

Supporting marginalised children with school problems in the COVID-19 pandemic

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In March 2020, the WHO's declaration of the COVID-19 global pandemic¹ resulted in unprecedented public health recommendations to minimise viral spread. This included a major disruption in the cornerstone of children's lives and well-being—school closures.

School boards have since sought to implement a range of novel measures to minimise viral transmission while maintaining access to education. Today, students have the option of learning via virtual learning platforms, in person or through hybridised virtual and in-person models. For the first time in decades, the conventional model of education delivery has undergone rapid change while simultaneously the COVID-19 pandemic has unveiled and exacerbated existing inequities for children with school problems. Consequently, health-care providers must adapt their response to school-based problems during the pandemic. They must also use lessons learnt to re-invent an approach to address inequities in caring for the 10%–15% of children who will present with these issues at some point in their school years.²

Children with learning, behavioural and social–emotional problems require careful assessment of their educational environment and socioeconomic circumstances. The learning ecosystem is informed by teachers and school paraprofessionals, while social risks are determined by careful history taking and screening. Distance learning however presents challenges for educators to characterise educational, behavioural and developmental needs. Additionally, school support staff such as educational assistants, speech and language pathologists, occupational therapists and psychologists may not be able to provide a comprehensive assessment using virtual platforms. Moreover, nearly 15% of children in the USA lack reliable access to broadband internet and many do not have a dedicated device to connect to school.³ While children with socioeconomic disadvantage are at greater risk of learning and

behavioural challenges and developmental disabilities, they face more barriers to distance learning and support. This conundrum will impact school attendance and performance and must be considered when assessing school challenges.⁴

The physical classroom may reveal features that suggest disorders such as learning disabilities, attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD), which can be overlooked in a virtual setting. For students attending virtual classes, the experience may be socially isolating, rather than a communal journey including: preparing for group projects, participating in team sports and recreation and interacting during unstructured lunch and recess times. The virtual school experience itself may negatively impact learning and behaviour which may not be recognised or readily monitored by educators or clinicians. Furthermore, for some children, learning at home may be stressful due to increased concerns for domestic violence, child maltreatment and parental mental health disorders exacerbated by the pandemic. Similarly, the learning losses associated with school closures have a greater impact for low-income students who have reduced access to supplementary educational materials and tutoring and are less likely to have parental supervision or support of learning at home. These factors must be taken into account when assessing learning needs.⁵

Virtual schooling also presents challenges in assessing the impact of both pharmacologic and non-pharmacologic behaviour interventions. Without direct observations and interactions, teachers have fewer occasions to observe changes in behaviours such as attention and focus, which help guide clinicians in the treatment of ADHD. Likewise, the behavioural impacts of social skills programmes and self-regulation curricula may be difficult to assess without direct peer interactions. Additionally,



clinicians' recommendations for accommodations and modifications to the curriculum and learning environment are more difficult to implement through virtual means.

Measures taken to limit viral transmission in the classroom, including mask wearing and physical distancing, impact learning, behaviour and social development. Since masks interfere with speech recognition, students with hearing and language impairment or new language learners may have difficulties understanding speech and instruction. Masks can obscure facial affect and non-verbal communication, further complicating children's perceptions of social interactions. Physical distancing may cause anxiety for young children learning to socialise. Further, students isolating from peers because of social challenges may be misunderstood as trying to conform to new social norms such as physical distancing. This misperception could result in teachers not recognising a student's social struggles and underreporting these challenges on standardised diagnostic questionnaires. For neurodevelopmental disorders that require time-sensitive therapeutic interventions, delayed or missed diagnoses could be detrimental. This phenomenon could also impact the reported prevalence and epidemiological patterns of these disorders.

It has also become more difficult to monitor children with known developmental disorders that impact socialisation, such as ASD, social anxiety or selective mutism, in the classroom setting. Worsening social difficulties may be attributed to a 'regression' in skills, rather than the struggle to navigate a dynamic, unfamiliar social landscape. Like many DSM5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) diagnoses, specialists must consider whether reported social challenges are causing functional impairments by comparing to accepted social norms, which are themselves shifting and nebulous for the neurotypical population.

The barriers associated with virtual learning and today's in-person classroom environment present challenges in obtaining and integrating educational history and observations into a plan. Increasing economic instability and parental unemployment may also contribute to academic and behavioural challenges whether studying online or in person. During the pandemic, paediatricians may not have enough input from educators and must rely more heavily on caregivers to provide behavioural and educational observations of children learning at home. This may not be feasible for caregivers who are essential workers or are overburdened with economic strain or family responsibilities. Clinicians also need to consider the impact of learning losses attributed to school closures and distance learning on a child's presentation, especially for marginalised students with barriers to accessing school online and encountering socioeconomic instability. When using standardised diagnostic tools to assess behaviour and development, practitioners must also consider the dynamics of the learning environment and psychosocial context. Further, there is a

need for increased vigilance for learning, behaviour and developmental problems that may be subclinical or insidious in this current educational climate, particularly for those with social risk factors. Paediatricians would benefit from more frequent follow-up and assessment with students who have a history of learning and behaviour challenges especially for students experiencing social inequities, after they have settled into their learning programme.

The COVID-19 pandemic has resulted in drastic changes to the environments in which children learn and play and has revealed vast disparities in access to virtual education, developmental resources and support. Paediatricians should use this opportunity to redefine a model of care to support at-risk children with school problems as diagnosticians, counsellors, advocates and liaisons with their educational teams. In response to these widespread changes, traditional approaches to the assessment and management of school problems must adapt to meet the evolving needs of marginalised children impacted by the pandemic and beyond.

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