

# Emergency psychiatry in the 21st century: critical issues for the future

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Throughout decades of deinstitutionalization, the primary purpose of psychiatric emergency facilities has been defined as rapid referral of patients, triaging those who need 'emergent' care for their mental or emotional problems from those who do not. However, a merely triage-based conceptualization of the psychiatric emergency room does not take into account the ever increasing number of patients, the low accessibility of specialized services, the high need for early recognition of mental problems, or the need toward a more continuous provision of care. In this paper we aim to address some contemporary problems of emergency psychiatry, and then we try to outline some issues that may be of importance in the future of the psychiatric emergency room. *European*

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## Introduction

Throughout decades of deinstitutionalization, the primary purpose of psychiatric emergency facilities has been defined as rapid referral of patients, triaging those who need 'emergent' care for their mental or emotional problems from those who do not [1,2]. However, a merely triage-based conceptualization of the psychiatric emergency room (PER) does not take into account the ever increasing number of patients, the low accessibility of specialized services, the high need for early recognition of mental problems, or the need toward a more continuous provision of care. In this paper we aim to address some contemporary problems of emergency psychiatry, and then we try to outline some issues that may be of importance in the future of the PER.

## The history of emergency psychiatry

The initial development of emergency psychiatry has traditionally been linked with the major changes that the provision of mental health care underwent during the past decades. The two most important dynamics for this change have traditionally been pointed out as the deinstitutionalizing, and the efforts of cost containment, in mental health services [3], mainly resulting in a greater emphasis on community instead of inpatient care. In general, these trends have resulted in, among others, a decrease in both the number of psychiatric beds and length of stay in psychiatric hospitals, with the particular consequence that gradually more patients with severe mental illness started to live in society instead of an institution [1]. However, this rapid transition to community care has highlighted existing gaps not only in the coordination of outpatient services, but also in treatment

protocols or strategies [4–6]. After this, emergency departments (ED) observed an increase in psychiatric emergency referrals, a trend that was being observed in the United States as well as in Europe [5]. In the 'early years', after the major deinstitutionalization of mental health care, 'typical PER patients' were former institutionalized patients, often with severe mental illness, who were in acute psychiatric crisis. Consequently, the quintessential task for psychiatric emergency services was to serve those patients by triaging them away as soon as possible, to a more appropriate treatment setting.

Since the early 1990s, however, there have been three important evolutions. First, although the prevalence of mental disorders in the population remained similar, the number of persons seeking help between the early 1990s and 2001 increased by 50%. Interestingly, persons were more likely to seek help in low-threshold and general medical settings [7]. Second, PERs viewed a dramatic increase in number of patients they serve (58% over a 4-year period and 150% over a 13-year period) [4,8]. An important finding is that the PER gradually became an important service for patients who did not seek help before [9]. Third, the increase was much more common in disorders that used to be relatively scarce in the PER, such as mood and anxiety disorders [10]. These findings indicate that clinical profiles of PER patients are subject to a progressive change and the PER seems to become a central entry point for a wide range of patients, or 'for both the worried well and the acutely psychotic patient' ([10], p. 675). These findings point to the question whether a triage-based care can still hold in a psychiatric emergency setting.

## Findings that challenge a pure triage-based care in a psychiatric emergency setting

A first consistent finding that challenges a triage-based idea of a psychiatric emergency setting is that persons with previous utilization of services are among the most frequent users of the PER [11–15]. Especially for these patients, aftercare is oftentimes not well arranged and, consequently, valuable opportunities could be missed to link patients to appropriate resources, or to mobilize existing facilities or resources [16,17]. In turn, this may lead to unnecessary hospitalizations, negative consequences for the patient and his family, such as loss of employment, housing, or increased stigma [18], and thus to a reinstitutionalization of mental health care [19].

Second, deinstitutionalization has largely succeeded in reducing the number of psychiatric hospitals, inpatient care, and length of treatment. However, it failed in developing accessible and community services instead [20]. Existing community services have shown to have too few resources to help patients with nonurgent psychiatric needs [21]. Emergency departments, therefore, have observed an increase in psychiatric emergency referrals owing to a lack of general linkage between institutional and community services [6]. These arguments point to the importance of the physical proximity of mental health facilities [22], and the importance of face-to-face contacts between patients and caregivers [23].

Third, access to a mental health delivery system is not always optimal. Research focusing on severe and intractable mental disorders showed that the care received is largely inadequate by any reasonable criterion [24–26]. Surveys that have measured the reasons why patients with mental disorders did not seek help indicate that persons did not always know which way to go with their mental or emotional problems [27]. This leads us to hypothesize that, throughout decades, an unplanned and unforeseen flow of patients has had little choice but to utilize PERs for their emotional problems. Given the fact that only a minority of those who need mental help actually seek professional help, it is evident to see that a triage-based conceptualization of a PER may have an adverse impact on the success of help-seeking [28,29].

## Proposals to improve mental health care in emergency psychiatry

### Innovations on the level of clinical care: screening and treatment approaches

As psychiatric hospitals will always stay a primary venue for persons with emotional or mental problems, the PER is an important entry point for seeking psychiatric help for a wide variety of disorders. Patients attending PERs show a huge diversity in demographic and clinical characteristics. They consist of several subgroups that differ significantly in their characteristics and, consequently, in their social, somatic, and psychiatric needs. Accordingly, the goals and functions of PER services may vary depending upon the

specific needs of patients. This implies that the PER will serve as an easily accessible step-up into more specialized mental health care, whereas for others, the PER will be consulted for crisis management, or nothing else as gathering information or counseling.

Thus, the question arises whether a triage philosophy should be maintained, implicating sending patients home when they have no mental disorder that needs urgent care. We believe that the importance of treatment motivation strategies, however, cannot be underestimated as enhanced motivation may decrease the number of repeated referrals to the PER [13–15,30]. However, a change of the PER into a treatment facility creates other risks, of which an overpopulated emergency room is the most important. The very scope of the problem of an overpopulated emergency room lies in the overall absence of valid screening instruments or clinical assessments that may be used to classify patients in terms of severity of their complaints. As patient classifications in PERs are oftentimes based on idiosyncratic clinical assessments of psychiatrists or residents [31], there is a great potential for inability of recognizing mental illness that may need emergent treatment. Such a prognostication classification system could be employed for an appropriate, cost-effective triage and management of PER patients in the setting of ED, by linking them to appropriate aftercare facilities.

### Innovations on the level of organizing psychiatric emergency rooms: building psychiatric networks

The changed locus of mental health care, loosely connected community mental health services, stipulated the need toward less fragmented and more organized inpatient and outpatient facilities. A more appropriate care can be achieved when community-based mental health facilities have a close collaboration between PER caregivers, primary care, and specialized caregivers that may offer patients a continual care [32,33]. An underlying aspect is that PERs may become part of a regional system or 'psychiatric network' [34–36]. In the field, there are two models in care delivery that complement the PER in encountering persons in crisis: mobile crisis teams and brief admission units [37]. This implies that psychiatric emergency care could be best organized by collaboration between the PER, the mobile crises team, and the brief admission unit. Such a collaboration could be beneficial for a few reasons: (a) coordination between services, (b) sharing resources with different services, (c) facilitation of continuity of care, (d) establishing working relationships with facilities outside the network, and (e) providing a consistent philosophy of care.

### Innovations on the level of policy making: toward a psychiatric emergency room mission statement

Although the establishment of psychiatric networks may be a good response to the lack of well-organized

psychiatric emergency care, their implementation will remain relatively suboptimal if they are not integrated in the policy making or strategic planning of the ED. It is therefore necessary for general hospitals to punctuate the role of their PER in their mission statement. Nowadays, ED mission statements often lack any reference to a PER [38]. As hospitals are more in the business of curing the acutely ill [39], it is important to recognize that there will be a greater emphasis on the need for organizational and managerial aspects of PER facilities.

## Conclusion

Deinstitutionalization of mental health care and policy emphasis on community care have led to increased use of acute and extended care by patients with mental illness. The rapid transition from institutionalized to community care exposed gaps in service standards, strategies, and protocols for a whole range of patients. This resulted in an increase in PER patients. Triaging patients away may not be the most optimal way to deal with these patients. After all, general hospital EDs will always be the first venue for persons in emotional crises, whether they are 'emergent' or 'nonemergent'. Hand in hand with the fact that mental health services are often uncoordinated, that treatment continuity is often lacking, and that the majority of persons with mental disorders do not receive adequate professional help, PERs nowadays are increasingly confronted with complex populations, ranging from 'revolving-door patients' to 'first-timers'. Now that psychiatric networks are rising, the concept of 'continuity of care' deserves more attention and may be even considered as a cornerstone of PERs. Accordingly, also important in rethinking PERs is the fact that policy makers should account for the fact that the gate-keeping function may be extended with a more treatment-based approach. In this way, also patients with a nonemergent need for care may thus have access to professional help.

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