Critical issues and opportunities of emergency psychiatry in Italian emergency departments

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Abstract

In Italy emergency physicians are the front line of care for patients with medical conditions such as trauma, heart attacks, strokes or psychiatric disorders. Triage represents the first clinical contact with the person to determine urgency of care, and includes initial risk assessment and determination of observation level. It is necessary to undertake mental health triage for all service users on entry to the Emergency Department (ED), alongside physical health triage. The recourse to emergency services for psychiatric complaints is increasing and ED providers are often the first contact a patient will have with psychiatric care. The organization of Italian EDs is constantly evolving under the pressure of various external forces (population aging, increasing use of new substances, immigration, choices of economic policy, and technological development). The psychiatric emergency service contact represents a key to addressing the presenting problem and it is a critical link for continuity of care. The management of psychiatric disorders is an evolving issue in Italy as in other countries. Research increasingly suggests the importance of specific training for EDs teams in order to provide appropriate handling in acute settings. Psychiatrists and ED physicians can – and should – play a fundamental role in promoting a targeted and shared training for emergency services to deal with crisis according to evidence-based medicine. Service organization, legal issues, safety, training and education are not well defined and established and still imply improvisation, while they deserve attention as fundamental prerequisite to implement specific treatment guidelines.

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Introduction

Italy experienced a radical change in mental health in 1978, with a shift to new community-based psychiatric services. The Law 180 marked a turning point in mental health care organization. It sanctioned the end of the Psychiatric Hospital as a segregating institution and the integration of psychiatric treatment into the general health service. The reform established a department model offering diversified and specialized structures within one facility, the Department of Mental Health (DMH). This basic structure is responsible for prevention, care and rehabilitation of individuals with psychiatric illnesses within a defined catchment area. It deals with the full array of mental health needs of the population and offers long-term multi-disciplinary interventions and continuity of care. Geographical variability in service provision has diminished over time: in many regions substance misuse disorders and mental disorders in children and adolescents are treated by specialist services which are part of the DMH with better integration and closer collaboration between different services. The DMH also provides emergency treatment at home and in the general hospital context, where there is a Psychiatric Diagnosis and Care Service (SPDC). The creation of psychiatric wards within general hospitals has brought psychiatry into the field of medicine at a national level for the first time in Italy. The general hospital inpatient wards respond to the needs of patients who require acute treatment, both in the case of voluntary admissions and in compulsory care (about 8% of all admissions in 2016).[1] It also guarantees emergency treatment in conjunction with the hospital's Emergency Department (ED). Psychiatrists working in hospital are usually involved in consultation-liaison programs with medical and surgical wards located in the general hospital. The Italian experience attracted international attention for its innovative aspects and helped achieve what was accomplished in other countries, but many problems remain for the implementation.[2] Sadly, the reform law established some general principles and indications but did not give detailed standards for service and staff provision and the quality of care is still a matter of dispute (often inadequate drug treatments, psychotherapeutic, psycho-educational and rehabilitation interventions not being available, inpatient admissions too short with high readmission rates).[3] Italian psychiatric services vary considerably from one geographic area to another. The regions are independent in the organisation of the health system and manage their services in different way. The funding of psychiatric departments in different regions varies from 2.1% to 6.5% of the region's total health budget (total spending on mental health currently stands at 3.5% of the total health budget).[4]

The scenario

In 2016, there were almost 600,000 accesses in Italian EDs for psychiatric problems (about 2,8% of all ED visits), of which 13.2% resulted in hospitalization and of these just over half in a psychi-

atric ward.[1] The ever-increasing recourse to Emergency Room (ER) for mental health problems is a part of the general increase of medical interventions provided in this setting.[5,6] Increasingly, ER providers have to deal with the evaluation and treatment of psychiatric patients in crisis, often for long periods of time and within often overcrowded, noisy, and hectic care environments. Nevertheless, clinicians in the emergency setting are often the first contact a patient will have with psychiatric care and a negative experience during this initial access to medical care may lead to an unwillingness seek help and to the avoidance of further psychiatric contacts. The impact these conditions have on the acute clinical setting has paved the way for emergency psychiatry as a nascent subspecialty of both psychiatry and emergency medicine. Conditions requiring psychiatric competence may include attempted suicide, depression, psychosis, violence or other rapid changes in behaviour. However, the overload of emergency hospital services is only partially related to mental disorders in the strict sense. A number of factors have contributed to the greater use of the ER by those who need psychiatric assessment and treatment. These factors include insufficient and fragmented outpatient mental health services, poor support for people with chronic psychiatric conditions, social deprivation, the increase of vulnerable people (*e.g.* homeless and migrants); moreover the ED often represents the place of first contact for conditions like behavioural alterations due to alcohol and others psychoactive substances. Psychiatric conditions are, by their very nature, difficult to manage, but with good knowledge and appropriate resources, patients can be effectively stabilized and managed in acute setting. Given this situation, virtually all ED practitioners will likely provide some psychiatric intervention, due to the limited psychiatric resources available for referral or inpatient care. Psychiatric and behavioural emergencies are grafted into a dynamic, unstable, and very challenging environment, like that of EDs. Emergency physicians in overburdened settings are the front line of care for patients with surgical conditions such as trauma, heart attacks, strokes or psychiatric disorders.

Care providers are routinely exposed to unstable and stressful situations, with patients suffering from traumatic injuries and medical conditions and often being forced to long wait times in slow throughput processes. Furthermore, the organization of Italian EDs is constantly evolving under the pressure of various external forces (population aging, increasing use of new substances, immigration, choices of economic policy, and technological development).[7]

Triage and medical assessment

Triage represents the first clinical contact with the person to determine urgency of care, and includes initial risk assessment and determination of observation level. It is necessary to undertake mental health triage for all service users on entry to EDs, alongside physical health triage. The recognition that concomitant conditions are often present is critical to the complete evaluation of a patient presenting for treatment, as the complexity of clinical situations is linked to the frequent intermix between physical and mental issues (Focused Medical Assessment). Take, for instance, the case of behavioural disturbances. They can have many causes, and may or may not be related to a mental illness (*e.g.* delirium is commonly missed). Nowadays, more and more medicine is entering an era of new and growing awareness of the frequent co-occurrence of psychiatric conditions and acute and chronic somatic disorders and the triage has improved over time according to this issue. The World Health Organization proposition that there can be *no health without mental health* emphasizes the need to promote a holistic and unitary medicine and to improve the quality of care for both mental and physical health conditions for people with mental disorders. We must strongly avoid the temptation to assume that the patient with psychiatric symptoms could only have a primary psychiatric problem and partner with our staff to assess and understand the patient's presentation and available clinical information. The ED remains one of the most challenging and high-risk settings for assessing and providing clinical care, but at the same time for many people it represents a real opportunity. Indeed, it is a critical support in times of crisis and a significant starting point for many people to undertake treatments for both acute and chronic disorders. Take, for instance, the case of drug abuse in young people. Many studies on brief interventions in an ED setting stress that this context offers an important *window of opportunity* to engage with people with substance use problems who might otherwise never receive any form of assessment, referral or intervention. In these situations, complex and multidisciplinary skills are required for an initial assessment of the physical, toxicological, and psychiatric aspects and the correct involvement of appropriate services as mental health services and/or other services such as drug and alcohol, or child and adolescent mental health services. A proper evaluation will allow a good immediate treatment based on a brief intervention, using the biopsychosocial paradigm: i) biological: *e.g.* treating any underlying cause, pharmacological treatment of presenting psychiatric symptoms, medication for sedation; ii) psychological: *e.g.* therapeutic engagement, supportive counselling, using de-escalation; iii) social: *e.g.* mobilizing social supports, family and others to provide care post-discharge, finding emergency accommodation. For some presentations, assessment by specialist mental health services is needed before discharge from the ED; while for others it will be sufficient to consult with the mental health staff and to refer patients to the community mental health service for follow-up. The psychiatric emergency service contact is a critical link for continuity of care. It represents a key to addressing the presenting problem and reducing the possibility of a return in the acute clinical setting (revolving door phenomenon). In this regard, the inclusion in the triage process of simple instruments to detect the risk of aggressive, suicidal or absconding behaviours should be considered as a further improvement possibility.[8]

Clinical and environmental safety issues

Safety is a very important and challenging issue when caring for patients with psychiatric conditions in the ER. Indeed, incidences of healthcare violence are growing, and the most prevalent and predictable location for violence is the ED. Almost 20-50% of emergency psychiatric evaluations involve verbally and/or physically aggressive patients, 10% of patients visited can be agitated and/or violent.[9] Approximately 55-60% of operators suffer from physical assaults by psychiatric patients each year, 40-70% of psychiatrists have experienced violence at least once in their lifetime.[10] The categories mostly at risk are female non-medical workers with poor psychiatric training. The impact of violence on operators can generate a sense of loss of safety, with fear and feelings of vulnerability, as well as a reduction in the sense of professional competence. Episodes of violence in the emergency service are rarely analysed through psychological supervision, which leads to underestimating the phenomenon and its consequences. The staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives. The presence of safety,

clinical, environmental, and legal issues requires the creation of a safety culture and a clear definition of the management of agitation and risk of violence. It is essential to recognize that this group of patients poses extraordinary problems and to have a program addressed to the risks associated, within a setting which has become a revolving door for many psychiatric patients. The first step is to have policies and to address the process of ED triage and the management of patients with psychiatric and other behavioural presentations. Triage practices should include risk assessment, and issues about communication between emergency and psychiatric clinicians, especially if a rapid consultation is possible. The ED dynamic environment and its potential for violent disruptions have emergency room staff, hospital administrators and security professionals searching for answers. Staff must know that the organization recognizes the reality of violence in the ER and should feel an organizational commitment to addressing the problem with the tools and training provided. This will reduce uncertainty and improve patient care and safety.[8] Physicians evaluating patients who are acutely suicidal, agitated, anxious, confused, psychotic, or intoxicated, should always consider their safety and ensure the safety of the patient, staff and other patients in the area. Most ERs do not have a space specifically designed to manage patients with psychiatric complaints, despite the recommendations of the guidelines. If a person is feeling paranoid, psychotic, shocked or suicidal, the environment can be clearly damaging, and potentially escalate symptoms. Ideally, the area would have wide visibility for assistance staff and privacy for patients. The National Institute for Health and Care Excellence guidelines prescribe that EDs have at least 1 designated interview room for mental health assessment, which is close to or part of the main ED receiving area, equipped with soft furnishings without potentially dangerous items, and is fitted with an emergency call system, an outward opening door, and a window for observation.[11] In Italy, the Ministry of Health in 2007 enacted recommendations for the prevention of acts of violence against health workers, which have been embraced by all local health organizations. In our country there is a lack of data and extensive statistics on the spread of the phenomenon, however the alarm present in emergency systems (ED and psychiatric settings in particular) is high today and indicates the need to activate prevention measures to counteract the occurrence. Some precautions may reduce the risk: not leaving dangerous items available, providing large and non-isolated rooms, maintaining a safe distance and providing escape possibilities; evaluating potential signs of evolution in violent behaviour such as motor hyperactivity, loud voice, tension, impulsivity against objects, threatening or provocative attitude; evaluating whether the carers have an effect of containment or favouring aggression and deciding whether or not to allow them to be present. It is crucial that other trained personnel is available because the presence of more people allows the control of critical situations or, in case of ineffective verbal containment, the carrying out of compulsory interventions.

Ethical and medical-legal problems

The presence of subjects with acute psychiatric complaints in ED requires knowledge and understanding of the complex relationships between emergency medicine, psychiatry, legal, and ethical aspects.[12] In particular, when ethical issues arise in emergency medicine, they frequently entail legal issues. Moreover, in this context a high risk is concentrated often without adequate and commensurate resources to deal with the severity of the patient's presentation. Physicians must make decisions without complete information, adequate time or access to legal advice. The duty of assistance that physicians have in providing care must refer to the patient best interests, the best of his/her ability, and the appropriateness to the situation. The clinicians need to know how to assess the ability to consent even in the context of ED in very difficult high-risk situations, such as those involving children, adolescents, people with intellectual problems, drug addicts and alcoholics, mentally ill people. When the special needs and often aberrant, disruptive, hostile behaviour of the emergency patient are introduced into the already difficult setting of the ED, unusual burdens and obligations are placed upon the hospital and its health care practitioners. The legal implications of these situations are numerous, and the clinicians must know the current legislation and the possible legal consequences. In Italy a compulsory mental health hospitalisation order is known as *Trattamento Sanitario Obbligatorio* (TSO). The matter of involuntary medical checks and treatment is governed in accordance with Law 833/1978, which confirms and extends the concepts introduced by Law 180/1978, and abrogates all laws enforced previously. The law eliminates the notion of social dangerousness and dictates that in the eventuality of prescription of mandatory care for the mentally ill, treatment "should take place in a hospital regime only in those cases where psychic conditions are such as to require urgent therapeutic intervention, if treatment is not consented by the patient, and where circumstances do not allow the adopting of timely and adequate measures in an outpatient regime". With regard to medical-legal aspects of urgency, the focus is on the refusal of treatment but, especially in the ED setting, it is not always clear what the appropriate way to behave is both in the time between proposal and validation, and then between validation and release of the TSO ordinance, and how to overcome the existing difficulty of finding a balance between the need to limit the freedom of a citizen in absence of authorization for a specific provision and at the same time to contain potentially harmful situations for the patient or other persons. Theoretically, health and non-health personnel should not be asked by the law to use coercive means, but it is not even clear who is allowed to do it: from this come the refusal attitudes from people who are involved in various ways. As regards physical restraint, there is a lack of studies in Italy, although it is a shared opinion that non-coercive de-escalation interventions, treating in the least restrictive level of care, and establishing of therapeutic alliance would be preferable. However, there are cases in which verbal or behavioural de-escalation are not sufficient and physical restraint protects patients and operators from the risk of harm. In Italy, however, there are no specific instructions from the scientific societies and, since no national regulations exist, it is neither prohibited nor allowed.

Utilization of emergency departments by migrants with psychiatric disorders

The increased demand for emergency care in Europe has coincided with rapid population change; in particular, growing rates of immigration are creating additional pressure. During the last three decades, Italy has become a popular destination for non-EU immigrants and refugees. The percentages and modalities of the use of healthcare systems by the migrant population differ from those of natives, due to various factors, such as health status, self-perceived needs, health seeking behaviour, language barriers and cultural differences in ED utilization among the immigrant population.[13] In

general, immigrants and refugees have an increased risk of suffering from mental health disorders due to the challenging experiences that they encounter during the migration process. Besides being one of the most important social phenomena in our country, migrations are transitions full of meaning and existential content with often unpredictable outcomes. An emerging problem is the presence in the ER of immigrants often brought by law enforcement, due to behavioural disorders or symptoms of discomfort that are not always easy to understand. The greater complexity of their pathways to specialist services and inequity in treatment may lead to increased disease severity and consequent emergency referrals. One of the consequences is that in emergency psychiatry, immigrants appear at higher risk of compulsory admissions and other coercive measures. Our territorial area is particularly interested in the phenomenon, being a border area with Switzerland and considered one of the *hottest* spots after Ventimiglia (on the border with France). The presence of a governmental reception centre for immigrants has motivated the need to organize dedicated services, able to intervene in different contexts (in particular the ER and the mental health centres), with new skills in transcultural psychiatry and cultural mediation. Indeed, the psychopathology associated with immigration could be incomprehensible if socio-economic and cultural factors of both the place of origin and the place of arrival are not taken into consideration. The transition from the home country to a new reality involves personal identity, often resulting in discomfort due to the loss of cultural protective envelopes with consequent manifestation of vulnerabilities. Several studies have shown that immigrants and refugees suffer from somatisation disorder, post-traumatic stress disorder, psychotic disorders, anxiety disorders, and depression; this is also the situation in our context. Among the symptoms that may occur are dissociative episodes with loss of contact with reality, related to situations that require an adaptation effort when a cultural component does not integrate with the local culture. Psychotic symptoms are common among immigrants in EDs and that mirrors the higher prevalence of psychotic episodes among ethnic minority groups. An acute psychotic episode can affect healthy individuals undergoing changes and, in many cases, it has a benign evolution and can be a reaction to new situations that are difficult to adapt to. The disorder is characterized by a sudden onset of symptoms, which may include delusions, hallucinations, disorganized speech or behaviour, alarm conditions or catatonic behaviour. The depression of the migrant is influenced by the heterogeneity of the various cultures, but mostly assumes the characteristics of a masked depression with a preponderance of somatic symptomatology with no mood changes. The course and the outcome of the different conditions depend above all on the support that the community shows towards the person. In the context of absence of organized responses, EDs have been asked to become an essential point of care, and to play a fundamental role for urgent (and not only) problems of a medical and psychiatric nature. Migrants utilize the ED more, and differently, with respect to the native populations in European Economic Area Countries. The higher use of the ED for low-acuity presentations suggests that migrant patients are not necessarily an unhealthy population in need of emergency care but, rather, that there may be barriers to accessing more appropriate healthcare services in their host countries. Migrants may have difficulty visiting a doctor during normal working hours and be forced to seek healthcare out-of-hours, as a result of inflexible and unstable working conditions. There are widespread defensive attitudes and serious limitations in the general and psychiatric care organization. For example, the migrants' clinical history is not well known and the paucity of cultural mediators makes it difficult to collect. Furthermore, there is a lack of competence among the staff of centres for migrants regarding psychiatric conditions, in addition to a lack of services with experienced professionals in migration and ethno-psychiatry. A national mental health funding strategy specifically for migrants and refugees needs to be implemented in Italy, with cross-cultural training programs, psychiatric teams, and consultation centres.

Conclusions

After 40 years a law can be refined, without betraying its informative principles and enriched with directives capable of counteracting proposals to legislative change oriented towards greater social control and other measures of custody for individuals with mental disorders. From the recognition of the failings proposals can arise to improve the weak points of the current legislation, in particular, combating insufficient coordination and efficiency along the pathways to care, and the limited availability of interventions. The management of psychiatric disorders is an evolving issue in Italy as in other countries. Awareness is the first step towards change. Today, research increasingly suggests the importance of specific training for emergency services teams. Regarding the training level of the psychiatric staff, in the very first years following the reform, it underwent a precarious and extemporized phase of *self-learning*, relying on common sense. After the initial enthusiasm, this created feelings of inadequacy and even of extreme pessimism in psychiatrists. The frustrating reality of chronicity and its difficult management in an environment lacking in facilities has highlighted the limits of this approach. Emergency physicians are experts in the treatment of physical injuries and diseases, but they often appear fearful in dealing with psychiatric emergencies because of their minimal training. Psychiatrists and ED physicians can – and should – play a fundamental role in promoting shared practical training for emergency services on crisis management according to evidence-based medicine. Targeted trainings allows ED physicians to take action in advance to alleviate the suffering of patient, waiting for the specialist, and this intervention can reduce the need for coercive treatment, improve outcomes and reduce both waiting times and number of hospitalization requests. Collaborating with the medical emergency environment in this way would also help psychiatrists to better understand the challenges and reality of crisis care in EDs. This would benefit everyone, especially patients. It is also desirable to hypothesise specific emergency services, equipped with beds, connected both to the ED and to the SPDC, able to exercise a filtering function on urgencies by carrying out 24-hour a day first-aid interventions (dedicated mental health wing of medical ED). This model improves on the simple consultant in the ED model by providing a separate, often more welcoming and calming environment. Since its location is within a medical ED, patients can receive full medical history and physicals as part of their evaluation. Good practices, awareness of one's own function, and integration within the ED prevent these holding areas from becoming a way of taking the patients out of the main part of the ED until placements are made.

Taking care of patients who are acutely ill in a timely manner requires incredible skill (especially if they are agitated, aggressive, or poorly collaborative), and the availability of dedicated areas to separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms), and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation), ensuring that staff does not become iso-

lated. In order to cope with the increase in psychiatric urgencies, some countries have organized psychiatric emergency services (*e.g.* the American Psychiatric Emergency Service) capable of handling urgencies that do not require hospitalization and also social problems, drug addiction and/or antisocial behaviour, through collaboration with other professionals. Where these realities do not yet exist, such as in Italy, there is an exponential growth in the use of hospital EDs, facilities that should be dedicated to the treatment of acute problems that cannot be tackled in different places, with a consequent increase in improper hospitalisations in the face of a marked reduction in the number of beds available. This is also related to the difficulty in managing psychiatric urgencies directly in EDs, which are not well equipped to cope with crises. It is correct for psychiatric patients to access emergency medical services because, like physical problems, psychopathological crises are symptom patterns that can often be stabilized in the ER and resolved within 24 hours without inpatient admission. We must change the widespread idea that most patients with urgent mental health presentations require hospitalisation, by implementing effective ways to deliver timely psychiatric care in the ED capable of reducing the prolonged stay of these patients in an unsuited environment (*psychiatric boarding* phenomenon), in the awareness that it is completely appropriate for emergency psychiatric patients to come to medical EDs because their emergencies must be categorized as equivalent to acute medical or surgical conditions.[14]

Instead, there is the belief that most patients with potentially lethal psychiatric emergencies such as suicidal risk and psychosis always require hospitalization. This leads to *diverting* psychiatric patients from emergency services, not due to negligence, but to the fear of situations that are difficult to manage because of the lack of adequate training. Rather than trying to avoid them, hospitals should better prepare to meet the needs of these patients, to ensure an adequate response to the problem immediately, saving beds for those who really have no alternative. Medical evaluation and triage, psychiatric assessment, verbal de-escalation, psychopharmacologic approaches, use of seclusion and restraint – if necessary - are the steps for a good treatment, but for working well it is mandatory a team approach. Facing psychiatric disorders in the ED represents an opportunity for both, emergency physicians and psychiatrists, everyone collaborating with his know-how. Strategies for managing violent behaviour in ED settings and training programs include shared educational programs and policies aimed at individual and collective skill sets. This vision is based on a person-centered approach to care based on values, in which personal relationships, continuity of care and a positive attitude in promoting health are the basis of the therapeutic relationship.

By getting rid of the condition of *social damper*, which actually leads it to replace social services, psychiatry can regain its prerogative of the medical discipline and provide an important contribution to individual and collective health, without renouncing being the bearer of an integrated and non-reductionist vision of the conditions of suffering and illness. Health care provider organizations and commissioners should ensure that every ED has routine and urgent access to a multidisciplinary liaison team that includes consultant specialists who are able to work with children, young people, adults and older adults. There should be regular meetings between the ED staff and providers of liaison psychiatry, in order to improve the links and the process of getting to know each other. Involvement in each other's induction programme really helps to improve response times and flow of service. Consultation-liaison psychiatry activities in EDs and in other hospital services carry out several significant tasks, including the contrast to some negative trends (such excessive specialisation and fragmentation), the preservation of a holistic perspective and the possibility for psychiatrists to treat patients that they otherwise would not have met.[15] It is time for a new alliance to improve mental health services for patients within the ED. This will result in a marked improvement in emergency care, saving time with reduced waiting periods in a non-therapeutic environment, and better satisfaction of users and staffs.

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