Coronavirus Disease 2019 and Effects of School Closure for Children and Their Families

To the Editor | Risks for mental health of children and adolescents in the era of the coronavirus disease 2019 (COVID-19) pandemic, owing to school closure and quarantine, have been delineated by Golberstein et al.\(^1\) We further extend their implications of school closure for children and their families, an issue that undergoes a deafening silence in the public debate.

Mental health of children and adolescents undergoes a sudden stress test during quarantine\(^1\) that causes a complete, sudden, and unprepared loss of direct social relationships with peers, representing a significant human need and stimulus for well-being, socioemotional development, and self-identity in this age range. Direct social relationships are limited to family members, with increased risks of loneliness; especially in the absence of home outdoor spaces, school closure significantly increases the risks for (1) physical health; (2) addiction to video games and binge watching (clearly exceeding daily time limits of screen exposure indicated by pediatric guidelines); and (3) alteration of circadian rhythms. Moreover, compulsory coexistence with family members may increase the risk of direct or assisted verbal or physical domestic violence. Finally, school closure may have profound effect on academic achievement, especially in the youngest children and in children of families with low socioeconomic status.\(^2,3\) If school closure will be confirmed for the remaining months and also summer camps will be impeded, the well-known summer learning gap will be amplified,\(^4\) especially for children of families at low socioeconomic status and for children with preexisting neuromotor developmental or mental health conditions of vulnerability. Families with low socioeconomic status have less available possibilities in terms of suitable places to do homework, electronic devices, internet access, and owned books\(^2,3\); parents themselves in the case of low socioeconomic status, exemplified by the immigrant parent-child acculturation gap,\(^5\) may be less able to motivate and help them in this new experience of online schooling. Therefore, educational systems should plan and finance extraordinary ad hoc interventions to reduce long-lasting effects of prolonged school closures, especially for more disadvantaged children, focused but not limited to learning. Moreover, school closure is a serious and impeding problem also for working parents if they are allowed to return to work, considering that other family members who can provide resources, such as grandparents, are probably quarantined themselves. In conclusion, medical, educational, and economic competencies should implement strategic plans for a progressive restart of educational activities that may ensure a calculated trade-off between risk of COVID-19 infection, reduction of learning gap, and restart of working for parents.

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To the Editor | The coronavirus disease 2019 (COVID-19) pandemic will have major implications on the mental health of children and adolescents. To address gaps in mental health care associated with COVID-19, Golberstein et al\(^1\) propose technology-enabled modalities, such as telehealth (ie, telemental health), as a potential solution.\(^1\) While acknowledging that some schools and families may lack access to technology to support telehealth and remarking that existing inequities must not be worsened,\(^1\) the authors missed an opportunity to note that in rural areas, where youth mental health needs are arguably most profound, limited broadband accessibility may preclude use of telehealth services entirely.

In rural areas, increases in suicides among children aged 10 to 19 years outpaced those of urban youths by 1.5 times between 2010 and 2018, exacerbating an existing disparity for youths with limited access to mental health clinicians. Ergo, the potential consequences social distancing may have on rural youths, particularly those with preexisting mental health difficulties, have generated concern. Rural youths have less access to technologies that many hope will temper the effects of isolation from friends and social networks. What if technology is not a viable option for mitigating youth mental health challenges posed by COVID-19?
Schools recognize that internet accessibility is critical to provide education continuity amidst school closures during the COVID-19 pandemic. \(^2\) However, short of providing tablets and devices to families, there is little schools can do. Internet providers in some areas have reduced service fees, but costs may remain a barrier in a time of economic crisis. Moreover, in many rural areas, broadband speed necessary for telehealth is simply not available. Rural broadband infrastructure is sorely needed. \(^3\) The health care/mental health community must be aware of disparities in mental health clinician access for rural youths, higher rates of suicide in rural areas, and the reality that telehealth may not be a realistic option for rural communities.

Technology-enabled modalities, such as telehealth, have often been cited as the sole tool to circumvent COVID-19-related restrictions to accessing mental health clinicians, without acknowledgment that the inadvertent ways that such interventions may actually exacerbate existing inequalities. Galea et al.\(^4\) suggested communities train nontraditional groups to offer psychological first aid and build community connectivity while maintaining social distancing. Others have provided considerations for suicide prevention tailored to rural communities during the COVID-19 pandemic. \(^5\) To reach youths in rural communities, creative approaches must be used until state and federal policies address the need for improved broadband infrastructure necessary to make telehealth a reality. \(^3\)

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In Reply Coronavirus disease 2019 (COVID-19) continues to highlight the critical importance of addressing mental health in children and adolescents and the foundational role of schools. In our Viewpoint,\(^1\) we highlighted 3 policy areas that deserved attention.

In response, Graves et al. astutely point out that without broadband infrastructure and accessibility, many rural youths will miss out on the opportunity to benefit from much needed telehealth mental health services. Most of the United States has access to broadband services, but major gaps remain in rural areas. \(^2\) We wholeheartedly agree that this should be a focus. Telehealth financing and regulation are important, and we encourage policy makers to make the changes to telehealth services from the Emergency Order permanent while working to expand these provisions for other commercial health plans. It is vital that children and their families can access quality mental health care through whatever remote modality is available to them. To facilitate this, telehealth services should be covered and paid at the same level as face-to-face visits, and the quality and outcomes from these telehealth services should be tracked. State Medicaid programs can take the lead here because they cover a large share of children and mental health services. But we should also invest in broadband expansion to ensure rural and other underserved communities have equitable access to mental health care.

Poletti and Raballo also respond and correctly describe the ways that quarantines and school closings negatively affect children and their families. They make a critical point about school closings: that there is a need to invest in and implement interventions to reduce long-lasting effects of prolonged school closures.

Beyond what we describe here, policy makers should prioritize 2 other areas for action. First, support frontline Medicaid clinicians who provide most mental health services in this country. A survey of mental health clinicians shows that many mental health clinics and community-based services are at risk of closing without financial help.\(^4\) With the expected increased demand for services, there needs to be a system in place for those seeking care. Second, policy makers and community leaders need to engage with and listen to youths while crafting COVID-19 response, recovery, and redesign plans. We need to listen to diverse youth voices for their take on the problems and solutions.\(^5\)

Unfortunately, we currently lack representative data on how COVID-19 is affecting youth mental health in the United States. However, nonrepresentative data suggests that serious problems exist. For example, a survey commissioned by 4-H, the national youth development organization, found that 64% of teenagers surveyed believed that COVID-19 will have a lasting effect on their generation’s mental health.\(^5\) From changes in social interactions to educational achievement to accessing much-needed mental health services, life for millions of children and adolescents has changed almost overnight. The ripple effects of these changes could negatively affect this generation for years to come if we do not begin to invest in policies and programs that can make a difference now.

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