


UNCLAIMED CHILDREN REVISITED
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Child and Youth Emergency Mental Health Care

A National Problem

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The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

Child and Youth Emergency Mental Health Care: A National Problem

by Janice L. Cooper and Rachel Masi

This report reviews current practices for children, youth, and families visiting hospital emergency rooms for mental health conditions, and makes recommendations for policy actions to improve care and encourage more community-based services.

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In 1982, Jane Knitzer's seminal study, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, called attention to the desperate state of the mental health system for children and adolescents with mental health problems and their families. The study became a turning point in the mental health field and led to a series of reforms. Twenty-five years later, the National Center for Children in Poverty (NCCP) has undertaken a national initiative, *Unclaimed Children Revisited*, to re-examine the status of policies that impact the optimal well-being of children, youth and their families. The initiative is guided by a stellar national advisory committee. It includes state case studies in California and Michigan, with separate state advisors. We are grateful for funding from the John D. & Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the California Endowment and the Zellerbach Family Foundation. We also thank Carole Oshinsky and Telly Valdellon who provided editorial and production support. Sarah Dababnah, Yumiko Aratani and Lola Adedokun also supported the writing of this brief. All errors and omissions remain the responsibility of the authors.

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Introduction

High levels of unmet need for community-based children's mental health services persist. Over the past decade child mental health-related visits to hospital emergency departments have significantly increased. Combined these factors suggest that emergency departments have become substitute sources of care for routine mental health problems.[1] Indeed, non-emergency mental health care accounts for the increases in mental health-related visits to hospital emergency departments.[2]

Increases in emergency use rates for mental health care by children and youth are emblematic of problems with access to community-based mental health services and supports. These visits further stretch an overextended emergency health care system.[3] Emergency departments are poorly equipped to address the mental health needs of children, youth, and their families who seek psychiatric attention.[4] While they encounter challenges meeting the need for pediatric and adolescent services, they are even less prepared to provide pediatric and adolescent mental health care.[5] This issue brief reviews the state of mental health services for children and youth who visit hospital emergency departments for mental health-related reasons and provides an overview of the challenges associated with mental health-related emergency department visits. It discusses the policy implications of using emergency department services for mental health reasons for children and youth and makes recommendations for policy action.

Increases in the use of hospital emergency departments point to the lack of availability of community-based services. This situation raises many concerns:

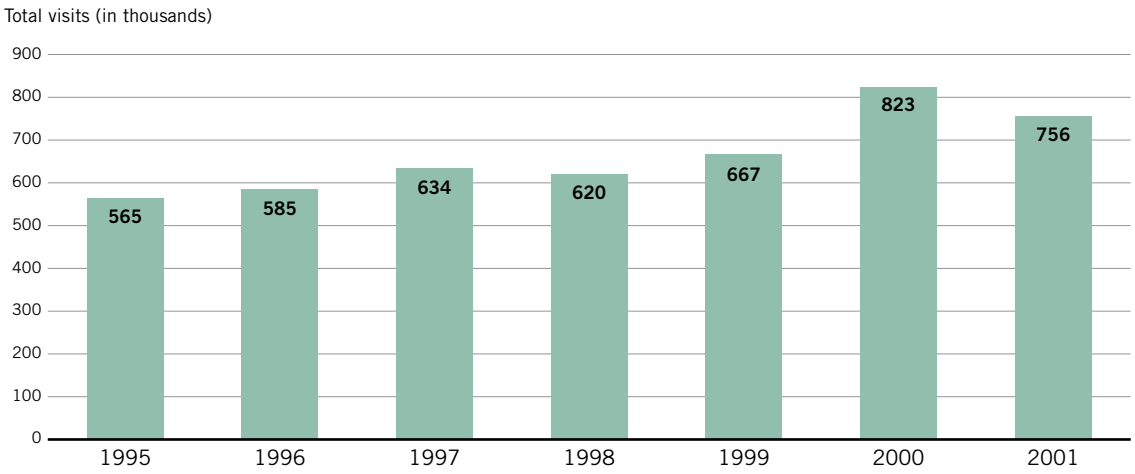
1) Inappropriate use of emergency departments for routine mental health care
2) Inefficient use of resources

3) Cost shifting due to the lack of community-based mental health services
4) Lack of capacity and competency in emergency departments to appropriately screen, treat, and refer children and youth with mental health-related problems
5) Potential to compromise quality and lead to poor health and mental health outcomes

Mental Health-Related Emergency Department Visits on the Rise

Estimates of hospital emergency department use by children and youth with mental health problems range from 200,000 to over 825,000 visits annually.[6] Mental health-related emergency department visits range from 2 percent to 5 percent of all pediatric hospital emergency department visits.[7] In rural areas, 5 percent of all pediatric emergency department visits and 10 percent of all psychiatric-related emergency department visits are made by children and youth with mental health problems.[8] Despite the small number of national studies that comprehensively examine this issue, various local and statewide studies provide a portrait of the escalating

Figure 1: Mental Health-Related Visits to Emergency Departments for Children and Youth, United States, 1995-2001



Source: Grupp-Phelen, J.; Harman, J.; & Kelleher, K. (2007). Trends in mental health and chronic conditions' visits by children presenting for care at U.S. emergency departments. *Public Health Reports, 122*(1), 55-61.

increases in the use of hospital emergency departments by children and youth for mental health treatment.

- Over a four-year period, one emergency department experienced a 59 percent increase in mental health-related visits to the emergency department compared to a 20 percent increase in non-psychiatric-related visits over the same time period.[9]
- Over a six-year period in Connecticut, emergency departments witnessed a 110 percent increase in child mental health-related emergencies.[10]
- A six-year study showed that overall hospital emergency department visits grew by 43 percent, with pediatric and pediatric mental health-related visits increasing by 72 percent and 102 percent, respectively.[11]
- Survey data from the National Hospital Ambulatory Medical Survey revealed that between 1995 and 2001 mental health visits fluctuated, rising from 4 percent in 1995 to nearly 6 percent in 2000 and decreasing to just over 5 percent in 2001.[12] (See Figure 1.)

Common Mental Health Conditions Among Children and Youth Using Emergency Departments

The types of mental health conditions presented in hospital emergency departments vary.[13] Violence-related conditions, emotional disturbance, child abuse and neglect, aggressive behaviors, suicide attempts/ideation, drug and alcohol abuse, depression and other mood disorders, and anxiety are among the disorders which are most commonly the source of an emergency department admission.[14] Youth with violence-related conditions in the emergency department are also likely to have mental health problems. One study of African-American youth in the emergency department with injuries from assaults found evidence of aggressive behaviors, general internalizing conditions, and post-traumatic stress.[15]

Mood and Other Disorders

Youth with bipolar disorder are 1.5 to 2.5 times more likely to use the emergency department than youth with other mental health disorders and youth without mental health disorders, respectively.[16] Among children and youth with intense mental health needs who access emergency departments, over one-fifth exhibit dangerous behaviors and two-fifths have a history of prior psychiatric hospitalizations.[17]

Suicide

Youth who attempt suicide or who visit hospital emergency department because of suicidal behaviors or risks account for 11 percent of pediatric mental health-related visits.[18]

Substance Abuse Disorders

Youth between ages 12 to 17 years old account for 10 percent of all substance use related visits to the hospital emergency department.[19] Marijuana, alcohol in combination with other substances, and cocaine were the most used drugs. Marijuana-related emergency department visits for youth increased 23 percent between 1997 and 2001.[20]

Approximately 4 percent of emergency department visits are made by children and youth who attempt suicide using drugs. Among the drugs used are pain medications (51 percent), psychotherapeutic drugs (38 percent), and illicit substances (19 percent).[21]

Selected Characteristics of Children and Youth Who Use Emergency Departments for Mental Health-Related Services

Similar to the diversity in conditions, research shows variation in the demographic composition of children and youth who use emergency departments for mental health services.

Race and Ethnicity

As with hospital emergency room visits among the pediatric population, most studies suggest that nonwhite children and youth are more likely to access emergency departments for health and mental health-related conditions.[22] Other research, however, shows significant under-identification of psychiatric diagnoses for youth of color in emergency departments.[23]

Gender

Some studies also suggest that mental health-related emergency department visits may vary based upon gender.[24]

Geographic Location

Regional variations in the use of emergency services are also evident. Children and youth in rural areas have higher mental health-related emergency visit rates.[25] Children and youth in the Northeast are much more likely to visit the emergency department for a mental health-related need than children and youth in the western United States.[26]

Age

Recent research shows more younger children with mental health-related conditions are visiting the emergency department than in the past.[27] On the whole, however, older children and youth are more likely to access mental health-related services in emergency departments. The vast majority of mental health-related visits to emergency departments were made by teenaged youth.[28]

Children and Youth in Foster Care

Children and youth in foster care with mental health problems are more likely to use emergency departments than those without a mental health diagnosis and those with other chronic health conditions.[29] Foster care placement is strongly associated with emergency department visits for suicide and repeat emergency room visits.[30] The more placements a child or youth in foster care experiences, the more emergency department visits they make.[31]

Specific mental health disorders also place children and youth in foster care at risk for increased emergency department use. Those with personality disorders are 10 times more likely to use the emergency department, and those with depression are five times more likely to use the emergency department than their peers.[32]

Emergency Departments are Failing to Meet the Needs of Children and Youth with Mental Health Problems

Challenges Associated with Increased Emergency Department Use for Mental Health-Related Conditions

Children and youth with mental health problems who use the emergency department to access care face particular challenges. In surveys, emergency department personnel report numerous barriers to comprehensive care, such as:[33]

- Long wait times
- Insufficient child and adolescent psychiatric expertise and resources either onsite or on call (for example, incomplete evaluations, lack of appropriate referral sites and lack of support personnel)
- Inferior quality of treatment practices

Inadequately Trained Staff

Despite evidence showing the relationship between the availability of mental health specialty care in emergency departments and significant reductions in length of stays and associated costs,[34] less than 25 percent of hospital emergency departments have a pediatric emergency physician on staff.[35] Additionally, over 75 percent of emergency medicine and pediatric emergency medicine residency programs surveyed report that they **do not require, nor do they provide, formal training in mental health emergencies**.[36]

Inappropriate, Poor, or Nonexisting Resources

Lack of sufficient expert staff, funding, medical supplies, and community-based outpatient services are major problems that cause hospitals to fail to treat mental health emergencies adequately. Inadequate resources to support mental health care for children and youth is compounded by a wider problem with resource allocation for emergency services for this group. Children and youth account for more than 27 percent of visits to emergency departments but only 6 percent of emergency departments have the resources needed to deal with child and youth-related emergencies.[37]

Research shows that:

- Addressing psychiatric problems in children is difficult and time consuming. Emergency departments' staff interviewed point to a general lack of resources within their departments and the surrounding community to respond to children's mental health needs.[38]
- Significant cost is associated with hiring personnel to protect suicidal, homicidal, and aggressive children and youth in the emergency department.[39]
- Many children and youth with mental health problems are seen on multiple occasions in the emergency department, indicating high rates of incomplete treatment and lack of follow-up care.[40]

Lengthy Wait Times and Stays

Wait times in emergency departments for mental health-related visits can average 5 hours and can take twice as long for children and youth with mental health-related problems than those with non-mental health-related conditions.[41] Children and youth with mental health problems generally spend twice as long to complete their emergency department visits than others.[42] Race/ethnicity and English language competency contribute to greater waiting times in emergency departments for all children and youth. Children and youth of Latino descent and children and youth from non-English speaking families experience longer waiting times than white or African-American children and youth and than children and youth from English-speaking families.[43]

Long wait times are generally the result of overcrowded emergency departments where demand for services outstrips the availability of staff and other resources.[44] A strong contributing factor is the lack of community inpatient psychiatric treatment.[45] Under these conditions, service quality can be compromised and the potential for health care errors increases.[46] Children and youth's symptoms may become more acute, and they may leave the emergency department prior to receiving services.

Standards of Care Inconsistently Applied

Psychiatric Evaluations and Referrals

Considerable variation has been documented in treatment for children and youth with mental health-related hospital emergency departments visits:[47]

- 73 percent of children and youth with emotional disturbances received a mental health evaluation by a mental health professional
- 44 percent of children and youth with emotional disturbances were discharged to a psychiatric hospital
- 35 percent of children and youth with drug or alcohol abuse were discharged to a psychiatric hospital

In one state, up to 23 percent of individuals—whether adult, youth, or child—who visited the emergency department for suicide-related reasons were discharged without a mental health evaluation.[48]

Children and youth who attempt suicide, those with suicidal ideation and those who harm themselves pose significant challenges to emergency departments:

- 30 percent of children and youth who attempted suicide did not receive a mental health evaluation by a mental health professional[49]

- Less than 40 percent of admissions to emergency departments for self-harm related conditions (poisonings and cutting) resulted in a mental status examination[50]
- 48 percent of children and youth who attempted suicide were discharged to a psychiatric hospital[51]

The Practice of Boarding

Over-extended emergency departments lead to "boarding," holding inpatient-ready children and youth in hospital emergency departments until beds become available. Children and youth with mental health problems who are boarders in emergency departments and require psychiatric hospitalization may instead be admitted to a general pediatric ward.

- One statewide assessment of emergency departments reports that children and youth are boarded up to 20 hours in the emergency department before an inpatient child/adolescent psychiatric bed becomes available.[52]
- Between 33 to 60 percent of children and youth with mental health problems are admitted to general pediatric wards while waiting for an appropriate child/adolescent psychiatric inpatient bed.[53]
- Youth average between 1 to 3.6 days on a general medical floor before getting a child/adolescent psychiatric bed.[54]
- African-American children and youth are more likely to become boarders than white children and youth.[55]
- Children and youth with intensive mental health needs (those with problems related to self-harm and violence) are more likely to become boarders.[56]
- Between 20 to 50 percent of child and youth mental health-related visits result in inpatient admission compared to 5.5 to 9.4 percent of non-mental health-related visits.[57]

Mental Health Problems Go Unidentified

Many mental health problems are not identified in emergency rooms. One study found that 72 percent of children and youth with mental health-related problems in emergency departments also have moderate to severe depressive symptoms.[58] An additional 12 percent of youth with trauma-related visits and 19 percent of children and youth with a medical diagnosis in the emergency room are identified with moderate to severe depressive symptoms.[59] **Yet, emergency departments do not systematically screen for mental health problems**.

Further, despite widespread recognition of the importance of co-occurring physical and mental health disorders in addressing the needs of children and youth with mental health problems, only 35 percent of emergency departments require that a range of medical tests be conducted when performing psychiatric medical screening examinations.[60] For children and youth, accurate identification of physical and mental health conditions is important for several reasons. Some physical health conditions are associated with mental health disorders. Some mental health problems show up as physical or general medical conditions.[61] In addition, our growing knowledge of the differences in presentation of some mental health problems based upon cultural background call for comprehensive, culturally, and linguistically appropriate assessments of those who visit emergency departments.[62]

Unidentified mental health problems can also lead to repeat visits. Repeat visits account for 26 percent of all pediatric emergency visits (both health and mental health).[63] More than 5 percent of repeat visits involve a missed diagnosis.[64]

Other Common Concerns about Community-Based Practice Reflected in Emergency Care

Children, and youth with mental health and substance use disorders and their families face barriers to access for community-based and emergency-based care that are exacerbated by several factors:

- Weak parent and youth engagement
- Poor attention to developmental needs, particularly for transition-aged youth
- Low levels of cultural and linguistic competency
- Slow take up of evidence-based/empirically supported practices

Family-Centered Practice

As with community-based mental health, emergency services often lack the degree of family and youth engagement that is increasingly recognized as a core component of quality care.[65] Research indicates that users of primary care who receive family-centered services and perceive access is obtainable tend to have:

"It is clear that emergency rooms in the country are barely able—and in many cases unable—to handle current, everyday demand for their services."

—Carolyn M. Clancy, Director, Agency for Healthcare Research and Quality (AHRQ).[80]

- Lower emergency department use for non-urgent care by young children[66]
- Fewer non-urgent emergency department visits for youth[67]

On the ground the movement toward family engagement in emergency health care continues to grow. Results are mixed. A small study of family-centered practice in hospital emergency departments reveals significant variation in policies and practices that advance family inclusion and support.[68]

- Significantly, one-third of emergency departments have a mission statement that reflects a family-centered care philosophy.
- In emergency health a growing consensus is emerging to better engage families in the care of children and youth with mental health needs.[69]
- More than 66 percent of emergency departments seek to make the emergency department environment child and youth friendly, although the methods used vary.
- Only 22 percent of emergency departments permit the presence of a primary caregiver in all medical situations.
- Few emergency departments have family advisory groups to assist in program design. Also, only one emergency department reported that it consults with family members with prior emergency department experience to support program development.
- No emergency department (that participated in the study) appropriately accommodates siblings who are not patients in a structured supervised environment; nor do they regularly provide referrals for respite, rehabilitation services, early intervention, or related services to families.[70]

Developmentally Appropriate Care: Access for Transition-Age Youth

Some emergency departments reflect several of the same shortcomings found in community-based mental health service delivery to transition-aged youth.[71]

- Nearly 45 percent of pediatric emergency departments have age limits on the treatment of youth up to 18 years old (9 percent had age limits below 18).[72]
- For 50 percent of all pediatric emergency departments, the age cut-off is 21 years old.[73]
- Over 63 percent of pediatric emergency departments have no pre-existing arrangements for the transfer of youth and young adults over their age limits to adult facilities.[74]

Cultural and Linguistic Competence

Inadequate culturally and linguistically competent community-based services contribute to disproportionate representation of children and youth from diverse racial, ethnic, and linguistic groups with poor access to appropriate levels of interventions and supports. For example:

- Across community-based settings, children and youth with mental health problems and their families are less likely to receive needed mental health services if they come from a diverse background, are part of an underrepresented minority group, or come from a family with limited English proficiency.[75]
- They are also more likely to access mental health services through the juvenile justice system.[76]
- In emergency department settings, children and youth of color and those from families with limited English proficiency are:
  - disproportionately under-identified[77]
  - more likely to experience long waiting times and longer lengths of stays[78]
  - more likely to have a mental health-related visit that involves law enforcement[79]

Empirically-Supported Practices

Measures to improve quality in health and mental health care increasingly focus on adopting evidence-based practices. Efforts to improve quality in emergency departments lag behind quality improvement efforts in the rest of health care.[81] For example a recent study[82]

found that:

- Slightly more than 50 percent of responding emergency departments are prepared, based upon five physical health-related conditions.[83]
- An estimated 52 percent of emergency departments have quality improvement plans for their pediatric services.[84]

Tellingly, these efforts to institute quality measures and raise the level of preparedness in emergency departments that serve children and youth **do not** include mental health among the list of conditions for which quality measures were developed.

A recent proposal to develop other quality measures includes adolescent mental health, but not child mental health measures.[85] Assessments of the emergency health delivery system using these measures are highly anticipated.

In community-based children's mental health, uptake of evidence-based practices has been gradual. Even among well-resourced initiatives, less than one-third of providers report that they consistently implement evidence-based practices.[86]

In emergency medicine:

- Less than one-quarter of emergency room nurses receive training in evidence-based risk-reduction strategies for suicide prevention.[87]
- Less than one-third of these nurses implement the practice.[88]
- Less than one-fifth of these nurses report the systematic use of these strategies in their emergency departments. [89]

Effective Interventions and Strategies for Emergency Care are Based on Specialized Training

Hospital emergency departments can play an integral role in addressing the mental health of children and youth and appropriately referring them for follow-up care in the community.

Emergency departments with pediatric behavioral health expertise and established crisis teams are more

Legislation Governing Emergency Services

The Emergency Medical Treatment and Labor Act (EMTALA)[1] passed in 1986, requires hospital emergency departments to:

- Provide medical screening for any one who presents in an emergency department requesting treatment
- Provide the necessary treatment to stabilize any individual in need of medical attention until an appropriate transfer if necessary can be made
- Screen, stabilize, and/or treat individuals without regard to the ability to pay

EMTALA establishes:

- Obligation by emergency departments to have on-call physicians available with expertise needed for evaluation and treatment
- Conditions under which individuals may be transferred
- Civil penalties for the violation of the law
- Requirements for documentation and communication of the rights of individuals who seek emergency services
- Provisions for minors to consent to care

EMTALA defines "emergency medical condition" as:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  - serious impairment to bodily functions, or
  - serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - that transfer may pose a threat to the health or safety of the woman or the unborn child

Federal guidelines clarify psychiatric emergencies in the following manner:

"In the case of psychiatric emergencies, if an individual expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others would be considered to have an EMC [emergency medical condition, sic]"[2]

Sources:

1. LexisNexis Code of Federal Regulations. (June 7, 2007). Title 42—Public Health, Chapter IV—Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter G—Standards and Certification, Part 489—Provider Agreements and Supplier Approval, Subpart B—Essentials of Provider Agreement, http://web.lexis-nexis.com (accessed June 10, 2007).

2. State Operations Manual: Appendix V—Interpretive Guidelines—Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 1, 05-21-04). (2004). Baltimore, MD: Centers for Medicare and Medicaid Services.

likely to routinely screen for mental health problems, to be knowledgeable about appropriate referral sources, and to have relationships with community-based mental health providers than emergency departments without such expertise.[90]

Well-trained emergency department providers can address the mental health problems of children and youth who they see. One study reports that adolescent female suicide attempters and their mothers treated in the emergency department using a specialized intervention program are more likely to participate in and complete community-based treatment and to report fewer mental health symptoms than those who received standard emergency department care.[91]

Pediatric emergency departments were more likely to:

- Identify and report child abuse.[92]
- Treat children and youth with medical problems in comparison to injuries.[93]
- Serve children and youth with more intensive needs.[94]

Strategies that Work—An Example from Community Practice

Boston Medical Center, Boston, Massachusetts

Boston Medical Center has developed a set of priorities to appropriately address the needs of children and youth with mental health problems in their emergency department.[95] These priorities include:

- Maintain a safe environment using patient room safety procedures and a checklist.
- Set up a triage system that assesses safety risk.
- Establish patient safety advocate positions that support and reinforce a climate of safety.
- Create a child psychiatric urgent care team with appropriate specialists.
- Develop and maintain a mental health patient flow sheet.
- Consistently train staff.
- Continually focus on clear communication between children, youth, families, and providers.
- Develop a child and youth/family guide that lays out what can be expected in the emergency department.

Strategies that Work—Examples from Research

Research suggests that parental control and depressive symptoms predict poor outcomes in suicide prevention programs.[96] Emergency department strategies that seek to identify depression and appropriately refer affected individuals to community mental health providers and help engage families in follow-up can contribute to effective interventions for children and youth. There are brief screening tools that can accurately detect depressive symptoms in the emergency department.[97]

In other research, the use of trained psychiatric interpreters has led to improving the quality of care for children and youth from families with limited English language proficiency.[98]

Ten Recommended Policy Actions

Improvements in emergency department experiences and outcomes rest fundamentally with increased community-based mental health resources. Also necessary are community members pressing to facilitate change. The following policy steps will result in better emergency room outcomes for children and youth with mental health and substance use conditions seeking care.

Federal and state policymakers should:

1) Support initiatives to train the nation's emergency department workforce to appropriately screen, intervene, and refer children and youth with mental health and substance use disorders who make emergency department visits to community-based resources.
2) Require universal implementation and requisite third-party insurance coverage of screening (using standardized tools) to accurately detect suicidal risks in children and adolescents who visit emergency departments.[99]
3) Develop short and long-term mechanisms for emergency departments to deal with the unique needs of children and youth with mental health and substance use disorders and their families. In particular:
    - create opportunities to increase pediatric psychiatric/behavioral health expertise in emergency departments;
    - require linkages to community mental health and substance use disorder treatment.

Federal and state policymakers and their counterparts in tribal communities and local jurisdictions should:

4) Provide more mental health and substance use disorder treatment in the community for children and youth. This will help:
   - prevent some mental health problems from reaching the point where emergency intervention is necessary, and
   - decrease the use of emergency departments for non-emergency mental health care.

Federal and state policymakers, leaders of higher education and professional associations should:

5) Adopt standardized emergency pediatric psychiatric/behavioral health training in programs that prepare emergency room clinicians and staff.

Federal and state policymakers, leaders of health care systems and professional organizations have an obligation to:

6) Create a standard of care consensus document that addresses the problems associated with children and youth with mental health and substance abuse conditions during emergency department visits and develop action steps to resolve these problems. In particular:
   - develop standards that regulate the practice of boarding;
   - establish guidelines for the treatment of transition-aged youth;
   - establish quality measures for emergency mental/behavioral health care for children and youth.

Federal and state policymakers and health care systems leaders must:

7) Address the need for culturally- and linguistically-competent services to reduce the racial/ethnic and English-language proficiency disparities associated with emergency room care for children, youth, and their families.

8) Track and publicly report outcomes for children and youth who access emergency departments for mental health services.

9) Promote and adopt family engagement strategies in emergency departments including the use of trained family members to assist in service planning and delivery.

10) Adopt proven effective strategies for emergency care for children, youth, and their families with mental health and substance use disorders.

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