A report into the ‘adapted’ use of Intensive Interaction during the Covid-19 Pandemic

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Introduction and Method:

This piece of action research was conducted across May and June of 2020 to help develop a deeper understanding of the continued practicing (or otherwise) of Intensive Interaction during the initial lockdown period of the 2020 Covid-19 pandemic.

With LYPFT Research & Development Dept approval (via email on 20/04/20), an electronic questionnaire was circulated via Facebook and email (across a number of Intensive Interaction related email distribution lists), with current practitioners asked to answer the various questions (see Appendix 1) if they were still working with or caring for someone with a social or communication impairment using Intensive Interaction.

Due to the rapid and somewhat ad hoc nature of recruitment to this piece of action research, and the broad range of respondents (39 from 4 countries) from a wide range of care and educational roles, no attempt has been made to infer any detailed quantitative aspect to the combined findings – general quantitative terms such as 'a majority', 'several', 'a few' are used to indicate the broad proportions of respondents answering in particular ways – no view as to the generalisability of the results given in this report should be inferred.

In writing up the report no attempt has been made to fully separate out issues that at times seem generic across all the respondents' services or lived experiences. This report can only indicate the broad nature of the issues raised for the respondents during their, their families, their services or their employing organisation's response to the ongoing Covid-19 crisis. Also, the current Covid-19 crisis is far from over, and any return to some kinds of normal working or care practices may well be many months, if not years away. This report only attempts to capture the working and care experiences of our respondents across May and early June in 2020.

It is the authors' belief that further, more in-depth research should therefore be carried out as a matter of some urgency to gain more detailed and generalisable data related to the issues emerging in this piece of action research.

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p.s. Thankfully, only one respondent indicated in their questionnaire that they had caught Covid-19 coronavirus, describing their symptoms as '*mild … but still very debilitating, lasting for 3 weeks of shortness of breath and bad fatigue'.*

If you would like to comment on or ask any questions about the issues raised in this action research report, then please email Graham Firth at g.s.r.firth@gmail.com

The Findings:

The respondent's roles and areas of work or care

Out of 39 responses in total, this survey garnered 17 responses from practitioners who identified themselves as working in education or with children (e.g. headteacher, teachers, coordinators, instructors, programme, pathway or practice leads), 14 adult service managers, leaders, coordinators, carers or support workers, 6 allied health professionals or nurses (e.g. speech and language therapists, LD nurses, therapy assistants), and 2 family carers.

This survey garnered 20 responses from practitioners working in schools or colleges (including those with children's residential services), 19 responses from practitioners working in or into adult day services and adult residential care, and 3 responses from practitioners caring or working in a family home (there being 3 respondents positioning themselves in more than one setting). The responses were mainly from across the UK, with 2 from Australia, and one each from Denmark and France.

The age range of those you care for or supported by the respondents in this survey were, in general terms: 16 working with or supporting children (from 2 years) or teenagers, 4 working with or supporting young adults, and 19 working with or supporting adults or older adults.

How roles, circumstances or services changed during the Covid-19 crisis

The respondents in this survey indicated a number of ways in which their practitioner role, circumstances or service changed during the Covid-19 crisis, although for 3 respondents there was no reported adaptations: one stating succinctly that '*My role has not changed'* although they also stated that they were '*now without assistance/carers and am exhausted!'.* Two respondents indicated no adaptations being made due to the closure of their school or service.

For a small number of services, it was reported that they '*remained fully open to residential and day students*', although even in such cases:

- *'A few families of day students have chosen to self-isolate and keep their child at home – this has helped out with staffing levels when staff have needed to self-isolate*'.

However, most respondents indicated some kinds of amendments or adaptations having been made to their working or care role, and their usual working environment**.** For the schools or services generally, this meant '*many changes have been introduced*' e.g.:

- Offering provision to a '*reduced'*, even '*small*' number of students e.g. those whose parents are '*key workers*' or those identified as being at '*crisis point*' or as '*at high risk*' or 'too difficult' to stay at home.
    - *'For some of the people that we support, parents have made the decision to keep them home'.*
    - *'We've remained open but with very restricted attendance … and all the staff remained in college … but gradually the student numbers reduced, and staff went on to reduced days'.*

  - *'The school closed down for most of our students … [it] did however stay open for some students because it was too difficult for their parents to let them stay at home'.*
  - *'We have reduced numbers of pupils … all deemed extremely vulnerable if they do not continue to access school. Social care worked with us to define this cohort of pupils whose family placements would be at risk if they remained at home during the current crisis'.*

- Stopping staff from cross-working '*between services*', and instead having dedicated staff teams for specific areas, units or organisations:
  - A service being *'separated into very small self-contained units with a high staff/client ratio, and no crossover of staff.*
  - Having different buildings *'where individuals are supported by their dedicated staff team'.*
- Restricting access to certain areas of the school or service:
  - *Preventing 'all visitors to the site (including families/parents) – this has been hard for parents, but they are all being very understanding'.*
  - No *'on or offsite visits including family as they live in different households'.*
  - *'We have been told to only stay at the school's playground for half an hour each day when no other students are there'.*
  - *'My students are not allowed to interact with students in other teams'.*
  - Not being allowed to use communal areas e.g. *'the gym hall'.*
  - Splitting a day service into 2 *'to allow space and safety'.*
- Stopping or at least '*restricting'* all community based outings e.g. '*outings involving going to shops, cafes, pubs, etc'* or those involving *'busy public places'.*
- No longer teaching some subject area e.g. '*employability skills*', this being due to '*workplace providers no longer being open*'.

Interestingly, one respondent defined their particular adaptations as attempting to continue *'to offer the consistency and routine that these pupils require, but whilst also reducing social contact and activities that may lead to challenging behaviour requiring physical intervention'.*

For the practitioners themselves, where following '*specific guidelines*' were reported to have '*made the role more difficult'*, this meant '*changing the way of teaching'* or working:

- Being fully redeployed from one role to another in another service e.g. moving from working in the day service to a role in a supported living service: '*to cover for staff shortages*' and also '*to interact and be company for the tenants who reside there'*.
- Working from home on some days e.g. 2 or 3 per week, or even entirely.
- Working different shift patterns e.g. '*Our management tried to organise for us to come in for fewer days but for more hours each time'* to '*minimise the risk of getting infected'.*
- Working with a different group of learners or service users e.g.

  - '*The first 3 weeks after the lockdown I was working with students I did not know because the students in my team were at home*'.
  - *'Now working in three teams caring for key worker children across the school rather than class based'.*

- Developing '*online safety guidance for teachers and parents'* or preparing work for '*home learning'*.
- Discharging '*most of our caseload*' in order to be freed up for redeployment to other services.
- Catching up on training or '*CPD'*; this being indicated as being via on-line training, with all face-to-face training having been cancelled.

Due to the restriction being put on face-to-face working, a small number of respondents indicated some increased, or even novel, use of technology as part of their working or care role. Such technology included an increase in the use of email, telephone, or '*learning to do video calls!*' (Teams, Zoom, Skype, Facetime, WebEx) to keep in regular contact with clients, families, and colleagues. This varied use of technology wasn't always reported as being easy or successful, although at other times such remote engagement appears to have worked quite well:

- *'Most of my screen time has been discussions with staff, viewing videos of interactions and observing interactions remotely'.*
- *'The Intensive Interaction over Webex [a video conferencing application] was not great when the students struggle with vision and space issues. It worked brilliantly with one Rets girl aged 16, she thought it was hilarious and was very responsive'.*

One respondent indicated the use of Skype to provide some '*minimal'* Intensive Interaction training to families supporting autistic children, and another respondent reported that technology had been used to remotely support '*staff emotional well-being'* as well as more usual '*consultation'* work or responding to '*queries/requests for advice, making and sharing resources, links, etc'.*

For some parents, the change in their care roles was immediate and dramatic:

- *'My son usually goes to a special needs school 5 days a week. Due to lockdown, I have been looking after him and his sister at home since 11th March (France).*

For one in-patient service respondent, the change to their service included receiving *'patients in recovery from Covid-19'.*

Several respondents gave some broad indications of the kind of changes being made to the usual timetabled or expected activities. Some of the adapted types of sessions or activities included:

- '*Not running on as strict a timetable'* as usual and offering students *'choices of activities'.* Also, a respondent identified *'providing more 'fun' activities for students rather than lessons on the timetable with set learning outcomes and targets'.*
- '*Spending a lot more time outside*' e.g. going for walks, or other '*outdoor activities*'. For one service this was enabled by having exclusive access to '*public gardens'* (these at the time being closed to the public). Another school in '*a very rural area with 28 acres of our own grounds*' deeming themselves '*very lucky'* to be able to use this area with their students.

- Offering reduced risk outings e.g. '*going to the local park'* with *'pack up lunches, drinks and snacks on the outings to create something different on every day to reinforce that one day is different from the day before'.*
- Offering or arranging '*home schooling'* this being *'as much as is reasonably possible': 'the children we support remain in the residential side of the school so as to keep those who live together in one place'.*
- For one respondent this was done through finding more '*in-house activities to occupy the people we support*', and one other respondent generally indicating *'more interactive activities onsite'.*

Many of the respondents indicated the adoption of some kind of social distancing, reduced physical contact, the use of personal protective equipment (PPE), and increased infection control measure being adopted:

- Many respondents indicated following '*government guidance'* of some generic '*social distancing'* measure (or attempting to), with both fellow staff and students e.g. making sure that '*the children do not sit close to each other and play with each other's toys'.*
- Reductions in the amount of physical contact with service users was also mentioned: *'Tactile contact has been restricted, unless necessary for personal care'.*
- Also, the availability and wearing of PPE (or 'increased use of PPE') was widely indicated; sometimes *'low level'* equipment such as '*gloves and aprons*', but also '*face masks*' and sometimes '*face shield … in case any residential students become symptomatic*'.
- '*Cross infection guidance*' was indicated as being '*tightened up to enable more frequent hand washing, access to hand gel'*, as was increased cleaning of classrooms or other rooms:
    - '*[We] have to clean the classroom twice a day'*
    - '*[We] were told that we could use the physiotherapy room if we clean the room before we leave it'*.
    - *'Improved cleaning schedules for disinfecting door handles and equipment'.*

For one speech and language therapist, the changes to the usual working routines were reported as being quite dramatic:

- *It's changed beyond all recognition! Face-to-face visits are … only taking place for high risk referrals where the contact is required to reduce risk of hospital admission or serious consequences to the service user. I have done no face-to-face communication visits but have done a few face-to-face visits for swallowing (dysphagia) assessments.*

Respondents' feelings concerning using Intensive Interaction during the Covid-19 crisis

Perhaps surprisingly (but equally perhaps not!), the most often indicated response in this section of the questionnaire was that there was a general continuation of some use of Intensive Interaction: '*It's normal, day to day', 'Fortunately in the city where I live [in Australia] there are very few cases and no community transfer, hence we are engaging in Intensive Interaction as normal'.* These reports were in contrast to a number of other

respondents (often from different roles or geographic areas) who reported the complete cessation of all Intensive Interaction activity with their learners or service users. This continued use of Intensive Interaction during such unprecedented and difficult times was celebrated by some respondents:

- *'I've felt so grateful to know Intensive Interaction as it's allowed us to stay connected, play together, and learn from each other. I've seen my son use new words and communicate in many new ways'.*
- *'It's been nice to maintain the communication and support during a time when there's so much unknown'.*

The central role of Intensive Interaction as a means of communicating with some people with learning disabilities meant that any discontinuation of Intensive Interaction use would be deemed somehow impossible or at least unconscionable:

- *'I have continued to use Intensive Interaction during interactions with service users and their peers when carrying out dysphagia assessment visits. It's such a core part of communicating with people with learning disabilities that [we] just can't stop'.*

For some learners or service users the continued use of Intensive Interaction was seen as especially necessary because of their heavy reliance on the approach:

- *'We still need to continue using this because of the nature of our students who rely heavily on Intensive Interaction for most of the time'.*

The continued use of Intensive Interaction was also indicated as helping some learners or service users to continue to feel socially '*connected'*, and to proactively reduce learners' or service users' levels of anxiety or frustration:

- *'One of the individuals that I am now supporting enjoys Intensive Interaction, so I have continued to use it, I don't have any issues as I feel that without this support the man that I am supporting would become very unsettled and anxious'.*
- *'It has helped with feeling connected with the children within the service and has helped to de-escalate some frustrations that have been caused due to restrictions around seeing family, going offsite, etc'.*

For one respondent, the '*enjoyable'* continuation of Intensive Interaction was seen as contrasting the generalised social distancing then in place outside of the work environment, and it also being valuable for their own '*emotional health'* needs:

- *Intensive Interaction has continued – where students have the capacity to understand change to interactions this has been supported via social stories/visual supports. But most of our students do not have the capacity to understand and need II for their emotional well-being as well as to support communication. It does feel a bit unreal keeping 2 metres apart from people in a supermarket, not being able to visit your own family and friends, then being at work and a child comes to squish your face or use you as a climbing frame. However, those parts of the day are probably as valuable for my own emotional health as they are for the child's. They certainly remain the most enjoyable part of my working day'.*

However, this '*Intensive Interaction has continued*' position was qualified with various other reports of some changes in practices, or different and sometimes conflicted practitioner feelings towards the challenges presented by its continuation with the

restrictions adopted to reduce Covid-19 transmission risks e.g. '*I have felt distinctly challenged',* or *'it has felt like a huge but obviously necessary compromise!'.* Perhaps most particularly, as powerfully articulated by one respondent, the introduction of social distancing *'has struck at the heart of what we do and what I feel is crucial for the people we support'.*

The continued use of Intensive Interaction was various described using terms such as '*strange', 'frustrating', 'hesitant', 'cautious',* especially so if a practitioner was required to wear various aspects of '*hot and uncomfortable' or 'one size fits all'* PPE which restricts, or even rules out, certain aspects of fundamental communication:

- *'It is a lot harder to achieve with a mask and visor or goggles on as your tone of voice is changed and people are unable to see the open face and your full facial expressions. I have found myself over exaggerating vocalisations and facial expressions when using Intensive Interaction'.*
- *'Unfortunately, only visual and verbal interaction has taken place, so it has felt I haven't engaged properly to tenants needs, as the tenants I support use a lot of touch when engaging in Intensive Interaction'.*

Heightened feelings of caution, concern, anxiety (including '*worry*'), and even fear were acknowledged by a significant number of respondents, such feelings being particularly focused around potentially transmitting the Covid-19 infection either to the students (which was reported in one instance) or to their '*loved ones'* from infected students. Such adverse emotional responses were most often associated with the often reported view that effective social distancing was '*almost impossible with our children with autism, severe learning difficulties and complex needs'*:

- *'I have felt anxious at times but a lot of my learners, particularly the one I work most closely with, do not understand the need for physical distancing'.*
- *'I was afraid of getting sick and infect my loved ones therefore I tried to keep as much distance as possible – staff members and students. I felt really bad because I have been doing a lot of Intensive Interaction over the years. There is especially one boy who is at an early level of development who now because of all the Intensive Interaction we have been doing really loves being physically close. He is a boy who has a lot of secretion everywhere and normally this does not bother me at all, but because of the Corona it does, and it is such a huge conflict within me'.*
- *'I worry … as mainly they [the students] do not have the capacity to understand the rules or implications [about social distancing]. I fear that rather they pass on anything to me that I could be passing on the virus to them… it has made me not want to get too close to the students unless I have to'.*

A potential rise in cross-infection risk associated with the use of shared '*equipment'* was highlighted by one respondent, who indicated a change in practice in this area:

- *'Sometimes I feel less inclined to use equipment etc. as I am worried about how this can be cleaned properly'.*

The particular vulnerability of some service users with high support needs made feelings of anxiety about a potentially fatal cross infection even more acute:

- *'I feel sometimes worried about infecting the residents with high support needs who would be vulnerable – I don't want to be the person who gives a potentially fatal infection to those very vulnerable people'.*

However, such feelings of vulnerability were balanced by '*comprehensive bio-secure measures'* being taken, and shared with families, to recognise and accommodate the risks:

- *'There is an inevitable degree of vulnerability, but it is balanced by the comprehensive bio-secure measures taken by the company … factors such as the local levels of infection and changing environmental circumstances are constantly monitored. Families are partners in decision taking for risk control'.*

Some practitioners acknowledged feeling '*very vulnerable and unsafe'* when continuing to practice Intensive Interaction – especially so if PPE **was not** being used: '*PPE is not worn here in the sense of masks etc. as this can also cause issues as the students don't understand what is going on, it makes me feel very vulnerable and unsafe'.*

Because generally social distancing (described by one respondent as '*inhuman')* wasn't practically achievable, then '*extra'* or *'comprehensive'* infection control strategies were employed e.g. '*no visitors, even families*'; a '*limit [on] the number of people in the building at any one time';* a '*rota to reduce the amount of time they [staff] spend in school*'; '*good hygiene and H&S practices*'; '*the correct PPE*'. When these other infection control issues were addressed, then the outcomes weren't necessarily seen as negative:

- *'Social distancing is almost impossible with the children we support. We are fortunate in that because we are a self-contained site it is similar to families living together. It still feels extremely odd though!'*

The initial anxiety produced by *'proximity with pupils'* early in the Covid-19 crisis, was reported by a few respondents as something that reduced over time with familiarity and a better understanding of the health risks of particular groupings. Interestingly another respondent indicated feelings of increased feelings of safety produced by the availability of PPE (even though it seems that the particular respondent then quickly rejected wearing such '*protection'* as it made them '*feel silly')*:

- *Initially I was quite anxious about proximity with pupils, however over time this has reduced. Now that I understand more about the risk groups etc. I feel I am at a low risk of severely being ill, and so are my pupils.*
- *'I know that time is a major factor in this situation too because I can feel that I am more relaxed at work as time goes by. At the beginning we did not have any protection at the school and that really made me feel unsafe because I knew it was impossible to keep the recommended distance. Now that we do have protection at our school, I do not really use it because I would feel silly wearing it but I do of course wash my hands and use hand gel.'*

A general acceptance by practitioners of the two-way Covid-19 infection risks, accompanied by some thoughtful adaptations in their kinds of responding (to lessen the risk), was seen as the best ways to move forward with a continuation of social responsiveness (even if it wasn't at the level of full-blown or classic Intensive Interaction):

- *'As a staff team, on the whole we feel that the need of the pupils for close contact and physical interaction is vital and although we have made amendments to how we interact physically with our pupils, we have also accepted the risk'.*
- *'I am aware of the restrictions and how that impacts the people I am interacting with e.g. a housemate of someone I was assessing was clearly seeking physical proximity, reaching out, attempting to hand hold etc and I didn't feel able to respond with physical contact, given my role and the risk of carrying Covid from care home to care home. That was difficult, but I was able to respond with big facial expressions (well, eyes and eyebrows!) and vocalisations and very deliberate attention'.*

Where there was an identified increased infection risk, this was reported to be ameliorated by a more reflective approach to the use of certain aspects of Intensive Interaction i.e. a more cautious or '*reserved'* use of '*positioning'* to help keep practitioners and students safe. Indeed, not all the reports of changes to Intensive Interaction practices were seen as essentially challenging or difficult; sometimes the outcomes from the necessary changes or challenges were reported as being very positive:

- *'The lady I have been supporting usually only comes in for 2 days a week, but since covid-19, she comes in for 4 days a week. We have certainly seen so many changes with this lady. We work closely with her using Intensive interaction daily, she's happy, seeking affection, so much more eye contact. She is sleeping less. It makes me smile, sense of achievement. I love my job'.*
- *'It has been a great way of getting to know children with whom I don't usually work'.*

New insights and new potential approaches to connecting through Intensive Interaction were also reported as more acute observations developed:

- *[the changes have] '… given new insights on the people we support and watching their expressions and body language as we have developed new things to try'.*

Where respondents accessed 'official' advice on continuing to work during the Covid-19 crisis

The source of official advice for respondents on continuing to work during the Covid-19 crisis was overwhelmingly reported to be from guidelines published by governmental departments or agencies e.g. the Dept of Health, the Dept of Education, the National Health Service (e.g. via '*NHS* video') and Public Health England. The World Health Organisation was also occasionally mentioned as a source of some advice.

For many respondents their reports indicated that advice was taken concurrently from several or even '*multiple sources*' e.g. '*Advice came from Dept of Health, Dept of Ed, the Union (UCU), NHS'* or even more comprehensively: *'From all those … DoH, DoE, NHS, RCSLT, BPS, Unions'.*

Also indicated by several respondents was advice coming from the level of the '*Local Authority*', area '*council'* or the local employing '*NHS trust'*, although the specific nature of that advice will have presumable originated within or be based upon guidelines produced by higher level national or even international bodies e.g. *'NHS trusts that I work for were the primary source, they were based on DoH advice and info from Public Health England'*. Such NHS trust advice to its own staff seems to have been delivered through

many electronic forms e.g. '*Trust's Covid-19 closed FB Group, weekly CEO Zoom conference for all staff, daily Coronavirus updates via communications team'.* The Care Quality Commission was also mentioned as a source of advice by one respondent, presumably covering issues of Covid-19 management within residential or care services.

Sometimes this advice was reported as being filtered down to practitioners (and to some extent presumably abridged or simplified) through their service or company management or '*senior leadership team'* e.g. '*Filtered from DoE, to Head Teacher and through CEO of company 'Covid-19' updates'*. One respondent working for a private provider indicated advice coming from their own 'Covid-lead', whilst another respondent indicated advice being taken from their '*company H+S*' team.

The means of accessing such 'official' advice was reported as being via national or local government websites e.g. gov.uk, Leeds.gov websites, and also directly *'after [the] Government said it on telly'* (with one respondent indicating the advice coming from the '*PM*'; presumable via TV briefings, and not by direct correspondence!), which most likely can only have been advice presented in the most general or broadest of terms.

Other organisations credited with providing advice included specific unions e.g. National Association of Head Teachers, the University and College Union, National Education Union, and '*other education unions'.* Other sources of professional advice were indicated by a small number of respondents e.g. advice from 'SLT' (i.e. Speech and Language Therapy), and from the 'RCSLT' (Royal College of Speech and Language Therapists). One respondent indicated advice being taken from (or at least being given by) '*nurses within college'*

Finally, more individual sources of advice were reported being accessed by a small number of respondents e.g. '*Intensive Interaction emails and Facebook pages and regular exchanges with Amandine Mourière [Intensive Interaction Institute Associate]'.* Some respondents reported accessing a number of Blog, Facebook and email communications from 'GF' - one of the authors of this research report (see Appendix 2a & 2b for Blogs of 08/04/20 & 15/04/20 on using Intensive Interaction during the Covid-19 pandemic):

- *'Just emails from GF … it was a useful reminder that this [Intensive Interaction] was still so important (if not more)'.*
- *'We did read the Intensive interaction papers from GF.'*
- *'GF our SALT team emails only information/consideration.'*

Unfortunately, one respondent indicated that they hadn't actually '*been pointed to any official guidance … in how to continue to engage with the residents',* although they did acknowledge having '*seen many links to advice on many days/links/forms'* – possibly their being an uncommunicated expectation on them that they should research all the often shared links to devise their own working response to Covid-19 crisis. Another respondent rather worryingly stated that: '*we have had to seek out advice, the advice hasn't come to us'.*

In the absence of '*official advice*' a more collaborative sharing of advice was also mentioned i.e. '*no advice, with the exception of my colleague (line manager) and I supporting each other and discussing best practice'.*

The timeliness of any 'official' advice during the Covid-19 crisis

In terms of the timeliness of any such Covid-19 advice, opinions were very mixed among the respondents. When answering the question of 'timeliness' of any Covid-19 advice received, many respondents kept their answers to concise statements of '*yes'* (including '*started at lockdown')* or '*no'* (including '*not at all'*). Luckily, many others added some more enlightening detail to their answers on this issue.

For those answering mainly in positive or supportive terms (i.e. '*yes'*) about the timeliness of any Covid-19 advice (although where such advice came from varied across these respondents), their statements included:

- *'Yes, and changed frequently to respond to new information'*
- *'I think we were told as soon as they knew'.*
- *'Acted at the right time and acted before lockdown'.*

However, even when the advice was reported as timely (i.e. '*yes'*), there were some caveats given about where the advice came from, or on aspects such as the more specific use or availability of any required PPE equipment:

- *'From the college perspective yes; from a government perspective, no'.*
- *'Yes, but a problem that we did not have any protection at the school'.*
- *'Yes, however there was no clear guidance around when masks should be worn in the early stages'.*

For those answering mainly in negative terms about the timeliness of any Covid-19 advice (and again the sources of such advice varied), their statements included:

- *'Earlier advice would have been appreciated'*
- *'No, it wasn't there when I needed it e.g. right from the start'.*
- *'Late and rushed'.*

Perhaps more worryingly, if guidance was seen as late, respondents had been continuing to work over extended periods without any clear guidance or continued to work in ways that increased the risk of Covid-19 transmission:

- *'We had already worked for several weeks without guidance when the guidelines arrived'.*
- *'We introduced PPE with the introduction of shielding for people: maybe could have been introduced earlier if it is seen as a means of protecting the people we support from our unknown virus status'.*

Some respondents were even more forthright in their negative comments about the nature and timing of any governmental advice:

- *'Practically it is not helpful for us with our current students, and it was a little too late as the damage had already started'.*
- *'Governmental action and advice was NOT timely, decisive or effective'.*

However, some respondents were more understanding or forgiving about the apparent difficulties of generating effective advice in a timely fashion during such an '*unprecedented situation*':

- *'Could have come sooner, but I think people did their best'.*
- *'It would have been nice to have had it sooner but that was perhaps unrealistic to expect'.*

Respondent views on official Covid-19 advice in terms of its practical applicability

The usefulness or specific applicability of any official Covid-19 advice garnered various kinds of response, ranging from it being judged as '*clear and applicable*' or '*very reliable'*, through '*quite general and lacking in clarity'* to '*difficult to follow*', and finally on to respondents claiming that such advice was '*very difficult',* '*not practical at all'* or even '*impossible'* to enact with learners or service users with complex needs.

For those respondents generally indicating positive views of the usefulness or applicability of any 'official' advice they received, their statements included:

- *'All the advice and information has been very valuable'.*
- *'We were given clear and detailed descriptions of what to do'.*
- *'Clear and applicable but was very specific to roles such as "community NHS teams visiting care homes"'.*

Despite there being '*a lot of advice*' offered '*particularly for the first few weeks*', the non-specific nature of such advice was seen as problematic. This was deemed due to the initiators of such advice apparently forgetting *'about the existence of specialist educational establishments. The SLT had to form their own plans. In terms of interacting with non-verbal sensory learners who rely on Intensive Interaction to gain social attention, there was nothing'*.

For some respondents, the advice they received ran in complete opposition to what they thought was important to achieve through the use of Intensive Interaction with their learners or service users:

- *'There is a conflict between some advice given to the public, and the requirements of Intensive Interaction. Decisions needed to be taken bearing in mind the essential nature of Intensive Interaction as a component in the provision for and wellbeing of clients'.*
- *'The young people within the service find communication hard enough and we work on breaking those barriers down and now we are asking them to remain distant again'.*

This theme of the plethora of central government advice not being clear or specific enough for services working to care for or support children and adults with learning difficulties, autism or complex needs, was often stated:

- *'There has been a lot (too much) general communication about Covid-19, but not sufficient specific advice about how to safely carry out my role.'*
- *'As usual working in a complex needs school we are always the last to be considered. Our young people don't fit into any sort of model that can be rolled out of central government'.*
- *'It's probably less to do with if the advice was timely enough and more relevant that I don't think there was sufficient focus on protecting people in residential care,*

supported living etc. and there's been little guidance on what steps we might be advised to take to prevent the virus getting into the care home, except for washing of hands'.

For one respondent there was a gradual change over time in terms of the quality and specificity of the advice and support given:

- *'I feel learning disabilities were initially overlooked but as soon as this was realised extra coping strategies were thought about.'*

One respondent described their service journeying from '*unorganised chaos'* through to '*to respectful and admirable advice and support'* as the quality of the advice and support improved over time:

- *'Unfortunately, in the interim it was unorganised chaos and very confusing, distressing and frustrating for ALL involved; steadily it progressed to slightly organised chaos to respectful and admirable advice and support.'*

For some respondents one of the problems with the advice they received (or accessed themselves) was that it was too often changing, too open to varying interpretation, or even that it was at times contradictory in nature:

- *'Some of the wearing of PPE advice has been difficult to follow as it has changed on numerous occasions'.*
- *'No, and really too vague. The announcement early on stating that children with ECHPs should still attend was very contradictory and I think made decisions near on impossible for both SLT, local authorities, social services and indeed parents and students themselves. So, the social distancing and control measures put in place were never going to be able to be adhered to with our cohort of learners.'*
- *'The guidance provided often contradicted itself (e.g. who was entitled a place in school once closed), and open to very different interpretations …'*
- *'Recommendations for children to stay at home wherever possible obviously meaningless when children are in an on-site children's home – we may be registered separately but we very much work as one cohesive service'.*

The criticisms respondents voiced often focused on the difficulty in enacting guidance on: a) following specific 'social distancing' guidance, b) the recommended use of PPE, and c) the reduction or avoidance of physical contact with learners or service users. Their more detailed views included:

On social distancing the respondents' views were generally as follows:

- *'Not practical at all. You can't effectively work with our students in a special school and practice social distancing or effective infection control'*
- *'Very hard to adapt practice around children with autism [and] severe learning difficulties and complex needs who are used to being up close and personal for their interactions.'*
- *'Very hard to implement with our pupils. They simply do not understand or can cope with social distancing. Personal space is not appreciated by our pupils and many continue to spit, grab or touch as primary means of communication … keeping 2 metres from our pupils is impossible'.*

- *Most of the advice has been easy to follow as most people we support are wheelchair users and can't move themselves so social distancing from each other has not been too stressful. But we can't work 2m away as we provide lots of hands on care, so firm guidance would have been helpful in the use of PPE'.*
- *'Difficulties in applying the social distancing advice has been where the space is limited (e.g. in someone's kitchen)'.*
- *'We do limit numbers in our rooms, spend much of the day outside and encourage staff to distance from each other as much as possible.'*

The practical applicability of social distancing was something that varies across different areas within the same services or across different age groups:

- *'Within the office environment, we have managed to maintain social distancing. In other working areas this is impossible.'*
- *'Very difficult to police social/physical distancing in a special classroom setting. Adult areas able to do so – not in class.'*

The differences between the advice given for care and educational establishments was an area of great concern and confusion for one respondent, highlighting an area of potential crossover or contradiction that obviously caused some staff great emotional difficulties:

- *'It is impossible to adhere to the 2m distance with the majority of students. Personal care still needs to happen. There has been a very vague line between 'care' and 'education' - I don't feel anyone knows exactly how to pitch either. This has led to fear, anxiety and a lot of guilt I believe.'*

On the recommended use of PPE (which appears to not always have been available) the respondents views were as follows:

- *'My team have carried on using Intensive Interaction at the same level that they have before – but with PPE in place.'*
- *'Impossible simply because we did not have any protection and to keep the recommended distance is not durable with my students'.*
- *'PPE at the level we are using is difficult when supporting people with learning disabilities due to their lack of ability to comprehend why we have had to take such measures'.*
- *Obtaining adequate PPE hasn't been too problematic, however may have impacted on the introduction of it due to not wishing to run out prior to a possible potential outbreak within the home … It is also been something the staff have wanted not to use for as long as possible as they are aware of the impact on communicating with people when wearing masks, visors or eye goggles.'*

On the reduction or avoidance of physical contact with learners or service users, their views were generally as follows:

- *'Whilst we have reduced the likelihood of physical interventions by reducing challenges in school, pupils still require touch and close contact'.*

In one specific area, two respondents indicated difficulties in the use of on-line communication technology, as either it wasn't made available, or the guidance they received was not practicable and needed to be changed '*some weeks into lockdown'*:

- *'We have had to adapt … most people on my caseload are vulnerable. I would add in confidence that remote technology was initially restricted to Microsoft Teams and we were not allowed to use Zoom as it was not felt to be secure. This has now changed – we can use other platforms if Teams is not available to practical. This change in advice has come some weeks into lockdown'.*
- *'My role is very difficult to do without being face to face! There is also still no appropriate video conferencing programme in place to allow us to do appointments electronically'.*

Interestingly, for some respondents the very basis of any official Covid-19 advice was questioned, with such guidance being described as *'unsubstantiated'* and *'without any scientific back-up or evidence'.* Although, for one respondent, the scientific basis or general applicability of any official advice was not seen a factor of any significance, as they simply stated that: '*I didn't pay any attention to it'.*

Respondents access to advice on using Intensive Interaction from their own service managers and/or colleagues

The most usual answer to the question of whether respondents received advice on using Intensive Interaction during the Covid-19 crisis from their colleagues or management was a simple '*no'*, or slightly more nuanced '*not specifically'*. More charitably, an understanding was advanced that management were perhaps concentrating on other, more pressing priorities:

- *'Nothing from the senior management team as their priorities lay, understandably elsewhere'.*

The lack of any such management advice was a source of particular frustration for one respondent, who did not apparently keep their frustrations to themselves:

- *'No, I did not, but I shared my frustration on my dilemma with someone from my management, members of my team and another practitioner'.*

Some respondents did acknowledge '*some advice*' coming from senior management teams (including from *'pro-active directors'*) or '*our SALT Team (who are working from home)*'. Indeed, a number of respondents were actually members of such management teams that shared advice:

- *'I offered this [advice] as the senior manager – it was basically follow your cross-infection guidance but carry on as normal as much as possible and as each individual staff member felt comfortable to do'.*
- *'Yes. I am part of the senior team and we produced guidance for all staff and regularly update the guidance'.*

It appeared that guidance and advice within larger organisations might have come from senior managers in consultation with, or from different managerial or administrative departments within that organisation:

- *'The college works on advice given by several departments'.*

- *'Responsibility for degrees of implementation made by the organisation, who consulted all interested parties to ensure confidence in safe practice'.*

The nature of such management or colleagues' advice was indicated as often being quite general, and seemingly covering the same issues as governmental advice e.g. '*to practice social distancing*', '*to wear PPE'* this being indicated *'if social distancing is not possible',* and to *'wash hands more, don't touch face, clean the areas and things used more frequently etc*.'.

The role of an Intensive Interaction coordinator within a service or school was also highlighted as having a specific role in developing and sharing more individualised advice on the continued use of Intensive Interaction:

- *'As Intensive Interaction Coordinator in our school, I will have conversations with teachers as students return on how Intensive Interaction might look for them in the near future'*
- *'I am the Intensive Interaction co-ordinator so have been working alongside SMT to advise individuals'.*

Other respondents acknowledged practical or hands-on advice coming from more experienced colleagues:

- *'I did get advice from other carers (the experienced ones) showing/telling me what they have been doing'.*

The role of a supportive team of practitioners was also identified, albeit within a small group (e.g. two practitioners – perhaps it being easier in smaller groups, or alternatively, perhaps these respondents felt they had no other supportive alternatives) or within a 'self-contained' area of work:

- *'Within our two person team we collaborated and bounced ideas off each other*' *and reflected on what worked well and what was difficult*.
- *'For our two person team there was none specifically so we discussed/advised best practice together and kept up daily Zoom calls for debrief, reflection and check-in'.*
- *'We discussed it as a team and really for us it is 'business as usual'; again this is because we are generally a self-contained site'.*

What respondents reported as working well in terms of using 'adapted' Intensive Interaction practices during the Covid-19 crisis

Unfortunately for a significant minority of the respondents, they reported that due to service lock-downs, and therefore there being no '*face-to-face*' contacts with clients or service users, they had not been able to continue to practice any Intensive Interaction during the Covid-19 crisis.

There were a number of areas of adapted Intensive Interaction practices used to accommodate infection control measures, and as reported above, these included the introduction of more social distancing, the use of PPE, and reduced physical contacts.

The accommodation of social distancing within respondents' Intensive Interaction practices was a theme that emerged strongly across the questionnaires. As previously stated, keeping a safe distance during Intensive Interaction wasn't always easy (or successful) but it was an issue of which practitioners were keenly aware.

Changes in Intensive Interaction practices made to accommodate or enable social distancing included: going outside for walk or in the '*extended play'* in the garden or playground, having a table between participants, interacting through a window, or making a change in a practitioners physical height or orientation. No matter the distance between Intensive Interaction partners, practitioners were still required to '*tuned in*' and give '*full focus and attention*' to the learner or service user:

- *'It has worked really well to do Intensive Interaction on our walks, to sit across from each other with a table between us (for instance during lunch etc), when the students are jumping on the trampoline or sitting on the swings. I have also invited students to do Intensive Interaction with a window between us which has worked so well because we are able to examine each other's faces up'.*
- *'Being sat away from the residents but lower down (i.e. not right next to them).'*
- *'Sitting beside our students for Intensive Interaction, and not in front of them.'*
- *'Outdoor/garden activities have worked well able to social distance within the service as all are supported 1.1'.*
- *'Going outside more (less anxious about proximity), feeling the wind and rain together (such a sensory experience to take the time to do), role play activities (with verbal learners developing repetition and our own 'catch phrases')'.*
- *'Making good use of being able to go outside for fresh air and extending play in familiar settings'.*

In terms of using PPE, which was noted as being compulsory in many cases, whilst one respondent reported becoming accustomed to it, and even trying to make positive use of some joint sensory exploration of aspects of the equipment. In contrast, another respondent preferred to consciously ignore '*all the advice'* around the use of PPE, citing potential problems that might arise with their use for their young person:

- *'The main adapted Intensive Interaction practice would be the wearing of PPE which was compulsory … However with that in place and once I became accustomed to wearing it I followed the flow of the Intensive Interaction approach as I usually and naturally would - following the lead of the person (observing, pausing being responsive) I was with at the time and attempted to highlight the positives that such garments could suggest i.e. gloves – for some clapping and tapping was a huge thing and the gloves provided a variation in soundtrack (a sharper, resounding focus on the clap) and texture inviting the touching/clapping/tapping, stretching (of gloves at fingertips) and exploring of hands/chairs/tables etc. in a safe way; the apron to a lesser degree could also provide a sharp, silky ruffling/shuffling sound/motion/texture when stroking/finger threading the plastic in a behavioural mirroring action'.*
- *'I wouldn't ever use a mask or gloves because that would hide my face and I would be introducing materials my YP [young person] would mouth or eat. What worked well was ignoring all the advice and just being; in the present; connected; with love; free of fear and anxiety'.*

In terms of reducing physical contact with learners or service users, this wasn't always reported as being straightforward or 100% effective, with a particular issue arising for people with visual impairments:

- *I have reduced my physical interaction and shifted to trying more vocal interaction with pupils that can do so. In some cases this has been effective, but on the whole my groups love the physical nature of our interaction and they will seek out touch based interaction*
- *'On one occasion I tried not to move as much, as this seemed to be increasing the person's attempts for physical contact e.g. if she waved or wanted a hug, if I waved back then that would increase the reaching, where if I kept my arms down and responded enthusiastically in other ways then that maintained the interaction without encouraging physical contact'.*
- *'Close proximity and touch continue as this is a significant communicative bonding process specifically for 2 of the tenants who have a visual impairment enabling them to have the opportunity to feel included and connected with someone else'.*

Such increased use of vocalisations (from a safe distance) or using exaggerated vocal tones was one adaption that was indicated as being successfully employed by several respondents instead of getting close in or using facial expressions or physical contacts as part of their Intensive Interaction practices:

- *'More vocal, pull mask down from a distance.'*
- *'Exaggeration of tone to compensate for inability to see my face due to PPE'.*
- *'More intentional with vocal responses, whether that's mirroring or responding vocally where I would have used touch or proximity normally'.*

Other changes to the Intensive Interaction practices that respondents reported included using '*more expressive eyes'* and *'exaggerating facial expressions',* '*more hand movements'* and more or exaggerated '*head movement',* often in combination with other '*more expressive*' behaviours with the voice, eyes, face, head or body:

- *'Use your eyes to engage with students to take away any worry they have looking at the mask'.*
- *'More exaggerated facial expressions, particularly eyes when wearing a mask'.*
- *'More/louder vocalisations, more/exaggerated head movements, bigger eyes that are more expressive'.*
- *'Eye contact, eyes/eyebrow raise, smiling (even behind the face mask – cheeks lifting), laughing, vocalisations, words/sentences/singing (2 of the 8 tenants are verbal), body movement etc. is much bigger, more dramatic, clearer, using pitch and intonation and acutely responsive in nature'.*

The use of *'exaggerating facial expressions'* was also reported to be used by one respondent during remote, screen-based interactions with one person; interestingly it being deemed somehow potentially compensatory in terms visual impact of the practitioners face via a small screen:

- *'I have tried … maintaining interactions with one person. She is used to screens and enjoys her iPad. Exaggerating facial expressions more seemed to engage her – my face on her screen was smaller than normal, so this compensated perhaps'.*

Unfortunately, one potential difficulty of continuing or increasing the use of vocalisations within Intensive Interaction engagements, was that some learners or service users were

reported to view such vocalisations as an invitation for increased proximity – the opposite to the 'social distancing' effect that was desired:

- *'I have tried to carry on using sounds and vocalisations to continue Intensive Interaction, but this often leads to the students getting quite close which worries me'.*

Quite a number of respondents indicated that they hadn't changed their Intensive Interaction practices at all, despite the guidance on social distancing, the use of PPE, and reduced physical contacts. Other increased infection control procedures e.g. more cleaning, greater personal hygiene, were indicated as being adopted, and the wearing of PPE seemed to be the required change (when necessary) that caused practitioners least disruption:

- *'No real adaptations – other than washing hands, considering a change of clothes, access to PPE if felt needed'.*
- *'We just have to carry on as normal and wash our hands an awful lot.'*
- *'We have had to carry on basically as normal.'*

Whatever changes in their use of Intensive Interaction with their learners or service users, the continued success of Intensive Interaction in terms of developing successful social inclusion was reported:

- *'The people are responding in the same way as they always have so there appears to be little impact on this for them in terms of their level of interaction with me and the team supporting them.'*

Mentioned several times was the adoption of '*strict'* or '*comprehensive'* cleaning protocols during the Covid-19 crisis to reduce the chances of cross-infection. In one case this change in non-Intensive Interaction practices allowed Intensive Interaction to go on relatively uninterrupted:

- *'Comprehensive hygiene protocols for before and after sessions. Strict cleaning protocols in the environment. These measures were as safe as could be without disabling Intensive Interaction sessions'.*

One very positive outcome reported in terms of changes made during the Covid-19 crisis was that more 'one-to-one' time was available for individuals to engage in Intensive Interaction, leading to improved social outcomes for some learners and service users:

- *'We have followed the plans we have in place … this has worked as staff have felt they have had more time to do Intensive interaction'.*
- *'Most things worked well as had longer time with individuals'.*

Interestingly for one respondent it was the children they support who were the ones who adapted their Intensive Interaction practices. In the instance reported it was through the children's use of '*eye movement*' that they were able to continue to socially interact with their staff wearing face masks:

- *The children we support adapted their practice! Of course, we allow them to initiate the interaction and 2 of our children used eye movements when interacting with staff who were wearing face masks. This was very interesting and proves to me we are doing things 'right' – the children lead'.*

What difficulties were reported in terms of respondents using 'adapted' Intensive Interaction practices during the Covid-19 crisis

There were a number of practical or procedural difficulties indicated by respondents in terms of using Intensive Interaction during the Covid-19 crisis. The issues that had a '*negative impact on the quality of interactions'* were those directly associated with the infection control procedures widely adopted across services and care environments i.e. those procedures required to keep both practitioners and their learners or service users safe from coronavirus infection.

Adapting to the necessary changes in procedures was seen to be particularly difficult for some children with autism due to their already heighten states of anxiety:

- *'We can only do our best given the circumstances. Many of our children have autism and find change extremely difficult. We are trying to put a fun element in, but this is not easy for children who are in heightened states of anxiety'.*

The most frequently reported difficulty was in trying to use the fundamental communication strategies of Intensive Interaction whilst wearing particular items of PPE which '*made connection with clients almost impossible'* e.g. face masks that '*muffled'* voices, or because of *'not seeing facial expressions when wearing the mask'.* Also reported was that *'using physical contact via latex gloves feels unnatural and a bit off-putting'.*

The practical difficulty in having to change all the PPE between interactions (i.e. with different learners or service users) was also noted as '*PPE began to run out due to demand as having to change into new PPE for each interaction'.*

However, it was suggested that this difficulty was (to some degree at least) time limited i.e. *'wearing masks whilst interacting caused [a] slight raise in anxieties during the first couple of days*', suggesting that a process of habituation to (i.e. getting used to) the new practitioner presentation could happen over a relatively short period of time, at least for some learners or service users – as one respondent said: '*it took a while to settle in'*.

More proactively, one respondent also reported using '*social stories and easy read documents'* with some verbal children '*to support their understanding'* of the staffs' use of PPE, presumably to counteract any initial anxieties caused by this dramatic change.

Interestingly, even though wearing a facemask was acknowledged as difficult in terms of reduced verbal comprehension by one respondent, there was actually one potentially positive consequence in using this aspect of PPE i.e. '*Of the required garb, the facemasks are a struggle re: clarity and understanding of words/short sentences for the tenants who are verbal. However, I even looked to find a positive within the mask and found that it can aid intensifying the echo of someone's breathing pattern'*.

The second most frequently reported difficulty was in trying to engage in Intensive Interaction whilst '*being at a distance'.* Enacting socially distance was directly associated by one respondent in unfortunately creating the potential for greater emotional distance for some people - *'It is hard to be 'socially distant' as that can feel emotionally distant to a person that doesn't read communication that well'.*

Greater distance could cause a variety of responses from leaners e.g. '*Sitting further apart – students looked confused and would often move towards us or go away'.* The central difficulty with enacting social distance whilst trying to socially engage with people was not lost on one respondent: '*These young people need us to be wanting to be with*

them, not wanting to get away!' Unfortunately, if other strategies were used to compensate for greater social distance (e.g. with more '*mirrored movements')* then this would actually result in drawing the learner or service user nearer to the practitioner:

- *'Responding with mirrored movements and gestures from a distance seemed to encourage the person to move more towards me, which was understandable but not the aim given the situation'.*

A difficulty keeping to the newly required safer social distance wasn't confined to the learners or service users, as one respondent honestly reported: '*I kept going with the flow sometimes, and forgetting to keep my distance'.*

As well as having to manage more social distancing with learners or service users, the associated absence or reduced frequency or intensity of physical contact was also reported as being problematic e.g. '*It makes interactions tricky, particularly with students who need a high level of close physical contact for and interaction to be successful'.*

- *'[the] person I was 'with' likes physical contact and enjoys pulling you close and sniffing your hair. As a result, it seemed that at moments of engagement and pleasure, she would reach for the support worker in the room with her and pull them close'.*

'One piece of advice' respondents would share with others in a similar situation

The vital and continued importance of Intensive Interaction was a strong theme that emerged from the responses to this piece of research:

- *'Our students/clients/children still desperately need our interactions'.*

Sharing '*thoughts and dilemmas'* and working collaboratively with peers, as part of a team, or as part of a wider Intensive Interaction community were seen as being particularly important at this difficult time:

- *'If you are anxious about the virus, and risks associated with working, discuss this with your team'.*
- *'Work with peers to come up with strategies. Even if it's not pure Intensive Interaction the benefits will still be there'.*
- *'For us, it's more about remaining part of an Intensive interaction Community as Intensive interaction is not yet known in France'.*

Working closely together within or across teams was also seen to have an additional positive consequence of enabling staff or family members to more diligently '*look out for individuals mental health during these challenging times'.* Indeed, working closely with families was also identified as being vitally important during the Covid-19 crisis:

- *'I have made sure that parents/carers have been given lots of information about Intensive Interaction and how to use this as families can get closer with less risk, and I feel at this stage this is a much safer option'.*
- *'I sent information packs with videos to the families for them to show to carers and family members how Intensive Interaction is done with their child. Some responded well and seemed to 'get it''.*

- *'Absolute honesty with families and other relevant parties is essential in maintaining confidence. Isolation and lack of communication and stimulation has devastating effects on people with PMLD, which should be taken into account when discerning whether to continue with Intensive Interaction'.*

The most common pieces of advice indicated by the respondents that they would share with others in similar care or working situations was to generally '*remain positive*' and to '*continue to use Intensive Interaction'* i.e. '*don't give up'* or '*carry on regardless*'. Similar to this theme, another general area of advice could best be summed up by the statements '*Don't be too hard on yourself',* or *'don't be over critical of yourself'*; perhaps even more generously, just '*be kind to yourself'*. Practitioners being realistic about the levels of expectation they should have about their own work or care practices was also indicated as useful as '*we are here to do a job as best we can*'.

- *'Don't be too discouraged with your results from Intensive Interaction, given the current circumstances'.*
- *'These are surreal times and you can only do what you are humanly capable of doing'.*

Also trying to '*find humour in the situation'* was suggested as good advice to follow (without providing any examples of precisely how to do this!), and also with one respondent insightfully noting - '*Covid-19 is serious, the people don't know it is serious, so don't forget to have fun!'.* So, as always with Intensive Interaction, it remains important to '*enjoy the moment, create that bubble, spend time with the person, enjoy being with them, rather than doing to'.*

Being both well informed and continuously adaptive with individualised Intensive Interaction strategies were seen as key ingredients to continued success:

- *'Keep finding ways to do Intensive Interaction - Explore your options'.*
- *'Keep trying to find different things to find what works best with each person'.*
- *'Adapt your response according to the risk in your town/city. Here in regional Queensland the current risk is minimal'.*

One respondent identified that the process of making adaptions in Intensive Interaction strategies was a one sided process i.e. the opportunities for adaptations to Intensive Interaction practices needed to be actively identified by the practitioner:

- *'I think it's easier for staff to find ways to use Intensive Interaction with service users than it would be for some service users to interact with staff, so staff may need to be more aware to look out for the opportunities to use the practices'.*

Keeping written and/or video records of any successful adaptations to Intensive Interaction practices was also indicated as being useful, both currently and at some point in the future:

- *'Try different approaches and document the response for others in the future'.*
- *'Keep regular records (written and video) so as to continually reflect on practice and consider new ways of responding in order to get better'.*

Trying to be or at least appearing to be calm and relaxed (as opposed to anxious) during engagements was seen as a secret to continued success with Intensive Interaction.

Indeed, communicating or transferring anxiety to learners or service users being identified as counterproductive:

- *''It only works with Intensive Interaction if you are relaxed and feel safe, so do not try to force yourself to do something you do not feel safe or comfortable'.*
- *'It's important to still be present and available for quality Intensive Interaction, even when we are anxious about the risks involved'.*
- *'You cannot do good Intensive Interaction if you are anxious, and you will probably have a negative impact on the young person by transference of your stress/anxiety!'.*

As well as appearing calm and relaxed (and thus to some extent '*reassuring*'), showing the person that they are the total focus of attention during Intensive Interaction engagements was identified as continuing to be important during the current Covid-19 crisis (as it always is with Intensive Interaction):

- *'Make sure the person you are working with knows they are your total focus for the time you are together and stay relaxed and responsive'.*
- *'Ensure that the individual is at the centre of what is best for them'.*
- *'These are not the times to be rushing through these moments, to be focussed solely on the task in hand and to miss the opportunity to connect, interact and hopefully reassure'.*
- *'Be reassuring, and in any way you can let the person you are with know you want to be with them'.*

Other advice included being as '*safe as you possibly can*' and to be continuously alert to cross-infection risk reduction e.g. '*carry on and wash your hands' and 'Pay close attention to hygiene; this is key to all infection control'.* Not only addressing the issue of infection control, but staying and feeling '*safe'* was seen as important in terms of developing good, attuned engagements with Intensive Interaction:

- *'You do need to feel safe in order to stay tuned in while doing Intensive Interaction'*

Some advice was offered focused on the use of technology during the current period:

- *'Remote interactions are possible for some people, but it is a poor second best'.*
- *'Limit your time on internet/phone. It's a highly addictive distraction, will take you away from your person to another reality where you will not be present with your person'.*

Some more specific advice related to adapted Intensive Interaction strategies was offered by some respondents:

- *'Replicating a sound or a rhythm or a movement, are all interactions that can be done a bit apart. Holding someone's hand and moving it or stroking someone's hand or foot or attaching something bright/soft/colourful to a short pole and carrying out some interaction using the device'.*
- *'Get outside as much as possible!'*
- *'Take some knitting in. Catch up on your CPD!'.*

Some final comments made by the respondents:

The continuation of Intensive Interaction ('*sticking with what works')* both during and after the current Covid-19 crisis was a strong theme that emerged when the respondents were given space for some final comments at the end of the research questionnaire.

- *'Enjoy doing intensive Interaction'.*
- *'[Intensive Interaction] remains vital to communicating with people'*
- *'It's so lovely and reassuring for the students to be engaging in Intensive Interaction with familiar adults'.*

For some respondents, the vital role that Intensive Interaction plays in combating social isolation was even more important to use during the lockdown than previously. This important social connection role of Intensive Interaction was also associated with improved mental health outcomes for both staff and students:

- *Still connecting with the residents is even more important as they are stuck in the same 4 walls 24/7 so Intensive Interaction is more important than before*
- *'I have emphasised to my colleagues that in these times of social isolation the connection brought about through Intensive Interaction sessions is really important for our students' and staff well-being and mental health so keep doing it and enjoy every minute!'*

However, the comfort and confidence of staff was highlighted as something to be taken serious account of when continuing to advocate for the use of Intensive Interaction:

- *I feel sad for any person out there whose interactions have reduced in frequency or quality at this current time, when increased anxieties about them probably make it more needed than ever. However, we as leaders need to be empathic to any staff who are feeling vulnerable – they need to feel as comfortable, safe and supported as possible within these challenging circumstances*

The need for those who have continued to practice Intensive Interaction during the crisis to share and learn from their collective experiences was also raised as an important issue:

- *'I think it is really important to share our experiences during the current situation so we can find ways to keep up the work with Intensive Interaction'.*
- *'This is a time we all need to pull together, be open and honest about how you feel and talk to your colleagues. Draw from each other – we can do this, we have to!'*

For one respondent (a peripatetic teacher) an increased use of Intensive Interaction with specific individuals during the crisis was actually reported as a very positive experience:

- *'I was delighted to be reminded how effectively I could work when I can be with clients for 6 hours a day, day after day, rather than one hour a week'.*

Another respondent (a parent) also indicated that they will look back at the current Covid-19 period with positive regard, even indicating increased Intensive Interaction use both during and after the current restrictions are eased:

- *'It's been a real opportunity to keep up very regular practice and therefore reflect on my practice and see real results in his communication and behaviour. Despite some difficult moments, I'll look back on this time with some great memories. It also*

led me to consider the possibility of removing him from school one day a week in order to maintain our practice at home in the future'.

However, a significant concern was raised by one respondent that, even as Covid-19 restrictions are eased, a return to using certain Intensive Interaction techniques more generally might not necessarily follow automatically:

- *'I am concerned that, even as there is a relaxation of the Covid 19 restrictions and children begin to return to nursery/school, practitioners in educational settings may be reluctant to engage in close contact elements of Intensive Interaction; this could have significant impact on early Autistic children's development of fundamental communication skills, emotional well-being and ability to develop relationships with the adults supporting them.'*

Another concern expressed was that the current situation (of social distancing, reduced physical contact and increased infection control measures) would somehow become 'a new normal' in terms of future care or educational practices:

- *'Let's make sure that this is not a new normal way of doing things!'*

For one respondent, their views on the importance of Intensive Interaction were presented in even stronger terms, stating that they '*Couldn't live through this nightmare without it!*

Finally, almost poetically, one respondent pointed out that '*Intensive Interaction … is required in order to live in life and not just exist in life',* which perhaps summarises the importance given to Intensive Interaction both now, and at any point in the future.

Appendix 1

Covid-19 'Adapted Intensive Interaction' Action Research Study

The answers you give to the questions below will be collated anonymously into a single final report that will not include any identifiable details of any individuals or services.

(This 'Word' questionnaire will expand as necessary as you type in each box, so please do not take the size of the boxes as an indication of how much you can or should write).

Area of your work or care? e.g. family home, special school, adult residential service, inpatient or respite service, etc.
Description of your role? e.g. parent, teacher, support worker, residential carer, service or home manager, etc.
Age range of those you care for or support? e.g. 0-5, 5-11, 4-19, 19+, older adults, etc.
How has your role, circumstances or service changed due to the current Covid-19 restrictions?
If you have continued using Intensive Interaction during the current Covid-19 crisis, how has this made you feel?
Where did any official advice on '*enacting social distancing and infection control*' within your role come from? e.g. Dept of Health, Dept of Ed, NHS, RCSLT, BPS, Unions, etc?
In your view was any such advice timely enough?
How would you describe any such official advice in terms of its practical applicability?
Did you receive any advice on using Intensive Interaction from your senior managers or colleagues? If so, what was this advice, and how useful was it?
In terms of using any adapted Intensive Interaction practices, what worked well for you? … and why do you think this was?
In terms of using any adapted Intensive Interaction practices, what didn't work so well? … and why do you think this was?
If you could share one piece of advice to others in a similar situation as yourself, what would that be?
Is there anything else you wish to say about your use of Intensive Interaction during the current Covid-19 pandemic?

Thank you very much for completing this questionnaire. From this action research endeavour we hope to help current and future Intensive Interaction practitioners to learn from the current situation and adapt their practices more safely and effectively.
Please return completed questionnaires to nicolaguthrie@nhs.net

Appendix 2a: GRAHAM FIRTH: INTENSIVE INTERACTION BLOG – 8TH APRIL 2020

Some guidance on the use of Intensive Interaction during the Covid-19 pandemic

These are certainly the most challenging of times.

During the current Covid-19 pandemic we are personally and professionally required to keep social contacts to a minimum, and strictly adhere to all social distancing and infection control practice guidance. Inevitably this crisis is therefore creating many complications in terms of how we continue to care for our most vulnerable people, including how best to continue to use Intensive Interaction.

Many of those we care for or support will not be able to understand the need for social distancing or increased infection control measures, but they will still expect and need some form of responsive and reassuring Intensive Interaction engagement.

Indeed, many of those we care for may currently be feeling highly anxious due to changes in their familiar care and support routines. Such increased anxiety will make the need for social engagement even more important for the mental health and well-being of those we support; all at a time when it is potentially more difficult to enact.

As we follow all the necessary steps to minimise the risk of a potentially fatal Covid-19 transmission, the use of gloves, face masks, and in some instances full Personal Protective Equipment (PPE) will become necessary (and is already in some services). Such mandated infection control practices will unfortunately limit some of our available means for social exchange e.g. physical contacts, close proximity, or if face masks are being used, even verbal/vocal exchanges and/or exchanges of positive facial expressions.

However, fortunately the varied means and flexible structure of Intensive Interaction allows us to explore some other potential means of social interactivity with those we care for and support. It may well be necessary to adapt our strategies for social engagement, avoiding when and where we can, or at least minimising physical contacts or close physical proximity (although for many this will still be required to meet their functional care needs).

Instead it may be necessary to use Intensive Interaction strategies that can be enacted with more and therefore safer social distance e.g.:

- Using more demonstrative body language e.g. using bigger hand gesturing or using more dramatised body posture, or shoulder movements, to communicate our social responsiveness.
- Finding more ways to exchange eye contacts and mirror facial signalling (from a safe social distance) e.g. using more dynamic, or even very dramatised eye-brow expressions and head movements from further away.
- Using more, or more kinds of behavioural mirroring (at a safe social distance), including amplified hand, arm or body movements to make our socially interactive responses clearer for the person to see or sense.
- Developing increased turn-taking in various forms (from a safe social distance) e.g. via sequenced hand, arm or body movements; clapping hands or stamping feet in sequence or together; tapping or banging items of furniture in sequence or together; using a range of sequenced voice or mouth sounds.
- Using standard vocal echoing or exchanges of vocal/verbal sequences (at a safe social distance): remember, responding to a person's vocalisations does not have to be via a direct echoing; some physical movement can also act as an appropriate response, so long as the shape of the movement somehow matches the pattern of the person's vocalisation.
- Using verbal "commentaries" on a person's actions, or the actions of others in a shared environment; possibly at increased volume from a safe distance.

- Using more forms of 'joint-focus' activity that can be enacted with greater social distancing e.g. jointly listening to music or watching mutually interesting TV or films together, and regularly signalling the mutual enjoyment of the joint activity with the person e.g. via frequent eye contact and shared smiles.

Also, while Intensive Interaction is a mainly responsive approach, due to social distancing then more proactive social initiation by a practitioner choosing the safest, socially distant means, seems entirely prudent and correct i.e. proactively using the safest interactive means available (taken from any previously developed interactive repertoire with a person) will often be the most advisable. Trialling different 'safer' interactive means will at times be necessary; some adaptations will work well, others may not – that is just the nature of Intensive Interaction anyway!

Remember, it will be up to every practitioner and manager to discuss, agree and then trial any 'safer' adaptations to their normal and individualised Intensive Interaction practices; this may not always be easy, but in many cases it will be absolutely necessary to support the well-being of those we support and care for.

Please stay well, and practice Intensive Interaction effectively but safely!

(Accessed on 14/07/20 at: https://intensiveinteractionblog.blogspot.com/2020/04/some-guidance-on-use-of-intensive.html)

Appendix 2b: GRAHAM FIRTH: INTENSIVE INTERACTION BLOG – 15TH APRIL 2020

Some Simple Dos & Don'ts for Intensive Interaction During the Covid-19 Pandemic

These continue to be the most difficult of times; for some, they are truly tragic. But, whilst following all social distancing and infection control guidelines, we also need to continue to practice Intensive Interaction (as best we can).

So, to take account of the current crisis, we have adapted some of our pre-crisis Intensive Interaction '**Simple Dos and Don'ts**'. So, please remember that:

- **Intensive Interaction is still a person-centred approach**: we are still trying to interact with our person by, in some way, sensitively joining in with (or reflecting back) some aspect(s) of their current activity or behaviour. ***We still want to do Intensive Interaction 'with' our person, not to them!***
- **Go at the pace of the person:** there is absolutely no rush; use all the time you need to find the best, and safest, means of socially interacting.
- **Good observation is as important as ever** in deciding how best to safely interact with our person. Sometimes just sitting back (at a safe social distance) and patiently waiting for the person to do something potentially small, but potentially interactive, can give us the best starting point.
- Be sure to **share your 'adapted' interactive successes** with everyone else who should know. If you have found something important (e.g. about how best to adapt your Intensive Interaction practices) then let everyone know!
- **Don't be put off if things don't always go well**; especially when adapting your Intensive Interaction practices to fit with safe 'social distancing' and infection control practices (e.g. with full PPE). But remember, that is the very nature of Intensive Interaction; sometimes things go well, sometimes they don't … but we adapt, try again, and thus continue to move forward.

- **Don't be afraid to ask for help and support** if you need it (from whoever else is available); this is surely never more true than at the moment. We all need help to stay strong and well for each other during this current crisis. Let's get, and let's give as much support as we all collectively need.
- Finally, please also remember that Intensive Interaction should still be **mutually pleasurable**, so to try to enjoy interacting with your person; this may be difficult at the moment, but it still remains our ultimate purpose.

(Adapted from Firth, G., Menzies, L. & Guthrie, N. - 2012)

Also, to support the continued fidelity of our Intensive Interaction practices, it might be useful to check any adaptations we make against Melanie Nind's '**5 central features of Intensive Interaction**' ('*Efficacy of Intensive Interaction*', 1996), these being (slightly adapted for the current Covid-19 crisis):

1. The central purpose of Intensive Interaction is still the creation of 'mutual pleasure' i.e. Intensive Interaction is still all about sociably 'being with' someone, with the purpose of mutually enjoying each other's company.

2. Intensive Interaction practitioners adjust their interactive behaviours (e.g. their use of eye contact and facial expressions, the use of their voice, the use of movements and posture) so that they can be more visibly and/or audibly meaningful, and therefore more socially engaging, to their person.

3. Intensive Interaction engagements will develop a mutually agreeable tempo and sense of 'flow'; such a flow being enabled by the judicious use of pauses (e.g. to allow for participant processing), and the repetition of aspects of a mutually negotiated interactive repertoire.

4. Intensive Interaction practitioners will accredit social 'intentionality' to the actions of their person, responding to all of a person's behaviours as if they potentially have intentional communicative significance.

5. Intensive Interaction practitioners contingently responding to the social initiations and subsequent actions of their person; following the person's lead and sharing control of any interactivity.

The now required Covid-19 infection control practices (i.e. social distancing, and the wearing of PPE) will inevitably limit some of the strategies we might use in our usual Intensive Interaction practices. But it will still be useful to have these '**5 central features of Intensive Interaction**' in mind to ensure that our adapted Intensive Interaction routines still fit within the true spirit of our socially responsive Intensive Interaction approach.

Please stay well, and practice Intensive Interaction effectively but safely!

(Accessed on 14/07/20 at: https://intensiveinteractionblog.blogspot.com/2020/04/some-simple-dos-donts-for-intensive.htmll)