crisis workers completed the HEADS-ED and CANS
- Youth completed the Children's Depression Inventory
  - Evidence of inter-rater reliability, and criterion, concurrent and predictive validity for HEADS-ED
  - The HEADS-ED correlated highly with youth's ratings of depression and a 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

- Simple interface to enter HEADS-ED scores
- Generates list of community resources (currently in Champlain LHIN only) based on patient's age, language, and needs according to the HEADS-ED
- Provides customized printout of resources for patients/families, including personalized discharge instructions and HEADS-ED score summary

HEADS-ED Tool

HEADS–ED	0 No action needed	1 Needs action but not immediate	2 Needs immediate action
Home	◦ Supportive	◦ Conflicts	◦ Chaotic / dysfunctional
Education	◦ On track	◦ Grades dropping / absenteeism	◦ Failing / not attending school
Activities & peers	◦ No change	◦ Reduced / peer conflicts	◦ Fully withdrawn / significant peer conflicts
Drugs & alcohol	◦ No or infrequent	◦ Occasional	◦ Frequent / daily
Suicidality	◦ No thoughts	◦ Ideation	◦ Plan or gesture
Emotions, behaviours, thought disturbance	◦ Mildly anxious / sad / acting out	◦ Moderately anxious / sad / acting out	◦ Significantly distressed / unable to function / out of control / bizarre thoughts
Discharge resources	◦ Ongoing / well connected	◦ Some / not meeting needs	◦ None / on wait list / non-compliant

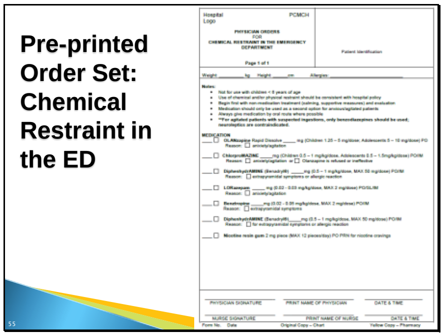
ED Pathway for MHC

Pre-printed Order Set

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


Pre-printed Order Set: Chemical Restraint in the ED
Hospital Logo
PCMCH
PHYSICIAN ORDERS
FOR
CHEMICAL RESTRAINT IN THE EMERGENCY DEPARTMENT
Page 1 of 1
Patient Identification
Weight ________ kg Height ______ cm Allergies: ____________
Notes:
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.
MEDICATION
OLANzapine Rapid Dissolve ____ mg (Children 1.25 – 5 mg/dose; Adolescents 5 – 10 mg/dose) PO
Reason: anxiety/agitation
ChlorproMAZINE ____ mg (Children 0.5 – 1 mg/kg/dose, Adolescents 0.5 – 1.5mg/kg/dose) PO/IM
Reason: anxiety/agitation or Olanzapine is refused or ineffective
DiphenhydrAMINE (Benadryl®) ____ mg (0.5 – 1 mg/kg/dose, MAX 50 mg/dose) PO/IM
Reason: extrapyramidal symptoms or allergic reaction
LORazepam ____ mg (0.02 - 0.03 mg/kg/dose, MAX 2 mg/dose) PO/SL/IM
Reason: anxiety/agitation
Benztropine ____ mg (0.02 - 0.05 mg/kg/dose, MAX 2 mg/dose) PO/IM
Reason: extrapyramidal symptoms
DiphenhydrAMINE (Benadryl®) ____ mg (0.5 – 1 mg/kg/dose, MAX 50 mg/dose) PO/IM
Reason: for extrapyramidal symptoms or allergic reaction
Nicotine resin gum 2 mg piece (MAX 12 pieces/day) PO PRN for nicotine cravings
PHYSICIAN SIGNATURE
PRINT NAME OF PHYSICIAN
DATE & TIME
NURSE SIGNATURE
PRINT NAME OF NURSE
DATE & TIME
Form No. Date
Original Copy – Chart
Yellow Copy – Pharmacy
55


Summary
The development of an ED CY MH clinical pathway will promote safe and integrated services for children and youth with mental health concerns through efficient risk assessment and timely follow-up.
This will provide better patient care and reduce unnecessary use of costly emergency services.
www.pcmch.on.ca
Provincial Council for Maternal and Child Health
56