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| Children and Young People’s Psychological Training (CYP PT)Infant and Early Years Practitioner (IEYP) training: for the early years’ workforce and the broader children and young people’s mental health community |
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# Background and context

#### Introduction

The first 5 years are an important time in children’s development because children are in the process of acquiring a range of social, emotional, behavioural, and cognitive abilities that are foundational in terms of their long-term wellbeing. Children’s development during this period is also ‘relational’, in that it is strongly influenced by the caregiving they receive. For example, very young children are highly dependent on their parents/caregivers during the first 5 years of life to help them learn key social, emotional, cognitive, and self-regulatory skills. Their attachment relationships with primary caregivers are key to the development of such abilities. The responsiveness of the interactions they experience with the adults who care for them, and the security of the attachments a child develops to them, also influence many other aspects of their development, including their peer relationships and learning.[[1]](#endnote-2) Other aspects of parenting are also important, including modelling and sensitive, authoritative guidance, encouragement, and limit setting. Evidence-based methods of working to support children within this age group who are experiencing regulatory, emotional, or behavioural problems are as such dyadic/triadic in nature (that is, targeting the parent/carer(s) and child together), in recognition of the relational nature of many of these problems and the key role that caregivers can play in supporting healthy early child development.

Significant numbers of young children experience relational, regulatory, emotional, and behavioural problems in the first 5 years of life, and it is therefore important that key frontline practitioners (for example, practitioners in child and adolescent mental health services (CAHMS), children’s centre workers, health visitors and social care practitioners) have the necessary skills to support children who may be experiencing such difficulties. The Infant and Early Years Practitioner (IEYP) training curriculum aims to establish a clear professional role and training pathway focusing on the high-quality delivery of support to families with children aged 0–5 years.

This document sets out the overall aims of the IEYP curriculum for working with the 0–5 population. This curriculum comprises a description of the three modules:

* Key knowledge, theory, and frameworks for working with 0–5s (15 credits)
* Foundations of early years assessment and formulation (30 credits)
* Interventions for 0–5s (45 credits)

A key feature of the training is its flexible pathways approach, which allows practitioners to receive training that provides both a broad-based foundation in early years practice and the ability to specialise in key skills for infants aged 0–2 years or young children aged 3–5 years, to meet the requirements of the service context they are working in.

It is advised that the 0–5 modules run alongside the core module, as opposed to the modules being completed consecutively.

#### Key guidance

* National Institute for Health and Care Excellence (NICE) (2012). ‘Social and emotional wellbeing: early years’, PH40 https://www.nice.org.uk/Guidance/PH40"https://www.nice.org.uk/Guidance/PH40
* NICE (2015). ‘Children’s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care’, NG26

https://www.nice.org.uk/guidance/ng26"https://www.nice.org.uk/guidance/ng26

* Early Intervention Foundation (2015). ‘The best start at home: What works to improve the quality of parent–child interactions from conception to age 5 years? A rapid review of interventions’

HYPERLINK "https://www.eif.org.uk/report/the-best-start-at-home"https://www.eif.org.uk/report/the-best-start-at-home

#### Entry requirements

It is intended that this programme supports the early years workforce in a range of sectors, including children’s social care, children’s centres and family hubs, Start4Life teams, CAMHS and the broader children and young people’s mental health community.

Students must meet the following entry requirements:

1. Training in a mental health-related profession (for example, psychology, nursing, health visiting, social work, occupational therapy, speech and language therapy, special needs teaching, psychiatry, other psychotherapy, or counselling).

If applicants do not have a core profession listed above (for example, health visitors, early intervention workers), yet feel they have sufficient experience as listed below, access can be via the Knowledge, Skills, and Attitudes route.

2. A minimum of 2 years’ experience of working within a professional setting concerned with the mental health, development and wellbeing of children and young people or families.

3. Some experience of working with families.

#### Statement of definitions

In this document, the term ‘caregiver’ is used to represent the individual who is primarily responsible for the infant/child’s direct care. This could represent a mother, father, extended family member, foster or adopted parent or special guardian.

The terms ‘infant’ and ‘young child’ are used to represent all children within the 0–5 age range, including infants, toddlers, pre-school and school-age children up until the age of 5. Where the evidence base for particular interventions has a recommended lower age parameter, this is clearly listed.

#### Other assumptions

It is assumed that throughout teaching, as well as in clinical practice, the child will be considered within their ecological, relational and cultural context. Teaching will be provided to support critical assessment and understanding of the child within this context; however, this assumption should be embedded in every part of the teaching.

#### Teaching and learning

Some elements of the training require a basic knowledge across trainees so that they can work in a consistent way within their services while participating in the IEYP programme. All trainees will be experienced professionals and so will bring this to the learning experience of the course.

Teaching across the curriculum should comprise the following elements:

* **Didactic teaching:**A small proportion of the curriculum should be delivered in a didactic style to ensure baseline knowledge in particular areas is obtained.
* **Large and small group discussions:**Trainers need to ensure that any didactic teaching is followed by sufficient time to explore the different perspectives of the trainee group. More intimate, self-exposing, reflective discussion and skills developmentshould take place in small groups. Trainers should ensure that the aims and competencies for each session are outlined at the beginning of any teaching session, and they should consider having a plenary session at the end to consolidate learning.
* **Extensive use of case discussion and role-play:** This will most likely form the largest part of the training, for two reasons. Firstly, the specific competencies underpinning the postgraduate diploma are ones of technique, rather than knowledge. Secondly, this allows trainees to examine their own existing skills and practices in an experimental way.
* **Reflective practice sessions:** An essential component of working with 0–5s is embodying an attuned and sensitive interaction in any clinical exchange. Trainees will be supported to adopt a mentalising stance within the training to help them develop ‘mind-mindedness’ and the ability to reflect on their own practice.
* **Observation skills:**Skilled observation is a further essential component of working with 0–5s. It is expected that trainees will become further skilled at observation through a combination of teaching and workshops, but also through close supervised practice in which dyadic interaction will be micro-analysed and discussed.

Trainees will be expected to complete observation of the infant/child-caregiver relationship as a minimum while undertaking assessment, and it is recommended that observations occur within multiple settings if possible.

#### Trainers and supervisors

All trainers and supervisors should have knowledge and experience of working clinically with the 0–5 population, as well as of the topic being taught.

For Module 3, trainers supporting the parent-infant pathway should be accredited video feedback practitioners and registered with the relevant association (for example, for video feedback intervention to promote positive parenting (VIPP) or Video Interaction Guidance (VIG)). Module 3 trainers supporting the early childhood pathway should be accredited in an evidence-based and recognised model of behavioural management (for example, Incredible Years, Triple P or Helping the Noncompliant Child).

#### Supervision and clinical practice requirements

The quality of supervision is a key factor in ensuring high-quality learning. Supervision of VIPP or VIG clinical work should, wherever possible, be carried out by an accredited supervisor. Supervision of behavioural work should be carried out by a practitioner who has achieved or who is working towards accreditation in an evidence-based model of behavioural management.

There will be specific requirements for clinical work for all three 0–5 modules (see the table below). This will be supervised on a weekly basis by a supervisor accredited in either behavioural management or video feedback. The individual higher education institution (HEI) will determine the specific arrangements for supervision; as a minimum this should include 1 hour weekly of service supervision and weekly HEI supervision during term time.

Clinical Practice Requirements:

Across both pathways, prior to commencing treatment trainees must have completed a thorough assessment and formulation with each family. In addition, three regulatory-focussed cases of 6 sessions (or goals completed) of intervention / consultation with parents / carers must be completed.

Parent-infant pathway:

* work with sufficient cases to meet the accrediting standards of the selected specialist intervention (currently 6 VIG cases/18 cycles or 5 VIPP cases).
* the 9 cases seen in total (including the regulatory cases referred to above) should be representative of the full age range of 0-2s, with at least six being focussed on an infant under two years of age. The cases seen should include experience of working individually with parents to support infants in the context of parent mental health difficulties.

Early childhood pathway:

* run at least one evidence-based parenting group or work with 6 individual parenting cases using an evidence-based approach for 6 sessions (or to goals completed).
* of the 9 cases (including the three regulatory cases referred to above), at least six cases / the group should be focussed on working with young children aged 3-5 years.
* the cases seen should include experience of working individually with parents to support young children with anxiety.

#### Assessment strategy

Assessment of competence will be the responsibility of the HEI(s) leading the learning collaborative and other providers of training that are part of the collaborative. The methods by which competencies will be tested must be specified, but the curriculum leaves open the method(s) by which learning collaboratives achieve this, although clear recommendations are made in this document. It is essential that the assessment of competence minimally includes the following:

* assessment of video-recorded therapy sessions
* reports of individual treatments that demonstrate the capacity to make theory–practice links and to integrate outcomes information into practice
* reports on feedback from supervisors, young people and/or parents/carers on their experience of the therapy offered
* a summary report of the therapist’s clinical outcomes over the training period

Guiding principles for assessments of practice:

* Students should be evidencing their demonstration of competencies through video recordings of their own practice.
* Submissions should not require ‘perfect’ examples of practice but will require all summative areas to be passed. Students should be encouraged to reflect on the competencies that they can see themselves demonstrating and those in development (including reflecting on why not fully demonstrated, what the barriers were to demonstrate these, and how they will be built upon in future practice).
* Assignments should always consider cultural and diversity factors that either facilitated or were barriers to good, competency-based practice.

# Course modules

The below gives a brief description of the overall aim of the modules for trainees.

#### Module 1: Key knowledge, theory, and frameworks for working with 0–5s (15 credits)

A broad foundation of knowledge, across the full age range of 0–5 years, of the core principles of early child development, context, theory, and ethical frameworks.

#### Module 2: Foundations of early years assessment and formulation (30 credits)

Focus on assessment, formulation, and safeguarding, with common content for all trainees, and selected specialist elements for trainees on the parent–infant pathway and the early childhood pathway.

#### Module 3: Interventions for 0–5s (45 credits)

Focus on intervention, with some shared content on common principles, and specialist elements for trainees on the parent–infant pathway and the early childhood pathway, with each respectively leading to accreditation for VIPP/VIG and Incredible Years or similar evidence-based intervention for behavioural management.

Module 3 will contain content for both strands but also pathway specific interventions and clinical requirements:

### Module 3: Interventions for 0-5’s (45 credits)

#### Parent-infant pathway:

Accredited Pathway: Core practice in attachment and parent-infant interaction (VIG or VIPP)

Addressing parental mental health difficulties and wider systemic factors

#### Both Pathways:

Core intervention skills for 0-5s

Developing a collaborative treatment plan

Core practice in managing behaviour using social elarning theory (sleep, toileting, feeding, crying, aggressive behaviour)

#### Early Years Pathway:

Accredited specialism: Parenting intervention for behavioural problems

Guided self help for child anxiety

# Course structure, teaching and learning strategies

#### Module 1: Key knowledge, theory, and frameworks for working with 0–5s (15 credits)

A broad foundation of knowledge, across the full age range of 0–5 years, of the core principles of early child development, context, theory, and ethical frameworks. All trainees receive this foundational training.

#### Module aims:

* To develop knowledge about social, emotional, physical, cognitive, motor and language development in infants and young children.
* This module will provide opportunities for trainees to develop and demonstrate the following areas of knowledge and competencies.
* To develop critical knowledge of the core theories and approaches underpinning early years working.
* To understand the key frameworks that are used in diagnosis and assessment in an early years population.
* To understand the relational and contextual factors within with such development occurs, and the factors that contribute to both risk and resilience and their impact on parenting.

#### Intended learning outcomes

Knowledge of:

* infant and child development in the context of significant caregiver–child relationships, as well as a broader context
* age-appropriate developmental milestones during infancy and early childhood in the domains of social, emotional, physical, cognitive, motor and language development
* early (pre- and post-natal) brain and physiological development, with a specific focus on social and emotional development
* the impact of trauma and maltreatment on child development
* attachment theory and the relevance of this to development, with a focus on the impact on emotional, relational, regulatory, and behavioural aspects. The behaviours associated with secure and insecure attachment towards a caregiver, and the implications for a developing child of a secure and insecure attachment relationship
* the role of social learning and behavioural theory in the reinforcement and shaping of children’s behaviour
* mentalisation, primary and secondary intersubjectivity, parental sensitivity and responsiveness, and attunement
* early childhood difficulties (sleep problems, crying, toileting difficulties, anxiety)
* the presentation of behavioural difficulties in the early years, including the behaviours associated with a diagnosis of oppositional defiant disorder
* the behavioural presentations associated with a diagnosis of autism spectrum disorder in the early years
* the behavioural presentations associated with a diagnosis of attention deficit hyperactivity disorder in the early years
* An understanding of typical and atypical behaviours and competencies at different ages, ensuring that diagnosis are not confused with traits that are typical for a given stage of child development. Understanding of the risks of incorrect diagnosis or diagnostic overshadowing.
* factors that may influence caregiving capacity and sensitivity, including:
* caregiver experiences and feelings around conception, pregnancy, birth, and parenthood
* caregiver learning disability
* caregiver attachment history and experience of being parented
* prior loss and grief
* mental health problems
* social and economic factors, including housing issues, poverty, community support and access to services
* domestic abuse
* substance abuse
* immigration status
* the evidence base for interventions to promote attachment and the parent–child relationship, and to prevent or treat behavioural and regulatory difficulties and anxiety in early childhood
* recognition of cultural impacts on parenting and awareness of diversity in parenting practices. Consideration of different cultural approaches in parenting. Adopting an anti-discriminatory approach. Using approaches such as GGRRAAACCEEESSS
* consideration of the diversity of family relationships and circumstances in which children live and are supported. Diverse family forms, such as single-parent families, kinship care and LGBTQI+ families, the discrimination or marginalisation they may face, and their outcomes.
* an introduction to the THRIVE framework and i-THRIVE implimentation model and its specific application to the 0–5 population and services working with them
* the importance of working collaboratively and in partnership with the parent/carer/family
* the importance of clear communication in multidisciplinary and multi-agency working with families, including relating to safeguarding issues
* legal frameworks relating to working with children and families, including the Children Act (1989), local and national consent and confidentiality frameworks (including the NHS Code of Practice) and the General Data Protection Regulation

#### Competencies

* Fundamental understanding of early years development, including emotional, social and behavioural development.
* Clear understanding of the key theories that influence early years development, including attachment theory, social learning, and behavioural theory.
* Ability to recognise potential attachment difficulties in children.
* An understanding of the diagnoses that can affect children in the early years.
* Ability to recognise the contextual influences on early years development and parenting, including common parental mental health problems; issues such as domestic abuse/substance dependency; and wider factors such as stress and poverty.
* An understanding of diversity and cultural influences on parenting.
* An understanding of the legal frameworks that are important in the early years.
* An understanding of evidence-based practice as it applies to the early years.

#### Module 2: Foundations of early years assessment and formulation (30 credits)

Focus on assessment, formulation, and safeguarding, with common content for all trainees, and selected specialist elements for trainees on the parent–infant pathway and the early childhood pathway.

#### Module aims:

The aim of this module is to provide trainee practitioners with a broad understanding of the purpose, principles, and practice of conducting comprehensive and holistic assessments, developing a formulation for the purposes of understanding a child and family’s needs, and collaboratively planning ongoing support and intervention.

#### Intended learning outcomes

#### Knowledge

Collaborative working

* Knowledge about the importance of working collaboratively with the whole family and the significant relationships that have an influence on the infant.
* Knowledge about the importance of establishing and sustaining respectful and trusting relationships.
* Knowledge of the importance of professional boundaries and ability to maintain these.
* Knowledge about possible barriers to and reasons for non-engagement with professional support.

Generic assessment

* Knowledge about the principles of appropriate information-gathering for the purpose of assessment.
* Knowledge about the importance of both confidentiality and information-sharing with other practitioners.
* Knowledge that one’s personal professional viewpoint can affect assessment and may be a cause of bias.

Child protection/safeguarding

* Knowledge about the possible signs of emotional, physical, or sexual abuse and neglect of the infant, including failure to meet developmental and healthcare needs.
* Knowledge about the importance of recognising caregiver behaviours that may be associated with abuse or neglect.
* Knowledge about the impact of abuse during infancy and childhood on short-, medium- and long-term development.
* Knowledge about the importance of prioritising the infant/child’s welfare to promote their safety at all times.

Meeting the needs of families with children aged 0–5

* Knowledge of the THRIVE model.
* Knowledge that different levels of support can be provided to families during the pre- and post-natal and early childhood periods.
* Knowledge that different types of intervention can be provided in terms of the focus of the intervention (for example, infant/child, parent, dyad, triad).
* Knowledge that the different level and type of support provided is determined by an assessment of need.
* Knowledge that all support/intervention should be socially/culturally acceptable to families.
* Knowledge that the benefit or otherwise of all support/intervention should be assessed to undertake appropriate further intervention.
* Knowledge that effective support/intervention may involve a ‘team around the child’ approach with other practitioners, and application of this to undertake appropriate liaison.

#### Competencies

Collaborative working

* Ability to work collaboratively with the whole family and any other people with a significant relationship/influence on the infant, in order to support the delivery of high-quality help to families and to facilitate and model collaborative working within a team.
* Ability to create and sustain respectful and trusting relationships with the parent(s)/caregiver(s) and the wider ‘helping system’.
* Ability to maintain professional boundaries and support others in doing so.

Engagement

Ability to:

* promote an environment that will encourage trust and engagement
* identify and address factors that are threatening engagement
* respectfully and non-defensively discuss concerns parents may have
* be appropriately flexible by providing alternative methods of promoting engagement (for example, alternative venues, text reminders) or alternative methods of support (for example, online)
* assess whether social and cultural factors and fears may be influencing parental understanding of and attitudes towards help-seeking. The ability to reflect on these, discuss barriers openly with parents and provide appropriate support.

Generic assessment skills

* The ability to conduct a broad assessment, gathering relevant information from a range of sources, including caregivers and other practitioners.
* The ability to communicate and maintain appropriate confidentiality and information-sharing with other practitioners to:

a) balance the interests of the infant and family in relation to keeping information confidential versus sharing information

b) inform decisions about information-sharing with individuals and organisations beyond the immediate work environment of the practitioner

* The ability to reflect on how one’s personal and professional viewpoint may affect assessment and cause bias
* The ability to reflect on one’s practice and discuss difficulties with appropriate colleagues/supervisor/manager.
* Awareness of the importance of culture and the ability to adapt assessments to recognise cultural differences.

Child protection/safeguarding

* Ability to identify possible signs of emotional, physical, or sexual abuse and neglect of the infant, including failure to meet developmental and healthcare needs, in order to:

a) discuss concerns with parents/caregivers

b) undertake further assessment

c) provide support to address concerns

d) liaise with and provide assessment information to child protection services where appropriate

* Ability to identify caregiver behaviours and home circumstances that may be associated with abuse or neglect, in order to:

a) discuss concerns with parents/caregivers

b) undertake further assessment

c) provide support to address concerns

d) liaise with and provide assessment information to child protection services where appropriate

* Ability to apply knowledge about the impact of abuse during infancy and childhood on short-, medium- and long-term development to support more junior/less experienced practitioners.
* Ability to apply knowledge about the importance of prioritising the infant’s/child’s welfare to promote their safety at all times.

Parent–infant pathway

* Knowledge of sensitive caregiving (for example, attuned or contingent) and appropriate responsiveness to infant development to inform work with families.
* Knowledge of the importance of keeping in mind and responding to the needs of both parents/caregivers and the infant, and the quality and content of the relationship between them in terms of all forms of assessment and support being provided.
* Knowledge about the importance of recognising infant behaviour as communication.
* Knowledge about the importance of communicating an awareness and appreciation of the infant’s feelings, thoughts, and experiences.

Developmental pathways in infancy

* Knowledge of age-appropriate developmental milestones during infancy and normal variation compared with more significant divergence from the norm.
* Knowledge about the rapid and environmentally dependent neurobiological development that occurs in pregnancy and infancy.

Attachments

* Knowledge about the importance of promoting secure infant attachment, and the different types of caregiving behaviours associated with different attachment classifications.
* Knowledge about the importance of parental reflective functioning.
* Knowledge about the infant’s ability to form a number of significant relationships.
* Knowledge about the impact of parents’/caregivers’ relationship histories, and the way in which these can unconsciously impact on their interactions with the infant.

Transition to parenthood

* Knowledge about parents’/caregivers’ life experiences and feelings about conception, pregnancy and birth.
* Knowledge about the emotional, psychological, and social changes that can occur in the transition to parenthood.
* Knowledge that a range of factors can affect parenting and the importance of working preventatively.
* Knowledge about the development of the parental relationship in the transition to parenthood and its role in early development and wellbeing.
* Knowledge of the diverse range of experiences of people as they become parents and the similarities, differences, and barriers (including discrimination) sometimes faced by LGBTQ+ families.

Pre- and post-natal factors that can affect caregiving

* Knowledge about the impact of substance misuse (including alcohol), domestic abuse and mental health problems on the development of the foetus/infant, and their impact on parent–infant interaction and relationships.
* Knowledge that changes in the family constellation and dynamics following pregnancy and the birth of a infant can affect the quality of the couple relationship and impact co-parenting.
* Knowledge about dispositional factors, regulatory disorders and infant characteristics that may increase vulnerability in the infant, and their impact on the caregiving relationship.
* Knowledge about mental health problems that can be experienced by caregivers during the pre- and post-natal period.
* Knowledge of perinatal red flags and risk indicators.

Assessment

* Knowledge about routinely adopting an observational stance.
* Knowledge about the importance of conducting formal assessments of caregiving and the range of tools available.
* Knowledge that the best model of working with parents/caregivers to promote infant mental health should focus on the factors that promote optimal mental health (for example, parental sensitivity, reflective functioning), and application of this knowledge to determine the most appropriate method of support/intervention.

CompetenciesAssessing infant development

* Ability to appropriately introduce, use, interpret and sensitively share the results of standardised assessments of developmental milestones during infancy, and to consider normal variation compared with more significant divergence from the norm, in the domains of:

a) social and emotional development

b) physical development (fine and gross motor skills)

c) language development (receptive and expressive)

d) cognitive development

* The ability to select from a range of alternatives, appropriately and sensitively conduct assessments of infant development, and provide appropriate feedback and support.
* The ability to select from a range of alternatives, appropriately and sensitively conduct assessments of infant mental health and wellbeing and provide appropriate feedback and support.
* The ability to use this knowledge to:

a) support optimal development

b) identify problems in these developmental domains

c) discuss concerns with parents

d) liaise with other practitioners

e) know when to make referrals to other services

Assessing sensitive caregiving and the caregiver–infant relationship

* Ability to keep in mind, and respond to, the needs of both the parents/caregivers and the infant, and to pay attention to the quality of the relationship between them when engaging and carrying out assessment work with families.
* Ability to:

a) model the provision of sensitive caregiving

b) identify problems in caregiving

c) provide links to other resources that focus on sensitive caregiving

d) liaise with other professionals and recognise when referral on to specialist services is needed

* Ability to apply knowledge about the importance of recognising infant behaviour as communication and the infant’s feelings, thoughts, and experiences, including the ability to:

a) observe and identify what is going well for the infant and highlight the parent’s role in this

b) sensitively and respectfully model optimal communication with the infant

c) model responsiveness to the infant’s cues and communications

d) provide links to other resources that focus on infants’ cues and communications

* The ability to routinely adopt an *observational stance* and the ability to appropriately and sensitively conduct *structured assessments* of caregiver–infant interaction, to:

a) observe the parent’s/caregiver’s interaction non-judgmentally and support growth-enhancing interaction

b) identify areas of concern or areas where further support may be beneficial

c) know when to provide appropriate interventions when interactions are detrimental to the infant’s development

d) be able to recognise when referral to specialist services is necessary and take appropriate action

* The ability to identify when cultural differences in parenting and parenting beliefs may be important, and to discuss with parents or other colleagues as appropriate.

Assessing parental mental health

The ability to select and appropriately use and interpret standardised screening assessments for parental mental health problems, in order to:

* 1. signpost to or provide support to caregivers experiencing mild common mental health problems (for example, online or one-to-one support)
	2. know when to make contact with specialist services for consultation and liaison/co-working as well as referral for more severe problems

Multilevel assessment and formulation

* Ability to use the knowledge and assessment skills acquired in this module to:
	1. identify problems, concerns and areas likely to benefit from support
	2. create a verbal and diagrammatic formulation based on the information gathered in assessment, including outcome measures, in collaboration with the parents/carers and also considering the voice of the infant/child
	3. discuss concerns and goals with parents/carers
	4. liaise with other practitioners
	5. support optimal development
	6. signpost families or refer, where applicable, to appropriate sources of support/services

Assessing the appropriate level of support

* Ability to apply knowledge of the different levels of support that can be provided to families during the pre- and post-natal period, to:

a) promote infant mental health (for example, primary, secondary, tertiary), and to know when and how to intervene to provide appropriate support and when to refer to more specialist services

b) have awareness of local agencies and pathways/networks relevant to promotion and treatment of infant mental health/perinatal mental health problems

* Ability to judge what types of intervention should be provided in terms of the focus of the intervention (for example, infant, parent, dyad, triad), to inform provision of appropriate services in order to:

a) identify the foci of difficulty in the family

b) identify the members of the family who need support

c) discuss with the family which type of support would be appropriate for them, and who should be supported

* Ability to conduct an assessment of need using appropriate validated tools and to use the outcomes of this assessment to identify appropriate intervention, including judging whether to refer to specialist services, whether additional support or resources related to environmental stressors are required, and whether some caregivers or family members need additional support.
* Ability to use supervision to make decisions about the appropriate level and pathway of support for families.
* Ability to apply the knowledge that effective support/intervention may involve a ‘team around the child’, and to work alongside others where appropriate.

#### Early childhood pathway

Assessment

* The ability to assess caregivers’ beliefs and attitudes to parenting, for example, family scripts, caregiver experiences of being parents and of being parented, caregivers’ assessment of children’s presenting difficulties and their current concerns, developmental history, current strengths and challenges of the child and caregivers, children’s and caregivers’ mental health (chronic and acute presentations as well as significant events, losses, transitions or traumatic experiences), expectations about child self-management, and socio-cultural factors.
* The ability to select and use appropriate tools for assessment and routine outcome monitoring, such as the Strengths and Difficulties Questionnaire (SDQ 2–4), Mothers’ Object Relations Scale, Social Communication Questionnaire, Vanderbilt/Conners Scale, and caregiver goals.
* The ability to use ABC charts, diaries, and record forms, as well as parent interview and observational information from parent–child interactions (including attunement and relationship) and from home, nursery, or school settings.
* The ability to conduct play-based assessments of the child.
* The ability to identify barriers to building working relationships with caregivers and to address these barriers, including consideration of a family’s relationship to seeking and receiving help, previous experiences of healthcare and support, systemic, racial, and cultural barriers to accessing help, and practical barriers such as language and literacy.
* Skills for helping parents to engage with the support offered, including working with interpreters and/or identifying features of any previous therapeutic experience that caregivers found unhelpful.

Formulation

The ability to use the knowledge and assessment skills acquired in this module to:

* + identify problems, concerns and areas likely to benefit from support
	+ create a verbal and diagrammatic formulation based on the information gathered in assessment, including outcome measures, in collaboration with the parents/carers and also considering the voice of the infant/child, risk and protective factors, child development, strengths, presenting difficulties, experiences, culture and beliefs
	+ express to the caregiver(s) a multifactorial understanding of the child’s strengths and difficulties, in a way that highlights that the problem is not located within the child and that the responsibility for change sits with the system supporting them
	+ discuss concerns and goals with parents/caregivers
	+ liaise with other practitioners
	+ support optimal development
	+ signpost families or refer, where applicable, to appropriate sources of support/services

#### Module 3: Interventions for 0–5s (45 credits)

This module will build on learning acquired in Modules 1 and 2 and will introduce students to evidence-based methods of working with babies and children aged 0–5.

After core principles of intervention are introduced, students on the parent–infant pathway will acquire the knowledge and skills to deliver evidence-based support to promote parental sensitivity and infant attachment in at-risk and vulnerable parents/carers and babies. Students on the early childhood pathway will learn skills for delivering parenting interventions to address common difficulties of early childhood, including behaviours that parents find challenging, sleep and toileting issues, and anxiety.

Students on the parent–infant pathway will aim to achieve a standard of practice that confers accreditation as a practitioner in either VIG or VIPP. Students on the early childhood pathway will aim to achieve a standard of practice that confers accreditation as a practitioner in an evidence-based parenting programme, such as Incredible Years.

#### Module aimsThe aim of this module is to provide trainee Infant and Early Years Practitioners with core knowledge and skills for intervening to support families with infants and young children. After completing common training on general principles of good practice, trainees will focus in depth on interventions that are central to their chosen pathway (the parent–infant pathway or the early childhood pathway). Trainees in each pathway will, in addition, complete accredited training in an evidence-based intervention (either VIPP or VIG in the parent–infant pathway, or Incredible Years or another evidence-based parent training programme in the early childhood pathway).

#### Part A: Core principles of intervention

Key learning outcomes

Competencies

* The ability to adopt an overall mentalising stance with parents/carers that holds the caregiver’s and infant’s/child’s voice in mind and embeds assessment and therapeutic interventions in an empathic, emotionally validating, and supportive relationship.
* The ability to engage a caregiver and infant/child in therapeutic assessment and/or treatment.
* The ability to develop shared goals with the parents/carers, while also considering the voice of the infant or child.
* The ability to co-construct an intervention with caregivers, making sure the intervention is paced correctly for the child and family to meet their goals, and collaboratively discussing any concerns or challenges.
* Helping caregivers to set goals congruent with their values and defining specific and clear targets for change. Choosing appropriate routine outcome measurements (ROMS) and interventions based on an evidence base and formulation.
* The ability to recognise and promote the importance of the voice of the infant or child, whatever their age, and the need to involve them and listen to them in appropriate ways during treatment.
* The ability to share and collaboratively use a holistic diagrammatic formulation to inform intervention and support.
* Awareness that a child’s behaviours are communications and cues for understanding their internal and external experience.
* Awareness of the fact that parents may experience guilt or shame related to their difficulties or parenting challenges, and that this needs to be considered and addressed sensitively and with empathy in a therapeutic intervention, so that parents do not feel blamed for their child’s or their own difficulties but can be supported to try something different to help their child.
* Ability to tailor support to the level of the infant or child and to facilitate parent/carer involvement in sessions in line with the formulation and intervention plan.
* Ability to structure sessions individually according to progress, or according to the group programme.
* Ability to know how and when to catch up or go slower by reviewing progress.
* Ability to make onward referrals, or signpost families to other organisations or to evidence-based sources of self-help.
* Ability to recognise difficulties that require referral for specialist intervention instead of, in addition to or following CYP PT intervention (for example, adult psychiatric/individual psychological therapies alongside dyadic/family based CYP PT work).
* Ability to prepare and engage productively in supervision.
* Ability to incorporate the monitoring of outcomes and progress during treatment and reflect upon, discuss, formulate, and take appropriate action if progress is not as expected.
* The ability to communicate outcomes with the system.
* Ability and confidence to follow up and re-engage families who do not attend, and/or to offer appropriate alternative interventions.
* Ability to understand, advocate and promote the use of infant/child-directed and parent/carer-directed self-help interventions based on a sound, accurate understanding of need.
* Ability to incorporate the use of developmentally sensitive written materials in sessions and facilitate the use of these between sessions.
* Ability to manage the ending of therapy and to plan for long-term maintenance of gains, with evidence of a relapse prevention plan.
* The ability to use supervision constructively.
* Understanding the theory and evidence to know when an intervention is indicated and to be able to formulate and plan the intervention, taking into account any parental vulnerabilities/needs with help from a supervisor.
* Awareness of the limits of training and clinical experience. Awareness of the importance of using supervision and a multidisciplinary team to plan and deliver safe and effective interventions and to recognise when other services may be better placed to support the family.
* The ability to recognise (with appropriate supervisory support) when one is unable to meet the need presented by the family and when to make a suitable referral to relevant local services.
* Awareness of the influence of key care settings and practitioners, including day care and children’s centres, and the value of using multi-informant reports and observations.
* Awareness of the advantages and risks involved in early identification and intervention, the use of personalised models of care, and stepped approaches to care that are led by individual and family need.

Specific competencies for supporting parents to manage common regulatory difficulties in infancy and early childhood.

Parenting interventions for sleep problems

* The ability to explore family and cultural beliefs around co-sleeping and independent sleeping, along with considerations of children’s age, development stage and needs, and the ability to explore parents’ expectations and concerns.
* Exploring sources of stress in parents associated with their children’s sleep and helping parents to anticipate and plan ahead in order to avoid stress or conflict where possible; supporting parents in problem-solving around the issues they are facing.
* The ability to support parents, where indicated, to use a sleep diary to monitor sleep patterns and progress.
* The ability to support parents in developing an individualised bedtime routine, reducing stimulation, and promoting relaxation and soothing, and a sleep programme (for example, a gradual reduction in parental presence once a child has been put to bed, and a graded transition to falling asleep alone).
* The ability to use core principles of behavioural interventions to support the learning of healthy sleeping habits, focusing on the establishment of helpful routines and the encouragement and gradual shaping of children’s behaviour through social or other appropriate rewards (for example, praise, stickers, star charts) in small steps.
* Signposting caregivers to, and supporting the use of, evidence-based written guidelines or psychoeducational groups.
* The ability to make appropriate referrals where the difficulties are complex (for example, difficulties associated with trauma or a chronic medical or developmental condition).

Parenting interventions for toileting issues

* The ability to explore family and cultural beliefs around toileting, along with considerations of children’s age, development stage and needs, and to explore parents’ expectations and concerns.
* The ability to explore sources of stress in parents associated with their child’s toileting, and to help parents anticipate and plan ahead in order to avoid stress or conflict where possible; supporting parents in problem-solving around the issues they are facing.
* The ability to explain principles of social learning such as graded exposure and chaining, according to the evidence base. For example, potty- or toilet-sitting might be a crucial intermediate step in learning to use the toilet, but children need to show signs of developmental readiness for this task and parents may need support to know whether their child is ready or not. Using basic narrative approaches such as ’Sneaky poo’ and ‘Poo goes to Pooland’ for children struggling with toilet training, and using praise or appropriate and acceptable rewards to support children who need additional motivation to use the potty or toilet.
* Signposting caregivers to, and supporting the use of, evidence-based written guidelines or psychoeducational groups.
* The ability to make appropriate referrals where the difficulties are complex (for example, difficulties associated with trauma or a chronic medical or developmental condition).

Parenting support for feeding or eating issues

* The ability to help caregivers establish culturally appropriate family mealtime experiences that encourage exploration, trying new tastes and enjoying the sharing of a meal.
* The ability to explain to caregivers how common-sense approaches can lead to unintended negative consequences when attempting to encourage healthy eating. For example, rewards for eating more, or the imperative to finish all the food on a plate, can lead to children eating more than they want or need; telling children certain foods are healthy can decrease acceptance; restriction of high-calorie foods can heighten a child’s preference for them; increased attention to eating can reinforce food avoidance or tantrums.
* The ability to support parents to explore their own approaches to eating, their values, and what eating means in their culture and family system. To recognise when they are expecting too much/too little of their children – for example, knowing how long their young child can sit at a table before needing to get down and play or run around, and how to respond when children reject or throw food.
* The ability to explore sources of stress in parents associated with their children’s eating, and to help parents anticipate and plan ahead in order to avoid stress or conflict where possible; supporting parents in problem-solving around the issues they are facing.
* Explaining to parents/carers how repeated exposure to novel foods increases children’s openness and exploration with food, and how playing and experimenting with food can help broaden toddlers’ and young children’s preferences.
* The ability to help parents/carers understand the role of physical health conditions and the impact of traumatic experiences (for example, gastrointestinal surgery, nasogastric tubes in the case of feeding difficulties), learning disability, temperament and other pre-existing factors that might increase the likelihood of difficulties developing, as appropriate.

#### Part B: Parent–infant pathway

Key learning outcomes

This module will provide opportunities for trainees to develop and demonstrate the following areas of knowledge, competency, and skills.

Knowledge

* Knowledge of attachment theory and research regarding infant and child development and parental provision of a secure base.
* Knowledge of the theory of change underpinning video feedback interventions and how this relates to key intervention strategies that are used to promote sensitive responding, attunement, parental reflective functioning/mind-mindedness, and attachment.
* Knowledge of how to use video feedback techniques to promote attachment and achieve the intervention goals.
* Knowledge about the style and structure of video feedback, including the number, length, and frequency of sessions; the requirements in terms of parental involvement; and the expectations of the infant or young child.
* Knowledge of how a typical video feedback session should be structured – for example, review of areas of progress and concerns since the last meeting; feedback on selected video clips with the aim of supporting the parent/carer to see what they are doing well to enhance interactions with their infant or child. Knowledge of the key stylistic features of video feedback – for example, identification of goals; reframing these goals to focus on enhancing parent–infant interaction; clips selected to give voice to the infant’s/child’s behaviour, experience and/or imagined thoughts and feelings to show attuned interaction and to match the parent’s/carer’s goals; professional modelling of attuned interaction with the parent/carer, helping them become active in their own change while supporting them with new ideas.
* Knowledge of how to adapt programme themes to individual dyad needs.
* Knowledge of how to integrate psychoeducation regarding infant/young child development and positive parenting strategies, including parental self-management.
* Knowledge of principles of attuned communication/interactions and guidance (for example, being attentive; encouraging initiatives; receiving initiatives; developing attuned interactions; carefully ‘scaffolding’ guidance and advice.

Competencies

* Ability to assess the suitability of the dyad for video feedback intervention.
* Ability to explain the principles and general procedures of video feedback to parents/carers responsible for informed consent to treatment.
* Ability to set up filming sessions in a way that maximises the likelihood of attuned interaction between the infant/young child and caregiver in accordance with the family’s goals or concerns; micro-analysis of video clips in order to facilitate the intervention; delivery of sessions where the video is jointly reviewed by the parent and clinician to develop a new understanding of attuned interactions from the perspective of the infant/child.
* Ability to build a supportive, therapeutic relationship with caregivers and consistently model sensitivity.
* Ability to observe and describe infant cues, signals, and responses.
* Ability to recognise cues from the infant/young child, to interpret the child’s behaviour based on the cues, and to support parents/carers to learn to recognise these cues for themselves.
* Demonstrating a capacity to maintain a stance of curiosity and bi-directional empathy towards the parent/carer and child.
* Ability to recognise, describe and support the parents’/carers’ sensitive responses to the infant/young child (through video feedback)
* Ability to build on parents’/carers’ strengths by recognising positive moments and sensitive behaviour, however subtle, promoting parents’/carers’ self-confidence, and showing them where they could use further sensitive responses.
* Ability to use supervision to support the learning and delivery of video feedback.
* Ability to deliver a video feedback intervention (either VIPP or VIG) to support caregiver sensitivity.
* Ability to sensitively use video feedback for different case scenarios (for example, couples, the use of an interpreter, twins).
* Ability to use clinical measurement to monitor the video feedback process and outcomes.

#### Part C: Early childhood pathway

Module aim: To develop practical skills and competencies in delivering interventions with caregivers for commonly presenting early childhood difficulties that affect child and family wellbeing, or where addressing them may prevent the development of further difficulties in the future.

#### Module overview

This sub-module will provide more in-depth teaching and clinical training for focusing on supporting early childhood difficulties (see below for examples) commonly presenting between the ages of 24 and 60 months (2–5 years). Students will complete all lectures and skills workshops to develop the skills and understanding needed for working with commonly presenting early childhood difficulties, including:

* behaviours that caregivers and peers find challenging – tantrums, aggression (hitting, biting, kicking, pushing) and refusal to follow adult instructions
* anxiety or early childhood fears such as separation anxiety, phobias, and post-traumatic stress (plus recognition of, but not treatment for, complex developmental trauma)
* emerging concerns around neurodiversity, learning, physical health, or developmental delay

With all common early childhood difficulties there is an understanding that developmental stage, age, temperament, strengths, abilities, challenges, and interactions and relationships with caregivers are key. Children learn to identify and regulate their emotions through caregiver presence, safety, attunement, soothing and co-regulation. They do this in the context of the wider family, community, culture and educational settings. There is a normative caregiver process which may include praise and play, the development of routines, setting limits and boundaries (for example, caregivers giving instructions or saying no for the child’s safety and wellbeing), opportunities for the development of peer interactions (sharing, playing) and dealing with environmental stressors and transitions (being in new places, tolerating change). Relationship quality with key caregivers and security of attachment remain crucial underpinning foundations for all work in this area.

Students are expected to incorporate learning in this module with the knowledge acquired in Modules 1 and 2 (such as key presenting difficulties, the range of early expected childhood development outcomes, family context, contextual/multilevel influencing factors, assessment methods, and generic/biopsychosocial formulation, including strengths, support systems and recognition of learning needs and neurodiversity) and core practice knowledge and skills from Module 3A, as well as the core skills module.

#### Knowledge

* Knowledge of how to successfully engage parents/carers and pre-school children through curiosity, empathy, and the use of developmentally and age-appropriate language, toys and play.
* Knowledge of the importance of play, positive relationships, and interaction in shaping emotional and social wellbeing for young children.
* Knowledge of the importance of establishing routines (for example, forming helpful sleep habits, sleep hygiene, toileting routines, regular mealtimes).
* Knowledge of Social Learning Theory principles and how to explain these to avoid misunderstanding or misuse by parents.
* Knowledge of how to support parents to use daily diaries to record the antecedents, behaviours, and consequences of a child’s behaviour, so that they can understand more about when it happens, how often it happens, and how they deal with it.
* Knowledge of the inclusion and exclusion criteria for parenting group interventions – for example, a diagnosis of global developmental delay or autism in the child which might indicate the need for, or benefit of, a more specialist group or individual intervention, or very limited language or literacy skills of the caregiver.

#### Competencies

Parenting groups for behaviours that parents find challenging.

* The ability to undertake pre-group assessments, use ROMS, including child measures (for example, SDQ 2–4) and adult mental health measures (PHQ-9, GAD-7), set goals and assess suitability for a group intervention. Screen for and identify adult mental health needs, risk and safeguarding issues that might require additional support, signposting, or referral to a more suitable service.
* The ability to weigh up the pros and cons of an individual approach and to assess which caregivers are likely to do better with such an approach, including consideration of caregiver shyness, the severity of adult mental health problems that might make joining a group or going at group pace difficult, and the ability to attend at group times.
* The ability to consider whether an intervention aligns with a family’s culture and values.
* The ability to deliver an evidence-based parenting group, for example an Incredible Years parenting group, or individual parent work supporting behaviour management (such as Helping the Noncompliant Child), including managing the practicalities of running a group, completing appropriate paperwork and mailings, preparing for sessions, managing session content, and timing, and supporting parents to express their views and work collaboratively.
* The ability to sensitively relate to and empathise with caregivers’ dilemmas or difficulties in maintaining engagement; following up caregivers who do not attend or engage with groups; and developing appropriate strategies for re-engaging parents/carers and/or offering appropriate alternatives.

Parent-led support for children’s anxiety, fears, and nightmares

* Use of age-appropriate techniques for addressing fears or nightmares; use of guided self-help with parents, including cognitive behavioural techniques, if indicated, to address caregivers’ beliefs and feelings about their children’s experience.
* The ability to deliver relevant psychoeducation about the development and maintenance of anxiety, including the physical, emotional, cognitive, and social manifestations of anxiety and fears, and the role of avoidance and modelling in their development and maintenance.
* The ability to draw on a formulation and principles of cognitive behavioural theory to offer structured support to parents to help their child overcome fears and anxiety, drawing on programmes with evidence from randomised controlled trials.
* The ability to provide appropriate written materials and evidence-based guided self-help.
* The ability to support parents to learn behavioural management strategies (for example, using praise, reducing overprotection, supporting gradual exposure) and anxiety management skills (for example, if developmentally suitable, cognitive restructuring).
* The ability to support caregivers in modelling adaptive and normative behavioural responses to perceived threat and fear, and reduced use of avoidant coping styles.
* The ability to raise parents’ awareness of, and reduce, any overprotective/controlling practices that limit the normative development of young children’s autonomy, confidence, and decision-making.
* The ability to support parents to develop a ‘coaching’ role in helping their children manage their fears and worries.
* Ability to work collaboratively with other professionals (for example, nursery staff) to support a common understanding of children’s needs and the consistent implementation of an agreed approach to support/intervention.

Evaluation and treatment ending

* The ability to help caregivers identify barriers to the successful implementation of treatment plans, working collaboratively to find solutions when they feel stuck.
* Helping parents see the value of evaluating the impact of therapy, supporting caregivers to notice and monitor patterns of children’s behaviour (for example, using questionnaires, forms, and diaries to record sleep patterns, length and intensity of crying, bowel movements and food intake), and repeating ROMS compared with initial baseline measures and ROMS.
* Identifying and noticing improvements in children’s and/or caregivers’ functioning and relationships by helping caregivers to compare their current parenting practices, interactions, beliefs, emotions, and behaviour with those at the start of treatment and linking these to their children’s behaviour and feelings.
* Helping caregivers and children to prepare for the end of an intervention from the beginning of treatment, by agreeing the number of planned sessions and reviews.

The ability to ensure that interventions end in a planned way by reviewing treatment, considering change, and planning for any future challenges. Saying goodbye, expressing appreciation to the family for their hard work, and writing an ending letter to the family and referrer.

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1. See, for example, Sroufe, L.A. (2005). ‘Attachment and development: A prospective, longitudinal study from birth to adulthood’. In *Attachment & Human Development* 7(4): 349-367. [↑](#endnote-ref-2)