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are risk factors for adverse outcomes. Future studies should also tackle how infants acquire parechovirus infection. Small studies implicate older siblings or parents as the source,<sup>8,9</sup> but we must better understand transmission patterns of parechovirus if we are to prevent infection in the most vulnerable. Furthermore, we need to better define the pathogenesis of disease from parechovirus to develop targeted therapies. Finally, we need to reach consensus on protocols for monitoring neurodevelopment in children following early childhood CNS infection to ensure comparability across studies. Guidelines exist for developmental follow-up of children born preterm, and expert recommendations exist for traumatic brain injury,<sup>10</sup> but consensus needs to be sought more broadly for CNS infection in children. Access to and more effective delivery of developmental interventions will depend on accurate and reliable detection of subtle emerging delays and deficits across early childhood.

We declare no competing interests.

\*Philip N Britton, Cheryl A Jones  
 philip.britton@health.nsw.gov.au

Sydney Medical School and the Marie Bashir Institute, University of Sydney, Sydney, NSW, Australia (PNB, CAJ); and Department of Infectious Diseases and

Microbiology, The Children's Hospital at Westmead, Westmead 2145 NSW, Australia

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For more on human behaviour and cash transfers see [https://www.ideas42.org/wp-content/uploads/2019/09/142-1160\\_CashTransfers\\_paper\\_final-4.pdf](https://www.ideas42.org/wp-content/uploads/2019/09/142-1160_CashTransfers_paper_final-4.pdf)



## Talking to children about illness and death of a loved one during the COVID-19 pandemic



In the midst of the devastating death toll and hospitalisations from COVID-19, the psychological effect of this unfolding pandemic on children has been unconscionably overlooked. The overwhelming media coverage and barrage of public health messages sustain a high level of physical and emotional threat within our communities, which is intensely observed by children. Age-appropriate explanations are paramount to ensure children have a coherent narrative and emotional support for their experiences.<sup>1</sup> This need is magnified when someone in the family is hospitalised for or dies from COVID-19.

COVID-19 predominantly affects adults, with patients treated in deliberate isolation from friends and family. As a result, children with whom the patient has important relationships are invisible to health-care staff. Crucially, the quality of communication with children

about life-threatening illness and death has a long-term effect on their psychological wellbeing and family functioning.<sup>2–4</sup> Therefore, health-care professionals need to identify affected children to promote and facilitate effective communication within the family. The diversity of family and social structures means that hospital staff contacting relatives should assume that the patient has an important role in a child's life.

Such communication must be tailored to children's evolving developmental understanding of illness and death.<sup>5</sup> Even though most children under 3 years have yet to acquire a complete understanding of death, they are still susceptible to the effect of serious illness or death within the family. Children are astute observers of their environment; within the first year, infants respond to changes in the behaviour and mood of their close caregivers. Children under the age of 2 years become

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distressed when caregivers leave and seek their return. At 3–4 years children understand death as a departure but might not yet grasp the concept of irreversibility (ie, after death a person cannot be made alive again). Therefore, following a bereavement, it is important to gently repeat the key message that the dead person will not, and cannot, return. By the age of 5–6 years, children appreciate the finality and irreversibility of death and recognise their own personal mortality, but it is not until around age 10 years that children acquire a fully mature comprehension of death.

Similarly, children's understanding of illness causality and transmission emerges over time. Of particular importance are the dual influences of magical thinking (that thoughts and beliefs can cause external events)<sup>1</sup> and children's developing sense of conscience and responsibility. Combined with a basic comprehension of how illness is transmitted, children can easily misattribute the cause of the illness and blame themselves (eg, illness is a punishment for their poor behaviour).<sup>6</sup> Even during adolescence, insufficient or distorted information about a sudden or unexpected death can result in feelings of regret and guilt about causing or not preventing a parent's death.<sup>7</sup> Children's specious feelings of responsibility might be exacerbated in the context of widespread public health messaging about behaviours such as hand washing to prevent the spread of COVID-19. Communication should be concrete and specific to avoid incorrect inferences or misunderstandings about how and why someone became ill or died.<sup>8</sup> Euphemisms are often used to soften sharing the news of a death, but these can create confusion for children who interpret these literally—eg, "We lost Grandpa last night" could be understood by a child that Grandpa can be found again.

Adults instinctively want to protect children from distress, especially when they themselves are worried and upset.<sup>2,5</sup> Uncertainty about how and what to share with children can be compounded by the unpredictable disease trajectory of patients with COVID-19. However, even toddlers are perceptive of subtle changes when someone in their family becomes unwell (eg, people crying and whispered conversations). If explanations are absent, children will draw their own conclusions about what is happening and face these challenging situations unsupported.

Research has shown that parents want guidance from health-care professionals about how to talk to children

about illness and death.<sup>2,5</sup> The need for this support is heightened when families are self-isolating together and adults have little time, space, or privacy to prepare how they will share the news with children. Staff face unprecedented clinical demands and emotional pressure, exacerbated by the absence of face-to-face consultations, which deny opportunities to develop relationships with families. However, professionals should play an active role in helping families tackle these seemingly impossible conversations.

A platform of free resources has been developed to support professionals and families in communicating with relatives and children when a patient is seriously ill or has died. The platform contains guides outlining a framework for telephone calls to relatives when a patient has died of COVID-19. Staff are prompted by a specific question to establish if the patient has important relationships with any children. When children are identified, the step-by-step guide provides a rationale for relatives about the importance of talking to children, with suggested phrases to help them approach these life-changing conversations. This content leads into a second infographic and animation, which staff should share with the family to facilitate caregivers' subsequent conversations with children.

COVID-19 presents a bewildering array of challenges for health care, public services, and communities across the world. Empowering adults to communicate with children about illness and death has the potential to mitigate the short-term and long-term psychological effect. The news that children currently face might seem almost unspeakable. But, together, we must find words, and ways, to give voice to their experience and prevent millions of children struggling with their fears and uncertainty alone.

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\**Elizabeth Rapa, Louise Dalton, Alan Stein*  
 elizabeth.rapa@psych.ox.ac.uk

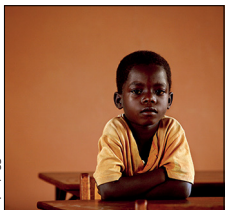
Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, UK

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## Institutionalisation and deinstitutionalisation of children: the Executive Summary from a *Lancet* Group Commission



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This *Lancet* Group Commission advocates global reform of the care of separated children through the progressive replacement of institutional provision with safe and nurturing family-based care. It provides essential information on both the global scale of institutionalisation and its physical, social, and mental health consequences. It presents a pragmatic roadmap for carefully managed change. Here we outline the ten key messages from the Commission.

1. Institutionalisation affects millions of children around the world. In 2015, it was estimated that 5.09–6.10 million children were living in institutions worldwide, the majority being in low-income and middle-income countries. Factors leading to institutionalisation include poverty, social deprivation and poor parenting skills, carer and child illness and disability, natural and human-made disasters, and child abuse and neglect.

2. Meeting a child’s sanitary and nutritional needs is not enough. Institutional care is typically inconsistent, being delivered by staff with poor pay and training. There is often a high turnover of staff, which limits effective relationship building, and creates insufficient time to provide a basic standard of care. Children might also experience maltreatment from peers and staff. Institutional care denies children and adolescents access to kinship networks that have a major role in many societies.

3. Institutionalisation often has a profound effect on a child’s physical and psychological development and can be associated with long-term mental health problems. The greatest effects are on physical growth and cognitive development: at least 80% of institutionalised children were below the mean of comparison groups in these domains. Institutionalised children are also at greater risk of attachment problems. Longer stays in institutions lead to more problems, and exposure between 6–24 months of age might be especially damaging.

4. When children leave institutions and are placed in family-based alternatives (adoption, kinship, or foster care), the situation rapidly improves—striking catch up is seen across all domains. Moreover, even children who have been exposed to severe deprivation can develop secure attachments with their new parents from adoption or foster placements.

5. The last 100 years have seen a significant shift towards family-based care for children in North America and most of Europe. The same shift elsewhere in the world is urgently needed. In December 2019, some 265 organisations, including UNICEF, endorsed comprehensive recommendations to implement the 2019 UN Resolution on the Rights of the Child, including measures to progressively replace institutions with family-based care.

6. Moving children from institutions to families requires the coordination of an integrated set of global, national, and local initiatives. Only a combined effort that links national and international policies and resources with local knowledge and practices can create meaningful, sustainable change. Global development, governmental, donor, faith-based, and volunteer agencies need to work together to transform care systems, address the drivers of institutionalisation, support child protection, and end child trafficking. Policy makers should reconsider incentives for supporting institutions, such as tax breaks for donations and other financial transfers through voluntourism to children’s institutions.

7. National frameworks for the progressive elimination of institutions as part of the continuum of care for children are needed. Countries should develop and budget for care reform with the ultimate goal of safe, sustainable, and nurturing family-based care for every child. This should include family strengthening, family-based alternative care, and progressive elimination of institutions, situated within a broader child protection

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