Improving the patient journey for children presenting to ED with behavioural disturbance and requiring mental health assistance

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Overview of presentation

- Introduction and background
- Governance for admitting children with behavioural disturbance/mental health concerns
- Case scenario
- Challenges and questions

The Patient Journey Challenge in NSW

- Children aged 12 years and under present to hospitals with behavioural disturbance or mental health problems as a result of a complex array of factors.
- These presentations are increasing in prevalence and complexity, and there is an earlier age of onset.
- Presentations to hospital tend to occur in the context of a crisis, with the focus of care on containment, safety and crisis resolution.
- Ongoing therapy and support occurs in the community and involves the child's family, and where relevant, school and other supports.

Admission trends in NSW

Hazel, P., Sprague, T. & Sharpe, J. (2016). Psychiatric hospital treatment of children and adolescents in NSW Australia: 12 year trends. *BJPsych Open, 1-5.* DOI: 10.1192/bjpo.bp.115.000794

258% increase in separations

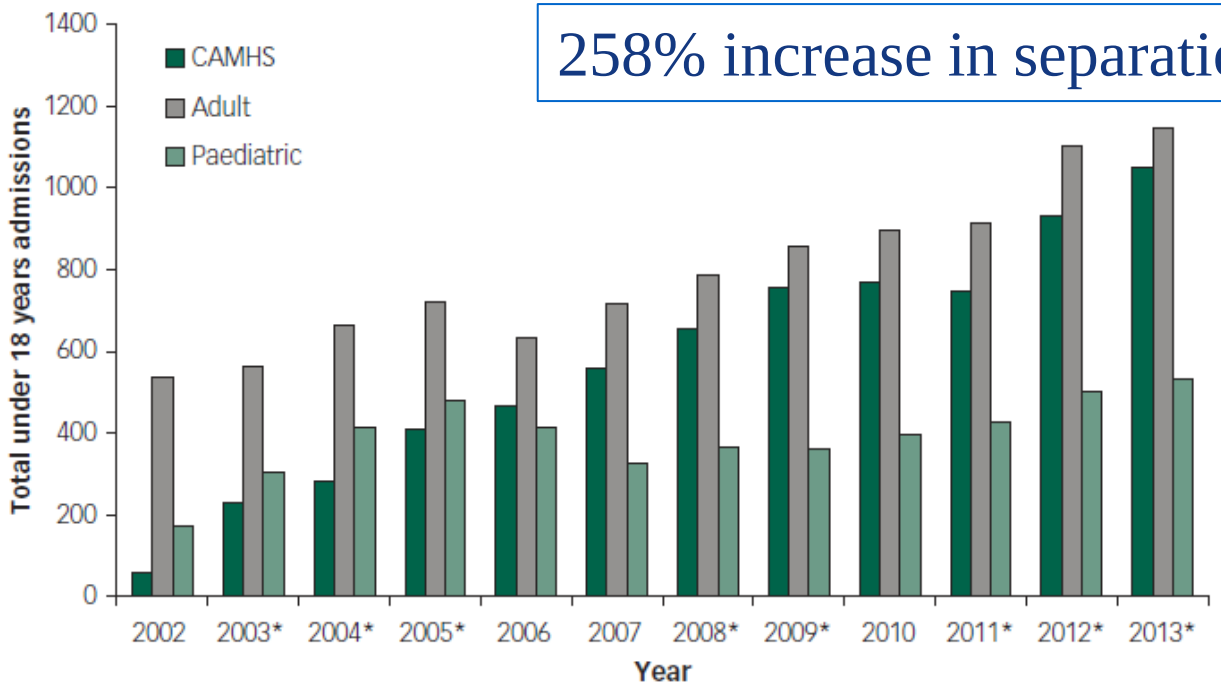

Fig. 1 Total admissions (n=22 615) for under 18-year-olds to in-patient CAMHS, adult acute mental health and paediatric medical units for mental health reasons in NSW from 2002 to 2013. Data are comprised of 16 local health districts (LHDs). Asterisks indicate the year in which a new CAMHS unit opened.

Admission trends in NSW: Summary

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- 258% increase in total admissions, greatly outstripping population growth
- The proportion of admissions to adult mental health units decreased significantly and to paediatric units decreased slightly
- Net number of admissions to adult and paediatric units increased

Governance for children's admissions

- **PD 2011_016 Children and Adolescents with Mental Health Problems Requiring Inpatient Care.**
  - Treats under 12 years and 12 -17 years differently
- Admission to a **paediatric ward** with access to **mental health consultation-liaison support** to the treating paediatric team is indicated for **most children <12 years**.
- A small number with more severe and complex problems and high needs will require more specialised inpatient mental health care than that available on a paediatric ward.

Governance for children's admissions

- Key principles of PD 2011_016 Children and Adolescents with Mental Health Problems Requiring Inpatient Care
- Inpatient services, if required, should be selected based on:
  - **Least restrictive alternative, and must consider the child's safety and that of others**
  - **Closest available to home and usual supports wherever possible, especially for younger children and Aboriginal families**
  - **Most developmentally and clinically appropriate given available resources**

Governance for children's admissions

- **Children and Young Persons' Care and Protection Act (1998)**
  - Minimum age of consent: 16 years
- Children may be vulnerable to sexual assault by others and/or may engage in sexually risky behaviour within inpatient mental health units
  - **PD2013_038 Sexual safety – Responsibilities and minimum requirements for mental health services** and accompanying guidelines govern mental health service requirements for protecting the sexual safety of all patients, and recognise the particular vulnerability of children
- Children and adolescents admitted to a mental health facility have the **right to "be separated from adult mental health patients and provided with accommodation and programs appropriate to their age and development**" (MHCC NSW 2012 http://mhrm.mhcc.org.au/chapter-8/8e.aspx).

Case scenario

- Two presentations of Lauren (pseudonym) to Emergency Department
  - Age 9 in July 2015
  - Age 11 in November 2016

Background

- Youngest of three female children; now 11 years of age
- Father and mother separated with history of domestic violence
  - Father (50 y/o) has ongoing mental illness with suicidal ideation and multiple admissions; also has diabetes (treated with insulin) and other health conditions
  - Mother (50 y/o) also has mental illness with admission in last 12 months
- Sisters:
  - 14 year old sister who is also active client of CYMHS
  - 17 year old sister receiving private counselling

Background

- At time of first referral to CYMHS June 2015:
  - Disengaged from school.
  - Diagnosis of PTSD after witnessing attempted murder of a neighbour. Current symptoms include panic attacks and sleeplessness.
  - Wanting to sleep with father due to separation anxiety.
  - Father had been recently hospitalised for suicidality.
  - High sibling conflict, parental mental illness, parental separation conflict.

Background

- ROSH reports:
  - Children sleeping in beds that contained dog faeces
  - Father reported that paternal grandmother's boyfriend had allowed her to view sexually explicit images on his computer (age 5)
  - Reports of children witnessing domestic violence and attempted murder of a neighbour
  - Father's non-compliance with medication repeated suicidal ideation and mental health admissions
  - Not attending school
  - Significant family financial stress

Background

- Subsequent information:
  - Lauren has been sexually assaulted by the boyfriend of her mother's niece

Admission 1: July 2015

- Presents at ED brought in by mother after threatening to kill her sister with a knife while staying at her father's house. Reports she sends texts regularly to her parents that she will kill herself.

- **Actions**
  - Discussed with PECC and paediatrics – both declined to see Lauren
  - Consulted with psychiatry registrar at specialist CAMHS unit

- **Outcome**

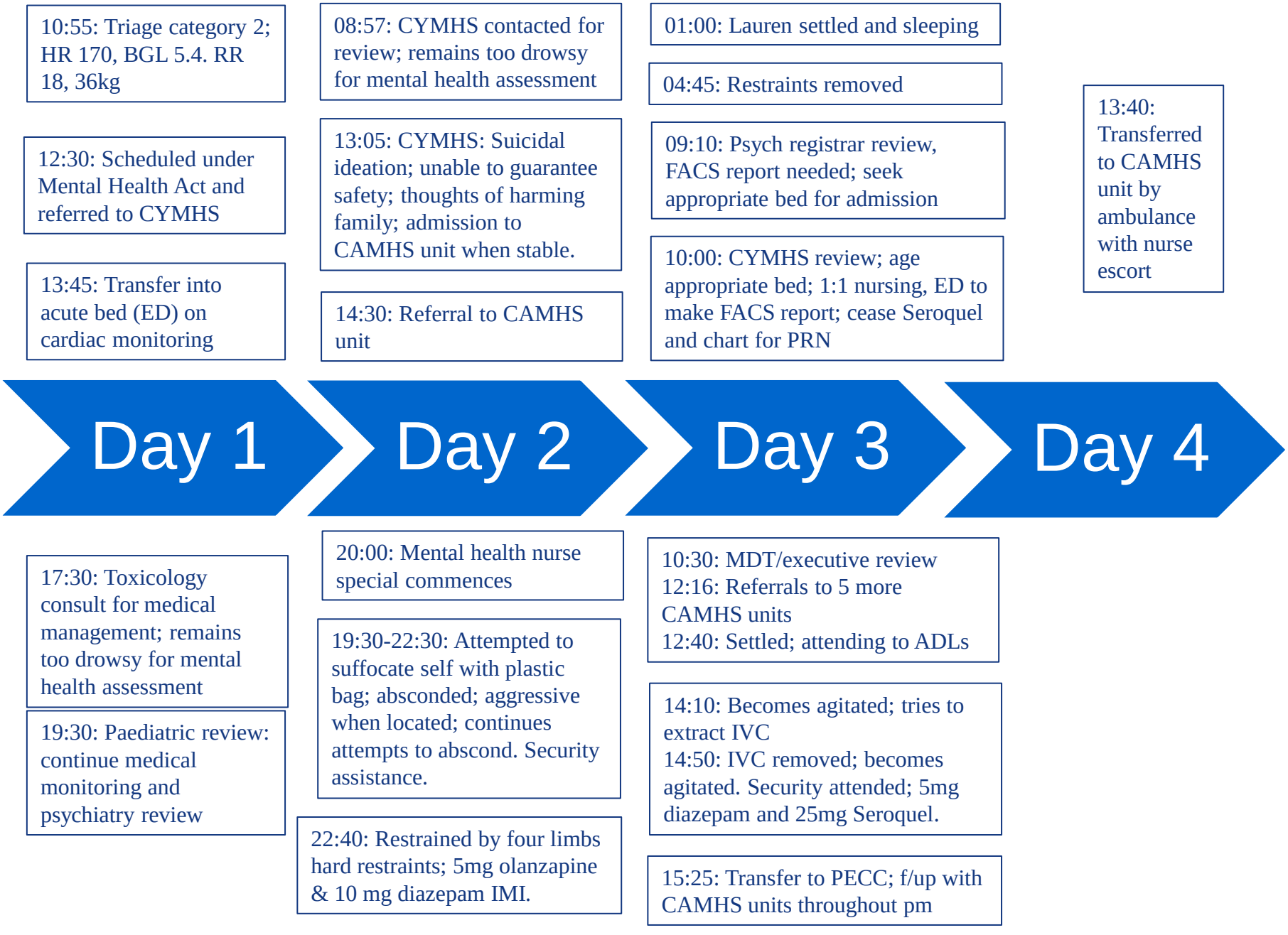
  Notwithstanding this, Lauren has been seeing CYMHS since this time, as parents decided to cease private counselling. This has included: individual sessions, parent sessions, family sessions with siblings, service planning meetings with school counsellor, school learning support and NGO

Questions arising from this admission

- PECC and paediatrics declined to see Lauren.
  - With what impact?
  - What might have been done differently and with what goal?
- Sent home at 11.30pm (9 years old), with a referral for immediate follow up but given the time of night it is unlikely that an appointment was in place.
  - What would be in the best interests of the child in this situation?

November 2016

- 4 suicide attempts within one month
- 2 admissions to specialist CAMHS unit
- 4th suicide attempt:
  - Intentional polypharmacy overdose of father's prescription medication from Webster pack including insulin (Quetiapine 1.2g; Simvastatin 80mg; Perindopril 5mg; Pariet 40mg; Mirtazapine 120mg; Epilim 3g; Efexor XR 600mg; Aspirin 200mg; Novo mix 30 up to 50 units [via subcutaneous injection])
  - Father in attendance.


10:55: Triage category 2; HR 170, BGL 5.4. RR 18, 36kg
12:30: Scheduled under Mental Health Act and referred to CYMHS
13:45: Transfer into acute bed (ED) on cardiac monitoring
08:57: CYMHS contacted for review; remains too drowsy for mental health assessment
13:05: CYMHS: Suicidal ideation; unable to guarantee safety; thoughts of harming family; admission to CAMHS unit when stable.
14:30: Referral to CAMHS unit
01:00: Lauren settled and sleeping
04:45: Restraints removed
09:10: Psych registrar review, FACS report needed; seek appropriate bed for admission
10:00: CYMHS review; age appropriate bed; 1:1 nursing, ED to make FACS report; cease Seroquel and chart for PRN
13:40: Transferred to CAMHS unit by ambulance with nurse escort
Day 1
Day 2
Day 3
Day 4
17:30: Toxicology consult for medical management; remains too drowsy for mental health assessment
19:30: Paediatric review: continue medical monitoring and psychiatry review
20:00: Mental health nurse special commences
19:30-22:30: Attempted to suffocate self with plastic bag; absconded; aggressive when located; continues attempts to abscond. Security assistance.
22:40: Restrained by four limbs hard restraints; 5mg olanzapine & 10 mg diazepam IMI.
10:30: MDT/executive review
12:16: Referrals to 5 more CAMHS units
12:40: Settled; attending to ADLs
14:10: Becomes agitated; tries to extract IVC
14:50: IVC removed; becomes agitated. Security attended; 5mg diazepam and 25mg Seroquel.
15:25: Transfer to PECC; f/up with CAMHS units throughout pm

Points of note

- >50 hours in ED before transfer to PECC
- Restrained by 4 limbs – background of sexual assault
  - Consider PD2013_038 Sexual safety – Responsibilities and minimum requirements for mental health services
- Impact of ED environment on children, especially extended stays
- Needed to close PECC to provide a safe environment for admission
- Issues with access to CAMHS units for crisis that cannot be managed locally

An update on Lauren

- Lauren was admitted to the specialist CAMHS unit for 4 days
- CYMHS have continued to work intensively with Lauren.
- The family are attending family therapy sessions at CYMHS. Parents are being guided in using co-parenting strategies.
- Commencing high school has been challenging, but with regular attendance so far in 2017.
- There have been no hospital admissions since November.

Challenges

- Difficulty accessing specialist CAMHS beds
- Community based CAMHS service needing to support inpatient services: competing priorities
  - This is the same service that is providing intensive community based therapy and support which have contributed to relative stability for Lauren
- Physical safety of ED and paediatric environments
- Admitting rights for psychiatry
- Psychiatrist and paediatrician skill sets
  - Paediatricians argue that they do not have the skill set for managing behavioural disturbance of this nature, while adult psychiatrists argue that they do not have the skill set to manage children
- Ability of EDs to manage behaviour

Questions

- Considering both of these presentations:
  - What would have been best for Lauren?
  - What is the purpose of admission for Lauren? How could this have been achieved?
  - Bearing in mind the competing tensions, what could have been done differently?
  - What to do while waiting for CAMHS units to respond to referrals? Especially for LHDs that do not have a CAMHS unit.
    - How do we improve the skill set and confidence of staff?
  - How do we work towards transfer of care to community while simultaneously working toward transfer to a specialist CAMHS unit?

In Conclusion:

"When you have exhausted all possibilities, remember this, you haven't ."

Thomas Edison