Pediatric Behavioral and Mental Health: EMSC Making an Impact

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Speaker Disclosure

I have no financial interests or relationships to disclose.

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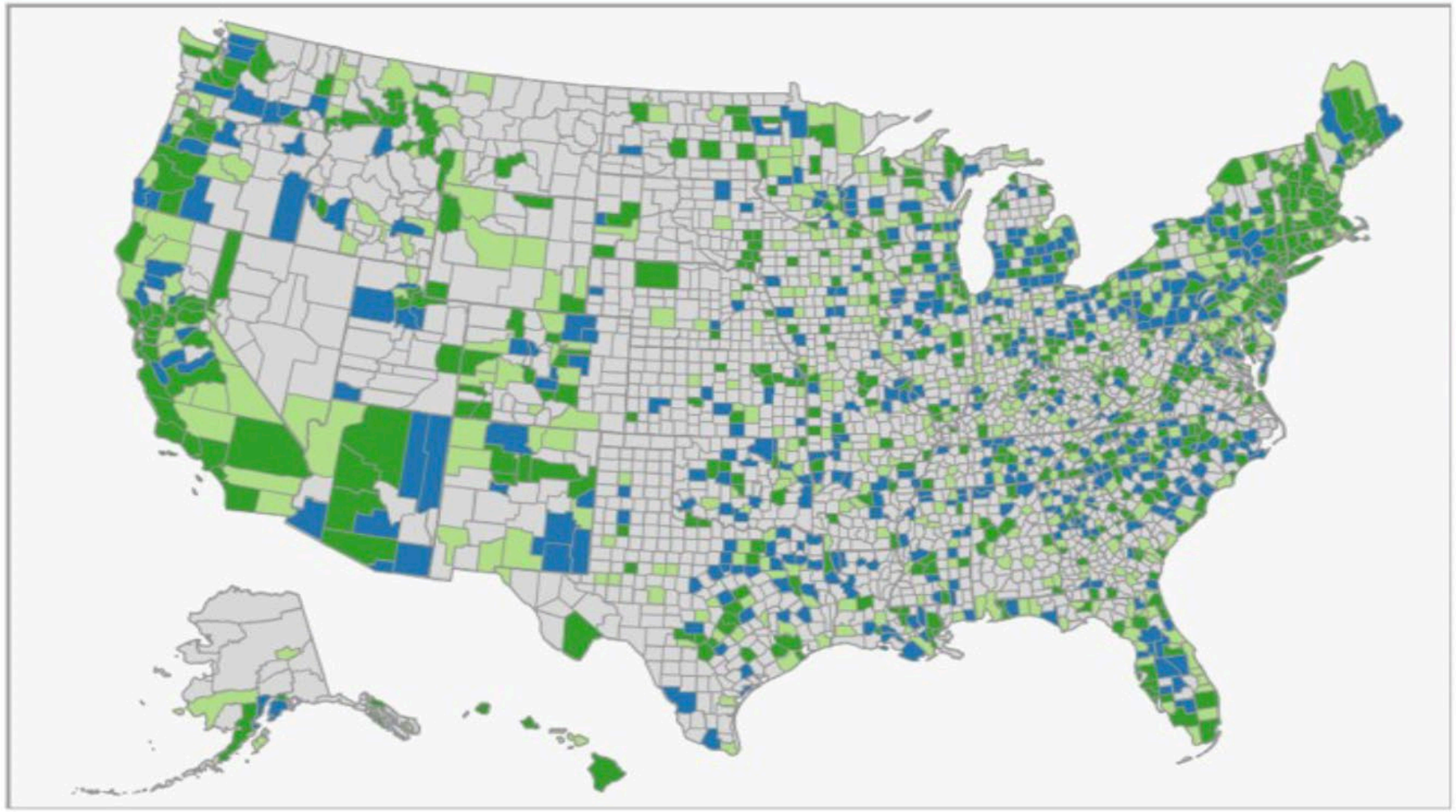
Outline

- Introduction and background
- Pediatric mental health and the ED
- The EMSC initiatives and impact
  - Resources and education
  - EIIC Quality Improvement Collaboratives
- Joint policy and technical report
- The work ahead

Introduction and background

Figure 1. Map of Psychiatrists per 100,000 Population by U.S. County



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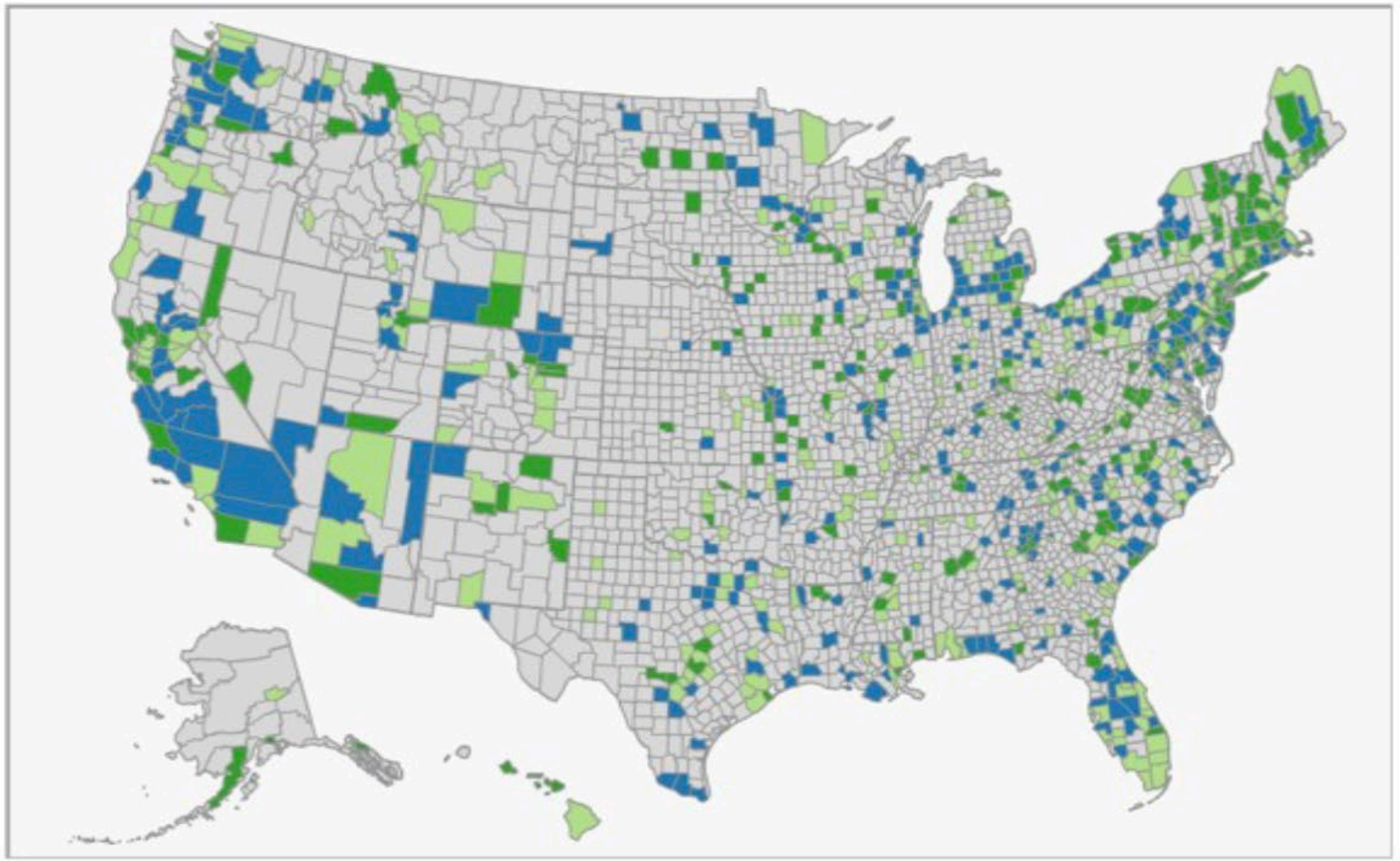
https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf

Figure 2. Map of Child & Adolescent Psychiatrists per 100,000 Population Under Age 18 by U.S. County



Child and Adolescent Psychiatrists per
100,000 County Population Aged 17 and Younger

- 0
- 0.1 - 8.7
- 8.8 - 17.7
- 17.8+

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https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf

Practicing Child and Adolescent Psychiatrists

Use the filter menu to the right to interact with this dashboard

State: All

* Hover for Data Source

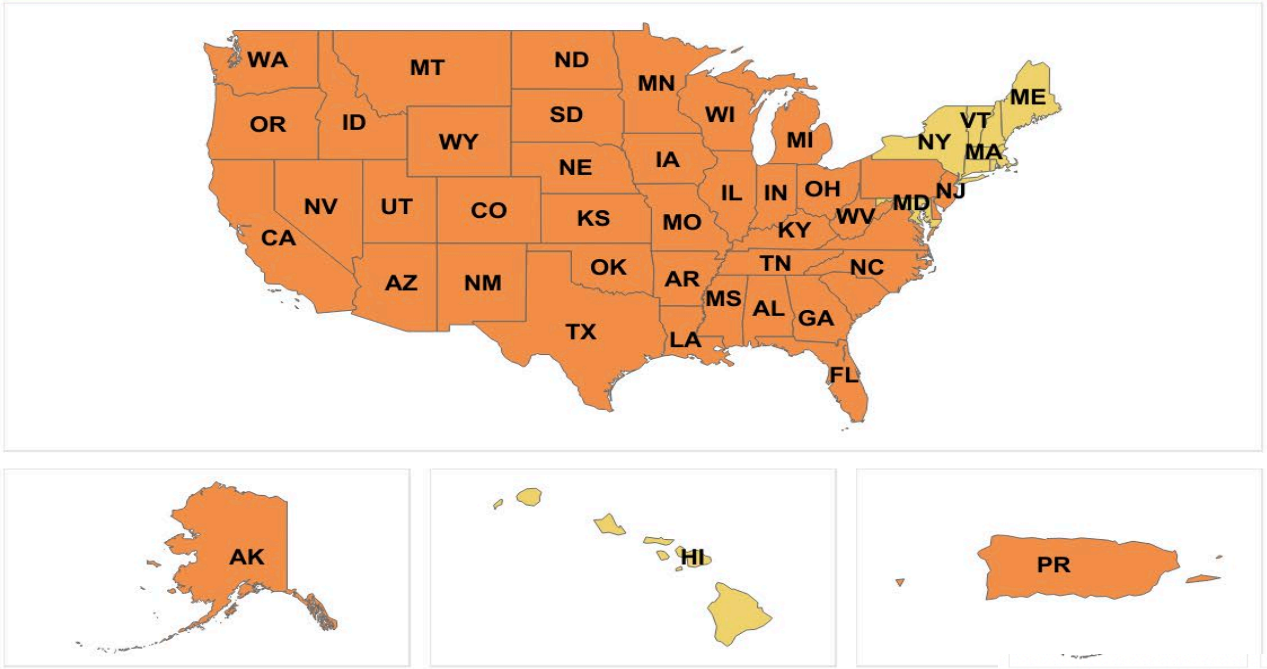
* Hover for Tips & Definitions

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Total CAPs	Number of Children < 18	Number of CAPs/100k Children	Average CAP Age
10,597	74,077,738	14	52

State Map

Mostly Sufficient Supply (>=47) | High Shortage (18-46)* | Severe Shortage (1-17)* | No CAPs



County Map

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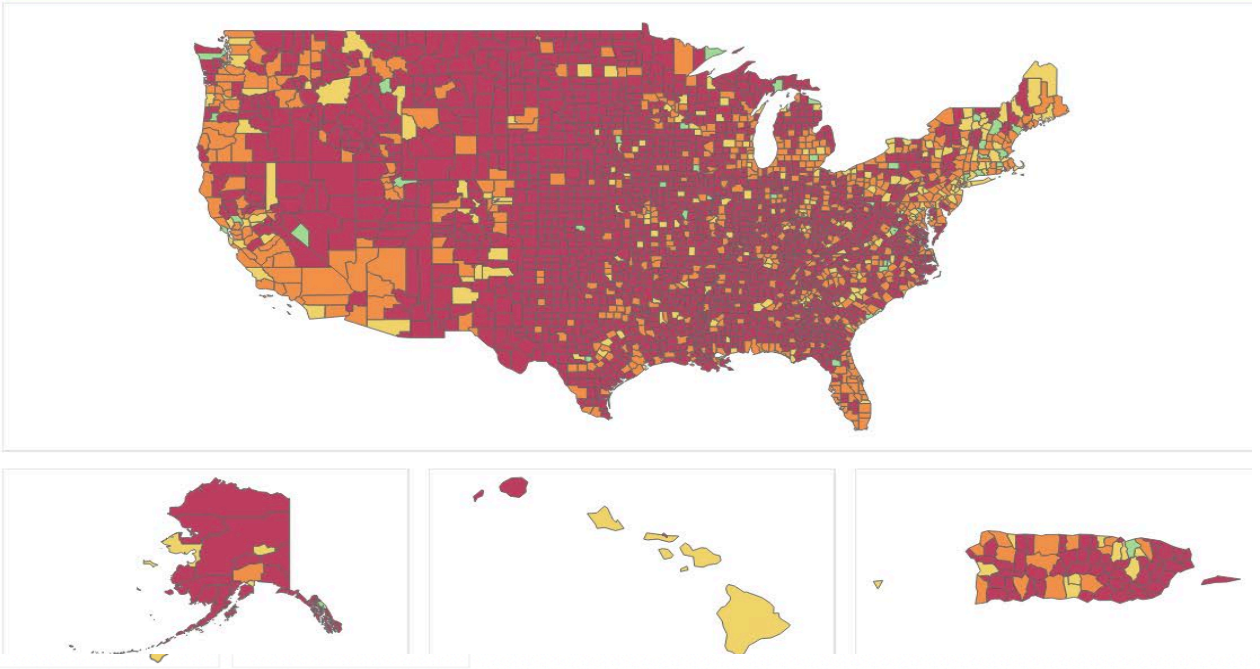
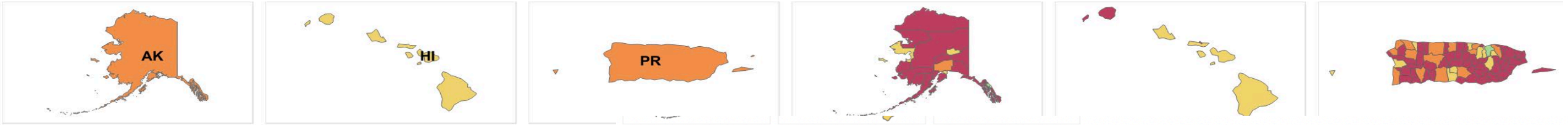
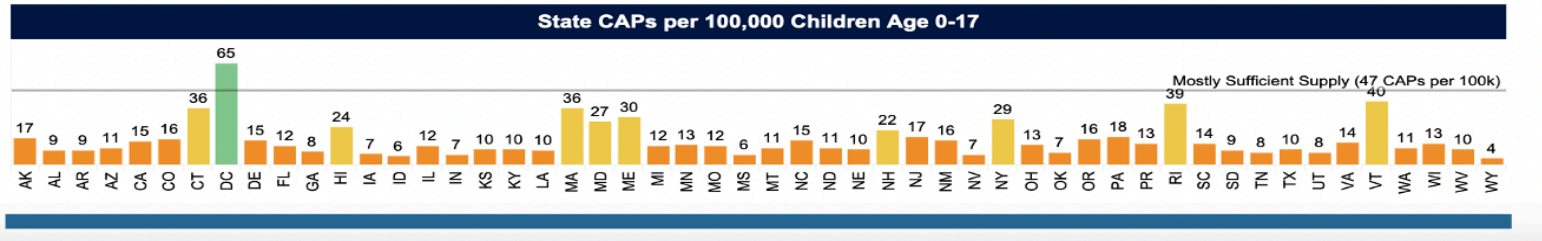




State CAPs per 100,000 Children Age 0-17



Source:AACAP
https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

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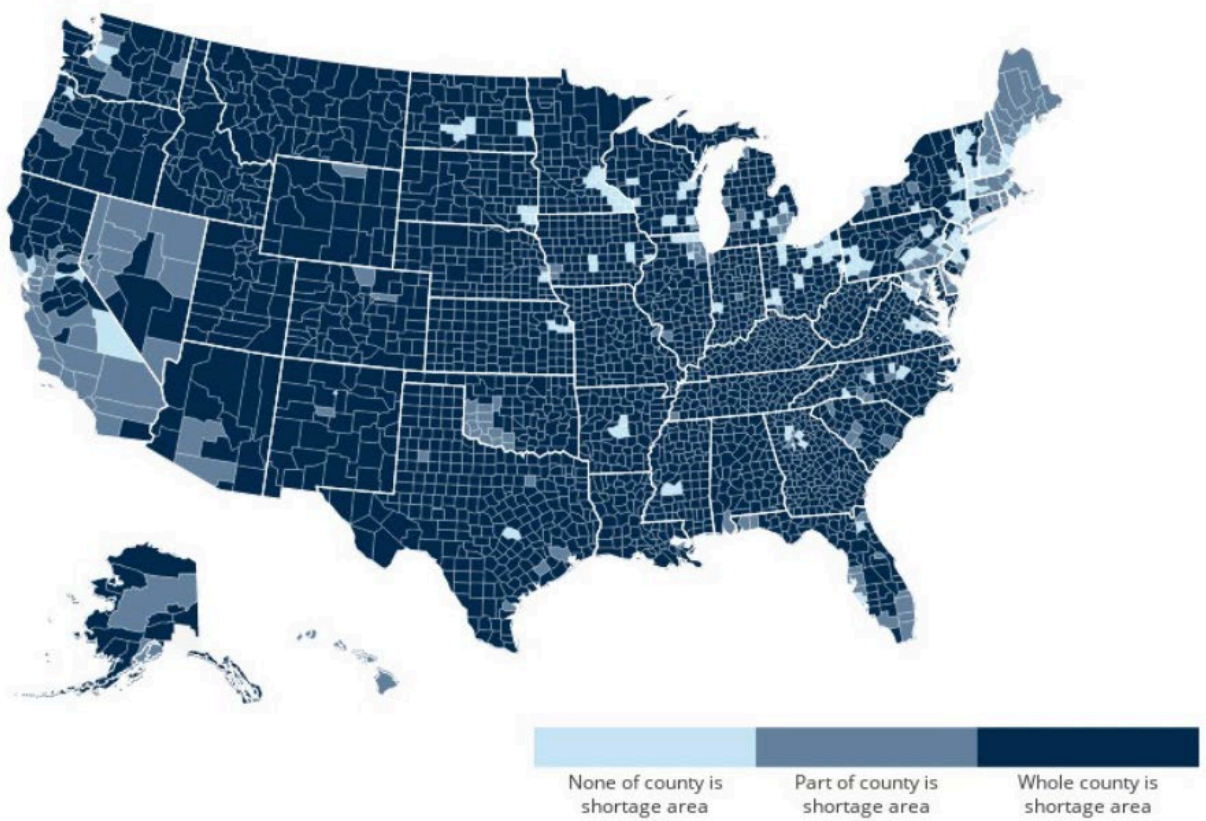
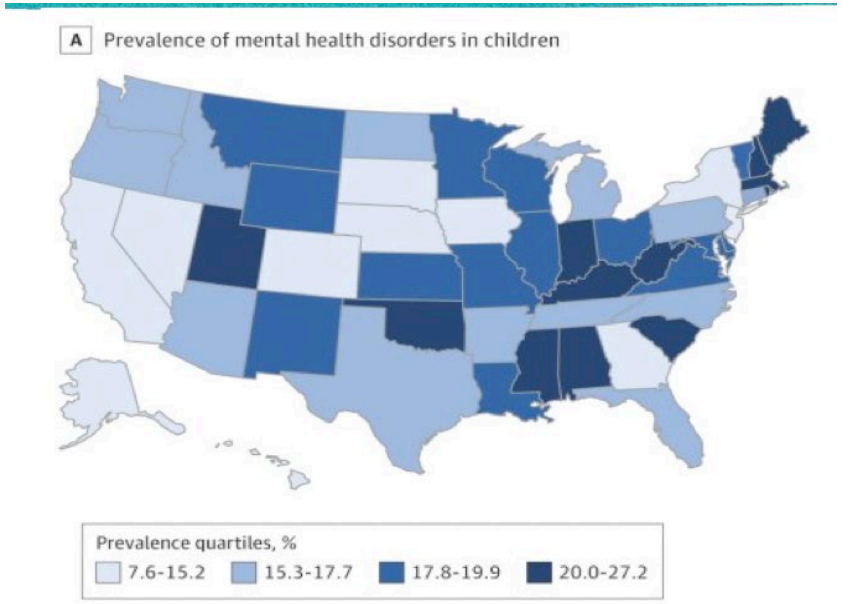
Health Professional Shortage Areas: Mental Health, by County, 2022

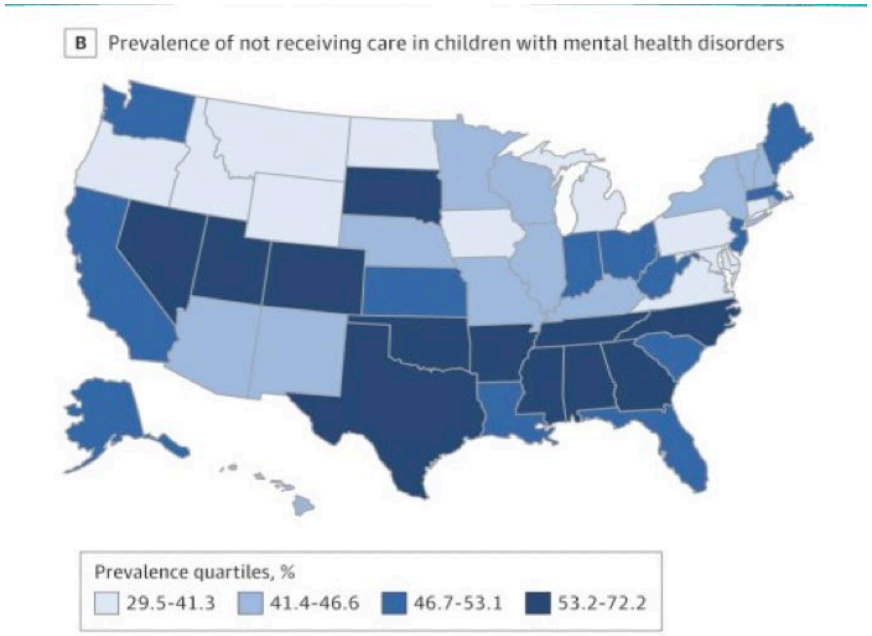


RHIhub Rural Health Information Hub

Source: data.HRSA.gov, January 2022.

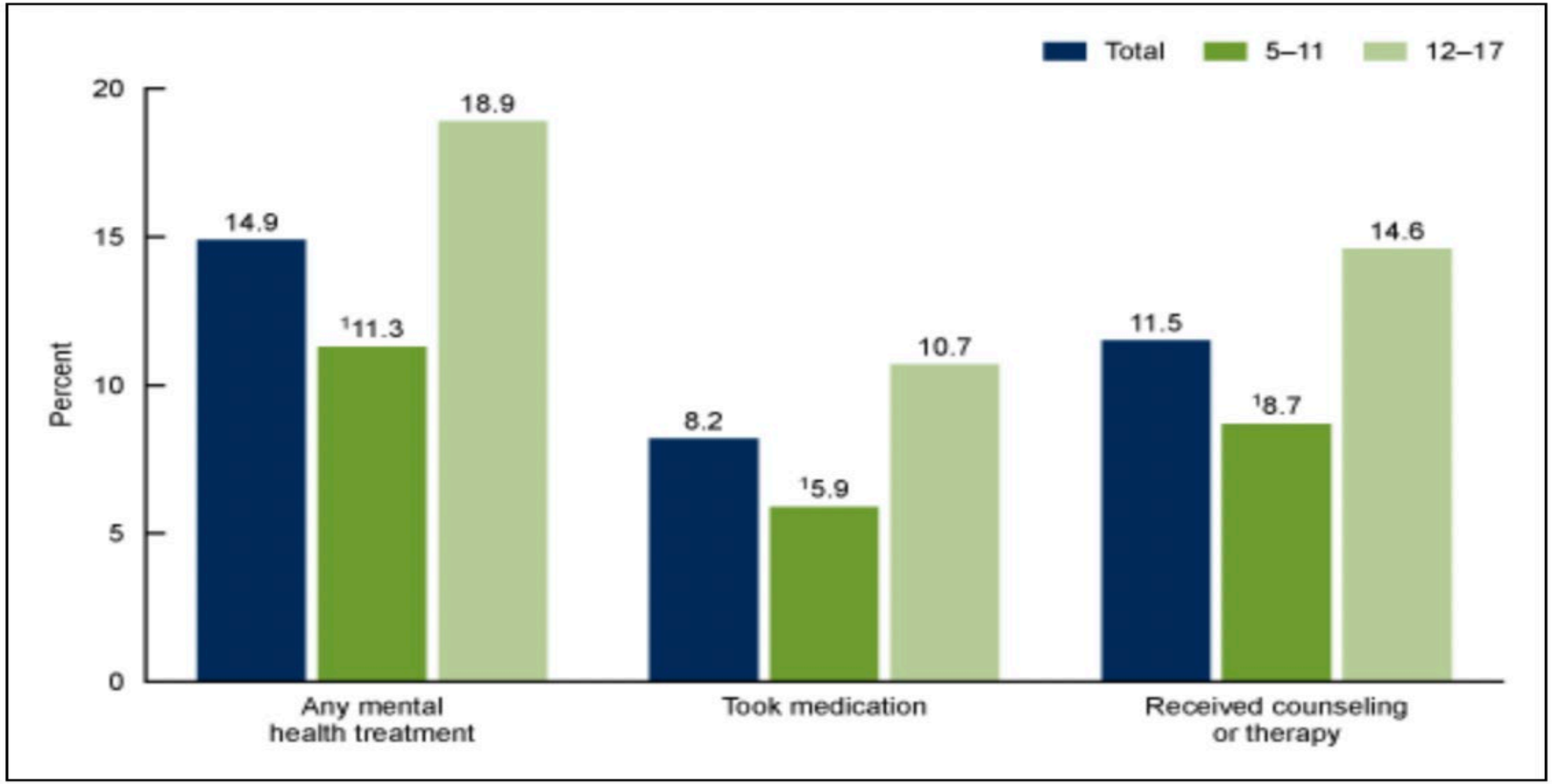
HRSA Health Resources & Services Administration





CENTERS FOR DISEASE CONTROL AND PREVENTION

Figure 1. Percentage of children aged 5–17 years who had received any mental health treatment, taken medication for their mental health, or received counseling or therapy from a mental health professional in the past 12 months, by age group: United States, 2021



Source:CDC Center for National Statistics

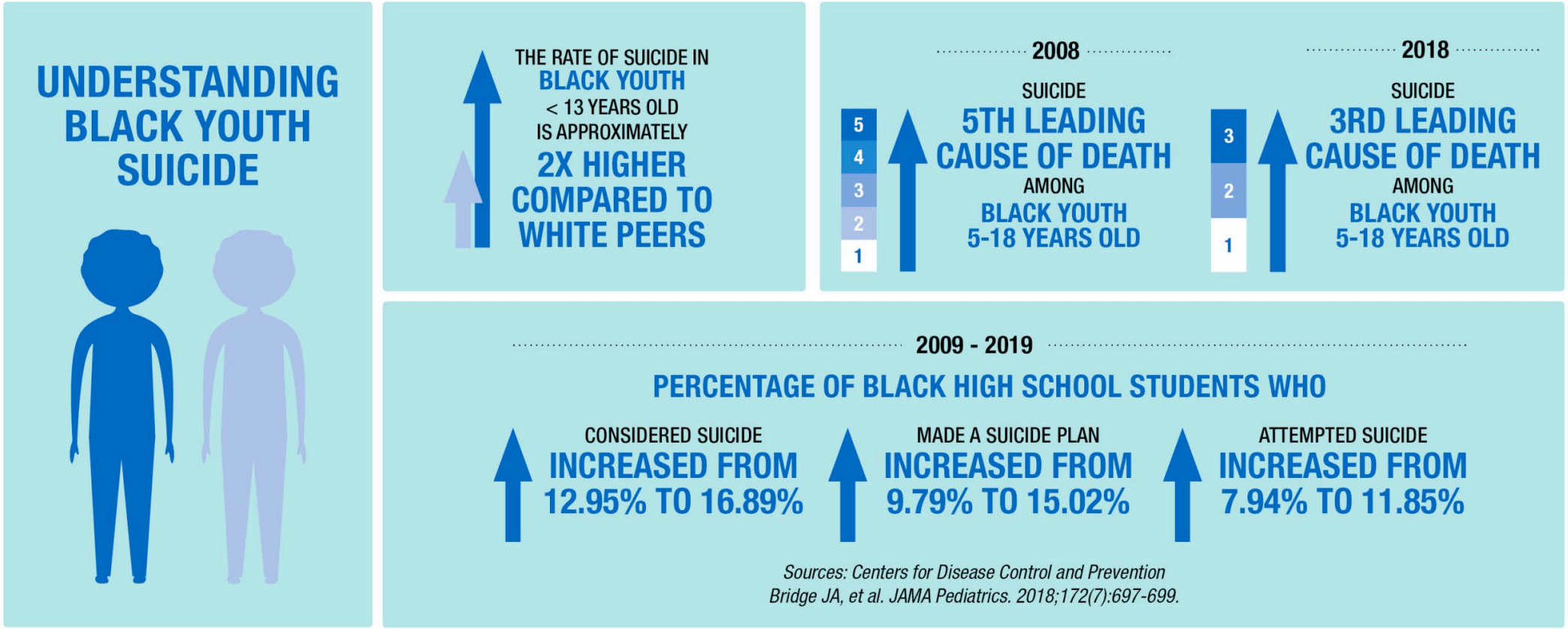
https://www.cdc.gov/nchs/products/databriefs/db472.htm

Disparities in pediatric suicide

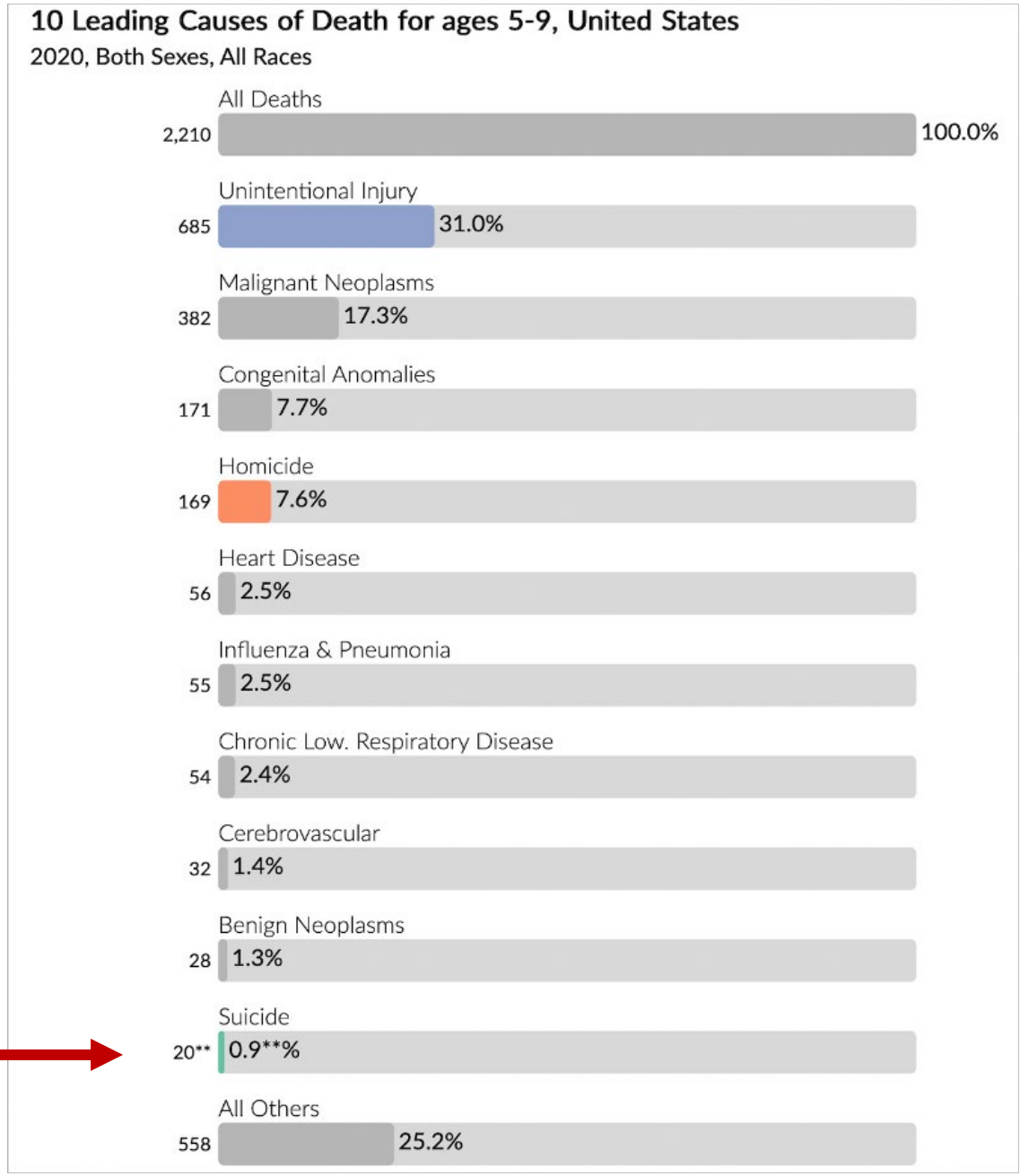
- Suicide - second leading cause of death (10-24-year-olds)
  - 7,126 deaths – and increased 52.2% between 2000-2021.
  - ED visits for 10-24 years almost 3X > adults ages 35-64 years.
  - For girls and young women, twice the rate for boys and young men
- In 2021, (26.3%) of high school students identifying LGBTQ+ reported attempting suicide in the prior 12 months.
  - five times > heterosexual students (5.2%)
- American Indian/Alaska natives have the highest suicide rates
- Black youth have disproportionally high suicide rates
- Urbanicity and income level also affects suicide

https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

Disparities in pediatric suicide



1 in 6 children aged 2-8 years has a mental, behavioral, or developmental disorder.

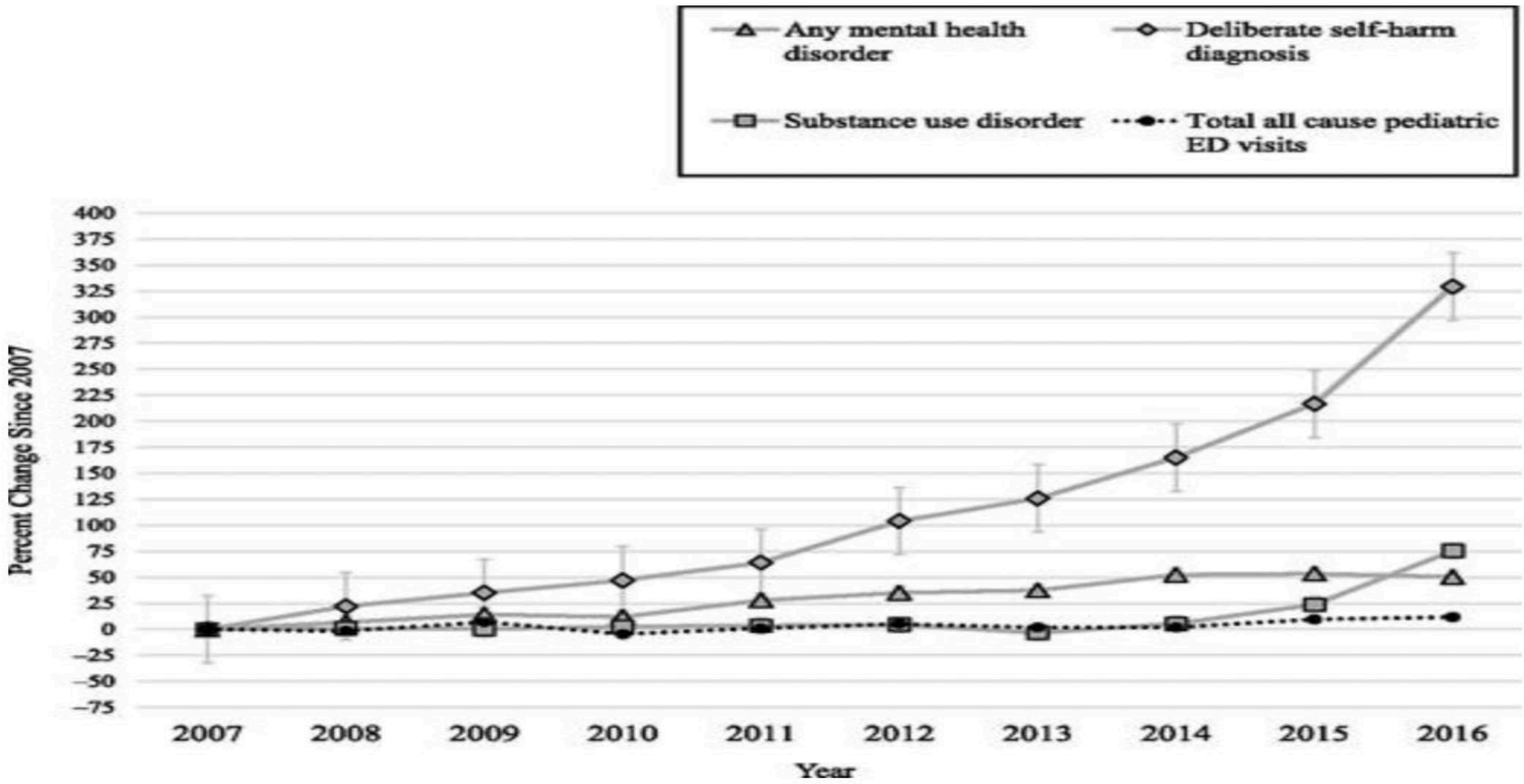


Pediatric Mental health in the ED

Pediatric mental health ED visits have been rising

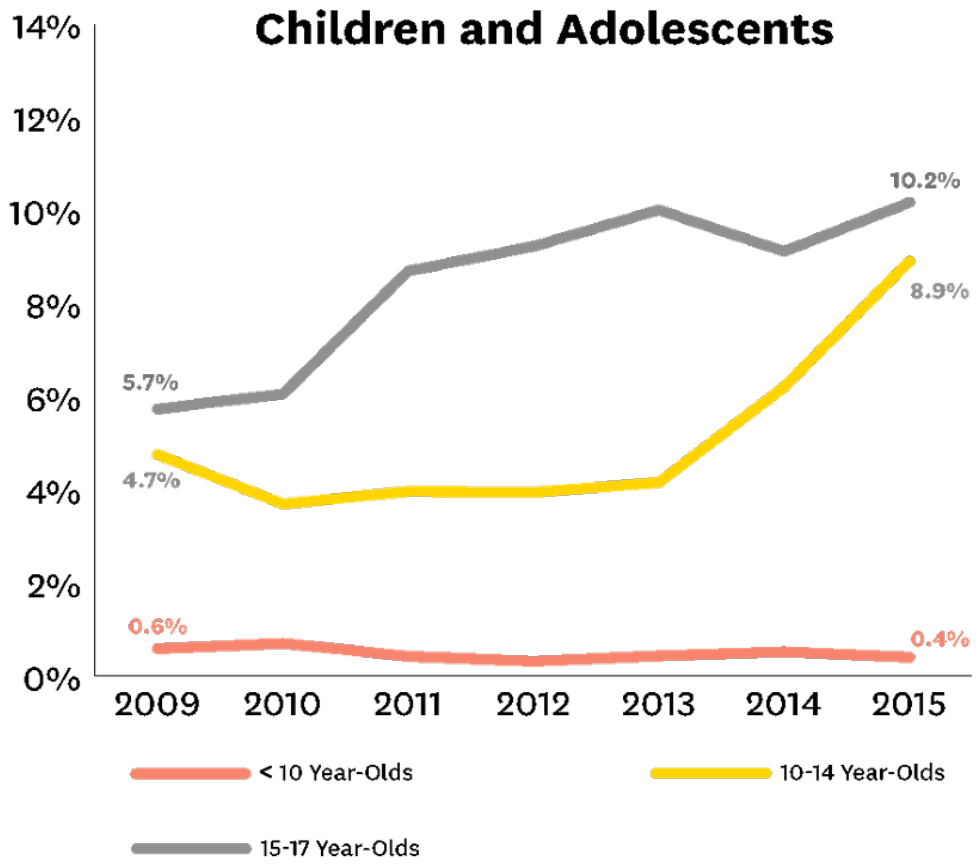
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

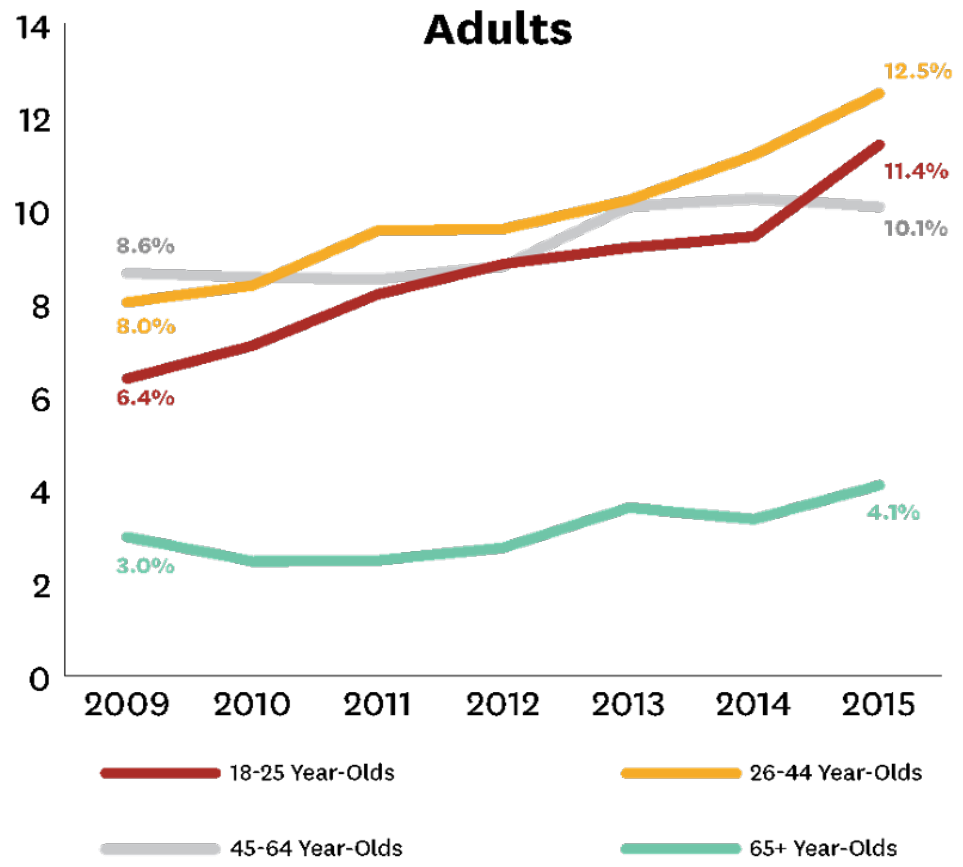
From: **Children's Mental Health Emergency Department Visits: 2007–2016**



Percent change of pediatric ED visits among mental health subgroups. Line graph depicting yearly percentage change from 2007 of ED visits made by US children and those with at least one of the following mental health disorders: any mental health disorder, substance use disorder, and deliberate self-harm diagnosis.

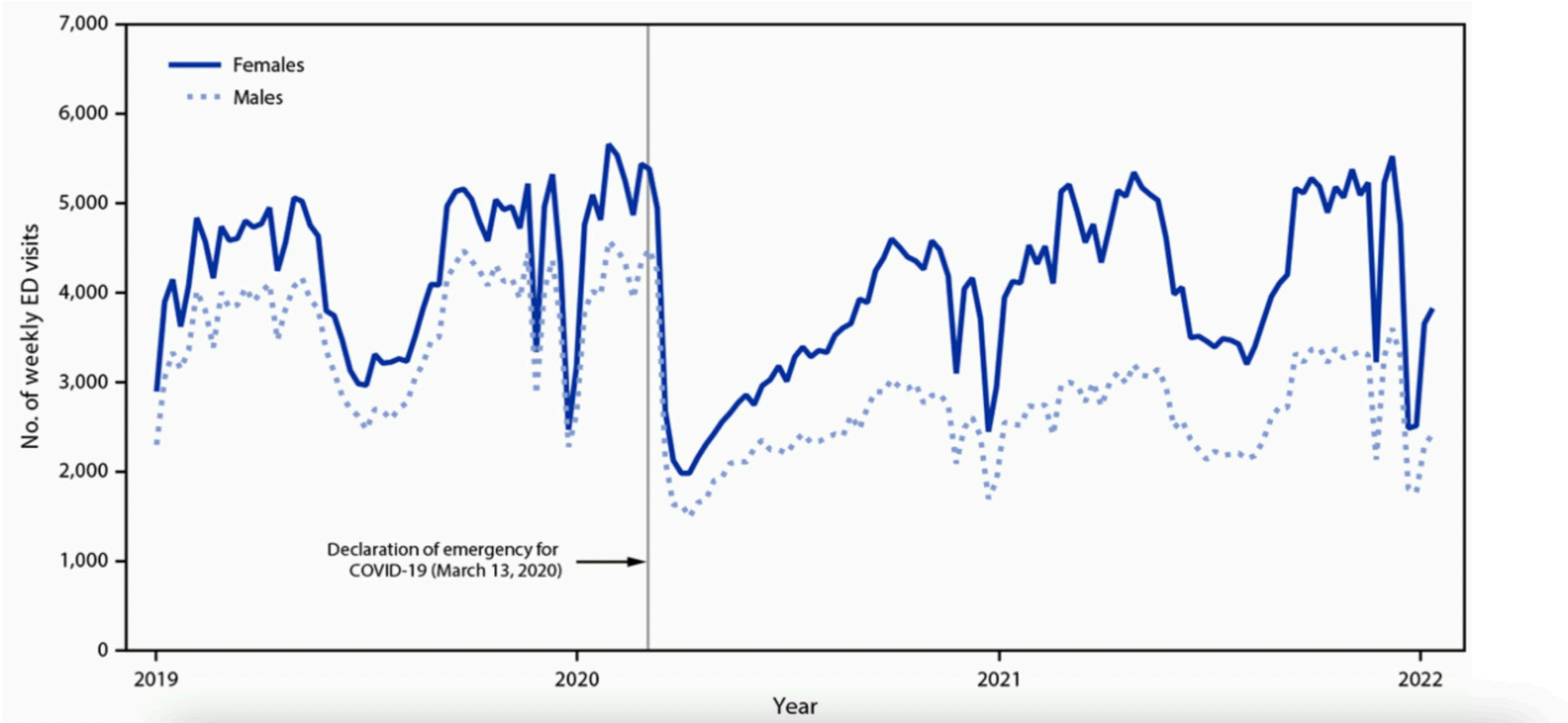
Trends in Proportion of ED Visits With a Mental Health Discharge Diagnosis, by Age





USC Schaeffer

FIGURE 1. Weekly number of emergency department visits* for overall mental health conditions† among children and adolescents aged 0–17 years, by sex — National Syndromic Surveillance Program, United States, 2019–2022



https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm

Pediatric Mental Health Crisis – Call to Action

- Critical Crossroads (2019)
- AAP, AACAP, CHA – Initial declaration (2021)
- 134 Organizations – Letter to Biden Administration (2022)
- US Preventive Services Task Force – Recommendation statements on screening for anxiety in children and adolescents and screening for depression and suicide risk in children and adolescents (2022)

AAP News

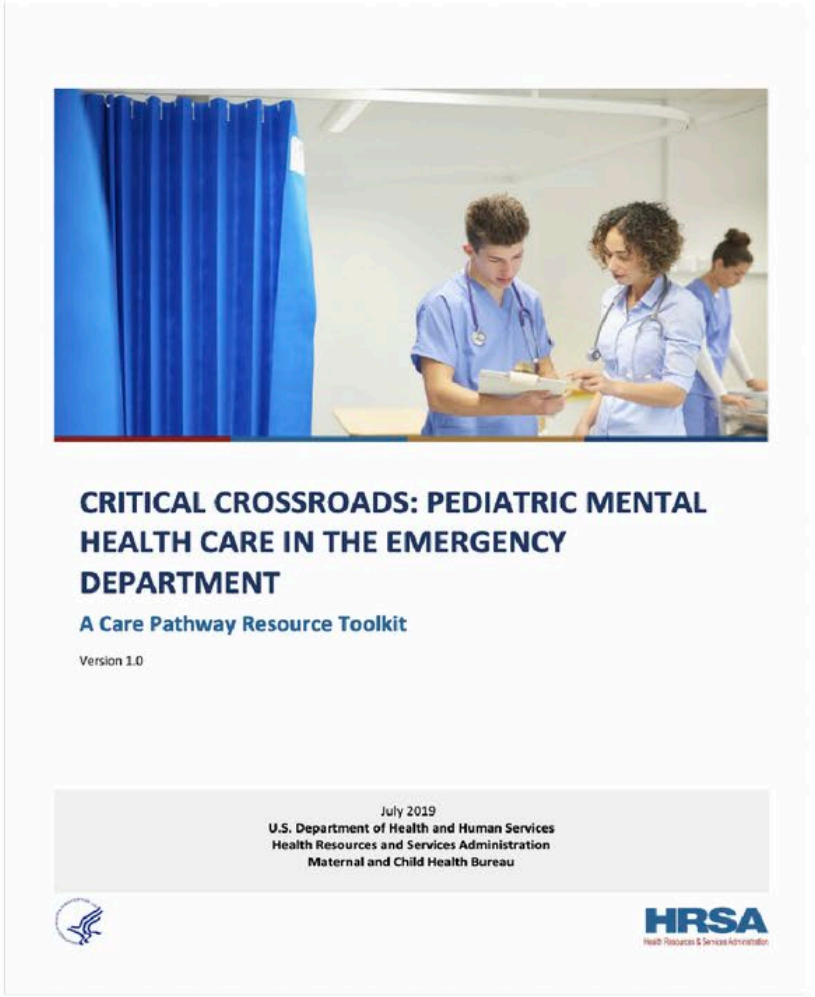
AAP, AACAP, CHA declare national emergency in children's mental health

October 19, 2021

The AAP, American Academy of Child and Adolescent Psychiatry (AACAP) and Children's Hospital Association have declared a national emergency in children's mental health, citing the serious toll of the COVID-19 pandemic on top of existing challenges.

They are urging policymakers to take action swiftly to address the crisis.

AAP News October 2021



https://www.hrsa.gov/critical-crossroads

EMSC Impact

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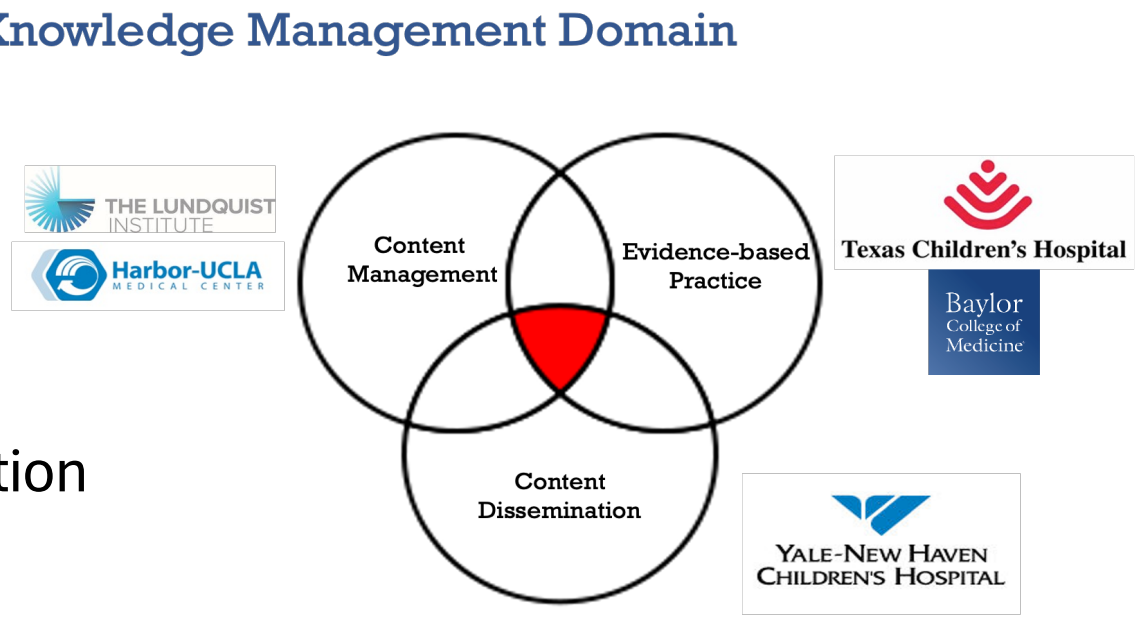
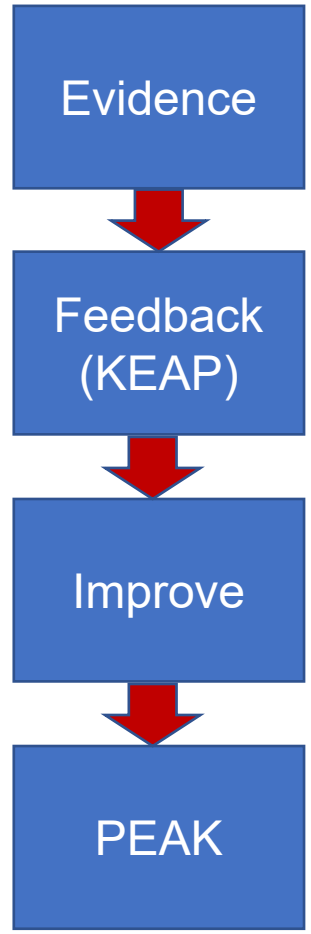
KEAP and PEAK

- Strategic plan to create a process for content
  - *Collation, curation, creation*

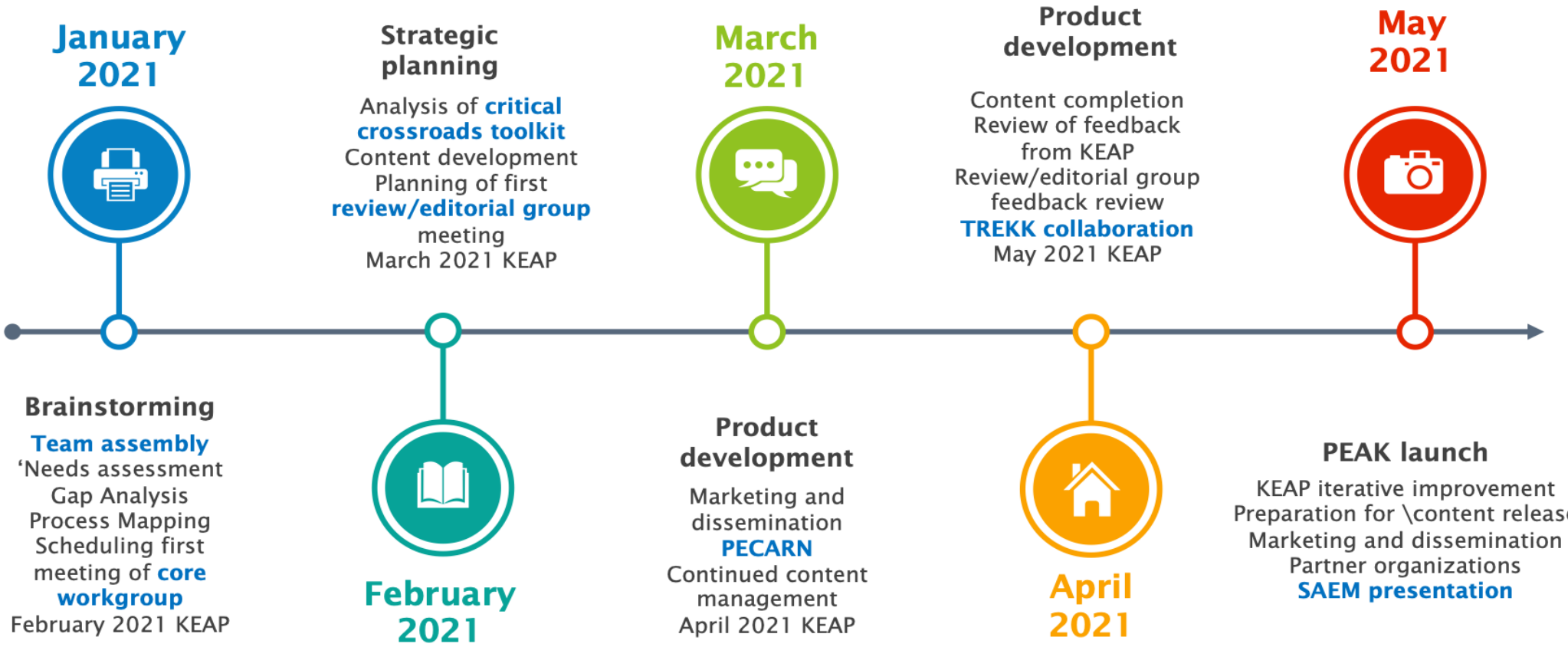
- Consideration for:
  - End user (target audience)
  - Evidence synthesis
  - Platform and format
  - Dissemination and implementation





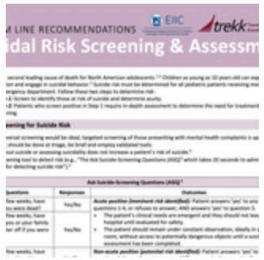
Mental health PEAK Pediatric Education and Advocacy Kits content timeline

Jan-June 2021



Focus area: Suicide

Featured Content



EIIC/TREKK BOTTOM LINE RECOMMENDATIONS: SUICIDAL RISK SCREENING AND ASSESSMENT

Key facts & recommendations for ED screening & assessment of suicidal risk in children

HRSA CRITICAL CROSSROADS: PEDIATRIC MENTAL HEALTH CARE IN THE EMERGENCY DEPARTMENT TOOLKIT

Toolkit designed to support the effective emergency care of children in psychiatric distress

AUDIENCE

- Advocates & Policymakers
- Clinicians 14
- Nurses 14
- Patients & Families 4
- Prehospital Practitioners 4

SORT ORDER

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Document | Pinned

HRSA Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Toolkit

45 minutes Details

Practice Guideline | Pinned

EIIC-TREKK Bottom Line Recommendation: Suicidal Risk Screening and Assessment Practice Guideline

10 minutes Details

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Video

American Foundation for Suicide Prevention Why Universal Screening in the Emergency Department with Lisa Horowitz, PhD, MPH, Video

2 minutes

Details

Infographic

EIIC ABCDs of Suicide Screening Infographic

2 minutes

Details

Podcast

EIIC Pediatric Suicide Screening with Lisa Horowitz, PhD, MPH, Podcast

15 minutes

Details

Podcast

EIIC Positive Suicide Screens in the Pediatric ED Patient with Joan Asarnow, PhD, Podcast

15 minutes

Details

Video

Well Being Trust - A Mother's Perspective: New Guide Gives Families Info to Become More Informed about Mental Health Care Coverage Video

6 minutes

Details

BOTTOM LINE RECOMMENDATIONS

Suicidal Risk Screening & Assessment

Suicide is the second leading cause of death for North American adolescents.[1,2] Children as young as 10 years old can experience suicidal ideation and engage in suicidal behavior.[3] Suicide risk must be determined for all pediatric patients receiving mental health care in an emergency department. Follow these two steps to determine risk:

- ***Step 1:*** Screen to identify those at risk of suicide and determine acuity.
- ***Step 2:*** Patients who screen positive in Step 1 require in-depth assessment to determine the need for treatment and safety planning.

Step 1: Screening for Suicide Risk

- While universal screening would be ideal, targeted screening of those presenting with mental health complaints is appropriate.
- Screening should be done at triage, be brief and employ validated tools.
- Asking about suicide or assessing suicidality does not increase a patient's risk of suicide.[4]
- Use a screening tool to *detect* risk (e.g., "The Ask Suicide-Screening Questions (ASQ)[5] which takes 20 seconds to administer, 98% sensitive for detecting suicide risk").[6]

Ask Suicide-Screening Questions (ASQ)[5]

Questions	Responses	Outcomes
1.In the past few weeks, have you wished you were dead?	Yes/No	***Acute positive (imminent risk identified):*** Patient answers 'yes' to any of questions 1-4, or refuses to answer, AND answers 'yes' to question 5. » The patient's clinical needs are emergent and they should not leave the hospital until evaluated for safety. » The patient should remain under constant observation, ideally in a private room, without access to potentially dangerous objects until a suicide risk assessment has been completed.
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 few weeks, have you been having thoughts about killing yourself?	Yes/No	***Non-acute positive (potential risk identified):*** Patient answers 'yes' to any of questions 1-4, or refuses to answer, AND answers 'no' to question 5. » The patient should not leave the hospital until a suicide risk assessment has been completed.
4.Have you ever tried to kill yourself?	Yes/No	
If a patient answers 'yes' to any of these questions, a 5th question is asked to determine risk acuity:		***Negative:*** A patient who answers 'no' to questions 1-4. » The patient does not require a further suicide risk assessment in the emergency department.
5.Are you having thoughts of killing yourself right now?	Yes/No	

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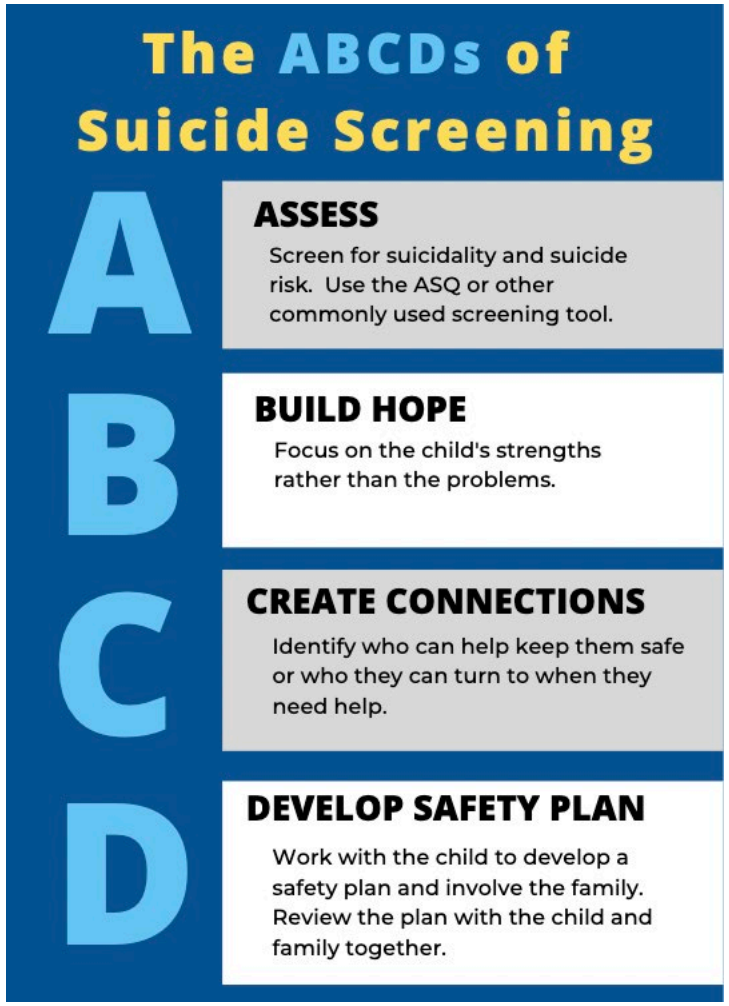
Infographics



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

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

   If yes, how? _____

   When? _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍Yes ❍No

   If yes, please describe: _____

Next steps:

- If 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 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 or clinician 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 clinician 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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 6/13/2017

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Any **YES** indicates that someone should **seek behavioral healthcare.**

However, if the answer to **4, 5** or **6** is **YES**, get **immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.**

Download Columbia Protocol app

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

Engagement data (August 2023)

PEAK Suicide	Page views	Unique users
Total	1695	248
Suicide screening	529	101
C-SSRI	481	64
ASQ	371	71
BLR (TREKK Collaboration)	184	40
ABCD of Suicide	101	19

PEAK agitation

Pediatric Education and Advocacy Kit (PEAK): Agitation

Children in emergency settings may become agitated for a number of reasons, including psychiatric disorders, delirium, withdrawal or intoxication, and pain. Acute agitation can lead to disrupted care, distress for the family, and harm to the patient or staff, making it vital to manage effectively (Gerson et al, 2019). When caring for the agitated pediatric patient, the approach must be safe, patient-centered, proactive, and begin with least restrictive options possible.

PEAK: Agitation resources were created to assist hospital and prehospital-based teams, in partnership with patients and families, to support children and youth with agitation—including identifying the etiology and initiating a continuum of care management strategies.

Last updated August 2022

AUDIENCE
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- Nurses 6
- Patients & Families 3
- Prehospital Practitioners 4

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- Alphabetical

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Practice Guideline · Pinned
EIIC/TREKK: Care of the Agitated Patient Algorithm
5 minutes · Details

Practice Guideline · Pinned
EIIC: Agitation Medication Dosing Recommendation Table
5 minutes · Details

Podcast · Pinned
EIIC: Agitation In Neurodivergent Patients with Drs. Alice Kuo and Ilene Claudius
15 minutes · Details

Infographic · Pinned
EIIC: De-escalation Tips for Pediatric Agitation Infographic
3 minutes · Details

7 Resources
EIIC: Safe Control of the Agitated Patient Webinar Series with Dr. Marianne Gausche-Hill
Details

EMSC Emergency Medical Services for Children

Care of the Agitated Patient

Recognition of Agitation

Mild: subtle behaviors such as fidgeting, irritability, fixed stare
Moderate: raising voice, yelling, pacing, head-banging, defensive stance
Severe*: combative, imminent risk to self or others

Gather information, if available:
- Engage family/caregiver
- Consult patient's behavioral care plan
- Check medical record
- Collateral history from EMS or police if present

Initial Stabilization & Management

- Assess ABCs, vital signs, consider bedside glucose
- Perform brief medical assessment, if possible
- Prepare the team with a brief huddle
- Designate a team lead and patient contact person

***If immediate safety risk to patient and/or staff, see medication recommendations below.**
Access dosing recommendations here.

Manage the Environment

- Remove dangerous objects/equipment
- Monitor patient in a safe space with dimmed lights, minimize noise
- Decrease sources of stress/stimulation, including family/caregivers as required to reduce patient triggers
- Avoid overuse of medications, physical restraints, and security personnel

Use Behavioral De-escalation Techniques

- Respect personal space
- Listen to patient and caregiver
- Keep neutral tone and body language
- Establish concise verbal contact
- Avoid provocative actions and words
- Identify wants and feelings
- Offer choices and optimism
- Reward cooperation

Use Calming Interventions

- Listen to patient, validate distress
- Address needs (e.g., food/drink)
- Use distraction (e.g., safe activity, food, warm blanket)
- Explain what to expect in ED, next steps, provide updates
- Debrief patient and care team

Are you able to de-escalate the patient so they are not a harm risk to themselves/staff?

Yes, no longer agitated.

Ongoing Evaluation

- Monitor vital signs and fall risks
- Initiate de-escalation strategies/calming interventions with signs of increasing agitation as needed
- Complete history and physical to potentially identify etiology for agitation

No, immediate harm risk.

Identify Etiology for Agitation

Developmental delay or autism spectrum disorder
- Involve caregiver, check behavioral care plan for strategies
- Utilize sensory tools and calming interventions
- Identify previously effective medication(s)

Suspected psychiatric diagnosis
- Use behavioral de-escalation techniques
- Assess for possible organic cause
- Identify previously effective medication(s)

Delirium (change in cognition and/or confusion)
- Obtain critical labs: glucose, electrolytes, toxins
- Assess for head trauma, encephalopathy (infectious or toxin)
- Address vital sign abnormalities, underlying medical etiology

Pain
- Assess for and address/treat potential causes of pain
- Assess patient's past response to pain

Withdrawal or intoxication
- Assess for multi-drug ingestion
- Closely monitor ABCs, vital signs, and temperature
- CAUTION: potential cardiac effects with unknown/multi-drug use

Unknown etiology
- Closely monitor patient, vital signs and temperature
- With hyperprexia, autonomic instability, mental status/neurologic changes consider catatonia, neuroleptic malignant syndrome, serotonin syndrome

Medications

- PO: clonidine OR risperidone OR olanzapine; Oral Dissolve Tablet: olazapine; IM: olanzapine
- AVOID IM route if possible
- Consider an extra dose of patient's home medication
- AVOID benzodiazepine–risk of disinhibition, unless effective in past

- Use a medication that has worked in the past or an additional dose of home medication
- If psychosis or anxiety/trauma related: benzodiazapine
- AVOID ketamine if concern for psychosis, antipsychotics if concern for catatonia

- PO: quetiapine OR risperidone OR clonidine OR olanzapine
- IM: olanzapine OR haloperidol
- IV: haloperidol
- AVOID benzodiazepines and anticholinergics, could worsen delirium

- PO: ibuprofen, acetaminophen
- IN: fentanyl, ketamine
- IM: ketorolac, ketamine
- IV: acetaminophen, ketorolac, opioid, low-dose ketamine
- AVOID NSAIDs (if suspect bleeding); ketorolac (if renal failure); respiratory depressants (if intoxication); ketamine (if psychosis)

- Unknown substance: benzodiazepine
- Opioid withdrawal: methadone or buprenorphine

- Moderate Agitation: diphendydramine or benzodiazepine
- Severe Agitation: haloperidol +/- benzodiazepine

CAUTION
- Evaluate for medication side effects
- Consider medication time to onset, peak, duration of effect
- Consider additive effects prior to additional dosing
- If using antipsychotic, monitor for acute dystonic reaction (involuntary contractions, movements or postures)

ACEP Now
The Official Voice of Emergency Medicine

An official publication of American College of Emergency Physicians
ADVANCING EMERGENCY CARE

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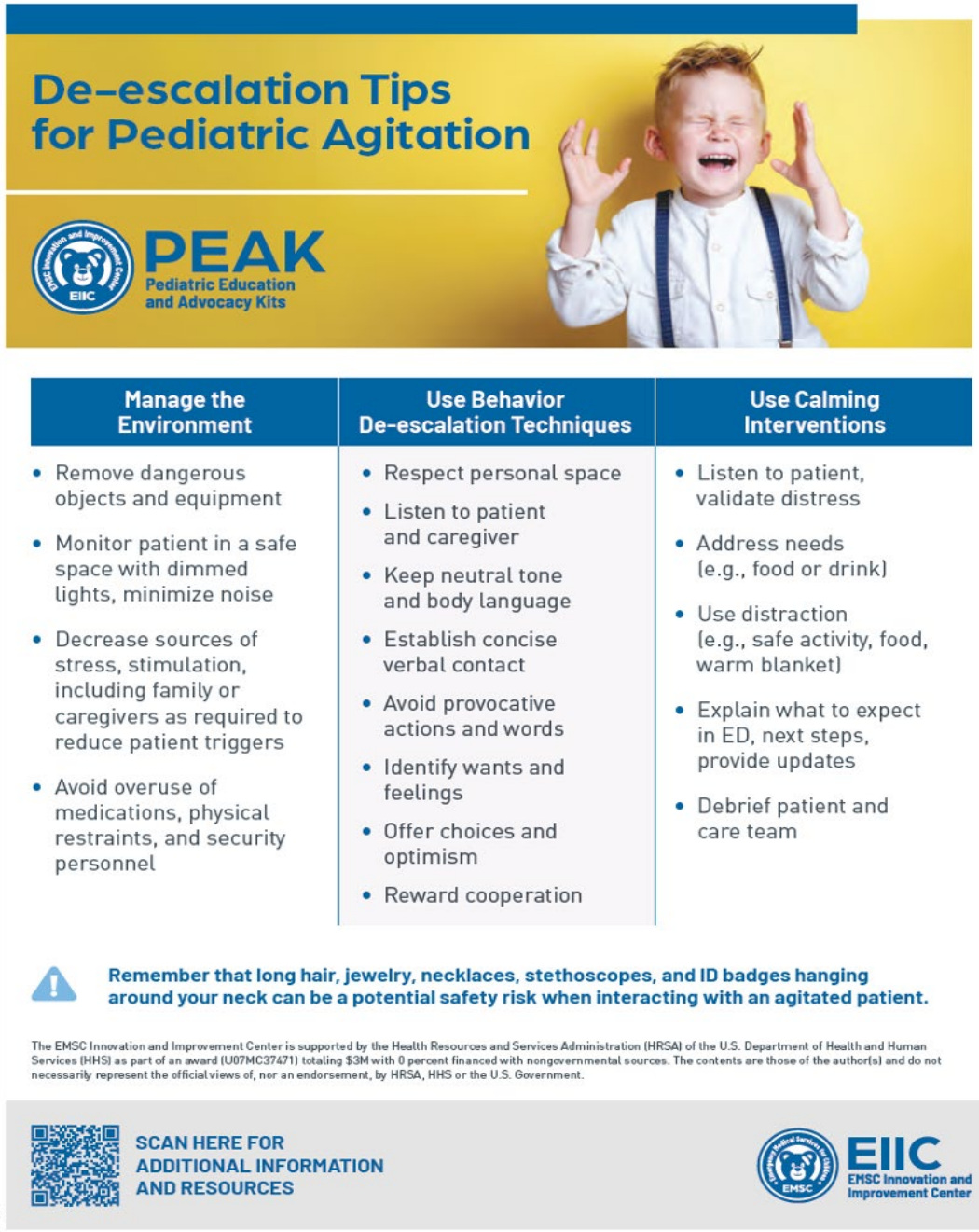
How to Manage Acute Agitation in Children

By Ashley Foster, MD; Joyce Li, MD, MPH; and Jennifer Hoffmann, MD, on behalf of the Emergency Medical Services for Children Innovation and Improvement Center | on November 9, 2022 | 0 Comment

Highlights from Our Partners

https://www.acepnow.com/article/how-to-manage-acute-agitation-in-children/



MEDICATION DOSING RECOMMENDATIONS | AGITATION

The agitation medication dosing recommendation table accompanies the Care of the Agitated Patient Algorithm, a clinical tool to guide decision-making when caring for agitated pediatric patients in emergency settings

PEAK Pediatric Education and Advocacy Kits

Drug	Route	Dose	PRN Interval	Onset	Considerations
Medications for MILD/MODERATE Agitation					
In individuals who are not able to behaviorally de-escalate, medication may be more effective and should be considered early to prevent agitation escalation.					
Diphenhydramine	PO/IM	1 mg/kg/dose MAX single dose: 50 mg	Every 6-8 hours	PO: 30-60 min IM: 5-30 min	**Contraindications:** AVOID in delirium and intoxication, or history of paradoxical reaction **Side effects:** QTc prolongation, disinhibition
Lorezepam	PO/SL/IM/IV	0.05-0.1 mg/kg/dose MAX single dose: 2 mg	Every 4-6 hours	PO: 30-60 min IM: 15-30 min IV: 5-15 min	**Contraindications:** AVOID in delirium, autism spectrum disorder, history of paradoxical reaction, or AVOID within 1 hour IM olanzapine **Side effects:** respiratory depression if administered with an antipsychotic, disinhibition, delirium
Clonidine	PO	0.05 mg-0.1 mg MAX total dose: 0.4 mg/day	Every 6-8 hours	PO: 30-60 min	**Contraindications:** hypotension, bradycardia. Caution use with antipsychotics and benzodiazepines **Side effects:** hypotension, bradycardia
Medications for SEVERE Agitation					
Antipsychotics are often required. An enteral route should be offered to the patient, but IM administration is often required.					
Chlorpromazine	PO	0.55 mg/kg/dose	Every 4-6 hours	30-60 min	Usual 1st single dose: 25 mg **Contraindications:** AVOID IV use due to risk of cardiovascular collapse/skin necrosis at injection site **Side effects:** hypotension, QTc prolongation
	IM	0.28-0.55 mg/kg/dose		15-30 min	
Haloperidol	PO/IM	0.025-0.075 mg/kg/dose	Every 6 hours	PO: 30-60 min IM: 15-30 min	Consider co-administration with a benzodiazepine and diphenhydramine **Contraindications:** history of NMS, severe dystonia, history of QTc prolongation **Side effects:** EPS, decreased seizure threshold, hypotension, QTc prolongation
Quetiapine	PO/IM	<40 kg: 6.25-12.5 mg ≥40 kg: 25-50 mg	Every 12-24 hours	IM: 30 min PO: 30 min	**Side effects:** hypotension, QTc prolongation (less risk than other antipsychotics)
Risperidone	PO/ODT	<20 kg: 0.25-0.5 mg ≥20 kg: 0.5-1 mg	Every 24 hours	30-60 min	**Contraindications:** history of NMS, severe dystonia, history of QTc prolongation **Side effects:** sedation, akathisia (restlessness/agitation), QTc prolongation, hypotension, EPS*
Olanzapine	PO/ODT	<40 kg: 1.25-2 mg ≥40 kg: 2.5-5 mg	Every 24 hours	1-8.5 hours	**Contraindications:** AVOID concurrent use of IM olanzapine and IM/IV benzodiazepines **Side effects:** paradoxical reaction, sedation
	IM	<40 kg: 2.5-5 mg ≥40 kg: 5-10 mg		15-45 min	

Mild: subtle behaviors such as fidgeting, irritability, fixed stare
Moderate: raising voice, yelling, pacing, head-banging, defensive stance
Severe: combative, imminent risk to self or others

EPS: extrapyramidal symptoms
NMS: neuroleptic malignant syndrome
PO: by mouth / **IM:** intramuscular / **IV:** intravenous

EIIC mental health educational content update

Pediatric Education and Advocacy Kits (PEAK)

- Interactive learning modules:
  - Agitation: hospital-based (available)
  - Agitation: pre-hospital (in development)
  - Suicide: hospital-based (in development)
- Algorithms and bottom-line recommendations (with TREKK)
  - Agitation (available)
  - Child abuse (near final)

PEAK Pediatric Education and Advocacy Kits

https://emscimprovement.center/education-and-resources/peak/

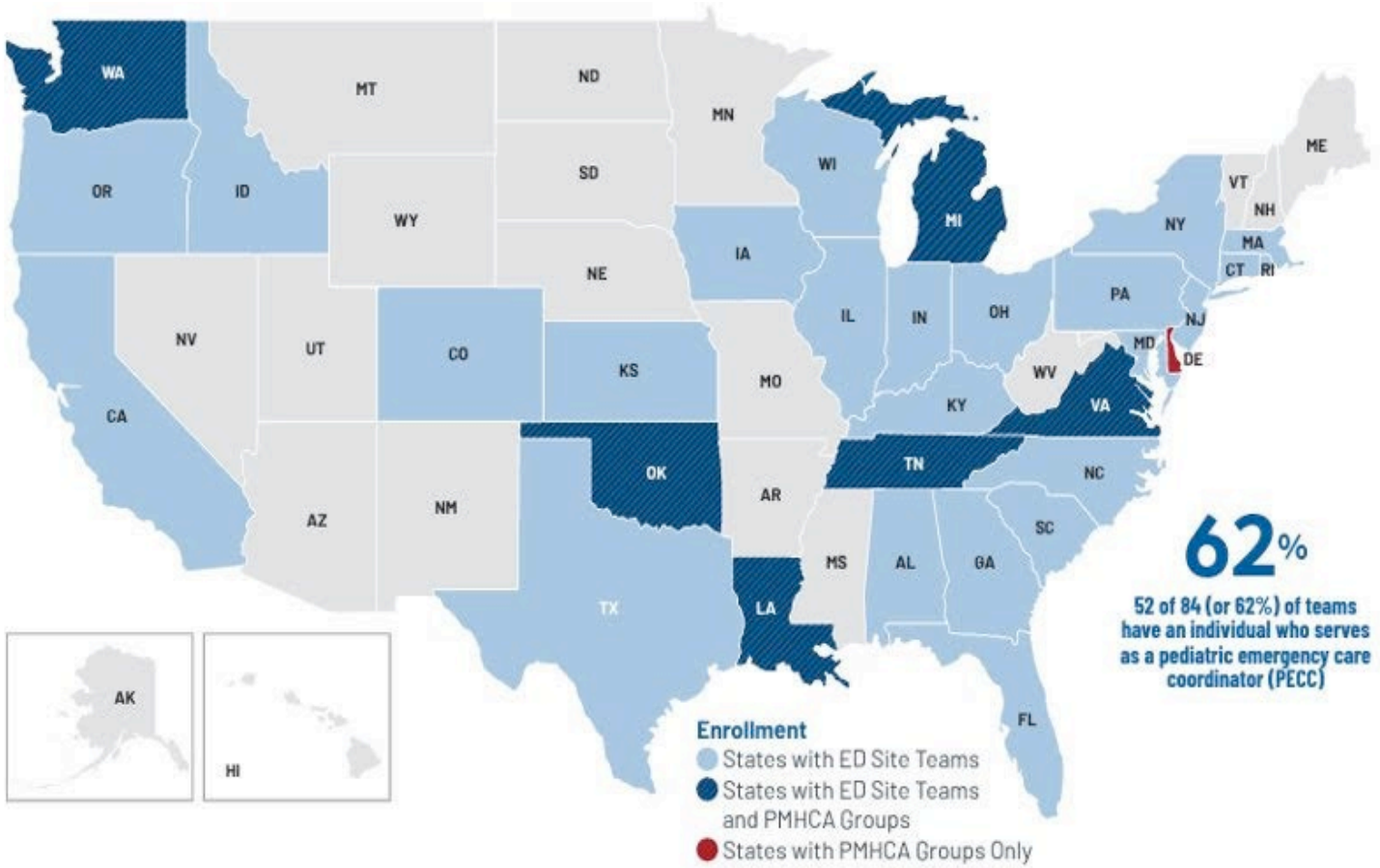
Engagement data (August 2023)

PEAK Agitation	Page views	Unique users
Total	1025	183
Agitation management webinar series	266	51
Agitation management Podcast series	98	23
Non-pharmacologic	371	71
Pharmacologic	29	11
Interactive learning module	14	6

ED STOP Suicide QI collaborative

- February –November 2023
- 85 teams (various settings)
- Subject matter experts and web resources

- Focus on suicide
- One of 4 intervention bundles
  - Screening
  - Assessment
  - ED-based interventions
  - Safe Discharge planning



ED STOP Suicide QI Collaborative update

34/78 completed ED STOP Check-in Survey
•Suicide Screening: 16 teams

•Mental Health Assessment: 2 teams

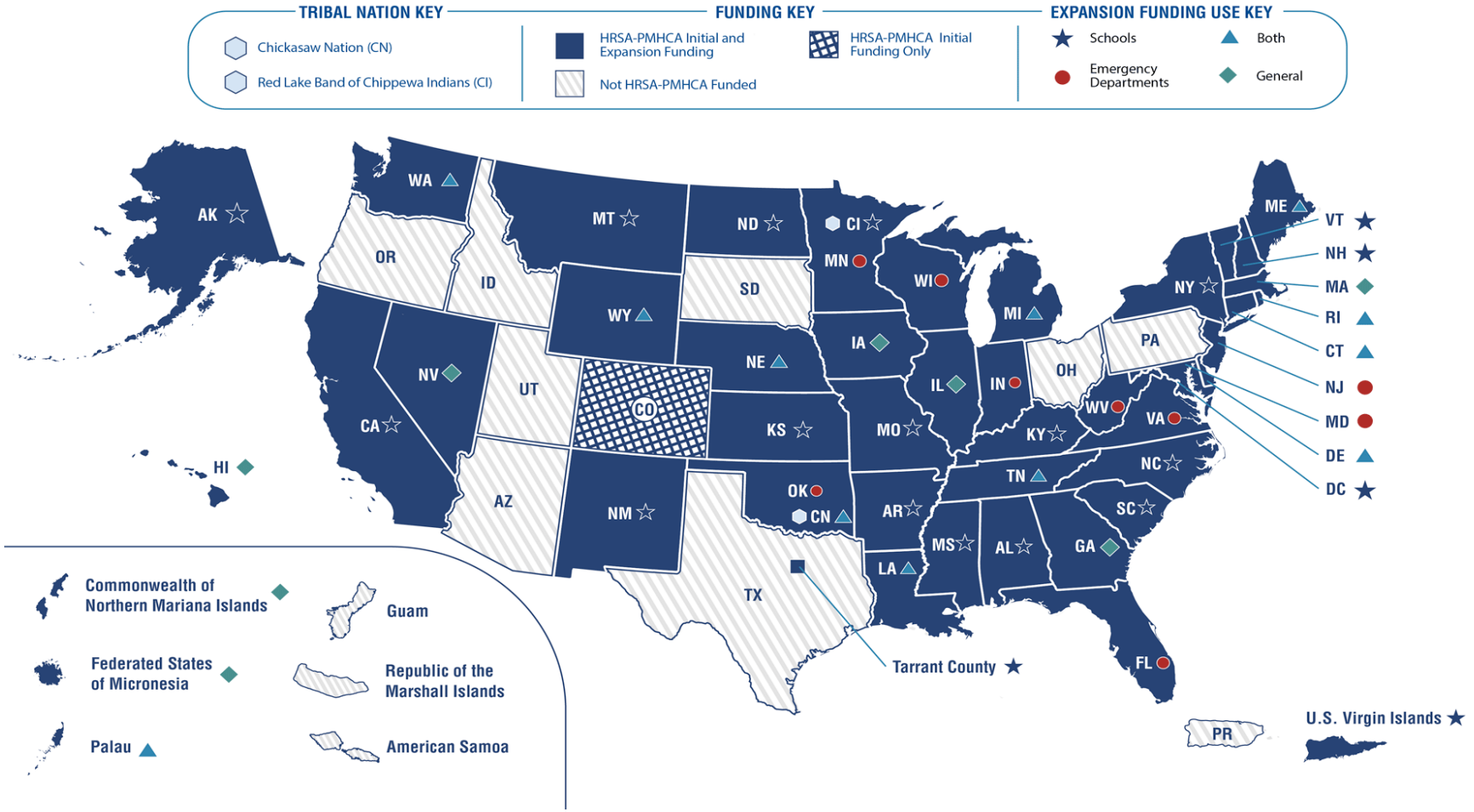
•ED-Based Interventions: 13 teams

•Discharge and Safety Planning: 22 teams

•**34/34 (100%)**: Identified a strategy to improve clinical care processes
•
24/34 (71%): Have implemented/plan to implement a strategy to improve clinical care processes
•
32/34 (94%): Have not yet been able to demonstrate an improvement as a result of that strategy

Pediatric Mental Health Care Access (PMHCA) Programs

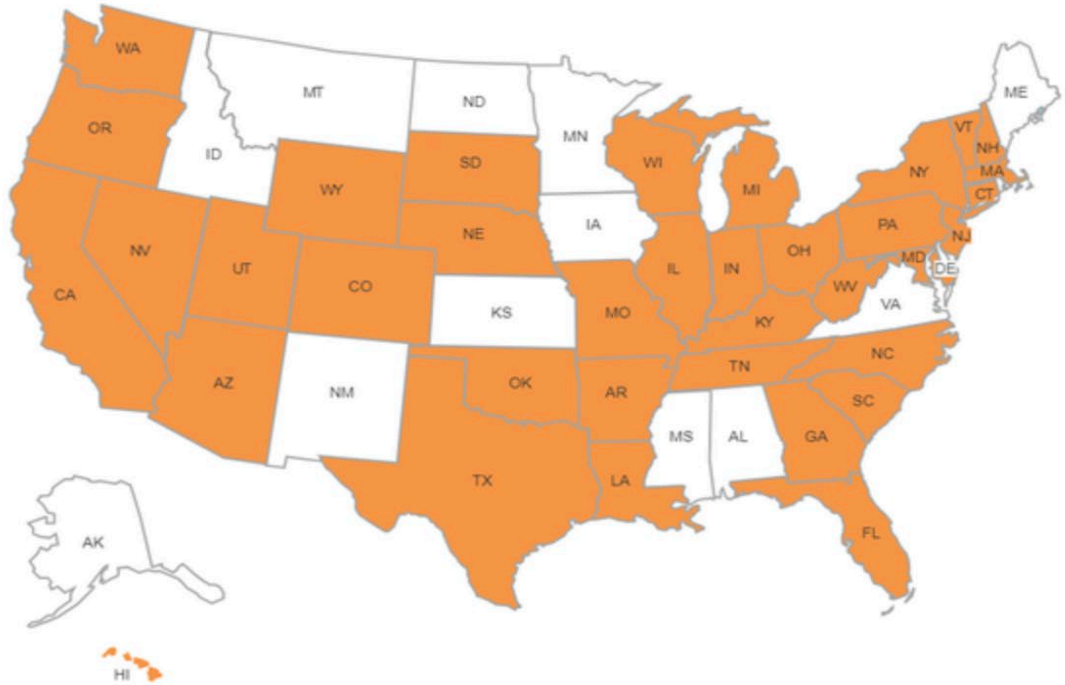
"Promote behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs"



PRQC 2.0

- Kicked off June 2023
- 18 months
- 4 intervention bundles
  - patient safety
  - patient assessment and reassessment
  - pain management
  - **suicide**

Participating States



*Additionally, sites from the following territories or freely associated states have registered:

- District of Columbia
- Northern Mariana Islands
- Palau
- Puerto Rico
- U.S. Virgin Islands.

Collaboratives Engagement data (August 2023)

Collaboratives	Page views	Unique users
ED STOP Suicide	225	38
PRQC (total)	5818	503
PRQC (about sessions)	1744	221
PRQC (resources)	371	71
PRQC (suicide)	458	74
Total	**7014**	**612**

New Pediatric Mental Health Policy Statement and Technical Report

#EMSC23

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

Mohsen Saidinejad, MD, MS; Susan Duffy, MD, MPH; Dina Wallin, MD; Jennifer A. Hoffmann, MD; Madeline Joseph, MD; Jennifer Schieferle Uhlenbrock, DNP, MBA; Kathleen Brown, MD; Muhammad Waseem, MD, MS; Sally K. Snow, BSN, RN; Madeline Andrew, MD; Alice A. Kuo, MD, PhD; Carmen Sulton, MD; Thomas Chun, MD, MPH; Lois K. Lee, MD, MPH

AMERICAN ACADEMY OF PEDIATRICS
Committee on Pediatric Emergency Medicine

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Pediatric Emergency Medicine Committee

EMERGENCY NURSES ASSOCIATION
Pediatric Committee

POLICY STATEMENT
Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

This article is being jointly published in *Pediatrics, Annals of Emergency Medicine,* and *Journal of Emergency Nursing.*

TECHNICAL REPORT

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

Mohsen Saidinejad, MD, MS, MBA, FAAP, FACEP,[a] Susan Duffy, MD, MPH, FAAP,[b] Dina Wallin, MD,[c] Jennifer A. Hoffmann, MD, FAAP,[d] Madeline M. Joseph, MD, FAAP, FACEP,[e] Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN,[f] Kathleen Brown, MD, FAAP,[g] Muhammad Waseem, MD, MS, FAAP, FACEP, CHSE-A,[h] Sally Snow, BSN, RN, CPEN, FAEN,[i] Madeline Andrew, MD,[j] Alice A. Kuo, MD, PhD, MBA, FAAP,[k] Carmen Sulton, MD, FAAP,[l] Thomas Chun, MD, MPH, FAAP,[m] Lois K. Lee, MD, MPH, FAAP, FACEP,[n] AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee

Basis for the new joint policy statement

01

CONSIDERATION FOR GENERAL EDS AND RURAL COMMUNITIES

02

CONSIDERATION FOR THE ENTIRE CONTINUUM OF PEDIATRIC EMERGENCY CARE

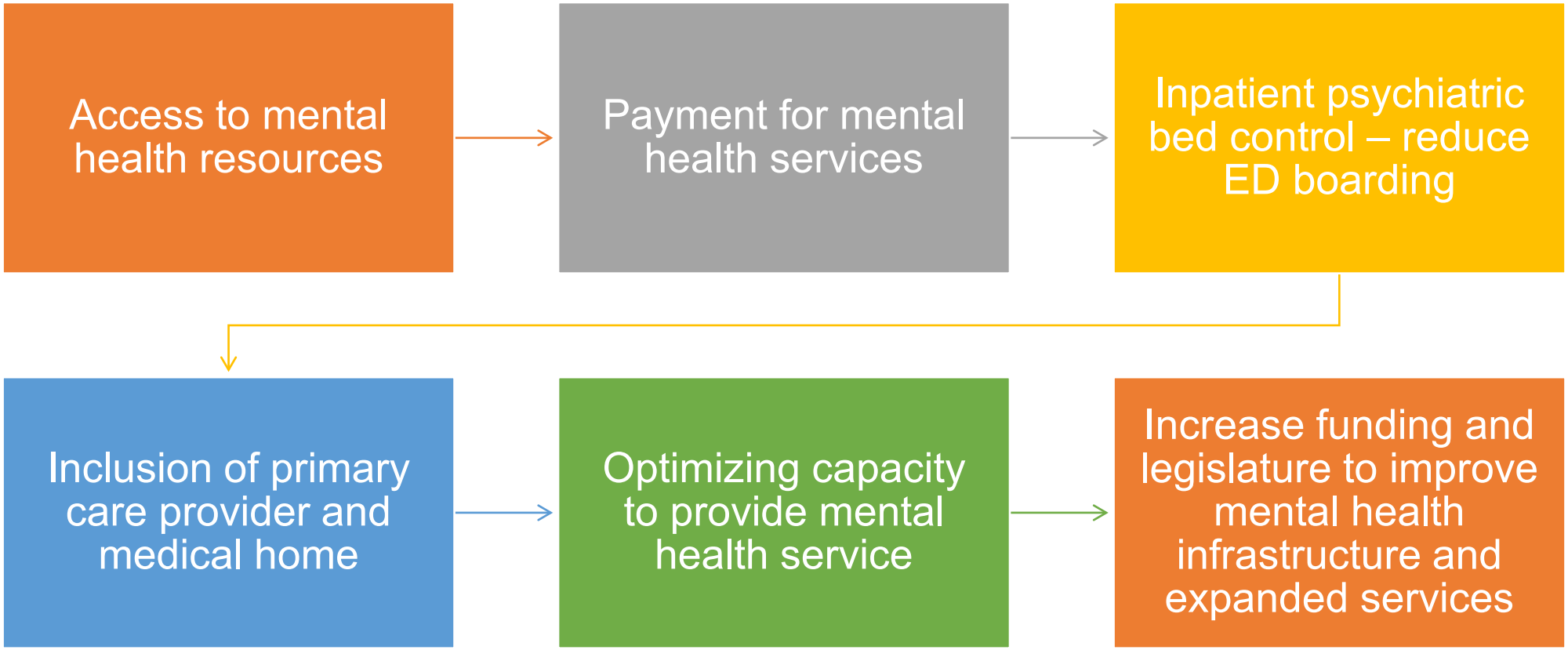
03

ALIGNING MENTAL HEALTH EMERGENCIES RECOMMENDATION BETWEEN AAP, ACEP, AND ENA

04

CONSIDERATION FOR EQUITY AND DIVERSITY IN ACCESS TO PEDIATRIC MENTAL HEALTH

System of care consideration



Research consideration

- Increase mental and behavioral health research funding for EMS for Children (screen, identify high risk, and connect to resources)
- Evidence-based guidelines for screening and treatment in the ED setting
- Research on the effect of media on youth mental health
- Consideration specific to mental health equity

Media coverage

NEWS

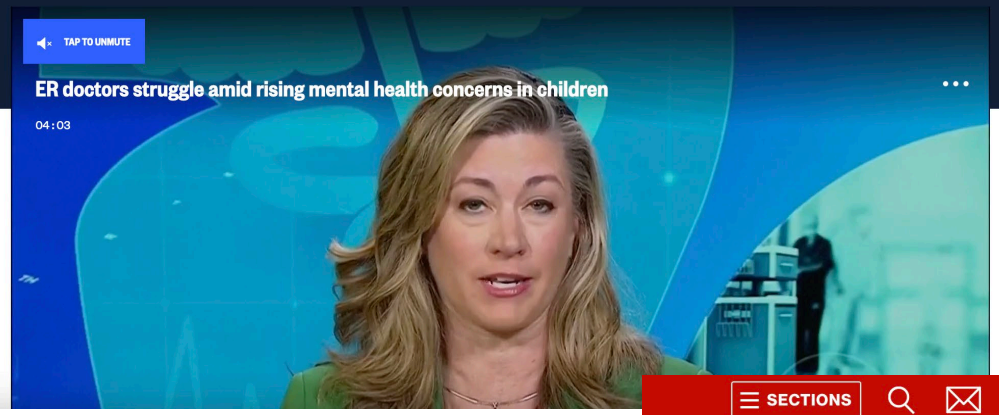
Emergency room doctors beg for help treating children with mental health illnesses

SHARE & SAVE

HEALTH NEWS

Emergency room doctors beg for help treating children with mental health illnesses

Faced with bottlenecks and backlogs of patients in need of emergency care, doctors say they are unequipped to handle the growing pediatric mental health crisis.



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Need to improve care of children with mental, behavioral health emergencies prompts new joint guidance

SECTIONS

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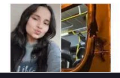
TRENDING NOW IN LIFESTYLE



Girl on school bus dies while waving to friends as head collides...

Airline 'hack' divides travelers: 'Jeopardizing other passengers'

Millionaire outs fiancée as a cheater during speech at their...

Influencer Burak Can Tas, 23, dies in horrific motorcycle crash...

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Home / News / Health News / ERs Are Flooded With Kids in ...

ERs Are Flooded With Kids in Mental Health Crisis, U.S. Doctors' Groups Warn

By HealthDay | Aug. 16, 2023, at 6:55 a.m.

Save | Comment

By Dennis Thompson HealthDay Reporter

WEDNESDAY, Aug. 16, 2023 (HealthDay News) -- America's emergency rooms are being flooded by children suffering from psychiatric emergencies like anxiety, depression and suicidal thoughts or attempts, a new joint report from three leading medical associations warns.

The work ahead

- Coordinating this work with other HRSA funded assets
- Mental health resources for children in schools and the community
- Integrating this work into the learning of future trainees
- Additional focus on addressing disparities and how to overcome this
- Continue the work through QI collaboratives
- Optimize data on disparity and progress in showing adoption of best practices and better mental health outcomes for all children

Conclusions

- Pediatric mental health is a problem of crisis proportions.
  - disproportionally affects certain groups
- The EDs are the de-facto referral centers and can not cope with the demand for timely and effective care.
  - results in prolonged boarding
- The EMSC has developed a variety of educational resources to match the diverse components of the community of practice.
- The EIIC quality collaboratives have successfully engaged those who are outside of the typical echo chambers.
- New Joint statement is meant to help provide guidance for pediatric mental health care across the emergency care continuum.

Thanks

Feel free to contact me with any questions.

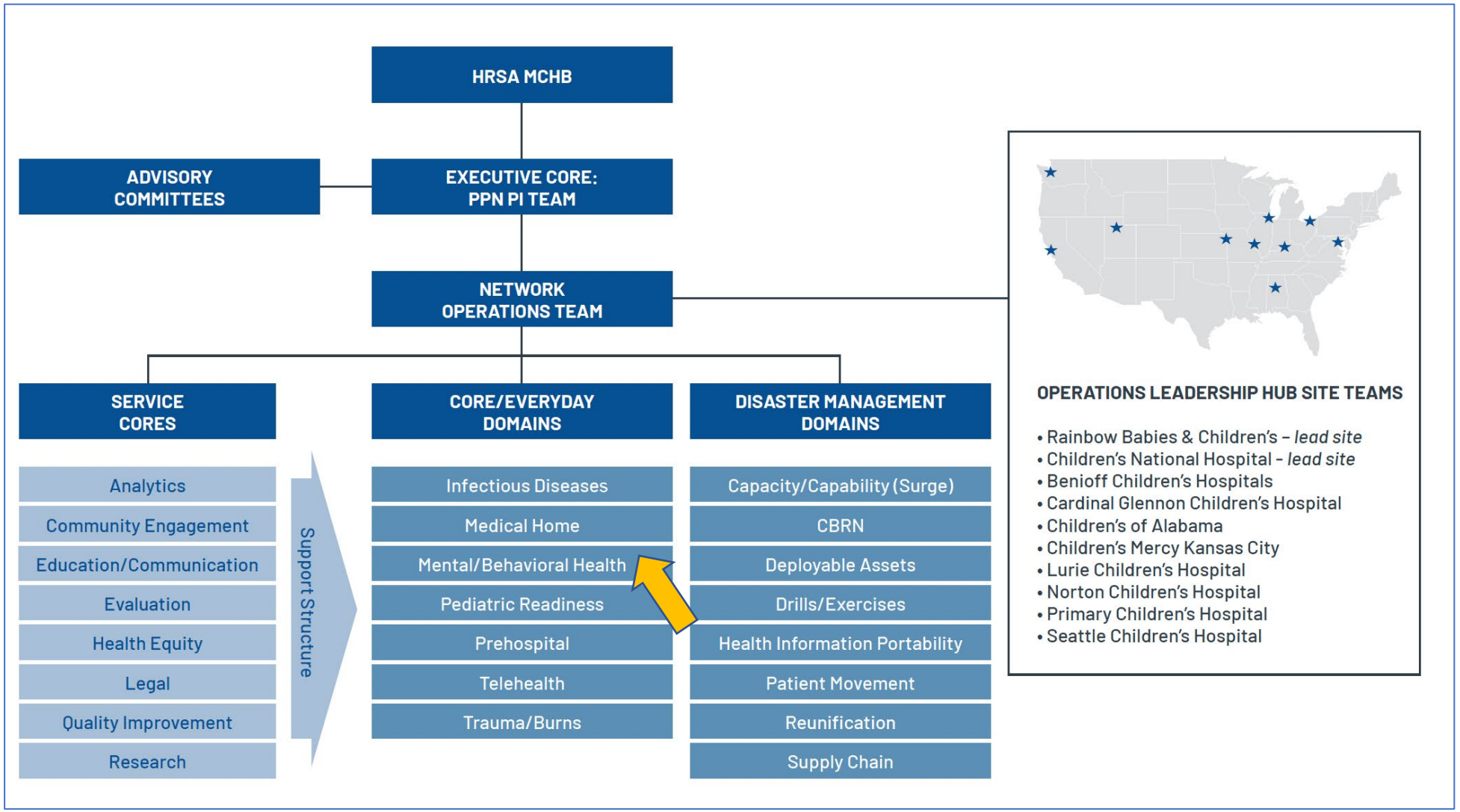
moh@emedharbor.edu

Mental & Behavioral Health Domain

Lee Beers, MD
Merritt Schreiber, PhD
Trevor Covington, CEM
and team

This project is part of the Pediatric Pandemic Network and is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of grant awards U1IMC43532 and U1IMC45814 with 0 percent financed with nongovernmental sources.

PPN Core Domain-Mental/Behavioral Health



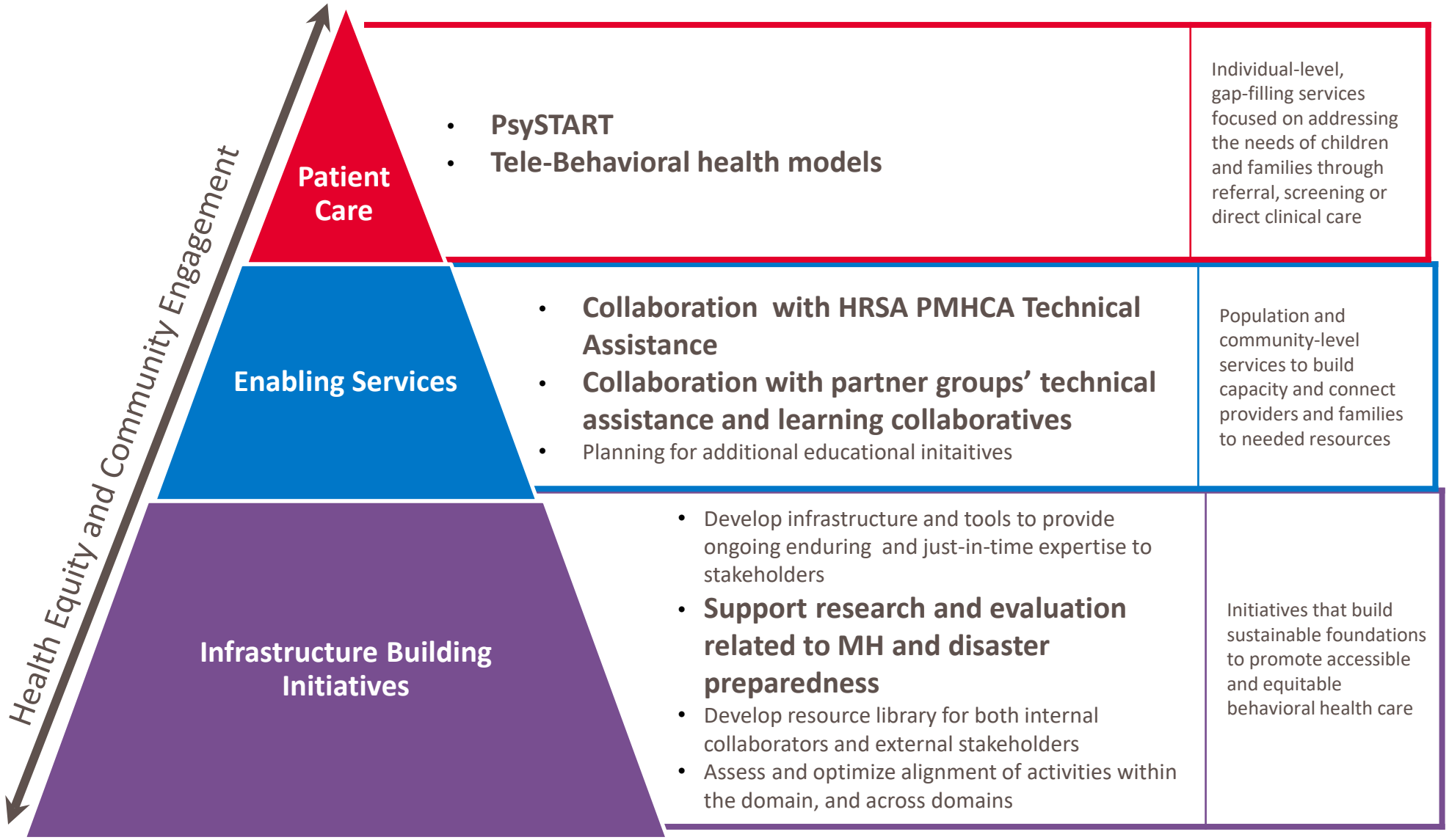
Charter -- Goals and Objectives

- Promote an ***equitable, effective and community-engaged disaster preparedness and response system of care*** which comprehensively addresses pediatric mental health and has the capacity to evaluate systems and interventions across the continuum of care, from health promotion to recovery.
- Increase the capacity and capability of ***tele-behavioral health*** to deliver mental health services to all children in emergencies, all-hazard disasters and pandemics.
- Develop and deliver training materials addressing a variety of scenarios to ***improve pediatric mental health preparedness*** and response across health systems and their communities for all children, including emergency plans for children with special needs and guidance on ensuring equitable delivery of care.

Goals and Objectives (con't)

- Serve as an expert workgroup to develop ***pediatric mental health rapid response materials*** in the event of a specific acute or ongoing incident.
- Deliver a model for ***triaging and increasing mental health surge capacity*** in children's hospitals and disseminating this approach across mental health emergencies and disaster systems of care (primary care, community hospitals, EMS, and schools).
- ***Work with federal, state, tribal and local agencies and healthcare facilities*** to equitably improve access to mental health care resources during emergencies, all-hazard disasters and pandemics.
- ***Work collaboratively with schools, school-based clinics, and other community partners*** to develop, disseminate, and educate on evidence-based mental health screening tools and interventions to improve resilience.

PPN Mental and Behavioral Health Domain Activities (Existing and/or Planned)



Patient Care

- **PsySTART**
- **Tele-Behavioral health models**

Individual-level, gap-filling services focused on addressing the needs of children and families through referral, screening or direct clinical care

Enabling Services

- **Collaboration with HRSA PMHCA Technical Assistance**
- **Collaboration with partner groups' technical assistance and learning collaboratives**
- Planning for additional educational initaitives

Population and community-level services to build capacity and connect providers and families to needed resources

Infrastructure Building Initiatives

- Develop infrastructure and tools to provide ongoing enduring and just-in-time expertise to stakeholders
- **Support research and evaluation related to MH and disaster preparedness**
- Develop resource library for both internal collaborators and external stakeholders
- Assess and optimize alignment of activities within the domain, and across domains

Initiatives that build sustainable foundations to promote accessible and equitable behavioral health care

Initiatives are classified by primary category and may fall within more than one level or move throughout levels

Collaboration and coordination across other domains and service cores

PPN Wide Research Initiative

- Scope and impact of COVID on MH/BH on Children
- Implement interventions that will better prepare communities for future disasters

PPN PsySTART Triage Learning Collaborative 1.0

1 – Establish Learning Collaborative

- Conduct project kick-off sessions
- Establish routine cadence for meetings and project check-ins
- Establish participant guided outcomes and evaluation criteria

2 – Intro to PsySTART

- Overview of PPN PsySTART System Configuration
- Engage site action agents

3 – Conduct Trainings

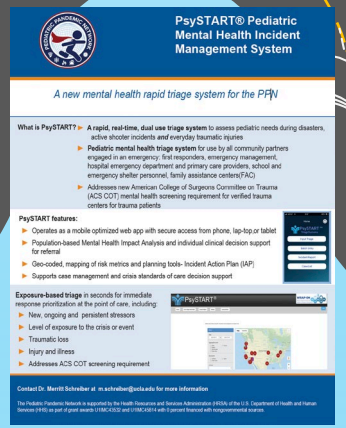
- Schedule and offer trainings for sites and partners including Train-the-Trainer

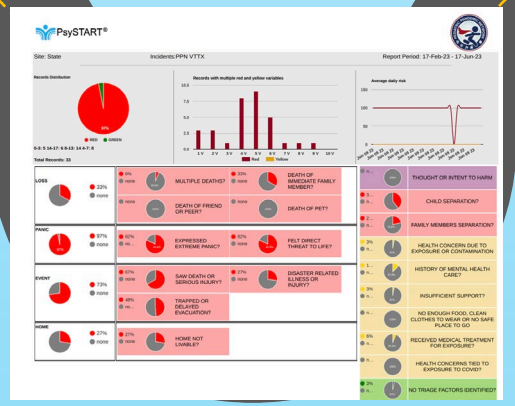
4 –Virtual Table-Top Exercise (VTTX)

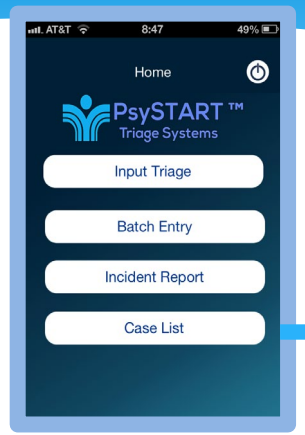
- Conduct feedback sessions/process for participants and project team
- Develop pilot outcome report including lessons learned

5 Evaluation/ next steps

- Pilot Review & Improvement Planning
- Evaluate PPN next steps







Stepped Triage to Care

Acute Danger

50-90%= Transitory Distress Response (symptoms)

(ex: Insomnia, Fears of recurrence)

"Green" Resilience pathway

Avg=16%
Range =20-40%
New Incidence
Disorder:
PTSD, PGD,

"RED Risk Pathway

Prior Trauma SED, SDOH/ (ACES)

Multi-gated triage, assessment, and tele- BH care

TRIAGE

High Risk:
Objective Features
Traumatic loss

SCREENING

Distress measures and functional impact

ASSESSMENT

- Clinical evaluation

Clinical Care

Trauma Informed Pediatric ED MH System

Goal: inform clinical decision making, enhance receipt of care, and ultimately promote patients' health

1. Improved EMSC care as unique catalyst to downstream mental health quality improvement for enhancing resilience

2. Increase awareness of trauma impact on wide range of pediatric mental health emergency pathways across disaster systems of care

2. Comply with new ACS CoT MH Screening requirements(8/23)

PsySTART PPN System : Bottom Line Up Front

"If you don't count it, it wont count"

- **Dual use**: Everyday trauma ***and*** disasters with EBT tele-bh intervention model
- **Individual decision support for stepped care (crisis standards of care)**
- **Population level risk mapping (community "trauma temperature")**
- **Situational awareness at hospital, health systems, community disaster systems of care including families**
  - Intention violence and accidents by geo-code
  - Selectable time frames, incidents and geo-code layers
- **GIS mapping options for *PPN sentinel surveillance*** for incident management
- **DEI-** Real-time awareness of differential impacts

PEDIATRIC PANDEMIC NETWORK

HARBOR-UCLA PEDIATRICS

Proposed PPN PsySTART Triage to Care Collaborative 2.0

- Step 1: Triage for trauma exposure/loss risk: PsySTART PPN System App(ED, EMS)
- Referral to: Tele-BH/MH provider (school, hospital, o/p)
- Stepped care trauma treatment: TF-CBT
  Step 2: TF-CBT PRAC components
  Repeat CPSS-5→ if clinically indicated→
  Step 3: TF-CBT TICE components (full model)
- Stepped and Tele-Health adaptation of TF-CBT

PsySTART data slides: removed due to DUAs

HARBOR-UCLA PEDIATRICS

PPN PsySTART Stepped Triage to Care and/or Mental Health Domain

Please join us !

Interest form:

https://forms.gle/TvhzxqPHo6TSxhkCA

HARBOR-UCLA PEDIATRICS

Pediatric emergency department MH boarding challenges: toward the pathways forward….

SEPTEMBER 26th SESSION:

WRAP-EM is conducting an initiative to address the ongoing crisis of youth mental health surge within emergency departments.

This initiative will include both a listening session (September 26th) and a **solution-focused webinar (November 8th**) :

Subject matter experts across the country to address specific challenges, provide tools and resources, and answer questions from attendees.