Caring for Children & Youth with Mental Health & Substance Use Concerns

CHILD HEALTH BC

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For the purpose of this booklet:

"Child" will be used to include both children and youth.

Definition of Family:

"Families are big, small, extended, nuclear, blended, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, fostering, adoption, marriage, or from a desire for mutual support. Together, our families create our neighbourhoods and communities."
(Pediatric Care Online, 2008).

OVERVIEW

This resource is for any staff member working in an acute care setting caring for patients experiencing mental health and/or substance use concerns.

The aim is to build on your current foundational competencies from the Pediatric Foundational Competencies eLearning course available on the Learning Hub.

The Pediatric Mental Health Resource is only a starting place on your learning journey; pediatric mental health is vast and complex. The goal of this resource is to provide a foundational level of knowledge that you can continue to build on and return to as needed. There are also links to resources to explore the topics in more detail.

Although the focus for this booklet is pediatric mental health patients, the skills and concepts presented are applicable across populations and we encourage you to assess the mental health needs of all your patients.

The role of an acute care staff member working with pediatric mental health patients:

As an acute care staff member working with pediatric patients you will see children who present with a range of medical and mental health conditions. As with any diagnosis, you will want to make sure you are familiar with the signs, symptoms and different management strategies. Your role with mental health patients may look slightly different, but the key factors are the same.

▶ ***Assessments*** ▶ ***Safety*** ▶ ***Positive Experience*** ▶ ***Clear Boundaries***
▶ ***Implement Treatment Plan***

Assessments:

Every child requires a head to toe assessment. A child presenting with mental health symptoms may have a contributing or co-occurring medical illness and a child with medical symptoms may also have a contributing or co-occurring mental illness. Nurses must be prepared to assess both the physical wellness and the psychological wellness of pediatric patients.

General Assessments:

- Head to toe assessments
- Mental status exams
- Presenting lab work
- Historical data
- Safety planning together with the child & family
- Effects of medication

Specific content of the assessments may include: patterns of behavior, identified triggers, shifts in mood, content of conversations/information shared, side effects and response to medications, sudden changes in mental or physical status, as well as any underlying physiological responses that could be causing mental deterioration.

The information nurses collect throughout their shift will inform the care team's diagnosis and treatment plan. Because mental health disorders in children may be new or combined with other chronic illnesses they can be difficult to tease out. Therefore, it is vitally important for nurses to provide ongoing assessments throughout their shifts. This strategy will allow nurses to identify risk and deterioration as well as to help build rapport with the child. Assessments are a critical aspect to providing safe care for patients, as well as to creating an engaging environment for patients and families.

DID YOU KNOW?

In the 2013 McCreary report 17% of adolescent females surveyed in BC had not accessed mental health services they thought they needed, 5% of males reported the same.

Supporting Safety:

This includes all types of safety: physical, emotional, social and cultural.

Scan the environment and determine if there are unsafe objects that can be removed (e.g. sharp objects, door hooks). Consider the reason for the visit/admission and work to create a safe and inviting space, which includes providing items for comfort and items to support coping. This can help to prevent problems.

- Remove as much clutter as possible and replace with safe activities that can be used for distraction and self-soothing.
- Support emotional, social and cultural safety by building rapport and asking about the things that are important for the child and family.
- This can be a difficult time with a great loss of privacy and control so check-in frequently with the child and family. Look for ways to provide privacy and control.
- Ensure the child knows that you want to hear their concerns and ideas and provide choices whenever possible.

Positive Experience:

You have the ability to positively impact every child and family you work with.

How you provide care can provide an invaluable positive experience with the healthcare system. As many children and families will need ongoing support, this can help keep them connected to resources or increase their likelihood to seek support in the future.

- Be genuine, clear and involve the child and family in care planning whenever possible.
- Ask what they like and provide choice when possible.
- If something can't change because it is a safety issue, let them know the reasons why.
- Take a few extra minutes to build rapport and try using humor to connect.

Remember that clear boundaries help to support safety:

Be clear that your role is to support safety and build trust.

Be aware of self-disclosure. This should only be used for therapeutic reasons. Be mindful of exploring the child's story too deeply as children in a mental health crisis often won't have the coping skills to deal with the big feelings that may come up as the result of too much discussion. They may become emotionally and behaviorally dysregulated as a result. These types of discussions should be left to the mental health team or a practitioner on your team with mental health training.

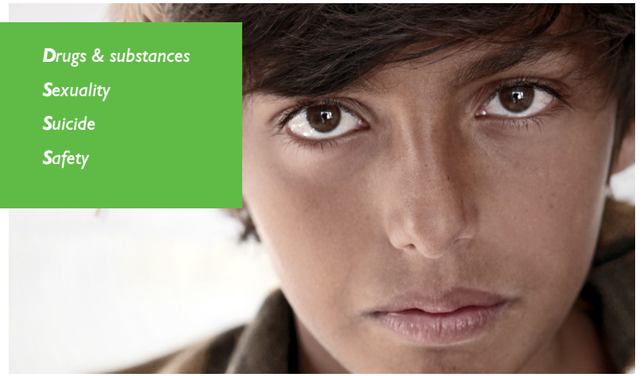
- Focus on topics of interest to them (movies, books, sports).
- Provide in the moment support for coping. This may include providing a supportive presence, helping with problem solving or helping with distraction.
- If the child wants to talk about their issues, acknowledge and validate their feelings. Suggest they discuss it further with their doctor or counsellor. You can also suggest that they write their thoughts down.
- If the child discloses abuse, follow your hospital's policy and procedure for child protection and duty to report.

HEEADSSS:
A psychosocial assessment for adolescents

- ***H**ome & environment*
- ***E**ducation & employment*
- ***E**ating & exercise*
- ***A**ctivities*
- ***D**rugs & substances*
- ***S**exuality*
- ***S**uicide*
- ***S**afety*

Implement the treatment plan:

Treatment plans for mental health patients may include medications along with specific instructions on day to day management. In settings such as the emergency department, there may be considerations like bed placement (in a quieter location or close to a nursing station for observation). As the issues are complex, it is best to develop the plans as a team and discuss your thoughts and concerns frequently. This is challenging work and a supportive team can make all of the difference. It is especially important to remain consistent in your approach. Whenever possible do not deviate from the plan or change the approach without first discussing as a team. Predictable responses can support stabilization. Even if the issues seem small, it is important that the team all be on the same page and delivering the same messages.



KEY INGREDIENTS OF SERVICE DELIVERY

A trauma informed practice

A trauma informed approach begins with building awareness of the commonness of trauma experiences; the range of adaptations people make to cope and survive after trauma; and the relationship of trauma with substance use, physical health and mental health concerns. This knowledge is the foundation of an organizational culture of trauma informed practice. A key principle of trauma-informed practice is the awareness of power relationships. To build trust people need to experience safety. Trauma informed teams build physical, emotional, social and cultural safety by recognizing the need for choice, collaboration, and connection; as well as by using a strengths-based and skill building approach (see page 9 for the section on Trauma Informed Practice).

A patient centered and family focused approach

A patient centered approach to care means keeping the patient's needs at the center of everything you do. A family focused approach recognizes and supports families in their key role of providing ongoing care and support to children. Patient centered and family focused approaches are based on a philosophy that service delivery involves a partnership between those using and those providing services. When we are working in partnership, the patient and family is a member of the health care team. Their choices, preferences, beliefs and goals are paramount to developing a collaborative treatment plan.

A recovery orientation

Hope of recovery and optimism about the future are important factors that aid recovery from any illness. A recovery focus is essential to promoting hope, wellbeing, and a sense of self-determination for people struggling with illness. A recovery orientation allows for and creates new meaning and purpose, and encourages children and families to pursue personal goals and interests.

In mental health, recovery is understood as a deeply personal, unique process of moving towards a satisfying and meaningful life. Recovery is viewed as both a process and an outcome towards which all those involved in the patient's treatment, care and support can work.

Culturally sensitive practice

A family's cultural background significantly influences the way they understand mental health and treatment. It can influence the nature and timing of help seeking behaviours. A lack of understanding of the way culture influences actions and behavior can lead to poor quality psychiatric assessment, inaccurate diagnosis and ineffective treatment and care. It is important to assess how a child and family implement cultural practices and beliefs as no culture is a homogeneous group.

Early intervention and relapse prevention

A growing body of evidence is showing that the impact of mental illness can be reduced and outcomes improved if problems are identified and treated early. Minimizing the disability and impairment associated with illness is critical in hastening recovery. Strategies to enhance early intervention include:

- learning to identify mental health problems at an early stage of life or early in the illness process.
- working with patients and caregivers to identify relapse patterns and early warning signs.
- using skill building and education to strengthen a child's resiliency to stress and relapse.

High risk behaviours, commonly encountered in Child and Youth Mental Health, are substance use and self- injury. These behaviors are distressing to children, families, caregivers and medical professionals as they can lead to adverse outcomes such as irreparable injury and even death. Children engage in high risk behaviours for a variety of reasons including relief from painful and distressing emotion, to help with feelings of dissociation and for distraction.

Harm reduction

Harm reduction is an approach used to lessen the negative social or physical consequences of high risk behaviours while recognizing that the high risk behaviour may continue despite the risks. It involves a range of support services and strategies to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

The harm reduction approach offers a framework of safety for individuals engaging in high risk behaviors while not removing what they are using to cope. Harm reduction aims to provide and or to enhance skills, knowledge, resources and support for people to be able to live safer, healthier lives. It encourages people to build strengths and to gain a sense of confidence.

Trauma is more common than you realize. The 2013 McCreary report "From Hastings Street to Haida Gwaii", a survey of more than 30,000 BC children in grades 7-12, reports that 15% of females and 10% of males indicate having been physically abused or mistreated in their lifetime. In addition, of the respondents, 13% of females and 4% of males report sexual abuse.

Examples of harm reduction

If a child engages in self-injurious cutting, without suicidal intent, harm reduction offers a safety net of strategies to help prevent extreme adverse events. Some of these strategies may include alternatives to cutting such as holding ice chips in your palms or snapping elastic bands against the wrist to help relieve stress. But it may also involve teaching sterilization of the cutting implement and wound care management for post injury so that infections do not develop.

Healthcare workers must be aware of and recognize their own judgements, beliefs and biases in order to provide care using a harm reduction approach.

TRAUMA INFORMED PRACTICE

What is Trauma?

Trauma: experiences, either physical or emotional, that overwhelm an individual's capacity to cope.

Trauma informed practice begins with an understanding of trauma, its prevalence and its effects on physical and psychological health. Trauma informed practice is about the way of being in the relationship, not a specific treatment strategy. The key principles of trauma informed practice include: trauma awareness, creating safety and trust, providing opportunity for choice, collaboration and connection, and using strengths based interventions and skill building.

Trauma Awareness

Complex trauma in childhood impacts childhood development and can lead to difficulties in developing a sense of self, learning abilities, building relationships, and understanding and managing emotions. These difficulties are reflected in the child's behaviours and coping mechanisms. Children who have experienced trauma are at increased risk for both physical and psychological illnesses.

Emphasis on Safety and Trustworthiness

Physical, emotional and cultural safety for children is a key part of trauma-informed practice. Trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships and may currently be in a situation where they do not feel safe. You may not know which children have experienced trauma, so this approach is recommended for all children.

DID YOU KNOW?

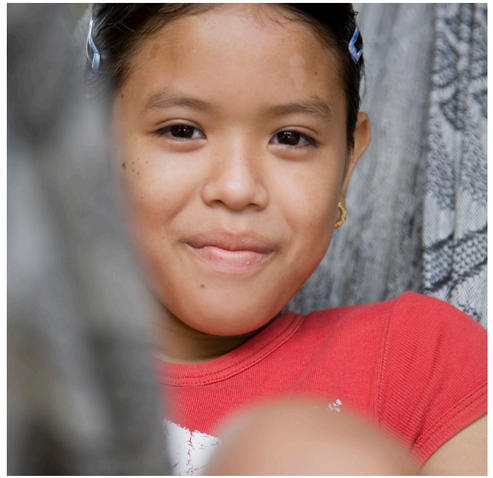
Trauma experiences can include single events such as accidents or natural disasters to chronic ongoing abuse, neglect and violence. Trauma can span generations and the effects can be passed from one generation to the next. Even hospitalizations and medical procedures can be experienced as traumatic.

TIPS FOR CREATING SAFETY

- *Introduce yourself every shift and explain your role*
- *Be clear about what you are able to do or not do and follow through with what you say you are going to do.*
- *Be aware of your own judgements, beliefs and biases to be able to provide a non-judgmental approach and respect for their beliefs.*
- *Provide explanations before procedures and prepare children for transitions.*
- *Have comfort measures available (parent support, stuffed animal, tea).*
- *Avoid power struggles and include the child in decisions about their care.*
- *Talk about safety. Plan with the child & family how to create safety together (do this before things feel unsafe).*
- *Explore potential triggers, what they do to cope, and how the team can support their coping.*

OPPORTUNITY FOR CHOICE, COLLABORATION AND CONNECTION

Part of having a trauma informed approach involves actively fostering a sense of self-efficacy and personal control. A common trigger for children who have experienced trauma is a perceived lack of power or control. Creating the opportunity for children to succeed and make decisions about their health can be empowering. Understanding the child's experiences and ways of being is essential to being able to provide choice, collaboration and connection.



Children's behaviour is often driven by unmet needs and previous trauma experiences. Abused and neglected children will often be emotionally and socially delayed and may regress when they are feeling stress. In these moments their true capacity to manage may be much less than our expectations demand. These are the times that we must try to understand what is behind their behaviour and recognize their emotional age.

Strength Based and Skills Building

A strength based approach identifies individuals' resilience in the face of adversity and builds resources that will increase this resilience. Helping children to cope starts with the belief that children do well if they can. When children are struggling, start from a place of curiosity and recognize that there are factors driving the behaviour that may be beyond the child's awareness and ability to manage. This is now an opportunity to help the child build the necessary skills to manage when they are struggling.

Building skills

Identify strengths: Help the child identify things they do well, their accomplishments, activities they enjoy, and previous coping strategies they have used. Reflect back to them strengths that you have noticed: "I noticed that even when you were really upset, you were able to tell me and I could give you the space you asked for – often that is not an easy thing for people to do when they are upset".

Identify coping strategies: Explore coping strategies, what they have used in past, what works or doesn't work and offer suggestions as needed. Support the child to practice the coping strategies during non-crisis times. The more it is ingrained the easier it is to use during a crisis. Review with them after using the strategies how they felt, what they noticed about their thoughts, feelings or sensations in their body. (See list of examples in Exploring Coping Strategies section).

Discuss how to stay safe: Work together with the child & their family to develop a safety plan using the identified coping strategies. Include in the discussion potential barriers, when it might be more difficult to use the plan, what might keep them from using the plan and potential ways to overcome the barriers. Practice the safety plan and review what worked or didn't work and make adjustments as needed.

CONCURRENT DISORDERS

A youth diagnosed with a concurrent disorder has both a mental health concern and co-occurring substance use. Youth are a high risk population. Youth between the ages of 15-24 are more likely than any other age group to report suffering from a mental illness and/or substance use disorder. But why are they at risk? One of reasons is simply about brain development. The adolescent brain attributes greater weight to the positives of their proposed decisions than the potential negatives, making them more likely to follow through and disregard the potential harms. They end up using for a variety of reasons: to have fun, to experiment, as self-medication, to deal with stress, or to relieve physical and psychological pain.

Working with youth with concurrent disorders is about engaging them through a respectful, non-judgemental approach. Start where they are at regarding their goals for treatment, which might include reducing one substance while continuing with another. Our job is not to direct them or confront them, but rather to guide them and support them in their treatment goals. One way to do this is through Motivational Interviewing (MI). MI is an evidence based approach that youth respond to and is used to address ambivalence about change. MI uses open ended questions and creates the space for choice. The nurse must put personal biases aside, thereby allowing for a respectful, non-judgemental approach. Believing in the youth and their ability to change and learn new coping skills is a powerful intervention in of itself that can instill hope.

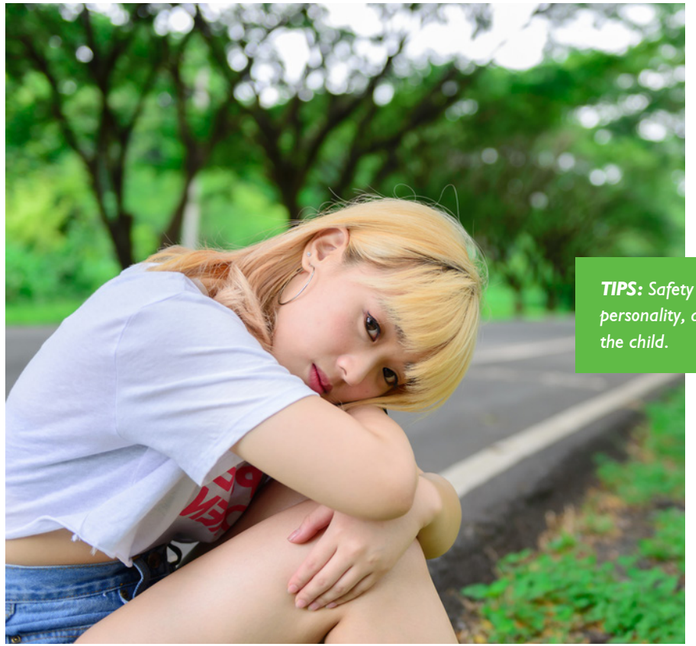
Once admitted to hospital, a youth who has been using substances is at risk for withdrawal.

Signs of withdrawal may include:

- sweating
- insomnia
- mood lability
- fatigue
- tachycardia
- agitation
- anxiety
- hallucinations

The withdrawal should be medically managed and supportive comfort measures should be implemented. Provide a physically and emotionally safe environment. Offer reassurance and support that symptoms will pass. Encourage small, well-balanced meals as they may have a tendency to gorge. They may be seeking carbohydrates or sweets so provide these with meals. Allow time for undisturbed sleep and encourage rest. Offer relaxation strategies as needed: music, baths or breathing exercises.

Remain open to working with the youth where they are at and provide a withdrawal that is humane and protects their dignity. Regardless of whether or not they are ready to make changes, every interaction has the ability to positively or negatively impact someone's life.



CREATING SAFETY PLANS

A safety plan is a written set of instructions that you create with a child and family as a contingency plan for when the child is experiencing distressing thoughts or emotions. While safety plans are generally created for self-harm and suicide, they can also be used for overwhelming feelings such as anxiety or anger. To explain the parts of a safety plan we will use suicide as an example.

TIPS: *Safety plans are unique and individual. Try making safety plans with personality, adding pictures, colour, and scrapbooking – whatever speaks to the child.*

Information to include in a safety plan

When the plan should be used:

Help the child identify their triggers and warning signs. What types of situations, images, thoughts, feelings or behaviours precede or accompany their suicidal urges.

Examples: feeling angry, thinking nothing will ever get better, isolating, thinking other people are laughing at me, people yelling at me

TIPS: *Practice, practice, practice! It is important to practice coping strategies during times of non-stress so that they become ingrained. The child is then more likely to use them during times of stress. Not every coping strategy works every time so it is important to have multiple options. When strategies involve the caregiver have them practice together.*

What to do: Help the child to create a list of activities or things that they find helpful or soothing. You may need to help them brainstorm, ask questions about what they like to do, their interests, things they would like to try, or things that have worked in the past. (See examples under Coping Strategies section).

Reasons for living (or using your plan): Help the child to create a list of reasons for living (or if safety plan is about self-harm their reasons for not self-harming). When someone is feeling suicidal, their thinking can narrow and suicide can seem like the only option. The list can help to refocus them on their reasons to keep going until the thoughts/feelings pass (which they do) or become more manageable. Explore people or animals that are important to them, future goals or things they would like to do one day or places they would like to go.

Who to talk to: Help the child create a list of people that they can turn to for support. List names, phone numbers or other contact information and have backup people.

Crisis plan: Provide local & virtual resources at the bottom of the safety plan.

TIPS: *Safety plans should be shared with the caregiver so they can be familiar with the triggers and warning signs. Encourage the child to come up with ways the caregiver can help when they notice the warning signs.*

EXPLORING COPING STRATEGIES

Coping strategies are methods a person uses to deal with stressful situations. A stressful situation can be anything from suicidal thoughts to being scared of the EEG machine. There are a wide range of potential coping strategies; our job is to support children in finding positive strategies that work for them. Think of all the different things you do to either calm your body when you are feeling stressed, or to help wake up and energize yourself when you are feeling low. You may need to help children brainstorm what to try. Consider creating a tool box of coping strategies with them. While in hospital consider activities that can be done in their room or bed.

Examples for the tool box:

- Colouring
- Drawing, journaling
- Stretching with a yoga mat
- Deep breathing, relaxation techniques
- Popping bubble wrap
- Using hand fidgets, stress balls
- Distraction with a DVD or audio tape (taped progressive muscle relaxation)
- Tea or other relaxation supports
- Support self-care (things that make them feel good- painting nails, doing hair, hand massages etc.)
- Completing a puzzle
- Playing cards
- Reading or being read to
- Hot shower or bath
- Writing out lyrics from their favorite song
- Putting a face mask on
- Listening to music
- Playing music (guitar)
- Their favourite game or activity

CONNECTING, BUILDING RAPPORT & INTERVENING

Whether you are working with children and families dealing with mental health issues or with medical issues, the basic principles of providing care remain the same: to engage the child and family in care, to develop a working relationship, and to support them in achieving their health goals. In mental health, the focus tends to be on thoughts and feelings rather than physical ailments. This can seem daunting; however you already have a number of the skills needed to help these children and families. Below is a review of ways to connect, build rapport and intervene; these are based in the philosophies of care described in the booklet.

General principles of engagement:

- Look beyond the condition to see the whole person.
- Use a strengths-based approach to recognize the inner resources of children and families.
- Promote collaboration through sharing information and decision making.
- Be adaptable to meet children and families where they are.
- Provide opportunity to include family and other close supporters as essential partners in recovery.
- Recognize the role of community, culture, faith, sexual orientation and gender identity, age, language, and economic status in health and recovery.

Connecting & building rapport:

- Read the chart before stepping in with the child and family.
- Introduce yourself to the child and the family, describe your role and ask permission to talk to them.
- Ask how the patient prefers to be addressed.
- Identify members of the family and alternate caregivers.
- Invite patient/family to ask questions and address immediate needs and concerns.
- Connect with family but speak directly to the child about their care.
- Introduce any new people in the room by name and role and what they can expect from them.
- Be clear about your availability.
- Remain within the scope of your expertise and designated role.

TIPS: *Words like manipulative, attention-seeking, controlling and borderline are deficit-based & invoke blame which leads to feelings of shame. Thinking about children in this way is limiting and may create barriers to care.*

- Be non-judgmental, empathetic and professional.
- Be curious and use active listening.
- Speak clearly and avoid the use of acronyms and jargon.
- Match your language to the child's developmental age.
- Be transparent in answering questions and if you don't know the answer let them know how you will find out.
- Consider your body position when talking to children, you may be bigger than them and they may feel intimidated. Try stepping back, sitting in a chair, or crouching on the floor, keeping in mind the environment around you and your safety.
- Be conscious of your language. Language communicates respect; keep a strength-based rather than a deficit-based perspective. Labelling children as their diagnosis creates stigma. A child is not their diagnosis – the child has autism not the autistic child.

Safety and Comfort: physically and emotionally:

- Provide orientation to the unit and the team.
- Have comfort measures available (blanket, toys, books).
- Explore daily schedule with parents and children, consider parents availability, parental self-care, visiting times and developmental needs of children.
- Provide explanations for procedures and preparation for transitions and allow time for expression of emotion.
- Engage child life if available.
- Remain curious about what they are experiencing.
- Offer distractions as needed (games, books, movies, music).

TIPS: *Being in hospital can be frightening, the room is unfamiliar and there are different smells and noises that we don't even notice. Try to be aware of potentially distressing noises and provide developmentally appropriate comfort measures and explanations.*

Interventions for in the moment coping:

Every child experiences distress in their own unique way. Explore how they experience distress so that you can help the child and caregiver brainstorm ideas to manage the distressing experience. Here are some examples to try but remember that each child is unique and you may have to improvise or ask caregivers what has worked well in similar situations.

Reduce stimulation and noise:

- Close doors and windows.
- Ask team members to reduce chatter around child's room.
- Turn down lighting and turn off any machines that are not needed.
- Decrease amount of people around while still providing numbers of staff to provide safety.
- Turn devices and TVs off or offer headphones to limit interference if a child is concentrating on a program.

TIPS: *Children may show subtle behavioral clues like expression changes, wincing, covering their ears, or hiding, which could indicate environmental stressors.*

Verbalize feeling:

- Identify and clarify the feeling, try using yes or no questions, cartoon faces/words or other pictures to indicate feeling states.
- Normalize feelings and be accepting of the child's experience. Provide safety by being aware of risk of harm to themselves and others. Provide reassurance that you are there to help them feel safe by supporting them to use their safety plan.

TIPS: *Spend time with the caregivers empowering them as the experts in their child's care. Teach them the new interventions so they can connect with their child during stressful moments. Support them in providing care in ways they are familiar with, as these can often be of most comfort to both the child and the caregiver.*

- Offer options to help the child pick an action that will help them reduce distressing feelings.
- Be curious and responsive to what they need from you to help with the distress. Include caregivers as much as possible.

Grounding exercises:

- Progressive muscle relaxation is helpful when children need to center into their body. Focus on one part of the body. Feet or hands are excellent choices. Now clench your toes or your fingers and hold while I count to three…now release. Repeat this for five clenches.
- Environmental grounding is helpful when children respond better to external distraction. What do you hear right now? Can you name the noise? Touch the blanket…what texture is it?

TIPS: *As you start any breathing exercise make sure you empty your lungs out first so you can get a big breath in on your inhale.*

- Use imaginative visualization and storytelling to relieve distress. Create a story with them about somewhere peaceful, relaxing or simply preferable. This could be based on their favorite space or their favorite imaginary space. Have the child build their story and ask questions to prompt if they get stuck. For example if you are creating an imaginary unicorn what color is the hair? What color is the hide? What is their name? Where do they like to play? And what does that area look like?

Breathing exercises:

- Bubble breathing: Take a deep breath in and as you exhale you are going to blow a really big bubble. You get to pick the color. (Some kids don't want to initially participate…you may have to demonstrate with a bubble of your own…really use your imagination).
- Box Breathing:

1. Sitting upright, slowly exhale, getting all the oxygen out of your lungs. Focus on this intention and be conscious of what you're doing.
2. Inhale slowly and deeply through your nose to the count of four. In this step, count to four very slowly in your head. Feel the air fill your lungs, one section at a time, until your lungs are completely full and the air moves into your abdomen.
3. Hold your breath for another slow count of four.
4. Exhale through your mouth for the same slow count of four, expelling the air from your lungs and abdomen. Be conscious of the feeling of the air leaving your lungs.
5. Hold your breath for the same slow count of four before repeating this process.

THERAPEUTIC COMMUNICATION SKILLS

There are many different skills used in therapeutic communication. You choose what skill you will use with your patient based on what they require as an individual in the moment that you are caring for them. Children will be more receptive to treatment plans and engage in their care when they trust their caregivers and feel safe in their environment. Therapeutic communication is a responsive communication style wherein you will participate in acknowledging and validating emotions while modelling active listening, curiosity and support. Below are some common skills necessary to foster responsive therapeutic communication:

Match Verbal with Non-Verbal: Attune your tone of voice, body language and words so that they clearly support the message of safety and trustworthiness.

Open-ended: Communication starters that are used to encourage discussion about personal experiences; they cannot be answered with a simple yes or no answer.

- "What would you like to tell your friends at school about your hospital admission?"
- "What would you like to discuss about…."

***TIPS:** Remember, collaboration helps promote safety and relationship building!*

Closed-ended and focused: These are helpful in de-escalating or to acquire specific information and can be answered in yes or no responses as well as short answers.

- "How long have you been hearing voices?"
- "Would you like to call your mom right now?"
- "Are you hungry? Sad? Angry with me? Etc."

Reflective comments (use mirroring and paraphrasing):

- "You want to go home"
- "It sounds like you may be confused about why you are here…"
- "From what you're saying, I can see how you would be…"
- "It sounds like you're saying…."
- "It seems that you are…."

Clarifying comments: Used to clarify your interpretation of what the patient has shared, to gain a clear understanding free of assumptions and judgements.

- "I hear you saying that you don't trust your mom because she brought you into hospital"

- "Tell me if I'm wrong. It sounds like you are hesitant to take this new medication?"
- "When I said that the lab is here to do bloodwork I saw your expression change. I thought you looked scared. Is that right?" (Opens a door to problem solving before a crisis)

Validating and empowering comments: These are used to encourage and support the child in their treatment. Remember that not every child likes positive re-enforcement. Always choose your style based on what is most therapeutic.

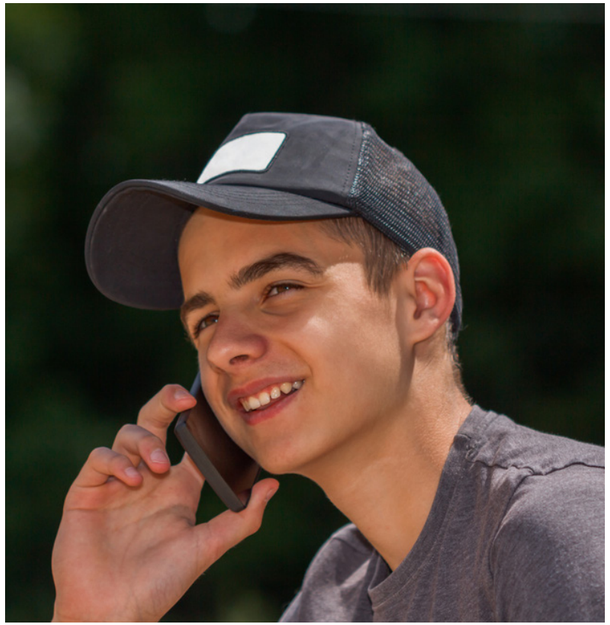
- "That sounds really hard…."
- "It is such a tough thing to go through something like this."
- "I'm really sorry this is such a tough time for you."
- "It sounds like this is really important for you. Would you like to set up some time to talk about this together?"
- "You have been working really hard these past few days, what can we do right now so you can have a bit of a break?"
- "That was a really tough talk with your mom and I saw you using your deep breathing. You did a great job."
- "What might make you feel better?" or "What have you tried before that worked really well?"
- "I noticed that when you were coloring your body seemed more at ease. Do you want to try that again?"

Use of Silence: A powerful tool to display active engagement in what is happening with the child. Silence, when done thoughtfully, can portray complete acceptance of what is going on and what the child is experiencing. During silence, stay tuned to your body language and facial expressions then your non-verbal communication will come through as authentic and wholehearted. As you are silent you may be doing an activity as a way to create space without awkwardness.

Activities to try with silence:

- Colouring or drawing
- Playdoh or Lego
- Going for a walk
- Yoga or meditation

***TIPS:** Try using cross-communication (talking to a caregiver or colleague in front of the child about the child) to explain something awesome the child has done. This can also be done to relay information you want the child to have but they are not engaging directly.*



Practice traps – trying to make the child feel better:
While we may say things to be helpful or to try to make the child feel better, they may actually feel invalidating to the child. Here are some examples of phrases we may fall back on and should try to avoid:

- *I know how you feel*
- *It's for the best*
- *Let's talk about something else*
- *You should work to get over this*
- *You are strong enough to deal with this*
- *That which doesn't kill us makes us stronger*
- *You'll feel better soon*
- *You need to relax*
- *It could be worse*
- *We are not given more than we can bear*
- *You need to talk about this*
- *You need to calm down*
- *We can talk when you are calm*
- *Excessive questions or questions starting with "why?"*

MENTAL STATUS EXAM

The Mental Status Exam (MSE) is an important part of your head to toe assessment. Many of the components of the exam you already readily assess. The exam provides a structure to your assessments. This structure enables you to easily communicate a clear picture of the child to the care team. The MSE is composed of a series of questions and observations that provide a snapshot of a patient's current mental, cognitive, and behavioural condition. **Completing a mental status assessment each shift, and more frequently if there are changes or concerns, provides an overall picture of the child's functioning.**

When completing a mental status assessment, much like any medical assessment, it is important to set the stage for the child to feel safe and comfortable. A younger child may be more open and talkative with their parents present, whereas an older child may want privacy and be concerned about confidentiality. Take your cues from the child and remember all the tools you already use to engage with children. An open conversational style works best with the MSE.

There is a lot of psychological vocabulary associated with the MSE. If this is of interest to you, a glossary is included at the end of this section. The most important part of your documentation is your description of what you are seeing and hearing. This description will provide the most accurate picture of the child.

For all areas of the MSE please consider developmental and cultural norms.

***TIPS:** An easy way to remember the parts of the MSE is to use an acronym ASEPTIC.*

***A**ppearance/behaviour*
***S**peech*
***E**motion (Mood/affect)*
***P**erceptions*
***T**hought form/content*
***I**nsight and judgement*
***C**ognition*

General appearance and behaviour

Consider your first steps in assessing children with medical concerns; you observe their behaviour, interactions with parents, skin colour, facial expressions and overall general well-being. This visual assessment is the beginning of your MSE and can provide important information about both their physical and mental well-being.

Areas to assess appearance: grooming/hygiene, dress, ethnicity, memorable aspects (tattoos, birthmarks, piercings), physical ailments or injury, gait.

Areas to assess behaviour: body language, eye contact, reaction to setting, psychomotor presentation (fidgeting, mannerisms, gestures, tics, repetitive behaviours, self- soothing behaviours), co-operation during interview, attentiveness, reliability, talkativeness.

Speech

This refers to the form or quality of speech not the content.

Areas to assess: rate, rhythm, volume, tone, accents, mispronunciations

Mood

The child's self-report of how they are feeling.

How to assess: encourage use of emotion words, offer scales or pictures to identify mood states.

Affect

The way the child shows their emotions to you, your objective observation of their emotional state.

Areas to assess:

- Congruency – does your observation of their emotion match how they describe their emotion?
- Stability – do their emotions change rapidly (one minute they are laughing and the next crying inconsolably)?
- Range – is there variability in their emotion or is it the same regardless of what is happening?
- Intensity – what is the level of the emotion (sad vs inconsolable)?

Perceptions

Perceptual disturbances such as hallucinations occur in the absence of sensory stimulus.

Areas to assess: hallucinations in relation to the 5 senses (auditory, visual, tactile, olfactory, and gustatory), degree of fear or distress associated with hallucination, the content of the hallucination.

Thought form

The way ideas are organized and communicated.

Areas to assess: rate (rapid or slow) and flow (goal directed and organized).

How to assess: How organized are their thoughts? Are you able to follow their train of thought? Are they able to answer questions coherently? Do they give a lot of extra non-relevant information?

Thought content

This is what the child is thinking about and the theme of the conversation. It includes the presence or absence of delusional or obsessional thinking (see glossary) and suicidal or homicidal ideas (see risk). If any of these thoughts are present, details regarding intensity and specificity should be obtained.

How to assess: What is the child thinking about? What does the child think is going on around them? What role do they play in it? What role do others play? Are they stuck on one topic? Are they expressing odd ideas or beliefs that don't seem true?

Insight

This refers to the child's awareness and understanding of their illness (or the concerns and stressors impacting their life) and the need for treatment or support.

How to assess: discuss in general what is going on for them; what is their understanding of why they are in hospital? What brings them to hospital? What are their goals for admission? How has what is going on for them impacted their life? Their relationships?

***TIPS:** Understanding a child's insight and judgement is important to determining their likelihood of following treatment plans or taking medication, whether for a medical illness or a psychiatric one.*

Judgment

Is the ability to make reasonable decisions and identify the consequences of actions.

How to assess: Engage in conversation about their life, decisions they have recently made in relation to school or home life, plans for when they leave hospital.

Cognition

Cognitive function includes the patient's level and stability of consciousness. A disturbance or fluctuation of consciousness may indicate delirium and can be an important assessment of life threatening medication side effects (lithium, antipsychotics).

Areas to assess:

- Orientation (person, place and time)
- Alertness
- Coherence
- Concentration and Attention
- Memory

Signs of Delirium:

- *Disturbance in attention (reduced ability to direct, focus, sustain, and shift attention)*
- *Reduced orientation to environment*
- *Fluctuates in severity*
- *Disturbance in cognition (memory, disorientation, language – coherence, visuospatial, perceptual)*

How to assess: through play and games, can they teach a game? Can they remember a game you taught them? What has been happening at school in regards to their concentration, attention, and memory? Do they remember your name?

Assessing Risk of Harm to Self or Others

Children are often in hospital because they have intentionally hurt themselves or others. Assessing the risk of harm to self or others is an important part of the MSE.

***Health Authorities may have specific suicide risk assessment tools and/or risk assessment processes that must be followed.**

Risk of Self-Harm

Self-harm, self-injury or non-suicidal self-injury is the act of deliberately harming your own body, such as cutting or burning yourself. It's typically not meant as a suicide attempt. Rather, this type of self-injury is a way to cope with overwhelming emotions. Self-harm also occurs with younger children, they may bang their head, scratch themselves or bite themselves. Suicide is a type of self-harm with the intention of killing oneself.

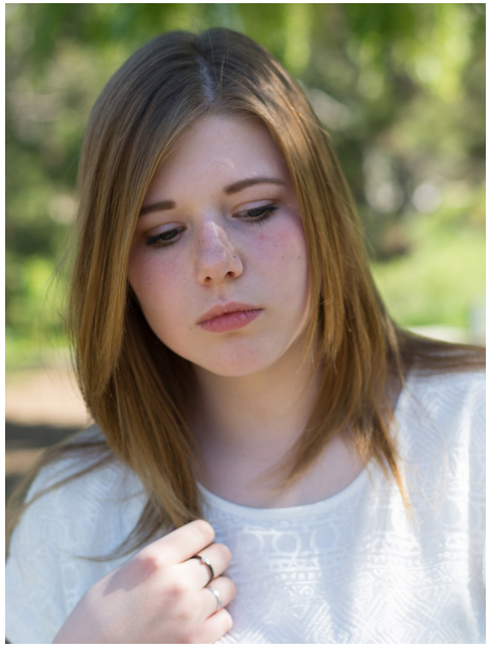
***TIPS:** When children are at risk for self-harm and suicide consider what is available in the environment for them to harm themselves and consider their level of observation. Talk with them to try to understand what is driving their behaviours and when they are at greater risk. Work with them on developing a safety plan (see section on Creating Safety Plans).*

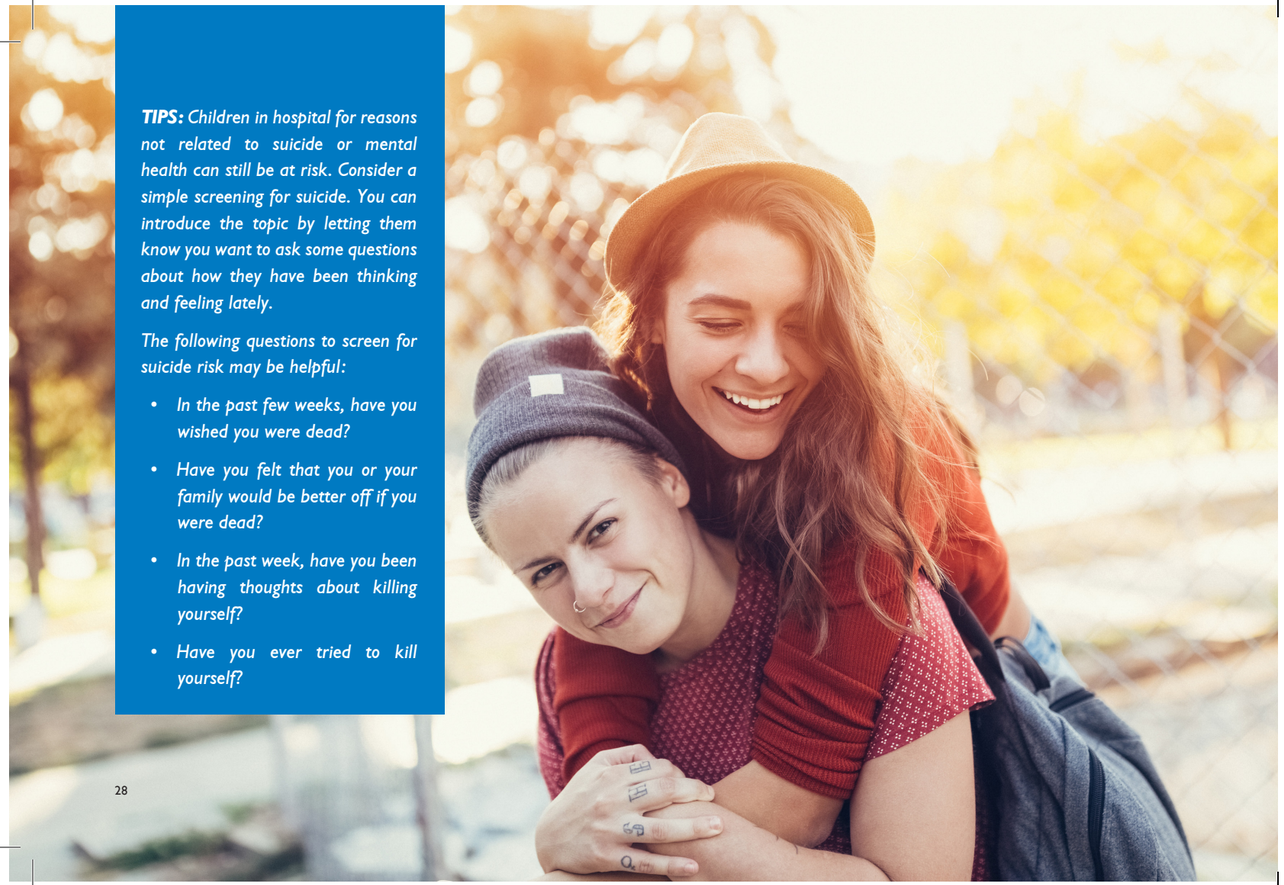
Assessing Risk of Suicide

While the comprehensive suicide assessment should be completed by a trained mental health clinician, a child's degree of risk is not static. It is your job to recognize times of stress that may increase risk and to ask specifically about their thoughts and plans in regards to suicide.

Discover if there are plans to carry out these ideas or if the person seems to have an undeniable intention. Thoughts present some danger, plans make the situation more dangerous, and the clear intention to go forward with the plans creates a high risk situation.

Examples of questions: Do you ever feel that life is not worth living? Have you ever thought about hurting yourself? Have you ever thought about killing yourself? If so, how would you do it?





TIPS: *Children in hospital for reasons not related to suicide or mental health can still be at risk. Consider a simple screening for suicide. You can introduce the topic by letting them know you want to ask some questions about how they have been thinking and feeling lately.*

The following questions to screen for suicide risk may be helpful:

- *In the past few weeks, have you wished you were dead?*
- *Have you felt that you or your family would be better off if you were dead?*
- *In the past week, have you been having thoughts about killing yourself?*
- *Have you ever tried to kill yourself?*

Risk of Harm to Others

Harm to others or violence is behaviours by people that are likely to cause physical or psychological injury to others.

Assessing Risk of Harm to Others: While the comprehensive violence assessment should be completed by a trained mental health clinician, it is important to screen for the possibility of risk. Areas of particular concern may be children experiencing command hallucinations to hurt others or delusions of persecution that people are out to harm them. Understanding how the child deals with anger, frustration, disappointment and conflict can help determine risk.

TIPS: *When trying to understand the risk of harm to others it is important to get collateral information from caregivers. Sometimes caregivers don't see aggression or violence in the same way health professionals might so it is important to ask questions about violence in different ways. How does your child deal with frustration? What does your child do when they are angry/scared/worried/sad? How do you know when your child is angry? What happens when your child is disappointed or when your child is told no?*

Examples of questions: Have you ever thought about hurting/killing others or getting even with those who have wronged you? What do you do when you are upset or someone hurts you? Have you ever physically hurt someone? What happens when you feel angry?

GLOSSARY

Delusions – fixed false beliefs that are held despite evidence to the contrary and despite the fact there is no logical support for the beliefs. Delusions are distinct from culturally or religiously based beliefs that may be seen as untrue by outsiders. Common types of delusions:

Delusions of grandeur – exaggerated beliefs of own importance or identity

Delusions of persecution – belief that someone or an organization is out to get them

Delusions of Control – belief that something or someone is controlling what they say, think or do (usually a machine)

Somatic Delusions – belief they have a severe illness, may include a preoccupation with or misinterpretation of abnormal bodily sensations

Ideas of reference – belief that general events are personally directed at oneself, often the newspaper, radio or TV is secretly about them or sending them messages

Thought Broadcasting – belief other people can read their mind or hear what they are thinking

Thought Insertion – belief other people are controlling or inserting thoughts into their mind

Thought withdrawal – belief other people can take thoughts out of your head

Obsession – an unwelcome, uncontrollable, and persistent idea, thought, image, or emotion that a person cannot help thinking even though it creates significant distress or anxiety (when the obsessive thought arouses intense fears, it is known as a phobia).

Compulsion – an insistent, repetitive, intrusive, and unwanted urge to perform an act contrary to the person's ordinary wishes or standards. If the person does not do the repetitive act it usually results in feelings of distress or anxiety (3 common types – repetitive cleaning, repetitive checking or counting).

Thought blocking – occurs when a person's speech is suddenly interrupted for no apparent reason. When the person begins speaking again, after the block, they will often speak about a subject unrelated to what was being discussed when blocking occurred. It is described as being experienced as an unanticipated, quick and total emptying of the mind.

Circumstantiality – a type of speech in which the person gives unnecessary, over detailed information but eventually answers the question asked.

Tangentiality – a pattern of speech in which the person tends to readily digress from one topic to another associated topic; one thought builds on the next and you can follow the direction of thought but the response never answers the point of the question asked.

Flight of ideas – a pattern of speech in which the person jumps from one idea to another; the ideas are fragmentary and you cannot follow the direction of thought.

Word salad – speech contains a mixture of words and phrases that lack comprehensive meaning; it is not coherent thought, but words just jumbled together.

CONSENT TO TREATMENT

Prior to providing treatment valid consent must be obtained. Consent must satisfy three requirements:

1. Voluntary – free from coercion.
2. Capacity – the individual is able to understand the nature and anticipated effect of the proposed medical treatment/test and alternatives, and is able to appreciate the consequences of refusing treatment.
3. Informed – the individual is given an explanation of the proposed medical treatment/test, the expected outcome, the risks involved and the alternative treatments.

All children in BC under the age of 19 are covered by the Infants Act. The Infants Act states that children may consent to a medical treatment on their own as long as the health care provider is sure that the treatment is in the child's best interest, and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child's understanding of the treatment.

Medical emergency – exception to the rule of consent. In cases of medical emergency when the patient (or substitute decision maker) is unable to consent, a physician has the duty to do what is immediately necessary without consent. There must be severe suffering or an imminent threat to the life or health of the patient. Treatments should be limited to those necessary to prevent prolonged suffering or to deal with imminent threats to life, limb or health.

For more information on the Infants Act:
www.bclaws.ca/civix/document/id/complete/statreg/96223_01

In the case of children receiving treatment for mental health concerns they are still covered under the Infant's Act, they may however, also be admitted to hospital under the Mental Health Act. Children can be admitted voluntarily (see form 1) or involuntarily (see form 4) under the Mental Health Act to a designated facility. **This does not remove the need for consent.**

- Treatment under the Mental Health Act refers only to *psychiatric* treatment.
- A child admitted involuntarily may still consent to treatment but if the child is deemed incapable of giving consent, consent may be obtained from the director of the designated facility (see form 5).
- Every child admitted under the Mental Health Act has rights and these must be reviewed with the child (see forms 13 and 14).

For more information on the Mental Health Act:
http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

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