New study identifies gaps in emergency care for youth in crisis

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Even before the COVID pandemic, visits to the emergency department and hospitalizations for children and young adults who have contemplated or attempted suicide had been rising. In North America

today, suicide is the second leading cause of death for youth between the ages of 10 and 24, behind only accidental death.

Close to 3% of visits to pediatric emergency departments involve young people in psychiatric crisis, but few studies have described the treatment these patients receive.

A new study by researchers at Columbia University Vagelos College of Physicians and Surgeons now suggests that not all emergency departments are providing young patients in crisis with the most recent, evidence-based care. The findings are based on a survey of North American chiefs of pediatric emergency medicine who were asked about their standard practices and needs.

"Our hope is that by describing the widespread need for additional mental health personnel to evaluate and treat children and adolescents, we can help support policies to increase these services," says the study's lead author, Megan M. Mroczkowski, MD, associate professor of psychiatry at Columbia University Vagelos College of Physicians and Surgeons and medical director of the pediatric psychiatry emergency service at NewYork-Presbyterian/Morgan Stanley Children's Hospital.

We spoke to Mroczkowski, who led the study with Madelyn Gould, PhD, the Irving Philips Professor of Epidemiology in Psychiatry at Columbia, about the findings and her advice for parents.

What are the areas where pediatric emergency departments can improve?

I think two things stood out in our survey.

First, in emergency medicine, physicians often use clinical pathways to

guide patient care, to ensure a certain standard of care in various situations. Our survey found that most children's hospitals do not have a standardized clinical pathway for patients presenting with suicidal ideation or attempts.

This means that there's no clear guidance for physicians to determine who is having a crisis and how each patient should be treated. This is an area where we may be able to work to improve as a field.

Secondly, most chiefs reported that their department does not routinely follow up with these patients after they are discharged. Other research with adults shows that follow-up telephone calls after discharge, in combination with a safety plan provided to the patient, reduces future suicidal behavior. The finding suggests making this a standard practice in the pediatric emergency department may be helpful.

Almost one in five pediatric emergency chiefs said they do have patients sign "no-suicide contracts" before discharge, but current research does not support such contracts, as they have not been shown to decrease further suicidal thinking or attempts. The standard of care for patients who are discharged home from the emergency department should include a safety plan—outlining coping mechanisms, support persons, and contacts for them in case of crisis—along with a plan for mental health treatment if indicated.

What else is preventing kids in crisis from getting the care they need?

Many chiefs reported that their communities lacked resources for referring pediatric patients to psychiatric outpatient care.

Some creative solutions do exist to address these gaps and these could be

expanded. Some facilities, for example, employ social workers and case managers who work closely with families to make appropriate referrals and help navigate roadblocks to care.

Another facility in Connecticut has deployed an emergency mobile psychiatric service that responds directly to patients in crisis in the home, school, or in the emergency department and connects them to follow-up care in less than 48 hours. The cost of a mobile consultation is less than $1,000, compared to more than $10,000 for inpatient admission, so this service is quite cost-effective.

What should parents know if they think their child is having a mental health crisis?

Several psychiatric emergencies should be addressed immediately, specifically if a patient is a danger to her/himself or others. These include suicidal ideation or attempts, breaks with reality (psychosis), depressive symptoms leading to significant decreases in functioning, or threats or violence toward others. If parents notice these, they should call 911 or take their child to the emergency department, where parents should expect connection with follow-up mental health care.

How would you describe the state of youth mental health today?

Young people have had significant stressors during the pandemic, including but not limited to remote learning and financial burdens on families, and it has taken a toll on their mental health. Many children and adolescents are not getting access to appropriate mental health treatment to address the additional stressors they have faced.

The American Academy of Child and Adolescent Psychiatry, the

American Academy of Pediatrics, and the Children's Hospital Association have declared a national emergency in children's mental health.

We believe that this declaration has increased awareness of the mental health treatment needs of this population, and we hope our findings can help inform public policy and increase funding for mental health services for children and youth.

The research was published in *Psychiatric Services*.

More information: Megan M. Mroczkowski et al, Treatment of Patients Presenting With Suicidal Behavior in North American Pediatric Emergency Departments, *Psychiatric Services* (2022). DOI: 10.1176/appi.ps.202100206

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