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EDITORIAL

Editorial: Global Widening of the Inequitable Child and Adolescent Mental Health Care Chasm During COVID-19

Bonnie T. Zima, MD, MPH

The long-standing and inequitable chasm between clinical need and child and adolescent mental health care has likely widened during the COVID-19 pandemic, especially for children and adolescents in developing low- and middle-income countries (LMICs). Internationally, the risk for suicidal behaviors among young people rose, while timely access to care worsened.[1] People in LMICs are envisioned to be precariously positioned within a perfect storm characterized by greater exposure to life-threatening COVID-19–related social determinants of health that also pose higher risk of new and recurrent mental disorders.[2] In this issue of the *Journal*, the study by Wong *et al.*[3] is the first international study to report a substantial rise in emergency department (ED) visits for any psychiatric disorder and self-harm among children and adolescents after the onset of the COVID-19 pandemic. Using a retrospective cohort study design, ED visits for any psychiatric disorder and self-harm were compared between March-April of 2019 (prepandemic), 2020 (early pandemic), and 2021 (later pandemic), with the most recent time interval corresponding to the "third wave of the pandemic worldwide." The total sample included 8,174 psychiatric ED visits to 62 emergency units in 25 countries, including developing countries with lower-middle, upper-middle, and high incomes as well as developed countries with upper-middle and high incomes. Of these, 3,865 psychiatric ED visits in 13 countries had data for all time intervals. Using the complete data, compared with March-April 2019, the rate of ED visits for any psychiatric disorder was lower in March-April 2020, consistent with the abrupt drop reported in the United States that broadly aligns with statewide school closures and shelter in place orders.[4,5] However, when comparing early pandemic with later pandemic time intervals matched by months, the rates for any psychiatric and self-harm ED visits were twice as high. Despite the sharp drop following the onset of the pandemic, when compared with the prepandemic time interval, the overall rates of ED visits for any psychiatric diagnosis and self-harm during the later pandemic were 50% and 70% higher, respectively. Girls were also at greater risk for self-harm ED visits following the onset of the COVID-19 pandemic. Compared with the prepandemic time interval matched by months, girls had almost twice the odds of a self-harm ED visit in March-April 2021. The international rise in self-harm ED visits likely driven by the increases among girls is also consistent with prior US studies.[4,5]

The heterogeneity of the study at several levels posed methodologic challenges that were meticulously addressed using transparency in data reporting, creating analytic areas to address small sample size at some sites, selecting appropriate statistical methods, conducting a series of sensitivity analyses, and being forthright in the study's limitations and their implications for data interpretation. The study's heterogeneity also demonstrates the extensive cooperation achieved to develop a convenience sample of 62 EDs from 25 countries, extending global collaborations from an earlier study of self-harm ED visits among children and adolescents in 23 EDs in 10 countries.[6] There were 15 countries that contributed data from 1 site, while the United Kingdom had 17 sites, Turkey had 9 sites, Hungary had 5 sites, and Italy had 4 sites; the United States contributed data from 2 Ivy League academic medical centers. Among the complete data sample, 13 countries including Nigeria, an LMIC, contributed data from at least 1 site. The investigators also developed a standardized approach for each site to extract and process their data using a web-based survey. Local principal investigators completed data collection in an impressive 7 months. Data sources were paper and electronic health care records, and availability of routine data varied across sites. The authors acknowledge the potential for selection bias using a convenience sample and humbly

remind us that this was "due to practicality," demonstrating a pragmatism to study design and an acceptance of potentially less statistical precision to be more inclusive of countries worldwide.

In addition, the study includes a clinically comprehensive set of independent variables. For each of the comparisons between time intervals, the study reports the odds ratios for self-harm ED visits by minoritized ethnic group, foster care, self-harm characteristics, use of social media, illicit drug consumption, alcohol consumption, psychiatric diagnostic group, current psychotropic medication, presence of suicidal thinking, and prior mental health service contact. Of these, the most prominent finding is the 4 times greater odds of documented offering of follow-up visits among self-harm ED visits in March-April 2021 compared with the same months before the pandemic. However, the odds of follow-up visit attendance did not significantly increase, identifying an all too common target area for quality improvement for suicidal youth who present to the ED.[7]

As with many administrative data sources, the clinical need for child and adolescent mental health care in the communities served by the hospitals and clinics in this study is unknown. We are left with the counts of ED visits for any psychiatric disorder and self-harm in cross sections of time matched by 2 months. We know little about the proportion of children and adolescents in the community who need care but do not access care, receive timely care, obtain appropriate care, or get equitable care. Linkage to data to examine the association of receipt of care and by type with individual-level clinical outcomes over time is challenging, even in developed high-income countries with a universal health care system.[8]

Nevertheless, this study is a rare gem. It validates the need to invest in public health strategies to mitigate child and adolescent mental health risk, especially for girls, in the United States[9] and internationally.[1] The rigor and timeliness of the study are a testament to the investigators' ingenuity and achievement of global cooperation across a wide breadth of 25 developed and developing countries. It also underscores the importance of investing in a more robust data infrastructure that is inclusive of persons in developing countries, with priority placed on LMICs, mental health, and children and adolescents.

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