Challenges of Managing Pediatric Mental Health Crises in the Emergency Department

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KEYWORDS

• Psychiatric emergency • Pediatric • Autism • Developmental disorders

KEY POINTS

- Children and adolescents presenting to emergency departments with psychiatric crises are burgeoning; optimal care of these patients includes close collaboration between emergency medicine and psychiatry physicians.
- The evaluation and management of aggressive and/or violent patients, requires a range of skills and knowledge, including verbal de-escalation as well as knowledge of safe chemical and physical restraint practices.
- Children with autism spectrum or other developmental disorders in the emergency department also require specialized skills for communication, transition planning, and calming and soothing the patient.

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COMMENTARY: CRISIS IN THE EMERGENCY ROOM: MANAGING PEDIATRIC MENTAL HEALTH CRISES IN THE EMERGENCY DEPARTMENT

The constriction of inpatient and outpatient services for children's mental health treatment, coupled with an increased awareness of the potentially disastrous consequences of untreated suicidality and aggression in children and adolescents, has led to a dramatic increase in youth presenting to the Emergency Room (ER) for psychiatric care. This article, updated from an article published in the *Pediatrics Clinics of North America* in 2013, highlights the key features of appropriate emergency evaluation and treatment of youth in psychiatric crisis. The article's description of detailed and structured risk assessment, involvement of family and other key caregivers, careful use of de-escalation strategies to ensure safety in the ER, and connection to appropriate inpatient or outpatient services provides a much-needed standard for high-quality emergency psychiatric care for children.

Unfortunately, too many children and adolescents in psychiatric crisis do not receive such care. Emergency programs, due to lack of funding, support, and training, have not kept pace with the escalating demand for emergency psychiatric care. Most children and adolescents in psychiatric crisis are seen in general pediatric or medical ERs, which are crowded, noisy, high-stimulation environments, often with long wait times and little available private or quiet space.[1,2] For agitated, paranoid, traumatized, or autistic youth, this can be disastrous, often ending in restraints or seclusions that might have been avoided in a quieter, calmer setting. Adding to the difficulty of managing these patients in ERs, most young people presenting with a psychiatric crisis are treated by pediatric emergency clinicians and staff who lack psychiatric training, or by adult psychiatric clinicians who lack training in the diagnosis and treatment of children and adolescents. In a statewide survey in California, only 10% of emergency programs had child psychiatrists available for consultation (and most who did were academic centers, not community hospitals); less than 35% had general psychiatrists available, only 15% had a psychiatric nurse present, and less than 50% programs had a social worker (and not necessarily a psychiatric social worker) to assist in evaluation or disposition.[3] Medical providers see most young people presenting to ERs in psychiatric crisis, but only a third of these providers have ever had any training in treating psychiatric patients.[4] More than half of the youth presenting to the ER after a suicide attempt or other episode of deliberate self-harm never receive any mental health evaluation.[5] Of youth presenting with mental health complaints (including self-harm and suicide attempts) to the ER, two-thirds are discharged, but only about a third of patients are given a referral for any psychiatric follow-up care.[1,5] Clinicians may lack sufficient training to recognize the need for a hospitalization or outpatient referral; there may not be inpatient beds or outpatient services available; or insurance may balk at paying for psychiatric treatment (particularly inpatient or intensive treatment). When an outpatient referral is made, there are often long wait lists to be seen in community clinics, and in most communities, acute care outpatient services such intensive outpatient programs, partial hospitalization programs, and home-based crisis services are either unavailable or prohibitively expensive.

To ensure that every child and adolescent presenting to an ER in psychiatric crisis receives the standard of care described below would require a broad investment and collaboration between child and adolescent psychiatrists and pediatricians. Together, the following must be advocated for:

1. Development of clear standards of care for emergency evaluation and treatment
2. Increased training for emergency medical providers and pediatricians in identification and treatment of child mental illness, as well as in de-escalation and crisis management