Inpatient care for emerging adults affected by mental health disorders: Editorial

Brian O'Donoghue^{1,2,3}

¹ Orygen, the National Centre of Excellence in Youth Mental Health

² Centre for Youth Mental Health, University of Melbourne, Australia

³ Orygen Youth Health, 35 Poplar rd, Parkville, VIC 3052, Australia

Corresponding Author

Dr Brian O'Donoghue

Orygen, the National Centre of Excellence in Youth Mental Health

35 Poplar rd, Parkville, VIC 3052, Australia

Email: briannoelodonoghue@gmail.com

Phone: +61-1-93422849

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as doi: [10.1111/eip.12539](https://doi.org/10.1111/eip.12539)

The study by Puyat et al delivers needed information on the inpatient care received by emerging adults experiencing early psychosis and other disorders (Puyat et al., 2017). A number of positive aspects of care were highlighted in the study, such as the use of low dose antipsychotic medication in those with a first episode of psychosis, however challenging aspects of inpatient care were also identified. First, high rates of aggressive behaviour were observed, with over half of the inpatients having a known history of aggressive behaviour and over one third having been victims of aggressive acts themselves. Second, substance use was common in this clinical population, with nearly half of inpatients testing positive for substances such as amphetamines, benzodiazepines, opiates or cannabis. Finally, there were high rates of restrictive interventions, with nearly one third of emerging adults being placed in seclusion at some time during their admission.

Preventing and minimizing the need for admission

There is an imperative to minimize the number of emerging adults who require an admission to hospital in order to receive the appropriate treatment for their mental health disorder. Preventing admission for an emerging adult with a psychotic disorder is possible, as it has been established that a longer duration of untreated illness in psychotic disorders increases the likelihood that an

admission will be required (Sipos, Harrison, Gunnell, Amin, & Singh, 2001). Therefore, reducing help-seeking and system delays by implementing wide-spread early intervention for psychosis services (Joa et al., 2008) should lead to lower admission rates, in particular those that are involuntary. Furthermore, adequately resourced home-based care teams are an essential component of early intervention for psychosis services, to ensure that emerging adults and their families can receive intensive supports in the community.

Youth specific inpatient units

While treatment in the community is preferable for young people affected by mental health disorders, there are times when inpatient care is indicated and necessary and therefore, specific inpatient units streamered for age and stage of illness are needed. The rationale for youth mental health services is based on the highly replicated finding that the vast majority of mental health disorders have their onset in last adolescences and early adulthood (P.D. McGorry, Purcell, Goldstone, & Amminger, 2011). Youth mental health services have the design, layout and atmosphere to cater for this specific age-group (P. McGorry, Bates, & Birchwood, 2013). As services that cater for young children would not be appropriate for those aged 15 to 17 and similarly, services designed to cater for adults up to the age of 65 would not be suitable for those in early adulthood. This disparity is most evident in inpatient units. However even within the age group of 15 to 24, there are specific needs of emerging adults to ensure that inpatient units are safe, supportive and inclusive. The study by Puyat et al demonstrated that inpatient units place acutely unwell individuals who are instigators of aggression in close proximity to those who

have been victims of violence. Therefore, it is a challenging task to ensure that emerging adults affected by mental health disorders are treated in the least restrictive environment within the inpatient unit, while also ensuring the safety of all inpatients. Similarly, sexual assaults can occur on inpatient units (Ford, Rosenberg, Holsten, & Boudreaux, 2003) and there is a need to promote a safe environment for all inpatients. One solution is to have specific areas designated for women only within the inpatient unit. Yet this solution may not be so straightforward, as inpatient units need to be inclusive and supportive, including those who identify as transgender or gender-diverse.

First impressions can last

Despite the development of intensive community treatment services, a significant proportion of emerging adults presenting with a first episode of psychosis are admitted to hospital at their initial presentation (Sipos et al., 2001). During inpatient admissions, restrictive interventions, such as restraint and seclusion, can at times be necessary to manage risks and to ensure individuals receive the required treatment, yet the impact on longer term engagement with services as a result of these practices is not known. Considering that engagement is a key component of early intervention for psychosis services (Lal & Malla, 2015), the relationship between the experience of restrictive interventions and subsequent engagement needs to be better understood. While the acute or immediate risks of restrictive interventions, such as injury to the emerging adult or staff are often considered, the potential medium term consequences such as re-traumatization or risk of disengagement may not be considered as often. It has been

Author Manuscript

demonstrated that a significant proportion of individuals who are admitted to hospital with a first episode of psychosis can subsequently exhibit symptoms of post-traumatic stress disorder relating to the experience of hospitalization and the use of restrictive interventions (P. D. McGorry et al., 1991; Meyer, Taiminen, Vuori, Aijala, & Helenius, 1999). However, simple interventions that aim to positively change the culture on inpatient units by providing training to nursing and medical staff have been demonstrated to reduce the frequency of conflict and restrictive interventions (Bowers et al., 2015). The application of these interventions, especially in youth mental health inpatient units, should be seen as a priority within clinical and research services.

Opportunity to intervene

Traditionally inpatient units had a number of features that could impact negatively upon an individual's physical health, such as increased sedentary behaviours, smoking and weight gain (Curtis & Shiers, 2014; Hjorth et al., 2014). However, there is now a focus on ensuring that physical health is either maintained or improved while receiving treatment for a mental health disorder. This paradigm shift is represented by mental health services now integrating services such as exercise physiologists and dietitians into routine clinical practice (Lederman et al., 2017). Inpatient units offer an ideal setting to address the physical health of emerging adults with their first episode of psychosis or other mental health disorder by offering activities such as physical exercise and cooking skills. Smoking is highly prevalent in this population (Myles et al., 2012)

and inpatient units are now adopted smoke free policies, so they are an ideal setting to address smoking by offering nicotine replacement therapy and psychological support for smoking cessation. This could have multiple benefits, as the appropriate use of nicotine replacement therapy can reduce agitation in individuals with a diagnosis of schizophrenia who are smokers (Allen et al., 2011), so it is plausible, that the treatment of nicotine withdrawals could lead to a decrease in aggressive incidents, in addition to the health benefits. Inpatient units are often an ideal time to engage family members or caregivers and deliver family interventions or psychoeducation, which can reduce relapse and readmission rates (Bird et al., 2010). Involving family members or caregivers is essential, as they can report feeling left out or overburdened (Jankovic et al., 2011) and an involuntary admission can also negatively impact upon the relationship with the family (O'Donoghue et al., 2010).

An atmosphere to recover

Deinstitutionalization resulted in individuals affected by mental health disorders being cared for in the community and led to a significant reduction in the number of psychiatric beds worldwide (Shen & Snowden, 2014). The median length of admission in the study by Puyat et al was 18 days (range 3–268 days), which could be considered short and may be a result of the demands for psychiatric beds. Interestingly, individuals who had multiple admissions were more likely to have shorter admissions compared to those who only had one admission. While there could be a number of explanations for this finding, one possibility is that premature discharge can result in a

subsequent admission and therefore represents a false economy. However, it has to be acknowledged that inpatient admissions are expensive and are provided at the cost of other services which could be provided in the community and therefore benefit a larger number of individuals. Yet, the threat of admission to hospital is often used as leverage to persuade individuals to engage in community treatment. The basis of community treatment orders are that an individual can be admitted to hospital if they do adhere to the conditions set out on the community treatment order (Rugkasa, Dawson, & Burns, 2014). This implies that admissions to psychiatric units are an unpleasant experience, which is something that will need to change if they are to be considered places for recovery.

Therefore, there is a need to review inpatient care for young people and to evaluate how it can be provided in a safe, inclusive environment that addresses the young person's mental and physical health, yet in a timely and efficient manner to be cost effective.

References

- Allen, M. H., Debanne, M., Lazignac, C., Adam, E., Dickinson, L. M., & Damsa, C. (2011). Effect of nicotine replacement therapy on agitation in smokers with schizophrenia: a double-blind, randomized, placebo-controlled study. *American Journal of Psychiatry*, 168(4), 395-399.

- Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J., & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review. *British Journal of Psychiatry*, 197(5), 350-356.
- Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, 52(9), 1412-1422.
- Curtis, J., & Shiers, D. (2014). Progress towards parity: Improving the physical health of long-term psychiatric inpatients. *Australian & New Zealand Journal of Psychiatry*, 48(11), 1060-1061.
- Ford, E., Rosenberg, M., Holsten, M., & Boudreaux, T. (2003). Managing sexual behavior on adult acute care inpatient psychiatric units. *Psychiatric Services*, 54(3), 346-350.
- Hjorth, P., Davidsen, A. S., Kilian, R., Eriksen, S. P., Jensen, S. O., Sørensen, H. Ø., & Munk-Jørgensen, P. (2014). Improving the physical health of long-term psychiatric inpatients. *Australian & New Zealand Journal of Psychiatry*, 48(9), 861-870.
- Jankovic, J., Yeeles, K., Katsakou, C., Amos, T., Morriss, R., Rose, D., Nichol, P., McCabe, R., Priebe, S. (2011). Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives--a qualitative study. *PLoS One*, 6(10), e25425.
- Joa, I., Johannessen, J. O., Auestad, B., Friis, S., McGlashan, T., Melle, I., Opjordsmoen, S., Simonsen, E., Vaglum, P., Larsen, T. K. (2008). The key to reducing duration of untreated first psychosis: information campaigns. *Schizophrenia Bulletin*, 34(3), 466-472.
- Lal, S., & Malla, A. (2015). Service Engagement in First-Episode Psychosis: Current Issues and Future Directions. *Canadian Journal of Psychiatry*, 60(8), 341-345.
- Lederman, O., Suetani, S., Stanton, R., Chapman, J., Korman, N., Rosenbaum, S., Ward, P.B., Siskind, D. (2017). Embedding exercise interventions as routine mental health care: implementation strategies in residential, inpatient and community settings. *Australasian Psychiatry*, Epublised ahead of print: doi:10.1177/1039856217711054
- McGorry, P., Bates, T., & Birchwood, M. (2013). Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. *British Journal of Psychiatry Supplement*, 54, s30-s35.

- McGorry, P. D., Chanen, A., McCarthy, E., Van Riel, R., McKenzie, D., & Singh, B. S. (1991). Posttraumatic stress disorder following recent-onset psychosis. An unrecognized postpsychotic syndrome. *Journal of Nervous & Mental Disorders*, 179(5), 253-258.
- McGorry, P. D., Purcell, R., Goldstone, S., & Amminger, G. P. (2011). Age of onset and timing of treatment for mental and substance use disorders: implications for preventive intervention strategies and models of care. *Current Opinion in Psychiatry*, 24(4), 301-306.
- Meyer, H., Taiminen, T., Vuori, T., Aijala, A., & Helenius, H. (1999). Posttraumatic stress disorder symptoms related to psychosis and acute involuntary hospitalization in schizophrenic and delusional patients. *Journal of Nervous & Mental Disorders*, 187(6), 343-352.
- Myles, N., Newall, H. D., Curtis, J., Nielssen, O., Shiers, D., & Large, M. (2012). Tobacco use before, at, and after first-episode psychosis: a systematic meta-analysis. *Journal of Clinical Psychiatry*, 73(4), 468-475.
- O'Donoghue, B., Lyne, J., Hill, M., Larkin, C., Feeney, L., & O'Callaghan, E. (2010). Involuntary admission from the patients' perspective. *Social Psychiatry and Psychiatric Epidemiology*, 45(6), 631-638.
- Puyat, J. H., Kamieniecki, R., Vaughan, B., Mihic, T., Bonnie, K., Danielson, J., & Williams, S. (2017). Characterizing the inpatient care of young adults experiencing early psychosis: A medical record review. *Early Intervention in Psychiatry*. Epublished ahead of print. doi:10.1111/eip.12468
- Rugkasa, J., Dawson, J., & Burns, T. (2014). CTOs: what is the state of the evidence? *Social Psychiatry and Psychiatric Epidemiology*, 49(12), 1861-1871.
- Shen, G. C., & Snowden, L. R. (2014). Institutionalization of deinstitutionalization: a cross-national analysis of mental health system reform. *International Journal of Mental Health Systems*, 8(1), 47.
- Sipos, A., Harrison, G., Gunnell, D., Amin, S., & Singh, S. P. (2001). Patterns and predictors of hospitalisation in first-episode psychosis. Prospective cohort study. *British Journal of Psychiatry*, 178, 518-523.

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

O'Donoghue, B

Title:

Inpatient care for emerging adults affected by mental health disorders

Date:

2018-10-01

Citation:

O'Donoghue, B. (2018). Inpatient care for emerging adults affected by mental health disorders. *EARLY INTERVENTION IN PSYCHIATRY*, 12 (5), pp.771-773. <https://doi.org/10.1111/eip.12539>.

Persistent Link:

<http://hdl.handle.net/11343/283658>