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Selected Topics: Psychiatric Emergencies

THE EFFECT OF A DEDICATED PSYCHIATRIC TEAM TO PEDIATRIC EMERGENCY MENTAL HEALTH CARE

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☐ **Abstract—Background: Pediatric emergency department (PED) visits among children and adolescents with acute mental health needs have increased over the past decade with long wait times in the PED awaiting disposition. Objective: The objective of this study was to evaluate the effect of a new pediatric mental health liaison program with the hypothesis that this model reduces length of stay (LOS) and hospitalization rates among pediatric mental health patients. Methods: This was a pre- and postintervention retrospective study of the year prior to (June 2012–June 2013) and the year after (October 2013–October 2014) implementation of a new PED psychiatric team. All patients aged 1–18 years with a mental health International Classification of Diseases-9th Revision code were included. Patients who did not receive a Psychiatry consult in the PED were excluded. Results: There were 83 encounters in the year prior to and 129 encounters in the year after the implementation of the liaison program. There was an increase in the suicidality of mental health patients during this time. There was a significant decrease in mean PED LOS of 27% (95% confidence interval [CI] 0–46%; $p = 0.05$) from pre- to postintervention period. The decrease in the proportion of patients admitted/transferred to an inpatient psychiatric facility in the postintervention year was statistically significant (odds ratio 0.35; 95% CI 0.17–0.71; $p < 0.01$). Conclusions: The use of a dedicated child psychiatrist and mental health social worker to the PED results in significantly decreased LOS and need for admission without any change in return visit rate. Larger, multicenter studies are needed to confirm these findings.** © **2016 Elsevier Inc.**

☐ **Keywords—child; mental; emergency department; acute**

INTRODUCTION

Pediatric mental health concerns are on the rise in the United States, with many children and adolescents utilizing the pediatric emergency department (PED) when acute mental health issues arise. Nationally representative studies using the National Hospital Ambulatory Medical Care Survey (NHAMCS) have documented increasing PED mental health visits over the past 2 decades (1–3). These studies have shown that approximately 5% of all PED visits are for mental health complaints, and this increase is out of proportion to what is being seen in other chronic medical conditions. A single-center study demonstrated a significant increase in volume, length of stay (LOS), and financial cost for children and adolescents in the PED with mental health disease over a recent 5-year period (4). Child and adolescent mental health has been called on as a research focus by the National Action Alliance for Suicide Prevention in an attempt

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to decrease suicide rates by 40% over the next 10 years (5).

Many pediatric patients with mental health problems who come to the PED for care have prolonged LOS due to limited availability of inpatient psychiatric beds and intensive outpatient services. A large multicenter study performed in PEDs across the nation showed that mental health patients consume more resources, have longer LOS, and higher rates of admission compared to all other patient populations (6). An NHAMCS study also showed that mental health patients have twice the odds of having a >4-h LOS in the PED (1). While children await disposition in the PED for extended periods of time, the treatment and interventions they receive are often quite limited, whether this waiting takes place in the PED or on the medical ward. One study showed that of all children admitted to the general medical ward with a mental health condition, 94% of them were solely there for boarding purposes, and only 6% of those patients received any type of counseling while boarding (7). This raises the important question of what can be done to help reduce the LOS and improve active treatment of children and adolescents in the PED with acute mental health crises.

Studies in the past have shown a benefit to family therapy in the PED (8–10). Yet, when children with mental health complaints are discharged directly from the PED, there are high return rates and subsequent need for inpatient psychiatric admission (11,12). Some of this may be secondary to poor continuity of care with the outpatient mental health system. There is the potential for improvements in care if a child establishes a relationship with a mental health team in the PED with the ability to follow up with that same team as an outpatient, though this model has yet to be studied.

To address the above issues, a multidisciplinary team was implemented in the PED at our institution, which included a child psychiatrist and a pediatric mental health social worker who were devoted to the PED and caring for children with acute mental health needs. This team was staffed by the same psychiatrist and social worker to provide continuity of care for the patients and ED team. In addition to the direct therapy and interventions provided in the PED, the social worker had the ability to follow these children for up to 1 month on an outpatient basis while they transitioned to appropriate outpatient mental health providers. The objective of this study was to evaluate the effect of the multidisciplinary PED mental health team and compare LOS, restraint use, and disposition among mental health patients in the PED the year prior to and the year after implementation of this new program. It was our hypothesis that these outcomes would improve in the year after the new program. To our knowledge this is the first program of its kind and the first study to assess it.

MATERIALS AND METHODS

Study Design and Setting

This was a pre- and postintervention retrospective study approved by the Institutional Review Board. The intervention consisted of a new pediatric psychiatric consultation liaison program in the PED. The preintervention period was from June 2012 through June 2013, and the postintervention period was from October 2013 through October 2014 to allow for a 4-month run-in period while the new program was implemented. All patients <19 years of age with mental health disease diagnosis codes at a pediatric tertiary care ED were included. The consultation liaison program consisted of a pediatric mental health social worker devoted to the PED as well as a 0.5 full-time-equivalent child psychiatrist. They consulted on children directly in the PED and then started family therapy directly at the bedside. If a child stayed longer than 24 h, this dedicated team rounded on them in the morning and continued to establish a relationship with the family, as well as work on coping strategies. If a child was showing escalating behaviors, they were available to come to the PED and help troubleshoot issues at hand.

Data Collection

Participants were identified by searching the electronic medical record (EPIC™ 2010; Verona, WI) for mental health International Classification of Diseases-9th Revision final diagnosis codes including 291, 292, 295–309, and 311–314. Patients who had one of these final diagnoses during the study period but did not receive a Psychiatry consult while in the PED were excluded. Data collected included patient demographics, suicidality on presentation as defined by a patient expressing active thoughts of harming themselves, past mental health history, patient-reported relationship with an established outpatient mental health provider, LOS in hours, restraint use, final diagnosis, and final disposition. Restraint use was categorized as physical, chemical, or both. Physical restraints were defined as an order in the electronic medical record for physical restraint, and chemical restraint was defined as any intramuscular medication or any antipsychotic agent that the patient was not receiving prior to the PED visit or discharged home on from the hospital encounter of interest. Charts were reviewed by a research assistant trained on abstracting the data of interest. The data were then reviewed for accuracy by a member of the study team to ensure accuracy.

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