

State of the State: Child Behavioral Health Services

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Objectives

- Describe youth behavioral health concerns, including national and local trends
- Describe current treatment resources available to families
- Recent study: Youth Mental Health and Psychiatric Concerns in the Pediatric Emergency Department
 - Describe factors that are linked to prolonged PED boarding times for kids experiencing a psychiatric crisis
 - Discuss the impact of biased chart language
- A call to action

Youth Behavioral Health Concerns: Nationwide

- Nearly **20% of children and young people ages 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder, and suicidal behaviors among high school students increased more than 40%** in the decade before 2019.
 - Mental health challenges were the **leading cause of death and disability** in this age group.
 - These trends were **exacerbated during the COVID-19 pandemic** (2022 National Healthcare Quality and Disparities Report, <https://www.ncbi.nlm.nih.gov/books/NBK587174/>).
- **Child behaviors and emotions can change frequently and rapidly**, making it difficult for teachers and parents to detect mental, behavioral, or emotional disorders early. **Swift, best-practice, interprofessional care** produces the best outcomes in children with emotional problems.
- About **9% of youth are estimated to require help** with emotional problems (Sturm et al., https://www.rand.org/pubs/research_briefs/RB4541.html).
 - Studies find that an estimated **70% to 80% of children with mental health disorders go without care** (Koppelman, Children With Mental Disorders: Making Sense of Their Needs and the Systems That Help Them. <https://www.ncbi.nlm.nih.gov/books/NBK559784/>)

Youth Behavioral Health Concerns: West Virginia

- Our **region has limited behavioral health care resources generally and very few child behavioral health resources** to effectively and efficiently meet the needs of youth with complex and high-risk behavioral health needs.
- This contributes to the **increasing number, frequency, and severity of behavioral health crises in youth**, notably suicide crises.
- Our **state has far too few inpatient child/adolescent psychiatry treatment centers** and too few available beds at the existing centers.
- Additionally, the **dearth of outpatient providers offering evidence-based intervention** for less acute child behavioral health in our region contributes to families utilizing emergency departments for distressing, but not emergency mental health care needs.
- 2021 Youth Risk Behavior Survey Outcomes for middle and high school students in West Virginia (Center for Disease Control and Prevention) demonstrate:
 - **47% of kids experienced clinical depression**
 - **27.8% of kids seriously considered attempting suicide**
 - **12.1% actually attempted suicide at least once in the last calendar year**

- There are **crippling numbers of children and teens presenting to emergency departments experiencing psychiatric crises, but unable to access inpatient care due to unavailability of inpatient beds**. Youth in this situation often become “boarders” in the emergency department and strain resources, but cannot be safely discharged to home without appropriate outpatient behavioral health support.
- **Clinicians refer patients to care outside of the system** if youth require hospitalization or intensive psychological/psychiatric services. This reduces the likelihood of collaborative care and creates inefficiencies and obstacles for patients and families.
- There are **prominent concerns for clinic space for the outpatient services that we can provide in local hospital systems**. The ever-increasing demand for services and expanding clinical faculty strain the current capacity.
- **Incoming referrals for specialty, best practice, psychological care far outpace the services we can provide with existing resources**. In some specialty programs, including the eating disorder program, there are times when we must ration care. This is unacceptable.
- **Children in West Virginia should receive immediate access to the very best behavioral health care.**

Youth Behavioral Health: Current Resources

Youth Mental Health and Psychiatric Concerns in the Pediatric Emergency Department

- **Background on Pediatric Mental Health Boarding:** meet criteria for inpatient admission but remain in the pediatric emergency department or another temporary location until there is availability
 - **Boarding times doubled** during COVID-19 pandemic
 - Patients rarely receive psychological or psychiatric **treatment**
 - **Variables associated with longer boarding times:** publicly insured, ages 15-18, youth discharged home, youth with psychosis, youth with neurodevelopmental disorders
- **Study Goals:**
 - Understand **variables associated with boarding times** in a rural, Appalachian community PED
 - Understand impact of **biased / non-biased chart language**

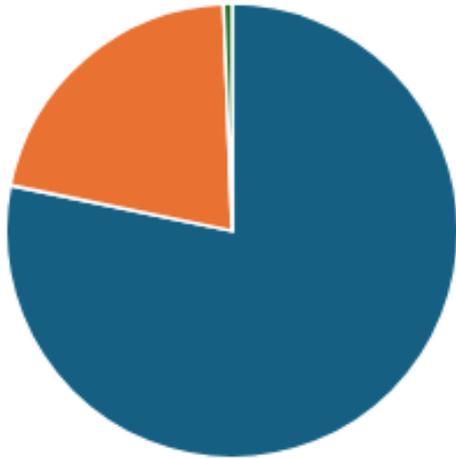
Youth Mental Health and Psychiatric Concerns in the Pediatric Emergency Department

- **Design:** Retrospective chart review, randomized sample of 500 participants, 2021-2024
- **Inclusion Criteria:** minor, PED visit for concern related to SA, SI, SH
- **Data Collected:**
 - Patient level demographic characteristics (age, sex, race/ethnicity, insurance payer)
 - Medical and psychological comorbidities
 - Use of ED resources (Social Worker and Behavior Medicine consults)
 - Boarding times, disposition times, discharge times
 - Count of biased/nonbiased language in the H&P chart note for the PED visit (subset of 200 charts)

Results: Initial vs. Final Disposition

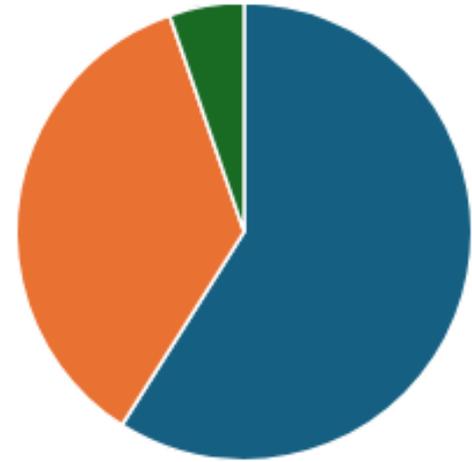
Determination of treatment recommendation after the ED visit

Initial Recommendation for Discharge



■ Psychiatric Hospitalization ■ Discharge Home ■ AMA before discharge recommendation

Final Discharge Status



■ Psychiatric Hospitalization ■ Home ■ Other

Kids with Neurodivergence

More likely to have a psychiatric hospital refuse admission

- 55% of NDD vs 31.7% of neurotypical children

Greater total time in the PED

- Median of 23.9 hours for NDD kids vs median of 12.3 hours for neurotypical children

Best Practice vs Biased Language in H&P charts

Examples of biased language:

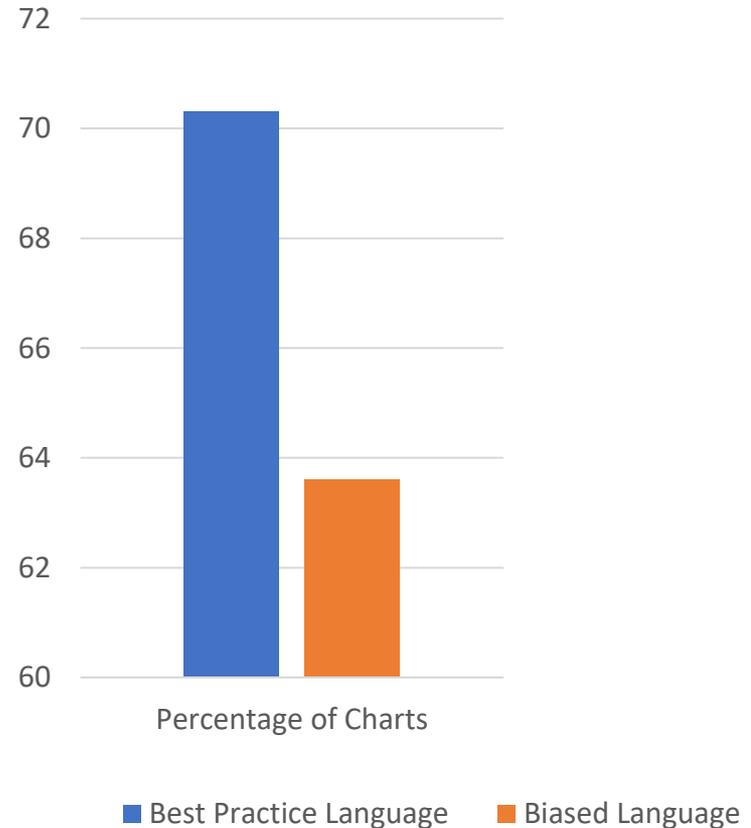
- *Failed suicide*
- *Manipulative act*
- *Cutting, cutter, mutilator*
- *Attention-seeking*
- *Medication compliance / non-compliance*
- *Resistant*
- *Threatened suicide*
- *Drug abuse, addict*

Examples of best practice language:

- *First person language*
- *Attempted to die by suicide*
- *Engaged in self-harm behavior*
- *Medication adherence*
- *Declined treatment*
- *Experiencing suicidal ideation*
- *Disclosed suicidal thoughts*
- *Substance misuse*

Biased Language – Does it relate to any patient factors?

- **Anxiety disorder diagnosis** – kids with Anxiety were less likely to have biased language in their chart notes
- **NSSI** – kids with non-suicidal self-harm behaviors were more likely to have biased language in their chart notes
- Presence of biased or best practice language **did not have a significant impact on PED Boarding times**



Our Study Dream Team

Jennie Hughes, *Attending Psychologist
and Co-Investigator*

Shreyaa Mukung, *MS3 WVSOM*

Kelsi Ross and Ali Roule, *Psychology
Interns*

Victoria Peruski, *Psychiatry Resident*

Lisa Calderwood, MPH and Stephanie
Thompson, PhD, *CAMC IAM*

Call to Action: Child Behavioral Health Pavilion

Goal: To build or acquire a property that would be transformed into a **Child Behavioral Health Pavilion (CBHP)**. This center would offer a centralized location where youth could access an array of services across a continuum of scaled care.

Call to Action: Child Behavioral Health Pavilion

1. **Psychiatric Emergency** services
2. Highest quality evidence-based **Psychiatric Hospitalization**, utilizing a team-based interprofessional approach, trauma-informed, patient-centered, family-focused, and offering only best practice treatments
3. Intensive day services including **Partial Hospitalization** (8-10 hours at the hospital every day, 5-6 days per week) and **Intensive Outpatient Services** (2-3 hours of treatment per day, a few days per week). These services represent a critical gap in current resources in our community, state, and region. By stepping youth down methodically through PHP and IOP, there is far less need for psychiatric hospitalization and emergency services.
4. Specialized, intensive, **outpatient treatment** programs using best-practice interventions. These services include psychiatry, psychology, and social work services tailored to specific problem areas that youth are impacted by. Services will include specialty tracks for **trauma-impacted youth, eating disorders, suicidal or self-harm behaviors, severe behavior problems, and other concerns**. Outpatient services may be offered in person or via telehealth modalities.
5. **Developmental and Behavioral Pediatrics** care to assist with diagnosis and treatment for children with developmental and neurodevelopmental concerns.
6. **Neuropsychological Assessment** services to identify and make treatment recommendations for children impacted by intellectual challenges, executive functioning problems, and neurodevelopmental conditions.
7. The **Children's Advocacy Center** could also be housed in the CBHP. This Center offers forensic interviews, medical evaluations, support services, and therapy for children impacted by abuse and neglect.