

Commentary

Social vulnerability and COVID-19: A call to action for paediatric clinicians

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Abstract

The COVID-19 pandemic has had dramatic effects on the lives of children globally. However, socially vulnerable children have been particularly impacted. Certain populations have increased vulnerabilities, including children and youth experiencing homelessness. Increased infection risk due to congregant living and challenges with physical distancing are contributing factors. An urgent need exists for a holistic approach to care with unique cross-sectoral partnerships across disciplines. A recognition of the unintended consequence of the COVID-19 pandemic on this population is urgently required by all those supporting children. Families should receive direct support in clinical settings to identify their social needs. Partnership with community agencies and advocacy for appropriate isolation facilities for patients experiencing homelessness are critical.

Keywords: COVID-19; Homelessness; Paediatrics; Social vulnerability

The coronavirus disease-2019 (COVID-19) pandemic has had wide ranging consequences for children in Canada and across the world. These include school and daycare closures, suspension of organized sport and activities, as well as limited access to peer groups and primary care services. The result is direct and indirect impacts on a child's physical and mental health as well as emotional wellbeing (1). While these disruptions are experienced by all children, those who are socially vulnerable—whether it be due to poverty, systemic racism, newcomer status, or otherwise—are more greatly impacted. This is illustrated in the following case of a young person experiencing homelessness who was hospitalized with COVID-19.

A 16-year-old female presented to the nephrology clinic for routine follow-up of chronic kidney disease. She was a recent refugee and lived in a temporary housing facility with her mother.

The patient reported a 7-day history of vomiting and diarrhea as well as 2 days of cough, dyspnea, and chest pain. She was subsequently admitted to hospital with acute chronic kidney injury and pneumonia. Nasopharyngeal swab polymerase chain reaction was positive for severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2), confirming a diagnosis of COVID-19. She received fluid replacement with partial recovery of her renal function, as well as experimental treatment with hydroxychloroquine. Despite being asymptomatic, her mother also tested positive for SARS-CoV-2 and was required to leave the hospital to self-isolate.

By day 7 of hospitalization, the patient's symptoms had resolved, and she was medically stable for discharge. However, her discharge was delayed for several reasons. First, there was no facility to safely discharge her to as her mother had relocated to a different shelter facility for individuals with

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COVID-19. This facility was not suitable for our patient given her medical comorbidities and immunocompromised status. The patient's nasopharyngeal swab polymerase chain reaction after 14 days was persistently positive for SARS-CoV-2 which precluded return to her original shelter. Fourteen days after she was medically stable for discharge (total 21 days of hospitalization and separation from her mother), a third temporary emergency housing facility was identified which accepted our patient.

DISCUSSION

Our patient's experience with prolonged hospitalization highlights the critical need for access to isolation facilities for families experiencing homelessness during the COVID-19 pandemic. Canada's youth face significant challenges with homelessness. The 2016 National Youth Homelessness Survey found that 20% of Canada's homeless population are people aged 13 to 24 years (2). For youth living in communal settings, physical distancing to prevent viral transmission is challenging. This is evidenced by outbreaks of COVID-19 in homeless shelters in the USA and Canada (3,4). While our patient had been residing in a shelter with basic amenities, people experiencing homelessness who live in refugee camps or other informal settings may not have access to proper hygiene measures or be able to adequately self-isolate when required (5,6). Indigenous children in Canada may also be particularly vulnerable, as overcrowded living conditions and insufficient personal protective equipment in some communities may increase the risk of infection (7). In addition to the direct negative impacts on children, an insufficient supply of public housing may place financial and capacity strains on health care systems as patients remain admitted to acute care facilities for extended periods of time. There has been a call for universal basic income supports during the pandemic, which has the potential to significantly improve housing security for disadvantaged children (1). Partnerships between public health, community agencies, housing groups, and medical institutions are urgently needed to address this pressing issue.

Principles of patient- and family-centred care may be strained in the setting of a pandemic. This form of care emphasizes the importance of a shared decision-making model with families and recognizes the vital role parents play in helping children cope with distressing parts of hospitalization. Separation of children from their parents for infection control purposes can have unintended consequences including contributing to emotional hardship and toxic stress. While our patient was neurodevelopmentally able to function independently in hospital, the 21-day physical separation from her mother may not have been feasible if she were younger. Disruption of the parent-child relationship can have significant negative effects on mental health and has been shown to increase the risk of

bipolar and psychotic disorders in adulthood (8). These concerns are in addition to reports of increased depression and anxiety symptoms among children during the pandemic (9). Adverse childhood experiences, including parent-child separation, have also been demonstrated to reduce scores on objective measures of social development (10).

Our first call to action is for paediatric clinicians to recognize their role in supporting patients and families experiencing homelessness in the context of COVID-19. This role is primarily as an advocate for families as they seek community services. At the individual clinician level, this may involve clinicians familiarizing themselves with paths to accessing community agencies and services, which may be aided by partnering with social workers and other allied health professionals. Clinicians should identify their patients experiencing social vulnerability to ensure close follow-up and contingency planning throughout the pandemic. Developing family-specific pandemic care plans, including identifying barriers to housing, isolation practices, and accessing testing centres, would be a valuable intervention. At the hospital level, clinical pathways and partnerships with emergency shelter facilities should be fostered in order to build capacity and support hospital to community transition.

Our second call to action is that clinicians and health care decision-makers should strive to balance the psychosocial impacts of separating children from their parents with infection mitigation strategies. Acknowledging the unique developmental needs of children and the important role parents play in promoting adaptive coping skills, hospitals should allow caregivers to be present at the bedside when feasible. Ensuring patient representatives, paediatric clinicians, and mental health experts are involved in formulating infection control practices, in addition to infectious disease experts, will aid in achieving this balance.

CONCLUSION

Socially vulnerable children may be at increased risk for COVID-19 infection, especially those experiencing homelessness. There is an urgent need for safe isolation facilities for children and families experiencing homelessness during the COVID-19 pandemic in order to facilitate family reunification and prevent prolonged hospital admissions. Parent-child separation for infection control purposes does not align with patient- and family-centred care principles and may have deleterious effects on coping, mental health, and child development. It is incumbent upon clinicians to advocate for policies that maintain the family unit during hospitalization and ensure that children and youth are safely discharged to adequate and secure housing.

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