Purpose

This protocol formalizes the process of assessment and disposition of patients who present with a mental health crisis to the Emergency Department (ED) and whom are placed on a Form 1 by the ED Physician under the Ontario Mental Health Act (OMHA). Patients may present to the ED with EMS, OPP or unaccompanied. It provides direction to promote safe and ethical care for patients presenting with a serious mental health issue and who are a risk to self or others.

Scope

The policy pertains to all staff members and physicians at Muskoka Algonquin Healthcare (MAHC).

Policy Statement

All patients who are placed on a Form 1, or who present with an identified risk to self or others shall follow the protocols described herein.

Definitions

Clinical Risk Assessment: The process of assessing the likelihood of an event happening with potentially harmful or beneficial outcomes for self and/or others. Possible behaviours include suicide, self-harm, aggression, violence and neglect; with an additional range of other positive or negative service user experiences (Morgan, 2000). Assessing risk is a process of action and evaluation. Developing and documenting a plan of care including interventions that reflect the level of risk must be part of the nurse's overall assessment. Professional judgement is integral to decision making and includes organizing data, giving them meaning and coming to a conclusion.

Health Education: A participatory educational approach aimed at preventing disease, promoting positive health, and incorporating the physical, mental, and social aspects of learning needs (Bastable, 2003).

Observe: The process of visually ascertaining the whereabouts and condition of a patient, assessing mental status and behaviour, and intervening appropriately when necessary.

Safe Environment: Maintaining a general awareness to provide a place free of physical hazards to personal safety.

Vital Signs include: temperature, blood pressure, pulse, respirations.

Procedure

1. The ED RN will assess the patient to determine the appropriate level of acuity based on the most current Canadian Triage and Acuity Scale (CTAS) and will determine the safest room within the department for the patient to await assessment by the ED physician (see Creating an Alternate Safe Room policy).

2. The ED physician will assess the patient in accordance with their presenting level of acuity (see CTAS guidelines) and will determine, in collaboration with nursing staff, the level of observation and/or restraint required to ensure patient, staff and visitor safety. If a Seclusion

Room Order is indicated, the patient's door is to be locked, and the nurse is responsible for visual checks every 15 minutes, either direct or through camera, to ensure patients safety. If the nurse determines that the patient is a flight risk and/or at imminent risk of harm to self or others and there is a delay in the physician writing an order for room seclusion, the nurse can proceed with the room seclusion to ensure patient and public's safety until the physician writes the order. Documentation of initial assessment, which includes description of patient, i.e., height, eye colour, hair colour and clothing along with visual checks will be completed. The Form 1 Observation Flow sheet is to be utilized by nursing staff.

3. The ED nurse will call the Child and Youth Crisis Line at 1-844-287-9072, for all requests to conduct a risk assessment on an child and youth 18 years of age and younger. A network navigator will discuss the options available for this assessment to be done either in person, on the phone, or next a.m. When available, the crisis worker will attend the ED to conduct a Risk Assessment and determine disposition in collaboration with the ED Staff and Physician.

4. The ED nurse will call Muskoka- Parry Sound- Canadian Mental Health Association (MPSCMHA) on the Crisis Line at 800-461-5424, for all requests to conduct a risk assessment on adults 16 years of age or older to determine disposition in collaboration with the ED staff and physician. Crisis workers are available for on-site assessments at both MAHC EDs, Monday to Friday 0800- 2300 hours and from 1000 to 1800 hours on weekends and statutory holidays. Crisis workers will call the ED's and leave their contact mobile for hours when on site. For all other hours, crisis workers are on call and staff will use the 1-800 crisis line above.

5. For patients 16-18 years of age, the ED nurse in collaboration with the ED Physician is to determine which service may best meet the patient's needs.

**Note: If the ED Physician determines the patient is at a high/imminent risk to harm self or others and have placed the patient on a Form 1 without a crisis assessment, the ED Physician may contact the schedule 1 facility to facilitate a "Doc-to-Doc" referral to expedite the transfer of the patient to a Schedule 1 facility.

6. The Physician will inform the patient that they have deemed them a risk to self or others and have placed them on a Form 1 to be transferred to a Schedule 1 facility for psychiatric assessment. Depending on the acuity and presentation of the patient, the Physician may require other staff/police/security to be present during this conversation for their safety.

7. If the patient leaves the ED during the assessment or once placed on a Form 1, OPP is to be notified immediately of patient's flight and hence risk to self or the public. Staff is not to chase the patient.

8. If police have brought the patient to the ED under the mental health act (MHA), the ED physician, in collaboration with the nursing team, will determine if the Transfer of Care (TOC) from police to the hospital can safely occur (see TOC guideline). If the patient poses a risk to public safety, measures will be taken to ensure the safety of staff, patients and visitors

before TOC from police to hospital occurs. These measures include but are not limited to: placing patient in a locked, safe, seclusion room; providing chemical and/or physical restraints (see "MAHC Least Restraint Policy", "Enhanced Observation Flowsheet" and "Levels of Observation Care Guidelines"); obtaining security staff; obtaining paid duty police officers.

9. All patients will have their vital signs completed on admission, and as often as clinically indicated thereafter.

10. Any significant changes/concerns regarding a patient's mental or physical health status are to be reported to the MRP (or delegate) immediately, and followed up as appropriate.

11. When the patient is "Formed" under the Mental Health Act (placed on a Form 1), the patient is to change into a hospital gown. A disposable gown may be indicated if the risk of self-harm is high. The patient is to have no personal belongings and these must be removed with 2 people present (e.g.: two nurses; a nurse and a security guard; a nurse and OPP etc.) All personal belongings, medication and clothing including shoes, are to be secured within the emergency department (i.e.: at the nurse's station or in a locker at the HDMH site). Ensure the bag(s) are well labelled and indicate in the progress note what valuables were sent home or placed in the safe. All belongings, including medication are to be secured away from the patient until they are transferred. All personal belongings must be clearly documented on the chart. Visitors must leave all belongings outside the patient room. **DO NOT** check contents of pockets and backpacks as they do not need to be searched.

12. Once a patient is medically cleared all documentation will be faxed to Orillia Soldiers Memorial Hospital (OSMH). All efforts are to be made to transfer the patient to a Schedule One facility to receive timely and appropriate treatment by a Psychiatric Team. For youth, ED nursing staff or designate are to contact the list of Child and Adolescent Inpatient Units (Appendix B) requesting transfer of the patient to a Schedule One facility.

13. If the risk of self-harm is high, patients should be in a disposable gown under constant observation by a security guard, RPN, RN or OPP. Actively suicidal patients require frequent monitoring and assessment both visually and verbally. The patient's arms should be above the blanket or visualized frequently to ensure the patient is not self-harming under the blanket. The room should be carefully checked after each person has entered and left the room (e.g.: lab staff, visitors etc.) to ensure no items such as pens, medical tape, scissors etc. have been left behind. Whoever is watching the patient should have limited or no distractions as it is these distractions that the patient will see as an opportune time to attempt self-harm. Patients quickly learn set routines and will find opportune times to attempt to self-harm.

14. Patient must be escorted to the bathroom and not left unattended. Nursing staff or security/OPP is to remain outside the bathroom door constantly talking to the patient and expect a verbal response back from the patient. When/if there is no response; whoever has escorted the patient must react and enter the bathroom. Actively suicidal patients forgo their

rights to complete privacy as safety is the priority. If the patient refuses staff to accompany, offer a bed pan, commode or urinal.

15. If the patient has utensils (plastic) at meals ensure these are returned to the tray.

16. Patients requiring restraint (chemical or physical) should be cared for by an RN. Please refer to Least Restraint Policy.

17. Patients on a Form 1 do not have privileges. They cannot go outside for a cigarette accompanied by staff. Offer patients nicotine replacement therapy.

18. If the patient is having behavior issues, collaborate with the physician, family, crisis worker etc. and create a care plan and assure all staff are following the plan of care. Security and others whom will be interacting with the patient must be made aware of the plan to ensure a consistent approach by all.

19. Whenever possible, try to have the patient away from high traffic areas or congested areas in the department. Patients may become more agitated or anxious if the environment is over stimulating.

20. Patient rooms should be searched at the beginning of every shift and PRN for any unwanted articles.

21. Documentation of ongoing assessments, including vital signs as clinically indicated, as well as visual checks as indicated by observation level, is to be conducted throughout the shift. Enhanced Observation Flowsheet is to be utilized by nursing staff (Appendix A).

22. The 72 Hour assessment and observation period of the Form 1 does not take effect until the patient enters a Schedule One facility.

23. If the nursing staff or designate is unable to secure a bed in a Schedule 1 facility, the patient is to remain in the ED until a bed is secured.

24. When a patient is accepted for transfer to an Adult or a Child and Adolescent Mental Health Unit:

a) Staff is to ensure that all appropriate paperwork and the **original Form 1** accompany the patient.
b) Patient belongings/valuables will be transferred with the patient and documented in the chart.
c) For youth, Simcoe Muskoka Connexions staff are to be notified.

Cross Reference

Current CTAS Guidelines
MAHC Least Restraint Policy
MAHC Levels of Observation Care Guidelines

MAHC Transfer of Care Policy

Notes

Appendices

A. MAHC Enhanced Observation Flowsheet
B. List of Child and Adolescent Inpatient Units
C. Simcoe Muskoka Integrated Crisis System Risk Screening Report
D. NSM LHIN Schedule 1 Algorithm: Care Pathway from ED to Inpatient MH
E. NSM LHIN Schedule 1 Algorithm: Care Pathway from ED to Inpatient MH Child and Youth

Appendix A

Enhanced Observation Flowsheet

Date:_____ Time Started_____

Legend:

Actions
- **A -** Awake in room
- **C** - With crisis worker
- **D** - With Doctor
- **E-** On Escort
- **M** - Eating Meal
- **P** - Police in attendance
- **R** – In Restraints (2,4,6)
- **S** - Sleeping in room

Behavior
- **1** - Cooperative
- **2** - Uncooperative
- **3**- Agitated
- **4 -** Resting comfortably
- **5 -** Aggressive
- **6** - Combative

Patient Description: **Male** ☐ **Female** ☐
Eyes: Brown ☐ **Blue** ☐ **Green** ☐ **Other** ☐ _____
Glasses ☐
Hair: Brown ☐☐☐☐☐☐ **Black** ☐ **Blonde** ☐ **Red** ☐
Other ☐ _____ **Straight** ☐ ☐☐☐☐**Curly** ☐ **Long** ☐ **Short** ☐

Ht._____ Wt._____lbs./Kg

Distinguishing Features_____
Wearing: _____

	0001	0015	0030	0045	0100	0115	0130	0145	0200	0215	0230	0245
Patients Activity												
Observers Initials												
	0300	**0315**	**0330**	**0345**	**0400**	**0415**	**0430**	**0445**	**0500**	**0515**	**0530**	**0545**
Patients Activity												
Observers Initials												
	0600	**0615**	**0630**	**0645**	**0700**	**0715**	**0730**	**0745**	**0800**	**0815**	**0830**	**0845**
Patients Activity												
Observers Initials												
	0900	**0915**	**0930**	**0945**	**1000**	**1015**	**1030**	**1045**	**1100**	**1115**	**1130**	**1145**
Patients Activity												
Observers Initials												
	1200	**1215**	**1230**	**1245**	**1300**	**1315**	**1330**	**1345**	**1400**	**1415**	**1430**	**1445**
Patients Activity												
Observers Initials												
	1500	**1515**	**1530**	**1545**	**1600**	**1615**	**1630**	**1645**	**1700**	**1715**	**1730**	**1745**
Patients Activity												
Observers Initials												
	1800	**1815**	**1830**	**1845**	**1900**	**1915**	**1930**	**1945**	**2000**	**2015**	**2030**	**2245**
Patients Activity												
Observers Initials												
	2100	**2115**	**2130**	**2145**	**2200**	**2214**	**2230**	**2245**	**2300**	**2315**	**2330**	**2345**
Patients Activity												
Observers Initials												

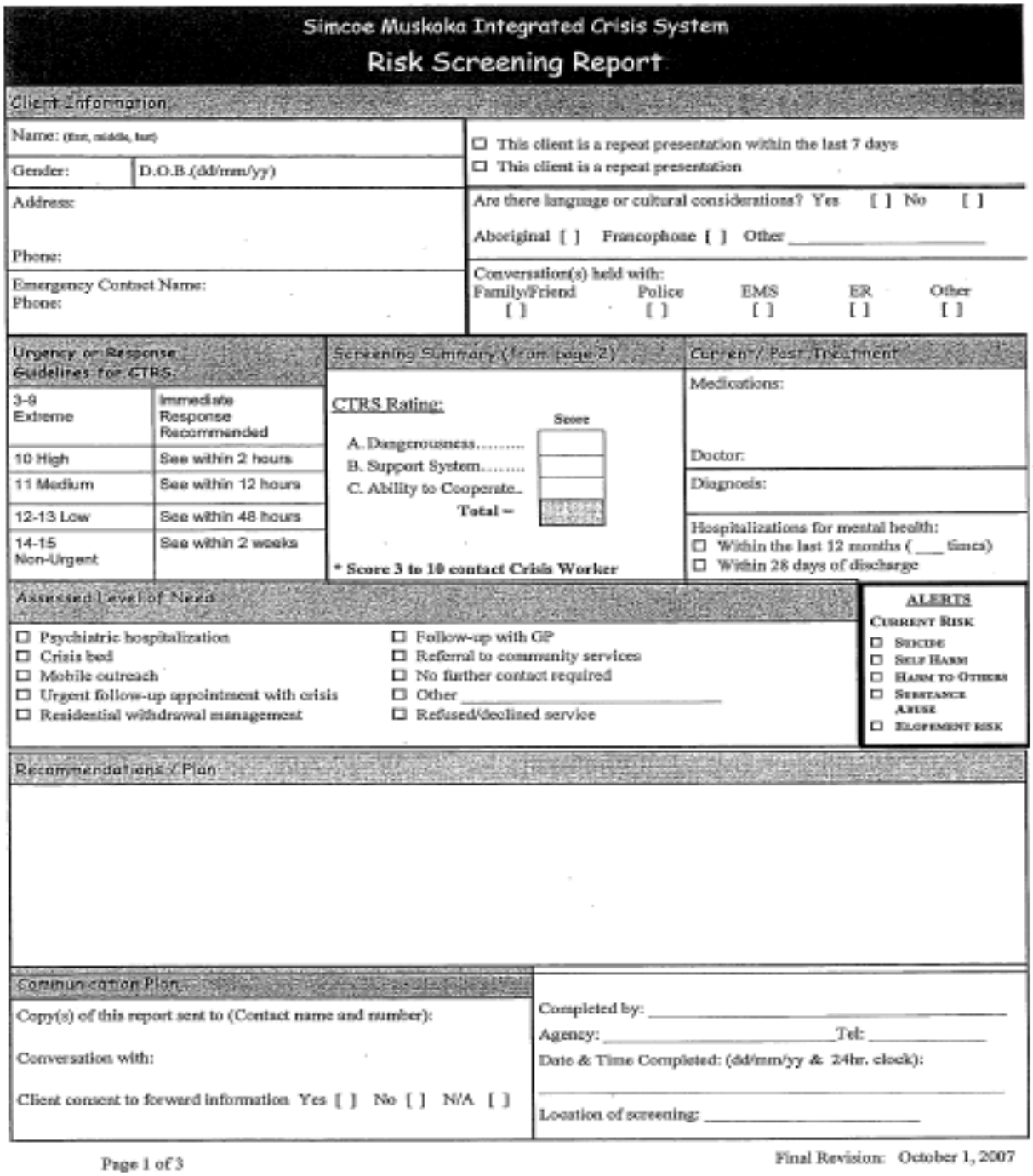
Appendix B

Child and Adolescent Inpatient Units

PSYCHIATRY UNIT	PHONE	EXT	FAX	BED Y/N	COMMENTS
RVH	705-728-9090	46031	705-728-9111		
NORTH BAY ASK FOR ON CALL PEDIATRICIAN	705-474-8600	4760	705-495-3683		
OSMH ASK FOR ON CALL PEDIATRICIAN	705-325-2201	6411	705-327-9172		
NEWMARKET-SOUTHLAKE	905-895-4521	2830	905-954-3882		
NORTH YORK GENERAL	416-756-6880		416-756-6689		
ST JOSEPH	416-530-6000	13826#			
SUNNYBROOK	416-480-6100	7532	416-480-6779		
YOUTHDALE	416-363-9990		416-363-7945		
OAKVILLE	905-815-5118		905-815-5136		
MCCMASTER	905-521-2100	72800	905-577-8499		
BRAMPTON CIVIC	416-494-2120	56455	905-494-6457		
TORONTO EAST UNDER 18	416-469-6580	3140	416-469-6855		

Call the first **3 in order**, and then call whichever facility has space according to "Critical Bed Board"

Appendix C



Simcoe Muskoka Integrated Crisis System

Risk Screening Report

Client Information

Name: (first, middle, last)

Gender: D.O.B.(dd/mm/yy)

Address:

Phone:

Emergency Contact Name:
Phone:

☐ This client is a repeat presentation within the last 7 days
☐ This client is a repeat presentation

Are there language or cultural considerations? Yes [ ] No [ ]

Aboriginal [ ] Francophone [ ] Other _____

Conversation(s) held with:
Family/Friend [ ] Police [ ] EMS [ ] ER [ ] Other [ ]

Urgency or Response Guidelines for CTRS:

3-9 Extreme	Immediate Response Recommended
10 High	See within 2 hours
11 Medium	See within 12 hours
12-13 Low	See within 48 hours
14-15 Non-Urgent	See within 2 weeks

Screening Summary (from page 2)

CTRS Rating:

	Score
A. Dangerousness.....	
B. Support System.....	
C. Ability to Cooperate..	
Total =	

* Score 3 to 10 contact Crisis Worker

Current/ Past Treatment

Medications:

Doctor:

Diagnosis:

Hospitalizations for mental health:
☐ Within the last 12 months (___ times)
☐ Within 28 days of discharge

Assessed Level of Need

☐ Psychiatric hospitalization
☐ Crisis bed
☐ Mobile outreach
☐ Urgent follow-up appointment with crisis
☐ Residential withdrawal management
☐ Follow-up with GP
☐ Referral to community services
☐ No further contact required
☐ Other _____
☐ Refused/declined service

ALERTS

CURRENT RISK
☐ SUICIDE
☐ SELF HARM
☐ HARM TO OTHERS
☐ SUBSTANCE ABUSE
☐ ELOPEMENT RISK

Recommendations / Plan

Communication Plan

Copy(s) of this report sent to (Contact name and number):

Conversation with:

Client consent to forward information Yes [ ] No [ ] N/A [ ]

Completed by: _____

Agency: _____ Tel: _____

Date & Time Completed: (dd/mm/yy & 24hr. clock):

_____

Location of screening: _____

Page 1 of 3

Final Revision: October 1, 2007

Simcoe Muskoka Integrated Crisis System **Risk Screening Report** Client Name:

Screening Section #1: Presenting Problem / Severity

Concern as voiced by client:

RELIABILITY OF CLIENT
☐ Good ☐ Fair ☐ Poor

CRISIS TRIAGE RATING SCALE

Circle the number with the description that most closely resembles the person's behaviour.

Rating A: DANGEROUSNESS (CHECK ONE)	**Score**
1. Expresses or hallucinates suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.	1
2. Expresses or hallucinates suicidal/homicidal ideas, without conviction. History of violent or impulsive behaviour but no current signs of this.	2
3. Expresses suicidal/homicidal ideas with ambivalence, or made only ineffectual gestures. Questionable impulse control.	3
4. Some suicidal/homicidal ideation or behaviour, or history of same, but clearly wishes to control behaviour.	4
5. No suicidal/homicidal ideation/behaviour. No history of violence or impulsive behaviour.	5
Rating B: SUPPORT SYSTEM (CHECK ONE)	**Score**
1. No family, friends or others. Agencies cannot provide immediate support needed.	1
2. Some support can be mobilized but its effectiveness will be limited.	2
3. Support systems potentially available but significant difficulties exist in mobilizing it.	3
4. Interested family/friends, or others but some question exists of ability or willingness to provide support needed.	4
5. Interested family, friends, or others able and willing to provide support needed.	5
RATING C: ABILITY TO COOPERATE (CHECK ONE)	**Score**
1. Unable to cooperate or actively refuses.	1
2. Shows little interest in or comprehension of efforts made on his behalf.	2
3. Passively accepts intervention strategies.	3
4. Wants help but is ambivalent or motivation is not strong.	4
5. Actively seeks treatment, willing to cooperate.	5
Total CTRS Score	

Clinical Observations of Presenting Risk by Assessor:

Page 2 of 3 Final Revision: October 1, 2007

Simcoe Muskoka Integrated Crisis System **Risk Screening Report** Client Name:

Screening Section # 2 – Alcohol/Substance Abuse:

Have you been using alcohol or drugs? Yes [ ] No [ ] Undetermined [ ]

Current

- ☐ None or specify
- ☐ Alcohol - Beer [ ] Wine [ ] Spirits [ ]
- ☐ Street Drugs - Crack/Cocaine [ ] Amphetamines (eg. speed, crystal meth, uppers) [ ] Cannabis (eg. marijuana, pot, weed, hash) [ ] Hallucinogenics (eg. Ecstasy, LSD, PCP) [ ] Narcotics (eg. heroin, opium) [ ]
- ☐ Inhalants (eg. glue, gas, solvents)
- ☐ Prescription Medication - Benzodiazepines (eg. downers, diazepam) [ ] Barbiturates (eg. seconal, valium, phenobarbital) Opiods (eg. codeine, morphine)
- ☐ Over the counter drugs

Other _____

How do you use substances (eg. orally, I.V., smoked, snorted)?

_____

How much have you had (eg. 26 oz., 3 Grams)? _____

Time since last use:
- 8 to 30 days ago [ ]
- 4 to 7 days ago [ ]
- 2 to 3 days ago [ ]
- In the last 24 hrs. [ ]

How often have you been using alcohol or drugs (eg. daily, weekly, hourly)? _____

How long have you been using alcohol or drugs (eg. 10 days, 5 years)? _____

Do you have a past history of withdrawal seizures? _____

Withdrawal Symptoms

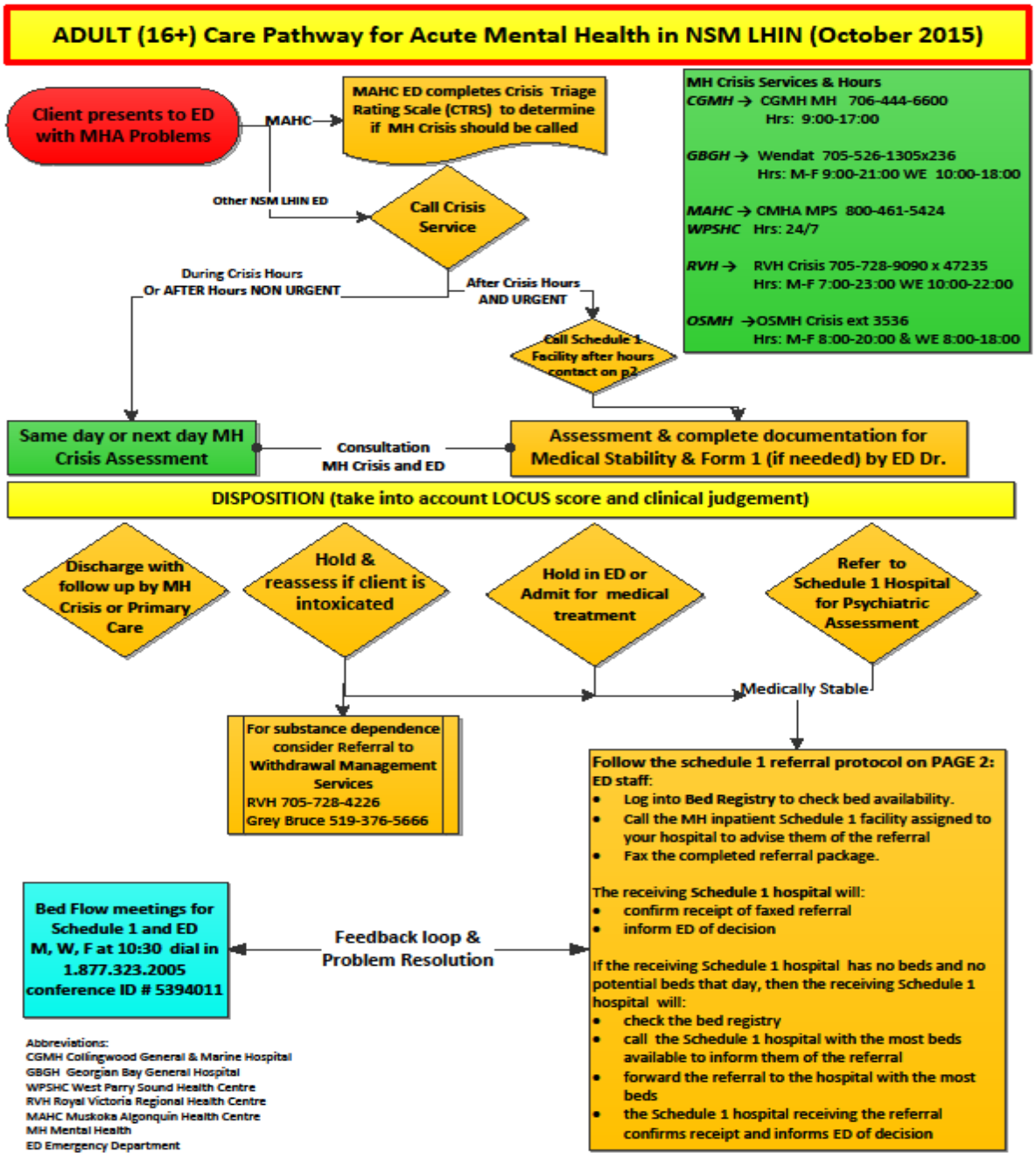
Severity of signs and symptoms possibly indicative of withdrawal from alcohol, drugs, or medication.

Check [√] the level that most closely reflects the person's current symptoms.

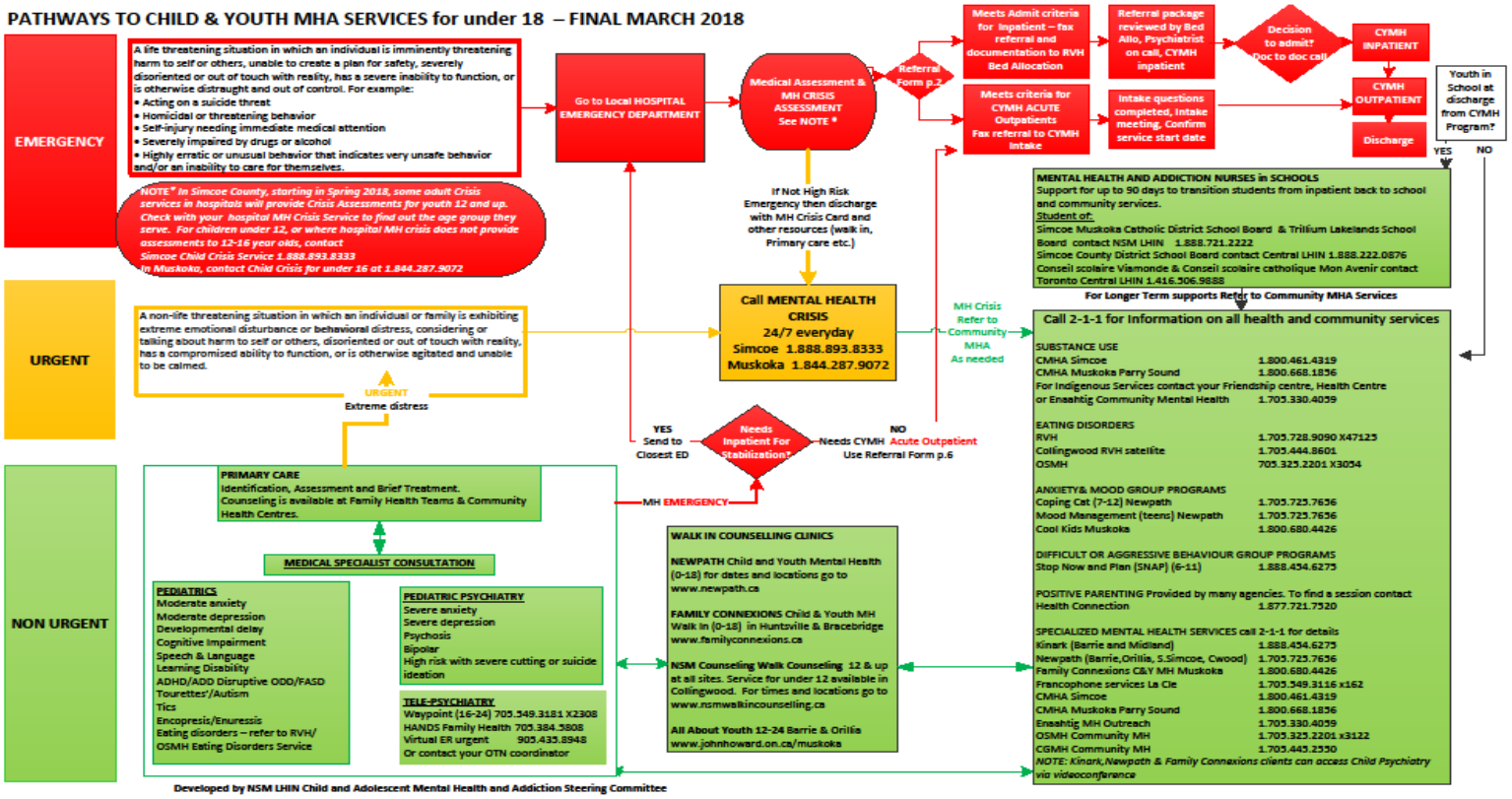
- ☐ None present
- ☐ Mild—Symptoms typical of early stages of withdrawal (e.g. agitation, "jitters", cravings, upset stomach, anxiety, hostility, vivid dreaming)
- ☐ Moderate—increased severity of early indicators, weakness, sweating, hot flashes, fainting, muscle twitching
- ☐ Severe—Symptoms typical of advanced stages of withdrawal (e.g. exhaustion, seizures, tremors, tachycardia, disorientation, hyperventilation)

Was Withdrawal Management Services contacted (tel: 1.866.850.7034)? Yes [ ] No [ ]

Appendix D


ADULT (16+) Care Pathway for Acute Mental Health in NSM LHIN (October 2015)
Client presents to ED with MHA Problems
MAHC
MAHC ED completes Crisis Triage Rating Scale (CTRS) to determine if MH Crisis should be called
Other NSM LHIN ED
Call Crisis Service
During Crisis Hours Or AFTER Hours NON URGENT
After Crisis Hours AND URGENT
Call Schedule 1 Facility after hours contact on p2
MH Crisis Services & Hours
CGMH → CGMH MH 706-444-6600 Hrs: 9:00-17:00
GBGH → Wendat 705-526-1305x236 Hrs: M-F 9:00-21:00 WE 10:00-18:00
MAHC → CMHA MPS 800-461-5424
WPSHC Hrs: 24/7
RVH → RVH Crisis 705-728-9090 x 47235 Hrs: M-F 7:00-23:00 WE 10:00-22:00
OSMH →OSMH Crisis ext 3536 Hrs: M-F 8:00-20:00 & WE 8:00-18:00
Same day or next day MH Crisis Assessment
Consultation MH Crisis and ED
Assessment & complete documentation for Medical Stability & Form 1 (if needed) by ED Dr.
DISPOSITION (take into account LOCUS score and clinical judgement)
Discharge with follow up by MH Crisis or Primary Care
Hold & reassess if client is intoxicated
Hold in ED or Admit for medical treatment
Refer to Schedule 1 Hospital for Psychiatric Assessment
Medically Stable
For substance dependence consider Referral to Withdrawal Management Services
RVH 705-728-4226
Grey Bruce 519-376-5666
Follow the schedule 1 referral protocol on PAGE 2:
ED staff:
Log into Bed Registry to check bed availability.
Call the MH inpatient Schedule 1 facility assigned to your hospital to advise them of the referral
Fax the completed referral package.
The receiving Schedule 1 hospital will:
confirm receipt of faxed referral
inform ED of decision
If the receiving Schedule 1 hospital has no beds and no potential beds that day, then the receiving Schedule 1 hospital will:
check the bed registry
call the Schedule 1 hospital with the most beds available to inform them of the referral
forward the referral to the hospital with the most beds
the Schedule 1 hospital receiving the referral confirms receipt and informs ED of decision
Bed Flow meetings for Schedule 1 and ED M, W, F at 10:30 dial in 1.877.323.2005 conference ID # 5394011
Feedback loop & Problem Resolution
Abbreviations:
CGMH Collingwood General & Marine Hospital
GBGH Georgian Bay General Hospital
WPSHC West Parry Sound Health Centre
RVH Royal Victoria Regional Health Centre
MAHC Muskoka Algonquin Health Centre
MH Mental Health
ED Emergency Department

Appendix E


PATHWAYS TO CHILD & YOUTH MHA SERVICES for under 18 – FINAL MARCH 2018
EMERGENCY
A life threatening situation in which an individual is imminently threatening harm to self or others, unable to create a plan for safety, severely disoriented or out of touch with reality, has a severe inability to function, or is otherwise distraught and out of control. For example:
• Acting on a suicide threat
• Homicidal or threatening behavior
• Self-injury needing immediate medical attention
• Severely impaired by drugs or alcohol
• Highly erratic or unusual behavior that indicates very unsafe behavior and/or an inability to care for themselves.
NOTE* In Simcoe County, starting in Spring 2018, some adult Crisis services in hospitals will provide Crisis Assessments for youth 12 and up. Check with your hospital MH Crisis Service to find out the age group they serve. For children under 12, or where hospital MH crisis does not provide assessments to 12-16 year olds, contact Simcoe Child Crisis Service 1.888.893.8333 In Muskoka, contact Child Crisis for under 16 at 1.844.287.9072
Go to Local HOSPITAL EMERGENCY DEPARTMENT
Medical Assessment & MH CRISIS ASSESSMENT See NOTE *
Referral Form p.2
Meets Admit criteria for Inpatient – fax referral and documentation to RVH Bed Allocation
Referral package reviewed by Bed Allo, Psychiatrist on call, CYMH inpatient
Decision to admit? Doc to doc call
CYMH INPATIENT
Meets criteria for CYMH ACUTE Outpatients Fax referral to CYMH Intake
Intake questions completed, intake meeting, Confirm service start date
CYMH OUTPATIENT
Discharge
Youth in School at discharge from CYMH Program?
YES
NO
If Not High Risk Emergency then discharge with MH Crisis Card and other resources (walk in, Primary care etc.)
MENTAL HEALTH AND ADDICTION NURSES in SCHOOLS
Support for up to 90 days to transition students from inpatient back to school and community services.
Student of:
Simcoe Muskoka Catholic District School Board & Trillium Lakelands School Board contact NSM LHIN 1.888.721.2222
Simcoe County District School Board contact Central LHIN 1.888.222.0876
Conseil scolaire Viamonde & Conseil scolaire catholique Mon Avenir contact Toronto Central LHIN 1.416.506.9888
For Longer Term supports Refer to Community MHA Services
URGENT
A non-life threatening situation in which an individual or family is exhibiting extreme emotional disturbance or behavioral distress, considering or talking about harm to self or others, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed.
URGENT
Extreme distress
Call MENTAL HEALTH CRISIS 24/7 everyday Simcoe 1.888.893.8333 Muskoka 1.844.287.9072
MH Crisis Refer to Community MHA As needed
Call 2-1-1 for Information on all health and community services
SUBSTANCE USE
CMHA Simcoe 1.800.461.4319
CMHA Muskoka Parry Sound 1.800.668.1856
For Indigenous Services contact your Friendship centre, Health Centre or Ensahtig Community Mental Health 1.705.330.4059
EATING DISORDERS
RVH 1.705.728.9090 X47125
Collingwood RVH satellite 1.705.444.8601
OSMH 705.325.2201 X3054
ANXIETY& MOOD GROUP PROGRAMS
Coping Cat (7-12) Newpath 1.705.725.7636
Mood Management (teens) Newpath 1.705.725.7636
Cool Kids Muskoka 1.800.680.4426
DIFFICULT OR AGGRESSIVE BEHAVIOUR GROUP PROGRAMS
Stop Now and Plan (SNAP) (6-11) 1.888.454.6275
POSITIVE PARENTING Provided by many agencies. To find a session contact Health Connection 1.877.721.7520
SPECIALIZED MENTAL HEALTH SERVICES call 2-1-1 for details
Kinark (Barrie and Midland) 1.888.454.6275
Newpath (Barrie,Orillia, S.Simcoe, Cwood) 1.705.725.7636
Family Connexions C&Y MH Muskoka 1.800.680.4426
Francophone services La Cle 1.705.549.3116 x162
CMHA Simcoe 1.800.461.4319
CMHA Muskoka Parry Sound 1.800.668.1856
Ensahtig MH Outreach 1.705.330.4059
OSMH Community MH 1.705.325.2201 x3122
CGMH Community MH 1.705.445.2550
NOTE: Kinark,Newpath & Family Connexions clients can access Child Psychiatry via videoconference
YES Send to Closest ED
Needs Inpatient For Stabilization?
NO Needs CYMH Acute Outpatient Use Referral Form p.6
MH EMERGENCY
NON URGENT
PRIMARY CARE
Identification, Assessment and Brief Treatment. Counseling is available at Family Health Teams & Community Health Centres.
MEDICAL SPECIALIST CONSULTATION
PEDIATRICS
Moderate anxiety
Moderate depression
Developmental delay
Cognitive Impairment
Speech & Language
Learning Disability
ADHD/ADD Disruptive ODD/FASD
Tourettes'/Autism
Tics
Encopresis/Enuresis
Eating disorders – refer to RVH/ OSMH Eating Disorders Service
PEDIATRIC PSYCHIATRY
Severe anxiety
Severe depression
Psychosis
Bipolar
High risk with severe cutting or suicide ideation
TELE-PSYCHIATRY
Waypoint (16-24) 705.549.3181 X2308
HANDS Family Health 705.384.5808
Virtual ER urgent 905.435.8948
Or contact your OTN coordinator
WALK IN COUNSELLING CLINICS
NEWPATH Child and Youth Mental Health (0-18) for dates and locations go to www.newpath.ca
FAMILY CONNEXIONS Child & Youth MH Walk in (0-18) in Huntsville & Bracebridge www.familyconnexions.ca
NSM Counseling Walk Counseling 12 & up at all sites. Service for under 12 available in Collingwood. For times and locations go to www.nsmwalkincounselling.ca
All About Youth 12-24 Barrie & Orillia www.johnhoward.on.ca/muskoka
Developed by NSM LHIN Child and Adolescent Mental Health and Addiction Steering Committee