

# Boarding for Youth Mental Health Conditions: How Can Hospitalists Be Part of the Solution?

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There is a clearly established and alarming increase in the prevalence of mental health disorders impacting our children and adolescents with a corresponding increase in the number of youth presenting with mental health crises to emergency departments (EDs) in need of hospitalization.<sup>1–4</sup> Coupled with a lack of pediatric and adolescent inpatient psychiatry beds and providers, these trends have resulted in an increase in boarding in EDs and inpatient medical or surgical units.<sup>5–7</sup> The coronavirus disease 2019 (COVID-19) pandemic has exacerbated and potentiated these concerns, leading to a joint statement by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children’s Hospital Association declaring a national emergency in child and adolescent mental health in October 2021.<sup>8–10</sup> Shortly after this declaration, in December of 2021, the US Surgeon General issued an advisory entitled “Protecting Youth Mental Health” further defining and outlining this crisis.<sup>11</sup>

In this issue of *Hospital Pediatrics*, Ibeziako et al<sup>12</sup> describe a single center retrospective study of pediatric mental health–related ED and inpatient admissions, comparing 12 months before and after the COVID-19 pandemic. They reported statistically significant increases in postpandemic proportions of presentations for suicidal ideation and attempts, depression, anxiety, eating disorders, substance use, and obsessive-compulsive–related disorders. Although these proportions changed, the overall volume of mental health–related visits actually decreased slightly in the postpandemic period. This is probably not surprising given pandemic-related mitigation efforts and decreased health care utilization observed in the first year of the COVID-19 pandemic. Yet, despite decreased volumes, this hospital’s average length of boarding, defined as medically-cleared patients awaiting definitive inpatient psychiatry placement, more than doubled postpandemic with 50% of patients boarding for  $\geq 2$  days compared to 30% before the pandemic. Concluding that patient volumes were not the primary driver of length of boarding stays, the authors proposed multifactorial etiologies including more severe and acute presentations (reflected in the changing proportions of different mental health diagnoses), challenges related to availability and/or coordination of outpatient behavioral health services, and a lack of inpatient psychiatry beds and/or staffing. However, the actual reasons for the longer mean boarding stay observed in their study is not clear and could reflect longer lengths of stay for most patients or disproportionate lengths of stay for a subset of patients, such as those with concurrent COVID-19 infection or those with comorbid medical conditions or in need of residential or foster care. The authors also analyzed pre- and postpandemic mental health visits with interrupted time series analyses. Again, as reflected in other recent studies, in the year before COVID, there was a positive linear slope of ED mental health visits, most striking among youth

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with suicidality and length of boarding. Postpandemic, these slopes showed a further sharp increase with the biggest sloped changes observed for anxiety, eating disorders, and boarding length.

The primary limitation of this study is the context of a single institution, large, urban, free-standing children's hospital. The authors report that their hospital's resources included 24/7 ED-based psychiatry availability, an inpatient psychiatric consult team, dedicated psychology, social work and nurse practitioner services, and resource specialists helping to coordinate disposition, placement, and referrals. This study's findings may not be generalizable to general hospitals, in which most children with mental health conditions present for care, and likely underrepresents rural-residing children who have higher suicide rates and reduced access to mental health care.

Limitations aside, this study supports a growing concern by highlighting a significant trend of increasing mental health ED visits and inpatient boarding with inadequate inpatient psychiatry bed availability, further exacerbated and accelerated by the pandemic. With the cascading impacts of the pandemic on mental health, we speculate the findings may be even more alarming now. Child and adolescent acute mental health presentations continue to rise. At present, prevention and early detection and treatment are clearly not optimized and, in many underresourced areas, not possible. Severity of acute presentations and associated comorbid medical complexity is daunting. Lack of available mental health professionals and clinician moral distress and burnout are significant challenges now and moving forward. ED and inpatient boarding are an unfortunate current reality that clearly does not represent the right care at the right time in the right location.

As illustrated by the interrupted time series analyses presented by Ibeziako et al,<sup>12</sup> this crisis was already well underway when the pandemic began. Parents and children across the country faced lengthy wait lists to see mental

health professionals if they could find a psychiatrist or therapist at all. Correspondingly, increases in services across the continuum of care are necessary to solve this current crisis and to prevent the next one. In addition to health policy changes and child mental health payment reform, addressing this crisis requires engagement and commitment from hospital and health system leadership. Most areas of the country are in need of more inpatient psychiatric beds, and hospital systems need to increase these resources to meet this need. Advocacy regarding inpatient behavioral health availability needs to capitalize on what we have learned from the pandemic with telemedicine and virtual consultation and care.<sup>13</sup> Another potential solution is greater availability of intensive outpatient programs, which are composed of many of the elements of inpatient psychiatry but are tailored to the needs of patients who do not require around the clock supervision. These allow for a transition to home while still treating serious conditions and can be integrated into existing inpatient and outpatient programs. Similarly, hospital systems can partner with specific outpatient providers or clinics to more effectively facilitate timely safe discharge planning. Because the wait list to see a new provider is quite long in most areas of the country, it is helpful to partner with a psychiatrist who can "bridge," ie, follow the patients after the hospitalization until they can be seen by their new long-term provider. These and other community-based resources must be a part of the solution.

As for pediatric hospitalists, what is within our sphere of influence to improve the care of this vulnerable population? Although most pediatric hospitalists may not have training or expertise in behavioral health, we are part of the solution in optimizing the care, quality, and outcomes for our boarded patients. We are experts in patient safety, quality improvement (QI), and high-value care. A recent survey on boarding answered by pediatric hospitalists in 88 different US hospitals showed that only 24% and 10% of hospitals used electronic order sets or

had clinical pathways, respectively, for this patient population.<sup>14</sup> We can promote quality and decrease costs by standardizing care in the form of evidence based clinical pathways and order sets decreasing unnecessary variation and testing, for example with suicide risk assessment, medical clearance evaluations, and approach to delirium.<sup>15-17</sup> We can help to ensure patient and staff safety by seeking out and establishing best practices in patient agitation management, physical and chemical restraints, unit design, and provider deescalation training. We can define and track metrics relative to boarding care; a study by Bardach et al<sup>18</sup> proposed a set of 8 measures for patients presenting with suicidality, psychosis, or substance use. As the adage goes, "what is not measured can't be improved": the number of youth experiencing boarding and length of stay are a great place to start, but we must go beyond these to truly improve care of this population. Where there are gaps in the available literature, we can help to create evidence and generalizable knowledge starting with local QI efforts.

We are also leaders and stewards of medical education, specifically training and mentoring the next generation of pediatric hospitalists. Multiple recent studies have demonstrated the gap in pediatric resident education, experience, and competency in behavioral health.<sup>19,20</sup> Behavioral health education will be more meaningful if it is championed by practicing pediatric hospitalists who learners see as experts on inpatient health care. As pediatric hospitalists, we can enhance our own education and competence like we have with so many other conditions that have developed or increased in prevalence since our medical training. We can demonstrate and model our expertise in operational efficiency, transitions of care, and patient or family-centered care and rounds. We must serve as educators and mentors to our inpatient student and residents so as to not perpetuate the lack of training and competence in the next generation of pediatric hospitalists.

Solutions to the youth mental health crisis are complicated and challenging. Inpatient psychiatric resources are clearly a bottleneck leading to ED and inpatient boarding. More proximal interventions and programs are necessary to help decrease the need for these beds. There are no easy or encompassing solutions. We will need to come together as leaders from behavioral health, ED, hospital medicine, hospitals and health systems, and community partners with ideas and innovation. Where can we start? By building on our expertise in QI and medical education, pediatric hospitalists can play key roles in improving the care of boarded patients. We are part of the solution.

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