UNIVERSITY OF BIRMINGHAM

DEPARTMENT OF SOCIAL WORK AND SOCIAL CARE

Research Briefing One: Child Protection, Social Distancing and Risks from COVID-19

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This briefing shares some emerging findings about the challenges of achieving social distancing during child protection work, especially on home visits, and how children and families and social workers can be kept safe from COVID-19.

About the project

This research project explores the impact of the COVID-19 pandemic on child protection practice and children and families, with the aim of improving the capacity of social workers to keep children safe in a period of institutionalised social distancing.

The 15 month research project is being funded by the Economic and Social Research Council as part of the UK Research and Innovation call for studies that can contribute to understanding and alleviating the social impact of the pandemic. The research is being done in four (anonymous) local authorities in England and our project partners Research in Practice and the British Association of Social Workers are working with us to help disseminate the findings and scale up the impact of the research.

Further information, including project reports, can be found on our website:

https://www.birmingham.ac.uk/child-protection-and-social-distancing

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Introduction

COVID-19 has completely disrupted the taken for granted routines of social care work with children and families and at a time when there is increased stress, poverty and risks of domestic abuse and other harms within families. Previous research has shown how a crucial way child protection work is achieved is by social workers and family support workers getting close to children, especially on home visits and helping parents by immersing themselves in their lives and the routines of the family (Ferguson et al, 2020). The aim of this research is to explore what social workers are doing to try to keep children safe and help families during the COVID-19 pandemic, when getting close is no longer safe (further information about the research can be found here and on our website, https://www.birmingham.ac.uk/child-protection-and-social-distancing).

Our data, gathered during April, May and early June 2020, show that social workers, family support workers and their managers have worked incredibly hard and creatively in addressing the complex practical and moral dilemmas they have faced in implementing social distancing guidance and in aspiring to best practice in helping children and families. This research briefing shares some emerging findings about the challenges and often impossibility of achieving social distancing during home visits and the implications of this for keeping children, families and social care staff safe from the virus.

Going into homes: The impossibility of social distancing

The family home is the most common place where children are seen in child protection work. Typically, the need to see the child in their home and check the home conditions is part of the local authority requirement for completing a 'statutory visit' to children on child protection plans. Social work organisations have adapted practice in various ways to protect workers and families from COVID-19. Following the introduction of 'lockdown' on the 23rd March 2020, central and local government guidance has sought to limit the need for social care staff to enter homes, suggesting '[T]here are many ways to keep in touch with a child, young person or family without physical face-to-face contact' (Department for Education, 2020a and 2020b).

A key strategy has been for safeguarding services to go online. In family situations assessed as lower risk – and importantly where both social workers and service users have access to suitable technology - social workers have been making 'virtual home visits' to families using video calling technology (PCFSW, 2020). This has also helped social care workers vulnerable to COVID-19 to continue their casework. However, the use of virtual visiting has varied across the country. A significant finding is that in areas where local authorities do not provide their staff with good quality smart phones and IT provision is poor, such that particularly WhatsApp which is popular with families can't be used, video calls are much less frequent and in person home visits more common. In effect, poor IT provision means social care staff and families have to have more face-to-face encounters and take more risks. Since lockdown social workers have been mostly working from home to avoid COVID-19 infection risks in the office. Local authority management teams introduced risk assessment processes and adapted existing case management systems to ensure children on child protection plans and in complex need are visited at home in person. If possible, the preferred approach is to remain outside, on doorsteps or in gardens and interacting with children and parents or other carers while maintaining two metre social distancing.

Where the risks to the children are assessed as high, social workers continue to visit in person by entering the home, although the amount of this varies across our research sites. All the social workers in the study who have entered family homes have described maintaining social distancing as impossible because the children are too young to understand the need for it. While this is always difficult, it is especially sensitive when the

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relationship between the social worker and children was established before lockdown and the children are used to having tactile contact as part of the therapeutic help they are receiving. The following social worker's story is typical, concerning a four year old girl who: "likes to come and put her head on my knee, I think it is almost like a comfort thing, I think she slightly understands that I am there trying to help". Other examples of such physical closeness during the COVID-19 pandemic include: children sitting on the practitioner's knee, climbing all over them, giving them full hugs, holding their hands, hugging worker's legs or arms, and putting the worker's hair in their mouth. Workers have invariably responded by humanely and sensitively providing children with the nurture they needed, while encouraging social distancing.

There is concern that some parents do not do anything to keep their children at a distance:

> **I am working also with a little girl who is four who has got additional needs, so she is probably more like an 18 month old. … I went to visit her last week and she was all over me, jumping all over me, jumping on me and I commented to the parents, you know, this isn't great social distancing, trying to give them a hint that maybe they should try and remove their child away from my knee, and the response from the father was just children can't carry this or get it, so what is the problem?**

Some older children with learning difficulties and learning disabilities struggle to understand and observe the rules. Even some older children and teenagers who do understand the need for distancing on occasion don't practice it because they too want to be close to the worker and gain comfort from being held and experiencing touch and just being close. Another practical barrier is that because families are often poor, the property is so small there is no room to achieve two metre social distancing. Some families who are visited in emergency accommodation, for instance, live in one room.

Although home visits have been the key way children and families have been seen for well over a hundred years, they are under-researched and poorly understood (Ferguson, 2018; Pink, 2015). In developing effective policies that can reduce as far as possible the risks COVID-19 infection presents for workers and families, it is crucial to appreciate the complexity of home visits and the ways in which social distancing with children (and adults) in their home is very different to doing it in a school, or any other public space, because workers have so little control over the environment. With respect to hygiene, workers report an increased fear of catching the virus when one of the reasons for visiting is poor home conditions linked to child neglect where they suspect that regular hand-washing is almost certainly not occurring.

Many home visits are calm, congenial affairs, and we have heard of many where families have been grateful for the thoughtful help social workers and family support workers have given them during the pandemic. However, some visits are volatile and dangerous. All are steeped in uncertainty and the unknown of what is behind the door. For instance, our data already contains many stories of social workers being in homes with men who are known domestic abusers and the sheer difficulties of trying to protect their partners, and the children. During the COVID-19 pandemic, social workers are still expected to look around homes to check on the standard of care provided for children in bedrooms, the amount of food available for the children and hygiene levels in kitchens and bathrooms. This makes avoiding contact with surfaces just about impossible. Several examples of the unexpected have already arisen in our data, including a father who was not supposed to be in the home being found by the social worker hiding in the bedroom behind a wardrobe, while in another case, on seeing the social worker a man jumped out of the bedroom window. Little wonder, perhaps, that some social workers have emphasised that it is crucial to understand that in addition to new risks of infection, home visiting has always been risky due to the

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threats of, or actual violence by some family members:

> **I think our risk kind of remains the same, we are still going into homes, we are going into people's houses. I got a Dettol spray and every visit I do I spray myself with this disinfectant spray, because I'm very conscious I'm going from house to house. Like sometimes I go into 3 houses, and whilst I'm not touching or sitting down or anything, you know, I'm still present and I worry that I am spreading something, if I've got something on my clothes. But also for us the risk is still very much there, that's not changed, the physical risk of being threatened by parents, sometimes teenagers, I think that's still there.**

A key implication of this is that the organising assumption about in person home visits to families with younger children must be that social distancing will not happen. It cannot be assumed either that all older children or teenagers and even all adults will keep their distance.

Personal Protective Equipment (PPE) use and dilemmas

When children's social care staff and children and families have to meet face to face, the availability and use of Personal Protective Equipment (PPE) has become a central area of debate. Government guidance for children's social care originally suggested that PPE is not required unless the people being visited have symptoms (such as a cough or high temperature) or have a confirmed diagnosis of COVID-19 (Department for Education, 2020a). This attracted serious concern from social work organisations (BASW, 2020a; Turner, 2020), given that Public Health England (2020) guidance stated: '[W]here the potential risk to health and social care workers cannot be established prior to face-to-face assessment or delivery of care (within 2 metres), the recommendation is for health and social care workers in any setting to have access to and where required wear aprons, FRSMs [Fluid Resistant Surgical Masks], eye protection and gloves'. BASW (2020a) challenged the suggestion that 'social workers can straightforwardly establish with people being visited that they or someone on their behalf can and will reliably communicate whether or not they are symptomatic or have a diagnosis' and that 'asymptomatic risk … should be discounted by social workers and other professionals and the families they are visiting'.

Updated guidance issued in May 2020 (Department for Education, 2020b and 2020c) suggests that steps should be taken 'where practical' to mitigate risk when it is not possible to ascertain if any member of the household is suffering from symptoms of COVID-19 prior to face-to-face contact. These include, but are not restricted to: 'knocking on the front door or ringing the doorbell and then stepping back to a distance of 2 metres in adherence to social distancing guidelines' and 'taking PPE with you as a precautionary measure'. The guidance continues to suggest that where households report no coronavirus symptoms, no PPE is required, but social workers should wash hands before and after a visit and follow social distancing guidelines (Department for Education, 2020b) or maintain a distance of 2 metres 'where possible' and carry out a risk assessment if it is not (Department for Education, 2020c). It is stated that: '[U]ltimately, where staff consider there is a risk to themselves or the individuals they are caring for, they should wear a fluid repellent surgical mask with or without eye protection, as determined by the individual staff member and in line with Public Health England guidance' (Department for Education, 2020b). These recommendations and caveats provide considerable scope for varied local implementation. Our data clearly suggest that it is possible for local authorities and managers to interpret this PPE guidance and assess the risk to social workers in significantly different ways.

Social workers in some areas were initially encouraged to carry soap and ask family members if they could wash their hands on arrival and before departing their houses. In many areas at the beginning of social distancing there was either none or not enough hand sanitiser and employers in some areas asked social workers to get their own. The approach in some offices is for the supply of hand sanitiser to be kept in a big container in the office, from which social workers have to refill their own small containers. This is regarded by some as a wasted journey that adds to the risk of exposure to COVID-19. Some remark ruefully that the tiny bottles of sanitizer they were eventually issued with reflects the low social status and value of social workers.

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The availability of PPE still varies. Some social workers have access to a good supply of masks, aprons and gloves, while others in our sample were provided with just one PPE kit for emergency situations only and had purchased their own gloves. Our findings suggest that while initial issues with hand sanitiser shortages have largely been addressed, over two months on from the beginning of lockdown, some social workers are still very concerned about the limited quantity of PPE that is available to them and messages about its use. Even in some areas where PPE supplies were judged to be adequate, there is confusion over its proper use when no COVID-19 symptoms are present and concerns that supplies might not be sufficient over time. In some areas, social workers are encouraged to use what makes them feel safe, some staff are being told they need their manager's permission not to wear PPE, while in other areas social workers need a manager's permission to wear PPE.

A vivid recent example is a social worker who was told that the agency's policy had changed to where if there were no known symptoms of the virus staff should only wear PPE if the family requested it. Within a day of being told this, the social worker had to go into a home and remove a one year old child by carrying them out to her car and taking them to the foster carers, while her colleague did the same with an older sibling. This distraught mother had no choice with respect to the COVID-19 risk to herself or her children and the social worker was disturbed by having to break social distancing rules without wearing PPE. Yet other social workers in the same local authority told us they were still wearing PPE when going into homes, with the support of managers. Different interpretations of PPE policy can be made not just between regions but within them.

In practice, PPE is used by children's social care workers in a variety of ways. Some wear a mask, gloves and apron throughout the visit. Some start the visit by wearing PPE and then take some, or all, of it off part-way through (usually the mask), especially when engaging with children. It is quite common for the gloves only to be worn, while some don't wear any PPE at all. On occasion goggles or face shields are worn, and a minority of workers have used full body suits.

Decisions to wear or not to wear PPE are influenced by local policies and social workers' understandings of its availability. If it is scarce, they have to take more risks, whether they want to or not. There has also been an element of not wanting to use up scarce supplies of PPE so that it is available for council staff who work in care homes where so many elderly residents have died from COVID-19. Social workers generally require little persuasion not to use PPE because they dislike wearing it so much, especially the mask, regarding it as a barrier to communication and relationships with children. As one exemplifies it: "wearing masks … interrupts those kind of key social work skills and things that we just use and do". Social workers are deeply uncomfortable if they are unable to see children and families in person and are straining at the leash to do so. They also dislike masks because of their experiences of scaring children by wearing them. Some workers also resist wearing the gloves, apron and mask because they feel this conveys a message that they regard the children and young people as contaminating. This is balanced by some families who are anxious about social workers spreading COVID-19 being reassured by them wearing PPE.

The risk of spreading the virus is potentially increased by entering multiple homes without changing or covering clothes. Management advice to social workers in some areas has included to go home and change clothes between visits. However, many social workers regard this as impractical since they often visit families who live too far from their home to make it possible to go back there and then go out again. Social workers then end up, as one put it, doing "back-to-back-to-back" visits. Social workers sometimes try to manage the risk introduced by entering multiple homes by visiting the most at-risk families first thing, such as where women are pregnant. On the other hand, as one social worker explained: "some of our families have been saying no we don't have symptoms but we don't want you coming in the house because I know how many other families you're seeing and I don't know what you're going to bring in".

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There is also increasing concern about the greater risk COVID-19 represents for black and minority ethic families and workers. Some practitioners who are white British have critically reflected on their power and the risks arising from their white privilege and the fact that they have visited black families while not wearing PPE. As one put it, "I suddenly thought, you know, maybe I should be asking the family more. You know, are you wanting me to wear it?".

Social workers are also worried about the risk of infecting their own families, often minimising the risk to themselves but expressing anxiety about their children or partners. This is typified by a social worker who was doing a lot of in person visits:

> **I do worry driving home in my clothes, wondering what I am carrying. … [a colleague] and me removed 2 children and they sat in my own children's car seats. You couldn't get closer to my family, I'd probably do it again … I had the gloves on, one was 4 months the other 3 yrs and had to be lifted into the car. … I work [from home] in the bedroom because there is nowhere else and I work on my bed, so my writing pad that I've had on visits and my pen are put onto the bed and my bag which has been into 8 families. … I've got 3 children and I worry about it because the youngest is at nursery and the older two at school, … we are potentially super spreaders.**

This exemplifies the risk taking and selflessness that our findings show is at the heart of how social workers and family support workers are endeavouring to relate to children in person and keep them safe. But as the worker is only too painfully aware, it brings with it the risk of infecting others. What is striking is the professionalism and commitment of social workers and family support workers to having close, face-to-face, hands-on relationships with children and families, even at great risk to themselves and their own families. The following quote typifies the value-base many have articulated:

> **Children being safe is as important as Covid, I can't not go into houses, I can't not see children on their own. That is the, you know, that can't stop because of Covid. That still just like feels so crucial and that is taking more risk probably than lots of other people, but we don't have a choice at this point.**

Selflessness, public accountability and leadership

Public service in the UK is guided by seven principles of public life: selflessness, integrity, objectivity, accountability, openness, honesty, leadership (Nolan Committee, 1995). As ethical public servants, during the COVID-19 pandemic social workers are regularly choosing to act with selflessness and integrity to help vulnerable children and families. At the same time however, many feel they don't have a choice. We suggest that social worker's choices and decision-making go well beyond their professional values and are deeply influenced by the circumstances they are being placed in and the systemic pressures that frame their choice and that push them into taking particular actions, including significant risks with their own health and that of their own families and the children and families they visit. While some social workers in our study are less worried than others, many are extremely anxious about the risks to which they are exposing themselves and their own families.

Our emerging findings suggest that decisions about whether or not to conduct in person visits, enter homes and then wear PPE are influenced by the interaction between:

- Professional values
- Understanding the complexity of home visits and workers' and families' safety concerns, needs and well-being
- Government guidance and how it is interpreted
- Availability of PPE
- Standards of IT provision and smart phones for staff
- IT provision for families

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- Skill and confidence levels using virtual communication
- Leadership and management culture, including openness to trying new things
- Preparing for Ofsted inspection and anxiety about organisational failure and blame

Through the interactions between these nine variables, different cultures of safety and risk taking have emerged in different places. For instance, a combination of poor availability of PPE, poor standards of IT provision and smart phones for staff and for families and limited skill development in using virtual communication pushes staff into doing more face-to-face visiting and to take greater risks. In terms of leadership, accountability, management culture and inspection, further pressure arises if the organisational culture places a very high emphasis on performance management, audit and insists that statutory visits to children are done face to face and within timescales and extensively written up, even within a global pandemic. As one social worker put it:

> **And I don't think it helps because at the moment we've got Ofsted lingering and kind of in the background. And it's just additional pressure. … and then the pressure from management just explodes… [which] really does make you feel you are just kind of failing at things.**

While Ofsted have made it clear that inspection visits are currently suspended, the disruption to normal practices caused by the pandemic can increase anxiety in anticipation of an inspection visit. Leaders and managers at all levels of the system have clearly put huge efforts and care into redesigning services to meet the unique challenges of COVID-19 and in thinking about the welfare of their staff, as well as children and families. The pandemic has led social workers to be innovative and creative in several ways in how they work with children and families, both virtually and in person, as we will show in more detail in future research briefings. Yet, not surprisingly, individuals and systems are experiencing extremely high levels of anxiety for their own safety and that of children and families. Managing this anxiety is being made more difficult by staff having to work from home and missing the informal support of colleagues at the next desk, in the corridor or the office kitchen. This further increases the risks of staff burnout.

We have heard a great deal about how incredibly hard operational managers are working to provide support that tries to make up for workers not being alongside one another in the office. Viewed systemically, however, social workers need to be protected from how their professional ethics may drive them to take excessive risks in being with children. Managers need to be protected from colluding with their staff's risk taking and even pushing it because of the drive to ensure compliance with procedures and the institutional logic that requires them to protect the organisation from judgements of failure and public criticism.

As Professor Mark Philp, Chair of the Research Advisory Board for the Committee on Standards in Public Life has observed, applying the seven principles of public service - selflessness, integrity, objectivity, accountability, openness, honesty, leadership - in this time of crisis is extremely complex. Many people have paid the ultimate price for doing their job with absolute integrity, while setting aside their own interests and welfare so that they can help those who depend upon them. What, he asks, does the principle of selflessness ask of social care workers and what it is reasonable to ask of public servants? (Philp, 2020). This is an immensely relevant and important question for child protection workers.

Philp suggests answers should be guided by three questions:

- 'What should those leading these services be saying to their staff?
- What provision and protection should be regarded as a minimally acceptable kit for those in such roles?
- What message those responsible for these services should be conveying to the public and to their staff in relation to what it is reasonable and fair for people to expect of those providing such services, and what it is reasonable for those doing so to expect of themselves?'

On the basis of the very early findings from this research, we suggest the following answers for social care work and social distancing with children where there are child protection concerns.

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Social work staff need to be told that they do not have to take any personal risks they do not feel comfortable with. We are not saying that this is not happening, however a range of systemic factors can reduce the choice practitioners feel they have and are realistically given. Our findings support the calls for recognition of the high risks social workers are exposed to on home visits (BASW, 2020a and 2020b) and the need for the barriers to social distancing, the complexity of home visiting and risks of asymptomatic spreading of the virus to be reflected in guidance.

Staff doing visits inside family homes need to be provided with full PPE and advised to wear it. Other creative ways of seeing children, like in gardens, on walks, and on virtual visits, need to continue as long as social distancing is in force. Investing in IT and smart phones is essential to providing more safety through the option of doing virtual home visits. As we write this (mid-June 2020), some local authorities have eased some COVID-19 visiting restrictions quicker than others so that all children

and families are seen face to face, rather than some being seen on video calls. It is vital that the factors influencing such decisions and policies locally are based on critical awareness of the effects of systemic influences from the interaction of the nine variables identified above and the cultures of safety and risk taking that have emerged during the pandemic.

Social work leaders in local authorities and Ofsted and managers at all levels need to address organisational anxieties by constantly being clear with frontline staff that how their practice and record keeping is evaluated will take full account of the constraints placed on their work by Covid-19 and social distancing. The message needs to be that the complexity and risks of the work are fully appreciated and that keeping children and families safe, including from COVID-19, requires that the emotional as well as physical well-being of frontline

workers and managers and leaders receive thoughtful attention in supervision and other forms of organisational support.

Child protection during social distancing raises complex practical and moral issues and dilemmas. Children need protection. Vulnerable parents need support. And children's social care workers have the right to as much physical safety from COVID-19 for themselves and their loved ones as possible. Social workers and family support workers also need to know that at a time when they can't get as close to children and families in their practice as they normally would, that the public will recognise their achievements and appreciate their hard work, courage and skill and the extraordinary risks they are taking every day.

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