

SPECIAL CONTRIBUTION

Pediatrics

# Management of youth with suicidal ideation: Challenges and best practices for emergency departments

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## Abstract

Suicide is a leading cause of death among youth, and emergency departments (EDs) play an important role in caring for youth with suicidality. Shortages in outpatient and inpatient mental and behavioral health capacity combined with a surge in ED visits for youth with suicidal ideation (SI) and self-harm challenge many EDs in the United States. This review highlights currently identified best practices that all EDs can implement in suicide screening, assessment of youth with self-harm and SI, care for patients awaiting inpatient psychiatric care, and discharge planning for youth determined not to require inpatient treatment. We will also highlight several controversies and

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challenges in implementation of these best practices in the ED. An enhanced continuum of care model recommended for youth with mental and behavioral health crises utilizes crisis lines, mobile crisis units, crisis receiving and stabilization units, and also maximizes interventions in home- and community-based settings. However, while local systems work to enhance continuum capacity, EDs remain a critical part of crisis care. Currently, EDs face barriers to providing optimal treatment for youth in crisis due to inadequate resources including the ability to obtain emergent mental health consultations via on-site professionals, telepsychiatry, and ED transfer agreements. To reduce ED utilization and better facilitate safe dispositions from EDs, the expansion of community- and home-based services, pediatric-receiving crisis stabilization units, inpatient psychiatric services, among other innovative solutions, is necessary.

#### KEYWORDS

mental and behavioral health, pediatric emergency, psychiatric emergency, suicide

## 1 | BACKGROUND

The United States has a youth suicide crisis. Suicide is in the top three causes of death among 10–24-year olds,<sup>1</sup> with death by suicide rates surging 62% from 2007 to 2021.<sup>2</sup> In 2021, 9% of US high school students reported a suicide attempt in the preceding year. In 2020, there were 224,341 emergency department (ED) visits for self-harm for 10–24-year olds,<sup>3</sup> with ED visit rates doubling for girls from 2001 to 2020.<sup>3</sup> Increased mental and behavioral health (MBH)-related ED visits,<sup>4–7</sup> combined with limited inpatient and outpatient MBH resources, are straining US EDs. Most youth present to general EDs with variable access to both pediatric-specific and MBH resources.<sup>8</sup> A study including 3612 US EDs found that most do not have defined policies for the care of youth with MBH conditions.<sup>9</sup> Additionally, an Emergency Nurses Association report found that emergency clinicians are often not comfortable with the care of patients with MBH conditions.<sup>10</sup> Over half of youth in MBH crisis in the ED require inpatient psychiatric care. Many experience boarding or a prolonged ED length of stay (LOS) after a disposition decision.<sup>11</sup> The lack of resources and barriers to optimal care for youth with MBH conditions are not only distressing to patients and families, but also cause moral distress to ED staff.<sup>12</sup>

### 1.1 | Current state of outpatient pediatric MBH care

As of 2016, most US states had fewer than 10 child psychiatrists for every 100,000 children, and 70% of counties had none.<sup>13</sup> In a national survey, 85% of primary care practices reported struggling to obtain advice and services for patients with MBH conditions.<sup>14</sup> Only 20–50% of youth with a MBH condition receive treatment from a MBH professional,<sup>15,16</sup> and those receiving services often wait months for appointments.<sup>17</sup> Additionally, specific populations within the US experience added challenges to accessing outpatient MBH care. Youth in

rural or low-income areas are less likely to have access to child psychiatrists, including via telehealth.<sup>13,18</sup> Although not pediatric specific, research conducted in New York City found a particular shortage of MBH providers for patients who do not speak English.<sup>19</sup> Sexual and gender minority populations have a high rate of suicide attempts and face additional obstacles, including fear of discrimination, when accessing MBH care.<sup>20</sup> Furthermore, financial barriers for some youth exist; MBH providers may not accept Medicaid or other forms of insurance payment.<sup>19</sup> Transportation and caregiver lost wages may also serve as barriers to appointment attendance.<sup>21</sup> Lack of access to outpatient MBH services likely contributes to patients presenting for ED care and complicates ED disposition, potentially resulting in hospitalization of some patients who could have been discharged if prompt outpatient MBH services were available.

### 1.2 | Current state for patients requiring inpatient MBH care

Acute MBH inpatient bed numbers have been declining for decades in the US, contributing to increased ED MBH boarding.<sup>11,22,23</sup> ED boarding is common despite the detrimental effects on patients, families, and staff.<sup>24–28</sup> Youth can wait for days, weeks, and at times, months, in both children's hospital and general EDs.<sup>29–33</sup> In one systematic review, 23–58% of youth requiring inpatient psychiatric care experienced boarding, and average ED boarding time ranged from 5 to 41 hours.<sup>11</sup>

Certain groups of patients are disproportionately impacted by a lack of inpatient beds. Many facilities are not equipped to care for youth with special healthcare needs and chronic disorders, such as diabetes and epilepsy, resulting in additional barriers to inpatient psychiatric placement and longer ED stays.<sup>34</sup> Youth with autism spectrum disorder and developmental delay face increased ED LOS.<sup>35</sup> Additionally, racial and ethnic disparities exist; in one study, Hispanic ethnicity was

associated with an almost threefold odds of an ED LOS >12 hours.<sup>23</sup> Prolonged boarding times and disparities are concerning as youth boarding in EDs or pediatric medical units while awaiting inpatient psychiatric placement are unlikely to receive optimal MBH treatment.<sup>36-38</sup>

### 1.3 | Scope of this review

In 2021, the American Academy of Pediatrics (AAP) declared a national emergency in child and adolescent mental health.<sup>39</sup> Until significant systems changes occur, the ED may serve as the only point of care for youth struggling with self-harm or suicidal ideation (SI). We therefore conducted a review of existing literature of ED care of youth (<18 years) and present currently identified best practices in suicide screening, assessment of youth with SI, care for patients awaiting inpatient psychiatric care, and discharge planning for youth that all EDs can implement. We also highlight several controversies and challenges in implementation of these best practices and offer possible next steps in research and advocacy.

## 2 | ED SUICIDE SCREENING

The Joint Commission requires EDs to screen for suicide risk using a validated tool in patients 12 years of age and older presenting for evaluation or treatment of MBH symptoms.<sup>40</sup> Two brief validated tools commonly used in the ED setting are the Ask Suicide-Screening Questions (ASQ) instrument and the Columbia-Suicide Severity Rating Scale (C-SSRS). The ASQ, designed to screen 10–24-year olds, has been demonstrated to have high sensitivity and negative predictive value (Figure 1).<sup>41</sup> The full toolkit is available at <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials>. The C-SSRS (Figure 2), useful in children as young as 6 years old,<sup>42</sup> is available at <https://cssrs.columbia.edu/>. A more recently validated tool, the Computerized Adaptive Screen for Suicidal Youth (CASSY), predicts probability of a suicide attempt in the next 3 months.<sup>43,44</sup> The CASSY holds promise for suicide screening and risk stratification but requires set up and annual fees for use.<sup>45</sup>

### 2.1 | Universal suicide screening

Implementation of universal ED suicide screening is controversial and recommendations vary among different national medical organizations. In 2022, the US Preventive Services Task Force concluded that evidence was inadequate to recommend universal screening for suicide risk in youth. However, some experts call for universal suicide screening of adolescents<sup>46,47</sup> given that most youth with a suicide attempt had a healthcare visit in the prior year.<sup>48</sup> A major concern about universal suicide screening in the ED is the negative impact on patient LOS. A modeling study concluded that although universal screening would likely not negatively impact ED LOS, abrupt implementation could significantly stress already stretched ED resources.<sup>49</sup> Further

study is needed on universal suicide screening efficacy and impact on ED flow.

## 3 | ED ASSESSMENT OF YOUTH WITH SI

### 3.1 | Legal considerations

The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that even EDs without dedicated MBH services conduct medical screening examinations and provide stabilizing care for patients presenting with MBH symptoms.<sup>50,51</sup> Stabilizing patients with SI may include evaluating and treating self-harm, determining if MBH consultation is needed, and potentially arranging for an involuntary psychiatric hold for patients presenting with concern for danger to themselves or others, or with grave disability. Variability in state involuntary psychiatric hold laws,<sup>52</sup> including criteria for initiating holds, which medical professionals can initiate holds, and patient rights during holds,<sup>52</sup> present a challenge to EDs. Therefore, emergency physicians (EPs) must understand local laws and institutional policies.<sup>53</sup> Caregivers sometimes want to leave the ED with their child, either because they disagree with the need for hospitalization or because of delays in the admission or transfer process. If careful discussion with the caregivers fails to resolve the situation, hospital risk management, law enforcement, and child protective services may need to be involved.

### 3.2 | Laboratory assessment

Historically, inpatient facilities required laboratory testing as part of the medical evaluation (colloquially known as “medical clearance”) prior to psychiatric evaluation or admission.<sup>54</sup> Routine laboratory testing is costly in terms of resources and ED LOS with an extremely low yield of unexpected, clinically important findings requiring a change in medical management.<sup>55-59</sup> The AAP and the Choosing Wisely Campaign recommend against screening laboratory testing in pediatric patients before psychiatric admission unless clinically indicated.<sup>60</sup> EPs can advocate to end requirements in their systems for routine laboratory evaluation and instead allow clinical evaluation to guide the need for testing.<sup>61</sup>

### 3.3 | Initial safety assessment

There is a lack of consensus on when MBH clinicians should be involved in the assessment of pediatric suicide risk in the ED. Some experts suggest that EPs should receive training in suicide risk assessment, collaborating with MBH professionals when needed.<sup>62-64</sup> Additional resources are needed, however, to support EPs in assessments. One risk assessment tool, the Suicide Assessment Five-step Evaluation and Triage,<sup>65</sup> helps identify risk factors and protective factors, determine risk level, and guide the level of intervention. It is available at <https://store.samhsa.gov/sites/default/files/sma09-4432.pdf> and as a phone



### Ask the patient:

1. In the past few weeks, have you wished you were dead?  Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  Yes  No
3. In the past week, have you been having thoughts about killing yourself?  Yes  No
4. Have you ever tried to kill yourself?  Yes  No

If yes, how? \_\_\_\_\_

\_\_\_\_\_

When? \_\_\_\_\_

\_\_\_\_\_

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  Yes  No

If yes, please describe: \_\_\_\_\_

### Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
  - “Yes” to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a **STAT safety/full mental health evaluation**.
    - **Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  - “No” to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. **Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient’s care.

### Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

**FIGURE 1** Ask Suicide-Screening Questions (ASQ) suicide risk screening tool.

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**  
*Screen with Triage Points for Emergency Department*

Ask questions that are bolded and <u>underlined</u> .	Past month	
	YES	NO
<b>Ask Questions 1 and 2</b>		
<b>1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
<b>2) <u>Have you actually had any thoughts of killing yourself?</u></b>		
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</b>		
<b>3) <u>Have you been thinking about how you might do this?</u></b> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
<b>4) <u>Have you had these thoughts and had some intention of acting on them?</u></b> As opposed to "I have the thoughts but I definitely will not do anything about them."		
<b>5) <u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u></b>		
<b>6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b> Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.  <b>If YES, ask: <u>Was this within the past three months?</u></b>	<b>Lifetime</b>	
	<b>Past 3 Months</b>	
Item 1 Behavioral Health Referral at Discharge Item 2 Behavioral Health Referral at Discharge Item 3 Behavioral Health Referral at Discharge Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions Item 6 Over 3 months ago: Behavioral Health Referral at Discharge Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions		

**FIGURE 2** Columbia–Suicide Severity Rating Scale.

application. Another risk assessment tool, the ASQ Brief Suicide Safety Assessment, is available as part of the ASQ toolkit,<sup>66</sup> with free online training available.<sup>67</sup>

**3.4 | MBH consultation**

Most US EDs lack adequate MBH clinician coverage to assess all youth with SI and other MBH emergencies.<sup>68</sup> Options for obtaining emergent MBH consultation for EDs without on-site MBH clinicians include telepsychiatry and transfer. Telepsychiatry enables off-site MBH professionals to provide comprehensive screening and safety assessments, determine acuity, and assist with disposition.<sup>69</sup> Telepsychiatry services require set-up and maintenance costs.<sup>70,71</sup> Additional con-

siderations are licensing, insurance, and wireless service availability, which may be a particular challenge in rural and low-resourced areas.<sup>71</sup> Alternatively, EDs may arrange transfer for psychiatric evaluation and safety assessment, ensuring compliance with EMTALA-mandated transfer requirements, including arrangements for safe transport to the receiving facility.<sup>72,73</sup>

**4 | ED CARE FOR YOUTH AWAITING INPATIENT MBH TREATMENT**

Best practices for youth awaiting inpatient MBH care include ensuring a safe ED environment and implementing a patient daily schedule.

#### 4.1 | Safe environment

Since ED LOS for youth with MBH conditions has substantially increased over time, development of standardized local processes for youth at risk of suicide is imperative to keep youth awaiting inpatient care safe. If available, patients should be in a specific safe room with potentially dangerous items such as cords either removed or secured to prevent self-harm or use as a weapon to harm others. A sample room safety checklist is available on the Emergency Medical Services for Children (EMSC) Innovation and Improvement Center New England Regional Behavioral Health Toolkit website.<sup>74</sup>

#### 4.2 | Daily schedule

EDs may consider implementing a daily schedule to provide a routine and expectations for patients with prolonged ED stays. Daily schedules can be reviewed with youth and families and can enhance patient-centered care. Further information including a templated daily schedule that can be modified based on local needs is available at EMSC Innovation and Improvement Center New England Regional Behavioral Health Toolkit website.<sup>74</sup>

#### 4.3 | Daily psychiatric evaluation

A pediatric psychiatry expert group conducted a Delphi consensus study and recommended daily evaluation by a psychiatry team on all youth boarding in EDs awaiting an inpatient psychiatric bed.<sup>38</sup> Although it is optimal for youth experiencing ED boarding to be re-evaluated by MBH professionals, this is not feasible in many ED settings. A 2008 American College of Emergency Physicians survey found that 62% of 328 ED directors reported having no formal psychiatric involvement with ED patients boarding while awaiting psychiatric admission or transfer.<sup>25</sup> Access to pediatric MBH specialists is an even greater challenge for rural EDs.<sup>9</sup> Given the immense challenge of ensuring that all EDs have the resources to provide daily psychiatric re-evaluations and the known problems of boarding, efforts to address underlying causes of ED boarding are needed.

### 5 | DISCHARGE PLANNING

Discharge planning for youth with SI who are determined not to require inpatient levels of care can be challenging. One practice that is no longer recommended is the “no suicide contract” (also known as a “no harm contract” or “safety contract”).<sup>41,75–78</sup> A “no suicide contract” is an agreement in which the patient pledges not to self-harm or attempt suicide, with a contingency plan if a situation develops where they feel that they would not be able to honor this contract. Previously, patient willingness to engage in a contract was felt to be one method of risk assessment. Most recent research suggests that these contracts do not reduce suicide risk and may actually increase suicidal behavior and medicolegal liability.<sup>79,80</sup>

#### 5.1 | Safety planning

Currently recommended best practices for brief ED-based interventions intended to prevent suicide attempts are safety planning, including lethal means counseling, as well as connecting patients to outpatient resources. Safety planning has shown potential to decrease suicidal behaviors in adults<sup>81–83</sup> and may help reduce the risk of suicide in youth.<sup>84</sup> Components of safety planning include: recognizing warning signs of an impending crisis; employing internal coping strategies; utilizing social contacts as a means of distraction from suicidal thoughts; contacting family members or friends who may help to resolve the crisis; contacting MBH professionals.<sup>82,85</sup> Tools such as the Stanley–Brown Safety Plan can assist EPs with discharge planning.<sup>82,86</sup> Safety planning seems especially effective when paired with structured outpatient follow-up.<sup>83</sup>

Safety planning includes counseling on lethal means restriction<sup>87–89</sup> or decreasing access to lethal means such as firearms, sharp objects, and medications.<sup>90</sup> The sometimes transient nature of SI and the impulsivity of youth suggests that limiting access to lethal methods may deter some youth from suicide.<sup>91</sup> One study found that most youth with nonfatal suicide attempts progressed from deciding to attempt suicide to implementing their plan under 1 h.<sup>92</sup> There is significant variability in lethal means counseling in EDs.<sup>90,93</sup> Formal training such as the Counseling on Access to Lethal Means program may lower provider barriers to providing this intervention.<sup>94,95</sup>

#### 5.2 | Challenges in ED delivery of safety planning

In addition to the paucity of data on efficacy of suicide prevention interventions, many EDs lack resources<sup>96</sup> to provide these interventions. Payment is variable; insurance companies do not reimburse all billing codes.<sup>97</sup> Even low-cost interventions require a health system or societal investment. Implementation of suicide prevention services requires funding to train staff in services such as suicide risk screening and safety planning, and institutional electronic medical record system changes.<sup>98</sup> EPs can advocate to improve payment for ED-based suicide assessment and brief suicide prevention interventions. Additionally, further research on efficacy and how best to implement suicide prevention services is needed.

#### 5.3 | Outpatient MBH follow-up

Close outpatient follow-up with a MBH professional after an ED visit for MBH symptoms may increase engagement with MBH care.<sup>99</sup> Rates of follow-up with a MBH professional within 7 and 30 days are currently part of the National Child Core set of quality measures by the Centers for Medicare & Medicaid Services.<sup>100,101</sup> However, ensuring rapid access to outpatient MBH follow-up is extraordinarily challenging: only 31.2% of pediatric patients had an outpatient MBH visit within 7 days after an ED MBH-related visit, and only 55.8% had a visit within 30 days.<sup>102</sup> One institution addressed the MBH follow-up challenge

by creating a Bridge Clinic and Intensive Outpatient Therapy Clinic. These services allow youth who are in crisis but not actively suicidal to be diverted from the ED to outpatient care and provide next day follow-up for youth in MBH crisis after ED discharge. The Bridge Clinic allows for outpatient therapy until a longer-term outpatient therapist can be scheduled.<sup>103</sup> Additional strategies to improve access to outpatient follow-up may include enhancing school-based MBH services and providing support and training to primary pediatricians who may then be able to serve as follow-up providers.<sup>103</sup>

## 6 | A NEW MODEL—A COMPREHENSIVE CRISIS RESPONSE SYSTEM

A novel strategy to address the MBH crisis is development of a more robust crisis continuum of care to meet the needs of youth and families available to anyone, anywhere, and anytime. The Substance Abuse and Mental Health Services Administration suggests essential elements of a crisis continuum for youth are “someone to talk to” (crisis line services), “someone to respond” (mobile crisis units), and “a safe place to be” (including options for crisis stabilization locations, ED, psychiatric inpatient care, or home-based stabilization services).<sup>104</sup> This model is different than adult crisis systems, with a significant effort to keep youth in their current living environment and in a family-based setting, with engagement from family and community members.<sup>105</sup>

One recent improvement in “someone to talk to” is the creation of the National Suicide Prevention Lifeline (9-8-8). EDs can provide this resource as part of a safety plan or even to all adolescents as anticipatory guidance. People can access the lifeline by calling or texting 9-8-8 or visiting the website [988lifeline.org](http://988lifeline.org) to communicate with trained individuals who are able to resolve approximately 80% of crisis calls remotely.<sup>106</sup> For calls requiring in-person intervention, mobile crisis units (someone to respond) can aid youth and families in their own environment. Mobile crisis units can perform brief safety assessments and engage youth and families in care planning with a goal to divert youth from restrictive levels of care and unnecessary contact with law enforcement.<sup>107</sup> Mobile crisis services have been shown to have the potential to decrease ED/hospital utilization and connect patients to outpatient resources.<sup>108–110</sup> For patients requiring further acute care, crisis stabilization units, also known as “23-hour units,” or emergency psychiatry assessment, treatment, and healing units (EmPATH units), can provide urgent diagnostic assessment, crisis intervention, treatment, and support.<sup>111</sup> Crisis stabilization units have been shown in adults to reduce psychiatric holds, increase outpatient follow-up, reduce ED LOS, and reduce inpatient MBH admissions.<sup>111</sup> Further study exploring how existing infrastructure can be tailored to serve youth and greater understanding of how the crisis continuum model impacts outcomes for youth is needed.

**TABLE 1** Recommendations for emergency department care of youth who present with self-harm or suicidal behaviors.

### Suicide screening

- Screen for suicide risk using a validated tool
  - Tools include the Columbia–Suicide Severity Rating Scale (C-SSRS), the Ask Suicide–Screening Questions (ASQ) Tool, and the Computerized Adaptive Screen for Suicidal Youth (CASSY)

### ED assessment

- Emergency departments should have an established process to obtain emergent mental health consultations
- Routine screening laboratories are not recommended

### ED care of patients who require inpatient mental and behavioral health treatment

- Rooms should be secured to ensure a safe environment
- Consider implementing a daily schedule for patients experiencing ED boarding

### Discharge planning

- Conduct safety planning for youths discharged to home
  - The Stanley–Brown Safety Plan is one tool to aid clinicians
- For youth at risk of suicide, counsel on lethal means restriction
- Provide National Suicide Prevention Lifeline (988) information
  - The crisis lifeline provides 24-h support available by calling or texting 988 or via [988lifeline.org](http://988lifeline.org)

## 7 | CONCLUSIONS

The entire continuum of care for youth in need of MBH treatment must be strengthened to address the US youth suicide crisis. Availability of more MBH professionals comfortable with the care of youth and availability of inpatient psychiatric services for all patients would help to alleviate the current crisis. Although improved access to outpatient MBH and crisis services might decrease ED visits for SI, the ED will continue to be part of this continuum of care. We have highlighted several best practices that can be employed to improve care for youth with SI (Table 1). Further research is necessary on ED-based suicide prevention interventions and ED risk stratification tools. Additionally, resources are needed to support EDs in implementing these strategies and facilitate safe discharge when possible, and transfer or admission to appropriate services, when necessary.

### AUTHOR CONTRIBUTIONS

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## CONFLICT OF INTEREST STATEMENT

None.

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