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The wider collateral damage to children because of the social distancing measures designed to reduce the impact of COVID-19 in adults.

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Paediatricians are increasingly concerned that parental worries over visiting hospitals is leading to the late presentation of serious illness in children causing avoidable deaths, a form of collateral damage from the COVID-19 emergency. In Italy, hospital statistics show a substantial decrease in paediatric emergency visits compared to the same time in 2018 and 2019 of between 73 and 78%.[1] In April 2020, both the Clinical Commissioning Groups and the Royal College of Paediatrics and Child Health provided guidance for General Practitioners and paediatricians in England that the threshold for face to face assessment hospital referrals in children should not change because of the Covid19 pandemic.[2] This intervention is welcome, however we remain concerned about wider, perhaps less immediately visible collateral damage of strategies used against COVID-19 on vulnerable children.

The Cambridge dictionary defines collateral damage is the "unintentional deaths and injuries of people who are not soldiers, and damage that is caused to their homes, hospitals, schools, etc." In the fight against Coronavirus, children are being put at risk, in order to reduce the spread of a disease that mainly causes direct harm to adults.

One of the unique characteristics of the Covid-19 pandemic is the low hospitalisation and mortality rate (<0.2% for teenagers).[3] However, children are experiencing additional risks due to social isolation, lack of protective school placements, increased anxiety and a drop in service provision from both the NHS and social services. This is particularly true for the most vulnerable children.

Impact of school closure and social isolation

School closures have a limited impact on preventing deaths in adults.[4] However, the closure of schools and confinement to home has multiple impacts on children in terms of education, social isolation, wellbeing and child protection. Schools throughout the UK closed in March 2020 and are only providing places for some primary school children of key workers and some vulnerable children. Uptake of these places in the latter group appears to be low.[5] Some schools are providing learning online, but completion rates are unknown, particularly for those children with no or limited access to the internet. Children with Special Educational Needs and Disabilities should have the special provision required to meet their particular needs specified in their Education Health and Care Plan, EHCP. This has not necessarily been adapted for home learning and many EHCPs specify provision that cannot be delivered outside of specialist settings. Similarly, much of the wider support normally available to disabled children and other vulnerable learners is provided through facilities that are now closed. and unlikely to be effectively replaced by efforts of volunteers.

Schools provide a safe space for vulnerable children and play a key role in safeguarding by detecting signs of abuse or neglect. The rapid closure of schools, has not been accompanied by strengthened

processes to support those most in need. This has occurred at the same time that the Coronavirus Act allows social services to reduce or suspend services (see below) leaving vulnerable children without a safety net.

Social isolation, the withdrawal of peer support, the lack of structure and support from school and the increased anxiety over Covid-19 infection and risk to parents, are all likely to have a negative impact on mental health in children and young people.[6] Social isolation and loneliness may lead to subsequent mental health problems (Chatburn et al, in prep), resulting in a substantial increase in need for Child and Adolescent Mental Health Services.

Increased risk to the mental health of children from social isolation will also result from their exposure to domestic violence and abuse (DVA) during the pandemic. We know that violence against women increases during epidemics, such as Ebola.[7] Now, in countries across the world that have imposed social isolation in response to COVID-19, there is evidence from helplines and police reports that the incidence and severity of DVA has increased.[8-10] Children confined to home from school closure and young people not being able to leave home to see their friends will be more exposed to DVA. The stress and anxiety caused by forced isolation, economic uncertainty, home schooling, and potentially difficult living conditions, drive the increase in abusive and controlling behaviour. In over a third of families where DVA occurs, there is also direct child maltreatment: physical and emotional abuse, exploitation and neglect.[11] The greatest risk will be to vulnerable children. Although the Government has issued guidance in relation to COVID-19 and DVA, there is no mention of exposed children and young people.[9] Moreover, as children's services and DVA agencies scramble to change their working practices to remote support, there is uncertainty about the effectiveness of emergency methods of working in this field.

Reduction in protection: withdrawal of services

Whilst the risk to children (and particularly vulnerable children) is increasing, the support mechanisms in both the NHS and social services are being withdrawn.

Hospital outpatient clinics have closed, been suspended or moved to virtual home based clinics. This will have the greatest impact on new appointments, or appointments requiring an examination. Child and Adolescent Mental health services have reduced or suspended assessment and treatment clinics in many parts of the UK at a time when children and young people are experiencing higher levels of anxiety and depression.This is likely to contribute to higher rates of mental health disorders, self harm and ultimately suicide. The impact is higher on vulnerable children

On the 3rd of March, the UK government introduced the Coronavirus Bill.[12] This included changes to the Care Act 2014 in England and the Social Services and Well-being (Wales) Act 2014 to "*enable local authorities to prioritise the services they offer in order to ensure the most urgent and serious care needs are met, even if this means not meeting everyone's assessed needs in full or delaying some assessments*."[12] These changes meant that "Local Authorities will not have to prepare or review care and support plans".[13] The intention of the bill was for this to only come into effect if "if demand pressures and workforce illness during the pandemic meant that local authorities were at imminent risk of failing to fulfil their duties and only last the duration of the emergency".[13] However, in the absence of coronavirus testing (which means that many families are self isolating) and with current government regulations on the movement of people, significant areas of social care have ceased with a potentially devastating impact on the most vulnerable children.

There are over 78,000 looked after children in England alone[14] who are now at higher risk because of the reduction or suspension of evidenced based protective support and interventions. A variety of

parental interventions, Looked after Children reviews, Social services input and respite care can improve children's outcomes.[15] Throughout the UK, these services have been suspended or reduced as Social services move to working from home meaning that children and foster carers can no longer access face to face support from their appointed social worker or their independent reviewing officer. Respite care has been suspended, increasing the risk of physical, emotional abuse or neglect in families that are struggling. Where looked after children were receiving additional support from CAMHS, this has either stopped or is being continued remotely. Inevitably these reductions in support and safeguards will have the greatest impact on the children with the most complex needs in the most challenged placements. Transition planning for children leaving care has essentially been suspended. Services that were already struggling with workforce issues are now struggling even more as recruitment is almost impossible currently because of practical and economic considerations.

Can we mitigate these effects and minimise the "collateral damage" experienced by children and young people? Several strategies have been suggested to reduce the risks of domestic violence including the organisation of safe spaces in hotels for women and children experiencing DVA, already implemented in Spain and France Improving video and online access to services for which there is some evidence of effectiveness (such as CBT from CAMHS) could improve children's resilience. The chronic underfunding and work-force crisis in social care and the domestic violence sector will only be exacerbated by the current emergency. The chancellor's recognition of the need for greater financial support of the NHS [16] should be matched with additional support to local authorities. CAMHS and social services for children are unlikely to be needed on the front line for Covid-19 and agile services could develop alternative methods to assess and treat children using video clinics. But perhaps more importantly, we all have a responsibility to promote the health and well being of children at home, and to ask questions and fight for service provision in areas where clinicians are not needed to fight Covid-19, but are needed to protect children.

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In the UK, Paediatricians are increasingly concerned that parental worries over visiting health care centres is leading to a drop in vaccination rates and the late presentation of serious illness in children. This is likely to cause avoidable deaths and illness in the short and long term, a form of collateral damage from the COVID-19 emergency. In Italy, hospital statistics show a substantial decrease in paediatric emergency visits compared to the same time in 2018 and 2019 of between 73 and 78%.[1] In April 2020, both the Clinical Commissioning Groups and the Royal College of Paediatrics and Child Health provided guidance for General Practitioners and paediatricians in England that the threshold for face to face assessment hospital referrals in children should not change because of the COVID-19 pandemic.[2] This intervention is welcome, however we remain concerned about wider, perhaps less immediately visible collateral damage of strategies used against COVID-19 on vulnerable children.

The Cambridge dictionary defines collateral damage is the "unintentional deaths and injuries of people who are not soldiers, and damage that is caused to their homes, hospitals, schools, etc." In the fight against Coronavirus, children are being put at risk, in order to reduce the spread of a disease that mainly causes direct harm to adults.

One of the unique characteristics of the COVID-19 pandemic is the low hospitalisation and mortality rate (<0.2% for teenagers).[3] However, children are experiencing additional harm due to social isolation, lack of protective school placements, increased anxiety and a drop in service provision from both the NHS, education and social services. This is particularly true for the most vulnerable children (see box 1).

Impact of school closure and social isolation

School closures may have a limited impact on preventing deaths in adults.[4] However, the closure of schools and confinement to home has multiple impacts on children in terms of education, social isolation, wellbeing and child protection. Almost all European countries have closed their schools (Sweden is an exception) to prevent the spread of COVID-19 and according to UNESCO, 91% of children have been impacted worldwide.[5] Schools throughout the UK closed in March 2020 (see table 2) and are only providing places for some primary school children of key workers and some vulnerable children. Uptake of these places in the latter group appears to be low.[6] Some schools are providing learning online, but completion rates are unknown, particularly for those children with no or limited access to the internet. Families of children from poorer families have fewer resources,

may be reliant on school meals and playgrounds for exercise, are less likely to have appropriate access to the internet/sufficient space to allow learning, or have access to additional resources to support other activities for mental or physical well-being. Children with Special Educational Needs and Disabilities should have the special provision required to meet their particular needs specified in their Education Health and Care Plan, EHCP. This has not necessarily been adapted for home learning and many EHCPs specify provision that cannot be delivered outside of specialist settings. Similarly, much of the wider support normally available to disabled children and other vulnerable learners is provided through facilities that are now closed and unlikely to be effectively replaced by efforts of volunteers.

Schools provide a safe space for vulnerable children and play a key role in safeguarding by detecting signs of abuse or neglect. The rapid closure of schools, has not been accompanied by strengthened processes to support those most in need. This has occurred at the same time that the Coronavirus Act allows social services to reduce or suspend services (see below) leaving vulnerable children without a safety net.

Social isolation, the withdrawal of peer support, the lack of structure and support from school and the increased anxiety over COVID-19 infection and risk to parents, are all likely to have a negative impact on mental health in children and young people.[7] Social isolation and loneliness in children, job loss, furlough and increased parental distress, may lead to subsequent mental health problems, resulting in a substantial increase in need for Child and Adolescent Mental Health Services.

Increased risk to the mental health of children from social isolation will also result from their exposure to domestic violence and abuse (DVA) during the pandemic. We know that violence against women increases during epidemics, such as Ebola.[8, 9] Now, in countries across the world that have imposed social isolation in response to COVID-19, there is evidence from helplines and police reports that the incidence and severity of DVA has increased.[10-12] Children confined to home from school closure and young people not being able to leave home to see their friends will be more exposed to DVA. The stress and anxiety caused by forced isolation, economic uncertainty, home schooling, and potentially difficult living conditions, drive the increase in abusive and controlling behaviour. In over a third of families where DVA occurs, there is also direct child maltreatment: physical and emotional abuse, exploitation and neglect.[13] The greatest risk will be to vulnerable children (defined in table 1). Although the Government has issued guidance in relation to COVID-19 and DVA, there is no mention of exposed children and young people.[11] Moreover, as children's services and DVA agencies scramble to change their working practices to remote support, there is uncertainty about the effectiveness of emergency methods of working in this field.

Reduction in protection: withdrawal of services

Whilst the risk to children (and particularly vulnerable children) is increasing, the support mechanisms in both the NHS and social services are being withdrawn.

Hospital outpatient clinics have closed, been suspended or moved to virtual home based clinics. This will have the greatest impact on new appointments, or appointments requiring an examination. Child and Adolescent Mental health services have reduced or suspended assessment and treatment clinics in many parts of the UK at a time when children and young people are experiencing higher levels of anxiety and depression. This is likely to contribute to higher rates of mental health disorders, self harm and ultimately suicide. The impact is higher on vulnerable children

On the 3rd of March, the UK government introduced the Coronavirus Bill,.[14] which became the Coronavirus Act on the 25th of March 2020. This included changes to the Care Act 2014 in England and the Social Services and Well-being (Wales) Act 2014 to "*enable local authorities to prioritise the*

services they offer in order to ensure the most urgent and serious care needs are met, even if this means not meeting everyone's assessed needs in full or delaying some assessments."[14] These changes meant that "Local authorities will not have to prepare or review care and support plans".[15] The intention of the bill was for this to only come into effect if "if demand pressures and workforce illness during the pandemic meant that local authorities were at imminent risk of failing to fulfil their duties and only last the duration of the emergency".[15] However, in the absence of coronavirus testing (which means that many families are self isolating) and with current government regulations on the movement of people, significant areas of social care have ceased with a potentially devastating impact on the most vulnerable children.

There are over 78,000 looked after children in England alone[16] who are now at higher risk because of the reduction or suspension of evidenced based protective support and interventions. A variety of parental interventions, Looked after Children reviews, social services input and respite care can improve children's outcomes.[17] Throughout the UK, these services have been suspended or reduced as social services move to working from home meaning that children and foster carers can no longer access face to face support from their appointed social worker or their independent reviewing officer. Respite care has generally been suspended, increasing the risk of physical, emotional abuse or neglect in families that are struggling. Where looked after children were receiving additional support from CAMHS, this has either stopped or is being continued remotely. Inevitably these reductions in support and safeguards will have the greatest impact on the children with the most complex needs in the most challenged placements. Transition planning for children leaving care has largely been suspended. Services that were already struggling with workforce issues are now struggling even more as recruitment is almost impossible currently because of practical and economic considerations.

It therefore seems likely that the decisions on social distancing contravene the UN Convention of the child. This convention states (article 3): "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. We believe that the social distancing measures introduced in the UK and elsewhere, may marginally reduce the infection rate in adults but harms children. We do not believe that the "best interest of the child" are the "primary consideration" and therefore these actions do not comply with this convention.

Can we mitigate these effects and minimise the "collateral damage" experienced by children and young people? Several strategies have been suggested to reduce the risks of domestic violence including the organisation of safe spaces in hotels for women and children experiencing DVA, already implemented in Spain and France. Improving video and online access to services for which there is some evidence of effectiveness (such as CBT from CAMHS) could improve children's resilience. The chronic underfunding and work-force crisis in social care and the domestic violence sector will only be exacerbated by the current emergency. The chancellor's recognition of the need for greater financial support of the NHS [18] should be matched with additional support to local authorities. CAMHS and social services for children are unlikely to be needed on the front line for COVID-19 and agile services could develop alternative methods to assess and treat children using video clinics. The physical and mental health needs of the UK's children are unlikely to be short term, and funding will need to continue well after the Covid-19 pandemic is over. Perhaps more importantly, we all have a responsibility to promote the health and well being of children at home, and to ask questions and fight for service provision in areas where clinicians are not needed to fight COVID-19, but are needed to protect children.

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Esther Crawley conceived the idea, supported and developed by John Macleod. Maria Loads, Gene Feder, Stuart Logan and Sabi Redwoord all contributed to the first and subsequent drafts. All authors approved the final draft.

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Table 1: Definitions of Vulnerable Children

Definitions of Vulnerability taken from The Children's commissioner Technical Paper 2, defines 7 groups of children as vulnerable.[19]
1. Formal categories of children in care of the state whether in care, or living in other forms of state provision such as offender institutions, residential special schools, mental health establishments or other forms of hospital **2. Formal categories of need that may reflect family circumstances** such as children receiving Free School Meals or Children in Need, and asylum seeking children **3. Categories of need that reflect features of child development** such as children in Pupil Referral Units or with Special Education Needs and Disability. These groups might also include wider categories such as children subject to assessment or supervision under the Children Act, children subject to court orders or in receipt of youth justice services and missing children **4. Children who are in receipt of services following assessment** even if they do not have a formal status. For instance, those with a CAHMS service but with no formal diagnosis, those receiving prevention services through children's care, or youth justice, all of whom have been assessed by statutory agencies as vulnerable in some manner **5. Informal types of vulnerability** that may be important to the practice of local agencies such as for example when a child is referred to CAMHS who does not reach the threshold required to access services but where unmet need and vulnerability may still exist, or a child identified as part of a family experiencing domestic violence and abuse **6. Definitions relating to national policy such as 'troubled families' or 'just about managing' families.** This category will often relate closely to other categories and where children are identified as in need of support through such mechanisms they are in scope of this review **7. Scientific and academic literature** on risk and resilience such as Sameroff (2005), Rutter (2012), and including tools and approaches such as the measurement of adverse childhood experiences (ACEs)
UK Government definition of Vulnerable Children and Young people[20]
• are assessed as being in need under section 17 of the Children Act 1989, including children who have a child in need plan, a child protection plan or who are a looked after child • have an education, health and care (EHC) plan whose needs cannot be met safely in the home environment • have been assessed as otherwise vulnerable by educational providers or local authorities (including children's social care services), and who are therefore in need of continued education provision "This might include children on the edge of receiving support from children's social care services, adopted children, or those who are young carers, and others at the provider and local authority discretion."

Table 2: What restrictions have been placed because of social distancing on children and young people in the UK? [Government guidance updated 29th March 2020]

1. Children and young people are not allowed to attend school, college, nurseries unless they are a vulnerable child defined according to the government (see above).

2. Children and young people are allowed “one form of exercise a day, for example a run, walk, or cycle – alone or with members of your household”
3. Where parents do not live in the same household, children under 18 can be moved between their parents homes
4. All public gatherings are of more than two people are stopped (including weddings, baptisms and other religious ceremonies.

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