As research regarding the role of the COVID-19 pandemic on the mental health and well-being of children and youth mounts, an apparent disconnect between certain study findings has emerged. On the one hand, numerous studies confirm increases in depression, anxiety, and eating disorders among youth since the onset of the pandemic. On the other hand, stable or declining rates of substance use, and to some extent, self-harm and suicidality, have been reported. We have also seen a disconnect between the magnitude of psychological distress reported among youth during the pandemic and the frequency with which they have presented to the hospital. For example, a recent meta-analysis over the first year of the pandemic found that 1 in 4 children (25%) now experience clinically significant depressive symptoms and 1 in 5 children (20%) experience clinically significant anxiety symptoms. However, some studies using administrative health data have observed no increases in hospital presentations for intentional youth self-harm or suicidality. How can these seemingly disparate sets of findings coexist?

As child and adolescent mental health clinician-scientists, whose research informs policy development, we see the effect that these apparent data discrepancies have had on the appreciation of the pandemic’s impact on youth. We have observed a splintering of understanding among the broader scientific and clinical community, decision makers, policy advisers, and the public, as scientists have had to both examine and apply research findings in real time to advocate for the health and needs of youth. Rather than advancing knowledge within a field of interest, as incongruent findings frequently do, these data discrepancies have inadvertently fueled the tinderbox of confusion and polarization regarding public health and policy responses for youth. Those who are counting on us to reconcile these findings are also those who stand to lose the most—the youth themselves.

It is unlikely that 1 single study can disentangle why rates of youth depression, anxiety, and eating disorders are increasing during the pandemic, whereas rates of youth presentations to hospital with suicidality and substance use appear to have been stable or declining. Explanations are needed to adequately inform policy and practice decision-making. In this Viewpoint, we speculate on why the apparent data divide may exist, with the objectives of building scientific understanding (and perhaps even some consensus) as to the complexity of the effect of the pandemic on youth, and how best to interpret and apply research findings to improve the lives of youth.

First, pandemic temporality is an important consideration. Compared with observational studies, research relying on administrative data has been frequently limited to, or weighted heavily by, early COVID-19 pandemic (2020) figures. It is now well documented that there was wide-scale decline in hospital presentations during this early period, as individuals, including parents, may have avoided emergency departments in fear of either COVID-19 infection or isolation in the hospital owing to COVID-19-related restrictions. Commensurate with the notion of a system-wide emergency department avoidance early in the pandemic, in a study of youth aged 5 to 17 years, presentations to emergency departments for mental distress were lower at the outset of the pandemic but steadily increased in the latter half of 2020.

Second, research examining hospital presentations does so in a vacuum. With the onset of the COVID-19 pandemic, countries have experienced transformational change in mental health care delivery with the rapid expansion of remote and virtual mental health services, including acute care services. Telephone and virtual mental health support have increased youths’ access to care during a time of restricted in-person interactions, and these services have been readily used by youth, including those in acute distress. In many countries with direct crisis or help phone lines for youth, massive call increases (eg, up to 350%) occurred from youth experiencing suicidal thoughts, abuse, or feeling overwhelmed by isolation and other stressors during the first year of the pandemic. These interactions are notable, signify serious distress among youth, and are completely invisible to administrative databases that focus largely on physician and other medical- and hospital-based health care services. Thus, although administrative databases may signal that youth self-harm and suicidality have declined during the pandemic, other (unmeasured) metrics signal that youth are seeking more immediate and accessible services to cope with their acute distress.

Third, some youth have experienced episodic mental health crises; for many, the role of COVID-19 pandemic-related stressors have been cumulative. Unlike pandemic restrictions, which have ebbed and flowed, the toll of the pandemic on youth mental health has been a constant, mounting force against youths’ ability to cope. In the global meta-analysis by Racine et al, which comprised solely cross-sectional data, the authors noted that rates of clinically significant depression and anxiety were higher among studies conducted later in the COVID-19 pandemic. This suggests an accumulation of impact, with greater effects over time indicating increased reach of the pandemic toward youths’ vulnerability thresholds. As self-harm and suicidality are an indication of moderate

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to severe depressive symptoms, they are likely lagging indicators of distress. The most recent US Centers for Disease Control and Prevention report notes a significant rise in 2021 youth emergency department presentations for suspected suicide attempts (50.6% increase for girls; 3.7% for boys), compared with 2019 rates from the same time period.8

Fourth, with significant restrictions on activities, including school, social, and extracurricular activities, youth have had increased parental monitoring, and limited opportunities to develop autonomy, take on new challenges (academic or extracurricular), and experience the daily demands that build identity and facilitate growth. Although these restrictions have been associated with significant increases in mental health symptoms9 and are of particular concern in shielding reports of child abuse or neglect, these restrictions also serve to limit the activities that are frequently the substrate for family and social conflict (including bullying), which are common acute precipitants of self-harm and suicidality.9,10

In a similar vein, substance use is most likely to occur among peers (vs with parents), and interactions with peers have been limited (and in some geographic regions, entirely restricted) during the pandemic. This may also explain why substance use rates have apparently decreased compared with pre-pandemic estimates and why we might anticipate similar artifact decreases in youth risk behavior in the 2021 Youth Risk Behavior Surveillance System.4

Most importantly, we cannot divorce the data from the context. Decades of research have taught us that risk and protective factors are never equally shared: developmental timing matters, there are individual differences in sensitivity to environmental conditions, dose-response relationships exist, and negative outcomes are more typically associated with prolonged exposures and/or extreme stressors.

The deconstruction of studies is easy—the placing of evidence into the broader literature and making policy recommendations to benefit all youth is hard. A polarized stance of “the kids are alright” vs “the kids are not alright” oversimplifies the heterogeneity and the complexity of the issues and ignores the critical nuances of the data. As researchers, we must try to avoid falling into the trap of a false dichotomy when presenting research that pits distress against hospital-based help-seeking because of our inability to accept the dialectic: that youth are struggling, and they have not presented to hospitals at rates commensurate with their distress. We need to be careful with, and contextualize, our research interpretations because the policy decisions that are being made for youth today will stand for years to come and are underpinned by the knowledge we generate now, for better or for worse.

ARTICLE INFORMATION
Published Online: April 25, 2022. doi:10.1001/jamapediatrics.2022.0791

Conflict of Interest Disclosures: Dr Korczak reported receiving grants from Canada Institutes of Health Research, the Ontario Ministry of Health, and the Department of Psychiatry, University of Toronto; funding for serving as Chair of the Hospital for Sick Children, SickKids, and the University of Toronto; and having the position of Chair of the Mental Health Task Force, the Canadian Pediatric Society, and the Research and Scientific Program Committee, Canadian Academy of Child and Adolescent Psychiatry. Drs Madigan and Vaillancourt reported receiving funding support from the Canada Research Chairs Program. No other disclosures were reported.

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