Special Considerations in Pediatric Psychiatric Populations

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KEYWORDS

• Autism • ASD • Autism spectrum disorders • ADHD
• Attention deficit hyperactivity disorder • Pediatric • Suicide

KEY POINTS

- Proper treatment of the pediatric psychiatric population can be challenging. Emergency department (ED) boarding, availability of child and adolescent psychiatrists, lack of parental understanding, and inexperience working with children with special needs are just some of the obstacles the ED physician will encounter.
- Suicidal ideation and aggressive or homicidal behavior are the 2 most common pediatric mental health presentations in the ED.
- Children and adolescents with autism spectrum disorder who present with acute behavioral regression that compromises safety should be evaluated using a multidisciplinary approach that includes organic, social, and psychiatric investigations.
- Oppositional-defiant disorder and conduct disorder are common presentations of disruptive behavior in the ED.
- The Internet and social media can have both a positive and negative effect on vulnerable children and adolescents.

INTRODUCTION

The increasing incidence of pediatric psychiatric disorders has been discussed in the literature for more than 2 decades. The 1999 US Surgeon General Report on Mental Health estimates 4 million children and adolescents in this country suffer from a

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serious mental disorder that causes significant functional impairments at home, at school, and with peers. Half of all lifetime cases of mental disorders begin by age 14 and in any given year, only 20% of children with mental disorders are identified and receive mental health services.[1]

The number of pediatric visits to the emergency department (ED) for psychiatric illness is also increasing.[2] Pediatric mental health visits now make up to 5% of total pediatric ED visits.[3] At our Psychiatry Emergency Center at Ben Taub Hospital (Houston, TX), a Level 1 Trauma Center that provides 24-hour coverage for psychiatric emergencies, a significant increase was seen from 2010 to 2012. Over these 3 years, we saw a sixfold increase of pediatric cases presenting for psychiatric evaluation.

This coupled with a decreased availability of inpatient and outpatient mental health services for children has created a crisis in EDs around the country.[4] The ED boarding of pediatric psychiatric patients also has become commonplace. In one study, the mean ED length of stay of children with psychiatric complaints deemed major was 1127 minutes.[5] This was 7 times longer than a control group with nonpsychiatric complaints in the same study.

Although the ED is a safety net for these patients, the environment itself can be counterproductive. The loud, crowded, and quick-paced ED can be detrimental to children suffering from anxiety, paranoia, or autism.

The ED provider is now obligated to care for this population for extended periods of time. We discuss the risk stratification and interventions necessary when dealing with children and adolescents presenting with suicidal ideation and violent behavior. In addition, we discuss the unique approaches to patients with autism spectrum disorders (ASDs) and attention deficit hyperactivity disorder (ADHD).

TRIAGE OF THE PEDIATRIC EMERGENCY PATIENT

With the increasing number of children presenting to the ED for psychiatric complaints, an effective triage tool is necessary. One study indicated that 40% of pediatric psychiatric ED visits were not urgent. Classification systems, such as the Rosenn urgency classification system, can help ED physicians and psychiatric consults classify need and acuity for psychiatric intervention.[6]

The following is the Rosenn urgency classification system for child and adolescent psychiatric emergencies[6]:

- Class I: Potentially life-threatening emergencies (eg, suicidal and homicidal behavior).
- Class II: States of heightened disturbance requiring urgent intervention (eg, witnessing or being a victim of rape, violence, kidnapping, death of a parent or sibling).
- Class III: Serious conditions requiring prompt but not necessarily immediate intervention (eg, school refusal, verbal threats of suicide or violence, child unmanageable but not dangerous).
- Class IV: Situations in which intervention is demanded but not necessarily psychiatrically warranted (eg, ignorance of proper mental health channels, consumer frustration with overburdened mental health system, interagency struggle, chronic antisocial behavior).

The mental status examination of a child also can help in classifying which cases require more urgent intervention. Observation and assessment of the following areas is necessary[7]:

- Physical appearance
- Manner of relating to examiner and parents

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