TECHNICAL REPORT

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The Management of Children and Youth With Pediatric Mental and Behavioral Health Emergencies

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Mental and behavioral health (MBH) visits of children and youth to emergency departments are increasing in the United States. Reasons for these visits range from suicidal ideation, self-harm, and eating and substance use disorders to behavioral outbursts, aggression, and psychosis. Despite the increase in prevalence of these conditions, the capacity of the health care system to screen, diagnose, and manage these patients continues to decline. Several social determinants also contribute to great disparities in child and adolescent (youth) health, which affect MBH outcomes. In addition, resources and space for emergency physicians, physician assistants, nurse practitioners, and prehospital practitioners to manage these patients remain limited and inconsistent throughout the United States, as is financial compensation and payment for such services. This technical report discusses the role of physicians, physician assistants, and nurse practitioners, and provides guidance for the management of acute MBH emergencies in children and youth. Unintentional ingestions and substance use disorder are not within the scope of this report and are not specifically discussed.

abstract

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INTRODUCTION

Mental health disorders are broadly defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* as a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."[1,2]

A mental health disorder is a psychological syndrome or pattern reflecting underlying dysfunction, causing clinically significant distress or functional impairment, and is not an expected response to a common stressor or event.[2] Behavioral health abnormality may be described as disruptive behaviors lasting at least 6 months, causing problems at school, at home, or in social situations.[1] Mental and behavioral health (MBH) conditions affect as many as 1 in 5 children younger than 18 years in the United States each year.[3]

MBH services provided in the emergency department (ED) are considered within the context of larger systems of care. Because of critical shortages of pediatric mental health specialists, long wait times for outpatient mental health care are common. The average wait time to a first appointment with a child psychiatrist in 5 US cities has been estimated at 42.9 days.[4,5] Subsequently, EDs serve as a critical access point and safety net,[6] providing a vital role for acute and subacute MBH problems.[7] Increasingly, children and youth are using EDs as the initial access site for MBH crises and lower-acuity conditions,[8–10] with high rates of revisits.[7] Underserved urban and rural families are more likely to seek mental and behavioral health services in the ED.[11–14] It is also important to note that the stigma related to MBH and its treatment is an important barrier for patients and families to seek this type of care. Factors such as bias and discrimination based on race, gender, immigration status, and socioeconomic status further complicate adequate and equitable access to MBH services.[15] Overall, the larger health care system has failed to adequately address system-level barriers to care, including increasing the pediatric mental health specialist workforce, providing education for general pediatricians, and ensuring appropriate payment for mental health services provided by these physicians. Finally, barriers to appropriate payment for emergency MBH services continues to disincentivize the development of a suitable structure and contributes to disparities in access to MBH services.[16] To bring national attention to this worsening mental health crisis among US children and youth, the AAP, along with the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association, declared a national emergency in children's mental health in October of 2021.[17]

Children and youth use the ED for a variety of MBH conditions, ranging from suicidal ideation, self-harm, and eating and substance use disorders to behavioral outbursts, aggression, adjustment disorder, and psychosis.[18] Pediatric patients with MBH crises are a heterogeneous group, often with complex medical and social problems, and ED personnel may not have the needed resources to meet their needs. To benefit all patients, ED personnel need dedicated suitable space and additional personnel resources to properly care for children with intellectual disabilities, autism spectrum disorders, and those who have lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ+) identities.[19,20] In addition, children of various cultural, language, and social backgrounds may require unique and specific skill sets and knowledge that may limit the ability of physicians, physician assistants (PAs), and nurse practitioners (NPs) to effectively manage their health care needs.[21–23] The National Institutes of Health Office of Equity, Diversity, and Inclusion defines LGBTQ+ as lesbian, gay, bisexual, transgender, queer, intersex, and other populations whose sexual orientation and/or gender identity and reproductive development is considered outside cultural, societal, or physiologic norms.[24]

To address the diverse MBH needs of children and youth, EDs need to adopt a systematic approach to care. This systematic approach involves understanding the potential underlying medical causes or other contributors to the acute MBH emergencies, determining the need for ongoing services, coordinating care with the child's medical home, and referral to a higher level of psychiatric care when needed.[25] Emergency physicians, PAs, nurse practitioners, and prehospital practitioners should also consider providing developmentally appropriate, culturally responsive, trauma-informed, and safe care for acute MBH emergencies in children.[26] This technical report summarizes the current landscape of pediatric MBH care and evidence-based, culturally responsive, trauma-informed care and patient-centered best practices for evaluation and management of children and youth with these conditions in the ED.[27] Substance use disorders are an important problem for youth and can intersect with MBH disorders. As substance use disorders are addressed in several other American Academy of Pediatrics (AAP) technical reports and policy statements,[28–30] the specific emergency management of youth presenting with unintentional overdoses and for substance use disorder treatment will not be covered.

SPECTRUM OF MBH EMERGENCIES

A psychiatric emergency is defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*[2] as an acute life-threatening disturbance of behavior, thought, or mood, which, if untreated, may lead to harm to self, others, or the environment. Every year in the United States, approximately half a million children with MBH conditions are evaluated in EDs[4] for urgent psychiatric emergencies.[10]

When comparing by ED volume between 2007 and 2016, although MBH visits increased by 120% in children's hospital EDs ($P = .08$), the absolute rate change among nonchildren's hospital EDs was even higher during the same time, increasing from 14.6 per 1000 to 22.7 per 1000, a difference of 55% ($P < .001$).[10]

The prevalence of depression and suicide among US youth have been increasing,[31,32] with a concomitant increase in ED visits for suicidality and self-injury from 2012 to 2016 of 50.7% versus 12.7% cumulative increase ($P < .001$).[33] In the pediatric population (<18 years old),

MBH emergencies have a higher prevalence in teenagers, English-speaking, non-Hispanic white populations, and publicly insured patients.[26,34,35] ED pediatric emergency MBH visits are also increasing in complexity, with significantly longer length of stays compared with all ED visits (17.0 [6.0–26.0] hours vs 5.3 [3.2–15.4] hours; median interquartile range, $P < .0001$), including for patients who were admitted (27.0 [21.0–36.0] hours vs 17.8 [7.4–24.6] hours, $P < .0001$) and for those who were discharged (8 [5–20] hours vs 4.5 [2.8–7.7] hours, $P < .0001$).[26]

Although inpatient psychiatric bed capacity has decreased over time because of the downsizing of state- and county-run mental hospitals,[36–38] pediatric ED resource utilization for mental health conditions has significantly increased over the last decade.[10,34,39] Despite these increases, admissions to inpatient psychiatric facilities have remained stable. This suggests a possible increase in mild to moderate behavioral health emergencies that could have outpatient management.[40] ED length of stay is significantly higher in children with psychiatric diagnoses compared with other medical and surgical conditions.[39,41] Prolonged ED length of stay for patients with MBH conditions waiting for placement (psychiatric boarding) may reflect the lack of available facilities to provide a higher level of care for pediatric mental health illnesses.[42]

MBH EMERGENCIES IN THE PREHOSPITAL SYSTEM

Many children with MBH emergencies are transported to the ED by emergency medical services (EMS).[43] Some regions have systems where prehospital personnel can screen and transport patients directly to specialized centers, such as community mental health and substance use treatment facilities. Adult studies of EMS prehospital mental health screening have found this is a safe and effective means of diverting patients from the ED to appropriate alternate destinations.[44,45] In the "Alameda Model," the use of a regional psychiatric emergency service in 5 hospitals reduced the length of ED boarding times for MBH patients by more than 80% compared with state averages, from 10 hours and 3 minutes to 1 hour and 48 minutes.[46]

Another prehospital option is the use of trained mobile crisis rapid response teams (MCRRTs) for on-scene crisis intervention (eg, New York City Behavioral Health Response Team).[47] If an MCRRT is not available to respond to a psychiatric crisis, having a structured intervention approach for trained prehospital personnel to manage aggressive or agitated patients is essential. As the focus is on care for the psychiatric emergency, the use of law enforcement should be avoided when possible.[48] In addition to MCRRTs, telehealth is an increasing option for prehospital MBH emergencies. In the postcoronavirus disease 2019 (COVID-19) era, some barriers to adopting telehealth, including institutional resistance and lack of payment structures for these services, have been substantially reduced.[49–52] Other barriers to telehealth use include narrow insurance plan networks, limiting patients' ability to access in-network mental health specialists, and lack of (consistent) broadband internet and equipment necessary for clinic-based telehealth services, especially in rural areas. Several states also have incorporated or implemented child psychiatrist access lines as another mode of telehealth resources.[53] Access to telehealth services may be limited or restricted by the insurance plan (payor),[54] whereas out-of-network use of telehealth services (often without payment) may be sought in the case of more restricted plans.[55]

ROLE OF THE ED IN MBH EMERGENCIES

Screening

The ED plays a critical role in the identification of patients at immediate risk for suicidality,[56] as the number of youth suicides, many without previous MBH history, continues to increase.[57] The ED presents a great opportunity to provide meaningful and sometimes life-saving interventions by suicide screening and prevention.[58] Up to 25% of patients who visit the ED after a suicide attempt will make additional attempts; between 5% and 10% of these patients die by a later suicide, and a large proportion of patients who die by suicide have had an ED visit during the year before death.[59–61]

More EDs are beginning to integrate some form of suicide screening into pediatric and adolescent care.[62–64] However, broader ED suicide screening is still limited because of time and resources needed, as well as lack of a universally recommended single best practice screening tool.[65] The National Action Alliance for Suicide Prevention, charged with implementing the National Suicide Prevention Strategy, and the Joint Commission recommend screening for suicide risk in EDs as critical patient safety and preventive initiatives.[66] The AAP also recommends using suicide screening tools to guide physicians, PAs, and NPs in suicide risk assessment among children and adolescents in medical settings, particularly among vulnerable populations, such as immigrants and refugees, incarcerated adolescents, LGBTQ+, and those living in underserved and resource-limited areas.[67] Computerized screening tools with adaptive modeling design for suicidality are increasingly being used.[68] It is important that this type of MBH screening be performed in a confidential manner and potentially not in a public or open area of the ED. Understanding trauma-informed care, a recognition that patients with early childhood traumatic experiences are particularly vulnerable to retraumatization and subsequent manifestation as MBH conditions, is important when screening prioritization is considered.[69] Depending on the ED setup, screening may be performed by the nurse, physician, PA, or NP, and no specific evidence points to improved effectiveness of physician-administered screening compared with nurse-administered.

Studies of ED suicide screening reveal that 5% to 12% of adolescents, including those with only somatic medical conditions, may still be at risk for self-harm.[21,22,70–72] The ED can provide initial suicide screening and is most effective when combined with the ability to refer to inpatient or outpatient mental health services. Because universal screening for BMH conditions (eg, suicidality) may not always be practical in the ED, physicians, PAs, and NPs should consider, at a minimum, suicide screening for higher-risk situations or patients. For example, patients with prior suicidal ideation or family history may benefit from suicide screening. Also, MBH concerns may increase during specific times of crisis[73] (eg, after natural disasters, pandemics, or other events affecting population-level stress). One higher-risk population for screening also includes LGBTQ+ children and adolescents because they are at increased risk for higher anxiety, depression, suicidality, and substance use.[74,75] Emergency physicians, PAs, NPs, and nurses each may screen for bullying and abuse in pediatric patients[76] as these can be a significant predictor of suicidal ideation.[77]

Because patients living in poverty are also at greater risk for MBH,[78] screening for social needs, including for poverty, housing, and food insecurity, should also be considered. A positive suicide screen can be followed by a more in-depth risk assessment, often in collaboration with experienced pediatric mental health professionals.[62,79–81] Incorporation or implementation for child psychiatrist access lines, which are in the majority of states, will be an additional resource to consider.

Brief validated screening tools can identify children and adolescents at risk for suicide more reliably than physician gestalt or questioning about suicidal thoughts using vague or softened language.[56,82,83] The Joint Commission mentions screening for suicidal ideation using validated tools for all adolescents 12 years and older.[84] These tools can be incorporated into ED nursing practice in addition to nursing assessments, monitoring, safety, and psychotherapeutic interventions[80,81,85,86] but can be administrated by physicians as well. Rapid screening frameworks such as the Home, Education, Activities and Peers, Drugs and Alcohol, Sexual Activity and Sexuality, Suicide and Depression,[87] HEADS-ED, HEADS, and SSHADESS[88] allow questions to be asked in triage or during a patient interview. These resources can be administered quickly and help physicians, PAs, and NPs to cover topics omitted in a routine medical interview. It is important to note that maintaining patient confidentiality in such interviews is important. This needs to be considered in the context of potentially actionable information that may require an acute intervention. Thus, in certain circumstances, the confidentiality may be limited to provide needed care to the at-risk patient. Such limits should be discussed a priori when a patient is being consented for this type of screening.

Suicide risk assessment is important both for patients presenting with suicidal ideation and for those with non-mental health chief complaints. Suicide risk assessment also predicts future risk.[89] This assessment directly asks the individual specifically about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.[84] Screening tools specifically validated in pediatric populations include the Ask Suicide Screening Questions (ASQ) (Fig 1)[81] and the Columbia Suicide Severity Rating Scale for pediatrics (C-SSRC).[86] The ASQ[81] is a 4-question screening instrument that can be used in children as young as 10 years old. It has good predictive value for identifying ED patients at risk for suicide and suicide attempts.[90] The C-SSRC can be used for adults and children 12 years and older[7,91,92] to quantify the severity of suicidal ideation and behavior. One modified version of the C-SSRC, with child-friendly questions, was developed for younger children. In one study, the standard C-SSRC was given to children as young as 7 years old, and depending on the child's cognitive ability, it was found to be used successfully.[93] The C-SSRC was shown to help with suicidal behavior classifications. In one study, participants with the 2 highest levels of ideation severity (intent or intent with plan) at baseline had higher odds for attempting suicide.[92]

MBH IN THE ED

Triage and Initial Assessment for Patient Presenting With a Mental or Behavioral Health Condition

ED triage and initial assessment are critical for identifying safety issues and acute medical and mental health crises.[56] The assignment of a triage acuity score based on both somatic and MBH-specific risk assessments may help anticipate resource utilization.[94–100] ED nurses can complete a comprehensive, evidence-based triage education and an ongoing triage competency validation process.[101] Standardized and validated tools, such as the Brief Rating of Aggression by Children and Adolescents Scale,[102] may be helpful in this assessment. Standardized triage and acuity assessment may include the following:

- Categorizing MBH an emergency severity index 2 as high risk to harm self or violence toward others and the environment.[103] In addition to this, considering substance use, as well as intentional or unintentional ingestions as high-risk behavior.
- When available, 1:1 monitoring for mental and behavioral health patients for those at immediate risk of elopement, self-harm, or violence toward others as recommended by Centers for Medicare and Medicaid Services.[104]
- Safety check for weapons or ligature marks on the patient or in his or her environment.[105,106]

ASQ Screening Tool

Ask the patient

1. In the past few weeks, have you wished you were dead? (Yes/No)
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? (Yes/No)
3. In the past week, have you been having thoughts about killing yourself? (Yes/No)
4. Have you ever tried to kill yourself? (Yes/No)
    a. If yes, how?
    b. When?
5. If the patient answers yes to any of the above, ask the following question:
    a. Are you having thoughts of killing yourself right now? (Yes/No)
        i. If yes, please describe:

Next steps

- If the patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- **If a patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
    - "Yes" to question #5 = acute positive screen (imminent risk identified)
        - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
        - Keep patient in sight. Remove all dangerous objects from room. Alert physician, physician assistant, or nurse practitioner responsible for patient's care.
    - "No" to question #5 = non-acute positive screen (potential risk identified)
        - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
        - Alert physician or physicians, physician assistants, or nurse practitioners responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

FIGURE 1
ASQ screening tool. Ask Suicide-Screening Questions (ASQ) Toolkit (Available at: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml).

- Use of a dedicated ED space for psychiatric screening, evaluation, and management,[107] whenever possible.
- Assess parents for communication barriers and honor language and communication preferences when available, particularly when parents prefer a different language or communication method (eg, American Sign Language) than the child.
- Make ED spaces safer for patients with acute suicidality or those who otherwise are a safety risk to self or others beyond 1:1 monitoring for at risk patients. Examples include removal of sharps, as well as any equipment that is not secured to the floor or walls, avoiding placement of plastic bags in trash bins, and creating a safety proofing checklist before placement of patient in the room.

The ED triage team is responsible for determining and instituting the necessary level of developmentally appropriate observation,[56] which is assessed and modified as needed throughout the ED stay. Parents and caregivers are an integral part of mental health care and encouraging them to remain with their child can be very valuable in helping the child and adolescent feel safe, unless there is concern their presence is disruptive or may be potentially harmful to the patient.

Diagnostic Considerations

To provide optimal care, emergency physicians, PAs, and NPs benefit from becoming familiar with the presentations and differential diagnoses of the major psychiatric conditions as well as possible concurrent somatic medical conditions in children and adolescents.[71,85] A thorough history (including a detailed review of systems) and physical examination is therefore essential, with attention to developmental and social history. It is beneficial for children and adolescents and their caregivers to be interviewed together and then separately (confidentially) during mental health assessments. A general physical examination with particular attention to the

skin to assess for visible self-inflicted injuries (eg, forearms, inner thighs, feet, lower abdomen), as well as a neurologic and cardiac examination,[108,109] can be useful in identifying a patient at risk. Because physicians, PAs, and NPs are not expected to declare patients "clear" of all somatic medical issues, the term "medical optimization" may be a more accurate term than "medical clearance." In cases in which the patient has an outpatient psychiatrist or therapist, contacting and notifying this mental health professional may also provide additional diagnostic assistance.

Medical screening evaluation has 3 objectives: (1) to assess for somatic medical processes causing psychiatric symptoms (eg, endocrine disorders, central nervous system infections); (2) to treat any illness or injury directly related to the behavioral health emergency (eg, self-inflicted wounds, intentional and unintentional drug overdose); and (3) to adequately stabilize chronic somatic medical conditions (eg, asthma, diabetes) before a psychiatric evaluation. One model for children or adolescents with MBH emergencies who have been medically screened and cleared by physicians, PAs, or NPs (eg, primary care clinic, urgent care center) to have no active somatic medical issues is to bypass the ED and potentially be referred directly to an available psychiatric treatment facility as long as they do not have acute altered mental status, history of ingestion, suicide attempt or hanging, traumatic injury, sexual assault, or any other specific somatic conditions or any concerns that require acute medical intervention.[110]

Laboratory and Diagnostic Testing

Routine "screening" laboratory tests or imaging procedures are rarely indicated as a component of the medical screening and evaluation of children presenting to the ED with MBH emergencies.[71] Only 5% to 6% of pediatric patients presenting to the ED with these emergencies require a change in management based on tests obtained during that visit, with less than 1% undergoing a change in disposition based on test results.[111] Thus, routine testing has limited utility, unless it is being performed to evaluate for possible organic causes based on the history and physical examination.[9,71,90,111] The American College of Emergency Physicians and the American Psychiatric Association have published clinical policies strongly recommending against routine laboratory testing in adult ED patients with behavioral health emergencies,[112,113] and these are supported by the AAP.[71] For pediatric patients, it is reasonable to obtain a urine pregnancy test in pubertal adolescents capable of becoming pregnant. Although a urine toxicology test is unlikely to change disposition,[114] knowledge of possible substance use may be useful in better contextualizing the child's presentation. Therefore, emergency physicians, PAs, and NPs are encouraged to discuss the utility of obtaining urine toxicology tests with mental health specialists in their community.

Consultation and Management

An ED psychiatric consultation is often necessary for patients with MBH emergencies, especially given the shortage of available resources for timely outpatient evaluation and follow-up in many areas.[56] Awareness of the level of pediatric expertise of the psychiatric consultants is important for the emergency physicians, PAs, and NPs, because the levels of pediatric specialization and experience of the consultants may vary (ie, social workers, psychologists, psychiatrists).[115] If in-person psychiatric consultation is not available, telehealth resources for mental health can be explored as an alternative.[56]

Brief ED interventions can take advantage of the high-risk event leading to an ED visit to promote behavioral change. Models of therapeutic ED interventions for adolescents with suicidality are typically focused on safety planning interventions for them and their families.[58,116,117] These interventions include lethal means restriction counseling to the patient and family (eg, medications, firearms) with the goal of mitigating risk after discharge. Frameworks include Counseling on Access to Lethal Means and Means Matter.[118,119] Leveraging technology, including electronic apps and social media, for safety planning may help improve follow-up and contact (eg, Emergency Department Safety Assessment and Follow up, Tennessee program for treatment and supplement treatment interventions, for accessioning help; Colorado Suicide app for teens).[120–125]

For patients boarding while awaiting transfer to a higher level of care, providing ongoing least restrictive care in a safe, calm environment while minimizing disruption to the ED is a critical challenge (Table 1).[96,126] Other elements of ED safety include eliminating sharps from the patient room and paper bags in trash cans, instead of plastic bags. During prolonged ED stays, practices for optimizing continuity of care in the ED include providing face-to-face handoffs during shift transition, ongoing medical care (eg, provision of daily medications), and facilitating reassessments for potential changing needs for higher level of psychiatric care can help optimize care.

Consultation Special Consideration: Telepsychiatry

Telehealth is gaining more traction in its use for screening and consultation. Telehealth can be a valuable mechanism for increasing access and decreasing time to mental health specialists in rural and underserved EDs with poor access to a live MBH specialist. Telepsychiatry can provide an effective method to conduct screening, provide risk assessment, initiate treatment, and determine need for interfacility transfer. Telepsychiatry can be particularly important in certain situations, including after a disaster and during a pandemic like COVID-19,[127] during

TABLE 1 Strategies for Care of the ED Mental Health Patient with Prolonged Length of Stay[41]
Strategies
1. Provide a safe ED environment in the patient's room and bathroom, including removal of dangerous objects from the patient and the room
2. Provide structure to the patient's day, including regular meals
3. Consider removal of devices (eg, cell phone, laptop computer), which could result disruptive behavior or thoughts with stimulation from outside the ED environment
4. Provide daily medications as regularly scheduled for the patient
5. Provide basic needs for hygiene (eg, shower) and comfort
6. Address safety with a 1-to-1 sitter or security personnel, as indicated
7. Provide activities for distraction and enrichment
8. Consider the use of calming applications (apps) to provide soothing redirection

which access to care can be substantially affected by stay-at-home orders and advisories and decreased access to health care.

Management of the Acutely Agitated or Aggressive ED Patient

Although expert consensus guidelines are available (Fig 2),[56,128–130] well-controlled studies of ED management of acute agitation and behavioral dysregulation in children are limited. Behavioral de-escalation techniques (including verbal de-escalation and environmental modification) are the first line of management.[71,95,131,132] When verbal de-escalation techniques are not sufficiently effective, condition- and symptom-directed medications may be used with appropriate weight-based dosing, with considerations for special populations, such as children and adolescents with autism.[71] If pharmacologic management fails to adequately protect the patient and staff, physical restraints or seclusion rooms (if available) may be necessary.[128,129] For physical restraint, best practices exist that can guide physicians, PAs, and NPs. These include minimizing time in physical restraints, continuous monitoring, and ongoing de-escalation attempts using behavioral and pharmacologic measures.[71]

Disposition Planning and Handoffs

Warm handoffs (transfer of care between 2 members of a health care team in which the handoff includes the patient and family)[133] can be extremely valuable when a patient remains in the ED during care transitions. The safe and effective disposition of children and adolescents with MBH emergencies requires collaboration between the emergency physicians, PAs, NPs, psychiatric specialists (if available), patients and their families, and the primary care medical home.[56]

Discharge From ED

Many children and adolescents are discharged from the hospital with outpatient mental health follow-up or to partial or day programs.[33] However, system- and patient-level barriers contribute to weak and frequently incomplete rates of psychiatric follow-up after ED discharge, including a paucity of available outpatient resources and emergency physicians, PAs, and NPs' unfamiliarity with the network of mental health services in their communities.[134] Timely access to urgent outpatient care may be difficult to obtain in under-resourced communities.[135] The primary care medical home, often the most accessible and familiar resource for families, may be underutilized.[71] Clear transitions back to the medical home are important, although infrastructure is not sufficiently resourced for primary care providers to universally provide mental health care. Increasing the supply of pediatric-trained MBH providers, as well as empowering the primary care providers, may help improve this issue. Ideally, families are provided with appointments, contact information, and community resources. Potential barriers to follow-up should also be identified and mitigated to improve engagement after discharge. An increasing number of medical homes have incorporated mental health specialists directly into their practices or may provide a bridge for mental health care for patients awaiting follow-up.[53,67,134]

ED visits are opportunities for multidisciplinary teams to provide crisis interventions, safety planning, anger and aggression interventions, suicide prevention, and follow-up contact.[80,136,137] Familiarization with the process and components of developing safety plans for at-risk patients is important for emergency physicians, PAs, and NPs.[71,138] Important elements of a safety plan include: (1) understanding warning signs and potential triggers for suicidal ideation; (2) coping strategies if suicidal ideation recurs; (3) healthy activities to distract from or suppress suicidal thoughts; (4) identification of responsible social supports for the patient if suicidal urges occur; (5) information on how to access professional supports or EMS if needed; (6) plan for means restriction (eg, of firearms, medications, sharp objects)[71]; (7) identification of exposure to racially targeted violence or being a victim or witness to hate crime; and (8) review of the safety plan with families at discharge. If the patient already has an outpatient psychiatrist or therapist, including this mental health professional in the discharge discussion helps connect the patient to the resources that have already been established.

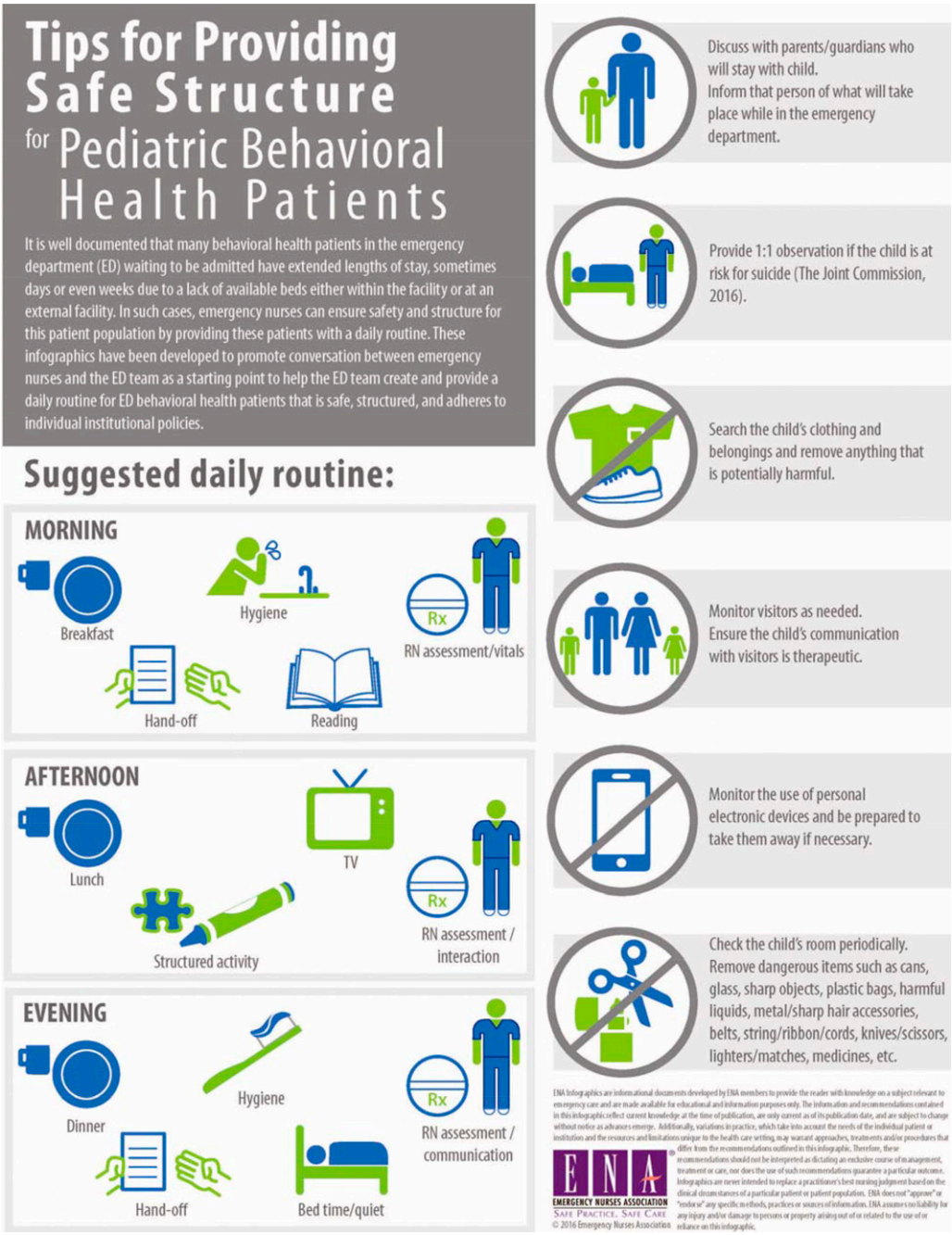

FIGURE 2
Emergency Nurses Association (ENA) infographic (used with permission from ENA).

Transfer for Higher Level of Psychiatric Care

Some children and adolescents evaluated in the ED will require a higher level of psychiatric care.[56,71] These options include inpatient psychiatric admission or community-based acute treatment units.[135] Patients transferred to psychiatric facilities typically require medical and behavioral optimization before transfer.[71]

Special Considerations: Behavioral Health Emergencies

Behavioral health emergencies can be particularly disruptive and stressful to children and their families. These can be a result of: (1) acute presentation of a new condition; (2) acute exacerbation of a chronic condition; or (3) subacute progression of a previously diagnosed condition. Many of these factors that affect behavior are extrinsic to

the child, including family (child abuse and neglect, intimate partner and other domestic violence, or traumatic events), school (academic challenges, social issues, or bullying), and societal (upheaval and unrest, community violence, disaster and mass casualty, or pandemics such as COVID-19). Because children cannot easily remove themselves from these tumultuous situations, they are more likely than adult patients to suffer from uncontrolled anxiety, sadness, and anger as a result of these experiences.[139,140] Therefore, addressing the context for these behavioral outbursts in addition to focusing on the primary behavioral health diagnoses and encouraging the child (and family) to participate in providing care is important for inclusion as part of the health care.

Developmental Delay, Intellectual Disability, and Autism Spectrum Disorder

Patients with intellectual disability (ID), autism spectrum disorder (ASD), and other chronic neurodevelopmental disabilities present unique challenges to emergency physicians, PAs, and NPs.[141] These individuals may have communication disorders, sensory processing disorders, or behavioral disturbances. ASD, a neurodevelopmental condition characterized by impairments in social interaction and restricted interests and/or repetitive behaviors, presents challenges, particularly in stressful situations, manifesting as difficulty accurately communicating needs or appearing distant, disengaged, or inappropriate. This can render evaluation and management challenging, regardless of whether the primary concern is medical or behavioral in nature.

In some instances, children and adolescents with ASD and ID present to the ED primarily with behavioral concerns. More severe behavioral outbursts can overwhelm parents because of the underlying severity of the condition, exacerbations from external stressors, or co-occurring medical issues causing pain (eg, ear infections, abdominal pain), particularly in nonverbal children. An ED visit is often a stressful experience for any patient, and this may be exacerbated for ASD patients. These patients often benefit from clear, concrete statements that are shorter in length, with multiple check-ins for understanding.[139]

Patients with ASD may experience sensory overload in the highly stimulating, noisy ED environment. Families may offer insight into calming behavioral strategies. Using light or sound devices that blend into ambient noise, placing the patient in rooms with dimmable lights and decreasing the number of people in the room are nonpharmacologic strategies for addressing agitation or worsening of self-stimulatory behaviors.[141] In addition, generalized anxiety is a common comorbidity for youth with ASD, which can result in emotional outbursts, signifying significant distress. Using a lower-volume, nonthreatening tone of voice and refraining from physical contact when addressing a stressed patient with ASD can help calm these patients.[141]

It is important to evaluate potential organic causes for a patient's presentation. If none are identified, calming and quieting measures can be attempted. This includes observing the patient in a quiet area (if available) for a few hours for improvement in the behavior. If severe behaviors do not improve with ED intervention, pharmacologic intervention, or involvement of a psychiatrist, consultation with a behavioral and developmental pediatrician may be necessary for safety.[139]

Behavioral health emergencies in children with ID and ASD in the ED include[139]:

- Increasing injurious and aggressive behavior toward self or family members
- Insomnia
- Refusal to eat or drink (if no underlying medical etiology can be identified)
- Refusal to take medications (psychiatric or somatic)
- Emotional lability (often without the verbal skills necessary to communicate emotions)

Sexual Orientation and Gender Considerations

LGBTQ+ youth are disproportionally affected by mental and behavioral health problems, including suicidality.[142] Between 2009 and 2017, the proportion of youth identifying themselves as LGBTQ+ increased from 7.3% to 14.3%.[143] The prevalence of mental health-related conditions among youth who identify themselves as LGBTQ+ has also been increasing and may be related to the internalization of negative societal perceptions, the influence of school environments and supports, and the impact of stigmatizing policies.[144,145] Inquiring about and using the pronouns the patient uses to provide patient-centered and equitable care can also help the patient feel more at ease. This includes using gender-inclusive language for those who identify themselves as nonbinary, refraining from stereotyping sexual activity issues, and engaging in more affirming practices such as asking rather than assuming.[146,147]

Marginalized Racial and Ethnic Groups

Youth in racial and ethnic minority groups, especially Black[148] and American Indian and Alaska Native youth,[39] also demonstrate inequities in mental and behavioral health conditions and outcomes. Suicide rates are higher in Black than they are in white children 5 to 11 years old (incidence rate ratio, 2.65, 95% confidence interval, 1.77–3.96; 2008–2012).[149] Black high school students have also demonstrated increased rates for suicide attempts (odds ratio, 1.02; 95% confidence interval, 1.01–1.04).[150] Since 2012 the rates of suicide-related ED visits by Black and Hispanic children and youth 6 to 24 years old have been increasing.[39] Overall, the highest rates of suicidal ideation are in American Indian and Alaska Native high school students.[150] Risk factors for mental and behavioral health disorders occurring disproportionately among children

and vulnerable youth from marginalized racial and ethnic groups include, but are not limited to, decreased access to and utilization of mental health services,[151,152] exposure to adverse childhood experiences, poverty,[152] chronic exposure to racism, experiences of discrimination, food insecurity, stigma related to mental and behavioral health disorders particularly in these groups,[152,153] and compounded community trauma as victims of[48] and witnesses to violence in both their homes and neighborhoods.[15,152,153] For the optimal and equitable care for children and youth from marginalized racial and ethnic groups, emergency physicians, PAs, and NPs should provide culturally sensitive care with a trauma-informed approach to these patients and their families.[15]

Immigrant and Refugee Families

Children of immigrants, particularly in families who have limited English proficiency, face unique challenges related to MBH emergencies. To provide optimal care for these children and families, considerations related to cultural humility,[154] implicit bias,[155] and providing trauma-informed care is important.[156] Having available interpreter services, either in-person, over the phone, or virtually, is essential for communicating with the patient and family.

Incarcerated Youth

Youth imprisoned and residing in juvenile detention centers are also disproportionately affected by MBH concerns. Two-thirds of male juvenile offenders in the United States meet criteria for at least 1 psychiatric condition.[157] The juvenile justice system is challenged with having to establish a balance between the welfare needs of a child and punishment, while optimizing the opportunity for rehabilitation. It has inadequate resources to screen for substance use, suicidality, or mental health or to provide acute psychiatric care for this group of high-risk youth. Providing culturally sensitive, trauma-informed care is important when caring for these youth.

CHALLENGES WITH THE CURRENT SYSTEM OF CARE FOR MBH EMERGENCIES

ED Preparedness

No comprehensive national assessments of ED preparedness for pediatric mental health emergencies are currently available. The Emergency Medical Services for Children (EMSC) National Pediatric Readiness Project assessed EDs in the United States for pediatric readiness.[158,159] It found presence of a pediatric emergency care coordinator in the ED was linked to the presence of policies and procedures for pediatric mental health.[160] The Province of Ontario, Canada, in 2016 piloted an assessment of ED readiness to care for children's mental health emergencies into its National Pediatric Readiness Project survey.[161,162]

ED Environment

Providing an optimal care environment for children and adolescents with MBH emergencies is also challenging in the fast-paced ED milieu. ED teams are accustomed to focusing on acute medical issues, and the time-pressured environment is not conducive to lengthy and intensive mental health interviews. Spaces for quiet and confidential conversations with patients and their families are limited. Most EDs lack specialized resources to create a therapeutic environment for children in crisis. The long waits for mental health evaluations with multiple care transitions and the intensive resources needed to care for these patients compound the burden on busy EDs. In addition, children and adolescents who need more intensive mental health care may board in the ED for a prolonged time while awaiting placement for inpatient or community-based acute treatment level of care.[34]

ED Management

Given the limited space and resources, emergency physicians, PAs, and NPs face challenges in adequately addressing the needs of children presenting with MBH disorders. This is particularly a concern in caring for children with developmental disabilities, those who are victims of or are witnesses to violence, children living in foster care or group homes, incarcerated youth, immigrant children, and LGBTQ+ youth.[115]

Outpatient Follow-up Care

Outpatient pediatric mental health resources are limited in many areas of the country,[163,164] even for high-risk patients.[168] After an ED visit, linkage to outpatient mental health care is low in some EDs.[58,166–168] The barriers to outpatient care for ED teams and families contribute to increased admissions, high return rates, and the failure of patients to engage in treatment. Lack of quality indicators guiding ED mental health evaluations, discharge planning, or follow-up ultimately contributes to disparities in care.[169]

STRATEGIES TO ADDRESS CHALLENGES AFFECTING THE ED CARE OF PATIENTS WITH MBH CONDITIONS

In 2019, in response to the recognition of the need for improvements in ED preparedness and mental health care guidelines, the US Department of Health and Human Services, Health Services and Resource Administration convened an expert panel to produce "Critical Crossroads: Improving Emergency Care for Children in Mental Health Crisis." This toolkit includes instruments designed for use by hospitals to support the creation of clinical care pathways to improve the identification and management of children and adolescents presenting to EDs in mental health crises.[56] In addition, the AAP and the American Foundation for Suicide Prevention created "Suicide:

Blueprint for Youth Suicide Prevention" to be an educational resource for health care professionals caring for children and youth at risk for suicide. This blueprint includes resources and guidance for screening, safety assessment, and care for suicide in different clinical settings, including the ED.[170] Strategies to address the challenges in caring for pediatric MBH patients in ED settings include, but are not limited to, the following:

Prehospital

- Engagement with the community for appropriate ED facility transfer strategies by EMS personnel has been emphasized.[171]
- Provision of telehealth emergency psychiatric medical control to EMS and schools can expand mental health guidance.[49]
- Mental health mobile crisis teams[172,173] can be used to divert low-acuity patients to facilities equipped to manage pediatric mental and behavioral health emergencies.

ED

- Adoption of a systematic method for patient assessment and care integrating patient-centered, trauma-informed ED policies and protocols for triage, safety assessment, monitoring, mental health and medical evaluation, and management of behavioral crisis to improve and ensure equitable and quality care has been successful in providing timely assessment and decrease time to definitive care.[156,174]
- Embedding pediatric-trained mental health professionals into ED teams when possible can improve pediatric specific care.[175]
- Redesigning the physical space of EDs to create low-stimulation and safe areas for patients with primary mental health presentations and development of a structure for day-to-day activities, addressing self-hygiene, and inclusion of age-appropriate distraction tools has been shown to positively affect the care of ED patients.
- Providing resources for counseling on lethal means restriction, using developmentally appropriate verbal de-escalation techniques,[176,177] and strategies for improving patient-centered care of vulnerable populations, including patients with developmental delay or ASD, children who are victims of or witnesses to violence, children living in foster care or group homes, incarcerated youth, immigrant children, and LGBTQ+ youth.
- Utilization of parents and/or guardians as resources and development of integrated, multidisciplinary behavioral care plans for those with recurrent visits[178] is an important element of patient- and family-centered care.
- Development of standards and systems to establish consultation and acute referral networks within hospitals and communities, including electronic referrals[179] and telehealth consultations, particularly in resource-limited areas and for patients with prolonged stays who are boarding in the ED while awaiting a higher level of care,[42] allows for more rapid access to the network of mental health care.
- Integration of physical and behavioral health and provision of payment for consultants for observation-level stays in the ED; this shift in payment for ED observation versus hospital admissions has had a significant financial impact on hospitals.[180]
- Recognizing the importance of providing culturally appropriate and trauma-informed care, especially as related to systemic racism and implicit bias.[181]
- Agreements by community hospitals with MBH services within the larger academic hospitals have proven to be useful in overcoming the challenges of timely and effective MBH care.[182]

Areas for Future Research

The gap between community mental health needs and available resources continues to widen, providing a wide array of opportunities for future research from prehospital, interfacility transport and destination decision to ED triage, assessment, management, best practices for restraint and de-escalation, and ED aftercare for pediatric MBH patients.[63] Some areas for research include:

- Screening tools (including for risks of suicide, bullying, depression, substance use disorder, violence, physical and sexual abuse, social needs, etc) for ED and prehospital settings.
- Use of telehealth for psychiatric consultations for rural, tribal, and critical access EDs.
- Optimization of resources for EDs.
- Effectiveness of brief interventions in the ED setting.
- Cost-effectiveness of integrated care models and cost of MBH emergency management.
- Examination of models for improved outpatient follow-up care after ED discharge.

CONCLUSIONS

Pediatric MBH emergencies continue to present to the ED at high rates and with increasing frequency and acuity. Emergency physicians, PAs, and NPs need improved staffing, and resources to better meet the needs of these patients. An evidence-based management strategy throughout the spectrum of care, from prehospital destination decision; to ED triage, evaluation, and management; to resource allocation and transition of care to inpatient, community-based, and outpatient settings, is critical. Further research, such as exploration of regionalization of care, telehealth best practices, standardized screening, and optimal utilization of scarce resources, is needed to continue to improve care for these patients. Understanding and integrating these best-practice principles are essential to provide patient-centered, trauma-informed care for children and adolescents presenting to the ED with a broad spectrum of MBH emergencies.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ASQ: Ask Suicide Screening Questions
C-SSRC: Columbia Suicide Severity Rating Scale for pediatrics
ED: emergency department
EMS: emergency medical services
MBH: mental and behavioral health
MCRRT: mobile crisis rapid response team
LGBTQ+ youth: lesbian, gay, bisexual, transgender and questioning or queer

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