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Editorial Perspective: Rethinking child and adolescent mental health care after COVID-19

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While COVID-19 pandemic has allegedly passed its first peak in most western countries, health systems are progressively adapting to the “new normality”. In child and adolescent mental health services (CAMHS), such organizational envisioning is needed to cope with the foreseeable psychological effects of prolonged social isolation induced by nation-wide public health measures such as school-closure. CAMHS need to ensure flexible responses to the psychopathological consequences of evolving societal dynamics, as dramatically actualized by the unexpected COVID-19 pandemic. This would imply 1) shifting the focus of intervention from symptom reduction and containment of acute crises in a comparatively small number of severe cases to a broader preventive strategy, guided by a gradient of increasing intensity and specificity of treatment, 2) promoting smooth access pathways into services and encouraging participation of families. 3) adopting a transdiagnostic staging model to capture the developmental fluctuations from subsyndromal to syndromal states and back, with related changes in the intensity of the need of care; 4) implementing digital tools to encourage help-seeking and compliance by digitally native youth.

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Introduction

While COVID-19 pandemic has allegedly passed its first peak in most western countries and lock-down measures are gradually being lifted, health systems are progressively adapting to the “new normality”. In child and adolescent mental health services (CAMHS), however, such organizational envisioning to cope with the “new normal” may impact on a thorny trade-off between the short-term safety of healthcare professionals, patients and their families (e.g. implementing telepsychiatry) and the foreseeable, mid/long-term increasing burden due to a wider need of care. Indeed, the prolonged social isolation

induced by nation-wide public health measures aimed at mitigating COVID-19 transmission, such as school-closure, is a potential widespread risk factor for precipitating psychopathology (Jefsen, Rohde, Nørremark, & Østergaard, 2020) and health (Becker & Gregory, 2020). In this respect both past and preliminary current evidence, indicate that the psychopathological risk associated with a prolonged social isolation or disconnection in developmental years is huge. This is particularly true for more vulnerable children, whose risk for depressive and anxious symptoms adds on to the loss of academic and social skills (Golberstein, Wen & Miller, 2020; Lee, 2020; Loades et al., 2020; Orben, Tomova & Blakemore, 2020).

Child and Adolescent Mental Health Services

Therefore, in the wake of the new, post-COVID-19, normality, the question of whether CAMHS will be able to cope with the predictable increased burden arises emphatically. This is clearly a sore point for many western health systems, as suggested by the recent survey of the MILESTONE Consortium on the architecture and functioning of childhood and adolescent mental health services in European countries (Signorini et al., 2017): this survey reported a macroscopic organizational heterogeneity across countries and revealed a clear dissonance between the organization of services (and the related distribution of resources) and users' needs. Such mismatch -which is almost certainly present at the global scale as well - is even more problematic as it clashes with the natural pattern of emerging mental disorders in young people and the related burden of disease. Childhood neurodevelopmental disorders (i.e. a set of conditions ranging from severe such as autism, intellectual disability and ADHD, to milder such as language and learning disorders), for example, represent the single most frequent diagnostic macro-category of individuals referred to CAMHS in all countries (Signorini et al., 2017); young people aged 12–25 years, in contrast, have the highest incidence and prevalence of mental illness across the lifespan but at the same time have poorer access to and engagement with mental health services in comparison with younger subjects (Eyre & Thapar, 2014). In this respect, the findings of the Milestone consortium survey (Signorini et al., 2017) are particularly revealing as they indicate that - at least in most European countries - CAMHS, are still pre-eminently organized to address a more circumscribed and relatively stable core business, i.e. childhood neurodevelopmental disorders, basically providing restricted access to a small subgroup of people with overt, severe, complex and chronic disorders. An

undesired side effect of such stable focus is that CAMHS mostly lack the vision and organizational infrastructure to deploy any specific, planned and timely response for dynamic and cyclic psychopathological consequences of societal upheavals and change, such as economic crisis, migration and widespread digitalization (with annexed new risk for social withdrawal with internet addiction, or cyberbullying). Nonetheless, the recent lock-down induced a fast-paced change in CAMHS with a widespread effort to implement online service provision. Furthermore some contributions on policy (e.g. the UK Green Paper on *Transforming children and young people's mental health provision* and the new approach on human-centered designs, Lyon et al., 2020) and innovative organizational models (e.g. THRIVE: the AFC-Tavistock model for CAMHS: Wolpert et al., 2014) clearly indicate the strategic value of implementing youth mental health services to yield significant, long-term improvement in public health outcomes.

Post-COVID-19 scenario

In the post-COVID-19 scenario, following the prolonged isolation and loneliness of many children and adolescents, CAMHS may have to cope with a substantially increased burden: on the one side, due to neurodevelopmental disorders that might present worsened clinical pictures (Eshraghi et al., 2020) and increased prevalences of learning difficulties, especially in early years of schooling (with high risk of false positives due to problematic access to e-learning); and on the other side, due to the plausible widespread increase of emotional problems, such as depression, anxiety, irritability and social withdrawal (Jensen et al., 2020; Loades et al., 2020). Moreover, the expected post-COVID-19 economic crisis will likely have long-lasting societal consequences for families, thereby indirectly impacting on children and adolescents. Indeed, the socioeconomic status of families is a well-known, important moderating (risk or protective) factor for physical and mental wellbeing in childhood and adolescence.

Therefore, health systems should take advantage of this predictable "perfect storm" to implement a radical review of the structure and resourcing of mental health care for young people. The clinical management of neurodevelopmental disorders in childhood, adolescence and in the transition to adulthood will certainly remain a crucial domain within CAMHS intervention spectrum.

However, now more than ever, CAMHS need also to ensure flexible responses to the psychopathological consequences of evolving societal dynamics, as dramatically

actualized by the unexpected COVID-19 pandemic. This will require large-scale re-envisioning and reorganization, shifting the focus of intervention from symptom reduction and containment of acute crises in a comparatively small proportion of the population with severe cases to a broader preventive strategy. This includes low-threshold early intervention and community involvement, especially in the 12-25 age range, presenting the highest incidence and prevalence of mental illness across the lifespan. This goal may be achieved by implementing youth mental health services capable of bridging the traditional gap in care between CAMHS and adult mental health services.

A crucial driving principle should be the stepwise gradient of increasing intensity and specificity of treatment: timely identification in the early phases is a major prerequisite for interventions that aim to positively modify the natural course of vulnerabilities, with potentially exponential cascading effects on long-term quality of life and socioemotional functioning (Raballo, Poletti & McGorry, 2017). This goal may be achieved by promoting smoother pathways into services and encouraging participation of families, i.e. focusing on the larger familial context rather than only on the symptomatic individual (So, McCord & Kaminski, 2019). Moreover, the adoption of a transdiagnostic staging model could provide a more suitable framework to capture developmental psychopathology and follow the multiple longitudinal fluctuations from subsyndromal to syndromal states and back, with related changes in the intensity of the need of care (Shah et al., 2020). Finally, the sudden implementation of digital tools to cope with physical distancing rules in mental health services may be an asset to further encourage help-seeking and compliance by digital native youth.

In conclusion, despite the world having changed substantially in the past three decades (and much more than expected in this pandemic year), mental health services, including those for children and adolescents, have remained largely unchanged and under-resourced: COVID-19 might be the occasion for an overdue step-change.

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