

Debate: Developmental and integrative approaches in child and adolescent psychiatry inpatient facilities: the case of a tertiary university hospital in Paris

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General information

The Child and Adolescent Psychiatric Department of the Pitié-Salpêtrière Hospital (CAPD-PS) is a tertiary care university referral center providing care to children and adolescents up to 18 years of age. It is the largest CAPD in the Paris area. It includes six inpatient units (67 beds), three day care hospitals (40 sits) and also provides many outpatient consultations ($\geq 20,000$ /year). The service catchment area includes around 12,000,000 people. The CAPD-PS was founded by Georges Heuyer before World War II. It is located in a hospital that serves mainly adult patients and admission are organized in the context of French free access to care for all.

Other inpatient facilities do exist in Paris area (see details in Figure 1, and indications in Table 1). Most of them focus on crisis management and are in the public health sector. Some are liaison psychiatry facilities in a pediatric department; others are autonomous CAPD inpatients units. Few focus on specific indications (e.g., eating disorders) or ages (e.g., children). Therefore, clinical management remains rather heterogeneous and refers to multiple theoretical approaches to provide a comprehensive and operational model for crisis management. Problematic behaviors may be understood as symptoms of a medical/psychiatric condition (medical model), as maladaptive strategies in a context of vulnerability/adversity (adaptation/developmental model), and finally as a mode of communication in a context of ill-adapted relational patterns (systemic model). We believe that a first-line CAPD inpatient unit should be able to combine these models to manage the diversity of clinical acute expressions. This means involving the intervention of professionals from various disciplines and being aware of such different levels of understanding could help to preclude any role confusion and to provide better targeted interventions (Guedj-Bourdiau et al., 2021).

Inpatients units

The CAPD-PS serves patients with severe treatment-refractory illness, with an average length of stay longer than most CADP hospital settings. Patients are admitted after second- or third-lines of treatment from other inpatient or outpatient services. Based on patient's age and clinical profile, they are admitted to one of the six

inpatients facilities. General inpatients facilities encompass three 15-bed units, one for the 6- to 12-year-old, another for the 12- to 15-year-old, and a last one for the 15- to 18-year-old inpatients. Each unit has a certain form of autonomy with specific paramedical team, psychologist, speech therapist, occupational therapist, social worker, and doctors (residents, chief resident, and senior psychiatrist). Activities provided involve individual counseling, supportive groups, occupational therapy, school when possible, recreational and sporting activities. The most significant feature of these units compared with others regionally or nationally is the lack of a priori duration of stay and the possibility of extending the length of stay based on patient's benefit. For example, the mean length of stay is three months in the adolescent wards with, unsurprisingly among these inpatients particularly enriched in resistant form of psychiatric disorders, a high rate of harsh environmental background and untreated mild developmental disabilities (e.g., specific learning disabilities, motor disorder; Benarous et al., 2020). Throughout admission, an emphasis is put on the family system with weekly family sessions. Inpatients are discharged only when a patient's centered project has been constructed without an a priori duration of stay. The opportunity for the patients to return home on progressive periods of leave helps us understand different perspectives involved in patients' difficulties and family burden. This is particularly true within contexts of shared insecure affective boundaries within families and difficulties in expressing ambivalent/conflicting views (Aouidad et al., 2020).

A 6-bed intensive psychiatric care unit has a higher professional/inpatients ratio. It serves patients with severe behavioral manifestations (e.g., delirium) sometimes associated with forensic issues, those requiring important nursing (e.g., catatonia) or those with medical comorbid conditions (e.g., treatment refusal with life-threatening risk). The department is a referral center for catatonia, bipolar disorder, early-onset schizophrenia, and rare medical conditions with psychiatric manifestations. Some patients require specific treatment in case of auto-immune disorders, inborn errors of metabolism, or genetic disorders (Consoli et al., 2019; Giannitelli et al., 2018). This unit is also the regional referral when electroconvulsive therapy (ECT) is indicated in minors (Consoli et al., 2013).

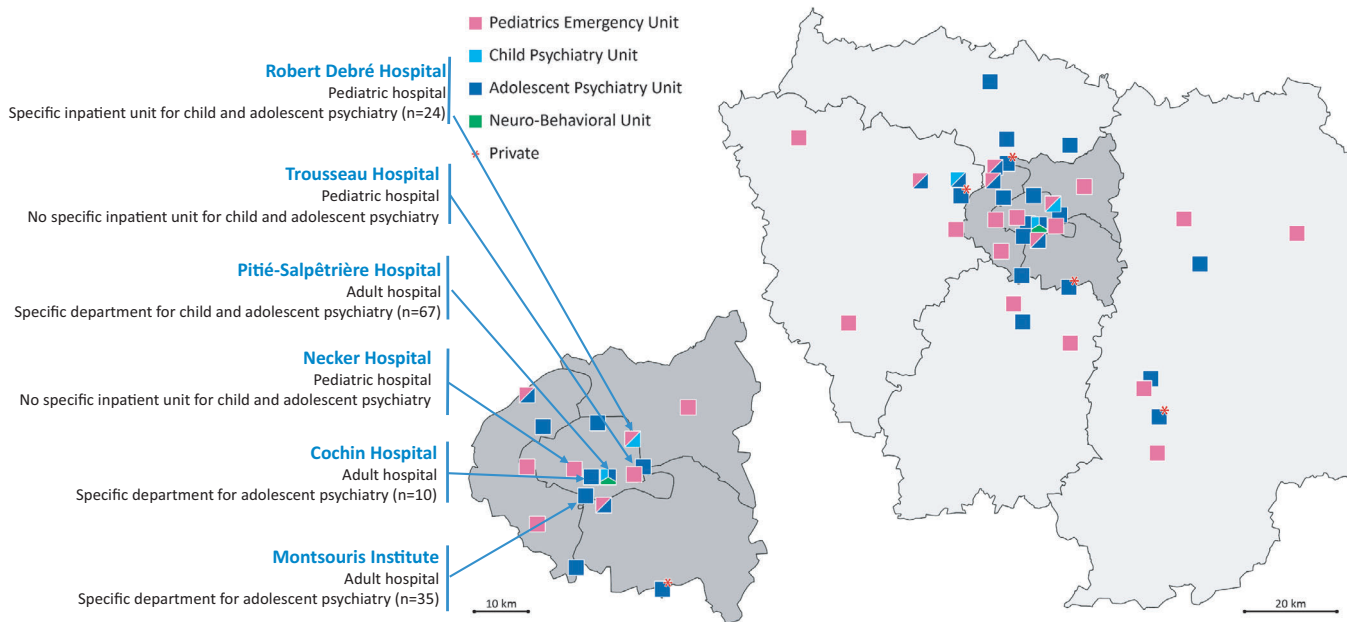


Figure 1. Inpatient units for children and adolescents with psychiatric conditions in the Paris area

The last two units are neurobehavioral units for children/adolescents or adults with autism and/or intellectual disability and resistant challenging behaviors (e.g., self-injurious behaviors, aggression, and disruptive behaviors). Treatment plans generally require a combination of symptomatic treatment (e.g., anti-pain drugs), treatment of associated psychiatric disorder (e.g., mood stabilizer for BD), and treatment of associated medical condition (e.g., anti-acid for gastritis). Functional analysis to identify environmental contingencies that contribute to the maintenance of the deviant behaviors

enable to implement tailored behavioral interventions. Specific approaches (e.g., compressive garments, therapeutic body wrap, or balneotherapy) centered on sensory-motor dysfunctions can be offered in some cases (Guinchat et al., 2020).

Theoretical frameworks

We summarize in Table 1 the main indications for a hospitalization in a CAPD. The listed is given by frequencies and costs. For the most complex cases, we believe that

Table 1. Main indications for inpatient stay in child and adolescent psychiatry

Indication	Objective of inpatient stay	Available at CAPD-PS	Alternatives in the city of Paris (Figure 1)
Acute behavioral crisis including suicide attempt	Brief duration of stay Separation from family and social network Individual and family assessment Organization of outpatient treatment	No	Departments of Pediatrics Other departments of child and adolescent psychiatry
Severe or repetitive behavioral manifestations	Longer duration of stay in secure units Separation from family and social network Individual and family assessment Forensic assessment when needed Organization of outpatient treatment	Yes	Other departments of child and adolescent psychiatry
Eating disorder	Specific inpatient program for eating disorders	No	Other departments of child and adolescent psychiatry
Rare disease, Catatonia, Early-onset schizophrenia, early-onset bipolar disorder	Individual psychiatric and medical assessment Treatment of both psychiatric and medical conditions	Yes	(Other departments of child and adolescent psychiatry)
Intractable Self-Injury Behaviors in patient with ASD or ID	Individual psychiatric and medical assessment Specific inpatient program in so-called 'neurobehavioral units'	Yes	No
Exceptional treatment	ECT Plasma exchange for autoimmune encephalitis with psychiatric presentation	Yes	No

ASD, autism spectrum disorder; ECT, electroconvulsive therapy; ID, intellectual disability; PSL, Pitié-Salpêtrière.

the theoretical framework should encompass the following perspectives. (a) Developmental: this implies that an early stressor impact development and its outcome will be a function of chronicity, treatment response, and resilience; (b) Multidimensional: this means that all dimensions of development (e.g., language, affect, motor) should be investigated to assess risk factors and tailored treatment (Xavier, Bursztejn, Stiskin, Canitano, & Cohen, 2015); (c) Eco-systemic: this means that a child develops in a system including proximal (e.g., family) and distant (e.g., cultural values) environments; and (d) Multifactorial causality: this means that causal factors are numerous and interact one with another (Cohen, 2010).

This theoretical framework has organizational staff and treatment implications. First, a modern CAPD should be multidisciplinary and include several allied disciplines (e.g., social worker, speech therapist, developmental psychologist, psychoanalyst, occupational therapist). Second, it should be implemented in a large medical setting with close disciplines (e.g., neuro-pediatrics). Third, treatment should be tailored according to clinical, family, and social assessments. Fourth, therapeutic proposals should be integrative (the opposite being exclusive) and discussed among staff members. They may include all types of psychotherapies, social support and intervention, and/or medication. Fifth, some organizational aspects (e.g., weekly meeting with members of all units to discuss complex cases) and teaching hospital care approach (with supervised tutoring) promote high-level of care. Sixth, a modern CAPD should also be opened to cultural interventions (e.g., art therapy) as some youths do not frequent school anymore but are still willing to join art/community activities. Seventh, the CAPD should include a school with specialist teachers to facilitate the required long duration stays for some cases and allow educational assessment before individualized projects. Finally, we believe that for complex cases we need to keep being ambitious in terms not only of clinical, but also functional recovery. This means sometimes promoting a life time project with the youth, and challenging the issue of costs with our administrative authorities.

Acknowledgements

The authors have declared that they have no competing or potential conflicts of interest.

Ethical approval

No ethical approval was required for this article.

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Accepted for publication: 1 March 2021