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Barriers to Pediatric Mental Healthcare Access: Qualitative Insights from Caregivers

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ABSTRACT

The Centers for Disease Control and Prevention approximates that 1 in 5 children experience a mental or behavioral health disorder. Pediatric mental healthcare service access cannot be improved without strong coordination between educational settings, social service providers for children, and adequate policy support. Addressing this critical child development issue is dependent on us understanding the barriers to mental healthcare access faced by pediatric populations. This qualitative study explored barriers to pediatric mental healthcare access based on in-depth interviews with 53 key informants representing childcare settings, K-12 schools, foster care settings, and evidence-based home visitation programs. Semi-structured interviews with participants identified barrier-related themes and subthemes. The themes reflect a series of hurdles related to pediatric mental healthcare access including, lack of preparedness/training for pediatric mental health screening and management, limited resources, lack of policy support, transportation, and family issues that have hindered mental health support for children. The findings highlight the compounding barriers to pediatric mental healthcare services and point to opportunities for improving pediatric mental health using a holistic approach. Future research should focus on designing and implementing community and organization-based strategies to break down these barriers for families to optimize their children's mental health and wellness.

KEYWORDS

Barriers; educators; caregivers; pediatric; mental healthcare; social services

Introduction

Mental healthcare access within the United States (U.S.) is a multifaceted and vexing issue. Not only is the system challenging to navigate for adults, but it is equally problematic to navigate for their children. Optimal health eludes many Americans due to multiple obstacles in the healthcare system, including high healthcare costs, insufficient or no health insurance coverage, inaccessibility of healthcare services, lack of cultural competency within the healthcare system, and language barriers (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). These barriers are also pervasive in mental healthcare for children and can cause delays in necessary treatments or care.

Poor mental health has received increased attention in the United States over recent years and has become recognized as a national public health crisis. Mental health-related issues afflict millions of Americans each year, many of whom are children. Positive mental health development is crucial for growing children, providing a foundation for a healthy adulthood. The Centers for Disease Control and Prevention (CDC) reports that approximately 20% of American children experience mental or behavioral health issues (Centers for Disease Control and Prevention (CDC), 2021), pointing to an urgent need for healthcare access for children and their families. The most prevalent mental health disorders in children include depression, various

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forms of anxiety, attention deficit hyperactivity disorder, and autism (Centers for Disease Control and Prevention (CDC), 2021). According to the 2018-2019 National Survey of Children's Health (NSCH), about 48000 Nebraska children were diagnosed with mental health disorders needing treatment. The most prevalent concerns were anxiety, attention deficit disorder/attention deficit hyperactivity disorder, depression, and autism spectrum disorders (Child and Adolescent Health Measurement Initiative (CAHMI), 2018–2019).

Because of the various disorders, many screening tools and techniques are used to assess children's needs. Screening for mental health burdens differs widely across age brackets. For example, young children below the age of 5 are seldom screened for mental health disorders, although they could be at risk. The widespread belief that children are resilient and unaffected by stressful situations and environments may be to blame (Pestaner et al., 2021). Literature has shown that the school environment and teachers play a significant role in meeting children's mental health needs (Anderson et al., 2019; Brown et al., 2017; Greytak et al., 2013; Hadlaczky et al., 2014; Kelly et al., 2011; Pullmann et al., 2013). Addressing gaps in mental healthcare screening could be facilitated through universal and routine screening at schools (Pestaner et al., 2021). However, the absence of universal screening persists in many educational settings, and some students may not be diagnosed until seen by their pediatrician (Hodgkinson et al., 2017). Adolescents are at particularly high risk for undiagnosed mental health issues due to the nature of the transitional life stage between childhood and adulthood (Borah et al., 2021). Poor engagement with healthcare services, including mental health among children's caregivers, can be an additional barrier to care (Becker et al., 2018).

The financial cost of children's mental healthcare is a commonly cited impediment for U.S. families. With many U.S. families struggling to be financially self-sufficient, obtaining the necessary care may not be affordable. Poverty in and of itself can be a risk factor in children's mental health and is part of a systemic barrier to obtaining mental health services (Santiago et al., 2013; Witt et al., 2003). Hodgkinson and colleagues (2016) suggest that systemic changes must be widely implemented to reduce the high levels of poverty affecting U.S. children, reducing the negative consequences of poverty on children's mental health. If a family is in crisis and needs access to a homeless shelter, poor mental health outcomes could arise for both the caregivers and children due to the accumulation of stress (Hussein, 2018; Marçal et al., 2021; Ma et al., 2008).

Health insurance can make obtaining mental health services and treatment options more feasible for Americans, but according to information compiled by the United States Census Bureau, approximately 8% of those living in the U.S. do not currently have health insurance (Keisler-Starkey & Bunch, 2020). This has likely been exacerbated by the COVID-19 pandemic, causing many Americans to lose health insurance through their employment. In addition, researchers found that Latino and African American children in the U.S. are at an increased risk of remaining uninsured for extended periods compared to white children (Flores et al., 2017), suggesting a need to focus on the intersection of race and healthcare accessibility. Furthermore, because there may be healthcare coverage gaps, simply having health insurance does not necessarily make pediatric mental healthcare affordable for all families.

There is a need to increase cultural competency among many healthcare workers in the United States. . For non-English speaking parents it is difficult to navigate the mental health treatment for their children. Therefore, it is important to increase the number of multi-lingual pediatricians and other providers. In addition to needing more diverse healthcare providers, the Midwest also needs additional culturally competent providers. This includes knowing how to engage with diverse patients and supporting families in their preferred language (St. John et al., 2012). Primary care providers must be committed to culturally competent training and reducing disparities afflicting economically disadvantaged populations (Hodgkinson et al., 2017). Schools must also be engaged with culturally appropriate care to provide feedback to families that may not access outside healthcare services.

Lack of access to healthcare services is another barrier that families in America face when seeking high-quality mental healthcare. In urban areas, acquiring the appropriate healthcare service is more accessible than in rural regions. Families living in rural areas often have limited access to resources in their local communities and may be required to travel long distances to find the necessary mental healthcare services for their children. Patients who lived within five miles of their healthcare provider were more likely to utilize services than patients who lived greater than five miles from a provider (Upadhyay et al., 2019). For financially insecure families, transportation continues to be a barrier to healthcare access (Syed et al., 2013; Bhandari et al., 2014). Accessing mental health services through a specialist is often more effective than seeking help from a primary care provider (Upadhyay et al., 2019), which may be more laborious for families given their transportation barriers. Bornheimer et al. (2018) found that one of the primary reasons families did not participate in mental health sessions was the lengthy travel time between home and the facility. This could be ameliorated by increased online services and broadband internet access.

Mental health stigma, involving negative perceptions from those in the community, may concern racial and ethnic minorities (Santiago et al., 2013), especially if culturally competent providers are locally unavailable. In addition, respondents of a recent study cited that they were expected to "get over" mental illness and have been accused of "faking" issues such as anxiety and depression to get attention in their rural communities (Crumb et al., 2019), further stigmatizing mental health and making it challenging to seek help from professionals.

Despite the documented barriers to pediatric mental healthcare access, to the best of our knowledge, no qualitative studies in the literature have focused on exploring the perception of key informants in the community representing childcare, schools at various levels, foster care, and evidence-based home visitation programs on pediatric mental healthcare access barriers. These community institutions or programs serve large numbers of children and can act as gatekeepers for mental health screening and referral. As the number of children with mental health disorders grows, the burden on these programs grow as there is not a concomitant increase in the number of mental health providers trained in serving children. This leaves many children at risk of not being treated. In addition, untreated mental health problems in children tend to worsen with development, resulting in disproportionate increases in mental illness rates across the life course. To improve pediatric mental healthcare in Nebraska, this study aims to qualitatively assess key informants' experience in addressing pediatric mental health issues and identifying related barriers to accessing mental healthcare services.

Methods

Participants and Setting

This study used data collected by the Center for Reducing Health Disparities at the University of Nebraska Medical Center as part of a statewide assessment of community-level screening of behavioral, mental and emotional problems among children and youths (Toure et al., 2020). The Institutional Review Board (IRB) of the University approved the study.

The research team worked with diverse education and social service organizations serving children and their families across Nebraska to recruit school nurses, teachers, program managers, or directors at various educational settings such as schools, daycare programs, foster care programs, and home visitation programs in both urban and rural areas in the state to achieve geographic diversity in the sample. Purposive sampling method and snowballing technique were used to recruit key informants of 19 years of age or older serving these programs throughout Nebraska. Fifty-three participants were recruited across the state using purposive sampling methods, allowing the findings to be generalized to the Nebraskan population. Pediatric behavioral and emotional healthcare accessibility is an ongoing and narrowly understood obstacle within the Nebraskan public health system.

Data Collection

The research team developed an interview guide to facilitate the discussion based on the study's purpose. The interview guide was structured in seven parts: (a) Opening the interview and welcoming the interviewee, (b) Explaining the purpose and the structure of the interview, (c) Assuring the interviewee that the results will be aggregated with no names attached, (d) Verbal consenting to record the interview, (e) Conducting the interview – ask main questions with probing and allow the participant to answer, (f) Closing the interview, and (g) Saving the recorded discussion at a secured location for transcription.

Key informants were recruited and interviewed from May through August 2020 in the form of semi-structured interviews (via Zoom) on a pre-arranged day and time according to participants' convenience. Before each interview, informed consent was emailed to potential participants to explain the study purpose, participation parameters, and foreseeable risk and benefit. At the beginning of the interview, informed consent was confirmed from those willing to participate. Each interview, on average, lasted approximately 30 to 45 minutes. Three trained research personnel with knowledge and experience in qualitative research conducted the interviews. During the interview, our interviewer would ask a key informant a series of questions using the semi-structured interview guide with open-ended questions and additional probes when needed (Table 1). The questions primarily focus on pediatric mental healthcare accessibility in the Nebraska healthcare system. Each interview was Zoom-recorded.

Data Analysis

The recorded interview was transcribed verbatim, and two research team members conducted thematic analysis through repeated reading of the transcripts. The analysis followed Smith and Shinebourne (2012) Six-Step protocol, which includes (i) Reading/Re-reading - By immersing themselves in the transcript, the research team becomes acquainted with the interview concept, (ii) Coding - The research team identifies codes and groups them into preliminary themes, (iii) Clustering - Themes emerge as a result of common themes and subthemes, (iv) Iteration - During the iterative process, several revisions are made, including checking themes, subthemes, and quotes, (v) Narration - Based on the findings, the research theme creates a narrative. The narration process entails describing the themes and illustrating them with quotes, and (vi) Contextualization - Refers to how researchers interpret their findings in relation to existing literature.

Thematic analysis transitions from descriptive to interpretive mode - The procedure started by categorizing each transcript into broad themes and then, through further review, translated the data into more specific themes. For methodological uniformity, two researchers separately coded the interviews once transcribed (Elo et al., 2014). The emerging ideas were then discussed and analyzed as a group to arrive at the

Table 1. Interview questions.

Questions	Probing questions
How do you know if a child in your program/school might have a behavioral or emotional disorder?	*Do you routinely screen for: Social and Emotional Development, Autism, …?* *Do you routinely screen for adolescent depression?* *Do you routinely screen for substance use among adolescents?* *Do you routinely screen for social needs such as food insecurity, lack of transportation, safe housing? If so, do you use a standardized approach?* *Do you routinely screen for interpersonal violence and trauma?* *Do you routinely screen for maternal or caregiver depression?* *Do you routinely screen for maternal or caregiver substance use?*
What is the procedure when a child is identified with a potential behavioral or emotional concern?	*How do you handle referrals for families with a child with a potential behavioral or emotional concern?* *Based on your observation and knowledge, what should be done to better detect and address behavioral or emotional problems among children in your program?*
How well do you think you and your colleagues are prepared or trained to cope with behavioral or emotional problems in your organization?	

Table 2. Barriers to pediatric mental health accessibility identified by participants.

Theme	Subthemes	Codes
Barriers of accessing mental health	Preparedness/Training	• Inadequate preparedness & training • Limited knowledge
	Limited Resources	• Lack of community resources • Lack of staff – diversity • Language issues • Referral issues
	Policy	• Strict guidelines • Limited Funding
	Transportation	• Distance • Affordability
	Family issues	• Parent mental status

final themes, achieving a 95% coding agreement. The qualitative analysis software NVivo 12 (QSR International Pty Ltd, 2018, Melbourne, Australia (NVivo, 2018)) was used to manage and code the data. The present study's reporting is based on the Standards for Reporting Qualitative Research (SRQR) framework (O'Brien et al., 2014).

Results

Participant Characteristics

A total of 53 participants completed the semi-structured interviews. Most of the participants were female (n = 49; 92%). Out of the 53 participants, 21 (40%) were associated with a school program, and 18 (34%) held a managerial position within their organization. Twenty-eight of the respondents were from rural areas and twenty-five from urban areas in Nebraska.

Thematic Findings

The participants identified a wide range of barriers related to the accessibility of services for pediatric mental health. Our coding of the qualitative data revealed five significant barriers, including (a) preparedness/training (inadequate preparedness and training, and limited knowledge), (b) limited resources (lack of community resources, limited staff with diverse race and ethnicity, language barriers, and referral issues), (c) policy (restrictive guidelines and limited funding), (d) transportation (distance and affordability), and (e) family issues (parental mental status), as exemplified by related representative quotes listed in Table 2.

Preparedness and Training of Key Informants Inhibiting Effective Pediatric Mental Healthcare

Most of the participants spoke extensively about the impact of limited training and their preparedness to provide pediatric mental healthcare. One of the participants stated that:

> "I don't seem very prepared…. if there is any kind of training, meaning that we could do to better identify clients [who] may be feeling depressed or have some natural or emotional behaviors disorders, training us in how to identify that. Because I do not feel like we're well equipped in that." [31]

Other participants acknowledged that they were not fully competent and needed more training to detect early signs of behavioral and emotional concerns and manage them.

> "I feel like we need training. I wouldn't say that we're totally competent. I think we do need a lot of training in terms of looking at behavioral and emotional problems and how to cope with them at student levels." [22]

> "I think we definitely, myself included, probably need some more training." [29]

Hence, as illustrated by Table 3, a participant reported that she seems to have inadequate knowledge or awareness regarding pediatric mental health assessment tools. Further, more respondents commented that their colleagues were not well trained to manage pediatrics mental health needs due to different education, training, and experiences.

Limited Resources Inhibiting Pediatric Mental Healthcare Access

Many participants reported inadequate resources to meet the full spectrum of pediatric mental

Table 3. Preparedness and training inhibiting pediatric mental healthcare access.

"I don't think I am as prepared as I should be. I don't think I have enough tools in my toolbox to really help." [17]
"As a school psychologist, I have a fair amount of training…. I would say that my colleagues are very much less well trained to cope with the very much changing behavioral and emotional needs of students." [47]
"For newer staff, I don't think they are well-trained to cope with it unless, depending on their background, like their education or their experiences." [25]
"I think it depends on our education and training. I have a Master's in psychology, but my coworker has a bachelor's in early elementary or early education…. we've been trained in different areas. So, I feel like I can handle a lot of the emotional behavioral issues. I worked in the foster care system and worked there for over 20 years, so I've dealt with a lot of emotional behavioral issues…. but she [new staff] was telling me that she feels like she needs more training in those areas. I think it just depends on what we have been exposed to and what we've been trained in." [16]

health needs. One participant was concerned about the resources they had in their community.

> "As you know, I always feel like our hands are tied because of the lack of community resources…." [11]

Another participant expressed concerns about the number of children compared to the available resources.

> "I think part of the concern is we have 10,000 kids, and we don't have the resources to meet the needs of 10,000 kids." [42]

Participants reported limited human resources, which leads to referral issues.

> "We have a waiting list in all of our program…developmental psychologist who serve kids under the age of five. There's usually pretty long waiting list for those kinds of referrals." [32]

> "The peer support is very, very important…. But you can't be there 24 hours a day and then these youth that are homeless, I mean, what do you even do? … You cannot take them to the places what they are lacking. And that, to me is the hardest part." [11]

Other participants were concerned about the referral process outside the school in the rural part of Nebraska and stated:

> "Okay, so I think referring families out to providers out of the school, honestly, in rural Nebraska, it can be difficult. I would also say that, you know, you are asking about insurance and things, and oftentimes families don't have the resources to go out of the school to seek therapy and maybe don't always follow up the number of times that maybe would be necessary. So, I think that parents accessing services outside of the school setting is difficult for families." [47]

Further, participants noted that the long waiting list and informal referral process could also be barriers to pediatric mental health. Some participants talked about the limited availability of culturally diverse providers who could be multi-lingual and assurance. Others also spoke in general terms about the importance of diversifying the staff. In addition to staff diversity, participants stated the language and insurance barriers as a hindrance to the accessibility of mental health (see Table 4 for illustrations).

Policy Inhibiting Access to Pediatric Mental Healthcare

Participants noted that it is beneficial to conduct comprehensive screening for pediatric mental health issues. However, they expressed that stringent policy limits their ability.

> "I do think that it could be beneficial to screen some behavioral or emotional concern among the children and their patterns. I think it would be helpful, but our Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) guidelines are so strict." [31]

> "We're not using a formal trauma or risk assessment tool because we're directed by the State Department to use the routines-based interview process." [45]

Another participant pointed out that the restricted funding to pediatric mental health for the school settings hinders to access to pediatric mental healthcare.

> "I believe it starts at legislation, and I think that our state government needs to put more funding in schools for mental health…." [44]

Transportation Barriers Inhibiting Pediatric Mental Healthcare Access

Participants stated that limited pediatric mental health providers in the community could hamper the referral process for families of low

Table 4. Limited resources inhibiting pediatric mental healthcare access.

"I think [referral process] could be better. Uh, again, it's not very formal or anything like that." [29]
"I need more providers in our community because the need is higher than the availability of folks. I think we need many Spanish speakers." [53]
"It would be nice if we could have a clinician in some ways on staff, although we found a very good one that we contract with like we'll even do staff training." [11]
"There's a need for our services, especially mental health services for families that…don't speak English or don't have health insurance." [32]
"Working with community leaders like for the Karen or any populations, a lot of them don't even have the words in their language to describe mental health issues and so figuring out how to work with those communities to normalize these things are real and there should be opportunities for help." [53]
"In our pediatric social work program, many of the parents we work with do not have health insurance." [32]
"They[parents] didn't feel like they could afford health insurance, or it wasn't provided through their job. So, there have been families that have struggled because, or this is another big problem." [16]

socioeconomic status as they cannot afford the transportation to visit providers from afar.

> "…Where to send families to that already living in poverty? They do not have the money to go back and forth between Omaha if their child can even get into one of these places." [11]

Another key informant suggested that transportation hinders the referral process as the nearest healthcare providers are far away.

> "In the areas [mental health] that we work in, and some of our community is just [limited] having access to…. when we need to do a referral that isn't available to our families…. But if you know this, the nearest mental health providers 40 to 50 minutes away, and our families don't have transportation." [15]

Family Issues Inhibiting Access to Pediatric Mental Healthcare

Uniquely, one of the rural participants singled out parents' mental health issues that could impact children access to mental health services. The participant stated:

> "Obviously family engagements are probably pretty huge. So, my main concern is typically how well the parents are functioning? If you have parents that have mental health and addiction issues, it is very hard for them to follow through with the requirements needed to support their kids." [42]

Participants also revealed that if parents/families are resistant to seeking help, this inhibits access to pediatric mental healthcare.

> "So, if they [parents] don't want to sign their consent, we usually have a conversation with them of their concerns and then we go back to the problem-solving process where we can offer them more accommodations and modifications. And so that's usually where we go and because if they don't sign their consent, then we can't go forward with an evaluation period." [44]

> "We try to counsel the families but at the end its the decision of family if they want the referral or not." [39]

> "I mean, if the family is not receptive, then you know, there's really not much more we could do unless it's something that's court ordered or something like that, you know, that we can only suggest —a recommender can't do any type of policing or enforcement." [22]

Discussion

This qualitative study assessed the perception of Nebraska's key informants working in childcare systems, schools, foster care, and home visitation programs on mental healthcare access for the pediatric populations. Overall, the study identifies various barriers to accessibility to pediatric mental healthcare services in Nebraska and recognizes the need to respond to these issues. The main themes identified are *barriers to accessing pediatric mental healthcare services*. Five subthemes emerged within the *barrier*s theme: preparedness/training, limited resources, policy, transportation, and family issues.

Most respondents reported *limited preparedness, training, and knowledge* as barriers inhibiting pediatric mental healthcare access. Consistent with the literature (Fazel et al., 2014; Hadlaczky et al., 2014), educators' training was overwhelmingly discussed as an area of needed improvement. Participants provided lists of various training sessions regarding specific topics; however, many of them agreed that the training often lacked content, method of delivery, or targeted inappropriate audiences. Previous research has consistently shown that educator training is more

congruous and effective if tailored to the specific audience (Brown et al., 2017; Greytak et al., 2013, Kelly et al., 2011); however, this is more expensive and time-consuming than general training provided to all child contacts within the school system. Additional evidence-based training programs and more precise role definitions for childcare educators could help address these gaps in knowledge. Social service agency workers serving children are experiencing high levels of workload, often with low salaries and poor opportunities for professional development. A recent study in England demonstrated that child and family social workers score significantly higher on all levels of burnout compared to adult social workers (Hussein, 2018). It may be challenging to add more training to a set of social service professionals already burdened at work. It is imperative to work to incentivize and grow a larger mental health workforce to serve the growing numbers of children with mental health disorders.

Associated with limited preparedness, *limited resources*, *staffing issues, and referral issues* were stated as barriers by urban and rural child educators. Limited resources included workforce, referral issues, and insurance impediments. Participants suggested a need for additional human resources, primarily for staffing within schools. Limited human resources within the schools and the local communities create barriers to receiving good mental healthcare services, particularly for students experiencing housing insecurity, insurance, and transportation issues. These barriers disproportionately affect children and families of low socioeconomic status, alluding to a need for comprehensive, affordable mental and behavioral healthcare services. To help address the challenges of K-12 teachers, it is important to prioritize the integration of education and mental health services for children (Anderson et al., 2019; Atkins et al., 2010). This has been increasingly important during the pandemic and will persist beyond the crisis point of the pandemic. Providing social service providers within the school setting or providing teaching and administrative staff with easy referral mechanisms to community mental health services would help meet student mental health needs while diminishing the burden on classroom teachers.

In our sample, referrals were handled appropriately within individual schools and facilities; however, breakdowns occurred in the communication between childcare educators and outside care providers. Clearer communication between schools and providers is needed to support pediatric behavioral and emotional health problems. Additionally, participants cited issues related to *insurance* and *income*, supporting the need to create more school-based resources for children and youth, and funding sources for these resources need to be clearly defined (Flores et al., 2017; Keisler-Starkey & Bunch, 2020; Strobel & Harpin, 2020). Moreover, increased cultural awareness is needed, especially in areas where Spanish is the preferred language. Particularly in rural areas of Nebraska, where there is a deficit of bilingual or multilingual healthcare providers. Early implementation of these resources could aid preventive care, increasing positive health outcomes and future successes for children and youth in Nebraska.

The subtheme of *transportation* was noted in the barriers to accessing mental healthcare. Transportation is commonly cited as an obstacle to providing care in rural areas (Bhandari et al., 2014; Bornheimer et al., 2018; Syed et al., 2013); however, this subtheme was only brought up in our study by a participant in an urban setting. This finding may be related to specific community limitations in our sampled participants where barriers were mainly related to income and resources, like accessing public transportation rather than location. Additional research is needed to explore further how transportation affects mental healthcare access in Nebraska.

Policy issues were stated as a barrier to accessing mental healthcare services. Healthcare access can be hindered by bureaucratic limitations (Upadhyay et al., 2019). Several participants noted that improved policies around screening and increased statewide funding would help to alleviate pediatric mental healthcare access barriers in Nebraska. This suggests a need to create collaborative policies through engagement between childcare educators, healthcare providers, and local public officials.

Lastly, several participants cited *family issues* as a barrier to receiving mental healthcare

services for children. Consistent with previous literature, a parent or guardian struggling with mental illness or addiction may have limited availability of resources to find the necessary health services for their children (Marçal et al., 2021; Ma et al., 2008; Witt et al., 2003). Regardless of childcare educators' best efforts to address the mental and behavioral health needs of children served, parents and educators must accept help and have the resources to follow through with assistance.

Limitations & Strengths

The limitations for this study include a predominantly female participation rate of 92%, although this is somewhat representative of the large number of women working within pediatric and youth education spaces. Further limitations may include hindrances in response due to the necessity of audio and video calls in contrast to in-person interviews. Due to the ongoing COVID-19 pandemic, safety precautions prevented in-person interviews, limiting verbal communication between the interviewer and interviewee, providing important insights into the discussion.

The present study cites numerous barriers and obstacles necessary to overcome disparities for pediatric mental healthcare across various educational systems, increase the pediatric mental health workforce, and provide a coordinated system of referral between educational and social service agencies to best serve the mental health needs of children. This study adds to the limited body of research on pediatric behavioral and emotional healthcare accessibility across Nebraska. New research questions could be generated from our data collection, supporting other community needs assessments and community asset mapping within urban and rural areas of Nebraska.

Conclusions and Future Directions

Accessing mental healthcare is urgently needed for pediatric communities across Nebraska to establish preventive care in early childhood development. Our qualitative study provides an in-depth analysis of mental healthcare services access for the pediatric populations from educators' perspectives, adding to the sparse literature in this area. The major identified barriers include (a) the lack of training, preparedness, and limited knowledge in detecting early signs of behavioral or mental health disorders among educational staff; (b) inadequate health care resources in the community that would allow for accessible referrals and timely provision of mental health services for children when needed; (c) the lack of policy support for incorporating pediatric mental health screening in extant health programs in educational systems; (d) transportation and geographic distance to the nearest mental health specialists and facilities as an important barrier; and (e) the urgent need of addressing family and parental factors such as depression, addiction, lack of awareness of children's mental health status and needs, and lack of willingness to seek mental health services for children when needed.

These identified barriers have implications for future steps the educational system, health care providers, social service providers and policymakers can take to improve pediatric mental health services and how the four systems can work together to develop coordinated program efforts to address each of the identified barriers. There is a need for school health programs to broaden their scope to include screening mental and behavioral health issues using validated assessment instruments and providing related training to staff members. Such a need becomes more apparent during the current COVID-19 pandemic when children and their families are on constant alert of how the evolving pandemic might pose health risks and disrupt schooling. Meanwhile, findings from our study also point to the need for increasing the provision of mental health services in underserved communities. Some of these services could be provided through telehealth or tele-consultation to overcome the geographic distance and avert related transportation costs for families. The relevant policy supports through reimbursements and updated program guidelines on addressing unmet needs in pediatric mental health will help facilitate and sustain the provision of related services in underserved communities. A child-centered, holistic approach involving educators, families, mental health and

social service providers, and policymakers will help address the multi-layers of barriers and improve access to pediatric mental health services. Future research should focus on designing and implementing community and organization-based strategies to break down these barriers for families to optimize their children's mental health and wellness.

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Informed Consent

Key informants were recruited and interviewed (via Zoom) on a pre-arranged day and time according to participants' convenience. Before each interview, informed consent was emailed to potential participants to explain the study purpose, what participation in the study incurs, and foreseeable risk and benefit. At the beginning of the interview, informed consent was confirmed from those willing to participate.

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