research in practice

Lancaster University

cfj Centre for Child & Family Justice Research

Enabling parent-infant interaction (contact, parenting assessment) in lock down and social distancing conditions. Practice forum write up July 2020

Background

Intervening in family life to protect an unborn or newly born baby is a highly contentious area of social work practice. In the context of the Covid-19 pandemic, this difficult practice terrain has become even more challenging. Over June and July we have coordinated a rapid knowledge exchange which focuses on infant-parent face-to-face interaction and how this may be safely enabled in current conditions.

During the initial phase of lock down in March and April local authorities and family courts worked under immense pressure to reconfigure their work in order to comply with government Covid-19 guidelines, minimise face-to-face activities and move practice largely online. Whilst there is no doubt that everyone has tried to do their best in intensely challenging circumstances, the scale of the change and the variation in response across the country raises questions regarding issues of fairness and equality for the families involved in the family justice system.

'Contact' or 'family time' arrangements have been radically adapted in lock down, with many local authorities introducing virtual versions of family time[1]. The feedback on the challenges and opportunities, the value and experience of virtual family time from parents, children and young people is varied. We decided to focus this knowledge exchange on face-to-face interaction between parents and new-born babies and young infants because the issues for children of this age group and their parents seem particularly consequential.

In order to deepen our understanding of the decisions being made regarding infants in the family justice system we wanted to hear directly from local authority practitioners and managers about the challenges they have faced and the decisions they have taken. Our aim was to provide a supportive space for discussion regarding challenges and to identify solutions that could be shared across the sector.

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Practice Forums

We put out a call on social media in early June, seeking examples of how child and family services are enabling face-to-face infant-parent contact under lock down and social distancing restrictions. We followed up around 16 responses from Directors of Children's Services (DCS), Service Leads and Principal Social Workers (PSWs) and arranged two virtual practice forums which were held online at the end of June. A total of nine participants attended, a mix of service and practice leads from seven organisations. We also had individual conversations with the DCS at Essex and the PSW in Leeds, and we have edited the very useful perspectives shared in these discussions into podcasts available here. The virtual forums highlighted factors shaping practice and decision-making regarding infant contact with parents. Whilst all were grappling with the same set of very difficult circumstances, children's

[1] https://www.nuffieldfjo.org.uk/coronavirus-family-justice-system/managing-family-contact

services responses have varied widely across the country. The forums helped shed light onto some of the drivers beneath these disparities, the detail of which is discussed below.

What Shaped Practice? Working with uncertainty

Response to the initial crisis differed. One practitioner described her frustration that a more proactive response was not taken from the outset:

> *We accepted lockdown which I had no problem with but we weren't beginning to think about, well- what next? We were just all sat waiting and waiting and I kept thinking well there must be something going on… But then I heard that (another local authority) had actually opened up contact, but we couldn't get more information.*

Others took a much more proactive local response in which they made early decisions to prioritise continued face-to-face contact for some children, assessing that on balance, the risks inherent in ceasing contact were greater than the risks of continuing it.

Participants described the huge uncertainty and lack of clarity at the start of lock down, followed by a period of intense work as they redesigned services and responded to the needs of local families. Some spoke about new services being developed or repurposed to respond to the situation.

One participant described a new service developed in partnership with a third sector charity to offer telephone support to parents living apart from their children. The service helped parents with difficult emotions regarding reduced contact and anxieties regarding their wellbeing. Another local authority had repurposed their in-house CAMHS service to provide advice and support specifically to foster carers during lock down.

Risk Assessments

> *We have been used to applying one set of procedures that apply to all and now that is so difficult we can't do that anymore, every situation is different.*

Practitioners spoke about the complexity of decision-making in conditions under which standard procedures were no longer relevant. Colleagues shared examples of the detailed risk assessments informing decisions regarding face-to-face interaction between families and professionals and contact between parents and children. Examples of useful materials shared by Bradford, Essex, Leeds and Rochdale can be found as appendices to this briefing.

In a context in which so little is known about the transmission routes of Covid-19, and in which the individual circumstances of the people involved vary greatly, some local authorities felt the only 'safe' decision was to stop all face-to-face contact, whilst others made decisions on a case by case basis. The forum discussions highlighted the many different factors influencing decision-making and the radically different service families have been experiencing across the country.

We discussed the challenges in situations where infants were placed with foster carers who also looked after children from different families and the implications for all the children, the foster carers and the all the children's parents' if any face-to-face contact took place. This was particularly challenging where toddlers were concerned and social distancing was impossible to manage. For some local authorities this complexity led to the decision to stop face-to-face contact altogether.

In another local authority this complexity was managed by undertaking a 'three pronged risk assessment' on each individual case that considered:
a) Foster household: including the vulnerabilities of individual foster carers, the number of children in placement and the potential for overlapping households involving different children's parents.
b) Parents: including an assessment of a parent's capacity to fully comply with lock down limitations. This may include home conditions, (for example are they homeless, in shared accommodation, in a hostel with shared toilet facilities), the extent to which they were self-isolating or shielding, drug/alcohol use.
c) Infant's health needs (e.g. some may be withdrawing from in utero substance ingestion, low weight, premature).

Legal liability

In some instances the question of an organisation's legal liability was at the forefront of decision-making. The idea, for instance, that a foster carer might be infected with Covid-19, trace the transmission to the contact with parent and take legal action (or vice versa).

No one in our discussions had considered the potential for legal challenge in regard to the rights of either parent or infant and the longer term risks that might arise from the interruption of the relationship and the impact a) developmentally on the infant or b) on the parents' right to a fair proceedings in the family court.

Placing family needs front and centre in decision-making enabled other authorities to work through issues of risk of transmission and liability, and the Leeds podcast provides a strong example of this.
A service manager from another local authority explained that from the beginning of lock down they worked on the basis that they would be able to enforce social distancing between adults and staff but that it was unreasonable to expect this between a parent and infant. Risk assessments were made on a case by case basis and signed off by service lead, IRO manager and the Assistant Director for facilities.

In another local authority, a senior management decision was made at the beginning of lock down to prioritise face-to-face physical contact between babies and parents. This centred on an understanding of the importance of promoting attachment.

> *We started to think through who would need to continue to have face-to-face and physical contact... So we worked up with the Public Health Director an approach to doing supervised contact for babies. We were very concerned that particularly for very young babies and parents where we have removed from birth that if we didn't maintain contact how were we going to do attachment. We said direct contact needs to continue. We have a lot of staff who have been in practice a long time and knew the consequences of not doing things properly. We made a decision to prioritise babies*.

Prioritisation

> *It is just a huge risk assessment trying to decide who to do face-to-face contact with. We have to take into account of not just safety in the immediate, but the wider picture.*

Participants described difficult decisions regarding prioritisation. In some local authorities a focus on the developmental needs of the child informed decision-making and led to infant face-to-face contact

being prioritised. However, even where this was the case restrictions surrounding the type and frequency of contact varied between authorities.

One manager reported that no physical contact was allowed between parents and infants during face-to-face contact. Parents were given the opportunity to push their baby in a park in a forward-facing pram and the manager recounted that:

> *… every parent said they felt really connected, to see and hear the child even if no physical contact.*

In another local authority the social worker described the distress caused to a parent who was told that she could only have a final contact before adoption with her infant if she agreed to wear full PPE. The mother's anguish was evident in the participant's account.

> *The mum said to me 'You're not telling me I've got to have my final cuddle with my baby with a mask and gloves. But it is so difficult because we can't produce the evidence (about transmission risk) to support any other decision.*

In a similar situation a practitioner from another local authority explained how a different decision had been made:

> *We facilitated a final contact and allowed cuddling (between baby and mother). We risk assessed and asked Mum to self-isolate seven days leading up to it, which she agreed to and this was signed off by our DCS (Director of Children's Services). It would be very cruel not to allow any physical contact.*

Discussions across the forums also highlighted differences in contact decisions for different parent-infant dyads. In one local authority this decision was based upon their assessment of the likelihood of reunification. Conversely, a manager from another authority shared an example of an infant where the plan was for adoption with the final hearing scheduled for September. In this case, face-to-face contact with the mother was still seen as a priority. This was met with significant resistance by the foster carer but the authority took an assertive position and made it clear that if the foster carer was unwilling to take the baby to contact then the social worker would transport the baby, and ensure it went ahead.

One participant from a third sector organisation supporting families with substance misuse issues described their rationale for continuing to offer a crèche facility for parents using their service:

> *We run a crèche which we have run throughout the pandemic. Most of children that use it are on child protection plans, some very small babies. It was done with reference to keeping services open for very vulnerable children. We let Public Health know our intentions and they were on board with that. We have also offered to facilitate contact where a baby had been removed and the parent was having no contact. We were prepared to facilitate that but we were told 'no the contact centres are closed'.*

This participant also went on to talk about how the cessation of contact has led to a loss of trust between parents and Children's Services. The negative impact on the parents' mental health and substance misuse was also raised.

Trying to balance the needs and anxieties of all parties has taken its toll on the workforce. As one manager told us:

Staff are exhausted having to think through new problems… In normal times, we've been used to applying one policy. But [with Covid-19 to consider] we have different families, different needs, different lifestyles… Working all this through case by case is exhausting for staff, thinking through pathways that are very new. There's an expectation that because I'm in higher management I have all the answers but I know as much about Covid-19 as any of you do.

Foster Carers

Foster carers have been key to the local authority response to contact during the pandemic. We have heard many examples of foster carers' high levels of flexibility and commitment in facilitating meaningful virtual family time between parents and infants. In many instances carers have had to develop their technological know-how to enable virtual contact to take place with parents

Virtual family time

Whilst not replacing face-to-face, some imaginative uses of digital contact were noted as rewarding for all concerned and participants were keen that these possibilities be retained beyond the need for social distancing. Examples of digital contact used for infants included:

- Parents recording stories to be played to the infant at bedtime
- Video calls to parents at key times of the day including bath-time and bed-time
- Foster carers sending photos and video clips daily to parents to keep them up to date with the infants developments

https://www.researchinpractice.org.uk/children/content-pages/videos/digital-family-contact-time-sharing-and-building-knowledge/
https://www.researchinpractice.org.uk/children/news-views/2020/april/virtual-contact-between-children-and-their-birth-families-during-lockdown-unexpected-opportunities/

The pandemic also raises anxiety for foster carers regarding the risks to themselves and their families which led to some being reluctant to facilitate contact. A number of practitioners explained that many of their foster carers were older and others may be shielding or have additional vulnerabilities. These situations presented particularly stark challenges for local authorities.

One of our biggest barriers (to face-to-face contact) has been foster carers, high levels of anxiety, and the conflicting national guidelines. Foster carers were rightly saying 'I can't go see my own daughter or grandchildren but you're telling me I should take this child to meet with his parents yet I have no idea how these people are living their lives and how careful or not they are being'. For a small number of carers there was a bit of a lack of empathy for parents, for how it might feel (to be) on the other-side, not seeing your baby for 12 weeks.

One local authority was seeking to address this issue head-on in carer recruitment and placement decision-making:

In placing with foster carers we're scoping willingness to enable face-to-face contact and provide transportation. We've had a wonderful response.

One social work manager discussed how working to allay foster carers' fears was a key part of their strategy from the outset. As part of a weekly Covid-19 management meeting, team managers came together to discuss a strategy for supporting and reassuring foster carers for whom this decision may raise concerns.

> *Our foster carers needed a lot of talking to and supporting but actually most of our baby carers are in-house carers and that made a big difference, we have a relationship with them so we could talk to them. We know the social worker who has the relationship with them and most of them are very experienced in working with babies who are removed from birth and the importance of working with parents.*
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> *A newsletter was produced and shared with foster carers every week so they could be kept up to date with developments. Regular webinars with foster carers were also scheduled to provide an opportunity for foster carers to share their updates and concerns and receive support.*

The lack of clarity in Government guidelines was felt to have contributed to difficulties. Practitioners expressed frustration at the inconsistency in guidelines regarding private and public law cases and the inequality inherent in guidance which allowed children to move between separated parents' households but did not consider children in foster care having face-to-face contact with their parents. One worker described her attempt to highlight this inequality.

> *I also felt we had not explored the whole fact that this legislation allowed children to move between parents. It's there - so why couldn't we set up foster parents as one loco parentis and parents as the other? But I was just told 'no, no we can't do that it is different'. I think we needed to push more on that front*.

Role of Public Health and Health

The role of local Public Health colleagues varied. In some areas children's services were simply told to follow national guidance (however unclear or inconsistent that might be); in others a more proactive response included case-level consultation and support offered by Public Health leads.
In one example a social work manager shared her frustration in trying to get advice regarding contact for an infant who had asthma. The worker was aware of the potential harm to the child if contact stopped abruptly, particularly given the child's age, however it took several weeks to get a response from the GP.

In another local authority the Public Health team established a 24 hour helpline, gave advice on individual cases and input into risk assessment for contact. The team manger described how this built confidence in the team to make bespoke decisions regarding individual cases

Venues for contact

The availability of suitable buildings for contact between infants and parents impacted upon decision-making significantly. In some local authorities buildings were not considered sufficiently safe due to shared entrances, narrow corridors and lack of outdoor space. A manager in one authority described how contact was weather dependent because they had made a decision to only arrange meetings outdoors. She was aware of a number of scheduled contacts that had been cancelled for young children because of poor weather and was concerned of the implications for parents:

> *The last thing we wanted to do is to say you are going to see your baby on this day and then cancel it.*

One practitioner told us of their frustration at the length of time taken for a risk assessment required for a building they wanted to repurpose for contact. The building had been shut down at the beginning of lock down and although this was only for a short period, Facilities had advised them that it would now needed multiple health and safety assessments before it could be re-opened.

> *I think one of the biggest challenges for us was closing the buildings, because what no one thought about when you have to reopen the buildings the amount of tests that need to be done. People thought we could just reopen buildings and start contact straight away but it has taken us almost a month to get it ready, things like legionella testing and having all your water systems flushed… We have had to have a surveyor in to do the markings on the floor, you can't just do that, you have to have a surveyor in to look at that... Things like passages and passing spaces have all had to be assessed*.

Facilities management were Identified as 'critical partners' as they were required to 'sign off' risk assessments to confirm buildings were safe to the public in Covid-19 conditions.

There were many examples of creative solutions to enabling contact

One local authority had repurposed a ground floor flat for infant-parent contact.
Other local authorities' buildings were kept open for contact throughout but at a much reduced capacity to allow for cleaning between each visit and to reduce the number of households in the building at any given time. Where local authorities did not own the building this added complications regarding risk assessments and negotiating cleaning fees.

The layout of buildings played an important part in allowing face-to-face contact to continue for at least some children.

> *We have a dedicated family time centre with large rooms and each has its own outside area so we have predominantly been outside… We have been able to do a whole building risk assessment and been able to use the inside too (In bad weather)*.

In another example, an old school building had been repurposed as a contact centre prior to the pandemic and leant itself to easy social distancing:

> *We were quite lucky as we had just redesigned one of the rooms in (old school building) to be solely for family time and to get to it you go through a really wide corridor and into a high ceiling room, that's the room we are using. The reception area was already glassed off and the entrance was an electronic door so no one needed to touch it.*

Steps taken to minimise risk during face-to-face contact

- People's temperatures being taken outside building before family time begins
- Family time limited to a maximum of an hour at a time to restrict the need for use of toilets
- Quite large rooms, ideally with their own access to their own outdoor space
- Removing almost all furniture and toys, especially soft toys which are harder to clean
- Arrangements for initial deep clean and then extensive cleaning between sessions, with need to leave gaps in between visits for cleaning
- Families being asked to aid cleaning by putting the toys and anything else they've touched on a table at the end of the session
- Written agreements with parents on expectations: essential hand washing; use of PPE where necessary; acceptance that staff will ask parent to leave if they are showing symptoms
- Hand sanitizers in toilets; hand dryers switched off and replaced with paper towels
- A blanket risk assessment in relation to the building, and individualised risk assessments from there.

The Courts

The centrality of the courts' role in decisions regarding contact between infants and parents was stressed by a number of participants. Accounts were shared of the court directing the local authority to intensify contact. Some participants raised concerns about the implications of such decisions:

> *In some cases the Judges are saying day to day contact virtually and if we only work Monday To Friday that then puts the responsibility on the foster carer on a Saturday and Sunday in order to supervise those contacts and that shouldn't be on their heads, that's for us to do as staff members to take on the responsibility to make sure it is a positive contact*.

In contrast, other local authorities described a case by case assessment of the necessity for a social worker to oversee virtual contact. Some practitioners shared very positive experiences of flexible arrangements being developed between parents and foster carers which optimised the quality of the contact and enhanced their relationship.

In one example the court had ordered four times a week face-to-face contact between a mother and her baby. The practitioner explained that it was the good will of a particular member of staff that had enabled this to happen and that it had had implications for the contact that could be offered to other children.

Another practitioner described the local authority as coming under a lot of criticism in the courts because all face-to-face contact had been stopped. This led to the local authority reconsidering their position and as a result It had 'opened the floodgates' regarding demands for increased contact which they were struggling to meet.

Assessments

The difficulties of undertaking assessments during the lock down was raised by a number of participants. The tension between the fairness of undertaking parenting assessments when families

were under so much additional stress balanced with the impact on an infant of delay was raised. The efficacy of assessments undertaken virtually was also considered. Whilst some practitioners felt that in some cases digital meetings were less threatening for parents and could increase levels of engagement, the obstacles were also clear.

Concerns were raised regarding the inconsistency. Whilst the efficacy of parenting assessments done virtually was queried in some hearings, in another example a practitioner spoke of feeling unduly pressured to complete an assessment in very difficult circumstances:

> *What I think has been really concerning is the lack of ability to assess parenting, and that part of care proceedings when parents are only having contact virtually and in some cases foster carers are doing all of that with very little recording of that. The courts are giving very mixed messages about how we proceed with the assessments. I've got one at the moment where the court is saying 'you have got to go ahead and finish this assessment.' But we are saying 'but Mum's out on the streets, she is using Spice, she is fairly high risk, how can we assess her parenting in the park with PPE on?' And it's like 'here is your deadline, it has got to be done' it's just really tricky.*

Staff Vulnerability

Participants acknowledged that some arrangements for face-to-face contact could only go ahead because of the willingness of individual staff to supervise and potentially put themselves at increased risk.

Concerns regarding the vulnerabilities of certain groups of staff, such as Black, Asian and minority ethnic practitioners and/or those with health or family considerations were taken into account when decisions were being made.

Creative Use of Placements

Whilst for many parents a decision to separate them from their baby during Covid-19 led to long periods without face-to-face contact, in some local authorities concerns about the long term impact led them to make different placement decisions.

> One authority provided a 24 hour, seven day a week support plan so that, despite the significant safeguarding concerns, the mother could go home with her baby and intensive assessment took place in her home. In another local authority an early decision was taken that separation at birth during the Covid-19 pandemic was to be replaced in all instances with residential assessment units or mother and baby foster placements.
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> However, whilst this was considered a more humane response, practitioners also discussed the intensity of being in a placement with high degree of monitoring during lock-down caused parents high levels of anxiety. As one practitioner expressed:
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> *We've got two mums in this set up at the moment, both mums are finding it really hard, not going out for a stroll or seeing friends or family. Huge pressure*.

Conclusion

The discussions within the practice forums have detailed the many difficulties and dilemmas faced by Local Authorities as they seek to find solutions in extraordinarily challenging times. They have also highlighted the range of responses and the impact this had had on families' ability to have contact with their infants. As we move out of lock down and into an autumn of continued uncertainty, we need to draw on the emerging evidence on transmission - see for instance new evidence published in The Lancet in July - a cohort study of 120 neonates born to mothers positive for Covid-19 at the

time of delivery which found no cases of virus transmission, even after two weeks of breastfeeding and skin-to-skin contact with appropriate hygiene precautions. And we must learn from the experiences of colleagues who have moved proactively in order to ensure a fair, humane approach to infant-parent interaction in the weeks and months ahead. We hope that the ideas and approaches shared here will enable other authorities to move swiftly to enable infant parent interaction that is so vital to relationship-based support to children and families.

Reflective points:

- At what disadvantage might families in proceedings be placed if they are not prioritised for face-to-face contact?
- How can adequate assessments of parenting be achieved virtually?
- Who might be best placed in your local public health team to provide advice and support regarding physical interaction between infants and parents?
- Using the guidance that allows children to move between separated parents, might we work on the basis of foster carers as one loco parentis and birth parent as another?
- How might your local CAMHS support to address foster carer anxieties?
- What are the key things the foster carer needs to consider in facilitating virtual contact without SW involvement (e.g. anonymity of the room in which they hold the video call; items included in the background in photos of the infant)?
- What venues does the local authority have access to that might be used/adapted for family time purposes?
- In placement decision-making and carer recruitment for mother and baby placements, are you scoping willingness and ability to transport for f2f meetings with parents?
- How will you draw on the evidence presented here to support parents, brothers and sisters and infants to have close physical contact at their farewell time before adoption?