BEDFORD BOROUGH COUNCIL

Early Help and Intervention Handbook

2022 - 2025

"Right support Right action Right time"

RIGHT ACTION • RIGHT TIME • RIGHT SUPPORT •

Contents

Introduction

What is Early Help?

Early Help is the term used to describe arrangements and services that provide help for children, young people and families as soon as a problem starts to emerge, or when there is a strong likelihood that problems will emerge in the future.

Early Help Assessment

The Early Help Assessment (EHA) is a partnership process designed to help professionals support children, young people and families. The EHA enables professionals to:

- Help a child or family receive the right support at an early stage, before a small need grows into a larger one.
- Complete a shared assessment, so that a family, child or young person, does not have to repeat the same information to different workers.
- Ensure that everyone involved with supporting the family, child or young person, such as teachers and health visitors, work together effectively.

An EHA is used when a family, child or young person would like to receive extra support.
The assessment enables both areas of strength and need to be identified; highlighting in the process whether other services may be appropriate to support the family, child or young person.

It is the families' choice whether they accept support and agree to who is involved in this process. They will be given a copy of the form and will be told who will see it, where it is stored and how it will be used.

Team Around the Family (TAF)

A Team Around the Family (TAF) is implemented where additional needs have been identified through and Early Help Assessment (EHA), and support is required from more than one agency, team or service. The TAF brings together young people, parents, extended family and a range of professionals/ practitioners, into a small, individualised team to co-ordinate support and interventions. All of the family members have a role in the TAF and their views and needs play a central role. A TAF should ensure that young people, parents/carers and extended family all have a role in agreeing goals, and agreeing actions to meet those goals.

Outcomes from a TAF meeting should include: The identification of a ‘Lead Professional’, the creation of a support package which identifies roles and responsibilities, and the setting of a review date for a subsequent meeting to assess whether needs are being adequately met by the support package.

Lead Professional

A ‘Lead Professional’ is chosen from amongst the professionals involved in a TAF; they should be selected by the end of the first TAF meeting. The family or child should have a key input into who should be the lead professional. The lead professional takes the lead to co-ordinate provision and act as a single point of contact for a child or young person and their family. The lead professional is to ensure that professional involvement is rationalised, co-ordinated and communicated effectively.

Information Sharing

Overview

Information sharing is the term used to describe the situation where practitioners use their professional judgement and experience on a case-by-case basis to decide whether and what personal information to share with other practitioners in order to meet the needs of a child or young person. Sharing information is vital for early intervention to ensure that children and young people get the services they require. It is essential for safeguarding and protecting the welfare of individuals and for providing effective and efficient services that are co-ordinated around the needs of an individual or family. It is important that practitioners understand when, why and how they should share information so that they can do so confidently and appropriately as part of their day-to-day practice.

Government Documents online

Advice for practitioners providing safeguarding services to children, young people, parents and carers:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

Seven Golden Rules for Information Sharing

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Graded Care Profile

The Graded Care Profile Version 2 (GCP2)

The GCP2 is a practical tool which supports practitioners in measuring the quality of care delivered to an individual child from an individual carer or carers over a short window of time, and is designed to give a representative overview of the current level of care. The grades are based on observations and good quality evidence gathered during this window. All practitioners using the GCP2 have attended and passed a licensed training programme.

The GCP2 reviews "what it's like" for the child not "why it's happening". However, parental issues are taken into account during the analysis and planning stage. The quality of care is scaled between 1 (best) and 5 (worst).

A judgement of whether parenting is neglectful or not is based upon whether the needs of the child are being met adequately. The GCP2 helps professionals to be clear as to what the basic needs of a child are, and to what degree they are being met. This allows practitioners to make reasoned and explicit judgements in relation to neglect.

The GCP2 separates out different areas of parenting and the needs of the child.
These areas are:

- Physical care
- Care of safety
- Emotional care
- Developmental Care

These areas are then further subdivided. These sub-areas have been drawn from research, empirical evidence and developmental psychology and cover:

Physical, Safety, Emotional Care and Developmental Care

Physical	Safety	Emotional Care	Developmental Care
Nutrition Housing Clothing Hygiene Health	Safety in parent's presence Safety when carer is absent	Parent /Carer's responsiveness Mutual engagement	Stimulation Approval Disapproval Acceptance

The quality of care the child receives in all the above areas is then graded according to the qualitative descriptors outlined below:

GCP2 Grade Descriptors

Grade	Description
1	All the child's needs are always met and the parent goes the extra mile. The child is always put first.
2	All essential needs are always met. The child is a priority.
3	Most of the time the essential needs of the child are met.
4	Most of the time the essential needs of the child are not met. The child's needs are placed second to those of the parent / carer's.
5	The child's essential needs are not met. May be due to intentional disregard. The child is not considered.

Research

The second version of the Graded Care Profile (GCP2) was tested for inter-rater reliability; concurrent and face validity. Inter-rater reliability is the fundamental test all assessment tools should be exposed to, and it provides a score of how much homogeneity or consensus there is in the ratings given by different raters/practitioners.

Validity refers to the accuracy of an assessment - whether or not it measures what it is supposed to measure.

The GCP2 has been rigorously evaluated and found to be reliable and valid. It can be used in the knowledge that it has sound psychometric properties, and is a reliable and valid assessment tool in aiding practitioners in the assessment of child neglect. (Johnson, Smith and Fisher 2015)

Useful Links

- *https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/graded-care-profile/*
- *https://www.nspcc.org.uk/services-and-resources/research-and-resources/2015/spotlight-preventing-child-neglect/*
- *http://developingchild.harvard.edu/resources/the-science-of-neglect-the-persistent-absence-of-responsive-care-disrupts-the-developing-brain/*

Outcomes Star™

About the Outcomes Star™

The Outcomes Star™ is a unique suite of tools for supporting and measuring change when working with people. There are over 25 versions of the Outcomes Star carefully adapted for different client groups and services, including older people, mental health, families, work and more. It is well researched, widely used and endorsed. Over 50 collaborators include the Department of Health, Big Lottery Fund, Camden Council, NESTA and NHS Trusts.

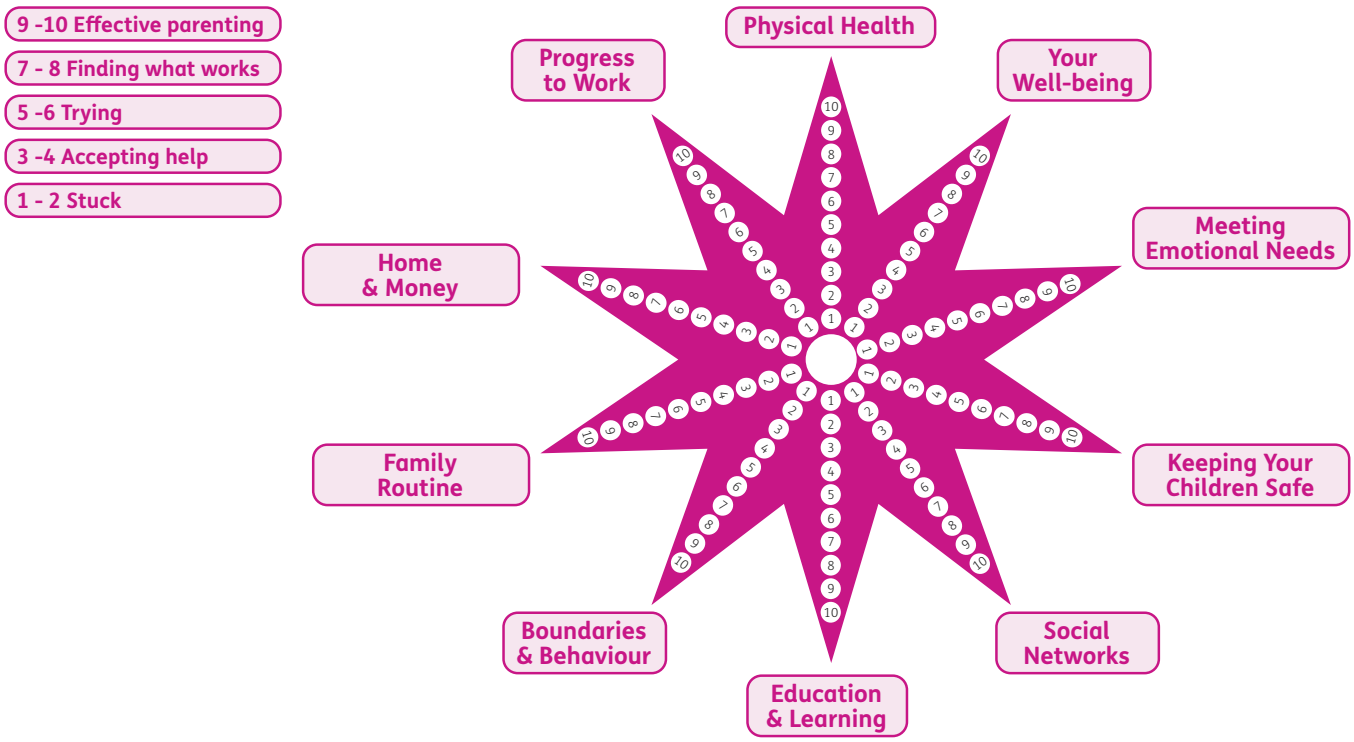
You can preview all of the Stars from this website and try out the Star Online web application at:

www.outcomesstar.org.uk/using-the-star/see-the-stars/

The Outcomes Star™ both measures and supports progress for service users towards self-reliance or other goals. The Stars are designed to be completed collaboratively as an integral part of keywork. They are sector wide tools - different versions of the Star include homelessness, mental health and young people. All versions consist of a number of scales based on an explicit model of change which creates coherence across the whole tool and a Star Chart onto which the service user and worker plot where the service user is on their journey. The attitudes and behaviour expected at each of the points on each scale are clearly defined, usually in detailed scale descriptions, summary ladders or a quiz format.

Family Star Plus

The Family Star Plus is an assessment tool for supporting and measuring change when carrying out direct work with children and families. The Family Star Plus recognises 10 different outcome areas within its 'star': Physical health, your well-being, meeting emotional needs, keeping your children safe, social networks, education and learning, boundaries and behaviour, family routine, home and money, progress to work.



An Outcomes Star™ reading is taken by the professional and service user at or near the beginning of their work together. Using the ladders or other scale descriptions, they identify together where on their ladder of change the service user is for each outcome area. Each step on the ladder is associated with a numerical score so at the end of the process the scores can be plotted onto the service user's Star. The process is then repeated at regular intervals (every three, six or 12 months depending on the project) to track progress. The data can be used to track the progress of an individual service user, to measure the outcomes achieved by a whole project and to benchmark with a national average for similar projects and client groups.

Evidencing Outcomes

The Outcomes Star™ can provide outcomes data at four levels:

For individual service users: the Star gives a snapshot of where they were on each outcome area when they joined the project and at each review – the difference between starting point and review shows the progress made in that time.

For a project as a whole: the average starting points on entry to the service and the amount of progress made in a specified time period or over their life-time in the project can be calculated – this gives a picture of the project outcomes. The Outcomes Star™ online can provide this information at the touch of a button.

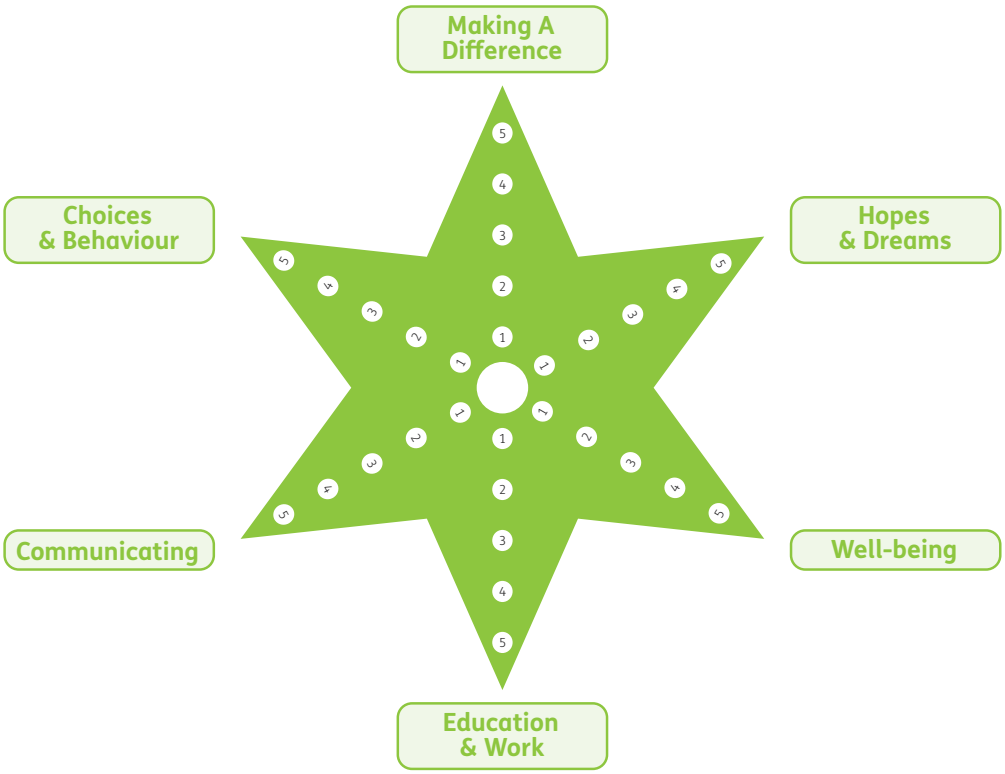
For a group of projects across an organisation: the same information as above can be calculated for each project allowing comparison between different services. In addition users of the Outcomes Star™ online can compare the progress made
by different sub-groups of clients, for example women and men or older and younger service users.

For similar projects across a sector: the same analyses as described above can be carried out for a sector as a whole. This makes it possible to establish benchmarks identifying good practice and building an outcomes-focused evidence base. This is only possible using the Outcomes Star™ online.

Youth Star

The Youth Star is a recent development, designed to provide the skills and tools necessary to engage young people and evaluate support being often to them by measuring change. Unlike the Family Star, the Youth Star has 6 points, with scales from 1 to 5, rather than 1 to 10. The six points on the Youth Star are:

1. Making a difference
2. Hopes & dreams
3. Well-being
4. Education & work
5. Communicating
6. Choices & behaviour



Useful Links

www.outcomesstar.org.uk

Solution Focused Practice

Overview - Solution building, not problem solving

Solution Focused Practice is all about solution building rather than problem solving. By this we mean staying as close as possible to the hoped-for outcome, rather than staying close to the problem. Solution building questions will focus on the client's preferred future and what instances there are of that already happening; whilst a problem solving approach will concern itself with identifying the problem, why it is happening and what it will take to solve.

"We're interested in the problem solved, not the problem that needs solving" ***Insoo Kim Berg***

To give a practical example of this, we can look at the following extract from a conversation between a client and a solution focused practitioner:

Client: (Comes into the room, sits down, sighs deeply and says) I want to be a better mother but I'm such a worthless, worthless, worthless person.

SF Practitioner: Oh – how terrible!... (pause)... (And) you want to be a better mother?

Client: Yes!

SF Practitioner: So – suppose you were successful with that – becoming a better mother – how would your children notice that you became a better parent? ***Inbetween-Neither inside nor outside: The radical simplicity of solution-focused brief therapy, Mckergow and Korman, 2009***

What we see in this example is the Solution Focused practitioner choosing to build the conversation around the potential solutions, not the client's problems. They do this by hearing and selecting 'I want to be a better mother' from the client's opening statement, whereas a problem solver would want to investigate why she feels so worthless.

Note that the word 'but' has been substituted with the word 'and' in the SF Practitioner's first question; this is done deliberately, to show that we are not to minimise nor dismiss the client's complaint, in this case that she is a 'worthless' person: Rather we are to focus on eliciting and exploring the equally valid positive narrative in their lives. Hence the SF practitioner asking "...and you want to be a better mother?"

The core components of an initial Solution Focused Session

1. Best Hopes

In order to stay as close to the hoped-for outcome as possible, a solution focused practitioner must first establish what the client's hoped-for outcome is. Solution focused practice refers to this stage of the process as the client's 'best hopes'. Below are some examples of questions typically used to elicit a client's best hopes:

- What are your best hopes from these sessions?
- What do you hope to achieve from attending these sessions?
- What is it that you hope will be different after attending these sessions?
- Thinking ahead to two or three days' time, what would tell you that this session had been useful?

The best hopes are also important as they help to shape a common project or contract between the client and the practitioner. The identified best hopes will go on to serve as indicators of progress, and so they must be both something that the client wants to achieve, and also something that fits with the practitioner's legitimate remit. To summarize, an effective best hope or best hopes, will be those which the client and practitioner could reasonably hope to achieve if working well.

2. Preferred Future/Miracle Question

Once a client's best hopes are established, the Solution Focused Practitioner can move on to exploring their 'preferred future'. A client's 'preferred future' is a description of what the client's life would be like if their best hopes from the work were achieved. So if one of their best hopes is to feel happier, the solution focused practitioner wants to explore what difference that would make to them and their life: What would they be doing if they were happier? What would people notice about them if they were happier?

It's important to note that the Solution Focused Practitioner is not interested in how the client will reach their best hope, but rather what their life will look like with their best hope already achieved. The power for change is found in a rich description of a client's preferred future already achieved, rather than discussing what steps they need to take to get there. The more clearly a person can see their future "vision" the more likely they are to start making moves towards it.

Solution Focused practitioners will commonly prompt the description of a preferred future by using either a 'miracle' question or 'tomorrow' question:

- Suppose tonight while you're sleeping a miracle happens and the problems that brought you here are solved. Because you're asleep, you don't know this has happened. When you wake up, what will be the first sign that the miracle has happened? And the next? What will others notice?
- So your best hopes from our work together are that you will be doing X. Let's suppose that tomorrow after you wake up you are doing/starting to do X. What will you be doing? What else will you be doing? Who will be the first person to notice? What will s/he see?

3. Instances of Success/Scales

Once the preferred future has been established, the SFBT practitioner can start asking about related and specific instances of success. This means drawing the client's attention toward occasions when their preferred future was and is already present in some way.

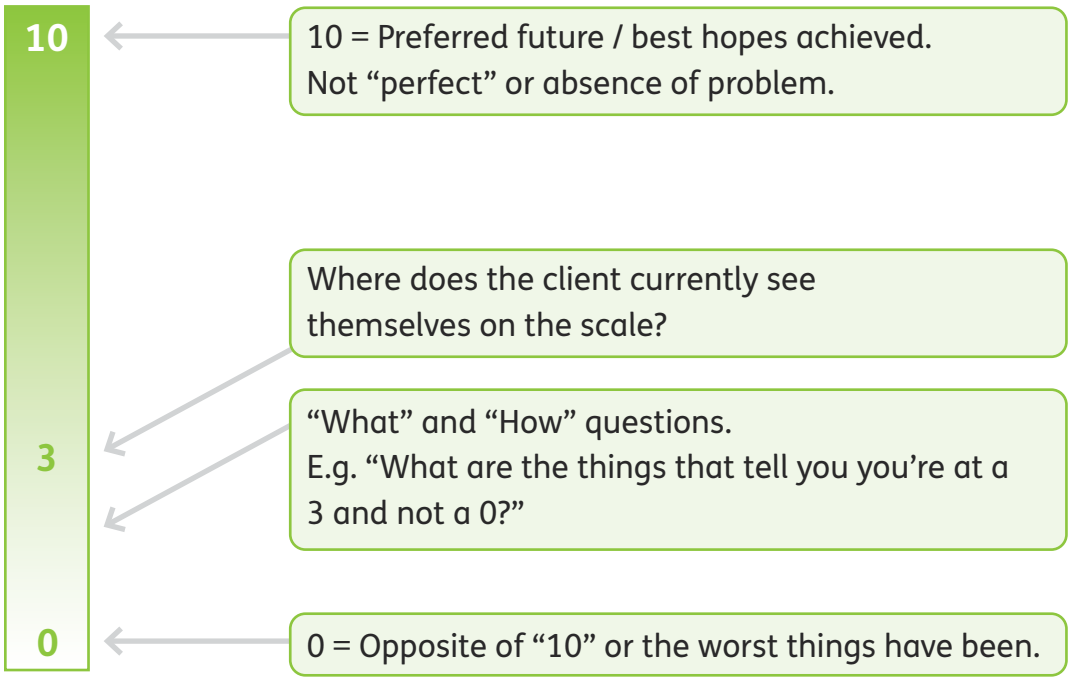
One of the best ways of eliciting instances of success is through the use of a scale. This technique asks the client to consider where they currently fit on a scale of 0 to 10, where '10' is their best hopes/ preferred future come true:

- If we imagine a scale, where '10' is your preferred future having come true and '0' is as far away from that as possible. Where would you place yourself right now?
- Imagine a scale from 0 to 10 with '10' representing your best hopes achieved and '0' being the absolute opposite. Where would you put yourself on the scale at the moment?

Typically the client will give a score of around '3 or 4', at which point the SF Practitioner begins to search for instances of success and resources:

- What is it that has helped you get from '0' to where you are now?
- What are you doing to be at a '3 or 4' rather than a '0'?

The proposition inherent in the question is that the client will have, or be doing something positive, which thereby invites a sense of personal agency on the part of the client.



Even if the client is particularly struggling with trying to notice/think of instances of success *(perhaps they claim to be a '0' out of 10 on the scale)*; the practitioner can ask them to consider what 'keeps them going' or 'how they have managed to cope'.

When encouraging even greater detail from the client around their instances of success, the practitioner may also ask specifically for historical examples. It is likely that some of these will have naturally appeared when the client reflects on the reasons for their scale score, however historical instances of success can also be elicited via more direct questions such as:

- Tell me about the last time you were reliable... (In an instance where a client's preferred future includes increased reliability).
- When was the last time you did something to be helpful? (In an instance where the client identifies their renewed helpfulness as something that locates them at their current point on the scale).

4. Signs of Progress

As the session moves to a close, the practitioner can ask how the client would know if they had moved up just one point on the scale. The answers the client provides to this line of enquiry help to form their 'Signs of Progress'.

The practitioner must resist the urge to turn scales into plans and targets! The key thing to remember here, is that the practitioner is *not* asking *how* the client might move up on the scale, rather, what they will notice *when* they get there. By doing this, we are inviting the client to consider what, if they did do something, would be their criteria for progress. As Solution Focused Practitioners we believe that clients are more likely to take some action once they have thought about how it would be helpful if they did.

- What will tell you that you have moved up one point on the scale?
- How will you know things have moved forward one point?
- What will you be doing that will tell you/others that you have moved up?

Summary of an initial Solution Focused Session

1. Establish the client's 'Best Hopes'

- What are your best hopes from these sessions?

2. Explore the client's 'Preferred Future'

- Suppose tonight while you're sleeping a miracle happens and the problems that brought you here are solved. Because you're asleep, you don't know this has happened. When you wake up, what will be the first sign that the miracle has happened? And the next? What will others notice?

3. Look for 'Instances of Success' already happening

- Imagine a scale from 0 to 10 with '10' representing your best hopes achieved and '0' being the absolute opposite. Where would you put yourself on the scale at the moment?
- What is it that has helped you get from '0' to where you are now?

4. Clarify what 'Signs of Progress' would look like

- What will tell you that you have moved up one point on the scale?

Subsequent Sessions

Follow up sessions are largely based around discovering what progress the client has made since the previous session. The practitioner wants to establish what has been better since the last time they met the client, what the client did to help themselves be successful, what others saw them doing and what they have learnt about themselves.

- What's been better since we last met?
- What did you do?
- How did you do it?
- What did others see you doing?
- What have you learned about yourself?
- What would be the signs that you were doing more of the things that are good for you?

Recommended Further Reading

- George, E., Iveson, C. and Ratner, H. (1999; 2nd edition) Problem to Solution. London: B T Press.
- George, E., Iveson, C., and Ratner, H. (2017) BRIEFER. A Solution Focused Practice Manual. London: BRIEF.
- Iveson, C., George, E. and Ratner, H. (2012) Brief coaching: A Solution Focused Approach. London: Routledge.
- Ratner, H., George, E. and Iveson, C. (2012) Solution Focused Brief therapy: 100 Key Points and Techniques. London: Routledge.

Transactional Analysis

Transactional Analysis in the Classroom and Staffroom

Transactional Analysis (TA) is an approach to understanding and resolving conflict in educational contexts. Developed by Eric Berne during the 1950s, TA provides a psychodynamic perspective on relational aspects of teaching and learning. The principles of the approach are essentially humanistic; the importance of positive unconditional regard, a common capacity to think and make decisions and a commitment to growth as a fundamental feature of human nature.

Nowadays TA in education has been recognised as a field of application in its own right; since the late 1990s educators in the UK have been incorporating, adapting and developing early TA models to create an educational psychological framework to support the learning relationship.

In its most developed form, educational TA provides a distinct pedagogical approach that promotes a radical, co-creative model of learning. Using the core concepts of TA can be useful in restoring relationships and promoting insights through conflict. It is important to recognise at the outset that TA provides a universal framework for making sense of human experience; it has not been designed to be used exclusively in relation to children's' behaviour but includes adult behaviour. Below are some of the concepts that underpin TA.

Introducing Egostates

Perhaps the most enduring image created during the early days of TA, is Berne's egostate model. Not to be confused with Freud's earlier concept of super ego, ego and id, Berne suggested a metaphor for understanding the structure of personality. In brief, he noticed that at any given moment individuals behave, think and feel in consistent patterns – an egostate - and that three such patterns can be discerned. For example, there are times where the individual replays the thinking, feeling and behaviour copied from the grown-ups who were in charge and cared for them in the past. Berne called this pattern the Parent egostate. He noticed that at other times individuals replay the thinking, feeling and behaviour that they experienced internally when they were in childhood and this is referred to as the Child egostate. Finally, Berne described how on occasion, the individual responds to the here and now reality with thinking, feeling and through their behaviour.

TA is a highly visual framework and Berne presented the egostates as three stacked circles, see fig. 1 below.

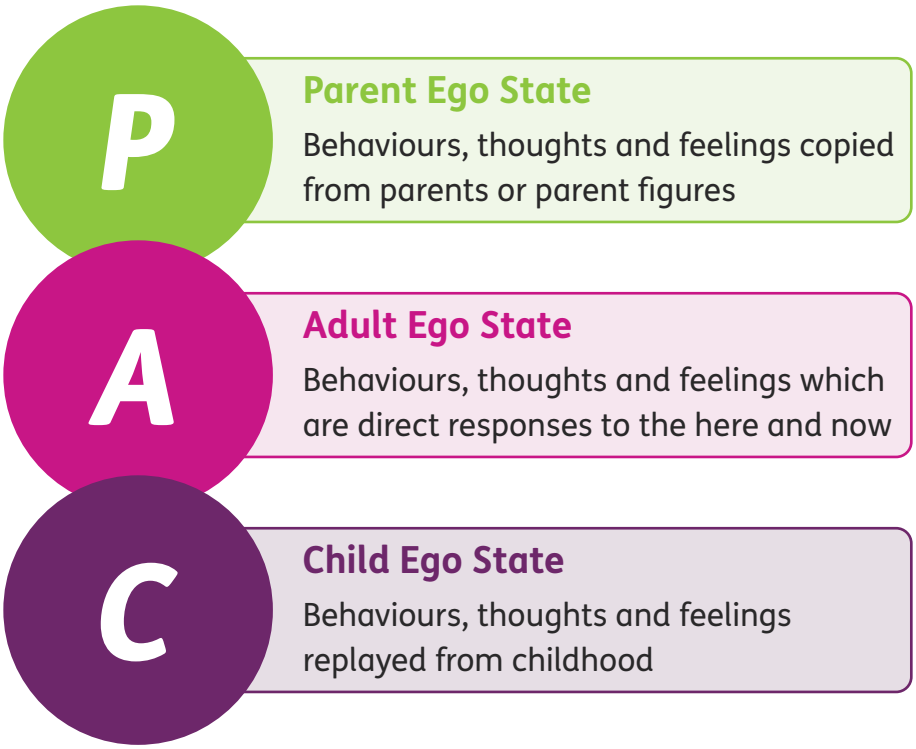


Figure 1: Berne's Structural Egostate Model

The **Parent** egostate comprises an archive of retrievable experiences of being cared for and controlled. Although this invariably includes episodes involving mothers, fathers and other family adults, it inevitably incorporates other parental figures including teachers. What this means is that at times when I am teaching there may be times where I replay the thinking, feeling and behaviour of one of my teachers from forty years ago. I do not consciously do this; it is simply a reaction to a situation and the archival material immediately 'downloads' into the present moment. There is a second consideration. When I am in the staffroom and I see a request to meet with the head teacher, I might re-experience being in trouble, just like when I was a young child. A churning in the stomach, the fidgeting and confusion resulting in a fumbling with books and papers indicates a much younger sense of self taking over my experience in the present moment. In TA terms this could be described as the activation of the **Child** egostate. The potential for conflict in these situations increases as in each instance the individual is not truly present, in relationship with others. To understand this more fully it is helpful to know about transactions, and why Berne called his model transactional analysis.

Egostates in action

It is one thing to create an idea about how individuals are internally structured, but what interests many people is what this means for being with others. Berne talked about a functional egostate model as a way of describing how the internal archive 'shows up' in the interplay with others. He described the way egostates function using additional language which is presented below:

Functional Egostate Model

Berne went on to explain that when individuals engage with one another they communicate using transactions. A transaction is a unit of communication and comprises of both a stimulus ('Do you want a cup of tea?') and a response ('No thanks, I'm not thirsty'). Crucially, Berne noticed that when transactions are stimulated from the functional elements of the Parent egostates they have a tendency to invite responses from the Child egostate. Again, the implication for classrooms is significant. For example, if when I teach I function from a Critical Parent position it is likely to generate the limited range of Adapted Child responses from pupils. I would not seek to create this dynamic with conscious intention but due to the reactive nature of the Parent and Child egostate archive I find myself in recurrent conflicts with specific students. Similarly, we may notice that individual students appear to have a well-developed capacity to function from a Rebel Child position and in turn invites a strong response from Critical Parent from staff.

When considering conflict in schools the egostate models and the idea of transactions offer a framework for making sense of what's happening in the situation. Perhaps more importantly, TA provides a way of doing something else instead. The important key to enabling effectiveness in resolving conflict starts with increased self-awareness, a capacity to take account of what is happening in the present moment. This can be surprisingly challenging to achieve in the busy context of the classroom. Functioning from Adult can be an elusive quality but is fundamental in understanding and responding to conflict. Being sufficiently aware and able to analyse transactions is the first step in shifting from conflict to resolution. The second part of the process involves accounting for what is needed to get the best of those involved, rather than remaining in conflict.

Functional Fluency

Susannah Temple has developed a powerful application of Berne's early concept of egostates in her model of Functional Fluency, (Temple, 2002). This continues to be one of the most straightforward ways of incorporating TA theory into the classroom. At the heart of the model are a series of behaviours which we can see in others and experience in ourselves at any given moment. Sometimes when we are using our energy to take care of or control others there will be some specific behaviour prominent, and when we are functioning at our best the two most effective behaviours will be our capacity to be **nurturing** and **structuring** toward ourselves and others in the situation. The impact of these behaviours has the tendency to motivate and affirm students and colleagues. However, there will be occasions where our capacity to achieve these qualities escapes us and instead we may become **domineering**, which leads to others disengaging from us. Over-nurturing – **marshmallowing**, as it has been referred to in TA is the negative dimension of caring, this is where it is misplaced, irrelevant, unasked for and unwelcome.

The impact on others is that they become increasingly confused. The matrix of these behaviours is presented in fig. 2 below.

Being in Charge	
Critical and Dominating (leading to disengagement withdrawal)	**Marshmallowing and Smothering** (leading to confusion e.g. compliance, rebelliousness, e.g. not knowing where they stand)
CONTROL	**CARE**
Structuring (leading to motivation, clear boundaries)	**Nurturing** (leading to affirmation and a sense of being noticed)

Fig. 2 Behaviour modes associated with being in charge of others

One of the useful observations about this part of Temple's model is that there's an interesting inter-play between these different behaviours. For example, there will be times where the most useful behaviour mode will be to be structuring as a way of addressing the situation. However, some teachers are unsure of how to be structuring; they don't want to become dominating and critical of students or colleagues but remain unsure of how to be structuring, for example by re-establishing boundaries. In the absence of clear structuring the other person experiences the teacher as **marshmallowing** – a push-over. Meanwhile, perhaps in the classroom next door, a different teacher encounters an issue where the most appropriate response is to provide nurturing. This member of staff though is unsure of how to 'do' nurturing because they don't want to be seen as a soft touch – **marshmallowing**. In the absence of valid nurturing the other person experiences the teacher as **critical or domineering**.

This cross-relationship between the behaviours can be a crucial way into understanding how people get into, and remain in conflict in classrooms and staffrooms. A couple of further observations can be helpful to apply the ideas further. It is worth noting that understanding the differences between **Structuring** and **Dominating**, and **Nurturing** and **Marshmallowing**, are useful to keep in mind, see fig. 3 below:

Being in Charge	
Critical and Dominating Focus becomes the person (It's always you causing trouble!)	**Marshmallowing and Smothering** Focus is on meeting own needs (Anything for a quiet life / avoid an argument)
CONTROL	**CARE**
Structuring Focus is on the rule (It's not ok to be shouting out of turn)	**Nurturing** Focus is on meeting others' needs (I notice you seem upset - is there anything I can do to help?)

Fig. 3 Calibrating between behaviour modes

Teachers often see which of the two negative behaviours they most lean toward when they are less effective in times of stress. Two qualities worthwhile developing in order to counter these are **assertiveness** and **empathy,** both of which are reflected in a restorative method.

In considering how to use TA in schools it is as important to hold both the student-teacher and colleague –colleague dynamics in mind. This can be especially important when reflecting on leadership behaviour. Using the idea of functional fluency in training middle and senior leaders can be helpful to widen the language and frame of reference to make further sense of the relational aspects of school management and leadership.

Contracting for Partnership

The most effective way of avoiding the conflict that comes with game-playing is the TA concept of contracting. In TA the concept of contracting has a particular meaning. Far from the functional business use of contracts, in TA the word refers to a process through which different partners clarify a range of factors which underpin effective working together. Contracting involves ensuring that individuals are clear about the extent of **permission**; what people are allowed to do and the limits of the partnership. It also includes ensuring that the partners have **protection**; they won't be asked to do what they can't do, or be caught out. Finally, it is important that the **potential** for growth and sabotage are also acknowledged.

These three dimensions – permission, protection and potency – provide the basis of sound partnerships in schools in both classrooms and staffrooms. In addition there are three levels at which the contracting takes place. The **procedural** level involves being clear about arrangements such as dates, times, equipment, rooms, payment and other domestic matters. The **professional** level concerns the purpose of the work, for example learning maths, developing social skills, establishing whole school policy, setting a budget, supporting parents. The **psychological** level refers to the unspoken hopes and fears that individuals bring to the partnership. This can include previous experiences of similar partnerships; both negative and positive. Often planning partnerships focuses on the professional procedural levels, although it is the psychological material that tends to drive the actual process. The three dimensions and the three levels can be explored using a series of questions, examples of which are presented in the table below:

1. Check the practical aspects of the work, eg. when and where will colleagues meet? Are notes necessary? How frequent will the triad meet and what works best for individuals in terms of time
2. Establish a clear and overt understanding about the respective roles of the leader, team members and other partners in relation to the context of the school/organisation. This includes detailing the anticipated content of the sessions as well as what won't be covered.
3. Clarify roles and responsibilities – don't assume people know who does what. Questions to clarify respective expectations and priorities are important in gauging the extent to which individuals will be willing and able to engage with the process.
4. Consider what might get in the way of an effective partnership. What might each partner do that could sabotage the work? How might this be pre-empted or minimised?
5. It is important that the work of each partner is linked to the overall direction and development of the school. Has this been considered by the individuals?

Recommended Further Reading

- Improving Behaviour and Raising Self Esteem (Barrow, Bradshaw & Newton, 2001)
- Functional fluency for educational transactional analysts TEMPLE, S. (1999), Transactional Analysis Journal
- Educational Transactional Analysis: An international guide to theory and practice by Giles Barrow (Editor), Trudi Newton (Editor)

Domestic Abuse

What is Domestic Abuse?

The Domestic Abuse Act 2021 brings in for the first time a legal definition of domestic abuse. Section 1 of the Act applies to the definition.

The behaviour of a person (A) towards another person (B) is "domestic abuse" if

a. A and B are aged over 16 years old and are personally connected to each other.
   and
b. The behaviour is abusive. Behaviour is abusive if it consists of any of the following – Physical or sexual abuse; Violent or threatening behaviour; Controlling or coercive behaviour; Economic abuse; Psychological, emotional or other abuse.

And it does not matter whether the behaviour consists of a single incident or a course of conduct.

The Act further defines economic abuse and personally connected.

Anyone can be a victim of domestic abuse, regardless of gender, race, religion, or class.

Domestic Abuse also encompasses:

Honour Based Abuse - a collection of practices used to control behaviour within families in order to protect perceived cultural and religious beliefs and/or honour.

Forced Marriage - where one or both people are 'forced' into a marriage that their families want, without the valid consent of both people, where physical pressure or emotional abuse is used. Victims are sometimes persuaded to return to their country of origin under false pretences.

Female Genital Mutilation - is a procedure that sees the partial or total removal of the external female genital organs for non-medical reasons.

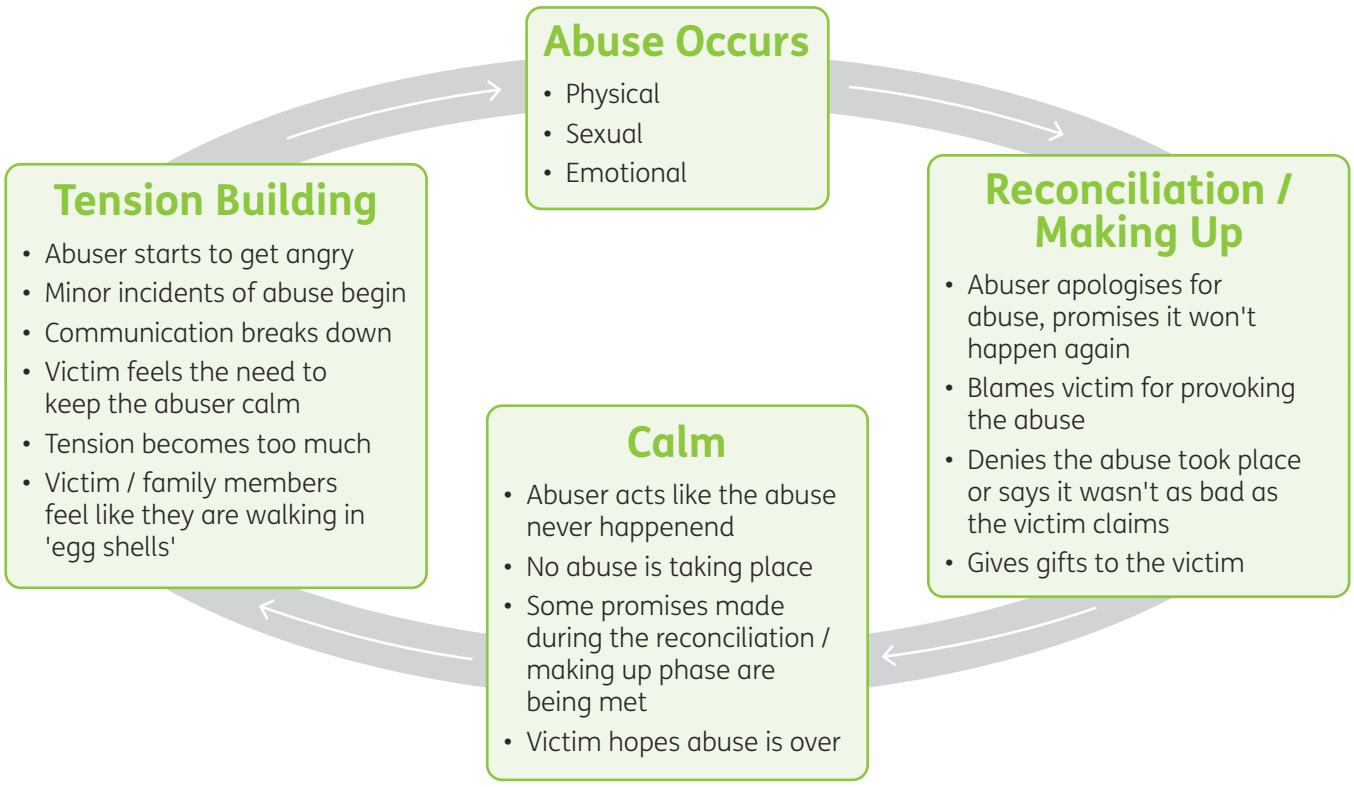
Types of Domestic Abuse

There are different types of domestic abuse that can occur in relationships, not all abuse leaves visible marks. Abuse of any kind can erode individuals' self-esteem and confidence and make them feel worthless. It diminishes their physical, mental, and emotional well-being, which can also have a negative impact on others around them.

Examples of types of abuse:

- **Physical** – biting, shaking, slapping, hitting with objects
- **Emotional/Psychological** – insults or being called nasty names, isolation, threats, intimidation
- **Sexual** – rape, forcing sex in front of others, unwanted touching
- **Financial** – making you ask for money, controlling all the money, taking your money away
- **Coercive and Controlling behaviours** – always monitoring where you are, constantly criticizing and constantly telling you where to go and/or what to wear.

There is a common pattern or cycle of violence that domestic abuse falls in to:



Why don't victims leave?

Healthy relationships should not involve one person controlling or hurting another. Many victims suffer in silence because they are afraid to ask for help. Here are **some of the reasons** why victims stay in abusive relationships:

Frequency and severity

Sometimes victims of abuse may down play incidents if they do not happen often. The abuser may say that that it will be the last time when it does happens. So the less frequent and severe the incidents, the more likely that they will stay.

Financial dependency

The partner may control all finances, and this means that the victim is dependent on them for money to survive. The result being that they can feel as though it is easier to keep the abuse to themselves and stay in the relationship, rather than leave and have no income at all.

Beliefs about marriage

Cultural or Religious beliefs can have a big impact on the decision to stay in an abusive relationship. These beliefs can encourage a need to maintain the façade of a happy marriage. In some cases believing that abuse is part of every marriage and that they have to stay together for the children.

Fear

A victim may be too scared to leave because they think that they cannot get away from their partner. Abusers, often say things like "I will never let you go" or "I will always find you". Comments like this can make the victim feel as though there is no way out. They are often so scared that they deny abuse is happening if police are called to avoid the repercussions from the abuser or wider family.

The victim may have a limited or non-existent support network due to the perpetrator isolating them from friends and family.

Impact

The victim may worry about the impact on the children of leaving the perpetrator.

Isolation

The victim may have a limited or non-existent support network due to the perpetrator isolating them from friends and family.

Statistics

Statistics indicate that women are at a greater risk of physical violence when they have left/ are leaving the abusive relationships. It is important to think about safety planning when someone is making the decision to leave a relationship.

- 2 women killed every week in England and Wales by a current or former partner (Refuge)
- 1 in 4 women will experience domestic abuse in their lifetime (Refuge)
- 1 in 6 men will be victims of domestic abuse at some stage in their lives and
- 1 man dies every 3 weeks due to domestic violence (The National Centre for Domestic Violence)
- 1 in 5 children have been exposed to domestic abuse (NSPCC)
- Domestic abuse is present in 60% of Serious Case Reviews (NSPCC)
- 62% of children in households where domestic violence is happening are also directly harmed (SafeLives, 2015)
- Domestic abuse often starts in pregnancy

130,000 children in the UK live in homes with domestic abuse where there's a high risk of murder or serious injury (Safelives 2015)

Effects on Children

Children who grow up in abusive households are negatively affected by the abuse regardless of whether they witness it or not. Hearing violent or angry interactions between parents or other family members on a regular basis will have an impact on their social and emotional development.

A child may display behaviour such as bed wetting, poor eating or sleeping or may be unable to make close relationships with those around have few or no friends. They may have difficulty concentrating at school which in turn will lead to problems with learning, this can also lead to refusing to go to school, (fear of leaving the abused parent at home and not knowing what may happen).

The abuser's poor behaviour can become the learnt behaviour of the children and this can lead to problems at school or in the community. They may become abusive to peers and or family members. This may also lead to a misdiagnosis of behavioural problems.

A parents' ability to look after their children can also be affected, which will either cause attachment issues, or result in children taking on a more adult role if the parent feels unable to look after them.

Violence to pregnant mothers may result in injuries to the unborn foetus, miscarriage, stillbirth, premature birth.

In certain situations the mother may resort to taking drugs/alcohol as a coping mechanism. This may also have consequences for the unborn child- Foetal alcohol syndrome or drug dependency at birth.

Chronic stress may also contribute to subtle differences in brain development that might lead to behavioural issues as the baby grows. Research in this area is still early and debatable.

Mothers who are stressed out in pregnancy 'transmit' the effect to their unborn baby as early as 17 weeks. Research suggests stress hormones activated by maternal anxiety may have a long-term effect on the child's brain development and future.

What to do if you have concerns

- Discuss concerns with your safeguarding lead in your setting
- If you are worried that a young person is at risk of harm complete a MASH referral
- If appropriate discuss support options with the parent (EHA, IDVA, DASH risk assessment, MARAC)

Useful links

http://www.safelives.org.uk/

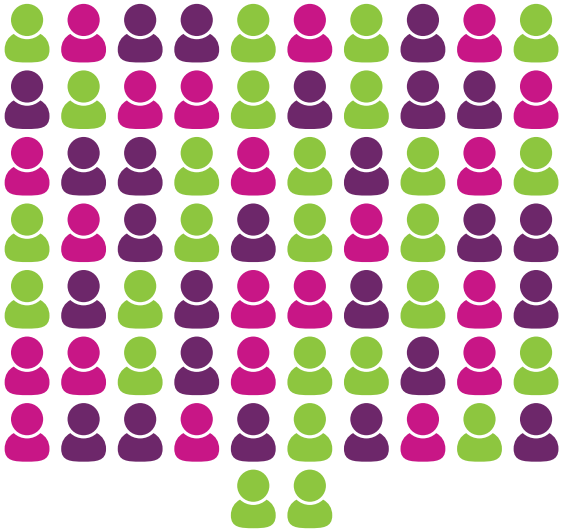
http://www.bedsdv.org.uk/

https://www.womensaid.org.uk/

Prevent

What is Prevent?

Prevent is about safeguarding people and communities from the threat of terrorism. Prevent is 1 of the 4 elements of CONTEST, the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.



The Prevent Strategy

- Responds to the ideological challenge we face from terrorism and aspects of extremism, and the threat we face from those who promote these views;
- Provides practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support; and
- Works with a wide range of sectors (including education, criminal justice, faith, charities, online and health) where there are risks of radicalisation that we need to deal with.

Prevent covers all forms of terrorism and extremism and some aspects of non-violent extremism.The Home Office works with local authorities, a wide range of government departments, and community organisations to deliver the Prevent strategy. The police also play a significant role in Prevent, in much the same way as they do when taking a preventative approach to other crimes.

Prevent uses a range of measures to challenge extremism including:

- Supporting people who are at risk of being drawn into terrorist or extremist activity through the Channel process
- Working with and supporting community groups and social enterprise projects who provide services and support to vulnerable people
- Working with faith groups and institutions to assist them in providing support and guidance to people who may be vulnerable; and
- Supporting local schools, local industry and partner agencies through engagement, advice and training.

What is Channel?

Channel provides support across the country to those who may be vulnerable to being drawn into terrorism. The overall aim of the programme is early intervention and diverting people away from the risk they may face.

Channel uses existing collaboration between partners to support individuals and protect them from being drawn into terrorism.

Who Delivers Channel?

The process is a multi-agency approach with a wide range of agencies and local partners working together to provide support for individuals. Coordinators are usually police officers with the multi-agency panel being chaired by the Local Authority.

How does Channel Work?

Channel works by partners jointly assessing the nature and the extent of the risk and where necessary, providing an appropriate support package tailored to the individual's needs.

The three key stages of Channel are:

- Identify individuals at risk of being drawn into terrorism;
- Assess the nature and extent of that risk; and
- Develop the most appropriate support plan for the individuals concerned.

Assessing the nature and extent of the risk

Where necessary, referring cases to a multi-agency panel for development of the most appropriate support package to divert and support the individual at risk.

How do you identify those at risk?

Referrals come from those who have concerns about individuals who may be vulnerable to being drawn into terrorism.

Who makes the referrals?

Referrals can come from a wide range of individuals and partners and could include youth offending teams, social services, health, police, education and local communities.

Who sits on the multi-agency panel?

The panel is designed to work in the same way as other multi agency structures that are used to safeguard individuals at risk – from drugs, knife and gun crime, gangs etc. The panel is chaired by the local authority and consists of statutory partners and the Channel coordinator.

What kind of support is provided through the channel?

Examples of support provided could include mentoring, diversionary activities such as sport, signposting to mainstream services such as education, employment or housing. Support is always tailored to specific needs of the individual following assessment by the multi-agency panel.

Useful Links

www.ltai.info

Protective Behaviours

Overview

Protective Behaviours is a practical and down to earth approach to personal safety. It is a process that encourages self-empowerment and brings with it the skills to avoid being victimised. This is achieved by helping people recognise and trust their intuitive feelings (early warning signs) and to develop strategies for self -protection. The Protective Behaviours process encourages an adventurous approach to life which satisfies the need for fun and excitement without violence and fear.

Protective Behaviours is a framework for **personal safety** consisting of **2 Themes** and **7 Strategies**. This is very different from the 'lock your doors', restrictive approach to personal safety - it is a dynamic, confidence building, empowering approach that links safety with having adventures and taking risks.

The Two Themes

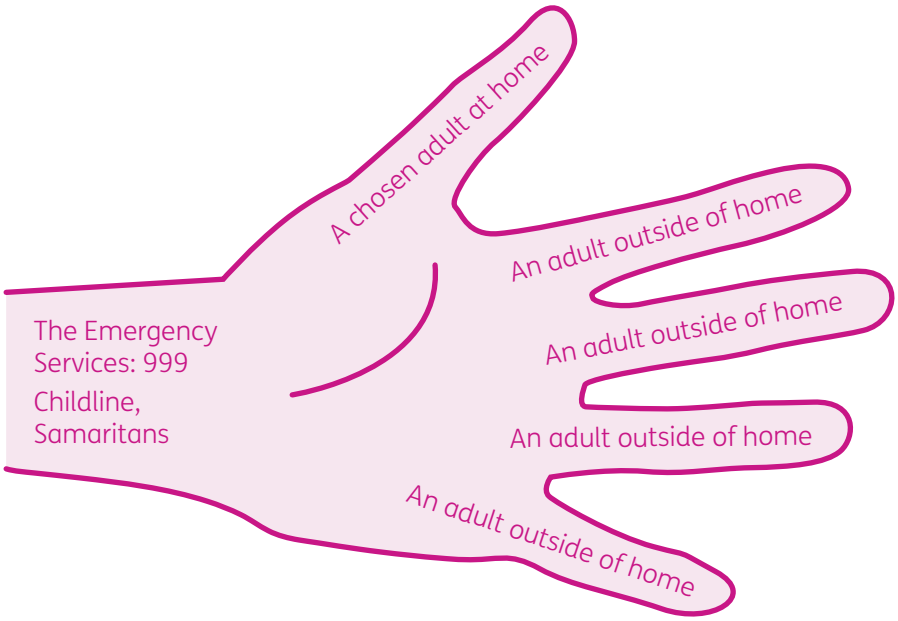
The approach starts with a positive statement about **feeling safe**: the first theme of PBs is:

"We all have the right to feel safe all the time."

With that right comes a responsibility not to do anything that would leave other people feeling unsafe and we can identify if we are feeling unsafe by tuning into our **early warning signs**, those things that happen in our body like butterflies in the stomach, wobbly knees etc. that let us know we don't feel OK in a particular situation. If we get those 'Early Warning Signs', PBs encourages us to **think** clearly about what our options are and work out what **action** we might need to take. That action might be to contact somebody on a **support network**, which is where Theme 2 of PBs comes in:-

"We can talk with someone about anything, even if it feels awful or small."

PBs encourages the development of a clear '**support network**' which we can call upon having identified that we are feeling unsafe. On the support network we would ideally have 5 people who might be able to help us do some **problem solving**. They might be people who ask questions so that we can come up with our own solutions; they might be people who actually give some advice; they could be friends or family or people at the end of a help line - sometimes it's easier to phone a help line as they, and us, remain anonymous. It doesn't necessarily have to be about something that's really terrible; it might be that we need to mull things over, or celebrate an achievement. Having four people plus the ones at home, is suggested so that we have got a bit of variety and have back up options if our first choice of contact is unavailable.



In this way the PBs process can increase our self-confidence and empower us to develop our own thinking and problem-solving skills. In turn, this can enhance our confidence to take **protective action** on our own behalf and seek the help of others when we need it in order to help us feel safe again. When we are feeling safe we are more likely to feel confident, strong and **empowered** so we can get 'out there', have some **adventures** and live life to the full within a framework of safety.

So if we believe we have the right to feel safe and have a support network we then have the opportunity to push the boundaries and take a few risks - not restricting ourselves and staying indoors all the time, but getting out there and having some fun.

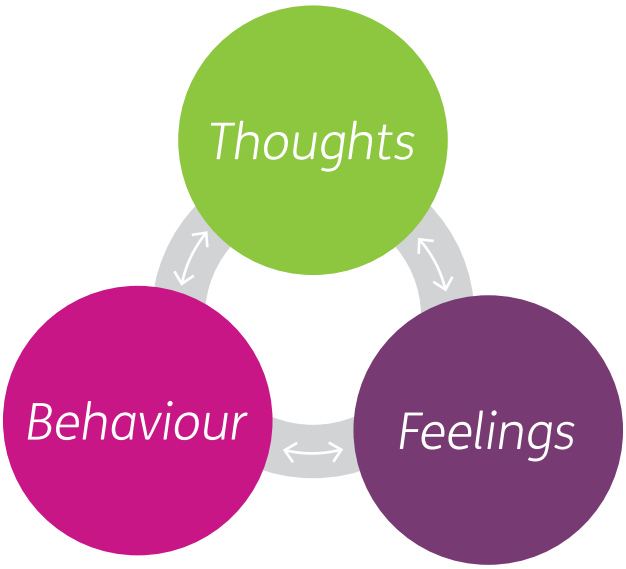
Unwritten Rules of Society

We see how certain rules of society have a powerful influence on our choices of behaviour. Whilst these rules can be positive and help guide our interactions, many of them tell us we ought, or must behave in a particular way. For instance, children should do as adults tell them; professionals should always have the answer; men should not show their feelings and women should behave in a ladylike

manner. These rules are not written down, are often contradictory and may not fit with our own experience. During training we looked at their function, how they develop, their effects and why we may choose to follow them or not.

Feelings, Thoughts and Behaviours

When looking at the interaction between our feelings, thoughts and behaviour we see that feelings are feelings; neither right nor wrong, good nor bad, positive nor negative. Some people seem to mask one feeling with another or use behaviour as a way of avoiding or covering feelings. We look at how behaviour is a choice with an effect. These effects may involve others as well as ourselves. Sometimes we do not know what our choices are or they may be limited by factors we cannot change. Once we are in touch with our feelings it helps free us to use our thinking.



The Seven Strategies

The seven strategies are used to effectively implement the 2 themes at the core of the process. The strategies are:

Theme Reinforcement

Reinforcing the two themes verbally, visually and especially by example.

Network Review

Constantly checking to ensure our networks are available and still fit our needs.

One Step Removed

Using a 'third person' approach for problem solving, to seek assistance or to check out someone's likely response before making a disclosure. This might include role play, videos or asking for help from another person.

Protective Interrupting

Any action we take to interrupt or halt any potential or actual unsafe situation, for instance, saying 'no' when someone is trying to make us do something we feel is wrong.

Persistence

Persisting in seeking help until we feel safe again and our EWS have gone. This includes seeking further help if our EWS return.

Risking on Purpose (ROP)

Deliberately choosing to take a risk when the outcome may be what we want or need, for example, going for a job interview. It also includes remembering other people have a right to feel safe.

The Language of Safety

This is the glue which holds all the Protective Behaviours elements together. It includes re-framing our language into an empowering, non-victimising and non-violent format consistent with the PBs process.

We demonstrate the difference between 'political correctness' when we may not believe in what we are saying and PBs language of safety where we know, for example, racist words are never acceptable because someone is likely to feel unsafe if we use such language. Using racist language would mean we were not observing our responsibility to other peoples' right to feel safe.

10 Tips for Personal Safety using the Protective Behaviours Process

1. We all have the right to feel safe all the time.
2. When we do not feel safe we also have the right to do what we need to do until we feel safe again.
3. When things are safe for us we have a choice, feel comfortable and are in control.
4. When things are not safe for us our body automatically tell us; for example our heart beats faster or our tummy feels funny etc.
5. The quicker we recognize and trust these feelings the more choices we have to either avoid or deal with the problem.
6. We can use our body's feelings to help us choose which option is the safest.
7. Once we are out of the immediate danger we can find someone to tell.
8. There is nothing so awful or too small that we can't talk about it with someone.
9. We can use our feelings to decide who the best person to talk with is and who will help us.
10. Part of our right to feel safe includes the responsibility to see that others are safe with us. In other words treat others the way we want to be treated ourselves.

Useful Links

www.protectivebehaviourstraining.co.uk

Mental Health

What is Mental Health?

Mental Health is the strength and capacity of our minds to grow and develop, to be able to overcome difficulties and challenges and to make the most of our abilities and opportunities.

A child's mental health includes:

- A capacity to enter into, and sustain, mutually satisfying relationships
- Continuing progression of psychological development
- An ability to play and learn so that attainments are appropriate for age and intellectual level
- A developing moral sense of right and wrong
- A degree of psychological distress and maladaptive behaviour within normal limits for the child's age and context
- A clear sense of identity and self-worth

Problems and Disorders

Mental health problems:

A disturbance of function in one area of; relationships, mood, behaviour or development, of sufficient severity to require professional intervention.

Mental disorder:

A severe problem (commonly persistent) or the co-occurrence of a number of problems, usually in the presence of several risk factors.

1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder – that is around three in every class. 72% of children in care have behavioural or emotional problems, 95% of imprisoned young offenders have a mental health disorder, and the number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.

Risk

The more risk factors to which a child is exposed the greater their vulnerability to mental health problems. Some of the risk factors include:

Genetic influences	Some chromosomal syndromes are associated with particular behavioural traits.
Low IQ and learning disability	Children with learning difficulties may have communication difficulties, low self-esteem, limited life experiences and losses, all of which may contribute to a greater vulnerability.
Specific development delay	Specific developmental problems such as dyslexia, dyspraxia and attention deficit disorder.
Communication difficulty	Language delay, English as a second language and cultural differences that are not understood or recognised, can all make the world seem a confusing and unresponsive place.
Difficult temperament	Children are born with different temperaments which determine how easily they adapt, settle and deal with stress.
Physical illness	Children who are often ill miss time from activities that other children do, at play and school. They may have to undergo uncomfortable or unpleasant treatment; they may miss out on developing friendships.
Academic failure	School is a big part of a child's life and not being able to cope at school will have a huge impact.
Low self-esteem	Low self-esteem can affect the way children deal with new challenges. We know that many children in care have low self-esteem due to experiences both prior to and entering the care system.
Overt parental conflict	When parents are caught up in tense, hostile and angry battles with each other.
Family breakdown	Children have to cope with the distress, disappointment and sadness that this brings; and after a separation, it proves to be very hard for many couples to continue to act as parents towards the children.
Abuse	Physical, sexual, neglect and/or emotional.
Parental illness	A parent suffering illness may go through times when they are unable to meet their children's needs.
Parental criminality or substance misuse	These factors can make it difficult for parents to provide a stable and secure family.
Death and loss	Whilst children need to learn how to cope with loss and bereavement, these experiences can be very traumatic.
Socio-economic disadvantage	Living in poverty is a powerful risk factor.
Homelessness	Families who do not have the stability of a home find it very difficult to provide a secure and predictable life for their children.
Disaster, accidents and war	Such contexts mean that the usual structures and supports are disrupted.
Discrimination	Children can experience discrimination amongst their peers if they appear to be different in any way from the majority, including race, colour, faith, culture, disability, sexual orientation.

Resilience

Resilient children can 'resist adversity, cope with uncertainty and recover more successfully from traumatic events or episodes' (Newman, T, 2002). Research has consistently identified the following protective factors for children's mental health:

- Being female (in younger children)
- Secure attachment experience
- Outgoing temperament as an infant
- Good communication skills, sociability
- Being a planner and having a belief in control
- Humour
- Problem solving skills and a positive attitude
- Experiences of success and achievement
- Faith or spirituality
- Capacity to reflect

Attachment Theory

Attachment theory is one of many helpful theories in understanding mental health. A securely attached child feels confident that should they feel anxious, their parents will respond. Such security is brought on by interactions which are:

- Sensitive
- Regularly available and reliable
- Warm
- Responsive
- Consistent

In addition to being formed around the child's needs for protection from danger, and need for comfort when they are feeling distressed, attachment relationships depend on the caregiver response to the expression of these needs.

Secure attachment is associated with:

- Emotional regulation and containment of anxiety
- Capacity to tolerate uncertainty
- Trust, adaptability, hope and belonging
- The child's 'internal working model'

Insecure attachment is associated with:

- Lack of trust of others
- Inability or difficulty with self-regulating feelings
- Poor self esteem
- Difficulty visualising the future (hope)

Types of attachment

Secure attachments: Characterised by the ability of the young person to use adult support appropriately at times of stress or challenge and, in particular, prior to or following brief separations, for example, visits to birth family, crossing the family boundary to school or college etc.

Avoidant attachment:

No attunement – needs rejected
Distressed feelings are 'cut off' so as not to cause frustration to caregiver(s)
Tends to over rely on cognitive ways of processing information (and not emotive)
Tend to retain control by comforting self – over self-reliance

Ambivalent attachment:

Caregiver will be inadequate at meeting child attachment needs (caregiver is passive, unresponsive and ineffective)
Child's strategy is to amplify attachment needs and signals in an effort to arouse a response (verbal and behavioural; bubbly affection to rage, anger, panic and despair. All experienced as controlling)
Relies on own internal affect state to alert self to danger – cognition cannot be trusted
Under-regulated

Disorganised attachment:

Child experiences the caregiver as BOTH the source of alarm and its only solution
Child unable to be guided by their mental model of the world – no coherent strategy works
Frightened, helpless, fragile and sad. Fragmented sense of self
At risk of mental health problems or anti-social behaviour

Useful Links

- *www.boingboing.org.uk*
- *www.youngminds.org.uk*
- *www.headspace.com*
- *www.childline.org.uk*

Young Carers

Overview

Young carers may be taking responsibility for a parent, grandparent, brother, sister or any other family member who is sick or disabled. Some may be the only person providing care, whilst others may take on responsibility alongside other members of the family. Many young people undertake their caring roles willingly and, however difficult this may make their lives, wish to continue helping.

The Children and Families Act and Care Act 2014, which came into force in April 2015, significantly strengthen the rights of young carers. The Children and Families Act 2014 is an important new piece of legislation for young carers, sibling carers, young adult carers and their families. It amends Section 17 of the Children Act 1989, introducing sections 17ZA, 17ZB and 17ZB.

Definition of a Young Carer

A young carer is defined as a person under 18 who provides or intends to provide care for another person, or is affected by their family member's illness. The concept of care includes practical or emotional support.

- All young carers under the age of 18 have a right to an assessment regardless of whom they care for, what type of care they provide or how often they provide it.
- Both young carers and sibling carers have the right to an assessment based on the appearance of need – which means that they will no longer have to request an assessment or be undertaking a 'regular and substantial' amount of care. An assessment also can be requested.

It is still the case that this definition excludes children providing care as part of contracted work or as voluntary work. However, the local authority can ignore this and carry out a young carer's need assessment if they think it would be appropriate.

The changes in the Care Act re-inforce these new rights by requiring that local authorities:

- Take a whole family approach to assessment and supporting adults so that young carer's needs are identified when undertaking an adult or adult carer's needs assessment.
- Ensure that adult's and children's social service work together to ensure assessments are effective.

This means when a child is identified as a young carer, the needs of everyone in the family are to be considered. This should trigger action from both children's and adults services – assessing why a child is caring, what needs to change and what would help the family to prevent children from taking on this responsibility in the first place.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/365345/Making_Sure_the_Care_Act_Works_EASY_READ.pdf

The Impact of Being a Young Carer

Whatever their background, young and sibling carers, may be disadvantaged in many ways. Not achieving their potential educationally because of caring responsibilities, for instance:

- Missing school
- Being late for school
- Poor exam grades
- Difficulty in completing homework
- Being bullied at school
- Bullying compounding other difficulties
- Limited time for social and leisure activities
- Health problems – caring for a physically disabled adult may lead to back problems for the young carers

Responsibilities a Carer may have:

- Taking siblings to and from school and/or supervising siblings
- Feeding, bathing, dressing
- Heavy lifting and/or manual handling
- Providing emotional support such as keeping an eye on the cared for or sitting with their cared for to ensure they are okay
- Practical tasks such as cooking and cleaning
- Dealing with financial matters such as paying bills, collecting benefits
- Providing communication such as interpreting or using sign language
- In terms of their personal identity, young carers may have difficulty seeing themselves as an individual – as a child or young person in their own right with a future and deserving of positive outcomes for themselves.

The Needs of Young Carers

Young carers require support because many of their needs are complex. In order to make informed decisions, they need accurate and understandable:

- Medical information
- Information about practical help
- Information about what services are available
- Information about welfare rights, financial advice and benefits
- Working with parents and carers

The success of practitioner's work with children and young people can be enhanced through effective helping relationships with their parents and carers. Practitioners therefore need to collaborate, work and communicate effectively with parents and carers to complement their work with children and young people.

Young carers need services that are adequate and flexible, for example, befriending, advocacy, respite and counselling. Young carers need to be listened to, acknowledged, respected, encouraged, believed and recognised. Young carers are children, and young people need to experience their childhood complete with fun, leisure activities, and even falling ill themselves without being burdened with worries and feeling responsible for the care of another person.

Supporting Young Carers

Raising awareness: Practitioners can raise the awareness of various professionals about the needs of young carers. For example, if a classroom teacher understands the caring role of a child or young person, then s/he is more likely to anticipate better their educational difficulties, take preventative action and intervene effectively and sensitively in response to any emerging needs. Schools should create a whole school commitment to young and sibling carers to ensure all staff are aware of young carers and who to signpost to. Schools can also sign up to the nation-wide Young Carers in Schools Award Programme which is facilitated by The Carers Trust and The Children's Society.

Practitioners can also empower and support young carers so that they can raise awareness among their peers about their caring responsibilities. If their peers understand the situation, young carers are less likely to be the subject of bullying. Identifying young carers: Practitioners need to know which of the children they work with are young carers, so they can support them. A means of actively identifying young carers needs to be set up – not just becoming aware of them by default. To help designing these systems, practitioners should talk to those young carers who have already been identified.

Partnership: Practitioners need to work in full partnership with young carers through consultation, assessing their needs, listening to them and acknowledging their rights. Fully including young carers in the planning process also empowers them. Practitioners also need to work not just with the individual young carer but with a focus on the needs of the whole family.

Working with other agencies: The needs of young carers are unlikely to be met by one practitioner working alone. Multi-agency is key to ensuring that the needs of young carers are acknowledged and met. Young and Young Adult carers can be signposted to Carers in Bedfordshire for support, who are able to provide bi-monthly clubs, activities, 1to1 support, Sibling Workshops, Peer Mentor Project support, Carers Cafés, Discount Card and a Carers Grant.

Useful Links

www.carersinbeds.org.uk

Early Help Parenting Offer

Early Help Parenting Offer

The Early Help Parenting offer helps families in Bedford to flourish by giving parents the confidence, kills, knowledge and understanding to build a strong family life to keep children safe, healthy and happy.

Provided for FREE, Bedford Borough Early Help's parenting offer supports parents and carers with children aged 0 to 19yrs as well as children and young people. We offer a range of information and support, from short workshops, seminars, group discussions and courses. A key component of this offer is Triple P Parenting.



Group Triple P

Group Triple P is an 8-week programme for any parent/carer of a child/ren aged 0–12 years. Groups are small (usually 8 – 10 parents/carers) and are made up of people who all want the same thing – to do the best for their children and enjoy a happy family life. Groups are run by accredited Triple P facilitators. There are four 2-hour group sessions (held weekly), followed by two/three 15 – 30 minute weekly phone calls to discuss progress and any concerns participants may have, and then a final group session.

Participants will learn about:

- Effective Parenting Strategies
- How to promote your child's development
- How to manage common child behavioural problems
- Principles to help you deal with almost any situation that may arise.
- Parents/carers should be available to attend every session.
- Teen Triple P Programme

Life with teenagers can be a challenge and Teen Triple P really understands that. As a child moves through to their teens, parents & carers have to learn a whole new set of parenting skills and as we know, this is difficult. The 8 week Teen Triple P programme offers parents & carers' knowledge and new skills to be able to manage conflict with teens, relate to them as they continue to grow, improve communication and promote their children's independence as they enter early adulthood.

Discussion Groups and Seminars

Parents/Carers may prefer to come along to Triple P Discussion Groups. This is a great way to cover key areas we know many parents want information and help with, including:

- Understanding general parenting issues, why children tend to behave in certain ways under certain influences, and what they best respond to.
- Dealing decisively and effectively with behaviours such as aggression, non-cooperation and disobedience.
- Recognising and managing situations that might be less obvious such as sadness, anxiety, difficulty with separation and problems mixing with other children.

Online Triple P

Online support: fast, direct and in your control...

Most parents looking for answers turn to the internet; and we have an online version of Triple P and Teen Triple P in response to overwhelming demand.

Triple P Online covers all the strategies a parent would learn by doing a similar face-to-face Triple P programme, with comparable or better ability to reduce social, emotional, and behavioural issues in children and improve their parents' confidence and capability, while also reducing parental levels of stress and depression.

Triple P Online has demonstrated reductions in behaviour problems in children with early-onset conduct disorders, as well as improvements in ADHD symptoms of pre-school children.

Triple P Online is:

- A flexible delivery model: self-paced and convenient
- A method of improving outcomes for families
- A programme that includes:
    - 8 interactive modules
    - 17 proven strategies
    - 12 months' unlimited access
    - Certificate of completion

Family Transitions Triple P

Family Transitions Triple P is designed for parents who are experiencing personal distress from separation or divorce, which is impacting on or complicating their parenting. The course focuses on skills to resolve conflict with former partners and how to cope positively with stress.

Principles for a Positive Transition:

Family Transitions Triple P promotes 5 main principles for a positive transition, these are:

1. Meeting the needs of children
2. An effective co-parenting relationship
3. Communicating appropriately with children
4. Setting up a new life as a single parent
5. Taking care of yourself

Meeting the needs of children:

Children need to know that the divorce or separation is not their fault and that both parents love them. Except in exceptional circumstances, children need to have an ongoing relationship with both their parents that involved stability and routine. This ensures that they grow up feeling they have two homes where they are loved and cared for, rather than feeling as though they come from a broken home.

An effective co-parenting relationship:

Parents are parents forever. While divorce or separation signals the end of a romantic relationship, parents need to develop and maintain an ongoing relationship as co-parents of their children. This requires the development of a new business-like relationship as co-parents and the letting go of the emotional relationship of partners.

Children whose parents learn to co-parent effectively are more likely to continue to have positive ongoing relationships with both of their parents and as a result, they are less likely to develop behavioural, emotional or academic problems, or relationship problems as adults.

Communicating appropriately with children:

Children need an age appropriate explanation for the divorce that does not undermine their relationship with either parent. They need to be able to voice their concerns and ask questions about what is happening in their family. Wherever possible they should have an input into changes that are going to affect them, but not be responsible for making decisions – that is the role of parents.

Setting up a new life as a single parent:

Divorce or separation involves a change from being part of a couple to a single parent. This involves numerous tasks including:

- Negotiating the legal processes
- Deciding on practical needs (housing, work, school)
- Managing financial issues
- Learning new skills
- Accessing support and services

Taking care of yourself:

Continuing to parent effectively while making the transition through divorce or separation is easier when you are taking care of your own needs. This includes:

- Managing difficult emotions constructively (e.g. anger, resentment, hurt, stress, depression and anxiety)
- Coming to terms with feelings of grief and loss associated with divorce/separation (dreams, hopes, home, friends, lifestyle)
- Creating a balance between work, parenting, recreational activities and spending time with friends
- Developing and maintaining social support networks (family, friends, work colleagues, church members, sporting associates)
- Adjusting to fewer or greater parenting responsibilities
- Forming new romantic relationships

Useful Links:

www.triplep.net

https://www.triplep-parenting.uk.net/uk-en/get-started/triple-p-courses-for-parents-of-children-birth-12-years/family-transitions/

Triple P Stepping Stones

Stepping Stones Triple P has been developed for parents of children with a developmental disability or additional need. Because it's based on Triple P's proven parenting strategies, it gives you ways to deal with the kinds of childhood behaviour problems and issues that can make family life stressful. Stepping Stones Triple P has been evaluated with real families and has been shown to work with children with intellectual and physical disabilities who have disruptive behaviour.

Who is this for?

- Parents of children with a disability (3years to 12years)

Stepping Stones Triple P can help you:

- Manage problem behaviour and developmental issues common in children with disabilities
- Encourage behaviour you like
- Cope with stress
- Develop a close relationship with your child
- Teach your child new skills

Strengthening Families

A programme for parents and children aged 10 to 14* to come to together.

The programme aims to help families to work together to solve problems, create and sustain a positive relationship and have fun together as a family.

It supports parents to manage misbehaviour, by using appropriate rewards and consequences and encourage and support their children to make good choices and decisions.

The programme supports young people to make positive choices and decisions, understand the need for rules and encourages young people to recognise their strengths and look at how they can use those to manage difficulties.

Parent Sessions:

- What are young people like at this age
- Making rules and applying consequences
- How to help young people with problem solving
- Ways to show love and support.

Young People's Sessions

- Handle frustration
- Resist peer pressure
- Appreciate parents
- Get along with others
- Use strategies to make good decisions and positive relationships.

Family Sessions

- Fun activities and games
- Discuss what makes families strong
- Solve problems together
- Acknowledge and appreciate family and individual strengths.

*The absolute minimum age limit is 8 due to the nature of the content in the children's group.

Who's in Charge

This is a 6 week programme to support parents where their children are especially challenging (violent/ aggressive) and all the usual strategies for managing behaviour do not seem to work.

This is a therapeutic group which offer alternative strategies tailored to particular personality types of both young people and parents and challenges parents to reflect on how their response can affect the outcome of situations. Age range 8-17.

The programme focuses on:

- Reducing the parent's feeling of isolation
- Challenging parents feelings of guilt
- Loosening deterministic thinking about causes (e.g. he can't help it because he has ADHD or he saw his father being violent).
- Creating belief in possibility of change
- Clarifying boundaries of what is acceptable and unacceptable behaviour
- Reinforcing progress and provide emotional support while they attempt to become more assertive parents.
- Exploring anger – both children and parents.
- Encouraging assertiveness
- Encouraging Self Care

Group Work

Overview

This resource has been created for professionals who would like to work with a group of young people that are identified as experiencing social or behavioural barriers that may be impacting on their learning.

This is for young people that are just starting to come to the attention of staff due to low level disruption or who may need a boost with their confidence. Ideally, the group should consist of a mix of personalities and peer groups, and should be male or female groups rather than a mix of genders as we feel that this encourages open discussions about some of the sensitive subjects that are covered during the sessions.

It is recommended that the focus should be year 8 and over to ensure we are taking a preventative approach. A pilot was completed with year 11's where it was identified that a more effective approach would be to work with younger students.

Two facilitators are required to facilitate a total of 10 sessions, (1 x per week – duration 1.5 hours).

Outcomes are measured by using the Youth Star tool, which will target the following key areas:

- Choices and behaviour
- Communicating
- Education and work
- Well-being
- Making a difference
- Hopes and dreams

The use of interactive activities and open discussion will encourage the group to think about their future aspirations.

At the end of each session, the young people are encouraged to rate the session using post it notes on a scale of 1-10. (1 = poor, 10 = excellent)

Once school have identified the students, it is advisable to meet and discuss the content of the sessions, get a brief description of the issues/concerns and attendance level of each student that will be attending.

Example of Session 1

Communicating

Activity 1

Discuss and list different ways of communicating / what affects the way we communicate with others.
Split young people into 2 groups with each group listing ideas on flipchart paper.
(Bring everyone back together to discuss as a whole group).

Activity 2

Have 2 people volunteer for this section Person A and Person B.
Person A will be the listener, Person B will be the talker
Group members will observe the activities:

Roadblocks

Person A and Person B will sit and face each other, Person B will discuss a topic of their choice for 2 minutes. Person A will sit quietly and act/show that they are not listening without communicating (e.g. looking around, turning away, looking on their phone etc.)

Body Language

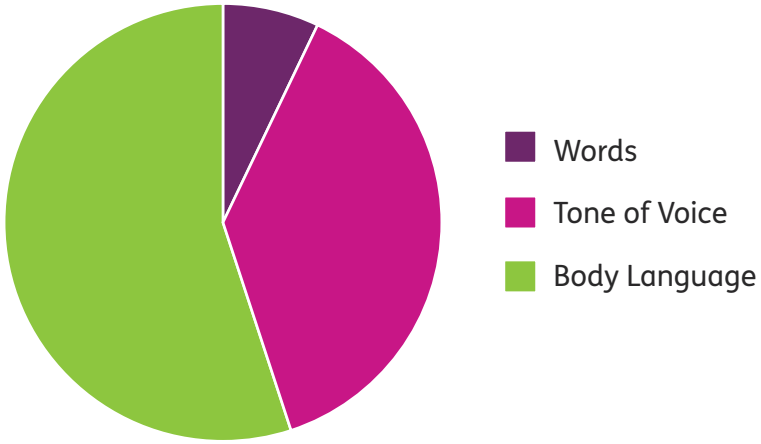
Person A and Person B will sit face to face, Person A will discuss a topic of their choice for 2 minutes. Person B will show they are actively listening and interested without communicating, just using their body language. (e.g. nod, smile, using facial expressions)

2 Way

Person A and Person B will sit face to face, Person B will discuss a topic of their choice for 2 minutes. Person A will encourage Person B to elaborate, show interest in what they are talking about.
(This can be helped by asking open questions that require more than a yes or no answers).

As a group discuss how this activity made Person A and Person B feel.

The group are then shown the communication pie chart below, which highlights how body language is the biggest factor in terms of our communication with one another.



Infant Mental Health (0-5yr olds)

Overview

The Infant Mental Health Practitioners have been trained to use a comprehensive skill set to clinicallyassess and treat parents and their infants, who are experiencing common mental health and relationship difficulties using the latest evidence based approaches.

The practitioners are trained to address how to effectively engage and assess families, how to develop formulations for complex presentations and integrate biological, psychological, relational, systemic and social factors.

Interventions

The interventions are recommended by NICE and the Healthy Child Programme, and are effective in improving parenting quality and sensitivity when that is of concern.

VIPP-SD (Video Intervention for Positive Parenting – with Sensitive Discipline) is delivered with parents and infants showing signs of attachment difficulties. It is the leading intervention for supporting parents to develop more attuned parenting in the context of difficulties in the parent-infant relationship. VIPP is used with parents of infants from 6 months to 60 months

Webster Stratton - The Incredible Years for parents with children aged 18 to 60 months. The parenting programme can be individualised to enable a personalised delivery of an evidence-based parenting programme to high risk and complex family situations, and also delivered as a group

IAPT Practitioners

Infant Mental Health Practitioners were trained via the CYP IAPT programme, that is a whole service transformation model that seeks to improve the quality of children and young people's mental health services. The principles behind CYP-IAPT underpin the development and delivery of the 'Local Transformation Plans' and run throughout 'Future in Mind'.

Routine outcome measures (ROMs) are used before, during and after treatment:

- PHQ9- measures the presence of depression of parents and the severity of this
- GAD7- measures the presence of anxiety in parents and the severity of this
- MORS- measures the quality of a parent / child relationship

Teen Brain Matters

Overview

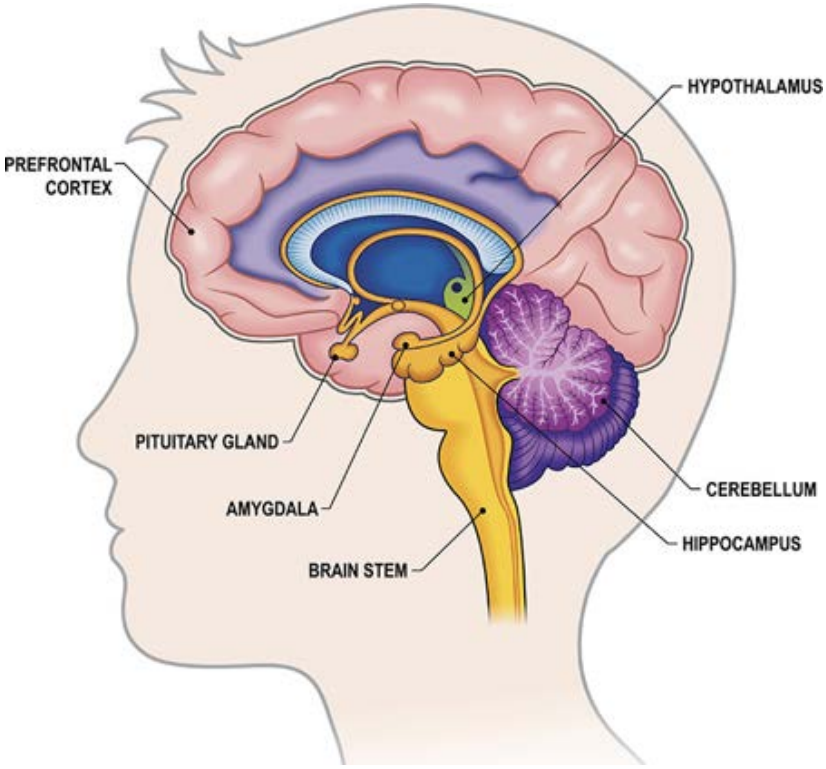
Teen Brain Matters' are specifically designed training and workshops for Professionals, Teachers, Parents and Young People to better understand the changes and development of the Teenage Brain. These packages of learning were developed by Dr John Coleman in collaboration with Bedford Borough Early Help.

Dr John Coleman is a world renowned Clinical Psychologist, Lecturer and Author. He is best known for his textbook "Why won't my teenager talk to me?" which offers parents and care-givers insightful and practical advice, as to how to encourage positive and respectful two-way communication between parents and their teenager.

Introduction

Until recently it was assumed that there was little further development in the brain after the end of childhood. However, we now know that the brain continues to change and develop all through adolescence. In fact, there is more change in the brain during adolescence than at any other time in human development apart from the first three years of life.

This means that the teenage years are a critical period. What happens during this period has major implications for later development. Of course the brain does not develop in isolation. The brain and the environment interact, each influencing the other.



Main areas of the brain – those to do with emotion and thinking are most affected

Two of the most important areas of the brain are the pre-frontal cortex and the amygdala. Both these areas undergo very significant change at this time. The pre-frontal cortex is the area most associated with thinking, planning and problem-solving. The amygdala is the area associated with emotion, sensation and arousal. There are also areas in the brain associated with pleasure seeking, and these are more active during the teenage years. These centres in the brain undergo significant alteration during these years. The brain is maturing, but this does not happen overnight. It takes a long time for all parts of the brain to function well together. The brain also matures from back to front meaning the pre – frontal cortex is last to fully mature compared to other areas like the amygdala.

In some young people the amygdala may develop at a faster rate than the prefrontal cortex, and this is sometimes considered to be an explanation for risky behaviour. There may be times when some teenagers simply do not think ahead and do not take into account the consequences of their actions. In these circumstances the parts of the brain associated with pleasure and rewards can, for a time, prove to be more powerful than the areas linked to thinking and reasoning. A third area of the brain which is important to mention is the hippocampus, the site in the brain most associated with memory. The hippocampus is the centre that processes and encodes memory traces, and is also associated with the retrieval of memories. It is especially active in adolescence, and plays an important role in learning.

The hormone balance

It has always been known that teenagers are affected by their hormones. This upset in the hormone balance is often seen as an explanation for moody or irritable behaviour. What is new in our knowledge is that the balance of hormones affects brain development. The alterations and fluctuations of hormones act on various parts of the brain that have already been mentioned, such as the amygdala and the prefrontal cortex.

Risk-taking and brain development

One of the most common ideas about teenagers is that they are risk-takers. As outlined this is in part due to the part of the brain responsible for planning and thinking matures more slowly than the area to do with sensation and arousal. If this is the case, behaviour may be more under the control of the parts of the brain to do with short-term rewards rather than with the areas related to problem-solving and thinking about consequences. It should be noted however that there are different views about this. Some commentators argue that it is not “defects” in the brain that lead teenagers to do risky things. Rather it is lack of experience, combined with the desire to explore the world and look for novelty and new experiences, that are the real factors to be taken into account.

Useful links

Sarah Jayne Blakemore’s TED talk at *www.TED.com* *“The mysterious workings of the adolescent brain”*

The Wellcome Trust *“Neuroscience and education programme”* *www.wellcome.ac.uk*

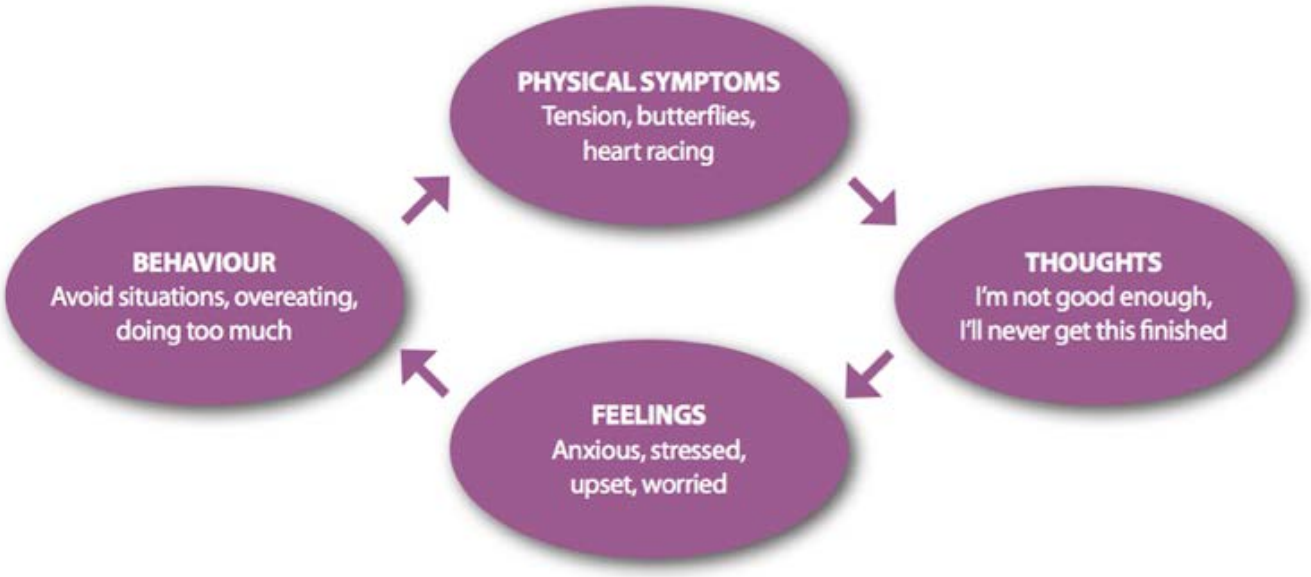
Enhanced Evidenced Based Practice (EEBP)

Overview

Enhanced Evidenced Based Practice (EEBP) is based upon Cognitive Behaviour Therapy (CBT) principles and is an evidence based treatment for young people with mild to moderate anxiety and/or depression. We are able to work with the young person at school, home or in the community.

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is a type of talking therapy which focuses on how thoughts, beliefs and attitudes affect your feelings and behaviour, and teaches you coping skills for dealing with different problems.



Format of support

Following the referrers completion and submission of an Early Help Assessment (EHA) an EEBP Practitioner will arrange to meet with the young person/family to conduct a comprehensive evidence based assessment. The assessment will consider elements of risk, triggers, routine outcome measures (ROM's) and gather all relevant information in order to get a good overview of the current need. If assessed as being an appropriate candidate for EEBP, six to eight sessions will be offered of support.

The Interventions

There are typically three interventions used within the EEBP to support young people. These are;

Graded Exposure – this intervention is a way of treating a range of anxiety problems. It works best with simple phobias or other problems where you can identify what it is that you are anxious about. The basic idea is to gradually expose yourself to the feared situation in a way that allows you to control your fear at each step.

Worry Management – this intervention is a set of techniques to help reduce the impact of worrying or to solve practical problems. Worry management includes identifying and classifying worries initially then using either Worry Time or Problem Solving to manage these.

Behaviour Activation – when you feel low or depressed you may be less likely to do the things you enjoy or avoid other potentially pleasurable activities. Behaviour activation is designed to increase your contact with positively rewarding activities.

Alongside these interventions there is an emphasis in delivering Psychoeducation to the young person in-order for them to have a better understanding of how certain mental health presentations can begin, be maintained and how their body works in relation to certain presentations.

Routine Outcome Measures (ROM's)

During assessment and in each session thereafter there will be an opportunity to complete Routine Outcome Measures (ROM's). ROM's generally come in the form of questionnaires or scales to help gain regular feedback from the young person/family in order to monitor progress and involve the young person in decisions about their care. Please see list of ROM's routinely used in the EEBP service below;

Revised Children's Anxiety and Depression Scale (RCAD) – this questionnaire helps pinpoint more precisely any difficulty you might be experiencing.

Strengths and Difficulties Questionnaire (SDQ) – this questionnaire gives us an idea of how you are feeling at the present time.

Goal Based Outcomes (GBO's) – are a way of evaluating progress towards a goal in clinical work. GBO's compare how far the young person feel they have moved towards reaching a goal set at the beginning of the intervention.

Parent Led CBT

Overview

A Cognitive Behavioural Therapy (CBT) informed approach to help your children and young people with their fears and worries. This could be around fears and worries around attending school, sleep or behaviour problems.

Early Help, Bedford Borough Council have trained practitioners that are able to support parents/carers with the delivery of this intervention.

Intervention

The programme consists of psychoeducation, identification and challenging of anxious thoughts through graded exposure and problem-solving. Parents are asked to complete various between-session tasks, both independently and with their child.

Commitment Required

Parents and carers will be asked to commit to 4 face to face sessions and 2 telephone conversations, over the course of 10 weeks. There will be an expectation that parents and carers do some reading prior to sessions and this is based on the book 'Helping your Child with Fears and Worries' By Cathy Creswell and Lucy Willets (University of Reading).

How to access

To access this intervention as well as any other Early Help support please complete an Early Help Assessment (EHA) which can be accessed in the Documents section of the Local Offer website.
For more information call 0800 023 2057

AMBIT in a nutshell

The problem AMBIT is designed to help with

Socially excluded youth with mental health problems and co-occurring difficulties (e.g. conduct disorder, family breakdown, homelessness, substance use, exploitation, educational failure) attract the involvement of multiple agencies. Poorly coordinated interventions often multiply in the face of such problems, so that a young person or family is approached by multiple workers from different agencies working towards different goals and using different treatment models; these are often overwhelming and may actually be experienced as aversive by the young person or their family. Failure to provide effective help is costly throughout life (effective early intervention in conduct disorder alone is estimated to save £150,000 per child; Friedli, 2007).

What is AMBIT?

AMBIT is a framework to support developing practice, rather than a self-contained model of therapy.

AMBIT is a collaborative project that involves feedback from practitioners, clients and evidence based treatment designers. It has been designed by and for community teams from Mental Health, Social Care, Youth work, or that may be purposefully multi-disciplinary/multi-agency. It emphasises the need to strengthen integration in the complex networks that tend to gather around such clients, minimising the likelihood of an experience of care that is aversive. AMBIT uses well evidenced 'Mentalization-based' approaches, that are at their core integrative (drawing on recent advances in neuroscience, psycho-analytic, social cognitive, and systemic "treatment models").

Evaluations at local levels have offered very promising results, and to date (2014) over 80 teams have been trained in the UK, Switzerland and USA. Publications in peer reviewed journals and presentations at international conferences have been well received, and demand for AMBIT training is very high.

AMBIT uses evidence based approaches developed for self-injurious, substance-using and often non-help-seeking, disaffected and socially excluded youth. It offers a robust framework within which to coordinate and integrate interventions from a range of agencies, which address complex problems that occur at the same time across a range of domains (from the biological, through individual psychological, family, and social interventions, and including Education and legal/forensic services.) At its core is the treatment model based on the science of "Mentalization" that has achieved strongly evidenced results with the condition known as adult borderline personality and also with adolescent self-injurious behaviour.

AMBIT is being applied in a widening range of treatment settings. Mentalizing theory is favoured because it is intrinsically respectful to other schools of thinking, and it is relatively easy to train workers in the core competencies. AMBIT places a very powerful emphasis on developing strong supervisory relationships between teams of workers, who are thus supported to form strong individual relationships of trust with young people, while close attention to professional peer relationships counters the risk of such client-worker relationships themselves becoming a destabilising influence, as is unfortunately often the case in this field.

A key goal in AMBIT is to improve young people's Relationship to help, to improve the likelihood of more adaptive help-seeking in the future, as well as addressing current symptoms, so prevention is at the heart of the AMBIT method of working.

AMBIT applies mentalization-based principles and practices in four main areas:

a. (a) In direct work with clients (young people and their families or carers)
b. (b) In shaping and supporting relationships between workers in teams
c. (c) In providing systematic approaches to identifying and addressing “dis-integration” in the complex multi-agency networks that gather around such youth
d. (d) In supporting local teams to adopt a learning stance towards their own practice, so that AMBIT is not simply a “one-size-fits-all” approach but supports the gathering of local outcomes evidence, and the use of this to develop a judicious balance between the use of existing evidence-based ways of working, and the onwards development of local practice that is culturally sensitive to the needs of local youth and to the organisational contexts in which this care is delivered.

What is Mentalization?

Mentalization is...

'The imaginative activity of making sense of the actions of oneself and others on the basis of intentional mental states such as desires feelings and beliefs'

'So, mentalizing is what we do when we are imagining what might be going on in the mind of someone, underneath the behaviour that we see on the outside'

We can mentalize ourselves... "Why do I keep getting into this same fix?..what am I thinking or feeling that means I keep ending up here?”

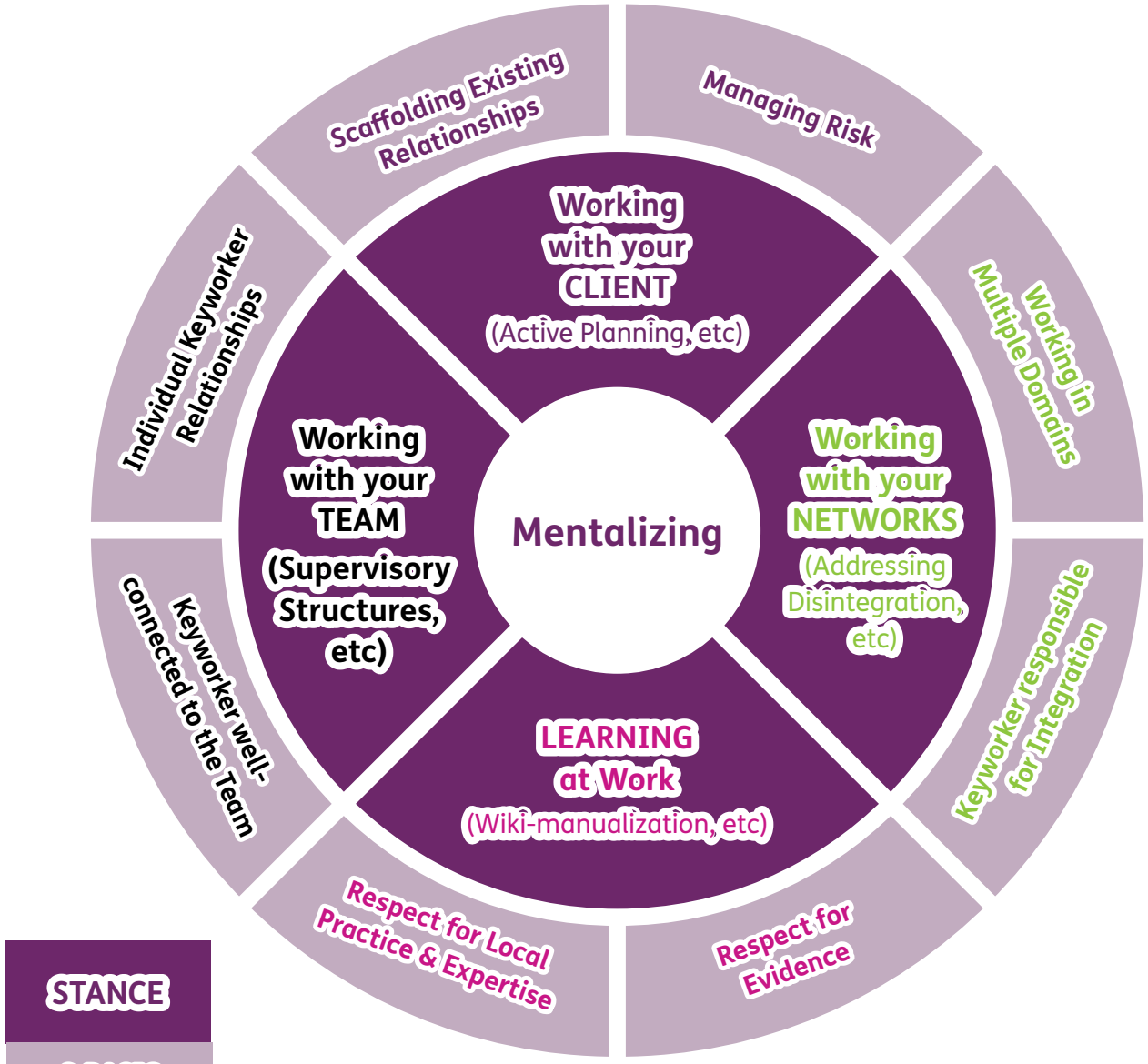
We can mentalize each other... “My mum doesn’t seem herself tonight...I wonder if it’s because she’s worrying about... or maybe she’s been thinking about...”

Mentalizing is a uniquely human process. It is something that we do automatically, often without conscious thought, in our every-day interactions. This is known as implicit mentalization

Almost all aspects of social interaction involve the capacity to mentalize: to understand the other person's behaviour in terms of the activity that has taken place inside their minds...

The Core Features of AMBIT

For the practitioner the most important thing is the Core Features of AMBIT, which are the highly practical "grab-rails" - defining a STANCE - and core features of PRACTICE, that are designed to help a practitioner stay 'on track' - especially at those times of high stress or anxiety that are common in this work. You'll find them summarised in a 'click-able' diagram at AMBIT WheeL, or here:



AMBIT

RPC (Reducing Parental Conflict)

What is 'parental conflict'?

Some level of arguing and conflict between parents is often a normal part of everyday life. However, there is strong evidence to show how inter-parental conflict that is frequent, intense and poorly resolved can have a significant negative impact on children's mental health and long-term life chances.

Damaging conflict between parents can be expressed in many ways such as:

- Aggression
- Silence
- Lack of respect
- Emotional control
- Lack of resolution
- Domestic abuse

The Reducing Parental Conflict (RPC) programme is aimed at conflict below the threshold of domestic abuse.

Conflict can affect children in all types of parental relationships, including:

- Parents who are in a relationship, whether married or not
- Parents who have separated or divorced
- Biological and step parents
- Other family members playing a parenting role
- Foster and adoptive parents
- Same-sex couples

The RPC programme focuses on the ways that a couple behave, rather than the status of the relationship.

Evidence on the impact of parental conflict on children

Frequent, intense and poorly resolved conflict between parents can place children at risk of mental health issues, and behavioural, social and academic problems. It can also have a significant effect on a child's long-term outcomes.

There is a strong body of evidence to show how damaging inter-parental conflict can:

- Harm children's outcomes, even when parents manage to sustain positive parent-child relationships
- Put children at more risk of:
  - Having problems with school and learning
  - Negative peer relationships
  - Physical health problems
  - Smoking and substance misuse
  - Mental health and wellbeing challenges

The risks can also have an effect on long-term life outcomes such as:

- Poor future relationship chances
- Reduced academic attainment
- Lower employability
- Heightened interpersonal violence
- Depression and anxiety

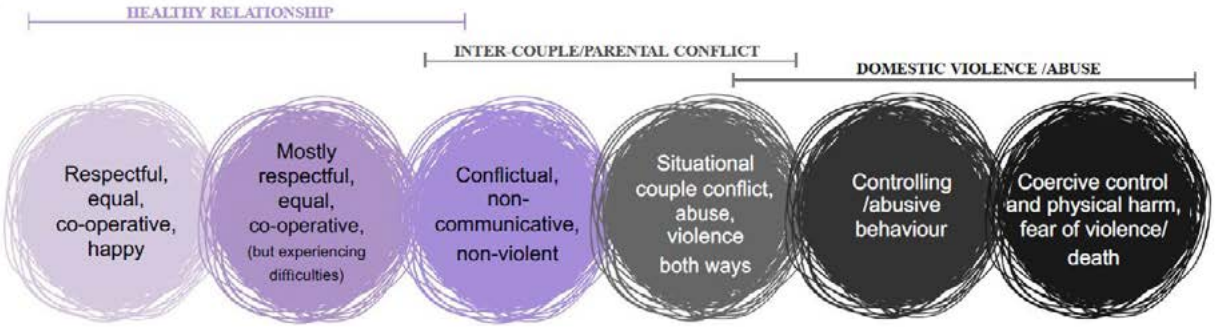
What the evidence tells us

Evidence on the impact of parental conflict on children shows that:

- Where a child lives with both parents in the same household, more than 1 in 10 (12%) children have at least one parent who reports relationship distress
- Children living in workless families are twice as likely to experience parental conflict than in families where both parents are in work

How does parental conflict differ from domestic abuse?

Parental Relationships Spectrum



SITUATION
All relationships have tricky moments, it's how they're experienced and resolved that matters

Children are experiencing constructive resolution of any arguments, characterised by mutual respect and emotional control

SITUATION
Lack of open and honest communication; difficulties are minimised, not recognised or addressed

Children beginning to be affected by conflict between their parents

SITUATION
Conflict is frequent, intense and poorly resolved; parents emotionally unavailable to their partner and children; lack of consistency in parenting; feeling isolated; toxic atmosphere

Children being adversely affected

SITUATION
Day to day unresolved and unresolvable conflicts; no consistent pattern of 'victim' or 'abuser'

Children being adversely affected; children may show signs of distress and their mental health/ behaviour may be affected

SITUATION
Clearer 'victim' and clearer 'abuser'

Children being significantly adversely affected; children's mental health and/or behaviour being affected

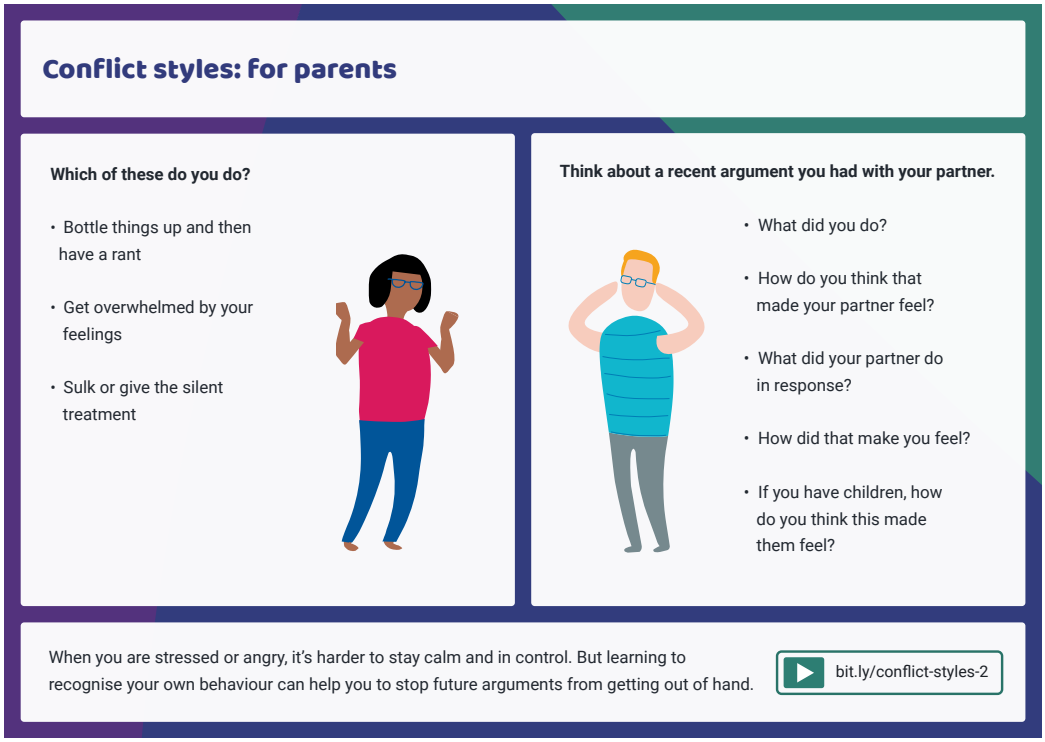
SITUATION
Clear 'abuser' and 'victim' who is at significant risk of harm

Children at risk of significant harm; children being traumatised

Activity Tool Examples

Some examples of RPC tools that can be used with parents include the following...

Conflict Styles:



The Magic Ratio:

The magic ratio: for parents

Even the happiest couples have negative moments. We snap and criticise. We shout and blame.

What would it take to balance these out? Relationship experts tell us that for every one negative moment, you need five positive moments.

So, for each time you have one negative moment with your partner:

- Criticising
- Trying to win
- Blaming
- Name-calling
- Sneering
- Sarcasm
- Shouting
- Being defensive
- Talking over each other

You need to have five positive moments:

- Laughing together
- Supporting each other
- Showing interest
- Listening
- Being grateful
- Thoughtful gifts
- Hugs
- Sharing
- Chatting

Now to start practicing with the magic ratio:

Think about your relationship.

What positive things could you do for each other?

What can you do to show that you care?

Better Communication:

Better communication: for parents

	What poor communication looks like:	How you can protect against it:
Criticism	Criticism isn't the same as complaining. It's a direct attack on your partner. "You only think about yourself."	Try starting a sentence with "I..." and asking for what you need. "I was worried last night. I'd like it if you could text me when you're going to be late."
Contempt	Contempt is when we are deliberately mean. We might use name-calling, or sarcasm, or roll our eyes to show we're not interested.	Try to focus on what you love about each other. Look for opportunities to pay each other compliments and do things together that you both enjoy.
Defensiveness	Defensiveness is usually a response to criticism. We deflect blame onto the other person. "I've been busy. Why couldn't you do it?"	Try to see things from each other's point of view. Take responsibility and say sorry when you're in the wrong.
Stonewalling	Stonewalling is when we get so overwhelmed that we shut down completely, blanking our partner, or walking out of the room.	Try to be good to yourself. Take some time out to do something relaxing and enjoyable.

Useful Links

https://reducingparentalconflict.eif.org.uk/child-impact/

Motivational Interviewing

What is Motivational Interviewing?

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."
(Miller & Rollnick, 2013, p. 29)

The most current version of MI is described in detail in Miller and Rollnick (2013) Motivational Interviewing: Helping people to change (3rd edition). Key qualities include:

- MI is a guiding style of communication, that sits between following (good listening) and directing (giving information and advice).
- MI is designed to empower people to change by drawing out their own meaning, importance and capacity for change.
- MI is based on a respectful and curious way of being with people that facilitates the natural process of change and honors client autonomy.

It is important to note that MI requires the clinician to engage with the client as an equal partner and refrain from unsolicited advice, confronting, instructing, directing, or warning. It is not a way to "get people to change" or a set of techniques to impose on the conversation. MI takes time, practice and requires self-awareness and discipline from the clinician. (Miller & Rollnick, 2009)

While the principles and skills of MI are useful in a wide range of conversations, MI is particularly useful to help people examine their situation and options when any of the following are present:

- Ambivalence is high and people are stuck in mixed feelings about change
- Confidence is low and people doubt their abilities to change
- Desire is low and people are uncertain about whether they want to make a change
- Importance is low and the benefits of change and disadvantages of the current situation are unclear.

Core elements of Motivational Interviewing

MI is practiced with an underlying spirit or way of being with people:

- Partnership
  MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.
- Evocation
  People have within themselves resources and skills needed for change. MI draws out the person's priorities, values, and wisdom to explore reasons for change and support success.
- Acceptance
  The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices about changing or not changing.
- Compassion
  The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.

MI has core skills of OARS, attending to the language of change and the artful exchange of information:

- Open questions draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide-Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.
- Affirmation of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
- Reflections are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
- Summarizing ensures shared understanding and reinforces key points made by the client.
- Attending to the language of change identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
- Exchange of information respects that both the clinician and client have expertise.
  Sharing information is considered a two way street and needs to be responsive to what the client is saying.

MI has four fundamental processes. These processes describe the "flow" of the conversation although we may move back and forth among processes as needed:

- Engaging:
  This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.
- Focusing:
  In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.
- Evoking:
  In this process the clinician gently explores and helps the person to build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.
- Planning:
  Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important.

Useful Links

https://motivationalinterviewing.org/understanding-motivational-interviewing

Notes

Finding out more

If you would like further copies, a large-print copy or information about us and our services, please telephone or write to us at our address below.

Për Informacion

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Informacja

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برای اطلاع

Za Informacije

Per Informazione

তথ্যের জন্য

01234 718700

Early Help
Early Help and Intervention
Bedford Borough Council
Borough Hall, Cauldwell Street
Bedford MK42 9AP

EarlyHelpHub@bedford.gov.uk

https://www.bedford.gov.uk/social-care-health-and-community/children-young-people/help-for-families/early-help/