

[music]

Geraldine Amori, PhD, ARM, DFASHRM, CPHRM: Before we begin, because this podcast is discussing pediatric mental health, including suicide, it might be disturbing to some listeners.

Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Dr. Cara Pratt, a psychologist who works with all age groups and specializes in clinical anxiety disorders; Dr. Neil Bruce, a psychiatrist who specializes in child and adolescent affective disorders; and Mary Kisting, a clinical nurse specialist who works primarily with the inpatient pediatric population at a Level 1 trauma teaching hospital. Welcome. Today's topic is the challenges in providing acute mental health care for kids and teens.

So let me take a minute here to give you a setup to our topic today. According to the *Journal of the American Medical Association*, which many of us know as *JAMA*, in an article published in 2022, pediatric mental health emergency room visits are commonly repeat visits, and most revisits occur within 6 months of an initial presentation. These visits are huge and have negative ramifications. Because youth often present with very disruptive behavioral disorders, they also were at the highest risk of return visits because of those aggressive behaviors and their agitation while in the emergency room. In addition, there's evidence that adolescents who came to the emergency room with violence-related injuries or substance-use injuries or self-harm behaviors were more likely to have higher rates of death over the next decade. This is not a pretty picture.

This raises the question about the emergency room as the appropriate venue to screen or even see these patients. Is it possible that the emergency room is not the right place? In fact, could the emergency room, with its busyness, noise, stimulation, and lack of appropriate people to perform trauma-based screening, be actually making the situation worse? In a study conducted at Yale by Hodge and his colleagues, it was stated that access to appropriate care is a major health inequity. According to the study, it is infrequent that children and youth are seen in the emergency rooms by a behavioral health professional or even receive evidence-based assessment of treatment, even though they're kept in the emergency rooms longer than those seen for other reasons unrelated to mental health.

The rate of increase in these referrals to emergency rooms appears much greater for African American and Latinx children and youth than White children and is increasing for the publicly insured and uninsured while decreasing for the privately insured. This is quite an indictment. So, I'd like to begin by asking our panelists some questions to give us some clarity about this topic. Neil, as a psychiatrist, the hospital is your venue. That's where you work. What are your thoughts about the use of the emergency room as an appropriate location for youth mental health screening?

Neil Bruce, MD: So I think the emergency room is an appropriate place. It's kind of a catchall. Like, kids can come to the emergency room for any various number of reasons, whether it's an asthma attack, they recently got a cut and they need stitches or sutures. But really it's a catchall. So, a lot of these mental health problems, they might not be immediately obvious to the parent. It's not like a physical deformity like a broken arm or a bloody nose. The emergency room is a place that's really equipped with medical professionals to screen for these questions, screen for these disorders, and if there is a problem, provide appropriate treatment or referrals.

Amori: So you think it is a good place. Mary, you're a pediatric clinical nurse specialist. You don't have to agree with Neil, or you might. What do you think?

Mary Kisting, MS, RN, CCNS, CCRN-K: I would have to say that every location and any location is a good place to screen for mental health. So, I would echo what Neil said and say that the emergency department has become a de facto safety net and that anytime we have an opportunity to screen as early as possible, help a child manage their symptoms and support their mental health and well-being, it's a great place to do it. And I think the emergency department can work really well if you have emergency medicine and psychiatric providers. It can be really a great avenue and one that children seem to access.

Amori: So I'm hearing you add to it that we need to make sure we have good mental health providers in the emergency room for it to work. And I'm noticing that you're both nodding your heads at me, even though our audience doesn't see that, so that seems to be a point of agreement. Cara, what are your suggestions for bringing a process to bring troubled youth into the acute-care setting?

Cara Pratt, PsyD, HSPP: So I'm in an outpatient setting, so I probably have a different perspective, and I imagine this changes based on geography quite dramatically. In our practice, we never direct families to go straight to an emergency room. It's not uncommon for me to have heard—again, in my area—for families or parents to be with a child for over 72 hours at an emergency department, waiting for beds somewhere or just waiting to get treatment. So, my first-line recommendation in our practice, we send families directly to local behavioral health facilities that have inpatient services. It's kind of like an emergency department in that they can go there and immediately be screened, but it's specifically for behavioral health. And then if the child needs to be inpatient, they have those services directly there. And we've had much better luck with families getting appropriate services quickly in those types of settings.

As a backup option, we always discuss emergency rooms as an option. They're available everywhere. If you don't know where your local behavioral health facility is, which is fair, I would always rather parents go somewhere with their child where they can be treated. But we just, for ability to wait times and bed availability, we always send people directly to behavioral health facilities.

Amori: So what I'm hearing from you guys is that it's up to kind of the parents to kind of know what's around or for local therapists to know what's around that might be the best avenue into the inpatient unit for wherever you are, and different places may have different things that are available. Neil, what are your thoughts about expanding access to step-down programs or short-stay stabilization units in lieu of hospitalization for youths?

Bruce: So there are programs outside of the hospital. These are called IOPs, which stands for Intensive Outpatient Program, or PHPs, Partial Hospitalization Programs. And these are outpatient basis, meaning outside of the hospital, but still providing intensive treatment. And I would say these don't replace hospitalization. Like if you have a kid who's extremely dysregulated and actively suicidal, and they just can't be safe at home, I wouldn't say these programs are a replacement because these kids will still be going home to you after an entire day of therapy, but I do think they're a good option to have.

Typically, you think of hospital versus clinic, and these are a kind of in between, where kids will be getting intensive therapy, usually all day, or at least half a day, so meeting in groups, individually with a therapist, and also meeting with a psychiatrist, in case medication is warranted. But I do think they are a very good option for kids who are kind of in this gray area where maybe they're not so sick that they need to be in the hospital, but also they really need more intensive health than just what you might get with like once-weekly therapy or meeting with a psychiatrist once a month.

Amori: That's good. You know, I think mental health services—having worked in mental health in Florida and then up here where I live now—when I first moved up here, I noticed that things are very different in different places, like not all states have the same kinds of facilities available, and they have different rules and laws and regulations about what to do. Mary, for the mentally ill youth, do you think we'd run into legal issues using a step-down program in lieu of an inpatient hospitalization if somebody's kind of sick? Is that the barrier?

Kisting: You know, Geri, our facility doesn't have an inpatient or step-down unit, but I think that some of the barriers are not as much the program, but the access and cost that is incurred for families and children in seeking mental health care and also, treatment takes time; if there's not adequate insurance coverage, that can also contribute to barriers.

Amori: Okay. Well, Cara, do you think outpatient intensive care work would work for youth with serious depression or suicidal ideation?

Pratt: Yeah. So, the way that we approach it is that we assess for safety, and only if there is imminent safety concerns, or if a parent doesn't feel like they can keep their child safe at home, those are the times that we would refer to an inpatient hospitalization program. And anything outside of that can be treated in other ways. And actually, what I find is an inpatient unit that truly is—the focus there is just on safety and keeping the child okay and alive and those programs afterwards. So, for example, intensive outpatient partial hospitalization programs, meeting with a group several times a week for a while, all of those things actually work very well. And I've seen kids for quite a while after they've

had something like a suicide attempt, and we absolutely can treat it in outpatient. We're just always evaluating for safety and assessing level of care that's required.

Amori: That's wonderful. I mean, that's yeah. So, Neil, this is kind of taking a turn here. How much of the resistance to building or creating appropriate treatment facilities for youth with mental health needs do you think is political or just plain denial? We tend to think that youth are resilient. You know, they're not really that disturbed. They're going to bounce back. But as we've been discussing, we're seeing increasing number of active shooters and other things we never used to believe could be done by youth. So, what do you think is the resistance to getting treatment?

Bruce: I think some of the resistance, I think it's a very fine line in terms of safety. So, children and adolescents can be very impulsive, which drives some of the decisions they make. And because of that, it's hard to say, like, oh, should this person be in the hospital? Should they be out of the hospital? You don't want to restrict someone's freedom unless you absolutely have to. So, you don't want to tell them, okay, you're in the hospital, this is the only place you can be safe, unless it's absolutely necessary. So, I think part of it is trying to keep kids out in society and functioning as best as we can.

A lot of it, I think, is financial, too. Psychiatry isn't necessarily a big money maker for hospitals. We don't do a lot of procedures. We're not neurosurgeons drawing in the big bucks. There is a big financial aspect as well. Inpatient units are fully staffed with nurses, psychologists, therapists, psychiatrists, so they can be expensive to run, but not the most lucrative. And I think we need to think about resources here.

Amori: Okay, resources. So, Mary, from your experience working in the hospital, what type of strain do the young adults with mental health needs put on the hospitals, considering the family is really the patient along with the patient, right? We've got to treat the system. There are certain parameters that dictate what and who can be with the child. And is there a way to make the hospital more therapeutic, in your eyes?

Kisting: I think that one of the challenges for hospitals is building that system. But it's not even a system, it's also a structure. If you're going to have children admitted to a medical surgical hospital that also have a concurrent mental health issue, or they've come in with a suicide attempt or getting the drugs out of their system, the facility that provides really solid medical care with devices and things is not the same setting that's ideal for a patient that has mental health disorders or illnesses that need a quiet environment, no movable items in the room, a really safe setting. And so, to meet both of those needs is a real burden for hospitals because they weren't built that way.

Amori: Yeah, you're right. They weren't built that way. What are your thoughts on that, Cara? Do you think that a young adult with acute mental illness should ever be subjected to the label of being in the hospital?

Pratt: As important as labels and the stigma of labels are, if it keeps a child safe, then absolutely I do not care about the label, and we will address those issues afterwards.

Safety is always number one, and that's why there would ever be referred to a place like that. Hopefully, I'm aware ahead of time of what's going on, and I can plan a little bit, ideally, with the kid and with the parents about what's going to happen in that process to minimize any potential stigma. But safety is number one, so that's got to be the priority.

Amori: Well, as we're drawing this conversation to a close, I'd like to ask our panelists what I always like to ask our panelists, which is, if you've got one thing—because we've been talking about a lot of stuff here—what's the one thing you would like our audience to take away today? And I'd like to start with Neil.

Bruce: I think the biggest thing to recognize is that safety for these kids is the number one priority, and knowing that if you're not aware of the resources, or this is your first time your kid has really had a mental health crisis, that the emergency room is always available. Mental health emergencies can be treated similar to physical emergencies but being able to take them to the emergency room or call 911, those are good first steps if you don't know what to do.

Amori: Okay. Thank you, Neil. Cara, what about you? What do you think?

Pratt: Building on that a little bit—that was beautiful—but I think, additionally, if you're concerned about your kid's safety in any of these areas, I would recommend getting in touch with one of your local outpatient providers, even just for like a phone consult. Because I think most of us would be absolutely willing to kind of walk through what the local options are, what we recommend, where we've had luck with families before. A lot of families just aren't aware of the different levels of care available or where they should go if there's an emergency. So reach out, and there are options available.

Amori: Thank you. And Mary, what are your thoughts?

Kisting: My last thought has to do with people that are working with children and families because I think it's important to remember that these kids are going to return to their home, and that environment may have the same stress and triggers that it had that brought that child in. And so, I think when we're working with families and children, it's really key to build as strong a family. They are key in the child's progress. And so, dealing with the child as well as the family, and providing as many supports as we have, I think is really going to bode well for those children.

Amori: Thank you, Mary. And thank you to all of our panelists today. You have brought very divergent and also similar views, which gives us a lot to think about. So thank you for sharing your perspectives. And thank you to our listening audience for joining us today and listening to all our perspectives. I hope we get to see you again soon, next time when we explore a topic in healthcare from another *Perspective 360*.

[music]