NURTURE

DRAFT

DEVELOPING SECURE ATTACHMENT

FOR VULNERABLE CHILDREN BY

ENHANCING CAREGIVER CHILD RELATIONSHIPS

OUTCOMES FROM THE 2015

MARGARET MAY BLACKWELL TRAVEL FELLOWSHIP

BY ANNE HODREN

"Unfortunately not every child will become an adult
but it is certainly true that every adult once was a child"
(Robert Block, President of the American Academy of Pediatrics)

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Thanks and Acknowledgements are made to the Margaret May Blackwell Travel Fellowship Trust and Committee for giving me the opportunity to undertake this international travel. The experience of meeting passionate highly skilled service providers and observing service delivery has opened my eyes to many possibilities for reducing vulnerability for New Zealand children and their whanau. I would like to thank those I visited for their generosity of time and willingness to share with me their thoughts and passion for best outcomes. I would also like to acknowledge the whanau who were kind enough to allow me to be with them as they explored their parenting experiences with their health care workers.

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Executive Summary

In 2015 the Margaret May Blackwell Travel Fellowship was awarded to explore how international services reduce vulnerability and improve short and long term health outcomes in children through enhancing parenting capacity and child attachment. The second aim was to explore education offered to health professionals internationally in relation to infant mental health and how this knowledge supports their role in reducing vulnerability including eLearning and face to face training programmes.

It is now well established that the quality of a child's attachment is related to concrete, definable parental capacities, caregiving behaviour patterns, and internal working models. There is increasing evidence that insecure attachment during infancy, especially one that is "disorganized," is an important component of the cumulative risk factors on a developmental pathway toward maladaptive child outcomes, whereas secure attachment has served as a protective factor for children whose families have experienced high levels of stressful life events. A history of early attachment-related competence has proved to be a major protective factor against the adverse effects of stressful life events (Circle of Security, 2016). Most parents living in poor social circumstances provide a loving and nurturing environment, despite many difficulties. However, children living in a disadvantaged family are more likely to be exposed to adverse factors such as parental substance misuse and mental illness, or neglect, abuse and domestic violence (Farrington et al; Shonkoff and Phillips as cited in NHS, 2012). This evidence supports the need to explore how services can enhance child attachment and caregiver parenting capacity with the aim of reducing vulnerability.

The services and infant mental health experts visited for the purpose of this report were in Sydney (Australia), San Francisco, Chicago, Minneapolis (The United States of America), Toronto (Canada), Geneva (Switzerland), Dublin, Cork (Ireland) and London (England) I explored their service delivery and the critical place that infant mental health and caregiver child relationship were placed within their service delivery and education programmes. Each of the programmes visited varied in their assessment and care offered to clients but they were all rooted in a belief of the importance of relational care provided by the health worker and hopefulness for the whanau. Some services provided training in a particular health worker whanau relational model. Others offered training that was based on the importance of a partnership approach but did not have a particular model

they worked from. It is ideal to base relational practice on a research informed model. Two of these were explored, namely the Fussy Network FAN and the Family Partnership model.

Enhancing child caregiver relationships is critical to enable secure attachment to develop. Relationship based early intervention programmes designed to enhance attachment security between children and parents would ideally be available universally throughout New Zealand. Services for vulnerable whanau need to have a focus on the infant caregiver relationship that is informed by robust neuroscience, development and attachment theory. Utilizing evidence based information is vital and an example explored for the purpose of the study fellowship was the Circle of Security an evidence based programme that showed the potential to help achieve this.

Home visiting services are a common method of supporting families, and in particular vulnerable families. "Home visiting has been shown to be an effective method of supporting families, particularly as part of a comprehensive and coordinated system of services." (Zero to Three, 2016). Home visiting services are becoming increasingly used internationally in high risk populations to mitigate parents stress, guide parents to positive parenting interactions, develop age appropriate strategies for regulating child behaviour and help families move out of poverty (Roggman & Cardia, 2016). Several services spoke about the effectiveness of embedding infant mental health more robustly into universal programmes and developing intensive home visiting programmes with a central focus on child caregiver relationships and reducing vulnerability. In New Zealand services need to provide a range of culturally safe options including Māori-responsive perinatal and infant mental health care. Greater collaboration among Māori-responsive services will provide a real opportunity to improve integrated care and health outcomes for Māori .

In the countries visited, home visiting programmes were rooted in evidence and strongly focused on developing secure child attachment by enhancing caregiver capacity. There appeared to be an increasing focus on intensive home visiting programmes with infant mental health assessments a critical part of the programmes as entry criteria, as a guide to service delivery and care planning and regular assessments throughout the engagement process. All the countries spoke about the need for training in assessment models and having infant mental health competencies to inform practice.

Common elements of effective parenting programmes included factors related to staffing, infrastructure , qualifications, training and support. There are many sources of initial training and ongoing professional development described by each service. This varied from short courses to

more extensive infant mental health speciality training using a variety of teaching methods and technology. A pathway forward would be to have three levels of training including core education for all those working with children, speciality education for each scope and specialist training for those working in highly skilled areas of infant mental health. It was evident that professional development cannot stand alone but needs to be supported by organisational structure, mentoring, infant mental health informed supervision and research of current practice. There also needs to be ongoing research to inform programme development and effectiveness of outcomes with ongoing monitoring and evaluation for programme improvement."

> *When we strengthen families, we ultimately strengthen the community. Our goal is that parents everywhere work with supportive providers, feel confident in their parenting role, and form strong, resilient attachments with their children. To help achieve this, providers must be responsive to parents, knowledgeable about child development, and eager to see every parent succeed. - T. Berry Brazelton, MD*

Introduction

When we strengthen families, we ultimately strengthen the community. Our goal is that parents everywhere work with supportive providers, feel confident in their parenting role, and form strong, resilient attachments with their children. To help achieve this, providers must be responsive to parents, knowledgeable about child development, and eager to see every parent succeed. - T. Berry Brazelton, MD

In 2015 I undertook the Margaret May Blackwell Travel Fellowship to explore how international services reduce child mental health vulnerability and improve short and long term health outcomes in children through enhancing parenting capacity and child attachment. This would inform potential improvements to the infant mental health care offered in New Zealand, in particular community based child service providers. The second aim was to explore education offered to health professionals internationally in relation to infant mental health exploring how this knowledge supports their role in reducing vulnerability. I was interested in both eLearning and face to face training programmes.

The Margaret May Blackwell Travel Fellowship provided an opportunity to spend time with services who support whanau with innovative programmes aimed to increase child caregiver relationships and child attachment relationships. This report will present the findings from the Travel Fellowship in core themes including examples of research informed programmes visited, how knowledge, competency and reflective capacity of those working with vulnerable whanau is enhanced in relation to infant mental health. The services identified how they aim to reduce the impact of vulnerability and adverse childhood experiences key factors that have long term neurobiological and social-emotional impacts. Consideration of some models of relational practice is included as respectful partnership in supporting vulnerable whanau is critical to outcomes and the success of any programme. Reducing vulnerability and enhancing infant caregiver relationship were central to the programmes and the variety of education offered to those supporting whanau. The relevance to the New Zealand context of the overseas practice and education services visited was extensive. The significant generosity of time and resources shown by those services enabled an opportunity to see potential for development in New Zealand in relation to enhancing attachment and child-caregiver relationships.

Background

The New Zealand Ministry of Health acknowledge that in New Zealand mental health services for mothers and infants do not exist in some places and where they do exist development has been somewhat piecemeal. In their document "Healthy Beginnings developing perinatal and infant mental health services in New Zealand" the Ministry of Health (2012) focus on improvements to the Maternal and Infant mental health services offered to families. This document articulates a need to provide training and support for service providers to strengthen capacity to cater for the mental health needs of a broad range of children and families . They saw a need for new ways of disseminating best practice information using current and new technology.

The New Zealand Government through the Ministry of Health aims to support and promote the healthy development of children and their families/whānau from birth to five years. The New Zealand Government offers as part of their services to families/whanau a free Well Child/Tamariki Ora (WCTO) universal programme with additional services available according to need/vulnerability ('proportionate universalism'). The Well Child Tamariki Ora programme includes clinical assessment, health promotion, family/whānau support and advice, interventions and referral as appropriate. The Plunket society is one of the providers of this WCTO programme and employs the author of this report as a National Educator.

The Importance of Secure Child Caregiver Relationships

All children need good health and positive early learning experiences. Nurturing relationships, safe environments, and enriching experiences foster their learning and development (Zero to Three, 2016). "Young children experience their world through their relationships with parents and caregivers. These relationships are fundamental to the healthy development of the brain and, consequently, the development of physical, emotional, social, behavioural, and intellectual capacities. Safe, stable, and nurturing relationships between children and their caregivers are the antithesis of adverse exposures that occur during childhood and compromise health over the lifespan. They can have synergistic effects on a broad range of health problems as well as contribute to the development of skills that will enhance the acquisition of healthy habits and lifestyles." (National Center for Injury Prevention and Control, n.d., p.3).

BACKGROUND

It is now well established that the quality of the child's attachment is related to concrete, definable parental capacities, caregiving behaviour patterns, and internal working models. There is increasing evidence that insecure attachment during infancy, especially one that is "disorganized," is an important component of the cumulative risk factors on a developmental pathway toward maladaptive child outcomes. These outcomes are related to emotion regulation struggles, social competence with peers and teachers, impulse control, conduct disorders, anxiety, depression, dissociative disorders, and other psychiatric and legal problems (Circle of Security, 2016).

Recent longitudinal studies at the University of Minnesota have found that secure attachment has served as a protective factor for children whose families have experienced high levels of stressful life events. Researchers found that a history of early attachment-related competence proved to be a major protective factor against the adverse effects of stressful life events. Allan Sroufe, concludes that "Overall, longitudinal findings have indicated that the early attachment relationship provides an important foundation for later development and that a secure attachment may serve as a protective factor against the negative impact of various adversities and risk factors. Our findings and those of other investigators are quite compelling and suggest that efforts aimed at promoting a secure attachment may prevent various forms of problems among children in high-risk circumstances" (Circle of Security, 2016).

Most parents living in poor social circumstances provide a loving and nurturing environment, despite many difficulties. However, children living in a disadvantaged family are more likely to be exposed to adverse factors such as parental substance misuse and mental illness, or neglect, abuse and domestic violence. Consequently, they are more likely to experience emotional and behavioural problems that can impact on their development and opportunities in life" (Farrington et al; Shonkoff and Phillips as cited in NHS, 2012).

Children who are affected by maltreatment, neglect, substance abuse or domestic violence in the absence of a buffering secure relationship with their primary attachment figure are extremely vulnerable to serious and chronic mental health problems. They frequently display serious behaviour problems, and may manifest conditions that can seriously impede their lifelong learning and later success (Knitzer; Hardin as cited in Ministry of Health, 2012). These factors are particularly relevant to New Zealand which has the fifth worst child abuse record out of 31 OECD Countries. On average one child is killed every 5 weeks and most of these children are under five years old with 90 percent perpetrated by someone the child knows (Child Matters, 2016)

BACKGROUND

The Health and Wellbeing of Māori Children

"In their most recent report on New Zealand, the UN Committee on the Rights of the Child expressed concerns about minimal progress on addressing the disparities experienced by Māori children and children in poverty and vulnerable situations; the failure of the government to harmonise its domestic laws with UNCROC; and the Committee "remains alarmed" at the high prevalence of abuse and neglect of children in the family" (UN Committee on the Rights of the Child, as cited in Child poverty Action Group, 2013).

"Māori infants and whānau disproportionately experience environments and risk factors associated with the development of severe emotional and behavioural problems (Tipene-Leach, nd). The outcomes for and impact of unmet need in Māori maternal health and infant mental health are evident in the high numbers of Māori children in Child, Youth and Family care, in justice settings, with conduct disorder, and experiencing earlier onset of anxiety and AOD problems" (Ministry of Health, 2012, p.19).

EVIDENCE FOR THE IMPORTANCE OF APPROPRIATE SUPPORT PREVISION

Early intervention programs for at-risk parent/infant dyads are using increasingly refined procedures for defining goals, developing intervention protocols and methods for identifying change. There is an increasing emphasis on developing interventions for specific challenges and opportunities to make a positive difference in the development of children and parents. Promoting secure attachments between young children and their parents should be a focus of this early intervention (Circle of Security, 2016).

Families need comprehensive services that promote children's physical wellness, development, and mental health to help support their children to thrive (Zero to Three, 2016). Services that support families must be high quality, culturally responsive, accessible and affordable to all children and families who need them. Services should not only focus on a reduction of risk factors but also focus on increasing protective factors. To achieve this services need; resources, and relationships that strengthen families, engage caregivers as leaders, and enhance their capacity to support children's wellbeing. Functions of a comprehensive system include an infrastructure that has: defined and coordinated governance; leadership; strategic finance; enhanced standards; support for quality

improvement and evaluation processes. Services need to support professional development, accountability; engage stakeholders, engage the public; and build political will (Zero to Three, 2016; National Center for Injury Prevention and Control, n.d.).

A countywide commitment to, research, a rigorous science base, a population approach, evaluation of interventions and learning how best to implement and disseminate them is needed in relation to infant mental health. Different sectors such as health, media, business, justice, behavioural science, epidemiology, social science, advocacy, and education all have important roles in reducing vulnerability. "Part of public health's broad view is an emphasis on population health—not just the health of individuals. Individuals experience violence and adverse experiences acutely, but its consequences and potential solutions also affect society in general. The long-term goal of public health is to achieve lasting change in the factors and conditions that place people at risk by making changes at the individual, family, community, and societal levels of the social ecology." (National Center for Injury Prevention and Control, n.d., p.2).

From the overwhelming evidence that identifies the impact of early child hood experiences on short and long term health outcomes and the rapidly developing knowledge of neurodevelopment, there is an important role for supportive health and social services. The Margaret May Blackwell travel Fellowship aim was to focus on how international services enhance parenting capacity and infant caregiver relationships to reduce vulnerability and improve long term health outcomes.

Services Visited

Services visited during the Margaret May Blackwell Travel Fellowship were selected for their relevance to the two aims of the trip. Firstly, to explore how international services reduce vulnerability through enhancing parenting capacity and attachment. The second aim was to explore education offered to health professionals internationally in relation to infant mental health exploring how this knowledge supports their role in reducing vulnerability. I was interested in both eLearning and face to face training programmes. The services and infant mental health experts visited were in Sydney (Australia), San Francisco, Chicago, Minneapolis (The United States of America), Toronto (Canada), Geneva (Switzerland), Dublin, Cork (Ireland) and London (England).

It must be acknowledged the services explored are only a small sample of the types of services available and further exploration of other services would be required to give a more in-depth analysis. This limits the number of intervention programmes and training options explored in relation to their relevance to New Zealand. This report is also limited to exploring the information shared by the individuals interviewed in relation to their particular scope and may not represent the opinions of others within their work place.

discussed with each programme visited the education entry requirements and ongoing professional development. I also visited with teaching services, including specific Infant Mental Health training and education institutes. These are only a limited number of education services selected for their international recognition to give a view of the potential for New Zealand to explore.

Sydney

In Sydney I visited the well child service Tresillian and met with Dr Catherine Fowler the Professor for the Tresillian Chair in Child and Family Health at UTS, with Julie Maddox Clinical Nurse Consultant, and with a Clinical Manager. Tresillian services are funded by the NSW Department of Health through Medicare. Tresillian is a Sydney based health service specifically designed to support parents in caring for their babies and young children. Tresillian offers a number of services for families, depending on the age of their child and what level of support they require including four family centres, day stay, residential stay, outreach, home visiting, clinic assessments, a phone service, facebook service, and parenting education. Care is provided by staff such as nurses, paraprofessionals, social workers, paediatricians and psychologists who have specialty skills in

Family and Child Health. Dr Catherine Fowler has been instrumental in the new child health programme development offered by the service and the University programme that provides the education for the Child Health nurses. She is also an expert advisor to Whitireia polytechnic in New Zealand for their Postgraduate Certificate in Primary Health Care Nursing (Well Child/Tamariki Ora programme).

San Francisco

In San Francisco I attended the Fussy Baby National Conference which was attended by 60 health professionals who were working in a range of services utilising the Facilitating Attuned Interactions (FAN) Model. The group were varied in their clinical background including nurses, psychologists, doctors, infant mental health specialists etc. The conference gave me the opportunity to meet a large number of infant mental health specialists and home visitors at one time and learn about how their services reduced vulnerability through their clinical expertise and their use of the FAN model.

Seattle

At the University of Washington Seattle, I met with Denise Findlay Director of Education & Outreach and Monica Oxford Executive Director of NCAST who have developed and manage the NCAST Programs. NCAST was developed to give professionals, parents and other caregivers the knowledge and skills to provide nurturing environments for young children by developing and disseminating innovative research-based products and training programs used in many disciplines and settings.

Chicago

In Chicago I had further opportunity to explore the usefulness of the FAN to improve health outcomes. The Erickson Institute is the base for the Fussy Baby Network. The Fussy Baby Network's unique approach in working with families is called the FAN (Facilitating Attuned interactions). In Chicago I had the opportunity to talk to Dr Linda Gilkerson the Director of the Fussy Baby Network, listening to a Warm Line call, attending a FAN supervision session with the Chicago Fussy Baby Network team and talking to members of the team based in Chicago. Also based at the Erickson Institute is Jon Korfmacher an Associate Professor who is undertaking research into the effectiveness of home visiting programmes.

SERVICES VISITED

In Chicago I met Diana Rauner the president of the Ounce of Prevention Fund. The Ounce of Prevention Fund has persistently pursued a single goal: that all American children particularly those born into poverty have quality early childhood experiences in the crucial first five years of life. The Ounce creates and supports research-based early learning programs for at-risk children and their families from before birth to age five; develops, educates, and coaches practitioners to provide more children with high-quality early education; and advocates and educates policymakers, business and civic leaders. They serve more than 4,000 children and families directly through birth-to-five programs they fund and operate in Chicago as well as through their network of voluntary home visiting programmes throughout Illinois. Diana Rauner talked about the services they provide and their interest in developing a service that could provide one universal visit to new born babies' families in the state. She was keen to discover what Plunket offer in New Zealand. I also met Nick Wechsler Director and programme developer at Ounce who discussed research and his particular interest in training and supervision. Nick also has been instrumental in exploring the effectiveness of home visiting models and the co-author of a book on Home Visiting that was published in 2016.

Minneapolis

In Minneapolis I met with a group of staff from the Department of Health. The meeting was arranged by Maureen Fuchs, MCH/Home Visiting Consultant and NFP State Nurse Consultant This group included two nurse consultants from different Nurse Family Partnership Home Visiting services, a nurse consultant from a Healthy Families America home visiting service (also a NCAST trainer and reflective supervisor), a manager who is also a reflective practice consultant, two training coordinators who coordinate training for all the staff in their areas, one also produces an e-bulletin/newsletter, a tribal nurse consultant including training in Family spirit a HV programme utilising a cultural based model, a Nurse Practitioner who works with communities at risk in a sparsely populated area with limited mental health services

In Minneapolis I also had the opportunity to meet with Dr Elizabeth Carlson who is researcher and lecturer at the University of Minnesota. She spoke about the infant mental health programmes offered through the University. Following this meeting I met with Christopher Watson a Co-Director of the Center for Early Education and Development (CEED) in the College of Education and Human Development at the University of Minnesota he spoke about the CEED programmes and the strong focus of supervision within programmes.

SERVICES VISITED

TORONTO

Alice Gorman is a Public Health Manager for Healthy Families in Toronto. She spoke about the services offered in Toronto by the Public Health nurses, the Healthy families programme and of the intensive programme of support that is offered to pregnant homeless women.

I also met with Riffaat Mamdani a Programme consultant from the Ministry of Children and Youth services. The HBHC Program is the foundation early identification and intervention programme related to child development offered in Ontario. Riffaat discussed the Public Health nurses role in the Vulnerable programme and the training they undertake to enhance parenting capacity and infant caregiver relationship.

In Toronto I met with Donna Hill from Infant Mental Health Promotion (IMHP). This is a coalition of professional representatives from service agencies dedicated to promoting optimal outcomes for infants (prenatal to 36 months) in collaboration with families and other caregivers. IMHP was initiated by the Hospital for Sick Children Department of Psychiatry to develop and promote best practices for infant mental health through education, advocacy and collaboration with families, professionals and the communities which influence the lives of children in Canada. The organization maintains strong representation from community-based agencies across Canada. They provide a collaborative, informed and passionate voice for infants, families and caregivers.

I met with Jean Wittenberg a paediatric psychiatrist who runs the infant psychiatry program at Sickkids. Jean discussed the services offered to the inpatient paediatrics to minimize the impact of trauma on children. Jean has been working in an integrated services programme. He also works with aboriginal communities with vulnerable families. Jean developed a parenting programme called Baby Love.

I met with Eileen Kilbride who is a key trainer in Circle of Security in Guelph Toronto. We also met with two Circle of Security facilitators, Monica and Tamara from Mental health and child welfare services. They considered the key to enhancing caregiver capacity is gaining emotional regulation and reflective capacity that is offered through understanding the Circle of Security.

SERVICES VISITED

Cork & Dublin

In Cork I met with Mary Fanning, an Integration Facilitator with a speech language therapy background who is working in the Youngballymun team. The Ready Steady Grow Youngballymun service strategy aims to maximise the social and emotional development of 0-3 year olds by supporting parents in fostering positive relationships with their infants. The strategy operates in partnership with health service practitioners and community organisations and delivers a series of services and programmes for parents and infants across a continuum of need, from universally-available services to more targeted support. The service is placed in a high needs area working closely with vulnerable families. I observed Mary conducting an Introductory Visit with a parent/baby which is the entry point to the Parent Child Psychological Support Programme, the cornerstone of their infant mental health initiative.

In Cork I met with Catherine Maguire a Senior Clinical Psychologist & Infant Mental Health Specialist & Mentor. Catherine is highly respected in the Irish infant mental health area for her leadership and clinical expertise. She discussed some innovative programmes being developed to support vulnerable families, and the importance of infant mental health competencies and supervision.

At the Mallow Primary Health Care Centre I visited with members of staff from the universal service in Mellow Cork Ireland. This gave me the opportunity to observe two well child assessments and talk with the Public Health nurse and the Clinical manager.

Teresa Fuller a team leader in Social Work with the Adult Mental Health Team discussed the maternal mental health services offered in Cork and their focus on infant mental health issues related to being cared for by a parent with mental health concerns.

Geneva

In Geneva I spent time with Dr Maree Foley. Maree is a New Zealand trained social worker and child psychotherapist. She has been practicing in the field of infant mental health for over twenty years in the public and private sector. She is especially interested in workplace relationships and the specific governance issues that apply to not-for-profit and non-governmental organisations. Maree is the Chair of the World Association for Infant Mental Health Affiliate Council since 2014, and an editor for the Infant Mental Health Journal. Maree spoke of the role of the world association and other

international issues in regards to infant mental health including education, supervision and embedding infant mental health into services.

LONDON

In London I spent time with the Centre for Parents and Child Support team they discussed some of the innovative programmes delivered in London that support vulnerable families to develop infant caregiver relationships. These included one-to-one programmes and group parenting education. I had the opportunity to spend some time with a Health Visitor during a drop-in clinic and attend a parenting group session.

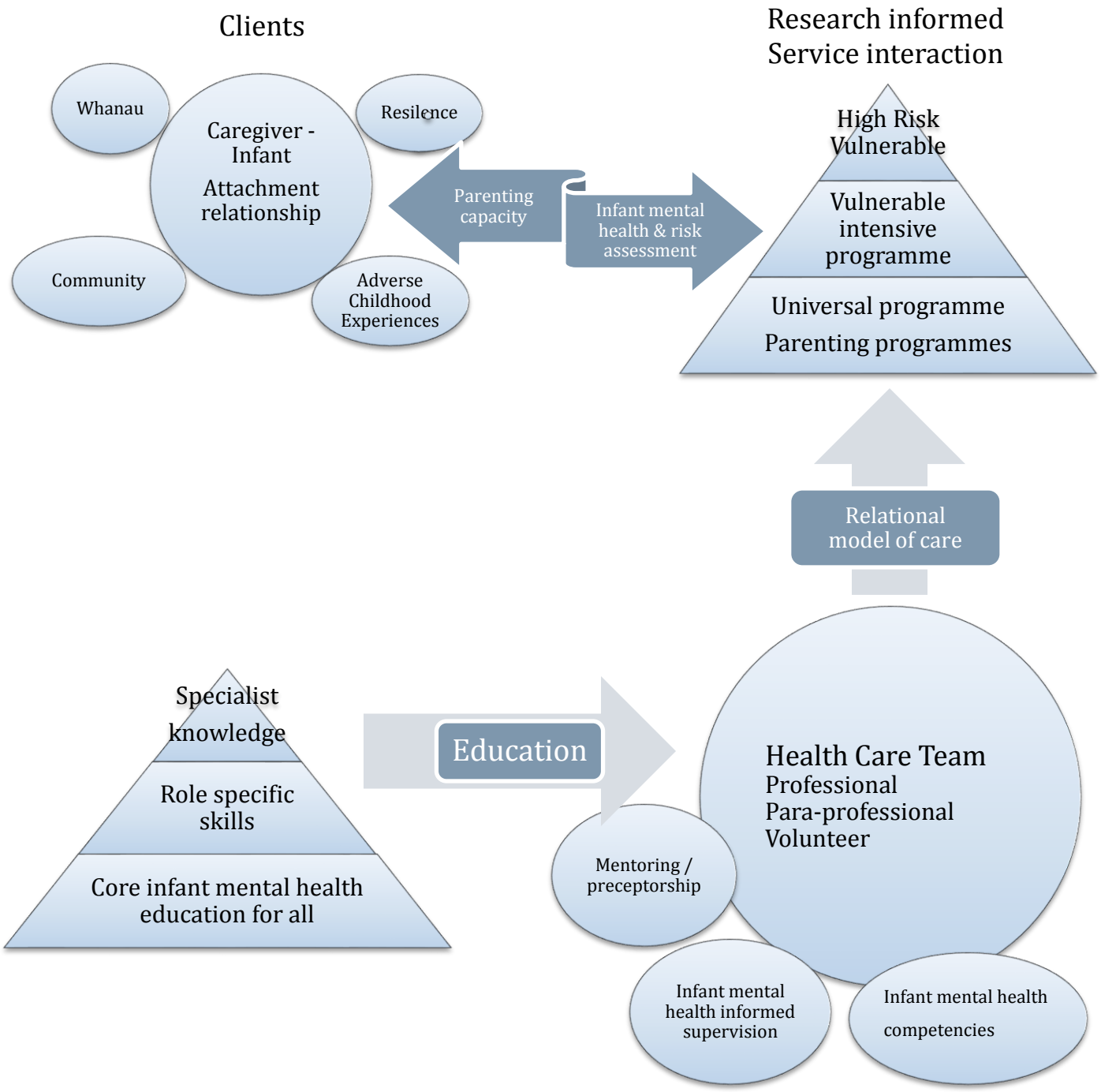
I visited Brunel University in London to talk to Elaine Tabony a Lecturer for the School of Nursing and Health Visiting Specialist Community Public Health Nurse Programme and other members of the Health Visitor teaching team. I also attended their Practice Teacher (Preceptor) professional development day. During this day I learnt about the Health Visiting training and also about the training for Practice teachers (preceptors).

From these visits common themes have been identified. These themes are explored in more depth in the following sections, including:

- How adverse childhood experiences impact on child outcomes and the relevance for practice,
- Relational models focus to improve health care services through client led partnership,
- The use of the circle of security as a parenting strategy for understanding their child's needs.
- Exploring some examples of services working with vulnerable whanau by developing secure child caregiver relationships as a reduction of risk,
- Infant mental health competencies and their benefits to services
- Infant mental health assessments
- Training and Ongoing professional development with the focus on infant mental health
- Supervision and the benefits of focusing on infant mental health in case reviews
- Research of current practice

Infant Mental Health Risk Management Framework

The following diagram shows the relationship between the focus areas of the Margaret May Blackwell study fellowship.



Vulnerability and Adverse Childhood Experiences (ACEs)

Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Many of the organisations visited spoke about the importance of acknowledging the impact of parents' childhood experiences and psychosocial factors on caregiver child relationship and the long term health outcomes for children. A common theme they spoke about was the usefulness of ACEs (Adverse Childhood Experiences) and their link to health outcomes throughout the life span.

There is good evidence that the outcomes for children and adults are strongly influenced by factors that operate during pregnancy and the early years. New information about neurological development and the impact of stress in pregnancy and further recognition of the importance of attachment all make early intervention and prevention an imperative. This is particularly true for children who are born into disadvantaged circumstances (Centre of the Developing Child as cited in Department of Health, 2009).

"Toxic Stress" can occur when a child experiences chronic, unmitigated adversity without access to stable, supportive relationships with caring adults. These adverse childhood experiences can include physical and emotional abuse, neglect, exposure to violence, food insecurity and economic hardship, among others. Toxic stress can affect a child's brain development and lead to the presence of many adult diseases, including heart disease, cancer, chronic lung disease and liver disease (American Academy of Paediatrics, 2016)

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations, with over 17,000 participants researched in relation to childhood abuse and neglect and later-life health and well-being. ACEs are scored on10 factors; recurrent physical abuse, recurrent emotional abuse, sexual abuse, alcohol or drug abuser in the household, household member in prison, parent with mental illness, mother treated violently, one or no parent, physical neglect, emotional neglect. The focus was to analyse the relationship between childhood trauma and the risk for physical and mental illness in adulthood. Breakthroughs in neurobiology demonstrate that fear-based childhoods disrupt neurodevelopment and can alter normal brain structure and function. As the number of ACEs increases, so does the risk for these outcomes. Adverse Childhood Experiences have been linked to risky health behaviours, chronic health

conditions, low life potential, and early death. In the United States study 60% of the participants were found to have 1 or more ACE, and 12% were found to have 4 or more. An ACE score of over 4 is considered to be toxic stress. The wide-ranging health and social consequences of ACEs underscore the importance of preventing them before they happen. ACEs are considered to be a useful tool to assess vulnerability (Stevens, 2014). Some of the services visited directed me to a very informative presentation on ACEs on TED Talks by a paediatrician in San Francisco called Nadine Burke Harris.

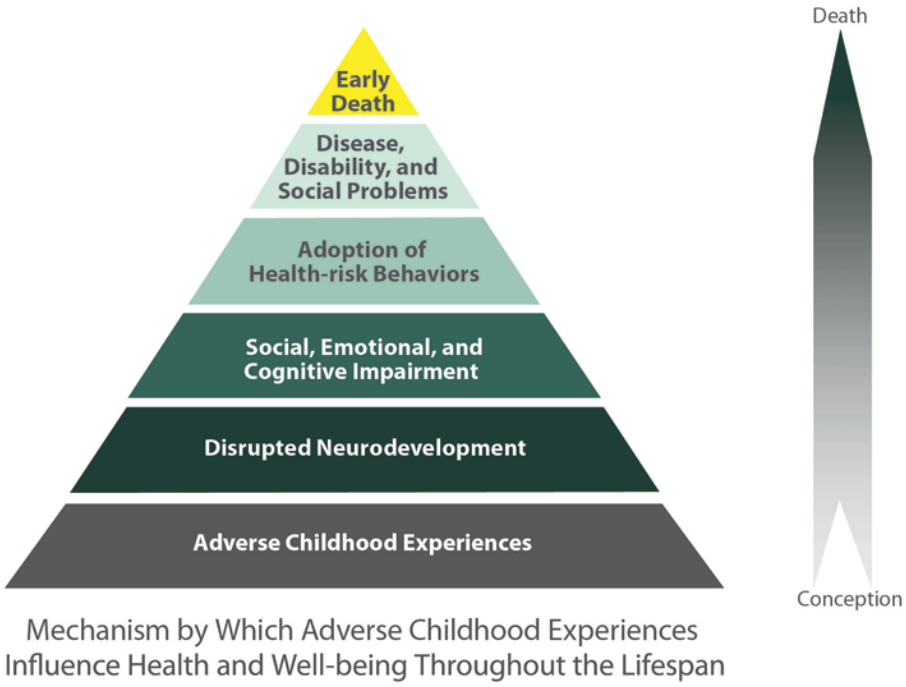


Figure 1 -Impact of Aces

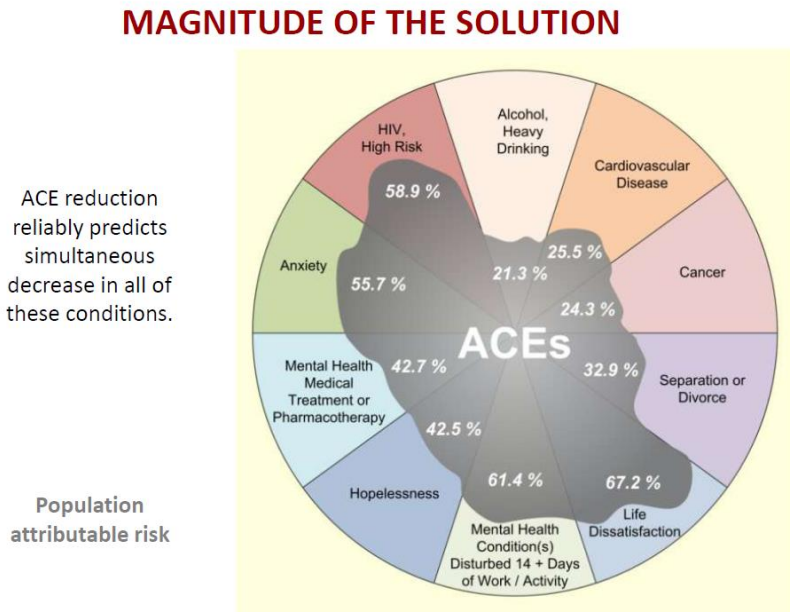


Figure 2 -The potential reduction of risk factors if the impact of ACEs is reduced. (Stevens, 2014).

THE RELEVANCE OF ACES TO THE FELLOWSHIP RECOMMENDATIONS

The ACEs study finding has been included in this report due to the common discussion of it throughout the Fellowship visits. The outcomes of specific adverse childhood experiences demonstrate the long term health outcomes for children and are clearly linked to neuroscience. The study and further academic writing on the ACEs are worthy of further exploration in the New Zealand context including the relevance for training to gain an understanding of the long term impacts of ACEs and links to neuroscience. The study findings are relevant for preventative work with caregivers who have experienced ACEs in their own childhood exploring the impact of these on their care-giving and also supporting their parenting capacity. The study findings are also useful in exploring the relevance to working with whanau who have children who have been impacted by ACEs. This could include support using knowledge of the ACEs impact on neurodevelopment and attachment relationships for both the caregiver and the child and minimising these impacts. It is worth considering if screening for ACEs in the New Zealand context may improve service provision for whanau, in particular vulnerable whanau.

Workforce Relational Models

"Health agencies provide visits to pregnant and parenting families in order to build protective factors and reduce risk. Essential to the effectiveness of this intervention is the capacity of the health worker to engage families in a relationship that encourages new learning and growth. Reflective practice is considered a best practice approach and defines the qualities of relationship that effectively promote healthy development in children" (Minnesota Department of Health, 2016).

This report section focuses on the importance expressed by the services visited of relational partnership interactions between the professional/paraprofessional and whanau prior to exploring some of the individual programmes offered to support vulnerable whanau. Each of the programmes visited varied in their assessment and care offered to clients but they were all rooted in a belief of relational care and hopefulness. Some services provided training in a particular relational model. Others offered training that was based on the importance of a partnership approach but did not have a particular model they worked from.

Communication and relationship were seen to be critical to effective service provision by Nic Wechsler at Ounce. Nic gave me a draft chapter of his co-authored book Home Visiting Programs Preventing Violence and Promoting Healthy Early Child Development. The book has since been published in 2016. He discussed his chapter on how parents and home visitors bring their own style into the relationship just as happens in the parent child relationship. Families and home visitors learn and grow together with experiences that are safe, secure, mutually respectful and trusting. Each brings their knowledge, experience and values that adds meaning and depth to the work they do together. Nic talks about how home visitors benefit from a framework to guide their work. He cites Bersteins five stages of helping relationships as a basis for a relational model that can be used by health care workers. These include orientation, acceptance, shared understanding, agreement and review/re-commitment (Roggman & Cardia, 2016).

Many of the services spoke about the benefits of motivational interviewing. Wave Trust (2013) in the United Kingdom recommend Health visitors should be trained in the use of Motivational Interviewing for use from first contact onwards. They considered this would help them to re-visit areas of risk outlined during the early pregnancy/postnatal visits and discuss these areas of vulnerability with the mother and (if appropriate) her partner.

Fussy Baby Network FAN

Facilitating Attuned Interactions (FAN) Fussy Baby Network

One of the models that appears to be gaining popularity internationally is the Erickson Institute Fussy Baby Network FAN (Facilitating Attuned interactions). The Erikson Institute Fussy Baby Network is located in Chicago USA with the network under the umbrella of the Erickson Institute. The Network started in 2003 as a prevention phone and home visiting program for families who were struggling with their baby's crying, sleeping, or feeding during the first year of life. The Fussy Baby Network's unique approach to working with families is called the FAN. The FAN approach focuses on the parent's concerns and uses five core processes to match interactions to what the parents are showing they can most use in the moment. The FAN approach also teaches professionals to track, regulate, understand, and use their own responses to families, thus building self-awareness and self-regulation. The Fan has been described as "bringing hope to families" "Holding hope". It helps the parents feel listened to, partners in exploring the issues and find the Angel moments. It helps the practitioner see the baby as the parent sees them (Erikson Institute, 2016).

Through the initial contact process for the Fellowship I had contact with Dr Linda Gilkerson the Executive director of Fussy baby network and the opportunity to attend the IMHAANZ Infant mental health conference in Queenstown where Linda was a keynote speaker. I was offered the opportunity to attend the first core FAN training in New Zealand giving me a depth of understanding of the model prior to the Fellowship travel. This opportunity enhanced the exploration of how the model has been embedded into practice internationally, inclusive of those working for Fussy Baby Services and for other programmes using it as a relational "infusion" model. During the Margaret May Blackwell Travel Fellowship several opportunities were made available to learn about the Fussy Baby network, the FAN and how the FAN is integrated into practice. These opportunities included meeting with Linda Gilkerson, attending the National Fussy Baby Network meeting attended by 60 professionals from services around the USA using the FAN in clinical practice, listening to a Warm Line call, attending a FAN supervision session with the Chicago Fussy Baby Network team and talking to members of the team based in Chicago.

The FAN has been proven applicable beyond issues of infant fussiness and generalizable as conceptual framework and practical tool. The FAN is now being used in diverse areas of interactions

to support attunment in "helping relationships" and promote reflective practice with individuals, families, groups and in supervision. The Fussy Baby Network provides training and consultation to organizations across the United States and internationally that wish to adopt the Fussy Baby Network FAN model.

The following graphic is the FAN approach. For more information on the Fussy Baby network there is a video on the Erikson website

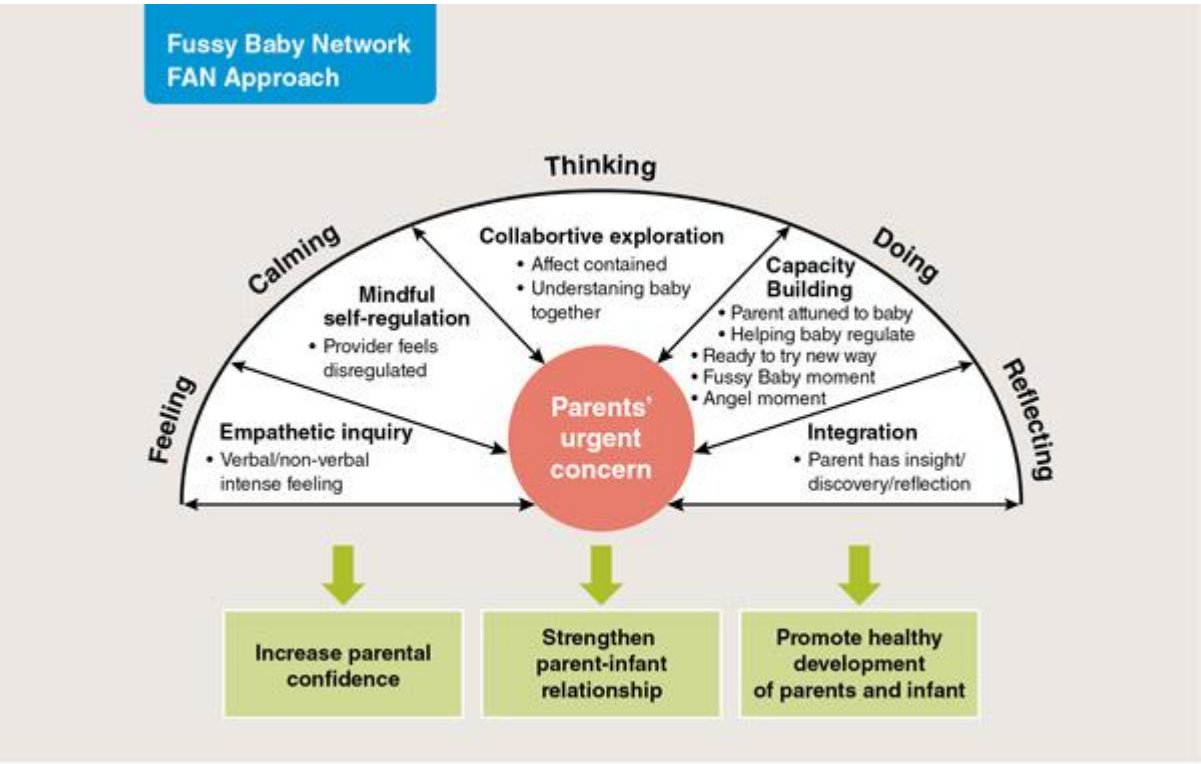


Figure 3 -Fussy Bay Network FAN

In the United States the FAN is used by many services to guide interactions with clients. The FAN model has been taught to health professionals in hospital services (medical students, paediatricians, psychologists, nurses) and in community services. There are 2 key ways the FAN has been integrated into services; firstly, as the guiding model used by services i.e. the Fussy Baby Warmline and Fussy baby home visiting services where the purpose of the interaction by the health professional is to support a family with a "fussy baby". Secondly by services that have infused it into

their current practice e.g. nurses, doctors, psychologists, infant mental health specialists, parenting support workers, teachers by using the FAN as a guiding model during relational interactions.

During the Fussy Baby National Network meeting held in San Francisco each USA State programme team presented their current use of the FAN and future planning. Each State presentation showed significant differences in the types of services using the FAN, funding source, staffing qualification and services offered. There were common themes through each, but they also reflected differences by population and service funders. This demonstrates the adaptability of the FAN to many and varied scopes of practice and relationships with clients and colleagues.

Some of the discussion at the National meeting included the different types of practice that use the FAN and demonstrated the adaptability of the model. The following are some of the ways the FAN has been implemented in the United States.

- San Francisco has a variety of services who use the FAN. These include A Better Way a collaborative programme, ARS (another road to safety) a differential response group, a home visiting programme for early intervention of high risk. Clients can be referred either for a concern for the child's well-being, family resource need or a child welfare referral. The services find the FAN particularly helpful as it gives multi skilled practitioners a core understanding and a tool to manage complexity.
- Spokane; This is an infusion site and a stand-alone Fussy baby site They use the FAN in supervision, Family services, substance abuse programme, traumatic birth, PND support group.
- Seattle has a warm line, using FAN with high risk clients, The neonatal unit are exploring using the FAN.
- Waltham; Several services use the FAN including the Jewish family and childrens' services early relationship support service, and NEST new babies exposed to substances. Healthy families are looking at using the FAN
- Maryland/Baltimore is an Infusion site. The FAN is used in multiple area. It is used in the PACT programme helping children with special needs including OT, speech
- Chicago; Head start, Parents as First teachers, Chicago public schools, home visitors, and Infant caregivers in child care centres are using the FAN. It is also part of the Medical Residents training. It is used by IMB who undertake new born assessments of high risk families and are also using a Brazleton based programme. Healthy families America are

going to start the training. Society of Osteopaths are talking about the potential of the FAN. 14 new programmes are going to use the FAN in the near future.

- Phoenix; They have a Fussy baby programme but have had staff cuts due to budget loss. Healthy families are looking at using the FAN.
- Napa; Beginning to infuse the FAN into programmes in Maternal and adolescent health programmes, Nurse HV programme of high risk infants/sick children.
- Berkeley; The FAN is used in Jewish family services, a womens' drug recovery programme and by Spanish speaking workers working with vulnerable Spanish families.
- New Mexico; The FAN is used in focused intervention programmes medical and home visiting intervention programmes. The FAN is used in Home Visiting 0-3 programmes as a foundation of infant mental health discussion. They have found that the FAN works well in their Circle of Security courses.
- Colorado; has a Fussy baby HV team with 80-90% referrals from Gps/Peads. It is also infused into other home visiting programmes.
- Florida; The FAN is used in Early childhood services- OT, speech and language etc. They find Circle of security and the FAN fit well together.
- New Orleans; The impact of hurricane Katrina has been significant both in emotion and financial impacts. There are limited services to refer to so as a result families stay with the Fussy baby network service for longer and they are trying to manage the complex concerns. There is a planned partnership with the neonatal unit and using the FAN as a base for the transition to home. Also early intervention programme are looking at using the FAN. Marketing of the service is through a door hanger with SHHH baby is sleeping on one side and information on the back about Fussy Baby services. There is also posters, and a power point protector plug with Fussy baby number on it.

Some of the comments made about the FAN by the group were it;

- The FAN is about "bringing hope to families" "Holding hope"
- It helps the parents find the Angel moments with their baby
- The FAN puts the baby and caregivers relationship at the centre of the assessment
- It helps the practitioner see the baby as the parent sees them.

The FAN puts the child and caregivers relationship at the centre of the interaction which fits with best practice for relational interactions. It also focuses on the helpers internal response which is

important if self-regulation is required. From attending the network meeting and hearing about the variety of ways the FAN is used there appears to be the potential for multiple areas of health and child services to train and use the FAN not just for fussy babies e.g. preschools, community services, A&E, child, adolescent and adult health services. There are a variety of areas the FAN can be used including one-to-one client interactions, working with a whanau (using the group FAN), groups, supervision of those embedding the FAN into practice, supervision, interactions with colleagues. During visits to other services in Australia, UK and Canada there appeared to be an enthusiasm to also explore the FANs relevance to their services.

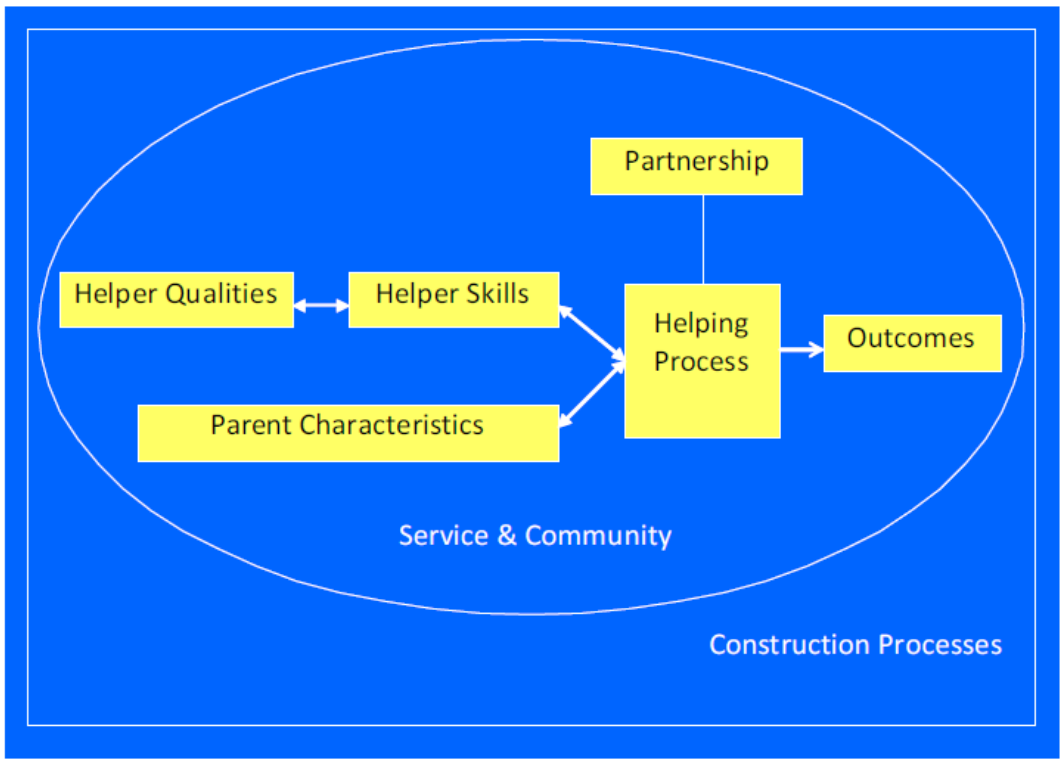
The process of integration of the FAN into practice is incremental by firstly learning about the FAN in a group situation then exploring the integration of the FAN into practice in supervision. The initial training involves a 2-day group workshop of approx. 15-25 participants with one facilitator. This is followed by a half day supervision training for those in the group previously selected to be supervisors. Following core training the group is offered monthly supervision for 5-6 sessions with one of the trained supervisors. During the supervision session the supervisee reflects on a case where the FAN has been used. This reflection is guided by a supervision FAN tool. This method of embedding the FAN into practice enables the participants to explore strengths and difficulties within client interactions through the use of the FAN. By selecting the supervisors from the group it becomes a self-sustaining process developing supervision skills from within the group. Potentially the supervisors can complete further levels of training to become FAN trainers. The models training process would initially require close support from Linda Gilkerson from the Fussy Baby Network as it is embedded into New Zealand then as the trainers become more skilled this need for support would lessen.

Family Partnership Model

The Family Partnership Model is an innovative approach developed by the Centre for Parent and Child Support. Family Partnership is based upon an explicit model of the helping process that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths and resilience and fulfil their goals more effectively.

The Family Partnership Model is an evidence-based method the effectiveness of which has been demonstrated through a number of research trials conducted by the Centre as well as independent randomised trials. The findings of these trials indicate positive benefits to the developmental progress of children, parent-child interaction and the psychological functioning of parents, families and children (The Centre for Parent and Child Support, 2016).

The Family Partnership model (Davis & Day, 2007)



As Family Partnership is a recognised course in New Zealand and has been delivered over several years to health care workers in New Zealand (also the report author is a trained facilitator in the

model) the programme was not explored in depth during the visit with The Centre for Parent and Child support staff. The Family Partnership model continues to be used in many countries around the world and training is offered to a wide variety of services working with whanau. As the training is 5 days, there have been concerns expressed about the length of time this takes staff out of practice and the time commitment for 2 facilitators per 12 participant groups. There has been extensive research on the effectiveness of the programme in relation to enhanced outcomes for families. Supervision is seen as an integral part of the effectiveness of the programme. The Centre for Parent and Child Support who developed the Family Partnership were visited as part of the Study Fellowship and the time together was used to explore some other models that have recently been developed.

Workforce Relational Models Recommendations

It is recommended workforce capacity to effectively engage with vulnerable whanau is built through relational model training. The two potential models explored in this report were The Centre for Parent and Child Support Family Partnership model and the Fussy Baby Network FAN. The Family Partnership model training is currently embedded in some services in New Zealand but this is not consistent. It is recommended to explore extending the Family partnership model and/or embedding the FAN into services. The benefits of the Family Partnership model and the FAN approach for professionals to track, regulate, understand, and use their own responses to families, thus building self-awareness and self-regulation appears to be well recognised internationally. There is strong support for integrating the FAN in New Zealand from a wide variety of infant and maternal mental health services and IMMHANZ. The first training programme has occurred in New Zealand with positive outcomes discussed by participants. The FAN training model would be offered to health services working within a variety of areas including one-to-one client interactions, extended whanau (using the group FAN), and groups. Supervision needs to be offered to those embedding the Family Partnership model or the FAN into practice. The process of embedding a model widely would involve collaboration between IMMHANZ, potential trainers and services.

Promotional guides

The Antenatal/Postnatal Promotional Guides have been developed by the Centre for Parent and Child Support and have a focus of development of infant caregiver relationship. They are developed for use at 2 visits; an antenatal visit and a visit at between 4 to 6 weeks. Visits are planned to support both parents and/or supporting whanau to attend. The Promotional Guide System provides a structured but flexible evidence based approach to help support the early development of babies, the transition of mothers and fathers to parenthood. They help both professionals and parents to identify and make well-informed decisions about the needs of the baby and the family. There is strong evidence for universal antenatal promotional guide use but currently it is targeted in particular to vulnerable families with an increasing use throughout England. They have used home visiting implementation money in the areas to deliver Promotional Guides, Family Partnership and supervision training.

The benefit of the postnatal guides is heightened with continuity of care from the same Health Visitor. The use of the postnatal guides vary with some utilising it at the first visit and others at the second visit postnatally. There appears to be some issues with Health Visitors receiving referrals from GPs and midwives to undertake the antenatal visit. In Doncaster they have done work with midwives so they can understand the role of the home visitor and the promotional guides. They are also looking to extend the programme to develop a new guide focusing on school readiness.

The Health Visitors undertake training in the use of the guides and “talk cards” with the parent/s. The training to use the guides is undertaken over 2 days, usually a month apart. Some areas only use the postnatal guide so undertake only 1day training. There is a train-the-trainer programme. After the training, the trainer is given the PDF of training resources and Manual for 25-35 pounds. Research has found The Promotional Guide training has high impact and practitioners strongly identified with the Guide's purpose, evidence-base and underpinning partnership-based approach. Managers supported practitioners with clear local guidance and address operational issues required for implementation. Systems need to be in place to monitor routine use and impact of the Guide. Reflective practice and supervision support should be available to ensure that the Promotional Guide practice is safe and effective (Day et al, 2013). Supervision was highlighted as a critical part of the embedding of the guides and analysis of relationships.

PROMOTIONAL GUIDES

The Centre for parents and Child Support are researching the impact of the promotional guides with the findings being published in 2016. Analysis of the topic cards has shown the home visitors see the uniqueness of each family, and their clients felt they set their own agenda and were listened to.

PROMOTIONAL GUIDES RECOMMENDATION

It is recommended to consider The Centre for Parents and Child Support antenatal and postnatal guides as tools for well child nurses. These would be used during an antenatal visit and postnatal visit commencing with use with vulnerable clients, and in time be used with all clients as the guides become more integrated into practice. It is also recommended that funding is explored for a routine antenatal visit to occur.

Circle of security

The Circle of Security is explored as a separate topic as it was a programme commonly discussed by services visited. Some services delivered the 8 week or 12 week parenting programme. Others used the circle to base their discussion with clients about the child's needs and their parenting response. It is a unique caregiver-infant relational programme based on attachment theory and through the useful graphics that have been created helps parents interpret their child's needs for exploration and connection. The Circle of Security is a relationship based early intervention program designed to enhance attachment security between parents and children. It focuses on the relationships which give children emotional support. Central to the program is the Circle of Security map, which helps parents and other carers to follow children's relationship needs to learn to be more emotionally available to them. The map draws a very clear link between attachment and learning. Decades of university-based research have confirmed that secure children exhibit increased empathy, greater self-esteem, better relationships with parents and peers, enhanced school readiness, and an increased capacity to handle emotions more effectively when compared with children who are not secure. (Circle of Security, 2016).

Being-With is, in many ways is at the heartbeat of the Circle of Security approach where a critical approach is the need every child has for caregivers (parents, teachers, etc.) to recognize and honour feelings by staying with core feelings rather than denying their importance. Co-regulation for the child leads to self-regulation. The shared management of feelings allows emotions to become safe and thus supports the ability to manage them in the future. The Circle of Security is relevant to all parents but has been demonstrated to support vulnerable families to reflect on their parenting, their "shark music" (areas of difficulty in parenting) and reflect on where their child is on the circle (exploration and connection needs) and meet their childs needs (Circle of Security, 2016).

The Circle of Security organization provides attachment and relational information to parents and health workers. Parenting information includes written information and they have recently developed 3 short video clips as a way to tell the basic story of the Circle in a brief, creative, enjoyable way that can be made available to any parent or professional who might be interested. They provide training to health workers to be used in one to one discussions of parent infant relationship. They also provide training to facilitators of 8-week and 12-week Circle of Security parenting education programmes. The programme is offered to caregivers from a wide level of care

giving capacity including parents who are significantly vulnerable. Research shows significant improvement in caregiver child interaction from attending these courses.

The training in all settings is based upon the following assumptions.

- Learning (including therapeutic change) occurs from within a secure base relationship.
- The quality of the parent/child attachment, plays a significant role in the life trajectory of the child.
- Interventions need to be based on a differential diagnosis that is informed by research-based theory.
- Lasting change comes from parents developing specific relationship capacities rather than learning techniques to manage behaviours. The capacities needed for a secure relationship include:
    - Observational skills informed by a coherent model of children's developmental needs,
    - Reflective functioning and the ability to enter into reflective dialogue,
    - The ability to engage with children in the regulation of their emotions,
    - Empathy.

Figure 4 developed by The Circle of Security is central to the discussion of the infant caregiver relationship in one to one discussions and for their 8 week and 12 week parenting programme. The circle has been adapted in further 1-page graphics to show miscuing and vulnerability when the parent is stressed or the child behaviour is overwhelming for the parent. They have also adapted the circle for infants and teenagers. The model can also be applied to adult relationships.

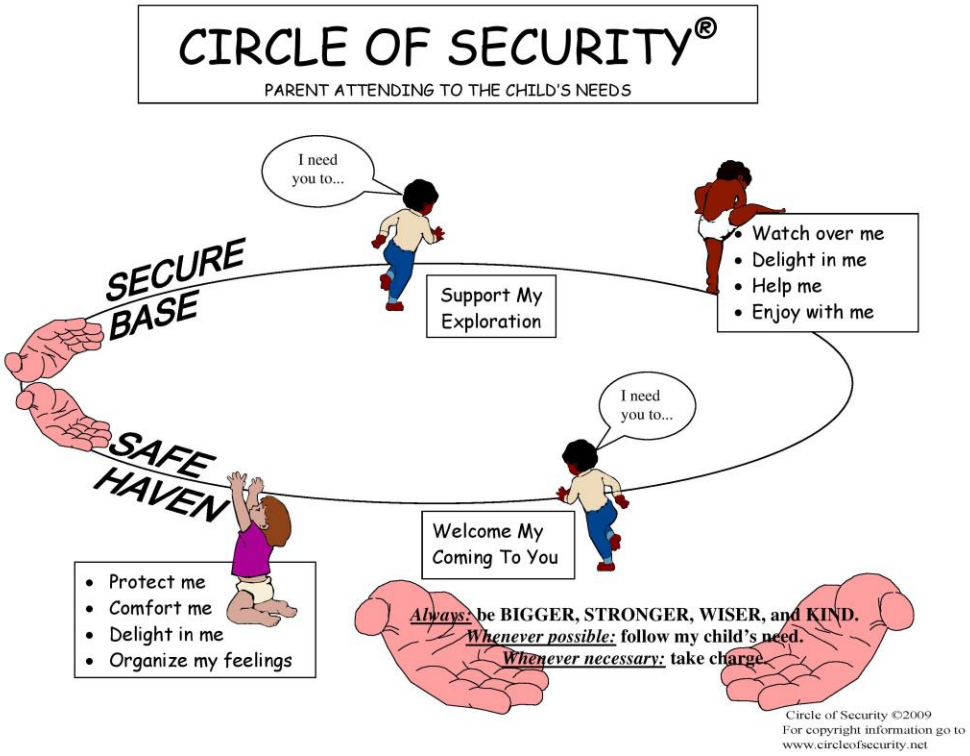


Figure 4 - Circle of Security

CIRCLE OF SECURITY BY COUNTRY VISITED

Two Circle of Security facilitators, one in Toronto one in London, were approached to gain a deeper understanding of how Circle of Security is currently embedded in programmes internationally.

CIRCLE OF SECURITY IN CANADA

In Canada I met with Eileen Kilbride who is an advanced trainer in Circle of Security in Guelph Toronto. We also met with two Circle of Security facilitators, Monica and Tamara from Mental health and child welfare services. They considered the key to enhancing caregiver capacity is gaining emotional regulation and reflective capacity that is offered through understanding the Circle of Security.

In Toronto, Circle of Security is offered in child welfare services. Referrals come from a variety of services, some self-referral, and some from judges. There are 20 trained facilitators who facilitate day and night sessions. Mostly these are 8 week sessions. If children are present the group size supports 6 babies and 6 parents. Without the children they have a greater capacity to take up to12 participants. Some are mother-only groups and some are with both parents present. They have tried a father-only group but this was not successful. They held some specialist groups for example Grandparents group (this is now an ongoing group), foster parents, parents separating, and courses held in preschool. Because of the vulnerability of the participants scaling questions pre and post are used to assess for changes, the assessment of struggles and strengths is identified in pre and post research.

They also spoke about a programme similar to Circle of Security focusing on older age groups (pre-teen 8-12 and teen 13-18) has been developed by Simon Frazer from the University of Vancouver. It recognizes the child's need to pull away from their parents to become more independent. Secure base equates to autonomy; Safe haven equates to connection.

They are working with schools to help teachers look at childrens behaviour through an attachment lens. The programme uses resources for the teacher so they can work with multiple relationships, secure and insecure. The focus is on how to look at children thoughtfully giving meaning to the behaviour. Schools use a triangle model of student, teacher and task. Focus to work with schools has resulted in a reduction in child behaviour issues.

They were very enthusiastic about the potential for the Circle of Security to enhance parenting capacity and develop secure relationships. They saw its adaptability to working with a wide variety of clients and its benefits for all relationships.

Circle of Security in London

I met with Jenny Peters who runs a small voluntary organization that delivers the Circle of Security programme in London. Jenny has a social worker background, and is the coordinator and lead facilitator for Circle of Security courses run in London. I met with Jenny to explore how Circle of Security programmes are delivered in London. She spoke about the complexity to access the programmes, with most of the caregivers self-referring onto the programmes. For vulnerable families they receive referrals from the perinatal team or midwife. They have found it difficult to engage Health Visitors as a referral source but do get referrals from other services. Potentially this is

related to recent changes to funding and structure locally. They have a high rate of retention in the groups once clients are on the programme. They run 2 to 3 groups a week with 11 trained facilitators with therapist backgrounds. The programme is usually held with 7 to 12 participants over the normal 8 weeks, but they have shortened it to 6 weeks occasionally. They are normally day sessions, but have held evening sessions for couples. Day time groups have volunteers to care for moving children, under 6 months babies often stay with their caregiver. The groups are usually mixed groups. Funding is through grants and other Government funding. Some funds come from parent donations. Facilitators receive some supervision from a reflective consultant.

Jenny spoke of the adaptability of the Circle of Security to many settings and interactions. She spoke of how a preschool in Australia has used the Circle of Security to frame its interaction with children. She also sees a potential for the use of the model antenatally. Some areas have trained staff in the Circle to use it in one to one relationships. Jenny arranged for Charlie Slaughter a coordinator for the Circle of Security to email me some research on the Circle of Security. Jenny also recommended a book for couples called Hold Me Tight by Sue Johnson. Jenny has been instrumental in the development of the 3 short animations that are freely available on YouTube. These animations give a short overview of the key points fundamental to the Circle of security programme. They are useful for clients to reflect on and for health professionals to use during parenting conversations. (Circle of security animation https://www.youtube.com/watch?v=1wpz8m0BFM8, Unconditional Love https://www.youtube.com/watch?v=F6DhnbgRAOo, Shark Music https://www.youtube.com/watch?v=gn2Uu8X9SS8)

Other countries use of Circle of Security

Circle of Security is offered in Sydney, with a variety of staff running these groups. Some of the groups are offered by allied health workers e.g. a group for Arabic mothers is run by a social worker. Positive feedback has been given by parents and they have been considered by staff to be effective in supporting parenting capacity. In Australia there is a preschool that is using Circle of Security as its relational model of care for the children. In the United States of America many States deliver Circle of Security programmes with some facilitators qualified to deliver training for health workers. In Ireland some areas use Circle of Security and find it effective, but it does not appear as embedded as other countries.

CIRCLE OF SECURITY

In New Zealand there have been some facilitator training in the 8 week courses. There are some courses run throughout the country but these vary in the areas they are offered and the access to clients. Some are funded through mental health services but others are reliant on clients paying for the course.

CIRCLE OF SECURITY RECOMMENDATIONS

There is significant potential for further integration of the Circle of Security into the New Zealand context. Further exploration of the Circle of Security has been mentioned by the Ministry of Health (2012) in their document Healthy Beginnings.

It is recommended that

- One day training of the core principles of the Circle of Security is offered broadly to community services. This would ideally increase the workers' knowledge of attachment and the use of the circle of security models. This knowledge would provide them with increased capacity to explore caregiver infant interactions and the child's need for exploration and connection in a one to one basis with caregivers and their whanau.
- 8 week parenting courses are made available throughout the country in a coordinated way. These may be offered internally by services, or accessed via self-referral or a service referral.

Service models

This section will explore some service models that focus on improving child health outcomes for vulnerable whanau. These services were selected to explore the extent that attachment theory, child growth and development and parent child interactions were embedded. Most of the services visited provided a predominantly home visiting service others provided their service in a variety of settings. For the purpose of this report when referring to services the intent is for home visiting to be looked at broadly in the sense of venue.

Home Visiting Services are a common method of supporting families in particular vulnerable families. "Home visiting has been shown to be an effective method of supporting families, particularly as part of a comprehensive and coordinated system of services. These voluntary programs match parents with trained professionals to provide information and support during pregnancy and throughout their child's first years—a critical developmental period" (Zero to Three, 2016). There is emerging global consensus that targeting children in early years is key to mitigating the risks associated with early aggression and developmental delay. Home visiting services are becoming increasingly used in high risk populations to mitigate parents stress, guide parents to positive parenting interactions, develop age appropriate strategies for regulating child behaviour and help families move out of poverty. The success of these programmes has promoted recent expansion of home visiting funding in the USA and other countries worldwide (Roggman & Cardia, 2016)

"Common elements or components of effective parenting programmes included factors related to: staffing and infrastructure (eg staff qualifications, training and support), programme design (eg clear programme logic and goals), programme delivery (eg adequate frequency and duration, individualised planning), programme content (eg focus on child behaviour and positive parenting strategies) and ongoing monitoring and evaluation for programme improvement." (Families Commission, 2014)

Service Models Sydney Australia

One of the first services visited during the Margaret May Blackwell Travel Fellowship was Tresillian in Sydney Australia. Tresillian services are funded by the NSW Department of Health through Medicare. Tresillian is a Sydney based health service specifically designed to support parents in caring for their babies and young children. Tresillian offers a number of services for families, depending on the age of their child and what level of support they require including four family centres, day stay, residential stay, outreach, home visiting, clinic assessments, a phone service, facebook service, and parenting education. Care is provided by staff such as nurses, paraprofessionals, social workers, paediatricians and psychologists who have specialty skills in Family and Child Health.

The visit included time with Dr Catherine Fowler who has been instrumental in the new child health programme development offered by the service and the University programme that provides the education for the Child Health nurses. I also spent time with a Clinical Manager and Clinical nurse consultant who work for the service. The model of care offered by Tresillian is based on extensive research The key evidence used to inform the programme are from Lyn Kemp, Mesh HV programme, David Olds Family nurse partnership programme, Miller early childhood sustained HV trial 2010 and sustaining NSW families forum programme

Services offered within the Sydney programme have recently been redeveloped following research into other programmes offered nationally and internationally. Their new structure has three levels of care:

- Level 1 is offered as a universal service by CFHNS (nursing staff) under local health districts. Core and additional service occur with approximately 6-12 visits. Each area has Key Performance Indicators (KPIs) to meet. Clients can be referred to additional services for example Tresillian day stay, outreach and overnight service for short term issues e,g feeding sleeping issues.
- Level 2 is offered to clients who have been assessed as having long term health needs. This service is area specific and is not offered in all areas but there is a plan to have a wider role out of the service. There are currently 5 sites in NSW in low socio-economic areas with 3 new sites planned. The client is referred into this programme and is ideally engaged in the service at 20 weeks gestation until 2 years. The Level 2 programme is an intensive home

visiting programme modelled on the MECSH programme (See link in useful websites). Staff are either solely based in the programme or work with clients from Level 1 and Level 2. Caseloads are 1 to 25 families per year. The programme uses Ncast (see professional development section), home inventory, ages and stages, and psychosocial screening as evidenced based tools. Close working relationships with other health professionals is integral to this service.

- Level 3 supports the very vulnerable and includes referral to outside services e.g. drug and alcohol, and maternal mental health. The Tresillian area programme offers 6-12 home visits. The nurses have a case-load of 100 families a year between 2 nurses. Again this programme is area specific and not offered in all areas.

Level 2 and 3 are structured early intervention HV programmes. The nurses delivering the programme have developed a model of care with the child in the centre and with programmes offered around the outside circle. All the levels screen for Family violence as per protocol and maternal mental health using the EPDS. Level 2 staff have ideally undertaken mental health papers.

All levels are supported by specialist services including, day stay/outreach/residential, community programmes, Mother/baby groups, nurse led breastfeeding clinics, Circle of Security parenting 8-week group, PND groups. Other services include a phone service and Facebook services.

The facebook services include live private messaging, but do not offer group or public services. It is a 5-11pm service Mon to Friday. As it is anonymous records are only kept for 3 months. They have approximately 270 contacts per month. The Parent help line is a similar service to PlunketLine with client led calls to service and a call back service if clients leave name and number. There are some issues with call back service as they are not able to identify if calls are national or international calls.

The day stay/outreach service work with two clients a day with a total of 3 visits per client. The choice of day stay or outreach is assessed by access barriers and need e.g. refugee clients are more often seen as outreach clients. Unfortunately, there is a long waiting list for their services.

Tresillian also offer Residential care of 4 to 5 days for parents with complex issues. Usually the mother stays the full 5 days with the father often staying 1-2 days. The service had been allocating care for an individual client to an individual staff member, but there were issues regarding care direction and delegation. Now there is a team care regime. On admission there is a psychosocial

assessment with support from an allied health team consisting of a Social Worker, Psychologist, Psychiatrist.

From the visit it appears that Tresillian offer a holistic service which is based on individual client need. The levels of care provided by Tresillian offers all clients a range of services from the core service with additional support from a wide variety of additional services as necessary. By having a second and third specialist service this offers vulnerable clients an intensive evidence based programme providing the ability to carefully plan care with a strong outcome focus. Tresillian have a workforce that appear to be strongly committed to education with training prior to commencing their role, specialist training for the area of practice they are working in and a commitment to ongoing professional development. They have a strong commitment to having staff who are trained in maternal and infant health with an expectation that the level two nurses have undertaken further training in these areas.

Service Models United States of America

The areas visited in the United States were Seattle, San Francisco, Chicago and Minneapolis. This section has combined comments from the services visited as well as specific comments about their service.

In the United States home visiting programs are recognised as an important strategy for helping at-risk families with young children. Depending on the program, home visiting may seek to prevent child maltreatment, improve maternal and child health outcomes, and increase school readiness.

Federal, state, local, and private funders have supported home visiting programs, which operate in thousands of communities around the USA. Although home visiting programs vary in goals and content of services, in general, they combine parenting and health care education, child abuse prevention, and early intervention and education services for young children and their families.

On March 23, 2010, the President of the United States of America signed into law the Patient Protection and Affordable Care Act of 2010 the health care reform bill. One provision authorized was the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which greatly expands federal funding of home visiting programs. This funding provided an unprecedented opportunity to improve health and development for at-risk children through federal funds to States and Tribal entities to support voluntary, evidence-based home visiting services to at-risk families. The program is jointly administered by the Health Resources and Services Administration and the Administration for Children and Families in the U.S Department of Health and Human Services.

Some States have adopted a specific model of home visiting. Other States fund a variety of evidence based models, often selecting from several nationally recognised programs and allowing communities to select the model that best meets their local needs (Pew Center on the States, as cited in Jon Korfmacher, Laszewski, Mariel Sparr, & Hammel, 2012).

The home visiting programs have the central goal to improve the health, development, and well-being of mothers, children, and their families. However, depending on the model and type of home visiting program (short- versus long-term) the target outcomes may vary. The Home Visiting Evidence of Effectiveness (HomVEE) Executive Summary highlights eight domains that home visiting models aim to improve with their services. The domains are child health, child development/school readiness, family self-sufficiency, linkage and referrals, maternal health and

family violence/crime. According to the specific structure and goals of a home visiting program, programs must decide the specific educational, professional and personal experiences that are necessary to do the job in their community and agency (Minnesota Department of Health, 2016).

Universal and Targeted services

Home visiting in the USA came from the community drive to connect families and in particular vulnerable families. This was often offered through community services. Over the last 15-20 years professionalism of the home visiting models has increased. This developed from a psychology and social worker focus and need to train in models to give a structure for those delivering the service. There now appears to exist a debate of professional vs paraprofessional. The service providers and researchers visited during the Margaret May Blackwell Travel Fellowship spoke of how Home Visiting programmes in the USA vary by State with most being targeted services working only with vulnerable populations. There are only a few universal programmes in the USA. These include one in LA county called the Welcome baby programme (10 visits). They offer extra visits but find clients, even high risk clients, often do not want them. There is also a universal programme in North Carolina Duram connects which has undertaken research about outcomes.

There appears to be debate in the United States whether greater outcomes come from universal or targeted services. Jon Korfmacher an Erikson Institute Researcher is researching the range of home visiting programmes and discussed how research would suggest best outcomes come from targeted home visiting services, but there exists a stigma around targeted services for those eligible. Clients have also refused to take part in programmes for example Healthy families America a child abuse prevention programme because of the stigma of being considered at risk of hurting their child. Jon also stated many who may meet service criteria miss out due to not being identified as vulnerable due to lack of access to the population group to screen. He discussed the value of universal programmes for families who did not meet the vulnerability criteria in relation to anticipatory developmental support and exploring unmet parenting issues. ONCE, a service I visited in Chicago (see below) are exploring a one off universal visit. They are also exploring the use of the Fussy Baby Network FAN as a basis of a relational approach as there are concerns that a one off visit can be perceived as a tick list assessment for vulnerability and eligibility for an intensive programme or referral to other services.

PROGRAMME LENGTH

Length of time on the programme and time commitment for visits can also impact on the client's willingness to engage in an intensive programme. Many of the programmes talked about starting visits antenatally and continued on the programme until age 2. Research has found that many families drop out of intensive home visiting programmes at around age 1. At times this occurred due to changes in circumstances or a perception that they are coping well and no longer need the support. Jon Korfmacher said there is some discussion of offering modules of care rather than a defined time period of a 2-3 year programme.

MIECHV FUNDED PROGRAMMES

The service providers and the researchers visited spoke about the benefits of the new MIECHV Federal funding from the "Obama health reforms." This has resulted in the eligible programmes being State and Federally funded. This funding is prescriptive for home visiting services. Services who want to access this funding must select one of 17 evidence based models to guide their service model. To access this funding the service is required to collect data for Government benchmarking. The most commonly used models are Nurse family partnership, Healthy families America, Parents as first teachers and Early Head Start which are discussed below. There is no certification given for Home Visiting that is independent of approved training models. Some comments made were concerns that the home visitors are now becoming very reliant on models used so may miss cues given in a more holistic client led approach. Discussions also covered conflict between model content and Government direction for services to cover other issues e.g. family violence resulting in the need for further education.

Some counties have historically developed their own programmes e.g. Hold nursing programme, but unless they meet the MIECHV criteria they do not gain MIECHV funding. As well as the larger home visiting programmes that provide support to vulnerable families there are a wide variety of programmes focusing on specific at risk groups e.g. premature babies, high risk sick children, children of parents with disabilities or mental illnesses

Professional vs Paraprofessional

There was an obvious variation in the skill mix and prior qualifications of the services staff. Most of the home visiting programmes are offered by a variety of people from various backgrounds and paraprofessionals. In some home visiting programmes visited there is a minimum requirement of 2 years supervised work with children and a high school diploma. Very few spoke of the use of volunteers in the role of family support.

Nurse family partnership is the only model offered solely by nurses. Most of the programmes with nurses as part of the team are state funded. There was some discussion of how services provided a cultural focus for the client population but this varied by the flexibility of the programme content and the skills of the health workers.

An ethnic specific programme was discussed was in Minneapolis. This was a targeted programme and had a broad range of skilled culturally appropriate support staff (see below for more detail of this programme). The flexibility of the MIECHV Federal funded programmes in relation to cultural diversity would need to be explored in relation to each programme and the content flexibility.

Relational focus of programmes

Each programme is based on different evidence in relation to screening and relational programmes but all appear to be based on robust attachment and child development research, there is a high value of the infant caregiver relationship placed in the visits. Programmes appear to have the parent and child relationship as the focus, using time with the parent to assess the relationship, focus on what the caregiver and support worker notice about the baby and the relationship exploring strategies the parent can use. Many services have a focus on exploring parents' history of adverse childhood experiences and the impact on Infant mental health.

It was interesting to note that there was a wide variety of assessment tools and programmes. Assessment tools are explored in more detail in the later section. Some examples of the programmes they use are NCAST programmes, "the dance" a relational approach used by Family Nurse Partnership, Promoting First Relationships, PICCOLO parenting interactions with children (a

check list of observations linked to outcomes), Brazelton (based on the parent as the expert in the baby).

Nick from ONCE explored the need to base the home visiting interaction on attachment theory with the primary focus on the attachment relationship rather than focus on the other factors impacting on their life. This focus aims to develop the capacity of the parent and as the visits progress the parents constructs and needs are also included. He said this theory is based on when there are successes in the infant adult relationships the parent's capacity is developed leading to them being more likely to be successful in managing other struggles. To develop a programme Nick suggested to start with child development, add dealing with conflict, and motivation to change.

Videoing interactions as a routine assessment of interaction between parent and child is used in several programmes focusing on the parent child interactions. Staff are trained in the use of videoing to be curious with the parents then talking about what they noticed in the interaction.

Four Key Models

The four key models discussed by the USA services I visited are;

- Nurse Family Partnership one of the larger home visiting programmes used by services throughout the USA and in some other countries. The Nurse Family Partnership programme was developed by David Olds and has strict criteria for delivery with clear goals. It is provided by Registered Nurses with additional training in the programme. Clients are referred to the programme at 27 weeks gestation and remain in the programme until the child is 2 years old. The entry criteria are to be vulnerable low income first time parents. It focuses on intergenerational poverty. There is a significant amount of evidence to support the programme. Reflective practice is built into the programme focusing on the family in a change process. The nurse works with the family on several domains including personal health, environment, support systems, maternal role, self-sufficiency. All domains are covered in each visits. If the family moves they can transfer into a new programme. Training includes face to face and online training for the Registered nurses employed onto the programme.
- Healthy Families America (HFA) a Home visiting program of the Prevent Child Abuse America model and offered in many States. The home visits are undertaken by trained staff

with various backgrounds some may be registered nurses. This model offers care to anyone at risk including second time parents. HFA is designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence. This is an accreditation programme in 38 States, and also offered internationally.

HFA is rooted in a theory that early, nurturing relationships are the foundation for life-long, healthy development. Interactions between direct service providers and families are relationship-based, designed to promote positive parent-child relationships and healthy attachment, strength-based, family centred, culturally sensitive and reflective. They collaborate with community partners to reach families.

All families complete a Parent Survey or similar assessment in order to determine the presence of risk factors for child maltreatment or other adverse childhood experiences, as well as identify family strengths and protective mechanisms. For this assessment they use the Kempe Star check list with 10 domains to determine eligibility (e.g. discipline, childhood, housing etc). It is based on the parent's concerns.

Families are enrolled prenatally or within three months of birth until the child's third birthday, and preferably until the child's fifth birthday. HFA sites offer at least one home visit per week for the first six months after the child's birth. After those initial months, visit frequency is based on families' needs and progress over time.

Typically, home visits last one hour. HFA includes screenings and assessments to determine families at risk and routine screening for child development and maternal depression. They focus on the parents exploring their own experiences of being parented and the impact of this on their parenting. In addition, many HFA sites offer services such as parent support groups and father involvement programs.

- Early Head Start (EHS) targets low-income pregnant women and families with children from birth through age 3, most of whom are at or below the federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their State. The program provides early, continuous, intensive, and comprehensive child development and family support services. EHS programs include home- or centre-based services, a combination of home- and centre-based programs, and family child care services (services provided in family child care homes). The focus of this report is on the home-based

service option. EHS home-based services include weekly 90-minute home visits and two group socialisation activities per month for parents and their children. Home visitors are required to have knowledge and experience in child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics.

- The Parents as Teachers (PAT) program aims to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The PAT model includes one-on-one home visits, monthly group meetings, developmental screenings, and linkages and connections for families to needed resources. Parent educators conduct the home visits using structured visit plans and guided planning tools. Local sites offer at least 12 hour-long home visits annually with more offered to higher-need families. PAT serves families for at least two years between pregnancy and kindergarten. PAT affiliate programs select the target population they plan to serve and the program duration. (Information source http://homvee.acf.hhs.gov/Models.aspx This site provides information about the programmes offered in the USA and the research undertaken on the programmes)

FUSSY BABY NETWORK HOME VISITING SERVICE

The Fussy Baby Network home visiting service has been included to demonstrate differences that programmes can offer. It differs in that it is a short term client led need service, there is no criteria to use the service and it prominently offers short term support to vulnerable parents. Generally, referral to the Fussy Baby Network home visiting team is via the phone service. Clients either self-refer to the service or are recommended to contact the service. The services support the family to gain skills to settle their child and manage parenting issues using the FAN approach (see previous section on relational models). There is a rapid response to needs and if complex needs are evident they are also referred to other service. In some States there are assessment teams who assess infant mental health then decide which programme to refer to this is done through an interview and observation of interactions. This is dependent on assessed need developmental or mental health or special needs. Some services use the FAN as intervention Infant /parent psychotherapy. Clients are

discharged from the fussy baby service when the initial concern is resolved, their role is not to support resolution of all other issues.

Additional Support and service collaboration

Additional services to intensive home visiting programmes are offered in all the States. Some examples of these include; Doulas (ante and postnatal) support, peer support groups which are part of some of the models in separate in other areas, services related to a specific issue e.g. lactation, behaviour issues etc. Dr Elizabeth Carlson a senior lecturer at The University of Minnesota discussed the importance of interdisciplinary work and knowledge of services in the community. The infant mental health programmes she offers through the University have a wide variety of participants from various areas of speciality. A common theme she has identified when working with them is a lack of knowledge and consultation between disciplines. Elizabeth considered more training is needed for mental health professionals to consult with each other. She said they "need to learn each other's language and to not be afraid to ask for help". She saw a need to try to make it seamless for families by training those working with families to notice issues and consult with others, this requires an understanding of each other's roles. To develop trust in other services Elizabeth stated the nurse needs to introduce others to the family and give a warm handover, explaining what the other services do as the nurse represents everyone they refer to. She saw challenges for those who have an infant mental health focus within the community to work with providers supporting adults to also get them to see the child.

The Department of Health Minneapolis

As an example of how a State offers a variety of programmes I visited with a team from The Department of Health in Minneapolis to learn about how home visiting services function (see the services visited section for those included in this group). In Minnesota most areas offer either Nurse Family Partnership or Healthy Families America as a home visiting service. Some other programmes offered do not come under a formalized home visiting model which can impact on their access to Federal funding. Funding comes partly from Federal and partly State funders this can cause some tension when meeting requirements for service. Some programmes accept self-referrals and professional referrals. A strong focus of the programmes is to work with families to help parents stop and think about interactions with their child and wonder what might be happening. They have a focus on motivational interviewing to support change.

During my meeting with The Minneapolis Department of Health the staff expressed concern at the variability of staff entry criteria into the roles for the various home visiting programmes. Home visiting programs across Minnesota employ a variety of individuals to conduct home visits. The knowledge and skills that these home visitors bring to their work varies based on their education/training and former work experience. Some had prior qualifications in health and others had a child development background. Depending on individual community needs and the available work force, home visiting programs in Minneapolis may focus their efforts on hiring either paraprofessional or professional staff. Regardless, they consider there are some basic knowledge and skills that translate across all home visiting programs, and training/professional development opportunities that can benefit a variety of staff to ensure their clients' needs are met (Minnesota Department of Health, 2016). This impacted on the service orientation and training. The group I spoke to were also concerned about the variation in initial and ongoing training offered. Most had a formalised initial training/orientation for the role e.g. Healthy families America has 4 day training with a strong focus on brain development and how trauma affects brain development. Some services did not have a model to guide their interactions or for their training. This was seen to be a risk to health outcomes for vulnerable families. Staff in some of the services have expressed concerns at the limitations of the training offered, finding it insufficient for their roles. For further training the Minnesota University CEED training is a strong focus of the programmes used.

TRIBAL PROGRAMME

One of the group I talked to was the Educator for a tribal programme. This is one of the few programmes discussed that is focused on meeting the needs of the people of the land. "The Tribal Home Visiting Program, administered by ACF, has awarded 25 grants to tribes, consortia of tribes, tribal organizations, and urban Indian organizations to develop, implement, and evaluate home visiting programs. The program is designed to develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families, expand the evidence base around home visiting in tribal communities, and support and strengthen cooperation and linkages between programs that serve Native children and their families. Due to the limited evidence base on effective home visiting in tribal communities, Tribal Home Visiting grantees may adopt home visiting models that are either evidence-based or considered a promising approach. Model selection is designed to be a collaborative and community-driven process based on community needs. Because most home visiting models selected by grantees are designed for non-

native populations, many grantees have enhanced or adapted models to fit culture and context" (HRSA, 2016, p.3). The Tribal Educator spoke of her experience with different levels of competencies of home visitors coming into the service. There are no requirements for qualifications, making training complex. The curriculum for their service is developed to focus on relationship. The home visitors work closely with the elders as they hold respect, wisdom and power. They also work with the Minnesota SIDS centre for safe sleep which is a cultural tribal programme.

Service Models in Toronto Canada

I visited with Riffaat Mamdani the programme consultant for the Ministry of Children and youth services and Alice Goreman a manager for Healthy Baby Healthy Children programme and Public health nurses in Toronto. I met separately with them but there were common themes through their discussions. They talked of the health issues confronting families in Ontario which are similar to New Zealand with 26% living in poverty, increasing food and accommodation costs, rising unemployment, poor housing, a 14 year waiting list for Government housing in Toronto, poor health outcomes including a high rate of obesity in particular for the Aboriginal children. They discussed how each Provence offers different services e.g. Family nurse partnership in some and HBHC (Healthy Baby Healthy Children) programme in others. The services have been legislated with a new protocol in 2012. Universal screen identifies need for targeted programme. In the Ontario area there are 36 Public Health districts with 480 nurses 250 health workers who offer home visiting services. These are 100% government funding through the district. Each district is able to act independently so there are some issues with consistency of what is offered, standard of practice and communication with Ministry of Health funded health programme.

Health Babies Healthy Children programme

The Healthy Babies Healthy Children programme is an attachment centred targeted programme. It is staffed by Registered nurses and unregulated support workers. There is a specific group that works with teens. The aim is for all clients to be screened at birth using a 40 question risk assessment tool. This is usually undertaken at birth but currently there is a variation of the completion rate as some clients are not screened prior to hospital discharge. The screen aims to identify at risk families where if two or more questions identify risk factors they are referred onto the Health Babies Healthy Children programme. The average is about 2-5 risk factors identified (this includes common birth complications, depression/anxiety, health conditions in family/child, concerns by the health worker). Approximately 46% of those screened have 2 or more risk factors. They are offered a phone call follow up with 80% agreeing. From this group on average 60% agree to a home visit but this rate of uptake varies by area. Some clients see it as a stigma to be on the programme and some second time parents do not see it as necessary even if they meet the 2 risk criteria. There are 9-

10,000 on the programme each year. There have been some issues with cell phones as they are unable to text potential clients unless they have previously agreed to it. They offer antenatal and postnatal care referral. Antenatal referrals come from their GP or midwife but this is not a common pathway onto the programme. The service is wanting to increase antenatal referrals due to the researched benefits of early intervention for vulnerable families. The antenatal programme is provided by Registered nurses.

Postnatal visits are 1-2 weekly usually for 6 months but this can be extended by need. The first visit is an in-depth evidence based assessment. The screens include PND depression assessment tool, mental health wellness tool, substance abuse scale, NCAST assessment tools. The assessment looks at a balance of risk and protective factors. The outcome is an assessment of high, moderate or low risk. If there are concerns for high risk families and they refuse support from either the initial or intensive assessment they may be referred to social services. The visits are client led with strengths and struggles identified, goals and plans developed with the family. Motivational interviewing, change theory and the Ministry of Children and Youth programme are key to the care offered. The care plan may also include referral to other services. Clients are also linked to parenting groups. Some areas have a healthy baby line to provide additional phone support. There are no weekend or evening visits due to legislation and regulations. There is also no skype or facebook services offered.

They are currently exploring service development to consider evidence based tools. They have set up 2 working groups to look at resources and training, including

- education; how to support best practice
- family service plan working group
- family friendly working plan to take into the family
- pathways for staff to help inform progress.

Ncast tools are commonly used tools by the Public Health nurses (NCAST training is discussed in more detail in the professional development section). The nurses working with pregnant clients use the resource “Promoting maternal mental health” during pregnancy to support the pregnant women who are referred to the programme. This enables them to explore their preparation for baby, reflect on how they were parented, including trauma experienced and relationships. NCAST Feeding and teaching scales are used as an assessment and reflective programmes with the clients. Some nurses

have found it complex to transfer NCAST assessment into interventions as they have been focused on passing assessment test a requirement of the 6 day training. They have just finished training 30 new master trainers (train the trainers) as a high turnover of master trainers has meant an impact on capacity to deliver.

The unregulated Health visitors use partners in parenting Education "how to read your baby" - a Colorado programme. It is a booklet listen, love and play with 4 steps for each session; setting the stage, undertaking an activity, role modelling with an object (e.g. doll or teddy), and encouraging the parent to do the same activity. The unit is US$500 for the kit but only one is needed per team as there is no copyright for the material. This has the potential for the New Zealand unregulated workforce as it could give some structure to the visit. The public Health nurses may work on the HBHC programme and also other health unit tasks e.g. Lactation Consultant.

Those not on the HBHC programme are offered other support services (e.g. breastfeeding support, parenting groups). Some other programmes offered in the area available to all parents include:

- Incredible years, living and learning, baby signs of safety
- PIPE partnership in parenting education. Health worker involved.
- Antenatal programmes
- peer support groups
- Canadian prenatal nutrition programme
- Lactation consultant and dietitian access.
- Breastfeeding BFCI accredited programme. This also covers safe sleep.
- Early years with some focus on Dads and Aboriginals
- Peer nutrition programme. This programme focuses on cooking for cultures and has developed a DVD
- Family health programme App
- Watch Wait and Wonder
- Behaviour and relational services
- Teen parenting programmes
- Drug and alcohol programme; breaking the cycle appears to be effective

Additional to the HBHC programme there are some specialist services. One of the specialist services offered by Toronto Public Health nurses is a targeted programme for homeless pregnant women. The number of visits and activity are determined by need. They rely on cell phone contact due to client mobility and meet in venues that are varied but often are food venues. They will attend appointments with them and will often be at the birth to support them. The focus of the team is for a healthy pregnancy to give the baby and the mother the best possible health outcomes. Due to the multiple risk factors approximately 85% of the babies are removed from their mother at birth.

Toronto Sick Children's Hospital

Other additional services that focus on the infant caregiver relationship were explored by Jean Wittenberg from the Department of Psychiatry at Toronto Sick Kids hospital.

Jean has been working in an integrated services programme. This was developed in response to the high waiting list for child psychiatric services. The programme works with other health and social professionals to have better coordination and improved knowledge enhancing capacity to community paediatricians and mental health services. This may be for children experiencing complex medical or mental health issues.

As well as consultation for children impacted by complex medical interventions (regulation issues, PTSD, anxiety) Jean is working on training staff to minimize trauma from interventions e.g. some staff only perform painful procedures, talking with the child about procedures, comfort strategies, working with parents to calm the child. They are developing protocol of identifying stress in the child and parents and giving the parents the capacity to console their child. They are also teaching staff to pay attention to the situation. They are currently undertaking research on this.

Baby love

Jean has developed the "Baby Love" parenting programme. It is a preventative intervention for up to 15 month olds. It aims to increase maternal sensitivity and reflective capacity. It has been designed to be cross cultural and adaptable to community belief systems. The focus is on attachment and development through 12 week group sessions (6-8 per group with 2 facilitators), individual sessions or shortened 6 week programme. Each session is approximately 2 hours long. The topics include; mindful meditation, attachment, impact of anxiety and depression, reflective functioning, watching baby, active learning exercises. Parents reflective capacity appears to be critical for change, with

parents able to step back and observe what is effective. They are looking at Baby Love with NNU babies, long term admissions and PND clients. Training is 2 days face to face, 2 case review and supervision. They are currently exploring a train-the-trainer approach.

Enhancing outcomes for Aboriginal communities

This is a programme developed for vulnerable children. It uses a sharing circle starting with a smoke ceremony and provides the opportunity for all to those present to explore the issues over a half day. Those attending include family and others who the family select (e.g. nurse, teacher). A care plan is made at the end of the half day. It increases the expertise and services in reserves rather than in town.

Service Models in Ireland

Ireland is struggling with significant socio economic factors with increases in house prices, limited housing availability and employment with lack of family support an increasing complex issue. With the recent economic changes in Ireland there is now a significant housing crisis with many families homeless without access even to social housing. Many services have limited funding so are struggling with long waiting lists for services. The workforce is currently not able to manage the demands for 0-5 years issues including developmental delays. There are also issues with the limited services they can refer to especially for infant mental health issues with up to a 1 year waiting list.

Mellow Cork Ireland

I visited with a universal service in Mellow Cork Ireland. This gave me the opportunity to observe two well child assessments and talk with the Public Health nurse and the Clinical manager. The Public Health nurses work with clients for the full life span. Postnatal home visiting is offered to all families and starts when the baby is 4 days old. The family also has an assessment by the GP at 2 and 6 weeks. Nurses undertake an assessment at 3-4 weeks, 3 months, 7-9 months 2 years then 3.5 years. Clients are linked to additional internal services for example breastfeeding support groups run by Public health nurses and externally run parenting courses. Referrals can be made directly to external services for example to physio, speech language, infant mental health, dietitian, or dental health. They also have Health worker support.

Mental Health Services in Mellow

If a Public health nurse identifies a maternal mental health concern e.g. PND they meet with a mental health nurse to assess the level of concern. The Maternal mental health team is involved quickly and either do a home visit or arrange for inpatient care. The assessment and interventions also includes the father and other family members. If inpatient care is necessary, they try to keep the mother and baby together. There are currently changes to the services with 2 units joining so the baby may not always be able to be with the mother. Concerns have been raised about the impact of

this separation on attachment. They encourage the baby to be brought in to the therapeutic inpatient or outpatient sessions and may speak for the baby to enhance the relationship. Links are made by the infant mental health specialists with the hospital so there can be a mother baby relationship focus.

The mental health team work with both parents at home and have a social worker home visiting to explore support needs. Collaboration is a strong focus including other services as necessary to support the family. The aim is a wrap-around service. They are mindful of the importance to enhance capacity and relationship to prevent child protection services being involved as much as possible but at times they need to be involved. There are strong links between health professionals including between the nurses and infant mental health specialists. They use Selma Freyberg interventions using observations and being with the mother. They also use her book Ghosts In The Nursery for guiding practice discussions.

YoungBallymun Dublin Ireland

Youngballymun is an area-based Prevention and Early Intervention strategy working to improve outcomes in education, health and mental health for all children, young people and families in Ballymun. They work with wider partners at national level and in other communities challenged by poverty and disadvantage. The project is funded from philanthropic funding for high deprivation community with intergenerational poverty. It was set up in an area where old high rise social housing was pulled down and replaced by low rise communities. YoungBallymun was started as a government initiative in 3 economicly vulnerable communities in the country where they wanted to establish prevention and early intervention programmes. The service was designed by the area who wanted more socio-economic recognition and maternal mental health integrated into services. The service is now seeing homeless parents in a higher number than previously. It is offered to all within the community and has a 70% reach.

I attended an introductory session with a mother of a 6 week baby. The YoungBallymun programme was explored with the client and an introduction to the system was offered. She was given a calendar for development and a leaflet called Babies brain is developing. An assessment was undertaken including some exploring questions such as one word to describe yourself as a child, what is the age you would expect her to walk, be toilet trained, what makes her cry, what helps her

settle. The programme was developed by Marte Meo. During visits they see a Public health nurse who does a physical assessment, a Public Health nurse for anticipatory guidance, developmental assessment, then filming in interaction for 5 mins focusing on social and emotional development. Following this filming they see a therapist (speech/language or psychotherapist) to explore issues, maternal well-being and set a plan for the next 3 months. All the films are sent to be reviewed in Valencia, Spain. At the next visit the same is repeated and in the final session the video is reviewed by the staff member and the parent giving parents guidance and self-reflection opportunities. At 15 months a strange situation is undertaken rather than a developmental assessment (scored by Valencia). The videos are given to the parents at the end of their programme. They have undertaken research which has shown a higher rate of secure attachment than in a similar population without the intervention programme. Findings also showed significant differences in parental stress and competence. They are finding they are picking up difficulties and self-regulation problems earlier.

Some of the team also carry a caseload of about 6-7 cases from referrals for children with possible insecure attachment, including those identified at 15 months during the strange situation. They offer a home visiting service with 2 weekly visits, part of this is videoing the caregiver infant relationship. The helper listens to the mother and talks with her about the baby to help her be more attuned to the baby and understand the world of the baby.

Training is 6 days theory then mentored for 2 years. They have study groups and work shop sessions on a regular basis. They have monthly supervision held with Valencia from Spain

Mellow/Cork (Catherine McGuire)

A new project is being set up in Cork similar to YoungBallymun with a focus on school readiness. Catherine McGuire an Infant Mental Health specialist will be instrumental in developing this service. They are planning to have a combined team with a broad understanding of infant mental health and a broad child health knowledge base. They want to focus on 0-18 year olds socio-emotional development. They will be focusing on how to promote emotional regulation and having red flags for early identification of issues. They are exploring how this can be done with a team approach. Currently Public health nurses undertake developmental assessments. They are exploring how to improve knowledge of the red flags, development of team competency and referral process.

Catherine is currently exploring sourcing government funding for a developmental and relational wheel developed by Debbie Weatherstones. This wheel is to be distributed by Public Health nurses to families to be placed on the fridge. There are several wheels, baby stages, toddler, father.

Service Models in London England

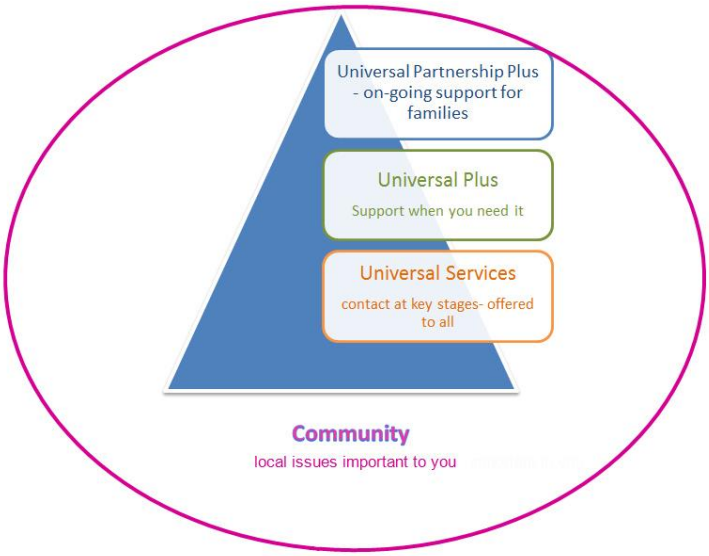
The Healthy Child Programme (HCP) 0-5 years is an early intervention and prevention programme. It is offered universally to every family with children of appropriate age, to support the healthy development of children and of parenting. It is founded on the principle of progressive universalism, to ensure that all children are given the opportunity to receive care appropriate to their needs. It is delivered at 4 levels - community, universal, universal plus and universal partnership plus, with Safeguarding a core part of each level. Although Health Visitors lead on the delivery of the 0-5 HCP, it is delivered in partnership with a wide range of professionals, i.e. midwives, GPs and staff in Early Years and Social Care (Bedford Borough Council, 2016)

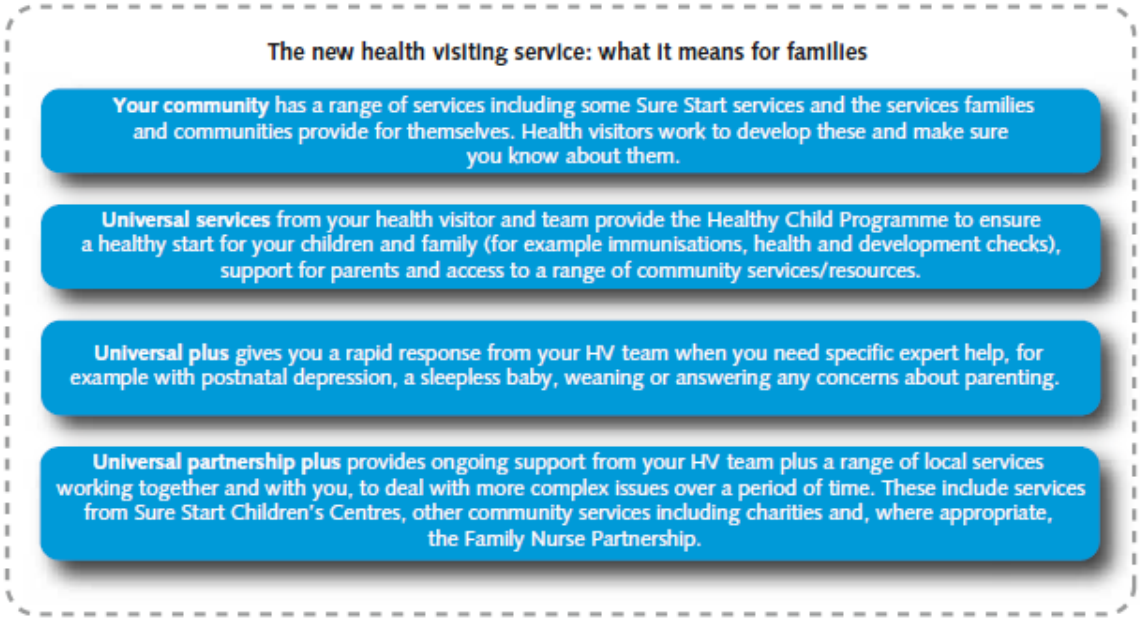
The Healthy Child Programme and targeted work through children's centres saw the importance of ensuring effective action is taken to identify and address the needs of vulnerable expectant parents and those with young children. A focus was also on ensuring that midwives and health visitors are resourced and trained to provide a level of support that promotes sensitively responsive, loving, nurturing parenting and communication between parents and children to promote sound social and emotional development.

Services spoke of the 3 tire system of Universal, Universal Plus, Universal Partnership Plus and Children's centers that are occurring in some areas. These are;

- Universal: health visiting teams lead delivery of the Healthy Child Programme. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

- Children's centres: Children's centres are in high needs areas. They prioritise high quality outreach and family support to work with the most vulnerable families suffering multiple risk factors, who may need long-term support to help them benefit from other services.





(Department of Health, 2011).

Several of the documents I was guided to focused on the importance of Practitioners having a good understanding of attachment as it relates to the child's key relationships and their own relationship with the child. Ideally, development of secure attachments would be supported throughout the Healthy Child Programme at a universal level and used as a determinant for the need for additional services such as Universal Plus. When significant risk is identified, targeted preventive interventions are implemented, through the provision of well-resourced specialist NHS (or a high quality alternative). Perinatal Parent Infant Mental Health Service support as well as access to regular and skilled supervision are encouraged by the programme.

There is an expectation that Health visitors should be trained in the use of motivational interviewing and be skilled at evaluating the interaction between the mother and baby. It was recommended in literature that a review of health visitor training include assessment of the interaction between the caregiver and baby, and to assess how families support the development of emotional health in their babies and toddlers. Also there have been recommendations that the Healthy Child Programme needs further development of detailed clinical guidance for earlier ages (e.g. first year of life). This development would include expanding assessment of attachment and specialist pathways, parental and infant mental health, drug and alcohol, domestic abuse, relationships, and links to 'Pregnancy, Birth and Beyond' (Wave Trust, 2013)

The NHS saw the importance of an intensive home visiting programme for assessed vulnerable clients where Health visitors offer a series of intensive home visits by an appropriately trained nurse. The trained nurse would visit families a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes). Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to: maternal sensitivity (how sensitive the mother is to her child's needs), the mother–child relationship, home learning (including speech, language and communication skills), parenting skills and practice. The nurse should, where possible, focus on developing the father–child relationship as part of an approach that involves the whole family. They saw a need for Health visitors or midwives to regularly check the parents' level of involvement in the intensive home visiting programme and if necessary offer them a break and continue to communicate with them on a regular basis aiming to reengage them in the programme (NHS, 2012)

Health Visitor Visit

An afternoon observing a Health Visitor in clinical practice in a high needs community was made available. During this time 3 baby visits were observed. Also there was an opportunity to talk to the Health Visitor which provided some insight into practice. Two of the visits were client led visits to have their babies assessed and to ask some questions about parenting. The other visit was with a mother where there were concerns about family violence, but as there were multiple family members present at the previous home visit the nurse could not screen for family violence, so invited her to clinic. As the clinics are un-booked drop in clinics, the client may not see their regular Health Visitor unless she specifically asks them to come on the day she is working in the clinic. The nurse spoke of the core visits offered (14 days, 4 weeks, 4 months, 8 months, 2 years) and additional visits as per need. The antenatally and postnatally promotional guide visits (see separate section), Maternal mood assessment, child development and physical assessment were discussed. The nurse explained the new focus on Vitamin D for children up to 5 years and for breastfeeding mothers to 1 year. She also spoke of additional services including lactation support, parenting groups, massage course.

Helping Families Programme

The Centre for parents and Child Support have developed The Helping Families Programme - an innovative parenting intervention developed for multi-stressed families living in complex social circumstances with primary-school-aged children who experience severe and persistent conduct problems. It places the family as the expert in their own situation and is based on Family Partnership. The plan is developed by the parent. Exploration with the parent is the first focus rather than referring to other services immediately. The focus is on mindfulness, taking time to explore and understand not to rush to the planning stage. The key focus is on sustaining change with the parent holding the plan. They are trying to minimize rigidity of the programme and developing multi-pathways. The Programme has been developed, implemented and evaluated through a research collaboration led by the National Academy for Parenting Research (NAPR), UK, and involving the University of Queensland and Griffith University, Australia. Preliminary evaluation has demonstrated very positive results. It has been found those on the programme had a significant reduction of social service engagement. They become accredited in the programme through 8 days training. There is research being undertaken of the programmes use with parents with personality

disorders. Supervision is considered a critical part of the model. I had the opportunity to meet with some health care professionals delivering The Helping Families Programme. They were very positive about the health and psychosocial outcomes they had seen for families. One of the areas had developed a video of parents talking about how their relationships with their child had improved and their confidence in parenting had increased.

SOME OF THE OTHER MODELS DISCUSSED BY THOSE VISITED

Video Interaction Guidance (VIG)

VIG is a Relationship-Based Intervention to help improve communication, interaction, promote empathy and wellbeing. Video interaction guidance is an intervention through which a "guider" aims to enhance communication within relationships. It works by engaging clients actively in a process of change towards realising their own hopes for a better future in their relationships with others who are important to them.

The Tavistock 'Under Fives' infant mental health service

The service is for parents and babies or toddlers who are struggling with the common developmental problems. Services are delivered to those who have a concern relating to their baby or young child, whether it is temporary or long standing, major or minor. A variety of talking therapies may be offered.
(http://www.tavistockandportman.nhs.uk/underfivesmentalhealthservice)

Mellow Babies

Mellow Babies programme has undergone a randomised trial with a controlled waiting list. Clinically and statistically significant positive effects on maternal depression and Mother child interaction.

Parents Under Pressure

Parents with drug or alcohol misuse, who have a child under 2 in their care receive a 20 week programme which aims to support family functioning, develop parenting skills and caring relationships with infants.

Minding the Baby

NSPCC delivered an intensive home visiting programme for vulnerable and at risk first time mothers under 25 and their babies. This is delivered by social workers and health staff. Currently it is being evaluated.

Baby steps

Baby steps is a perinatal programme for vulnerable parents to be, which promotes secure attachments and aims to help parents with the transition to parenthood. This transition has since been identified as one of the six high impact areas. Some Health Visitors are delivering these with midwives or Family support workers across the country. It has started to be used in Warwickshire with practitioners seeing the difference it can make to families. Fathers are also engaging http://www.nspcc.org.uk/fighting-for-childhood/our-services/services-for-children-and-families/baby-steps/ (Source https://vivbennett.blog.gov.uk/2014/11/17/infant-mental-health-theresa-bishop/).

PARENTING GROUPS

Empowering Parents, Empowering Communities parenting programme (EPCP) is a community-based programme, training local parents to run parenting groups for high risk parents. It was developed in Southwark under The Centre for Parent and Child Support. The programme has received a national Sure Start award for innovation and user involvement. The model assumes that parents find it less stigmatising and more supportive to attend parenting groups run by local people who are in very similar circumstances to themselves.

Pairs of trained peer facilitators delivered the programme to groups of 7-14 parents over the course of eight weekly, two hour sessions. The parenting groups aim to support high risk parents to improve parent-child relationships, reduce behavioural problems, and increase participants' confidence in their parenting abilities. The course is delivered according to a structured manual. It uses attachment, social learning, structural, relational, and cognitive behavioural theories and methods, for the treatment of disruptive behaviour in children. Intervention sessions involved sharing of information, group discussion, demonstration, role play, reflection, and planning/review of homework tasks (Day, Michelson, Thomson, Penney, & Draper, 2012).

Clients on the programmes are self-referred or referred through social services or their Health Visitor. Some have their babies with them, while others have child care provided. The programme offers accreditation through Open Polytechnic for the attendees. This is achieved through attendance and assessment of a workbook completed after each session. The participants can achieve level 1 or 2. Level 2 requires demonstration of reflective capacity and emotional intelligence by demonstrating links of relationship and interactions to outcomes. The workbooks are marked by the facilitators. The courses are partly funded by the NHS and partly by the local authority. Facilitators are paid and mostly run 1-2 courses a term.

I had the opportunity to attend an Empowering Parents, Empowering Communities parenting programme session and a parenting group facilitator supervision session. During this time I had the opportunity to talk with 2 parenting group facilitators, the coordinator of the groups and writers for the group programme. The parenting session I observed, had a strong focus on building parenting capacity and the discussion was facilitated skillfully by the male and female facilitators. The course was a day course and attended by both mothers and fathers.

To become a Facilitator they need to have attended a core parenting course as a participant, have achieved level 2, then they are interviewed for the position, undertaken 60 hours of training and complete a portfolio. Supervision is a strong component of the support for the facilitator. Supervision is offered every second session with the supervisor attending half of the parenting session and then having supervision directly after the session. The group are aware of this and due to the regularity of the supervisor attending appeared comfortable with her presence in the group I attended.

I was also given 2 randomized control trial research articles that demonstrate the positive outcomes of these peer to peer programmes both articles explore the positive outcomes from the perspective of the participants and the benefits for the peer facilitators. The findings of the research show positive parenting strategies used more commonly, increased parent self-esteem improved child behaviour (Day, Michelson, Thomson, Penney, & Draper, 2012, Thomson, Michelson, & Day, 2014).

Another course developed by Caroline Penny, Crispin Day and Jillian Jagessor is the Baby and Me course. Parents are met prior to the course to explore their strengths and difficulties. The fathers are asked to attend one session about week 5/6. There is a strong focus of adjustment to parenting.

Service Recommendations

The service provision to children needs to reflect new evidence that has emerged about neurological development and the importance of forming a strong child-parent attachment in the first years of life. All levels of service provision need to have an evidence base to inform practice. It is recommended that services review their guiding service documents for currency with attachment and neuro science research. It is also recommended that services review the level of relational (infant/caregiver) focus that occurs in client interactions

Programmes have a strong focus on the infant attachment relationship

Services for vulnerable whanau need to have a focus on the infant caregiver relationship that is informed by robust neuroscience, development and attachment theory. The time together with clients needs to be used to assess the relationship, focus on what the caregiver and support worker notice about the baby and the relationship and explore strategies and support for the parent and child. For vulnerable whanau this would include having a focus on exploring parents history of adverse childhood experiences and the impact on their parenting. This includes programmes that are one to one, for groups and any written or visual resources.

Explore opportunities to develop intensive home visiting programmes within Service Delivery Models

It is recommended that opportunities for intensive home visiting services be explored nationally. No one programme is going to suit all parents' needs, or target all the potential outcomes with a single stand-alone programme. This requires funders and providers to determine the needs of the community and to match these with the appropriate programmes (Family Commission, 2014). Services who work with communities with vulnerable populations ideally will explore the current services offered in their community, identify gaps in services for vulnerable whanau and develop services that are evidence based with a caregiver child relational focus. This includes programmes that are one to one, group and any written or visual resources. These programmes need to be inclusive of both parents and whanau who support the caregiving.

Internationally universal programmes tend to have a specific focus on offering intensive services for vulnerable clients. It is recommended that New Zealand universal services explore opportunities for

development of an intensive programme within their service or to work in partnership with intensive home visiting services in their community while also embedding a more robust focus on infant mental health secure attachment into their programmes. By having a second and/or third level specialist service this would offer vulnerable clients a planned intensive evidence based programme. The levels of care provided would ideally offer clients a range of services, the ability to transition between levels as per need and additional support from a wide variety of additional services as necessary. An evidenced based entry criterion /assessment would need to be explored.

Explore skill mix within teams and community collaboration.

Skill mix will depend on the community and purpose of programmes but there may be areas of workforce capacity within services that could be enhanced in relation to infant mental health with professionals/paraprofessionals/volunteers level of knowledge and skills. Exploring options of different service delivery e.g. professional, paraprofessional, volunteers, groups, peer support parenting may impact on the skill mix within the team. An example of this is the CEED programme which consists of Social welfare workers, infant mental health and public health nurses and parent partners (parents who have had a history of adversity and are more confident in parenting), and several services working collaboratively. To increase confidence and capacity to work with whanau in relation to infant mental health may require services to consult externally with infant mental health services or to employ staff with these speciality skills.

Develop Maternal and infant mental health services that are culturally appropriate for Maori whanau

DHBs and other services need to provide a range of options for Māori-responsive perinatal and infant mental health care, from which individuals can choose. Greater collaboration among Māori-responsive services will provide a real opportunity to improve integrated care and health outcomes for Māori. Stronger links with specialist mental health services are needed to strengthen effective care that is responsive to Māori mothers with mental health and AOD needs and infant mental health (Tupara & Ihimaera as cited in MOH, 2012)

SERVICE RECOMMENDATIONS

INCREASE THE USE OF TECHNOLOGY

Some services are using facebook as a method of communication with individual clients which appears to be an effective method for client interaction. Other potential areas to explore are skype interactions and the use of cell phones to share health promotion messages. It is also recommended to explore the use of videoing as a method of client self reflection.

Infant mental health assessments

Sensitive responsiveness in parent–infant interaction is a significant predictor of infant attachment security, but most frontline practitioners do not currently have the tools to identify 'high-risk' dyads. There is an urgent need for a brief screening tool that can be used by practitioners to screen new parents (Svanberga, Barlow & Tigbe, 2012). There are many assessment tools with the questionnaire being the most common, but in order to assess what really matters to the child it is necessary to observe parenting in action as this is what the child experiences. Integrating an assessment tool into the child/family assessment can provide the missing piece to the assessment, improving planning, progress assessment, enhancing reflective capacity for the parent and health care worker and inform quality improvement (Gordon & Comfort, 2013). Wave Trust (2013) in the United Kingdom recommend this is ideally by using a short video clip, which can also be used in reflective video feedback discussions with the parents.

Infant mental health assessments were commonly spoken about by the services visited. Some services used an assessment as entry criteria to the programme and others used them as a guide to service delivery and care planning with regular assessments throughout the engagement process. All the countries spoke about the need for training in the assessment model chosen by the service.

Each country used varying assessments some of which are described below and others in other sections of this report (i.e. NCAST in the education section). In the United states many services used specific infant attachment tools for example the NCAST, Zero to three assessment tools, others talked about the use of other tools for assessment for example ACEs to assess risk (see section on ACEs)

Some examples of possible assessment tools suggested by Wave Trust (2013) and Gordon and Comfort (2013) include;

- Zero to Three assessment tools. Many of the infant mental health specialists spoke of Zero to Three's DC O-3 assessment tools. In 1994, ZERO TO THREE published its ground breaking manual, *DC:0–3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. The first developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers, this critically important guide quickly became an indispensable resource for mental health clinicians, counsellors,

physicians, early interventionists, educators, and researchers, and established ZERO TO THREE as a leading authority in the field of infant mental health.

- The Brazelton Institute is a training institute for clinicians and researchers, which provides training on the Neonatal Behavioral Assessment Scale (NBAS) Used in hundreds of research studies across the globe, the NBAS is the most comprehensive neurobehavioral assessment available. Pioneered and developed by Brazelton, it has transformed forever that world's understanding of infant behavior. The NBO is a clinical relationship-building tool, designed for pediatricians, nurses, infant mental health specialists, early intervention providers, home visitors and other allied health professionals, to help parents understand their baby's language. The NBAS is is a neuro-behavioural assessment of the newborn, designed to document the newborn's contribution to the parent-infant system, the competencies and individual differences of the newborn, as well as any difficulties. The main feature of the NBAS is that it is an interactive assessment, which gives a clear profile of the baby's behaviour, and how it must feel to parent the infant.

- Neonatal Behavioural Observation (NBO) scales during the first month of the baby's life. This establishes the baby's sensitivity to external stimulation and helps the parents to understand the baby's signals and cues. The system was designed to give parents the confidence to read and understand their baby's cues and to promote positive interactions between parents and their infants from the very beginning. The NBO is a relationship-building tool between practitioner and parent, that supports the developing parent-infant relationship, and provides an introduction to their infant's behaviour.

- Coding Interactive Behaviour (CIB) is a coding system providing a global measure that assesses parent, child and dyadic affective states and interactive styles for children aged 2–36 months. Using pre-recorded videotaped material, the CIB is broken down into 43 codes that are rated on five-point scales. There are 21 parent codes, 16 child codes and five dyadic codes. Subscales can be calculated for parental sensitivity, intrusiveness and limit-setting, child involvement, withdrawal and compliance, and dyadic reciprocity and negative state. See www.thecodingconsortium.com/cib.html

- At 3-4 months an evaluation of the quality of the parent-infant interaction in terms of parental sensitive responsiveness using tools like the Parent-Infant Interaction Observation Scale (a 13 item scale used to guide the assessment and evaluation of a video of a brief

parent-infant interaction). Currently the planned web-based training for this scale is not available although the group based training now is.

- 'Keys to Interactive Parenting Scale'
- 'CARE-Index'. The CARE-Index is the simplest and most versatile of the DMM measures. It assesses mother-infant interaction from birth to about two years of age based on a short, videotaped play interaction of 3-5 minutes. Once the coder is trained, coding of an interaction takes about 15-20 minutes. The measure assesses mothers on three scales: sensitivity, control and unresponsiveness. There are also four scales for infants: cooperativeness, compulsivity, difficultness, and passivity (http://familyrelationsinstitute.org/include/care_index.htm). http://tinyurl.com/nu9fapk.
- The Parent–Infant Interaction Observation Scale (PIIOS) in screening parent–infant interaction at 2–7 months. In addition to its simplicity of use, one of the strengths of this tool is that it has been specifically designed for use as part of the Healthy Child Programme. The three levels of interactional risk that can be screened using the PIIOS (no concern; some concern; significant concern) correspond to the three levels of service provision identified in the Health Visitor Implementation Plan – Universal; Universal Plus and Universal Partnership (Department of Health, 2011) and the PIIOS should therefore prove useful in the clinical practice of health visitors
- Emotional Availability Scales provide a video-based method of assessing interaction for the emotional availability of the parent to child and child to parent. It is a global measure of overall interactional style in each partner, and requires clinical judgment and an awareness of contextual factors. See http://tinyurl.com/ovvedjx.
- Indicator of Parent-Child Interaction (IPCI) assesses interactions of parents and children aged 2–42 months during 10-minute observation of four prescribed routine activities. Ratings include eight parent behaviours and six child behaviours. See http://tinyurl.com/py68qyy.
- Keys to Interactive Parenting Scale (KIPS) assesses 12 research-based parenting behaviours, rated on five-point scales during 15-minute observations of parent–child play interaction. Videotaped observations are recommended. KIPS has been validated with parents/care-

givers of children aged 2–71 months. Training and certification are offered online and re-certification is required on an annual basis to ensure reliable scoring. KIPS produces clinically useful information that can be fed back to the care-giver and documents quality of parenting outcomes. See http://comfortconsults.com.

- NCAST-PCI Teaching Scale measures parent–child interaction with children from birth to 36 months during a 1–6-minute observation of a parent teaching a pre-selected age-appropriate activity. The 73 binary items yield four parent subscales—sensitivity to cues, response to distress, social-emotional growth fostering and cognitive growth fostering—along with two child subscales—clarity of cues and responsiveness to care-giver. For those interested, there is also an NCAST-PCI Feeding Scale. See http://tinyurl.com/qx7a9np.
- Parent–Infant Relational Assessment Tool (PIRAT) focuses on affect and behaviours of parents and infants from birth to 2 years, observed during videotaped interactions. It includes ratings of optimal and risk behaviours. See http://tinyurl.com/kkmtnzw.
- Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) uses a 10-minute video to rate 29 parenting behaviours with children aged 10–47 months on four domains: affection, responsiveness, encouragement and teaching.See http://tinyurl.com/nhtqhqq.
- An assessment of attachment behaviour at age 12-15 months using the
    - TAS-45 measure
    - Ages and Stages Questionnaire (ASQ),
    - The Maternal Attitude Scale
    - The Mother's Object Relations Scale (MORS). .

It is recommended that Infant Mental Health Assessment tools have a greater implementation into health care practice

Professionals such as health visitors should be trained to evaluate the interaction between the mother and baby and to have this as a part of their assessment process. In recent years there has

been a greater interest in assessing and documenting parenting outcomes. A number of practical, reliable and valid tools for parenting assessment are available. Observational parenting assessment should be considered for best practice. When choosing a tool, practitioners should consider the goals of the programme and cultures of the families served. Using a validated parenting assessment, practitioners can tailor services to individual families, reinforce parents' progress and build their confidence (Gordon & Comfort, 2013).

It is recommended to explore assessment tools for infant caregiver interactions. For example, including an assessment at 3-4 months, using the Parent Infant Interaction Observation Scale, The Keys to Interactive Parenting Scale (KIPS), the CARE-Index or similar. Also it is recommended to explore the introduction of a reliable and valid assessment of attachment type at age 12 – 14 months. The gold standard of attachment assessment is The Strange Situation which unfortunately is too cumbersome and complex to be used in routine practice. An acceptable proxy measure is the TAS-45 measure or a similar model, which could be adapted for routine use (Wave Trust, 2015).

Research on outcomes of Home Visiting Programmes.

Research was considered critical by those visited for the Margaret May Blackwell Study Fellowship. Services discussed the need for robust research in particular to meet the needs of vulnerable whanau. They also discussed the importance of undertaking research to analyze the effectiveness of programmes. Research in relation to enhancing infant caregiver relationship and attachment is rapidly developing and this needs to be taken into account when reflecting on service provision and the evidence that supports practice. This includes the rapid advances in neuro-development research with direct links to attachment relationships and in particular the impacts of adverse childhood experiences on short and long term outcomes (See previous section on Adverse Childhood experiences).

A review by The Families Commission (2014) found there are few well designed studies examining the effectiveness or impact of New Zealand parenting programmes or that used comparison group designs to assess impact. The lack of research is particularly relevant for vulnerable whanau inclusive of Maori and Pacific who are over represented in vulnerable populations. This knowledge gap is significant and needs addressing.

In each country visited there appears to be a strong focus of research in relation to intervention programmes and infant mental health education. This includes the use of research to inform programme changes. They discussed the importance of offering programmes that are based on evidence and considered the education of the health care staff to be critical to the health outcomes.

"It has been found that many program evaluations focus more generally on exploring the efficacy of home visiting as a service strategy (i.e. outcome-focused) and less on understanding specific program components that are essential for effective programs. In other instances the best practice elements reflect a consensus or conventional wisdom within the field of aspects of program quality (e.g. program theory, use of assessment and screening tools), but have not necessarily been directly tested in research" (Korfmacher, Laszewski, Sparr & Hammel, 2012, p.4). Christopher Watson Coordinator for CEED discussed how client research has shown several services coming into homes and clients feeling "done too". It also showed a lack of coordination and priorities between services which the clients felt was ineffective.

RESEARCH ON OUTCOMES OF HOME VISITING PROGRAMMES.

In the United States the Government have directed that MIECHV funding will only be allocated for home visiting programmes that are evidence based. They have selected seven programmes that meet this requirement. The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a legislatively mandated evaluation of the MIECHV program. MIHOPE has a number of aims namely to assess the effects of the programs on child and parent outcomes, how the program models operate in their context, strategies that might lead to greater impacts on families, potential to affect the health care system and to reduce costs.

The Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) review to conduct a thorough and transparent review of the home visiting research literature. HomVEE provides an assessment of the evidence of effectiveness for each home visiting program models that target families with pregnant women and children from birth to kindergarten entry (that is, up through age 5). The HomVEE project assesses the quality of the research evidence this information is clearly described on their website.

A Self-Assessment Tool for States has been developed by ZERO TO THREE, it is called the ZERO TO THREE Home Visiting Community Planning Tool. It has been developed to help states define the home visiting system; assess the home visiting system's capacity; and prioritize areas for improvement. The tool is useful for states preparing for home visiting grant application process, and can be used for ongoing assessment and continuous quality improvement. Zero to three Key Components of a Successful Early Childhood Home Visitation System is a Self-Assessment Tool it helps assess how well systems addresses eight core components of a home visitation system.

Jon Korfmacher from the Erickson Institute has undertaken research of home visiting programmes. Jon's research aimed to gain an understanding of the interactions that happen in a home visit between the health worker and caregiver. In one study they used videoing that identified different practice despite delivering a programme with specific interventions. They found the required programme activities could be detracting from the caregivers priority or the relational interaction. One factor he identified was that some programmes could be "a tick list approach". Jon discussed the comprehensive assessment tool he developed with three others to measure program implementation of best practice elements in home visiting programs. This tool has been named the Home Visiting Program Quality Rating Tool (HVPQRT), It was designed to be a practical, yet multi-dimensional evaluation of a program's capacity to provide high quality home visiting services to

families with infants and toddlers (including the provision of prenatal home visiting). (Korfmacher, Laszewski, Sparr & Hammel, 2012). See useful web sites for a link to this model.

Several of the services visited have undertaken research. Some have done this within their own service provision or have undertaken it organisationally. There has been research undertaken on the two relational models discussed namely the FAN and Family partnership. There has been programme evaluation of the Fussy baby network and the impact of the FAN. The outcomes from pre and post comparisons found a higher engagement rate with services, reduced depression and improved self-efficiency, on the 0-5 Fussy Baby stress level score with mostly reduced stress level. The Family Partnership model has also been extensively researched with positive outcomes from the perspective of the service delivery and parent/child outcomes.

I was given some research outcomes papers during my visit with Jenny Peters a Circle of Security Facilitator in London. Quantitative and qualitative evaluations suggest that the Circle of Security project had strong impacts on providers' mental health, their sense of self-efficacy, and their relationships with the children in their care. Self-ratings of depression decreased significantly sense of self-efficacy significantly improved, decreases in stress and increases in emotion regulation, reflection, observational skills, as well as improved relationships with children (Gray, 2013).

In the book that Nick Wechsler co-authored it acknowledged that the research literature is still quite limited regarding the specific strategies and components of home visiting. Several researchers working in this area have written chapters for the recently published book Home Visitation Programs Preventing violence and promoting healthy early child development. "The chapters in the book summarize and report research on home visiting. They guide the planning, implementation and improvement of home visitation to provide culturally adaptable individualized infancy and early childhood services that address the roots of violence and promote optimal development."(Roggman &Cardia, 2016, p.v)

It is recommended that research is undertaken into service delivery utilising a formal assessment tool. Research is also required into infant caregiver relationships and the integration of this as a focus into service delivery.

Research informed approaches to enhancing child caregiver relationships are necessary. It is considered important to not just look at the programme being delivered but to also address research

for training and support needs. It is to recommend that child health home visiting programmes in New Zealand assess their effectiveness for vulnerable clients especially Maori and Pacific utilize programme assessment tools. It is recommended that training for programmes is researched in relation to their currency and inclusion of infant mental health theory. Research also needs to be undertaken to ensure information shared with parents is based in current infant mental health evidence and neuro science and to explore the relational model used.

Infant Mental Health Competencies

Assessing competency is a continuous process of building knowledge, skills. For a home visiting program, this knowledge and skills pertains to providing families with a range of information and tools, from prenatal and pediatric health care to the establishment of social and community connections. Having well-defined program outcomes and a set of competencies by which these outcomes are based upon and can be evaluated from allows home visitors and their supervisors to identify staff strengths and areas for development (Minnesota Department of Health, 2016). Infant mental health focused competencies were commonly discussed by the services visited.

WAIMH the world association in infant mental health connects infant mental health specialists and professionals working within infant well-being. It has 1000 members 58 Affiliate organisations/countries. They offer a conference ever 1-2 years and publish an infant mental health Journal and consider this is their role in supporting services working in the infant mental health area. WAIMH are planning to develop a more useful website that has links to education and potentially access to conference presentations.

Marie Foley the Affiliate Council Chairperson discussed how there are no international competencies and there is also no plan for WAIMH to develop them. She explored that New Zealand currently does not have infant mental health competencies but if there were relevant ones for the New Zealand context there would be benefits especially with the limited resources available when working with complex clients. With no international competencies New Zealand would need to look at purchasing some international competencies or to develop them internally which is complex for a small country to do and would require extensive collaboration for services.

It could be questioned if producing generic international infant mental health competencies would have a greater or less impact on the outcomes for children over locally developed competencies. During the Study Fellowship competencies were discussed and considered to be beneficial. Some areas did not have competencies, some were in the process of developing them and others had developed their own or were using competencies developed by other organisations.

Minnesota Competencies

In Minneapolis the Department of Health team spoke about their competencies. They spoke of the need to minimize risk to clients from variation in entry qualification and training within each

programme and saw the development of the Minnesota competencies as reducing this risk. They considered reflective practice and reflective supervision on infant mental health as critical to the competencies. They also considered the competencies can be used as the basis to build the training/education for home visitors.

The Home Visiting Core Competencies were drafted by the Practice Matters Workgroup, a subcommittee of the Minnesota Coalition for Targeted Home Visiting. The purpose of the Core Competencies is to identify the theoretical underpinnings and demonstrated abilities of effective home visiting practice. The Core Competencies are not intended to be an exhaustive inventory of all underpinnings and abilities but rather an attempt to identify the essential foundation to assuring effective home visiting services.

The intended use of the Core Competencies include:

1. Program design and implementation
2. Job development tool
3. Self-assessment tool for home visitors and identification of training needs

The expectation is that individual programs will use the Core Competencies and add to them based on the needs of their program model and design.

The Core Competencies were designed using a framework for professional development recently developed by the Minnesota Department of Health. The Family Home Visiting Professional Development Framework document lays out this framework. In later sections, the “colors” (GOLD, PURPLE, GREEN) referred to reference this framework document. These core competencies will help drive work in developing trainings for home visitors which will be funded by United Way in the next year.

The Family Home Visiting Professional Development Framework is:

- Developing Strong Home Visiting Programs: Leadership and Supervision (BLUE)
- Building and Strengthening Relationships with Families, Planning and Conducting Effective Home Visits (GOLD)
- Strengthening Parent / Child Relationships, Positive Parenting, Early Learning and School Readiness (PURPLE)
- Promoting Healthy Family Functioning, Self-Sufficiency, Family Health and Safety (GREEN)

INFANT MENTAL HEALTH COMPETENCIES

Michigan Competencies

In Ireland Catherine Maguire spoke of their interest in developing competencies and their particular interest in the Michigan Competencies. The Michigan Association for Infant Mental Health (MI-AIMH) is an interdisciplinary, professional organization established to promote and support the optimal development of infants, very young children, and families through relationship-focused workforce development and advocacy efforts They have developed competencies which other states/countries can become endorsed in. The competencies are purchased through country infant mental health association. They have 4 levels

Level 1 Basic level

Level 2 Middle level of expertise

Level 3 Specialist (e.g. psychologists)

Level 4 Supervisor.

Each level recognizes the educational experiences, specialized in-service training experiences, and work experiences appropriate for best service outcomes for infants, very young children, and families. Detailed information about the requirements for specialized education, work, in-service training, and reflective supervision/consultation experiences are different at each level.

It is recommended to explore the development or purchase of Core Infant Mental Health Competencies for those working with Whanau

Having well-defined program outcomes and a set of competencies by which these outcomes are based upon and can be evaluated from allows home visitors and their supervisors to identify staff strengths and areas for development (Minnesota Department of Health, 2016).

Professional Development

Services need to consider the value of initial training and ongoing professional development for those working with whanau and in particular vulnerable whanau. This require strategies for building an effective workforce to partner with parents to create positive early childhood experiences. It is not a linier or evenly paced experience and needs to be individualized. It must be acknowledged there will be periods of disorganization as new skills are being mastered transforming learning into executing appropriate care. Home visiting professional development is embedded in intersecting relationships from formal training, self-directed learning, supervision, peer environments and self-reflection. This informs a better understand what they experience with caregivers and children and builds health worker capacity. Training should be characterized by a repeated cycle of exposure to new ideas, opportunities for practicing new strategies and consistent reflection on new practices (Wechsler, as cited in Roggman & Cardia, 2016),

There are considered nine core topics areas for training;

- Child development, parental resilience through change, infant caregiver interaction
- Skillful use of self,
- Stages of helping relationship,
- Parent development (including adolescent parents),
- Parenting in the context of family history, systems, dynamics
- Communication with parents
- Parental problem solving
- Accessing and coordinating community resources
- Professional and personal self-care (Wechsler, as cited in Roggman & Cardia, 2016),

Wave Trust (2013) recommend Health visitors should be trained in the use of Motivational Interviewing for use from first contact onwards. This would help them to re-visit areas of risk outlined during the early pregnancy and discuss these areas of vulnerability with the mother and (if appropriate) her partner.

TRAINING AND ONGOING PROFESSIONAL DEVELOPMENT

Services that I visited were providing support to families with staff who held varied qualifications and skills. This variability can impact on the effectiveness of the programmes, client risk and staff satisfaction. This is particularly significant when working with vulnerable families. There are complexities for services in relation to how to choose education programmes, the cost of the programme and relevance to the cultural context of the country if utilising programmes from overseas. Added to this complexity there are a wide range of early childhood care and infant mental health education programmes internationally available. The level of programme training an ongoing professional development depended on the intervention of the programme, the skills requirement of the staff member/volunteer, access to training and the cost. There appeared to be a strong commitment to including infant mental health into each level of training from pre training/orientation to ongoing professional development. It must be acknowledged that this report does not have the capacity to include all the training opportunities available.

Each country varied in their entry requirement and training expectations. The five countries visited all employed Registered nurses to provide community based service provision but not all programmes employed registered nurses. Some services were solely Registered nurses, some had staff with a wide variety of qualifications, others with unregulated workforces and regulated work forces.

Tracillian Sydney Australia

The Tracillian service employed nurses who had ideally already completed the postgraduate University qualification Child and Family Health. The requirements have changed from needing to hold both this qualification and a Midwifery qualification before employment. Now there is no longer a requirement to be a midwife as well there are less nurses employed with this qualification. If a nurse is employed without the Child and Family Health qualification this is expected to be commenced within their first year of employment. There is a close working relationship between the service and the University offering the Child and Family Health programme. If new graduates are employed they are required to have undertaken a year new graduate programme prior to employment.

Level 2, Level 3 and day stay/outreach service nurses (see section on models of service) are expected to be a Postgraduate child health nurse as well as hold the Child and Family Health

qualification. Each service has different requirements for training which can include mental health training, Lactation Consultant or counselling. They are also trained in NCAST programmes (see below for NCAST) including; keys for care giving (1 day), parent and child 5 days, feeding/teaching scales, beginning rhythms, infant mental health, Seeing is Believing (where clients are filmed in interaction with their child and the film is watched together). Some other training programmes are 1-2-3 magic programme (a behaviour programme), mothering at a distance (programme for parents in prison), motivational interviewing.

Nurses undertake Family Partnership training in a similar model to Plunket with training undertaken with their local area team or as part of the Masters of child and family health training.

Ongoing Professional development is offered on a regular basis this includes internal training and the Department of Health mandatory annual training e.g. CPR, code of conduct. Professional Development hours are considered the nurses responsibility. At the beginning of the year staff are provided with a list of professional development available including a mix of full day courses and short sessions of 0.5 to 1.5 hours. The nurse needs to apply to their manager to attend full day training but not short sessions. They also utilize Infant mental health institute and other external education services for professional development.

An Australian programme offered with a strong focus on infant mental health and attachment theory is the Advanced nursing practice sustaining NSW programme. It is an Accredited 12 month programme that builds on core child and family health and family partnership training. The programme includes infant mental health theory, relevant NCAST courses, MECSH, motivational interviewing. The nurses attend workshops held regularly throughout the year, they connect with each other through the use of smart boards monthly, work through a workbook and present 1 case study.

Some of the specialist assessment and parenting support programmes offered in Sydney were offered to all of the staff, others were specific to the nurses role. Some examples of these are NCAST (promoting maternal mental health),WHO thinking healthy Online manual, international practice development Norway helping nurses change practice, conference school in Aussie, Mothering in prison (a programme based on Matha programme from Minnesota), PINS project developing 8 nursing performance indicators

PROFESSIONAL DEVELOPMENT

TRAINING OFFERED IN THE USA STATES VISITED

From discussions with services it appears most programmes have an education focus on teaching assessment of infant relationships and intervention but this varied between services, some used face to face training and some online course. There was a common theme of the importance of supervision to embed training. For the programmes employing registered nurses most of the nurses have completed a 4 year nursing degree programme. They ideally have completed a public health placement. The level of training then undertaken will depend on the intervention of the programme they work on.

An example of training requirements is Healthy Families America programme where a knowledgeable and well-informed workforce continual professional development are the focus. Healthy Families training for new staff consists of 4 days block and then 12 online modules including safety, development, family violence, substance abuse, relationship issues and promoting mental health. This core training includes trauma-informed practice, key parent-child attachment principles and how to support parents in implementing these, as well as reflective strategies that support parents in feeling competent and empowered to make positive changes in their lives. HFA offers wraparound distance learning training to affiliated sites that includes access to fourteen modules available to staff.

TORONTO CANADA

In Canada registered nurses are the main staff who provide the client care in the home visiting services. They ideally have had some community practice or an intern-ship. There appears to be inconsistent orientation and limited formal training strategy. The nurse managers I spoke to said this has resulted in visits to families being varied. They are trying to establish a community of practice for nurses and to develop competencies. They have undertaken research on what nurses see their education needs common behaviour issues were rated highly.

The services I spoke to have a high utilization of NCAST training programmes and they have been allowed to adapt a one day NCAST programme to be online with additional resources to support this learning. This programme can be utilised individually with families or as a group. They also have the

locally available IMHP programmes which include conferences, training programmes and short presentations (See below)

They utilize online learning as a significant method of sharing information including

- captivate model LMS.
- Machealth as a community of practice platform. This has a resource page, chat room, blog, webinars
- sharepoint for presentation between regions.
- Webinars
- motivational interviewing online module of 2.5 hours. This can be done on own or in a group with a case study at the end.
- NCAST programmes including Keys for caregiving (including an annual recertification)
- IMHP courses (see below)

IRELAND

In Ireland Public Health nurses provide support to families and are trained in public and child health prior to commencing their role.

In relation to their infant mental health training needs they undertake face to face and online courses. Some of these courses include:

- Michigan training,
- Minnasota, CEED on line training
- University Infant Mental Health programme
- Programmes that teach infant observations
- Exploring ACEs and their relevance to practice
- Anna Freud centre training
- ZERO to THREE resources
- Infant mental health training course offered by Catherine Mcguire

PROFESSIONAL DEVELOPMENT

London England

In England there are a variety of supporting education courses available some of the ones talked about by services were CEED online courses including the online course introduction to infant mental health, NCAST, Circle of Security, Family Partnership, Promotional guides.

The institute of Health Visiting Excellence in Practice work closely with their members, the public health workforce and wider community to develop and implement a wide range of policy and projects to educate and empower individuals, effect change and celebrate excellence. They offer extensive online training for health visitors via their website.

Links are also made by some health visitors to a learning site (http://www.chimat.org.uk/pimh) This site provide information to improve decision-making for high quality, cost effective services. Their work supports policy makers, commissioners, managers, regulators, and other health stakeholders working on children's, young people's and maternal health. This site links to other key sites for robust information

Brunel University

I visited Brunel University to talk to Elaine Tabony a Lecturer for the School of Nursing and Health Visiting and other members of the Health Visitor teaching team. I also attended their Practice Teacher (Preceptor) professional development day.

Practice Teachers

Practice teachers are experienced Health Visitors who have undertaken a 60 credit Postgraduate Diploma followed by a 1 year consolidation. Training includes videoing a teaching session, face to face and self-directed learning, writing a reflective assignment and presenting a portfolio. They have their own competencies that guides them in their role. Practice Teacher students have 3 days training and attend 3 professional development days annually with the qualified practice teachers. Practice teachers have a caseload that is ideally reduced so they can support new staff and Health Visitor trainees.

Health Visitor Training

There are 15-20 Universities offering Health Visitor training. The nurses choose which University they will undertake their programme. Cohort size varies between universities. The programme is regulated by the Nursing and Midwifery Council. Nurses undertake a numeracy and literacy test prior to starting the course. Brunel University has recently made several changes to their programme. They have 2 levels both levels do the same core study but those undertaking a Postgraduate Diploma have further academic requirements and implement a change process into the community gaining the higher qualification. About a third of the students carry on to complete their Masters.

The nurses are employed and paid by the NHS throughout the course but are not required to have a caseload until they are qualified. The Course is completed over a year but can be undertaken over 2 years. The 4 themes of the programme are professional perspective in specialty practice, health promotion and public health perspective, evidence based practice and mental health and wellbeing. Promotional guides (see Promotional Guide section) are taught in the home visiting training but not Family Partnership. Family partnership is taught as a separate model in community practice. During the programme the nurses attend 2 days a week teaching and have a minimum of 80 days in practice. They have 15 days in alternative practice e.g. with social workers. Clinical assessments are a self-assessment, a formative Educator assessment and a Summative Practice assessment. They use an online system called Pebble which contains the nurses progress and assessments so the nurse and Practice teacher both have access to them and communicate with each other. Reflective tools are also on held on Pebble. The practice teacher decides when the nurse can practice on their own; usually at 6 months.

The following section will discuss some examples of specific infant mental health training

Fussy Baby Network FAN (Facilitating Attuned Interactions)

The training module used for the FAN is discussed in the earlier section “Fussy Baby Network FAN”

NCAST

NCAST was developed to give professionals, parents and other caregivers the knowledge and skills to provide nurturing environments for young children by developing and disseminating innovative research-based products and training programs. These are now used in many disciplines and settings. NCAST has a strong commitment to research and have undertaken extensive research on their training programmes. NCAST offer different types of training ranging from short self-led training to facilitated training. Some services visited require all their staff to undertake some of the NCAST programmes others encouraged individual staff to take relevant programmes for their roles. Many services internationally are using NCAST including healthy families in the USA, Tracillian in Australia and 2 facilitators are trained to deliver "feeding and teaching scales" in New Zealand. Tracillian staff discussed their use of NCAST resources including the cues for care giving, PCI feeding scale and stated they had significant benefit to practice in particular supporting vulnerable families. This training is considered core training for their staff working with vulnerable families in their Level 2 service. The NCAST resources provide a range of tools for use with caregivers including universal services and for working with vulnerable clients. They appear to be culturally appropriate but this would need to be explored in more detail. The benefit of these resources is the robust research that has informed their development and that supports their effectiveness. The wide variety of resources and training provides a variety of levels of skill development in infant mental health. As this is a commonly used training provider more detail of the programmes offered is included below

Programme offered by NCAST includes:

- Keys to caregiving a video education programme. This programme teaches participants about baby cues e.g. of engagement and disengagement, babies different states, settling a fussy baby. This programme is considered a first level programme and ideal for all health workers to gain a core understanding
- Promoting first relationships is a two-day training which gives professionals the knowledge, tools, and strategies in relation to infant mental health. The Promoting First Relationships

program integrates theory, practice and intervention. Trainers use various learning approaches including case studies, role-playing, and reflective dialogue. These approaches allow participants to apply the framework directly to issues they face in their environment whether in high-risk, special needs, child-care, or other early childhood fields.

- Promoting first relationships in paediatric primary care is a framework that operationalizes attachment and child development theory into applied practice. It helps health professionals understand how to promote and support stable and secure early parent-child relationships in everyday visits. It is a DVD and manual curriculum that uses videos and case studies to support learning. It also provides well-child check handouts for each visit (newborn - three years old). It is aimed for Pediatricians, Family Physicians, Pediatric and Family Nurse Practitioners, Care Managers
- Promoting first relationships is a research based antenatal programme used for high risk pregnant women promoting maternal mental health during pregnancy. It focuses on assessment (e.g. history, parenting experiences as a child) and interventions building on knowledge and capacity. Health worker can purchase the book and undertake the self-directed training
- Parent-Child Interaction (PCI) feeding scale and teaching scale training are 2 separate programmes which can be completed individually or together. It is taught over 6 days using videos to support learning. The training is based on the Barnard model.
    - The feeding scale looks at the dyad, the dance between caregiver and baby. The participants learn observation of the infant and caregiver relationship. It includes watching the feed from the beginning to the end of the feed then they code the feed. Feedback is provided to the parent on what is noticed. This is a focused observation that occurs at any stage between birth and 1 year old.
    - The teaching scale ask the caregiver to teach their baby something. It assesses mainly verbal interaction as well as cognitive. It is based on research that shows the importance of language.
- Sleep module which looks at sleep rhythms. This includes education for nurses/health workers and sleep leaflets/sleep record for parents.
- Baby cue cards and video. This involves practicing watching a baby on a video to observe what the baby is doing and learn how to read cues. There is also a set of cue cards with

photos of babies in different states to support interpreting cues. These activities are useful for staff and facilitate learning for parents. Handout are available on line

- Your baby and you Attachment DVD is a DVD for professionals showing how attachment develops in the first year of life and how this important process of building a secure attachment is very much the same across families
- 10 week Parent intervention programme. The programme teaches the use of simple filming for 10 mins. They take the film away to detect moments of strength/delight. They use the tape to talk with the parent about attachment with 6-8 stops where social and emotion needs are met. Then they look at hard moments with the parent stopping the tape and asking questions e.g. “Im wondering what you are feeling at that/the moment” “I wonder what Joey was feeling at the moment”. Parent feedback of this approach has been positive with stated benefits of watching their own baby and their interactions.
- Personal Environment Assessments are useful research based tools which allow systematic assessment of the family's environment. The PEA's provide a unique set of "windows" for assessing the family in particular vulnerable families and for developing strategies for intervention. Information from these tools helps in assisting families with challenges they might be facing, the components of their supportive network and their utilization of community resources The PEA's include the Difficult Life Circumstances, Community Life Skills Scale and the Network Survey and are excellent as pre and post-treatment measures in research and practice.

Infant Mental Health Promotion (IMHP)

IMHP is a face to face and web based infant metal health education service that has two core roles Professional Education and Advocacy. It is based in Toronto and works closely with Sick Kids Hospital. It was started in 1989 by the Department of Psychiatry due to demand for infant mental health knowledge. Membership costs for Agencies is Canadian $250 or individual $75. Agency can have 5 users then they can disseminate information to staff. They have internally created modules using the online package creator Articulate. Training ranges from short web links, conferences, grand rounds, guest presentations to specific training packages. They have also developed Posters for use around the hospital to have the childs voice more apparent and in the mind of parents and

caregivers e.g. “be my voice”, “I like you watching me……..” Advocacy and the development of best practice guidelines are other focuses of the service

Their programmes include

- One day training providing core knowledge on infant mental health. It is completed online and consists of two parts taking approximately three hours each. It was described as being ideal for those taking parenting groups and health workers. The costs are Canadian $20 per person or $100 for an agency.
- A 15 part web based training. This training uses webcast of slides/presenter. Each topic is presented by an expert in the field. The presenters appear to be well respected in their field. After completing each module there is a short 5 question quiz/knowledge test. Participants can attend presentations on site, via web link when it is occurring (providing an opportunity to pose questions) or complete the modules in their own time. A team may like to join together for the session then have a group reflection on the session at completion. The Fee is $2000 for an agency, this is an annual licence fee and shared amongst staff members. Each person is the registered as a guest. The total hours are 30 (approx. 2 hours per module). It is suitable for those with a beginning level of attachment knowledge. The main participants are Public health practitioner’s child protection, early childhood educators, Home Visitors and Doctors. There is a pre and post training knowledge survey. Certificate of participation is provided on completion of the modules and all quizzes. In 2015 there were 2,000 undertaking the programme. They can start at any time during the year and have a licence to undertake the modules for 2 years.
- Monthly Rounds - These are 1-2 hour presentations. Generally, they are a presentation from a community partner about service or topic of interest. They are free for members and for public. They are archived for a year. A log in is required.
- Video for health worker to use with the parents. They present 3 topics attachment, regulation of emotions, toddler based. The cost is Canadian $200 for the kit which includes video, guides for parents and worker. They focus on ending the cycle of hurt-intergeneration helping parents understand what to do to help their experience of being parented not impact on their parenting.
- Five free newly developed Modules. These modules have been developed for those working with child protection concerns and vulnerable high risk families. The first 3 modules are

generic on infant trauma, infant mental health and creating and nurturing parent infant relationships. The last 2 are related more closely to Child protection tasks and relevant to the local area. Currently the modules are in hard and soft copy, looking at going on line as articulate packages. These modules include Australian assessment tool from Victoria www.dhs.vic.gov.au/everychildeverychance

- Comfort, play and teach is a free programme aimed at parents, or health professionals/early child care workers to use with parents. It looks at ages and stages focusing on milestones for particular ages. Each stage is broken down to comfort, play and teach. There are tip sheets with idea then comfort, play, teach and games and activities Including talking and reading to your baby. This programme provides interim support for families with a vulnerable child prior to a referral to a child protection, developmental or support service or while waiting for action on a referral. It can be used if a parent has a concern or for parents with limited knowledge of stages of development. The programme gives day to day strategies to enable relationship and development. The plan is written from the child's point of view. It uses the waiting time for action on a referral to improve outcome and reduce risk. There is a blank template online with the child age entered then information related to areas for development is provided including communication, socioeconomic, gross and fine motor. It uses developmental assessment tools and observation to inform plan. The Circle of security principles are integrated into the modules. It is free for members to download, no training required. They are currently undertaking research in this programme to compare and look at outcomes.

Baby in mind

Dr Maree Foley spoke about "Baby in mind" a free online course aimed at anyone who has an interest in promoting the well-being of their own baby, or the parents and babies they work with. There is no need for any prior knowledge of infant or child development, just a desire to learn about parents and babies, and the way that early interaction shapes later development. The course is based on the latest research in the field and introduces the key concepts relating to infant psychology and attachment.

PROFESSIONAL DEVELOPMENT

MINNESOTA 2 YEAR PROGRAMME

At Minnesota University I met with Elizabeth Carlson who runs a 2 year infant mental health programme for USA and international students from a wide variety of health disciplines. The course content covers

- child development
- infant observation
- assessment models
- prevention and interventions
- relationships
- evidence based models

Elizabeth Carlson acknowledged that there is a need to know normal development so health professionals can identify disturbance with strategies to work back to normal. She saw benefits of infant mental health education being offered with an interdisciplinary approach

CEED

Christopher Watson from the University of Minnesota talked about some of the programmes offered by CEED, the universities specialist education services focused on infant mental health, these included

- Introduction to mental health online training which has recently been updated. This is used by many countries.
- A new programme bridging education in mental health supporting childrens social and emotional needs for all ages. There is a strong behavioural focus of this programme.
- A foundation online course with a focus on socio-emotional and infant mental health geared to childcare services.
- 2 year programme run by Betty Carlson (see previous section)
- They are planning to develop a middle level training A hybrid for out of state and international students.

The training mainly uses online. Some courses are face to face but there are issues with access

for many especially for rural participants. They are trailing different online methods including infant mental health and reflective practice

The centre of the Developing Child Harvard University

The centre of the Developing Child Harvard University was recommended by several of the infant mental health specialist for their range of information. They have some very useful short videos that can be used for training purposes.

The ITSIEY online training programme

In conjunction with The Anna Freud Centre (UK) and Yale University Child Study Centre (USA) a unique collaboration occurred and established the International Training School in Infancy and Early Years (ITSIEY). The three organisations are internationally acclaimed contributors to the clinical, academic and research fields of infants' and young children's mental health. ITSIEY has drawn on the expertise of these Centres of Excellence to set expert-agreed standards of knowledge and skills that the broad range of professionals and practitioners need in order to work confidently with infants, young children and their families.

ZERO to THREE

Zero to Three offer a wide range of on-site programs, virtual training, or combinations of both, to help you maximize your professional development resources and meet the unique requirements of your staff in a convenient and cost-effective way.

It is recommended that education in relation to infant mental health is more readily accessible

Those working with vulnerable communities professional/paraprofessional and volunteers would ideally have a level of knowledge and skill in home visiting, development, infant mental health, collaboration with services and working with vulnerable communities. Having a workforce that is strongly committed to education with training prior to commencing their role, specialist training for

the area of practice they are working in and a commitment to ongoing professional development is necessary. There needs to be a strong commitment to having staff who are trained in maternal and infant health with an expectation that intensive programme staff have undertaken further training in these areas.

It is recommended that

- A formal process of professional development on infant mental health is offered to those working with whanau and in particular vulnerable whanau. This might be through face to face or online learning with a variety of teaching methods explored. This professional development should not be cost prohibitive for services.
- Specific courses to enhance the skills of the support worker are made available e.g. motivational interviewing, infant assessment, circle of security, ACEs, videoing interactions. There are several evidenced based resources and training that could be utilized in the New Zealand context.
- There are levels of professional development offered with the core level of infant mental health professional development being a requirement for all those working with Whanau. Other levels of training would be available to those working at more advanced levels.
- A relational based training is offered to those working with families and in particular those working with vulnerable families/whanau. The Fussy Baby Network FAN or Family Partnership models appear to have potential to achieve this. There appears to be a willingness of services working in infant mental health to work collaboratively to see the FAN model more integrated into practice.
- New Zealand develops a formal approach to PD on attachment that is Ministry of health and IMMHANZ guided.
- Supervision training is offered with a caregiver child relational focus.
- New practitioners are supported by Preceptors/mentors who have had infant mental health training.

Supervision

Effective support and guidance through supervision for home visitors can reduce the experience of pressure and burn-out on the job. Regular individual or group sessions of reflective supervision provides an opportunity for processing feelings and experiences. This practice also assures home visitors to feel comfortable and trust their supervisors to support them at times of need along with assuring compliance to program goals, training in evidence-based practice and providing professional development (Minnesota Department of Health, 2016). There is considered an importance of reflective supervision that focuses on the infant parent relationship.

There are different models of supervision with increasing attention towards direct observation of practice and/or videoing. Innocenti (as cited in Roggman & Cardia, 2016) discusses the limited research in relation to supervision in home visiting practice and explores moving from reflective supervision to developmental supervision which maintains reflective supervision while building on coaching and the use of measurement tools.

In all the countries visited supervision was considered integral to the support workers practice. Supervision was undertaken in a variety of ways from one to one supervision to the more popular group supervision model with an internal team or a multidisciplinary team. There was an expressed benefit by many of the services visited of one to one or group supervision reflecting on a case presentation. The method of doing this varied.

Some models of supervision in the states visited in the USA

Supervision is used as an integral part of the Fussy baby network training model. It is used as a reflective model to support new users of the FAN model to help embed it into practice. In the initial training the supervisors are selected out of the participant group. They receive an extra half day training focusing on supervision and then meet with their supervisee monthly using a reflective tool that is based on the FAN. The supervisee presents a case where they used the FAN exploring strengths and areas for development in relation to their use of the FAN to improve outcomes for the client interaction. The supervisor reflects on their role using the FAN and has supervision with one of the trainers. It was also discussed as a model of ongoing supervision.

In Chicago one model of supervision that was shared with me was infant mental health learning groups. These groups meet four times a year and focus on attachment relationships. They are for

direct service staff and led by a supervisor. Participants can come and go into these groups with about 12 to 16 in each group. The team presents an area of practice/case which is explored in relation to the impact on the parent child relationship. Nick Wechsler Director and programme developer at Ounce who I spoke to about this model has a published article that explores the effectiveness of this model.

The relevance of supervision to Public health outcomes has been identified by some funders and in Oakland they have supported the training of a large group in reflective supervision including Public health nurses. Mary Claire who I spoke to in San Francisco has co-authored a book on reflective practice and is currently about to train a large group in reflective supervision including Public health nurses. She spoke about the importance of supervision for those working with families.

In Minnesota there is a commitment by the Department of Health to infuse infant mental health into home visiting and to build the capacity for reflective practice through supervision. Funds were set up for an evidence based model of supervision to be developed. It was established as a 2 year programme but there was a demand to continue it. The decision was made to use an infant mental health consultant to support the home visitor supervisors. MDH provide support to the consultant infant mental health specialist. As there are limited infant mental health consultants as to this model utilizes the time of the infant mental health specialist wisely and develops the internal capacity of the service.

In Minneapolis the supervision model used has an endorsement in Infant and early childhood mental health. In this model they meet monthly with the team where a case is presented using infant mental health principles. There is a reflective stance to any cases. The focus of supervision in this model is to embed infant mental health into reflective practice. The goal is to enhance their understanding of the relationships and the responses between the infant and their caregiver. The Home Visitors supervision focuses on enhancing their skills in helping the parent wonder what might be happening in their interactions with their child. There are considered benefit of presenting a case rather than general topics. With a focus on infant mental health staff have found it orientates them to a new way of thinking.

With this model supervisors and staff are trained in supervision. This training included a 3 hour work shop on purposeful infant mental health strategies, a 3 hour workshop on reflective practice. There is also a 2.5 days reflective practice intensive, an Online learning module promoting

relationships and 2 day training. The model also includes mentoring and supervision for supervisors with an infant mental health specialist.

Christopher Watson the Coordinator for CEED talked about the benefits of the Minnesota supervision model where having a mental health specialist contracted to work with the supervisors supported internal capacity building. The Department of Health research showed it was effective compared to those not undertaking supervision. Group supervision was considered more cost effective and had the benefit of learning from a wider group. The supervisors also wanted to have reflective supervision so they are supported in their practice.

From research undertaken by CEED they conclude that Minnesota is well on its way to building a sustainable infrastructure for reflective practice moving away from a more directive approach and incorporating more collaboration and a reflective approach. They considered that that training needed beyond the basics provided by the models is difficult to determine, but supervisors, infant mental health consultants and home visitors believe there is a need for more training. They suggest developing a tiered intervention model of training that provides a foundational training and different types of training as the person gets more experience. They consider that the infant mental health consultants are crucial to the continued implementation of reflective practice. They provide content training in infant and adult mental health, consultation to supervisors, and model a reflective approach in case consultation (Minnesota Department of Health, 2015).

Supervision models in Cork and Dublin Ireland

In Cork Ireland supervision is seen as necessary but is not a routine expectation. Staff are encouraged to attend an infant mental health network meeting with a multidisciplinary team monthly where a case review is used to reflect on practice and infant mental health. Having a multidisciplinary team enables different perspectives to be shared and a greater understanding of infant caregiver relationships. The person presenting the case, links their discussion to current evidence and resources related to the case. The nurses have found that they go into visits with a different way of thinking, looking more closely at infant caregiver relationships and infant mental health, picking up more issues, and working more in partnership. As well as this model staff can undertake supervision one to one with their manager or a social worker.

Another model used in Ireland is in Dublin where they hold an infant mental health study group with about 25 to 30 participants. They explore infant mental health assessment, review an article

and break into groups for feedback. Youngballymun convene a monthly Infant Mental Health Study Group with over 30 practitioners from diverse disciplines in the Ballymun area (including Primary Care Health professionals, Addiction Services, Adult Mental Health Services, Social Work, Youth Work, Early Years and Family Support Services) to support capacity building in infant mental health practices.

Supervision in London England

In order to be most effective in the context of working with families of young children the English workforce is considered to need not only to be highly skilled, but should also receive regular, effective supervision, and possibly access to specialised consultations. They consider effective supervision to be one of the keys to delivering positive outcomes for everyone. It is important for all organisations to have an unambiguous commitment to a well-structured supervision system, provided in the context of a clear organisation approach/culture. (Wave Trust, 2013)

The services I spoke to in England all considered supervision as an important part of Health Visiting, parenting groups and in Circle of Security. In some areas Health Visitors are meeting monthly for group supervision after undertaking supervision training. The supervision model developed as part of Family Partnership is used by some. The services varied in the focus of this supervision on the child caregiver relationship.

Supervision Recommendations

It is recommended that supervision is embedded as a regular part of practice for all those working to support whanau, inclusive of professional/paraprofessional and volunteers. This in particularly important for those working with vulnerable whanau. Supervision options will need to be appropriate to the client needs, service area and individual needs. Supervision needs to be a formally taught process with supervisors appropriately trained. It is recommended that models used overseas are explore for relevance to the New Zealand context. Of note was the strong international support for group based supervision with a central focus on the child caregiver relationship. Interdisciplinary supervision appeared to be well supported or to have an infant mental health consultant to supervise the supervisors. It is also recommended that for one to one supervision a supervision tool is utilized for example the FAN supervision tool or Family Partnership model.

Recommendations

Increase knowledge on ACEs and explore the potential to use ACES for assessment and care planning

The outcomes of specific adverse childhood experiences demonstrate the long term health outcomes for children and are clearly linked to neuroscience. The study and further academic writing on the ACEs are worthy of further exploration in the New Zealand context including the relevance for training to gain an understanding of the long term impacts of ACEs and links to neuroscience. The study findings are relevant for preventative work with caregivers who have experienced ACEs in their own childhood exploring the impact of these on their care-giving and also supporting their parenting capacity. The study finding are also useful in exploring the relevance to working with whanau who have children who have been impacted by ACEs. This could include support using knowledge of the ACEs impact on neurodevelopment and attachment relationships for both the caregiver and the child and minimizing these impacts. It is worth considering if screening more widely for ACEs in the New Zealand context may improve service provision for whanau in particular vulnerable whanau.

Vulnerable whanau services have a Relational Model embedded

It is recommended workforce capacity to effectively engage with vulnerable whanau is built through relational model training. The two potential models explored in this report were The Centre for Parent and Child Support Family Partnership model and the Fussy Baby Network FAN. The Family Partnership model training is currently embedded in some services in New Zealand but this is not consistent. It is recommended to explore extending the Family partnership model and/or embedding the FAN into services. The benefits of the Family Partnership model and the FAN approach for professionals to track, regulate, understand, and use their own responses to families, thus building self-awareness and self-regulation appears to be well recognised internationally. There is strong support for integrating the FAN in New Zealand from a wide variety of infant and maternal mental health services and IMMHANZ. The first training programme has occurred in New Zealand with positive outcomes discussed by participants. The FAN training model would be offered to health services working within a variety of areas including one-to-one client interactions, extended whanau (using the group FAN), and groups. Supervision needs to be offered to those

embedding the Family Partnership model or the FAN into practice. The process of embedding a model widely would involve collaboration between IMMHANZ, potential trainers and services.

Promotional Guides are implemented in practice

It is recommended that The Centre for Parents and Child Support antenatal and postnatal guides training be considered as tools for well child nurses. These would be used during an antenatal visit and postnatal visit commencing with use with vulnerable clients and as they become more integrated I practice to be used with all clients. It is also recommended that funding is explored for a routine antenatal visit to occur.

Circle of Security is integrated more widely

There is significant potential for further integration of the Circle of Security into the New Zealand context. Further exploration of the Circle of Security has been mentioned by the Ministry of Health (2012) in their document Healthy Beginnings

It is recommended that

- One day training of the core principles of the Circle of Security is offered broadly to community services. This would ideally increase the workers knowledge of attachment and the use of the circle of security graphics. This would provide them with increased capacity to explore caregiver infant interactions and the child's need for exploration and connection in a one to one basis with caregivers and their whanau
- 8 week parenting courses are made available throughout the country in a coordinated way. These may be offered internally by services or accessed via self-referral or a service referral

Programmes have a strong focus on the infant attachment relationship

Services for vulnerable whanau need to have a focus on the infant caregiver relationship that is informed by robust neuroscience, development and attachment theory. The time together with clients needs to be used to assess the relationship, focus on what the caregiver and support worker notice about the baby and the relationship and explore strategies and support for the parent and child. For vulnerable whanau this would include having a focus on exploring parents history of adverse childhood experiences and the impact on their parenting. This includes programmes that are one to one, for groups and any written or visual resources.

RECOMMENDATIONS

Services guiding documents and practice are based on the most up to date neuroscience and attachment theory

The service provision to children needs to reflect new evidence that has emerged about neurological development and the importance of forming a strong child-parent attachment in the first years of life. All levels of service provision needs to have an evidence base to inform practice. It is recommended that services review their guiding service documents for currency with attachment and neuro science research. It is also recommended that services review the level of relational (infant/caregiver) focus that occurs in client interactions.

Explore opportunities to develop intensive home visiting programmes within Service Delivery Models

It is recommended that opportunities for intensive home visiting services be explored nationally. No one programme is going to suit all parents' needs, or target all the potential outcomes with a single stand-alone programme. This requires funders and providers to determine the needs of the community and to match these with the appropriate programmes (Family Commission, 2014). Services who work with communities with vulnerable populations ideally will explore the current services offered in their community, identify gaps in services for vulnerable whanau and develop services that are evidence based with a caregiver child relational focus. This includes programmes that are one to one, group and any written or visual resources. These programmes need to be inclusive of both parents and whanau who support the caregiving.

Internationally universal programmes tend to have a specific focus on offering intensive services for vulnerable clients. It is recommended that New Zealand universal services explore opportunities for development of an intensive programme within their service or to work in partnership with intensive home visiting services in their community while also embedding a more robust focus on infant mental health secure attachment into their programmes. By having a second and/or third level specialist service this would offer vulnerable clients a planned intensive evidence based programme. The levels of care provided would ideally offer clients a range of services, the ability to transition between levels as per need and additional support from a wide variety of additional services as necessary. An evidenced based entry criterion /assessment would need to be explored.

RECOMMENDATIONS

Explore skill mix within teams and community collaboration.

Skill mix will depend on the community and purpose of programmes but there may be areas of workforce capacity within services that could be enhanced in relation to infant mental health with professionals/paraprofessionals/volunteers level of knowledge and skills. Exploring options of different service delivery e.g. professional, paraprofessional, volunteers, groups, peer support parenting may impact on the skill mix within the team. An example of this is the CEED programme which consists of Social welfare workers, infant mental health and public health nurses and parent partners (parents who have had a history of adversity and are more confident in parenting), and several services working collaboratively. To increase confidence and capacity to work with whanau in relation to infant mental health may require services to consult externally with infant mental health services or to employ staff with these speciality skills.

Maternal and infant mental health services that are culturally appropriate for Maori whanau are developed

DHBs and other services need to provide a range of options for Māori-responsive perinatal and infant mental health care, from which individuals can choose. Greater collaboration among Māori-responsive services will provide a real opportunity to improve integrated care and health outcomes for Māori. Stronger links with specialist mental health services are needed to strengthen effective care that is responsive to Māori mothers with mental health and AOD needs and infant mental health (Tupara & Ihimaera as cited in MOH, 2012)

Increase the use of technology

Some services are using facebook as a method of communication with individual clients which appears to be an effective method for client interaction. Other potential areas to explore are skype interactions and the use of cell phones to share health promotion messages. It is also recommended to explore the use of videoing as a method of client self-reflection and it can also be used as a reflective learning tool for staff to film scenarios or practice.

Infant Mental Health Assessment tools are explored for greater implementation into health care practice

RECOMMENDATIONS

In recent years there has been a greater interest in assessing and documenting parenting outcomes. A number of practical, reliable and valid tools for parenting assessment are available. Observational parenting assessment should be considered for best practice. When choosing a tool, practitioners should consider the goals of the programme and cultures of the families served. Using a validated parenting assessment, practitioners can tailor services to individual families, reinforce parents' progress and build their confidence (Gordon & Comfort, 2013).

It is recommended to explore assessment tools for infant caregiver interactions. For example, including an assessment at 3-4 months, using the Parent Infant Interaction Observation Scale, The Keys to Interactive Parenting Scale (KIPS), the CARE-Index or similar. Also it is recommended to explore the introduction of a reliable and valid assessment of attachment type at age 12 – 14 months. The gold standard of attachment assessment is The Strange Situation which unfortunately is too cumbersome and complex to be used in routine practice. An acceptable proxy measure is the TAS-45 measure or a similar model, which could be adapted for routine use (Wave Trust, 2015).

RESEARCH IS UNDERTAKEN INTO SERVICE DELIVERY IDEALLY UTILISING A FORMAL ASSESSMENT TOOL.

RESEARCH IS ALSO REQUIRED INTO INFANT CAREGIVER RELATIONSHIPS AND THE INTEGRATION OF THIS AS A FOCUS INTO SERVICE DELIVERY.

Research informed approaches to enhancing child caregiver relationships are necessary. It is considered important to not just look at the programme being delivered but to also address research for training and support needs. It is to recommend that child health home visiting programmes in New Zealand assess their effectiveness for vulnerable clients especially Maori and Pacific utilize programme assessment tools. It is recommended that training for programmes is researched in relation to their currency and inclusion of infant mental health theory. Research also needs to be undertaken to ensure information shared with parents is based in current infant mental health evidence and neuro science and to explore the relational model used.

IT IS RECOMMENDED TO EXPLORE THE DEVELOPMENT OR PURCHASE OF CORE INFANT MENTAL HEALTH COMPETENCIES FOR THOSE WORKING WITH WHANAU

RECOMMENDATIONS

Having well-defined program outcomes and a set of competencies by which these outcomes are based upon and can be evaluated from allows home visitors and their supervisors to identify staff strengths and areas for development (Minnesota Department of Health, 2016).

EDUCATION IN RELATION TO INFANT MENTAL HEALTH IS MORE READILY ACCESSIBLE

Those working with vulnerable communities professional/paraprofessional and volunteers would ideally have a level of knowledge and skill in home visiting, development, infant mental health, collaboration with services and working with vulnerable communities. Having a workforce that is strongly committed to education with training prior to commencing their role, specialist training for the area of practice they are working in and a commitment to ongoing professional development is necessary. There needs to be a strong commitment to having staff who are trained in maternal and infant health with an expectation that intensive programme staff have undertaken further training in these areas.

It is recommended that

- A formal process of professional development on infant mental health is offered to those working with whanau and in particular vulnerable whanau. This might be through face to face or online learning with a variety of teaching methods explored. This professional development should not be cost prohibitive for services.
- There are levels of professional development offered with a core level of infant mental health professional development being a requirement for all those working with Whanau. Other levels of training would be available to those working at more advanced levels.
- A relational based training is offered to those working with families and in particular those working with vulnerable families/whanau. The Fussy Baby Network FAN or Family Partnership models appear to have potential to achieve this. There appears to be a willingness of services working in infant mental health to work collaboratively to see the FAN model more integrated into practice.
- New Zealand develops a formal approach to PD on attachment that is Ministry of health and IMMHANZ guided.
- Supervision training is offered with a caregiver child relational focus.

RECOMMENDATIONS

- New practitioners are supported by Preceptors/mentors who have had infant mental health training.
- Specific courses to enhance the skills of the support worker are made available e.g. motivational interviewing, infant assessment, circle of security, ACEs, videoing interactions.

REGULAR INFANT MENTAL HEALTH INFORMED SUPERVISION IS EMBEDDED INTO PRACTICE

It is recommended that supervision is embedded as a regular part of practice for all those working to support whanau, inclusive of professional/paraprofessional and volunteers. This in particularly important for those working with vulnerable whanau. Supervision options will need to be appropriate to the client needs, service area and individual needs. Supervision needs to be a formally taught process with supervisors appropriately trained. It is recommended that models used overseas are explore for relevance to the New Zealand context. Of note was the strong international support for group based supervision with a central focus on the child caregiver relationship. Interdisciplinary supervision appeared to be well supported or to have an infant mental health consultant to supervise the supervisors. It is also recommended that for one to one supervision a supervision tool is utilized for example the FAN supervision tool or Family Partnership model

Conclusion

All children need good health and positive early learning experiences. Nurturing relationships, safe environments, and enriching experiences foster their learning and development. Safe, stable, and nurturing relationships between children and their caregivers are the antithesis of adverse exposures that occur during childhood and compromise health over the lifespan. Individuals experience violence and adverse experiences acutely, but its consequences and potential solutions also affect society. This is particularly significant for New Zealand with Māori infants and whānau disproportionately experience environments and risk factors associated with the development of severe emotional and behavioural problems (National Center for Injury Prevention and Control, n.d., Zero to Three, 2016, Ministry of Health, 2012).

From the overwhelming evidence that identifies the impact of early child hood experiences on short and long term health outcomes and the rapidly developing knowledge of neurodevelopment, there is an important role for supportive health and social services. The Margaret May Blackwell travel Fellowship explored how international services enhance parenting capacity and infant caregiver relationships to reduce vulnerability and improve long term health outcomes. It was found there is significant potential to achieve this through comprehensive services that promote children's physical wellness, development, and mental health to help support children to thrive.

Services that support whanau must be high quality, culturally responsive, accessible and affordable to all children and whanau in particular for vulnerable Maori whanau. Services should not only focus on a reduction of risk factors but also focus on increasing protective factors. In relation to the finding of the Margaret May Blackwell Travel Fellowship this was seen to be achieved through building caregiver capacity and secure child attachment. To achieve this services need to be appropriately resourced, and to work in relational ways. Services were found to need strong commitment to evidence based professional development, infant mental health informed supervision, to have specific infant mental health competencies, engage the public; and build political will. A nationwide commitment to research informed practice, a population approach, evaluation of interventions and learning how best to implement and disseminate them is needed in relation to enhancing infant mental health outcomes in New Zealand (Zero to Three, 2016; National Center for Injury Prevention and Control, n.d.).

CONCLUSION

Babies are “hard-wired” to experience joy with their caregivers, mutual joy is the basis for increased brain growth. A baby feels more secure knowing that Life is good, because their parent enjoys life when they are with them. Every child should have the right to a parent who can be counted on to lovingly provide tenderness, comfort, guidance and protection during the good times and inevitable difficulties of life (Circle of Security, 2016):

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Web sites

Competencies

- Minnesota http://www.macmh.org/about-maiecmh/infant-early-childhood-division/
- Minnesota competencies and qualities and skills http://www.health.state.mn.us/divs/cfh/program/fhv/content/document/pdf/news1604.pdf
- Minnesota competencies http://unitedfrontmn.org/homevisiting/practice/
- Minnesota united core competencies http://unitedfrontmn.org/homevisiting/practice/
- Core competencies gold http://unitedfrontmn.org/homevisiting/files/Home-Visiting-Coalition-Best-Practices-Work-Groupgold.pdf
- Michigan Association for Infant Mental Health http://mi-aimh.org/alliance/
- Home visitor quality and skills http://sophia.stkate.edu/cgi/viewcontent.cgi?article=1508&context=msw_papers
- Job standards and training needs of short term HV http://www.lifebalance-solutions.org/#!job-standards-and-training-needs/c20yj
- Pennsylvania home visiting competencies https://www.pakeys.org/uploadedContent/Docs/Early%20Learning%20Programs/Home%20Visiting/PHVC%20-%20Competencies%20Book-final9-1-15.pdf
- Hillsborough county standards http://www.ecctampabay.org/site/images/IMHproject/competencies/HillsboroughIMHcompetencies.pdf

Adverse Childhood experiences

- https://acestoohigh.com/resources/
- https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/
- https://nzfvc.org.nz/news/ace-study-connects-adverse-childhood-experiences-health-and-social-problems

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- The Healthy Child Programme England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
- MCVEE list the main Home visiting programmes http://homvee.acf.hhs.gov/Models.aspx
- Youngballymun http://www.youngballymun.org/home/#gslide1 http://www.youngballymun.org/our_work/our_work/
- Promoting infant mental health in Irish children http://www.pcpsparenting.org/consists-of/
- Minding the Baby programme. Baby helps caregivers to understand how best to respond to their baby, how a baby develops as well as giving parenting advice and practical tips https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/minding-the-baby/
- The Helping Families programme developed by the Centre for Parent and Child Support . http://www.cpcs.org.uk/index.php?page=helping-families-programme
- Mellow parenting http://www.mellowparenting.org/
- MECSH programme http://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/about-mecsh
- http://homvee.acf.hhs.gov/Implementation/3/Maternal-Early-Childhood-Sustained-Home-Visiting-Program--MECSH-/47/1
- http://www.families.nsw.gov.au/support/child-health-services.htm
- The Maternal, Infant, and Early Childhood Home Visiting Program Partnering with Parents to Help Children Succeed information on home visiting programmes including Tribal programme https://www.acf.hhs.gov/sites/default/files/ecd/home_visiting_issue_brief_2015.pdf
- Healthy Families America training http://www.healthyfamiliesamerica.org/core-training/
- Minnesota Home visiting programmes for a useful newsletter on home visiting programmes http://www.health.state.mn.us/divs/cfh/program/fhv/content/document/pdf/news1604.pdf
- Nurse Family Partnership http://www.nursefamilypartnership.org/nurses

WEB SITES

- Canada Baby Love is an attachment-based program to help caregivers give their babies a better start in life. There are also a set of videos on the cite. http://babylove.ca/
- Kansas Early Childhood Mental Health Services in Kansas file:///C:/Users/anneh/Downloads/Childrens_Mental_Health_KS%20_Report_1.pdf
- Ounce of Prevention Fund (Chicargo) ://www.theounce.org/who-we-are/about-us
- Promoting infant mental health in Irish children http://www.pcpsparenting.org/consists-of/
- Warwick Medical school information on programmes and assessment tools http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/mhpathway/postnatal/
- Peeple (England) http://www.peeple.org.uk/programmes

Support services

- the Centre for Parent and Child Support http://www.cpcs.org.uk/
- http://www.brazelton-institute.com/ngntbio.html
- Brazelton book touchpoints http://www.amazon.com/Touchpoints-Birth-Three-T-Berry-Brazelton/dp/0738210498/ref=pd_bxgy_14_img_2?ie=UTF8&refRID=0PK0X2PQV8T2FN3NYW1K

Assessments of infants

- Newborn behavioral observation. https://drkevinnugent.files.wordpress.com/2012/01/the-newborn-period-e28093-where-hope-and-happiness-meet1.pdf
- Brazelton The Neonatal Behavioral Assessment Scale http://www.brazelton-institute.com/intro.html
- Parenting Interactions with Children: Checklist of Observations Linked to Outcomes™ (PICCOLO™), Atraining programme of how to use a checklist of 29 observable developmentally supportive parenting behaviors, to work more effectively with parents of young children
- http://www.brookespublishing.com/training/seminars/piccolo/
- Promoting first relationships http://pfrprogram.org/

WEB SITES

- Range of assessment models https://www.ucl.ac.uk/ebpu/docs/publication_files/mental_health_outcome_measures_for_children_yp
- Zero to Three assessment tools https://www.zerotothree.org/resources/series/decision-guidelines-for-axes-i-ii-and-v-of-dc-0-3r
- Adult Attachment Interview http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf

Research and Evaluation

- A New Zealand study of international and NZ services http://www.superu.govt.nz/publication/effective-parenting-programmes-review-effectiveness-parenting-programmes-parents
- A summary of latest research on child health topics and implications for services and education https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf
- Mother and Infant Home Visiting Program Evaluation (MIHOPE), a large-scale, random evaluation of the effectiveness of the Home Visiting Program. http://www.acf.hhs.gov/programs/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope
- Home Visiting Evidence of Effectiveness. This is an extremely useful website with individual home visiting programmes research http://homvee.acf.hhs.gov/Default.aspx
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- Zero to three assessment tool https://www.zerotothree.org/resources/174-key-components-of-a-successful-early-childhood-home-visitation-system
- file:///C:/Users/anneh/Downloads/Key%20Components%20of%20a%20Successful%20Early%20Childhood%20Home%20Visitation%20System.pdf

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- Sustained home visiting for vulnerable families and children A literature review of effective programs http://www.rch.org.au/uploadedFiles/Main/Content/ccch/resources_and_publications/Home_visiting_lit_review_programs_revised_Nov2012(1).pdf
- Warwick Medical school information on programmes and assessment tools http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/mhpathway/postnatal/
- Australian Research Alliance for Children and Youth Better systems better chances review of research and practice for prevention and early intervention https://www.aracy.org.au/publications-resources/command/download_file/id/274/filename/Better-systems-better-chances.pdf
- Alberta knowledge and skills check list http://www.ahvna.org/tiny_uploads/forms/personneltoolkit/homevisitorchecklist.pdf

Report/guiding docs

- The English Department of Health released a critical document The health Child programme https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
- Wave Trust English review document http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf
- Englands core service specs https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf
- Key document for the Healthy Child programme https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
- Health Visitor implementation plan for changes https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213110/Health-visitor-implementation-plan.pdf

WEB SITES

- Warwick Background information for changes in England http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/mhpathway/about/policy/
- Tribal Home visiting programmes http://www.acf.hhs.gov/sites/default/files/occ/tribal_hv_implementation_plan_guidance_cohort_3_revised_final_508.pdf

Education sites

- NCAST http://www.ncast.org/
- The Institute of Health Visiting Excellence in Practice A key site for health visitors http://ihv.org.uk/
- Minnesota CEED http://www.cehd.umn.edu/CEED/projects/imh/default.html
- Babies in mind free course https://www.futurelearn.com/courses/babies-in-mind
- National Child and maternal health intelligence network http://www.chimat.org.uk/pimh
- The Healthy Child Programme 0-5 an e-learning site for health visitors, healthcare professionals contains over 70 e-learning sessions covering a broad range of topics, http://www.e-lfh.org.uk/programmes/healthy-child-programme/
- https://www.zerotothree.org/ Zero to Three
- https://www.zerotothree.org/early-development/infant-and-early-childhood-mental-health
- Zero to three https://www.zerotothree.org/resources/services/professional-development
- The Tavistock centre http://tavistockandportman.uk/
- The itsiey course is an online programme http://tavistockandportman.uk/training/courses/international-training-school-infancy-and-early-years-itsiey
- How to Read Your Baby is a programme to empower, educate and support professionals who promote positive relationships between primary caregivers and infants/toddlers http://www.howtoreadyourbaby.org/
- http://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/
- Harvard the developing child information http://developingchild.harvard.edu/resourcecategory/multimedia/
- http://developingchild.harvard.edu/

WEB SITES

- A Harvard University article with a depth of information on attachment http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netdna-cdn.com/wp-content/uploads/2016/05/From_Best_Practices_to_Breakthrough_Impacts-1.pdf
- Anna Freud (England)http://www.annafreud.org/training-research/
- Brazelton touch points programme http://www.brazeltontouchpoints.org/offerings/professional-development/touchpoints-early-care-and-education-training-program/
- Infant mental health promotion http://www.imhpromotion.ca/HOME.aspx
- Minnesota Department of Health's http://www.health.state.mn.us/divs/cfh/program/fhv/training.cfm
- Curriculum of some of the programmes in Minnesota http://www.health.state.mn.us/divs/cfh/program/fhv/hfa.cfm
- New Zealand Werry Centre http://www.werrycentre.org.nz/elearning-courses
- Promoting first relationships http://pfrprogram.org/
- Online preceptor programmes http://www.preceptor.ca/index.html
- Training offered by Kansas Early Childhood Mental Health Services in Kansas http://www.kaimh.org/
- Training videos from the infant parent institute site http://www.infant-parent.com/pages/resources
- Ghosts in the nursery Selma Fraiberg http://mhfamilypsychology.com/docs/Ghosts%20in%20the%20nursery%20paper%20copy.pdf
- Minnesota dept of health http://www.health.state.mn.us/divs/cfh/program/fhv/training.cfm

Parenting sites aimed at understanding cues/attachment

- http://www.your-baby.org.uk/
- **getting to know you** App/website for Health visitors/other practitioners to use with parents who are pregnant or with babies under 6 months to enhance appropriate parent infant interaction.

WEB SITES

- https://www.bestbeginnings.org.uk/watch-small-wonders-online Incudes APPs for parents
- http://solihullapproachparenting.com/ Online parenting course (fee is paid)
- http://www.nct.org.uk/parenting/baby-blues
- https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/baby-steps/ Baby steps is a parenting programme
- https://www.zerotothree.org/ Zero to Three
- http://www.peeple.org.uk/ Peeple programme
- http://www.netmums.com/ Netmums parenting info
- http://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/ Harvard University information
- Parenting Toronto site http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=538f1291bfc30410VgnVCM10000071d60f89RCRD

Circle of Security

- file:///C:/Users/anneh/Downloads/The%20Circle%20of%20Security%20-%20Roadmap%20to%20building%20supportive%20relationships%20-%20Robyn%20Dolby%20-%20chapter%201%20(1).pdf

Neuro science

- http://developingchild.harvard.edu/ http://developingchild.harvard.edu/science/key-concepts/serve-and-return/
- Language development https://www.youtube.com/watch?v=qRRiWg6wYXw

Other useful sites

- A Harvard University article with a depth of information on attachment http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netdna-cdn.com/wp-content/uploads/2016/05/From_Best_Practices_to_Breakthrough_Impacts-1.pdf
- Harvard the developing child information http://developingchild.harvard.edu/resourcecategory/multimedia/ http://developingchild.harvard.edu/
- NICE National Institute for Health and Care Excellence http://pathways.nice.org.uk/

- Thinking Healthy A manual for psychological management of perinatal depression http://www.who.int/mental_health/maternal-child/thinking_healthy/en/

Books and resources

- A practical guide for health professionals to help understand early childhood mental health (book) http://products.brookespublishing.com/Understanding-Early-Childhood-Mental-Health-P232.aspx
- online book on development http://www.imd.inder.cu/adjuntos/article/378/Child%20Development%20A%20Practitioner's%20Guide.pdf

Videos clips for parents and health professionals

- child coping parent https://www.youtube.com/watch?v=8AcWo3gbtBk
- The Magic of every day moments (Zerotothree Several parenting videos) https://vimeo.com/103169425

Bruce Perry

- https://www.youtube.com/watch?v=jYyEEMlMMb0
- https://www.youtube.com/watch?v=vkJwFRAwDNE
- https://www.youtube.com/watch?v=vkJwFRAwDNE
- 7 slide series by Bruce perry https://www.youtube.com/watch?v=uOsgDkeH52o
- Bruce perry/child trauma http://childtrauma.org/
- Empathy/ Bruce perry https://www.youtube.com/watch?v=dh3aEAeKBhc
- Nadine Burke Harris http://shriverreport.org/the-chronic-stress-of-poverty-toxic-to-children-nadine-burke-harris/
- zero to three http://www.zerotothree.org/about-us/board-staff/alicia-lieberman-bio.html?referrer=https://www.google.co.nz/
- Shore https://www.youtube.com/watch?v=vQkgzLB7vQU Right and left brain attachment self regulation 12.14 to 13.20 and 15.18 to 18.31 predictable consistent emotionally available , play states positive states, joy, interest and excitement, guilt and shame reward

systems also key to regulation. Focus on empathy 29 implicit memory 37 trauma and panic impact on child

- Attachment and brain development (fairly old) https://www.youtube.com/watch?v=YyVHIZVP8Mk 14.25 own childhood 14.39 joy and dopamine (includes fathers) 20 warmth and inconsistent warmth leads to resilience and ability to cope with emotional states
- Toxic stress and ACES https://www.youtube.com/watch?v=aKU4pAs3A3c "Unfortunately not every child will become an adult but it is certainly true that every adult once was a child" (Robert Block, President of the American Academy of Pediatrics)
- Harvard University
    - http://developingchild.harvard.edu/science/key-concepts/brain-architecture/
    - Baby brain architecture https://www.youtube.com/watch?v=VNNsN9IJkws
    - Serve and return https://www.youtube.com/watch?v=m_5u8-QSh6A&ebc=ANyPxKqlxMoqFsh2IMPA87PZhQePWfIK7tgGZ5AC6FuW2cgqrKpOqevVtB4KkPM5byF5yH3jMnv_2mxVOHJ_mIQByJceKzTziA
    - https://www.youtube.com/watch?v=rVwFkcOZHJw
    - Toxic stress http://developingchild.harvard.edu/science/key-concepts/toxic-stress/