Compounding this is a significant increase in suicidal chief complaints. A national perspective is vital because most emergency care for children in this country occurs in emergency departments (EDs) with small pediatric volumes and limited pediatric resources. Kalb et al’s work contributes additional information that adolescents and young adults, especially from multiracial populations or people of color, account for the most significant increase.

With suicide as the second leading cause of death for youth in the age group of 10 to 19 years, EDs are a critical link to screening, risk identification, and care. Lack of access to mental health services, and the role of EDs as de facto mental health crisis settings, has led to the 2.5-fold increase in suicidal chief complaints. Compounding this is a significant increase in the proportion of ED visits due to lower-acuity mental health complaints. Additionally, children who live in poverty are more likely to be seen in the ED, highlighting that EDs have become safety nets for access to children’s mental health care.5,6

The long lengths of stay in the ED and increased resource use for patients with mental health complaints add to the burden. This results in suboptimal care (eg, “boarding” in the ED) and patient and caregiver frustration and impacts an ED’s ability to care for and provide safety-net care for these and all other ED patients. The fast-paced, stimulating environment of the ED is not well suited to meet the needs of children and families with mental health problems. Some of the factors contributing to deficiencies in ED preparedness include a lack of staff trained in the identification and management of acute mental health problems; safe and quiet spaces within the ED; appropriate milieu for respectful, safe care; policies and procedures for ensuring best practices and consistent care; professional expertise to evaluate children’s mental health problems; and access to appropriate and timely follow-up care.

The reasons for the rocketing rates of psychiatric-related ED visits are unclear and include: a true increase in the incidence of mental health problems; increased awareness of such problems; decreased stigma of seeking mental health care; a lack of accessible children’s community mental health services; particularly acute care; long waits for appointments; a lack of insight by clinicians as to what is appropriate treatment of children’s mental health problems; not having enough trained child mental health providers; having few specialized services; and the impact of social media or other societal factors.

Several federal agencies, including the Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, and the...
Substance Abuse and Mental Health Services Administration, have funded initiatives to explore this problem. In November 2018, the Health Resources and Services Administration convened a multidisciplinary panel to review ED preparedness for managing children’s mental health problems, identify barriers to care for patients, and propose next steps for addressing this problem. Parallel efforts are occurring in Canada, which experienced similar trends in ED mental health. Further work is needed to better understand this problem, especially the needs of patients and their families as well as those of the ED and the clinicians who care for these patients.

Although this problem will undoubtedly require concerted, coordinated solutions, novel approaches are currently being investigated. Diversion from the ED by prehospital providers to appropriate community mental health resources has been trialed with promising results. Some sites have reported decreases in ED emergency mental health visits by instituting next-day or other timely mental health evaluations. Some EDs have embedded child psychiatry services and/or created dedicated evaluation and stabilization units adjacent to EDs. Mobile mental health crisis units are responding to primary care offices, schools, homes, and even EDs that have limited mental health resources. Telepsychiatry and/or formal agreements for sharing of community (hospital, municipality, county, or state) mental health resources in rural and low mental health–resource areas are evolving as ways to extend mental health care in settings with low access to expert care. Colocating mental health resources in schools, clinics, and primary care settings and with first responders may be another method for expanding the reach of mental health care.

Given the increasing prevalence of children’s mental health problems, a reassessment of medical education is also warranted. Most graduate and postgraduate medical training programs in pediatrics and emergency medicine do not address the diagnosis and management of mental health conditions as comprehensively as other areas of medicine. Lacking adequate training leaves physicians ill equipped to provide the best care to their patients or use their medical expertise to work in multidisciplinary teams to address the many-faceted issues involved in providing high-quality mental health care. Embracing mental health problems as a routine component of pediatric medicine may be part of the solution to addressing the crisis.

**ABBREVIATION**

ED: emergency department

**REFERENCES**


