Panel Discussion

Complex Clinical Needs including Mental Health, Intoxication and/or Organic Illness with associated challenging behaviours.

Facilitator – Carrie Schulman

Why this topic?

- 2012 PECC Review
- WOHP Site Visits- Clinician Expressed Need
- Patients present with multiple complex comorbidities requiring collaborative models of care
- Patients have poor engagement with services and poorer health outcomes
- Patients re-present frequently, spend longer in ED and utilise multiple resources incl. hospital, ambulance & police
- High risk of harm to self or others in an ED environment

PECC Review

Recommendation 14:

That the hospital executive in conjunction with ED, mental health and drug & alcohol staff, develop agreed systems and processes to manage the care of patients who are intoxicated, overdosed or with challenging behaviours who present with a mental health issue and to determine the most appropriate clinical pathways for these patients. This may include, for example, consideration of a short-term medical admission for intoxicants where these patients can be assessed and cleared by ward based teams.

Panel members

- Dr Scott Clark , A' Chief Psychiatrist MHDAO, Clinical Director WNSWLHD
- Dr Betty Chan, ED Staff Specialist and Toxicologist, SESLHD
- Dr Allan Forrester, Emergency Department Network Director, MNCLHD
- Dr John Dobrohotoff, Clinical Director Specialist Mental Health Older Personas Services (SMHOPS), CCLHD
- Dr Jackie Huber, Senior Psychiatry Registrar, SVHN
- Dr Adrian Dunlop, Clinical Advisor Drug & Alcohol- MHDAO, Director AOD, HNELHD
- Sue Dentice, CNC Mental Health Emergency Care Service (MHECS), MLHD
- Jenni Bryant, Consultation Liason Psychiatry CNC, CMH
- Richard Walker, Emergency Department CNC, MNCLHD

Case Study 1- Dr Betty Chan

Poly pharmacy overdose/deliberate self harm

- 39 Year old Male, presented to ED following overdose of psychotropic medications with alcohol in the context of a fight with his ex-partner
- Multiple past psychiatric diagnosis
- Aggressive behaviour in ED warranted the use of IV sedation for behavioural containment
- Patient was difficult to sedate, requiring the use of multiple sedating agents which resulted in his becoming over sedated and acquiring aspiration pneumonia
- Patient was treated for medical complications in ED for 3 days before being transferred to a Mental Health Inpatient Unit

Questions:

- *Who should review this patient?*
- *How and where should this patient be managed?*
- *When should this patient has a mental health assessment?*

Case Study 2- Jenni Bryant, MH CNC

Alcohol intoxication/suicidal ideation

- 35 year old female, BIBA with Police Escort Under S22 MHA
- Suicidal ideation; found on a cliff to jump. Combative at scene. Breath Alcohol Level 0.225
- On presentation to ED, distressed, tearful, shouting, unable to be deescalated, attempted AWOL, assaultive towards staff, Non cooperative with physical health assessment
- Alcohol dependant, previous brief MH admissions for suicidality in the context of intoxication, recent social stressors

Discussion

- *Ruth needs a SAFE environment. Where is the most appropriate place to care for Ruth and who is responsible for care?*
- *When is an intoxicated person sober enough for a valid MH assessment*
- *Who conducts the MH assessment?*

Case Study 3- Dr Jackie Huber

Methamphetamine/paranoia/aggression

- 0100hrs- 32 year old male brought in by police, S22 MHA, found running in traffic, behaving bizarrely
- On presentation, paranoid, intimidating, unable to be deescalated, declining physical investigations including UDS, not divulging personal information
- IV Sedation required to contain behaviour and risk. Bloods drawn during procedure which show CK raised, WCC raised, EUC's normal
- Psych r/v at point of presentation through behavioural observation: likely Dx ICE induced psychosis- Admitted to Psych ward when cardio vascularly safe

WHO, WHEN and Where?

- Immediate sedation required- Psych team review before sedation? If not WHEN?
- WHEN should formulation of care plan take place? With WHOM?
- Where should pt be cared for post sedation? MH, ED, Gen Ward, Combined specialty ward?

Case Study 4 - Dr John Dohobrotoff

Suspected delirium/behavioural problem

- 81 married woman with 60 year history of schizophrenia. Referred to community MH team by her son: reports increasing first rank psychotic symptoms, Verbal aggression and 'memory on the decline' Withdrew $30 000, threw a glass of water over her frail husband
- Comorbid leukaemia (CLL), glaucoma and hyperlipidaemia. Nil insight into illness says that her medical conditions were 'misdiagnosed' and denies presence of psychotic symptoms
- Accepted one dose IMI Paliperidone on initial CMHT home visit. On subsequent visit appeared suspicious, agitated & hostile, refusing further follow up. Scheduled by community MH team – Mentally Ill for.

Questions

•What are the likely causes of symptoms & behaviour?

•Is medical comorbidity likely to be contributing to the presentation?

•What is the urgency? Who should transport her & to Where?

Discussion

- What are we doing that currently works well?
- What are potential solutions?
- What are the next steps?