Comparing Needs and Strengths of Crisis and Elective Admissions to Children's Acute Care Inpatient Services

Stephanie L. Greenham, Ph.D.
Lise Bisnaire, Ph.D.
Sophia Hrycko, M.D.
Kristin Schaub, B.A. (cand.)

Psychiatric & Mental Health Inpatient Services
Children's Hospital of Eastern Ontario

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- Interdisciplinary team on the Child Inpatient Unit

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Objectives

- To review the first 15 months of data from a new psychiatric inpatient service for children
- To gain a better understanding of similarities and differences between children admitted following a crisis/emergency situation versus a planned, elective admission
- To use this data to inform the system of the role of appropriate hospitalization within the system of care

Background

- Children's Hospital of Eastern Ontario
- Tertiary care, pediatric teaching hospital
- Serves children and youth in Eastern Ontario, Western Quebec, and Baffin Island
- Catchment area of approximately 600,000 children and youth (under age 18)

Model of Service

- **Target population:** Children age 12 and under presenting with acute, severe and complex needs who cannot function in a less restrictive setting (i.e., outpatient setting)
- **Service:** Short-term crisis stabilization and assessment within a safe, supervised and structured environment
- **Goal:** To reduce, not eliminate, level of risk and symptoms and facilitate reintegration of the child to his/her family/caregiver and community environment for ongoing care
- **Average Length of Stay:** 14 days to minimize the time a child is separated from family and community

Philosophy of Care: Key Elements

- Respectful, child-focused, family-centered environment
- Parents/caregivers are seen as partners in care
- Individualized and strengths-based approach, aiming to identify and build on each child's strengths and talents
- Collaborative and inclusive with families and the broader community
- Outcomes management approach to meet standards of care and evidence-based practice

Goals for Admission

- Stabilization
- Interdisciplinary observations and assessment
- Diagnostic clarification / formulation
- Medication review and/or adjustments
- Treatment planning
  - internal and external linkages

Exclusion Criteria

- First-line assessment or diagnosis
- Respite only
- Court-ordered and/or custody and access assessments

Interdisciplinary Clinical Team

- Case Coordinator
- Psychiatric Nurses
- Child and Youth Counselors
- Social Worker
- Teacher
- Occupational Therapist
- Psychiatrist
- Psychologists
- Medical consultants within the hospital as needed (e.g., Neurology, Pediatrics, etc.)

Outcomes Management Approach

- Adoption of Total Clinical Outcomes Management, a strategy proposed by Dr. John S. Lyons (2004)
- Program evaluation fully integrated within the delivery of clinical service
- Written informed consent for use of clinical information for program evaluation
- Use of clinical information throughout admission for assessment and treatment planning
- Iterative use of clinical information at all levels

Total Clinical Outcomes Management

- Comprehensive strategy
- Flexible to meet the needs of patients and their families
- Accountable at all levels
  - individual, program, agency, network, full system levels
- **Central importance of using clinical needs and strengths of children and families to inform and manage decision making at all levels of the system**
  - **patient, program**, hospital, community, network levels

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Outcomes Management Approach

- Routine collection of clinical data at admission
  - Child: CDI, MASC-10, YSR
  - Parent/Caregiver: CBCL, Conner's, FAM-III, PSI-S
  - Staff: CANS-MH, CAPI, background history, demographics
- Collection of outcome data at discharge
  - Child: CDI, MASC-10 (if length of stay 14 days or more and significant mood or anxiety symptoms)
  - Staff: CAPI, treatment plan
- Patient and parent/caregiver satisfaction

Patient Population

- 122 discharges between Sept. 2003 and Dec 2004
- 16 readmissions (13 patients total) (13% readmit rate)

- 98% consent rate for program evaluation research
- data on 104 patients available

- 24 (23%) admitted through Emergency Dept.
- 80 (77%) planned elective admissions

Similarities

- There were no differences between Crisis and Elective patients for:
  - Gender distribution (male)
  - Living situation or guardianship (one or both parents)
  - Community
  - School placement
  - History of inpatient or hospital-based outpatient mental health services
  - Current mental health resources
  - Discharge destination (living situation at admission)

Similarities (cont'd)

- Both groups had moderate to severe difficulties with:
  - Oppositional behaviour
  - School, family, and peer functioning
  - Consistency of problems across settings
  - Intensity of treatment required
- Mothers and fathers rated levels of internalizing, externalizing, and total problems in the clinical range
- Youth self reports for total problems were in the clinical range

Similarities (cont'd)

- No differences on any functioning or caregiver items of the CANS-MH
- No differences on any strengths items of the CANS-MH
- Strengths identified for both groups:
  - Interpersonal skills
  - Relationship permanence
  - Optimism
- No differences on any items of the CAPI at discharge

Key Differences

- Compared to Elective group, Crisis group is:
  - Older (10.5 vs 9.3 years)
  - More likely to be admitted with no clear diagnosis (33% vs. 11%) or with a primary diagnosis of depression (21% vs. 1%)
    Electives more likely to have behaviour disorder (58% vs. 13%) or pervasive developmental disorder (8% vs. 0%)
  - More suicidal at admission and in the past
  - Higher risk factor and symptom ratings at admission (CAPI)
  - Higher psychosis and depression ratings at admission (CANS-MH)
  - More likely to have had symptom-free periods over time
  - Less likely to have received previous community-based mental health services (79% vs. 98%)

Key Differences

- Compared to Elective group, Crisis group is:
  - Rated by mothers as less externalizing on CBCL (mean T-score of 72 vs. 77)
  - Rated by mothers as less hyperactive-impulsive (mean # DSM-IV symptoms = 4.4 vs. 6.5)
  - Mothers report lower levels of total parenting stress (at 81st %ile vs. 94th %ile)

Key Differences

- Compared to Elective group, Crisis group is:
  - Shorter length of stay (10.5 vs. 16.9 days)
  - More likely to be discharged with primary diagnosis of depression (13% vs. 3%) or adjustment disorder (21% vs. 3%)
    - *Electives more likely to have behaviour disorder (60% vs. 33%) or anxiety disorder (10% vs. 0%)*

Conclusions

- **Meeting our mandate as a tertiary care hospital setting within the system of care**
- Both crisis and elective admissions experience moderate to severe difficulties functioning at home, school and in the community
- Majority of each group have had community-based and hospital-based outpatient mental health services in the past

Conclusions (cont'd)

- Understanding the clinical needs of the population leads to the implementation of evidence-based approaches
  - Collaborative Problem Solving (Greene & Ablon, in press)
- Unit can respond to children's needs in an individualized way:
  - Two streams to address urgent vs. emergent needs
  - Focus on crisis stabilization vs. comprehensive assessment
- Despite shorter length of stay for crisis group, both groups are discharged appropriately and responsibility at a lower level of acuity

Questions / comments?

greenham@cheo.on.ca
bisnaire@cheo.on.ca