



THE REORGANIZATION OF A COMMUNITY MENTAL HEALTH CENTER FOR CHILDREN AND YOUTH DUE TO THE COVID-19 PANDEMIC

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La crisis sanitaria causada por la COVID-19 ha forzado una reorganización de los servicios de salud mental. El presente artículo describe una propuesta de reorganización aplicada en una unidad de salud mental infanto-juvenil (atención ambulatoria y comunitaria). Se exponen las estrategias concretas de intervención desarrolladas en las distintas fases de la pandemia según las medidas de restricción sanitarias y los distintos niveles de intervención requeridos (prevención, atención primaria y atención especializada). Además, se compara el número de visitas hechas durante el periodo de Marzo-Julio de 2020 con el mismo periodo en 2019. Concluimos que se ha producido una rápida adaptación del marco asistencial presencial a la metodología telemática mediante una reorganización flexible. Sin embargo, la disminución de la asistencia presencial y la cancelación de grupos terapéuticos han incrementado la presión asistencial notablemente. Se ha observado un incremento de conductas autolíticas y de problemas relacionados con la conducta alimentaria que deberán ser investigados en futuros estudios.

Palabras clave: Psicología clínica infanto-juvenil, Salud mental, COVID-19, Salud mental infanto-juvenil, Organización servicios.

The health crisis caused by COVID-19 has caused a reorganization of mental health centers. This article describes the reorganization proposal that was applied in a child and adolescent mental health unit (outpatient and community care). The specific intervention strategies developed in the different phases of the pandemic are presented according to the restriction measures and the different levels of intervention required (prevention, primary care, and specialized care). In addition, the number of visits made during March-July 2020 are compared to the same period in 2019. We conclude that there has been a rapid adaptation from the face-to-face care framework to a telematic approach through a flexible reorganization. However, the decrease in face-to-face assistance and the cancellation of therapeutic groups have significantly increased the pressure of care. A rise in autolytic behaviors and eating pathologies has been observed that should be investigated in future studies.

Key Words: Clinical psychology, Mental health, COVID-19, Child and adolescent mental health, Services organization.

The effect on the general population's mental health of the COVID-19 pandemic and the lockdown carried out as a containment measure has already been the subject of study in the literature, for example Brooks et al. (2020). Regarding the mental health impact that pandemic situations can produce, it is known that most of the population will have sufficient coping resources (Taylor, 2019). However, Inchausti, García-Poveda, Prado-Abril, and Sánchez-Reales (2020) point out several population groups that are at special risk of presenting psychological consequences, and the population that has a history of having suffered one or more mental health problems is one of the most relevant. Therefore, The Lancet in its editorial (2020) and Yao, Chen, and Xu (2020) call for adequate care for this population.

Child and adolescent mental health care in particular is especially relevant, since it is known that most mental disorders develop during

this life stage and that early intervention is decisive (Vyas, Birchwood, & Singh, 2014). Regarding the psychological effects of the pandemic on children, Marques de Miranda, da Silva Athanasio, Sena Oliveira, and Simoes-e-Silva (2020) find that children have experienced anxiety, depression, and the post-traumatic symptoms expected after any disaster. The effects of school closures, social isolation, and changes in family dynamics should be considered for a more detailed study.

The closure of schools has meant that families in situations of social vulnerability have been able to provide fewer educational resources for their children (Oxfam Intermón, 2019). On the other hand, the subsequent return to the classroom may have reactivated separation anxiety due to the rupture of family dependencies and adaptation to new routines (Pelaez & Novak, 2020). In addition, children had their regular sources of social connection removed, with the negative effects of social distancing likely to be particularly acute in adolescents (Blakemore, Orben, & Tomova, 2020). A recent review (Loades et al., 2020) links children's social isolation to higher rates of anxious and depressive symptomatology. In addition, Liu et al (2020) point out the concrete consequences of separation from parents in cases of isolation to avoid contagion, finding that 30% of children develop post-traumatic stress disorder.

Received: 26 February 2021 - Accepted: 20 September 2021

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In many cases the containment measures also meant intensive cohabitation for families unaccustomed to it, with high relational conflict or in precarious housing conditions. Save The Children (2020) found an increase in conflict situations between parents and children during confinement in 31% of families. To this we must add that parents have presented high levels of stress related to the combination of teleworking and childcare, the loss of work and income, concerns about the risk of contagion, or affection by the death of family members (Fegert, Vitiello, Plener, & Clemens, 2020).

To prevent the future emergence of more severe mental disorders, several articles and guidelines, including the World Health Organisation itself, advise of a potential increase in mental health problems and the need for specific policies and investment in specialist health services, particularly for the younger ages (Pierce et al., 2020; World Health Organisation, 2020).

However, the public mental health network has been affected not only by the reduction in outpatient face-to-face activity but also by the indication to avoid emergency consultations and the temporary closure of psychiatric hospitalization units so they could be dedicated to the medical care of COVID-19 patients. As a result, outpatient centers have had to attend to patients who were already being visited, to serious patients who could not be hospitalized in inpatient units, and to new demands arising in relation to the crisis.

For these reasons, it has been fundamental to have been able to adapt child and adolescent mental health services in order to guarantee care. There have been few clear recommendations found in the literature on how to do this, and some of them are mentioned here:

- ✓ Planning and coordination of the psychological interventions applied at different levels and by different professionals (Inchausti, MacBeth, Hasson-Ohayon, & DiDimaggio, 2020; Zhang, Wu, Zhao, & Zhang, 2020).
- ✓ Information to the population on managing stress and uncertainty, addressing the fear of contagion and possible symptomatology arising from the confinement situation (Zhang et al., 2020).
- ✓ Primary care screening of the most vulnerable cases related to stressors associated with COVID-19 (Pfefferbaum & North, 2020).

The objectives of this article were to describe the reorganization of a child and adolescent mental health center (CAMHC), following these recommendations and according to criteria agreed between the professional team and the institution to which it belongs. CAMHCs are outpatient care services specialized in mental health aimed at people under 18 years of age and their families. Specifically, the CAMHC of Les Corts and Sarrià - Sant Gervasi, of the Associació CHM Les Corts (Barcelona), has a reference population of 41,020

minors up to the age of 18 years (Barcelona City Council, 2020), and its methodology and community care vision contemplate the comprehensive care of the person (in individual, family, educational, and social aspects) and multidisciplinary networking.

CARE REORGANIZATION

On 14 March 2020, the Spanish Government declared a state of alarm (RD 463/2020; published in the BOE no. 67 of 14/03/2020), which was extended until 21 June 2020. The state of alarm involved the application of special measures such as limiting the free movement of persons, the suspension of face-to-face educational activities, and the strengthening of the national health system. At the beginning of May, after the strict lockdown, a gradual relaxing of restrictions began until the end of June. Subsequently, and in response to further outbreaks of the epidemic, new temporary measures have been implemented to contain contagion. In this context, we proceed to detail the reorganization of care in the aforementioned child and adolescent mental health center. To make this possible, institutional support for the IT aspects and flexibility in the management of the teams have been fundamental. Likewise, the multidisciplinary support among professionals from different services of the institution has been key in the teams’ moments of greatest fragility.

From the beginning, the reorganization was approached dynamically and was adapted to each of the stages of the crisis, combining short and long-term measures to ensure treatment and continuity of care at different times of the pandemic and potential new waves of positive cases. A review of the literature on the different strategies used in other countries for mental health intervention was carried out. The management and care team of the center opted for a reorganization based on different phases, according to the restriction measures, taking into account the different levels of intervention (prevention, primary care, and specialized care), establishing specific strategies for each of them (see Figure 1).

Initial phase

The initial phase was developed during the first weeks of strict lockdown and involved a cessation of ordinary face-to-face activity. In compliance with government recommendations on the monitoring of prevention measures, the reduction of mobility and the facilitation of teleworking, the objectives of the service were to reorganize the care activity so that it became mostly telematic, to protect patients and professionals by avoiding travel, to maintain contact with the agents of the community network of care for families (health, education, social services), and to provide information to the general population.

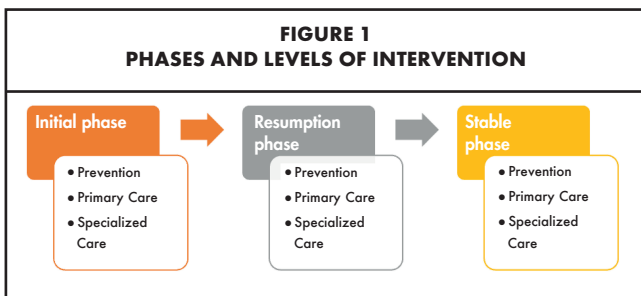
The specific strategies carried out at each level of intervention are detailed below (see Figure 2).

Level I. Prevention and promotion of mental health.

The strategies developed were aimed at providing information to the general population and the community network on COVID-19 adapted to minors, the management of stress, fear, and uncertainty, common adaptive reactions in the child and adolescent population, promotion of healthy habits, and advice for parents.

- ✓ Strategy 1: Development of infographics with psychoeducational material disseminated through the institution’s website, social networks, and distributed to the community network.

**FIGURE 1
PHASES AND LEVELS OF INTERVENTION**





- ✓ Strategy 2: Telephone and email hotline within the framework of a pre-existing program (Ajuntament de Barcelona [Barcelona City Council], 2020), aimed at young people aged between 12 and 22 who suffer from emotional distress, their families, and professionals who work with adolescents. The program aims to promote healthy habits as well as early detection and immediate care. The activity is carried out through an open consultation one afternoon a week and contact via telephone or email.
- ✓ Strategy 3: Psychoeducational video capsules on physical and mental health promotion habits during lockdown for adolescents through educational centers. Reconversion of a mental health literacy workshop program (Casañas, Mas-Expósito, Teixidó, & Lallucat-Jo, 2020) for secondary school students aimed at promoting mental health, preventing mental disorders, eradicating stigma, and improving help-seeking.

Level II. Specialized psychological intervention in primary health care. The presence of mental health professionals ceased, and the regular activity was cancelled.

- ✓ Strategy 1: Telephone assessment of the first scheduled visits.
- ✓ Strategy 2: Maintaining communication with primary care professionals, facilitating interconsultation, and referral in reactive and emergency situations.

Level III. Specialized intervention in CAMHC.

The activity was reorganized to be mostly telematic, in order to give continuity to the treatments and to attend to new demands.

- ✓ Strategy 1: Establishing of shift work teams to reduce attendance and ensure coverage of urgent consultations.
- ✓ Strategy 2: Provision of protective equipment and review of prevention protocols.
- ✓ Strategy 3: Telematic patient care with the remote installation of the clinical management program, the use of telephone calls and videoconferencing, and the review of data protection procedures.
- ✓ Strategy 4: Inter-team communication through weekly telematic meetings to update information.
- ✓ Strategy 5: Analysis and prioritization of patients at greater risk of psychopathological destabilization. Maintenance of face-to-face care for post hospital discharge visits, clinical cases of autolytic or psychotic behaviors, turmoil at home, or dispensing of injectable psychopharmacological treatments.
- ✓ Strategy 6: Initial screening of first consultations. As described in Pfefferbaum et al. (2020), the initial assessment included a

screening for COVID-19-related stressors, secondary adversities, psychosocial effects, and vulnerability indicators (see Table 1).

- ✓ Strategy 7: Telephone clinical examination and intervention in crisis situations at home. A specific procedure was established that included: i) analysis of the context and manifestation of the crisis, ii) description of precipitating and maintaining elements, and iii) creation of an intervention plan together with the family. Certain clinical profiles and environmental situations of higher risk were considered, such as patients with psychotic and autistic spectrum diagnoses, emotional instability, obsessive-compulsive, anxious-depressive-avoidant, substance abuse and dependence, minors in residential care due to removal of custody, children of adults with severe mental disorder, children of parents in legal separation processes, or children in a situation of domestic violence.
- ✓ Strategy 8: Specific elements for intervention. Several tools were identified as key to psychological intervention:
 - Validation and contextualization of normal adaptive reactions.
 - Self-awareness of stress reactions and training in identification of cognitive, emotional, and bodily factors.
 - Identification and development of coping skills.
 - Grief intervention.

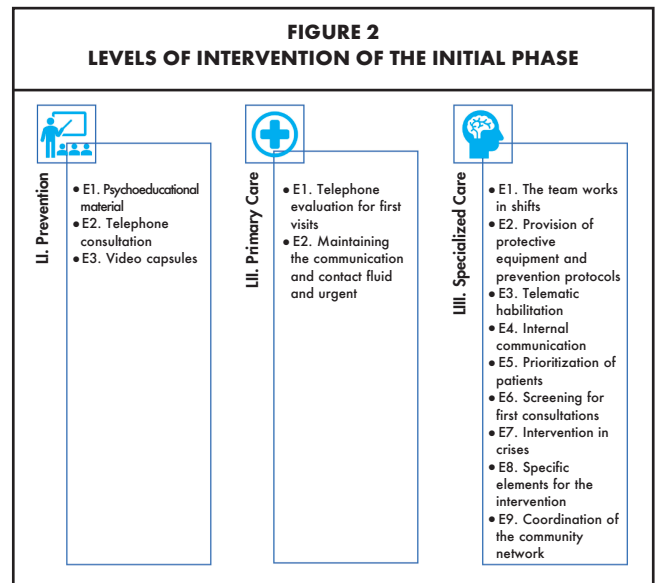


TABLE 1
SCREENING ITEMS FOR INITIAL PSYCHOLOGICAL EVALUATION

Stressors related to COVID-19	Secondary Adversities	Psychosocial Effects	Indicators of vulnerability
<ul style="list-style-type: none"> ✓ Has anyone in your family been infected? ✓ Has a family member passed away? ✓ Have any family members had to be isolated due to COVID-19? ✓ Has the child been able to maintain contact with loved ones and friends? 	<ul style="list-style-type: none"> ✓ Do any parents have concerns about job loss? ✓ Does the family have financial problems? ✓ Have they had to go to social services to apply for financial or food assistance? 	<ul style="list-style-type: none"> ✓ Has the child exhibited symptoms of anxiety or depression? ✓ Has the child presented alterations in eating or sleeping? ✓ Have any parents had symptoms of anxiety or depression? ✓ Have there been situations of domestic violence? 	<ul style="list-style-type: none"> ✓ Was there any previous somatic or psychological history in the child? ✓ Was there any previous somatic or psychological history in the parents?



- ✓ Strategy 9: Constant coordination with the community network (such as psycho-pedagogical care teams, social services, child and adolescent care programs, shelters, and residential centers, among others).

Resumption phase

The resumption phase of activity began with an increase in the presence of professionals at the center in the format of alternating teams during the week and the progressive resumption of face-to-face visits to 50% (see Figure 3).

Level I. Prevention and promotion of mental health.

Maintenance of the strategies initiated in the initial phase, with an increase in the presence on social networks and the implementation of evaluation surveys.

Level II. Specialized psychological intervention in primary health care.

- Resumption of the standard operation of the program telematically.
- ✓ Strategy 1: Enabling remote access to primary care medical record programs.
- ✓ Strategy 2: Emotional screening for pediatric consultations (see Table 2).
- ✓ Strategy 3: Brief and focal telematic intervention in pandemic reactive situations in relation to emotional distress, technology abuse, and bereavement.
- ✓ Strategy 4: Resumption of individual interconsultations and meetings. Work was carried out with the pediatric teams on guidelines to promote family coping in the pandemic (Jiao et al., 2020): in-

creasing communication between parents and children; actively asking about the situation and redirecting concerns; playing collaborative family games; maintaining eating, sleeping, and physical exercise habits; encouraging a positive and productive attitude; and using relaxation methods.

Level III. Specialized intervention in CAMHC.

In view of the possible increase of conflict in families, stress, irritability, sadness, and fears in both parents and children, specific preventive interventions were developed.

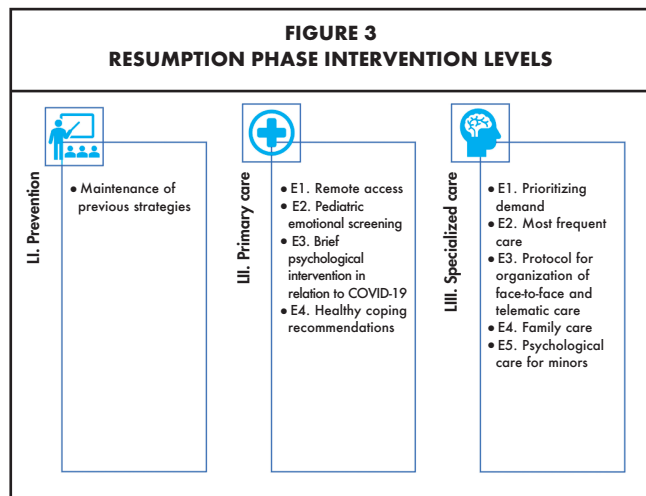
- ✓ Strategy 1: Prioritization of the waiting list for first visits.
- ✓ Strategy 2: Prioritization of users attended to, in order to increase the intensity of treatment in cases of greater fragility.
- ✓ Strategy 3: Organization of face-to-face and telematic activity through specific protocols: i) clinical criteria for telematic and face-to-face care (see Table 3), ii) safety measures for face-to-face visits, iii) telematic intervention with data protection consents.
- ✓ Strategy 4: Attention to the anxiety and depression symptomatology of parents based on a family systemic orientation as a previous approach to the symptomatology presented by the children, as well as the awareness of their own reactions to fear, uncertainty, sadness, or stress. Open conversations between parents and children were encouraged in order to improve the understanding of the symptoms and the development of coping skills.

A situation that received special attention was the overexposure to dysfunctional family dynamics and intra-family violence without the presence of other environments that previously offered healthier bonding alternatives, such as school. To this end, the sensitivity and capacity to detect possible risk situations was increased, and greater availability was offered in the cases that were identified.

- ✓ Strategy 5: Psychological care for minors. From an ideographic approach and in order to design an individualized intervention plan, a history of each case was made to analyze previous experiences of loss and coping style along with the detection of needs, risk factors, and protective factors. The analysis and promotion of cognitive flexibility was considered to be a key determinant of adaptive capacity.

Stabilization phase

The **phase of stabilization** of activity after the strict confinement from the end of June onwards entailed the maintenance of telematic activity as a stable therapeutic option and the creation of a plan for the reorganization of care in the event of new outbreaks. This phase has been extended over time with the appearance of new waves of infection of the disease. Although the marketing of the first vaccines for



**TABLE 2
SCREENING ITEMS FOR PEDIATRIC EVALUATION**

Stressors related to COVID-19	Psychosocial situation	Psychological symptoms
<ul style="list-style-type: none"> ✓ Has anyone in your family been infected? ✓ Has a family member passed away? ✓ Has the child been able to maintain contact with loved ones and friends? 	<ul style="list-style-type: none"> ✓ Is the family a user of social services? ✓ Do you have financial difficulties? ✓ Is domestic violence suspected? 	<ul style="list-style-type: none"> ✓ Sleep pattern disturbance ✓ Altered intake pattern ✓ Difficulty concentrating ✓ Irritability ✓ Hyperactivity and/or hypoactivity ✓ Concerns ✓ Fear of infection ✓ Sadness ✓ Increased dependence



COVID-19 in December 2020 suggests a more favorable scenario, we can expect continuity in prevention measures and the need for maintenance in the medium and long term.

At the methodological level, the strategies implemented have been consolidated, and activities that had been interrupted have been resumed.

Level I. Prevention and promotion of mental health.

At the time of the reopening of the educational centers, mental health literacy workshops have been restarted in classroom and online formats, addressing the effects of the pandemic on adolescents in a comprehensive way. Online training courses in emotional first aid for professionals working with young people are also being carried out.

Level II. Specialized psychological intervention in primary health care.

The leading role in this third phase of primary health care as an agent in the detection and treatment of COVID-19 prevents many basic health areas from carrying out face-to-face visits by specialists, so care activity and interconsultation continue to be carried out telematically. Inter-team sessions are being organized to enable joint training throughout the area of influence to improve the early detection of psychopathology in minors.

Level III. Specialized intervention in CAMHC.

The team continues to be divided into shifts, with 50% of visits being face-to-face and 50% telematic. Immersion in the use of telematic tools for intervention has been a challenge and has involved a capacity for adaptation in both patients and practitioners during these months. The definition of a portfolio of telematic services, the development of specific procedures, and the training of professionals in their use will be a challenge for the coming months.

Quantitative description of the telematic care activity at the CAMHC

An analysis was carried out of the quantitative data relating to the number of visits made during the period 16 March to 31 July 2020 as well as a comparison with respect to the same period in 2019.

Of the total care activity carried out in the 2020 period, 86.25% was telematic and 13.75% face-to-face. The breakdown of visits by type is as follows: 54% of first visits were telematic compared to 46% in person, 86% of individual visits were telematic compared to 14% in

person, 90% of visits with parents or guardians were telematic compared to 10% in person, and 82% of family visits were telematic compared to 18% in person. Regarding coordination and interconsultations among professionals of the same team and other services, 100% were carried out telematically (see Table 4).

Of the total care activity carried out during the same period in 2019, 11.18% were telephone visits and 88.82% were face-to-face visits. As for coordination and interconsultations, 58.23% were by telephone and 63.20% were face-to-face (see Table 5).

Comparing the same periods in 2020 with respect to 2019, we can see how the number of telematic visits has gone from a token presence to practically all of them. In 2020, the total number of first visits made, regardless of the format, was 30.32% less than the corresponding figure for 2019.

In the data analysis it is also worth noting the cancellation of all ongoing group therapeutic treatments. Some telematic group treatment sessions were carried out. These treatments are regularly a fundamental axis of the therapeutic approach of the CAMHC and represented 36.19% of the total number of treatments in the period from March 16 to July 31, 2019. During the 2020 period, there was an increase of 38.85% in non-group treatments compared to 2019.

CONCLUSIONS

This article synthesizes a proposal for the reorganization of care applied in the CAMHC of Les Corts and Sarrià - Sant Gervasi (Barcelona), based fundamentally on the different state and international health recommendations during the COVID-19 crisis, and on the methodology and the community care vision that characterize this institution.

At the institutional level, the design and implementation of this reorganization of care has had two major complementary objectives: to provide it with a solid structure that is applicable in the very short term, which would quickly reach all layers of the service, and in turn have flexibility and/or adaptability to change in constant interaction with the evolution of this health crisis, including the future “post-COVID” phase. The latter has been critical given the changing and novel nature of this pandemic, the urgent measures to combat it, and the present and future needs of mental health service users. To ensure the above, the close collaboration of all staff has been required, with direct and weekly communication among senior management, middle management, and the whole care team. The schedules and shifts of

**TABLE 3
CHARACTERISTICS AND OBJECTIVES OF THE FACE-TO-FACE AND TELEMATIC INTERVENTION**

Face-to-face intervention	Telematic intervention
<ul style="list-style-type: none"> ✓ Assessment requiring specific psychodiagnostic testing ✓ Psychopathological exacerbation ✓ Hospital or emergency discharges ✓ Suicidal risk and self-injurious behaviors ✓ Eating behavioral disturbances of moderate severity ✓ Suspicion of risk to the child in the home ✓ Doubts about the confidentiality of telematic processing ✓ Severe patients at risk of social isolation 	<ul style="list-style-type: none"> ✓ Treatment of known and stable patients ✓ Treatment of patients in lockdown ✓ Treatment of patients or relatives at risk due to organic pathology. ✓ First visits of parents to collect the reason for consultation and anamnesis. ✓ Patients with emotional and behavioral management difficulties who cannot follow safety measures even with a companion. ✓ Adolescents with face-to-face bonding difficulties ✓ Network coordination meetings

**TABLE 4
PERCENTAGE OF TELEMATIC AND FACE-TO-FACE VISITS IN THE PERIOD FROM 16 MARCH TO 31 JULY 2020**

Type of visit	% Telematic visits	% Face-to-face visits
First visits	54%	46%
Individual visits	86%	14%
Parent/Guardian Visits	90%	10%
Family visits	82%	18%
Group visits	100%	0%
Interconsultations	100%	0%
Total	89%	11%



the practitioners have been restructured taking into consideration their diversity of needs and work conciliation, and naturally, the adaptation of the face-to-face care framework to a telematic one. Although many of the measures taken are of a temporary nature, it has been fundamental that these form part of the usual and already existing protocols of the mental health care service, in order to reactivate them as quickly, efficiently, and flexibly as possible. In this sense, the data show a rapid implementation and adaptation of the telematic methodology among professionals, within a framework of community intervention at different levels. In short, it has been possible to maintain an adequate care intervention. However, the impossibility of carrying out group treatments has had to be compensated by individual interventions. Another worrying occurrence is the decrease in the number of first visits during the first months of the pandemic. This could be explained by a greater retention and endurance of the reasons for consultation and by the lower accessibility to the agents of early detection and referral to the CAMHC such as primary care, social services, and schools. To test this hypothesis, the evolution of care data during 2021, in new waves, and in the future post-COVID phase will be studied.

At the level of user demands, in the first phase of the pandemic it was possible to delineate a perceived increase in insomnia, irritability, tantrums, anxiety crises, increased use of screens, fear of contagion, and missing friendships, school ties, and significant family relationships. At the time of completion of this article in January 2021, in the hospital and community mental health network of the area, an increase has been reported with respect to previous levels of first visits of adolescents with ideation, self-harming behaviors, and eating disorders. These observations need to be empirically contrasted in future descriptive research.

With regard to the assistance provided to users, it has been complex to combine the above with a comprehensive vision of the child and the parents and/or family (individual and group), and of course, the essential multidisciplinary networking. The planning and continuity of intervention in mental health has prioritized coordination with the different health and community services, and especially with educational ones. The absence of the structuring and socializing framework exercised by the school has been central in many of the interventions carried out.

With regard to psychological interventions via telematic means, although these are described as effective, in addition to their

undeniable versatility in such a changing context of health crisis, they have made it difficult to carry out clinical and/or diagnostic assessments that required the use of face-to-face methods and tools or group treatments where play and real interaction are fundamental. It is considered that the video call cannot replace face-to-face contact with the user, who may find therein the necessary safe and confidential space, especially for those people who do not have telematic access or who live in situations of risk or neglect.

Another relevant aspect is that telematic intervention may generate a change in the responsibility for the therapeutic process, with the professional instead of the family initiating the contact. Likewise, it can also foster the idea that, through this channel, complex diagnostic, relational, and family problems will be solved. It is therefore important to clarify and specify in the protocols the opportunities and limitations of this methodology.

As an advantage, the telematic framework presents possibilities in non-care interventions such as intra-team coordination in situations of territorial dispersion, and inter-team and training activities among others.

Finally, and to sum up, this crisis, with its undesirable consequences, is also a heuristic that has provided cohesion, polyvalence, and greater diversity of care possibilities that, if well organized, can benefit users and the promotion of current community resources. The implementation of this reorganization of care has demonstrated the great flexibility and permeability of the care team towards the demands and urgent needs of the context, without losing sight of the necessary resources that professionals require in order to, at the very least, continue to provide a mental health service that adds quality.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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TABLE 5
PERCENTAGE OF TELEMATIC AND FACE-TO-FACE VISITS IN THE PERIOD FROM MARCH 16 TO JULY 31, 2019

Type of visit	% Telematic visits	% Face-to-face visits
First visits	0%	100%
Individual visits	11%	89%
Parent/guardian visits	0%	100%
Family visits	0%	100%
Group visits	0%	100%
Interconsultations	8%	92%
Total	7%	93%



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