

Adolescent mental health, COVID-19, and the value of school-community partnerships

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ABSTRACT

Newly released 2019 Youth Risk Behavior Surveillance System data and the Center for Disease Control and Prevention's (CDC) 2019 Youth Risk Behavior Survey Data Summary and Trends Report show that US adolescents continue to suffer from poor mental health and suicidality at alarming rates. These data alone would be cause for concern, but the COVID-19 pandemic has the potential to further erode adolescent mental health, particularly for those whose mental health was poor prior to the pandemic. Given the status of adolescent mental health prior to COVID-19 and the impact of COVID-19, health professionals and schools must partner together now to mitigate potentially deleterious health, mental health and education impacts for children and adolescents.

New data from the Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) show a troubling trend: statistically significant increases in adolescent suicide-related behaviours and feelings of sadness and hopelessness. From 2009–2019, the nationally representative survey found significant increases in the per cent of US high school students experiencing persistent sadness or hopelessness (from 26% in 2009 to 37% in 2019), seriously considering attempting suicide (14%–19%), making a suicide plan (11%–16%) or attempting suicide (6% to 9%).¹ White, woman or sexual minority (lesbian, gay or bisexual) students were at higher risk than non-white, men and heterosexual students.²

These data alone would be concerning, but the COVID-19 pandemic³ may further erode adolescent mental health, particularly for those with poor mental health prior to the pandemic. Early evidence from China and literature on youth and mass trauma indicate that COVID-19 could have immediate and long-term mental health impacts on children and adolescents.⁴ A rapid review of the impact of loneliness on child and adolescent mental health found strong associations between feelings of loneliness and depression and mental health problems up to 9 years after the social isolation. The duration of the loneliness was a stronger predictor of depression than the intensity of the loneliness.⁵ Studies examining the impact of COVID-19 on youth mental health found similar effects, including worry, irritability, acting out, eating and sleeping changes, depression and post-traumatic stress disorder. The number, severity and duration of these symptoms are influenced by age, history of trauma, psychological status before the event, hours spent watching

media coverage of the event, having a family member who died and the presence or absence of social and economic supports.^{6,7}

Nationwide school closures may also limit access to and receipt of mental health services for many vulnerable youths. In 2018, nearly 3.5 million adolescents received mental health services in education settings.⁸ Adolescents with public insurance, from low-income households and from racial/ethnic minority groups, were more likely to only access services in an educational setting, compared with services in both educational and other settings or in other settings only (private specialty or general medical settings).⁹ While some mental health providers have offered telemedicine services, the capacity of schools to provide these services is unclear. Furthermore, some families may lack the technology required to access these services, if they do exist.

Given the status of adolescent mental health prior to COVID-19, the potential impact of COVID-19, and below-recommended ratios of school counsellors and psychologists to students,^{10,11} school-community partnerships can be instrumental in supporting students and staff. The Multi-Tiered System of Supports (MTSS) framework,¹² used by many school districts to guide their mental health activities, can structure this work. MTSS includes three tiers of support. Tier 1 provides supports for all or nearly all students; tier 2 focuses on smaller groups of students needing support beyond those offered in tier 1 and tier 3 includes more intensive, tailored services for individual students.

Tier 1 emphasises mental and emotional health; these interventions are often delivered school-wide or to an entire grade. During the 2020–21 school year, schools can consider implementing or expanding social and emotional learning (SEL) programmes. SEL programmes such as the Good Behaviour Game for elementary students and Youth Aware of Mental Health programme for teens are associated with decreases in suicide ideation and attempts¹³ and increases in social and emotional skills, attitudes, behaviours and academic performance.¹⁴ SEL programmes are also associated with reductions in clinical diagnoses (ie, depression, anxiety) across racial, ethnic and socioeconomic status groups, for several years after programme implementation.¹⁵ Student connection to school can also protect or buffer young people from health risk behaviours, including suicide ideation and attempts.¹⁶ School-wide programmes with evidence of increasing student connectedness include the Child Development Project, Seattle Social Development Program and Raising Healthy Children.¹⁷



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Schools alone cannot identify youth needing greater mental health support. Universal screening, which may also be a tier 1 approach, offers an opportunity for health professionals and schools to partner. Effective school-based mental health screening requires: (1) a sufficient number of trained health professionals to conduct screening and review results in a timely manner; predetermined follow-up timelines, including a tiered follow-up approach based on risk level¹⁸; (2) staff to immediately identify students in crisis and who need immediate intervention (may be the same staff as number 1)¹⁹ and (3) partnerships with youth-friendly health services for those needing intensive intervention. Community partnerships can vastly improve the ability of schools to provide mental health screening and treatment.

More students may need tier 2 approaches in the 2020–2021 school year. Tier 2 approaches can be delivered by either a school counsellor or community health professional. These approaches focus on issues such as problem-solving, grief and loss and typically occur in smaller groups than tier 1 approaches, such as small group counselling sessions.²⁰

Tier 3 strategies, such as individual counselling, are for students already experiencing mental health challenges to prevent symptoms from worsening and other symptoms from developing.²¹ Tiers 2 and 3 create many opportunities for partnerships with community health professionals. Revised Centre for Medicaid Services criteria for allowable mental health services and additional federal funding through, for example, the US Department of Education can help increase the ability of schools to partner community health providers. These partnerships can be vital in increasing student access to youth-friendly, affordable, local services that could be provided on-site, at a convenient off-site location, or remotely.

Implementing school-based prevention and intervention strategies promoting social and emotional well-being at all three MTSS levels can improve educational outcomes,²² save money²³ and promote mental and physical well-being for students and their families.¹⁵ Community-based health providers can support schools in this work and can work with students and their families in community-based settings. Moving forward, YRBS will measure patterns in adolescent well-being. The 2021 YRBS will include new mental health and household financial instability questions, including questions about the impact of the COVID-19 pandemic. These data will be used to monitor the impact of COVID-19 epidemic and enable practitioners to enhance or adapt efforts accordingly. Given the increased COVID-19-related mental health stress on the nation's students, school-community mental health partnerships are now, more than ever, essential to the health and well-being of our young people.

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