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COMMENTARY - UNSOLICITED

Supporting youth mental health during the COVID-19 pandemic

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The COVID-19 pandemic has worsened youth mental health and exposed inadequate mental health infrastructure in the United States for children, leading to rising emergency department (ED) visit rates for mental health. Prior to the pandemic, pediatric mental health ED visits and hospitalizations were already increasing, with suicide as the second leading cause of death among youth 10–19 years old.[1] While mental health conditions are prevalent among children, only a small proportion of children receive needed mental health services, in part due to a workforce shortage of pediatric mental health professionals.[2] The COVID-19 pandemic contributed additional physical, psychological, and economic stressors that further worsened youth mental health.

During the pandemic, more children reached the point of mental health crisis. From mid March 2020 to October 2020, Centers for Disease Control and Prevention surveillance data indicated that the proportion of ED visits by children for mental health conditions increased by 24% among children aged 5–11 and by 31% among adolescents aged 12–17.[3] In a particularly alarming trend, ED visits for suspected suicide attempts among girls aged 12–17 were 50.6% higher in February–March 2021 than during the same period in 2019.[4] Severity of illness was also higher, with increased hospital admission rates (52.7% vs. 42.9% before the pandemic) from the ED for youth mental health conditions and more prolonged hospital stays (3.4 days longer) compared to prior to the pandemic.[5] ED boarding of children with mental health conditions continues to present a challenge, with prolonged ED stays due to insufficient availability of inpatient psychiatric beds, limited outpatient intensive treatment options, and inadequate community resources. Taken together, the current U.S. mental health infrastructure does not have sufficient capacity to support rising youth mental health needs.

Multiple societal changes during the pandemic may have contributed to this worsening of youth mental health outcomes. Increased social isolation is a well-known risk factor for depression and suicide. Compared with before the pandemic, children were spending less time with friends and family members in person, less time outside and being physically active, and more time using screens.[6] Virtual schooling led to fewer opportunities for children to connect with caring adults, such as educators and coaches, who often serve as important sources of support. Some children lost loved ones due to COVID-19. Moreover, pandemic-related impacts of poverty, food and housing insecurity, and loss of health insurance coverage placed additional stressors on families. As youth faced increased risk factors for poor mental health, they concurrently faced a loss of access to mental health services. Over half of adolescents who receive mental health services in the United States depended on school-based services, but access to these services was markedly reduced during transitions to virtual schooling.[7] During the pandemic, youth also faced reductions in access to primary care and community mental health services.

The consequences of the COVID-19 pandemic on youth mental health have not been evenly distributed in U.S. society. Black and Hispanic children face inequitable access to mental health services, diagnosis, and treatment, leading to increased likelihood of presentation to the ED for mental health reasons.[8] Children in rural areas are more likely to visit the ED for self-harm, and children living in

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high-poverty areas are at increased risk of adverse mental health outcomes such as suicide.[9,10] These communities also face disproportionate physical health and economic impacts of COVID-19, potentially accelerating existing disparities in youth mental health outcomes. Additionally, children with preexisting mental health conditions such as autism spectrum disorder may be particularly vulnerable to the loss of regular access to mental health services during the pandemic.

Myriad policy solutions are available to improve children's access to mental health services during this critical time. A coordinated approach is required to support children's mental health throughout the continuum of care, beginning with prevention, early identification, and diagnosis and continuing through treatment and crisis management. First and foremost, an upstream focus on the relationship between early childhood development and social determinants of health is needed to mitigate underlying factors contributing to child mental health problems. Attention must be given to address child poverty, housing needs, food insecurity, and gaps in health insurance coverage. Specific policy efforts should include, for example, strengthening the child tax credit and earned income tax credit, raising the minimum wage, supporting paid family leave, bolstering child nutrition support programs, and funding the Children's Health Insurance Program.

Second, policies must support integration of behavioral health care services into pediatric primary care and schools. To do so, increased funding should be dedicated to mental health training for primary care providers, care coordination, and partnerships between primary care offices and schools. For example, the U.S. Health Resources and Services Administration Pediatric Mental Health Care Access program allows primary care providers to access child psychiatric virtual consultation. In tandem, funding school-based health centers with integrated mental health professionals would allow care to be provided in the setting where young people spend the majority of their time. Moreover, all school staff should receive basic training to recognize the signs of pediatric mental health problems. Heightened support for primary care offices and schools could improve prevention, earlier diagnosis, and initiation of treatment.

Third, to serve children with existing mental health needs, pediatric mental health care capacity must be expanded across all levels of care, including hospitals, EDs, and community settings. The Children's Mental Health Infrastructure Act of 2021 (H.R. 4943) would provide grants to children's hospitals to increase their capacity to provide pediatric mental health services. Increased availability of "step down" services such as partial hospitalization and intensive outpatient programs would promote more effective care transitions following hospitalizations. EDs should be redesigned with the necessary staff, environmental space, and resources to care for children with behavioral health needs, particularly those who are boarding awaiting definitive mental health care. Formalized collaborations and referral networks between EDs and community mental health services would improve coordination of care upon ED discharge. Community services should be expanded to include mobile crisis intervention (accessible 24/7 from homes, schools, and primary care), intensive case management, respite services, and ED diversion programs such as psychiatric urgent care centers. Suicide prevention call centers should be funded to match the increased call volume expected with the establishment of 988 as a national dialing code for mental health crises starting in July 2022. Outpatient care services should be designed to serve children with unique needs, such as children with autism spectrum disorder, substance abuse, and eating disorders. To address population health needs, increased funding for data surveillance systems such as the National Violent Death Reporting System would improve our understanding of the circumstances and epidemiology of youth suicides and allow for the development of tailored prevention programs.

Fourth, federal funds should be allocated to expand the behavioral health workforce and address provider shortages in underserved areas. The workforce includes not only child and adolescent psychiatrists, but also psychologists, psychiatric nurses, social workers, and other behavioral health clinicians with expertise in child and adolescent health. Workforce development programs should target high-need geographic areas, enhance workforce diversity, and promote cultural and linguistic competency. For example, the National Health Services Corps of the U.S. Health Resources and Services Administration provides loan forgiveness for behavioral health clinicians who practice in underserved areas. If passed, the Helping Kids Cope Act of 2021 (H.R. 4944) would provide funding to support workforce training for a range of pediatric behavioral health professionals. Additionally, federal investment in the Children's Hospital Graduate Medical Education Program would strengthen the pediatric workforce and improve access to care for all children.

Fifth, insurance coverage and reimbursement should be enhanced for pediatric mental health services, including services delivered via telehealth. Despite improvements in mental health parity in insurance coverage over the past decade, many children and families experience more restrictive insurance limits for mental health services compared to medical and surgical services. For many, cost-sharing requirements remain high, access to out-of-network clinicians is prohibited, and specific mental health services such as counseling are not adequately covered. Both Medicaid and commercial coverage for pediatric mental health services must be improved. Moreover, insurance payment models must be designed to support integrated, team-based care that includes reimbursement for primary care management and service coordination. Additionally, equitable payment should be provided for services delivered through telehealth, as an emerging option to expand access to mental health care, particularly for geographic areas facing mental health workforce shortages.

In sum, the COVID-19 pandemic has created recognition of an urgent need to expand mental health services for children. Solutions for this crisis must address social determinants of health, support integration of behavioral health services into primary care and schools, expand pediatric behavioral health capacity, promote workforce training, and improve mental health insurance coverage (Figure 1). As emergency medicine clinicians are increasingly on the front lines of providing crisis mental health service for youth, now is the time to

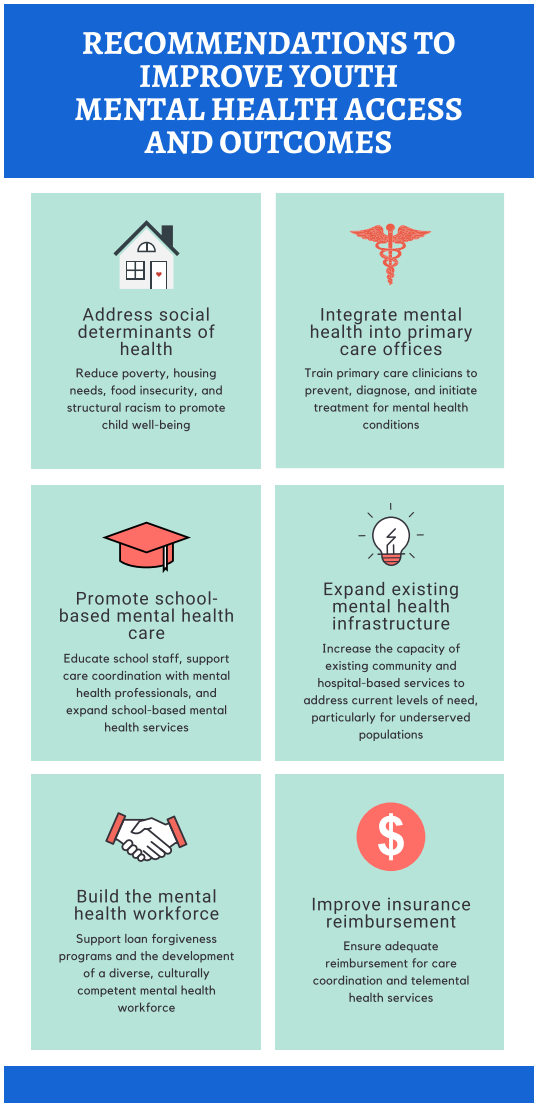

FIGURE 1 Recommendations to improve youth mental health access and outcomes

advocate for these youth at the individual and systems levels. As a first step, we must accept the paradigm that children's *mental health* is synonymous with children's *health*.

CONFLICT OF INTERESTS

The authors report no conflicts of interest.

AUTHOR CONTRIBUTIONS

Dr. Hoffmann contributed to the conception and design of the article and drafted the initial manuscript. Dr. Duffy contributed to the conception and design of the article and critically reviewed the manuscript for important intellectual content. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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