

# Psychiatric Emergency Department for Youth: A Challenge for the Future of Child and Adolescent Mental Health

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In his recent paper, Zun (2016) has outlined some critical issues in the management of psychiatric patients in Emergency Departments (ED). He underlines disparities in the care of medical vs. psychiatric patients, as well as negative attitudes of emergency physicians towards psychiatric patients. Consistently, Appelbaum (2015) has recently reported on the growing frequency of the “boarding” phenomenon (Stefan, 2006; Bender, Pande & Ludwig, 2008), consisting in the prolonged stay of psychiatric patients in an unsuited environment such as ED, which could lead to serious consequences, for psychiatric patients and ED staff, as well as for other patients (Bender, Pande & Ludwig, 2008). Although these papers have focused on adult patients, most considerations can be translated to paediatric ED as well.

Carubia et al. (2016) have reviewed practical challenges in the care of child psychiatric emergencies. They focused on two main themes: agitation and suicidality, both strongly threatening patient’s own as well as other’s safety. Despite the increasing number of children and adolescents referred to ED for psychiatric crises, there is an astonishing lack of research aimed at systematically assess best strategies of management, as most of the evidences are translated from outpatients or planned inpatients. Moreover, according to Zun (2016), at educational level, there are few intensive, specific and continuous training programmes in psychiatric emergency (even less in psychiatric paediatric emergency). The need for a specific model of intervention for youth in ED due to psychiatric crisis is clearly warranted.

The length of stay in a paediatric ED should be kept at minimum. Possibly, a timely consultation with a child psychiatrist should be provided, whilst emergency paediatrician could perform all the assessments aimed to exclude non-psychiatric causes of the crisis. All efforts, pharmacological and non-pharmacological, to stabilize the patient should be performed at this stage. The most frequent and troublesome clinical condition is agitation. It may arise from different psychiatric disorders, including, among others, the massive deficit of information processing and/or frustration/limits intolerance in the context of Conduct Disorders, the temper outburst or acute emotional dysregulation within acute Mood Disorders, or the severe, massive, intrusion of paranoid thoughts or hallucinations in Psychotic Disorders. The timely identification of the specific psychiatric disorder can help to correctly manage the crisis (Master et al., 2002), but it usually needs a consultation by a trained child psychiatrist. While the least restrictive measures should be initially taken (e.g. behavioural de-escalation), when they fail, a more restrictive intervention becomes imminently necessary (Carubia, Becker & Lewine, 2016). Although pharmacological interventions should be preferred on physical restraints, very scarce data and approved compounds are available for paediatric populations. Risperidone is usually the most used and studied (at least for impulsive aggression (Gurnani, Ivanov & Newcorn, 2016), but further evidences for other second generation antipsychotics, benzodiazepines, mood stabilizers and first generation antipsychotics are warranted, to amplify the spectrum of possible effective drugs (Carubia, Becker & Lewine,

2016). Once achieved a first stabilization, clinicians may erroneously consider the patient ready for discharge. We here advocate the need for an inpatient ward, able to a fast admission of youths, directly transferred from ED. A timely hospitalization after the discharge from ED may be the turning point for a real benefit for patients and families. During the inpatient stay (i.e., two weeks), patients should receive an intensive, multimodal, well-tailored treatment, including psychoeducational, psychotherapy and psychopharmacological interventions. In this context, the family engagement is crucial. Intensive hospitalizations are often associated to better outcomes in paediatric patients with bipolar disorder in a department of child psychiatry and psychopharmacology (Masi, Mucci, Pias & Muratori, 2010). In his recent paper about suicidal adolescents, O’ Brian (2015) claimed for more evidence-based brief, but intensive interventions (multiple hours for day) to be delivered in an inpatient psychiatric unit. We maintain that the hospitalization for psychiatric emergency should be part of an integrated plan of interventions, instead of a simple window of time to stabilize the patient, and to prepare the right outpatient treatment. After discharge, a less intensive form of take care should be provided, such as a day-hospital programme, which gradually allows the patient to return to his usual life, parallel with an adequate monitoring intervention by the clinicians.

This kind of organization may help to avoid some frequent risks related to the care of acute psychiatric youths. We here mention, beside the above-mentioned “boarding” phenomenon, the so-called “revolving door” effect, that is recurrent hospitalizations via ED, e.g. readmission usually considered a marker of inadequate mental health system (Bender, Pande & Ludwig, 2008; Jeppesen, Christensen & Vestergaard, 2016). This phenomenon may be unrelated to the real patient conditions and needs, but consequence of the lack of availability of outpatient resources that is community care services, social, family and school support. All these after-discharge resources should be activated and enhanced before the first discharge, to avoid the “revolving door” effect. At this regard, the transition from the inpatient to a day-hospital programme will reduce the risk for re-hospitalization (James et al., 2010), and consequently further economic charges for the mental health system. At this regard, a clear communication and coordination between ED, inpatient ward and community-based services is absolutely needed.

In summary, we think that from the admission (via ED or with prior referral) to the discharge, clinicians should carefully assess diagnostic and therapeutic issues, potential resilience resources and/or hindrances to good outcome in order to plan the best tailored long term care.

## CONCLUSION

Whilst it is finally well established that severe mental illness arises since childhood, and represents a potential target to ameliorate adult suffering and morbidity (Copeland, Wolke, Shanahan & Costello, 2015), a commensurate effort to achieve such result is still lacking. Academics, stakeholders, private and public investors should now realize that caring about child and adolescent mental health means caring about the future population well-being. Psychiatry emergency

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departments for youths are one of the main challenges for the future of child and adolescent mental health. Obviously, it is a matter of resources, but an up-to-date health care system cannot ignore such an increasing need.

### Conflict of Interest

Dr. Masi was in the advisory boards for Eli Lilly, Shire and Angelini, has received research grants from Eli Lilly and Shire, and has been speaker for Eli Lilly, Shire, Lundbeck, and Otsuka. Other authors have not conflict of interest to declare.

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