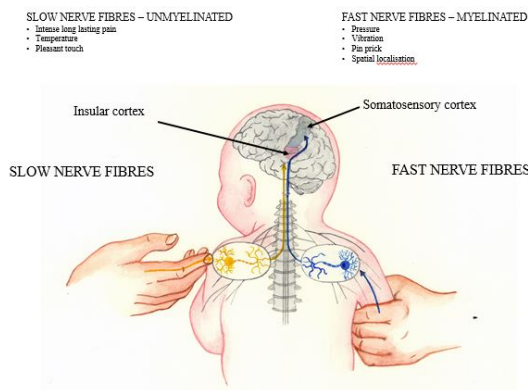




A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP ON A FIT AND HEALTHY CHILDHOOD

THE TWO SIDES OF TOUCH



WELLBEING AND NURTURE: PHYSICAL AND EMOTIONAL SECURITY IN CHILDHOOD

Please note that this is not an official publication of the House of Commons or the House of Lords. It has not been approved by the House or its Committees. All-party groups are informal groups of members of both Houses with a common interest in particular issues. The views expressed in this Report are those of the Group but not necessarily the views of each individual Group Officer or each contributor. This Report seeks to influence the views of Parliament and the performance of Government to better address issues relating to the Wellbeing and Nurture of Children.

We thank Liverpool John Moores University for the financial support that made this Report possible and wish to make it clear that Liverpool John Moores University neither requested nor received approval of its contents.

This Report was prepared by a Working Group of the All-Party Parliamentary Group on a Fit and Healthy Childhood and we are grateful for the contribution of:

HELEN CLARK	Chair of the Working Group
PHIL ROYAL	APPG Secretariat
HELEN WEST	APPG Secretariat
PROF. FRANCIS MCGLONE	Liverpool John Moores University
ASSOC PROF. SUSANNAH WALKER	Liverpool John Moores University
SHAUNNA LYDIA DEVINE	Liverpool John Moores University
JEAN BARLOW	Educational Consultant
DR DEBORAH ALBON	University of Roehampton
DR PETER ELFER	University of Roehampton
DR AMANDA NORMAN	University of Winchester
DR ARIC SIGMAN	Consultant
CLAIRE GRAHAM	South Tyneside Lifestyle Choices
CATHERINE HUTCHINSON	London Borough of Waltham Forest
DR GILLIAN HARRIS	The Infant & Toddler Forum
LUCY UPTON	The Infant & Toddler Forum
JEFF THOMAS	Play Therapy UK
MONIKA JEPHCOTT	Play Therapy UK
DR EMMA WHEWELL	University of Northampton
DR EUNICE LUMSDEN	University of Northampton
EDWINA REVELL	The Early Start Group
ANNA HODGSON	Clear Sky Children's Charity
KATHRYN SALT MBE	Emotional Education Academic
PAULA LOCHRIE	Oxfordshire County Council
PROF. FRASER BROWN	Leeds Beckett University
DR ALISON MURRAY	University of Roehampton
DR PAMELA MURRAY	University of Worcester
MARY LUBRANO	Association of Play Industries
KATE DAY	The National Counselling Society
JESSICA GRIBBLE	KRD Training and Consultancy

THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this Report is a sub-group of the All-Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the APPG is to promote evidence-based discussion and produce reports on all aspects of childhood health and wellbeing including obesity; to inform policy decisions and public debate relating to childhood; and to enable communication between interested parties and relevant parliamentarians. Group details are recorded on the Parliamentary website at:

<https://publications.parliament.uk/pa/cm/cmallparty/190911/fit-and-healthy-childhood.htm>

The Working Group is chaired by Helen Clark, a member of the APPG secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the previous page.

The Report is divided into themed subject chapters with recommendations that we hope will influence active Government policy.

The Officers of the APPG are:

CHAIR

Steve McCabe MP

CO CHAIR

Baroness (Floella) Benjamin OBE

VICE CHAIRS

Diana Johnson MP, Lord McColl of Dulwich, Julie Elliott MP, Adam Holloway MP.

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WELLBEING AND NURTURE: PHYSICAL AND EMOTIONAL SECURITY IN CHILDHOOD

A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP
ON A FIT AND HEALTHY CHILDHOOD

INTRODUCTION

While there is increasing concern about developing and reinforcing children's physical and emotional security, researchers have been busy working out the actual mechanics, even at the cellular level, of how this can be achieved. This report will provide a concise update on what is known about optimising children's wellbeing and security in childhood and far beyond.

'As human primates, we are wired for touch, whether we like to or not' says Francis McGlone, a professor of neuroscience at Liverpool John Moores University..... 'Brains are good' he says, 'If they're lacking something, they'll tell you to take action.'....With the lack of social touch mandated by Covid-19, your brain may well be telling you that you desperately need a hug':

<https://www.independent.co.uk/life-style/touch-skin-hunger-hugs-coronavirus-lockdown-isolation-ctactile-afferent-nerve-a9501676.html>

'Evidence from previous pandemic studies shows that children isolated or quarantined are more likely to develop acute stress disorder, attachment disorder and grief.... The longer this continues, the more profound the difficulties will be and the greater the cost and challenge will be to overcome them':

<https://www.theguardian.com/commentisfree/2020/jun/20/childrens-mental-health-will-suffer-irreparably-if-schools-dont-reopen-soon>

The experience of nurturing touch for infants is now known to be an essential requirement for social brain development and the subsequent development of secure attachment.

When the All-Party Group on A Fit and Healthy Childhood decided to contribute to the ever-increasing public discourse about child wellbeing and nurture by making it the subject of our seventeenth report, we did so against a society backdrop that even the most positive of commentators would describe as 'fractured'.

The trend towards individualism as opposed to what is understood by 'community' has been thrown increasingly into sharp relief in the early years of the 21st century, but the fall-out from the 1989 toppling of Romanian dictator Nicolae Ceausescu's regime and

the exposure to world opprobrium of his infamous Romanian orphanages are equally relevant to a 21st century understanding of child development and wellbeing.

The permanent damage to the adults that these neglected, socially starved children have become is the subject of recent findings in the journal 'Proceedings of the National Academy of Sciences': <https://doi.org/10.1073/pnas.1911264116> and ongoing research in the UK and Sweden shows that much mental illness experienced by children and young people today has its genesis in the early days and months of a new life.

Basic human contact is just as central to a child's development as nutrition. Emergent neuroscientific evidence shows that nurturing touch is essential to foster the physical and emotional security that every child needs in order to thrive.

The unheralded and cataclysmic effect of the Covid-19 pandemic makes these arguments relevant in a way that we could never have envisaged originally. This report has unexpectedly been written in a new and unwelcome world in which:

'Milestone birthdays are being celebrated over video calls; elderly people are talking to neighbours through windows and those who live alone are going without any human touch at all, as they obey the government guidelines to stay at home and keep 2m (6ft) apart from others': <https://www.bbc.co.uk/news/uk-52279411>

'At the still point of the turning world... there the dance is ...and do not call it fixity' (TS Eliot, 'Four Quartets'). Pandemics don't stand still. Requirements for social distancing will be removed; there will be a medical 'answer' to Covid-19.

But here we argue that things cannot go on as before. The experience of Covid-19 has taught us that:

'What's happening now is that, for the first time in evolution, people aren't able to experience this thing we usually take for granted. You don't miss something until it's gone – but when touch is removed, people will notice that there's something missing, even if they can't pin down what it is.' (Professor Francis McGlone: 'The Independent' as above).

In examining the ways in which children grow and develop, we can learn from that because their physical and emotional wellbeing and therefore that of our future society will depend on it.

This report represents what we have learned and we hope that it will contribute in a small way to the making of the brave new 'post-Covid' world.

SUMMARY OF RECOMMENDATIONS

1. BABY/INFANT CARE: A HISTORICAL PERSPECTIVE AND SUMMARY OF PRACTICE:

No recommendations given.

2. THE PRESENT SITUATION IN THE DEVOLVED UK WITH ILLUSTRATIVE EXAMPLES OF GOOD PRACTICE AND SHORTCOMINGS:

- 2.1 All therapeutic practitioners (and those who work therapeutically with children in other contexts) to be registered by a Government-Approved Professional Standards Accredited Register
- 2.2 All staff involved in the delivery of support with infant feeding to have had access to accredited professional training in responsive feeding. This should include midwifery assistants, health visiting assistants, peer-to-peer breast feeding support groups and public organisations or individuals offering support who are unlikely to have had access to training in responsive feeding education programmes
- 2.3 Standardised antenatal education surrounding feeding to be made universally available; thereby including lower economic group families, where there are also known to be lower rates of breast feeding and higher rates of childhood obesity
- 2.4 Standardised and compulsory initial and ongoing training to be provided for all school staff in children's mental and emotional health needs
- 2.5 Policy-making initiatives to consider ways in which mother/infant time contact can be maximised and seen as a developmental priority zone.

3. C TACTILE-AFFERENT (CT) RESEARCH FINDINGS IN THE UK AND ELSEWHERE WITH IMPLICATIONS FOR THE CARE OF BABIES AND INFANTS:

- 3.1 Positive touch work to become an established part of the school curriculum, possibly as a component of PSHE.

4. THE PRACTICE AND TRAINING NEEDS OF THE WORKFORCE IN INTERACTION WITH PARENTS/CARERS TO INCLUDE:

- NHS
- EARLY YEARS AND EDUCATION PROFESSIONALS
- IMPLICATIONS FOR THE CONTENT AND TEACHING OF THE NATIONAL CURRICULUM IN SCHOOLS:

- 4.1 Training in nutrition to be statutory for all professionals involved in advising parents/caregivers on infant feeding. This should be embedded within Continual Professional Development (CPD)

- 4.2 A Government-commissioned wide-scale review of the Early Years Profession to include training, staff turn-over, remuneration, career progression and public funding as an initial step in a strategy designed to enable the retention of the most skilled and talented individuals
- 4.3 'Professional reflection' time, to include attention to babies', young children's and adults' emotional experience at nursery, to be a statutory component of EYP professional support
- 4.4 Staff teaching PHSE to receive subject-specific training; to be experienced and well-trained in the subject content and pedagogies available to them
- 4.5 Initial Teacher Education (ITE) and Early Years education courses to include subject-specific PHSE/personal development education training including early childhood development, trauma and attachment
- 4.6 PHSE should be taught in regularly timetabled lessons to allow for learning to develop longitudinally with due regard to the needs of children and community. The lessons should build cumulatively in a 'spiral curriculum' approach where core elements are revisited and consolidated
- 4.7 The curriculum should address appropriately sensitive issues including sexual exploitation, mental health, domestic violence and substance abuse.

5. THE CONTRIBUTION OF CT FINDINGS AND TOUCH THERAPIES TO THE WELLBEING OF CHILDREN WHO HAVE ENCOUNTERED ADVERSITY

THIS MAY INCLUDE:

- ADVERSE CHILDHOOD EXPERIENCES
- DISABILITY
- FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES:

- 5.1 Department for Education through Ofsted to compile and cascade a compendium of best practice models and evaluations of affective touch strategies for classroom use
- 5.2 Re-modelling of training systems for officials and carers working with children in care to better educate them in appropriate touch and thus improve their practice
- 5.3 To encourage appropriate ideals and aims and strategy surrounding touch and social development in caring for marginalised groups of children.

6. INTERNATIONAL PRACTICE AND EXAMPLES:

- 6.1 The four Children's Commissioners to be involved in drawing up a set of agreed UK indicators for Emotional Health and Wellbeing to be incorporated into all statutory child developmental health assessment programmes

- 6.2 Emotional Health and Wellbeing to be incorporated into Initial Training and Continual Professional Development for all health and education professionals involved in the provision of care and advice to children and their parents/carers.

7. SOME ILLUSTRATIVE CASE STUDIES:

No recommendations given.

8. THE EFFECT OF SOCIAL ISOLATION ON MENTAL HEALTH AND WELLBEING:

- 8.1 All children and young people isolated from mainstream education should continue to have contact with mental health services and access to school or outreach counselling services to assess their wellbeing and help them to develop continuing social connections
- 8.2 Ensure that Sure Start Centres are integral to a new social isolation reduction strategy because they have the capacity to offer early intervention in a variety of locations (not exclusively more built-up areas)
- 8.3 Government to provide funding for emergency accommodation and any other resources needed to appropriately protect those who are at risk from domestic abuse
- 8.4 An immediate call to combat the adverse impact on the mental health of children and young people of social isolation beyond the pandemic. Services offering face to face contact and related activities should be commissioned especially in rural communities
- 8.5 Services offering low cost or free and safe places for young people to congregate would be of benefit to key 'at risk' groups. Councils should examine the feasibility of converting waste land into parks and allotments to be used freely by those without gardens or play areas
- 8.6 'Pop up' mental health centres to be created to help 'hard to reach' communities inside local amenities such as village halls, schools and churches. A statutory School-Based Counselling Strategy (SBCS) to be set up, similar to that enacted by the Welsh Government in 2010. This would alleviate the burden on Child and Adolescent Mental Health Services (CAMHS). In-school counselling could help to reduce the number of school exclusions and as a consequence, the number of children experiencing isolation
- 8.7 The Government to fund more specific research to discover appropriate support mechanisms for children and young people with refugee status, ethnic minority groups, disabled children, children from low income families and children living with physical and mental health conditions.

9. A CHILD'S EYE-VIEW OF THE LOCKDOWN:

No recommendations given.

10. THE WAY FORWARD FOR CHILD MENTAL AND PHYSICAL SECURITY AND WELLBEING:

- 10.1 Approaches to create a classroom 'to fit all' should be considered if appropriate
- 10.2 Research and pilot studies should be conducted on the efficacy of replacing traditional sanctions in school with mindfulness and wellbeing interventions
- 10.3 The appropriateness and adequacy of sex and relationships programmes within school should be a matter of continual review with a view to update as circumstances require
- 10.4 Post-pandemic planning should reflect a renewed recognition of the importance of providing free, outdoor space and facilities for ALL children to play
- 10.5 The funding of public playgrounds should in particular be a priority as they fulfil a unique role in improving children's movement, social interaction, fitness and physical and mental health
- 10.6 Embed training and education in the strategic use of curricular approaches (inclusive of teaching models, styles and strategies) for Early Years, Primary and Secondary teachers in appropriate social touch in order to enable children to give and receive this beneficial practice
- 10.7 Adopt a more holistic approach to Ofsted Inspection and educate Ofsted Inspectors in ways in which to better support school initiatives in enabling children to participate in the affective benefit of appropriate socialised touch
- 10.8 Policy-making initiatives should consider ways in which mother/infant time and physical contact can be maximised and seen as a developmental priority.

1. BABY/INFANT CARE: A HISTORICAL PERSPECTIVE AND SUMMARY OF PRACTICE

In 2018, The World Health Organisation defined Nurturing Care as:

'A stable environment created by parents and other caregivers that ensures children's good health and nutrition, protects them from threats, and gives young children opportunities for early learning, through interactions that are emotionally supportive and responsive.' WHO, 'Nurturing care for early childhood; a global framework for action and results'.

The importance of the early years in human development is not new. Aristotle, writing between 335-323 BC said:

'Give me a child until he is 7 and I will show you the man.'

Yet there has been little unanimity about the optimum care of very young children.

In the 18th century, Frederick William II of Prussia (1712-86) and Jean-Jacques Rousseau (1712-78) are illustrative of diametrically opposed strands of opinion.

The impact of touch deprivation is shown in a bizarre 'experiment' by Frederick II who removed all newborn infants in the kingdom from their mothers; placing them with foster parents. He aimed to discover what language the children would speak instinctively; therefore the foster parents were ordered to feed and change the babies but not to speak to them or fondle them. The infants developed no language at all; all died and the reason given was that this was due to a lack of 'petting.' (Montague A, 1986, 'Touching: The human significance of the skin'. New York, Harper & Row).

Rousseau said that a mother should be the primary carer for her infant:

'Does not the child need a mother's care as much as her milk? Other women or even other animals may give him the milk she denies him, but there is no substitute for a mother's love': <https://oll.libertyfund.org/titles/rousseau-emile-or-education>

Wet nurses and 'help' outside the home were customary, but to Rousseau, the absence of touch between infant and parent held the key to a resultant relationship characterised by physical and emotional distance.

Frederick William's experiment finds a 20th century echo in the arguments of John Broadus Watson (1878-1958) who interpreted Freudian theory by stigmatising a mother's need to touch her infant as self indulgent and sexually derived; therefore best avoided. Children were to be treated as 'young adults.' In similar style, Frederic

Truby King (1858-1938) advocated the adoption of rigid regimes that were predominantly disciplined and detached in order to 'harden and strengthen' infants.

By contrast, Benjamin Spock (1903-1998) and John Bowlby (1907-1990) had more in common with Rousseau.

Spock stressed the importance of practice that was affectionate, respectful of parental instinct and treated babies as distinct from adults. Bowlby's attachment theory acknowledged that infants thrive and prosper when their physical and emotional needs are supplied by a significant primary carer. Douglas Winnicott (1896-1971) championed the warmth of the mothering approach and regarded the baby and primary carer as indivisible.

Spitz' work was based on findings from German foundling homes and dealt with the importance of nurturing touch in infancy. The children's basic needs were met, but the homes recorded high mortality rates in the first year of life. What the children lacked was physical touch. (Spitz RA, 1945, 'Hospitalism. The Psychoanalytic Study of the Child', Volume 1, RS Eissler, ed. New York: International Universities Press, pp.53-73; Spitz RA, 1946, 'Hospitalism: A Follow-up Report'. The Psychoanalytic Study of the Child, Volume 11, RS Eissler, ed. New York; International Universities Press, pp 113-117).

'Kangaroo Care' (Rey E, Martinez H, 'Rational management of the premature infant [Manejo racional del nino prematuro] In Curso de medicina fetal y neonatal.' Bogota, Colombia. 1983: 137-51) is an alternative approach to familiar care patterns for low birth-weight infants and is seen to exemplify the benefits of affiliative touch.

Premature babies are customarily isolated in incubators and therefore deprived of much of the tactile stimulation they would otherwise receive in utero. However, 15 minutes of gentle touch stimulation three times per day for 10 days led to superior growth and development, showing an average 50% greater weight gain per day than 'non-touched' groups with the infants discharged six days earlier.

The stimulated infants were awake and active for longer periods and exhibited more mature habituation, orientation and motor and range-of-state behaviours on the Brazelton Neonatal Behaviour Assessment Scale. Positive effects were retained when re-testing occurred at eight and 12 months.

Kangaroo care in wider contexts has shown that the 'skin to skin' contact between parent and infant comforts and soothes infants and encourages parents to persevere with breast feeding and bonding experiences (DiMenna L, 2006, 'Consideration for implementation of a neonatal Kangaroo care protocol', Neonatal Network. 25(6)405-412).

The sensory experience of 'skin to skin' is considered to be an important component of a close relationship and thriving infant (Norman A, 2019, 'From Conception to Two. Development, Policy and Practice', London, Routledge).

The history of public policy in the area of infant/baby care is a complex (sometimes contradictory) mix of perceptions and economic drivers.

The view that the best care for young children is always in the home provided by the birth mother is deeply ingrained, but care has long been undertaken by other individuals including family members such as grandparents. In addition, affluent families have traditionally been accustomed to employ nannies and au pairs whose workplace is the family home. This largely unregulated option has been utilised for centuries by middle and upper-class families (Adamson E and Brennan D, 2017, 'Return of the Nanny: Public Policy towards In-home Childcare in the UK, Canada and Australia', *Social Policy and Administration*, 51(7):1386-1405).

Childminding generally takes place in the childminder's home and serves a wider demographic. It is now regulated and subject to Ofsted inspection but reports suggest that the balance in England is weighted towards business support for childminders rather than the promotion of superior childcare practice (Lewis J and West A, 2017, 'Early Childhood Education and Care in England under Austerity: Continuity or Change in Political Ideas, Policy Goals, Availability, Affordability and Quality in a Childcare Market?', *Journal of Social Policy*, 46(2): 331-318).

The development of UK childcare outside the home has been at best, piecemeal.

Two 20th century World Wars saw a proportionate increase in external childcare places as women were enthusiastically enlisted in support of the economy by filling the jobs of conscripted men. However, placement quality was variable (Moss P and Penn H, 2003, 'Transforming Nursery Education', London: Sage) and Government support for the nurseries largely disappeared after World War Two; linking childcare policy as much with economic imperative as with societal assumption about 'a woman's place' (Yeandle S, 1984, 'Women's Working Lives', London; Tavistock).

In 1967, the Plowden Report recommended the extension of nursery education to all 3-5-year-olds whose parents wished to access it ('Children and Their Primary Schools', Central Advisory Council on Education, 1967) but local authority day nurseries offering full time day-care (also available to younger children) were deemed appropriate only when the mother was unable to supply total care herself.

For the next four decades, full-day childcare was generally only considered to be satisfactory when the child's home environment most certainly was not; thus stigmatising the provision with connotations of 'last' rather than 'first' choice service.

The Ten Year Childcare Strategy (HMT, DfES (Department for Education and Skills), DWP and DTI (Department of Trade and Industry), 2004, 'Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare', London: The Stationery Office) was designed to re-position the childcare agenda to support parental return (usually that of a mother) to the workforce.

The quality and quantity of childcare available outside the home at an affordable price was once more in the limelight but the initiative barely addressed the needs of the very youngest children.

'Birth to Three Matters', DES (Department for Education and Skills), 2002, London DfES Publications) aimed to encompass the primacy of care and relationships whilst also supporting better quality early childhood practice for the youngest age group. In England this merged with the Curriculum Guidance for the Foundation Stage to become the 'Early Years Foundation Stage' spanning birth to five years and including a set of 'early learning' goals to be achieved by the end of the stage (Department for Education 2-17 'Statutory Framework for the Early Years Foundation Stage): <https://www.gov.uk/government/publications/early-years-foundation-stage-framework--2>

Each of the UK nations has produced an Early Years' good practice framework document with some differences in content that are likely to remain in the immediate future.

The Early Years Foundation Stage is the statutory framework for Ofsted Inspection in early childhood settings and its seeming shift to more formalised 'teaching' for the very youngest children has prompted concern.

Whilst nobody wants children to be unprepared for formal schooling, serious reservations have been expressed about compelling early years children to follow an increasingly formalised curriculum rather than a schedule promoting ideas long-cherished by Early Child Education specialists such as the importance of wellbeing, the primacy of relationships and a sensitive appreciation of spontaneous play (Albon D, 2014, 'Play, Playfulness and Young Children's Well-Being' in J Manning-Morton (Ed), 'Exploring Well-Being in the Early Years', Maidenhead: OUP).

In 2006, new publicly funded places for two-year-olds were seen as welcome support for 'disadvantaged' families and children but did nothing to stem disquiet about the nature of provision.

Reservations still persist (in particular where provision is school-based) about the possibility that two-year-olds will be expected to conform to a curriculum designed for

much older children. The impulse to 'hot-house' attainment goals (in order to 'compensate' for perceived deficiencies in a child's home upbringing) is seen by critics as 'too much too soon': <https://www.savechildhood.net/vision-and-values.html>

The public policy challenge is therefore to provide ECEC for the very youngest children in a way that fulfils their need for security, continuity of relationships, attachment and high quality play, whilst also meeting the economic imperative for families to work; safe in the knowledge that that the children are well-cared for.

Covid-19 has highlighted the precarious situation of both nurseries and parents.

Families have been asked to pay nurseries a full or part-time placement fee for childcare that they have subsequently been unable to take up because of the rules on social distancing. There is additionally a very real possibility that nurseries may be forced to close following the considerable financial cost of the pandemic and U-Turn in Government commitment to provide furlough funding (Gaunt C, 2020, 'Thousands sign petition against Government cut to furlough funding for nurseries', Nursery World, 20.4.20).

Neil Leitch, Chief Executive of the Early Years Alliance, has warned that 'multiple' providers could go out of business. The advent of Covid-19, hard on the heels of a decade of austerity has 'put a brake on progress and returned the early years to its former lowly status': <https://www.theguardian.com/commentisfree/2020/jun/01/the-guardian-view-on-nurseries-a-case-of-neglect>

2. THE PRESENT SITUATION IN THE DEVOLVED UK WITH ILLUSTRATIVE EXAMPLES OF GOOD PRACTICE AND SHORTCOMINGS

'The bodily felt awareness furnishes the drive towards relating. Through his felt body the child becomes aware of himself. This bodily felt awareness carries the consciousness of the self', (Viola Brody PHD, 'The Dialogue of Touch: Developmental Play Therapy', 1997).

Viola Brody's work is emblematic of a childcare theory in which caring touch is central to the physical, psychological and emotional growth of a child. Modern research findings (Chapter three) validate this perspective; here some current practice is described and discussed.

First it is important to emphasise the primacy of safeguarding and that the use of touch can be misunderstood by parents and professionals.

In 2018, Play Therapy UK published a revised set of good practice competences for therapists working with children. They are listed below in logical arrangement:

<https://playtherapy.org.uk>

1. Communicating clearly and accurately the value of touch as essential to human wellbeing
2. Developing self-awareness related to touch
3. Avoiding the misuse of touch
4. Using touch appropriately in therapy practice
5. Making sound decisions involving the use of touch in therapy
6. Obtaining consent for the use of touch
7. Keeping adequate records about the occurrence of touch
8. Applying ethical principles to the occurrence of touch
9. Handling non-clinical or unanticipated touch
10. Using touch with children who have experienced trauma or abuse
11. Using touch in group work
12. Using physical restraint.

Regrettably, many therapeutic practitioners (or those who work with children in other contexts) are not registered through a Government-approved Professional Standards Authority Accredited Register; leading to some unsafe and ineffective practice.

The Touch Research Institute (TRI) at the University Of Miami, School Of Medicine has conducted a series of studies on the effects of massage on infants and children. Massage therapy impacts the psychological and physiological functions of the body by reducing anxiety, lowering stress hormones, enhancing mood, decreasing pain and improving immune response:

<https://www.massagetherapy.com/articles/child-development>

From the mid to late 1990s, the UK saw a growth in the number of parent-accessed baby massage, yoga and sensory groups. Group settings facilitate babies socialising with others of their age group from a very young age.

Vicky Thompson; owner and instructor at KalmBaby, South Tyneside says:

'Our sessions show the correct use of massage to develop circulatory and breathing rhythms, introduce easy tummy time for older babies, develop muscle strength and flexibility whilst relieving some common ailments. Parents learn the correct oils to use for massage and learn easy massage sequences including singing, playing, kissing and talking. It is a lovely bonding experience for parent and infant.'

Perceived health benefits include baby weight gain, increase in bone density in pre-term infants and help in alleviating sleeplessness, colic, constipation, digestion problems, stiffness, floppiness and developmental delay. Further studies have explored how baby massage can enable fathers to bond with their infants in the early postpartum period which in turn lessens parent-related stress (Norman A, 2019, 'From Conception to Two. Development, Policy and Practice', London, Routledge).

Other ways to promote attachment include 'story massage'; a combination of positive touch and storytelling in which gentle touch images are 'drawn' on an infant or child's back whilst vocalising guided imagery (Courtney J and Nolan R, 2017, 'Touch in Child Counselling and Play Therapy. An Ethical and Clinical Guide', NY, Routledge).

This has been used in therapeutic and educational contexts. Children's Reflex Workshops also teach parents and carers simple techniques of feet reflex (for babies) and hand reflex (for toddlers) to promote relaxation and bonding. It also supports calmness and ease, and relief and reduction of discomforting conditions in babies and toddlers. Research has shown that positive touch for children improves calmness and concentration whilst also increasing self-confidence, self-awareness and self-esteem:

<https://kidsinspire.org.uk/the-benefits-of-positive-touch/>

A study conducted in Swedish day centres aimed to evaluate the effects of massage in 4-5-year-olds who had been recorded as displaying aggressive/deviant behaviour ('How massage decreases aggression in preschool children: a long-term study', Knorrning A, Soderberg A, Austin L & Uvnas-Moberg K, 2008, Acta Paediatrica, 97, 1265-1269).

The survey involved 110 children from 9 day-care centres; none of whom had previously received massage. After six months of the programme, children with high behaviour problem scores showed significant decreasing aggression scores. This also applied to those receiving massage and/or extra attention. Staff evaluation found

that the massaged children's social problems decreased and that daily massage touch lasting 5-10 minutes could be a simple and inexpensive way to lessen aggression in pre-school children.

A further study concerned the effectiveness of peer massage in a primary school (Davies, 2010) with evaluations suggesting that the massage contributed significantly to the overall behaviour and wellbeing of the children who received it:

www.misa.org

'Kiss, cuddle and squeeze': the experiences and meaning of touch among parents of children with autism attending a Touch Therapy Programme was studied by Cullen L & Barlow J, *Journal of Child Health Care*, 2002 Sep, 6(3): 171-81.

This work analysed the experiences and meaning of touch between parents and children with autism before and after attending a Touch Therapy Programme. The sample comprised of 12 parents (1 father and 11 mothers) of children (1 female and 11 male) with autism. Parents were interviewed before and immediately after the 8-week programme.

Post-programme results suggested that the children appeared to tolerate touch and parents reported that routine tasks (eg dressing) were accomplished more easily with the children appearing generally more relaxed. Parents also reported feeling 'closer' to their children with touch therapy creating an opportunity to open a communication channel between themselves and their children:

<https://www.storymassage.co.uk/research>

Baby and infant feeding is central to ideas of the 'bodily felt awareness' highlighted by Viola Brody.

Early 20th century baby manuals encouraged rigidly 'clock-timed' patterns of breast feeding (analogous to the scheduling followed at that time in bottle feeding). Later advice advocated baby-led 'feeding on demand.'

'Responsive' feeding is usually defined as sensitive reciprocal interaction between caregiver and infant during which the caregiver responds immediately and appropriately to an infant's signs of distress. Its proponents cite a role in preventing obesity with the emphasis on touch and contact in response to crying rather than feeding in all circumstances.

The INSIGHT programme (Savage JS, Hohmann EE, Marini ME, Shelley A, Paul IM & Birch LL, 'INSIGHT responsive parenting intervention and infant feeding practices: randomized clinical trial', *International Journal of Behavioural Nutrition and Physical Activity*, 2018; vol 15, Article number:64) in the USA achieved its aim of assisting

parents to interpret their infants' crying/distress signals correctly. Feeding guidance for parents was based on highlighting contingent feeding ie only to feed in response to hunger signals and to stop feeding when the infant indicated signs of satiety.

Parents who participated in the programme had tended to use feeding as a method of soothing the infant. Feeding in order to pacify a crying infant who is not hungry can lead to overfeeding, disproportionate weight gain and a risk of obesity. Parents were therefore taught alternative soothing strategies including wrapping and holding to provide a touch-based form of nurturing and prompted to use methods which would pre-empt feeding as a first/sole response to infant crying. The key differentiation learned was to distinguish between hunger and other distress signals.

NHS.uk refers to 'responsive feeding' on the website but confuses it with 'on demand' feeding:

'Breast feeding is not only about your baby getting enough milk. Your baby feeds for comfort and reassurance too.'

Similarly NHS.uk/start4life has no website reference to the original aims of the responsive feeding programme which were to both reduce obesity and the use of food for emotional regulation.

However, there are some examples of good practice in the UK (eg Southern West Midlands Neonatal Network) embedding responsive feeding within a wider support package of 'family integrated care' (Hodges E, Johnson SL, O'Hughes S, Hopkinson JM, Butte N & Fisher J, 'Development of the Responsiveness to Child Feeding Cues Scale', *Appetite*. 2014 65:210-219).

All staff within the unit including nurses and doctors, clinical support workers, dieticians, speech and language therapists and infant feeding advisors are involved. They receive specialised training on responsive feeding and developmental care (because all have a role to support and encourage parents to care for their baby) understanding and implementing aspects such as:

- Modified demand feeding and responsive feeding
- Understanding feeding as communication – including not just approach cues but stress cues and non-feeding cues
- Positive touch
- Non-nutritive sucking
- Kangaroo care; cluster care; environment management eg noise, light.

However, consistency in the interpretation and practice of responsive feeding across UK Trusts (including method of implementation, training requirements assessment and

monitoring outcomes) is variable. Too frequently, feeding advice is given by those who remain untrained in responsive feeding and touch-based soothing and programmes which are in place do not reach out to at-risk groups, low socioeconomic groups and/or bottle-feeding caregivers.

Mother-child relationship

A mother-child relationship begins many months before birth. Foetuses recognise their mother's voice as distinct from that of others and when a pregnant mother sings a nursery rhyme, a foetus may display the rudimentary beginnings of mirroring their mother's behaviour through changes in foetal mouth movements:

'Fetuses seem to be predisposed to respond selectively to specific maternal stimuli. Such responses may play a role in the development of behavioural and emotional attunement with their mothers long before birth', (Ferrari GA et al, 2016, 'Ultrasonographic Investigation of Human Fetus Responses to Maternal Communicative and Non-communicative Stimuli', *Front Psychol.* 7:354.doi:10.3389/fpsyg.2016.00354).

A study found that children recognised their biological mother's voice with 97% accuracy compared with a 'control' voice (Abrams DA et al, 2016, 'Neural circuits underlying mothers' voice perception predict social communication abilities in children', *Proceedings of the National Academy of Sciences*, 113(22), 6295-6300) and mothers can identify their own baby by smell alone after being exposed to their newborn for only 10 minutes (Kaitz M et al, 1987, 'Mothers' recognition of their newborns by olfactory cues', *Developmental Psychobiology*, 20(6), 887-591. DOI: 10.1002/dev.420200604 and Corona R & Levy F, 2015, 'Chemical olfactory signals and parenthood in mammals', *Hormones and Behaviour*, 68, 77-90. DOI; 10.1016/j.yhbeh.2014.06.018).

Maternal touch is an important means of communication during early social exchanges. Mothers and infants can exchange perceptions, thought and feelings which promote emotional and non-emotional or informative communication. A major longitudinal UK Millennium Cohort Study of over 8,100 children concluded 'the more time mothers spend with their children the higher cognitive and non-cognitive outcomes over ages 3-7', (Bono ED et al, 2016, 'Early maternal time investment and early child outcomes', *The Economic Journal*, 126(596), F96-F135. Doi: 10.1111/eoj.12342).

Establishing and fortifying the mother/child bond should be an overriding objective and ideally, infants and young toddlers should, wherever possible, have a great deal of physical contact with their mothers.

It is important that future policy making should consider ways in which this time could be ring-fenced with the mother/infant contact time seen as a developmental priority zone.

PSHE

In 2019, Ofsted published a new framework for educational settings: 'Education inspection framework for September 2019'.

The framework contains a section on Personal Development; specifically stating that:

'The curriculum and the provider's wider work support learners to develop their character – including their resilience, confidence, and independence – and help them know how to keep physically and mentally healthy.'

Children and young people spend a significant amount of time in educational settings and these settings should be well-placed to provide support for them in every aspect of their life; in particular how to look after their mental wellbeing.

Personal, Social, Health and Economic Education (PSHE) is a school subject through which pupils are helped to be healthy and safe whilst being equipped for future aspects of life and work. From September 2020, PSHE will become a statutory requirement for all schools under the Children and Social Work Act 2017. This includes Relationship Education at key stages 1 and 2, Relationships and Sex Education (RSE) at key stages 3 and 4 and Health Education in primary and secondary phases.

Schools are expected to use PSHE to build on the statutory content already outlined in the National Curriculum, the basic school curriculum and in statutory guidance on: drug education, financial education, sex and relationship education (SRE) and the importance of physical activity and diet for a healthy lifestyle. Outside this framework, schools may tailor their PSHE programme to reflect the needs of their pupils including mental health needs.

Around one in ten children have a diagnosable mental health issue; however, only one in four obtains access to the treatment and care that they need (Young Minds, 2017, 'Wise Up. Prioritising Wellbeing in Schools'). Evidence shows that the earlier a mental health issue is identified and treated, the better the recovery process is likely to be (MHFA ENGLAND 2020):

<https://mhfaengland.org/mhfa-centre/programmes/london-schools-faq/>

As children and young people spend a lot of their time in educational settings, school staff, if trained adequately, are in a prime position to identify those who have mental health needs and to guide them to appropriate sources of help.

However, at the present time, many school staff continue to report that they feel entirely unequipped to have these conversations and are unable to discharge this important responsibility because they have no access to essential professional training and support themselves.

Recommendations:

- 2.1 All therapeutic practitioners (and those who work therapeutically with children in other contexts) to be registered by a Government-Approved Professional Standards Accredited Register**
- 2.2 All staff involved in the delivery of support with infant feeding to have had access to accredited professional training in responsive feeding. This should include midwifery assistants, health visiting assistants, peer-to-peer breast feeding support groups and public organisations or individuals offering support who are unlikely to have had access to training in responsive feeding education programmes**
- 2.3 Standardised antenatal education surrounding feeding to be made universally available; thereby including lower economic group families, where there are also known to be lower rates of breast feeding and higher rates of childhood obesity**
- 2.4 Standardised and compulsory initial and ongoing training to be provided for all school staff in children's mental and emotional health needs**
- 2.5 Policy-making initiatives to consider ways in which mother/infant time contact can be maximised and seen as a developmental priority zone.**

3. CT RESEARCH FINDINGS IN THE UK AND ELSEWHERE WITH IMPLICATIONS FOR THE CARE OF BABIES AND INFANTS

The scientific background

'Touch' is comprised of discriminatory touch and emotional touch; the latter discussed below.

The skin contains sensory receptors classically described as coding for touch, temperature, pain, itch and a fifth modality, pleasant touch (McGlone F, Wessberg J, Olausson H, 2014, 'Discriminative and affective touch: sensing and feeling', *Neuron* 82 (4); 737-755).

From around 12 weeks' gestation, touch develops in utero and is used from birth onwards to explore surrounding physical environment.

As the foundation of social bonding and key to emotional communication, it is now understood to be pivotal in shaping major functions of the developing brain (Montissor R, McGlone F, 2020, 'The body comes first. Embodied reparation and the co-creation of infant bodily-self', *Neuroscience& Biobehavioral Reviews*, 113; 77-87, ISSN 0149-7634).

The sense of touch is mediated by a population of low threshold mechanoreceptors (LTM) in the skin; connected to nerve centres that transmit signals to the brain in milliseconds. High transmission speed occurs because the nerves (A-beta afferents) are sheathed in fatty layers of myelin that enable them to send rapid electrical signals to the brain; the fast touch system.

In the late 1980s, Ake Vallbo (a Swedish neurophysiologist) discovered a population of mechanosensitive nerves in the skin that responded best to a gentle stroking touch (Vallbo A, Olausson H, Wessberg J, 1999, 'Unmyelinated afferents constitute a second system coding tactile stimuli of the human hairy skin', *Journal of neurophysiology* 81 (6); 2753-2763):

<https://doi.org/10.1152/jn.1999.81.6.2753>

Unmyelinated C-fibres definitively conduct electrical signals to the brain very slowly (in seconds) so cannot serve any purpose requiring an immediate response; the slow touch system.

Vallbo's C fibre; a C-tactile afferent, makes a vital contribution across the lifespan. CTs are distributed more densely in the skin of trunk regions, face and head and have been proposed to subserve a 'social touch system.' They respond most favourably to a gentle, stroking touch delivered at around a 3cm/sec speed at a skin-like temperature

(mimicking naturalistic nurturing behaviours of 'skin on skin;' similar to the mother-infant interaction).

CT nerves in the skin are tuned to respond to a gentle stroking touch reported as 'pleasant'. Research now indicates that inadequate CT stimulation during the early stages of an infant's life has quantifiable adverse effects on the developing brain with a corresponding negative impact on behaviours. This endures over the course of a lifetime.

Social touch mediated by CTs is a powerful force in the development of the human brain, shaping attachment, cognitive function, social reward, communication and emotional regulation from infancy throughout the lifespan. The enforced lack of it, occasioned by social distancing measures imposed in response to the Covid-19 pandemic has produced widespread reports of stress, depression, loneliness and anxiety:

'Human primates are wired for touch whether we like it or not' says Francis McGlone, a professor of neuroscience at Liverpool John Moores University:

'The nerve fibre fires up areas of the brain that connect to reward. There's a release of oxytocin, a hormone that plays a fundamental role in our social behaviour. It has an effect on our dopamine levels, which is the brain's reward system; it impacts on the release of serotonin, which is connected to our happiness and wellbeing; it has an impact on our stress system; and it helps lower our heart rate.....'

We know that this nerve has evolved over millions of years and that it's very important. What's happening now is that, for the first time in human evolution, people are not able to experience the thing we usually take for granted. You don't miss something until it's gone – but when touch is removed, people will notice that there's something missing even if they can't pin down what it is ...'

'With the lack of social touch mandated by Covid-19, your brain may well be telling you that you desperately need a hug':

<https://www.independent.co.uk/life-style/touch-skin-hunger-hugs-coronavirus-lockdown-isolation-ctactcile-afferent-nerve-a9501676.html>

Infancy

Touching is involved in over 70% of face-to-face interactions between mothers and infants.

Gentle stroking CT touch generates more smiling in infants as young as 9 months than static touch, demonstrating decreased heart rate and increased engagement in response (Jean ADL, Stack DM, Fogel A, 2009, 'A longitudinal investigation of maternal

touching across the first six months of life; age and contact effects.' *Infant Behav. Dev.*32:344-349 - PMC – PubMed).

Over longer timescales, skin to skin contact promotes weight gain, shorter hospital stays and stronger neural responses in preterm infants and has analgesic effects in healthy newborns.

Infants as young as five months use social touch to communicate their emotional state to their mothers and six month infants of mothers with depression show more self-touch; interpreted as a compensatory behaviour for reduced positive touch from their mothers. Even in the first few months of life, there is reciprocity and an active component of social touch experience that shapes social, communication and cognitive development in the months and years to come.

Infants who are deprived of touch (or avoid it) are at higher risk for sensory/emotional processing problems and the avoidance of social touch in infancy is a predictor of autism spectrum disorder in older children. Lack of touch impacts the sensory scaffold on which the perceptual distinction between 'self' and 'other' is built; further impacting social responses and abilities throughout development.

Toddlerhood and Childhood: Affective touch continues to influence brain development beyond infancy

The repertoire of parent-child touch expands as infants become toddlers and gain mobility. Touch is an important factor in family dynamics and within the nuclear family; it is a primary predictor of children's sustained expression of positive emotions. A new study 'The untenable omission of touch in maternal sensitivity and attachment research', Botero M, Langley H A & Venta A, 2020, *Infant and child Development*, 29(2), e2159) found that infants are sensitive to even subtle changes in their mothers' touch.

During the toddlerhood and preschool transition, the critical role of touch expands beyond caregivers and immediate family to include teachers and peers. As the child gets older and becomes more independent, the sphere narrows again and they receive tactile input from fewer people in fewer contexts than when they were very young. A child's empowerment to seek and permit touch when desired and deny it when it is not, should have positive developmental outcomes and more research is needed to consider how best to facilitate this whilst remaining aware of child protection issues.

In the classroom, positive, contingent touch from teachers has been demonstrated to increase on-task behaviour and reduce disruptive behaviour in young children.

Social touch and disordered development

The impact of social touch on the developing brain and the consequences of its altered trajectory in childhood are relevant for a range of psychopathologies that emerge at

around two years of age, such as Autistic Spectrum Disorders (ASD) and latterly, throughout childhood and adolescence such as depression and anxiety (Casco CJ, Moore D, McGlone F, 2018, 'Social touch and human development', *Dev Cogn Neurosci*. 35:5-11.doi:10.1016/j.dcn.2018.04.009).

Children diagnosed with ASD exhibit aberrant behavioural responses to touch which are strongly linked both with the core clinical symptoms of the disorder and with brain biomarkers in touch processing areas (Kaiser MD, Yang DY-J, Voos AC, Bennett RH, Gordon I, Pretzsch C, Beam D, Keifer C, Eilbott J, McGlone F, Pelphrey KA, 2015, 'Brain mechanisms for processing affective (and non-affective) touch are atypical in autism', *Cereb. Cortex*. 1991). Research indicates that social touch is altered in social brain disorders.

Given the importance of affective social touch for an infant's formation of secure attachment and children's subsequent cognitive and linguistic development and emotional regulation, optimising their touch environment is a fundamental right that will have far-reaching effects if denied to them. Below are some examples of current work in schools.

Touch strategies

All children experience adversity, but those who come from strong, nurturing home environments are best equipped to deal with it. Children affected by physical, verbal or sexual abuse, domestic violence, physical or emotional neglect, a parent/carer with mental illness, drug, or alcohol addiction, separation or divorce are most likely to have Adverse Childhood Experiences (ACEs). The behaviour that a child adopts to cope often serves to highlight the problem that they are 'managing.'

'A Child2Child Kind and Caring Hands Programme' is delivered by nursery, primary, secondary and specialist schools nationwide and impact evaluations have provided much evidence to support the benefit of 'peer to peer' massage for individual children.

Feedback from local primary schools participating in the 2015 North West and Cambridgeshire Study showed that peer to peer respectful touch extended children's social networks and helped in the building of positive behaviours that were conducive to a calmer classroom atmosphere. After a month's experience of the programme, children with additional needs (including those on the autistic spectrum) made significant progress. The benefits are depicted in a 2016 film produced by Thea Blair: 'Calm, Focused and Friendly':

<https://youtu.be/OUrFpuAXuZU>

Feedback below is derived from programme evaluation. Children's names have been changed to preserve their anonymity.

'Kevin' was a Reception class pupil at a Bolton school who was cared for by his grandmother. His mother used drugs and he was born with foetal addiction; necessitating protracted hospitalisation and medical supervision. Kevin's behaviour in school was 'unpredictable' and he displayed 'butterfly concentration'. When the class first began peer massage, nursery rhymes and story massage he was physically restless until the advent of partnering and group activities. His desire to 'join the game' was a first indication that he had taken notice of the other children.

Using coloured spots to randomise small groups of three, the children were asked to pick a counter from a bag, 'Traffic light' colours were used and when everybody had a colour, the children formed a group with the colours arranged in traffic light order. The groups were then organised into rows for the massage routine. Kevin enjoyed participating (especially when he was in the middle) and often asked to swap colours with another child to pick his place in the row. He settled surprisingly quickly and his grandmother told the teacher that he had shown her some of the strokes and liked to have a massage at bedtime.

The head teacher of a school in the Cambridgeshire Study gave feedback to the entire school community:

'Peer massage within a daily regime has significance for the majority of children, of all ages within the primary setting. The improvement in social integration, children being able to take personal responsibility about their participation in the touch sessions and their ability to articulate their feelings about the touch routines with their partner, seems to build esteem and confidence for most children.

Children recognise the benefits for themselves and others, and there is a definite atmosphere of calm during the session. The fact that the children requested the session before their SATS tests shows that they recognise that they feel more focused and ready for learning. The 'knock-on' effect is that it creates greater co-operation between children and makes a more responsive and respectful atmosphere throughout the school.'

The headteacher illustrated the programme's impact on individual children:

'At the beginning of Year 2, 'Ann' had been struggling academically and socially. In her SATS results she achieved 2b across all tests. As the weeks of peer massage passed, her confidence increased as did her friendship group. The teacher noticed that when she was becoming anxious in class, she would do the hand massage strokes on her own hand, as though using it as a calming mechanism. After one month, her socio-gram score showed that she had increased her friendship groups by five children.'

'There are many concerns around the home situation of 'Cassie', a 10-year-old 'premium' pupil of average ability. She has social care involvement.

'Cassie' is considered vulnerable in many ways. She has developed the habit of talking over people... being dominating. At the beginning of the study ...she soon realised that people did not want to work with her when she was being loud and fussy.

She began to adapt fairly quickly in the session, asking permission, using a quieter tone and responding in a calmer way to her partners. She soon became expert in the massage technique...and began to be recognised as an excellent partner. She liked the peer massage so much she decided that she wanted to become a vet or a beautician when she grew up.

Children who chose not to partner her at the beginning of the project were eagerly partnering her by the end. Her socio-gram scores showed that she had increased her friendship group by three, in that month.'

The questionnaire analysis and feedback from the teachers, headteacher and parents confirm that peer massage routines and touch activities have a positive impact on social relationships in the classroom and overall pupil behaviour and learning. Strategies such as 'A Child2Child Kind and Caring Hands Programme' build children's emotional and mental resilience and help to support and develop their overall wellbeing and academic potential.

There is a compelling case, not least from the neuroscience evidence, for work in positive touch to become an established part of the school curriculum. The inter relationship of children families and schools shapes society and forges common goals. Touch deprivation can have serious negative repercussions on child development.

In addition to countering the effects of ACEs, much will now need to be undertaken to support the many children who have experienced trauma and the depletion of the only world they have always known due to Covid-19.

Touch enhances the ability to adjust and become engaged in independent and creative 'social connecting.' It may help to counterbalance the negative effects of social isolation and stress that so many children are now known to experience (Prof G Neil Martin, Neil R Coleman, William Buskist, 'Psychology', Pearson, 2009).

Recommendations:

- 3.1 Positive touch work to become an established part of the school curriculum, possibly as a component of PSHE.

4. THE PRACTICE AND TRAINING NEEDS OF THE WORKFORCE IN INTERACTION WITH PARENTS/CARERS TO INCLUDE:

- NHS
- EARLY YEARS AND EDUCATION PROFESSIONALS
- IMPLICATIONS FOR THE CONTENT AND TEACHING OF THE NATIONAL CURRICULUM IN SCHOOLS

Feeding and nutrition

In the early stages of a pregnancy, women are likely to go to their GP for nutritional advice.

A recent British Medical Journal study revealed that 74% of junior doctors felt uncertain about nutrition when talking to their patients, due to lack of knowledge, lack of time and confidence. Only 45% had received training in nutrition and this in essence highlights some of the gaps that exist in translating key messages to families; including pregnant women:

<https://nutrition.bmj.com/content/early/2020/04/15/bmjnph-2019-000049>

Many healthcare professionals do not possess the basic expertise to recommend appropriate dietary strategies to their patients and the NHS Long Term Plan (published in January 2019) acknowledged that nutrition training for doctors is insufficient in the UK (NHS England 2019).

Parents need immediate guidance in the area of infant feeding.

Responsive feeding strategies (described earlier) are especially helpful for 'at risk' populations, who have had disturbed/non-contingent relationships with their own families and use a more avoidant interactive style (typified by lack of physical nurturing).

However, existing training resources (including on-line) appear to be aimed at lower risk groups and areas and families of greatest need are not being reached.

Health professionals (including midwives, health visitors, nursery nurses and providers of Early Years support) who are in regular contact with caregivers are ideally placed to deliver training programmes but must be fully trained themselves including how to respond with appropriate touch and holding to a distressed and upset infant.

Standardised training based on evidence-based protocols should consist of:

- Early responsive feeding techniques; recognising and differentiating between hunger, satiety and non-hunger-related distress
- The need for holding and touching as a means of alleviating infant distress
- The appropriate introduction of complementary foods; emphasising (if spoon feeding) the need to be aware of satiety signals, and to refrain from 'pressure to eat' strategies
- General, consistent, contingent and timely responses to an infant or child's behavioural signals.

The aims of the integrated programme are to establish:

- A nurturing, touch-based, contingent and sensitively responsive interaction between infant and caregiver
- An understanding of the need for consistency in response to infant and toddler, which helps to establish the best caregiver-child interaction for secure attachment formation: <https://infantandtoddlerforum.org>

Training should be available for all infant care professionals (including GPs and practice nurses, nursery and childcare providers, midwifery assistants, clinical support workers and children's centre staff) and be updated throughout their particular career trajectories.

Parents frequently approach their Early Years setting for advice on nutrition.

In Newham, the Early Start Nutrient Team deliver a range of training sessions to Early Years staff and health visitors to ensure that they are best equipped to give consistent, frequent and evidence-based information to families. The team use a Continued Professional Development (CPD) model to support the delivery of health and wellbeing messages (Early Start Nutrition Training):

<https://www.earlystartgroup.com/nutrition/nutrition-training/>

Parent/baby relationship training

The early conversations that professionals have with parents and babies are the first parent-baby intervention. 'Sprinkling' helpful relational knowledge onto everyday professional practice and sharing play ideas (including apps) may reduce the need for upward referral to specialist services.

The 'sprinkling' concept is favoured by Warwickshire's County Council Director of Public Health who adopted a matrix of training needs, following a mapping exercise of all professionals involved in frontline training work with new parents, carers and babies. A parent programme and intervention training model was subsequently

approved for inclusion in a Parenting Framework. One component was Baby Bonding; an affordable, inter-disciplinary attachment and play-based method.

Similar approaches are taken by Tameside and Glossop Integrated Care NHS Trust and the Tameside and Glossop Early Attachment Service (an award-winning NHS provision for parents and babies up to age three). Entire inter-disciplinary teams including midwives, health visitors, 'Home Start' workers, breast feeding counsellors, psychologists, mental health nurses for adults, mental health workers for infants and 'mother and baby' unit staff are trained in a cost-effective, holistic attachment programme (Baby Bonding).

However, the progressively corrosive impact of austerity policies on overall capacity to offer training generally within both local authority and NHS settings has been extensive and cannot be over-stated.

Play therapy training

Play Therapy UK has published a comprehensive set of competencies to accompany its own dedicated training programmes for play therapists and could be adapted for other therapeutic working with children: <https://playtherapy.org.uk>

They are listed below:

1. Communicate clearly and accurately the value of touch as being essential to human wellbeing
2. Develop self-awareness related to touch
3. Avoid misuse of touch
4. Use touch appropriately in therapy practice
5. Make sound decisions involving use of touch in therapy
6. Obtaining consent for use of touch
7. Keeping adequate records about the occurrence of touch
8. Apply ethical principles to the occurrence of touch
9. Handling non-clinical or unanticipated touch
10. Using touch with children who have experienced trauma or abuse
11. Using touch in group work.

However, as with Newham's specialist nutrition training, there is no requirement for therapeutic training to take place; much less meet the standards of a Government-Approved Accredited Professional Register.

Therapists are placed in the invidious position of discharging professional duties without the benefit of professional protection and the effect is to undermine their confidence.

Supporting the Early Years Professional

The education and care of babies and young children is physically and intellectually and emotionally demanding.

UK and much international Early Years' policy emphasises the importance of attachment interactions in nursery settings (Organisation for Economic Cooperation and Development, 2017, 'Starting Strong. Key OECD Indicators on Early Childhood Education and Care', 21 June 2017).

Enabling children to feel attached is immensely rewarding for practitioners and also stressful and exhausting. This is the case when working with children who are seemingly free of obvious problems stemming from their family background.

However, successive governments have envisaged a major role for nurseries in addressing social disadvantage and gaps in educational attainment and reducing the effects of social exclusion.

The initial 'universal' purpose and reach of the Sure Start programme has been subsumed by a targeted approach, focusing on 2-4-year-olds with additional needs who live in disadvantaged areas or come from low-income families (Smith G, Sylva K, Smith T, Sammons P, Omonigho A, 2018, 'Stop Start. Analysis of the decline, adaptation and struggle of Sure Start Centres across England', The Sutton Trust, April 2018).

The emotional demands of working closely with young children can be intense and in the absence of adequate support, Early Years Professionals (EYPs) sometimes seek to avoid children's demands - or even become 'blind' to them (Datler, Datler and Funder, 2010; Elfer, 2014).

The vast majority of EYPs are overwhelmingly dedicated to the wellbeing and development of the children in their care. But it is increasingly difficult for them to be fully effective without the 'permitting circumstances' of sufficient staff numbers, remuneration that is commensurate with professional responsibilities and working conditions, ongoing training and regular and frequent opportunities to process the considerable emotional demands of the role.

There has been a steady rise in official recognition of the importance of relationship between staff and children; from 'official guidance' to statutory requirement. Each baby/young child in nursery must now be allocated to a named individual ('key person') who assumes main responsibility for the child during the day and builds a relationship with the family (Department for Education (DfE), 2017 'Statutory Framework for the Early Years Foundation Stage', Runcorn: Department for Education).

If Early Years Professionals must be fully responsive to the emotional needs of the children, attention to their own emotional wellbeing should be integral to the systems in which they work.

However, this cannot be seen as an 'interchangeable' substitute for a recognised career structure, working conditions and pay scales that properly reflect the demands of the job. The competence of EYPs is consequent upon competent systems of early years' provision (Urban M, Vandenbroeck M, Van Laere K, Lazzari A and Peeters J, 2012 'Towards Competent Systems in Early Childhood Education and Care. Implications for Policy and Practice', *European Journal of Education*, 47(4), 508-526).

Despite statutory underpinning for nursery attachment and 'good enough' staff-child ratios, implementation remains patchy and the role of the key person is surrounded by confusion. It is especially demanding in nursery baby rooms where physical and emotional engagement with the babies is vital and can be intense (Page J and Elfer P, 2013, 'The Emotional Complexity of Attachment Interactions in Nursery', *European Early Childhood Education Research Journal* 21 (4): 553-567. doi: 10.1080/1350293X.2013.766032).

In the most recent major review of Early Years training and qualifications, Nutbrown acknowledged a rapid growth in EY qualifications but also concern about the didactic or skills-based nature of much training and the need for attention to the processes of thinking and learning (Nutbrown C, 2012, 'Foundations for quality: The independent review of early education and childcare qualifications', *The Nutbrown Review*, June 2012).

The Coalition Government rejected Nutbrown's main recommendations, but required EYPs to have access to regular supervision (DfE 2017), creating some possibility of fulfilling the need for a space for thoughtful and informed reflection; possibly supported by Ofsted.

There is also a need to improve partnership working with parents and to better support EYPs in negotiating a balance between enabling children to become attached and respecting the role of parents. Support is also needed to help them to differentiate between attachments that facilitate and restrict children's exploration (Page and Elfer as above).

Work is ongoing in developing official models to afford the individual EYP opportunity for in-depth reflection on their work with children and families. A model originating in the Tavistock and Portman NHS Foundation Trust is the 'Work Discussion' (WD): currently used with EYPs and evaluated by the Froebel Trust:

<https://www.froebel.org.uk/research-library/4ps-project/developing-close-thoughtful-attention-to-children-families-in-early-years-pedagogy>

The evaluation concluded that:

1. All participants thought that the WD groups had enabled practitioners to be less judgemental, more understanding, better at sharing information with the team and more objective about the children
2. The majority of children made significant progress over the course of the study and the WD may have had a beneficial effect upon their behaviour.

(Elfer P, Greenfield S, Robson S, Wilson D and Zachariou A, 2018, 'Love, satisfaction and exhaustion in the nursery: methodological issues in evaluating the impact of Work Discussion groups in the nursery', *Early Child Development and Care*. 893-904).

National Curriculum Implications

The school environment and the way in which PHSE is taught can influence provision.

The PHSE Association (2017, 'A Curriculum for Life. The case for statutory Personal, Social, Health and Economic (PHSE) Education') argues that the aim of PHSE should be to reduce the stigma associated with emotional wellbeing whilst improving outcomes for young people. The Association hope that the 2020 statutory status of PHSE will ensure high quality training in the subject and see more lessons taught by experienced teachers instead of 'Untrained, unprepared and inexperienced teachers' as in the past.

Ofsted (2013, 'Not yet good enough: personal, social, health and economic education in schools', Crown Copyright) also notes that the lack of subject- specific training in Initial Teacher Education (ITE) can lead to poorly planned, overly simplistic content that is poorly assessed and at worst, inaccurate:

<https://www.gov.uk/government/publications/not-yet-good-enough-personal-social-health-and-economic-education>

In the early years, mental and physical wellbeing is encouraged by working with children towards their early learning goals.

Lumsden and Doyle (Lumsden E and Doyle Celia, 2018, 'Child Protection in the Early Years: A Practical Guide', London: Jessica Kingsley) identify the importance of well-trained, knowledgeable staff, strong leadership and monitoring of progress and compliance. The DfE (2017, 'Statutory framework for the early years foundation stage. Setting the standards for learning, development and care for children from birth to five', Crown Copyright) advocate a 'well qualified, skilled, staff team' that will allow for the best possible outcomes for children.

The Royal College of Paediatrics and Child Health (RCPCH, 2020, 'State of Child Health 2020', {England}) identify that in England, the prevalence of mental health disorders in

5-15-year-olds (and consequent referral to mental health services) is increasing:
<https://stateofchildhealth.rcpch.ac.uk/evidence/nations/england/>

Pupils told Ofsted (2013) that they wanted to learn more about mental health, stress and bereavement but the Inspectorate found this to be the weakest aspect of the provision. Staff had neither the expertise nor requisite sensitivity to address topics such as sexuality, mental health and domestic violence. In over a third of schools, sex and relationships education was deemed to be inadequate and insufficient as a preparation for the physical and emotional challenges and changes of growing up.

Ensuring a curriculum that focuses on the health and wellbeing of children and young people is paramount if the September 2020 PHSE advice is to succeed.

The Children and Social Work Act 2017:

<https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted>

This Act details the role of PHSE education and calls for the Secretary of State to have in place provision for effective Relationship and Sex Education for all children of compulsory school age (including academies, free schools and independent schools) and that they must learn about safe and healthy relationships and how relationships might impact physical health, mental health and wellbeing.

However, unless teachers receive high quality training, they will lack confidence in delivering an expanded PHSE and the new statutory status of the subject could have damaging outcomes as yet unknown.

Recommendations:

- 4.1 Training in nutrition to be statutory for all professionals involved in advising parents/caregivers on infant feeding. This should be embedded within Continual Professional Development (CPD)
- 4.2 A Government-commissioned wide-scale review of the Early Years Profession to include training, staff turn-over, remuneration, career progression and public funding as an initial step in a strategy designed to enable the retention of the most skilled and talented individuals
- 4.3 'Professional reflection' time, to include attention to babies', young children's and adults' emotional experience at nursery, to be a statutory component of EYP professional support
- 4.4 Staff teaching PHSE to receive subject-specific training; to be experienced and well-trained in the subject content and pedagogies available to them
- 4.5 Initial Teacher Education (ITE) and Early Years education courses to include subject-specific PHSE/personal development education training including early childhood development, trauma and attachment

- 4.6 PHSE should be taught in regularly timetabled lessons to allow for learning to develop longitudinally with due regard to the needs of children and community. The lessons should build cumulatively in a 'spiral curriculum' approach where core elements are revisited and consolidated
- 4.7 The curriculum should address appropriately sensitive issues including sexual exploitation, mental health, domestic violence and substance abuse.

5. THE CONTRIBUTION OF CT FINDINGS AND TOUCH THERAPIES TO THE WELLBEING OF CHILDREN WHO HAVE ENCOUNTERED ADVERSITY

THIS MAY INCLUDE:

- ADVERSE CHILDHOOD EXPERIENCES
- DISABILITY
- FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES.

'We now have converging evidence from electrophysiological recordings, psychophysical and behavioural studies, and functional brain imaging proving that CTs are responsible for the rewarding and pleasant responses we have to touch and that, importantly, they play a fundamental and critical role during the development of the social brain. Activating these nerves during peer-to-peer touch feeds the social brain with the 'fuel' it needs to grow into a healthy and resilient adolescent and adult'(Francis McGlone: 2018, 'The Sense of Touch').

Without a sense of attachment and security, a child's personal and emotional development and potential will be impeded. Stress, lack of structure and order, unpredictable and chaotic life experiences, trauma and deprivation inhibit the capacity to flourish and in adult life, continue to have a negative impact on mental health and emotional wellbeing.

The mechanisms underlying social touch (a unique system of unmyelinated nerve fibre, C-tactile afferents or CTs) are described earlier. Parental bonding with a child is often conducted through touch.

The hormone oxytocin increases markedly during social care exchanges; it promotes social bonding and this neurotransmitter is important for social development. The touch system, like other neural systems, relies upon sufficient activation to allow for healthy development, from birth to late adolescence. Negative (or lack of) touch is likely to cause developmental deficits to the perception of social touch in adulthood.

Currently, the predominant reason for a child's entry into the UK foster system is physical neglect or abuse.

The presence of high levels of learning disability, mental health and speech problems are regularly observed amongst care-experienced children (often due to early life medical neglect which later contributes to difficulties in social interaction). Following exposure of the horrifying developmental outcomes of the children from Ceausescu's Romanian orphanages, the UK (in the main) transitioned from institutionalised care models to foster care. UK fostering regulations state that:

'Carers should provide a level of care, including physical affection, which is designed to demonstrate warmth, friendliness and positive regard for children.' (Fostering Services, 2011)

The principle was based upon the importance of a nurturing environment in promoting healthy development; physical, cognitive and psychological.

However, local authorities and independent fostering agencies offer guidance to foster carers and professionals in which an emphasis is placed upon the dissuasion of physical affection due to the potential risks of misinterpretation (Narey M & Owers M, 2018, 'Foster care in England: a review for the Department for Education').

Media publicity has revealed deep-seated fears from carers concerning their ability to provide positive social interaction. Therefore care-experienced children and young people are likely to have reduced nurturing contact throughout their development compared to their peers who have never been in care. Stein (Stein M, 2006, 'Research review; young people leaving care', *Child and Family Social Work*, 11(3) 273-279) argues that care-leavers are vulnerable to social exclusion (likely to be exacerbated by frequent placement changes) poor educational attainment and poverty risk.

Ongoing social exclusions experienced by care-leavers demonstrate a relationship between childhood adversities and the level of parental interaction (Department for Education (DfE), 2017, 'The fostering system in England: evidence in review. Research report':

<https://www.scie-socialcareonline.org.uk/the-fostering-system-in-england-evidence-review-research-report/r/a110f00000NeJ0eAAF>

Research findings point to the importance of childhood attachments and social interactions for healthy development. Attachment style is a significant predictor of sensitivity to CT optimal affective touch (Krahe C, von Mohr M, Gentsch A, Guy L, Vari C, Nolte T & Fotopoulou A, 2018, 'Sensitivity to CT-optimal, Affective Touch Depends on Adult Attachment Style', *Scientific reports* 8(1), 1-10).

Individuals who illustrated a secure attachment style also portrayed enhanced sensitivity to the rewarding value of CT targeted touch, most likely formed through a positive social history of experiences in seeking proximity to others.

Children who are the recipients of frequent affectionate touch from their mothers are more likely to display secure attachment compared to those experiencing low levels of affective touch and a secure and reinforcing relationship with a primary carer is a key predictor of positive outcomes for care-experienced children (Cocker C & Scott S, 2006, 'Improving the mental and emotional well-being of looked after children: connecting

research, policy and practice', *The Journal of the Royal Society for the Promotion of Health*, 126(1) 18-23).

This is not the norm.

In 2012, over 89% of children in care experienced two or more placement changes a year (Department for Education (DfE) 2013 Data Pack: Improving permanence for looked-after children) which prevent the formation of a secure attachment to primary care givers. The sparse, uncertain nature of foster placements makes frequent change inevitable. Children in care often suffer from significant mental health risk with their needs poorly met.

Some studies have indicated that care-leavers may respond atypically to CT optimal touch and that childhood experiences of trauma and neglect have a prolonged impact on the processing of socially relevant tactile stimuli.

Participants in recent research also completed a Childhood Trauma Questionnaire and Touch Experiences and Attitudes Questionnaire (Trotter PD, McGlone F, Reniers RLEP & Deakin JFW, 2018, 'Construction and validation of the Touch Experiences and Attitudes Questionnaire (TEAQ): a self-report measure to determine attitudes toward and experiences of positive touch', *Journal of nonverbal behaviour*, 42(4) 379-416).

The Questionnaire findings highlighted some explicit differences between care leavers and a control group.

Care-leavers reported significantly higher scores for all trauma scales (physical abuse, physical neglect, emotional abuse, emotional neglect and sexual abuse) with levels of physical abuse and physical neglect portraying the largest variance in scores between groups.

The results (supporting the theory that care-leavers tend to experience less nurturing care compared to matched peers) are a serious cause for concern because the long-term consequences of social exclusion are likely to lead to an increased vulnerability to risky behaviours, such as committing crime, substance abuse and being victims of domestic abuse. Care-experienced individuals are at risk of continued adversities in adulthood; frequently exacerbated by poor socio-economic opportunities.

A plethora of research has demonstrated that care givers' interactions with children form a social history that guides behaviours.

Alternatively, in the absence of appropriate stimulation, the child may experience structural and neural changes to the developing social brain, promoting atypical social processes. It has become abundantly clear that care-giver interactions with the child

build security and promote healthy development. Following local guidelines, foster carers often express anxiety regarding nurturing touch between themselves and the child, with fears of misinterpretations and accusations, often leaving children in care deprived of appropriate touch (Narey & Owers as above). As a consequence, important questions have emerged regarding policy and guideline changes to ensure best possible outcomes for children in care; the responsibility of corporate parents.

An increasing number of schools now use peer massage as a positive touch strategy with the goal of building a classroom culture where pupil to pupil relationships are strong and attachment is high.

Some classrooms where the approach was used included children who were isolated and withdrawn; not relating to others during lessons and exhibiting volatile behaviour and/or poor language skills. They displayed particular behaviours which kept them 'off-task' much of the time and requiring adult attention for non-learning reasons. Common traits were low self-esteem, shy/anxious mannerisms and an inability to articulate their needs or contribute for more than a few minutes. The children were often late entrants to the class due to exclusion from a former school; had recently arrived in the country or had a history of family travelling. Some were victims of trauma or had lived through Adverse Childhood Experiences (ACEs).

Many schools in the UK and abroad have adopted A Child2Child Kind and Caring Hands Programme (mentioned earlier) and there are other programmes of the same type eg Relax Kids, Massage in Schools, Peaceful Hands.

One of the benefits of the programme is that it opens a dialogue around safe and unsafe touch. The children become enabled to protect themselves through the simple protocols and discussion with the teacher. When delivered as a 'whole school' initiative as the children move through key stages, their awareness, confidence and understanding of safeguarding grow with them. They know how to be calm and support their peers, interpret kindness in a wide context, show empathy and consideration whilst practising positive social behaviours.

Headteachers recognise that the peer massage helps to build happy, relaxed and safe classrooms where children can trust one another and improve their academic performance. The strategy can also help children who have been identified with specific disabilities.

In a North Manchester Special Needs School, one class of boys (all of whom had received a diagnosis of Autism Spectrum Disorder) were introduced to the 'AC2C Kind and Caring Hands' programme.

'Michael' was an elective mute who had joined the school at the beginning of the year at the time of the introduction of the programme. After a few weeks he began to be curious about participating in the peer massage routine. The teacher invited him to join with two others by making a row and asked Michael where he would like to be positioned, standing or sitting.

After this first experience, he began to talk in class.

After the Christmas break, two visitors from the United States who were making a film about the work, came into the classroom to talk to the boys and Michael volunteered to talk on camera:

'It makes me feel calm and relaxed!' (Blair 2013): <https://youtu.be/OUrFpuAXuZU>

Recommendations:

- 5.1 Department for Education through Ofsted to compile and cascade a compendium of best practice models and evaluations of affective touch strategies for classroom use
- 5.2 Re-modelling of training systems for officials and carers working with children in care to better educate them in appropriate touch and thus improve their practice
- 5.3 To encourage appropriate ideals and aims and strategy surrounding touch and social development in caring for marginalised groups of children.

6. INTERNATIONAL PRACTICE AND EXAMPLES

If children's physical and emotional needs are frustrated, their development and wellbeing will be adversely affected.

The institutional isolation prevalent in the notorious orphanages of some countries may have disappeared but it is widely accepted that many children continue to endure difficult life experiences that will have a detrimental impact on their development.

Policy and practice vary, but it is now generally accepted that:

- Children who have been deprived of ample physical and emotional attention are at higher risk for behavioural, emotional and wellbeing concerns as they grow up
- Children benefit from nurturing relationships
- For children to develop a strong attachment, parents or caregivers must be responsive, sensitive and provide the physical and emotional security for healthy development and growth.

ENGLAND

There is evidence in the UK that those who spent time in care as children are almost twice as likely to die prematurely as those who did not.

University College London researchers, tracked more than 350,000 people using official government data between 1971–2013 and found that the likelihood of dying earlier among those who have been in care increased over time; contrary to the general population which, during the same period, experienced a decline in mortality risk. Throughout the 42-year period, it was found that adults who spent time as children in the care system were 70% more likely to die prematurely than those who did not. Researchers believe that the impact of austerity may have worsened the situation since December 2013; the last date for which 'all-cause mortality data' was made available. The majority of premature deaths have been attributed to causes such as self-harm and accidents or were related to mental illness.

The number of children in care has increased over the past decade, reaching almost 82,000 in England and Wales at the start of 2018. Professor Amanda Sacker from the UCL team said:

'The figures are really quite shocking and indicate that while the majority of us are living longer, healthier lives, this is far from the case for those who spent time as children in care. Rather, the inequalities have increased.'

The UCL team is now asking the Government to act on the findings, paying particular attention to mental health. NICE (2015) state that 15-20% of UK women experience anxiety or depression in the year following giving birth and a mother's mental health is closely linked to a child's wellbeing.

SCOTLAND

The Scottish Government has a mental health strategy 2017-2027; recommends the prevention and early identification of children's wellbeing and is providing evidenced parenting programmes to support parental nurturing skills. However, funding issues have undermined the strategy:

<https://www.gov.scot/publications/mental-health-strategy-2017-2027/>

The Scottish Government (2017) has identified nurture as one of eight indicators of the Wheel of Well-Being; all of which connect and overlap:

- Safe
- Healthy
- Achieving
- Nurtured
- Active
- Respected
- Responsible
- Included.

'Learning in Health and Wellbeing' emphasises the need to ensure that children and young people develop the knowledge, understanding, skills, capabilities and attributes that are essential for their present and future emotional, social and physical wellbeing. Health and Wellbeing is also seen as a 'Responsibility of All.'

WALES

Improving mental wellbeing and building resilience is prioritised in Wales. Family life is considered to be of crucial importance to a child's wellbeing.

The Welsh Government has identified that social and economic inequalities impact the level of resources that are available to support family life and increase the risk of poor health and developmental outcomes for children as well as educational and employment outcomes. There is a focus on collaborative working to support good relationships and the growth of resilience and an understanding of the detrimental effect of poor parenting skills:

<https://phw.nhs.wales/about-us/our-priorities/long-term-strategy-documents/public-health-wales-strategic-plan-2019-22/>

NORTHERN IRELAND

Northern Ireland's Commissioner for Children and Young People focuses on Wellbeing in Children. 20-30% of children will develop mental health problems before the age of 18. Children need the nurturing and support of adults as they grow to reduce their anxiety levels and improve their wellbeing. The statutory duties and powers of the Commissioner include:

- To promote an awareness and understanding of the rights and best interests of children and young persons
- To keep under review the adequacy and effectiveness of law and practice relating to the rights and welfare of children and young persons
- To communicate effectively with children and young persons and their parents and raise awareness of the function and location of the Commissioner and how they can contact her
- To seek the views of children and young persons in exercising her functions
- To make the services of the Commissioner available to children and young people in their local area.

Working collaboratively and supporting parents' nurturing skills are part of Northern Ireland's 'Promoting Wellbeing in Our Children' strategy.

ROMANIA AND CANADA

Some children from deprived surroundings such as orphanages have vastly different hormone levels from their parent-raised peers, even beyond the baby years. And not just deprived surroundings.

"We reviewed nine studies in which children's cortisol levels at center daycare were assessed. Our first hypothesis, concerning intraindividual differences in cortisol levels across home and daycare settings, was also tested in a meta-analysis. Our main finding was that at daycare children display higher cortisol levels compared to the home setting" Vermeer & van IJzendoorn Early Childhood Research Quarterly 21 (2006) 390–401

In Romania in the 1980s, by ages 6-12, levels of the stress hormone cortisol were still much higher in children who had lived in orphanages for more than eight months than those who were adopted at or before the age of four months:

<https://pubmed.ncbi.nlm.nih.gov/11523851>

In 1989, children from Romanian orphanages were adopted into Canadian homes and the longer a child had spent in the orphanage, the more likely they were to have longer-term wellbeing issues.

However, even if they had been in an orphanage for a long time, moving into a family environment was seen to be beneficial. Some children took longer than others to develop and some had long-term wellbeing issues; including being over-friendly with

strangers. Bigelow et al ('Maternal Sensitivity Throughout Infancy: Continuity and Relation to Attachment Security', 2010) argue that the main thing to help children emotionally and support their wellbeing is to give them the love that they have never experienced.

CHINA

A study in China examined the processes and predictors of change in maternal ratings of internalising and externalising symptoms and attachment security in 70 infant girls adopted from China at a mean age of 13.5 months.

The children's mental and language development were also directly assessed. The adopted children were assessed within the first month of adoption and again 6, 12 and 24 months later. Comparisons were made with 43 girls of similar age and family background. Results indicated that from six months post adoption onward, adopted children exhibited a rapid increase in internalising symptoms, especially in emotion reactivity.

Adopted children initially formed attachment rapidly.

Growth in attachment gradually slowed over time and individual differences that emerged in the rate of attachment growth from six months post adoption were related to mental ability in both groups. The results point to the effects of potential risk factors on the processes of change, at least in the two years following adoption: <https://journals.sagepub.com/doi/abs/10.1177/0165025410371602>

The study aimed to examine the rates of depression among migrant children (MC) and left-behind children (LBC) as compared to non-left-behind children (NLBC) and to examine the relationship between depression among these children and the quality of their parent-child and teacher-child relationships.

Data was collected from a sample of 3,759 children aged between 8-17 years, including 834 who had been left behind by one parent (LBCO), 423 who had been left behind by both parents (LBCB), 568 MC and 1844 NLBC. Children's Depression Inventory-Short Form was used to measure child depression. Parent-Child Relationship Scale (PCRS) and Teacher-Child Relationship Scale (TCRS) were used to measure the quality of parent-child and teacher-child relationships respectively.

Results showed that the prevalence of depression was 10.5% among NLBC, 13.1% among LBCO, 16.1% among LBCB and 20.1% among MC. The wellbeing of children was related to parent-child relationship quality and teacher-child relationship quality. Negative parent-child relationship was more relevant to depression than negative teacher-child relationship among LBCB, while negative teacher-child relationship was most correlated with depression among MC: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699918/>

GERMANY

In contemporary Western societies, emphasis and value are placed on the development of the unique 'self' and a private emotional world. Attachment theory is child-centred; focusing on the emotional needs of infants and the connection between parents' responses to the child and infant wellbeing.

In Nazi Germany, attachment and how subsequent generations have struggled to bond with their children raises questions about the absence of physical and emotional security in childhood.

German historians and psychologists have written extensively about the Nazi educator and physician, Johanna Haarer. 'The German Mother and her First Child' was published in 1935 and by 1945 had sold 600,000 copies. It has been described as an 'anti attachment manual'; decrying as it does, the need for physical and emotional stability.

Haarer advised that babies should be removed from their mothers within 24 hours of birth to protect them from germs and to allow the mother to rest.

It was advised that the lack of nurturing should continue for the first three months of a baby's life. A mother was permitted to visit her baby for no longer than 20 minutes to breastfeed and no other interaction was allowed. If a baby cried after it had been fed on schedule, provided it was clean and dry and had been offered a dummy it should be left to cry.

Ultimately, Haarer's work reflected and shaped the child-rearing practices aligned to the goals of the Hitler Youth Movement. Parents were encouraged to produce children who could be integrated into the community, showed no signs of self-pity, self-indulgence or self-concern and were brave, obedient and disciplined.

Attachment theorists such as Klaus Grossmann have suggested that the Nazi child-rearing movement reflected a set of social, historical and political circumstances that probably ensured that a generation of young children was raised in the absence of attachment security. Grossmann argued that this form of emotional and physical neglect mirrored what was found in Romanian orphanages. Nicolae Ceausescu's rule from 1965-1989 and Johanna Haarer's child-rearing advice promoted extreme forms of neglect:

<https://theconversation.com/parenting-practices-around-the-world-are-diverse-and-not-all-about-attachment-111281>

There is now a priority within health and social care to improve parents' interactions with and care for their children. This was in response to a 2007 study of children's health and development that identified 20% of children aged 3-17 as being at risk of a mental health disorder. Gaps in the child protection system were becoming

increasingly obvious and high-profile cases of child neglect led to public demand for action. Burdened families were 'slipping through the net' of social support and welfare and being driven towards susceptibility to negligent parenting and in the worst cases, child maltreatment.

Intensive professional support is now offered to families with high needs who are not subject to indicated (non-voluntary) support. For example, the STEEP (Steps Towards Effective and Enjoyable Parenting) programme supports the development of secure infant-parent attachment (a powerful predictor for child social and emotional outcomes).

Germany's early childhood intervention (ECI) support measures are effective in enhancing of families' competencies. The programme includes long-term home visits by health professionals (nurses).

The home visitation programme 'nobody slips through the net' was tested in 2007-2011 in ECI pilot projects and showed improved social development of children compared with those in the control group. Mothers judged their 1-year-olds' characters as 'less difficult' and the mother-child interactions in the intervention group were less 'dysfunctional' than those in the control group.

The home visitation programme 'Pro Kind' showed a tendency for positive treatment effects on infant cognitive development at 6 and 12 months and improved parental capabilities at 12 months compared with controls. A longitudinal observational study conducted in 2013-2015 with 937 families receiving home visits by health professionals showed increased parental capabilities (WHO 2018).

Recommendations:

- 6.1 The four Children's Commissioners to be involved in drawing up a set of agreed UK indicators for Emotional Health and Wellbeing to be incorporated into all statutory child developmental health assessment programmes
- 6.2 Emotional Health and Wellbeing to be incorporated into Initial Training and Continual Professional Development for all health and education professionals involved in the provision of care and advice to children and their parents/carers.

7. SOME ILLUSTRATIVE CASE STUDIES

'Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status,' (Marmot M, 2010, 'Fair Societies, Healthy Lives').

Marmot contends that children's life chances are improved through secure attachments (touch), responsive parenting and good quality early learning experiences.

Below are some community initiatives in the UK designed to encourage children's social and emotional development and support families with care and nurture in the earliest years. They are followed by an account of the impact of a therapeutic playwork project on a group of 16 abandoned children living in a ward of a Romanian paediatric hospital, ten years after the overthrow of Ceausescu. A more extensive version of the project (based on extracts from a research diary kept by Sophie Webb) can be found in 'Play and Playwork: 101 Stories of Children Playing', Brown F, 2014a, Maidenhead: Open University Press.

Parent Infant Partnership (PIP) UK was established in 2012.

It was hoped to develop a national network; supporting parents who were struggling to develop attachment with their babies. PIPs offer a range of therapeutic services to promote the parent-infant relationship and now exist in Oxford, Northampton, Liverpool, Enfield, Brighton, Croydon, Newcastle, Dorset and Ballygown in Northern Ireland. PIPUK is now re-named as the 'Parent-Infant Foundation' and aims to unite diverse stakeholders in their role as national and local champions of the crucial conception – age two window.

Local Case Studies

OXPIP began over 20 years ago in Oxfordshire. It offers specialist intensive therapeutic support for parents and infants in the first two years consisting of:

- Therapeutic interventions with parents to improve the parent/infant relationship focusing on emotional development and mental health
- Therapeutic groups aimed at improving parents' confidence and attunement with their infants
- Training therapists and other professionals.

NorPip is Northamptonshire-based and was founded in 2011 to work with parents of infants in the 0-2 age bracket who are experiencing a range of mental health challenges which are impacting on the parent/infant relationship.

It runs 'Flourishing Babies', a National Lottery Community Fund project providing antenatal/postnatal support to vulnerable families, one of which, 'First Steps' gives specific support to young adults under age 25 who have a local authority care history and are now transitioning into parenthood.

Blackpool, Bradford, Lambeth, Nottingham and Southend-on-Sea are participating in a National Lottery Community Fund programme called 'Better Start'.

This 10-year programme (2015-25) tests five different approaches for sustainable interventions in family life in the earliest years. The interventions aim to enhance infants' and young children's diet and nutrition, social and emotional development and speech, language and communication.

Local Case Study - Blackpool Better Start

The project aims to create system change in Blackpool that strengthens local communities via:

- A Public Health Response
- Evidence-based interventions
- System change
- Research through the Centre of Early Childhood Development.

A range of services have been introduced via family hubs to support families and develop their knowledge and parenting skills. There is a focus on the role of the Health Visitor, with increased visits to families for early intervention in speech and language and specific mental health work with parents who have experienced trauma in their own childhoods.

Community Co-ordinator roles prioritise work in the community, promoting early childhood development and a range of early interventions, including oral health. All are being evaluated to inform both local development and the national evaluation of all the Best Start programmes.

The Positive Parenting Programme (Triple P) is an evidence-based international programme designed to develop confidence in parents and support them in developing positive familial relationships. There have been 335 evaluations of the programme including 172 randomised trials internationally.

Local Case Study - Triple P and Sheffield City Council

- Seminars for up to 200 people and 'one-off' discussion groups affording parents easy access to particular support alongside more intensive help
- Two thirds of cases feeding through the City Council's early intervention and prevention service (which filters cases referred in from council teams as well as health professionals, schools and early years services) cited problems in parenting/the home environment as a reason for needing help
- Five secondary schools (with hopes for more in the future) have become involved with seminars scheduled on average, once a fortnight
- There are six types of seminar; three for parents of children under twelve and three for parents of teenagers.

Local Case Study - Triple P and East Sussex and Hastings

- East Sussex County Council is achieving success with a 'population health' approach using the Triple-P multi-level system
- Triple P programmes including seminars and group programmes are being delivered through more than 20 local schools and in partnership with other early intervention services offered as part of the Healthy Hastings and Rother project to reduce substantial regional health inequalities
- The East Sussex Better Together Programme is a successful example of integrating early intervention and prevention services across the community to transform primary care.

National and international Triple P evaluations suggest that the programme:

- Reduces children's challenging behaviours whilst improving parents' wellbeing and parenting skills
- Enhances children's social and emotional wellbeing
- Lessens parental stress, depression and anger
- Reduces parental conflict over parenting.

Therapeutic Playwork Project with Romanian Orphans

The project (began in 1999 and continuing; albeit much-changed) stemmed from the concerns of the newly appointed Director of the Sighisoara Paediatric Hospital, Dr Cornel Puscas concerning the plight of some abandoned children who lived in the hospital. Aged between one and ten, they had been chronically neglected and abused and had spent most of their lives tied to the same cot in the same hospital ward.

Dr Puscas obtained funding from a Yorkshire charity called The White Rose Initiative and the first Romanian playworker was trained by Leeds Beckett University on a specially designed programme. Following her return to Romania, she was joined for differing periods of time by Leeds Beckett researchers Sophie Webb and Fraser Brown. The original project was followed in the first year by a small-scale research study by

Webb and Brown ('Children without play', Journal of Education, No 35, March 2005 special issue: Early Childhood Research in Developing Countries).

Consequences of play deprivation

'The opposite of play – if redefined in terms which stress its reinforcing optimism and excitement – is not work, it is depression. Players come out of their ludic paradoxes...with renewed belief in the worthwhileness of merely living,' (Brian Sutton-Smith, 1999, 'Evolving a consilience of play definitions: Playfully', Play and Culture Studies, Vol 2: Play Contexts Revisited, Reifel S (Ed.) Stamford, CT; Ablex Publishing Corporation).

The static nature of the Romanian children's world meant that they had no sense of fun and playfulness. They stared vacantly ahead amidst none of the usual vibrant noise to be found in a typical paediatric ward.

The children's gross motor skills were poorly developed; their fine-motor skills virtually non-existent and they also exhibited apparently irrational fears which erupted without warning into a frantic rocking which caused their heads to sometimes bang against the cot sides or the wall. Instances of specific self-harm were observed including purposeful head banging and scratching; in severe cases drawing blood.

The children had no meaningful social interactions with each other and the absence of verbal exchanges between nurses and children afforded them no opportunity to form an attachment to a sensitive, consistent and emotionally warm carer.

Hospital records awarded the children incorrect names and many supposedly shared a birthday. The common 'birthdays' merely meant that they had been transferred to the ward on the same day and no records existed for them prior to their admittance. It was therefore unsurprising that the children exhibited no sense of individuality.

Early Developments

When the project began, it was hard to assess which children had been born with a disability and which were suffering due to years of abuse and neglect. However, distinctions quickly emerged as the children developed.

Every child made progress and the overall change in them was so marked that an independent observer commented:

'It is almost as if their intellect has been sitting there, waiting to be switched on.'

Within the first eighteen months, 13 of the original 16 had been adopted or fostered within Romania; unthinkable at the beginning of the project, but something that their changed demeanour and behaviour certainly made possible.

For example, Virgil, (a six-year-old in nappies) went from silently rocking in his cot to meaningful social engagement in the form of playful conversation within six months. He made dozens of new discoveries every day and excitedly shared them with his new friends. Olivia (who had been born two months prematurely and had serious learning difficulties) began to walk independently during the first year; was able to join in with a range of simple activities and appeared to understand the complex idea that games have rules which apply to everybody.

However, signs of residual fear and emotional insecurity sometimes resulted in the type of extreme regressive response originally conceptualized by Anna Freud (Freud A, 1968, 'The Ego and the Mechanisms of Defence', International Psychoanalysis Library, revised edition, London: Hogarth Press Ltd).

On one occasion, the children were playing happily when they witnessed a slightly tense verbal altercation between a playworker and the hospital accountant about wage payment. Each child climbed back into their cot and started rocking. It may not be possible for the emotional equilibrium of such children to be recovered; however, in most other areas of development, they made remarkable progress.

Some significant indicators of recovery

Within four weeks, all children had learned how to initiate contact and generally responded appropriately to contact instituted by another child. Sophie Webb's research diary (Webb S, 2014, 'Therapeutic playwork project; Extracts from a reflective diary', Brown F, 'Play and Playwork: 101 Stories of Children Playing', Maidenhead: Open University Press) charts the rate of progress.

In week one there is a complete absence of social skills:

'When I observed the children in the playroom, they were unaware of each other, fixed on their own activities – barely communicating. Some just sat and seemed bewildered and vacant.'

However, by day 22 she recorded:

'The way the children sit around the table has proved to be more than just eating together. Olympia started to feed Nicolae today, so they are really interacting with each other so much more. They seem to be enjoying the social event.'

Language skills took longer to develop. Initially, the children's language was non-existent (except for 'Hiya' from a couple of them) however, once the project had been running for several months, some began to verbalise to explain themselves and express their feelings:

'Virgil especially loved the Lego bricks and we helped him to build a house, which is 'casa'. He walked around the room saying 'casa-casa,' in his little voice and he was so proud of it.'

After about nine months, the children's language skills had developed to such an extent that the UK playworkers were sometimes out of their depth compared to their Romanian colleagues.

All the children developed 'cuing' behaviour. Despite Nicoale's learning difficulties, he was recorded playing a game with one of the playworkers where he was copying her arm and leg movements and exclaiming as he did so. The pair developed a type of sitting down dance routine. Later in the day Nicolae sat down with another playworker and tried to replicate the earlier game by cuing with his arms and legs. When she did not respond, he became frustrated but persevered; eventually succeeding in getting the playworker to understand and follow his lead so that they could dance together.

The muscular-skeletal development of the children was remarkable and unexpected. At the start of the project, all children appeared to have considerably stunted growth and despite their increasing strength and activity, the researchers expected that their height would be permanently damaged by their earlier lives.

This proved to be false.

Nicolae began the project as a 10-year-old child with the build of a 3-year-old. In 2009 during a visit to a special centre in Sighisoara for youngsters with learning difficulties, Nicolae was discovered. He was now considerably taller and stronger than one of the original researchers. It is clearly not possible to link this specifically to the activity of playing; however, it raises the possibility that human beings are genetically programmed at birth with an optimal height.

Conclusions

A detailed discussion of the particular therapeutic method for the Romanian children project can be found in Brown F, 2014b, 'The Healing Power of Play: therapeutic work with chronically neglected and abused children', Children Journal, Special Issue: The Role of Play in Children's Health and Development). Thankfully, the hospital's approach to the children changed dramatically after about 18 months and the major causal factor for the improved attitude was almost certainly the example provided by the WRI playworkers who were encouraged to treat the children with love and respect at all times.

In less than a year, these chronically abused and neglected children made the sort of progress that many experts assumed would be impossible. During the whole period of

the research study, when the children were not in the playroom with the playworkers, they were tied back into their cots by the nurses. They were not fed properly; were not bathed; their nappies were not changed, and nobody gave them any meaningful attention at all. Nothing changed in their lives during the first year except their experience of a therapeutic playwork project.

Clearly, the children's learning and development resulted substantially from the playworkers' creation of an enriched play environment that was substantially supportive of the play process.

The playworkers' non-judgemental approach, coupled with a determination to take each child's agenda as his/her own starting point, helped to create a good playwork environment; one offering adaptability to the children and therefore encouraged the compound flexibility process (Brown F, '2003b 'Compound Flexibility; The Role of Playwork in Child Development', Brown F (Ed.), *Playwork Theory and Practice*, Buckingham: Open University Press).

Through their empathy and ability to interpret the children's play cues effectively; the playworkers were able to create strong, trusting relationships, which in turn, helped to enhance the children's self-esteem (Brown F & Webb S, 2012, 'Children without play', Johnson R & Maguire N (Eds), *Complex Trauma and Its Effects: Perspectives on creating an Environment for Recovery*, Brighton: Pavilion Publishing Ltd).

If such approaches were applied in a typical playwork setting in the UK, it would be taken for granted that children would learn and develop naturally.

The Romanian experience was remarkable in that this straightforward playwork approach appeared to work just as effectively with some of the most play-deprived children in the world. The playworkers' approach was generally non-interventionist and it is clear that they had an influence, but largely by virtue of the environment that they created.

Their sensitive input may have been a trigger and a supportive factor in initiating a trajectory toward degrees of recovery. It is also tempting to conclude that the major healing factor was the children themselves, but to substantiate that claim would require more comparative work using different types of intervention (including play) to be able to isolate peer to peer play as the causative factor.

It is therefore the hypothesis of this case study that the remarkable development that was witnessed in such a short period of time was substantially stimulated by the children's interactions with each other.

8. THE EFFECT OF SOCIAL ISOLATION ON MENTAL HEALTH AND WELLBEING

'Three million children in the UK are at risk of developing mental health problems due to the coronavirus pandemic, research has found.

With kids unable to go to school or see friends nearly a third of parents say they've noticed a negative impact on their child's mental wellbeing', Terri-Ann Williams, Digital Health & Fitness Reporter:

<https://www.thesun.co.uk/news/health-news/11602552/kids-risk-mental-health-problems-covid-crisis-nine-signs-to-watch/>

Terri-Ann Williams cites findings from Benenden Research concerning the effects of social isolation on children during the Covid-19 pandemic and listing nine warning signs for parents:

www.benenden.co.uk

- Having suicidal or self-harm thoughts
- Bad mood that won't go away
- Low self esteem; tearful or emotional outbursts
- Lack of concentration
- Lack of interest in fun things they used to love
- Trouble sleeping
- Feeling tired all the time
- Eating less or binge eating.

Society is in the midst of a global pandemic which has caused the majority of the world to be socially isolated. These are unprecedented times; but the first pandemic of the 21st century was only eleven years ago – with lessons to be learned.

Research following the 2009 SARS (severe acute respiratory syndrome) pandemic indicated a significant negative impact on mental health across many populations which were affected by the virus.

One survey in Hong Kong found that of those who recovered, over 50% displayed prolonged anxiety symptoms and over 50% of family members of patients who were directly affected showed psychological distress (Tsang HW, Scudds RJ & Chan EY, 2004, 'Psychological impact of SARS. Emerging Infectious Diseases', 10(7) 1326-1327). This presents the stark reality of what could happen after the coronavirus pandemic. The two viruses are related genetically but are not the same and so, of course, could bring very different outcomes.

Nevertheless, research demonstrated that following the SARS outbreak, post-traumatic stress disorder increased significantly (PTSD) (Wu P, Fang Y, Guan Z, Fan B, Kong J, Yao Z & Hoven CW, 2009, 'The psychological impact of the SARS epidemic on hospital employees in China; exposure, risk perception, and altruistic acceptance of risk', *The Canadian Journal of Psychiatry*, 54(5), 302-311) and adds weight to a growing contemporary awareness that the negative outcomes for children of school closure and lockdown may be open-ended:

'The effect on some of our students has been horrendous and the fall out for our vulnerable students and referrals could take at least the next two years to resolve.'
(Kathryn Salt: Emotional Education Academic)

'The National Counselling Society is acutely aware of the needs of socially isolated young people at this time. The global pandemic has resulted in many young people being cut off from much-needed avenues of support, alongside the myriad other issues that have been brought to the fore. We predict that this will have unforeseeable side effects in the future, in addition to the immediate lack of support they may now be experiencing' (Megan Nunn, CEO, National Counselling Society).

Some immediate effects of lockdown include a devastating surge in domestic abuse. In April 2020, the UK Victims Commissioner, Dame Vera Baird stated:

'Refuge's website has experienced 700% increase in visits recently,' (House of Commons Home Affairs Committee 2020. Oral evidence: Home Office preparedness for Covid-19 (Coronavirus) HC 232).

This is a global problem.

In China's Hubei provenance, reports to police about domestic abuse have tripled since lockdown (likely to be an underestimate as victims' access to phones are often limited). Brazil has estimated up to a 50% increase in cases as a direct consequence of coronavirus restrictions. In 2018, the previous UK Home Affairs Select Committee noted that:

'Victims of domestic abuse and their children and other family members can endure long-term harm from their experiences. In addition to the immediate trauma and physical harm, domestic abuse contributes to a number of health problems, including depression and anxiety, alcohol and substance misuse, and sexually transmitted diseases. The social and economic consequences of abuse can include homelessness, loss or separation from family and friends, isolation, loss of employment, debt and destitution. Children exposed to domestic abuse are at higher risk of having mental ill health, poor relationships, and physical health as adults.'

Research studies indicate a strong association between social isolation or loneliness and a range of mental health disorders as well as physical conditions (Leigh-Hunt N, Bagguley D, Bash K, Turner V, Turnbull S, Valtorta N, Caan W, 2017, 'An overview of systematic reviews on the public health consequences of social isolation and loneliness', Leeds: Public Health 152, 157-171). Additionally, a longitudinal study in the USA found that:

'At both primary and secondary school entry, children who are socially isolated experience greater mental health difficulties than their non isolated peers' (Matthews et al, 2015, 'Social Isolation and Mental Health at Primary and Secondary School Entry; A Longitudinal Cohort Study', The Journal of the American Academy of Child & Adolescent Psychiatry, 225-232).

The creation of social relationships is central to a child's mental health, wellbeing and development and high levels of stress caused by social isolation is a threat to their health, not only in the early years but also in adulthood.

Recent research has shown that a lack of social interaction affects the development of the prefrontal cortex in the brain which is associated with a variety of cognitive functions including planning, higher level thought and social interaction ('A Critical Period or Social Experience', 2012, Makinodan, Rosen, Ito & Corfas).

Families can experience many difficulties related to their rurality (Pullman et al, 2010, 'Barriers to and Supports of Family Participation in a Rural System of Care for Children with Serious Emotional Problems', Community Mental Health Journal 46, 211-220). These include infrastructural barriers as well as stigma and isolation and they pose an even greater challenge for children with impaired movement or emotional difficulties. Many children and young people living in South West England, attending school or outreach counselling services and experiencing social isolation, often have pre-existing mental health difficulties.

Those who are not able to experience the necessary level of social contact and observation of behaviour are prone to heightened stress levels, anxiety and symptoms of depression. Precisely the sequelae predicted from a lack of affiliative (CT) touch. There is a severe lack of services in many rural areas and a decline in limited youth services, activity opportunities or social groups is a compounding factor in social isolation. In many cases, the child's mental health can be so impacted by feelings of isolation that they become frequently absent from school or withdraw altogether.

From 2015–2018, the number of children being homeschooled in the UK rose by a significant 40%.

A BBC report gave existing mental health issues as one of two primary reasons for removing children from classrooms; the other being to avoid exclusion (Issimdar, M, 2018, 'Homeschooling in the UK increases 40% over three years'):

<https://www.bbc.co.uk/news/uk-england-42624220>

Excluding children from school could be due to behavioural issues or lack of resources in school to support Special Educational Needs and Disabilities (SEND). A large majority of home learning provided by local authorities and private referral units is online and the current pandemic has intensified isolation for these groups and introduced it to a massive new cohort. Schools have remained open for children classed as 'vulnerable' but only 10% of them are known to have attended and quite apart from the debate over the quality and educational value of online learning, poorer children have lacked access to the requisite technology.

They have also lacked access to gardens or nearby parks in which to exercise.

A necessary relaxation in the rules governing outside exercise for those with existing mental health conditions was secured by Bindmans LLP in pre-action correspondence with the Government on behalf of two families with children with autistic spectrum disorder:

<https://www.bindmans.com/news/disabled-people-and-carers-challenge-governments-limit-on-outdoor-exercise>

During the Covid-19 pandemic, the world has stayed connected via the internet.

Online platforms have enabled friends and families to stay connected and Government schemes such as Tech-Force 19 have demonstrated a positive effect in offering mental health support online to those who are socially vulnerable such as care leavers (Gov 2020, 'Digital Innovations tested to support vulnerable people during COVID-19 outbreak':

<https://www.gov.uk/government/news/digital-innovations-tested-to-support-vulnerable-people-during-covid-19-outbreak>

However, lockdown has also exposed children to an increased risk of online abuse from a potential minimum pool of over 300,000 people:

<https://www.theguardian.com/society/2020/apr/03/nca-predicts-rise-in-online-child-sexual-abuse-during-coronavirus-pandemic>

The National Police Chiefs' Council Lead for Child Protection; Chief Constable Simon Bailey has said that some criminals 'are looking to exploit the coronavirus crisis to cause harm online' and the National Crime Agency has pointed out that it is possible to access child sexual abuse content on the open web in just three clicks.

The advent of the Covid-19 pandemic and the subsequent enforcement of social distancing has almost certainly had a severe impact not only on the mental health outcomes for children and young people but on the local services' ability to support them.

Many counselling practitioners are self-employed or work on zero-hour contracts meaning that the pandemic will have put a further strain on the services that they provide.

Children and young people with existing mental health issues and those with new problems triggered by the conditions and on-going situation of lockdown are more vulnerable to complications arising from the pandemic and there is a serious concern about a reduction in staffing for crucial mental health services.

Recommendations:

- 8.1 All children and young people isolated from mainstream education should continue to have contact with mental health services and access to school or outreach counselling services to assess their wellbeing and help them to develop continuing social connections
- 8.2 Ensure that Sure Start Centres are integral to a new social isolation reduction strategy because they have the capacity to offer early intervention in a variety of locations (not exclusively more built-up areas)
- 8.3 Government to provide funding for emergency accommodation and any other resources needed to appropriately protect those who are at risk from domestic abuse
- 8.4 An immediate call to combat the adverse impact on the mental health of children and young people of social isolation beyond the pandemic. Services offering face to face contact and related activities should be commissioned especially in rural communities
- 8.5 Services offering low cost or free and safe places for young people to congregate would be of benefit to key 'at risk' groups. Councils should examine the feasibility of converting waste land into parks and allotments to be used freely by those without gardens or play areas
- 8.6 'Pop up' mental health centres to be created to help 'hard to reach' communities inside local amenities such as village halls, schools and churches. A statutory School-Based Counselling Strategy (SBCS) to be set up, similar to that enacted by the Welsh Government in 2010. This would alleviate the burden on CAMHS services. In-school counselling could help to reduce the number of school exclusions and as a consequence, the number of children experiencing isolation
- 8.7 The Government to fund more specific research to discover appropriate support mechanisms for children and young people with refugee status, ethnic minority groups, disabled children, children from low income families and children living with physical and mental health conditions.

9. A CHILD'S EYE-VIEW OF THE LOCKDOWN

Educational consultant and trainer, Jean Barlow specialises in the emotional and mental health of children. She has worked in mainstream primary and secondary schools and a CAMHS hospital school; also as a Behaviour Support team and Behaviour Management team member. She has introduced Pyramid Clubs, Circle Time and 'A Child2Child Kind and Caring Hands' peer massage to schools:

www.jeanbarlowtrainingsolutions.co.uk

Jean studied children's direct experiences of lockdown by devising a small sample questionnaire for use in a faith secondary academy from South Bolton, three primary schools and a secondary high school from North Bolton. Two young adults who had left school also responded and some outcomes are discussed below.

The majority of those asked completed the questionnaire, and all who responded said that they were frightened by many things; most relating to their own lives and circumstances. All hated being in isolation; sharing a wish for life to go back to how it had been before the pandemic. Many feared that somebody in their family would be infected; particularly members who had often featured prominently but were unable to be with them now. These tended to be children whose parents or extended family members worked in hospitals or other public services.

Primary aged children were frightened that they would catch Covid-19 and students in Years 6, 11 and 13 were particularly anxious about their future.

All were saddened that the abrupt school closures had prevented expected 'farewell rituals' with friends and teachers. Older students were worried about the fairness of teacher assessment of their work. Some students were given only two hours' notice that school was closing for an extended period; affording them little or no time to consider what they should take with them (i.e. personal possessions; essential books, work for each subject). There had been no discussion led by adults about the decision to 'change everything' before schools were closed.

Some students reported that they felt depressed, cried a lot or argued with friends. They were 'too scared' to talk to their parents, siblings or friends about this. All acknowledged feeling trapped and struggling emotionally with being alone:

'Being in lockdown for me has been challenging, as I am the type of person who likes to be out socialising and staying active.' (Year 10 girl).

On the final day, all students were told that they were expected to complete daily tasks at home; that they would be directed via web link and that teachers would contact them to set work. All work was to be sent by the day indicated. Exceptional

changes were made to the schools' format. Some primaries used social media blogs to keep children connected to each other and the school community. Secondary schools created PPE equipment for the NHS and began fundraisers and/or food banks for 'in need' community members. Most felt that their teachers were pressurising them too much about completing homework and complained that some teachers were not giving written feedback and were sending more work before responding to assignments that had already been submitted.

Uncertainty about 'what to do next' or 'what to do for the best' causes unnecessary anxiety for some children, whilst others relished a sense of freedom in choosing either not to respond to requests for schoolwork or not to attend school if they were in a group expected to do so. Some were prevented from keeping up with the assignments due to family commitments or constraints.

Many students fretted about what would await them when they did return to school; were they ready to begin the next stage in their subject work and would they remember what they had already learned? All were consumed by an overwhelming sense of fear and in the absence of nothing to look forward to, their worries magnified because they did not 'understand' Covid-19.

Children already suffering from anxiety experienced magnified difficulties.

They were being regularly deluged by an information overload that they could not decode and some therefore chose to retreat to their own rooms rather than joining the family. News reports stating that some teenagers have committed suicide have served to legitimise their fears; children who have experienced personal loss are not mourning the fact of the loss; they are angry because they have been unable to see the loved one before death; to attend a funeral, hug relatives and comfort one another. This has made the whole event 'unreal;' and emotionally more confusing for the child and adolescent and added to their parents' feelings of stress.

Life after lockdown will bring new problems.

'No touching' policies and safe distancing measures will inhibit the mental health of the school population. Within schools, positive touch interventions that enhance bonding, social cohesion and self-esteem should be included in daily routines. All schools will need to establish positive support networks and peer-led initiatives to encourage shared experiences in learning and social activities should be directed as part of the National Curriculum in all schools.

It will be necessary to make changes to school ethos and mission statements in order to adopt a 'whole school' inclusive policy that protects the Rights of the Child; including the need for respectful touch.

The effect of social isolation on the mental health and wellbeing of families

Example 1:

This is a family of four with all members on lockdown; parents both home-working on computers and two boys aged 10 and 16. The older boy was disappointed not to be taking the external exams he had been working towards in the final year of his courses. The younger child was sad because he could not play with friends and go out to sports activities and guitar lessons. The boys shared one computer.

Being deprived of his usual routines over a short time exacerbated the anxieties that the younger boy had already developed during his primary school years. Worries about contracting the virus impelled him to isolate in his bedroom and become 'Xbox-focused.' He was only interested in playing games with his friends and unless his mother 'organised' him; he was not interested in completing the daily tasks set by his teacher. The boy said that he did not want to return to school because he was frightened about catching the virus.

The older boy also chose to isolate in his room and focused on exercise, drinking water and shaving off all his hair. He was not tempted to go outside in the sunshine. Shaved heads are the new Covid hairstyle and social media has screenshots of many friends displaying their new 'Covid cut.' The parents realised that they needed to juggle their work commitments to ensure that the boys were getting sufficient fresh air and exercise. Workload pressures, video conferences, telephone queries, and getting the boys on their bikes, walking the dog and generally striving for more balanced interventions created tensions for everybody.

Example 2:

This is a family of nine children; five of whom still live at home with their parents. The only family member in work was the father (a low paid service provider). A 13-year-old boy was experiencing difficulties with all his academic work because of his poor reading skills. The family had one computer. All the academic work set by school needed to be done by computer so the mother was finding it increasingly difficult to allocate equal computer time and ensure that everybody kept to their timeslot. Her time was stretched between the teaching obligation and overall family needs and temper tantrums and verbal fights between the children became the norm. The boy opted out of computer tensions by watching television all the time and his parents agreed to this on condition that the sound was switched off and all programmes ran subtitles. For a while, that served as a makeshift 'solution to the squabbles about computer turn-taking. In the longer term, it is very likely that there will be other tensions between the parents because of the additional and unfamiliar teaching role.

Example 3: Older student comments

Year 8 student:

'I am worried that I'm not going to understand my work and if my teachers don't answer their emails I won't be able to do the work properly. That I'm not going to be able to get all my work done by the end of my normal school time. My concerns that I have are am I going to be fully ready for Year 9 when I go back to school? Am I going to know everything I should?'

Year 9 student:

'The hardest thing for me to manage is the schoolwork. Not the work as I can just get on with it but I have a thing about everything needing to be neat and tidy, so I end up spending extra time on work. For example: a lesson that should take 50 minutes could take 150 mins because I like everything to look nice and also laid out how I like it. I don't have this problem in school as I know that I have 50 minutes to complete work and everything is already printed and ready for me but at home I have more time to make it look nice and neat. So that is the hardest part for me.'

Year 10 student:

'I think it's unfair that I, being a year 10 student, have to teach myself months of GCSE content and still have to do my GCSEs next summer. Only one of my teachers is actually giving us feedback on the work we're sending so I don't even know how I'm doing or if I'm teaching myself correctly. The lack of education we are having will have a massive impact on our end GCSE results which isn't fair at all. I'm also struggling because I can't see my friends and I miss them a lot.'

Year 11 student:

'Obviously in isolation it's stressful. I want to see my friends; it's hard to communicate with people. You can feel lonely and it's upsetting. The best way is to be positive and hope this is all over soon. Due to this virus, a lot of 15-16-year-olds, as well as many other people, have missed out on crucial memories. For me personally, I've missed out on GCSEs and education as well as prom which is one of the most exciting things in somebody's life.'

Year 12 student:

'I'm not really scared anymore. I was at the beginning but now I'm just used to the circumstances. When they first shut schools, I was anxious, as a lot of other people were just because of the uncertainty about grades and what was going to happen to our lives. Now I'm just more scared about what will happen after, like when things will open and if it will ever go back to 'normal'.'

Year 13 student:

'So I think it's the right thing that everyone is staying at home because obviously it will save a lot of lives but I think if they were going to do a lockdown they should have done it fully, as it is unfair that people are still going meeting friends and everything. Also it

is very worrying for our year (13) as we haven't done exams for our A levels so we have no idea what is happening in terms of university, whether we will get a place and if we do whether we will be starting it normally or online and all that. I think they should have informed self-employed people earlier about their situation and I think everything should have been done earlier to be honest (the lockdown) as we could have avoided a lot of this.'

Young Apprentice:

'I'm worried about what it's going to be like as we are coming out of lockdown, like the restrictions are still going to be on? Or what? I don't have a clue. I'm worried my work will shut down because it's a private nursery and if the lockdown continues it's going to struggle. My education – when will I be able to continue with my apprenticeship and get it finished?'

Employed young people:

'To be honest, I'm not finding this too bad because I've got time off work to relax but I just miss seeing family and friends and feel quite lonely some days.'

10. THE WAY FORWARD FOR CHILD MENTAL AND PHYSICAL SECURITY AND WELLBEING

Social touch is recognised as 'a powerful force in human development, shaping social attachment and emotional regulation from infancy and throughout life.' (Cascio CJ, Moore D and McGlone F, 2019, 'Social touch and human development', *Developmental Cognitive Neuroscience*, 35, 5-11).

Maternal touch and contact with an infant is vital in cultivating wellbeing and emotional security for early infancy and beyond. Where possible, establishing and fortifying the early mother/infant bond should be an overriding objective. Policy-making initiatives should consider ways in which mother/infant time and physical contact can be maximised and seen as a developmental priority zone, and ideally, infants and young toddlers should, wherever possible, have a great deal of physical contact with their mothers.

Play is of fundamental importance to the social and emotional wellbeing of children and Article 31 of the UN Convention on the Rights of the Child states that:

'Every child has the right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts': <http://ipaworld.org/childs-right-to-play/article-31/>

Play enables the development of both gross motor skills (walking, running, jumping, coordination) and fine motor skills (writing, manipulating small tools, detailed hand work) and Jan Panksepp (Panksepp J, 2003, 'Affective neuroscience: The foundations of human and animal emotions', Oxford University Press) was one of the first neuroscientists to recognise the 'social joy' of play represented by 'the pleasure of touch.'

The 'specialised receptors... for detecting social contact' in mammalian skin have been identified recently as C-tactile afferents (Chapter 3) that when stimulated generate a rewarding sensation that promotes behaviours involving close vigorous physical contact.

This might be running and chasing and physically active games between siblings, peers and parents, including 'rough and tumble,' 'rough-housing' play and play-fighting. The urge to play seems to be intrinsic and a socially isolated child becomes despondent and depressed, exhibiting relatively little play behaviour (Chapter 7: Romanian orphanage children). Given the social significance of touch and the fact that the physical embodiment of attachment is touch, it is not unlikely that the CT-system represents an evolutionary mechanism responsible for prompting normative social development and the development of adaptive 'secure' attachment behaviours.

It is also reasonable to hypothesise that the pleasure of touch may have established an evolved neural framework for the emergence of play.

'Rough and tumble' play shapes a range of social, emotional and cognitive behaviours; teaching children about their own abilities in comparison with others and helping them to develop social skills such as compassion, self-control and social boundaries (McArdle P, 2001, 'Children's play, *Child: Care, Health and Development*, 27(6); 509-514). This type of vigorous physical play has also been found to improve pre-school children's attention during subsequent learning tasks and to better enable them in later years to distinguish between real fighting and play fighting (also true for children with learning disabilities).

Children who are less successful at grasping the concept of play fighting in early childhood are more likely to become less socially skilled and more aggressive in adolescence. Play balances two opposing social skills; competition and cooperation and its decline could lead to a generation of children with too much of either trait; leading them to become socially isolated and unable to work with others.

The global increase in 'screen time' and technology use coupled with the fact that children have progressively less time and safe spaces to enjoy social 'rough and tumble' play is heralding the decline and threatening the continuance of 'rough and tumble' in the play of current and future generations.

Outdoor play for many children is now minimal in comparison to previous generations; in particular free, unstructured outdoor play. The dominance of digital culture has created a strong inducement for children to remain indoors in sedentary isolation for long stretches of time. In addition, there is a dramatic and sustained reduction in public outdoor play provision (Association of Play Industries, 2016/2018: 'Nowhere To Play').

For millions of children, community playgrounds are essential requirements for their present and future health and the funding of public playgrounds should be a priority because they fulfil a unique role in improving children's movement, social interaction, fitness and physical and mental health (Sigman A, 2019, 'Movement for Movement; Screen time, physical activity and sleep; a new integrated approach for children', Commissioned by the Association of Play Industries).

The Covid-19 pandemic has highlighted the central role that playgrounds have in getting children out of doors. Post-pandemic planning must reflect a renewed recognition of the importance of providing free, outdoor space and facilities for all children to play.

It is important to consider how a child's developmental resilience impacts their future mental and physical security and wellbeing.

The education system should be founded on a properly inclusive environment. Social exclusion with consequent adverse effects is predominant across many pathologies in children. Often, when a school cannot support a child's individual needs, the child will spend time away from traditional mainstream school, resulting in restricted interactions among matched peers.

In cases where a child who is experiencing difficulties can remain in school, they are often alienated from their peers because of their differing needs. Remaining in general education often serves to protect them from adversity in adulthood.

School settings allow children to mix freely with peers of differing ethnicities, backgrounds and abilities; furthering social and cognitive development for all. Attendance at school is important for healthy development and the school environment should aim to fit all needs; thus reducing isolation and diminishing attention drawn to differences in ability among disabled students in comparison to their age-matched peers.

Research has vastly documented the anxiety-reducing effects of mindfulness and meditation. Some schools have responded by replacing traditional punishment models with strategies designed to promote feelings of wellbeing. Results from a 24 week mindfulness programme involving primary school children indicated significant improvements in selective and sustained attention (Napoli M, Krech PR, & Holley LC, 2005, 'Mindfulness training for elementary school students: The attention academy', *Journal of Applied School Psychology*, 21(1) 99-125).

The study also suggested that exam-related anxiety (experienced by most students) is significantly reduced and analysis of the results indicated that mindfulness conducted over a period of time may improve psychological state and boost resilience in coping with psychological stress.

These results were corroborated in part by a later study (Semple RJ, Lee J, Rosa D & Miller LF, 2010, 'A randomised trial of mindfulness-based cognitive therapy for children: Promoting mindful attention to enhance social-emotional resiliency in children', *Journal of Child and Family Studies*, 19(2) 218-229).

Following mindfulness intervention, children displayed a reduction in attention problems for up to three months afterwards and further analysis depicted that attention and behaviour had a strong relationship; indicating that improved attention is likely to assist in resolving behavioural problems. These preliminary results open an exciting avenue for positive conflict solving and the promotion of wellbeing within

schools. The intervention promotes physical and mental wellbeing; furthers the building of resilience and is of benefit to children's mental security.

However, "researchers and clinicians have to be put on guard, educated about, and encouraged to address the potential adverse events stemming from mindfulness practices. Research on the nature and scope of potential AEs should receive considerable further attention and government funding, because of the public's rapidly increasing involvement in practicing mindfulness. Van Dam NT, van Vugt MK, Vago DR, et al. Mind the Hype: A Critical Evaluation and Prescriptive Agenda for Research on Mindfulness and Meditation. *Perspect Psychol Sci.* 2018;13(1):36-61. doi:10.1177/1745691617709589

Social support as mediated through affective touch is illustrated via the work of von Mohr and colleagues (von Mohr M, Kirsch LP & Fotopoulou A, 2017, 'The soothing function of touch: affective touch reduces feelings of social exclusion', *Sci Rep* 7, 13516 and as has been discussed earlier (Chapter 5) it is plausible to develop the ideas in an educational setting whereby social touch can be planned and mediated for the benefit of the child: <https://doi.org/10.1038/s41598-017-13355-7>

The National Curriculum advocates a progression of fundamental movement skills which support a broad range of physical activities and promote the leading of healthy and active lives (DfE, 2013, Department for Education 'Physical education programmes of study: key stages 1 and 2. National Curriculum in England'). Physical education teaching that is underpinned by values of respect (rights and feelings of others) effort, self direction and caring and leadership is another way in which social touch can be explored, unpacked and understood through a student-centred physical activity approach (Hellison D, 2011, 'Teaching Personal and Social Responsibility Through Physical Education', Champaign: IL: Human Kinetics).

Introducing appropriate sex education to all ages may serve as a protective mechanism against future abuse and help children to process developmental changes which can often elevate psychological distress. It is now widely held that in order to protect children against abuse, it is necessary to educate them about the matter, including advice on where to seek help while offering a trusting dialogue between children and adults.

From September 2020, the Department for Education (DfE) will introduce compulsory Relationships Education for primary pupils and Relationships and Sex Education (RSE) for secondary pupils:

<https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education>

Prior to the reform, although existing forms of sex education are likely to have been a protective factor against sexually transmitted disease and unwanted pregnancy, they may not have covered LGBTQ+ issues to the same degree as heterosexual themes (if at all). The Government advice note about the forthcoming change states that:

‘Children should receive teaching on LGBTQ+ content during their school years. Teaching children about the society we live in and the different types of loving, healthy relationships that exist can be done in a way that respects everyone. Primary schools are strongly encouraged and enabled to cover LGBTQ+ content when teaching about different types of families’:

<https://www.gov.uk/government/news/relationships-education-relationships-and-sex-education-rse-and-health-education-faqs>

Experience in other countries such as the Netherlands (which has the lowest rate of teenage pregnancy in Europe) shows that when children are appropriately informed, behaviours can be changed in a positive way which will ultimately promote a healthier wellbeing.

Simple and pragmatic changes can be advantageous to children through to adulthood both in protecting them against infection and complex factors like abuse. They can also contribute to a mix of positive policies designed to enhance mental and physical wellbeing, reduce social exclusion and promote social development and security in children of all ages, ethnicity and sex.

Recommendations:

- 10.1 Approaches to create a classroom ‘to fit all’ should be considered if appropriate
- 10.2 Research and pilot studies should be conducted on the efficacy of replacing traditional sanctions in school with mindfulness and wellbeing interventions
- 10.3 The appropriateness and adequacy of sex and relationships programmes within school should be a matter of continual review with a view to update as circumstances require
- 10.4 Post-pandemic planning should reflect a renewed recognition of the importance of providing free, outdoor space and facilities for ALL children to play
- 10.5 The funding of public playgrounds should in particular be a priority as they fulfil a unique role in improving children’s movement, social interaction, fitness and physical and mental health
- 10.6 Embed training and education in the strategic use of curricular approaches (inclusive of teaching models, styles and strategies) for Early Years, Primary and Secondary teachers in appropriate social touch in order to enable children to give and receive this beneficial practice

- 10.7 Adopt a more holistic approach to Ofsted Inspection and educate Ofsted Inspectors in ways in which to better support school initiatives in enabling children to participate in the affective benefit of appropriate socialised touch
- 10.8 Policy-making initiatives should consider ways in which mother/infant time and physical contact can be maximised and seen as a developmental priority.