WINSTON CHURCHILL MEMORIAL TRUST

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COMMUNITIES, TRAUMA AND THE EARLY YEARS

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Cheryl-lee Brown

I am the Chief Executive and founder of Midlothian Sure Start where I have worked for the past 20+ years.

Midlothian Sure Start is a non-profit which provides universal and targeted holistic services to families with children under the age of 12 in Midlothian, Scotland.

The 6 Family Learning Centre's operated by Midlothian Sure Start offer quality early learning and childcare, attachment-based parenting support, family learning, positive destinations and welfare advice and therapeutic services.

I started my working career at the South African National Council on Alcohol and Drug Dependence and moved to Scotland after travelling around Europe.

I have an honours degree in Social Work and Psychology from Rhodes University and the University of South Africa. I obtained my Master's in Business Administration (MBA) from Napier University.

Having witnessed the impact of inter-generational adversity on the communities in which I have worked, I was keen to explore how emerging research on the impact of childhood adversity/trauma has been successfully shared with local communities.

I was keen to understand if any communities were using this information to start "community conversations" to support change.

As a passionate advocate for early intervention and prevention services developed in co-production, I was keen to observe innovative projects that I could learn from and I have and will continue to share what I have learnt with my colleagues and the families who attend our services in the hope that we can continue to strive to give our children "Best Beginnings."

Midlothian Sure Start

Building Best Beginnings

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ACKNOWLEDGEMENTS

I am extremely grateful to the Winston Churchill Memorial Trust and the Band Trust for awarding me this Fellowship. It afforded me the opportunity to travel to Australia and the U.S.A to research practice I would not otherwise been able to explore.

I would like to thank all the individuals and organisations that hosted and supported me during my travelling Fellowship. Their generosity in sharing their work with such openness and enthusiasm was most appreciated.
Janise Mitchell and colleagues, Australian Childhood Foundation

- **Janet Williams-Smith and colleagues ECMS, Melbourne, Australia**
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- **Christina Tsai and Dr Ng, 7th Avenue Family Health Centre, Brooklyn, New York**
- **Chandra Gosh Ippen and Ann Chu, San Francisco**

I would like to thank the children and families I met in Adelaide, Sydney and Baltimore and the students and teachers in Monroe who were so welcoming and willing to talk to me about the impact of the initiatives they were involved in.

I am grateful to my employers, Midlothian Sure Start for allowing me time off to travel and all colleagues at work who have been so supportive during my trip and on my return as we test out new ideas.

Finally, I would like to thank my family who have provided support to me through the course of my travels and as I have completed this report.

EXECUTIVE SUMMARY

The overall aim of this travelling fellowship was to explore how services in the United States of America (U.S.A.) and Australia are sharing emerging evidence of the impact of childhood adversity with individuals and communities in order to **understand how we can use the research on adverse childhood experiences and trauma informed practice to break the cycle of deprivation and support communities to develop 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.

This report will address how learning from the work of these projects leads the author to explore the potential opportunity of a paradigm shift with childhood adversity tackled in the early years and/or community settings. The author will suggest 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.

Recommendations for the Scottish Government

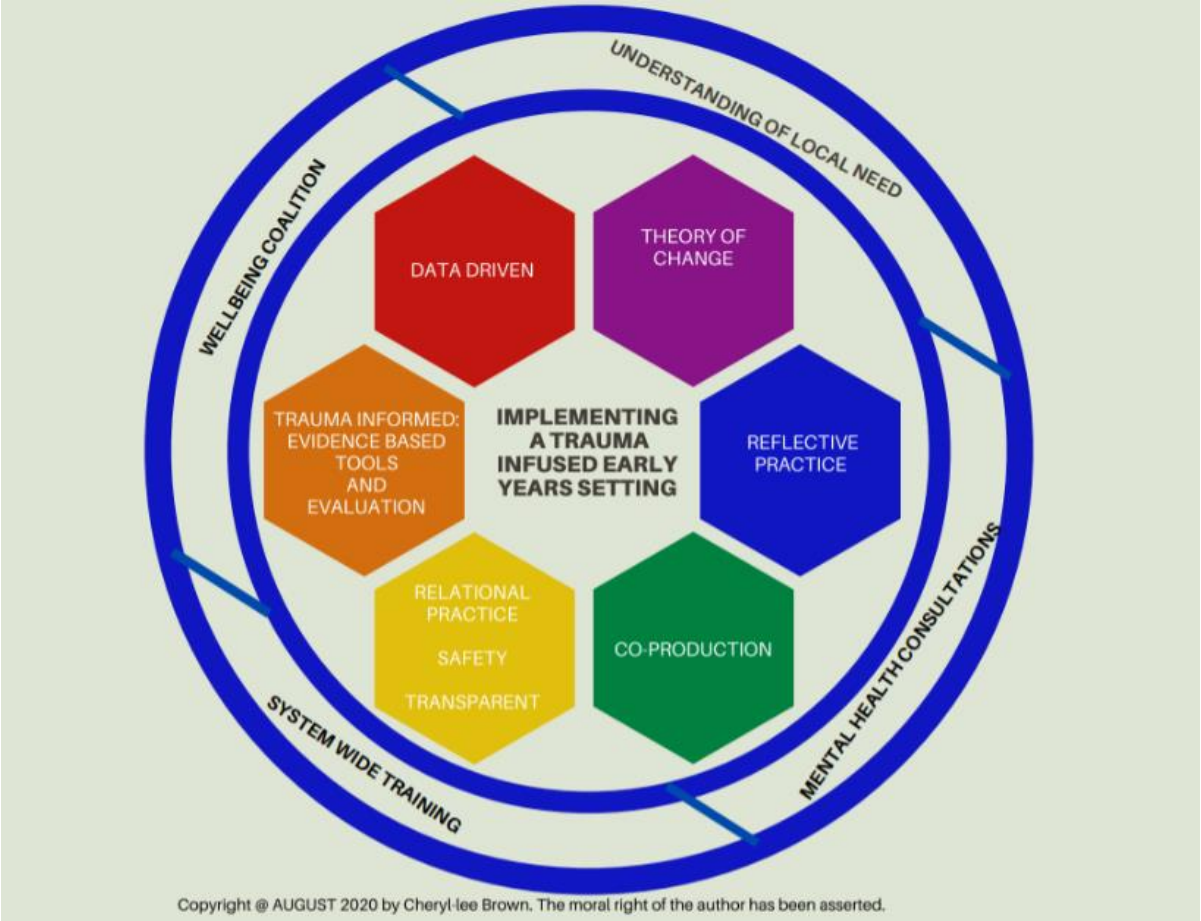
- To build a trauma informed Scotland will require a joined up approach with collaboration from across the macroeconomic system involving both traditional mental health services but also public and primary health care, academia, industry and services impacting on all the social determinants of public health e.g. employment and housing. Local authorities should be encouraged to engage all stakeholders in implementing local trauma informed practice. Wellbeing Coalitions can support this approach as can the use of ethnographic research.
- Local communities need to be involved in the roll out of a trauma-informed Nation. This will support the identification of micro and macro inequities which perpetuate inter-generational adversity. Opportunities for local conversations around developing "resilience" should be considered. Dr Chandra Gosh Ippen provides a useful tool to support this. Whatever tool is used, it is imperative that parents and children and young people's voices are heard and they are involved in the planning of such an initiative. This will help to ensure that these initiatives are not inadvertently re-traumatizing.
- To roll out multi-disciplinary training to all to support a shared language and an understanding of trauma- informed practice. The NHS Education for Scotland- Scottish Psychological Trauma Training Plan is already in place to support this objective.
- To work with interested early years settings to test the feasibility of early years settings becoming involved in providing "trauma informed" support along a continuum of intensity. The economic argument for early intervention and prevention has long been made and evidence indicates the impact of intervening early to address ACEs. Local early years settings can be supported to become more "trauma informed" with training, access to data, access to local mental health consultancy and resources to deliver trauma-informed evidence-based programmes e.g. mindful parenting programmes.
- To consider supporting a local Scottish Random Control Trial/feasibility study of the use of the PAX Good Behaviour Game.
- To consider how "Mental Health Consultations"/Reflective practice opportunities could be made available to support the roll out of a trauma-informed approach. This is of particular urgency if early years and primary school settings are encouraged to become more "trauma informed".
- To develop a Centre of Excellence in Peri-natal and Early Years Mental Health, or similar, to ensure ongoing leadership and development of-trauma informed services.

Recommendations for funders and commissioners

To recognise that Randomized Control Trials (RCT) evidence-based imported programmes may not always be the best solution for the local community. Local services can be supported to use a Theory of Change model, both to support locally developed programmes and to implement trauma informed evidence-based programmes.

Recommendations for Midlothian Sure Start

- To explore collaboration with local academic institutions for mutual benefit.
- To explore the use of the Facilitating attuned conversation (FAN Model) approach to support relational practice and self-care of staff.
- To pilot a "therapeutic" nursery at one of its six family learning centres. This pilot should ensure that the essential ingredients of a therapeutic nursery contained in the therapeutic nursery infographic can be supported.



INTRODUCTION

This report is set in the context of Scotland where the Scottish Government has a stated aspiration to make Scotland the 'best place to grow up' with a government vision of placing the wellbeing of Scotland's children at the heart of everything they do. The Scottish Government believe that this will be accomplished by policy and practice which is:

- Embedded with Getting it right for every child (GIRFEC).
- Transparent and uses evidence.
- Recognises the need for a public health model which prioritises universal provision
- Is underpinned by prevention, early intervention and partnership working recognising that child wellbeing and protection is a collective responsibility and that it is people not policies which protects children.
- Aims to support those who have been in the child protection system to have the same outcomes as other children and young people.
- Engages with families and listens to children, young people and families to provide the right support at the right time
- Enables practitioners to make the right decisions at the right time to protect children and values and supports the workforce.

Scotland is the first country to develop a knowledge and skills framework for psychological trauma and is in the process of implementing ambitious targets of 1140 hours of early learning and childcare for all 3-5-year olds and eligible 2-year olds.

On the converse side child poverty has been rising since 2012 and Local Authorities have been facing tightening budgets. Children and young people are increasingly being referred to Children and Adolescent Mental Health Services (CAMHS) where waiting lists have continued to grow. In September 2018 an Audit Scotland report[1] on children and young people's mental health highlighted *"a big increase in young people being referred to mental health services and longer waiting times are signs of a system under significant pressure"* The report called for a step change in the way that the public sector responds to the mental health needs of children and young people and noted that there is often too great a focus on crisis and specialist services despite government strategy being focussed on early intervention and prevention.

The author has worked in a local community early years project for the past 20 years. During this time, she has witnessed the impact of community empowerment while at the same time recognising the impact of inter- generational adversity on the local level. Growing evidence has demonstrated the association between exposure to Adverse Childhood Experiences (ACEs) and vulnerability to long term health/mental health impacts with higher incidences of increased use of alcohol and substances, unintended teenage pregnancy and involvement in the justice system. In addition, children of those affected by ACEs are at increased risk of exposing their own children to ACEs.

In the hope of understanding how to improve efforts to successfully interrupt the inter-generational transmission of adversity the author chose to travel to visit services in Australia and the U.S.A. The key aim and objectives of these visits were:

Aim: To understand how we can use the research on adverse childhood experiences and trauma informed practice to break the cycle of deprivation and support communities to develop solutions in a co-productive way.

Key Objectives:

- Understand how they were using this approach to break the intergenerational transmission of adversity- the cycle of deprivation.

[1] https://www.audit-scotland.gov.uk/news/step-change-required-to-tackle-young-peoples-mental-health

- Explore how services have worked in co-production with communities and/or families
- Explore if services have shared knowledge of emerging research around trauma with local communities and/or understand how they go about creating lasting change by giving parents the tools they need to be partners in their child's success?
- Explore how services are measuring and evaluating their work?
- How are they convincing policy makers/funders/the community?
- How do they improve access for the less advantaged/engage most disadvantaged?

The author travelled to Melbourne, Adelaide and Sydney in Australia in July 2018 and met with the Deputy CEO of the Australian Childhood Foundation, local policy makers in Early Years and Health and Human services and service providers in the early years and mental health field in Melbourne, Sydney and Adelaide.

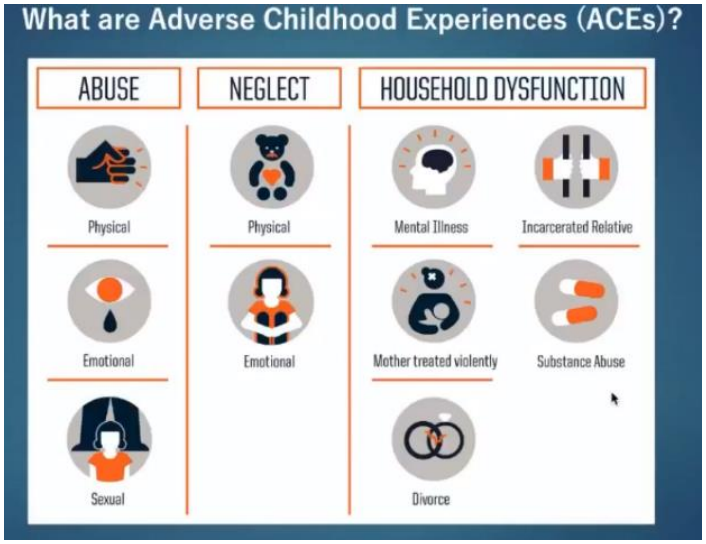
In October 2019, the author visited several sites in the U.S.A. These included Health Steps sites in New York, the Headquarters of Zero to Three in Washington, the Director of Dissemination and Implementation for Child-Parent Psychotherapy in San Francisco and local policy makers and service providers implementing trauma informed services in a local therapeutic nursery, primary and high school in Baltimore, Washington and Monroe School District, Snohomish County.

This report will focus on a range of initiatives encountered through these visits which have taken a "trauma informed" approach to their work either at a systemic or local level. The focus is primarily but not exclusively, on the early years and community settings and will be contextualised within research on adverse childhood experiences, best practice in trauma informed care and these countries' approach to early years policy and practice. This approach has been taken to provide a perspective on how some of the initiatives may be of relevance to the Scottish context within which the author works to support children and families.

ADVERSE CHILDHOOD EXPERIENCES (ACE)

Vincent Feletti and Robert Anda in their ground-breaking [CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) Study] found a strong graded relationship between the breadth of exposure to a range of childhood adversities and multiple risk factors for several of the leading causes of death in adults.

10 adverse childhood experiences were identified. According to the study, the higher the number of ACEs, the more prevalent negative life outcomes.



Further studies around the world have replicated the findings. The National Workforce Centre for Child Mental Health, Australia found that 2/3 of children will have experienced a potentially traumatic event by the time they are 16. This included natural disasters (5-6%), being a refugee and considered that 20% of children are like to experience 3 or more adversities.[2]

According to the Centre for Disease Control (CDC) in the U.S.A. in 2016 nearly half of all children were considered to have at least one of nine Adverse Childhood Experiences (ACEs), and more than 20 percent had two or more.[3] The prevalence and the way ACEs are measured varies from country to country and in the U.S.A. from state to state.

An English study conducted by Liverpool John Moores University[4] found that almost 50% of people reported experiencing a least one ACE and over 8% reported experiencing four or more. The first Welsh ACE study conducted by Public Health Wales[5] in collaboration with Liverpool John Moores University found that 47% of respondents reported having experienced at least one ACE and 14% experiencing four or more ACEs. The research found that the impact of having more than 4 ACEs in either the English or Welsh cohort (higher levels in this cohort) to include[6]:

- 2-4 times higher risk drinking alcohol
- 3-6 times more likely to be a smoker
- 5-6 times more likely to have had sex while under 16 years of age
- 6 times more likely to have had or caused an unplanned teenage pregnancy
- 11-20 times more likely have been incarcerated.

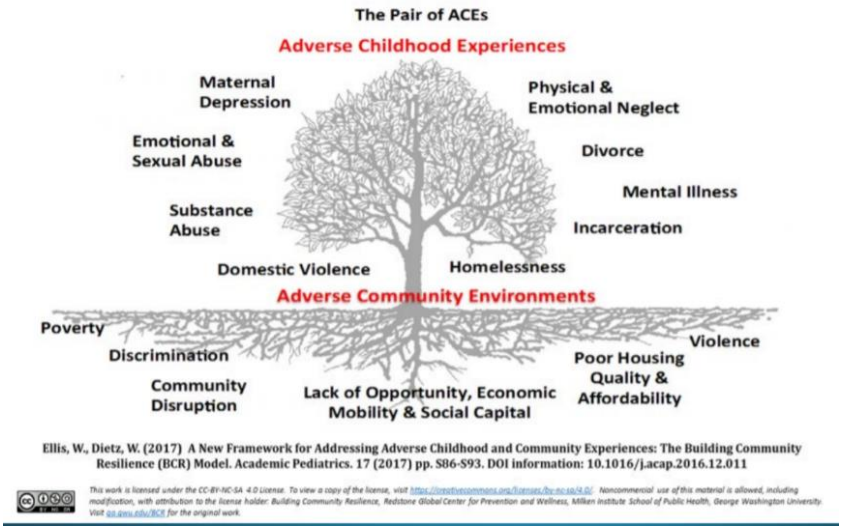
ACEs AND INEQUALITY

Felitti and Anda's original Adverse Childhood Experiences study is now considered to only capture a piece of the story. Communities in which families and children live may also face adversity such as childhood poverty, lack of opportunity, discrimination, poor housing, violence and a lack of services—including mental health.

[2] https://d2p3kdr0nr4o3z.cloudfront.net/content/uploads/2020/02/12112353/Parent-tip-sheet-ACEs-and-resilience.pdf
[3] https://www.cahmi.org/wp-content/uploads/2018/05/aces_fact_sheet.pdf
[4] https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72
[5] http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf
[6] https://www.scotphn.net/wp-content/uploads/2016/06/2016_05_26-ACE-Report-Final-AF.pdf

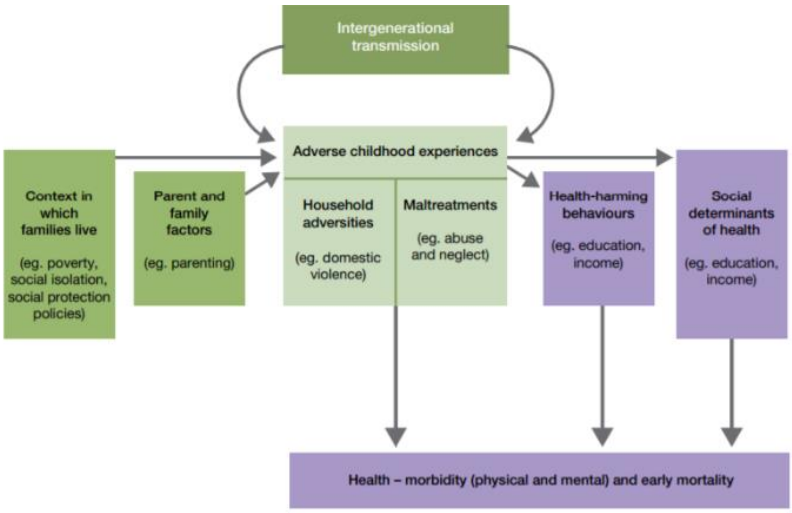
The "Pair of ACEs" tree was developed by Ellis and Dietz (2017) to illustrate this relationship between adversity within a family and adversity within a community. A comprehensive approach to addressing childhood adversity need to acknowledge and address adversities experienced at both the individual and community level.

According to Ellis and Dietz, the leaves on the tree on the diagram below represent the 'symptoms' of ACEs that are easily recognized in clinical, educational and social service settings. The tree is planted in poor soil that is steeped in systemic inequities, robbing it of nutrients necessary to support a thriving community. Adverse community environments such as a lack of affordable and safe housing, community violence, systemic discrimination, and limited access to social and economic mobility compound one another, creating a negative cycle of ever worsening soil that results in withering leaves on the tree.[7]



ACEs AND INTERGENERATIONAL ADVERSITY

The UCL Institute of Health Equity 2015 paper[8] utilizes the conceptual framework below to explain the interlink between ACEs and the social determinants of health. They state: *"While all ACEs are present across society, inequalities in wealth, disadvantage and the existence of poverty impact on the chances of experiencing ACE. Children growing up in disadvantaged areas, in poverty, and those of a lower socioeconomic status are more likely to be exposed to ACEs compared to their more advantaged peers - and more likely to experience 'clustering' (co-occurring) of ACEs."* They add that *"There is also evidence that ACEs are 'transmitted' across generations - so that the children of parents who experienced ACEs in their own childhood are also more likely to experience ACEs. This perpetuates inequalities in health across generations."*



[7] https://publichealth.gwu.edu/sites/default/files/downloads/Redstone-Center/Resource%20Description_Pair%20of%20ACEs%20Tree.pdf
[8] http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf

A TRAUMA INFORMED APPROACH

The Substance Abuse and Mental Health Services Administration[9] (SAMHSA) is viewed as a leading authority on trauma and trauma informed work in the U.S.A. SAMHSA conceptualises trauma as: *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*

SAMHSA believes that the context in which trauma is addressed contributes to the outcomes for both the people receiving services, and the individuals staffing the systems. Their trauma-informed approach is grounded in a set of four assumptions and six principles:

Four Assumptions: People at all levels in the organization or system are also able to:

1. Have a basic **Realisation** of trauma and its effects.
2. **Recognize** the signs of trauma.
3. **Respond** by applying the principles of a trauma-informed approach to all areas of functioning.
4. **Resists** re-traumatization of clients as well as staff.

Six key principles:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

SAMHSA acknowledge that addressing trauma requires: *"a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment"*

The U.S.A. National Child Traumatic Stress Network views a trauma-informed child and family service system as one in which all parties involved *"recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive."*[10]

The network recommends that organisations wishing to implement trauma informed services should focus on building meaningful partnerships that *"create mutuality among children, families, caregivers and professionals at both the individual and organisational level"*.

The network recommends:

1. Routine screening.
2. Using evidence-based, culturally responsive assessment and treatment.
3. Making training and treatment resources available.
4. Engaging in efforts to strengthen communities, families and services and ensure an environment of care for staff.
5. Highlights the importance of collaboration across child-service systems.

[9] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[10] https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

POLICY CONTEXT

EARLY YEARS AND EARLY MENTAL HEALTH POLICY IN SCOTLAND

The Early Years Framework, developed in 2008, set out the importance of early intervention, particularly in the early years with the ambition to give all young children in Scotland the best start in life. In 2012 the Scottish Government launched The Getting it Right for Every Child approach (GIRFEC), a framework to support joined up working to enable services to identify what children and families need to help children grown and develop. It has been successful in providing a common language for all those working with children.

There have been a number of other relevant policies which include inter-alia The Children and Young People (Scotland) Act 2014, The Scottish Attainment Challenge, The Adult Learning in Scotland Statement of Ambition, The Community Empowerment (Scotland) Act 2015, The Fairer Scotland Action Plan (October 2016), Community Planning Guidance (2016), Child Poverty (Scotland) Act 2017, Every Child, Every Chance: Tackling Child Poverty Delivery Plan 2018-22, the Human Rights of Children in Scotland: An Action Plan 2018-21 and a number of initiatives such as national rollout of Family Nurse Partnership, the introduction of the Best Start grant, baby boxes and the most recent plan to roll out an increase in the number of hours of funded early learning and childcare available. This is not a comprehensive list.

On the mental health side, in 2016 the Scottish Public Health Network published "Polishing the Diamonds" a report addressing Adverse Childhood Experiences (ACEs) in Scotland. The report called for the creation of awareness and understanding of ACEs, data collection, routine enquiry and prevention[11]. NHS Education for Scotland was commissioned to develop a National Trauma Training Framework and in May 2017 The Scottish Government/NHS Education for Scotland 'Transforming Psychological Trauma: A Skills and Knowledge Framework for The Scottish Workforce' was launched.

In 2018, a Children and Young People's Mental Health Taskforce was set up to improve mental health services for children and young people. This was followed in December 2018 by the Better Mental Health in Scotland: Programme for Government Delivery Plan. The plan states: *"A decisive change is needed in the way that children and young people are supported."*[12]

In May 2019, Scottish Government published Scotland's Wellbeing – Delivering the National Outcomes which describes the National Performance Framework as a Wellbeing Framework that explicitly includes increased wellbeing as part of its purpose[13].

EARLY YEARS SERVICES IN AUSTRALIA AND THE U.S.A.

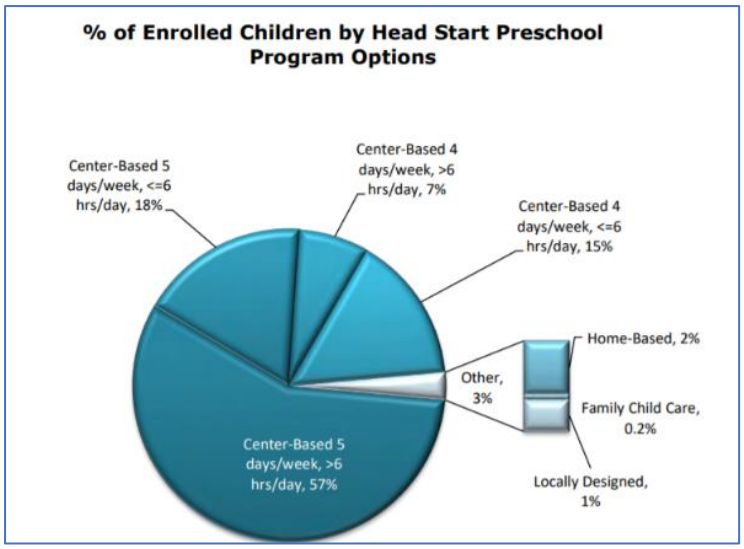
Unlike the United Kingdom and Australia, the U.S.A. does not have a free universal child and family health service. In the U.S.A., Paediatric primary care is the only service which reaches almost all children.

There are several key differences between the provision of Early Childhood Education and Care (ECEC) in the 3 countries. In Australia the remit for the provision and quality falls under the auspices of the Ministry of Education (like the U.K.) while in the U.S.A., the Department of Education's has a statement of strategic intent which refers to supporting the health, social-emotional and cognitive development of all children from birth. The federal government primarily supports this initiative indirectly, by providing grants to states to support young children and their families. This leads to large differences between regions for example, 80% of 3-5 year-olds are enrolled in ECEC and primary education in the District of Columbia,

[11] https://www.scotphn.net/wp-content/uploads/2016/06/2016_05_26-ACE-Report-Final-AF.pdf
[12] https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/12/programme-government-delivery-plan-mental-health/documents/better-mental-health-scotland/better-mental-health-scotland/govscot%3Adocument/00544534.pdf
[13] https://nationalperformance.gov.scot/scotlands-wellbeing-report

compared to only 46% in North Dakota.[14] ECEC in the U.S.A. was described as *"like the wild west"* by staff at ZERO TO THREE.

Data from the Organisation for Economic Co-operation and Development (OECD) shows that the U.K. has a considerably higher rate of enrolment of children aged 3-5 year as well as a higher gross domestic product(GDP) expenditure at approximately 0.7% vs Australia (0.6%) and the U.S.A. (0.4%). However, wider enrolment in ECEC services does not guarantee the quality of education provided to children.



In the U.S.A., Head Start and Early Head Start programs are delivered through 1700 agencies in local communities using a variety of service models dependent on local need to promote school readiness of children ages birth to five from low-income families by supporting the development of the whole child. Approximately 80% of children are 3- and 4-year-olds with the remaining 20% under 3. In the past fiscal year, approximately 1 million children attended this programme. 71% of pre-school teachers have a BA or higher qualification.

In Victoria, Australia, Early Start Kindergarten (E.S.K.) provides eligible children with 15 hours of free or low-cost kindergarten for up to 2 years prior to school starting. The provision is led by a qualified Victorian Institute of Teaching (V.I.T.) registered teacher.
ESK is available to children who are at least three years old by 30 April in the year they are enrolled to attend the program and are:

- Aboriginal and/or Torres Strait Islander, or
- Known to Child Protection or who have been referred by Child Protection to Child FIRST.

The Early Learning Participation Branch in Victoria is responsible for ensuring regulation (including the quality assessment of childcare) and funding. Regulation is guided by Belonging, Being and Becoming[15] the countries first national Early Years framework. It was developed to support its vision of: *"All children have the best start in life to create a better future for themselves and for the nation."*

[14] https://www.oecd-ilibrary.org/docserver/0a156279-en.pdf?expires=1598792655&id=id&accname=guest&checksum=E6DB226E26A706D46037963241054A95
[15]https://www.acecqa.gov.au/sites/default/files/201802/belonging_being_and_becoming_the_early_years_learning_framework_for_australia.pdf

MENTAL HEALTH IN CHILDREN ACROSS AUSTRALIA AND THE U.S.A.

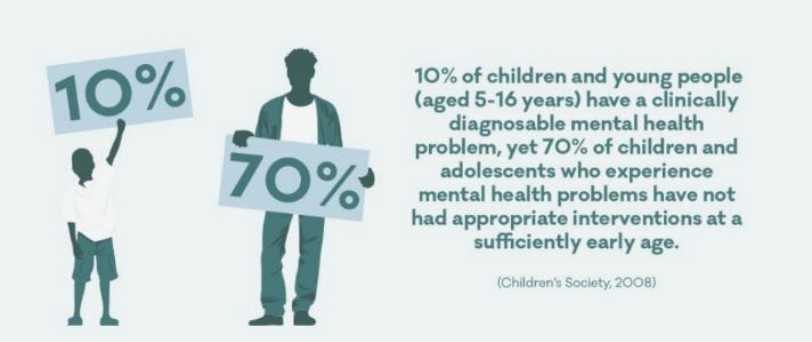
The Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015) [16] is a comprehensive review of the state of mental health in children in Australia. Their second survey was published in 2015 and is based on responses from 6300 families. The report notes that:

- Almost one in seven (13.9%) 4-17-year-olds were assessed as having mental disorders in the previous 12 months.
- Attention Deficit Hyperactivity Disorder (ADHD) was the most common disorder in children and adolescents (7.4%), followed by anxiety disorders (6.9%), major depressive disorder (2.8%) and conduct disorder (2.1%).

Services to pupils are available through a range of platforms including health, school, telephone and online. Counselling is the most used medium (68%) while specialist child and adolescent mental health services were used by 3.3% of 4-17-year-olds. 78% of Parents and carers report they received information, counselling, parenting courses, respite care and support groups to help them.

In the U.S.A., ADHD (9.4%), behaviour problems (7.4%), anxiety (7.1%), and depression (3.2%) are the most diagnosed issues in children, with almost 75% of children with depression also having anxiety and 47.2% behaviour problems.

The Centre for Disease Control (C.D.C.) in the U.S.A. reports that levels of depression and anxiety have increased over time and begin in early childhood with 1 in 6 children aged 2–8 years having a diagnosed mental, behavioural, or developmental disorder. Treatment rates vary from 78.1% children and young people aged 3-17 years with depression receiving treatment. vs 59.3% with anxiety treatment and 53.5% with behaviour disorders.
The incidence of depression and anxiety have been increasing world-wide, with 10-20% of children and adolescents experiencing mental disorders with half of them beginning by the age of 14 years. The Children's Society[17] noted the lack of appropriate intervention in the early years in 2008 .The World Health Organisation (W.H.O.)[18] in its mental health action plan 2013-2020 plan called for a change in the attitudes that perpetuate stigma and discrimination and called for strengthened leadership, governance, data, promotion and prevention and the provision of comprehensive integrated and responsive mental health and social care services in community-based settings.



The need for a multi- disciplinary and trans-diagnostic model has recently been captured by Colizzi et al[19] when they state that evidence suggests: ***"It would be unrealistic to consider promotion and prevention in mental health the responsibility of mental health professionals alone. Integrated and multidisciplinary services are needed to increase the range of possible interventions and limit the risk of poor long-term outcome."***

[16] https://www1.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf
[17] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-children-and-young-people
[18] https://www.who.int/mental_health/action_plan_2013
[19] Colizzi, M., Lasalvia, A. & Ruggeri, M. Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?. *Int J Ment Health Syst* **14,** 23 (2020). https://doi.org/10.1186/s13033-020-00356-9

FINDINGS

The author visited a diverse range of services in Australia and the U.S.A. These ranged from services operating at a system-wide level to small local community projects. In addition, they varied from traditional mental health projects to nursery schools.

In order to understand the relevance of these diverse services in relation to what they offer to local efforts to interrupt the inter-generational transmission of adversity and/or promote the use of co-production, the author has grouped services visited under six themes that emerged through the course of this journey of exploration into community based mental health:

THEME 1 – SYSTEM WIDE OR POPULATION LEVEL IMPLEMENTATION.

- Snohomish County, Washington State. The description of the implementation of trauma informed schools is augmented by two practice examples- PAX Good Behaviour Game and Training delivered by Continua Consulting.
- Healthy Steps
- Piplo Productions
- Mental Health Consultations

This theme explores how one local county, Snohomish has successfully implemented a system wide trauma informed approach and offers practice examples of local tools. Three other nationally implemented approaches are explored in relation to what they can offer local trauma informed initiatives in relation to training and community conversations.

THEME 2- EARLY YEARS SETTINGS

- Early Childhood Management Services (ECMS) and the Australian Childhood Foundation.
- The Pact Therapeutic Nursery, Baltimore. The description of the working of the therapeutic nursery is augmented by a three practice examples- Dealing with separation anxiety, the use of the FAN model and Mindful Awareness Play.

This theme explores how "trauma informed" practice is used in 2 very diverse early years settings. This demonstrate how early years settings can develop their practice to support "trauma informed" practice along a continuum from using some tools to becoming a fully-fledged therapeutic nursery.

THEME 3– A SOCIAL CAPITAL APPROACH

- Family by Family

This theme explores how one setting has used ethnographic research to develop a new programme in one local area. This provides an example of how local services can work with local communities to develop appropriate services and ensure local buy-in.

THEME 4- TAKING A 2-GENERATIONAL APPROACH

- United Way, New York

This theme will explore how a setting has used a 2-generational approach and collaboration to support work to communities impacted by the social determinants of health.

THEME 5 – TRAUMA INFORMED EVALUATION

This theme will address a range of dilemma's in relation to proving evidence of impact. This includes the expense of evaluation, ethical considerations, the risk of re-traumatization or the licencing restrictions of imported programmes which do not allow for comparative analysis.

THEME 6 - THE USE OF ROUTINE ENQUIRY

This theme will address the issue of the use of routine enquiry to screen the number of ACEs at the services visited.

THEME 1: SYSTEM WIDE OR POPULATION LEVEL IMPLEMENTATION

This theme will explore how one local county, Snohomish County uses research on childhood adversity to inform their practice. Snohomish County's system wide implementation offers ideas, tools and techniques which can be used by other counties considering implementing a system level trauma informed approach. Two of the tools utilised by Snohomish, PAX Good Behaviour Game and Continua Consulting are explored as practice examples both in relation to what they can offer to a population wide implementation of a trauma informed approach as well as tools that could be replicated as stand-alone interventions locally.

The report also explores the Healthy Steps approach implemented by ZERO TO THREE, the work of Piplo Productions and Mental Health Consultations. The author suggests ways in which the learning from these approaches can support local trauma informed initiatives, training and community conversations.

SNOHOMISH COUNTY, WASHINGTON STATE

Snohomish County Human Services Behavioral Health and the Children's Wellness Coalition in Snohomish county has been instrumental in driving the trauma informed approach taken in the County. The infographic below summarizes their reason for doing so, and this co-ordinated vision was the reason for the author choosing to visit this County to learn how they are doing this work in practice.

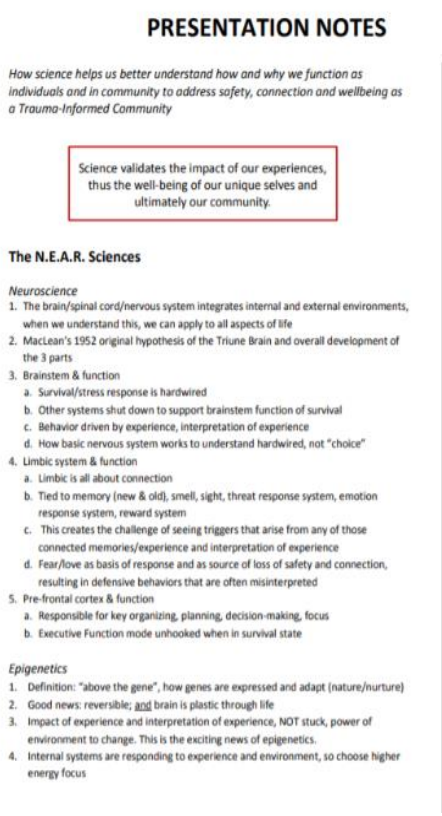
Washington State is in the Pacific northwest region of the USA and has a population of approximately 7.6 million people in an area that is 71,362 square miles. Washington State has adopted a state-wide ACEs and resilience approach a range of services and resources offered through local counties to support a trauma informed approach.

The author visited Snohomish County, the third largest county in the state of Washington. It has an estimated population of 822,083 as of 2019,[20] to understand how this has been implemented locally.

> ***"The ACEs study provides us a glimpse of the impact and cost of prolonged periods of toxic stress, and the disruption to neurodevelopment. Conversely, as we lighten the load, generation to generation more is possible than we ever imagined.*** (Executive Summary "Framing the Crossroads of Trauma-Informed Care and

[20] https://en.wikipedia.org/wiki/Snohomish_County,_Washington

Snohomish County was chosen as it was the host county for the May 2019 Washington State ACEs and resilience community of practice gathering. The report ***"Framing the Crossroads of Trauma-Informed Care and Equity"***[21] captures some of the work that is being undertaken to implement a systemic trauma informed approach locally.



PRESENTATION NOTES

How science helps us better understand how and why we function as individuals and in community to address safety, connection and wellbeing as a Trauma-Informed Community

Science validates the impact of our experiences, thus the well-being of our unique selves and ultimately our community.

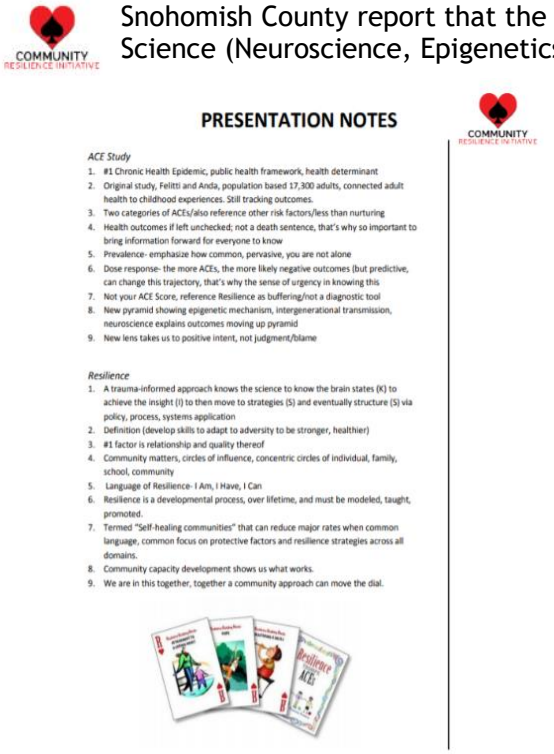
The N.E.A.R. Sciences

Neuroscience

1. The brain/spinal cord/nervous system integrates internal and external environments, when we understand this, we can apply to all aspects of life
2. MacLean's 1952 original hypothesis of the Triune Brain and overall development of the 3 parts
3. Brainstem & function
   a. Survival/stress response is hardwired
   b. Other systems shut down to support brainstem function of survival
   c. Behavior driven by experience, interpretation of experience
   d. How basic nervous system works to understand hardwired, not "choice"
4. Limbic system & function
   a. Limbic is all about connection
   b. Tied to memory (new & old), smell, sight, threat response system, emotion response system, reward system
   c. This creates the challenge of seeing triggers that arise from any of those connected memories/experience and interpretation of experience
   d. Fear/love as basis of response and as source of loss of safety and connection, resulting in defensive behaviors that are often misinterpreted
5. Pre-frontal cortex & function
   a. Responsible for key organizing, planning, decision-making, focus
   b. Executive Function mode unhooked when in survival state

Epigenetics

1. Definition: "above the gene", how genes are expressed and adapt (nature/nurture)
2. Good news: reversible; and brain is plastic through life
3. Impact of experience and interpretation of experience, NOT stuck, power of environment to change. This is the exciting news of epigenetics.
4. Internal systems are responding to experience and environment, so choose higher energy focus



PRESENTATION NOTES

ACE Study

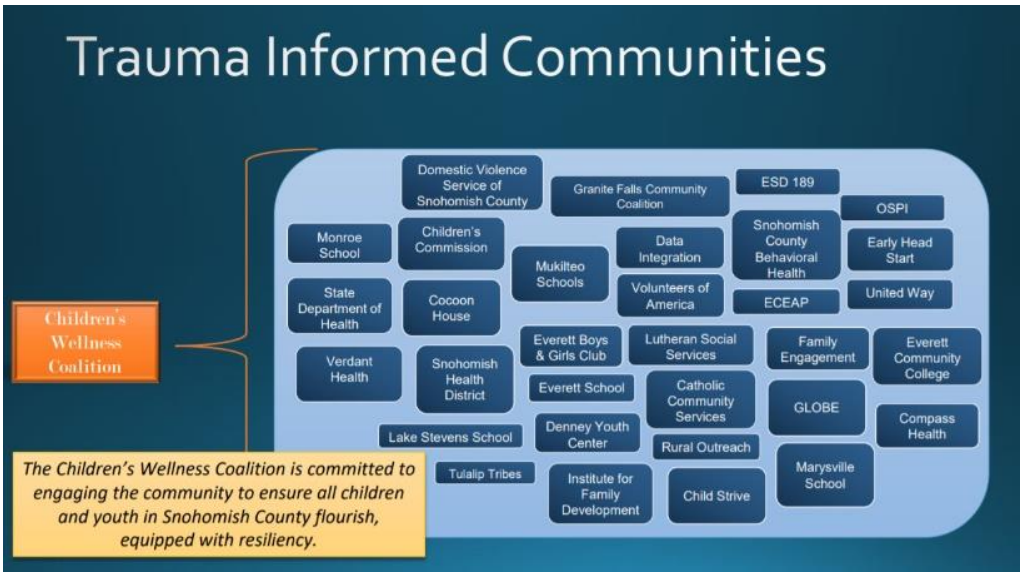
1. #1 Chronic Health Epidemic, public health framework, health determinant
2. Original study, Felitti and Anda, population based 17,300 adults, connected adult health to childhood experiences. Still tracking outcomes.
3. Two categories of ACEs/also reference other risk factors/less than nurturing
4. Health outcomes if left unchecked; not a death sentence, that's why so important to bring information forward for everyone to know
5. Prevalence- emphasize how common, pervasive, you are not alone
6. Dose response- the more ACEs, the more likely negative outcomes (but predictive, can change this trajectory, that's why the sense of urgency in knowing this
7. Not your ACE Score, reference Resilience as buffering/not a diagnostic tool
8. New pyramid showing epigenetic mechanism, intergenerational transmission, neuroscience explains outcomes moving up pyramid
9. New lens takes us to positive intent, not judgment/blame

Resilience

1. A trauma-informed approach knows the science to know the brain states (K) to achieve the insight (I) to then move to strategies (S) and eventually structure (S) via policy, process, systems application
2. Definition (develop skills to adapt to adversity to be stronger, healthier)
3. #1 factor is relationship and quality thereof
4. Community matters, circles of influence, concentric circles of individual, family, school, community
5. Language of Resilience- I Am, I Have, I Can
6. Resilience is a developmental process, over lifetime, and must be modeled, taught, promoted.
7. Termed "Self-healing communities" that can reduce major rates when common language, common focus on protective factors and resilience strategies across all domains.
8. Community capacity development shows us what works.
9. We are in this together, together a community approach can move the dial.

Snohomish County report that the use of NEAR Science (Neuroscience, Epigenetics, ACEs, and Resilience) has been foundational to their work in adopting trauma-informed approaches across its systems from schools to public health and social services.

Snohomish's trauma informed work is led by the children's wellness coalition which meets every month to talk about how to keep growing their community. The coalition recognises that the



[21] https://www.doh.wa.gov/Portals/1/Documents/Pubs/141-007-EfC-CoP-May19ActivityHarvest.pdf

challenges facing their communities are complex and intergenerational and broader than adverse childhood experiences.

They host a variety of training and community events designed to move Snohomish County from Trauma-blind to Trauma-Informed. [22]They have an annual children's wellness fair that offers workshops; and in the most recent fair had 1,100 attendees with 70 stands.

When services undertake training to become trauma informed, each member organization forms a trauma-informed leadership team (TILT) to work on changing policies and procedures in their organization. Learning collaboratives/ cohort model are used to build strong connections and learning across organisations.

Snohomish have brought together almost 50 organizations to support their effort of adopting a systemic trauma- informed approach. These organisations achieve a CARE site designation (which stands for compassion, resilience, and empowerment) and this designation means the organisation:

- Recognizes the prevalence and impact of trauma to the individual and society
- Recognizes the signs and symptoms of trauma in their clients, customers, staff and students
- Responds by putting knowledge into practice
- Resists the re-traumatization of clients and staff

The county recognised the need for determining their THEORY OF CHANGE to support their evaluation framework, which is a pillar of their implementation. Measurement is based on local relevant data that is already collected. In addressing measuring impact in their report, they warn that current systems for collecting data can *"retraumatize individuals in order to collect data. The data should be inspirational and should have a healing-centred focus to engage community…… let the community decide what is meaningful to measure."*

"We are committed to this work, schools and organizations are working together and working to become more trauma informed, Rather than suspensions and expulsions in schools they take the approach of asking "what happened?" not "what's wrong?"

Liza Patchen-Short, Snohomish County Human Services

TRAUMA INFORMED SCHOOLS IN SNOHOMISH COUNTY

The author met Joe Neigal the Prevention Services Manager, Monroe School District in Snohomish County. This school's district has approximately 7,000 pupils over a large rural geographic area and with approximately 24% of pupils on free or reduced cost meals (vs a federal level of approximately 12.5%).

The author visited a primary and secondary school in this district. Joe described how the trauma informed approach has been used in the local education department. He described partnership working and trauma training as having an impact on staff and how this and a data led approach with a focus on using evidence-based services was making a difference for students. School have developed a baseline understanding of the issues in the region, within the context of pupil experience. This is supported by an annual "Healthy You" survey. From the data, schools recognised the high incidence of attempted suicide and implemented

[22] https://snocochildrenswellnesscoalition.com/

"Sources of strength" in high schools.[23] This has led to a reduction in attempted suicide from 17% to 6%.

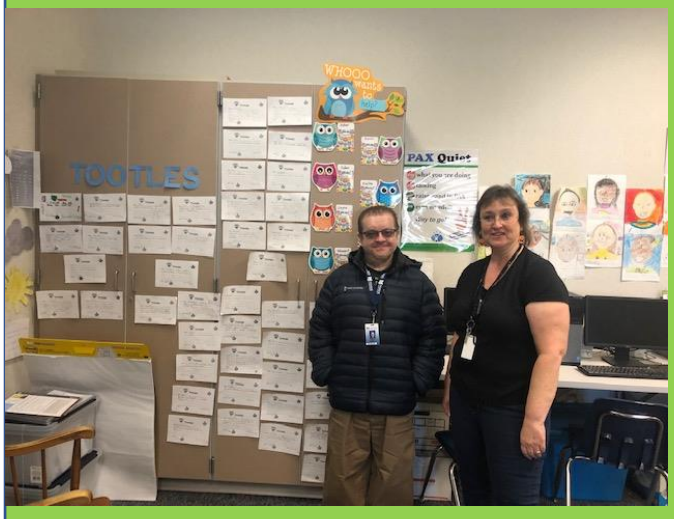
Joe described the use of the PAX Good Behaviour Game (GBG) in primary schools and introduced the author to Mary, a teacher in a local primary school. Joe describe PAX GBG as the singular most effective initiative they have implemented. He stated that he would implement it in every school if he could. Mary described how the game worked at her school. She explained that prior to the introduction of the game she had been feeling burnout and had approached Joe in order to find an intervention that could be used in her school to address the issues that they were experiencing, which when described sounded very similar to issues experienced by primary teachers in local schools in Scotland.

***"PAX has revitalized me as a teacher and helped reduce stress."* Mary, teacher at local school**

Mary explained that since the introduction of the PAX GBG she has experienced less stress and feels revitalized as a teacher. Mary noted that the children in her school enjoyed the PAX game and that it helped her students to become "scientists" and data driven.

PRACTICE EXAMPLE- PAX GOOD BEHAVIOUR GAME (PAX GBG)

The Good Behaviour Game (GBG) was developed by Muriel Saunders in 1969 to address disruptive behaviour and improve self- regulation. This initial programme has been adapted and currently there are 2 versions of the GBG- the American Institutes of Research (AIR) GBG and the PAX GBG. This report will focus on the PAX GBG designed by Dr Denis Embry and offered through the PAXIS Institute.



The PAX GBG is described as a powerful classroom-based game that helps to teach children self-regulation skills. Children first create a classroom vision of what they would like to see, hear, do and feel more of and less of in a 'wonderful' classroom[24].

PAX GBG adheres to SAMHSA's six key principles of a trauma-informed approach. Examples of this are available on the PAX GBG Website.[25] An example given is that the game and training is aimed at reducing "toxic influences" in classrooms by for example PAX Quiet- the use of a harmonica and peace-sing for transitions instead of clapping hands, shushing children, raising voices or other methods that may be reminders of trauma.

[23] https://sourcesofstrength.org/

[24] http://paxgoodbehaviorgame.promoteprevent.org/what-pax-good-behavior-game

[25] https://www.goodbehaviorgame.org/post/can-paxgbg-reduce-aces

HOW THE MODEL WORKS

The idea behind the PAX GBG is that by learning to regulate their emotions, to get on with others, to express their feelings, to have healthy self-esteem, to be independent and solve problems themselves; children can achieve better academic outcomes, better mental health and can succeed throughout their lives both at work and in relationships.

To deliver the programme, teachers are trained in the approach over two days and provided with materials. The foundational training of PAX GBG ensures proficiency in each of the PAX Kernels as well as the PAX Game and trained staff are provided with a PAX kit, PAX GBG Manual and trained to use the PAX UP! APP which is used to support implementation and monitoring of the programme in their classroom. In addition, training ensures that PAX strategies integrate seamlessly into existing tiered-intervention and additional school-wide procedures.

In addition to implementing strategies, teachers learn the importance of a nurturing environment and its effects on trauma, self-regulation, and mental health outcomes throughout the lifespan. Teachers also learn about the role they can play in supporting students.

They then apply PAX within the ongoing classroom work, with support from a mentor who briefly visits the classrooms four times to support the teacher.

The programme is based upon promoting desirable behaviours using proven strategies which are practised as fun activities. Children are divided into teams, which are rewarded for delivering positive behaviours that support classroom activity. The games are played doing normal class work and can last from a couple of minutes to 45 minutes. They are played at least three times a day and are increased in duration over time.

IMPACT

The original GBG has had 30 years of research and evidence on supporting children's behaviour and learning. Since 1999, PAX GBG has been used in 38 states, Canada, Ireland, Estonia, Sweden and Australia. PAX has been credited with improved classroom behaviour and improving self-regulation in children and co-regulation with peers.

According to PAX GBG the most recent cost benefit analysis on the PAX GBG by the Washington Institute for Public Policy has shown a social return of $57 for every $1 invested, making it possibly the highest return on investment for any schools-based programme worldwide.

REPLICATION IN THE U.K. AND IRELAND

The PAX GBG has not been replicated in England or Scotland. AIR GBG has been trialled with variable success. A small-scale implementation in Oxfordshire found that *"the GBG was perceived positively across all groups. Despite initial reservations about participation in this project, teachers typically said that the experience was valuable for themselves and their pupils in terms of skill development and self-management.*[26]

Manchester Institute of Education, Manchester University and Mentor UK implemented AIR GBG in 77 state schools in Greater Manchester, Yorkshire, and the Midlands. Evaluation by the Education Endowment Foundation[27] found that there was:

- No evidence that the GBG improves pupils' behaviour (specifically, concentration problems, disruptive behaviour, and pro-social behaviour).
- Most classes in the trial played the game less often and for shorter time periods than recommended and a quarter of schools stopped before the end of the trial.

[26] Chan, G., Foxcroft, D., Smurthwaite, B., Coombes, L., & Allen, D. (2012). Improving child behaviour management: An evaluation of the Good Behaviour Game in UK primary schools. Oxford: Oxford Brookes University.
[27] https://educationendowmentfoundation.org.uk/public/files/GBG_evaluation_report.pdf

- Higher levels of pupil engagement with the game were associated with improved reading, concentration, and disruptive behaviour scores at follow-up, with tentative evidence that boys identified as at-risk of developing conduct problems at the beginning of the project benefitted from the GBG.

Northern Ireland has implemented PAX GBG and subjected it to a randomised control study conducted by Joanne O'Keefe[28] as part of a PHD through Queen's University Belfast in 2018/2019 on the implementation of PAX GBG on 353 pupils at 15 primary schools (P3) in Northern Ireland. The researcher found that PAX GBG was:

- Delivered effectively with high fidelity and was well received by the pupils and teachers.
- After the 12 weeks of implementation, the study provided some evidence that the PAX GBG may help improve self-regulation in participating pupils.
- Evidence of differential effects, suggesting that the PAX GBG is more effective for males, pupils with Special Educational Needs and those living in areas of high deprivation.
- The programme had a low cost of £30.48 per pupil.
- Ms O'Keefe concludes that: ***"preliminary evidence reported in this study suggested that the PAX GBG may offer a feasible and cost effective, mental health prevention and early intervention approach for Northern Ireland classrooms. However, a larger effectiveness study would be needed to verify the findings in this study."***

Preparing for Life and partners – Midlands Area Parenting Partnership and TUSLA, piloted PAX GBG across 21 schools in Ireland between 2015-2017 and reported positive results with a reported 58% reduction in children's off task behaviours. The recommendation was the continuation and extension of PAX GBG in Irish schools. The Midlands Area Partnership Manager Conor Owens[29] added that the programme is highly cost efficient and scalable.
"Once the teacher is trained, they can then apply PAX to each class every year for the rest of their teaching careers – so the benefit is applied over a career rather than for just one class."

In the Irish study researchers[30] found that relationships improved, both between pupils and between teacher and child. In turn, pupils became more respectful to others, more skilled at resolving conflict, and were experiencing more feelings of happiness both in themselves and in the classroom environment."

The benefits were found to support pupils generally and not just those with behaviour difficulties.

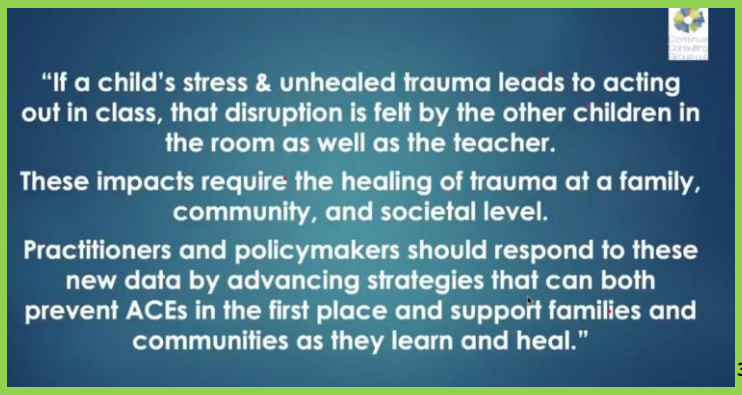
Teachers reported that the programme positively changed their professional lives, reduced stress levels and re-aligned their relationships with all pupils. The teachers were strongly in favour of the programme and all of those trained said they planned to keep using it.
"As pupils become more skilled in self-regulation, there was a significant reduction in teacher stress which in turn led to a much more positive learning environment with the teachers being able to focus on teaching and learning as opposed to continuously correcting and monitoring inappropriate behaviours," the report stated.

[28] O'Keefe, J. (2019) A Feasibility Study and a Pilot Cluster Randomised Controlled Trial of the PAX 'Good Behaviour Game' in Disadvantaged Schools. Belfast: Queen's University Belfast.

[29] www.paxireland.ie / www.mapp.ie or www.preparingforlife.ie

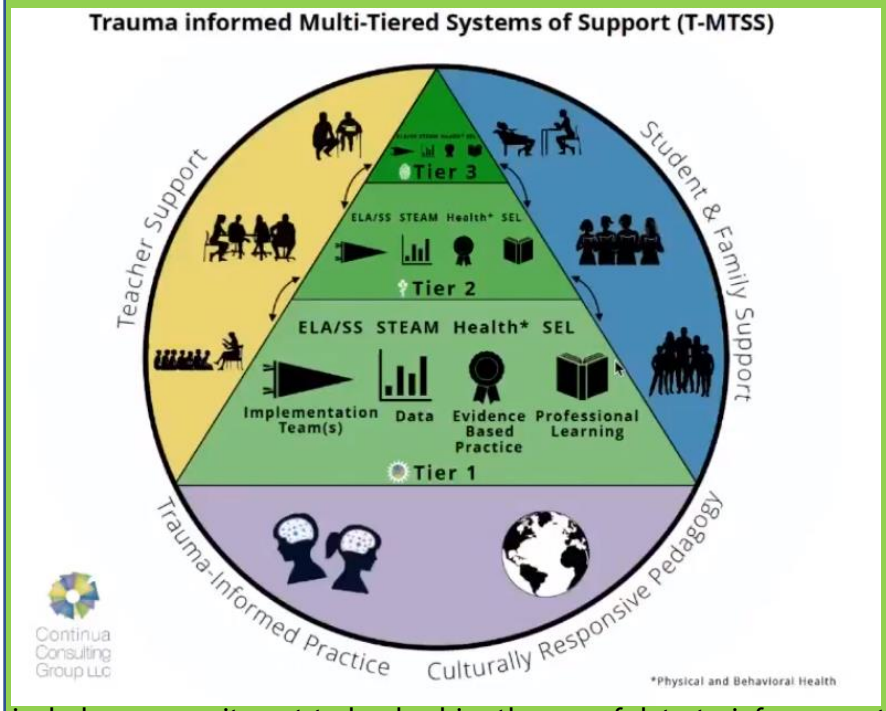
[30] Morgan, M., and O'Donnell, M. (2015). Evaluation of the PAX Good Behaviour Game Pilot Study: Final Report. Retrieved from Dublin, Ireland. Available at: http://www.paxireland.ie.

PRACTICE EXAMPLE – TRAUMA INFORMED SCHOOL CONSULTING AND TRAINING IN WASHINGTON STATE



[31]

Continua Consulting use a constructivist model to tailor consultation and training supporting school districts and communities to create systemic, sustainable solutions. Chris and Courtney Daikos have developed a multi-tiered approach to introduce trauma informed practice in schools.



Their multi-tiered system is based on some anchor concepts which include:

- Common language and practice
- High expectations and high support
- Collective efficacy
- Predictability
- Fidelity of practice

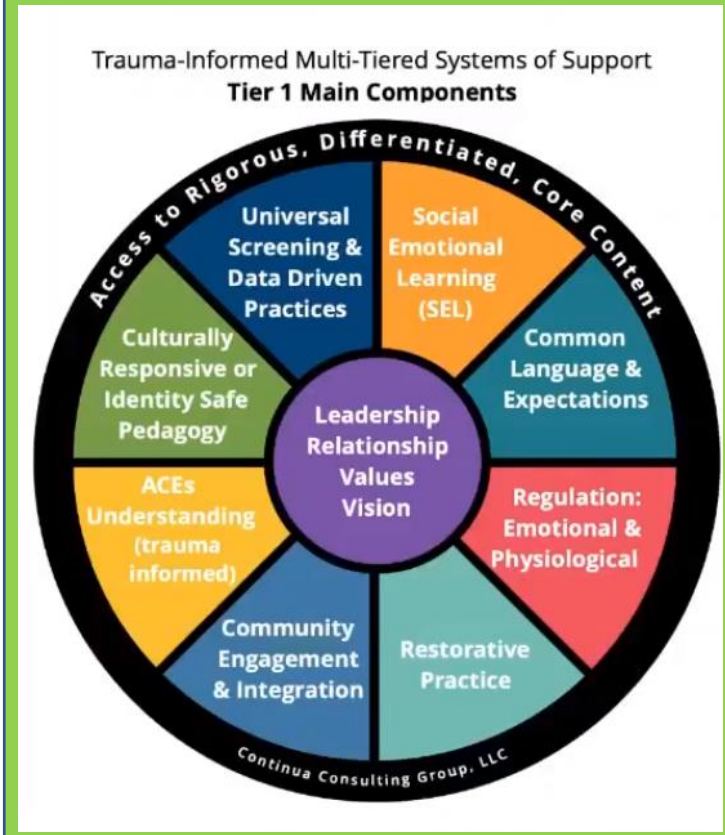
When Chris and Courtney start working with a school, they start by observing existing practice. Schools cannot get the programme unless they commit to change practice This includes a commitment to leadership, the use of data to inform practice, evidence-based programmes which are implemented with fidelity and professional learning. This started as attainment data but has now moved to data on social and emotional functioning such as trust of peers and a sense of belonging.

Their initial training starts with an understanding of ACEs and the function of behaviour and focusses on predictability, consistency, strategies to calm students, a positive greeting at the door and immediate entry tasks. (what they describe as "quick wins".) Staff are trained to depersonalise behaviour- not get into a power struggle- rather take a deep breath. Staff are taught to focus on the function of the behaviour and how to support acceptable alternatives.

The PAX model works well to support this.

[31] https://www.continuaconsulting.com/

In addition to training, Chris and Courtney support the school to set up implementation teams. They feel it is vital that the implementation team include representation across the school with teaching staff, administrative and support staff, parents and children/young people as part of the team.

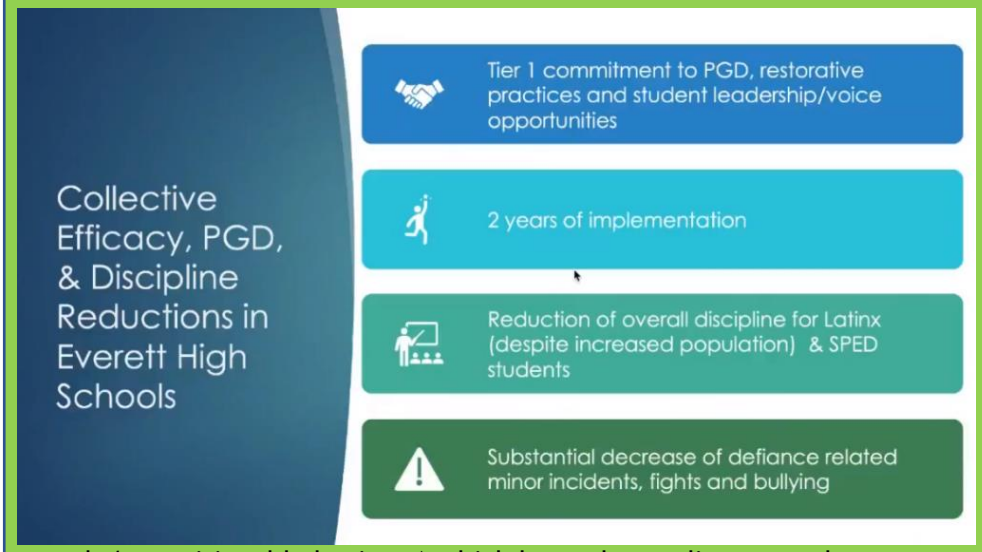


They also suggest that the team should intentionally include sceptics.

The implementation team (TILT) meets at least weekly, preferably bi-weekly, supports communication and helps consolidate why the activity is in place- e.g. one if the suggested low cost high yield initiatives is a "positive greeting at the door" which provides a protective factor in the form of a consistent positive adult who will have positive regard which helps student lower their cortisol levels. They suggest this strategy is best implemented if it is combined with a positive pre- correct (e.g. how was your game yesterday- hey remember when you take your seat and the bell goes we're going to start…..right away"- a positive reminder of what is expected- a stimulation to the pre-fontal cortex and an entry task.

Training is followed by time in the school and then reporting back to the implementation team to check in – "Does this sound accurate". The implementation team is supported to use data e.g. attendance, given new ideas and encouraged to have honest ideas about what is working and not working.

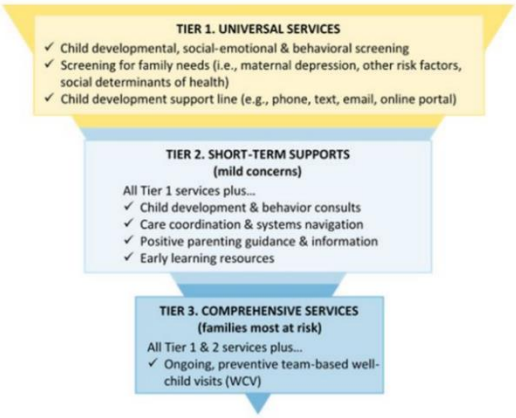
Chris and Courtney state that if Tier 1 interventions are not working, this leads to false positives at higher tier levels. The goal of the school is to have 5% of students needing a Tier 3 level intervention.



Courtney and Chris report that this approach and a focus on the collective efficacy of teachers has led to substantial decrease in discipline issues including low levels of defiance (refusal to comply/oppositional behaviours) which have almost disappeared.

HEALTHY STEPS

ZERO TO THREE has developed an evidence-based programme called Healthy Steps which aims to promote health, well-being and school readiness of babies and toddlers, particularly for families living in low-income communities.



Healthy Steps is a population health model. It is delivered by HealthySteps Specialists in association with the paediatric team. It incorporates eight core components organised into 3 tiers of service. This programme offers such interventions as screening, child development support, parenting support on dealing with feeding, behaviour, sleep, attachment, maternal depression and access to social supports.

The author visited 3 different Healthy Steps programmes in New York. At all sites HealthSteps Specialist and paediatricians were enthusiastic about the impact the programme was having. They spoke about how the programme helped engage families as the paediatrician and HealthSteps Specialist worked in close association and the paediatrician is a trusted person.

The programme uses a non-judgmental approach and is relationship based. HealthySteps Specialists run groups such as “Baby and me” with a social worker. Referrals are made to home visiting and specialist services. However, as access to health care insurance (or lack of) in the USA, there was a lot of variation in resources available to providers, with the most resourced providers speaking of the impact of speedy referrals (within 3 weeks) to appropriate services.

Providers highlighted what they considered the most useful resources:

- Therapists in schools – a new model for the USA
- Mental Health First Aid
- Power of two- FUN programme based on parent playing with the child as they find that often because of stress or other factors, parents are not stimulating children enough.
- Parent coaches- available for 10 weeks.
- Family needs assessment- a review of what the parent and child need with supports to link to food/clothes
- One provider spoke about how local services set up a table in the health centre which parents can visit and sign up to services.
- Work of SAMSA in developing learning communities, collaborating with and supporting organisations to become trauma informed. One of the domains of their work is the education of communities.
- Use of Eye Movement Desensitization and Reprocessing (EMDR)
- Cognitive process training, an evidence-based programme for 14 years+

Health Steps incorporates “trauma informed” training. Not all providers have become “Trauma Informed” sites. To qualify they require widespread education of the workforce with efforts to ensure that they were aware of inter-generational trauma and the need to intervene early. One paediatrician spoke about the need for culture change if the site were to become more “trauma informed”.

The use of routine enquiry was limited. Where used, it was only used where the provider was not already aware of trauma within the family with providers talking about using a more nuanced approach to avoid re-traumatisation. Providers reported that they tended to rather

use developmental screening (Age and Stage Questionnaires (ASQ))- which are also used for research as opposed to routine enquiry. Post-natal depression screening and a Social

determinants of health needs survey which is based on 10 questions which focus on language, finance, childcare, job training and high school attainment is used.

Providers stated that they were convinced to use the Healthy Steps programme as the science around early intervention was overwhelming, with excellent training, and they could see how they could change the trajectories for children. What providers liked about the Health Steps programme is the fact that the service is available at the time it is needed and helps the health centre navigate a complex world of service. Provider noted that unlike Family Nurse Partnership or Healthy Families, it was not seen as having a restrictive criterion for who can access the service.

PIPLO PRODUCTIONS

Dr Chandra Ghosh Ippen and her family have set up Piplo Productions with the mission "*to help children and families recover after stressful and traumatic events by using story, clinical psychology and cute creatures.*"

Chandra is currently the Associate Director of the Child Trauma Research Program at UCSF and the Director of Dissemination and Implementation for Child-Parent Psychotherapy (CPP). She has co-authored over 20 publications related to trauma and diversity-informed practice including the book Don't Hit My Mommy, which has become a manual for Child-Parent Psychotherapy with young witnesses of family violence. Chandra has over 15 years of experience conducting trainings nationally and internationally.

Chandra notes that she combines her love of story and cute creatures and her experience as a Child-Parent Psychotherapist (a therapeutic intervention that is considered a "gold standard" evidenced based approach which has been subjected to a number of randomized control studies and has been adopted across the world) to make information on stress and trauma widely available.

Chandra has used her stories "Once I was very scared" and "Healing paces" as a population-based intervention to help adults and children understand and talk more about stress and trauma. The book is available as a free pdf[32]. In addition, she has created a free webinar to explore the issues raised.[33]

Chandra attributes her success with public engagement in the topics of stress and trauma (she has received several accolades in relation to her training) to the use of humour and analogy. Her books, as can be seen above are based on animals which represent emotions as they are an accessible medium.

In addition to making her work available through her website Chandra provides training to a range of stakeholders in trauma.

This includes parents. She states that "*this training supports dialogue on the issue of trauma and provides tools that workers can use to support practice".* Chandra views trauma informed practice as a public health issue. She states: *"Like asthma, there is no cure*

[32] https://piploproductions.com/
[33] https://www.youtube.com/watch?v=DcAPbDpgoso

but when the environment is bad e.g. there is lots of pollen that will increase the symptoms".

She suggests that there are a range of ways in which workers can use the tools available in their work with children and families to mitigate the trauma impact. As an example, she describes how when a social worker is going on holiday, they can mitigate the known impact on the child by providing young children with a picture of the worker leaving and then returning.

MENTAL HEALTH CONSULTATIONS

Lindsay Usry, Director of Infant and Early Childhood Mental Health Strategy at Zero to Three advises that one of the ways that the United States is addressing the drastic shortage of mental health clinicians, especially in the early years is through mental health consultations.

HOW THE MODEL WORKS

According to The Centre of Excellence for Infant and Early Childhood Mental Health (IECMHC), over the last decade, infant and early childhood mental health consultation (IECMHC) has emerged as an effective and evidence-based strategy to promote young children's positive social and emotional development and behavioural health. It is a prevention-based approach that pairs a mental health consultant with adults who work with infants and young children in a range of early years settings such as child-care, preschool, home visiting or early intervention.

A set of IECMHC national competencies was developed by Georgetown University Centre for Child and Human Development faculty and colleagues in 2015 and have subsequently been updated. The competencies support local implementation but are not meant to replace those developed by local or national IECMHC programmes.

IECMHC has three areas of focus:

- To serve as a clearinghouse for best practice resources related to developing, implementing and maintaining an IECMHC program at a state, territorial, community or tribal level.
- To provide technical assistance to states, territories, programs, communities, or tribal nations in any stage of IECMHC program development.
- To provide professional development to IECMH consultants nationally.

THE ROLE OF MENTAL HEALTH CONSULTANTS[34]

- Focus on building the capacity of the adults in children's lives to understand young children's social emotional development
- Are highly trained licensed or license-eligible professionals with specialized knowledge in childhood development, 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
- Use a strengths-based approach
- Are sensitive to the setting and take equity and culture into account, suggest and supporting appropriate resources
- Promote reflective practice and assists others in reflecting
- Provide a "toolbox"
- Supports evaluation and research to support data-driven decision-making and innovation in the field

Mental health consultation is about equipping frontline staff, not about "fixing kids." Nor is it therapy. Mental health consultants use the "circle" of the "Circle of Security" as a concrete way to talk about attachment.

[34] https://www.iecmhc.org/documents/measures-used-evaluate-outcomes-iecmhc.pdf

IMPACT

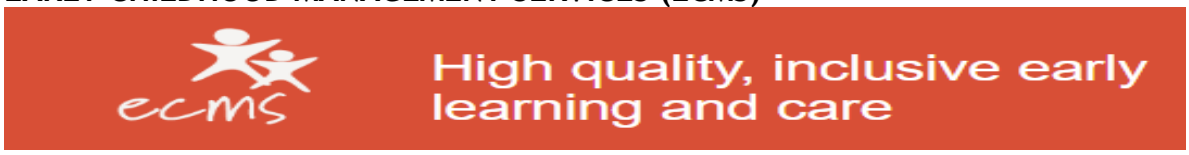
IECMHC [35] have developed a comprehensive toolkit to measure the impact. Evaluation indicates IECMHC has been shown to play an important role in helping to prevent, identify, and reduce the impact of mental health problems among young children and their families.
It has also been linked to improved children's social skills and emotional functioning, promotion of healthy relationships, reduced challenging behaviours, reduced number of suspensions and expulsions and improved classroom quality.

In addition, evaluations of these programmes have seen a significant reduction in staff burnout. They have been particularly helpful in Early Years settings.

THEME 2- EARLY YEARS SETTINGS

This theme explores how "trauma informed" practice is used in 2 very different early years settings and in 2 very different ways. In the authors opinion, these 2 diverse settings demonstrate how early years settings can develop their practice to support "trauma informed" practice along a continuum from being trauma aware and being supported to use appropriate tools to becoming a fully-fledged therapeutic nursery.

EARLY CHILDHOOD MANAGEMENT SERVICES (ECMS)



Early Childhood Management Services (ECMS) is a not-for-profit organisation that has been providing high quality and inclusive early learning and care for Melbourne children, families and communities for more than 22 years.

The author visited the Early Childhood Management Services Offices and met with Janet Williams- Smith, Director Service Development & Strategy on the recommendation and in the company of Mathew Lundgren, Director, Early Learning Participation Branch, Early Years and Primary Reform Division, Victoria State Government, who contract ECMS to provide Early Start Kindergarten.

HOW THE MODEL WORKS

ECMS run almost 70 kindergartens and childcare centres working with approximately 6500 children across Melbourne each week.

> "When school staff are supported to understand how violence and fear impact children's capacity to feel safe and develop strategies that help children feel calm and connected, children begin to engage in their learning and their school" **Australian Childhood Foundation**

ECMS recognise the adversity of the children attending their kindergartens and childcare centres. Services are therefore designed to reflect the needs of the centre's local community and families. In addition, ECMS have taken a trauma informed approach to their work, offering:

- High-quality play-based educational programs designed around children's interests and developmental needs
- Highly qualified and dedicated educators who work in close partnership with families to maximise children's learning outcomes before school
- Safe and stimulating indoor and outdoor learning environments filled with plenty of natural resources to support children's learning

[35] https://gucchd.georgetown.edu/products/ECMHCToolkit.pdf

- Strong ties to the local community to enhance children's social connections and a sense of belonging.
- Family Violence workers employed to support children, going to the home to collect children and role modelling behaviour and who is available to build relationships with parents and asking challenging questions like "I'm worried about you…"
- Trauma informed training provided to staff by the Australian Childhood Foundation.
- Trauma informed initiatives like having a "therapet" at one of the kindergartens.

PACT THERAPEUTIC NURSERY, BALTIMORE

Founded in 1987, PACT's Therapeutic Nursery provides the only Early Head Start (a comprehensive programme aimed at women and children from pregnancy and available to 7% of families in the USA) specializing in attachment-based and trauma-informed child-care to families with young children 8 weeks to 3 years of age currently living in homeless shelters in Baltimore City. It is based at the Sarah's Hope Homeless shelter and provides services to children 6 weeks to 36 months old, and their families, who are currently residing in homeless shelters or experiencing housing uncertainty. The majority of families using the service are African- American. Families have experienced a variety of adversity including poverty and the impact of homelessness. The Therapeutic Nursery is licensed by the Maryland Office of Child Care Administration.

The nursery is supported by a multi-disciplinary team of educators, mental health clinicians, occupational/physical/speech and language therapists, family support and program coordinators. The clinical team, in addition to service provision, conducts research on the effectiveness of these interventions, and provides training locally, nationally, and internationally to trainees and professionals from a wide range of disciplines.

HOW THE MODEL WORKS

Carole Norris-Shortle, Clinical Assistant Professor, Psychiatry, at the University of Maryland and Kim Cosgrove, Director, Therapeutic Nursery introduced the author to the nursery.

The nursery aims to offer an attachment-based, trauma-informed child-care program, with services on offer based on approaches that support this.

The range of services include:

- Quality child-care/ comprehensive early head start programme
- Services for families: Parent-child play therapy, parent training, family engagement, interventions targeting the quality of play, family support and
- Interventions in relation to speech and language and physical therapies
- Training for child-care professionals: training in infant mental health and attachment and helping children and families cope with trauma, training in family engagement, training in reflective practice and certification in research-based parent-child assessment tools,

The staff focus on relationships and the parent-child attachment. A lot of attention is paid to engaging families. This includes offering events like Family Traditions Breakfast. Further evidence-based programmes offered include interventions such as Circle of Security and "Wee Toddle and Grow," based on the Nursing Child Assessment Satellite Training Tool. The "Family Traditions Breakfast," based on Dr. Laurel Kiser's work on Strengthening Family Coping Resources.[36]

IMPACTS

The nursery has been prolific in publishing the impact of its work. Publications (see references) include ***"Let's spend more time together like this!" Fussy baby infusion in a***

[36] https://www.homelesshub.ca/resource/essential-bonds-pact-therapeutic-nursery-baltimore

Baltimore homeless nursery program,(2014) ***"Mindful awareness play"(2011),*** 2010 ***"Supporting positive parenting for young children experiencing homelessness"*** (2010) and "**Targeted Interventions for Homeless Children at a Therapeutic Nursery**"*(2006)*.

The Therapeutic Nursery was identified in the 2013 American Almanac of Family Homelessness as being a national model program for Early Childhood Development.

The research report ***"I'm opening my arms rather than pushing away"*** found that the seventeen mothers who participated (majority homeless) had benefitted from maternal self-regulation, "me time", dyadic connectedness and child-wellbeing.[37]

PRACTICE EXAMPLE: MINDFUL AWARENESS PLAY (MAP)

Senior therapists from the Centre for Infant study and the PACT Therapeutic Nursery jointly developed a MAP component for the nursery as a key intervention.[38] It is used with babies and parents to strengthen their attachment relationship, promote mutual regulation and address trauma- induced developmental delays.

HOW THE MODEL WORKS

During a MAP session a child and carer (parent) is paired with a therapist and seated on a brightly coloured blanket on the floor. The parent and child (dyad) are presented with a bag/box with specially selected item(s) e.g. toys, shaker etc. The therapist supports the parent to be the "Curious Observer" and follows the child's Curious Explorer" lead by narrating observations. The therapist is the witness to this playful dyad, supporting the parent in the mode of to notice the child's interest and restrain from directing play for the protected moment. This can at first be difficult for the parent but they soon recognise that allowing their child to explore without judgement creates opportunities for the emergence of creativity and innovation in the child that lie at the heart of play.

THEORETICAL UNDERPINNINGS

MAP is an integration of attachment theory, play therapy and mindfulness. It builds on the ideas of parental delight in child play developed by Stanley Greenspan's Floor Time and Watch Wait and Wonder. It also integrates the theoretical models of Parent Child Interaction Therapy, (Hershell et al.), Filial Therapy (Guerney), and Lieberman and Van Horn's work to target joint capacities for play and communication within the dyad to restore age-appropriate functioning and strengthen the parent-child attachment. with young children. MAP integrates this with the additional goal of mutual regulation through mindful self-awareness.[39]

IMPACT

The author had the opportunity to participate in a session with a child attending the nursery- taking on the role of carer. The role feels unnatural to start with, but the role of clinician is to facilitate this, enabling the process. The nursery has found that this approach creates a nurturing environment that allows the child's creativity, focus and problem-solving skills to emerge. In addition, they note that it provides a space for curious exploration which in turn facilitates emotional connection and non-judgmental play interactions. The session supported a strong focus on the child which after a single session and one year later leaves the author with the "child still in mind".

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[37] Norris-Shortle, Cosgrove, K. Marks, L, I'm opening my arms rather than pushing away: **"Perceived benefits of a mindfulness-based intervention among homeless women and young children."** Infant Mental Health Journal, Vol 38 (3), 434-442 (2017), Michigan Association for Infant Mental Health

[38] Cosgrove, Kim, Norris-Shortle, Carole **"Let's Spend More Time Together Like This!":** Fussy Baby Network Infusion in Baltimore Homeless Nursery Program. Zero to Three Vol 35 No.3,January 2015.

[39] Bloom Connolly, Amy, Cosgrove, Kim, Norris-Shortle, Carole, Taylor, Susan **"Mindful Awareness Play".** Play Therapy, Volume 6 (4), Dec 2011.

PRACTICE EXAMPLE: DEALING WITH SEPARATION ANXIETY

Early Years staff are trained in the importance of attachment and how to address separation anxiety. The goal of this process is to help the child develop his memory of object permanency and constancy—that the parent will return at the end of the day.

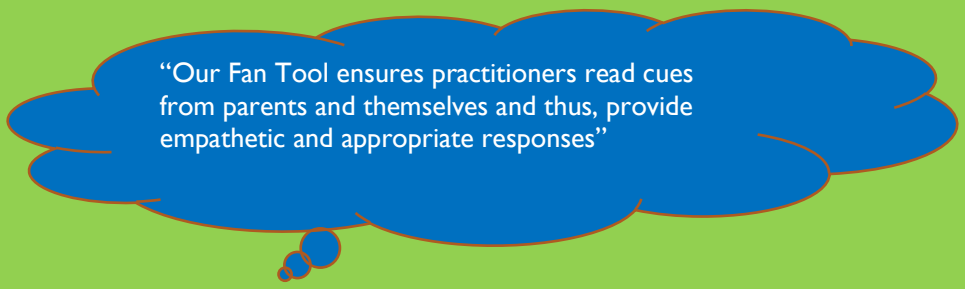
The clinician works with teacher, parent, and child to implement a specially developed behaviourally based separation practice in which parents say practices goodbye while a staff member holds and consoles the child. Parent and clinician walk outside the door and reflect on how hard separations are for both the child and parent and discuss the importance of the parent's facial language when the parent returns in a moment to reunite with their child.

At the same time the staff is holding and comforting the child. Teacher also sing a song called "Mommy comes back" while showing a picture of the parent to the child. Clinician and parent then return to the nursery and the parent consoles their child.

The process is repeated two or three times to help the child understand that the parent will return. Staff always acknowledge the child's distress and provide them with photographs which are displayed where the child is e.g. where they eat and the repeat the singing of the song "Mommy comes back" and engage in games e.g. "peek-a-boo" to support the process.

PRACTICE EXAMPLE: THE FACILITATING ATTUNED INTERACTIONS APPROACH (FAN)

The clinicians at the nursery state that they were looking for a framework and practical tool that all the workers could learn. The FAN model offered a needed structure and a skill set that could be integrated with their own clinical expertise.



The team describe the use of the FAN approach as a model that underpins all their interactions, both in terms of direct work with families and in terms of their own interactions- using it in staff meetings as an example.

The FAN model was developed in Chicago by Dr Linda Gilkerson and colleagues at the Erikson Institute's Fussy Baby Network. The developers describe it as both a conceptual model and practical tool for family engagement and reflective practice. They state that it[40]:

- Improves their ability to read parents' cues and respond with interventions that match what parents most need moment-to-moment
- Recognize and regulate their own feelings when working with families to build their reflective capacity
- Improve the relationship they have with harder-to-engage families
- Enhance their ability to provide attuned developmental information in a way that increases parental capacity

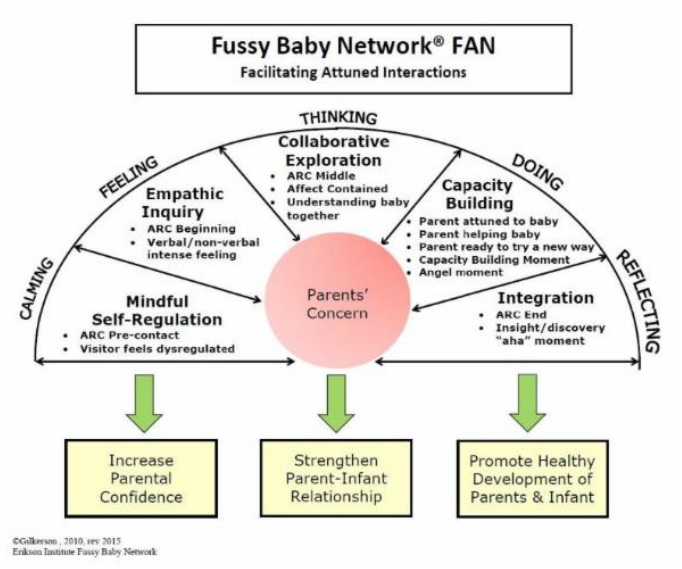
The FAN Approach can also serve as a framework for Reflective Supervision and provides a structure for reflective clinical or supervision sessions by:

- Preparing clinicians and supervisors to be fully present
- Clinicians and supervisors understand the "felt experience" of the person(s) receiving support

[40] https://education.illinoisstate.edu/csep/b3/2018_conference_materials/Plenary%20-%20MTSS%20FAN%20training%20handout.pdf

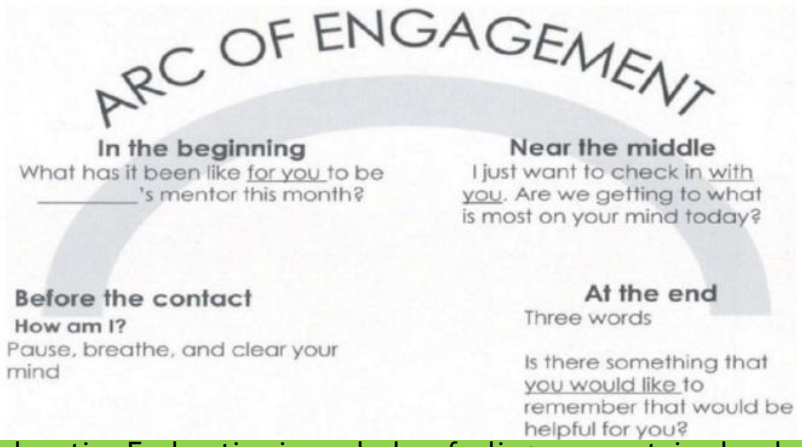
- Clinicians and supervisors share power and collaborate with each other and parents
- Build clinician and parent capacity for reflective functioning

The Erikson faculty claim that they have trained professionals in home visitation, early intervention, early childhood mental health consultation, paediatrics and child welfare with approximately 2000 professionals across the USA and abroad trained per year.
The THEORY OF CHANGE guiding the FAN is based on the concept of attunement, defined as an individual's sense of feeling connected and understood which opens the space for change (Siegel & Hartzell, 2003).



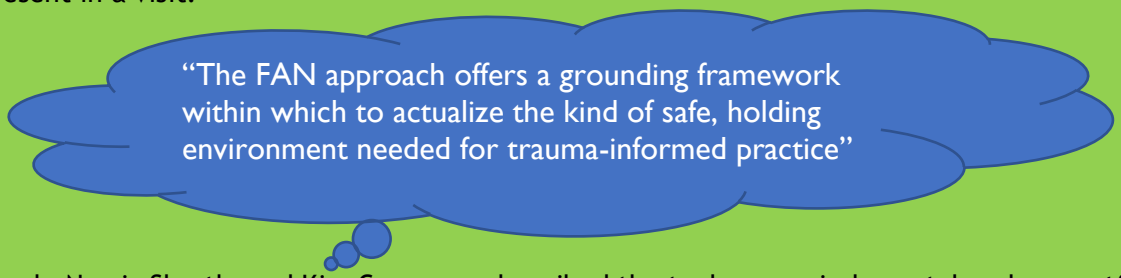
To implement the theory of change, the FAN identifies five core processes that can be used to support the attunement process (see Figure). The FAN Core Processes are each used based on reading cues rather than in a prescribed sequence.

The first core process, Calming or Mindful Self-Regulation, focuses on the ability to track and regulate one's own state (judgments, feelings, urges) during a visit to stay calm and present for the family. The four remaining processes (Empathic Inquiry, Collaborative Exploration, Capacity Building and Integration) are intended to facilitate one's ability to shift flexibly based on parent's concerns and cues for engagement.
The visits typically follow an arc, beginning with Empathic Inquiry which is used when parents are showing feelings or there is an absence of feelings around a concern that is important to the parent., The worker invites parents to share their experience by asking, ***"What has it been like for you to take care of your baby?"***



In the middle, Collaborative Exploration is used when feelings are contained and when the parent want to think together about an issue of concern. It can be used to check in with the parents by asking, ***"I'm wondering if we are getting to what you most hoped we would talk about?"*** Capacity Building is used when parents are seeking new information, actively caring for the child, or seeming ready try something new. At the end, Integration is used to support new insights the parents have about their child or themselves as parents and to build coherence by offering parents time to reflect about their baby ***("If you could describe your baby today in three words, what would they be?")*** and about what has been most meaningful to them ***("We have talked about so many important things. I'm wondering if there is something you would like to remember or hold on to that would be helpful to you in the next week?")***.

Beyond the Arc of the Visit, there is no requirement that all the core processes must be present in a visit.[41][42]



Carole Norris-Shortle and Kim Cosgrove, described the tool as non-judgmental and respectful. They state that infusing FAN into trauma treatments helps the worker stay internally organised and in touch with the parent as FAN promotes careful listening, pacing, empathic responsiveness and the conscious development of Mindful Self-Regulation, which builds self-awareness and provides a way for the worker to monitor and hold his own urges, feelings, and judgments.

They state that: ***"the provider's (therapist) middle question, which asks parents whether we are getting at what is most important for them, demonstrates that the provider is truly interested in the parents and their experience and can refocus the visit in real time, based on their needs.***

Trauma creates vivid memories that may trigger a reliving of the experience, which can hijack attention from a present need, such as a baby's signal, or incline the parent to avoid a painful topic. With the middle question, the provider explicitly invites the parent to share control, an important element of trauma-informed practice.

The last part of the ARC slows down the interaction and offers time for the parent to integrate his thoughts and develop some coherence at the end of what may have been a highly emotional session."

IMPACT

Since 1998, this partnership of institutions and professionals has served over 1000 families in the Therapeutic Nursery and provided training for over 2000 professionals from a variety of disciplines. These include educators, paediatricians, nurses, psychiatrists, psychologists, social workers, family therapists and other mental health clinicians, occupational/physical/speech and language therapists, undergraduate and graduate students.

Key Findings after FAN Training:[43]
Increased Empathy
Increase Collaboration
More effective therapy and job satisfaction.

PARTNERSHIP WORKING

The work of the PACT Therapeutic Nursery is made possible by the partnership between the Kennedy Krieger Institute's affiliate PACT: Helping Children with Special Needs, and the University of Maryland School of Medicine, Department of Psychiatry's Taghi Modarressi Centre

[41]Heffron, MaryClaire, Gilkerson, Linda, Cosgrove, Kim, Heller, Sherryl Scott, Imberger, Jaci, Leviton, Audrey, Mueller, Mary, Norris-Shortle, Carole, Phillips, Caroline, Spielman, Eda, Wasserman, Kate **"Using the FAN Approach to Deepen Trauma-Informed Care for Infants, Toddlers, and Families."** Zero to Three Volume 36 No.6, July 2016.

[42] Cosgrove, K., Gilkerson, L., Levition, A., Mueller, M Norris-Shortle, C. and Gouvea, M. (2019). "Building professional capacity to strengthen parent/professional relationships in early intervention: The FAN approach" Infants and Young Children , Wolters Kluwer Health, Inc Vol 32 pp 245-254.

[43] Cosgrove, K., Gilkerson, L., Levition, A., Mueller, M Norris-Shortle, C. and Gouvea, M. (2019). "Building professional capacity to strengthen parent/professional relationships in early intervention: The FAN approach" Infants and Young Children , Wolters Kluwer Health, Inc Vol 32 pp 245-254.

for Infant Study: Secure Starts. Both institutions are leaders in the field of early intervention and prevention in early childhood mental health and trauma-informed care. Mental health clinicians from each institution have created programs and interventions to support and promote parent-child attachment and foster skills and stability within each child and family, and the community.

The Taghi Modarressi Centre for Infant Study: Secure Starts provides multidisciplinary, outpatient mental health and behavioural care for families with children birth through five years of age. It offers assessment, testing, consultation, urgent care, and psychotherapy to children, families, and groups in a range of sites. Research and training are key to the mission of the Centre for Infant Study with staff providing program development, training, and national leadership through programs including: Strengthening Family Coping Resources; the National Child Traumatic Stress Network; Parent-Child Relationship Programs, formerly Nursing child assessment satellite training (NCAST) Programs, at the University of Washington; Child Parent Psychotherapy; the Fussy Baby Network; the Centre on the Social Emotional Foundations of Early Learning; and the University of Maryland Centre of Excellence in Infant and Early Childhood Mental Health.

THEME 3: A SOCIAL CAPITAL APPROACH

This theme explores how the Family by Family service has used ethnographic research to develop a new programme in Australia. The tools utilised to develop this local service, including the use of ethnographic research, provide valuable ideas for local community projects considering ways of engaging local communities to ensure that new services both meet local need and will receive community buy-in.

FAMILY BY FAMILY

FAMILY BY family

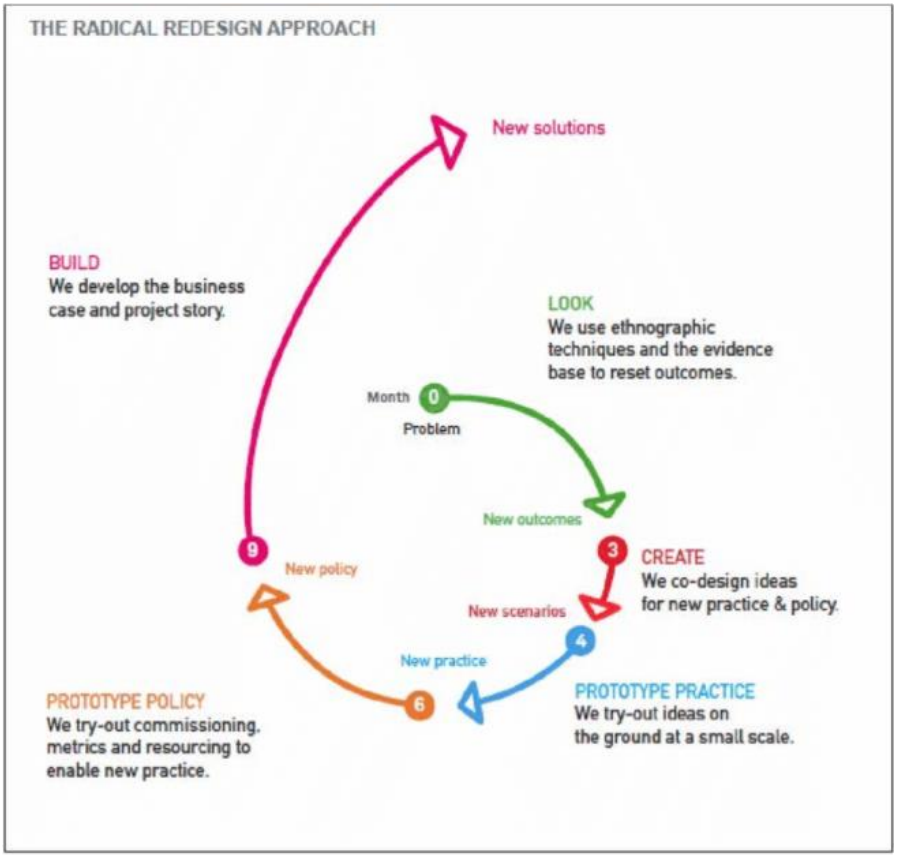
The author met Vita Maiorano and Danielle Madsen at The Australian Centre for Social Innovation (TACSI) office in Adelaide and was able to observe a family by family coaching session and talk to the coaches following the session. The development and operation of the model were described.

"One of the real strengths of this model is that families don't work nine to five, Monday to Friday- they're there to support each other 24 hours a day"

The 'Family by Family' model was developed by TACSI which was formed in 2009 as an initiative of the South Australian Government. TACSI is now an independent social enterprise. At the heart of the TACSI approach is the fundamental belief that people are the experts in their own lives. Using methods from the social sciences, policy, community development, business and design.[44] TACSI's work is based on three underlying principles: Human-centred, Systemic and Creative. They work alongside the people who face the challenges they are trying to solve.

"Families Voices need to be heard" Dani

[44] https://www.tacsi.org.au/work/family-by-family/



The 'Family by Family' project was one of TACSI's early developments. A multi- disciplinary team was set up and using the radical design approach pictured. TACSI worked with families using a range of tools and games to really understand the barriers faced and what would be helpful. Staff described the ETHNOGRAPHIC RESEARCH APPROACH taken as "hanging" out for up to 3 days with families to really understand. Initial prototypes were tested with families as were all the key concepts and training materials.

HOW DOES THE MODEL WORK?

"Sharing" families are recruited and trained. They are provided with individual and team coaching of up to 2 hours weekly. Initial training is done over 2 days and inspirational speakers are involved in the training. They are paid to attend training and coaching but not to support families. Coaches explained that this payment is in fact a re-imbursement as it supports some of the costs "sharing" families have in delivery of their support. The difference between this and many other "befriending" programmes is that the whole family is involved. The children are not necessarily around at all contacts, but most families will do something together at the weekend.

"Seeking" families are families who need support. They are linked to "sharing" families. The support provided is based on the theory of change model. There is a "soft" entry to the programme and families are recruited through a range of methods including "pop up's" at local events. Links last between 10-30 weeks on average and at the end of the programme a celebration is held. When I visited, coaches stated that they support on average 12-13 families at a time.

IMPACTS

Family by Family report that they have worked with over 1500 families to make change. They stated that the programme supports:

Family by Family states that a key element of the success of the Family by Family programme is the integration of a focus on the "change journey" (THEORY OF CHANGE) with families setting their own goals and being coached and guided to make a lasting change in their lives. Family by Family claim that at its peak, the programme has supported families in breaking the cycles of intergenerational disadvantage.[45]

[45]https://familybyfamily.org.au/our-impact/

"How do you empower the community to do it for themselves? Families become agents for change in their own communities!" Dani

Family by Family state that the model is scalable. They believe that it will allow them to grow exponentially and create wide-reaching and sustainable social change. The cost effectiveness is based on their view that one professional Family Coach can work with 15 Sharing Families, who in turn work with 40 Seeking Families, reaching up to 100 children at risk. On this basis they estimate that the program has a cost benefit ratio of 1:7.

When I met with the team, they explained that evaluations of the project had been completed but that funders were looking to more "gold" standard randomised control evaluations.

They summarise the findings from their external evaluation as:

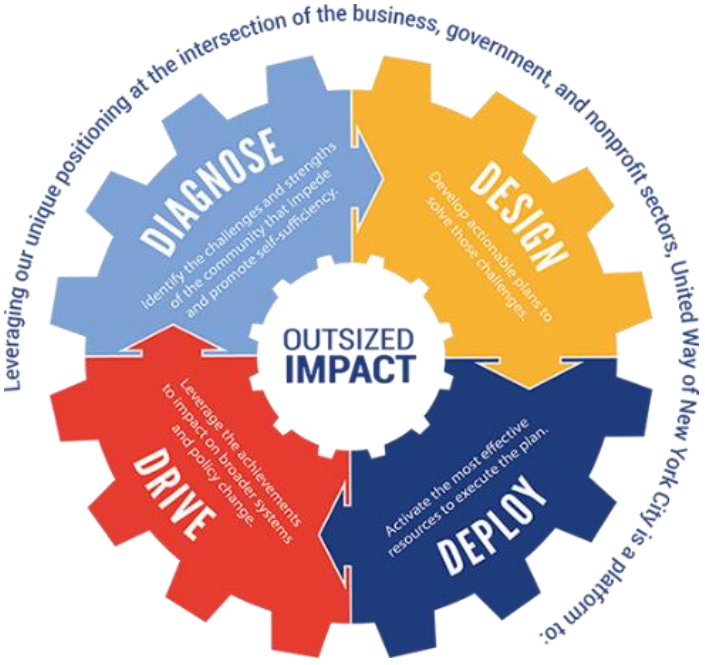
- Increased confidence and self-agency
- Increased parenting skills and confidence
- Increased personal health and wellbeing
- Decrease in social isolation
- Reduced stress
- Reduced Child Protection notifications
- Skills for "sharing" families

THEME 4- TAKING A 2-GENERATIONAL APPROACH

This theme explores how United Way of New York City has used a 2-generational approach and collaborated extensively in their efforts to create change.

UNITED WAY OF NEW YORK CITY (UWNYC)

UWNYC[46] is a non-profit organization dedicated to creating change through collective impact. United Way work with their partners from government, business, foundations, non-profits and the community, through a common agenda and with shared measurement to help low-income New Yorkers make ends meet and lead self-sufficient lives.



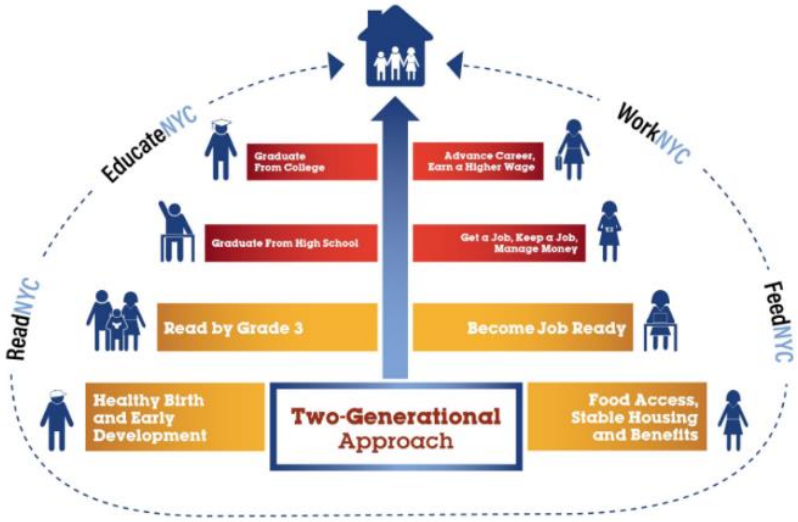
United Way recognises that efforts to help move families is complex and they have devised their collective impact approach to incorporate what they term the 4 D's which provide the infrastructure for stakeholders to:

- Diagnose the root cause of community challenges
- Design actionable plans to solve those challenges
- Deploy resources to execute and carry out the plan
- Drive systems and policy change

[46] https://unitedwaynyc.org/

United Way are committed to the use of data, both in terms of helping to evaluate impact but also to keep stakeholders engaged. They state that they adopted their two-generational approach to address local need.

This approach looks at families/households as a unit, helping both the child and caregiver simultaneously- addressing both the immediate and long-term needs in the areas of education, health, and financial stability. United Way of New York believes this model supports their efforts to help families in New York on to the path to self-sufficiency.



THEME 5: TRAUMA INFORMED EVALUATION

The often singular focus on "evidence-based programmes" was addressed by a number of the projects the author visited who expressed frustration that local work which is unable to undertake "golden standard" RCT's for a range of reasons most notably ethical issue and resource were discounted.

This issue was discussed with Janis Mitchel Deputy CEO at the Australian Childhood Foundation. Ms Mitchel directed the author to the work of Ghate and Fonagy who have decried this practice. Fonagy et al. (2014) reflects that while historically, there has been a tendency to assume that a treatment can be 'branded' once and for all as an evidence-based practice, there is a need to further reflect on how or for whom it is to be implemented.

The report "Supporting the Roadmap for Reform: Evidence-informed practice"[47] prepared for the Department of Health and Human Services, Victoria, Australia addresses the singular focus on evidence -based practice and trauma informed practice and suggests a broader approach – a three pronged focus on client and professional values, evidence based programmes and evidence based processes.

"The best form of treatment to address complex trauma in parents is not a proven intervention program, but a sustained relationship that can meet some of the unmet dependency needs of clients, thereby helping them to function better in their parental role, and help clients to develop understanding about the impact of

[47] Moore, T, Beaston, R., Rushton, S., Poweres, R., Deery, A., Arefadib, N. & West, S (2016) Supporting the Roadmap for Reform: Evidence-informed practice *The Centre for Community Child Health*, The Royal Children's Hospital Melbourne

their own life experiences on their parenting"

Most of the interventions highlighted in this report have highlighted the importance of articulating the theory of change at the heart of the intervention. Deborah Ghate[48] in her article "***Developing theories of change for social programmes: co-producing evidence-supported quality improvement"*** sets out the method and describes a process that could, in principle, be used by any social programme wishing to strengthen its implementation quality and its evaluability. She advocates for not overlooking valuable local work in the race to implement Evidence Based Programmes (EBP); *"With their elaborate infrastructures, voluminous research bases and strict licensing criteria, they have seemed to offer certainty of success over less packaged, less well-evidenced locally developed approaches. Yet recently, evaluation research is showing that success is not assured. EBPs can and regularly do fail, at substantial cost to the public purse. In times of severe resource pressure, a pressing question is, therefore, whether lower cost, home-grown, practitioner-developed programmes—the sort often overlooked by policy-makers —can deliver socially significant and scientifically convincing outcomes at lower cost and at least on a par with their better resourced cousins."*

Most of the services visited felt that the clear expression of a Theory of Change supports successful implementation and evaluation. Logic modelling is used extensively in the U.K., but a Theory of Change is different in that it specifies the pathway that leads to change. This helpful for implementing training as it can help make sure trainees are trained in the essential elements of the programme and for supporting programme implementation with fidelity.

Ghate however warns that theories of change should be seen as dynamic rather than static, evolving over time as learning from implementation in practice accumulates.

THEME 6- THE USE OF ROUTINE ENQUIRY

In their race to the top project: Addressing Early Childhood Mental Health in Pediatric Primary Care project[49], conducted by Kay Connors and colleagues at the University of Maryland, the authors found that while the American Association of Pediatrics recommended that primary care providers should screen for toxic stress, no specific guidance is provided. Surveying primary care providers and families in Maryland they found that 77% of 78 providers regularly conduct formal development screening vs only 1 provider using a formal ACE screening tool.

They highlight that their project found that developmental screening makes issues easier to address as many family's approach health services for a developmental issue vs the stigma associated with addressing mental health concerns. They also found that language and culture can be barriers to addressing concerns which were seen to be more pronounced when using ACE screening.

The use of ACE enquiry in primary schools was addressed with Chris Daikos who was keen to stress that when he and his wife Courtney provide training in schools on the ACE studies, it is to ensure educators understand how adversity impacts on behaviour as a result of toxic stress. Chris expressed his concern around this deficit approach. He states: *"Our work is about foundational knowledge and not assessment. Our goal is always to help foster resilience in youth through egalitarian psychological tools & practices. Provide youth the tools to potentially lessen the impact of adverse childhood experiences."*

These findings replicate reports from all the services visited. None of the projects/services that were visited during this fellowship utilized or advocated for the use of routine ACE screenings.

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[48] Ghate, D. Developing theories of change for social programmes: co-producing evidence-supported quality improvement. *Palgrave Commun* **4**, 90 (2018).

[49] Harrison, J., Connors, K., Weiss, C. & Wasserman K., "Race to the Top Project: Addressing Early Childhood Mental Health in Pediatric Primary Care: Development, Impact and Lessons Learned", University of Maryland School of Medicine

CONCLUSIONS

Australia, the U.K./Scotland and the USA. have many similarities and many differences in both policy and practice. This diversity makes drawing simple conclusions from a range of visits on their likely beneficial impact within a Scottish context, complex. As an example, while the U.S.A has some strong evidence-based programmes, these are not grounded in either the systemic framework i.e. a universal home visiting programme or policy landscape e.g. paid family leave, found in Scotland.

The author set out to understand how we can use research on adverse childhood experiences to break the cycle of deprivation and support communities to develop solutions in a co-productive way. In line with this, the author wished to ascertain whether or not, research on ACEs could be safely shared with communities in a way that would support the development of community resilience and a breaking of the intergenerational transmission of adversity- the breaking of the circle of deprivation.

Piplo Production's use of animals to describe emotions makes their tools very accessible and safe for communities to use to begin to have these conversations. These tools can be used by communities or local community organisations to support a new narrative on resilience instead of adversity.

The benefits of intervening in the early years is not new. In 2012 the Economist James Heckman ***noted*** *"The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families",*[50] Introducing a trauma infused approach in the early years supports an informed intervention in the early years. The benefits and ways in which this can be done are demonstrated by the work of ECMS and the PACT Therapeutic Nursery.

The fact that ECMS, a non-profit early year's childcare provider has been able to implement a trauma informed approach in a large nursery chain, shows the potential for replication in Scotland. This is more pertinent than ever as the world deals with COVID 19 or any future local or international disasters. A trauma informed approach and training can support early years staff to understand the behaviour presented by children and implement tools to intervene early, preventing longer term impacts and supporting early referral for additional support where required.

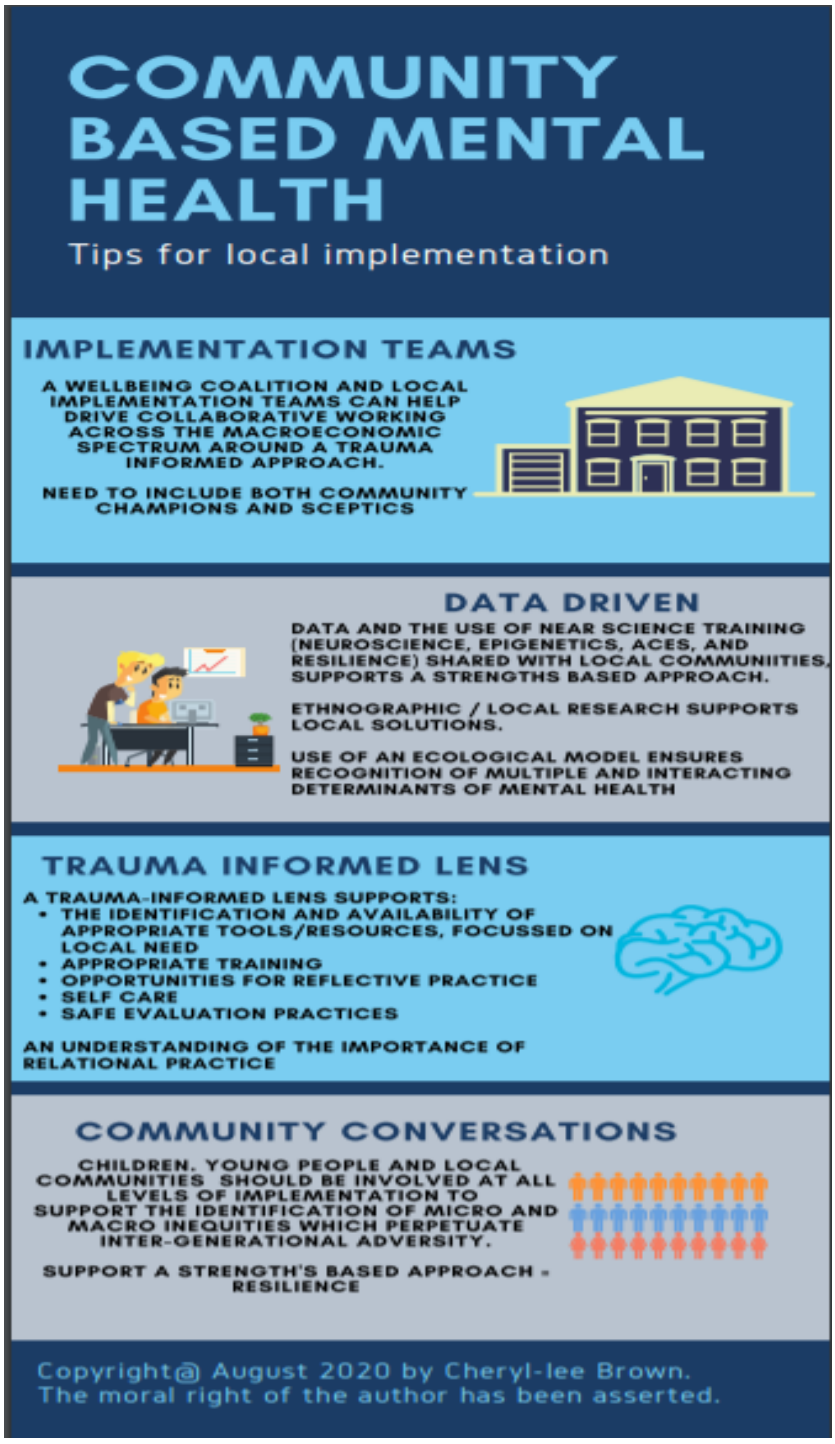
PACT Therapeutic Nursery on the other hand offers a community-based opportunity to intervene early in breaking the cycle of inter-generational adversity. This nursery offers ideas of good practice that can be replicated by local community based early years settings which wish to support early intervention.

PAX GBG could similarly be a useful tool to support a trauma informed approach in primary schools. The benefits of PAX GBG to primary schools in the U.S.A. and many other countries and the strong support by Snohomish County leads the author to consider that there may be merit in testing the feasibility of this approach in Scottish schools. While local (U.K and Ireland. rather than specifically Scottish) implementation has had variable results, much of the research has been based on the AIR version rather than the PAX version of the GBG. The research in England on the AIR GBG also lacked implementation with fidelity which makes an assessment of the effectiveness of it in England, challenging.

Concerns expressed in the English study around the "strictly manualised" nature of implementation provides a caution that teachers in the UK may find the nature of the programme challenging. However, evidence in Northern Ireland and Ireland, and across the world, indicates that if this intervention is implemented with fidelity it may have positive

[50] https://heckmanequation.org/www/assets/2013/07/F_HeckmanDeficitPieceCUSTOM-Generic_052714-3-1.pdf

impacts for improved relationships and children's ability to self-regulate. This latter research indicates that PAX GBG has merits and would benefit from further exploration.



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. To build a trauma informed Scotland will require a joined up approach with collaboration from across the macro-economic system involving both traditional mental health services but also public and primary health care, academia, industry and services impacting on all the social determinants of public health e.g. employment and housing. A psychiatrist at a Healthy Steps site visited was impressed with Scotland's vison but warned that the Country would not achieve national implementation without a systemic approach which included links with health (including primary care), mental health, the third and private sector and local communities.

Scotland has already developed a comprehensive training framework to support the roll out of Trauma informed training. The roll out of this training needs to be accompanied by access to high quality tools and resources for self-care of staff. This should include opportunities for both reflective practice but also to easy access to mental health consultations.

The author would advocate 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.

Local Child and Adolescent Mental Health Service (CAMHS) teams have provided some of these service on an adhoc basis in some areas. These services however tend to be withdrawn in response to meeting waiting list targets. This resourcing would enable some settings to support early intervention and prevention approaches. Efforts to implement a “trauma informed” approach without appropriate resource could be unsafe as it could lead to inadvertent re-traumatizing and staff burnout.

In conclusion, the author believes that there is an opportunity for early years and community settings to support a paradigm shift from providing trauma informed care in mental health settings to collaborative, multilevel, culturally situated community based mental health interventions.

“Opportunity for early years and community settings to support a paradigm shift from providing trauma informed care in mental health settings to collaborative, multilevel, culturally situated community based mental health interventions.”

RECOMMENDATIONS

Recommendations for the Scottish Government

- To build a trauma informed Scotland will require a joined up approach with collaboration from across the macroeconomic system involving both traditional mental health services but also public and primary health care, academia, industry and services impacting on all the social determinants of public health e.g. employment and housing. Local authorities should be encouraged to engage all stakeholders in implementing local trauma informed practice. Wellbeing Coalitions can support this approach as can the use of ethnographic research.
- Local communities need to be involved in the roll out of a trauma-informed nation. This will support the identification of micro and macro inequities which perpetuate inter-generational adversity.
- Opportunities for local conversations around developing "resilience" should be considered. Piplo Productions provides free useful tools to support this. Whatever tool is used, it is imperative that parents and children and young people's voices are heard and they are involved in the planning of such an initiative. This will help to ensure that these initiatives are not inadvertently re-traumatizing.
- To roll out multi-disciplinary training to all to support a shared language and an understanding of trauma- informed practice. The NHS Education for Scotland- Scottish Psychological Trauma Training Plan is already in place to support this objective.
- To work with interested early years settings to test the feasibility of early years settings becoming involved in providing "trauma informed" support along a continuum of intensity. The economic argument for early intervention and prevention has long been made and evidence indicates the impact of intervening early to address ACEs. Local early years settings can be supported to become more "trauma informed" with training, access to data, access to local mental health consultancy and resources to deliver trauma-informed evidence-based programmes e.g. mindful parenting programmes.
- To consider supporting a local Scottish RCT feasibility study of the use of the PAX GBG.
- To consider how mental health consultations could be made available to support the roll out of a trauma-informed approach. This is of particular urgency if early years and primary school settings are encouraged to become more "trauma informed".
- To develop a Centre of Excellence in Peri-natal and Early Years Mental Health, or similar, to ensure ongoing leadership and development of-trauma informed services.

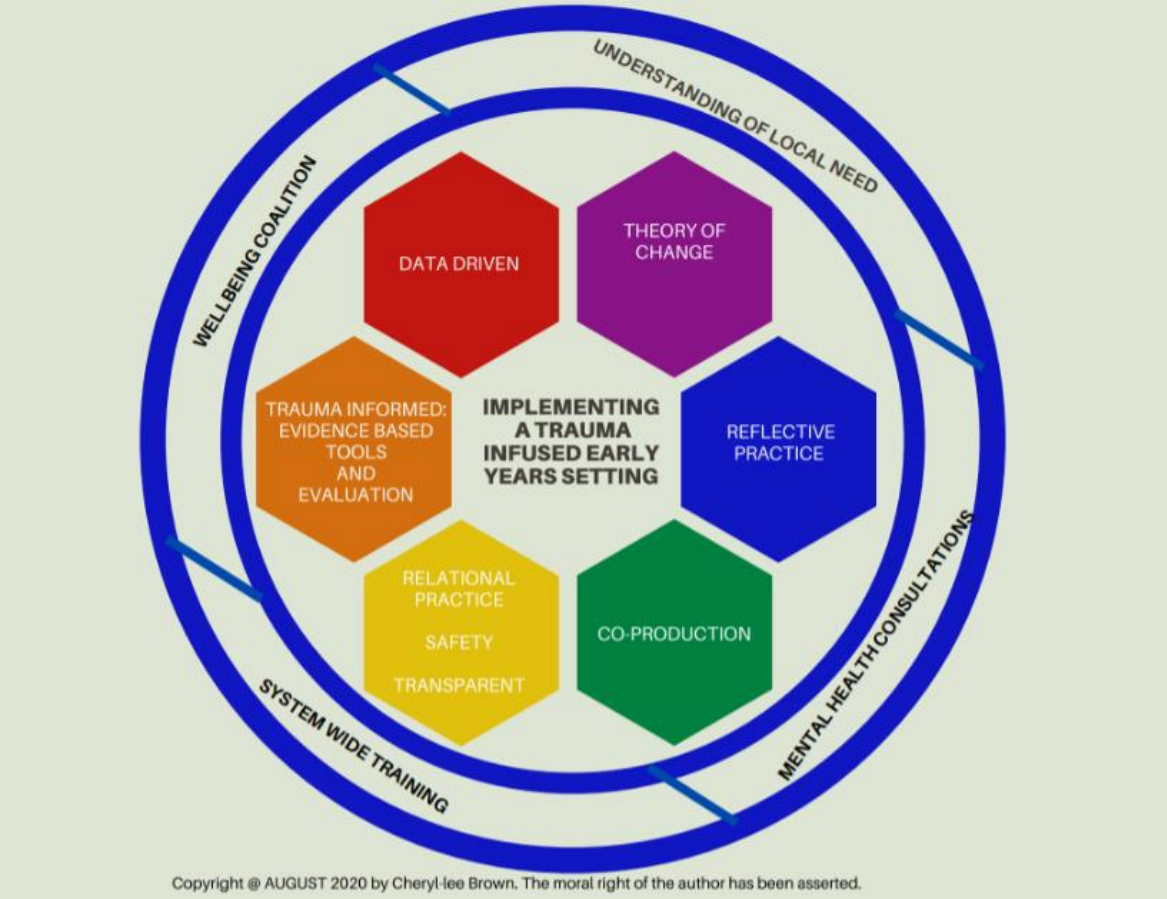
Recommendations for funders and commissioners

To recognise that RCT evidence-based imported programmes may not always be the best solution for the local community. Local services can be supported to use a Theory of Change model, both to support locally developed programmes and to implement trauma informed evidence-based programmes.

Recommendations for Midlothian Sure Start

- To explore collaboration with local academic institutions for mutual benefit.
- To explore the use of the FAN approach to support relational practice and self-care of staff.

- To pilot a “therapeutic” nursery at one of its six family learning centres. This pilot should ensure that the essential ingredients of a therapeutic nursery contained in the therapeutic nursery infographic can be supported.



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