The GKL/ Campbelltown experience

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Background

- Campbelltown LGA and surrounds, has a very high proportion of adolescents.
- Over 40000 under 18s in the Campbelltown LGA.
- 43 primary, 24 High schools and 7 Specialist School Programs’s (SSP’s).

Background

- High density of social disadvantage, mental illness and drug and alcohol problems.
- Historically poorly resourced community mental health, NGO and other support services.
- The combination = large number of ED utilization by young people.

ICAMHS in SWSLHD

- Gna Ka Lun (healing of the mind) 10 bed Adolescent Acute Mental Health Inpatient unit at Campbelltown Hospital.
- ICAMHS Community service centres:
  - Macarthur ICAMHS
  - Liverpool – Fairfield ICAMHS
  - Bankstown CAMHS
  - *Bowral Centre of Youth*

ICAMHS Service partners

- 5 Emergency departments of SWSLHD.
- CoMHET.
- Headspace (Bankstown, Liverpool, Campbelltown).
- Community Health centres(The Corner, FLHYT, Traxside).
- Schools.
- G.P's, paediatricians, private psychologists.
- FACs (Out of Home Care & Sherwood House).
- Justice Health.

Early days

- Pre GKL – general/ adult services assessed and managed adolescents.
- Once GKL was established, the onus steadily shifted
  - Adult services under-resourced and had an increasing load themselves.
  - Poor confidence in being able to assess and manage the young.
  - Presence of ‘specialists’ on campus.
  - ‘Aggressive general team’ and a ‘naïve child team’.

About Gna Ka Lun

- 13-17yr olds (17yr olds enrolled at school).
- Referrals accepted from hospitals, mental health clinicians from Community CAMHS, Psychiatrists, Paediatricians.
- Increase in C&A MH inpatient services across the state over recent years. Trend of reduction in out of area admissions/increase from LHD
- Admission priorities - within LHD; age; location of patient; acuity; referring area

GKL staff who provide outreach

- CNC – 0.6FTE available for consultation.
- Registrars – basic and advanced trainees. Usually 2 Registrars are on the GKL rotation- 0.4FTE available for consultation.
- Consultants – 1.8 FTE at GKL.
- The GKL social worker and the GKL diversion therapist available as needed.
- The GKL Clinical psychologists available as needed, usually if they know the young person well.
  e.g. Eating disorders, conversion disorders.

Consultation referral process

From Emergency department:

- Triage Nurse refers young person to PECC.
- PECC Nurse refers young person to C&A team during business hours and ED MH team after hours.
- ED MH team cover all age groups after hours.
- From medical wards: Consultation request form.

Clinical Consultation

- MH assessment/review.
- Collateral from family/carers, community MH services, schools, other support services.
- Formulate a plan upon discussion with the C&A Consultant.
- Frequent presenter plans used. Currently in the process of entering into EMR.

Admit to Gna Ka Lun

- Least time consuming.
- Document using MHOAT forms.
- Assist with orientation process.
- Handover to GKL team using ISBAR.
- Liaise with key stakeholders.

Admit to Adult MH units, medical units

- Usually PECC or the Paediatric unit.
  - Considered for Gna ka Lun admission however no beds or not safe to be discharged.
  - Gna Ka Lun admission assessed to be countertherapeutic.
- YP with eating disorders, conversion disorder, under 12yrs old admitted to Paeds.

Care for ‘outliers’

- Treatment and discharge planning commences on admission
  - Regular reviews.
  - Brief intervention, crisis management, safety planning, solution focused therapy, family meetings.
  - Consultant, Psych Reg, CNC, Diversional therapist, Social worker, Psychologists.
  - Provide resources for staff, YP and carers.
  - Care plans, management plans, support and education to staff.

Discharge

- Most time consuming.
- Educate and support Parents/Carers.
- Develop family focused plans
- Brief intervention. Solution focused.
- Parents seeking respite service for YP. (limited services available for respite)
- Accommodation issues (liaison with social worker and other services)
- Liaise with FACS, JJ's, schools, community MH teams and other community support services.
- Documentation.
- Transfer of care.

Emergency department presentations of YP (under 18)

- 2008- 108
- 2011 – 180
- 2012 – 550
- 2014 – 725
- 2015- Over 400 so far

Emergency department presentations of YP (under 18)

- Average 60-65 per month.
- Two thirds between 15 and 18 years of age.
- Self harm/suicide over half of all presentations to ED.
- More females than males.

The Result

- GKL team being possibly the only unit in the state which uses its resources to care for all children and adolescents with mental health problems on campus.
- GKL team stretching itself to take responsibility for and providing care to all children and adolescents anywhere in Campbelltown hospital from initial presentation (during hours) through until discharge
  - ED
  - PECC
  - Paediatrics
  - ICU
  - Other MH and general medical wards

Consultants

- Day consults-separate roster for Campbelltown ED (GKL consultants responsible).
- District wide on call roster
  - Degree of confidence in assessment and confidence to discharge varies.
  - The GKL team next day called in to sort out unresolved issues.

Follow-up

- Huge emphasis on supporting the local ICAMHS service.
- High pressure liaison with the crisis service.
- Liaison also with other players
  - Headspace
  - Youth team
  - Traxide (community youth health)
  - Paediatricians

Following D/C from ED

- Clinical notes that includes recommendations faxed to CoMHET/ ICAMHS.
- T/C and face to face F/U within 7 days.
- Back to ICAMHS intake for a further F/U within 2 weeks.
- Taken to MDT to decide the best course of next action.
- Significant reworking of the ICAMHS intake system.

What's good?

- YP and families get (good) sub-specialist care from the outset.
- Decision makers aware of service pressures and options within the system and are able to make practical decisions (read bed pressure).
- Less 'passing the buck' and less angst overall.
- Adult MH services/ managers (who control us) very happy.

What's not?

- Longer ED wait times as staff have to juggle competing needs.
- Not enough beds.
- Care in adult units still not ideal.
- Deskilling of general/ adult mental health and reinforcing a notion that under 18s with mental illness are a ***different species.***
- Tension between ED/ general MH/ child MH.
- Not able to respond to non-urgent paeds CL type requests.

The other predicament

- A high proportion of YP present to ED due to their predicaments
  - Some MH issues.
  - Significant psychosocial difficulties.
- D/C difficult; not suitable to GKL either.
- Need 1-2 night stays
  - PECC/ Paeds-not always possible.

The challenge

- Ever increasing number of presentations
  - *"asked to go to Campbelltown ED"*
- Campbelltown hospital expanding.
- Significantly increasing load on the GKL staff – staff burnout.
- Community teams feeling the pressure as well – need further bolstering.
- Consultants and the system carries and attempts to manage increased risk in the community.

Potential solution

- Bolstering the existing general/ adult ED/ PECC MH service with CAMHS expertise
  - This is in the second week of trial.
  - Admitting roster for ED.
  - Consults with GKL Psychiatrists.
  - CNC reviews all admitted patients wherever they are in the hospital.
  - Three month trial.
  - This model working well in other parts of SWSLHD.

Other potential solutions

- Enhancing GKL/ ICAMHS profile to allow it to appropriately respond to all child and adolescent mental health needs.
- Having a dedicated C-L CAMHS service which will also respond to ED requests.
- Having a dedicated ED/ PECC CAMHS service
  - ***All of which need money!***