Royal College of Emergency Medicine

Paediatric Emergency Medicine Professional Advisory Group

Management of Adolescent/Young Adult (AYA) Patients in the Emergency Department

March 2023

Summary of Recommendations

1. **The clinical area where adolescents are assessed should be appropriate for their needs.**
2. **Staff assessing and caring for AYA patients should have specific training in how to undertake this task. This training should include communication, managing issues specific to the adolescent population and the importance of psycho-social assessment.**
3. **If a patient needs to be admitted to hospital, there should be a clear policy of where and under which clinical team adolescent patients should be admitted.**
4. **Assessment of adolescent patients should always include consideration of a form of psychosocial assessment.**
5. **There should be close cooperation and communication between emergency departments and CAMHS/psychiatric liaison services to ensure effective mental health care for this population.**
6. **AYA patients are a vulnerable group and clear procedures for reporting concerns to safeguarding teams, social services and the police should be in place. In areas where violence is endemic violence reduction programs should be in place.**
7. **The management of AYA patients who refuse medical treatment is complex. Senior clinical staff should be consulted in this scenario.**
8. **There should be a senior member of medical staff identified to lead the design and development of emergency department services for adolescent patients.**
9. **The design and configuration of services should involve consultation with AYA patients.**

Scope

Adolescent/Young Adult patients attending emergency department settings.

Adolescents/Young adult patients are defined as being between the ages of 12 and 25 years. Different Trusts/Health Boards may wish to define the population for which the guideline should apply. The authors of this guideline would strongly advocate for bespoke policy for the 16-19 year old age group.

Reason for Development

Adolescent patients presenting to emergency departments may present a challenge. These patients often present a degree of complexity and may have significant organic medical, social and psychological components to their presenting issue. Meeting this challenge is not always optimally addressed with a one size fits all emergency department adult or paediatric approach. In many cases hospitals will be organised to care for children in paediatrics and for adults in the other specialties, with adolescents sometimes falling through the gap between the two services. Royal colleges including RCPCH, RCP and RCEM all have working groups which agree that the current situation is not acceptable and that things need to change to improve care for AYA patients. In many hospitals care in paediatric settings stops when a patient reaches 16 in others 18. Whichever cut off is used, patients often find the differences between paediatric and adult care in hospitals to be extreme. Different hospitals will have individual approaches and solutions for AYA patients whom they care for. This best practice guideline aims to set out in general terms, ways in which departments can optimally care for this population.

Contents

What's different about adolescents/young adults

Adolescent and young adults are in a period of transition between childhood and adulthood. There is evidence that developmental changes in the brain are not complete until the age of 25. AYA are often in situations that increase levels of stress and anxiety, whilst not being as resilient to dealing with this as older adults. They often strive to have independence but will lack the financial resources to achieve this without support from adult carers. This can lead to breakdown in relationships between young people and their adult carers and them being put into vulnerable situations where they are at risk of exploitation by others. Changes in priorities and life circumstances can also make it more difficult to manage medical conditions. AYA may also find it challenging to navigate the health and social care system, meaning that they can end up in the emergency department in crisis. AYA patients report lower levels of satisfaction with hospital care than older adult patients. It is reported that adolescent patients are the only age group whose mortality rate is currently increasing in the UK. The UK has not managed to reduce the number of deaths in the AYA population as much as similar developed countries. The most common causes of death are accidents, cancer and intentional self harm. 3% of deaths in the 15-19 year old age group are due to assault. AYA are likely to have many years ahead of them when they may need to consult with health services, so dealing with them in a positive way will optimise this now and for any future dealings with the health service for themselves and their family. **Their ED attendance may be the only time they have consulted a healthcare professional for a significant amount of time, and it is vitally important that we do our best to get it right.**

Environment

AYA can find it challenging to cope with stressful situations. Where possible they should be cared for in a calm environment, where it is possible to discuss the situation and issues that the AYA patient is facing, whilst maintaining confidentiality. An attempt to minimise exposure to the potentially distressing activities within ED should be made. A decision of where to locate this area should take into account the wide variety of presentations of AYA patients. The potential for violence and aggression means this area is often not best suited to a paediatric area, but the vulnerability of the AYA population also means that open adult areas of the department are often not suitable either. In an ideal world there would be a bespoke unit for this patient group. It is acknowledged that whilst most hospitals do not currently have the resources to provide this, there should be some effort to provide an appropriate area for these patients. It should be acknowledged that overcrowded, noisy, stressful emergency departments with excessive waits for treatment are amongst the worst possible environments to care for AYA patients who are unwell or in times of crisis. Emergency departments need to ensure that assessment space is used only for the assessment and emergency management of patients. It is not appropriate to use this space to 'hold' patients whilst awaiting a more appropriate disposal such as a mental health bed, or social care placement. Additionally this space would not be appropriate for a patient to wait a prolonged period for a mental health assessment.

Training

Staff who are involved with assessing and caring for AYA patients should have experience and training in how best to communicate with and assess these patients. The background and job title of these clinicians is less important than the fact they have an interest and understand the issues and challenges that this population face. This training should include the importance and content of a psychosocial assessment such as 'HEEADSSS' or similar. Staff should also be aware of local and national services available to help and support AYA patients and know how to navigate and access these services. For example, they should know how to access sexual health, mental health, drug and alcohol and social support

services and be able to effectively signpost AYA to these services. Training can have a range of approaches including simulation based training.

Examples of resources that may be useful to incorporate into training are:

- eLFH adolescent modules
- RCEM study days: The forgotten tribe
- Healthy London Partnership
- Healthy Teen Minds
- MARSIPAN eating disorder guidance
- Anna Freud National Centre for young people
- This may help – website
- Battle scars

Please see appendix 2 for additional resources

Admission

Where a AYA patient needs to be admitted to hospital, there should be clear policies in place of where the patient should be admitted, and which clinical team should have responsibility. A patients choice of where in the hospital to be admitted, should be taken into account, as should the request for an adult carer to be able to stay with the patient. It is not acceptable for the ED clinician to be expected to negotiate with inpatient teams for each individual patient. There should be clear arrangements for transitioning of care between paediatric and adult medicine and an effective method of communicating this situation, so that AYA patients presenting to the ED can be triaged to the correct part of the service. Some children with specific needs for example those with regular attendance to the ED or children with complex medical needs, may require a transition process between the paediatric and adult emergency department services. In addition consideration of tailored management plan may assist staff in making appropriate management decisions.

Psychosocial Assessment

AYA patients may present with a number of issues including physical, mental health, psychological, social and safeguarding problems. Often these are interlinked. To enable clinicians to appropriately assess the patient it is important that a psychosocial history is included in the assessment. This should be done without parents/carers present where possible. There are different ways of doing this but the most commonly used and accepted method is the 'HEEADSSS' assessment. Some units use pre-assessment questionnaires which patients can fill in before being seen as a way of obtaining this information. Obtaining a psychosocial history is acknowledged to be challenging and requires training and practice to be done effectively. Education around doing this should be included in induction training and a way of accurately recording this information in the clinical notes developed.

HEEADSSS Assessment

Home
Education & Employment
Eating
Activities
Drugs/Drinking
Sex
Self-harm, depression and suicide
Safety (including social media/online)

If a member of staff has concerns regarding issues raised in the psychosocial **assessment**, their should be robust systems in place to escalate these concerns.

Mental Health Services

Where the AYA patient presents with a mental health issue, there should be close collaboration with CAMHS/Psychiatry liaison regarding appropriate support and timely assessment. The design of the system should minimise unnecessary time waiting in the emergency department or short stay/observation units or unnecessary admission to hospital. The provision of services should be adequate to permit the assessment of patients 24 hours a day, including weekends and bank holidays. Where a patient presents with a mixed physical/mental health condition emergency department clinicians and mental health staff should collaborate to provide optimal care for the patient **in parallel**. This approach is supported by guidance issued by RCPsych and NICE.

Acute Behavioural Disturbance

Acute behavioural disturbance is a challenge to manage in the ED. Effective management of this situation is best managed by senior staff and may require discussion between agencies. This could include ED staff, social services, CAMHS, psychiatry liaison and the Police. Please see the RCEM Acute Behavioural Disturbance Guideline for further guidance.

Safeguarding

There are differences in the legal definitions of a child in the nations of the UK and in safeguarding obligations. In England, Wales and Northern Ireland a child is defined as being under the age of 18, however this definition is under 16 in Scotland. Clear processes should be in place to ensure that appropriate safeguarding measures are undertaken when AYA patients present with certain presentations. The list is not exhaustive, but these would include:

- Alcohol/drug intoxication
- Deliberate self-harm
- Physical assault
- Domestic violence
- Sexual abuse
- Neglect
- Exploitation/grooming
- Pregnancy in patient under the age 16
- Female genital mutilation
- Engagement in illegal activity eg. Involvement with gangs, carrying weapons, transport or dealing in drugs (eg.County Lines).

There should be education about what to report and clear mechanisms to involve safeguarding teams, social services and the police.
In areas where there are significant number of patients presenting with injury due to violence, violence reduction programs should be developed and utilised.

Youth Violence, Exploitation and Developing an In-Hospital Violence Reduction Programme

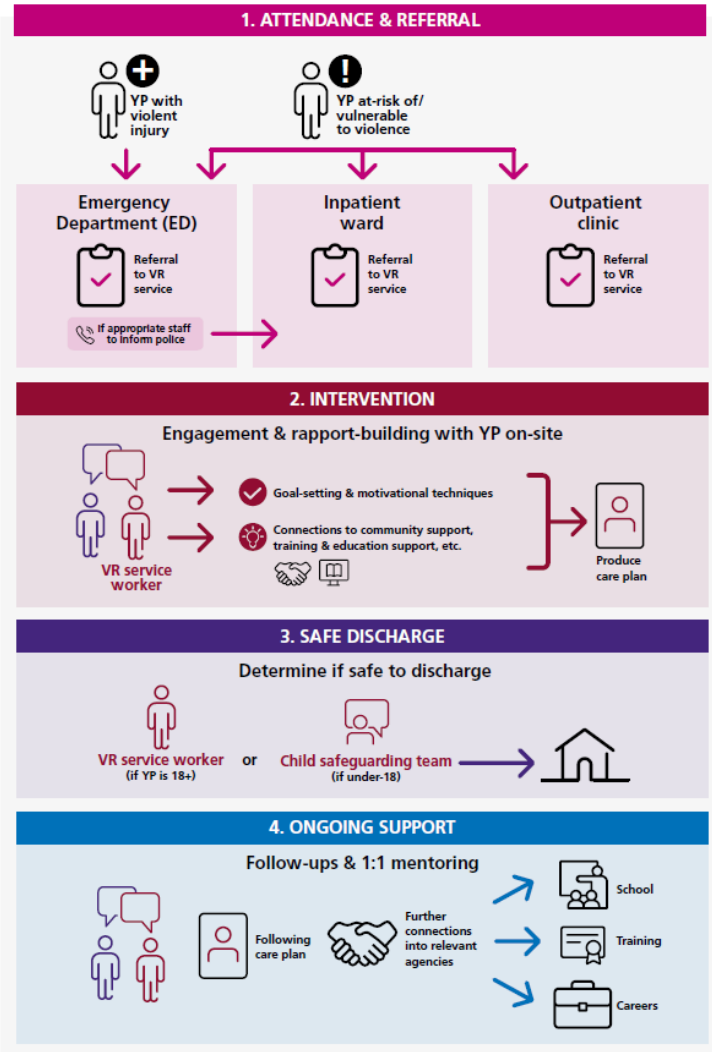
Violence is a major cause of ill-health for young people with homicide being the 3rd cause of mortality under the age of 18 years in England and Wales after suicide and road traffic accidents (ONS, 2018). The increasing rate of assault is weighted disproportionately in the under 18 years and contributes to 2.8% of Emergency Department attendances. [1]

Research has shown that 35% of all adolescent (11-19) attendances to an emergency department were for adversity-related injury (self-harm, assault, injuries, maltreatment or intoxication); 39% would be Emergency Department re-attenders[2].

There needs to be implementation of In-Hospital Violence Reduction programmes that are based on a contextual safeguarding and trauma informed practice approaches. It is recommended that Emergency Departments have a Violence Reduction Steering Group to monitor attendances, promote referral pathways to support violence reduction and link with community providers to support vulnerable and at risk young people. The recommended Steering Group should provide representation from Emergency Department clinical lead, named doctor/nurse for safeguarding, service manager, In-Hospital Violence Reduction team provider team leader, children's services representatives. The In-Hospital Violence Reduction service should have an achievable set of key performance indicators and use audit and data to share best practice.[3]

The Violence Reduction Programme London in February 2022 has implemented a set of guidelines to implement In-Hospital Violence Reduction Services and provide a best practice framework for a referral pathway to support violence reduction.[3]

An example of a typical violence reduction and exploitation referral pathway to support violence.[3]



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1. Baker, C. Accident and Emergency Statistics: demand, performance and pressure. House of Commons Briefing Paper number 6964. February 2017.
2. Herbert, A., Gilbert, R., Gonzalez-Izquierdo, A., et al. Violence, self-harm and drug and alcohol misuse in adolescents admitted to hospitals in England for injury a retrospective cohort study. BMJ Open 2015; 5:e006079. Doi: 10.1136/bmjopen-2014-006079
3. Violence Reduction Programme London. In-Hospital Violence Reduction Services: A Guide to Effective Implementation. February 2022

Adolescent patients who refuse treatment

The law is complex around AYA patients who refuse treatment. Therefore a senior clinician should be consulted and involved. Senior clinicians should ensure that they are aware of the key issues involved in managing patients in this scenario and of the law relevant to the locality where they are practicing. In particular be able to access legal advice and know how to contact the relevant court if required. Looked after children are a special group and have an additional level of complexity, again senior advice should be sought when dealing with this patient group. The Children Act 1989 sets out the legislation in this area.

Leading provision of services for AYA patients

A senior clinician should take the responsibility for leading, designing and providing services for AYA patients. This individual should have training and experience appropriate to this role. The role lends itself to somebody who understand things from both a paediatric and adult perspective and has an interest in providing care to this population. This individual should have time within their job plan to undertake this work.

Design and configuration of services should involve consultation with AYA patients

AYA patients should be given a voice with regards to the services that are provided to care for them. They have valuable insights and opinions about how their care and support is best provided. When considering the design of services or re-configuration service, consultation with this patient group is recommended.

Multidisciplinary governance meeting

Multidisciplinary governance meetings should take place to review cases involving AYA patients. This will allow incidents and pathways to be discussed/developed and action taken when necessary.

Unexpected death in childhood

A policy should be in place determining who is responsible for undertaking the unexpected death in childhood process, when a patient under 18 unexpectedly dies. The responsibility for determining this policy is normally taken by a lead SUDIC clinician, who in the majority of hospitals is from a paediatric background. The ED and ED staff should not be seen as the default for this process.

References

1. On the margins of medical care. Why young adults and adolescents need better healthcare. Royal College of Physicians. Goddard et al. 2015

2. Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH. [Available at: stateofchildhealth.rcpch.ac.uk]

3. Childrens Act, 1989. https://www.legislation.gov.uk/ukpga/1989/41/contents

4. NICE Guideline 225, Self Harm Assessment, management and preventing recurrence. https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757

5. RCPsych PLAN 7th Edition Standards. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychiatric-liaison-services-plan/plan-7th-edition-standards.pdf?sfvrsn=718ddb5b_2

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Declarations of interest

Several authors are members of the RCEM Paediatric Emergency Medicine Professional Advisory Group. There are no other declarations of interest.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Acknowledgements

RCEM Paediatric Emergency Medicine, Professional Advisory Group

Evidence

Where evidence is available it has been appraised using standard methods. Where evidence does not exist to guide recommendations consensus expert opinion has been used.

Audit standards

Standard	**Essential or Aspirational?**
Is there a clinical area designated for AYA?	Aspirational
Staff who assess AYA patients have had training in psychosocial assessment	Essential
Policy for admission to hospital exists	Essential
AYA patients should have documentation that psychosocial issues have been considered or completed	Essential
Patients with safeguarding concerns have a multi agency report completed	Essential
Lead for adolescent care	Aspirational

Appendix 1 – Examples of good practice

1. In a DGH a multidisciplinary group was formed to focus on the needs of AYA. Run by an ED clinician, it involved staff from paediatrics, ED, medicine, surgery, volunteer services and comms. They achieved various changes in practice including bidding for charitable funding to buy a mobile trolley which was stocked with age-appropriate games, books and healthcare leaflets which volunteers would take to departments to give to AYA, whilst chatting to them and supporting them whilst they were in hospital.

2. In one ED a rebuild allowed staff to design an adolescent area/room within the paediatric ED but away from the general waiting area where AYA could wait to be seen in a calmer and more appropriate environment. There were age-appropriate magazines to read, a charging point for devices and neutral décor.

3. Instead of/as well as physical observations, one hospital used *emotional observations* for patients where appropriate. This involved regularly asking if the AYA patient was comfortable and whether staff could do anything to make their time in the ED as good as it could be. This was documented on an observation chart.

4. In some departments trained youth volunteers sit with and support AYA patients in the ED (in adult or paediatric areas) whilst they wait. Sometimes they are able to visit them if admitted to a ward and the volunteer has a shift that day.

5. Sleep support packs were funded and given to AYA to help them to rest whilst in the ED/on a ward. These contained an eye mask, ear plugs, lavender bag and a sachet of hot chocolate.

6. Department uses same cas card in young people as in paediatrics to prompt consideration of safeguarding issues.

7. Departments use electronic prompts to direct clinicians to appropriate screening questions in certain conditions.

University Hospitals Leicester Examples of good practice:

1. Purpose built waiting area, adjoined to main paediatric waiting area

2. Electronic assessment tool performed on each patient designed to automatically highlight CYP who attend where there are safeguarding or MH concerns

3. Provision of onsite CAMHS crisis practitioners between 08.00 – 20.00, and close liason with the onsite all age mental health team , to provide immediate access for each AYA requiring mental health support.

4. Appointment of an ED Mental health matron to support children and AYA presenting to the ED.

5. Provision of appropriate information and resources addressing AYA issues eg mental health resources, LGBTQ+ resources, Violence Intervention programmes

Recent Innovations and Developments:

6. Development of the ED CYP liaison group (Mind Matters), comprising of ED, CAMHS, and paediatric staff to develop appropriate pathways and environments, and advocacy for these patients. To develop MH champions throughout ED and in-patient facilities

7. CYP MH weekly liaison meeting with ED/CH and CAMHS staff

8. Funding for General paediatrician with MH interest (50:50) to support with CYP <18 when in the ED and onwards into the in-patient environment

9. To raise the needs of this specific age population to Trust level:
    a. Development of transitional care leads (one consultant from paediatrics and one from adults, to develop appropriate services for these patients, to plan and develop transition and to work with the emergency department to support transition)
    b. Appointment of Trust CYP Mental Health Lead to work alongside Trust Adult Mental Health Lead.
    c. To work with the Trust Board to develop a "choice" pathway where the AVA can determine if requiring in-patient care, whether they would prefer an adult or CYP environment and receive specialist care accordingly (currently pilot being developed amongst surgical subspecialties in MSS)

Appendix 2 – Useful Resources

- https://www.mefirst.org.uk
- https://www.mefirst.org.uk/training/
- Battle Scars https://www.battle-scars-self-harm.org.uk
- Harmless https://harmless.org.uk
- Self Injury Support https://www.selfinjurysupport.org.uk
- Young Minds https://www.youngminds.org.uk
- Kooth https://www.kooth.com
- The Education blog https://educationhub.blog.gov.uk/2021/09/03/mental-health-resources-for-children-parents-carers-and-school-staff/
- Drugs and Alcohol https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/young-people/drugs-and-alcohol-for-young-people
- Ask Frank https://www.talktofrank.com
- Andrew Tagg: Mental Health screening, Don't forget the bubbles https://dontforgetthebubbles.com/mental-health-screening/
- https://www.nice.org.uk/guidance/ng225

- https://www.battle-scars-self-harm.org.uk
- https://www2.nphs.wales.nhs.uk/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf
- Rutter PA, Behrendt AE. Adolescent suicide risk: four psychosocial factors. *Adolescence* 2004;39:295–302
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