Early Years Intervention and Prevention.

Reports from Winston Churchill Memorial Trust Travel Fellowships.

See: https://www.wcmt.org.uk/tags/early-years-intervention-and-prevention

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24. Co-productive use of trauma-informed practice in the early years.

Helping troubled young men become 'good enough' fathers.

Shirley Gracias.
https://www.wcmt.org.uk/fellows/reports/helping-troubled-young-men-become-good-enough-fathers#downloads

Précis.

The visits I made reinforced for me the importance of fatherhood in the lives of men and boys. Many of those I came across suffered from the lack of positive parenting in their childhoods that had resulted in trauma and loss. For some of the people I met this was through the intervention of the state in removing children from their homes, for others it was because of what happened in their homes that included the experience of violence often perpetrated by their fathers. Looking specifically for interventions targeting men and boys I saw that there were limitations in what was being offered. However, there was a range of interventions many of which provided modest inexpensive ways of connecting with men.

Many of the changes I saw to allow men access services, the provision of which has traditionally focused on mothers, were simple and inexpensive.
• In some of the Circle of Security work the change was simply to allow men to join their partners in the groups at a late stage. This encouraged mixed sex groups that allowed for some discussion about cultural expectations.
• 'Coaching Boys into Men' demonstrated that offering short educational sessions as part of sports development increased an understanding of violence and it's impact on others.
• The texting service offered by Newcastle University had an impact in helping young fathers engage with their children's pregnancies and change their behaviour.
• The boisterous play intervention was not expensive in terms of equipment or the intervention. It's essence is to get fathers doing what in many families happens naturally and it is linked not only with the development of the father-child relationship but with confidence and self-esteem in the child.

Offering men and boys services to explore their parenting works. For men coming out of the prison justice system the provision of a COS group that was part of their rehabilitation programme allowed them to explore the impact of the parenting they had received on their lives and how they were fathers. This was being shown to lead to a connection (or reconnection) with their families that then became an important factor in preventing them reoffending.

Parent infant projects in New York: Early years prevention and intervention.

Kerry Taylor.
https://www.wcmt.org.uk/fellows/reports/developing-preventative-mental-health-babies-and-their-parents#downloads

Précis.

The aim of the Fellowship was to gather knowledge, understanding, and practical skills in the field of therapeutic parent infant projects. This research was carried out by interviewing knowledgeable and inspiring people active in the field of early intervention, infant mental health, and parent infant therapy. Parent infant projects were located across New York City; Manhattan, Harlem, The Bronx and Brooklyn with one project on Long Island. Projects were often linked to academic institutions and these were Columbia University, Adelphi University, The New York Center for Child Development and the New School for Social Research.

Key findings of the research were firstly on collaborative and collective movements that will establish and raise the profile of infant mental health across the UK. Secondly, key factors were identified for successful parent infant project intervention with the most vulnerable families. These key factors translate into recommendations for UK practice of:

- Progressive leadership in order to mobilise a cultural shift amongst policy makers and professionals so that infant mental health has adequate recognition.
- Early and universal screening for parents and their infant's mental health including potential diagnosis of infant mental health difficulties using evidence based methods *and*
- Services that are embedded, accessible and trusted by each community.

Visiting and talking to projects in different areas and contexts of NYC has enabled greater understanding of families that are deemed 'hard-to-engage' in the UK. It was particularly interesting to consider how practice could be applied in an accessible way for families. While there is a great deal of skill being employed in the UK in engaging families, there are several ideas taken from US models that are embedded, accessible and trusted that can confirm and develop our practice. Attachment based interventions in the US confirmed that our Children's Centre community model has massive validity.

Observing best practice in parent-infant psychotherapy.

Yvonne Osafo.
https://www.wcmt.org.uk/fellows/reports/learning-best-practice-parent-infant-psychotherapy-pip#downloads

Précis.

My WCMT Fellowship took me to Prague, Sweden, Norway and the USA to observe best practice in parent-infant psychotherapy (PIP). I explored: a) The historical development of PIP within the context of the nation. b) The different methods of delivery of parent infant psychotherapy, the tools and measures used. c) The training and ongoing professional development of the PIP workforce. b) The way parent infant psychotherapy teams are cared for and supported to manage the trauma of the work. To achieve my goals, I met with pioneers, policy makers, clinicians, academics and service users of projects that are working with the parent-infant relationship (0-2 years).

My main findings were: 1) That there are clear links between the historical development of PIP within each country's context and the current mental health of the nation.

2) Each country or State brings something unique with regard to their methods of delivery of PIP (groups, residential care, etc.) and what works in one country does not necessarily work in another.

3) The training and ongoing professional development of the PIP workforce is also context specific. A well-funded, integrated national strategy for parent infant psychotherapy has a much better impact on the mental well-being of the nation than a fragmented approach.

4) The tools and measures used to help clinicians to 'see the baby' and to measure outcomes, can either enhance the work or feel cumbersome and intrusive.

5) Parent infant psychotherapy teams that feel nurtured and well cared for enjoy longevity; are more productive and are better able to manage the trauma of the work.

Based on my findings I feel that the model of parent infant psychotherapy practiced in the UK; grounded in psychodynamic practice and developmental science; is a good model, and this is also the view of the professionals that I met. However, I feel that an increased focus on group and residential interventions could result in better outcomes. A competency framework and a national strategy would also improve IMH outcomes, as well as the establishing of a centre that holds together the strategy for IMH in the UK. I have set out my recommendations for an ideal practice at the end of this report.

Learning from best practice in Australia: Developing perinatal mental health services.

Jill Dolmoney.
https://www.wcmt.org.uk/fellows/reports/learning-best-practice-australia-developing-perinatal-mental-health-services#downloads

Précis.

Perinatal mental health is a major public health problem with around 1 in 5 women thought to have a mental health difficulty during the perinatal period from conception to 12 months postnatally. Many of these women are struggling with depression and anxiety, but a significant number also suffer from eating disorders, post-traumatic stress, and psychotic disorders. These difficulties not only affect the wellbeing of the mother but also impact on the wider family and, in particular, on the mental and physical health of the infant.

The objective of the Fellowship was to explore how professionals in both clinical and academic settings in Australia have worked to create and maintain best practice in perinatal mental health services. Across the five weeks of the Fellowship I was able to visit a wide variety of services and institutions in Australia who were leading the way in research and clinical practice in perinatal mental health. This provided both an overview of the general structure of services as well as a detailed insight into specific practices and models. Australia is a world leader in developing and implementing evidence-based services in this field. Having travelled across three states, visiting research institutes and universities, mother baby units and early parenting services, perinatal and infant mental health services, and attending a major international conference, several themes clearly came through about how to develop high quality perinatal mental health services.

Firstly, whole family approaches which incorporate father-inclusive practice are necessary to ensure infants get the best start in life. Services in Australia provide groups and interventions for fathers as part of standard care, good quality information and resources for fathers are provided in accessible formats online, and there are several innovative projects taking place which explore new ways of engaging fathers and supporting the couple relationship across the perinatal period.
Secondly, digital technology can be used to build sustainable, cost-effective services, including the use of e-screening tools to operationalise national guidance on identification of mental health problems, video conferencing to train and connect with practitioners across the care pathway, and text messaging interventions to reach families outside of the clinic setting.
Finally, ensuring provision of services that focus on infant mental health and the development of a strong attachment relationship is an essential part of quality perinatal care. In Australia this included both hospital and community based infant mental health services, as well as residential early parenting services for struggling families.

Putting the baby first in perinatal mental health.

Christine Puckering.
https://www.wcmt.org.uk/fellows/reports/putting-baby-first-perinatal-mental-health#downloads

Précis.

Outcomes for children begin in the womb; indeed many inequalities can be traced back to powerful influences in the pre-conception period. Many risks, including maternal and paternal stress and social risks such as domestic violence and abuse can be evaluated before birth. The identification of babies at risk during pregnancy and the implementation of interventions in pregnancy and postnatally can support mothers and/or fathers to develop closely attuned interaction with their babies. This may be the basis of secure attachment, the foundation of later positive social emotional and mental health. An eight weeks Winston Churchill Travelling Fellowship in 2015, allowed travel to four countries where children have better health, education and wellbeing outcomes than in the UK, according to the UNICEF/Innocenti Report Card 12. The countries chosen were Norway, The Netherlands, Finland and Iceland.

My initial questions were: 1) what are these countries doing to identify babies at risk as early as possible, in pregnancy or very early infancy; and 2) what services are provided to enable the development of the best possible relationships between these babies and their mothers and fathers which give them such a good start in life?

In practice, it soon became clear that the identification of vulnerable families depended on well-trained and well-supported universal services and low thresholds of referral to specialist services as required. Where continuity of professionals and seamless access to infant mental health expertise was facilitated, good quality psychologically informed practice was the norm. Generous parental leave and financial support for both mothers and fathers, and excellence in child- care, was also evident, with well-qualified staff and access to outdoor play, free from excessive and petty restrictions because of risk-averse safety fears. Male early years' practitioners were considered the norm, providing a healthy balance. Late entry to formal schooling, as late as seven in Finland, did not mean lack of consideration of children's learning and led to better educational outcomes than in the UK. The Netherlands does not have generous parental leave or allowances, but it is the norm for at least one parent, and even grandparents to reduce their working hours, and invest their time in the children. Apart from paternal leave and the presence of men in childcare no specific interventions for fathers were observed.

Relationship-based early intervention services for children with complex needs: lessons from New Zealand.

Carolyn Blackburn.
https://www.wcmt.org.uk/users/carolynblackburn2015

Précis.

For children at risk of or identified with developmental delays or disabilities Early Intervention (EI) services can alter developmental trajectories significantly. Current EI services in the UK run the risk of devaluing families' contribution to children's learning and development and children's varying competencies and strengths.

The Champion Centre programme in New Zealand is provided in a centre-based model of service, in partnership with parents, and in accordance with international best practice. The programme is offered to children from birth to school age who have significant delays in at least two areas of development and is underpinned by five principles. These are that the programme is relational, family-centred, strengths-based, ecological and reflective. The relationship-based, strengths-based, family-focused, ecological and reflective approach to working with children and families delivered by the Champion Centre have been demonstrated to provide perceived benefits in terms of family relationships and child development.

Characteristics of the Champion Centre relationship-based EI services that were valued by parents included professionals empowering parents to support their child in the context of family life as well as preparing their child for formal education. They appreciated the knowledgeable, well-trained professionals who invested time in getting to know (and love) children and families and family practices, worked together in harmony and valued the contribution that parents made to their child's progress and achievement. This included listening to and responding sensitively to children and parents.

Interviews with professionals revealed that professionals placed the parent-child relationship at the centre of their professional practice and viewed this as fundamental to ensuring progress for children across developmental domains. Also fundamental to their practice was interdisciplinary working that incorporated frequent communication and a culture of learning with and from each other. This was perceived to benefit individual professional development as well as the development of teams. Communication with other professionals and agencies outside the Centre was also perceived to be important. Professional aspirations for children and families included acceptance and inclusion of children as well as meaningful employment and achievement in life. However, they also extended to aspirations for successful parent-child relationships in the hope that parents would become advocates for children and young people with disabilities.

Early intervention for speech disorder: Not just desirable but essential.

Suzanne Churcher.
https://www.wcmt.org.uk/fellows/reports/early-intervention-speech-disorder-not-just-desirable-essential#downloads

Précis.

Preschool children with a difficulty specifically with speech form a high proportion (47%) of the caseloads of clinicians whom work with children within the 4-5 years age group, indicating that a significant number of children under four have a difficulty acquiring age appropriate speech. Yet, intervention for speech does not factor until these children are 4 and over. Anecdotally therapists report feeling unsure as to which interventions are evidence based, if any, for children under three with speech difficulties. Of those with an evidence base, many do not have one for children under three leaving clinicians, even if they feel they want to intervene, unsure what to select as an evidence based intervention approach.

Interventions considered suitable for children between 2 and 4 years of age were reported on across Australia. Some already have a good and developing evidence base, some are yet to be investigated and a few are interventions that we already know work with older children, but need to be studied on with younger cohorts. Research being carried out in Australia, some in collaboration with the UK, is adding substantially to our knowledge of typical development, early identification of delay versa disorder and even in identification of early risk factors. This potentially would enable targeted interventions to facilitate speech and language development to those at risk of significant difficulties.

Along with intervention aimed specifically at young children, Australian SLPs confidently reported on their selection of intervention from a wide range of interventions. Some of which are commonly used in the UK. Others much less so. SLPs reported feeling supported in their desire to access recent research and developments in the field of speech pathology. Strong connections with the universities, in terms of cascaded information, training workshops, online blogs, and an increased range of publications and webcasts all facilitated their professional and personal development.

Speech and Language Pathology/Therapy is a relatively young profession and there is still much to learn about the development of speech, the early identification of disorder and the most appropriate treatment approaches. The research reported on here provides further support for the effective use of known interventions and the potential refinement of others. It adds much to our knowledge of typical development and underlines the importance of continued investigation. Australian SLPs appear to have both easier access to research and a wider range of interventions that they are confident to select from.

Supporting speech and language development within early years settings.

Christine Hickey.
https://www.wcmt.org.uk/fellows/reports/supporting-speech-and-language-development-within-early-years-settings#downloads

Précis.

Models of intervention and care pathways for children with speech, language and communication needs have changed and evolved over the years, with a greater focus now than ever on the importance of early intervention and prevention. Ensuring that universal and holistic services are available for children and families is crucial; however shrinking time and resources can create barriers in helping families to access the right type of support when it is needed. With a prominence now also being placed on preventative methods, health professionals are working to ensure improved outcomes for children in the long-term, therefore creating a positive impact for the child on their overall wellbeing. These drivers were the force behind my Fellowship opportunity and I was keen to evaluate what other services overseas are offering children and families to meet these needs.

The early intervention programmes that run in Simcoe County, Ontario, rely heavily on the successful partnership of parental engagement and involvement. Before embarking upon my journey, I was keen to find out more about the services offered and how they are provided to promote health, wellbeing and early education.

To summarise, this report will discuss the following key findings further:

- The importance of parental education and parent coaching within an intervention model.
- My investigation into an SLT's role in supporting children with SLCN at a universal level.
- The level of team integration within a care package for those services surrounding a child.
- The importance of creating opportunities to gather feedback from service providers and users to evaluate outcomes and inform future delivery.
- The full report discusses each of these key points in more detail, including their relevance to service provision in the UK.

I have the following recommendations (for current practice and further research) for SLTs working within the UK.
1) Universal level input
2) Parent coaching model
3) Integrated working
4) Gathering feedback from service users

Learning from the USA speech and language therapy service delivery models.

Elena Moore.
https://www.wcmt.org.uk/fellows/reports/learning-usa-speech-and-language-therapy-models#downloads

Précis.

The Winston Churchill Memorial Trust (WCMT) funding provided the researcher with an exciting opportunity to investigate a family-centred approach to service delivery used in government funded centres in the USA and to consider applications for our current NHS service. Six government funded centres across three States took part during the one month visit; Texas who have recently transitioned to the model in the 12 months prior to the researchers visit, North Carolina who have carried out the three component model for 15 years and Kansas who rolled the model out state-wide.

Key Points:
1. UK Speech and Language Therapists typically use a child-centred model of service delivery and recognise the importance of caregivers as communication partners.
2. Multiple appointments in the UK impact family life which can lead to higher non-attendance rates leading to economical costs to the NHS.
3. In the USA, government guidelines suggest that clinicians must consider the child in the context of family and deliver services in the child's natural setting.
4. Early Intervention programs in 28 States in America use a three component service delivery model collectively known as 'evidence-based practices in early childhood intervention'. The model comprises of a) natural learning environment practices b) coaching and c) primary service provider approach to teaming.
5. The model has been found to decrease rates of non-attendance by increasing parent participation and better meeting the child and family's needs.
6. The model increases parent confidence and equips them to better support their child's health needs within their daily routines.

The case studies, survey results and subsequent analysis have revealed two key outcomes. Firstly, that UK Early Years services could be more cohesive in their approach to teaming by using the Primary Service Provider approach which fosters joint working among professionals. Secondly, that UK Early Years services could create therapy services for 0-5 year olds which are part of family routines, more functional and equip parents to become lifelong advocates for their child's health needs.

Harnessing the power of the community to improve outcomes for children.

Vikki Raymond.
https://www.wcmt.org.uk/fellows/reports/harnessing-power-community-improve-childrens-outcomes#downloads

Précis.

This report and research project looks at the contribution the community, and more specifically children's centres based in their local communities, can make to improving outcomes for children. It explores the sustainability of children's centres in the UK and makes recommendations for their future development. The report includes ideas for adapting practice in order to continue to reach both universal and targeted families with reducing budgets. It also considers programmes of support for targeted families and approaches to family support services based within children's centres. The major findings from the six weeks of visits to projects in Australia and New Zealand are detailed throughout this report and summarized below.

- There is an opportunity for universal services to transition to community leaders from the children's centre delivery model.
- Community leaders and volunteers need a comprehensive model of support incorporating guidance documents, ongoing training and supervisory support from children's centres.
- Children's centres have the potential to be developed further into community hubs for families and early years based practitioners
- A physical hub is crucial to the future of children's centre to bring services, practitioners and families together.
- Further community consultation would ensure that residents feel a sense of ownership for services and that their needs are met.
- Embracing the concept of social capital would mean professionals and organisations working together to empower communities and families rather than servicing their needs.
- Families need consistency in the support offered by organisations and a central point of contact.
- Multi-agency working needs to continue to be embraced by all practitioners to identify need and work together on early interventions for families Targeted interventions could adapt evidence based models from New Zealand and Australia to support families in the UK Models of family support need to continue to be strengths based and family focused with a consideration of recording tools and coordination.

Supporting families in the early years in Scandinavia: The use of childcare.

Clare Simpson.
https://www.wcmt.org.uk/fellows/reports/use-childcare-provide-support-vulnerable-families#downloads

Précis.

I visited a number of family centres in Norway and Sweden. Family centres are said to have four legs: midwifery; child health nursing; early years education; and social work. Services are co-located and parents are able to attend the one centre from the time they know that they are pregnant. Having a familiar place to go that is so family orientated establishes a supportive and preventive environment for family support.

Midwives provide support throughout pregnancy, and shortly afterwards. After this, families move on to the child health nurse service with nurses visiting families at home in the early days of their child's life, and then parents visiting the family centres for a programme of visits. Where this varied from the UK system was that parents saw the same child health nurse establishing an ongoing relationship, and that there was a far greater number of contacts (monthly over the first two years of their child's life) allowing problems to be picked up early. Another difference was that because of co-location, the nurses were able to refer parents onto other services more easily.

Family centres also had an open kindergarten which parents could attend along with their children. Drop in sessions, staffed by early years staff and social workers, supported parents in looking after their children, providing support and help where needed. They also had an important function in enabling parents to come together to meet one another and provide peer support. Sessions were open to children from 0 - 6 but in practice tend to be attended by mothers and fathers on parental leave with younger children. Childcare is universally available to families covering the period from when parental leave finishes. It is of high quality with well-qualified staff and an ethos built on the rights of the child. Childcare is heavily subsidised by the state and of low cost to parents.

The policy frameworks which support families are far better integrated in the Scandinavian countries than in the UK. High quality, intensive midwifery services prepare parents for parenthood; generous parental leave allows parents to form attachments with their child and adjust to their new life together as a family; an intensive programme of child health nursing together with the remarkable open kindergarten system helps parents to find the support they need in the early years; and a comprehensive child care enables them to return to work. Policy responds to the stages of child and family lives in a logical and integrated fashion.

Best practice in early years education: securing the best life chances for young children.

Geraldine Leydon.
https://www.wcmt.org.uk/fellows/reports/best-practice-early-years-education-securing-best-life-chances-young-children#downloads

Précis.

I spent five days in Germany included meeting Dr Karl Heinz Brisch, the founder of the attachment based Babywatching programme at the Dr von Hauner Children's Hospital in Munich. This is an attachment-based programme which can increase empathy and reduce anxiety in children. Babywatching is evidence-based and has been implemented successfully on a large scale. The importance of confident leaders is key and it can be beneficial across age phases. I learnt of the overwhelming evidence for the positive impacts of the programme.

Later I spent six weeks in New Zealand observing and discussing best practice in early years education. This included two visits to Initial Teacher Education institutions and a number of visits throughout New Zealand to early years settings. I also visited the University of Otago to discuss the world-renowned Dunedin project.

The Te Whaiku curriculum due to its longevity is firmly embedded in practice and practitioners were overwhelmingly supportive of the guidance. Emerging themes were identified with one key theme however mostly being applicable to all teaching professionals wherever they may be: that the discipline and practice of teaching is highly complex, and this cannot be overstated. Teacher expertise including a highly developed multidisciplinary knowledge of child development in its widest sense is paramount in executing the discipline of teaching. Being knowledgeable at the government, corporate, community, setting and practitioner level accords authority for each to respond effectively locally. This is key to enhancing the long-term life chances of all children wherever they may be.

Teacher's motivation in New Zealand is intrinsic rather than externally driven. The Education Review Office was seen to be supportive of practitioners. Teachers took responsibility for their practice and development and were active participants in their own professional development. They were key factors in contributing to their setting's policy and direction. I think that New Zealand's practising teacher criteria, which requires teachers to participate in ongoing research, is germane to this. I began to understand that this not only fueled teacher's motivation, but it also secured a sense of ownership of practice and an ensuing commitment to it.

Developing a 'Families of Character' programme for Scotland.

Jackie Tolland.
https://www.wcmt.org.uk/fellows/reports/developing-families-character-programme-scotland#downloads

Précis.

Parenting is the most complex and important role in the world. Parents are a child's first role model, yet they receive little or no training for this role. Many families struggle with the normal every day issues such as setting boundaries, listening and looking after themselves because of the stresses and strains of everyday living. By offering short fixes sold as the answer, much superficial work does not anchor them. The idea for this report is to find something that helps us go back to basics and offers a new way forward for parents and their children.

Aims of the Project:

- Learn new skills and disseminate firstly within a staff team and then roll out into local communities.
- Introduce families to the idea of values as a way of being and how this can impact their family.
- Develop local networks for support so that when parents are struggling they have local support.
- Train up to ten parents per year in the Families of Character work.
- Enable Parent Network Scotland to become a leader in the field of parenting support.

Background: Families of Character is an organisation based in Denver, Colorado USA. They believe that strong family virtues are what holds a family together and sets them on a path of joy as a family. They believe that this transfers into the community and has a huge benefit for society. We all have values that we live by, that sets us for life and helps us teach our children. But what happens when there are no clear, positive values?

Families of Character supports parents to unpack the underlying issues within their family, looking at the virtues within the family and how embedding these can make the biggest difference in small steps. The work carried out with FOC is with groups mainly in churches and communities. They work through a list of virtues and take home work in order to try these out. By working through some chosen virtues and recording what is working well families can then have a more enjoyable experience. Parents come together to chat about what this means, how can it impact life, what would it look like if this was the norm within the family? They are then given a take-home toolkit to experience and role model. Coming back four weeks later they then discuss the highs and lows.

Continuing to care: The Californian connection.

Emily Warren.
https://www.wcmt.org.uk/fellows/reports/continuing-care-californian-connection#downloads

Précis.

My fellowship explores the 'Continuum of Care' reforms in California, which demonstrate a large-scale shift in thinking and in the delivery of services for looked after children. The report provides the story of how the 'Continuum of Care' reforms came into being and draws out those areas of innovation which could be applied in a Welsh context.

The reforms in California were achieved from having a space for senior leaders to come together collaboratively to consider what foster care should look like in California. In California, they are re constructing a new Continuum of Care, underpinned by new legislation and a policy framework; and they have adopted an ACE led approach to underpin the development of services, reframing care services so that they are able to more effectively mitigate the impact of ACE on children and reduce harmful impacts on health and wellbeing across the life course of looked after children.

The Californian reforms are predicated on the following shared principles with Wales:

- Early Intervention and Prevention services, designed to be community led and with new tools, practices and models to create a family strengths approach.
- A common model of practice across agencies- Sandbox approach.
- Strengthening families to promote the growth of relative care givers and relative guardians.
- Improved support for care givers- Team around the Family/Training etc.

- Effective out of home foster care, with an emphasis on placing the Care Giver at the heart of the team around the child, and a Multi-Agency Service Delivery Framework that is individualized, responsive and home based.
- Step Up/Step Down short term residential 'therapeutic' services that can be effective for exits from the Youth Justice System, or those with complex needs that will likely prevent permanence within a home setting.

Specifically, the reforms are underpinned by increased collaboration across health, mental health, education, probation and social care services -driven at a practice, rather than structural level.

Starting young: Lifelong lessons from intergenerational care and learning.

Lorraine George.
https://www.wcmt.org.uk/fellows/reports/starting-young-lifelong-lessons-intergenerational-care-and-learning#downloads

Précis.

There is a growing body of qualitative evidence that suggests that regular engagement between the different ages benefits both the old and the young as well as also having a positive impact upon staff, employers and the community and also possibly reducing overhead costs by co-locating care in the same building. This Fellowship focused on the following:

- Investigating how co-located settings were established and the different business models that are used
- Exploring co-located care within the US as a means of raising awareness of the mutual benefits of intergenerational learning
- Considering whether these models could be replicated in the UK.

The major findings were as follows:
That daily interactions between children and residents as part of an intergenerational programme impacts favourably not only upon both groups of participants but also upon staff, employers and the community.
That the co-located model should not be restricted to early years or the provision of child day care but works equally well as a satellite school-based provision, such as a reception class or year one class.
That young children, due to their non-judgmental nature, are often drawn to the most vulnerable residents regardless of impairment, disability or ability to communicate, enabling intergenerational programmes as best practice, to be inclusive and open to all.
That co-location works beneficially for all parties across a range of business models from non-profit to private, although cutting costs should not be the only consideration as in reality direct short-term savings may be minimal.
That co-location can work at its very best in terms of mutual benefits, to both the young and the old, regardless of size i.e. converted resident bedroom space is just as effective as a large purpose -uilt classroom facility as long as best practice is observed.
The role of the Liaison person working between the childcare provision and the elder care provision is key in terms of effective intergenerational best practice and works best when the role is ring-fenced to enable the Liaison to know both the children and residents well enough, to ensure that all interactions, both spontaneous and planned are positive.
That one person committed to sharing their intergenerational vision can make a difference by influencing, supporting and initiating others in the creation of new co-located settings as in the case of Oklahoma and Kansas.

Exploring effective engagement with parents to improve child outcomes.

Jo Hillier.
https://www.wcmt.org.uk/fellows/reports/exploring-effective-engagement-parents-improve-child-outcomes#downloads

Précis.

I aimed to observe good practice within a family support environment that is using Signs of Safety, or strength-based approaches. I wanted to see how strength-based approaches are embedded into everyday support, how it is used with families and how this improves the outcomes for children. I wanted to observe the direct practice, the team around the child planning and supervision processes.

The following agencies working with families and young children were visited:
1) Ministry of Children's Services, Alberta. This agency started using Signs of Safety in 2010. I was interested to learn how they embedded the approach as they have got a huge Province and to learn what structure was needed to enable them to support their staff and bring best practice to the families they serve.
2) Ktunaxa Kinbasket Child and Family Services, Rocky Mountains. This service provides child welfare and child protection services to all Aboriginal Peoples (First Nations, Métis, and Inuit) On and Off Reserve in the Ktunaxa Traditional Territory. This agency made a commitment to start using Signs of Safety in 2008. I wanted to see how Signs of safety tools were used to work with families to support effective communication and understanding and how to support the family network to be at the centre of safety planning.
3) High Fidelity Wraparound is a collaborative partnership in the Province of Alberta. This agency provides a process that helps children, youth and families put together a team of people who help them meet their goals. This team is made up of natural supports like family and community members, as well as formal supports like school, justice and mental health support providers.
4) Children's Aid Society of Stormont, Ontario. The agency is one of many mandated to provide child protection services, and it took on Signs of Safety in 2010 and also uses the Family Finding approach with Families.

Throughout my Fellowship all the Agencies I visited worked with families using Strength based approaches that hinge on workers building relationships and listening and really understanding the issues in the families and using the families own strengths and skills to create safety and work towards change.

My recommendations are:
1. Services using the Signs of Safety approach should be encouraged to embed the Signs of Safety 12 practice principles that build partnerships,
2. That the Family Finding approach is to be explored as a working practice.

Supporting couple relationship changes during the transition to parenthood.

Akvinder Bola-Emerson.

https://www.wcmt.org.uk/sites/default/files/report-documents/Bola%20Emerson%20A%20Report%202017_0.pdf

Précis.

This report describes some of the many interventions and developments in Australia and the USA that address couple relationship changes when becoming new parents. Highlighted within the report are the aspects of these interventions which could have significant relevance to UK based services. Embedding some of these programs and systems within current perinatal mental health provision needs to include whole- family approaches rather than traditional mother and baby services would indicate better outcomes for families especially children.

Using digital technology such as social media or a smart phone App can help build manageable and sustainable service provision which meet the needs of new parents efficiently and in a timely manner by tapping into the current ways parent's access information.

The stark difference in healthcare provision and access to treatment across the two countries was certainly intriguing. Compared to our incredible National Health Service (NHS) in the UK where health care provision is free, the USA is not so fortunate in being able to offer a similar service.

Active engagement and conversations must become routinely embedded in assessments and at every contact made by professionals in order normalize and encourage couples to seek support. We urgently need to increase and expand our knowledge about which services and interventions work to support inter-parental relationships in different contexts. Using skills such as those already established methods found in Australia and the USA we could initiate these into our existing services and as part of all routine assessments in all services for families.

Making relationship discussions routine at every assessment or contact with relevant onward signposting and support will strengthen families to do the best they can. Providing extended training for all disciplines in brief couple therapy is needed for all professionals especially those in mental health and working with children and families services.

Abusive head trauma: The case for prevention.

Suzanne Smith.
https://www.wcmt.org.uk/fellows/reports/abusive-head-trauma-case-prevention#downloads

Précis.

The aim of this Fellowship was to explore international programmes related to the prevention of child maltreatment with a particular focus on the devastating form of child abuse that is Abusive Head Trauma (AHT) in infants and to gain an understanding about the wider context of the delivery of care and the systems and processes in which they are provided and commissioned. Specific outputs from the Travel Fellowship include the development of a UK based primary prevention programme. Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse. Its incidence in the UK is not decreasing. Catastrophic injuries which result often present in a constellation including intracranial injuries, retinal hemorrhage and certain long bone fractures and spinal fractures.

The Fellowship has included the observation and study of the powerful programmes visited and the passionate and dedicated professionals who lead and research them. A critical analysis of the applicability of the different programmes within the UK health and social care context is considered alongside the evidence base underpinning prevention of Abusive Head Trauma and helping parents and caregivers cope with crying. The findings highlight what makes AHT prevention programmes and child protection, family support services generally, successful. The constant forward planning for funding and rooting the programme within a secure organisational infrastructure cannot be underestimated.

The development of a multi-agency coordinated programme that can fit into mainstream service delivery, that has a simple message, is well led and operates throughout the public health levels of prevention spectrum are key success indicators. Careful thought should be given to measuring success of a programme from the outset including the resources involved in data collection and analysis and the need to respond to current political imperatives in order to attract funders.

A hospital based programme would reach more men. The programme would extend into the community embedding its message by repeated reiteration of the essential messages throughout the first two months of a baby's life at the least and supported by accessible materials. A one size fits all programme is unlikely to work and flexibility to support local delivery whilst maintaining fidelity to the essential core message is crucial.

(NB. Members will find details the outcome of this fellowship on https://iconcope.org and if this programme has not been established in their area should ask - Why not?)

Learning from attachment-based interventions in the early years. Westside Infant-Family Network: A model for transformation.

Sarah Rogers.
https://www.wcmt.org.uk/fellows/reports/learning-attachment-based-interventions-early-years#downloads

Précis.

The service at WIN is based on the understanding that changes in an infant's environment and crises in their family do affect them, they do remember, and there are practical ways in which the impact of these changes can be minimised through the strengthening of connection and relationships. These relationships exist not only between parents and children, but across the agencies that serve them. WIN is an example of an agency which has looked at the relationship between infant mental health and the trajectory of a child's later life and taken up that challenge in a bid to improve the lives of families both right now and in the future. In doing so, they disrupt cycles of trauma that have spanned generations.

An emphasis on nuance and the strengths of the client permeate WIN's attitude to managing domestic abuse. By no means advocating a victim-blaming approach - which would unjustly hold women accountable for their own abuse - the perspective of WIN is to explore the ways in which pre-existing trauma has informed the survivor's expectations of what she can and must expect in her relationships, with the ultimate objective being to increase her reflective capacity and so space for agency. Individual therapy is available for women to name and unpick the trauma they have experienced; meanwhile dyadic therapy assesses the ways in which this trauma has impacted upon her parenting style.

Key to their success has been their refusal to deal in binaries. Instead of limiting themselves to individual or dyadic therapy, they offer both. In pursuing objectives for the overall social good, they employ business principles. The boundaries between staff members and service users are blurred in that both are treated by WIN as human beings, with all the vulnerability and strength that that entails. Despite, or because of, their significant successes, WIN continues to seek opportunities to advance their service and improve outcomes for the families they work with. A key message from my visit was that WIN should not be viewed as a prevention service: at the stage where they intervene, they are already working with a traumatised infant. WIN strives to move ever closer to true prevention through screening earlier and integrating more. Only through reducing the number of severely traumatised people that need WIN's services will this demand ever be met.

Early interventions: Keeping families affected by substance abuse together.

Lyndsay Fraser Robertson.
https://www.wcmt.org.uk/fellows/reports/early-interventions-keeping-families-affected-substance-use-together

Précis.

Major Findings
1. Family interventions for working with parental substance use include integrated substance use treatment. 2. Residential facilities provide safe environments for women and children. 3. Pregnant and parenting women benefit from longer periods of support. 4. Powerful dynamics in peer support and group work.

The main benefit regarding residential options for women and children is the provision of allowing mothers and their children to recover in a safe, stable and supervised environment. Many of the mothers I met had experienced abuse, neglect, violence, homelessness, poverty and other traumatic circumstances by the time they presented for a residential recovery option.

Time is an important factor when providing sustainable recovery options for this client group. Many women and children have learned unhealthy coping mechanisms that have revolved around problematic substance use. We must allow mothers time to recover and practice healthy coping skills in a safe and predictable environment before expecting them manage this without support. Along with time comes building relationships and trust with support workers. The mothers I met and continue to meet in my work have been betrayed by those closest to them and are understandably mistrustful. The opposite of addiction is connection and the residential services I visited had peer mentor programs which provided a unique source of support from other mothers with similar lived experiences. The dynamics of learning from each other during group therapy was powerful and effective.

Nurturing the mother-child relationship is important when considering effective interventions for keeping families together safely. When residential treatment is not an option, situations involving parental substance use become risky to manage and can make workers understandably anxious. However, by providing intensive and evidence-based parenting interventions alongside treatment, allows necessary monitoring, evaluation and supervision whilst causing the least disruption to the mother-child relationship. Mothers who use substances display lower levels of sensitivity and responsiveness to their children's emotional cues so providing support for mothers as early in their child's life as possible is important when fostering that relationship and improving parenting styles.

Helping infants traumatised by family violence.

Jenny Griffiths.
https://www.wcmt.org.uk/fellows/reports/helping-infants-traumatised-family-violence#downloads

Précis.

This Fellowship focused on learning about evidence-based interventions that address the infant experience of violence within the family. The aim was to compare and contrast these approaches, in order to understand which particular techniques, methods and approaches are most effective and practical for this group given the current economic climate in the UK health service.
Objectives:

- To learn about specific and effective targeted interventions for children in the early years and their families who have experienced DVA.
- To observe live 'Peek a Boo' group interventions in Australia in order to learn by direct experience.
- To meet with 'Child Parent Psychotherapy' (CPP) and 'Attachment and Bio-behavioural Catchup' (ABC) experts in California and Delaware to learn about their trauma-informed models and the challenges of applying them in practice.
- To establish what evaluation of these measures has taken place – is there an evidence base for effectiveness?

One overriding theme inherent in each of the three models was how essential regular supervision is for familiarisation with and adherence to that model, professional development and learning.

Major findings:
1. The best chance to help parents and infants through trauma is to help their relationship
2. Trauma-informed practice is key from conception through to 100 years old
3. Emotion Regulation and Nurturing are vital for recovery from trauma
4. Attachment security predicts outcome, so target the attachment relationship
5. Ongoing supervision is the most effective way to learn and apply a model, this can be supported through model fidelity measures
6. There are many ways to skin a cat – Targeted and specialist approaches at different levels of complexity
7. Parental trauma interrupts the parents' emotional availability as protectors and attachment figures

Preventing child abuse and neglect in families with complex needs.

Jessica Cundy.
https://www.wcmt.org.uk/fellows/reports/early-intervention-families-complex-needs#downloads

Précis.

I travelled to Australia and New Zealand to learn from approaches to preventing child abuse and neglect in families with complex needs (defined as those where domestic abuse, parental mental ill-health and/or parental substance misuse are potential or actual risks to children). In the UK, we have struggled to intervene early enough with families facing one or more of these issues, which are often compounded by social isolation, poverty, temporary housing, and unemployment. There is widespread recognition that intervening early with vulnerable families can improve children's life chances and break intergenerational cycles of negative outcomes. In practice it has proved difficult to truly prevent risks to children from escalating.

Practitioners working with vulnerable families hold the tension between helping to strengthen families so that they are able to stay together and removing children when the risks to their wellbeing become too great. Child protection thresholds for taking children into care are high, which means that children's daily experience of living with adversity may be prolonged. This makes understanding how best to intervene early in families with complex needs critical to children's safety and wellbeing in the here and now, as well as to their future outcomes.

Across different states of Australia and in New Zealand, I learnt about government-led initiatives which aimed to coordinate service provision, de-escalate risk, prevent referrals to child protection, and create efficiencies through joint case working. Each approach was slightly different but had a central focus on prevention. In Western Australia, New South Wales, Victoria and in New Zealand state governments have put in place mechanisms to coordinate a response to families in need that work across systems, towards a set of agreed outcomes. The common features of these approaches are that: a) a lead agency takes responsibility for case management and the coordination of support for a family; b) adult and child services work together, including health, education, housing, police, child protection, domestic abuse, and substance misuse services; c) a helpline serves to triage cases; d) a shared data system and outcomes framework is in place; and e) the aim is to intervene early to prevent issues from escalating.

When developing strategies for early intervention with families, and protecting children, it is essential to consider the role of schools in local communities. The Department for Education in New South Wales explained that in rural and remote parts of Australia, schools may be the only community hub in the area. They have therefore developed an innovative approach to linking families to resources, facilitated by 'Networked Specialist Centres'.

Co-productive use of trauma informed practice in the early years.

Cheryl-lee Brown.
https://www.wcmt.org.uk/sites/default/files/report-documents/Brown%20C%202018%20Final.pdf

Précis.

The overall aim of this travelling fellowship was to explore how services in the USA and Australia are sharing the emerging evidence on the impact of childhood adversity with individuals and communities in order to understand how the ACE research and the development of trauma-informed practice may be used to break the cycle of deprivation and maltreatment and support communities to develop their own solutions in a co-productive way. Seeking new working practices and the latest research in order to impact on the negative cycle of inter-generational adversity led the author to visit a varied range of services in Australia and the United States of America and attend a high profile week long trauma conference in Melbourne Australia run by the Australian Childhood Foundation. It is suggested that early years services can support a community-based approach to trauma informed care. The author believes that the level of engagement can be on a continuum from a light touch approach through to a fully- fledged therapeutic nursery approach. Details of a range of innovative practices are described in the body of the report.

The author believes that the implementation of a trauma informed approach in the early years or primary school level would work most effectively as part of a comprehensive and systemic community level approach to trauma informed care. A key takeaway for the successful implementation of trauma-informed model from all services visited was the importance of collaboration. The report concludes that Mental Health Consultations would be a useful adjunct to adopting a trauma informed approach in an early year's settings. Such a resource locally could provide local third sector, private and local authority early years and childcare settings with:

- Training in implementing a "trauma informed" approach.
- Specialist knowledge and support to early years workers on the effects of stress and trauma on families, the importance of attachment for young children, and the impacts of adult mental health on developing children.
- Modelling the use of a strengths-based trauma informed approach.
- Suggesting and supporting appropriate resources/interventions in a culturally sensitive manner.
- Providing reflective practice to assist early years workers in reflecting on their practice
- Provide a "toolbox".
- Support evaluation and research to support data-driven decision-making and innovation in the field.