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Addressing the Clinical Impact of COVID-19 on Pediatric Mental Health

Nicole Bartek, DNP, APRN, PMHNP,
Jessica L. Peck, DNP, APRN, CPNP-PC, CNE, CNL, FAANP, FAAN,
Dawn Garzon, PhD, CPNP-PC, PMHS, FAANP, FAAN, &
Susan VanCleve, DNP, RN, CPNP-PC, PMHHS, FAANP, FAAN

The COVID-19 pandemic impacts daily lives of families globally. Sequelae are not limited to physical consequences of medical complications but extend into social, emotional, spiritual, and psychological health. Interventions including mask-wearing and physical distancing are intended to prevent viral spread, but have unintended negative effects on mental health and child development. Although it is too early to know the full impact, practicing pediatric clinicians are well-positioned to help young people recover and thrive despite challenges presented. This article will review the impact of COVID-19 on child mental health and give practical interventions to foster resilience in youth and their families. *J Pediatr Health Care.* (2021) 35, 377–386

Nicole Bartek, Psychiatric-Mental Health Nurse Practitioner, University of Texas Health Science Center at Houston, Houston, TX.

Jessica L. Peck, Clinical Professor of Nursing, Louise Herrington School of Nursing, Baylor University, Dallas, TX.

Dawn Garzon, Psychiatric Nurse Practitioner, LifeStance Health, Chesterfield, MO.

Susan VanCleve, Clinical Professor and Primary Care Pediatric, Nurse Practitioner Program Director, College of Nursing, University of Iowa, Iowa City, IA.

Conflicts of interest: None to report.

This work has not been published previously and is not under consideration for publication with any other entity.

Correspondence: Jessica L. Peck, DNP, APRN, CPNP-PC, CNE, CNL, FAANP, FAAN, Louise Herrington School of Nursing, Baylor University, 333 N Washington Ave., Dallas, TX 77429; e-mail: Jessica_Peck@Baylor.edu.

J Pediatr Health Care. (2021) 35, 377–386

0891-5245/\$36.00

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Published online March 24, 2021.

<https://doi.org/10.1016/j.pedhc.2021.03.006>

KEY WORDS

COVID-19, adolescent, mental health, access to care, resilience

INTRODUCTION

The COVID-19 global pandemic has tremendously disrupted societal behaviors and norms. The unique impact on children presents critical challenges to pediatric clinicians struggling to respond quickly and adeptly to families in need of support as they navigate emerging health threats (Peck, 2020). Children already struggling experienced greater stress and increased risk for long-term negative health outcomes from the economic, psychological, and physical effects related to the lockdown measures during the COVID-19 pandemic (Singh et al., 2020). Emergency departments are frequently used as an access point to mental health care for those without access to other resources. In the United States, pediatric visits for mental health issues increased 31% from April 2020 to October 2020 (Leeb et al., 2020). Increased prevalence of posttraumatic stress disorder, depression, and anxiety are documented effects following disaster conditions, including a pandemic. As analysis of the long-term impacts of mental health on children begins to emerge in the literature, it is important for pediatric clinicians to respond to vulnerability and risk in all age groups from infancy through early adulthood (generally termed in this article as “child” or “children”). This article will review emerging evidence on the impact of the COVID-19 pandemic on mental health in children and discuss practical steps and interventions that can be used in primary care to foster resilience in children and their families.

CONTRIBUTING FACTORS

Although children of all ages have been impacted worldwide by COVID-19 societal changes, school closures perhaps,

most significantly represent a very real traumatic disruption for students with far-reaching impacts on holistic health, particularly mental health (Graves, Mackelprand, & Abshire, 2021; Hoffman & Miller, 2020; Lee, 2020; Tang, Xiang, Cheung, Xiang, 2021). Disruptions to these critical resource supports negatively impacted over 91% of the student population globally (Lee, 2020). Beyond the purpose of facilitating traditional academic learning, schools provide social and emotional connections, meals for children in need, and millions of students receive both primary and mental health services in school clinics. Three million children report receiving mental health services exclusively through a school or school-based program (Golberstein, Wen & Miller, 2020). During school closures following the outbreak of COVID-19, lost access to these supportive and stabilizing services appears to be a contributor to the increase in early symptomatic subthreshold experiences that may not yet rise to the level of diagnosable disorders, affording opportunity for early intervention (Guessoum et al., 2020; Yeasmin et al., 2020). A potential delay of 2–4 years may be observed between the initial presentation of symptomatic experiences and the development of a mental health disorder (National Association of Pediatric Nurse Practitioners et al., 2020). Virtual learning presents unique challenges, including lack of assistance and supervision related to parental work requirements, distance challenges physically separating students from teachers, limited technological skills to transfer to online modalities, and access to electronic devices or broadband Internet. Distractions at home are more prevalent, and keeping a family's daily routine in which everyone may be sharing spaces and electronic devices presents unique stresses and barriers to academic and social success outside of school (Shah, Mann, Singh, Bangar, Kulkarni, 2020).

Beyond school disruptions, jobless claims and financial insecurity of caregivers during COVID-19 have an impact on the whole household, including children. Food scarcity estimates more than tripled to 38% for families nationally at the onset of the pandemic, with many temporary benefits now expired. For children, food insecurity is associated with detrimental academic and behavioral impacts (Wolfson & Leung, 2020). These struggles collectively increase stress and the risk for mental health issues, creating further challenges for an already struggling family (Duan et al., 2020; Feed America, 2020; Guessoum et al., 2020; Loades et al., 2020; Yeasmin et al., 2020; Zhou et al., 2020).

Racial disparities in access to health care, particularly mental health care, are longstanding in the United States. A report from the Substance Abuse and Mental Health Service Administration (SAMHSA) identifies the COVID-19 pandemic as a “double jeopardy” for Black and Hispanic families because they were already at higher risk for inadequate care, and the stress on resources disproportionately increased that risk (SAMHSA, 2020). The SAMHSA report outlines policies to address these risks, including addressing financial inequities and empowering community engagement to enhance access to direct care and education for families

(SAMHSA, 2020). Black and Hispanic Americans are more than twice as likely as White Americans to experience food insecurities.

The economic stress of COVID-19 also increases stress on those who are at higher risk for developing mental illness (Guessoum et al., 2020; Shah et al., 2020; Singh et al., 2020; Zhou et al., 2020). The lack of access to food and basic household supplies, out of real or perceived scarcity, was heightened during the initial phases of the pandemic lockdown measures (Singh et al., 2020). Children whose parents do not have a high-school degree are more than five times as likely to experience food insecurity compared with households with parents who have a college degree (Silva, 2020). These social determinants of health are critical to addressing this issue.

HISTORICAL IMPACT OF OUTBREAK AND DISASTERS ON CHILDREN

Understanding what is known about child and adolescent response to previous outbreaks, quarantines, and natural disasters around the world helps identify those at risk for mental health concerns related to the COVID-19 pandemic and subsequent response. In the aftermath of the severe acute respiratory syndrome, Middle East Respiratory Syndrome, Ebola, and the anthrax scare after September 11th, 2001, increased anxiety levels and feelings of uncertainty, mistrust, and anger were observed in children (Guessoum et al., 2020; Singh et al., 2020). The stress of COVID-19 is likely to increase the symptomatic presentation of mental illness for those already diagnosed with or at risk for mental illness, those with trauma and stress-related responses, and subthreshold symptomatic presentations that may not yet clearly fit criteria for a diagnosable disorder (Esterwood & Saeed, 2020).

A unique geosocial event like the COVID-19 pandemic can impact life trajectory for children, especially those aged 5 years and younger. Experiencing adverse events, including disease outbreaks, civil conflict, and natural disasters like hurricanes and famine before age 5 years is associated with long-lasting negative impacts on health, education, and relationships (SAMHSA, 2018). Although natural disaster research is not precisely equivalent to the COVID-19 pandemic, generally, parental responses (emotionally supportive vs. maltreatment behaviors) to children during similar periods of stress can impact long-term health outcomes (Maclean, Popovici, & French, 2016). A look at pediatric posttraumatic stress disorder and depression following Hurricane Ike identified children with predisposing risk for depression and trauma responses expressed sustained symptomatic presentations up to 15 months after the event. Early assessment, screening, and intervention (including anticipatory guidance and parent coaching) help improve outcomes following disasters (Lai, Greca, Auslander, & Short, 2013). Exposure to these kinds of geopolitical events and other adverse childhood events increases the risk for children to develop mental illness (National Institute of Mental Health, 2017).

Systemic organization and emotional or personal responses to Ebola and the anthrax scare provide important insight regarding how to disseminate consistent messaging and fact-based information to foster healthy child resiliency through effective coping mechanisms. Neither event had a widespread global societal impact in the way COVID-19 has, but both led to global patterned changes in individual behaviors related to the use and trust of the health care system (Esterwood & Saeed, 2020). Children with distress related to adverse events may present with loss of interest, fatigue, boredom, and loneliness. Social isolation and loneliness are linked with negative health outcomes, particularly for older school-aged children and adolescents. Their increased use of social media and screen time may predispose them to vulnerability to exploitation, abuse, cyberbullying, and exposure to violent or harmful content (Singh et al., 2020). Clinicians may see an increase in anxious and depressive symptoms during and after social isolation related to school closures and virtual schooling, prompting increased urgency for early screening and intervention (Loades et al., 2020). In clinical practice, the diagnosis of *adjustment disorder* is often applied to cases of concerning symptomatic presentation associated with stress or change, like COVID-19 but not rising to the threshold, by time or severity, of a diagnosis like major depression (American Psychiatric Association, 2013).

CLINICAL PRESENTATION OF MENTAL HEALTH ISSUES IN CHILDREN AND TEENS

Despite many families being confined together during the COVID-19 pandemic, loneliness remains a significant issue for teens. A recent systematic review (Loades et al., 2020) found 63 of 83 studies included reported on the measured negative impact loneliness had on mental health in previously healthy children and adolescents. Children impacted by loneliness are more likely to experience symptoms of anxiety and depression persisting into postpandemic conditions (Loades et al., 2020). In children, symptoms of depression and anxiety may present like apathy and lack of self-care than verbal expressions of hopelessness. Difficulty focusing and impaired concentration are also common in children struggling with anxiety and depression. Children who are at risk for suicide may present with symptoms of depression, anxiety, and sleep disturbances. These kinds of nonspecific psychosomatic clinical presentations often benefit from early diagnosis and referral to mental-behavioral health services or psychiatry (Malas, Ortiz-Aguayo, Giles, & Ibeziako, 2017).

Preexisting family conflict can also impact the level of struggle anticipated with the COVID-19 pandemic. For many children, school and other social gatherings are not only essential for the accomplishment of developmental tasks but can also be a reprieve from violence occurring in their home. The COVID-19 pandemic preceded a global spike in calls to domestic violence hotlines and an increase in Internet searches for related resources (National Center on Safe Supportive Learning Environments, 2020).

Optimizing opportunities to screen children for signs of abuse, neglect and food scarcity at every visit can improve health outcomes and provide much-needed support for families who are struggling (Kaukinen, 2020).

Data collected by the Centers for Disease Control and Prevention before the pandemic illustrate the baseline level of suicidal thoughts in teens surveyed using the Youth Risk Behavior Survey. In 2019, 18.8% of youth expressed thoughts of suicide, and 16% made plans for a suicide attempt (Ivey-Stephenson et al., 2020). The 2020 data from the Youth Risk Behavior Survey and the pandemic's impact on teen quality of life are actively collected, with preliminary discussions indicating reports of suicidal thoughts and loneliness are likely significantly increasing postpandemic (Golberstine et al., 2020). Assessing and addressing sleep issues can improve mental and physical health outcomes (Paruthi et al., 2016). Lesbian, gay, bisexual, transgender, queer, intersex, and other gender nonconformity youth are at a uniquely high-risk, up to five times more likely to attempt suicide than age-matched peers. Those youth with access to guns in the home are also at higher risk for completed suicide than those without access to guns (Ivey-Stephenson et al., 2020). Means restriction is the term used to describe the removal of immediate means of suicide (Yip et al., 2012). Although the removal of lethal means, such as guns, does not eliminate the risk for suicide, it does increase the amount of time and effort required to attempt suicide. Extra time affords the opportunity for intervention and decreases the likelihood of a death by suicide (Yip et al., 2012).

IMPLICATIONS FOR PEDIATRIC CARE PROVIDERS

It is essential for providers to focus on basic elements of self-care as part of addressing the mental health concerns of primary care patients. Many parents may fear the rapid commencement of prescriptive medication therapies for mental health concerns. Adopting a holistic approach also encompassing nonpharmacological supportive therapies is essential for holistic care. Some children may benefit from evidence-based psychosocial interventions such as counseling and cognitive-behavioral approaches, whereas others may need specialized psychiatric services, including pharmacotherapy (Riddle, 2019).

Daily Routine

Health organizations across the globe stress supporting families and children in maintaining as much normalcy as possible in their daily lives during COVID-19 and the recovery period (Hou, Lai, Ben-Ezra, & Goodwin, 2020). Regular disruptions in daily routines happen easily and contribute to poor mental and physical health. Helping families focus on primary routines, including eating healthy meals together, maintaining a consistent sleep schedule, and attending school regularly (whether in-person or virtual), helps maintain a sense of normalcy and supports good mental health, especially for socially isolated teens (Guessoum et al., 2020);

Hou, et al., 2020). Specific strategies like setting alarms to help promote adherence to routine can also be normalizing for families seeking support and guidance during the pandemic (Utter et al., 2017). Limit exposure to daily news consumption, and empower children to seek fact-based, reliable sources of information. Encouraging children to pursue creative outlets like arts, dance, music, or writing can promote well-being (Singh et al., 2020). Positive parenting techniques and consistent scheduling to avoid affliction associated with unstructured malaise-filled days can be a powerful constructive influence (Shah et al., 2020).

Healthy Eating

During the pandemic, many families are facing initial, ongoing, or worsening food scarcity. The American Academy of Pediatrics and the Food Research & Action Center (2017) have a toolkit for clinicians to effectively address food insecurity with sensitivity and cultural responsiveness. Having accessible information about food pantries can help support family health while minimizing the stigma of asking for resources (Feed America, 2020). Over- and under-eating are common stress responses at all ages and can trigger underlying eating disorder behaviors. If patients or families are struggling with healthy eating, consider referral to a dietitian for counseling on healthy eating support. Anticipatory guidance about eating together as a family is an evidence-based intervention supporting the mental health of teens (Utter et al., 2017). One in nine people in the United States used the Supplemental Nutrition Assistance Program in 2019. Because of COVID-19, demand has risen at a three-fold rate. Ensuring access to school lunch programs (some offered temporarily through other community venues following school closures) is critical for primary care providers (Silva, 2020). The six-item U.S. Household Food Security Survey Module is a screening tool available to help identify families in need of referral for supplementary resources (Bottino, Rhodes, KREATSOULAS, Cox, & FleeGler, 2017; Peltz & Garg, 2019).

Sleep Hygiene

Children and adolescents need more sleep than adults (Centers for Disease Control and Prevention, 2018). Sleep in teens can be adversely impacted by biological impulses to stay up later despite required early awakenings, overweight or obesity, pain caused by acute or chronic conditions, experiences of illness, and lack of sufficient physical exercise to prompt body fatigue (Bruce, Lunt, & McDonagh, 2017). Talking with families about good sleep routines and prioritizing a full night's sleep is important for mental health and well-being. Sleep hygiene is the routine used when falling asleep and waking up from sleep and is a cornerstone of cognitive-behavioral therapy for insomnia (Williams, Roth, Vathhauser, & McCrea, 2013). Good sleep hygiene in children and caregivers alike is simple and includes things like brushing teeth, washing face or bathing, and reading a book or praying (Blake et al., 2017). For adolescents especially, advice should include limiting the ingestion of caffeinated

beverages, limiting screen time at least 2 hr before bedtime, encouraging exposure to natural sunlight during the day, designating a separate place for daytime activities, including school, while only using the bed for nighttime sleeping, and keeping a tidy, relaxing sleep environment (Bruce et al., 2017). The Sleep and Education: Learning New Skill Early study educated adolescents aged 12–17 years around positive sleep behaviors and creating a sleep routine and found sleep education focused on daily routine and relaxation around bedtime was found to statistically improve sleep quality in study participants (Blake et al., 2017). New severe presentations or worsening of persistent or severe sleep issues predating the COVID-19 pandemic may warrant further evaluation for possible referral to a mental health provider and consideration of pharmacotherapy.

Validation

Validation is a term that is becoming more common in contemporary culture. The idea of emotional validation is to express that emotion is real and that it is okay for the person feeling that emotion to feel and express it (Benitez, Howard, & Cheavens, 2020). Validation is not listener agreement but rather a communication of understanding. Research supports that acknowledging and validating struggles can decrease stress and have positive effects on mood (Benitez et al., 2020). Mentalization-based therapy uses validation as a therapeutic tool to help foster identity and ego strength (Bateman & Fonagy, 2013). The use of validation as a communication tool can be a shared strategy between the parent, child, and provider (Bateman & Fonagy, 2013). Providing anticipatory coaching for parents to validate rather than dissuade painful emotions may help use known effective strategies for resilience and apply them to mental health effects stemming from the COVID-19 pandemic.

Routine Screening for Mental Health Concerns

Screenings are a helpful tool in identifying mental health issues in primary care patients. Validated and reliable assessment tools for children can be helpful in identifying underlying mental illnesses that may present as physical complaints such as loss of appetite or frequent stomachaches (see Table 1). These brief evidence-based surveys can be easily used during a primary care appointment. The American Academy of Pediatrics recommends annual screening of all patients aged 12 years and older for depression (Zuckerbrot et al., 2018). The recommendation does not include a specific tool. During the COVID-19 pandemic and the recovery period, presentations of children with symptoms of depression, anxiety, substance use, and sleep disturbance should prompt an interval screening in addition to the routine annual screening recommendation.

Once children with mental health issues are identified, the primary care provider should be prepared to address those needs. Much like addressing their physical needs, there are many factors to be considered when providing mental health care. Before initiating routine screenings, it is important to identify community resources for referral and what

TABLE 1. Screening tools for common mental health conditions

| Tool | Purpose | Age range | Length |
|---|---|--------------|----------|
| Y-PSC | Recognition of cognitive, emotional, and behavioral problems | > 11 years | 35 items |
| PHQ-9 | Depression screening | > 12 years | 9 items |
| PHQ-A (PHQ-9 modified for adolescents) | Depression screening and suicidality | 11–17 years | 9 items |
| SCARED (SCARED-P for parents and SCARED-C for children) | Anxiety screening | 9–18 years | 41 items |
| GAD-7 | Anxiety screening | > 13 years | 7 items |
| Ask suicide screening questionnaire (ASQ) | Suicide screening | > 10 years | 4 items |
| CRAFT | Substance use | 12–21 years | 6 items |
| BEARS | Sleep disturbance | 2–18 years | 5 items |
| Early childhood screening assessment | Emotional and behavioral development | 18–60 months | 40 items |
| SDQ | Psychosocial screening including emotional assessment, conduct issues, peer relationship challenges, and prosocial behavior | 3–17 years | 25 items |
| BIS | Assesses function in interpersonal relations, school/work, and self-care/fulfillment | 4–17 years | 23 items |

Note. Y-PSC, youth patient symptom checklist; PHQ-9, Patient Health Questionnaire-9; PHQ-A, Patient Health Questionnaire-A; SCARED, Screen for Child Anxiety-related Disorders; GAD-7, Generalized Anxiety Disorder-7; CRAFT, car, relax, alone, forget, friends/family, trouble; BEARS, Bedtime problems, Excessive daytime sleepiness, Awakenings during the night, Regularity and duration of sleep, and Sleep-disordered breathing; SDQ, Strengths and Difficulties Questionnaire; BIS, Brief Impairment Scale.

interventions the primary care setting can provide (Sisler, Schapiro, Nakaishi, & Steinbuchel, 2020). For mental health issues, priority is given to safety concerns, like suicidal and homicidal ideation.

Treatment in Primary Care Scope of Practice

Scope of practice for advanced practice nursing is determined primarily through state licensure and national specialty certification. It is important that each provider be aware of limitations in diagnosing and prescribing medications for mental illness (Balestra, 2019). The focus of care remains on accurately diagnosing medical conditions and any accompanying comorbid conditions. Specialist referral and/or collaboration are recommended for primary care clinicians when providing care for anything beyond uncomplicated common mental illnesses such as attention deficit hyperactivity disorder, depression, or anxiety (Balestra, 2019). Deciding when to refer to a psychiatric specialist can be a challenge. Table 2 contains a framework to address thinking through the process of when to refer mental health concerns identified in the primary care setting, although each clinician should adhere to their own scope of practice as set by licensing and certification regulations, considering each case on an individual basis. Patient access to care and limitations of the care setting are also important factors in addressing mental illness concerns.

Response to Suicide Risk

Stigma in mental health is often perpetuated by fear and misunderstanding. Media portrayal of lived experiences and painful memories of being separated or alienated from family members can contribute to reluctance to access mental health care services. There is much misunderstanding and stigma surrounding suicide. Considering 30% to 40% of adults consider suicide to be punitive, selfish, offensive, or reckless, some families may want to keep suicidal ideation secretive. Other words associated with suicide stigma include irresponsible, cowardly, senseless, and attention-seeking (Carpiniello & Pinna, 2017). Language describing suicidal behavior is important. The term “committed suicide” subtly implicates criminalization, whereas “completed suicide” implies previous attempts. Labeling suicide attempts as “failed” or “successful” is judgmental in characterization and should be discouraged. “Died by suicide,” “died of suicide,” and “suicide behavior” are sensitive and recommended terms (Maine Department of Health and Human Services, 2020). As one in five adolescents report thoughts of suicide, it can be understood why these teens may struggle to disclose ideation to loved ones and even health care professionals (Ivey-Stephenson et al., 2020).

Pediatric care providers are experts in therapeutic communication and are skilled at having difficult conversations with families about sensitive subjects such as suicide, self-harm, substance use, anxiety, or depression. The evidence is clear: asking plainly about suicidal ideation does not increase the risk for suicide or give people thoughts of suicide (Dazzi, Gribble, Wessely, & Fear, 2014). Asking does save

TABLE 2. Decision-making for referral to mental health specialty care

| Reflective questions For provider | | | | Implication |
|---|----------|--------------------------------|-------------|---|
| Is safety an issue? ^a | | | | |
| Suicidal or homicidal thoughts with: | Plan | Intent | Access | Acute safety concern warrants referral to inpatient treatment. Consider the use of ASQ or other evidence-based tools to make an assessment on Plan, Intent, and Access for acuity if danger present |
| Concerns for abuse, neglect, or otherwise unsafe home situation | Parental | Other environment or caregiver | | Comply with mandated reporting state laws. Work with child protective services and/or law enforcement for immediate removal |
| How severe is the illness? | | | | |
| Does it impact daily life at: | Home | School | Social life | More severe illnesses should be referred to specialty care. Areas of life that symptoms impact can be a guide for determining the severity |
| Has the patient recently been discharged from a psychiatric hospital admission? | Yes | No | | Recent hospitalization warrants referral to specialty care |
| Has the patient had previous treatment for the current issue? | Yes | No | | If this is an existing issue and has been successfully managed before, restarting successful treatment may be a good starting option. If complex comorbidities exist, previous treatment failed or response to first-line medications is inadequate, referral to specialty care is warranted. |
| Was treatment successful? | Yes | No | | |

Note. ASQ, *Ages and Stages Questionnaire*. This table was created using adapted guidelines from Recommendations for Pediatricians, Family Practitioners, Psychiatrists, and Non-physician mental health practitioners from the *American Academy of Child and Adolescent Psychiatry* (n.d.).

^aPrimary self-harm behavior without suicidality—consider therapy referral for evidence-based treatment.

TABLE 3. Pathways to access pediatric behavioral or mental health care

| Provider | Credential/degree | Care model | Services provided | Prescriptive therapy |
|---|--|---|--|--|
| Pediatric Nurse Practitioner Primary Care | PNP-PC Master's or doctoral degree in pediatric nursing with a state license and national certification | Primary care, some outpatient specialty settings | Health promotion, wellness, management of uncomplicated and common mental health concerns including anxiety, depression, attention deficit disorder | Yes, for simple conditions |
| Pediatrician | MD Doctoral degree with specialty training in pediatrics, board certification | Primary care, some outpatient or inpatient specialty settings | Health promotion, wellness, management of uncomplicated and common mental health concerns including anxiety, depression, attention deficit disorder | Yes, for simple conditions |
| Primary Care Mental Health Specialist (Pediatric Nurse Practitioner or Clinical Nurse Specialist) | PMHS Master's or doctoral degree in pediatric nursing with a state license and national certification | Can be co-located with primary care, or in outpatient specialty care services, or inpatient consultation and management | Experienced in early identification and intervention for developmental, behavioral, or mental health concerns for children. Therapeutic services include the use of screening tools, diagnosis, and psychotherapeutic interventions. Helps to collaborate with other health professionals and coordinate care | Yes, for simple and moderate-to-complex conditions |
| Psychiatric-Mental Health Nurse Practitioner | PMHNP-BC Master's or doctoral degree in nursing with a state license and national certification | Can be co-located with primary care, or in outpatient behavioral health centers, or inpatient consultation and management | This professional is trained to provide integrated care across the life span for comprehensive mental health, substance use, and other comorbid physical or mental health conditions. They also provide emergency psychiatric care and evaluate the effectiveness of prescribed therapy | Yes, for simple and moderate-to-complex conditions |
| Professional child counselor or therapist (Some state variation in title protection and license) | Varies (credentials) master's degree with a focus on child and adolescent development; national certification | Often work in schools, social-service offices, juvenile detention centers, domestic violence centers, child advocacy centers, homeless shelters, outpatient primary care, and specialty clinics | Help empower coping skills to foster emotional and mental health. They may care for children experiencing divorce, loss through death, serious illness, learning disabilities, emotional trauma, effects of abuse, familial conflict, bullying, peer pressure, disordered eating, or identity crises | No |
| Child Psychologist | Varies (credentials) Master's or doctoral degree in child psychology | Can work in schools, social-service offices, juvenile detention centers, domestic violence centers, child advocacy centers, homeless shelters, outpatient primary care, and specialty clinics; maybe in private or group practice; often works with governmental agencies | Provide a variety of services to children, sometimes adolescents and families, on a range of issues from developmental concerns, social skills, educational challenges, behavioral or emotional problems, substance misuse, or learning disabilities. Some are generalists, whereas others specialize in certain disorders. They may also conduct or oversee group or family therapy | No |
| Child Psychiatrist | MD Board-certified first in general psychiatry followed by training and board certification in child psychiatry | Usually works in a private or group outpatient practice, also works inpatient intensive therapy settings for long-term treatment of conditions like suicidality, substance abuse, and disordered eating | Most child psychiatrists are trained to see patients across the life span. Highly trained and qualified specialist equipped to deal with complex, severe behavioral and mental health concerns. Highly specialized and educated to provide complex pharmacotherapeutic training. May collaborate with psychologists, counselors, and/or therapists for adjunctive therapies | Yes, mild to highly specialized and complex |

lives and provides an important opportunity for connection and education. It is important for providers who ask, however, to be prepared with a plan for action should the answers be affirmative of risk (Dazzi et al., 2014). Having a plan and policy in place to address mental health and safety concerns with confidence can change the dynamic from avoidance and fear to acceptance and positive planning (Sisler et al., 2020). It is important to note hospitalization decisions should be made on a case-by-case basis with an assessment of lethality of means, access to means, and imminent intention for suicide (Sisler et al., 2020).

Provider Resources

The shortage of child and adolescent psychiatrists across the country can be a barrier to care for many patients (American Academy of Child and Adolescent Psychiatry, 2018). As a response to the COVID-19 pandemic, more practices and states have expanded access to telehealth, including tele-mental health. A recommendation for developing networks of collaborative providers, including in-person, consultation, and virtual services, is recommended (Singh et al., 2020). Programs have been developed on a state-by-state basis, such as the Child Psychiatric Access Network program in Texas to connect pediatric providers with child and adolescent psychiatrists for guidance (McGovern School of Medicine, n.d.). Each state and local area has its own unique resources and organizations like the National Alliance for Mental Health, which helps keep lists of those resources. The National Network of Child Psychiatry Access Programs (2020) is another national database of programs across the United States that help integrate physical and behavioral health care for every child.

Enhancing Access Through Pediatric Primary Care

The National Association of Pediatric Nurse Practitioners recently revised guidance for clinicians on the integration of mental health in primary care settings. A holistic, family-centered, life span approach is advocated in conjunction with a collaborative model including telehealth, community partnerships between primary and mental health care, and colocation of services. Other recommendations include rapid integration of evidence-based research into clinical practice; integrating anticipatory guidance and risk-screening into preventive care; educating families about early signs of mental and behavioral health concerns; advocating for adequate reimbursement for mental health services; strengthening nursing curricula in assessment; diagnosis and management of mental health curricula; promoting community integration of awareness and resources; and supporting legislative and regulatory efforts to increase access to developmental, behavioral, and mental health services (National Association of Pediatric Nurse Practitioners et al., 2020).

If the primary care practice is integrated into mental health care, there may be a nurse practitioner who has the pediatric mental health specialist or psychiatric-mental health nurse practitioner certification who can provide care to this

population. Alternatively, in a practice that is co-located, a mental health therapist may be present in practice or available for immediate referrals (National Association of Pediatric Nurse Practitioners et al., 2020). Table 3 identifies different pathways available to behavioral or mental health in primary care. Given the rapid increase in mental health conditions because of the pandemic, practices should pursue or implement access to mental health resources for patients that are seamless and immediate.

The COVID-19 pandemic has increased the risk and clinical presentation of mental health issues among children while presenting providers with new challenges as social effects and stress impacts are felt universally. Often, care providers are outside prescriptive helping to solve a problem or offer answers to stress and worries. Pediatric providers can do many things to help foster strength in families and children. They have a unique opportunity to work collaboratively to identify mental health concerns. Addressing these concerns with anticipatory guidance and routine screenings can provide an opportunity for early identification and access to evidence-based care. There is hope in the partnerships between pediatric primary care and developmental, behavioral health, and psychiatric providers to help community recovery. Innovative profession and patient-based supports are part of the solution to the ongoing stress and risk to the mental health of children during the COVID-19 pandemic and recovery process.

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