Pediatric Mental Health Hospitalizations at US Acute Care Hospitals

To the Editor A recent study1 highlighted substantial increases in pediatric mental health hospitalizations in the US from 2009 to 2019. It is noteworthy that the time frame included in this analysis predated the COVID-19 pandemic, which led many to declare a national pediatric mental health crisis. Had this study1 included data from 2020 onward, the findings would likely have even more dire.2 Instead, the lack of pandemic-era data shed light on the perhaps lesser-acknowledged reality—one that is all too familiar to families, schools, and clinicians—that the youth mental health crisis is far from novel.

At best, changes in acute care utilization tell only half of the story. While the current crisis may manifest most conspicuously in hospitalization and suicide rates, effective and scalable solutions will inevitably occur far upstream. Currently, most mental health care for children and adolescents is provided by pediatricians, with little guidance from mental health care professionals. Research has unequivocally demonstrated that optimal treatment of chronic illnesses requires early detection, effective treatment, and ongoing monitoring. As this study1 noted, outpatient service delivery is not keeping pace with the increased prevalence of mental health problems among youths.

One evidence-based3 outpatient solution incorporates these vital components, leverages existing pediatric relationships, and has designated billing codes to guarantee financial sustainability.4 This strategy, the pediatric collaborative care model, uses task sharing, universal screening, measurement-based care, and other population health practices to support pediatricians. A trained care manager serves as the primary contact for patients, schools, and families by gathering clinical information and sometimes providing brief therapeutic interventions, all under the supervision of a psychiatric consultant who can contribute to the treatment of far more patients than they could ever see individually.

The pediatric collaborative care model is validated and immediately actionable. In December 2022, Congress acknowledged as much by passing the Consolidated Appropriations Act of 2023 (HR 2617),5 which included dedicated funding for pediatric collaborative care model implementation grants and technical assistance. The time is now for payers, states, nonprofit organizations, and other organizations to match this support and make the pediatric collaborative care model a reality for every pediatric practice nationwide. As this study1 has demonstrated, US children cannot wait another day.

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Conflict of Interest Disclosures: Dr Carlo reported receipt of personal fees from Otsuka Pharmaceuticals (consulting). No other disclosures were reported.

Additional Information: Meadows Mental Health Policy Institute is a nonprofit institution that, among other activities, assists medical practices throughout Texas with the implementation of the pediatric collaborative care model and measurement-based care.


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Attitudes about mental health diagnoses confound the diagnosis of bipolar disorder among children and adolescents. Using a national data set of inpatient hospitalizations in the US, population-adjusted rates of bipolar disorder increased from 1996 to 2004 and then decreased until 2010 for children and adolescents. This trend coincided with recommended conservative diagnostic practices due to concerns about overdiagnosis of bipolar disorder and potential adverse effects of medications used to treat bipolar disorder in youths. In contrast to this study,1 which reported a decrease in hospitalizations for attention-deficit/hyperactivity disorder (ADHD) from 2009 to 2019, the US National Health Interview Survey showed an increase in the prevalence of ADHD from 8.5% to 9.5% from 2009 to 2017 in children aged 3 to 17 years. Furthermore, it is important to consider the use of outpatient mental health services among adolescents, as it is relevant to the trend of hospitalizations. According to the National Survey on Drug Use and Health, among 19.7% of adolescent participants aged 12 to 17 years who received mental health care, the use of outpatient mental health services increased from 58.1% in 2005-2006 to 67.3% in 2017-2018.4

Additionally, COVID-19 caused unemployment, social distancing, and economic changes within households, leading to increased depression and anxiety, which affected younger individuals more than older people.5 Therefore, the results of this study1 might not be generalizable during or after the COVID-19 pandemic.

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Conflict of Interest Disclosures: None reported.


In Reply Inspired by our team’s experiences working with children and adolescents in inpatient settings, we used the Kids’ Inpatient Database to chronicle how hospitalizations for mental health diagnoses changed from 2009 to 2019 among youths aged 3 to 17 years.1 While the objective of our work was to highlight trends in hospitalizations at the national level, our findings also raised the following questions: why have the numbers of hospitalizations for mental health diagnoses increased and what needs to be done?

The urgency of upstream solutions that focus on preventing mental health conditions and improving outpatient care for youths cannot be understated. In their Letter, Dr. Carlo and colleagues propose the pediatric collaborative care model—an approach that integrates mental, behavioral, and physical health in the primary care setting—as a solution to the findings described in our study. While the pediatric collaborative care model has a strong evidence base, it requires mental health resources that are not available in all settings and is therefore not the only solution. A national survey of recent pediatric residency graduates found that less than 60% had an on-site mental or behavioral mental health care professional in their primary care continuity clinic; mental health care professionals are likely even less accessible outside of academic training environments.

As suggested by Drs. Chien and Hsu, our study1 needs to be interpreted within the broader context of population prevalence of mental health conditions, outpatient care utilization patterns, and socioeconomic factors. At the same time, our article revealed that children and adolescents are increasingly turning to acute care hospitals for mental health needs, where the availability of child psychiatry services varies. The high transfer rate observed in our study raises concerns about the frequency of boarding (the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made), a phenomenon experienced by almost all acute care hospitals.6 While we agree with Carlo and colleagues as well as Chien and Hsu that sustainable upstream solutions are essential, the current crisis at acute care hospitals also requires hospital-based resource investment and the attention of researchers, quality improvement experts, payers, and policy makers.

As high competence in behavioral and mental health assessment is reported by only 1 in 3 recent residency graduates, and less than 1 in 5 report high competence in behavioral and mental health treatment, building the competence of pediatricians and other clinicians who care for youths at these hospitals is one path forward. Inpatient-based integrated care models between psychiatry and pediatrics have the potential to increase competence among pediatricians and trainees while providing evidence-based mental health services. Additional approaches to improve care include coordination of pediatric mental health services across hospitals, state- and payer-supported telepsychiatry services, payment parity, and enhanced community services to improve transitions from the hospital to home.6 To address the national emergency in child and adolescent mental health, both hospital- and community-based resources are needed to enhance access to evidence-based mental health services across the continuum of care.

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**Conflict of Interest Disclosures:** Dr McLaren reported receipt of grants from the Thomas Marshall Foundation and the Natalia Mental Health Foundation and consulting for the National Center for START Services. Dr Leyenaar reported receipt of personal fees from the American Board of Pediatrics Foundation. No other disclosures were reported.


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