Maintaining Safety and Improving the Care of Pediatric Behavioral Health Patients in the Emergency Department

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KEYWORDS

• Pediatric • Mental health • Behavioral health • Triage • Emergency departments • Safety • Work place injury • Nursing

KEY POINTS

- The number of pediatric patients seeking care for behavioral health issues through emergency departments (EDs) is increasing. Increased volume can lead to lengthy wait times, increased aggression, and poor outcomes.
- Workflow modifications may be helpful to avoid overcrowding, delays in care and allow for safe management of this vulnerable patient population.
- The use of mental health triage tools allows for early identification of high-risk patients, supports a split-flow process, and improves outcomes by matching ED resources to specific patient needs.
- Early recognition of patients who are at high risk of harm to self or others and utilization of designated safe locations in the ED improves staff and patient safety.
- Close collaboration between emergency medicine and behavioral health departments, as well as expanding from a single consultant to a multidisciplinary team, allows for timely assessment, decreases length of stay and admission rates, and improves outcomes.

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INTRODUCTION

Pediatric behavioral health (BH) care in the Unites States is in crisis. Although about 20% of children need mental health care, only about 20% receive the care they need.[1] A report released by the American Medical Association highlighted that there are approximately 8300 child and adolescent psychiatrists practicing in the United States, where the needs are estimated at 30,000. According to a Children's Hospital Association survey, the wait time for appointments for child and adolescent psychiatric care is almost 10 weeks, which far exceeds the prevailing benchmark for pediatric ambulatory care.[2] This is compounded by a dearth of inpatient psychiatric beds and community crisis services.[3] With an increasing demand for psychiatric care and a shortage of qualified providers, emergency departments (EDs) continue to function as the default location for patients to receive care. The ED is in fact the only treatment setting that guarantees that patients will receive an evaluation to determine if there is a psychiatric emergency, a guarantee ensured by the federal Emergency Medical Treatment and Labor Act.[3]

Most EDs are not equipped to deal with the exponential growth in the BH population. Studies have shown that patients presenting to the ED with mental health complaints have an increased chance of prolonged length of stay (LOS) and higher admission rates than patients with medical complaints.[4] The lack of expertise and resources, along with excessive volume, can lead to overcrowding, which compromises access to high-quality emergency services for the most acute patient populations and families.[3]

The ED is often a highly stimulating environment that can be countertherapeutic for patients and families. Comprehensive psychiatric assessments require lengthy interviews of parents and other collateral sources of information, which can be challenging in an ED environment characterized by limited private space and multiple distractions and disruptions. The use of dedicated areas within the ED to manage patients presenting with BH complaints is beneficial because such areas offer enhanced privacy, safety features, and a therapeutic milieu.[5]

Triage, rapid assessment, and split-flow models are well-established evidence-based strategies in emergency medicine for the improvement in flow and reduction in ED crowding.[6] These evidence-based principles can be applied to the management of BH patients in the ED.

The goal of triage is to sort and prioritize patients; that is, to assign them to resources and physical space based on their clinical need. Using a mental health triage scale improves the overall quality of care for BH patients.[7] The identification of patients at highest risk allows for the allocation of necessary resources in a timely manner, such as moving the patient to a safe space within the ED, assigning staff to monitor the patient for safety, reducing access to potentially dangerous objects, and obtaining psychiatric consultations in a timely manner.[8]

Rapid assessment by a medical or BH provider allows for the initiation of diagnostic investigations and pharmacologic or nonpharmacologic treatment early in the patient's ED stay, promoting safety, preventing escalation, and expediting decision-making regarding patient disposition. Because many ED and pediatric staff have minimal training and expertise regarding management of patients with BH complaints,[9] the completion of the rapid assessment by a BH expert can be essential in determining the needs of such patients.

Splitting off the flow of low-acuity patients to a specific care area can improve resource allocation, spare many patients from the potentially traumatic experience of a locked BH area, and prevent nonurgent care needs from obstructing patient