Community Mental Health Centers
(Managing Risks and Challenges)

Inpatient Hospitalization
(New Hampshire Hospital)
(Assessment, Treatment Planning/Discharge)

Community, Schools, Cyberspace and Peers
(Initial Identification)

Emergency Department
(Stabilization, Initial Psychiatric Evaluation)
New Hampshire Hospital

Child and Adolescent Treatment at Anna Philbrook Center
From Admission to Discharge
Facts about New Hampshire Hospital’s Anna Philbrook Unit (APC)

- APC (the children’s unit) is located in Concord in the Acute Psychiatric Services building in Concord, NH. It is about 2+ hours from the North Country.
- One of 3 inpatient facilities in NH that treats children and adolescents.
- NHH is the primary backup system for community mental health services.
- It is the only inpatient hospital in NH supported to accept patients who have no insurance and can’t pay for care themselves.
- Funding is included in the budget for New Hampshire Hospital and is controlled by the legislature. Budget reform has caused consequences that affect children’s services.
- Most hospital stays at NHH are between 3-10 days. However the average length of stay is around 14 days for children and adolescents.
Who can be treated at New Hampshire Hospital’s Anna Philbrook Center (APC)?

• Any patient can be treated who meets criteria for inpatient care; who is unsafe towards self or others and/or warrant inpatient assessment in a structured setting.
• Patients at APC range in age from pre-school to age 17 and come from all socio-economic situations.
• Patients of all levels of intellectual ability are treated at APC; ranging from very bright to intellectually disabled. Tutoring services are available, but limited as the budget ended funding for educational staff.
• APC and NHH do not offer treatment for primary substance/alcohol dependency issues.
• Some patients who are admitted have significant legal issues in addition to their psychiatric and safety needs. This can create a barrier to discharge, but does not preclude admission.
Typical issues that may require inpatient treatment for children and adolescents

- Suicidal Ideation and Behavior
- Extreme aggression or homicidal ideation
- Trauma–related symptoms that result in suicidal ideation
- Mood disorders (e.g., depression, bipolar disorder)
- Autistic Spectrum disorders if patients are a danger to themselves or others.
- Schizophrenia Spectrum disorders (and prodromal syndromes in children).
- Anxiety disorders that impair functioning and require hospitalization (e.g. severe OCD, with catatonic presentations.)
- Cognitive or neuropsychiatric conditions that severely impair functioning
Situational stressors that may acutely impact safety and mental status in children

• Problems with family (including abuse/neglect situations).
• Trauma (e.g. Sexual, physical, emotional, loss issues, suicidality of peers or family members and victims of bullying.)
• Difficulty managing social relationships with same aged-peers.
• Academic difficulty secondary to cognitive deficits or psychiatric symptoms
• Effects of mental health secondary to drinking and substance abuse
Waiting for Inpatient Hospitalization in the Community

- Patients are not admitted directly to NHH, but receive initial evaluation via emergency services or ED departments.
- Average waiting time in the ED is 3-4 days.
- Often patients are waiting in general waiting areas without specialized mental health services available.
- Family issues can be escalated by the additional pressures of the emergency room stay.
- Children are often left in emergency rooms as parents need to return home to attend to other children, or need to work the next day.
Issues related to Admission

- Patients are admitted either on a voluntary or involuntary basis to NHH. Legal criteria must be met for Involuntary Emergency Admission.
- When children are admitted involuntarily (on an IEA) they receive a hearing with a judge within 72 hours of admission to determine whether the burden was met for involuntary admission. If the petitioner is the parent, they will have to make the case for IEA to the judge.
- Parents sometimes seek voluntary admissions, but these are subject to bed availability and case-by-case assessment.
- The child’s situation may have remitted to some degree while they have been waiting in the ED and it is suspected that some patients could be discharged home safely once the immediate crisis has passed.
- An evaluation to establish a basis for admission is generalized with regard to suicidal behavior. Further evaluation and intervention with the patient occurs after admission.
Admission Process

- All patients are admitted by an admitting psychiatrist or APRN.
- A physical exam is conducted by a Physicians' assistant, APRN or MD is done as part of admission to assess for medical issues and contagious health conditions.
- The patient is screened/searched for unsafe objects and contraband prior to being allowed on the unit.
- Any belongings they bring with them must be searched by staff to make sure they can be allowed on the unit safely.
- The patient meets nursing staff on the Unit when they arrive and they are given a room. At this point they may be assigned to a room with another patient.
- Sometimes parents are unable to be present during this process as children are often transferred to NHH at the convenience of bed-availability and transportation availability. APC would like to see a transition to more daytime admissions to make it more convenient for parents who live at a distance to attend the admission meeting.
Treatment

- The patient is assigned to one of three treatment teams based on availability and rotation assignment. Treatment team consists of Child Psychiatrist, Social Worker, Nursing staff, and Rehab staff. The patient meets the treatment team on the first working day after their admission.
- A treatment plan is formulated for the patient and the Team continues to gather information and revise treatment strategies and goals as is appropriate with the goal of stabilization and accurate diagnosis to maximize future treatment.
- Psychology staff perform initial, single session interventions with every patient and help identify goals for treatment (during and after hospitalization) and needs for additional assessment.
- Psychology staff complete the Columbia Suicidality Screening Scale for current and Lifetime events and the Columbia Risk Assessment/Protective Factor Tool for every patient.
- Consultations with Psychology Dept. and the Neuropsychology Dept. are available to the team to provide assessment of psychological, cognitive, and neuropsychological issues that may affect treatment and discharge.
- Parent consultations are available to parents of children and adolescents to develop behavioral interventions for after discharge.
Goals of Treatment

• Treatment is focused on stabilization and patients who are involuntarily admitted need to be discharged to least restrictive standard of care by law when they no longer meet an acute level of care.

• Evaluation needs to occur quickly and typically clarifies diagnosis, which can help physicians accurately target medications and make recommendations for supportive follow up care. Getting access to school and community records quickly is important.

• Assessment includes gathering information from parents, and treating providers (prescribers, therapists, school, and other agencies) are identified and contacted for information if release of information is obtained.

• Children or their guardians may be reluctant to provide information or make themselves available for treatment.

• Every effort is made to tailor treatment to the needs of the patient. This can include development of behavior plans, assignments to a specific age group, or limited privileges on the Unit.
Discharge Planning

- Begins at Day 1.
- Parents may have meetings with the treatment team to review major changes in treatment strategies (such as reviewing implications of a change to the diagnosis that requires parent education.)
- Community meetings occur when multiple systems are involved (e.g. DCYF, School, CMHC’s, Probation etc.) Review of testing performed at NHH by Psychology and implications for treatment and behavioral intervention, or educational programming for managing learning deficits.
- For children and adolescents, barriers to discharge are almost always related to housing issues for a variety of reasons (e.g. safety of environment, danger to siblings, psychiatric acuity).
- Children may require residential care, however there are minimal options for this level of care currently in NH. Schools may be reluctant to place children in residential school settings due to costs.
Addressing mythology

• 1. Some believe that patients typically have long stays or “live” in the hospital due to lack of resources in the community. 

_We only hospitalize those who cannot be managed safely in the community, and only until we are able to locate an appropriate discharge setting._

• 2. Some believe that only those with severe and persistent mental illness or severe intellectual disabilities are treated at Anna Philbrook Center. 

_The reality is that we treat many children who are suffering from an acute psychiatric or suicidal crisis. Many are able to be stabilized and returned to the community for their care and do not need to return. It is beneficial to get a very thorough assessment of any child in an acute crisis, to help them avoid further restrictive placements._

• 3. Some believe that NHH is an old facility that treats primarily the poor. 

_We are a modern, teaching facility with great staff who receive referrals from private hospitals when cases are too complex for them to manage._
Ethical issues around competence in the assessment of suicidality in children and adolescents

• The role of professionals in different settings does not guarantee competence.
• Competence is developed through supervised training and experience with real patients.
• Identification of potential need for suicide evaluation can be done by everyone!
• Formal, suicide assessment, that could result in treatment decisions should be performed by trained, experienced clinical professionals who work frequently with this population.
Ethical issues around confidentiality regarding suicidal presentations and history of inpatient treatment

- Confidentiality is essential to being able to offer care to suicidal children and adolescents.
- There is a great deal of stigma associated with suicidality that can significantly interfere with a person’s recovery from suicidality.
- There is even greater stigma associated with an Involuntary Admission to NHH.
- Parents may not want to share information with schools due to fear of stigma.
- Schools should develop policies that allow them to plan for a child’s safe return to school, while protecting confidentiality.
Risk Factors for Suicidality

- History of suicidal ideation and behavior
- History of psychiatric treatment or illness (e.g. depression, bipolar disorder, anxiety, PTSD etc.)
- Trauma history
- History of aggression/impulsivity, conduct disorder or alcohol/substance abuse
- Hopelessness and a wish to die
- Family or peer history of suicidality
- Perceived burden on family or friends
- Lack of access to mental health treatment or uncooperative with treatment
- Access to lethal means
- Instability in relationships/poor support system
Protective Factors

• Feels that others rely on him/her and does not want to disappoint or hurt them, or needs to be there for them
• Fears pain and suffering related to suicide
• Against the idea of suicide because of the religious or moral implications
• Engaged in Work or School
• Has goals that could transcend immediate situation
• Has positive, supportive relationships (family, loved ones, peers, therapist, etc.)
• Can see the situation as changeable (can feel hopeful for change)