Echo Session Follow Up #3

General tips to approaching patients

· Remember ideally we want to be consistent with all patients, but if kids need time to adjust to what is needed in the ED, we have to be prepared to be flexible, especially if we think being rigid may lead to a restraint

· Generally it is better to present choices to patients whenever possible but for necessary safety items in which they must comply (e.g. they have an item that is a ligature risk), these are times when it is better to present as not a choice, to not set in term of asking permission (especially for oppositional patients) and avoid negotiating.

· When first rooming a patient, consider offering them food, clearing out the room to minimize stuff in the room in case an aggressive situation emerges

· Remember that your role is not to be a parent but to keep them safe. Also remember to think about what your own personal reactions and feelings are to the situation and patient to make sure it is not influencing your interactions. You may need to take a step away to re-focus on the patient.

    - Consider practicing active ignoring for small non-destructive behaviors. For example, a patent repeatedly saying your name, while mildly disruptive, it may be best to ignore the patient than to engage.

· For younger patients, consider earning a small reward system during the boarding may help

Guidelines for cell phones/clothing/valuables locked up—

In general, recommend a guideline regarding cell phone, clothing, valuables. Items to think about

· Attempt to initially remove and lock up all items for general safety reasons.

    - For EDs where the pediatric patients are kept with the adult patients: Consider universal guidelines for adult and pediatric patients

· Potential Script for explaining to child about removal of items and clothing change:

    - Our main goal is to keep you safe. I know it may be hard to understand but for right now, we need to have you change into our hospital clothing and review all your items for safety reasons. We will keep these safe and secure for you until our mental health clinician can come and see you. We do this for all patients who come in with a mental health crisis because your safety is important to us.

- Best to initially present this as not a choice, avoid negotiating if possible and will not aggravate agitation

· However, if it will trigger severe agitation or potentially lead to restraint, then strongly consider not forcing removal of whichever item is exacerbating agitation.

· If the cell phone removal is the item causing agitation to the degree of leading to a restraint, you can let them initially keep it and let the battery run out. By the time the battery runs out, the patient will likely be less agitated when they can have an easier conversation about why the phone has to be removed. You can also phrase it as a way to keep their phone safe by locking it up.

· If the clothing removal will cause agitation to the degree of leading to a restraint, you can ask them to turn out all their pockets, any other potential areas with items to make sure nothing that could be a safety risk such as ligature risks, sharp edges. Any objects that are a self harm risk should be removed.

· For other valuables/items, again should be reviewed for ability to cause for self harm. Any items that could be a self harm risk should be removed

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Questions below were discussed with Jennifer Schlebusch and the team in preparation for the session but we did not have a chance to discuss

Should patients be allowed to go outside for fresh air?

· This is a huge elopement and safety risk. If you don't have an enclosed area, this is generally strongly not recommended and likely not ok based on insurance for the hospital.

What should the policy be for visitors?

· This is already more restrictive due to covid in most EDs. Any covid policy you already have for your ED should be applied to these patients (e.g. only one visitor at a time).

· Prior to covid, patients less than 18 years old are generally not allowed outside visitors other than caregivers.

Who qualifies for a 1:1 sitter?

Ideally everyone would have a 1:1 sitter however this is not always feasible.

Things to consider in deciding level of sitter:

· After eval, the mental health clinician should help decide the level of sitter such as 1:2 sitter or no 1:1 sitter

· In general, patients assessed as high risk for self-harm or elopement who could need an immediate intervention (e.g. immediate need for someone to stop from eloping or stop from harming themselves) should have a true 1:1 in person sitter.

· In general, patients with anxiety or eating disorders also generally can be considered for a lower level of sitter, especially when a parent is present.

· Regarding video surveillance, there is no evidence showing whether video surveillance is better or worse than in person surveillance in regards to safety or for improved patient care. Some theorize that video surveillance may be better for some low risk patients because having an in person sitter may be more likely to cause agitation.

<u>What is the best practice when child and caregiver don't agree about disposition</u>

· In general, for children less than 16 years old, if the mental health clinicians are concerned for significant risk to self or others that would qualify for section 12, the patient would need to stay regardless of child or caregiver opinion about need for inpatient admission due to safety concerns. For families that want to take them home, there should be discussion to help them understand the specific safety concerns and why the safest path for the child is to stay for higher level of care. If families are still in strong disagreement, you can offer daily re-assessments.

  - For older than 16 years old, the laws are different in different states as these patients are now approaching adult age and may be eligible for adult laws (e.g. in Massachusetts, adult patients generally are only required for a 24 hour hold after admission to an inpatient evaluation and then they can sign out so some inpatient facilities do not want to accept patients that are not on board with the care plan). The mental health clinician doing your assessment should be familiar with these laws as state credentialing requires that they know how these laws apply to different age groups.

· In cases when the child and/or family has been deemed safe for home but either child or family does not feel safe:

  - In situations, where caregiver does not feel safe to take child home for concern for harm for themselves or other in their home (e.g. younger siblings), first steps would be re-discussion with your mental health care team and their outpatient management team to investigate if there is a potential safe discharge plan, which could include temporary stay with other family members (e.g. patient is triggered by younger siblings but is fine with aunt). If you can't come up with a safe discharge plan, you will likely have to involve your legal team and possibly your local DCF service team.

  - For children who say they don't feel they can keep themselves safe to go home but mental health clinicians want them to go home, these patients should

be sectioned until you can have re-discussion with families and re-evaluation with mental health clinicians as a child who says they can’t keep themselves safe at home should be highly considered for a higher level of care.