



SPOTLIGHT ON

The “New Normal” and Life Beyond COVID-19

A Report by the Evidence-Based Policy Institute

Contributing Authors:

Jackie Shen, Ellen Conner, Julie Welch, and Matthew Pecoraro, MSW

Editors:

Kimberly Hopkins, LICSW, Robert Franks, PhD and Christopher Bellonci, MD

The authors would also like to acknowledge Raffael Holz-Eckmann, Amy Doyle, MSW, MPH and Michaela Harris, MPH

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Please Direct All Correspondence to:

Matthew Pecoraro, MSW

Director, Evidence-Based Policy Institute
mpecoraro@jbcc.harvard.edu

The Baker Center for Children and Families

53 Parker Hill Avenue, Boston, MA 02120
(617) 232-8390



HARVARD MEDICAL SCHOOL
AFFILIATE



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Abstract

The COVID-19 pandemic has had a profound impact on the emotional wellbeing of children and families across the nation. Between April 2020 and June 2021, more than 140,000 children in the United States under the age of 18 lost a caregiver due to COVID-19.¹ That number has increased in the months since and may now have reached as high as 175,000 children.² In addition to the loss of life, pandemic-related stressors such as social isolation due to extended stay-at-home orders and quarantine, family loss and separation, unhealthy coping strategies such as substance use, and caregiver hardship have exacerbated existing behavioral health needs in children and families while introducing a host of new concerns. The increased need for behavioral health supports and services is exemplified by the concerning rise in an array of symptoms such as anxiety, depression, suicidal ideation and eating disorders. While highly effective vaccines and boosters and the recent decrease in daily case numbers, hospitalizations and deaths are certainly cause for optimism and even celebration, the pandemic's impact on children's social and emotional health must not be ignored. If unaddressed, the new and exacerbated behavioral health conditions may worsen and lead to unnecessary and prolonged suffering and even premature death. Moving forward, our nation must prioritize understanding and addressing the negative impact of COVID-19 on children's mental health and development and create and implement research-driven strategies to address challenges and promote the best possible outcomes for children.

¹Caregiver is defined as parent, custodial grandparent, or grandparent caregiver who provided a child's home and basic needs; National Institutes of Health, 2021

²National Institutes of Health, 2021; Chatterjee & Wroth, 2021



Introduction

The COVID-19 pandemic has resulted in communities nationwide experiencing prolonged, unprecedented levels of stress, and has exacerbated the behavioral health needs of many children and families.

While highly effective vaccines and new COVID-19 treatments have brought some measure of normalcy to people across the country, persistent challenges related to misinformation-driven vaccine hesitancy, the rise of the Delta and Omicron variants and the threat of new virus mutations have prevented children and families from fully returning to pre-pandemic routines. Pandemic-related stressors and disruptions experienced by families, communities and child-serving systems have negatively impacted children, the effects of which are likely to persist for years to come. This risk to long-term individual and community health and wellbeing must be addressed as quickly as possible.

Prior to the pandemic, one in five children experienced a diagnosable behavioral health concern.³ In 2016, there were 7.7 million children with treatable mental health disorders, however, only about half received adequate treatment.⁴ Emerging research suggests this need is increasing in the wake of COVID-19; initial findings are showing marked increases in challenges such as anxiety, depression, eating disorders and substance abuse.⁵ Many experts are especially concerned with the pandemic's impact on youth suicide, which was already on the rise pre-pandemic.⁶ If unaddressed, our country faces a significant and dangerous threat to the long-term health and wellbeing of families and related social and financial costs. Further, while the pandemic's negative effects have been universally experienced, underrepresented communities - especially communities of color - have been disproportionately affected.⁷ It is imperative that states and communities focus on understanding the ways COVID-19 has impacted children and families and develop proactive strategies to ensure that children's behavioral health needs are identified and treated as quickly as possible.

Drawing from available state and national data, this report - an update to the Evidence-Based Policy Institute's (EBPI) September 2020 brief, *Spotlight On: The Impact of the COVID-19 Pandemic on Children, Youth and Families*, – will identify select environments, settings and experiences that contribute to child development and explore the pandemic's impact on each, as well as offer actionable recommendations to address the increase in behavioral health needs among children and families brought on by the COVID-19 pandemic. While this exploration is intended to support state and local leaders across the country, the authors have chosen to periodically spotlight specific Massachusetts data, home state of the EBPI, to illustrate the broader national trends covered throughout this report.

Note to the reader: All data and information presented in this report is as up-to-date as possible at the time of publication. It should be noted, however, that the COVID-19 pandemic continues to be a rapid and ever-evolving situation. In some cases, available data changes daily. Readers are encouraged to visit their state's website, the Centers for Disease Control and Prevention (CDC) website and other leading national and state agencies for the most up-to-date information and to stay apprised of current safety measures and guidelines.



³Perou, et. al., 2013

⁴Murthy, 2021; Whitney & Peterson, 2019

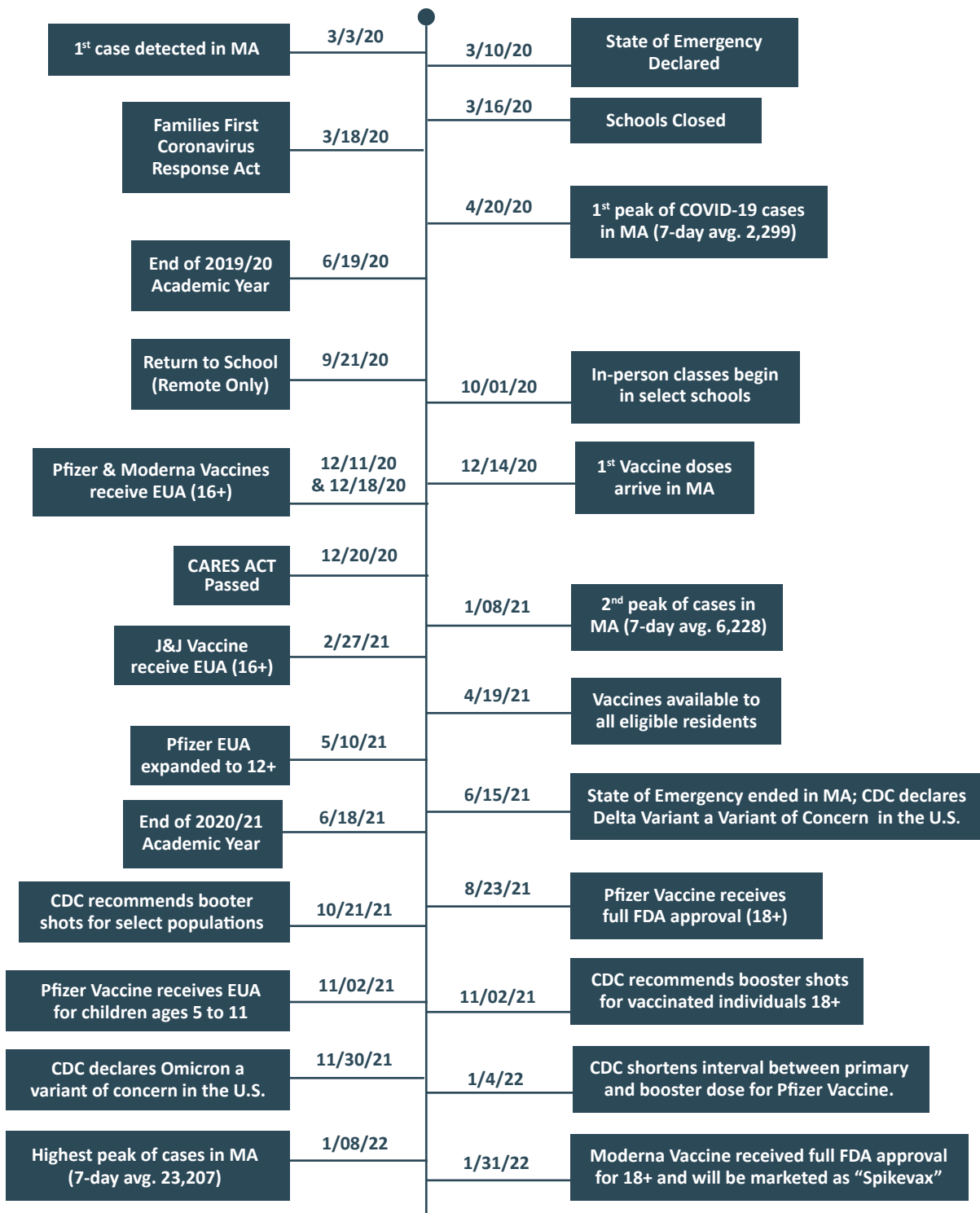
⁵Nguyen, 2016

⁶Murthy, 2021; Panchal et al., 2021

⁷Centers for Disease Control and Prevention, 2021b

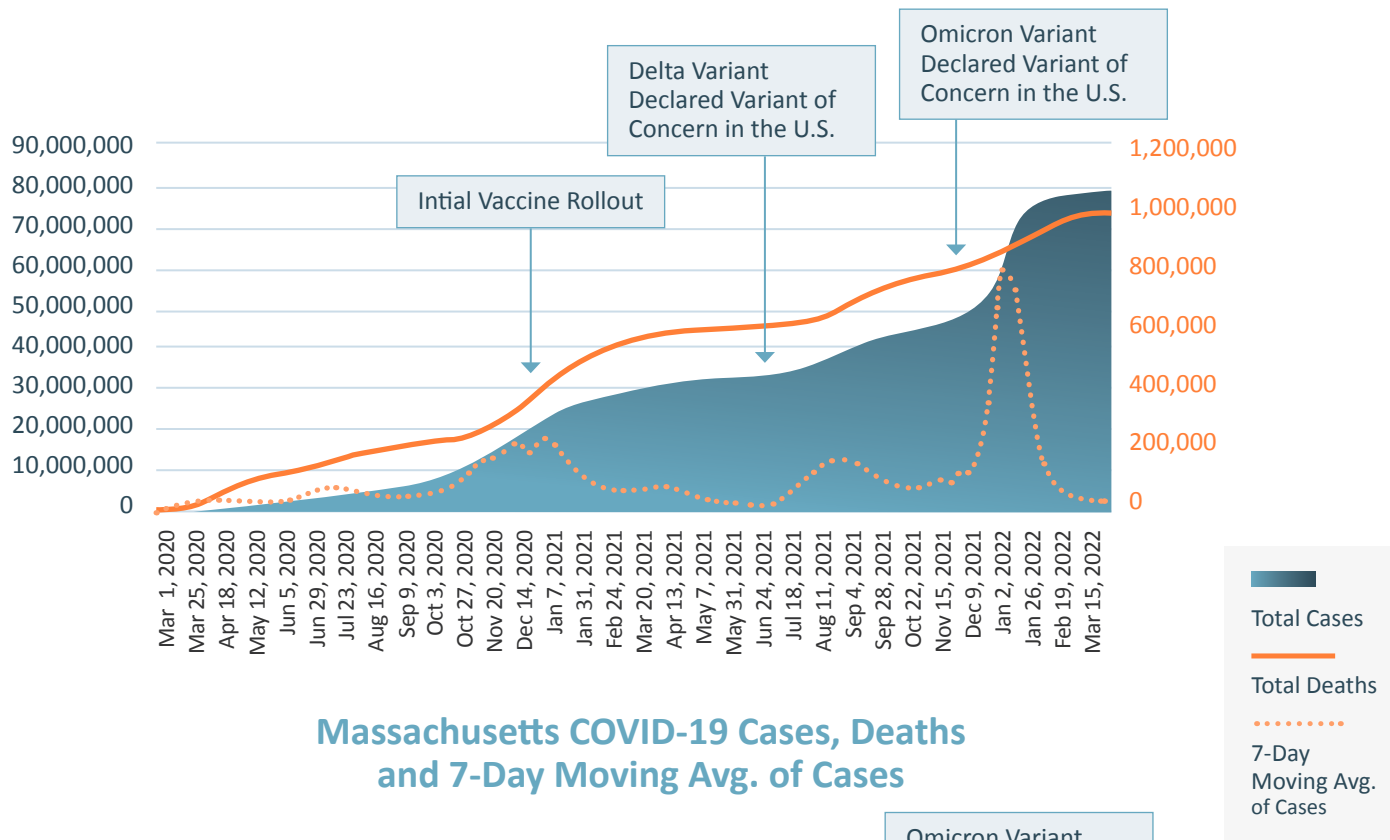
Timeline of COVID-19 State of Emergency in Massachusetts⁸

On March 3, 2020, public health experts identified the first case of COVID-19 in Massachusetts. Below is a timeline of major events in the months that followed.

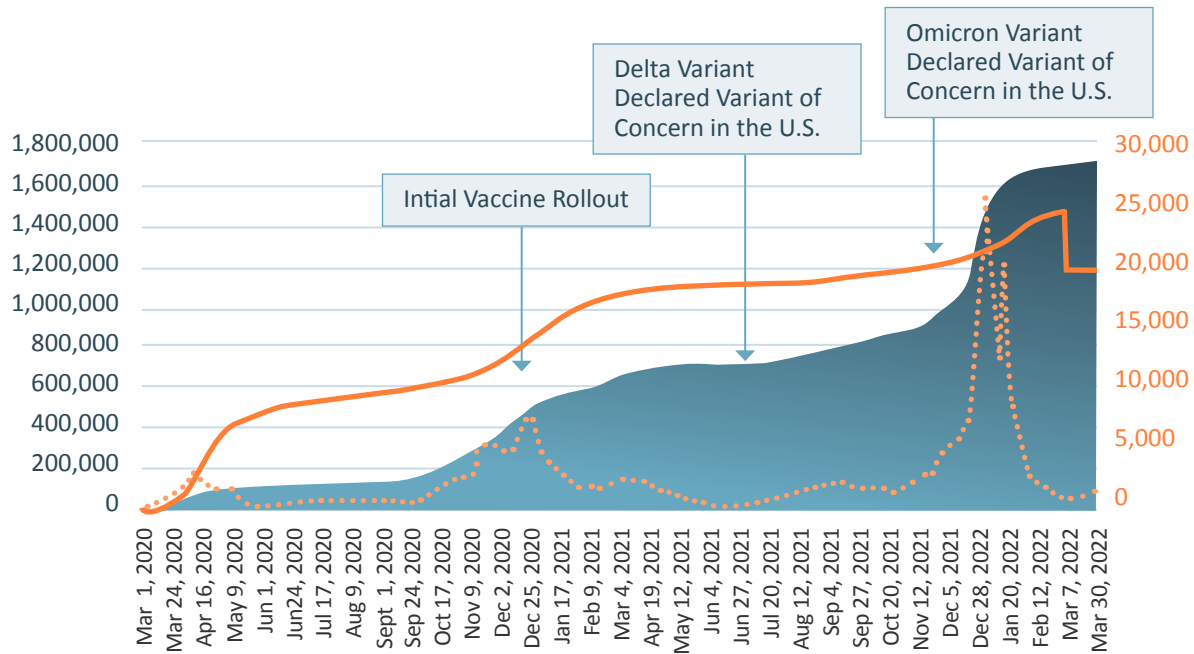


⁸Massachusetts Department of Public Health, 2020; Office of Governor Charlie Baker and Lt. Governor Karyn Polito, 2021; Baker, n.d.; Massachusetts Department of Elementary and Secondary Education, 2020; Centers for Disease Control and Prevention, 2021j; Centers for Disease Control and Prevention, 2021k; Centers for Disease Control and Prevention, 20

United States COVID-19 Cases, Deaths and 7-Day Moving Avg. of Cases

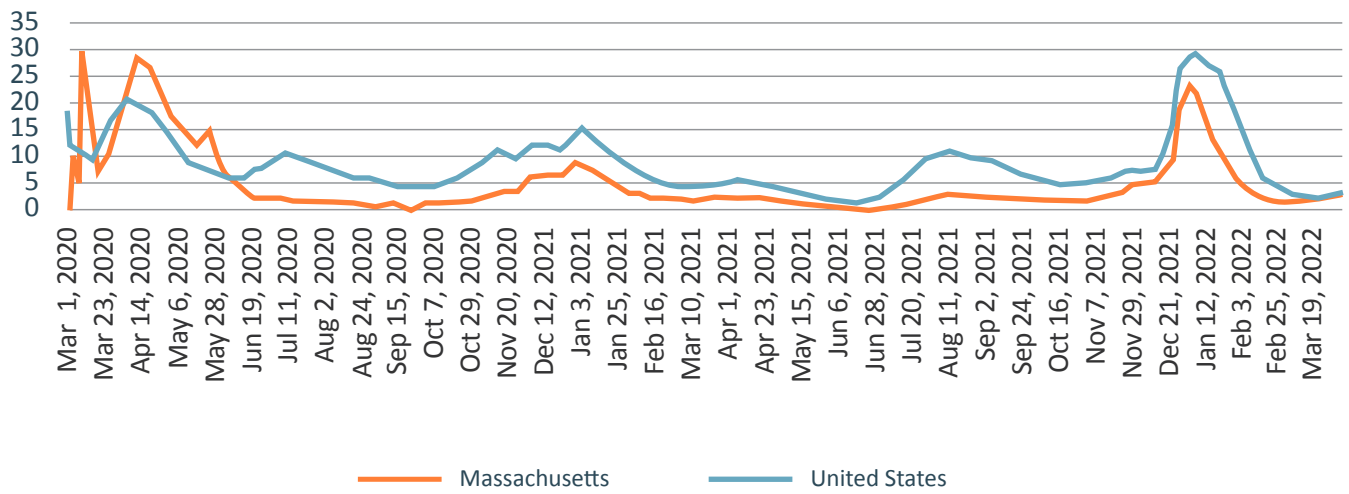


Massachusetts COVID-19 Cases, Deaths and 7-Day Moving Avg. of Cases



⁹Centers for Disease Control and Prevention. n.d. (b); Centers for Disease Control and Prevention. n.d. (c); Centers for Disease Control and Prevention. 2021j; Centers for Disease Control and Prevention. 2021k
¹⁰State and National data regarding COVID-19 cases and deaths were collected from the CDC's COVID-19 Data Tracker as of 04/11/2022. Information in this chart may vary from data found on the Mass.gov website.

COVID-19 Testing 7-Day % Positivity in Massachusetts and the United States^{11,12}



¹¹Centers for Disease Control and Prevention. n.d. (b); Centers for Disease Control and Prevention. n.d. (c)
¹²State and National data regarding COVID-19 case positivity rates were collected from the CDC's COVID-19 Data Tracker as of 04/11/2022. Information in this chart may vary from data found on the Mass.gov website.

COVID-19 in Massachusetts, Testing and Vaccines

By the summer of 2021, vaccination rates were on the rise. Daily cases, 7-day case rolling averages, deaths, and hospitalizations sharply fell and it seemed that a return to pre-pandemic life was soon to be had. However, with the emergence of the Delta variant and then Omicron, our hopes for a return to normal were brought to a halt. For many people, this unexpected shift represented a distressing step backward and likely reintroduced feelings of anxiety, uncertainty and despair, and left many wondering if their lives would ever return to normal.

As of April 07, 2022 Massachusetts has had 1,571,136 COVID-19 cases and 21,546 COVID-related deaths.¹³ Children ages 0-19 account for 276,696 (17.7%) of those COVID-19 cases and 14 of the deaths.¹⁴ The first peak of COVID-19 came between March and May of 2020. The second, dramatically higher peak occurred at the end of 2020, and only started to decrease with the introduction of vaccinations. While confirmed case rates overall fell going into the fall of 2021 (reaching a low 7-day average of 64.1 confirmed cases in June), rates began to rise again in September 2021 and overall continued to rise into January 2022.¹⁵

While January 2022 saw a major spike in COVID-19 case positivity rates, primarily due to the highly transmissible Omicron variant, COVID-19-related deaths have remained low. During this time, Omicron accounted for the majority of positive COVID-19 cases across the nation including Massachusetts, and, while more transmissible, has shown to cause less severe symptoms among those infected, and especially among vaccinated and fully boosted individuals. The available and highly effective COVID-19 vaccines have proven effective at preventing severe illness, hospitalization and death from any of the known COVID-19 variants and has likely contributed to the lower death rate.¹⁶ While the lower mortality rate is good news, there is still cause for concern as hospitals reached and exceeded their capacity at multiple points during the pandemic. Even with lower mortality rates, an overburdened healthcare system can still lead to unnecessary death and suffering for many.¹⁷ As of January 4, 2022 the rate of COVID-19 hospitalizations was comparable to that of January 2021, which was the highest peak in hospitalizations aside from the start of the pandemic.¹⁸ Encouragingly, the Omicron-spike peaked in early January, 2022 and daily case numbers dropped steeply into February, 2022.



¹³Massachusetts Department of Public Health, 2021a

¹⁴American Academy of Pediatrics & Children's Hospital Association, 2020

¹⁵Massachusetts Department of Public Health, n.d.

¹⁶Goodman, 2021

¹⁷It should also be noted that the rise in COVID-related hospitalizations means many individuals seeking non-COVID-related care are often not able to access that care due to hospitals being at capacity.

¹⁸Massachusetts Department of Public Health, n.d.



Disproportionality in Testing

One study conducted by Mass. General Brigham found that, between May and October of 2020, testing rates for communities with high concentrations of low income, minority or non-English speaking residents across Massachusetts and in Boston were equal to or lower than other, more affluent communities.¹⁹ This was especially concerning considering available data also show that these same communities experienced higher rates of infection, hospitalization and death.

Testing

Testing efforts have been one of the most important proactive strategies to track and minimize the spread of COVID-19. Initially, due to the extremely rapid onset of the COVID-19 pandemic, the country struggled to ramp up test production and processing, leading to limited access and availability. Anecdotally, there were many reports of prohibitively long wait times with many people waiting only to eventually be turned away due to the site running out of tests.

In the months following the initial pandemic onset, the U.S. was eventually able to catch up to testing needs, resulting in wider availability. In addition to city- and state-run testing sites (which provided by-appointment or walk-in options, as well as drive-through and walk-in sites), many pharmacies, health care providers and schools were able to provide testing routinely. Additionally, the healthcare system refined its ability to test symptomatic patients or those referred by a contract tracer due to exposure. In the latter part of 2021, at-home COVID-19 test kits became more readily available for purchase or through free distribution programs across the country. The Massachusetts Department of Public Health delivered over 2 million at-home tests to cities and towns with high COVID-19 positivity rates and those experiencing financial barriers.²⁰ However, free programs quickly ran out, and the costs and limited availability of at-home tests have created additional scarcity and access issues. On January 10, 2022, Massachusetts announced that they intended to purchase another 26 million testing kits for distribution. The next day, the White House proclaimed that health insurance providers would need to cover FDA-approved, over-the-counter COVID-19 diagnostic tests beginning January 15.²¹

¹⁹ Dryden-Peterson et al., 2021

²⁰ Massachusetts Executive Office of Health and Human Services, 2022

²¹ U.S. Department of Health and Human Services, 2022; Office of Governor Charlie Baker and Lt. Governor Karyn Polito, et. al., 2022

Vaccination Efforts

At the time of writing this report, there are three vaccines available in the United States: Pfizer-BioNTech, Moderna and Johnson & Johnson (J&J). Initially, the vaccines proved highly effective at preventing COVID-19 infection from the original strain of the virus. While less effective at preventing infection from Delta and Omicron, data continue to show that the vaccines are highly effective at preventing severe illness, hospitalization and death in fully vaccinated individuals. The exact efficacy against contracting the Omicron variant is still being explored, however data are continuing to show that individuals who are fully vaccinated and boosted commonly experience milder symptoms as well as fewer hospitalizations and deaths.²² Pfizer and Moderna require two doses while J&J requires one dose. For all vaccines, full protection is expected roughly two weeks after the final dose is administered.²³ Emerging research has also found that vaccine efficacy wanes over time and an mRNA booster is needed to enhance vaccine protection. On January 4th, the CDC updated their recommendation for when booster shots should be provided. At the time of writing, individuals **received the Pfizer-BioNTech COVID-19 Vaccine are advised to get boosted five months after completing the primary series.** Individuals who received **Moderna's vaccine are advised to get boosted 6 months after completing the primary series; J&J recipients should get boosted 2 months after receiving the one-dose regimen.** Research is continuing to show boosters extend protection against infection, serious illness and/or death due to COVID-19.²⁴ As the pandemic persists, experts continue to evaluate the efficacy of booster shots and will offer further guidance about additional vaccine doses and booster shots as appropriate.

Each vaccine initially sought and received Emergency Use Authorizations (EUA) from the Food and Drug Administration (FDA). Pfizer and Moderna each received EUA in December of 2020, with J&J following in February of 2021. Since then, Pfizer sought and was granted full approval from the FDA for individuals over the age of 18. At the time of this report, Pfizer and Moderna both have full FDA approval. Once approved for individuals over the age of 18, vaccine eligibility was sought for adolescents ages 12 to 16 and children ages 5 to 11. Pfizer received this approval in May 2021 and October 2021, respectively. As of February 2022, Moderna and J&J have not received approval for either age range.²⁵



²²Centers for Disease Control and Prevention, 2021c; Centers for Disease Control and Prevention, 2021d, Centers for Disease Control and Prevention, 2021e
²³Centers for Disease Control and Prevention, 2021c; Centers for Disease Control and Prevention, 2021d, Centers for Disease Control and Prevention, 2021e

²⁴Centers for Disease Control and Prevention, 2022
²⁵Food and Drug Administration, 2021

Phased Vaccine Rollout in Massachusetts:

As vaccines received emergency use authorization and started to be distributed to states, Massachusetts developed a phased roll out plan to match the number of eligible individuals with available doses. Cases and deaths started to decline significantly after COVID-19 vaccines received Emergency Use Authorization and became widely available.²⁶

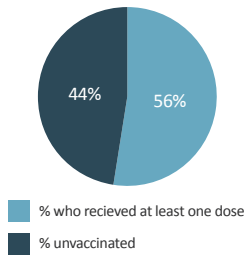
Phase 1 December 2020 to January 2021	<ul style="list-style-type: none">• Clinical and non-clinical health care workers doing direct and COVID-facing care• Long-term care facilities, rest homes and assisted living facilities• First Responders• Congregate care settings• Home-based health care workers• Health care workers doing non-COVID-facing care
Phase 2 February 2021 to April 2021	<ul style="list-style-type: none">• People who are 75 or older• People who are 65 or older• People with 2 or more certain medical conditions• People who live or work in low-income and affordable senior housing• K-12 educators, K-12 school staff, and childcare workers• People who are 60 or older• Workers in certain categories• People who are 55 or older• People with 1 or more certain medical conditions
Phase 3 April 2021 to May 2021	<ul style="list-style-type: none">• People ages 16 and older who live, work or study in Massachusetts• People ages 12 and older who live, work or study in Massachusetts
Phase 4 November 2021	<ul style="list-style-type: none">• Children ages 5-11 who live or study in Massachusetts

²⁶Food and Drug Administration, 2021; Massachusetts Department of Public Health, 2022

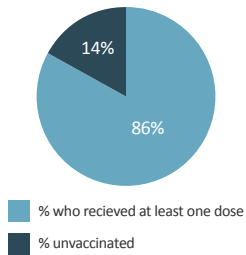
Vaccination Status in Massachusetts as of April 07, 2022

Vaccination rates continued to rise until May of 2021 when the rate of newly vaccinated individuals in the State started to slow. As of April 2022, 89% of Massachusetts residents have received at least one dose of a COVID-19 vaccine, though notable discrepancies exist among certain populations.²⁷

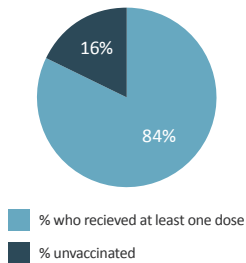
Youth Aged 5-11



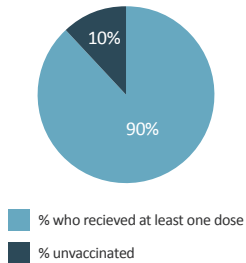
Youth Aged 12-15



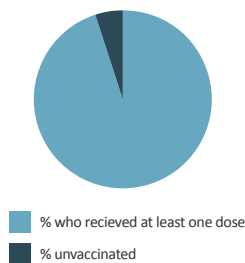
Youth Aged 16-19



Young Adults 20-29



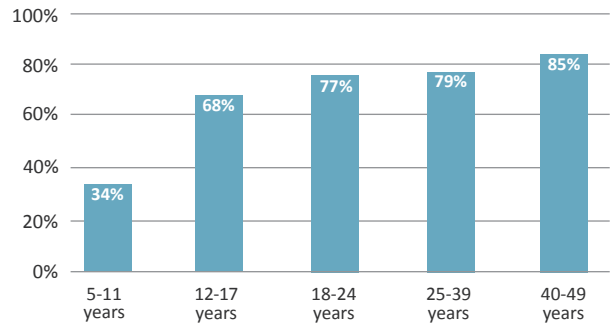
Adults 30-49



Percent of Massachusetts residents who have received at least 1 dose of a COVID-19 vaccine by age group (as of 04/07/2022)²⁸

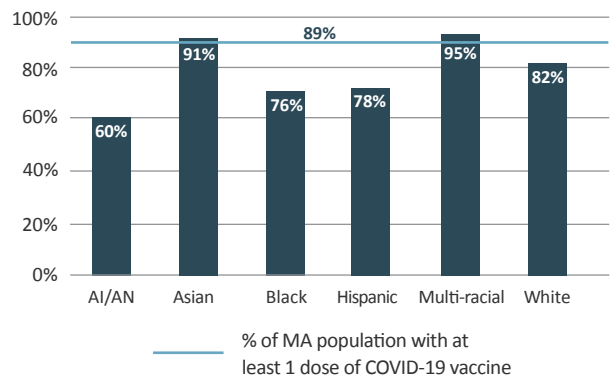
Vaccination Status in the United States as of April 07, 2022²⁹

National COVID-19 Vaccination Rates by Age Group as of 04/07/2022



Percent of U.S. population with at least 1 dose of a COVID-19 vaccine by age group as of 04/07/2022³⁰

COVID-19 Vaccination Rates by Race/Ethnicity



Percent of Massachusetts residents with at least 1 dose of a COVID-19 vaccine by race/ethnicity as of 04/07/2022³¹

²⁷Massachusetts Department of Public Health, n.d.
²⁸Massachusetts Department of Public Health, 2021c
²⁹Erzurum, 2021

³⁰Massachusetts Department of Public Health, 2021c; Published national and state level data was not available with matching age cohorts
³¹Massachusetts Department of Public Health, 2021c



Both the Delta and Omicron variants are substantially more contagious than the original COVID-19 strain. However, research suggests that vaccinated individuals are protected from Delta and, in the event of a breakthrough infection,³² are much less likely to experience severe illness, hospitalization or death. Emerging research on Omicron (which, as stated above, accounts for the vast majority of new cases across the country) is also showing that, while this variant is capable of infecting even vaccinated individuals, breakthrough infections are rare as compared to unvaccinated un-boosted individuals.³³ Vaccinated individuals are also far less likely to experience serious illness, hospitalization or death.³⁴

Vaccination and boosters remain the most promising strategy to protect individuals, families and communities from the harmful effects of COVID-19 and are the primary pathway to end the current crisis.

At the time of publication, about three-quarters of the U.S. population have received at least one dose of a vaccine. However, less than half of those eligible for a booster shot have received one.³⁵ Massachusetts numbers are higher with almost 90% of the state having received at least one vaccine dose, though just over half of eligible individuals have received a booster.³⁶ Moving forward, it is important Massachusetts and the country at large continue to understand and safely expand eligibility and utilization of COVID-19 vaccines and boosters.

³² Defined as contracting COVID-19 despite being fully vaccinated and boosted

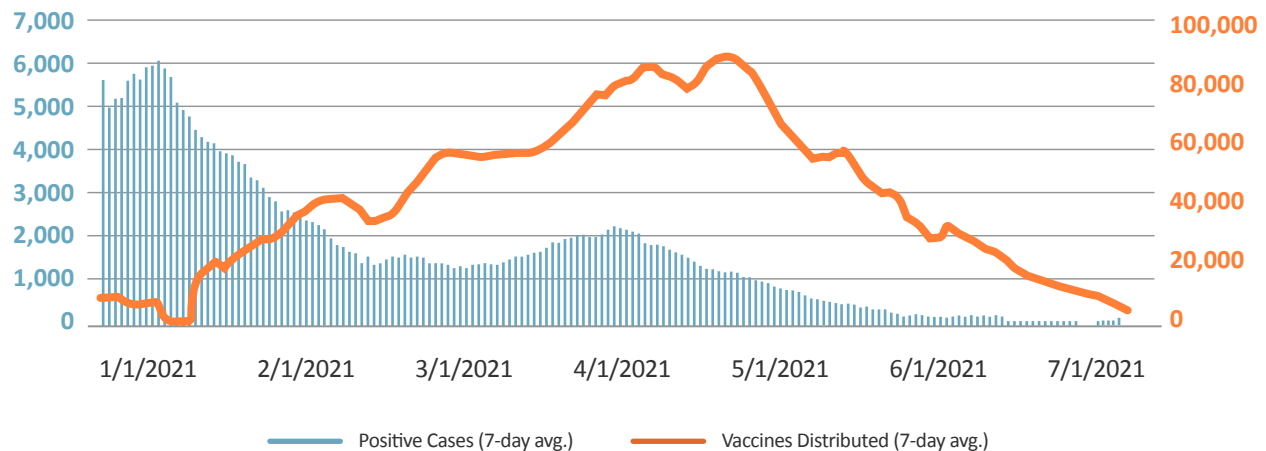
³³ Centers for Disease Control and Prevention, 2021h;
Centers for Disease Control and Prevention, 2021i

³⁴ Centers for Disease Control and Prevention, 2021a

³⁵ Massachusetts Department of Public Health, 2021c

³⁶ Massachusetts Department of Public Health, 2021c

Relationship Between COVID-19 Infections and Initial Vaccine Rollout



7-day average of COVID-19 infection and vaccination rates in Massachusetts between January 1st and July 1st, 2021.³⁷

Readers should note the above chart provides only a snapshot of the early months of vaccine availability. Following this initial vaccine rollout, case numbers dropped, mask mandates and many other COVID-19 prevention measures began to diminish, and for many across the country the summer of 2021 felt like life had returned to pre-pandemic normal. However, waning vaccine effectiveness requiring additional doses and booster shots coupled with the emergence of the more transmissible Delta and Omicron variants contributed to COVID-19 cases again beginning to rise into early 2022 reintroducing the need for prevention measures such as social distancing and masking. For many, this sudden and unexpected return to stricter precautions contributed to feelings of distress and uncertainty, and for many behavioral health professionals, renewed concerns about the pandemic’s impact on emotional health and

wellbeing. The spike into early 2022 also brought renewed dedication to vaccination and boosting efforts. Data continued to show that vaccination and boosting is one of the most important COVID-19 prevention strategies, with fully vaccinated and boosted individuals typically faring far better than those who are unvaccinated. According to a recent article from Harvard Medical School, “mRNA COVID-19 vaccines have not protected as well against infection with Omicron as they did against previous SARS-CoV-2 variants. However, the vaccines continue to significantly reduce the chance of severe symptoms, hospitalization, and death, especially for people who have received a booster dose.”³⁸

³⁷Massachusetts Department of Public Health, n.d.

³⁸Harvard Medical School, 2022

The Impact of COVID-19 on Children, Youth and Families

COVID-19's rapid progression and the Massachusetts' subsequent move to prevention measures such as lockdowns, social distancing and virtual learning forced families to rapidly abandon old routines, adopt new ones, incorporate new safety measures and navigate constantly changing guidelines. These unexpected and sudden shifts coupled with the constant uncertainty and risk of harm brought on by the pandemic contributed to increased at times toxic levels of stress on children and families.³⁹ One study from the Harvard T.H. Chan School of Public Health found that **50% of households surveyed reported experiencing serious depression, anxiety, stress or sleeping problems.**⁴⁰

Similarly, **the Community Impact Survey conducted in Massachusetts between September and November of 2020 found 48% of youth in Massachusetts felt sad or hopeless almost every day in the past two weeks, a 21% increase from the 2017 survey.**⁴¹ Notably, rates of depression, anxiety and suicidal ideation among youth have all increased during this time period.⁴²

The environments in which children grow shape their development from infancy to adulthood. Drawing from Bronfenbrenner's Ecological Systems Theory, the following exploration divides these environments into three overlapping layers beginning with the child and family and radiating out from most to least proximal.⁴³ The first, most immediate environment is the home and community environment, sometimes called the "micro" environment. The relationships found in the *home and community* are the most important in a child's life, including their caregivers, siblings, other members of the immediate or extended family as well as the child's peers and neighborhood.



Environments Impacting Child Development

The next environmental layer are the *child-serving systems* children interact with, such as schools and healthcare, sometimes referred to as the "meso" environment. The final environment includes the broader *social, cultural and political constructs* that indirectly impact children and families through shared communal beliefs, values and culture, known as the "macro" environment. Each environmental layer is expanded upon in the following sections. This exploration is not meant to be an exhaustive list, but rather to identify several of the most prominent challenges faced by children and families during the pandemic, as well as an examination of what the coming months and years may bring.

³⁹Asby et al., 2020.; Loades et al., 2020

⁴⁰Harvard T.H. Chan School of Public Health, 2021;
Survey respondents were 18+ years of age.

⁴¹W.W. Sanouri Ursprung et al., 2021

⁴²Czeisler et al., 2020

⁴³Bronfenbrenner, 1979

Section 1:

The Home and Community (Micro)

Quarantine/Isolation

Studies from previous infectious disease outbreaks found that the duration of isolation, rather than the intensity of loneliness, was more strongly associated with an increase in mental health symptoms.⁴⁴ During the COVID-19 pandemic, many children and families were able to remain virtually connected to some networks. However, most experienced months-long stay-at-home orders and social distancing restrictions.⁴⁵ Given the length of isolation and the global impact of COVID-19, it is difficult to draw distinct conclusions from previous public health crises. Prior studies assessing the impact of quarantine and isolation typically assessed shorter-term individual- or family-level quarantine; not city, state, or national level implications of months-long shut-downs.⁴⁶

Research has found that quarantine can have a lasting negative impact on youth mental health leading to feelings of anger, frustration, loneliness and despair in the short term (among other experiences) and longer-term challenges such as post-traumatic stress disorder (PTSD).⁴⁷ Considering the unprecedented duration and intensity of isolation and quarantine experienced during this pandemic, combined with early data on current mental health needs (explored below), it is likely that the impact on children's mental health will be significant. Many experts are noticing a rise in behavioral health concerns and predicting that the nation will face increased demand for behavioral health supports and services.⁴⁸

The pandemic has also negatively impacted many children's ability to cultivate healthy social connections outside their home. A national survey found that 66% of youth (ages 13-19) in 2020 felt "disconnected" or "somewhat disconnected" from their peers.⁴⁹ Parents are expressing similar concerns. A Mass Inc. poll conducted in the spring of 2021 found that 35% of parents felt the pandemic had a major negative impact on their child's "opportunities to



form or maintain friendships."⁵⁰ Older youth faced the loss of important milestones, such as celebrations of major life events including graduation, prom and leaving home for the first time (to attend college, for example).

Similarly, results from a national survey conducted by the Pew Research Center in 2020 found that caregivers were increasingly worried about the impact of COVID-19 on their child's wellbeing. Sixty percent of parents of K-12 children reported being more concerned about their child's ability to maintain social connections and friendship. Caregivers also showed increased concern for their child's emotional wellbeing, whether their child was getting enough physical exercise and that their child was having too much time without adult supervision.⁵¹

Increases in loneliness, social anxiety and the clear disruptions to play and social interactions experienced by children and families suggest pandemic-related safety measures have disrupted children's ability to engage in developmentally necessary activities.⁵² Play and peer group connections are critical to healthy child development and identity formation. Disruptions, especially for very young children, could have longer-lasting negative impacts if not adequately addressed.⁵³ Past studies have suggested that the negative impact of social isolation can persist for up to 9 years.⁵⁴

Finally, as many schools and communities have opened up, children, especially those with pre-existing behavioral health conditions, may have been wary of returning to in-person learning, possibly requiring additional supports to ease back into what they find to be a stressful environment.⁵⁵

⁴⁴Loades et al., 2020; Wagner, 2020

⁴⁵W.W. Sanouri Ursprung et al., 2021

⁴⁶Loades et al., 2020

⁴⁷Jiao, et al., 2020; Dubey et al., 2020

⁴⁸Massachusetts Health Policy Commission, 2021

⁴⁹Margolius et al., 2020

⁵⁰Mass Inc Polling, 2021a

⁵¹Horowitz & Igielnik, 2020

⁵²Loades et al., 2020

⁵³Loades et al., 2020

⁵⁴Loades et al., 2020; Wagner, 2020

⁵⁵Wagner, 2020

Family Loss and Separation

Between April 2020 and June 2021, more than 140,000 children in the United States under the age of 18 lost a caregiver due to COVID-19.⁵⁶ This number has increased in the months since the study was completed and may now have reached as high as 175,000 children.⁵⁷ In general, this type of significant loss puts children at greater risk for behavioral health challenges including depression, post-traumatic stress disorder, alcohol or substance abuse and reduced educational attainment and peer connection.⁵⁸ Further, children and families who experienced the death of a loved one during the pandemic, either from COVID-19 or another cause, likely also experienced pandemic-induced barriers to traditional grieving practices. COVID-19 precautions limited the ability to visit loved ones who were sick, dying or in the hospital, impacting many families who were unable to be present at the end of life or to say goodbye. The ability to gather for traditional mourning practices such as funerals and burials was also disrupted.⁵⁹

Children and youth at different developmental stages are likely to react to the loss of a family member in various ways. For example, some children may experience “magical thinking”⁶⁰ and inappropriately blame themselves for the sickness or death of a loved one, potentially causing significant distress. Young children may also struggle to understand the permanent nature of death, a response that may be more common in families unable to complete a healthy grieving process. Children who do understand the irreversibility of death may begin to worry for the wellbeing of those around them, especially their caregivers and siblings. Teens and older adolescents often process death similarly to adults, likely experiencing feelings of sadness, anxiety and anger, and may need additional support to help process those emotions.⁶¹

Behavioral Health Outcomes

DEPRESSION AND ANXIETY

Since the beginning of the pandemic, depression and anxiety among young people has increased. A global exploration of 80,000 youth showed depressive and anxiety symptoms have doubled. One in four youth experienced depressive symptoms; one in five experienced anxiety symptoms.⁶² Nationally, over 25%

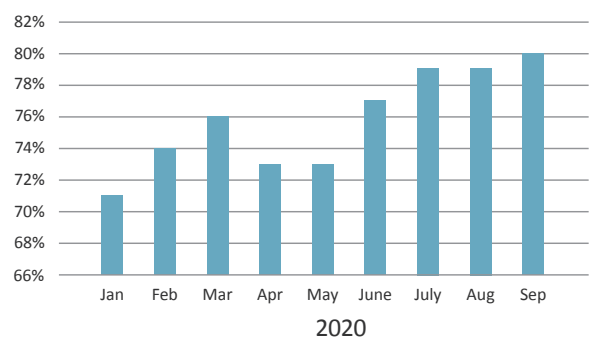
of high school students reported worsened emotional and cognitive health during the pandemic, and many parents of younger children (ages 5 to 12) reported their children were displaying increased symptoms of depression, anxiety and psychological stress.⁶³ In 2020, depression, anxiety and adjustment disorder were the most commonly diagnosed mental health conditions.⁶⁴

Rates of anxiety and depression also varied by population. For example, one survey of LGBTQ+ youth ages 13-17 found that 73% of respondents reported symptoms of anxiety, 67% reported symptoms of depression and 48% reported serious thoughts of suicide during the pandemic.⁶⁵

Insight from the Field: Mental Health America (MHA)

According to Mental Health America (MHA) utilization data, nationally, there was a 93% increase in the number of individuals who sought out and completed an MHA anxiety screening, and a 62% increase in depression screenings from January to September of 2020 compared to the same months in 2019.⁶⁶ Youth ages 11-17 were more likely than any other age group to score moderate to severe on these self-selected screenings. Over half of youth in this age group reported having thoughts of suicide or self-harm nearly every day.⁶⁷

% Scoring Moderate to Severe Anxiety



National percentage of all ages scoring ‘moderate’ to ‘severe’ on anxiety screenings between January-September 2020⁶⁸

⁵⁶Caregiver is defined as parent, custodial grandparent, or grandparent caregiver who provided a child’s home and basic needs; National Institutes of Health, 2021

⁵⁷National Institutes of Health, 2021; Chatterjee & Wroth, 2021

⁵⁸Ellis, Dowrick, & Lloyd-Williams, 2013

⁵⁹Santos et al., 2021

⁶⁰Magical thinking - an illogical thought pattern that leads individuals to believe that their behaviors, thoughts, or words can influence the outcome of unrelated events; Raypole, 2020

⁶¹Dryden-Edwards, 2020

⁶²Murthy, 2021; Racine, McArthur, Cooke, Eirich, Zhu & Madigan, 2021

⁶³Panchal et al., 2021

⁶⁴Panchal et al., 2021

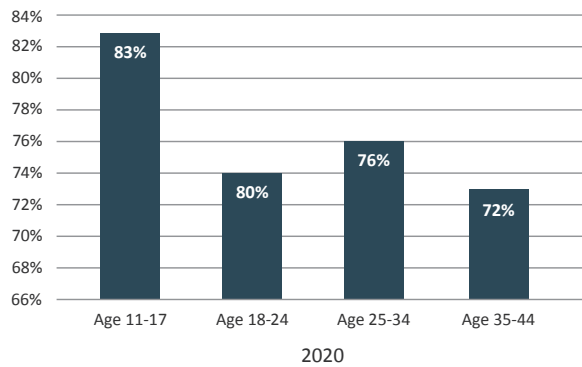
⁶⁵Panchal et al., 2021

⁶⁶Mental Health America provides online, anonymous screening tools for numerous mental health conditions such as depression, anxiety, PTSD, etc.

⁶⁷Reinert, Nguyen, & Fritze, 2021

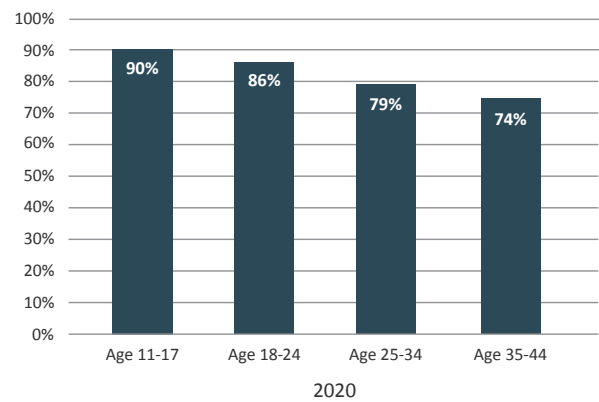
⁶⁸Reinert, Nguyen, & Fritze, 2021

Moderate to Severe Anxiety



National percentages of various age groups scoring 'moderate' to 'severe' on anxiety screenings from January-September 2020⁶⁹

Moderate to Severe Depression



National percentage of various age groups scoring 'moderate' to 'severe' on depression screenings from January-September 2020⁷⁰

Readers should note that these data are not the result of a survey or academic study, but rather a self-selected group seeking out MHA screening. The increased demand for these screenings is of note to the authors, as are the high positivity rates, since they potentially speak to an increased community-level awareness of behavioral health needs during the pandemic and therefore an opportunity to both improve access to high quality care and decrease behavioral health stigma moving forward. However, these data do not necessarily accurately reflect the percent of the general population experiencing anxiety or depression.

The Massachusetts Child Psychiatry Access Project (MCPAP)

Pediatricians working to meet the changing needs of their patients sought expert guidance through the Massachusetts Child Psychiatric Access Program (MCPAP), a service to improve access to behavioral health supports for pediatricians serving children with behavioral health needs. MCPAP experienced a 34% increase in calls since the start of the pandemic.⁷¹



⁶⁹Reinert, Nguyen, & Fritze, 2021

⁷⁰Reinert, Nguyen, & Fritze, 2021

⁷¹Bebinger, 2021

Youth Suicide

Youth suicide was a rising concern even before the pandemic. Among high school students between 2009 and 2019, the rate of serious contemplation of suicide rose from 14% to 19%, suicide planning rose from 11% to 16% and suicide attempts rose from 6% to 9%.⁷² Between 2011 and 2015, 77% of youth suicide victims were between the ages of 18 and 24.⁷³ Since the start of the pandemic, the crisis has continued to increase at an even more alarming rate. Nationally, behavioral health-related emergency room visits increased by 31% for youth ages 12-17 and 24% for those ages 5-11 in 2020 compared to 2019.⁷⁴ Data from early 2021 show emergency department visits saw a 51% increase in suspected suicide attempts for adolescent girls and a 4% increase for adolescent boys (also compared to 2019).⁷⁵ Older youth were similarly affected. A CDC study conducted in June 2020 found that 26% of transition age youth 18-24 years old reported having “seriously considered suicide in the past 30 days.”⁷⁶

UNHEALTHY COPING STRATEGIES

The unprecedented levels of stress, uncertainty and routine change required during the pandemic has resulted in many children, adolescents and adults developing unhealthy coping strategies. One notable area of concern that has emerged particularly among adolescent girls is the prevalence of eating disorders.⁷⁷ A 2021 study revealed a 30% increase in hospitalizations for eating disorders among female adolescents ages 12-18,⁷⁸ and a 37% increase in outpatient feeding and eating disorder diagnoses for the same cohort compared to pre-pandemic trends.⁷⁹ The impact of social isolation and reduced access to treatment combined with economic stressors, stockpiling of food when supply chains were disrupted and reduced control in other areas of life have all contributed to an increase in eating disorders and an exacerbation of symptoms in those with existing conditions.⁸⁰ **Boston Children’s Hospital reported an increased demand for their eating disorder services with outpatient requests twice as high as and inpatient service usage at three to four times pre-pandemic rates.**⁸¹ Service providers across the country are experiencing similar increased demand. A treatment center in North Carolina reports they “have seen roughly a 30% to 40% increase in referrals to our clinic alone” and that they “simply cannot provide adequate services at this point



because demand for treatment is so high.”⁸² Individuals with existing eating disorders report feeling concerned that their symptoms will worsen due to pandemic-related loss of structure, lack of social support or increased time in triggering environments.⁸³

⁷² Centers for Disease Control, 2021g

⁷³ Office of the Child Advocate, 2020

⁷⁴ Between the months of March and October; Leeb, et al. 2020.

⁷⁵ Murthy, 2021

⁷⁶ Czeisler et al., 2020

⁷⁷ Gaffney, 2021; Termorshuizen et al., 2020

⁷⁸ Thayer et al., 2021

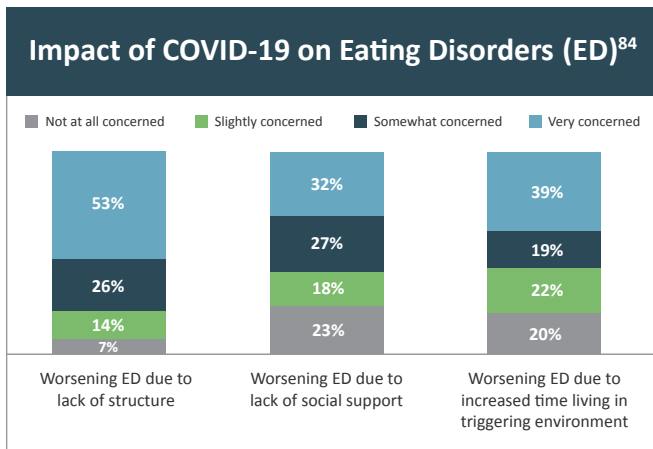
⁷⁹ Little et al., 2021

⁸⁰ D’Amrosio, 2021; Termorshuizen et al., 2020

⁸¹ Fliesler, 2021

⁸² D’Amrosio, 2021

⁸³ Elflein, 2021



Some children, disengaged from school and with fewer extracurricular activities available, turned to electronic escapes such as video games or social media.⁸⁵ This is not inherently a negative phenomenon. Many adults and teens report positive effects of increased gaming such as social connection, a sense of normalcy and feelings of personal agency at a time when so many things were beyond their control.⁸⁶ However, while many adults report reduced anxiety connected to gaming during the pandemic, for children, over utilization of electronic escapes as a coping strategy may have a negative effect on their emotional wellbeing.⁸⁷ One survey by ParentsTogether found that 85% of parents are concerned with the increase in screen time their children have had over the course of the pandemic. Screen time ranged from virtual learning and gaming to increased use of apps and streaming services like YouTube, Netflix, and TikTok.⁸⁸ **Forty-eight percent of parents reported their children were spending more than 6 hours a day online, nearly a 500% increase in screen time compared to pre-pandemic rates.**⁸⁹ Other risky electronics-related coping behaviors that increased during the pandemic include gambling, online shopping, or watching pornography.⁹⁰ Prolonged reliance on such activities may lead to long-lasting dependence and related negative social, emotional and financial outcomes.⁹¹

A recent report from the Surgeon General also identified technology as a point of interest for youth during the COVID-19 pandemic. While online and virtual platforms can

be a source of connection and nurture healthy relationship development, excessive dependence and possible negative experiences online such as bullying or access to harmful misinformation may have a negative impact on children.⁹²

SUBSTANCE USE

One especially risky coping mechanism worthy of its own exploration is substance use. Since the start of the pandemic, many older youth have turned to alcohol and other substances to manage pandemic-related anxiety and the boredom of extended stay-at-home orders.⁹³ A Community Impact Survey conducted between September and November 2020 by the Massachusetts Department of Public Health found that, of respondents who had used substances in the last 30 days, **41% said that their substance use had increased compared to pre-pandemic levels.**⁹⁴ According to the same survey, many individuals ages 14 to 24 reported increased substance use during the pandemic.

Youth Substance Use in Massachusetts Compared to Pre-Pandemic⁹⁵

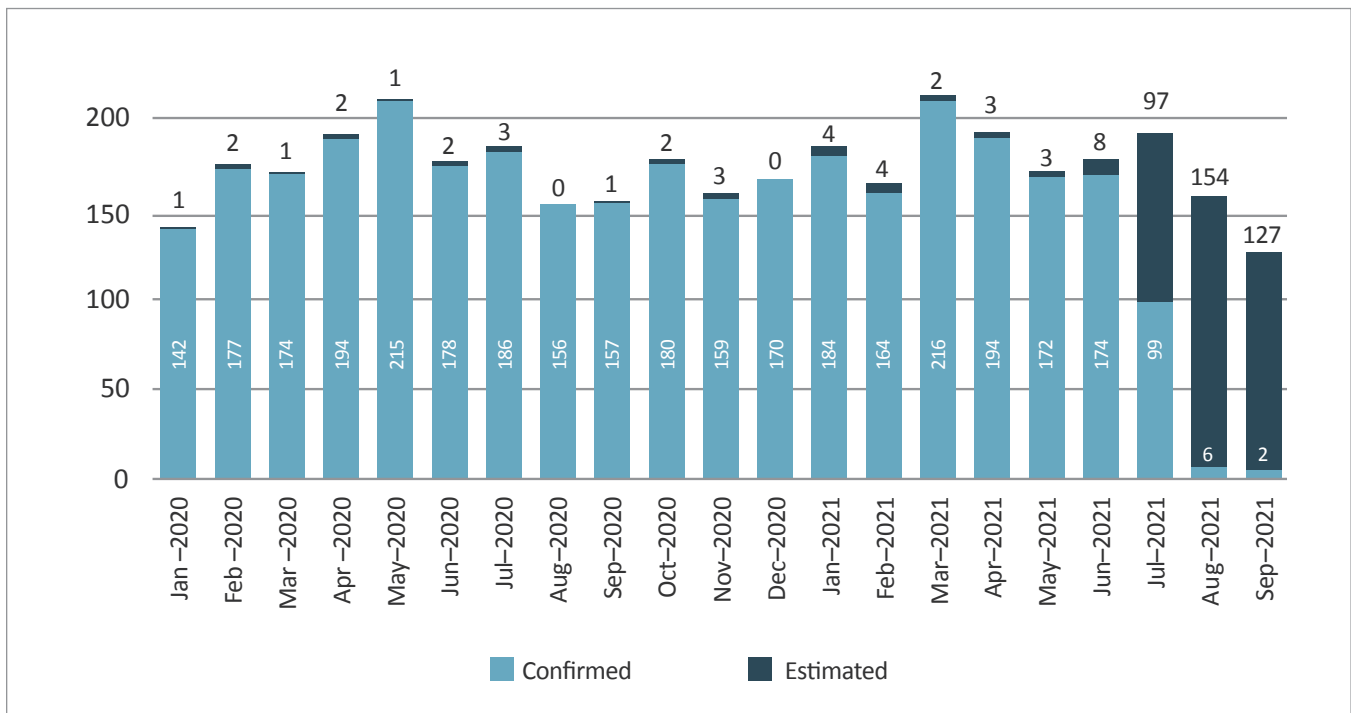
	A Lot Less	Somewhat Less	About the Same	Somewhat More	A Lot More
Ages 14–17	7%	7%	42%	28%	16%
Ages 18–24	8%	15%	38%	28%	11%

The pandemic also likely exacerbated the existing opioid epidemic. In Massachusetts, opioid-related deaths increased by 5% from 2019 to 2020, with a total of 2,106 estimated opioid overdose deaths in 2020.⁹⁶ The rates of opioid-related deaths increased the most among populations hit hardest by the pandemic: Black, Asian, Pacific Islander and Hispanic communities. The Black male community experienced a 69% spike - the highest increase in opioid-related overdose deaths among any subgroup.⁹⁷

⁸⁴ Elflein, 2021
⁸⁵ Nogel, 2020; ParentsTogether Foundation, 2020
⁸⁶ Barr & Copeland-Stewart, 2021
⁸⁷ Barr & Copeland-Stewart, 2021
⁸⁸ Shevenock, 2020
⁸⁹ Parents Together Foundation, 2020
⁹⁰ Kiraly et al., 2020

⁹¹ King et al., 2020
⁹² Murthy, 2021
⁹³ Panchal, et. al., 2021
⁹⁴ W.W. Sanouri Ursprung et al., 2021
⁹⁵ W.W. Sanouri Ursprung et al., 2021
⁹⁶ Massachusetts Department of Public Health, 2021b
⁹⁷ Massachusetts Department of Public Health, 2021b

Opioid Related Overdose Deaths in Massachusetts by Month⁹⁸



National data also suggest a surge in overdose deaths. CDC data indicate that between April 2020 and April 2021, there were an estimated 100,306 drug overdose deaths in the United States. This is almost a 30% increase from the same period in the year prior.¹⁰⁰

A rise in substance use and overdose deaths may present unique challenges for children whose caregivers are actively using substances. Previous research has shown that children exposed to substance use in the home are more likely to experience negative outcomes including (though not limited to) substance use themselves, academic challenges, social and familial conflict, abuse and/or neglect. These challenges pose a risk to the child both in immediate and longer-term outcomes.¹⁰¹

⁹⁸Massachusetts Department of Public Health, 2021b – Later months are still primarily estimates as there is a significant delay in finalizing death certificates in the state.

⁹⁹Frieden, 2021

¹⁰⁰Ahmad, Rossen & Sutton, 2021; Center for Disease Control and Prevention, 2021

¹⁰¹Lipari and Van Horn, 2017



Substance Use Increase Among Youth

The majority of substance use increase among youth ages 14-24 was in marijuana (20%) and alcohol use (36%). According to one survey of Massachusetts youth across racial and ethnic groups, 32%-44% of respondents reported using substances “more” than pre-pandemic, with the highest being among Black youth (44%), White youth (40%) and Hispanic/Latinx youth (38%). Thirty-two to 48% of respondents report using substances “about the same.”¹⁰²

Academic Loss and Challenges

The transition to fully remote learning in the spring of 2020 and a continuation of remote or hybrid learning for more than 80% of students through March of the 2020-21 academic year placed significant strain on schools and students alike. Student outcomes have been mixed and there is continued concern about the potential long-term negative impact of learning disruptions during the pandemic. In the immediate term, the national student achievement report for the 2020-21 academic year has shown that student reading achievement in 2020 was similar to that of 2019, however math achievements were 5 to 10 percent lower.¹⁰³ The Harvard School of Public Health conducted a national household survey from August to September 2021 and found that, during the last year, 69% of households with children in grades K-12 reported that their children fell behind academically because of COVID-19, and 70% of households reported it will be difficult for their child to close that achievement gap in the coming school years.¹⁰⁴ Some estimates project that students will experience even greater learning delays – as high as 30% in reading and 50% in mathematics.¹⁰⁵ Many parents are similarly concerned about the educational impact of the pandemic.

A poll of Massachusetts parents in March of 2021 found that 19% believe the pandemic had a major negative impact on their child’s academic learning;

31% believed it had a minor negative impact. The percent of parents who felt their child was behind their grade level also increased from 15% to 26%.¹⁰⁶

In addition to the impact of pandemic-related stress on learning gains, several groups of students had lower attendance rates and higher instances of chronic absenteeism as depicted below. One survey showed that rates of chronic absenteeism were consistently higher among English Language Learners than their English-speaking peers across all learning models (in-person, hybrid, remote). According to Massachusetts student attendance data, populations who displayed higher rates of chronic absenteeism were those students who identified as economically disadvantaged, high needs, English-Language Learners, ethnic minorities or students with disabilities.¹⁰⁷

¹⁰² W.W. Sanouri Ursprung et al., 2021

¹⁰³ Kuhfeld, et. al., 2020

¹⁰⁴ Harvard T.H. Chan School of Public Health, 2021

¹⁰⁵ Kuhfeld & Tarasawa, 2020

¹⁰⁶ Mass Inc. Polling, 2021a

¹⁰⁷ Chang et al., 2021; Office of the Child Advocate, 2021



National estimates suggest that as many as 3 million children were absent from or not actively participating in remote learning.¹⁰⁸ In Boston, it is estimated that approximately 20% of students did not participate in virtual school during the spring of 2020.¹⁰⁹ Similar challenges were experienced across the country.

In addition to absenteeism, there is also some concern about school enrollment, particularly for pre-kindergarten and kindergarten age children. Preliminary findings from the National Center for Education Statistics estimate that pre-kindergarten enrollment dropped by 22% and kindergarten enrollment dropped by 9% in the fall of 2020.¹¹⁰ Similar findings were presented in an NPR survey of more than 60 school districts across 20 states found that kindergarten enrollment was down an average of 16% in 2020–2021.¹¹¹ With 19% of Massachusetts caregivers preferring a hybrid model going into the 2021–2022 school year, it is possible that enrollment for the youngest students will fluctuate or decline.¹¹² Due to the lack of clear enrollment data around kindergarten, pre-kindergarten and daycare, it is difficult to assess changes in caregiver decisions regarding enrollment at this time, however, it will be important to monitor registration numbers going forward and the impact of any decrease on funding for early education systems. A delayed

start in school raises the question of the impact of reduced exposure to peer-play and developmentally important activities.

Older youth also faced a rapid change in their learning environment and disruptions to academic and social development. Students lost out on transitional events such as high school graduation which can serve as an important mile-marker in their transition to adulthood. For those going to college, many had to adjust their expectations around being able to take the developmentally important step of living on their own as college campuses moved to virtual learning, implemented new safety measures including limited in-person activities or living arrangements or because the student could no longer afford the cost of higher education.¹¹³ Nationally, there was a 3.6% decline in undergraduate enrollment in 2020, and an 11.4% decline in the number of graduates from high-poverty high schools that went straight to college.¹¹⁴

¹⁰⁸ Mchugh, 2021

¹⁰⁹ Korman, Okeefe & Rekpa, 2020

¹¹⁰ National Center for Education Statistics, 2021

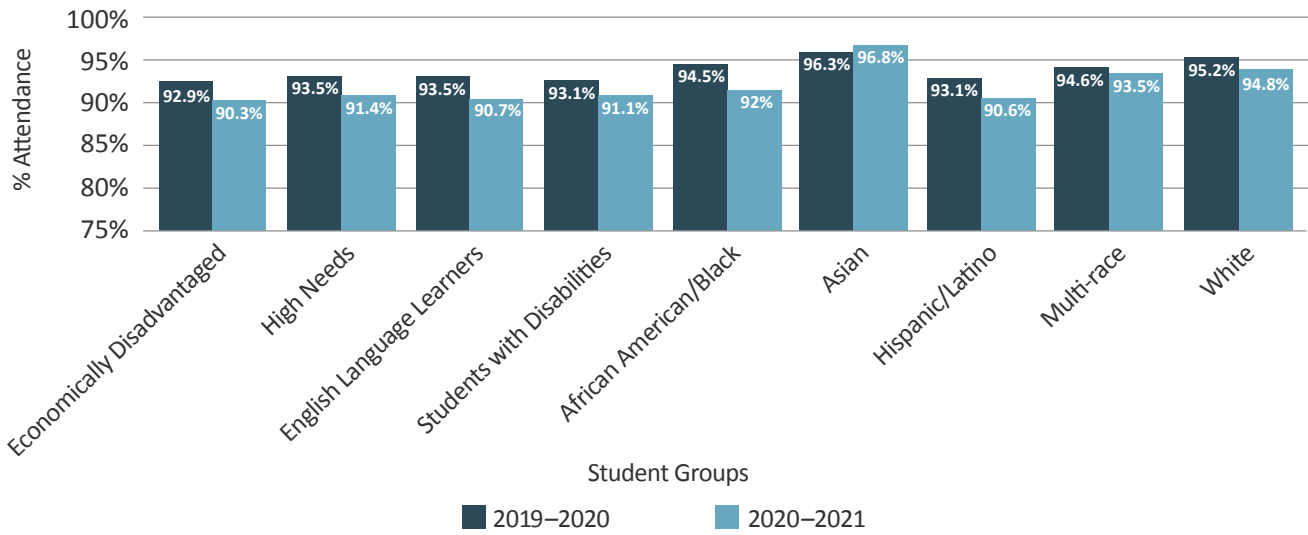
¹¹¹ Dorn et al., 2020

¹¹² Mass Inc. Polling, 2021b

¹¹³ Centers for Disease Control and Prevention, 2021f

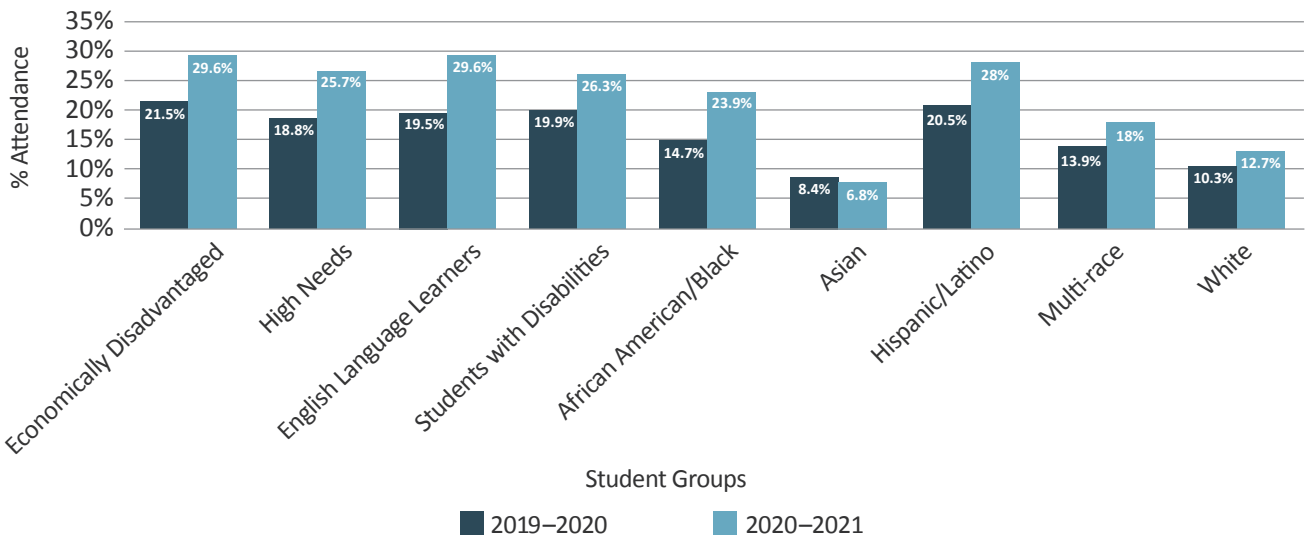
¹¹⁴ National Student Clearinghouse Research Center, 2021; Causey et al., 2021

Student Attendance Rates



Massachusetts public school student attendance by race¹¹⁵

Chronic Absenteeism Rates



Massachusetts public school rates of chronic absenteeism in academic year 2020–21 compared to 2019–20; defined as missing at least 10% of enrolled school days¹¹⁶

¹¹⁵ Massachusetts Department of Education, 2020; Massachusetts Department of Education 2021

¹¹⁶ Massachusetts Department of Education, 2020; Massachusetts Department of Education 2021

Caregiver Wellbeing and Stress

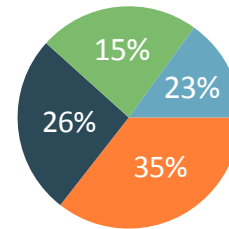
The health and wellbeing of children is directly tied to the health and wellbeing of their caregivers. As such, it is important to consider the impact of COVID-19 on adults ages 25–50, who are most likely to be parents or caretakers of children under the age of 18.¹¹⁷ In Massachusetts, residents ages 20 to 39 are consistently experiencing some of the highest rates of infection in the state compared to September 2020 when the average age for all infections was 60 years old.¹¹⁸

Stress on parents and caregivers, who were often required to fill various roles in their child’s life, has been enormous during the pandemic. Many caregivers with school-aged children had to become teacher’s assistants while working from home or facing the economic hardship of reduced income, all while coping with the ubiquitous stress and uncertainty brought on by the pandemic. The typical relief that came from, for example, sending a child to a play date or summer camp, was interrupted or ceased to exist. The toll on caregivers is being expressed in new wellbeing measures. An American Psychological Association survey found that, “parents were more likely than those without children to have received treatment from a mental health professional (32% vs. 12%) and to have been diagnosed with a mental health disorder since the coronavirus pandemic began (24% vs. 9%).”¹¹⁹ Despite an increase in help-seeking, **75% of parents nationally report they did not receive sufficient emotional support during the pandemic.**¹²⁰ Adults are reporting at least one adverse mental health or behavioral condition such as, but not limited to, depression, anxiety or substance use at rates 3-4 times higher compared to 2019. **Notably, 10.7% of all adults and 22% of essential workers reported seriously considering suicide in the last 30 days in a survey conducted in June of 2020.**¹²¹

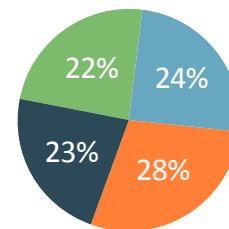
Caregivers facing a mental health crisis of their own are less able to monitor the wellbeing of their children.

In times of uncertainty, children look to the adults in their lives for stability and safety. Children with caregivers in crisis were less likely to receive such assurances or have someone to model positive coping mechanisms.

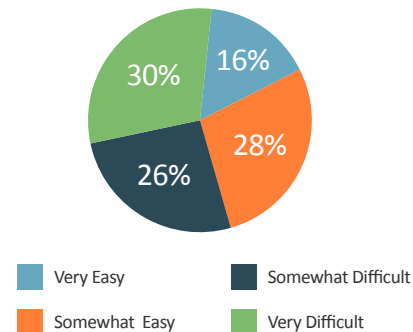
How easy or difficult has it been to manage your child's schedule?



How easy or difficult has it been to balance work and child care?



How easy or difficult has it been to find safe activities for your children to do outside of school?



Household difficulty managing children’s schedule and balancing work and childcare as of March 2021.¹²²

Children often perceive and internalize increases in stress, anxiety and other serious mental health challenges among caregivers.¹²³

¹¹⁷Mathews & Hamilton, 2016 (Based on average age of first-time parent and statistics around average age of all caregivers)

¹¹⁸Massachusetts Department of Public Health, n.d.

¹¹⁹American Psychological Association, 2021b

¹²⁰Basu & Koenen, 2021

¹²¹Czeisler et al., 2020

¹²²Mass Inc Polling, 2021a

¹²³Walton, 2012

Handhold MA

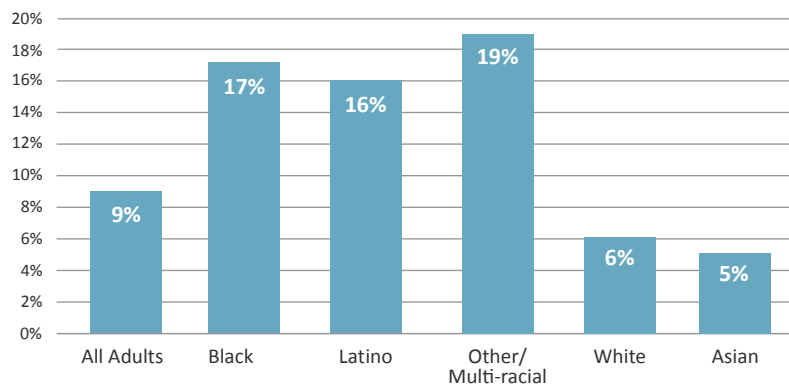
There are a number of resources available to Massachusetts families to assist them in identifying and responding to the behavioral health needs of their children, such as Handhold. Handhold was created by a team of mental health and child development experts in partnership with parents to help families who are concerned about the mental health and emotional wellbeing of their children to find resources, support and access needed care.

For more information, visit handholdma.org.

Food Insecurity

In October 2021, 7% of Massachusetts adults living with children reported not having enough to eat,¹²⁴ and 29% reported difficulty covering usual household expenses.¹²⁵ The racial and ethnic breakdown of financial insecurity shows that certain communities of color have been disproportionately impacted by the economic toll of the pandemic.¹²⁶ Similar challenges were faced across the nation.

Households that did not have enough to eat in the 7 days (as of 10/1/2021)



National percentage of adults that did not have enough to eat in the past 7 days by race as of October, 2021.¹²⁷



In 2019, 50% of Massachusetts students were eligible for free or reduced school lunches¹²⁸ and almost 12% of individuals under the age of 18 were living in poverty.¹²⁹ It is likely these numbers have increased in light of COVID-19. Massachusetts, like states across the nation, has taken steps to ensure children in schools have access to food, such as the Governor signing into law An Act Promoting Student Nutrition, which increased access to meals in schools and prevented punitive action against students with meal debt.¹³⁰ To buffer the impact of food insecurity on families with school-aged children and offset the loss of free and reduced lunches during times of school closures, districts across Massachusetts also worked to set up ‘grab and go’ sites for families to pick up prepared meals. The federal government enacted programs aimed at addressing youth food insecurity. Despite these efforts, an estimated **119,000 Massachusetts families report their children sometimes do not have enough to eat due to economic hardship.**¹³¹

¹²⁴Center on Budget and Policy Priorities, 2021

¹²⁵Center on Budget and Policy Priorities, 2021

¹²⁶Center on Budget and Policy Priorities, 2021

¹²⁷Center on Budget and Policy Priorities, 2021

¹²⁸Massachusetts Department of Elementary and Secondary Education, 2019

¹²⁹U.S. Department of Education, 2020

¹³⁰Office of Governor Charlie Baker and Lt. Governor Karyn Polito, 2021

¹³¹Center on Budget and Policy Priorities, 2021



Caregivers, Working Conditions and Unemployment

Again, caregiver health and wellbeing is directly tied to child health and wellbeing. When primary caregivers experience adversity such as under- or unemployment, there is an increased risk that their children will experience adversity. In the early stages of the pandemic, stay-at-home orders forced many businesses to close and unemployment to increase from 3.5% to 5.9% nationally.¹³⁶ The service industry, reliant on face-to-face interactions and more frequently individuals from underrepresented and economically distressed communities, accounted for an appreciable share of layoffs and closures.¹³⁷ Caregivers faced disproportionate rates of unemployment with 35% reporting loss of employment or reduced hours.¹³⁸ While pandemic unemployment benefits passed through the CARES Act protected millions from sudden financial crisis, many families still struggled to make financial ends meet, remained ineligible for certain assistance programs or waited months for aid to arrive.¹³⁹ According to a national survey conducted from August to September 2021, 38% of households experienced serious financial problems over the preceding months, despite 67% of U.S. households receiving increased financial assistance from the government.¹⁴⁰ Due to job loss and other COVID-19 constraints, 19% of households reported losing their savings during the pandemic or not currently having any savings.¹⁴¹

Adults working in certain industries such as food service, construction, transportation and warehousing were less likely to have employer-implemented safety precautions such as social distancing and distribution of personal protective equipment.¹⁴² Those working outside the home were twice as likely to have tested positive for COVID-19 compared to those working from home, according to one Massachusetts survey.¹⁴³ Nationally, access to sick leave also varied greatly by industry. For example, only 64% of retail employees reported having access to sick leave compared to 94% of business and financial workers.¹⁴⁴

Housing Insecurity

As of January 2020, 3,714 Massachusetts families were experiencing homelessness, including 9,122 public school students living in shelters or hotels and 15,330 living with friends or family.¹³² Initial reports from several Massachusetts cities showed a slight decrease in family homelessness in 2021 compared to 2020, however, the decrease may be due to fear of exposure to COVID-19 in shelters and increased access to emergency housing through COVID-19 funds that are not guaranteed to be renewed.¹³³ Emerging data, such as the annual Department of Housing and Urban Development (HUD) Point-in-Time national homeless count, will help clarify the true impact of the pandemic on homelessness.

In addition to families that meet the official definition of 'homeless,' many families are behind on rent or mortgage payments. A national household survey found that, when the CDC's eviction moratorium ended, 27% of renters reported serious difficulty with paying their rent.¹³⁴ In Massachusetts, 10% of renters are behind on payments.¹³⁵ While data specific to families with children is not available, the higher rates of food insecurity and other negative financial indicators suggest that many youth are likely facing increased housing insecurity as well.

¹³²United States Interagency Council on Homelessness, n.d.

¹³³City of New Bedford, 2021

¹³⁴Harvard T.H. Chan School of Public Health, 2021

¹³⁵Center on Budget and Policy Priorities, 2021

¹³⁶Center on Budget and Policy Priorities, 2021

¹³⁷Falk, Carter, Nicchitta, Nyhof, & Romero, 2021

¹³⁸W.W. Sanouri Ursprung et al., 2021

¹³⁹U.S. Department of Labor, 2020; Chen, Byrne, & Vélez, 2021

¹⁴⁰Harvard T.H. Chan School of Public Health, 2021

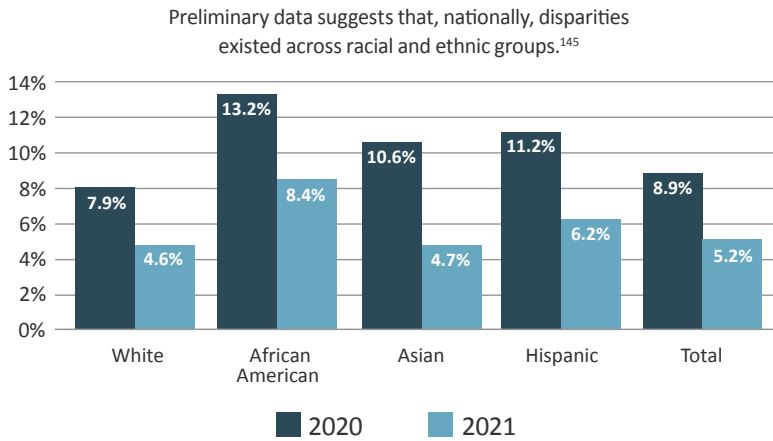
¹⁴¹Harvard T.H. Chan School of Public Health, 2021

¹⁴²Wolfe, Harknett, & Schneider, 2021

¹⁴³Lisinsky, 2021

¹⁴⁴DeSilver, 2020

Average Unemployment by Race and Ethnicity: Preliminary Data – Q3 2020 vs Q3 2021



National Unemployment Rates by Race and Ethnicity
July-September 2020 and July-September 2021¹⁴⁶

Domestic Violence, Abuse and Neglect

Estimates of domestic violence and abuse have increased nationally during the COVID-19 pandemic.¹⁴⁷ Though insufficient data are available to describe rates in Massachusetts, one anecdotal report from Massachusetts General Hospital suggests that the frequency and intensity of domestic violence-related cases have increased.¹⁴⁸ Nationally, calls reporting domestic violence increased by 10-27%.¹⁴⁹ The National Domestic Violence Hotline has also seen an increase in calls and reports from survivors that their abusers are using the pandemic as a means to control them.¹⁵⁰ Isolation, a tactic used by many abusers, was made easier by stay-at-home orders and social distancing guidelines. Additionally, work from home policies forced many to remain indoors with their abusers and out of sight from potential interveners, or without the time to safely plan an exit strategy. The economic toll of the pandemic made it more difficult to leave abusive situations and exacerbated the stress and anger that causes some to lash out at their partners, children or other family members.¹⁵¹ However, it is difficult to thoroughly describe the impact on children since there is extremely limited child-specific data. More information is needed to fully understand how domestic violence, abuse and neglect has impacted children during the pandemic, especially given some experts' pre-pandemic concerns around racially biased reporting and overreporting. Exposure to abuse or neglect can have a profound, life-long impact on the health and wellbeing of children. In addition to the risk of physical harm, youth exposed to domestic violence and abuse lose the sense of security and calm that allows them to take risks, learn and develop appropriate social behaviors of their own.¹⁵²



¹⁴⁵Center on Budget and Policy Priorities, 2021

¹⁴⁶U.S. Bureau of Labor Statistics, 2021c

¹⁴⁷Piquero, Jennings, Jemison & Kaukinen, 2021

¹⁴⁸Massachusetts General Hospital, 2020

¹⁴⁹Sharma & Borah, 2020

¹⁵⁰The National Domestic Violence Hotline, 2020

¹⁵¹Sharma & Borah, 2020

¹⁵²Walton, 2012



U.S. Surgeon General, Dr. Vivek H. Murthy, provides an excellent exploration of how COVID has impacted children’s mental health and offers a comprehensive list of recommendations for systems, providers, families and individuals to support the health and wellbeing of children. In his report, Dr. Murthy identifies several prominent risk factors contributing to children’s mental health symptoms during the pandemic including:¹⁵³

- Having pre-existing mental health challenges
- Living in an urban area or an area with more severe COVID-19 outbreaks
- Having parents or caregivers who were frontline workers
- Having parents or caregivers at elevated risk of burnout
- Being worried about COVID-19
- Experiencing disruptions in routine, for example, not seeing friends or needing to navigate remote schooling
- Experiencing more adverse childhood experiences (ACEs) such as abuse, neglect, community violence and discrimination
- Experiencing more financial instability, food shortages or housing instability
- Experiencing trauma, such as losing a family member or caregiver to COVID-19

The full report can be found [here](#).

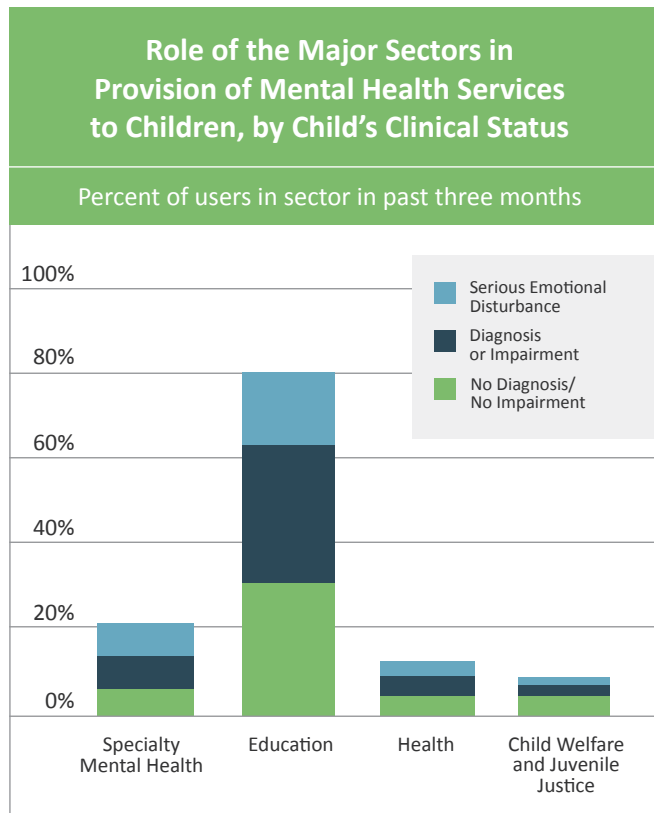
¹⁵³Murthy, 2021

Section 2:

Child Serving Systems (Meso)

Education System

As schools transitioned to fully remote or hybrid schedules, students lost access to behavioral health supports and resources traditionally delivered through the education system. Pre-pandemic data shows that, of those who received mental health services, about 80% obtained services from school settings, with about a third receiving services exclusively from school settings. Further, youth who were from low-income households, had public insurance or were from racial or ethnic minority communities were more likely to receive mental health services exclusively from school settings.¹⁵⁴



Source: Burns et al. "Children's Mental Health Service Use across Service Sectors."¹⁵⁵

The Massachusetts Department of Elementary and Secondary Education (DESE) responded to concerned parents and teachers with a number of new guidelines and online resources rolled out over the course of the pandemic. Requirements surrounding Individualized Education Plans (IEPs) and language access services were adapted to accommodate pandemic-related delays and changes in service delivery methods. Regarding COVID-19 safety measures, Massachusetts also implemented a number of risk mitigation strategies and infection monitoring plans. Schools were also put in a challenging position of needing to respond to frequent changes in federal and state guidelines, constant concerns from families and adapting to deliver education services virtually. This placed enormous pressure on administrators, teachers and other staff. Teachers in multiple surveys reported needing assistance keeping students engaged and motivated during remote learning.¹⁵⁶ Further, teachers in virtual classrooms were less able to access support systems traditionally available within the school building, such as being able to send a student to the school nurse or guidance counselor, leading to enormous pressure on teachers to address behavioral challenges with individual students while still supporting the rest of their class. Since many teachers have little to no behavioral health training, the lack of support for teachers also increased the risk of behavioral health needs of children going unrecognized. Due to the difficult nature of assessing student engagement and variations in definitions of 'engagement' in available data, the true extent of reduced student engagement during virtual learning sessions is still not fully known.

Public health officials noted that surveillance testing for community spread is an extra layer of protection. Given the low levels of transmission found in schools, it appears these testing efforts may have been effective at reassuring parents and teachers that some amount of in-person learning was safe.¹⁵⁷ While children and young adults made up a small portion of cases in the spring and summer of 2020, plans to return to in-person learning in the fall raised questions of testing among students and teachers. In Massachusetts, the the Department of Elementary and Secondary Education, in conjunction with the Massachusetts Governor's office, implemented a rapid response team that could be deployed to schools that had a cluster of cases to conduct community testing and tracing. The State also coordinated the "Stop the Spread" initiative to ramp up community testing access in areas with higher rates of infection to ensure teachers

¹⁵⁴ Hoover et al., 2019; Ali et al., 2019

¹⁵⁵ Burns et al., 1995

¹⁵⁶ Barnum & Bryan, 2020

¹⁵⁷ Bilinski et al., 2021

and students had adequate testing availability upon the return to classes.¹⁵⁸ In addition to outbreak responses, DESE also worked to implement pooled testing while individual districts fundraised to conduct their own surveillance testing.¹⁵⁹

With ongoing vaccine hesitancy and the rise of virus variants such as Delta and Omicron, schools have continued working with caregivers, teachers and public health experts to determine procedures necessary to operate classrooms safely while ensuring students are able to access the academic, social and behavioral health resources critical to their development and recovery from pandemic-related traumas. With rising COVID-19 positivity rates, some school districts across Massachusetts have returned to remote learning due to staff shortages. At the time of this writing, Governor Baker expressed his commitment to ensuring schools can remain in person and not transition to remote learning. Test-and-stay models have been implemented in schools across Massachusetts, which has helped with early infection detection and to minimize unnecessary quarantines. Massachusetts also utilized a portion of their COVID-19 relief funds to purchase at-home testing kits for school employees as well as the distribution of KN-95 masks to teachers and bus drivers.¹⁶⁰

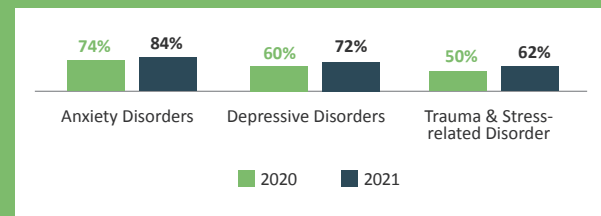
Healthcare System

The pandemic's unprecedented impact on children and families has many experts concerned about the healthcare system's ability to adequately identify and respond to the increase in behavioral health needs. Before the pandemic, workforce shortages, long wait-times and limited access to evidence-based care already inhibited the ability for many families to access effective supports and services. The COVID-19 pandemic has likely exacerbated this issue, as many child-serving professionals are "burning out" and leaving the field at a time when demand is at an all-time high. Despite expanded avenues for connecting with mental health clinicians through telehealth, patients may still struggle to identify and connect with a provider well-suited to address their needs. **According to some reports, wait times to access out-patient care can be up to 6-12 months.**¹⁶¹

In March 2020, Massachusetts providers were seeing about 30,000 behavioral health visits a month. Over the next 5 months, this number increased among almost all age categories, with the proportion of visits being conducted via telehealth also increasing.¹⁶²

Increase in Demand for Specific Treatments:

The American Psychological Association's (APA) 2021 national survey of psychologists reports increasing demand for treatment such as anxiety, depressive and trauma/stress-related disorders from 2020 to 2021. Needs increased across almost all age groups including adolescents ages 13-17 years and individuals ages 18-64 years, which includes transition age youth. Data were collected from several settings including K-12 schools, colleges and universities and clinical service settings.¹⁶³



TELEHEALTH

At the start of the pandemic, many healthcare providers suspended in-person service provision and turned to delivering services via telehealth. This shift ensured children and families could still access needed educational, behavioral health and medical supports and services despite stay-at-home orders and the need for social distancing. Several billing and regulatory agencies temporarily suspended or amended some of their policies. Changes included allowing out-of-state providers to obtain emergency licensure and deliver telehealth services across state lines, as well as increasing reimbursement rates for telehealth services to match in-person service rates.¹⁶⁴ These changes not only made it easier for families to access treatment, but also for providers to offer care, and contributed to marked increases in telehealth usage. One study found that there was a 154% increase in telehealth visits in March 2020 compared to March 2019.¹⁶⁵ A survey conducted by the American Psychiatric Association found that, by May of 2020, 85% of clinicians were conducting the majority of visits virtually, a massive increase from

¹⁵⁸Office of Governor Charlie Baker and Lt. Governor Karyn Polito, 2020

¹⁵⁹Massachusetts Department of Elementary and Secondary Education, 2021; Jung, 2021

¹⁶⁰Executive Office of Education & Department of Elementary and Secondary Education, 2021; Massachusetts Department of Elementary and Secondary Education, 2022

¹⁶¹Bebinger, 2021

¹⁶²Massachusetts Health Policy Commission, 2021

¹⁶³American Psychological Association, 2021a

¹⁶⁴Office of Governor Charlie Baker and Lt.

Governor Karyn Polito, 2021

¹⁶⁵Koonin, et. al., 2020

just 2% prior to COVID-19.¹⁶⁶ Nearly one-quarter of pediatric patients engaged in psychotherapy prior to the pandemic discontinued care, but the majority (72%) transitioned to fully virtual or a mix of virtual and in-person appointments.¹⁶⁷ Additionally, national CDC data shows that, on average, telehealth sessions increased by about 50% when comparing January to March 2019 and January to March 2020.¹⁶⁸ In April 2020, 70% of behavioral health visits were performed via telehealth with utilization peaking at 80% in May and declining to 69% in October 2020.¹⁶⁹

Telehealth remains a promising strategy for ensuring that children and families can access effective care for the foreseeable future, having received positive reception by both clinicians and families alike. A Parent/Professional Advocacy League (PPAL) survey¹⁷⁰ found that **59% of young people and 62% of families reported feeling services delivered via telehealth were more effective than in-person services.**¹⁷¹ Challenges to obtaining mental health care via telehealth during the COVID-19 pandemic include access to reliable technology, such as broadband internet, and privacy concerns when delivering or taking part in services.¹⁷²

Clinician Reports on Telehealth Across Child and Adult Age Groups¹⁷³

According to a 2021 national survey by the American Psychological Association:

- 96% of psychologists agreed or strongly agreed that telehealth has proven to be a **useful therapeutic tool** throughout the pandemic.
- 93% agreed or strongly agreed that they **intend to continue providing telehealth services** in their practice post-COVID-19.
- 50% of psychologists **have adopted a hybrid (in-person and telehealth) schedule** in 2021.

It should be noted that these data include respondents serving a variety of age ranges. Additional exploration is needed to better understand how telehealth can best support children and families.



¹⁶⁶Ducharme, 2021

¹⁶⁷Massachusetts Health Policy Commission, 2021

¹⁶⁸Koonin, et. al., 2020

¹⁶⁹Ducharme, 2021

¹⁷⁰“Youth” survey respondents were between the ages of 13 and 30 years old. The largest group (46%) were 18 to 25 years old.

¹⁷¹Lambert, 2020

¹⁷²Ducharme, 2021

¹⁷³American Psychological Association, 2021a

EMERGENCY DEPARTMENT BOARDING

There remains a shortage of providers and beds for acute emergency psychiatric needs.¹⁷⁴ According to the Health Policy Commission, 39% of children's mental health emergency room visits between March and September of 2020 resulted in emergency department (ED) boarding.¹⁷⁵ This is an increase of 7% from 2019 rates.¹⁷⁶ Additionally, pediatric behavioral health patients were also more likely than other age groups to wait more than 48 hours for in-patient admission.¹⁷⁷ Some of the increase in rates and length of ED boarding may stem from reduced bed capacity to allow for required social distancing.¹⁷⁸ To decrease wait times, many parents with the

financial resources began paying out of pocket for services rather than waiting for an in-network provider.¹⁷⁹

One report estimates that between 23–58% of children in need of inpatient mental health care will have to wait in the emergency room prior to admission, though this figure was calculated using a small collection of studies as no national ED boarding statistics are available.¹⁸⁰ According to the Massachusetts Department of Public Health, **there was a 200–400% increase in ED boarding for all patients in June of 2020 compared to the previous year.**¹⁸¹



¹⁷⁴ Basu & Koenen, 2021

¹⁷⁵ Emergency department boarding: Spending 12 or more hours in the emergency department after being assessed and deemed in need of inpatient care; The Massachusetts Health Policy Commission 2021

¹⁷⁶ The Massachusetts Health Policy Commission, 2021

¹⁷⁷ The Massachusetts Health Policy Commission, 2021

¹⁷⁸ The Massachusetts Health Policy Commission, 2021

¹⁷⁹ Bebinger, 2021

¹⁸⁰ McEnany, Ojugbele, Doherty, McLaren, & Leyenaar, 2020

¹⁸¹ Lenthang, 2021

Child Welfare System

In 2019, prior to the pandemic, approximately 26,000 children were assessed for abuse and neglect in Massachusetts.¹⁸² Despite a suspected rise in instances of abuse and neglect, reports to the Department of Children and Family Services (DCF) dropped 55% statewide in the early months of the pandemic.¹⁸³ Eventually, reporting rates did improve, though did not completely return to pre-pandemic levels. When comparing DCF abuse and neglect reporting from March to October 2019 to the same months in 2021, the latter remained lower, but was within 9% of pre-COVID rates.¹⁸⁴

Historically, 80% of reports in Massachusetts come from mandated reporters, including teachers, medical or behavioral health providers and other child-serving professionals.¹⁸⁵ Experts believe, that during the period of reduced reporting to DCF, many cases went unnoticed due to reduced visibility of children and families.

The pandemic also placed significant strain on the child welfare system and contributed to case closure rates dropping 28.7% compared to the pre-pandemic average.¹⁸⁶ As the pandemic continued, other challenges related to family engagement emerged. Like other child and family serving sectors, much of the work was transitioned to virtual platforms, including DCF social workers conducting home visits and virtual family visits. Little data exists to describe the relative impact of virtual visits on families' ability to connect with children that have been removed from their homes or of social workers' ability to adequately assess safety and wellbeing. Additional questions remain regarding the impact of COVID-19 on children in foster care and the degree to which the pandemic inhibited case workers' ability to perform routine duties.

Impact of COVID-19 on the Child-Serving Workforce

In addition to the stress and strain families experienced during the COVID-19 pandemic, child and family-serving professionals in education and healthcare were also subjected to greater demands and expectations along with navigating their own personal and familial tension related to the pandemic. This contributed to unprecedented levels of stress, burnout and related behavioral health challenges in the professional workforce.



In the summer of 2020, schools across the country needed to plan for a return to in-person learning, including additional measures to protect students and staff against COVID-19 to the best of their ability.¹⁸⁷ In addition to the typical work associated with planning for the coming school year, school-based professionals were also required to redesign classroom and school procedures in compliance with current safety guidelines, design hybrid schedules that would allow students to safely return to the classroom and receive high quality educational programming, all while encountering the increased student emotional and behavioral health needs as previously discussed with limited ability to effectively intervene.¹⁸⁸ Due in part to this increase in stress and demand, it is estimated that 28% of teachers are more likely to consider retiring early or leaving the profession since the start of the pandemic. This includes one in five teachers with 10 years of experience or less.¹⁸⁹ These early departures from the profession will most likely exacerbate the existing teacher shortage nationwide.

Healthcare providers were similarly impacted by increased demands and overwhelming needs of the communities they serve. Pre-pandemic, there were already workforce shortages contributing to gaps in access to effective behavioral health care. Pandemic-related provider shortages are exacerbating this need and leading to concerns about the availability of effective care at a time when the need is greatest.

¹⁸²Betancourt, 2020

¹⁸³Callahan & Mink, 2020

¹⁸⁴Massachusetts Department of Children and Families, 2021

¹⁸⁵Betancourt, 2020

¹⁸⁶Massachusetts Department of Children and Families, 2021

¹⁸⁷Jung & Larkin, 2020

¹⁸⁸Massachusetts Department of Elementary and Secondary Education, 2021

¹⁸⁹Flannery, 2020

A 2021 national survey by the American Psychological Association found that 41% of psychologists report being unable to meet patient demand for treatment. 46% of those surveyed report feelings of burnout.¹⁹⁰

Primary care providers also faced significant financial challenges associated with pandemic-related closures and a rapid decline in in-person visits. A 2020 survey found 6% of independent primary care providers had to close their practice and another 35% had to furlough staff due to increased costs and decreased patient visits. Many who were able to continue providing care needed to make the immediate and challenging transition to virtual services. While demanding, this switch did create an opportunity for non-traditional care delivery systems which may be explored and leveraged in the months and years to come. Virtual primary care platforms that offer one-time consultations for a flat rate fee marketed themselves as tech savvy and easy to access, while they generally operated outside the insurance market.¹⁹¹ More analysis of these new service delivery models will be needed to assess their effectiveness in providing quality, ongoing basic care and to understand the potential impact on traditional primary care service delivery.

Impact of COVID-19 on Mental Health Workforce¹⁹²

A June 2020 survey of state MH commissioners found:

- 71% of respondents reported pandemic-related workforce shortages
- 73% reported community providers reducing staff or services
- 26% reported community providers closing

A February to March 2021 survey conducted by the Washington Post and Kaiser Family Foundation found that 20–30% of frontline healthcare workers in the U.S. were considering leaving the field.¹⁹³ Reasons included the toll of the pandemic on providers’ mental health, excessive workload and insufficient leadership.¹⁹⁴ Anecdotally, many providers felt undervalued and overworked and were further disheartened by the lack of protective equipment and other safety measures at the onset of the pandemic.¹⁹⁵

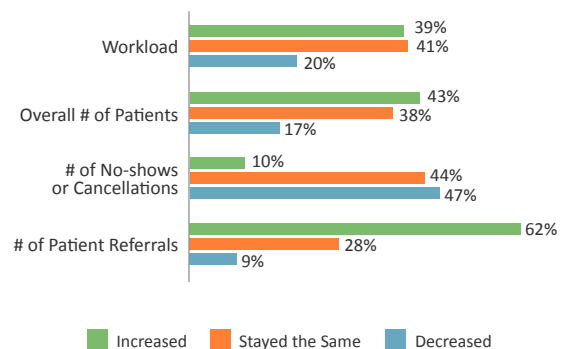
In addition to workforce shortages, there is significant concern about the health and wellbeing of front-line workers. One study in September-October of 2020 found that **36% of physicians and 49% of non-physician healthcare workers were showing symptoms of PTSD.** Health care workers who scored positive for PTSD were more likely to report suicidal ideation than their colleagues (16.8% compared to 5%).¹⁹⁶



Changes in Practitioner Workload¹⁹⁷

According to a 2021 survey by the American Psychological Association, practicing psychologists have reported an increase in workload, total number of patients on their caseload and patient referrals. Encouragingly, practitioners have also noted that the move to providing services via telehealth has contributed to a decrease in no-shows and cancellations.

Changes in Practitioner Workload



¹⁹⁰American Psychological Association, 2021a

¹⁹¹Schneider, 2021

¹⁹²Druss, et. al., 2021

¹⁹³Gilchrist, 2021

¹⁹⁴Gilchrist, 2021

¹⁹⁵Gilchrist, 2021

¹⁹⁶Bayazit et al., 2021

¹⁹⁷American Psychological Association, 2021a

Section 3:

Social, Cultural and Political (Macro)

Throughout the pandemic, the experiences of individual children, families and communities have overlapped with broader social, cultural and political elements. These broader “macro” level factors have manifested in a number of ways including disproportionate COVID-19 cases, hospitalizations, deaths, and vaccination rates (and related efforts to address equity issues), a troubling rise in xenophobia and racism, as well as state and federal efforts to alleviate pandemic-related strain on families and increase access to needed supports and services.

Equity

The impacts of the pandemic, while widespread, affected some communities more harshly than others. Racial and ethnic disparities were exacerbated with rates of infections and deaths, loss of employment, housing and food insecurity, reduced academic gains and negative mental health outcomes being experienced more frequently by marginalized communities including people of color.¹⁹⁸



According to one survey, youth from communities of color in non-English speaking households and those whose caregivers held low-wage, service industry jobs were more likely to know someone who was infected with or died from COVID-19. Notable findings from this survey included:¹⁹⁹

Disparate Impact of COVID-19 on Various Groups of Youth			
Population	Tested Positive for COVID-19	Household member tested positive for COVID-19	Lost someone close due to COVID-19
All Surveyed Youth	3%	6%	6%
Black, non-Hispanic Youth	6%	6%	11%
Hispanic/Latinx Youth	5%	13%	9%
Young Parents (14–24)	6%	14%	14%
Youth who speak a language other than English at home	4%	9%	9%

Adapted from COVID-19 Community Impact Survey conducted in Massachusetts between September and November 2020.²⁰⁰

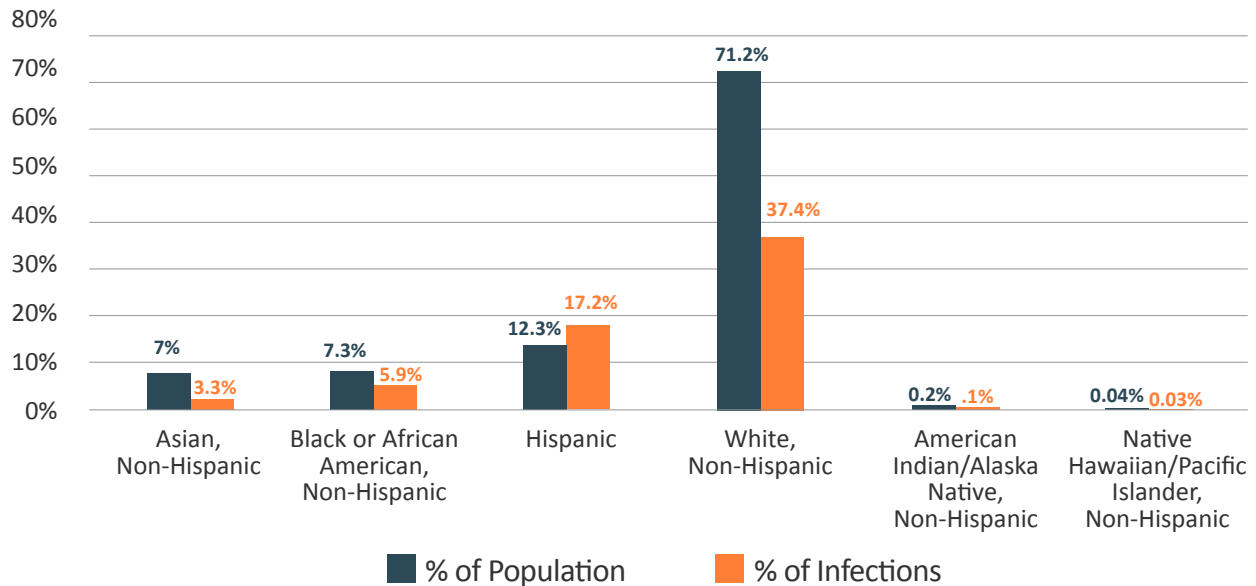
¹⁹⁸Center on Budget and Policy Priorities, 2021

¹⁹⁹Comparison data for non-Hispanic White youth were unavailable at the time of writing.

²⁰⁰W.W. Sanouri Ursprung et al., 2021

In Massachusetts and nationally, COVID-19 infection rates have been disproportionately high in communities of color. Minority populations and those with fewer financial resources are also more likely to live in crowded or multi-generational housing where it is difficult to quarantine and engage in necessary social distancing. As a result, the virus spread more easily among family members and communities.²⁰¹

Share of COVID-19 Infections by Race and Ethnicity



Massachusetts COVID-19 Infection by Race and Ethnicity: Share of Infections Compared to Percentage of the Population as of 04/07/2021²⁰²

People of color were generally more likely to test positive, and Black, Hispanic and Asian patients were more likely to require oxygen or ventilation at the time of diagnosis, suggesting prolonged time between the onset of symptoms and seeking medical assistance.²⁰³ Similar disparities persisted through the vaccine roll-out process. Despite Massachusetts maintaining vaccination rates higher than the national average, disparities across communities and key demographics persist.²⁰⁴

Although deaths from COVID-19 have been higher among non-Hispanic White adults (likely a reflection of that group’s share of the overall population, and older average age as compared to other demographic groups²⁰⁵), Black and Hispanic residents make up a disproportionate share of deaths from COVID-19. Black and Hispanic residents were more likely to die from COVID-19 than White residents at a rate of 14% and 35% respectively.²⁰⁶ The racial and ethnic differences between infection and death rates may be explained in part by higher levels of infection in communities of color among healthier, younger essential workers and among older, more vulnerable White communities, such as nursing home residents.

²⁰¹Rubin-Miller, Alban, Sullivan, & Artiga, 2020

²⁰²Massachusetts Department of Public Health, n.d.; all data retrieved from the Massachusetts COVID-19 Interactive Data Dashboard as of April 07, 2022; remaining cases not reflected in chart above fall under either “Other Race, Non-Hispanic,” (9% of cases) or “Unknown, Missing or Refused” (27% of cases) as reported by Mass.Gov.

²⁰³Rubin-Miller et al., 2020

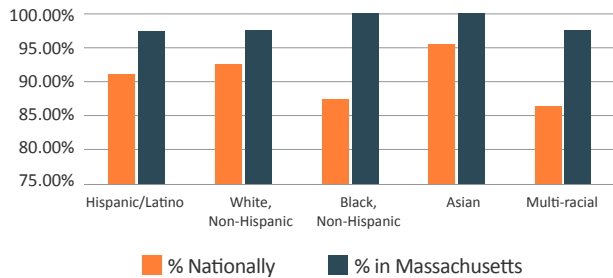
²⁰⁴Data Strategy and Execution Workgroup, 2021

²⁰⁵Hill & Artiga, 2022

²⁰⁶Massachusetts Department of Public Health, n.d.

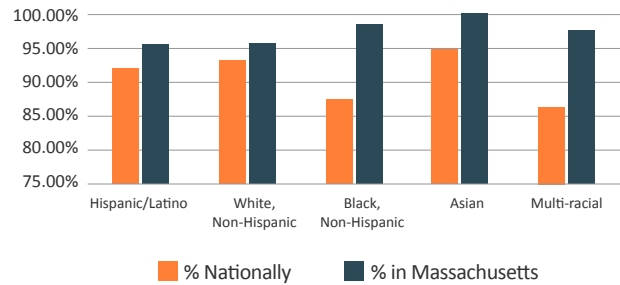
The loss of academic achievement discussed above has also negatively impacted students of color with one estimate suggesting that White students may be 4–6 months behind in mathematics while students of color may be as much as 6–12 months behind.²⁰⁷ Nationally, Black and Hispanic students were twice as likely to have no live access to teachers, according to a survey conducted in the fall of 2020.²⁰⁸ Despite alarming disparities in access to these resources nationally, Massachusetts was able to achieve relatively high and equitable rates as shown below.²⁰⁹

Access to Computers or Digital Devices for Educational Purposes



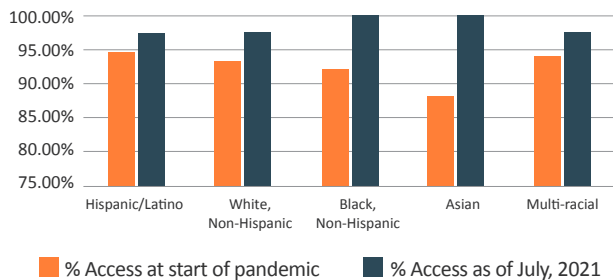
Percentage of student access to computers or devices ‘always’ or ‘usually’ for educational purposes as of July 2021, national comparison to Massachusetts²¹⁰

Access to Internet for Educational Purposes



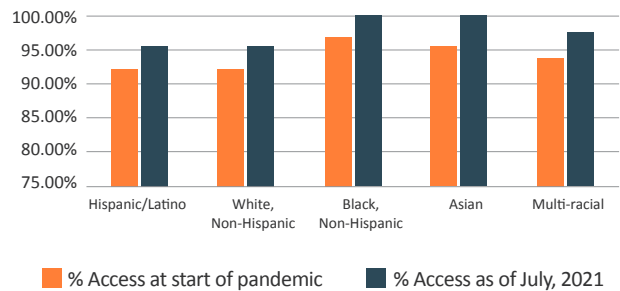
Percentage of student access to internet ‘always’ or ‘usually’ for educational purposes as of July 2021, national comparison to Massachusetts²¹¹

Access to Computers or Devices for Educational Purposes in Massachusetts



Massachusetts’ student access to computers or devices ‘always’ or ‘usually’ for educational purposes in April–May 2020 compared to May–July 2021²¹²

Access to Internet for Educational Purposes in Massachusetts



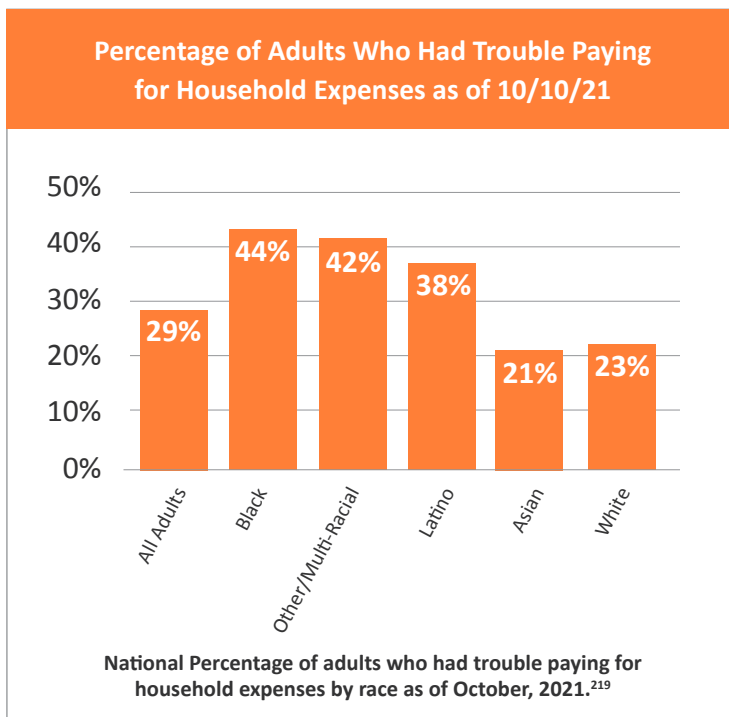
Massachusetts’ student access to internet ‘always’ or ‘usually’ for educational purposes in April–May 2020 compared to May–July 2021²¹³

²⁰⁷Dorn et al., 2020
²⁰⁸Dorn et al., 2020
²⁰⁹Dorn et al., 2020
²¹⁰US Census Bureau, 2021a (Week 32)

²¹¹US Census Bureau, 2021a (Week 32)
²¹²US Census Bureau, 2021a (Weeks 1 & 32)
²¹³US Census Bureau, 2021a (Weeks 1 & 32)

Black, Latino, and multi-racial households with children were 8–11% more likely to experience food insecurity than Asian and White households.²¹⁴ As explored in the above sections, unemployment rates also varied greatly by race. The trend persists across numerous economic indicators and signifies the ongoing impact of systemic racism and continued inequities in the economy. LGBTQ+ youth have also faced unique challenges over the course of the pandemic. A Trevor Project report confirmed that schools are an important safety net for LGBTQ+ youth with 50% reporting their school was an LGBTQ+ affirming space compared to 34% of home environments. Furthermore, COVID-19 increased stress in living conditions for 80% of LGBTQ+ youth.²¹⁵ The pandemic limited access to school-based supports and stay-at-home orders forced some to remain in unsupportive environments, potentially leading to negative emotional outcomes.²¹⁶ Finally, children with intellectual and developmental disabilities were more likely to experience difficulty with managing challenges and disruptions to their school and service routines, and, as a result, are at greater risk of falling even further behind.²¹⁷

Systems and support services designed to protect these vulnerable populations faced reduced capacity at the same time that demand was increasing. Expanding support systems that can build youth resiliency will be key to an equitable recovery.²¹⁸



²¹⁴Center on Budget and Policy Priorities, 2021

²¹⁵The Trevor Project, 2021

²¹⁶W.W. Sanouri Ursprung et al., 2021

²¹⁷Murthy, 2021

²¹⁸Juvenile Justice Policy and Data Board, 2020; OECD, 2020; Garfield & Chidambaram, 2020

²¹⁹Center on Budget and Policy Priorities, 2021

Xenophobia & Racism

As explored in our 2020 report, *Spotlight On: Impact of the COVID-19 Pandemic on Children, Youth and Families*, racial and ethnic discrimination is associated with poorer mental health outcomes and is considered a risk factor for depression, anxiety and PTSD.²²⁰ Discrimination is also associated with lower self-esteem and conduct problems in children.²²¹ Misinformation and bias in the media has persisted throughout the pandemic. Use of xenophobic terms like “The Chinese Virus” has encouraged false associations between the coronavirus pandemic and Chinese American communities.²²² Such biased coverage has been shown to contribute to mental health illnesses like PTSD, generalized anxiety disorder and substance abuse disorders in those who the bias is directed against.²²³ It has also contributed to an increase in anti-Asian hate crimes across the country, which first spiked at the beginning of the pandemic in March 2020.²²⁴ These hate crimes have largely taken the form of verbal harassment, avoidance/shunning and physical assault,²²⁵ and they have continued to occur at concerning rates. According to data reported to police departments across 15 of America’s largest cities, there was a 169% increase in anti-Asian hate crimes in the first quarter of 2021 compared to the first quarter of 2020.²²⁶ In Massachusetts, there were almost 100 hate-driven incidents reported between late March 2020 and February 2021.²²⁷ The intensified hostility against Asian Americans has resulted in increased fear and anxiety among Asian communities in the U.S. Asian American and Pacific Islander youth interviewed for the Stop AAPI Hate Youth Campaign expressed anger, disappointment, sadness and concern for their families.²²⁸

Previous studies have shown that perceived racial discrimination is positively correlated with a mental illness diagnosis.²²⁹ Given that people are more likely to resort to expressions of xenophobia when they feel uncertainty or perceive themselves to have greater vulnerability to the virus,²³⁰ constant communication with the public about risks and guidelines is key. Public health awareness campaigns are critical for dispelling misconceptions and misinformation that may facilitate harboring of anger and hostility towards scapegoated communities.



²²⁰Elias & Paradies, 2016

²²¹Priest et al., 2017; Williams, 2018

²²²Hswen, Xi, Hing, Hawkins, Brownstein & Gee, 2021

²²³Aten, 2020

²²⁴Center for the Study of Hate & Extremism, 2021

²²⁵Jeung et al., 2021

²²⁶Aten, 2020

²²⁷Cromar, 2021

²²⁸Stop AAPI Hate Youth Campaign, 2020

²²⁹Crowder, 2020

²³⁰Taylor, 2020



COVID-19 Relief: State and Federal Responses

The federal government has made an unprecedented amount of COVID-19 relief resources available to states nationwide. At the time of writing, Congress has allocated nearly \$4.6 trillion to be spent on COVID-19 relief, including funds already distributed and those allocated for future distribution.²³¹

Since the start of the pandemic, there has been a substantial influx of funds made available to Massachusetts dedicated to addressing the impacts of COVID-19. According to the Mass.gov website, the total estimated amount of federal COVID-19 relief funding to Massachusetts and Massachusetts residents will be approximately \$115 billion. These funds, distributed over time and through several mechanisms, include \$63 billion in direct aid to businesses, individuals and public entities (for example, stimulus checks to individuals), \$41 billion for targeted aid such as COVID-19 related unemployment insurance and \$11 billion in “flexible” aid with an array of possible uses.²³² Six pieces of federal legislation of particular importance are spotlighted on the Mass.gov website:²³³

- The **Coronavirus Preparedness and Response Supplemental Appropriations Act (CPR)** and the **Paycheck Protection Program and Healthcare Enhancement Act (PPPHE)**, which primarily focused on supporting public and private agencies and organizations to enhance testing, infection control, and other COVID-19-related precautions.
- The **Families First Coronavirus Response Act (FFCR)** provided funding for emergency food assistance programs, increased funding for the Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Programs (SNAP) and implemented the Pandemic Electronic Benefit Transfer (P-EBT) program to provide funds for families who were unable to access free or reduced school meals due to school closures.
- The **Coronavirus Aid, Relief, and Economic Security Act (CARES)** provided increased access to COVID-19 supports and services (e.g., testing and PPE), as well as providing specific assistance to individuals and families for rent and utilities payments, food assistance and free COVID-19 testing, treatment and vaccinations. Additionally, this Act provided additional funding for Head Start programs to purchase PPE and implement social distancing protocols, support for Child Nutrition Programs and increased flexibility for eligibility for the National School Lunch Program.
- The **Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA)** provided funding to help individuals and families cover rent or utilities payments as well as direct stimulus payments to individuals, extended services and support for youth aging out of foster care, increased mental health and substance abuse services, immediate grants and funding to childcare providers and improved testing in communities traditionally underserved or at high-risk for COVID-19.
- The **Families First Coronavirus Response Act (FFCR)** allowed states to issue emergency waivers for government benefits such as P-EBT, SNAP and WIC, and allowed for these benefits to be used in online platforms (e.g., mobile ordering) to promote social distancing.

²³¹ USAspending.gov, 2022

²³² For a full description of federal funds awarded to Massachusetts visit the Mass.gov website: <https://www.mass.gov/info-details/about-covid-19-federal-funds>

²³³ Executive Office for Administration and Finance, 2022

Federal COVID-19 Relief Legislation in Chronological Order of Enactment

Federal Legislation	Date Enacted
Coronavirus Preparedness and Response Supplemental Appropriations Act (CPR)	March 6, 2020
Families First Coronavirus Response Act (FFCR)	March 18, 2020
Coronavirus Aid, Relief, and Economic Security Act (CARES)	March 27, 2020
Paycheck Protection Program and Healthcare Enhancement Act (PPPHE)	July 4, 2020
Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA)	December 27, 2020
American Rescue Plan Act (ARPA)	March 11, 2021

While the above acts provided immediate financial aid in the fight against COVID-19, the American Rescue Plan Act (ARPA) had both immediate and longer-term components. Federal guidelines for how ARPA funds are to be used include:

- To offset financial deficits incurred as a result of lost service provision during the COVID-19 state of emergency;
- To provide economic recovery to small businesses, households and industries hit hardest by the pandemic;
- To provide essential workers with premium pay;
- To investment in infrastructure.²³⁴

States across the nation are at different stages of allocating this funding, and are working diligently to utilize these resources effectively and equitably to address the impact of COVID-19 on communities. To date, Massachusetts has utilized ARPA funding to provide direct aid to communities disproportionately impacted by the pandemic, enforcing temporary emergency paid sick leave and implementing programs to increase vaccination rates. In the coming years, Massachusetts is planning to use ARPA funding for projects that focus on long-term sustainability. Governor Baker's December 2021 ARPA funding plan includes using a portion of ARPA funding for housing development, improved access to healthcare services and regenerating the healthcare

workforce, providing funds to education systems and supporting teacher recruitment, as well as regenerating the Massachusetts economy by increasing job training opportunities and implementing public works projects.²³⁵

In addition to the federal funds made available to states, there were an array of local and private initiatives created to provide COVID-19 relief. Two notable examples in the Massachusetts are the COVID-19 Relief Fund, and the United Way of Massachusetts Bay and Merrimack Valley's joint COVID-19 Family Support Fund. The **Massachusetts COVID-19 Relief Fund**, which raised \$32.2 million in contributions from local and national organizations, provided funding for nonprofit organizations serving vulnerable populations. These funds targeted organizations assisting frontline essential workers, immigrants and those with disabilities, while also providing support to address food insecurity, homelessness and housing insecurity.²³⁶ The **United Way COVID-19 Family Support Fund** has raised over \$8 million in donations and has distributed these funds to over 170 organizations across Massachusetts. These funds were allocated to food distribution programs (i.e. food pantries and shelters) and provided targeted assistance to families at risk of eviction or unemployment due to pandemic-related lockdowns.²³⁷ The authors acknowledge that this is not an exhaustive list of supports; other efforts exist around Massachusetts and the country as communities have banded together to support one another during this unprecedented crisis.

²³⁴ Government Finance Officers Association, 2022
²³⁵ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, Governor's Press Office, & Executive Office for Administration and Finance, 2022

²³⁶ Massachusetts COVID-19 Relief Fund, 2022

²³⁷ United Way of Massachusetts Bay and Merrimack Valley, n.d.

Conclusions & Implications

The COVID-19 pandemic has impacted everyone in our nation in ways we could never have imagined. While some communities have felt the effects more acutely than others, this universally adverse experience will likely have a long-lasting impact on the mental health and emotional wellbeing of children and families for many years to come. In fact, the current generation of children may be impacted across their lifespan in ways we cannot fully anticipate. Using Massachusetts as a case example to highlight national trends, this report has established that pandemic-related stressors such as social isolation due to extended stay-at-home orders and quarantine, family loss and separation, unhealthy coping strategies such as substance use, and caregiver stress and hardship, have exacerbated existing behavioral health needs in children and families while introducing a host of new concerns. The increased need for behavioral health supports and services is exemplified by the concerning rise in challenges such as anxiety, depression, suicidal ideation and eating disorders among other concerns - the full extent of which may not be fully known for some time. Overburdened education and healthcare systems, coupled with the limited visibility of at-risk children and families during lockdown, has resulted in many behavioral health concerns and learning disabilities that have not been properly identified due to limited screening and diagnoses, workforce shortages and access to care.



While universally felt, the pandemic has especially negatively impacted historically marginalized communities. Communities of color in Massachusetts and across the nation, particularly Black and Brown communities, have comprised a disproportionate share of hospitalizations and deaths from COVID-19, and children in these communities are at increased risk for concerning conditions including depression, anxiety and disengagement from school. Xenophobia and racism have further contributed to stress, especially for Asian communities who have experienced increased hate, aggression and unfounded blame for COVID-19.

Despite these challenges, there is reason to hope. This report has spotlighted a number of positive steps taken to support children and families and to help bring an end to the COVID-19 crisis. In addition to rolling out vaccination, booster, testing and other measures to minimize the spread of COVID-19 and its variants, an unprecedented amount of federal and local financial aid has been allocated to further address the pandemic's impact on communities, increase vaccination rates and expand access to needed supports and services. In communities across the nation, teachers and health care providers have routinely gone above and beyond to support the children in their care and adapt to the "new normal." Video gatherings, phone calls and socially distant activities have in some cases replaced normal routines and family gatherings. Families also used the time at home to adopt positive, nurturing activities such as regularly shared meals and activities. Many communities also came together with creative ways to safely celebrate lost milestones including virtual graduations and "drive-by" birthday parties. Educators and healthcare providers rapidly switched to virtual formats and navigated the complexities of teaching and providing care online to support children as best as possible, which has opened virtual doors for service provision in the future. In short, both in Massachusetts and across the nation, people adapted as best they could to the new, challenging circumstances, developed new strategies to maintain positive connections in their lives and worked together to try and support the most vulnerable members of our society.

While much progress has been made during the COVID-19 pandemic, additional steps are needed at the local, state and national levels to proactively address the increased needs and profound psychological and emotional impact the pandemic has had on families and communities. Further, given the increased federal and state funding and resources being made available in the wake of the pandemic, it is critical that we spend these dollars wisely and ensure that our most vulnerable populations are

provided with the appropriate preventive, supportive and effective resources to ameliorate the impact of this prolonged and unprecedented time in our history.

At the **policy level**, states would benefit from making a significant investment to address the emotional wellbeing and mental health of its citizens, especially those disproportionately impacted by the pandemic. Given the influx of financial assistance and available funding, policy makers are advised to work together to ensure that all families have access to effective, evidence-based care to reduce behavioral health challenges and help children get back on a healthy developmental track. **Evidence-based practices (EBPs)** are the most effective way to address the behavioral health needs of children, typically achieving desired results sooner than care as usual and sustaining improvement longer. EBPs have been used effectively to treat a wide range of challenges in multiple real-world settings across the nation. However, access to EBPs is commonly inconsistently available and insufficiently reimbursed. An initial investment in the implementation, training, scale-up and ongoing quality assurance of EBPs is necessary and would pay long-term dividends in the health and wellbeing of our citizens. Investing in creating an evidence-based system of care now will likely result in significant medium- and long-term cost savings. In the past, many states, including Massachusetts, have invested in increasing access to care coordination and in-home care in order to improve the behavioral health system. Investing in building a workforce to deliver evidence-based care would be an excellent complement to the work that has been done to date. With the substantial influx of COVID relief funding into states across the nation, we have an opportunity to build on this past work by systematically investing in proven evidence-based interventions. By identifying behavioral health concerns early and responding to them as quickly and effectively as possible with EBPs, we can decrease the need for hospitalizations, residential placement and more intensive, higher cost long-term care. Further improving and expanding our behavioral health system to provide all children and families with access to evidence-based services in their homes, schools and communities, will allow states across the nation to invest in our future and prevent more serious, costly concerns for our next generation.

Though vaccines, booster shots and other proven effective prevention and harm-mitigation strategies are readily available and have lessened the risk of serious illness and death for the majority, especially those who are fully vaccinated and boosted, a sizable minority of people across the nation are still choosing not to adopt these proven effective measures. The reasons for this are complex, ranging from long-standing systemic racism that has led communities of color to be wary of the medical system and vaccination, to widespread misinformation and the over-politicizing of vaccination and other proven effective prevention strategies. State-level efforts moving forward must continue to build on existing initiatives to communicate the effectiveness of vaccination and other prevention and harm-reduction approaches and continue to work to increase their adoption. Similarly, efforts must be made to explore, understand and address the complex issues that led to some communities (especially people of color) experiencing disproportionate negative outcomes.

At the **systems level**, states and child-serving systems would benefit from supporting the health and wellbeing of the child-serving workforce, and developing infrastructure for workforce development, training, quality improvement and outcome monitoring to ensure the services families receive are of the highest quality, culturally and linguistically competent, and facilitate positive child outcomes. One of the most pressing issues is the limited capacity of our health care system and the related ability to provide needed care for individuals suffering from COVID-19 and its sequelae. While it may be possible to develop and implement new strategies to ensure people get the care they need, the most promising approach to reducing the pressure on our healthcare system is to reduce the number of people in need of intensive COVID-19-related care through vaccination, boosters and other prevention and harm-reduction strategies. Again, we must sustain and expand efforts to communicate the efficacy of these proven strategies while simultaneously investing in systems development to ensure that access to high quality care is available across the lifespan, not only for the immediate health concerns related to COVID, but to the long-term impact on our citizens health and wellbeing.

To reduce long-lasting negative impacts of the pandemic on children and families, we must respond to the growing demand for community-based services and enhance structures to address new and exacerbated behavioral health needs. At the **practice level**, communities and community-based service providers must invest in both increasing their capacity to deliver in-person and telehealth services to families in need, as well as investing in workforce development to ensure that our providers are offering the highest quality care. Communities are advised to develop proactive strategies to ensure: **a)** behavioral health needs among children and families are being identified and met as quickly as possible, **b)** providers are trained in effective models of care and adequately prepared to identify and respond to family needs, **c)** outcomes are routinely monitored to ensure that families are benefitting from the care being provided and **d)** the strategies we employ are supported by evidence, strengths-based, culturally and linguistically appropriate and responsive to the strengths and needs of the community. Additionally, attention must be paid to the health and wellbeing of the child-serving workforce who have also been experiencing greater stress, burnout and related negative behavioral health outcomes during the pandemic.

When implemented appropriately, evidence-based interventions delivered by trained professionals can enhance the community-level strategies already being used across the nation to combat the negative effects of the pandemic. By building on the resiliency and strengths of communities and increasing access to proven effective care we can ameliorate the impact of COVID-19 and give children and families the tools they need to thrive – now and for years to come.



Recommendations

The following recommendations are intended to support state and local leaders as they work to promote positive outcomes for children and families at the policy, systems and practice levels:

- 1. Sustain and expand comprehensive public awareness and education campaigns and initiatives designed to:**
 - a. Increase the vaccination and booster rates in low-vaccinated/boosted communities;
 - b. Promote the use of appropriate, proven effective prevention and harm-reduction strategies which have included masking, physical distancing and COVID-19 testing;
 - c. Raise awareness and decrease stigma about behavioral health concerns, as well as the pandemic's universal impact on emotional health and wellbeing;
 - d. Utilize anti-racist and inclusive practices designed to deconstruct racism and xenophobia.
- 2. Foster positive outcomes for children by cultivating supportive, nurturing, loving environments – at home, at school, and in the community:**
 - a. Develop and implement proactive strategies to ensure that behavioral health needs among children and families are being identified and met as quickly as possible;
 - b. Identify and leverage the strengths, needs and capacities of communities in addressing the sequelae of the COVID-19 pandemic;
 - c. Invest in workforce development, training, education and sharing of resources to build community capacity to address the needs of families;
 - d. Provide psychoeducation and support to parents and caregivers about the impact of the pandemic on their family's wellbeing and how to best support their children;
 - e. Implement family-centered policies and ensure that families are at every table where decisions are being made;
 - f. Convene multi-disciplinary coalitions including community-based behavioral and medical health providers, faith-based institutions, community centers, social service agencies, schools and caregivers to ensure that the needs of children and families are being identified and addressed, and that children can process and acknowledge their experiences of adversity, stress and loss during the pandemic;
 - g. Ensure that schools have access to sufficient and well-trained behavioral health and support staff to meet the mental health needs of their students;
 - h. Identify and address pandemic-related barriers to school attendance (in person and virtual) and enrollment to ensure all children have access to high quality educational programming, Pre-K through grade 12.
- 3. Design and implement state-wide and community-level strategies to provide parents and other primary caregivers with tools and resources to take care of themselves and of their children:**
 - a. Identify and address the social-emotional and behavioral health needs of parents and primary caregivers, and ensure they have access to needed resources to engage in self-care and to manage their own stress and anxiety;
 - b. Raise awareness about the impact of the COVID-19 pandemic on children and caregivers' mental health and wellbeing;
 - c. Provide parents and caregivers with adequate resources, information and guidance around how to talk to their children about COVID-19 and pandemic related stressors;
 - d. Design and implement new and/or sustain existing supports to help parents identify the behavioral health needs of themselves and their children and to identify and connect to needed supports and services.
- 4. Explore and ascertain the full impact of the COVID-19 pandemic on child-serving systems, and develop and implement strategies to support the emotional health and wellbeing of child-serving professionals:**
 - a. Expand access to workplace-based mental health services and supports to ensure child-serving professionals are able to address their own mental health and emotional wellbeing, including traumatic stress;
 - b. Prioritize supports for front-line workers including teachers and other school staff, human service workers, medical providers and behavioral healthcare providers who are experiencing high rates of burnout, toxic stress and related negative outcomes;
 - c. Offer training and ongoing technical assistance to child-serving professionals, and especially teachers and school staff, to build individual skills and resources to identify warning signs for behavioral health challenges in children;
 - d. Implement policies, procedures and partnerships to ensure child-serving professionals can connect children and families to appropriate care;
 - e. Build the capacity of community-based providers to deliver effective, ideally evidence-based care.
- 5. Utilize available COVID-relief funding to invest in a state-wide system of care built on proven effective, evidence-based practices:**
 - a. Prioritize state funding to implement and build workforce and systems capacity to deliver evidence-based practices;
 - b. Identify and implement evidence-based practices proven to address the behavioral health needs identified in this report including anxiety, depression and traumatic stress;
 - c. Invest in early identification, screening and assessment to identify children at risk and in need of services and build infrastructure to connect them to timely and appropriate care;
 - d. Invest in workforce development and quality assurance to train community-based providers to deliver culturally-responsive, evidence-based care;

- e. Examine and reform reimbursement structures as needed to ensure that evidence-based care is sufficiently reimbursed in order to build the necessary structures, systems and supports to provide and incentivize high quality care (explore implementing an enhanced rate for EBPs);
- f. Create a statewide data infrastructure to track and monitor progress and outcomes for all children and families receiving care;
- g. Sustain existing and explore new strategies to utilize telehealth as a method to deliver behavioral health supports and services, including strategies to facilitate delivery of services via telehealth across state lines.

6. Invest in research to:

- a. Explore the long-term impact of COVID-19 on children and families’ mental health and wellbeing;
- b. Monitor outcomes of children and families receiving behavioral health services;
- c. Explore the long-term impact of COVID-19 on the educational achievement and adjustment of children and adolescents in order to develop and implement strategies to address any learning loss and other delays or interruptions caused by the pandemic;
- d. Explore the use of telehealth as an ongoing strategy to ensure children and families have access to effective behavioral health supports and services. Specifically, identify existing evidence-based practices that are well-suited to delivery via telehealth, as well as explore new and promising culturally and linguistically competent practices that may be adapted to serve diverse populations.

7. Sustain data collection and reporting practices to ensure accurate and up-to-date information continues to be publicly available and is used to drive decision making at the policy, systems and practice levels:

- a. States should adhere to CDC guidelines, especially with regard to vaccines, boosters and other proven effective prevention and harm-reduction strategies;
- b. Adapt policies as needed to any emerging threats or future potential harmful variants of the COVID-19 virus;
- c. Utilize data and consult with experts to drive decisions regarding virtual or hybrid schooling, community-based business closures, social distancing needs and other measures to minimize the spread of COVID-19.

8. Identify and implement equity- and inclusion-centered strategies designed to support vulnerable communities and diverse populations:

- a. Prioritize supporting and building trust with our most vulnerable communities, especially those experiencing higher rates of infection, hospitalization, death and hesitancy toward vaccination, boosters and other prevention and harm-reduction strategies;

- b. Identify strategies to address social and economic barriers to accessing behavioral health care and COVID-19 prevention and harm-reduction strategies, especially vaccination and boosters;
- c. Implement anti-racist strategies to dispel misconceptions that have led to anger and hostility toward specific communities, and ensure that policies are inclusive and representative;
- d. Engage communities directly to ensure strategies are culturally and linguistically responsive, are relevant to the local community and build upon existing community strengths.



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