

Commentary

## Supporting children and youth during the COVID-19 pandemic and beyond: A rights-centred approach

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### Abstract

The COVID-19 pandemic is an unprecedented global crisis, affecting millions globally and in Canada. While efforts to limit the spread of the infection and 'flatten the curve' may buffer children and youth from acute illness, these public health measures may worsen existing inequities for those living on the margins of society. In this commentary, we highlight current and potential long-term impacts of COVID-19 on children and youth centring on the UN Convention of the Rights of the Child (UNCRC), with special attention to the accumulated toxic stress for those in difficult social circumstances. By taking responsive action, providers can promote optimal child and youth health and well-being, now and in the future, through adopting social history screening, flexible care models, a child/youth-centred approach to "essential" services, and continual advocacy for the rights of children and youth.

**Keywords:** *Child rights; COVID; Social determinants of health; Social paediatrics; Toxic stress*

In 1991, Canada ratified the UN Convention of the Rights of the Child (UNCRC) and so promised to uphold basic human rights for children and youth: to 'recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development' (Article 27) (1). These form the building blocks of healthy, whole child and youth development, including access to healthcare and nutrition (Article 24), adequate housing (Article 27), education (Article 28), and recreation (Article 29) (1). As stated by the

World Health Organization, health is more than the absence of disease: it encapsulates physical, emotional, mental, and ecological health (2).

The social determinants of health—including optimal housing, nutrition, social support, and financial resources—remain essential components of healthy child development, and even more so during a global pandemic (3). On the contrary, exposure to abuse, neglect, or violence (Articles 19, 33, 36–39), family separation, or worsening mental health in caregivers

(Articles 9, 10, 20) can have deleterious consequences on the trajectory of children and youth (1,4). These adverse childhood experiences (ACEs) may lead to prolonged activation of the hypothalamic–pituitary axis, known as toxic stress, impacting neurodevelopment and increasing risk of an array of physical and mental health conditions, incarceration, substance use, heart disease, and early death with impairments in following generations (4). We describe how the COVID-19 pandemic and necessary responses threaten the rights of children and increase the risk of toxic stress, with special attention to children and youth at risk.

## THREATS TO CHILD RIGHTS DURING THE COVID-19 PANDEMIC

Efforts to dampen the spread of COVID-19 infections have required significant shifts in behaviour at a societal level. From reducing mass gatherings to enforcing physical distancing, public health strategies are essential to reduce the spread of infection but have also led to a reduction in multiple face-to-face essential services, such as schools, after-school programs, and daycare. These are more than classrooms: they support healthy whole child and youth development (Article 27), build academic trajectories (Article 28), and provide nutritious meals, respite, play, and recreation services (Article 31) (1). With widespread closures, children and youth are at risk of lower educational attainment due to inequities in access to technology (Article 13, 17), and reduced access to services such as speech and physical therapies, psychological services (Article 23), and meal programs (Article 27) (1).

Many Canadian families who experience marginalization, such as those new to Canada with limited social support networks and single parents, depend on home visitation programs to provide mental health and social support during early childhood, adolescence, and resettlement (Article 22, 30) (1,5). With increased social distancing, many in-person visitation programs have been suspended, making it much more difficult to reach families living in precarious situations with limited social support for mental wellness during a crisis. Children and youth with complex health needs or disabilities are more vulnerable to deterioration in health and developmental status, increased behavioural difficulties, and worsening mental health status due to disruptions in their essential routines, reduced access to intervention services, and attenuation of respite supports, thus leading to increased risk of emergency visits and hospitalizations (Article 23, 24) (1). For children in foster care, social distancing can lead to unstable or cancelled family visits, arrested care plans, and precarious transitions for youth (Article 20) (1). Some provinces have committed to supporting youth who would otherwise age out, but this is not uniform across the country, leaving them vulnerable to homelessness, food insecurity, and worsening mental health outcomes (6).

Child health providers must remember that the home environment may not always be safe (7). Substandard housing conditions can also be crowded and poorly maintained, increasing the likelihood of infectious spread (7). For those who experience homelessness or are dependent on shelters, their home environment may not only increase their risk of COVID-19 infection, but also contribute to increased family stress, raising the potential for household dysfunction, child maltreatment, or witnessed domestic violence (Article 27) (1,8).

No family will be immune to the economic consequences of the COVID-19 pandemic, but for families living in poverty, the impact has been catastrophic. Many middle- and working-class families are struggling to make ends meet, worried about employment, and their ability to pay for housing, utilities, or food (Article 18) (1). Food banks are running out of supplies to keep up with demand. The negative impact of poverty on children is well known (9). Another worrisome consequence of the COVID-19 pandemic is the risk for Canada's child poverty rate rise, even further lowering Canada's ranking internationally (Article 27) (1,10).

Above all, it is important to recognize how structural inequities are magnified by pandemics. The disproportionate impact of the H1N1 pandemic on Canadian Indigenous populations highlighted the need for culturally appropriate, community-level plans tailored to local languages and context (11). There have been rising reports of xenophobia directed at children and youth, from politicians who choose explicitly racist descriptions for the COVID-19 virus to insults hurled in school. The negative impact of xenophobia and racism on the mental health and development of children and youth cannot be understated (Article 2, 30) (1,12).

## WHAT CHILD HEALTH PROVIDERS CAN DO

Without immediate attention, the toxic stress of the COVID-19 pandemic may extend far beyond this immediate period. In order to mitigate these potential negative impacts, paediatric and other child health providers and advocates must strive to promote equity and access during the pandemic and beyond. We propose a tiered action plan, based on the UNCRC, from the individual to the community:

### Tier 1: Take a comprehensive and respectful social history and facilitate access to supportive programs

Child and youth health providers should screen for the social determinants of health during all in-person medical and telemedicine assessments in the COVID-19 pandemic and after, ensuring children and youth are informed and appropriately included in decision-making (Article 12,17) (1). More than ever, providers should inquire about safety, social supports, income,

food and housing insecurity, access to services and medication, and risk factors such as substance use, parental stress, and poor mental health (13,14). Early identification of families experiencing social barriers may help identify resources and build resilience for these families to weather the pandemic. Many families will benefit from support with completing applications for newly created federal and provincial relief programs, which can be incorporated into current or subsequent visits.

### Tier 2: Promote flexible, inclusive models of care

Creative ways of connecting with families, such as telephone or virtual check-ins, increases access to care for children and youth, particularly for families that are harder to reach. By focusing these visits on what is important to families, such as completing forms for funding, paediatricians can continue to build trust with more marginalized patients and families. For families with limited English or French proficiency, remote interpretation should be offered. A collaborative approach with community services and inter-disciplinary providers, such as social work and public health, can strengthen support for vulnerable families. Appropriate personal protective equipment (PPE) and testing must also be available for multi-disciplinary healthcare providers to safely deliver essential in-person visits in clinics, homes, or communities, and for children and youth to safely return to daycare and school.

### Tier 3: Re-define ‘essential’ services

Service providers should examine their definitions of “essential” services and visits in context of the child, youth, and family. In doing so, providers can advocate for more flexible and patient-centred “essential” services. For example, a non-urgent consultation with a subspecialist may be an essential visit for a family living remotely and cannot readily access a rescheduled appointment. For a new mother living alone in isolation, home visiting programs by public health nurses may be an essential lifeline. Homeless youth may depend on drop-in programs for access to nutrition and essential medicines, including emergency contraception and testing.

### Tier 4: Foster community-led initiatives to buffer stress and build resilience

As a community, we must remember that while ACEs cannot always be prevented, their impact can be greatly attenuated by positive and protective experiences (4). Supporting community initiatives such as grocery and food drives, advocating for moratoriums on rent, developing partnerships with teachers who check in with students regularly and with industry to allow universal access to connectivity, education, health and mental health services through affordable technology and the Internet, are some ways providers can build inclusive and supportive communities. Paediatricians and other providers can intervene when discriminatory descriptions are used to describe the

global crisis, providing accurate and scientific information and addressing the harmful impacts of racism and xenophobia.

## CONCLUSION

The COVID-19 pandemic is a stressful time globally, but our most marginalized cannot be left behind. We must remember the wide-reaching sequelae of pandemics on children and youth, far beyond the infectious period. By “building back better,” we can emerge from this time with strengthened, not weakened, future generations (15). We must continue to advocate for enhanced investment in services for children, including a Federal Commissioner for Children (Article 43) (1), to uphold our commitment to the UNCRC and build safe, inclusive communities of support to promote optimal physical, emotional and mental health for children, youth and their families.

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