The Current Practices and Responses to Adolescents in North America That Are Seeking Psychiatric Care from an Emergency Department

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Abstract

Adolescence and early adulthood are typically when most mental health disorders present (Gandhi et al., 2016; Kessler et al., 2005). Emergency departments frequently play a crucial part in treating mental health crises and are the entry point for individuals needing hospitalization for their mental health care (Saunders et al., 2018). The purpose of this literature review is to gain an understanding of the North American current practices and interdisciplinary approaches to youth that seek psychiatric care at an emergency department for a mental health concern or crisis. The review will look at the common presenting mental health issues at hospital emergency departments such as anxiety, depression, suicidality, and self-harm. Furthermore, an in-depth examination will be taken to address why youth have been showing up in increasing numbers at emergency departments seeking mental health care. The review will explore some of the current assessments and screening tools being utilized in emergency departments. Additionally, the review will examine youths' perspectives and experiences while accessing psychiatric care in hospital emergency departments and look at how some of the hospital emergency departments are attempting to provide more effective services to adolescents seeking psychiatric care. Lastly, the literature review will look at gaps in the literature and explore how social workers could be playing a more significant role in supporting adolescents and working within the interdisciplinary team when adolescents present at the hospital with a mental health crisis or concern.

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List of Acronyms

ASQ- Ask Suicide-Screening Questions

CBT- Cognitive-Behavioral Therapy

CYMH- Child and Youth Mental Health

ED- Emergency Department in a Hospital Setting

ER- Emergency Room in a Hospital Setting

EDSTARS- Emergency Department Screen for Teens at Risk for Suicide

EDMHCP- Emergency Department Mental Health Clinical Pathway

FBCI- Family-Based Crisis Intervention

FISP- Family Intervention for Suicide Prevention

HEADS-ED- Home, Education, Activities and Peers, Drugs and Alcohol, Suicidality, Emotions and Behaviours, and Discharge resources.

HEARTSMAP- Home, Education and Activities, Alcohol and Drugs, Relationships and Bullying, Thoughts and Anxiety, Safety, Sexual Health, Mood, Abuse, Professional and Resources

LCSW- Licensed Clinical Social Worker

MH- Mental Health

MST- Multi-Systemic Therapy

POC- Perceptions of Care

SH- Self-Harm

SU-Substance Use

Introduction

As a result of the limited services for youth needing mental health care, hospital emergency departments in North America have gradually developed into a primary center where families show up for assistance (Jabbour et al., 2016). For youth with a psychiatric concern, the hospital emergency department plays a critical role in their care (Dolan & Fein 2011; Leon et al., 2017). When youth are experiencing a mental health crisis and have failed to access treatment elsewhere, hospital emergency departments are a vital contact point (Dolan & Fein 2011; Dolan & Mace, 2006; Newton et al., 2012; Leon et al., 2017).

Youth in psychiatric need are showing up at hospital emergency departments (ED) in growing numbers, "and just as the cause for this trend is likely multi-factorial, so must be our professional response to address this burgeoning clinical need" (Carubia, Becker & Levine 2016, p. 41). For this reason, it is imperative that emergency room hospitals are adequately prepared to treat youth in a mental health crisis because the youth may leave the hospital with inadequate treatment, which could potentially place them at significant risk or even death, particularly in cases of adolescents who are presenting as suicidal.

The literature review includes research primarily from Canada, and the United States of America (North America) as Canadian studies on the research question were more limited (Carlisle et al., 2012; Gandhi et al., 2016). It is important to note that fundamentally, the Canadian and United States healthcare systems are very different, the Canadian health care system is grounded in a publicly funded health service (Cawthrope, 2013) and healthcare coverage is universal (Ridic, Gleason & Ridic, 2012). While the USA health care system "has no single nationwide system of health insurance" (Ridic et al., 2012, p.115). In the USA health care

system, individuals can access EDs even in circumstances where the individuals do not have insurance or the means to pay (Asarnow, Babeva & Horstmann, 2017). It is not the intent of this literature review to discuss or examine these differences. However, despite the difference in health care systems, and as the literature review will reveal, Canada and the United States face similar challenges and issues when adolescents seek MH care from an emergency department.

The research questions being addressed in this literature review include what are the current practices and responses in place in North America for adolescents seeking psychiatric care from an ED and what are their perceptions and experiences of that treatment? This paper has two goals. The first is to gain an understanding of the current practices and interdisciplinary approaches in place in North American emergency departments for adolescents seeking psychiatric care. Secondly, this paper will uncover a clearer picture of adolescent's experiences and perceptions of receiving psychiatric care at the hospital emergency department.

The problem that this research paper is examining is how adolescents who are seeking psychiatric care from a hospital emergency department due to a mental health crisis or concern, may not be receiving adequate or effective community care and treatment plans when they are discharged from the hospital ED. According to the United Nations, 'youth' is described as a development period between the ages of 15 and 24 (Hawke et al., 2019; United Nations Department of Economic and Social Affairs, 2013). Although, for the purposes of this research, "youth" includes individuals from the age range of 12-24, since some of the research studies included youth as young as age 12. Other terms used in this paper to describe this population are adolescents and, in some cases, pediatrics is also utilized.

The research topic is significant because several emergency departments fail to provide clear, consistent and integrated referral procedures to suitable community service providers

(Jabbour et al., 2016). This is an essential process in regard to treatment planning. This is a gap that could be addressed and handled more effectively with input from a hospital social worker. Identifying this gap through research could potentially demonstrate the need for the presence of more clinical social workers in hospital emergency departments to assess adolescents that are presenting with a mental health crisis or concern.

Further research in this area is crucial as it could potentially provide better responses and more adequate services for adolescents seeking mental health services from a hospital emergency department. In addition, gaining an understanding of adolescents' experiences within the hospital-based system of psychiatric care allows their voices to be heard and acknowledged. This is often overseen or not considered and could lead to recommendations and possible changes in policies and guidelines in response to this particular research. The potential outcomes of this research paper could assist hospital staff in altering treatment approaches and recognizing more effective operative practices (Bate & Robert, 2007; Chenail, 2011). At the very least, dialogue and awareness around these issues could be generated and a possible re-examination of current policies and practices in place at hospital EDs that service adolescents seeking psychiatric care for a mental health concern or crisis.

Background

In Canada, approximately one million youth are living with an MH condition (Virk, Stenstrom & Doan, 2018). One in every three adolescents aged 13-18, on average, will report having experienced a psychotic symptom such as a delusion or hallucination (Kelleher et al., 2012; Soleimani, Rosychuk & Newton, 2016). Canadian adolescents with a psychiatric disorder have exceeded bodily injuries as the central cause for admittance to the hospital (Carlisle Mamdani, Schachar, 2016 & To, 2012; To, Guttmann & Dick, 2001). In the USA, in the last 15

years, presentations to the emergency department for youth and children in a mental health crisis have almost doubled (Carubia et al., 2016). Similarly, in Canada, adolescent psychiatric service users' attendance had an upsurge of more than 50 percent from 2010 to 2011 (Children's Hospital of Eastern Ontario, n.d.; Jabbour et al., 2016).

Even though families attempt to gain psychiatric care and treatment for their youth, emergency departments are not prepared nor equipped to handle this specific population (Jabbour et al., 2016). While there appears to be a broad spectrum of adolescents that present at emergency rooms for mental health concerns, there is also a variance of presenting psychiatric disorders; suicidality and aggression are reported to be some of the most frequent presenting mental health concerns (Carubia et al., 2016).

Gandhi and colleagues (2016) discovered that the most frequent presentation of MH concerns to the ED was related to anxiety disorders, whereas mood and affective disorders were the greatest reason for hospital admissions. In another study conducted by Cloutier and colleagues (2010), the top five primary explanations that were given by adolescents and their caregivers for presenting at the ED were suicidal ideations, depression or mood, suicide attempts, anxiety and self-injury (Leon et al., 2019). Moreover, Newton and colleagues (2009) conducted a study in Alberta, looking at pediatric MH presentations at the ED; they found that out of the 16,154 youth with documented presentations, 21.4% were associated with mood disorders and 32.5% to anxiety disorders. In addition, Newton and colleagues (2009), discovered that the most predominant reason for MH presentations was for substance misuse at 41.3 %. While there was a variance of the percentages and a range of the types of mental health presentations to the ED, overall, the most commonly observed in the research were depression, anxiety, suicidality, self-harm, aggression, and substance use.

Methodology

In creating this thematic literature review, the author utilized the University of the Fraser Valley library database, which included the use of Academic Search Complete, CINAHL Complete, MEDLINE with Full Text, PsycARTICLES, PsycINFO, Social Sciences Abstracts, SocINDEX with Full Text and Social Work Abstracts. In addition to this, the Google Scholar database search engine was also employed. Keywords utilized in the search included: "adolescents," "youth" "psychiatric care" "youth engagement," "mental health," "emergency department," "hospital," "adolescent psychiatric care," "suicidal youth," "social workers" and "adolescents' perspectives and experiences."

To create a parameter for the articles chosen for the literature review, the author focused on research that was conducted primarily within the last 5 to 7 years, approximately inside the period of 2012 to 2019. Most of the articles and journals utilized came from North America, although some of the articles included came from outside of North America, and those articles originated from the United Kingdom and Iceland.

The articles selected for the literature review were generally comprised of peer-reviewed research articles that were taken from an extensive range of journals that included: *Child and Adolescent Psychiatric Clinics of North America*, *Social Work in Health Care*, *Current Psychiatry Reports*, *Pediatric Emergency Care*, *Journal of Child and Adolescent Psychiatric Nursing*, *Pediatrics*, *CJEM: Canadian Journal of Emergency Medicine*, *Journal of the American Academy of Child & Adolescent Psychiatry*, *Clinical Pediatric Emergency Medicine*, *Hospital Pediatrics*, *Canadian Journal of Psychiatry*, *CMAJ: Canadian Medical Association Journal*, *BMC Emergency Medicine and Health Services Research*, *Managing Psychiatric Emergencies in Children and Adolescents*, *Psychiatric Services*, *Journal of Child & Family Studies*, *Canadian*

Journal of Community Mental Health, Implementation Science, Psychological Medicine, Paediatrics & Child Health, Journal of the Canadian Academy of Child & Adolescent Psychiatry, Clinical Psychology: Science & Practice, Journal for Healthcare Quality: Promoting Excellence in Healthcare, Social Psychiatry & Psychiatric Epidemiology, The British Journal of Psychiatry, Patients Child and Adolescent Psychiatric Clinics of North America, Mental Health Services Research, Archives of Suicide Research, Research on Social Work Practice, Administration, The Western Journal of Emergency Medicine, and Policy in Mental Health and Mental Health Services Research.

Government sources and provincial reports were also included, such as *The mental health and wellbeing of Ontario students, Youth engagement toolkit resource guide, Canadian Institute for Health Information (CIHI, 2018), The human face of mental health and mental illness in Canada, National Vital Statistics Reports, Government of Canada (2006), Out of the shadows at last: Transforming mental health, mental illness, and addiction services in Canada (2006), Changing directions, changing lives: The mental health strategy for Canada (2012),* and *Walking the talk: A toolkit for engaging youth in mental health (2012).*

In the initial search, abstracts were reviewed for relevance to the research questions "What are the North American current practices and interdisciplinary approaches to youth that seek psychiatric care at an emergency department for a mental health concern or crisis?" and "What are the experiences adolescent's experiences and perceptions of receiving psychiatric care at the hospital emergency department?" Many articles were discovered by utilizing several mixtures of key search terms, as listed above. Articles searched pertaining to mental health, youth and emergency departments generated a large number of articles used in the paper.

However, there were some gaps and limited research in relation to youths' perceptions and experiences with receiving psychiatric care at the hospital emergency department.

The articles selected utilized a blend of qualitative and quantitative methods, which included data sources such as population-based cross-sectional cohort studies, interviews, health record audits, national ambulatory care reporting system, administrative databases, secondary analysis from an online discussion forum and patient surveys.

Findings

Consistent throughout the literature was the concept that emergency departments are the primary point of contact (Cappelli et al., 2019; Dolan & Mace, 2006; Jabbour et al., 2016; Newton et al., 2012) and the attendance has increased in numbers over the last few years (Carubia et al., 2016, Leon et al., 2017). In fact, "[f]or more than half of youth with a first mental health-related ED visit, the visit represents their first contact for outpatient mental health care" (Gill et al., 2017; Rosic et al., 2019, p.83). In Canada, individuals between the ages of 5 and 24 years who attended the ED for an MH issue rose by sixty-six percent from 2007-2017 (CIHI, 2018; Rosic et al., 2019). The literature showed growth in adolescents attending emergency departments in both Canada and the USA (Carlisle et al., 2016).

Some of the researchers contended that hospital emergency departments should not always be the first point of contact for an adolescent that is experiencing a mental health concern. There were contrasting opinions on this matter, as there were some researchers that suggested ED's where a good point of contact because it provided the opportunity to identify, screen, and assess for MH concerns (Asarnow et al., 2017; Babeva et al., 2016; Chun et al., 2013; Esposito, 2019). However, other literature (Anderson et al., 2013; Bhui, Ullrich & Coid, 2014; van der Post et al.,

2012) suggested that ED's were not optimal settings for adolescents to "engage with the mental health system for the first time, as such visits are associated with worse outcomes, including more severe disease at presentation, longer duration of untreated illness and higher future use of acute care services" (Saunders et al., 2018, p. E1183). Furthermore, the literature highlighted the importance of early intervention and prevention by enhancing early identification in schools, along with connecting students to effective mental health services (Cawthrope et al., 2018; Patten et al., 2015).

Some of the researchers' theories proposed in the literature are that the growing numbers of adolescents seeking MH care in emergency departments are due to a lack of community MH services, as well as barriers to accessing MH services within the community (Dolan & Fein, 2011; Gill et al., 2017; Leon et al., 2017). In addition, "ED utilization can also highlight the need for increased attention to mental health services in the greater health system" (Hoffmann, Stack, Samnaliev, Monuteaux & Lee, 2019, p.386). Furthermore, there was a consistent acknowledgment in the literature around the high number of repeat visits following a presentation to ED (Dolan and Fein, 2011; Cloutier et al., 2017; Roman et al., 2018). As Dolan and Fein (2011) highlight, as much as fifty percent of youth that had presented to the ED came back within two months.

The general consensuses in the literature are that adolescents are showing up in high numbers because of the shortage of adolescent psychiatric services (Jabbour et al., 2016). This shortage has been noted across both Canada and the United States (Jabbour et al., 2016). Cappelli and colleagues (2019) point out that further studies should examine impediments to community outpatient mental health intervention to gain a better understanding of why adolescents are utilizing emergency departments as the entry point to receiving psychiatric

treatment. Newton and colleagues (2009) proposed that mental health services in the community may not be immediately accessible, and those services may not be adequately meeting the needs of the service user. In the United States, as MH presentations to ED's have grown, gaining access to MH services remains inadequate, which is a consequence of the psychosocial inequalities and the confines in health insurance plans (Sheridan, Sheridan, Johnson & Marshall, 2017; Mental Health America, 2016). American researchers Lynch and colleagues (2015) point out that impoverished families maybe going to the ED for MH care because there is a limited amount of primary care providers that accept Medicaid, the public health insurance in the USA, that is provided to low-income families (Redic et al., 2012). Moreover, Lynch and colleagues (2015) assert that the shortage of public funding for MH services is frequently the reason for the lack of accessibility and range of MH treatment options.

In addition, the literature highlighted the necessity for further clinical guidelines and a framework when adolescents do show up at hospital emergency departments with a mental health concern (Cappelli et al., 2019). Organized clinical practice strategies are absent in EDs, and the scope of MH services provided in the ED is significantly varied (Cappelli et al., 2019; Leon et al., 2013). There also appears to the absence of "clear standards for assessments, treatments, clinical tools, and MH training for ED physicians" (Capelli et al., 2012; Chun, Katz, Duffy & Gerson, 2015; Leon et al., 2017, p.178). Cappelli and colleagues (2019, p.84) identified two essential areas around ED clinical management: "1) clinical pathways using a set of evidence-based standards to facilitate the management and transition of care from EDs to outpatient and community resources (Jabbour et al., 2016; Barwick et al., 2015; "Clinical Trials.gov,"n.d.); and 2) an integrated system linking EDs, primary care, and community MH agencies" (Cappelli et al., 2017).

When Adolescents Present at the ED in a Mental Health Crisis

ED's have steadily become a "safety net" for adolescents who need mental health and psychiatric care and are unable to receive those services in an appropriate timeframe (Cooper & Masi 2007; Mapelli, Black & Doan, 2015, p.906). Mapelli and colleagues (2015), emphasize that frequent usage of the emergency departments for "psychiatric needs points to the failure of EDs in establishing long-lasting and stable mental health services to prevent recurrent crises, particularly in the face of the chronic nature of mental health diseases and their associated lack of absolute and effective treatments" (p.907). According to Soleimani and colleagues (2016), a current emergency department study showed that a clearer understanding of the role that emergency departments play in an adolescent's journey to mental health help is required to advance first detection and intervention strategies.

The health care teams in ED's are expected to identify any severe and life-threatening illnesses (Esposito, 2019). Some patients present with concerns that are easily recognizable, while others necessitate further assessment and diagnostic examination (Esposito, 2019). When a patient arrives in ED, the health care team is expected to respond in a manner "according to current evidence and expert consensus" (Esposito, 2019, p.63). This approach by the health care team in ED should also apply to adolescents seeking psychiatric care, although the research suggests that this may not always be the case. As Doupnik, Esposito, and Lavelle, (2018) point out, adolescents who show up at an ED with either an apparent or even less obvious mental health issue warrant an organized and methodical approach to appropriate and competent psychiatric care. Regrettably, Doupnik and colleagues (2018), suggest that developments in prevention and treatment in adolescents with mental health conditions have not seen the incredible advances as seen in the prevention and treatment of physical illnesses in youth.

The literature suggests that there is a variation of emergency psychiatric services that are available when an adolescent present at the hospital. Conversely, there is a lack of clinical organization and clinical intervention procedural guidelines (Leon et al., 2013; Cappelli et al., 2019). This can make the process complicated and convoluted, particularly when dealing with an adolescent who is experiencing symptoms of complex mental illness and substance use and may have never sought mental health assistance previously. A few hospitals assimilate a mental health specialist into the ED process such as a psychiatrist, nurse, or social worker, whereas other hospitals depend on community service providers or telemedicine access for a full assessment (Esposito, 2019). While not as prevalent in Canada as in the United States, telemedicine is an alternative way of accessing healthcare, which allows the individual to virtually connect and consult with a health care provider such as a physician or nurse practitioner (Owens, 2018).

Sheridan and colleagues (2017) suggest that the beneficial approach to developing improved psychiatric care for youth in a mental health crisis at the ED is to begin the therapeutic intervention while they are in the hospital awaiting disposition. Disposition in this setting refers to the emergency health care team making the choice of whether the patient will be admitted or discharged from the hospital (Calder et al., 2012). Research studies have demonstrated positive outcomes from starting interventions at this stage (Rotheram-Borus, Piacentini, Cantwell, Belin, & Song, 2000; Wharff, Ginnis, & Ross, 2012). Yet, Brown, Green, Desai, Weitzman, and Rosenthal (2014) emphasize the importance of establishing follow-up outside of the hospital, immediately after discharge as being just as critical.

According to Havens and Marr (2014, p.192), in the United States, “30%–40% of current presentations of youths in psychiatric emergency result in in-patient admission” (Case et al., 2011; Mahajan et al., 2009; Pottick et al., 1995; Sills &Bland 2002). Another identified concern

with adolescents seeking psychiatric care is that when they are admitted to the hospital, they often are placed in adult psychiatric settings (Havens & Marr, 2014). The adult psychiatric units frequently do not have ongoing access to adolescent psychiatric clinicians, and access is even more limited on nights and weekends (Havens & Marr, 2014). Fundamentally, combining youths and adults in a psychiatric unit is not optimal, and yet this occurs frequently for youth requiring hospitalization for mental health treatment.

The ED's Response to Adolescents with a Mental Health Concern

The ED does present some difficulties in supporting adolescents with MH concerns. They are frequently packed, loud and do not have sufficient quiet space, and adolescents may be reluctant to have a conversation about their MH challenges with a clinician that they just encountered (Asarnow, Babeva & Horstmann, 2017). Sheridan and colleagues (2017) found that one of the central reasons stated "by patients and their families is how initiating therapy in the hospital and being able to continue with the same provider after discharge greatly increases satisfaction and the efficacy of the intervention" (p.178). While this arrangement is not frequently available in most current practices in hospitals, it does speak to the importance and value of consistency for youth and their families following a visit to the hospital for a mental health concern.

In the ED, the accessibility of MH specialists is inadequate, and frequently, the staff is minimally trained in MH (Chun et al., 2015; Cloutier et al., 2017). Oftentimes, emergency departments are not equipped with psychiatric screening tools or competent mental health experts (Jabbour et al., 2016). These shortfalls in the ED are a strain on an overstretched and limited funded MH system, which ultimately negatively influences patient outcomes (Dolan & Fein, 2011; Holder, Rogers, Peterson, Shoenleben & Blackhurst, 2017).

Essentially, this puts the adolescent at risk – they are not adequately being assessed nor given the necessary treatment for their mental health needs. In response to these challenges, a group of Canadian hospital and community-based professional service providers was appointed by Provincial Council on Maternal Child Health in Ontario to produce a clinical pathway, identified as the Emergency Department Mental Health Clinical Pathway (EDMHCP) for children and adolescents showing up with psychiatric concerns (Jabbour et al., 2016; Provincial Council for Maternal and Child Health, 2013). In 2013, the EDMHCP was developed, and its primary goals were to "(i) improve early identification and intervention for CYMH issues, (ii) provide more timely access to community MH services, and (iii) reduce service gaps for vulnerable children and youth" (Jabbour et al., 2016, p.2). Moreover, the EDMHCP objective is to deliver a "seamless transition of care for children/youth and caregivers between the ED, outpatient hospital services and community MH agencies (CMHA), with tailored linkages to community resources through the [Home, Education, Activities and Peers, Drugs and Alcohol, Suicidality, Emotions and Behaviours, and Discharge resources] HEADS-ED screening tool" (Jabbour et al., 2016, p.2).

In 2016, Jabbour and colleagues started a clinical trial utilizing a mixed method that examined the effects of EDMHCP at four different ED's in Ontario, and their study included data from qualitative interviews, health record audits, administrative databases, and patient surveys. While the outcomes of this particular study are not yet available at this time, Jabbour and colleagues (2016), proposed that their clinical trial on EDCMHCP "will standardize language and care provided through improved communication and explicit expectations for [the] transition between ED and CMHA settings" (p.8).

Carubia, Becker, and Levine (2016) point out that "[s]tandards of care and evidence-based models for practice are often lacking, and our ability to build our collective knowledge will be enhanced by our use of common definitions" (p. 40). Furthermore, there is a growing awareness on the advancement and translation of evidence-based approaches for various medical circumstances in the ED, and it is just essential for the psychiatric staff to adopt these practices (Ginnis, White, Ross & Wharff, 2015; Iyer, Reeves, Varadarajan & Alessandrini, 2011).

Repeat Visits

Overall, most children and youth that attend ED for psychiatric care are discharged (Roman et al., 2018). However, the return rate is high (Roman et al., 2018). Repeat visits make up for a considerable amount of all MH visits to the pediatric emergency departments, with roughly 50% revisiting the ED within two months of their first visit (Cloutier et al., 2017; Dolan & Fein, 2011; Sobolewski, Richey, Kowatch & Grupp-Phelan, 2013). This could suggest that the youth are not receiving the appropriate care upon presentation to the ED and a possible lack of connecting to mental health services in the community. The large number of youth MH repeat visits to the ED are contributing to ED congestion and may paint a picture of the clinical needs not being met (Leon et al., 2019).

Alternatively, the high number of repeat visits could also indicate that youth with MH concerns have more crisis-related issues that require them to attend the ED for repeat visits to access acute care. Studies suggest that factors contributing to ED recidivism—specifically, the probability that the youth will present again at the ED— are involved with child welfare systems, social determinants of health, historical and current involvement in MH services, prescription medications, mood disturbances, and identification as female (Cloutier et al., 2017; Leon et al., 2017; Roman et al., 2018).

Similarly, in a recent study conducted on repeat visits by Rosic and colleagues (2019), five identified factors are being "older age (14-17 years), female sex, receiving a risk assessment by the psychiatry team, having an inpatient psychiatric admission, and – for female but not for male patients – receiving a discharge diagnosis of a depression-related disorder" (p.86). Rosic and colleagues (2019), also found that similar to other studies, about one in five adolescents presenting to the ED for a mental health issue had a return visit within six months. Moreover, Soleimani and colleagues (2016), found that youth under age 18 who came to the ED with psychotic symptoms had the most significant risk of a repeat presentation to the ED in comparison to repeat presentations for other psychiatric challenges (Newton et al., 2010). Whereas, Gardner and colleagues (2019) found in their study that "adolescents who presented with self-harm were almost five times more likely to have repeat emergency department visits or hospital admissions related to self-harm, with about 1 in 3 having a repeat admission" (p.E1213).

In another study conducted by Leon and colleagues, (2019) the researchers looked at family characteristics connected to repeat ED visits, and they discovered that "post-visit MH services, prior psychiatric hospitalization, higher severity of symptoms, and living closer to the hospital increased the odds of repeat visits" (p.9). In addition, Leon and colleagues, (2019) found that "caregiver history of MH treatment decreased the odds of having a repeat ED visit, family functioning, and perceived family burden were not associated with repeat visits" (p.9). Based on the outcomes of this study, Leon and colleagues (2019) recommend that healthcare service providers must take into account caregiver and youth service use aspects to advise patient management and disposition preparation. Another noted additional challenge with adolescents who are repeat visitors is that they are more often less inclined to follow-up with mental health services in the community (Dolan & Fein, 2011; Sobolewski et al., 2013).

Self-Harm

Attending the ED for intentional self-harm, such as a self-inflicted injury or overdose, is a multifaceted situation with overt and unseen components (Owens, Hansford, Sharkey & Ford, 2016). In Ontario, ED presentations for adolescents who have self-harmed have over doubled since 2009 (Gardner et al., 2019). According to Owens and colleagues (2016), many who self-harm are treated without a hospital visit because of emotional shame or feelings of worthlessness. Those adverse feelings are further validated when they attend the ED and interact with hospital staff who comes across as unempathetic and stigmatizing (Owens et al., 2016).

In the United Kingdom, researchers Owens and colleagues (2016) conducted a secondary analysis of qualitative data from an experimental online discussion forum study on youth that self-harmed and had attended an ED. Owens and colleagues (2016) found that participants evaded the ED because of their own or others' past negative experiences. When they attended the ED, the youth experienced feelings of shame, unworthiness and "undeserving of treatment" (Owens et al., 2016, p.287).

These emotions were further perpetuated when they received punitive, stigmatizing, and unempathetic interventions from the ED health care team (Owens et al., 2016). The participants reported that helpful interactions with the health care team occurred when "they received 'treatment as usual,' i.e. non-discriminatory care, delivered with kindness, which had the potential to challenge negative self-evaluation and break the cycle" (Owens et al., 2016, p.286).

Gardner and colleagues (2019) conducted a study on health outcomes for youth that self-harmed and attended the ED, and they found that an ED presentation connected to intentional self-harm elevates the risk of recurring intended self-harm and suicide. Gardner and colleagues

(2019), propose that the creation "of algorithms and interventions that can identify and help adolescents at highest risk of recurrent self-harm is warranted" (p. E1207). This population of adolescents is a highly vulnerable group and a "largely hidden population," and when they present to the ED, this is a crucial moment for "engagement and even possible suicide prevention" (Owens et al., 2016; Royal College of Psychiatrists, 2010, p.286).

Suicide

In Canada, the second most common cause of death among youth is suicide (Hawke et al., 2019; Statistics Canada, 2015). Similarly, in the USA, suicide is the second leading cause of death, which translates to "over 2000 deaths in the 10–19 age group in the year 2012" (Heron, 2013; Carubia et al., 2016, p. 41). Additionally, Plemmons and colleagues (2018) found that hospital admissions for youth that have attempted suicide or had suicidal thoughts from 2008 to 2015 have over doubled (Esposito, 2019). Carubia and colleagues (2016) suggest that it is imperative to increase the capacity to adequately respond to the clinical MH demands of a hospital emergency department environment. This includes assessment and treatment of youth that shows up with depression, suicidality, and anxiety, and to further train staff with the necessary expertise and ability to respond in this limited environment (Carubia et al., 2016). Hughes and Asarnow (2013) propose that frequently suicidal adolescents fail to obtain MH treatment following discharge from the ED, and interventions are essential to increase connection to out-patient services.

In a randomized controlled trial study, American researchers Hughes and Asarnow (2013) compared the Family Intervention for Suicide Prevention (FISP) with the usual ED care received. FISP is a brief "family-based cognitive behavior therapy session designed to increase motivation for follow-up treatment, support, coping, and safety, augmented by care linkage

telephone contacts after discharge" (Hughes and Asarnow, 2013, p.28). Hughes and Asarnow (2013) found that the FISP intervention was linked with enhanced connection to outpatient follow-up MH care. A critical component of the FISP intervention is the follow-up call by the clinician within 48 hours following discharge (Hughes and Asarnow, 2013). This contact provides the opportunity for the clinician, client, and family to collaborate and to discuss any obstacles or challenges that have presented following the adolescent's discharge from the ED (Hughes and Asarnow, 2013). The second-generation Emergency Department/Family Intervention for Suicide Prevention (ED/FISP) seeks to advance and strengthen adolescents' skills for managing suicidal desires and assembling support and increasing family connectedness (Asarnow et al., 2017). Asarnow and colleagues (2017), describe the ED/FISP as:

> Balanc[ing] the need for evaluation and treatment using a brief behavioral assessment of imminent risk which evaluates the youth's ability to generate behaviors incompatible with [Substance Use] SU/SH, [Self-Harm] specifically: 1. recognizing personal strengths; 2. identifying ≥3 persons from whom to seek support; 3. discriminating emotional states and identifying SU/SH prompting situations using an "emotional thermometer"; 4. developing a SAFETY plan with concrete steps for safe-coping (activities, thoughts, behaviors, support persons); 5. committing to using the SAFETY plan versus SU/SH for a specified period. (pp. 4-5)

According to Ginnis and colleagues (2015), "[t]here is little evidence in the literature or in clinical practice of psychiatric intervention that occurs exclusively in the ED" (p.173). In response to this, Ginnis and colleagues (2015) developed Family-Based Crisis Intervention (FBCI), a one-time session intervention created explicitly for the ED to work with the youth and their family in the moment of crisis, with the aim of decreasing the suicidality in the youth. FBCI

is a collaborative approach that includes CBT skills building, psycho-education, safety planning, therapeutic readiness, and treatment planning (Ginnis et al., 2015). The FBCI objective is to decrease the youth's suicidal symptoms and give the youth, their family and clinician the chance to create a safety plan (Ginnis et al., 2015). The FBCI approach will be examined further in this paper in the models and theoretical frameworks section.

Ongoing studies and further advancement for medical (i.e. "physical") conditions have contributed to better outcomes, whereas unfortunately, funding, research, and improvement for MH conditions such as suicide prevention for adolescent patients have lagged behind (Esposito, 2019). This is despite the fact that during the last five years, hospitals have come to understand the significance of prevention and assessment in relation to suicide (Ginnis et al., 2015).

Considering the frequency of suicidal adolescents that present at emergency departments, this setting is "a crucial environment for suicide screening, intervention, and prevention to occur" (Carubia et al., 2016, p. 41). Adolescent visits to the ED can present a space to assess and screen adolescents with psychiatric and suicide risk, prioritize adolescents established on need and provide adequate follow-up mental health services (Babeva, Hughes & Asarnow, 2016). Taking into consideration the usual wait times, there is often a sufficient amount of time in the ED for the adolescents and their family or caregiver to fill out a brief-self report instrument (Babeva et al., 2016). Most importantly, it is critical that the information provided on the questionnaire is thoroughly analyzed by the clinician as the youth may reveal suicidal risks that they may fail to address in the interviews (Babeva et al., 2016). Unfortunately, according to Sobolewski and colleagues (2013) and Hughes and Asarnow (2013), there has been minimal research conducted on youth who are discharged from ED following an assessment for suicidal behaviour or thoughts.

Suicide Screening Tools

The literature highlighted a variety of suicide screening tools. Some were identified that were explicitly designed for the ED, such as the ASQ (Ask Suicide-Screening Questions) (Esposito, 2019). ASQ was created specifically for the ED setting, although it can be utilized in various clinical situations (Esposito, 2019), and the ASQ has demonstrated predictive validity (Asarnow et al., 2017; Horowitz et al., 2012). The ASQ is a very brief screening tool that consists of four yes or no questions, and it can be completed in fewer then 2 minutes and if the youth answers "yes" to any of the four questions it is considered a positive screen and question 5 is then asked, "Are you having thoughts of killing yourself right now?" (National Institute of Mental Health, n.d.). Under these circumstances, the patient will then be required to have a complete safety/full mental health evaluation (NIMH, n.d.).

While providing suicide screening for adolescents that present to the hospital with MH concerns is critical, it is vital for hospital staff to be prepared to deal with a positive screen and this preparation works best with a multidisciplinary team, that encompasses medical personnel such as nurses and doctors but also allied health care workers such as social workers and community mental health specialists (Esposito, 2019). Furthermore, developing connections to MH services after ED discharge is vital for youth, specifically those experiencing suicidality (Grupp-Phelan, Delgado & Kelleher, 2007; MacWilliams, Curran, Racek, Cloutier & Cappelli, 2017; Roman et al., 2018).

Screening and Assessment

Roman and colleagues (2018) suggest that despite the fact that several clinical reports and guidelines highlight the need for greater staff competency in treating children and

adolescents in the ED with MH needs, there is still a small number of evidence-based practices being utilized in response to the growing number of youths showing up at ED in an MH crisis.

In addition, Carubia and colleagues (2016) suggest that it is imperative to increase capacity to adequately respond to the clinical mental health demands of a hospital emergency department environment, including assessment and treatment of youth that show up with depression, suicidality, and anxiety, to further train staff with the necessary expertise and ability to respond in this limited environment. Emergency departments have begun to create and assess new mental health processes among emergency departments and community mental health service providers to formalize adolescent psychiatric care ("ClinicalTrials.gov." n.d.; Leon et al., 2017).

However, establishing an evidence-based method for rigorous and competent screening and intervention is a significant component that necessitates additional research (Carubia et al., 2016). An ongoing effort in this field encompasses "the Emergency Department Screen for Teens at Risk for Suicide [EDSTARS], …. whose aim is to develop a computer-based screening tool which will aid [the] ability to effectively assess and stratify suicide risk in our adolescent patients." (Carubia et al., 2016, p.41).

In addition to this screening tool, there is an interview tool named "the HEADS-ED [which] is a rapid screening and disposition planning tool for emergency clinicians" (MacWilliams et al., 2017, p.778). Cappelli and colleagues (2012) created "HEADS-ED," as an instrument to be used by clinicians to rate the degree of psychosocial challenges across seven segments to evaluate whether the youth needs urgent psychiatric treatment or can be sent to an on-site mental health team (Lee et al., 2019, p.88). The HEADS-ED has the ability to recognize the necessity for improved "discharge planning, complete charting, and standardized assessments

for the increasing population of pediatric mental health patients who present to [emergency departments]" (MacWilliams et al., 2017, p.778).

Despite HEADS-ED's value as a screening tool, "it currently does not provide guidance as to the types or urgency of services required and does not distinguish psychiatric from social or behavioural needs" (Lee et al., 2019, p.88). To address this need, "HEARTSMAP" was developed, which unlike HEADS-ED, has two additional pieces that include sexual health and abuse, to assist with deciding what the most suitable adolescent health or social work requirements (Lee et al., 2019, p.88) is. HEARTSMAP created at British Columbia Children's Hospital, gives clinicians the ability to conduct an extensive psychosocial assessment with a tailored tool-developed report to provide youth and families with detailed recommendations as well as a "suggested level of urgency" (Virk, Stenstrom & Doan, 2018, p.504). Moreover, "HEARTSMAP is one of few known clinician-administered, digital and broad-based psychosocial assessment tools for youth, designed exclusively for the ED" (Virk et al., 2018, p.505).

Virk and researchers (2018) conducted a cross-sectional study that examined the inter-rater reliability of HEARTSMAP when utilized by clinicians of diverse backgrounds such as ED doctors, nurses, social workers, and psychiatric nurse liaisons. Virk and colleagues (2018) found "moderate to near excellent agreement, overall among clinicians for all 10 of the tool's psychosocial sections (κ=0.43 to 0.93) and domain scores (κ=0.75 to 0.90), with acceptable agreement across all tool-triggered service recommendations (κ=0.36 to 0.65)" (p.503). HEARTSMAP has demonstrated to the have the capacity to be a dependable tool in providing a comprehensive and standardized MH assessment that can be utilized by various clinicians

(physicians and allied health workers) that practice in ED settings, and it is being implemented in community EDs throughout British Columbia (Virk et al., 2018).

While these screening tools are a good start for establishing some clinical guidelines for assessing adolescents who present at emergency departments, it is also essential to ensure that adolescents are being released with a comprehensive psychiatric intervention plan.

Canadian Governments' Response to Address Adolescents Mental Health

In 2006, the Government of Canada published a report titled "*Out of the shadows at last: Transforming mental health, mental illness, and addiction services in Canada."* This report highlighted the profound concerns around the competence of the mental health system in relation to the MH treatment needs of children and adolescents (Keon & Kirby, 2006). The concerns highlighted in the report were "fragmentation, coupled with under-funding, a shortage of mental health professionals, and a failure to involve younger people, and their families in long-term treatment solutions have resulted in the delayed application of inadequate treatment interventions" (Keon & Kirby, 2006, p.155). Unfortunately, even though this report came out in 2006, it appears that the same ongoing issues that were highlighted in the report continue to negatively impact youth and the mental health system.

According to Gandhi and colleagues (2016), "[l]ess is known about the proportion of health care use attributable to mental health care use among children and youth in Canada" (p. 120). In their study in Ontario, the researchers led a population-based cross-sectional study on children and youth aged 10-24 to look at the trends in mental health visits to the ED, psychiatric hospitalizations and MH connected outpatient physician visits between the period of 2006 and 2011. Gandhi and colleagues (2016) discovered substantial growth in outpatient visit rates,

although increases were double for ED visits and triple for hospitalizations connected to outpatient visit rates.

The literature highlighted that most of the government initiatives and research appeared to be taking place in Ontario; perhaps this is due to the fact that Ontario holds the largest population in Canada. For example, in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) have initiated some substantial expenditure in a provincial action centred on enhancing MH services with a specific focus on "right care, right time, right place meaning having access to timely and appropriate services in the community when mental health and addictions issues arise" (Gandhi et al., 2016, p.120; Ontario Centre of Excellence for Child and Youth Mental Health, 2016; Ontario Ministry of Health and Long-Term Care, 2012).

Another initiative in Ontario named the *Be Safe* was created in partnership with youth with MH lived experience (Boak, Hamilton, Adlaf, Henderson & Mann, 2016; Huggett, Flynn, Jaouich, Taylor-Gates, & Davidson, 2017). In creating *Be Safe*, the London Service Collaborative joined with mindyourmind, a national youth mental health program (www.mindyourmind.ca) located in London, Ontario (Huggett et al., 2017). The *Be Safe* "is a mobile application (app) with a paper-based pocket guide companion designed to help youth manage mental health and addictions crises and identify appropriate supports based on their level of need" (Huggett et al., 2017, p.122).

In the development of this systems navigation tool, youth were integral to the process and provided input and ideas that resulted in an app that:

1. A customized safety plan, which youth are encouraged to complete when they are not in crisis and with the assistance of a trusted person in their support network (e.g., service

> provider, family member, friend, etc.). 2. A decision aid to support identification of appropriate community resources based on level of need at any given point in time. Youth provide responses in real time to a series of guided questions (e.g., about current emotions and level of safety); the output that is generated by the app provides relevant details for suggested services or supports, such as agency contact information, to help users access these resources.3. A comprehensive listing of mental health services and supports in the community.4. A personalized "Get Help" script, generated from data provided by users (e.g., name, specific concerns, medications, etc.) to facilitate their communication with professionals and other supports at times of crisis. 5. Information on how to wait safely for help, what youth can expect when they access resources, and youth rights as a client. (Huggett et al., 2017, p.124).

When factoring in the high costs of ED visits, Newton, Rosychuk, Niu, Radomski, and McGrath (2015), highlight that expensive ED care could be decreased by employing approaches that increase doctors' use of evidence-based treatment and caregiver access to coordinated community treatment. Unfortunately, the current adolescent mental health systems in Canada are frequently splintered among various organizations, ministries and service providers (Jabbour et al., 2016), which can create challenges for youth and families navigating these systems. Connecting youth to outpatient MH services has additional problems in that contact among these organizations is frequently insufficient, which in turn generates gaps in service (Jabbour et al., 2016).

Longer Wait Times and Boarding

The United States experiences similar issues like Canada in relation to adolescents seeking psychiatric care due to limited numbers of MH staff and inpatient beds, which in turn

has led to long waits and, frequently results in adolescents leaving the ED without being adequately assessed (Asarnow et al., 2017; Zeller, Calma & Stone, 2014). Consequently, this puts the adolescent at risk for not being formally evaluated and treated when they are potentially in a vulnerable state and needing psychiatric care. In comparison to a youth, who presents with general medical illness to the ED, the youth that presents with an MH issue will typically wait longer (Asarnow et al., 2017; Zeller et al., 2014). In a recent study in the United States, conducted by Hoffmann and colleagues (2019), the researchers analyzed the length of stay (LOS) in the ED and found that "[m]ental health visits were more likely than non−mental health visits to have a length of stay between 24 and 47 hours (11.1% vs 0.2%) and a length of stay ≥48 hours (2.6% vs 0.1%)"(p.388). The lack of specifically trained MH and psychiatric staff and the shortage of psychiatric beds all increase greater waiting times and LOS (Asarnow et al., 2017; Zeller et al., 2014). Regrettably, in this situation, the LOS is not equated with more time spend on interventions and treatment while in the ED, but instead merely waiting to be seen by the appropriate MH healthcare team.

Extended periods of waiting in the ED have clinical and systematic consequences (Ginnis et al., 2015). One of the issues that came in the literature review was "boarding," which is characterized as prolonged waits in the ED or a different non-psychiatric location while waiting for a psychiatric placement, and suicidal youth are particularly at risk for boarding (Ginnis et al., 2015; Mansbach, Wharff, Austin, Ginnis & Woods, 2003; Wharff, Ginnis, Ross & Blood, 2011). Boarding among youth needing psychiatric care remains a continuing challenge (Wharff et al., 2011; Sheridan et al., 2017). In their retrospective cohort study, Wharff and researchers (2011) discovered that over a third (34.1%) of patients who were assessed and required psychiatric hospitalization, resulted in boarding in the ED. In another study on pediatric boarding,

researchers Claudius, Donofrio, Lam, and Santillanes (2014) found that of the youth admitted to a general medical ward with a psychiatric condition, “94 percent were for boarding, with only 6 percent receiving any type of counseling” (Sheridan et al., 2017, p.177).

Prevention and Early Detection

Adolescence is a period in an individual’s life where there is significant developmental growth that takes place, their bodies and minds are in continuous flux, and this sometimes can present challenges around mental health assessment. In other words, mental health professionals must determine whether presenting behaviour is typical or if it is indicative of an underlying mental health concern. Typically, psychiatric disorders start between adolescence and early adulthood, which emphasizes the necessity for access to early intervention at the beginning of the mental health concern (Gandhi et al., 2016; Kessler et al., 2005). According to the Government of Canada (2006), 70% of MH challenges initiate during childhood or adolescence. Early MH detection and treatment increase the everyday functioning in developing adolescents, and proper screening in the ED can save lives (Esposito, 2019).

Gill and colleagues (2017) conducted a study that looked at the first contact for MH concerns for youth, and they found that over half of the youth needing ED care had failed to seek outpatient MH treatment (Gill et al., 2017). In the overall population of Canada, 54 % of adults and 32 % of children and adolescents received a psychiatric diagnosis over a 16-year period, with the per-person rate for children and adolescents doubling over the interval (Cawthrope 2013).

Given these statistics, it would be advantageous to standardize mental health services by concentrating on early intervention (Cawthorpe, 2018). Furthermore, given the increase of youth

presenting at the ED in an MH crisis and the prevalence of return visits, Newton and colleagues (2009) propose that this is an opportunity for prevention by utilizing community-based services. The overcrowding and the high expenses associated with ED presentations could be decreased by increasing access to competent MH services that are connected to a system of care (Baren et al., 2008; Lynch, Bautista, Freer, Kalynych & Hendry, 2015). In addition, an ED that can enable early interventions and provide connections to community MH services may possibly decrease future crises and have a positive impact on short- and long-term behavioural outcomes (Cloutier et al., 2010: Roman et al., 2018).

Connecting Youth to Outpatient Mental Health Care

In the literature, there was the recognition that attending an ED when an adolescent is in a mental health crisis was not necessarily the best option. Roman and colleagues (2018) highlight that EDs are not an optimal space for individuals with complex psychiatric needs, given that it is an exceedingly stimulating setting that can further aggravate symptoms and lead to a more significant decline. Contrary to this opinion, researchers Chun, Duffy, and Linakis, (2013) argue that the ED is uniquely situated to identify various high-risk youth that would not be recognized in other environments, as several adolescents do not have a family physician and encounter obstacles when trying to access a family physician.

According to Roman and colleagues (2018), children and youth presenting with psychiatric concerns, similar to children and youth with multifaceted medical and physical needs, are regarded as a significantly vulnerable group that needs a diverse combination of service providers and resources. Given that the number of ED presentations by adolescents is increasing to a greater degree than outpatient presentations, it appears adolescents are gaining access to

mental health services in the ED instead of the outpatient services when psychiatric care is required (Gandhi et al., 2016). The literature highlighted several reasons for barriers and challenges to accessing outpatient MH care following an ED visit. Some of the most common obstacles were the lack of connecting youths to the appropriate mental health care in the community and the limited availability of outpatient mental health services for youth (Dolan & Fein, 2011; Gill et al., 2017; Leon et al., 2017; Sheridan et al., 2017).

According to Frosch, dosReis, and Maloney (2011), ED's are frequently viewed as the "front doors to care, that is, points of access to mental health care" and there appears to be a "disconnection of the emergency department from other services" (p. 648). This presents challenges for youth that require continuing psychiatric care once they have been discharged from the hospital. Lynch and colleagues (2015) suggest that it is critical that ED's be involved inside the greater child and youth mental health care system to decrease "service fragmentation" (p.477). Furthermore, establishing community contacts can further limit additional pressure and reduce the likelihood of the "deterioration of functioning" (Auerbach & Mason, 2010, p.316).

Lynch and colleagues (2015), propose that it is the shortage of accessible outpatient community MH services, in addition to families' difficulties with transportation to MH appointments, that could point families to the ED for psychiatric care. The ED may be the nearest health facility in their neighbourhood (Lynch et al., 2015). Furthermore, Doupnik, Esposito, and Lavelle (2018) suggest that both stigma and logistical difficulties can stop patients from accessing mental health care following a hospital visit.

Barriers and Stigma

In general, the stigma associated with mental illness can produce secrecy, shame, and lead to the inability to pursue psychiatric care (Esposito, 2019; Schnyder, Panczak, Groth & Schultze-Lutter, 2017). Hoyle and White (2003) highlighted the barriers that youth encounter when accessing effective psychiatric care in an ED setting as the following:

> (1) a lack of information relating to pediatric psychiatric illness, (2) limitations of the ED setting that influence timely and comprehensive evaluation, (3) need for education and training of ED staff regarding identification and management of pediatric psychiatric illness, and (4) a lack of access to and effectiveness of inpatient and outpatient mental health services (as cited in Dolan & Fein, 2011, p.1358)

In a study conducted by Owens and colleagues (2016), they found that youth who had attended the ED for self-harm had experienced stigma and judgment as they reported "unfair discrimination and of having been denied usual care, including pain relief, on account of having caused their own injuries" (p.288). While Owens and colleagues (2016) study did draw attention to the discrimination and stigma that occurs for youth that attends the ED for self-harm, there were positive reports from the participants towards their experience such as being shown "sensitivity and a genuine desire to understand the functions of self-harm" (p.288).

Frosch and colleagues (2011) point out that there may be stigma connected to accessing outpatient MH treatment, which in turn may be contributing to the higher numbers of youth and their families accessing psychiatric care from an ED when they are in an MH crisis.

Another identified issue why connecting youth to MH services following an ED visit is challenging is due to the fact that there is a deficiency in "public funding for mental health services [that] is often a cause of the limited availability and scope of mental health services" (Lynch et al., 2015, p.473). According to Lynch and colleagues (2015), the consequences of this result in limited accessibility of community MH services and may produce a "shift [of] the provision of care from the specialty mental health system into EDs in the physical health system" (Lynch et al., 2015, p.473). While Lynch and colleagues (2015) identified this as an issue in the United States, lack of funding and inadequate availability of MH services for youth is similarly a recognized concern in Canada (Keon & Kirby, 2006).

Doupnik and colleagues (2018), emphasize that following discharge, there should be an arrangement of follow-up from the hospital MH care team that can help the youth navigate through any identified barriers to accessing MH care in the community. This is a role that could be well-suited to a hospital social worker, given social workers' expertise in systems navigation and supporting patients around addressing any systematic barriers that impede their ability to access and receive mental health treatment. Doupnik and colleagues (2018), further suggested that this role should involve a nurse or community health worker and the expertise of a social worker.

Adolescents Perspectives on Accessing MH in the ED

There is limited research in the area of adults' experiences with seeking mental health care in an ED. Wise-Harris and colleagues (2016), confirm that this is an area that is infrequently examined. Qualitative research on adolescents' experiences and perceptions of accessing psychiatric care from a hospital ED was even more limited. The greatest amount of research in

this area has been conducted in outpatient MH care settings (Biering & Jensen, 2017). Presently, there is minimal research or understanding around youth's perception of what elements of mental health inpatient care are significant to them (Madan, Sharp, Newlin, Vanwoerden & Fowler, 2016). Currently, no valid measures exist to examine these adolescent-specific concepts in the context of patient satisfaction (Madan et al., 2016). Though, recently Biering and Jensen (2017) conducted a qualitative study in a psychiatric ward for adolescents that analyzed what ways youth identify values and quality of mental health care in a hospital setting. Biering and Jensen (2017) discovered in their study five elements that lead to patient approval: "secure place, tough love, peer solidarity, self-expression, and person not patient" (p.162).

Madan and colleagues (2016) conducted an exploratory study of adolescent psychiatric inpatients and their guardian's approval with treatment and compared their perceptions' association with treatment results. One hundred twenty-nine adolescents (n= 129; 62.6% participation rate) and 101 parents (49.0% participation rate) completed a measure of patient satisfaction, [Perceptions of Care] POC (Madan et al., 2016). The POC survey is a 20-item measure of satisfaction the inpatient care they received across four areas interpersonal aspects of care, continuity/coordination of care, communication/information received from treatment providers, and global evaluation of treatment (Madan et al., 2016). The youth and their parents separately completed the POC at discharge. Interestingly, Madan and colleagues (2016) discovered that most of the adolescents (83.7%) and parents (94.1%) provided general positive assessments of the treatment they were given. Although Madan and colleagues (2016) noted that one of the weaknesses in their research was a lack of sociodemographic representation and ethnic diversity as most of the participants were Caucasian (86.9%). It is imperative to gain an understanding of the population being served, to best develop programs and interventions that

reflect their specific needs, instead of the service provider making assumptions about their needs (Cloutier et al., 2010; Lyons, 2004). Despite this, there is still be a limited amount of research around adolescent needs and how they feel that their mental health needs could be better understood and met.

Engaging Youth and Getting their Perspective on Accessing MH Care

Current statistics in Ontario, show that 17% of students aged 12-18 report their mental health as being fair or poor, while 28% indicated that they wanted help for their MH concern, but they were unaware of how to find support or assistance (Boak, Hamilton, Adlaf, Henderson, & Mann, 2016; Huggett et al., 2017). These statistics have identified a gap in services for adolescents who need mental health services and given this insight; it could be one of the factors contributing to adolescents showing up in higher numbers in EDs seeking MH services.

Empowering youth with lived experience to be a part of initiatives to better improve services "requires meaningfully collaborating with them to plan, organize, deliver, and evaluate services, resources, and supports" (Huggett et al., 2017; Mental Health Commission of Canada [MHCC], 2012, p.122). Furthermore, taking part in the initiative can legitimize the youth's perspectives and knowledge and allow them to actively contribute to the development of MH resources and services (Huggett et al., 2017). This results in the enhancement and application of accessibility of MH care specifically for youth (Huggett et al., 2017; Ontario Centre of Excellence for Child and Youth Mental Health, 2016). Engaging youth to have a collaborative role and active partnership in the process of program development can provide the service providers with a clearer picture of the youth's strengths, needs, and abilities, in addition to different perspectives on how to deal with some of the presenting concerns (British Columbia Ministry of Children and Family Development [BC MCFD], 2013; Huggett et al., 2017; Ontario

Centre of Excellence for Child and Youth Mental Health, 2016). Hawke and colleagues (2019) point out that it is vital to be inclusive in this process; it is essential to include youth from diverse backgrounds, cultures, and identities.

Models and Theoretical Frameworks

In the literature review, there were some models and theoretical frameworks that were presented as appropriate approaches to the issues that this paper is examining. The models and theoretical frameworks included in the next section are family-centred approaches, family-based crisis intervention, multi-systemic therapy, and strengths-based approach. While the models and theoretical frameworks listed below are just a small number of theories and models that guide the practice of supporting youth, families and their mental health concerns. These particular models and theoretical frameworks provide a rich understanding of how to view the issue and proceed with providing effective MH care and supporting youth and their families when challenged with an MH crisis or concern.

Family-Centred Approach

Unlike adults, adolescents frequently rely on their parents or caregivers to connect with MH services and are typically involved first hand in the process of acquiring MH care (Leon et al., 2019; Logan & King, 2001). According to Leon and colleagues (2019), 56-62% of adolescence are escorted by a caregiver upon presentation to the ED (Cloutier et al., 2010; Grupp-Phelan et al., 2009), and centering all the attention on the adolescent fails to gain an understanding of the caregiver's perspective of the situation (Logan & King, 2001). It is estimated that 40 % of families with a youth that has a psychiatric illness report needing

assistance with managing their youth's care (Brown et al., 2014; Roman et al., 2018). Moreover, "[t]he role of caregivers has been largely neglected within this context" (Leon et al., 2019, p.15).

Cloutier and colleagues (2010), suggest that vigilant attention of parents and caregivers' insights concerning the precipitating events, their perceptions of the needs of their youth, and their hopes for treatment are just as significant as those of the youth. Facilitating a conversation with youth and their caregivers on what triggered the ED visit could also assist with establishing a starting point that leads to appropriate recommendations for future treatment (Newton et al., 2009). Unfortunately, research of MH emergencies in youth suggests that there are no regulated and consistent methods for gathering information from caregivers, despite the fact that caregiver viewpoint plays a key part in the clinician's assessment and may even impact the diagnoses and follow-up recommendations (Cloutier et al., 2010).

As a result of their research study, Cloutier, and colleagues (2010) recommend the caregiver and youth complete a brief assessment before the interview with the clinician, to gain appropriate data. Additionally, recognizing the caregivers' and youths' needs creates an essential basis for the interview with the caregivers and can identify the triggers for the youth's presentation to the ED (Cloutier et al., 2010). Leon and colleagues (2019) recommend that by involving "both caregiver and clinician perspectives as part of standard care can indicate areas of agreement and discrepancy and help the clinician to tailor services and recommendations to meet their patient needs" (p.80). Most importantly, the "[i]nvolvement of family members and friends who attend the ED with pediatric patients has been shown to increased adherence with follow-up care" (Baren et al., 2008; Newton et al., 2009, p.452).

While involving caregivers and family in the process is important, it is imperative to talk to the youth in privacy, as they may not feel comfortable disclosing how they are actually feeling

in the presence of their caregivers (Esposito, 2019). Information could be suppressed, and this could make it difficult to get an idea of those who are at high risk (Esposito, 2019).

Family-Based Crisis Intervention

Family-based crisis interventions (FBCI) include CBT, brief family systems therapy and a blend of therapeutic strategies to support the youth and caregiver with a reframing of the crisis, recognizing how to create and sustain safety, increase communication and respond to beliefs about seeking psychiatric care (Havens & Marr, 2014; Rotheram-Borus et al., 2000; Wharff et al., 2012). FBCI incorporates the joint crisis narrative where the clinician utilizes the chance to "help the caregivers and adolescent understand each other's perspective, thereby creating a single, unified crisis narrative that incorporates aspects of their previously disparate accounts of what transpired" (Ginnis et al., 2015, p.174). The joint crisis narrative is the central component of FBCI and distinguishes this treatment from typical psychiatric care given in the ED (Ginnis et al., 2015). The joint crisis narrative helps the youth and their families come to "a mutual understanding" around what triggered the MH crisis and what they can do together to assist in evading a future MH crisis (Ginnis et al., 2015, p.174). FBCI intervention aligns with the values and practices of the social work perspective by recognizing the youths' and families' intrinsic strengths while connecting them to the necessary supports (Ginnis et al., 2015).

FBCI is centered on the belief that inpatient hospitalization is not always the best direction for mental health treatment for suicidal youth (Wharff et al. 2012). Interventions incorporating the family members such as the FBCI empowers families and adolescents with knowledge and education (Ginnis et al., 2015). Although the adolescent is demonstrating suicidal behaviour, there are strategies and tools that can help the youth to lessen or cope better with their psychological discomfort (Ginnis et al., 2015). Interventions such as FBCI that involve the

family perspective and supporting the family will be more time consuming (Ginnis et al., 2015). However, when FBCI is utilized in the ED, patients can have symptoms alleviated and be released home to circumvent a lengthy stay in the ED (Ginnis et al., 2015). Moreover, FBCI engenders hope for families who come to the ED in an MH crisis and the joint crisis narrative "allows the family and adolescent to develop empathy and mutual understanding that promotes reduced symptoms and improved family functioning" (Ginnis et al., 2015, p.177).

Following FBCI intervention, youth are only released from the ED when there is an agreement among the patient, family, psychiatrist and social worker that the patient is going home with a reduction in acute suicidal symptoms and a thorough safety plan in place (Wharff et al. 2012).

Multi-Systemic Therapy

Other alternative approaches have demonstrated in the literature to be effective, such as multi-systemic therapy (MST) (Havens & Marr, 2014). MST incorporates "family, behavioral, and psychosocial interventions to assist families in identifying and using available resources and family strengths to enact change" (Havens & Marr, 2014, p.194). A study conducted on youth randomly allocated to MST or inpatient hospitalization demonstrated much lower rates of self-reported attempted suicide at 1-year follow-up for the MST group in comparison to the sample of youth that had been admitted to inpatient care at the hospital (Ginnis et al., 2015; Henggeler et al. 1999). Moreover, the MST approach stopped inpatient hospital admissions for 57% of patients enlisted in a randomized controlled study of MST versus inpatient hospital admissions after a mental health crisis (Schoenwald, Ward, Henggeler & Rowland, 2000) and decreased suicide attempts for youth who were suicidal or self-harming and had been referred for hospitalization (Havens & Marr, 2014; Huey et al. 2004). According to Frosch and colleagues (2011), systems-

based approaches have concentrated on access to and sustained use of community MH services, as well as the application of portable crisis services to avert youth from going to the ED for mental health care.

Strengths-Based Approach

The strengths-based approach, which is inherent to social work practice explores the "strengths, alliance with the patient and the patient's self-confidence are enhanced, both of which are essential in working together toward solving the problems that have led to a psychiatric crisis" (Sams, Garrison & Bartlett, 2016, p.110). A strengths-based approach to assessment is imperative in a psychiatric setting in hospital, as this framework can "bring alliance and confidence within the family to persevere through the crisis after hospitalization" [and] "allows for increased focus on exploring patient's goals, strengths, relationships, skills, and family communication" (Sams et al., 2016, p110). Furthermore, utilizing the strengths-based approach when working with adolescents is essential, particularly for adolescents who present with depression and suicidal thoughts as there is often a sense of hopelessness and a frame of mind that life will not change.

Sams and colleagues (2016) conducted a study on strengths-based interventions for children and adolescents in an inpatient psychiatry ward, and the feedback that patients and families provided was that the strengths-based interventions such as learning coping skills and gaining a better understanding of family communication presented in the ED during admission was beneficial and these skills were utilized post-admission to hospital. In addition, Sams and colleagues (2016) also found positive outcomes on their evaluation of the program, which included strengths-based exercise in narrative therapy. The narrative therapy exercise consists of the clinician meeting with the patient to collect information and then to craft a positive,

strengths-based story of the patient (Sams et al., 2016). Following an evaluation with the patient's primary team, the patient is given the opportunity to hear the story and provide feedback and make any amendments, which are "to be made in the context of therapeutic reflection and processing" and then the patient is encouraged to read the story in a family session (Sams et al., 2016, p.115). This strengths-based narrative therapy exercise was found to be a "powerful experience of processing the reactions, emotions, and perspectives of the others in the room" (Sams et al., 2016, p.115).

Gaps in the Literature

North American literature that examines the attitudes of youth hospitalized for psychiatric care is vastly limited (Gros, Parr, Wright, Montreuil and Frechette, 2017). There is minimal research examining service user's satisfaction with adolescent psychiatric care given in emergency wards (Cappelli et al., 2019) as several of the research studies in the literature focused on adult mental health satisfaction and their understanding of psychiatric care (Madan et al., 2016). In general, studies around adolescents' perceptions of their MH issues are absent (Cloutier et al., 2010), as this was identified consistently as a gap throughout the literature. Greater research is required to gain a clearer understanding of adolescents' experiences and perspectives when they seek mental health, to better equip and prepare ED hospital staff when adolescents present for psychiatric health care.

Another gap in the literature was the lack of use of social work researchers, and their perspectives as most of the research examined for this paper came from a medical perspective and from health care providers such as psychiatrists, physicians, and nurses. The social worker's role and involvement with the adolescents as they sought mental health care from a hospital setting was very limited in the research. Future research studies that include social work

researchers and perspectives are warranted. Social worker researchers would provide a vastly different lens and approach to research than the medical model perspective that is frequently taken by medical professionals.

Implications

Social Workers Role

Creating multidisciplinary teams within the ED to service children and adolescents with psychiatric needs generates a space for sooner identification, symptom awareness, and suitable treatments while managing proper interventions and care transitions (Baren et al., 2008; Roman et al., 2018). Adequate treatment of an MH concern or crises in the ED requires an interdisciplinary team that can provide competent and evidence-based treatment to adolescents who present with multifaced MH concerns (Doupnik et al., 2018). Dolan and Fein, (2011) highlight that by establishing "a skilled, culturally sensitive, multidisciplinary approach, EDs can safely and effectively manage child and adolescent patients" (p.1363). Morevoer, Larson (2008) suggests that mental health is socially constructed and urges that social workers take a more active role in understanding other cultures and worldviews because the Western medical approaches fail to understand or accommodate cultural and gender variances.

Hospital social workers are going to be more invested in understanding the social and environmental features connected to mental health than their medical colleagues, such as physicians and nurses, although this presents a challenge as foundations of care generally derive from the medical model (Larson 2008). Arguably, social workers are adequately skilled and encompass the required competencies to support and work with this population. In addition, their interventions also provide a more holistic approach to mental health treatment.

While there was recognition in the literature around the value and importance of the involvement of multi-disciplinary teams in hospitals there appeared to be a lack of social workers' voices or role involved in the multidisciplinary team that could screen, assess and provides intervention to the youth that presents at the emergency department in hospitals.

For example, Sam and colleagues (2016) conducted a study on a multidisciplinary team that included psychiatrists, psychologists, nurses, and social workers that utilized a strengths-based framework in an acute inpatient unit. Sam and colleagues (2016) stated that "[in] a collaborative effort, between nursing, psychology, and psychiatry, CBT-based psychoeducational and skills-based worksheets were developed" (p. 111), the social worker's role was not identified as being part of the collaboration. Unfortunately, according to Auerbach and Mason (2010), the social worker's role and involvement in the ED are not always well understood by the medical health staff. This is surprising given that it is approximated that social workers are the nation's biggest providers of mental health services, exceeding psychiatric nurses, psychologists, and psychiatrists (Forenza & Eckert, 2018; National Association of Social Workers, 2016).

Despite this, there were some examples of social workers roles in treating youth in hospital settings, such as the care model program at Oregon Health & Science University Hospital, which consists of an LCSW (licensed clinical social worker) who provides clinical counselling, care management at admission, and follow-through post-discharge while working with community providers to establish a plan of further treatment (Sheridan et al., 2017). In Ontario, at McMaster Children's Hospital, some of the youth patients who get a referral for a further psychiatric risk assessment may include a one-on-one assessment with a psychiatrist or a clinical mental health professional such as a social worker (Rosic et al., 2019). In addition to this, Eposito (2019) highlighted the importance of the social work role in the ED by acknowledging

that they can conduct an ED assessment and start teaching the youth about MH strategies for coping with mental health concerns related to panic, anxiety and relationship stressors.

Unfortunately, in the literature, there appeared to be a lack of representation of social workers involved in supporting adolescents that presented to the ED in a mental health crisis. Often the hospital staff that assists adolescents seeking psychiatric care are comprised of nurses and doctors, and while they have an important role to play in the process, social workers have an integral and valuable role in this process and should also be included in a greater capacity.

Newton and colleagues (2009) highlight that a greater comprehensive examination of a multidisciplinary team approach to emergency department MH services involving "dependent, interdependent and independent health care role functions, as well as the role of patients and families, is needed" (p.452).

There was a model that explicitly outlined the social work role in an ED setting and dealing with psychiatric adolescent patients. The model was "the child guidance model (Mahajan et al. 2007), a team comprising a psychiatric social worker and a child psychiatrist evaluates all children and adolescents presenting with psychiatric complaints" (Havens & Marr, 2014, p.196). The psychiatric social worker is accessible 24 hours a day in the ED and is equipped to deliver psychiatric assessment and complete a discharge plan (Havens & Marr, 2014).

Additionally, Wharff and colleagues (2012) describe the active role that the clinical social worker in their research study on FBCI and suicidal youth in the ED led. The social worker utilized a narrative approach in facilitating a separate meeting with the family and youth to evaluate the course of events and to gain a picture of the various understandings of what lead to the suicidal presentation (Wharff et al. 2012).

Furthermore, Sheridan and colleagues (2017) found in their study where the LCSW had a prominent role in the model they were researching, that there were decreased numbers in the length of stay and a reduction in admissions to inpatient psychiatry. Sheridan and colleagues (2017) highlighted that "[h]aving a dedicated LCSW who can initiate psychotherapy and care coordination during admission, as well as follow up after discharge home, supports the identified intervention" (p.180).

The literature review revealed that there is a very sparse amount of qualitative research conducted on youth and their experiences and perspectives of seeking MH care from an ED. This is surprising given the growing number of adolescents that have been presenting at emergency departments for mental health care as consistently noted throughout the literature. As such, it is imperative to include youth voices with lived experiences in this research.

Hospital emergency departments need to be better prepared to deal with adolescents in a mental health crisis, and when the youth leaves the hospital, a more comprehensive discharge plan that refers them to the appropriate services is also necessary. Currently, youth and their families have to navigate a fragmented system following a visit to the ED, which often does not lead them to access or receive appropriate and effective mental health treatment care. Greater communication and partnerships between the ED health care teams and the outpatient services in the community necessitates greater attention in order to provide a more congruent system of mental health care to adolescents.

Further research in this area is necessary to better inform policies and practices that directly impact this population. In addition to this, the research findings could provide additional education for hospital social workers that want to specialize in this area of practice.

Conclusion

It is well documented in the literature that there is an increasing number of adolescents that are presenting in EDs seeking help for a mental health concern or crisis. While there are some effective screening tools being utilized in Canada and the USA, such as HEADS-ED, HEARTSMAP, EDSTARS, and ASQ. There, however, does not appear to be any clear path or systematic process in place in North America for adolescents and their families when they do seek help from an ED, which can make his often confusing and complicated journey of treating mental illness even more challenging and overwhelming.

Overall, the literature did provide some examples of how social workers are involved in the interventions and supporting youth in an ED in a hospital setting, although their presence in the literature was not as overt as the other hospital team members such as nurses, doctors, and psychiatrists. Hospital social workers' expertise in systems navigation, family systems, crisis intervention, and their skills in working with adolescents and supporting their mental health needs should encourage them to be more actively involved in the process of supporting adolescents that present at the ED in a mental health crisis.

While adolescences have had greater participation in their healthcare than previously, it is vital that clinicians and service providers also increase their understanding of adolescents' needs and satisfaction around treatment (Madan et al., 2016). The choice to admit or release a youth after a psychiatric crisis and the recommendations linked to this choice are significantly important (Cappelli 2019), and it is imperative that the care they receive when they attend the emergency department meets their specific psychiatric needs. While there are awareness and acknowledgment in the literature of this need, further research is warranted into the ways in

which the mental health needs of adolescents can be understood and met as this is a vulnerable population that could be better served.

References

Anderson, K. K., Fuhrer, R., Wynant, W., Abrahamowicz, M., Buckeridge, D. L., & Malla, A. (2013). Patterns of health services use prior to a first diagnosis of psychosis: the importance of primary care. *Social Psychiatry and Psychiatric Epidemiology*, (9), 1389. https://doi-org.proxy.ufv.ca:2443/10.1007/s00127-013-0665-3

Asarnow, J. R., Babeva, K., & Horstmann, E. (2017). The Emergency Department: Challenges and Opportunities for Suicide Prevention. *Child and Adolescent Psychiatric Clinics of North America*, *26*(4), 771–783. doi:10.1016/j.chc.2017.05.002

Auerbach, C., & Mason, S. E. (2010). The value of the presence of social work in emergency departments. *Social Work in Health Care*, *49*(4), 314–326. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=swh&AN=79803&site=eds-live

Babeva, K., Hughes, J. L., & Asarnow, J. (2016). Emergency department screening for suicide and mental health risk. *Current Psychiatry Reports*, (11), 1. Retrieved from: https://doi-org.proxy.ufv.ca:2443/10.1007/s11920-016-0738-6

Baren J, M., Mace S, E., Hendry P, L., Dietrich A.M., Grupp-Phelan J., & Mullin J. (2008). Children's mental health emergencies-part 1: challenges in care: definition of the problem, barriers to care, screening, advocacy, and resources. *Pediatric Emergency Care*, *24*(6), 399–408. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=ccm&AN=105812311&site=eds-live

Barwick M., Boydell K, M., Horning J., Stasiulis E., & Gladstone B. (2015). *Evaluation of Ontario's emergency department clinical pathway for children and youth with mental health conditions.* Toronto, ON: The Hospital for Sick Children.

Bate, P., & Robert, G. (2007). *Bringing user experience to healthcare improvement*: *The concepts, methods, and practices of experience-based design.* Radcliffe Publishing: Abingdon, UK.

Biering, P., & Jensen, V. H. (2017). The concept of patient satisfaction in adolescent psychiatric care: A qualitative study. *Journal of Child and Adolescent Psychiatric Nursing*, (4), 162. https://doi-org.proxy.ufv.ca:2443/10.1111/jcap.12189

Boak, A., Hamilton, H. A., Adlaf, E. M., Henderson, J. L., & Mann, R. E. (2016). *The mental health and wellbeing of Ontario students, 1991–2015: Detailed OSDUHS findings* (CAMH Research Document Series No. 43). Toronto, ON: Centre for Addiction and Mental Health. Retrieved from http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2015%20OSDUHS%20Documents/2015OSDUHS_Detailed%20MentalHealthReport.pdf

Brown, N. M., Green, J. C., Desai, M. M., Weitzman, C. C., & Rosenthal, M. S. (2014). Need and unmet need for care coordination among children with mental health conditions. *Pediatrics*, (3), 530. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&db=edsggo&AN=edsgcl.370817261&site=eds-live

British Columbia Ministry of Children and Family Development. (2013). *Youth engagement toolkit resource guide*. Retrieved from http://www.mcf.gov.bc.ca/youth_engagement/pdf/yet_resource_guide.pdf

Bhui, K., Ullrich, S. & Coid, J.W. (2014). Which pathways to psychiatric care lead to earlier treatment and a shorter duration of first-episode psychosis? *BMC Psychiatry* 14, 72 doi:10.1186/1471-244X-14-72

Calder, L. A., Forster, A. J., Stiell, I. G., Carr, L. K., Perry, J. J., Vaillancourt, C., & Brehaut, J. (2012). Mapping Out the Emergency Department Disposition Decision for High-Acuity Patients. *Annals of Emergency Medicine*, *60*(5), 567–576. https://doi-org.proxy.ufv.ca:2443/10.1016/j.annemergmed.2012.04.013

Canadian Institute for Health Information (CIHI). (2018). Care for children and youth with mental disorders, 2018 update. Retrieved from: https://www.cihi.ca/en/child-and-youth-mental-health-in-canada-infographic.

Cappelli, M., Gray, C., Zemek, R., Cloutier, P., Kennedy, A., Glennie, E., Lyons, J. S. (2012). The HEADS-ED: a rapid mental health screening tool for pediatric patients in the emergency department. *Pediatrics*, (2), 321. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgao&AN=edsgcl.303182329&site=eds-live

Cappelli, M., Zemek, R., Polihronis, C., Thibedeau, N. R., Kennedy, A., Gray, C., Jabbour, M., Reid, S., Cloutier, P. (2017). The HEADS-ED: Evaluating the clinical use of a brief, action-oriented, pediatric mental health screening tool. *Pediatric Emergency Care, 0(0), 1-7.* https://doi.org/10.1097/PEC.0000000000001180

Cappelli, M., Cloutier, P., Newton, A. S., Fitzpatrick, E., Ali, S., Dong, K. Gray, C., Kennedy, A., Lyons, J. S., Polihronis, C. Rosychuk, R. J. (2019). Evaluating mental health service use during and after emergency department visits in a multisite cohort of Canadian children and youth. *CJEM: Canadian Journal of Emergency Medicine*, *21*(1), 75. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=134327899&site=eds-live

Carlisle, C. E., Mamdani, M., Schachar, R., & To, T. (2012). Aftercare, emergency department visits, and readmission in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(3), 283–293. https://doi-org.proxy.ufv.ca:2443/10.1016/j.jaac.2011.12.003

Carubia, B., Becker, A., & Levine, B. H. (2016). Child Psychiatric Emergencies: Updates on Trends, Clinical Care, and Practice Challenges. *Current Psychiatry Reports*, *18*(4), 41. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=113474672&site=eds-live

Case, S. D., Case, B. G., Olfson, M., Linakis, J. G., & Laska, E. M. (2011). Length of Stay of Pediatric Mental Health Emergency Department Visits in the United States. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(11), 1110–1119. https://doi-org.proxy.ufv.ca:2443/10.1016/j.jaac.2011.08.011

Cawthorpe, D. (2013). A novel population-based health index for mental disorder. *The Permanente Journal, 17*(2), 50–54. Retrieved from https://doi-org.proxy.ufv.ca:2443/10.7812/TPP/12-081

Cawthorpe, D. (2018). Improving youth mental health supports in Canada. *CMAJ: Canadian Medical Association Journal*, *190*(40), E1181. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=132201517&site=eds-live

Chenail, R. J. (2011). How to conduct clinical qualitative research on the patient's experience. *The Qualitative Report, 16(4), 1173-1190*. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search-proquest-com.proxy.ufv.ca:2443/docview/877885986?accountid=10969

Children's Hospital of Eastern Ontario (n.d.). Advocacy of Mental Health. Ottawa, Canada: http://www.cheo.on.ca/en/mentalhealth. Accessed on March 1, 2019.

Chun, T. H., Duffy, S. J., & Linakis, J. G. (2013). Emergency Department Screening for Adolescent Mental Health Disorders: The Who, What, When, Where, Why, and How It Could and Should Be Done. *Clinical Pediatric Emergency Medicine*, *14*(1), 3–11. https://doi-org.proxy.ufv.ca:2443/10.1016/j.cpem.2013.01.003

Chun T. H., Katz, E.R., Duffy, S.J., & Gerson R.S. (2015). Challenges of managing pediatric mental health crises in the emergency department. *Child Adolescent Psychiatric Clinic North America* 24 (1):21-40. doi:10.1016/j.chc.2014.09.003.

Claudius, I., Donofrio, J. J., Lam, C. N., & Santillanes, G. (2014). Impact of boarding pediatric psychiatric patients on a medical ward. *Hospital Pediatrics*, *4*(3), 125–132. https://doi-org.proxy.ufv.ca:2443/10.1542/hpeds.2013-0079

ClinicalTrials.gov. (n.d.). Improving transitions in care for children and youth with mental health concerns. Available at: https:// clinicaltrials.gov/ct2/show/NCT02590302. Accessed March 1, 2019.

Cloutier P, Kennedy A, Maysenhoelder H, Glennie EJ, Cappelli M, & Gray C. (2010). Pediatric mental health concerns in the emergency department: caregiver and youth perceptions and expectations. *Pediatric Emergency Care*, *26*(2), 99–106. https://doi-org.proxy.ufv.ca:2443/10.1097/PEC.0b013e3181cdcae1

Cloutier, P., Thibedeau, N., Barrowman, N., Gray, C., Kennedy, A., Leon, S. L., Polihronis, C., & Cappelli, M. (2017). Predictors of Repeated Visits to a Pediatric Emergency Department Crisis Intervention Program. *CJEM: Canadian Journal of Emergency Medicine*, *19*(2), 122. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=122203246&site=eds-live

Cooper J., & Masi R., (2007). Child and youth emergency mental health care: A national problem. New York (NY): *National Center for Children in Poverty*, Columbia University Academic Commons.

Dolan, M. A., & Mace S. E., (2006). American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians and Pediatric Emergency Medicine Committee. *Pediatric mental health emergencies in the emergency medical services system. Pediatrics* 118:1764-7.

Dolan M. A., & Fein J.A., (2011). The Committee on Pediatric Emergency Medicine. Pediatric and adolescent mental health emergencies in the emergency medical services system. *Journal of Pediatrics*. 2011;127: e1356–e1366

Doupnik, S. K., Esposito, J., & Lavelle, J. (2018). Beyond mental health crisis stabilization in emergency departments and acute care hospitals. *Pediatrics*, *141*(5), 1–3. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=psyh&AN=2018-54537-019&site=eds-live

Esposito, J. (2019). Suicide Screening and Behavioral Health Assessment in the Emergency Department. *Clinical Pediatric Emergency Medicine*. https://doi-org.proxy.ufv.ca:2443/10.1016/j.cpem.2019.02.002

Frosch, E., dosReis, S., & Maloney, K. (2011). Connections to outpatient mental health care of youths with repeat emergency department visits for psychiatric crises. *Psychiatric Services*, *62*(6), 646–649. https://doi-org.proxy.ufv.ca:2443/10.1176/appi.ps.62.6.646

Forenza, B., & Eckert, C. (2018). Social Worker Identity: A Profession in Context. *Social Work*, *63*(1), 17–26. https://doi-org.proxy.ufv.ca:2443/10.1093/SW/SWX052

Gandhi, S., Chiu, M., Lam, K., Cairney, J. C., Guttmann, A., & Kurdyak, P. (2016). Mental Health Service Use Among Children and Youth in Ontario: Population-Based Trends Over Time. *Canadian Journal of Psychiatry*, *61*(2), 119–124. https://doi-org.proxy.ufv.ca:2443/10.1177/0706743715621254

Gardner, W., Pajer, K., Cloutier, P., Currie, L., Colman, I., Zemek, R., Hather, S., Lima, I., & Cappelli, M. (2019). Health outcomes associated with emergency department visits by adolescents for self-harm: a propensity-matched cohort study. *CMAJ: Canadian Medical Association Journal*, (44), E1207. Retrieved from https://search-ebscohost-

com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edsgsc&AN=edsgcl.604791534&site=eds-live

Gill, P. J., Saunders, N., Gandhi, S., Gonzalez, A., Kurdyak, P., Vigod, S., & Guttmann, A. (2017). New research: Emergency Department as a First Contact for Mental Health Problems in Children and Youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*, 475–482.e4. https://doi-org.proxy.ufv.ca:2443/10.1016/j.jaac.2017.03.012

Ginnis, K., White, E., Ross, A., & Wharff, E. (2015). Family-Based Crisis Intervention in the Emergency Department: A New Model of Care. *Journal of Child & Family Studies*, *24*(1), 172–179. https://doi-org.proxy.ufv.ca:2443/10.1007/s10826-013-9823-1

Government of Canada. (2006). The human face of mental health and mental illness in Canada. Retrieved from https:// www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf

Gros, C. P., Parr, C., Wright, D. K., Montreuil, M., & Frechette, J. (2017). Hospital rules and regulations: The perspectives of youth receiving psychiatric care. *Journal of Child and Adolescent Psychiatric Nursing*, *30*(1), 18–24. https://doi-org.proxy.ufv.ca:2443/10.1111/jcap.12166

Grupp-Phelan, J., Delgado, S. V., & Kelleher, K. J. (2007). Failure of psychiatric referrals from the pediatric emergency department. *BMC Emergency Medicine*, *7*, 12–7. https://doi-org.proxy.ufv.ca:2443/10.1186/1471-227X-7-12

Grupp-Phelan J., Mahajan P., Foltin G, L., Jacobs, E., Tunik, M., Sonnett, M., Miller, S., Dayan, P., (2009). Referral and resource use patterns for psychiatric-related visits to pediatric

emergency departments. *Pediatric Emergency Care*, *25*(4), 217–220. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=ccm&AN=105509371&site=eds-live

Havens, J., & Marr, M., (2014). Models of Emergency Psychiatric Care for Children and Adolescents Moving From Triage to Meaningful Engagement in Mental Health Treatment. In Haddad, F., & Gerson, R. (Eds), *Helping Kids in Crisis: Managing Psychiatric Emergencies in Children and Adolescents* (Vol. First edition). Washington, DC: American Psychiatric Association Publishing. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=nlebk&AN=1610202&site=eds-liv

Hawke, L. D., Mehra, K., Settipani, C., Relihan, J., Darnay, K., Chaim, G., & Henderson, J. (2019). What makes mental health and substance use services youth-friendly? A scoping review of the literature. *BMC Health Services Research*, *19*(1), 257. https://doi-org.proxy.ufv.ca:2443/10.1186/s12913-019-4066-5

Henggeler, S. W., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edward, J., Zealberg, J, J., Hand, L, D., & Santos, A. B. (1999). Home-Based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(11), 1331–1339. https://doi-org.proxy.ufv.ca:2443/10.1097/00004583-199911000-00006

Heron, M. (2013). National Vital Statistics Reports Deaths: Leading Causes for 2010. *National Vital Statistics Reports*, *62*(6), 1. Retrieved from

https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=98135729&site=eds-liv

Hoffmann, J. A., Stack, A. M., Samnaliev, M., Monuteaux, M. C., & Lee, L. K. (2019). Trends in Visits and Costs for Mental Health Emergencies in a Pediatric Emergency Department, 2010–2016. *Academic Pediatrics*, *19*(4), 386–393. https://doi-org.proxy.ufv.ca:2443/10.1016/j.acap.2019.02.006

Holder, S. M., Rogers, K., Peterson, E., Shoenleben, R., & Blackhurst, D. (2017). The impact of mental health services in a pediatric emergency department. *The implications of having trained Psychiatric professionals. PEDIATRIC EMERGENCY CARE*, *33*(5), 311–314. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edswss&AN=000401250000001&site=eds-live

Horowitz, L. M., Bridge J.A., Teach, S.J., Ballad, E., Kilma, J., Rosenstien, D. L., Wharff, E.A., Ginnis, K., Cannon, E., Joshi, P., & Pao, M. (2012). Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. *Arch Pediatr Adolesc Med.* 166(12):1170–1176. doi:10.1001/archpediatrics.2012.1276

Huey, J. S. J., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunnignham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(2), 183–190. https://doi-org.proxy.ufv.ca:2443/10.1097/00004583-200402000-00014

Hughes, J. L., & Asarnow, J. R. (2013). Enhanced Mental Health Interventions in the Emergency Department: Suicide and Suicide Attempt Prevention. *Clinical Pediatric Emergency Medicine*, *14*(1), 28–34. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=ccm&AN=104266306&site=eds-live

Huggett, D., Flynn, A., Jaouich, A., Taylor-Gates, M., & Davidson, S. (2017). Engaging Youth in a Mental Health System Improvement Initiative in Ontario: Developing the Be Safe Resource. *Canadian Journal of Community Mental Health*, *36*, 121–131. https://doi-org.proxy.ufv.ca:2443/10.7870/cjcmh-2017-019

Hoyle, J.D., & White, L. J., (2003). Treatment of pediatric and adolescent mental health emergencies in the United States: current practices, models, barriers and potential solutions. *Prehospital Emergency Care,* 7:1, 66-73, DOI: 10.1080/10903120390937120

Iyer, S., Reeves, S., Varadarajan, K., & Alessandrini, E. (2011). The acute care model: A new framework for quality care in emergency medicine. *Clinical Pediatric Emergency Medicine*, 12(2), 91–101. doi:10.1016/j.cpem.2011.04.002

Jabbour, M., Reid, S., Polihronis, C., Cloutier, P., Gardner, W., Kennedy, A., Gray, C., Zemek, R., Pajer, K., Barrowman, N., & Cappelli, M. (2016). Improving mental health care transitions for children and youth: a protocol to implement and evaluate an emergency department clinical pathway. *Implementation Science, 11*, 1. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=116749808&site=eds-live

Kelleher, I., Connor D., Clarke M., Devlin N., Harley M., & Cannon, M. (2012). Prevalence of psychotic symptoms in childhood and adolescence: a systematic review and meta-

analysis of population-based studies. *Psychological Medicine*, *42*(9), 1857. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=79351932&site=eds-live*Psychol Med*.

Keon, W. J., & Kirby, M. J. L. (2006). *Out of the shadows at last: Transforming mental health, mental illness, and addiction services in Canada: final report of The Standing Senate Committee on Social Affairs, Science and Technology*. Standing Senate Committee on Social Affairs, Science and Technology. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=cat00744a&AN=ufv.466183&site=eds-live

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, (6), 593. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edsgao&AN=edsgcl.133770248&site=eds-live

Larson, G. (2008). Anti-oppressive Practice in Mental Health. *Journal of Progressive Human Services*, *19* (1), 39. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=33892502&site=eds-live

Lee, A., Deevska, M., Stillwell, K., Black, T., Meckler, G., Park, D., Eslami, A., & Doan, Q. (2019). A psychosocial assessment and management tool for children and youth in crisis. *CJEM: Canadian Journal of Emergency Medicine*, *21*(1), 87. Retrieved from

https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=134327901&site=eds-live

Leon, S. L., Cappelli, M., Ali, S., Craig, W., Curran, J., Gokiert, R., Klassen, T., Osmond, M., Scott, S., Newton, A. S. (2013). The current state of mental health services in Canada's pediatric emergency departments. *Paediatrics & Child Health (1205-7088), 18*(2), 81–85. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=85635384&site=eds-live

Leon, S. L., Cloutier, P., Polihronis, C., Zemek, R., Newton, A. S., Gray, C., & Cappelli, M. (2017). Child and Adolescent Mental Health Repeat Visits to the Emergency Department: A Systematic Review. *Hospital Pediatrics*, *7*(3), 177. https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=122052344&site=eds-live

Leon, S. L., Polihronis, C., Cloutier, P., Zemek, R., Newton, A. S., Gray, C., & Cappelli, M. (2019). Family Factors and Repeat Pediatric Emergency Department Visits for Mental Health: A Retrospective Cohort Study. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, *28*(1), 9–20. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=135786179&site=eds-live

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science & Practice, 8(3), 319-333.*

Lynch, S., Bautista, M., Freer, C., Kalynych, C., & Hendry, P. (2015). Child Mental Health Services in the Emergency Department Disparities in Access. *PEDIATRIC EMERGENCY CARE*, *31*(7), 473–478. https://doi-org.proxy.ufv.ca:2443/10.1097/PEC.0000000000000336

Lyons, J. (2004). Redressing the emperor; improving our children's public mental health system. (Book Review)(Brief Review). *SciTech Book News*, (4), 112. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edscpi&AN=edscpi.A128136648&site=eds-live

MacWilliams, K., Curran, J., Racek, J., Cloutier, P., & Cappelli, M. (2017). Barriers and Facilitators to Implementing the HEADS-ED: A Rapid Screening Tool for Pediatric Patients in Emergency Departments. *Pediatric Emergency Care*, *33*(12), 774. Retrieved from https://proxy.ufv.ca:2443/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=126685914&site=eds-live

Madan, A., Sharp, C., Newlin, E., Vanwoerden, S., & Fowler, J. C. (2016). Adolescents Are Less Satisfied with Inpatient Psychiatric Care than Their Parents: Does It Matter? *Journal for Healthcare Quality: Promoting Excellence in Healthcare*, *38*(4), e19–e24. https://doi-org.proxy.ufv.ca:2443/10.1111/jhq.12081

Mahajan, P., Alpern, E. R., Grupp-Phelan, J., Chamberlain, J., Dong, L., Holubkov, R., Jacobs, E., Stanley, R., Tunik, M., Sonnett, M., Miller, S., & Fotlin, G. L., (2009). Epidemiology of Psychiatric-Related Visits to Emergency Departments in a Multicenter Collaborative

Research Pediatric Network. *PEDIATRIC EMERGENCY CARE*, *25*(11), 715–720. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edswss&AN=000271988100001&site=eds-live

Mansbach, J. M., Wharff, E., Austin, S. B., Ginnis, K., & Woods, E. R. (2003). Which psychiatric patients board on the medical service? *Pediatrics*, *111*(6 Pt 1), e693–e698.

Mapelli, E., Black, T., & Doan, Q. (2015). Trends in Pediatric Emergency Department Utilization for Mental Health-Related Visits. *The Journal of Pediatrics*, *167*(4), 905–910. https://doi-org.proxy.ufv.ca:2443/10.1016/j.jpeds.2015.07.004

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* Retrieved from http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pd

Mental Health America. (2016). *Prevention and early intervention B4Stage4: The state of mental health in America 2016.* Retrieved from http://www.mentalhealthamerica.net/issues/state-mental-health-america

National Association of Social Workers. (2016). *Social work profession*. Retrieved from https://www.socialworkers .org/pressroom/features/general/profession.asp

National Instituite of Mental Health (n.d.). Ask Suicide-Screening Questions (ASQ) Toolkit Retrieved from https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml#emergency

Newton, A. S., Ali, S., Johnson, D. W., Haines, C., Rosychuk, R. J., Keaschuk, R. A., Jacobs, P., & Klassen, T. P. (2009). A 4-year review of pediatric mental health emergencies in Alberta. *CJEM: Canadian Journal of Emergency Medicine*, *11*(5), 447–454. https://doi-org.proxy.ufv.ca:2443/10.1017/S1481803500011647

Newton A.S., Ali S., Johnson D, W., Haines C., Rosychuk R, J., Keaschuk R, A., Jacobs, P., Cappelli, M., Klassen T, P. (2010). Who comes back? Characteristics and predictors of return to emergency department services for pediatric mental health care. *Academic Emergency Medicine*, *17*(2), 177–186. https://doi-org.proxy.ufv.ca:2443/10.1111/j.1553-2712.2009.00633.x

Newton, A. S., Rosychuk, R. J., Dong, K., Curran, J., Slomp, M., & McGrath, P. J. (2012). Emergency health care use and follow-up among sociodemographic groups of children who visit emergency departments for mental health crises. (Research)(Report). *CMAJ: Canadian Medical Association Journal*, (12), E665. https://doi-org.proxy.ufv.ca:2443/10.1503/cmaj.111697

Newton, A., Rosychuk, R., Niu, X., Radomski, A., & McGrath, P. (2015). Predicting time to emergency department return for anxiety disorders and acute stress reactions in children and adolescents: a cohort study. *Social Psychiatry & Psychiatric Epidemiology*, *50*(8), 1199–1206. https://doi-org.proxy.ufv.ca:2443/10.1007/s00127-015-1073-7

Ontario Centre of Excellence for Child and Youth Mental Health. (2016). *Walking the talk: A toolkit for engaging youth in mental health.* Retrieved from http://www.yetoolkit.ca

Ontario Ministry of Health and Long-Term Care (2012). *Ontario's Action Plan For Health Care.* Toronto (ON): Ontario Ministry of Health and Long-Term Care.

Ontario Ministry of Health and Long-Term Care. Open Minds, Healthy Minds (2011*). Ontario's Comprehensive Mental Health and Addictions Strategy.* Toronto (ON): Ontario Ministry of Health and Long-Term Care; 2011.

Owens, B. (2018). Telemedicine on the rise but lagging in Canada. *Canadian Medical Association Journal*, *190*(38), E1149–E1150. https://doi-org.proxy.ufv.ca:2443/10.1503/cmaj.109-5634

Owens, C., Hansford, L., Sharkey, S., & Ford, T. (2016). Needs and fears of young people presenting at accident and emergency department following an act of self-harm: Secondary analysis of qualitative data. *The British Journal of Psychiatry*, *208*(3), 286–291. https://doi-org.proxy.ufv.ca:2443/10.1192/bjp.bp.113.141242

Patten, S. B., Williams, J. V. A., Lavorato, D. H., Wang, J. L., McDonald, K., & Bulloch, A. G. M. (2015). Descriptive epidemiology of major depressive disorder in Canada in 2012. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, *60*(1), 23–30.

Plemmons, G., Hall, M., Doupnik, S., Gay, J., Brown, C., Browning, W., Casey, R., Freundlich, K., Johnson, D., Lind, C., Rehm, K., Thomas, S., & Williams, D. (2018). Hospitalization for Suicide Ideation or Attempt: 2008-2015. *Pediatrics*, *141*(6), 1–10. https://doi-org.proxy.ufv.ca:2443/10.1542/peds.2017-2426

Pottick, K., Hansell, S., Gutterman, E., & White, H. R. (1995). Factors associated with inpatient and outpatient treatment for children and adolescents with serious mental illness. *Journal of the American Academy of Child and Adolescent Psychiatry*, *4*, 425.

Provincial Council for Maternal and Child Health (2013). *Implementation toolkit: emergency department clinical pathway for children and youth with mental health conditions*. Provincial Council Maternity and Child Health. Retrieved from http://www.pcmch.on.ca/wp-content/uploads/2015/09/1.0-Toolkit-ED_Clinical_Pathway-Tookit_Oct_29_2014_Updated-PPO.pdf

Ridic, G., Gleason, S., & Ridic, O. (2012). Comparisons of health care systems in the United States, Germany, and Canada. *Materia socio-medica*, *24*(2), 112–120. https://doi.org/10.5455/msm.2012.24.112-120

Roman, S.B., Matthews-Wilson, A., Dickinson, P., Chenard, D., & Rogers, S. (2018). Current Pediatric Emergency Department Innovative Programs to Improve the Care of Psychiatric. *Patients Child and Adolescent Psychiatric Clinics of North America.* 27, 441–454 https://doi.org/10.1016/j.chc.2018.02.004 childpsych.theclinics.com 1056-4993/18

Rosic, T., Duncan, L., Li Wang, Eltorki, M., Boyle, M., Sassi, R., Bennett, K., Brotherston, L., Pires, P., Akintan, O., Lipman, E. (2019). Trends and Predictors of Repeat Mental Health Visits to a Pediatric Emergency Department in Hamilton, Ontario. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, *28*(2), 82–90. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=a9h&AN=138017194&site=eds-live

Rotheram-Borus, M. J., Piacentini, J., Cantwell, C., Belin, T. R., & Song, J. (2000). The 18-month impact of an emergency room intervention for adolescent female suicide

attempters. *Journal of Consulting and Clinical Psychology*, *68*(6), 1081–1093. https://doi-org.proxy.ufv.ca:2443/10.1037/0022-006X.68.6.1081

Royal College of Psychiatrists (2010). *Self-harm, suicide, and risk: Helping people who self-harm.* Final report of a working group (College Report CR158). Royal College of Psychiatrists.

Sams, D. P., Garrison, D. and Bartlett, J. (2016), Innovative Strength-Based Care in Child and Adolescent Inpatient Psychiatry. *J Child Adolesc Psychiatric Nursing, 29*(3), 110–117. https://doi-org.proxy.ufv.ca:2443/10.1111/jcap.12147

Saunders, N. R., Gill, P. J., Holder, L., Vigod, S., Kurdyak, P., Gandhi, S., & Guttmann, A. (2018). Use of the emergency department as a first point of contact for mental health care by immigrant youth in Canada: a population-based study. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne*, *190*(40), E1183–E1191. https://doi-org.proxy.ufv.ca:2443/10.1503/cmaj.180277

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *British Journal of Psychiatry*, *210*(4), 261. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=122949169&site=eds-live

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). Multisystemic therapy versus hospitalization for crisis stabilization of youth: Placement outcomes 4 months post referral. *Mental Health Services Research*, *2*(1), 3–12. https://doi-org.proxy.ufv.ca:2443/10.1023/A:1010187706952

Sheridan, J. S., Sheridan, D. C., Johnson, K. P., & Marshall, R. D. (2017). Can't We Just Get Some Help? Providing Innovative Care to Children in Acute Psychiatric Crisis. *Health & Social Work*, *42*(3), 177–181. https://doi-org.proxy.ufv.ca:2443/10.1093/hsw/hlx025

Sills, M., & Bland, S. (2002). Summary statistics for pediatric psychiatric visits to US emergency departments, 1993-1999. *PEDIATRICS*, *110*(4).

Sobolewski, B., Richey, L., Kowatch, R., & Grupp-Phelan, J. (2013). Mental Health Follow-Up among Adolescents with Suicidal Behaviors after Emergency Department Discharge. *Archives of Suicide Research*, *17*(4), 323. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edb&AN=91968065&site=eds-live

Soleimani, A., Rosychuk, R. J., & Newton, A. S. (2016). Predicting time to emergency department re-visits and inpatient hospitalization among adolescents who visited an emergency department for psychotic symptoms: a retrospective cohort study. *BMC Psychiatry*, *16*, 1–7. https://doi-org.proxy.ufv.ca:2443/10.1186/s12888-016-1106-0

Statistics Canada (2015). Leading causes of death, total population, by age group and sex [Table 102-0561] Canada, CANSIM (database). Retrieved from http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020561

To T., Guttmann A., & Dick P.T. (2001) Inpatient and Day Surgery Use by Children in Ontario. *ICES Atlas.* Toronto: *Institute for Clinical Evaluative Sciences.*

United Nations Department of Economic and Social Affairs (2013). Definition of Youth. Retrieved from https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

van der Post, L., Visch, I., Mulder, C., Schoevers, R., Dekker, J., & Beekman, A. (2012). Factors associated with higher risks of emergency compulsory admission for immigrants: a report from the ASAP study. *The International Journal of Social Psychiatry*, (4), 374. Retrieved from https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=edsggo&AN=edsgcl.338646165&site=eds-live

Virk, P., Stenstrom, R., & Doan, Q. (2018). Reliability testing of the HEARTSMAP psychosocial assessment tool for multidisciplinary use and in diverse emergency settings. *Paediatrics & Child Health (1205-7088)*, *23*(8), 503–508. https://doi-org.proxy.ufv.ca:2443/10.1093/pch/pxy017

Wharff, E. A., Ginnis, K. B., Ross, A. M., & Blood, E. A. (2011). Predictors of psychiatric boarding in the pediatric emergency department: implications for emergency care. *Pediatric Emergency Care*, *27*(6), 483–489. https://doi.org/10.1097/PEC.0b013e31821d8571

Wharff, E. A., Ginnis, K. M., & Ross, A. M. (2012). Family-based Crisis Intervention with Suicidal Adolescents in the Emergency Room: A Pilot Study. *Social Work*, *57*(2), 133–143. https://doi-org.proxy.ufv.ca:2443/sw/sws017

Wise-Harris, D., Pauly, D., Kahan, D., de Bibiana, J. T., Hwang, S. W., & Stergiopoulos, V. (2016). “Hospital was the Only Option”: Experiences of Frequent Emergency Department Users in Mental Health. *Administration and Policy in Mental Health and Mental Health Services Research 44*(3), 405–412. https://doi-org.proxy.ufv.ca:2443/10.1007/s10488-016-0728-3

Zeller, S., Calma, N., & Stone, A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *The western journal of emergency medicine*, *15*(1), 1–6. doi:10.5811/westjem.2013.6.17848