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No Health without Mental Health:
Risks and Benefits of School Closures during a Pandemic

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School closure and re-opening has been a significant focus of debate worldwide. Many working with young people are concerned about the relative risks of school non- attendance, particularly for vulnerable groups. At least 90% of learners (1·5 billion young people) worldwide are now out of education, and "the global scale and speed of the current educational disruption is unparalleled" according to UNESCO Director-General Audrey Azoulay.[1]

The COVID-19 crisis and school closures have the potential to have both negative and positive effects on young people's mental health [2, 3]. Young people have experienced profound losses. Limitations of social contacts, educational losses, psychological impact of infection control precautions, dilemmas regarding the Junior and Leaving Certificate examinations, and sadly for some, fear, grief and bereavement, have weighed heavy on the mental health of some students. Ongoing reduced ability to play and exercise may impact on sleep, mood and anxiety levels. Children with pre-existing adverse life experiences, mental health disorders, or medical illnesses, may feel this most acutely. Closures also impact the health of carers/ parents. The unexpected and rapid transition to remote learning raises issues around parent/carer ability to support, as well as issues around equity and access. Socioeconomic and digital divides are apparent [3].We know that in addition to safety and security within their primary relationships, for optimal wellbeing children and young people need "opportunities to play and learn"[4].

However, there may be parallel benefits for some young people. The experience of going through an event as a community and coping with challenges arising, and the opportunity to spend more quality time with family members, may have positive impacts for some. For others, a break from school may prove a welcome respite.

What are the risks that need to be balanced? School return will require careful consideration of medical and mental health risks. Regarding medical vulnerability, Viner et al [5] have reviewed and sign-posted information on this. Evidence suggests that COVID-19 is generally milder in children than adults, and recognises psychological harms [5, 6]. Munro et al highlight data and close case analysis across the globe, concluding that children are not "super spreaders", while recognising the need for longer term exploration of the role of young people through longer term monitoring, early contact tracing, and seroprevalence data once school returns [6]. Parental anxiety and the need to discuss with healthcare providers is understandable. Crawley et al raise the risks of non -attendance for medical assessments and also the unintentional harms for vulnerable young people [2]. Several organisations have recognised these

issues and produced guidance on conversations with families regarding school return. The RCPCH recognises that "extremely vulnerable children should remain "shielded", while recognising that children with lower levels of need in primary and secondary care can likely return to school[7].

Schools have a crucial role for other vulnerable and marginalised students. In 2019, RCPI highlighted the physical and mental health consequences of homelessness, including concern around educational access and attainment [8]. Fegert et al highlight the current risks of domestic violence and parental mental health. There are risks for young people who have already experienced Adverse Life Experiences (ACES) [3]. "Schools are sometimes a haven for children subjected to abuse in the home…an essential part of the healthcare system, particularly as safety net providers" [9].

For young people with intellectual disability or neurodevelopmental disorders, change in routine may exacerbate distress and mental health issues. Young people may not understand the situation and the necessity for changes. Behaviour that challenges, without the support of school (and indeed other services that may be supported in the school setting, or linked services such as respite services), has impacts on the family system. In some countries, school attendance has continued for select groups, such as the children of frontline workers or for the most vulnerable cohorts. In Denmark and the Netherlands, young people with special educational needs have been able to return earlier to in- person classes [9].

The very many young people in Ireland with pre-existing mental health disorders are also vulnerable. Mental health disorders impact around 20% of the population aged under 16 at any one time – at least 2% with significant disability, and recently there is much interest in adolescent cohorts and transition issues [10]. School is of course a critical time in adolescence, with many associated rites of passage for many young people. Before COVID-19, services in Ireland were seeing huge increases in need- including in emergency departments, which are not always the best place for young people to be supported, perhaps particularly at the current time [11]. Gunnell et al outline the need to develop new ways of working and managing increasing case- loads in mental health and educational services. "Consideration must be given not only to individuals' current situations but also their futures…Educational institutions must seek alternative ways to deliver curricula and governments need to be prepared to offer them financial support if necessary" [12]. Others recognise the need to mitigate these effects and minimise the 'collateral damage' experienced by children and young people [2]. Strategies include tackling risks relating to domestic violence; improving online services and effective treatment access (including for example access to CAMHS and CBT). Crawley et al recognise that challenges such as "chronic underfunding and workforce crisis" need to be tackled by policymakers as a matter of urgency [2]. In Ireland, this would include implementing staffing levels at minimum supported in 'A Vision for Change' to support families and young people [4]. Irish services also need the capacity to rapidly scale up in terms of telemedicine and acute mental health supports- both in the community mental health teams and in psychological medicine teams in paediatric hospitals. This will need paediatricians, mental health services, educational and social services working closely together.

School reopening and future planning will require planning around medical and mental health needs**.** International approaches involve consideration of mitigation measures (reducing contacts, physical distancing, physical supports e.g. ventilation and enhanced hygiene). Educationally, a range of approaches, including remote and blended learning, are needed [9]. Existing guidance and expertise, and groups who currently work on supporting mental health in schools are likely to need enhancement and support [2,11,13,14]. Often staff in schools and community organisations have not received formal training in mental health. Links and educational support across academic, mental health and paediatric disciplines will be crucial in supporting young people. Those vulnerable groups who might have been scaffolded by supports available within the school system now lack that critical support network. This is an acute concern for health services, clinicians, policy makers and wider society.

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