Impact Of Covid-19 On Pediatric Mental Health

Children, along with their families, are experiencing unprecedented changes in their lives. They may have family members who are sick, out of work, or on the frontlines of the fight against COVID-19. Families are now piled on top of each other as many parents work at home. Children are asked to attend school online, with little preparation. Parents are asked to be schoolteachers, health and safety monitors, and activity directors, all while handling their work and their own anxieties about the virus.

Children are also surrounded by adults who are inundated with changing circumstances and anxiety-producing new situations. Yet, children still rely heavily on parents to show them the way to respond. They gauge their safety as they look to their parents for direction on how to feel and behave. They are asked to alter all their routines, many without the cognitive capacity to understand the seriousness of the health and safety risks of not changing their behaviors. Children and families are asked to participate in social distancing when social connections may be how they typically deal with stressful and uncertain times.

Parents may be reporting shifts in behavior to mental health practitioners. Symptoms of stress and anxiety can appear in very young children, including infants. Infants may show disruptions in their biological functioning due to the changes in routine and to the stress of their caregiver. Changes are often noticeable in the infants’ sleep and feeding schedule or their ability to be soothed; they may even begin showing some developmental regression or delay. Preschool children may also show disruptions in sleeping and eating patterns, as well as developmental regression (e.g., bed wetting, loss of bowel or bladder control). They may also show mood disruptions in the form of increased temper tantrums, whining, or clinging behaviors. School-age children may additionally show physical symptoms, like stomach- and headaches. They may begin to push back on routine changes, refusing to do chores or homework. Either withdrawal from family and peers or an increased competition for parental attention may be present.

Adolescents, in addition to some of the changes seen in younger children, may ignore health-promoting behaviors, refuse schooling, or show increased agitation or apathy. It is important for mental health practitioners to educate parents and children about these symptoms, as well as to empathize with them. Helping parents and children to understand that these feelings and behavior could be a reaction to the changes, validating their feelings, and finding strategies to respond are good practices that can be achieved through telehealth sessions.

Exacerbation Of Pediatric Mental Health And Trauma

Some children have underlying mental health conditions and/or have experienced trauma. For them, the symptoms
described above may be more intense or frequent. Trauma symptoms are often exacerbated when children feel out of control or threatened or are reminded of feelings or events that were traumatic prior to COVID-19.\textsuperscript{5,7, 14} Practitioners should also keep in mind that while a sensitive and attuned caregiver may be ideal, many children may not have such a person available during this time because of being separated from whomever this was in their life or of having caregivers who are overwhelmed by the conditions created by COVID-19.\textsuperscript{14}

Telehealth practitioners will need to try to create safety for children in any way possible.\textsuperscript{5,14} If the caregivers can provide this safety with guidance, this is ideal but not always plausible. The practitioner may need to reconceptualize the case for the caregivers in terms of the current circumstances, combined with the historical issues.\textsuperscript{5,14}

### Considerations In The Use Of Telehealth

Prior to COVID-19, telehealth has been transforming the way health care is delivered in the U.S. A shortage of professional workforce, particularly in rural areas, results in a lack of access to needed services or requires significant travel to get to available services. For families without reliable transportation or public transportation, the result is the same—needed services cannot be obtained. Additionally, parents may be required to take time from work, and children and adolescents must be absent from school to travel to appointments. Telehealth can address these barriers. The use of telehealth in mental health has expanded into schools and other non-traditional settings and now into homes. In this time of COVID-19, telehealth has become essential for an array of medical, mental health, and child welfare services.

Although the use of telehealth has been demonstrated to be an effective strategy in the provision of care, the decision to provide telehealth and the way it is provided requires careful consideration of a number of factors, including:

- **Technology:** Consideration of the technology needed for quality telehealth is a primary concern. The availability of broadband and reliable connectivity at sufficient speed are required for effective services. These may be very problematic in rural areas. Other considerations include the platform to be used, integration or compatibility with electronic health records, what types of devices are supported (computers, tablets, Smart phones, physical health monitoring devices, etc.), and how the technology gets embedded in workflows. Finally, security and HIPAA concerns must be addressed. Although there has been new guidance on the use of technology and HIPAA regulations as a result of the COVID-19 pandemic, care must still be taken to provide protection of information.\textsuperscript{10,11,12}

- **Setting:** The setting for telehealth services should include a room that offers privacy, comfort, limited distractions, and good lighting (windows should not be behind the speaker); appropriate and clear audio equipment (good speakers, a microphone, headphones); a camera that is fixed and steady; and adequate seating for all participants. Ideally, seating should allow space between participants; this can be particularly problematic for children, adolescents, or adults who have experienced physical or sexual abuse and are hypervigilant about the proximity of others. Consideration should also be given to having a trusted adult available who can respond to a crisis should one arise. (Note: Some states are allowing services to be provided telephonically at this time. Regardless of whether services are provided telephonically or through traditional telehealth, there needs to be some discussion with the clients(s) about making sure that privacy is ensured.)

- **Backup Mode of Communication:** Given the sensitive nature of discussions and the importance of trust with clients participating in telehealth care, possibly for the first time during this pandemic, it’s important to discuss with them the possibility of connectivity issues and the backup plan that will be in place, should there be a lost connection. It is important to have a plan for what to do in such
instances to reconnect with the client and to complete the service. Getting a reliable phone number for the client is important. This needs to be discussed with him/her at the initiation of the service.

Clinical Considerations

Informed Consent
Practitioners should have some form of written informed consent for their clients and/or the legal guardians to sign, which should be modified to explain the special circumstances of telehealth. Confidentiality should be explained, including its limits when the practitioner can only control his/her side of the sessions and communications. Communications should be described in detail to avoid any confusion about what kind of communication is acceptable (e.g., text, email, videoconferencing) and how protected this communication is. For many, this may be their first experience with telehealth or technology-supported services of any kind. This switch may cause role and boundary confusion. Practitioners should consider the use of electronic signatures for documents, when able. If this is not possible, have the client indicate in writing that s/he received and reviewed the policies.

Beyond a written informed consent, the practitioner should spend ample time discussing the parameters of the telehealth sessions, as detailed in the written consent. This should be a discussion that helps the client or his/her guardian understand any difference, if the sessions were previously held in person. The practitioner should also discuss the expectations of the client and their guardian for therapy. These may include special conditions, like allowing the guardian to call in prior to the session to update the practitioner or allowing the child a private space for therapy. Crisis management should also be addressed, both in writing and by discussion. Helping children and their caregivers feel safe is paramount at this time. This includes planning for what to do if situations become unsafe. This discussion will have to take into consideration what protocols local agencies may have in place due to COVID-19.

Building And Maintaining A Relationship
Technology can influence the practitioner-client relationship. For those beginning the therapeutic relationship via telemental health, this should be processed thoroughly in the first sessions with good informed consent. For those switching to telehealth sessions, it should not be assumed that the relationship will remain intact or the same. For pediatric populations, many clinicians use a variety of media, such as art, games, or play, to help with the therapeutic process. Telehealth can include some of these interventions, but many adjustments will need to be made for sessions to be productive.

Social constraints may loosen when conducting telehealth sessions. Virtual disinhibition is a concept that originally arose from online communications but applies to telehealth sessions, as well. As opposed to the client attending at an office, a controlled setting, the client will likely be in his/her home. Keep in mind that for many of us, home is a comforting place that may aid in easing the anxiety of the therapeutic process. However, this is not the case for every child or family. For some, home is a place that may inhibit their ability to participate in the therapeutic process or even impact their safety. This should be monitored throughout the sessions, discussed in supervision, and, if necessary, reported to the proper agencies.

Developmental Considerations

Pediatric mental health practice should always take into consideration the client’s development. Telehealth has definite challenges when working with a client group that may have less language abilities, difficulty concentrating, or issues with boundaries.

Young Children
Young children are introduced to technology at younger ages, and even very young children can be quite adept at its use. The use of technology is an effective strategy in motivating and educating children. Engagement strategies for young children being served via telehealth may need to be adapted from those typically used in traditional office settings and can include the use of online videos, screen sharing, or interactive handouts and games. The makeup of sessions for young children will be similar to that in the office setting. The caregiver and child should be present together, unless the caregiver needs to talk privately with the practitioner. If this is the case, the practitioner and caregiver should come to an agreement about how this will occur, either telephonically outside the session or in the telehealth session, with arrangements being made for the child’s supervision.

Much of the work of the practitioner will be to support the caregivers in this difficult time so they can be a consistent, nurturing, and safe presence in the life of the child. Times of stress often bring to the forefront feelings of helplessness, loss of control, anger, frustration, and grief in both the caregiver and the child. Practitioners can offer emotional
support during the sessions, as well as with check-ins at other, agreed-upon times. Acknowledging and validating the caregivers’ feelings can help them self-regulate, in turn allowing them to co-regulate their children. Specific regulation strategies can also be taught and practiced for both the caregiver and children (e.g., massage, yoga and movement, breathing exercises). Providing information and support that normalizes caregivers’ feelings can also be helpful. They will likely be stretched thin during this time, so permission and encouragement to engage in self-care is important. Caregivers cannot give what they don’t possess.

Keep in mind that trauma can (re)surface during these difficult times. Helping the caregiver and/or the child make connections to trauma reminders and providing grounding strategies may be helpful. Developmental guidance is often used in office sessions for children. This practice should continue during telehealth, including specific resources on reactions children may have to the stress of the changes due to COVID-19. The practitioner can be a curator of information for the caregiver and the child, helping sift through a sea of information to determine the most helpful and least sensational. An important piece of developmental guidance will be the need for play with children. Encouraging this as a therapeutic strategy in the telehealth session, perhaps even facilitating this (if the practitioner has video conferencing available), will be helpful to the caregiver.

In all the interactions with the caregiver and child, the practitioner should keep in mind the role of culture, being aware not only of differences in reactions to crisis or in resources available, but also of strengths. Connecting children and their caregivers to cultural practices that bring hope and foster resilience are helpful during these uncertain times. They may also help ease some of the isolation felt during the restrictions due to COVID-19.

Adolescents
The use of telehealth for adolescents may be a logical fit. Because adolescents have been raised on technology, they are quite comfortable with videoconferencing and may even prefer to receive services via telehealth rather than in traditional office settings. Youth may not feel comfortable receiving services in traditional clinic settings, as they can be intimidating, overwhelming, or overstimulating. The building layout (such as waiting rooms), bright lights, number and diversity of people who are waiting or moving about the clinic, and other environmental factors can create severe anxiety or fear and perhaps result in disruptive behavior. This is particularly true for children and adolescents who have experienced trauma or those with intellectual or developmental disabilities, who may struggle with safety issues, or find transitions to different or unfamiliar environments very challenging. These factors are mitigated if the youth can remain in a comfortable and familiar setting.

Another way that telehealth is supportive of adolescent developmental needs is related to the need for power and control and a sense of competence. Telehealth contributes to these needs being met in several ways. Adolescents are very sensitive to power differentials that occur, as a result of their age and relationships, which can be challenging due to a lack of trust of adults. When adolescents are in a safe and comfortable place and face-to-face with the practitioner, there is equality in the physical comparison of both individuals shown on monitors, and the acknowledgement and demonstration of technology skills can provide a sense of competency and power in the relationship. Adolescents’ technological competence may also carry over to the family power structure.

Finally, providing services through the use of technology can help reduce stigma and promote engagement. Adolescents worry a great deal about what their peers think of them and may be concerned about what peers will think if it becomes known that they are going to therapy. The use of telehealth can allay some of these concerns and promote engagement and treatment compliance.

Overall, there is significant evidence both that adolescents are quite comfortable with the use of telehealth and that telehealth is effective with a number of adolescent problems, including school-related behaviors, ADHD, trauma, and substance use disorders (SUDs), among others. Even if well

**Supervision Considerations**
Now more than ever, practitioners need good supervision. Telehealth and video platforms provide the ability for practitioners to meet virtually with supervisors and colleagues for support and guidance. The COVID-19 situation is rapidly changing, as are the responses of many health and safety agencies. Quality supervision that is case based and reflective provides support to practitioners that are holding difficult space for children and families during this time.

In addition to the clinical challenges, practitioners are also likely dealing with their own adjustments due to COVID-19. For many, they are also at home with family members, attempting to cope with their issues and anxieties related to the virus. Supervision should include reflecting on how this is impacting the practitioners’ therapeutic work. Even if well
versed in telehealth services, most practitioners were not practicing in settings like bedrooms with their entire family at home. Holding space for their own families, themselves, and their clients is likely to produce burn out, secondary trauma, and decreased effectiveness without getting adequate supervision and support. Practitioners should be a model to their clients by taking good care of themselves through supervision and other means.

Summary
COVID-19 provides many challenges to the well-being and social emotional functioning of children. The stress on caregivers makes it difficult for them to provide the needed support for children. Mental health practitioners can provide a helpful service to children and their families through the use of telehealth and other technologies. With some adjustments and careful set-up, providers can connect with children and families to give them the tools and support they need to get through these difficult times.

JBS Staff: Experts You Can Trust
Our staff offer an array of clinical and technical expertise to address the prevention and treatment of mental health issues and SUDs. Brief bios of a sampling of our staff are provided below.

Melinda Campopiano von Klimo, MD, JBS Senior Medical Advisor: Dr. Campopiano is a family doctor, boarded in addiction medicine, and an expert in primary care. Over her 18-year career, she has led a family medical practice, served as Medical Director of opioid treatment programs (OTPs), and treated patients with buprenorphine in an office-based setting. As a Medical Officer at SAMHSA for 5 years, Melinda had regulatory authority for OTPs, updated the federal guidelines for OTPs, and wrote new regulations expanding access to buprenorphine, before joining JBS.

Jennie Cole-Mossman, MA: Ms. Cole-Mossman is a mental health specialist, whose expertise spans child-parent relationships, family drug courts, opioid use disorder (OUDs) and SUDs, and trauma screening for young children (ages 0 to 3). She currently supports the Office for Victims of Crime (OVC) Training and Technical Assistance (TTA) project. She brings a special expertise to serving the youngest child victims of opioid-related crimes. Jennie has served as Co-Director of the Nebraska Resource Project for Vulnerable Young Children at the Center on Children, Families, and the Law, University of Nebraska, for the past 5 years. Earlier, she led the Safe Start project for young children. She conducts extensive training and provides TTA to strengthen relationships between providers of children’s trauma services and drug courts, with a focus on increasing trauma care for infants and toddlers.

Yanika Lewis, CADC: Ms. Lewis is one of many JBS staff who are certified as and have served as addiction counselors, providing treatment to patients in the full range of settings and focusing on OUDs. These staff now serve as technical experts on JBS’ consultation work with community coalitions and providers, state systems, and federal programs.

Joseph Perpich, MD, JD, JBS Senior Medical Advisor: Dr. Perpich is a board-certified psychiatrist, trained in forensic psychiatry, with a focus on SUD treatment, and an attorney by training. He has been involved with OUD, SUD, and mental health programs for much of his 40-year career, including working in the early 1970s in methadone clinics to treat heroin addiction, which were being created in Washington, D.C., by Dr. Robert DuPont, who went on to be the first director of the NIDA and then the second White House Drug Czar. Joe was Director for Program Planning and Evaluation in the NIH Office of the Director and the Vice President for Grants at the Howard Hughes Medical Institute and has built research learning collaboratives on SUD training and treatment and on suicide prevention programs.

Kim Walsh, LSW, MPA: Ms. Walsh is an experienced state director and non-profit administrator, with more than 34 years as a behavioral health practitioner, specializing in mental health; substance use prevention, treatment, and recovery; children’s services; and victim and tribal family services. In her role as a West Virginia (WV) State Director, she oversaw the state’s SUD prevention, treatment, and mental health systems; the State Opioid Treatment Authority; and specialty women’s services. Drawing on her experience as a survivor of intimate partner violence, Kim has served in various counseling and advocacy roles throughout her career and currently serves as the lead for the OVC TTA project, with 59 grantees across 37 states, helping to ensure program access and support for young victims impacted by substance use.

Aldrenna Williams, DrPH: Dr. Williams has over 30 years of experience in addressing social determinants of health in marginalized groups, including justice-involved populations. She
currently provides TTA to OVC project grantees to support children and youth who are crime victims as a result of OUD/SUD and to HRSA’s RCORP project grantees addressing OUD/SUD in their rural communities. Previously, Aldrenna led a team providing TTA supporting a federally funded clinical TA criminal justice treatment contract for more than 200 federally funded grantee drug courts, offender reentry programs, teen courts, and tribal wellness-to-healing courts that provided substance use treatment services for justice-involved adults, juveniles, and families.

Karen Yost, MA, LSW, LPC, NCC, ALPS, MAC, CCDVC, CSOTS: Ms. Yost has many years’ experience in behavioral health services to children, adolescents, and adults as a therapist, program developer, and administrator. She is a specialist in trauma, addictions, domestic violence, and sex offender treatment and is a certified school counselor in grades K-12. Previous experience includes being the Chief Executive Officer of WV’s largest comprehensive behavioral health center, and she currently supports the OVC TTA project. In addition, Karen has significant grant experience and successfully implemented many federal and state grants that resulted in creative services for children and families in WV.

References And Resources


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