**Appendix A: Connections for wellbeing**

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| Age and Stage | **Developmental, experiential and practical considerations** :  These are indicative prompts for general consideration. Developmental stage and communication support needs and therefore resource considerations are specific to each child in context.  **Trauma informed**:   * All contact decision making for children in need of care and protection is made within the context of childhood trauma. Whatever the chronological age of the ‘looked after’ infant, child or young person they may well have experienced and be impacted by emotional, physical,  cognitive and developmental consequences of trauma, (including pre-birth). * The ‘voice’ and experience of young infants should be articulated and made evident on their behalf by their lead professional (and/or legal representative). A baby may experience relational trauma through triggered sensory memory. Contact venue and support arrangements should be as reassuring and enabling as possible for child and parent . Carers and others involved should be sensitive to impact of contact and eg prolonged distress following contact. * Trauma can influence lifelong stress response and behaviour patterns. Unattended to, trauma may hinder realisation of potential and health and development throughout life. * Alongside trauma, practical consideration should be given to the communication and support needs of children with organic emotional, physical or cognitive disabilities, so that they are enabled to express themselves and participate in holistic assessment and planning of contact that is optimal for them. |
| 0-9 months | **Developmental considerations**   * Babies are reliant upon looking at adult faces to pick up their cues, connect and gauge their own experience of the world. * Babies require to be physically touched on a frequent basis by their adult care givers in responding to needs * Babies physically grow and develop quickly |
| **Considering direct contact** when this is essential to wellbeing /stage of planning: subject to risk assessment, it may be viewed as essential that direct contact is supported   * The venue – there may require to be a cleaning process between use for different children, families and practitioners. Therefore this will impact on both frequency and time for the session to ensure the safety of all involved. * If contact is to be supervised for more than 15 minutes in an enclosed space– are there facilities at the venue where the practitioner can safely observe via a screen and/or maintain a level of physical distance while still understanding the detail of the time between a parent/parents and the baby? * If not – is it safe, and respectful of confidentiality, to have the contact outside in the open air? * It is believed that the Covid-19 virus could remain live on plastic materials for around 72 hours. Is it safe for the child, and possible, to have duplicates of any formula and feeding equipment? * A car seat/any objects moving between households may need to be ‘wiped down’ after each use due to handling by more than one adult * A baby may be less aware of difference in routine regarding the use of PPE equipment such as masks however what impact will this have for a sensory experience and engagement? * It may be deemed essential travel. Travel between locations and contact with others increases risk of transmission. What is the mode and method of transport, timing and finance required for safer travel?   The additional vigilance required for those being asked to facilitate contact for children and their families cannot be underestimated. The additional layer of safety planning and enactment will require time and energy. Practitioners and carers will require time for preparation, planning, enactment – and debrief to maintain the levels of safety required |
| **Resource considerations if considering direct contact include:**   * Duplicate feeding equipment * Support to access any practical provisions * Handwashing facilities and/or anti-bacterial gel and wipes * PPE equipment in enclosed spaces and transitions * Safe methods of transport * Venue (inclusive of cleaning routines and practices in line with infection control methods) * Access to health advice to consider vulnerabilities for babies and all primary care-givers and the risk of transmission   Time written into any plan for preparation/acquiring resources/communicating the plan/on-going risk assessment and debrief |
| 9 months-5 years | **Developmental considerations**   * Children are far more aware of being separated from a specific primary care giver from the age of nine months old * Children who are teething and explore the world using their mouth and hands, * Children are involved in magical thinking at this time and look for different ways to interact. |
| **Considering the child’s experience**   * Is it more distressing or confusing to be told not to touch things and people – than see and interact with adults through a screen which is a physical safeguard? * What is the impact of seeing masks and PPE on adults if this is deemed to be part of the safety plan for those involved? * How can play and story telling be used to support a child make sense both of the plan – and to support interactions? * Thinking about balancing both adult needs and child’s needs – what is the expectations of screen time? Ten minutes may meet the child’s needs to concentrate at this time. A parent may wish to have more time therefore   **Supporting parents and carers**  For example: Are there opportunities to talk for a while with the primary care giver while watching their child play? 2. What supports does the primary care giver need to manage this (both practical and emotional) – how can the team around the child be used well? |
| **Resources required**   * In the use of virtual contact – what technology is required and is this accessible? * What data is required and is this accessible? * A different form of planning for activities may be required in this context – if the agreed plan is to draw/bake/play a game in two households via shared screen time – are there the same ingredients/equipment/books/play equipment in two venues to allow a child to see a mirror image on the screen? This will require additional resources – and plan in advance to coordinate * Can a (social) story be written to explain the specific Covid-19 restrictions or book be sourced? * What additional resources can be put in place to support a parent’s connection with their child such as a diary of the child’s experiences and milestones? |
| 5 to 11 years | **Developmental considerations and opportunities** Including…   * Increasing curiosity about the world around them – and stories to help process where they fit within this world * When experiencing separation and loss may lack confidence and/or become overwhelmed when faced with new situations. Children may be experiencing the loss of a known situation but equally the loss of time with peers in a school environment, routine and structure * Concentration increases * Begin to develop a sense of humour at the age of 8 years old * Around 10 years old family activities and friendships are becoming very important. There is also a greater capacity to be involved in discussions about problems and values * At the same time fears about the world can begin to become more dominant * Likes a plan and feels safe when adults can anticipate and articulate what is happening next * Depending on the experience of the child – they may be able to increasingly self-regulate and therefore manage carefully delivered messages about social distancing |
| **Considering the child’s experience**   * Although a child may cognitively be able to engage with a concept about social distancing what would be the impact of being near a parent or significant other without being able to touch them? * If a child has been a young carer for a parent or sibling – they may experience a sense of loss of control and/or have deep concern about others well-being magnified by information regarding Covid-19. What information does the child need in addition to any contact arrangements? * Who is important to the child? Would more screen time with a sibling meet a need to connect without a responsibility to manage physical safety or direct play equipment between households? * Would a visual plan help a child to anticipate and identify time with the parent – particularly when their routine does not involve as many physical transitions of venue inclusive of school as it would usually do? * If a child uses communication tools – there may be increased risk of transmission if used in the same physical space. If used virtually - can there be duplicate copies in all relevant households? |
| **Resource considerations**   * Increased use of postal services may be considered to exchange letters, pictures and cards to maintain senses of connections. This will require usual needs and risks assessment * Additional play equipment may be required * Data and technology * Amended observation methods to take into account digital methods if used * Visual charts and plans – duplicate copies * Methods of review as to affect of variance in facilitating family time |
| 11 years and over | **Developmental considerations and opportunities**   * Due to further growth stages in the brain, young people may revert to difficulty in reading adults emotions and facial expressions. * Young people are more likely to have their own mobile phone/tablets/devices * Some young people may be struggling more with the restrictions and have left the house more frequently to connect with peers. Others will have remained at home and had a close connection to primary care-giver. * Due to developmental stage a young person’s view of the ability to manage and control risk may be more than is the case * Identity formation in the midst of increased isolation |
| **Practical planning considerations**   * The impact of PPE equipment may have the same effect as those for a young child despite a young person being able to more actively engage in other ways * Increasing consideration may be required to be given to mental health and wellbeing – either due to increased risks of self-harm – or increased resilience due to absence of usual pressures * If independently a young person has had increased contact with other households – and in information gathered a parent (for example due to substance use) has also had contact with more than once household – how does this impact on any risk assessment of likelihood of transmission? * If a young person has an increased health vulnerability – or a care giver does – how is this explained to the young person and what expectations are given to them – and which are held by adults to manage? * Attention to trauma and disability is necessary to  provide preparation and individualised support before and after transitions of every kind in a looked after child’s life |
| **Resource considerations**   * Contextual mapping exercise of associations will assist understanding of risk and opportunities for collaborative safeguarding * Support to young people who are using their own technology to engage in conversations as to what they have seen, heard or experienced * Providing support to structure a plan than a young person creating or engineering this individually * Increasingly providing a ‘toolkit’ for young people so they can enact safety plan and be part of the team. This may involve a pack including hand sanitiser and a mask for use in public places. |

Example of practical feedback: “ *Where face masks required, we have asked parents and workers to have a virtual contact with the children in advance wearing the masks so children know what to expect. In some outdoor contacts, we have asked staff and parents to wear masks around their neck that they safely put over their mouth/nose if they need to be within 2 metres of a child. In other cases, carers and social workers have agreed in advance with parents and children a way to greet and say good bye that does not involve touching e.g. throwing a kiss or a hug*.”