Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Commentary

Supporting Adolescents and Young Adults Exposed to or Experiencing Violence During the COVID-19 Pandemic

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Supporting adolescents and young adults (AYAs) exposed to or experiencing violence is a crucial responsibility of AYA-serving health professionals. In the United States, exposure to parental or caregiver intimate partner violence (IPV), adolescent relationship abuse (ARA), and youth violence pose significant threats to AYA health and disproportionally impact youth of color living in neighborhoods with concentrated disadvantage [1–4]. The COVID-19 pandemic is both transforming the epidemiology of violence experienced by AYAs and impacting AYA-serving programs and services designed to prevent violence and mitigate negative health sequalae. As AYA-serving health professionals grapple with caring for youth during this pandemic, we recommend actionable, trauma-sensitive practices to address AYAs' unique needs and challenges.

The Impact of COVID-19 on Violence

Although little empirical evidence exists, there is anecdotal evidence COVID-19 has brought an increase in violence. The lay press has reported an escalation of adult IPV [5] and ARA helplines have seen high call volumes. Detroit and Philadelphia have reported increased community violence [6] and shootings [7], respectively. Experiencing multiple forms of violence concurrently can compound risks [8]. For example, AYAs living in homes with IPV that is escalating during necessary shelter-in place orders may leave their homes to keep themselves safe, potentially leading to more dangerous situations (e.g., residing with an abusive partner), housing insecurity, and increased risk of exposure to COVID-19. The sudden and rapid technological transformation of all facets of adolescents' lives also increases vulnerability to cyber-based violence. Increased reliance on technology creates opportunities for cyber abuse, where abusive partners control, stalk, or discredit their partners through texts, social media, or mobile applications [9]. For those who may be at risk for perpetrating interpersonal harm, including gang and clique-related violence, social media becomes a place to share frustrations and threats about future acts of violence—called "Internet banging" [10]. While more research is needed to understand these trends, the pandemic has amplified unique vulnerabilities faced by AYAs in violent environments and relationships.

Physical distancing, a necessary consequence of the COVID-19 pandemic, further escalates the challenges faced by AYAs exposed to or experiencing violence by disrupting the social supports and services that help reduce violence, including those that address systemic racism. With the closure of many school-based health centers, clinics, and pharmacies, access to safe and confidential reproductive health services may be limited for youth experiencing reproductive coercion or sexual violence. Youth experiencing community violence may have more limited access to violence intervention specialists known to be critical for supporting victims and reducing reinjury. In addition, with school and community program closures, youth may lose access to programs which provide connection to trusted adults, peer support, and access to food and behavioral health services. Violence prevention programs, such as school- or community-based interventions focused on promoting healthy relationships and developing positive conflict resolution strategies, have also likely stopped during this pandemic.

Recommendations for AYA-Serving Health Professionals

AYA-serving health professionals can support youth exposed to or experiencing violence during the COVID-19 pandemic, by implementing policies to promote safety during virtual care, integrating strength-based discussions into all visits, drawing from innovative community-based practices, and prioritizing the well-being of frontline AYA-serving professionals. Table 1

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Table 1
Patient vignettes related to the way COVID-19 has impacted youth exposed to or experiencing violence with potential responses from AYA-serving health professionals

Patient vignette	Potential response with resource provision
Gabby[a] is a 16-year-old girl with symptoms of discharge, abdominal pain, and spotting. She missed her last Depo-Provera injection at the school-based health center six weeks ago. The health center staff sent her several reminder messages; and then school closed abruptly, including the health center. The school-based health center was a safe space for her to receive contraception. Her partner, who goes to a different school, does not want her to use hormonal contraception.	Responding to a post on social media about AYA telemedicine services, Gabby calls to schedule an appointment. She is asked if she has a private place to have the visit through telehealth. During the visit, the clinician shares information with her about the national dating abuse helpline (loveisrespect.org), saying, "In case you or your friends could use this information, we make sure to share this with all our patients." Arrangement is made for Gabby to be seen at the AYA medicine clinic closest to her home for a nurse visit to receive a pregnancy test, Depo-Provera, and antibiotics for presumed pelvic inflammatory disease. She receives daily check-in calls from the clinic to ensure her symptoms are resolving; during each call she also receives adolescent-relevant resources.
Aarav[a] is a 17-year-old boy with a history of anxiety and ADHD. He was about to start therapy when the pandemic started and behavioral health visits were switched to telehealth. His primary care provider called and spoke with him about virtual visits. He said he does not feel safe doing visits in his home because his father is emotionally abusive to his mother and also to him if he tries to stop the abuse. He says the walls are thin and it would be impossible to start therapy now.	His pediatric clinician called and asked for a safe time to schedule a telehealth call. Aarav provided his and his sister's cellphone number, both which he felt safe using. They decided on a time when his father was out of the house. Aarav spoke with the clinician first and then asked his sister to join. They decided to start therapy, using behavioral health resources provided by the clinician, but would need to limit it to times when their father was not at home. The clinician also provided resources to a local victim services agency for youth exposed to parental IPV.
Daneesha,[a] a 9th grader, was an active participant in a support group on healthy relationships in an after-school program. In group, she had shared her fears about her stepfather's anger. One of the facilitators saw bruises on her wrist. With the support of the group facilitators, child protective services got involved. Several weeks later, she shared how grateful she was to have the support of the adult facilitators who cared about her safety as well as the counselor whom she sees in school. Owing to COVID-19, the schools and after-school programs closed. The facilitator has not been able to reach her by phone; no one from the school district has responded to messages from the facilitator. The facilitator wonders what more she can do.	The facilitator reached out to the clinician who was overseeing the group, who then reached out to the school principal. The principal was grateful to hear that community partners were also seeking to support students during this difficult time and connected the facilitator to the school social worker. The school social worker was able to reach the home to check in and speak with Daneesha, and to let her know the facilitator was worried about her and offered the facilitator's phone number so that Daneesha could call her.
Since school closed, Daniel[a] (age 17) has had fights almost daily with his mother. A housekeeper in a large hotel downtown, his mother is now without work. He cut his electronic ankle monitor and left his house to go stay with his boyfriend. This boyfriend was working in construction; three weeks ago, he was laid off as all nonessential building has stopped. He threatens to call Daniel's probation officer if Daniel seems reluctant to do what his boyfriend wants to do sexually.	Daniel sees a post on social media about the drop-in clinic for youth run by a local community health agency. While the clinic is closed due to the pandemic, he receives a call from a youth coach who offers a phone or video visit with a clinician. The youth coach also offers information about confidential services provided by a local intimate partner violence agency. The clinician speaks with Daniel by phone and offers to help make a call to this victim service agency together. While Daniel declines, he also knows that he can reach out to the youth coach or clinician any time.
Nate[a] (age 16 years) sustained a gunshot wound after a dispute in his neighborhood. Nate is admitted to the hospital trauma service for medical stabilization. His physical wounds begin to heal and he is discharged home to continue his recovery. Sitting in the passenger seat on his way home, his heart begins to race as his mother's car nears the block where the shooting took place. Nate is worried about his safety and the safety of his siblings amidst an escalating turf war.	Following consent from Nate's mother and a referral from a nurse, a violence intervention specialist reaches out to Nate after discharge to discuss safety planning. Nate is skeptical about speaking with the interventionist by phone. The interventionist offers to send take-out to Nate's home and they enjoy a virtual meal together to build their relationship.

[a] Patient names are pseudonyms.

includes adolescent vignettes with potential responses and resource provision.

Confidentiality and safety during telehealth and virtual visits

Health care systems have dramatically shifted to providing virtual care. Using telehealth offers opportunities for clinicians, as youth feel more comfortable using technology as compared with older adults. However, unlike in-person visits, providers cannot ensure during virtual visits that adolescents feel safe speaking confidentially. Providers should prioritize confidentiality during all parts of a visit, from scheduling to documenting. Schedulers should ask adolescents if they have a comfortable space to speak and if they have a safe phone where the virtual visit can be completed without being monitored. When completing AYA virtual visits with parents or other parties present, clinicians should set up expectations regarding the importance of having time to speak alone with the adolescent, aligned with best practices during in-person visits. If an adolescent does not feel safe talking during a virtual visit, providers may consider using the chat function, as long as the adolescent's phone or computer is not being monitored and conversations are not being saved. In addition, although conducting visits virtually is safer for physical distancing, AYAs should be given a choice about completing a visit virtually or in-person. For some AYAs, health care centers may be one of the only available safe places.

Serving AYAs impacted by violence requires extending beyond the virtual walls of telehealth to also leverage the remarkable infrastructure of community-based organizations. ARA and sexual violence advocates, as well as violence intervention specialists, are continuing to work directly with youth. However, virtual relationship-building assumes that adolescents have access to stable sources of Internet, data access, and phone and computer equipment to sustain these relationships. AYA-serving health professionals can encourage this critical relationship-building by advocating for access to free or low-cost technology.

Integrate strengths-based discussions and resource provision with every visit

AYA-serving health professionals should integrate strengths-based discussions into all visits. Adolescents should be asked if they have a safe, supportive adult with whom they can communicate. Adolescents without a supportive adult, or those whose access to a supportive adult is limited by COVID-19 (i.e., a parent who is experiencing escalated IPV, a teacher who they no longer see), should be offered additional connections to an AYA-serving community mentor.

Violence assessments should not require disclosure. CUES (Confidentiality, Universal Education, Empowerment, and Support) is an evidence-based approach that prioritizes offering information and resources to all AYAs during clinical encounters [11]. Universal education can be provided by having links posted in a "virtual waiting room" or via the chat function. Encouraging youth to share information creates empowerment opportunities. Should a youth disclose, providers should be prepared to link them to victim services agencies (using 3-way calling). If there is concern for abuse or neglect, providers will need to involve child protective services.

Innovative community-based solutions

During the COVID-19 pandemic, community-based organizations have developed innovative solutions to continue supporting AYAs exposed to or experiencing violence. For example, in Los Angeles, violence intervention specialists are deemed essential personnel and leverage their relationships in vulnerable communities to provide a pipeline for basic services, access to life-saving care, and information about COVID-19 [12]. National ARA helplines, such the 24/7 confidential *Love is Respect* helpline, are continuing to offer chat, text, and phone services with advocates working remotely.

Self- and community-care for AYA-Serving professionals

Attention should be given to the physical and mental well-being of frontline providers serving AYAs during the COVID-19 pandemic. All frontline staff (health professionals, community advocates, violence intervention specialists) should have appropriate personal protective equipment and training in telehealth strategies to help them continue fostering connections with clients. Supporting the mental well-being of frontline staff is crucial during this stressful time and can include (1) development of self-care plans; (2) group support sessions; and (3) flexible work schedules to accommodate caregiver responsibilities, including sick leave and paid time off.

To promote health equity and well-being, AYA-serving health professionals have an urgent responsibility to collaboratively and creatively support AYAs exposed to or experiencing violence during the COVID-19 pandemic.

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