VIEWPOINT

Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents

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States and localities are taking unprecedented steps to respond to the public health threat posed by the coronavirus disease 2019 (COVID-19) pandemic. Among the measures intended to promote social distancing, many schools have been closed and classes shifted to home-based distance-learning models. The first school closures began in mid-March 2020 and some states have already closed schools for the rest of the academic year. Nearly all of the 55 million students in kindergarten through 12th grade in the US are affected by these closures. School closures substantially disrupt the lives of students and their families and may have consequences for child health. As such, we must consider the potential associations school closures have with children's well-being and what can be done to mitigate them.

Children and adolescents are generally healthy and do not require much health care outside of regular checkups and immunizations. However, mental health care is very important for children and adolescents. Most mental health disorders begin in childhood, making it essential that mental health needs are identified early and treated during this sensitive time in child development.[1] If untreated, mental health problems can lead to many negative health and social outcomes.

The COVID-19 pandemic may worsen existing mental health problems and lead to more cases among children and adolescents because of the unique combination of the public health crisis, social isolation, and economic recession. Economic downturns are associated with increased mental health problems for youth that may be affected by the ways that economic downturns affect adult unemployment, adult mental health, and child maltreatment.[2]

Educators, administrators, and policy makers must minimize the disruptions that school closures will have on academic development. Schools offer many other critical services to students outside of education. For example, schools are a major source of nutrition for many students, and ensuring food security has been a common component of school closure plans. However, other services are equally essential to children's health and must be addressed.

One potentially overlooked role played by schools is the delivery of health care, and especially of mental health services. Schools have long served as a de facto mental health system for many children and adolescents.[3] Data from the nationally representative National Survey of Drug Use and Health (NSDUH) include information on mental health services for children age 12 to 17 years and illustrate the implications of school closures on access to mental health services.

An analysis of the 2014 NSDUH by found that 13.2% of adolescents received some sort of mental health services from a school setting in the past 12 months, corresponding to 3 million adolescents.[4] This includes a mix of adolescents who attend a regular school and receive services from a mental health clinician there and adolescents who attend a special school or a special program at a regular school for behavioral or emotional problems. An analysis of the 2012 to 2015 NSDUH found that among all adolescents who used any mental health services in the year, 57% received some school-based mental health services.[5]

Furthermore, among adolescents who received any mental health services during 2012 to 2015, 35% received their mental health services exclusively from school settings.[5] School closures will be especially disruptive for the mental health services of that group. It is important to also understand that school closures will be relatively more disruptive for the mental health care of some youths. Adolescents in racial and ethnic minority groups, with lower family income, or with public health insurance were disproportionately likely to receive mental health services exclusively from school settings.[5] These students may lack the family resources and existing relationships with clinicians to quickly gain access to alternative community-based services. Policy makers should consider responses to address COVID-19's short-term disruptions for children's mental health services while also laying groundwork to improve children's mental health services in the long term.

Facilitating Technology-Enabled Modalities That Expand, Extend, and Sometimes Replace Traditional Face-to-Face Encounters

Telemental health services are shown to be similarly effective as in-person services.[6] Not all school-based clinicians and not all families have the technology needed to implement this as a comprehensive immediate solution, but when possible, it can help in the short term. However, close attention must be paid to not exacerbate inequities in access to care. In the long term, policy, financing, and delivery reform can help expand these modalities and reduce the existing barriers to timely mental health care. Options include adopting Medicaid policies that deem all patient and client contact equivalent and guaranteeing full-cost reimbursement for telemental health services as not to diminish the needed workforce during a crisis. If school-based and other in-person mental health services are inaccessible to children and adolescents, it highlights the potential value for other technology-enabled interventions. Although there is limited effectiveness of mobile mental health apps for adolescents currently, this is an area in which innovative technologies could fill a substantial gap if demonstrated to be effective.

Addressing Privacy Concerns

The US Department of Health and Human Services has allowed for a limited waiver to loosen Health Insurance Portability and Accountability Act (HIPAA) rules in response to COVID-19. This means that tools that had not been HIPAA compliant (eg, Facetime [Apple]) are now available to clinicians for evaluation and treatment. This temporary change may be instructive for whether HIPAA regulations might be rebalanced in the longer term if the relaxed rules improve access to care. Other privacy restrictions might be reconsidered, even temporarily. For example, the US Federal Educational Rights and Privacy Act disallows disclosure of identifiable information from education records. This may be a barrier to coordinated care for students who now must receive services outside of school but whose clinicians are unaware of relevant information that the school may possess. In addition to privacy regulation, clinicians should be mindful that other privacy considerations may hinder the use of telemental health services. With physical distancing recommendations in place, some youth may be unable to access telemental health services in a private setting away from parents and siblings. This barrier may be especially important for lower-income families with smaller living spaces.

Coordination With Community Mental Health

The Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration have issued guidance to states about what state Medicaid programs can do to increase and improve the delivery of mental health services in schools.[7] One model involves schools coordinating with community mental health agencies to deliver services within schools. This model can allow students to engage with those service clinicians even outside of school settings, which is particularly advantageous during a school closing but can also help encourage continuity of care more broadly. Medicaid is the largest funder of mental health services in the US, and states can submit State Plan Amendments to provide federal financing for this model of services, which can enhance the financial viability of this mode, and mental health services for students more broadly.

COVID-19 will have major repercussions for children and adolescents' health and well-being. Timely action can help lessen the effects and improve long-term capacities for mental health services.

ARTICLE INFORMATION

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