Children's Hospital of Philadelphia PolicyLab

Bridging the Gap: How Neighborhood Opportunity Shapes Follow-Up Care for Adolescents After a Mental Health Crisis

Behavioral Health

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When I meet adolescents in the emergency department (ED) who are struggling with depression or suicidal thoughts, one of my biggest worries after ensuring their immediate safety is what comes next. Will they be able to connect with a mental health provider? Will they see any medical provider soon to check in on how they are doing?

As a?pediatric emergency medicine physician and health services researcher, I spend much of my time thinking about these transitions—from the ED to outpatient care—and how our systems can better support young people in crisis.

Our latest study sheds light on one important factor shaping these transitions: the neighborhoods where teens live. Our findings paint a troubling picture—the very adolescents who face the greatest structural and socioeconomic challenges are the least likely to receive timely care after an ED visit with a positive screen for depression or suicidal ideation. In this post, I'll unpack our research and share recommendations to bridge these gaps in care.

Neighborhood Opportunity and Gaps in Follow-Up Care After ED Mental Health Visits

In our study,?we examined 3,362 adolescents aged 12 to 19?years who visited our ED between 2015 and 2023. All had screened positive for moderate/severe depression or current/past suicidal ideation (SI) and were discharged home from the ED. We examined whether neighborhood conditions, as measured by the Child Opportunity Index (COI), were associated with adolescents' likelihood of receiving timely primary care follow-up after an ED visit. The COI reflects a community's access to educational, health, environmental and social resources that promote healthy child development.

Access to timely mental health care remains a major challenge—average wait times to see a psychiatrist range from 43 to 50 days across U.S. cities, with even longer delays for Medicaid-insured youth. In contrast, pediatric primary care appointments are typically available within two weeks.

Because primary care offers accessible, longitudinal, and trusted relationships with adolescents and families, it is well positioned to serve as an early follow-up setting after ED-based identification of mental health needs. Despite this greater accessibility, only one in five (21%) adolescents in our study had a primary care visit within 30 days of their ED encounter, and just 11% were seen within seven days.

Notably, adolescents residing in higher-opportunity neighborhoods were significantly more likely to complete timely follow-up care compared with those living in lower-opportunity areas. Furthermore, self-identified Black adolescents were?30% less likely?than self-identified white adolescents to complete follow-up. Privately insured teens were?35% more likely?to follow up than those with public insurance.

Why These Findings Matter

This gap in follow-up care represents a?missed opportunity?to build trust and prevent repeat crises. For teens leaving the ED after a mental health emergency, timely follow-up can mean the difference between stabilization and another ED visit or hospitalization.

The?National Committee for Quality Assurance's (NCQA)?quality measures recommend follow-up within 7 and 30 days after an ED visit for mental health crisis to ensure continuity of care, with?state Medicaid agencies now reporting adherence starting in 2024. However,?fewer than two-thirds of children receive outpatient mental health follow-up within 30 days?of a mental health-related ED visit.

These data underscore why primary care can be an important partner in supporting timely follow-up for adolescents in crisis. Yet,?neighborhood factors—such as high poverty rates, limited transportation and fewer available providers—can make even primary care access difficult, especially in low-opportunity communities. Our study reinforces how these structural inequities impact adolescents' access to the care they need during this vulnerable transition period.

Where We Go From Here

As a physician, I see firsthand the barriers families face after leaving the ED: long waitlists for therapy, limited transportation and the sheer complexity of navigating fragmented systems. As a researcher, I see an urgent need for?interventions that bridge the ED and community settings, especially for youth in under-resourced neighborhoods.

Some promising strategies include:

- Embedding health navigators?or community health workers in EDs to coordinate follow-up care and connect families with outpatient providers.
- Leveraging telehealth?for post-discharge check-ins, particularly for families with transportation or access barriers.

However, health care payment policy plays an important role in implementing these promising strategies. For example, Medicaid policy can support the integration of community health workers in pediatric health care teams through a variety of mechanisms, and states are taking these up to varying degrees.

Building a Career Around Transitions of Care

This study is part of my broader effort to build a research portfolio centered on?improving effective and equitable transitions of care for high-risk youth. Adolescents experiencing mental health crises are often caught between systems—pediatric and adult, acute and outpatient, medical and behavioral health. By identifying where those transitions break down and designing evidence-based solutions, I hope to help health systems ensure that no young person falls through the cracks, especially in a time of need.

Our findings are a reminder that?the systems and supports that help adolescents move from crisis to continuity of care must be as robust and equitable as the emergency response itself. Investing in?data-driven accountability,?community-informed interventions, and?cross-sector partnerships?is essential to ensuring that all youth—regardless of where they live—can access the timely and continuous care they deserve.

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