Title: An evaluation of a newly established psychoanalytically informed Under-fives Service in four children's centres

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Abstract

A new community CAHMS Under-fives Service was commissioned by the local NHS commissioning group CCG to address unmet mental health provision for children under five, their families and allied professionals in health and social care. The research did not commission the service. Under-fives clinicians are co-located one day a week in each of the four children's centres, attending universal stay and play sessions, consultations with parents and staff and deliver clinical intervention, parent–infant psychotherapy.

The study investigates the experiences of children's centre practitioners who have worked alongside under-fives clinicians or made use of the consultations The views of six children's centre practitioners, from four centres, were gathered using semi-structured interviews and analysed using Thematic Analysis. Four core themes emerged: presence in the children's centres; a different way of thinking; learning and development; and organisational challenges.

The findings suggest the co-location of the Under-fives Service has generated a working alliance and broken-down barriers of engagement. The findings identify the informality of the service: clinicians being visible, approachable and working alongside the children's centre practitioners in the universal group settings is key to the successful integration of the Under-fives Service. The findings further indicate informal reflective discussions, as opposed to a more formal work discussion model, with opportunities to reflect and share observations broke down professional defences. Clinicians skills were also

identified: observations, reflective thinking and specialist knowledge contained practitioners' anxieties and developed a joint focus on emotional communications. Practitioners are more thoughtful to the meanings of a child's behaviour, and are more likely to focus on children's emotional wellbeing and on the parent–child relationship than on parents' difficulties and developmental issues that keep the child at the centre.

The findings also indicate practitioners have developed a deeper understanding of the importance of the quality of the early parent–child relationship in the development of a child. Practitioners are more confident in identifying infant mental health/parent–infant difficulties and feel more skilled to intervene. They feel more knowledgeable about CAMHS and better supported and are more likely to refer a child to CAMHS if needed. They feel CAMHS is a more accessible and less stigmatising service.

The practitioners identified a lack of resources as the primary limitation of the Under-fives Service, and a need for training in infant mental health for all staff in the children's centres. They suggest this model of working could be introduced to all children's centres to support staff in delivering child-focused practice.

Declaration

I declare that my research required ethical approval from the University Ethics Committee (URES) and confirmation of approval is embedded within the thesis

Chapter 1: Origins of the project

1.1 The development of a designated community CAMHS Under-fives Service

The National Health Service (NHS) mental health services are organised along the dividing lines of chronological age: adult mental services and separate services for children and adolescents. NHS community child adolescent mental health teams (CAMHS) provide mental health support for children, young people and their families between the ages of 0 and 18 years and do not usually have a dedicated Under-fives Service.

Whilst community CAMHS teams serve all children under 18, there was a noticeable pattern of lower referrals for children under the age of five, and a high number of referrals for children seven years old and above, who presented with more serious difficulties. Child psychotherapists in our local CAMHS were curious to understand the reasons for the lower referrals for younger children. In 2016, the trust's consultant child and adolescent psychotherapists and their colleagues consulted 52 agencies across the borough, including social care and early years, regarding local provision for the under-fives.

This scoping exercise identified gaps in mental health provision for the under-fives. Difficulties were not identified due to a lack of easily accessible, specialist infant and young child mental health perspectives on the under-fives to provide early intervention for significant attachment difficulties and identification of infant/young child mental health issues in other areas. Ill-served by current infant mental health provision, the scoping exercise identified a need for a

specialist mental health under-fives service. Their findings helped to secure investment from the local Clinical Commissioning Group (2016) to fund a pilot CAMHS specialist under-fives mental health service to address the unmet need in mental health provision for the under-fives.

The aims of Under-fives Service are to:

- make CAMHS easily accessible;
- improve the early identification and intervention of infant mental health difficulties;
- 'skill-up' early years practitioners/children's centre practitioners;
- destigmatise mental health.

The service will provide:

- consultation;
- specialist assessment;
- evidence-based treatments: parent–child psychotherapy and video-interaction guidance (VIG);
- inter-agency partnership working, co-location in children's centres.

1.2 The Under-fives Service

The Under-fives Service is a psychoanalytically informed service. It is managed by a consultant child and adolescent psychoanalytic psychotherapist. The framework is based on the Tavistock Under-fives Model. Psychoanalytic thinking is imbedded in the practice and draws on psychoanalytic observational skills, child development theory, research and attachment theory. The psychoanalytic technique is based on close and detailed observation of the

parent/family–child relationship, verbal and non-verbal communications, children's free play, drawings and conversation. The aim is to put into words the understanding of what the child and parent communicates, including conscious and unconscious thoughts and feelings. Central to the work is the understanding of unconscious processes and powerful projective processes that can impinge on the parent–infant/young child relationship and disrupt the relational bond. I will explore these areas in the literature review in Chapter 2.

An under-fives CAMHS clinician is co-located in a children's centre for a regular time each week, one day a week. The team comprises three child psychotherapists, a family therapist and a clinical nurse specialist. Three clinicians are also accredited VIG practitioners. All clinicians receive psychoanalytically informed supervision.

I am one of the qualified child psychotherapists in the team, I am also an accredited VIG practitioner. I joined the newly formed under-fives team in November 2016 prior to the launch of the service in January 2017.

Routine outcomes measures are embedded into Under-fives Service practice for all our clinical work. There is an additional requirement to request feedback forms for each non-clinical activity, such as for a consultation, attending the universal group and the reflective time.

The Under-fives Service aims to respond promptly to parental concerns about their infant/young child, offering families a brief, psychoanalytically informed

intervention and up to six sessions of parent–child psychotherapy. The service offers support and treatment to parents and children who are experiencing difficulties beyond ordinary developmental expectations such as excessive temper tantrums, ‘being over clingy’, sleep and eating difficulties, relationship difficulties, a typical bedwetting/soiling problem and being very withdrawn or non-communicative. We offer consultations and have a presence in children’s centres, where clinicians screen a range of professional/parental concerns and identify referrals that are appropriate for treatment in the Under-fives Service. Other less serious concerns are signposted elsewhere or contained through the consultation process, rather than leading to a treatment. The service aims to promote resilience, prevention and early intervention (DoH, 2015).

Clinicians are presented with ‘problem’ children or problem behaviours to be fixed. The task is to assess/explore where the root of the difficulty lies – in the child, mother, father, parent–child relationship or the couple relationship – and to do it sensitively.

The Under-fives CAMHS service has made its journey from conception to birth and on to infancy and is now four years old.

It brings together area of my interests:

- psychoanalytic psychotherapy;
- supporting frontline staff in social care;

- the value of working with the parent–infant relationship. [1]

1.3 Personal interest: accessibility of CAMHS for frontline practitioners

Before I trained as a psychoanalytic child psychotherapist at the Tavistock Centre, I worked as a social worker with children who had suffered early trauma and who were looked after by the local authority. A significant proportion were children under the age of five. I recall the inaccessibility of child mental health services to support children and social workers.

The team received group supervision from a child and adolescent psychoanalytic psychotherapist. I was sceptical about psychoanalytic thinking as it had received negative press during my undergraduate degree. In one of the first meetings, the clinical supervisor used the term 'nappy mummy' to describe the work of the therapist, this confirmed my reservations that psychoanalytic thinking was full of strange ideas and terminology that I could neither relate to or translate into my practice in a meaningful way.

The therapist listened, was thoughtful and reflective. As a team we valued her, she was supportive. Her observations began to make sense. I recall one particular supervision when a colleague presented case material from his work with a young seven-year-old boy, Dylan[1], who had experienced terror. During play, the boy liked to initiate scary games, allocating the therapist the role of a monster. As he presented the session material, the therapist appeared to transform, he seemed overbearing and we wanted him to stop. The group's

[1] pseudonym to protect identity

powerful experience brought Dylan's lived experience of terror to life more than a descriptive account could. It brought into focus the power of projective processes. The therapist was not only drawn into playing the part allocated to him, but fleetingly he had become the terrifying monster. It helped to understand Dylan's communications, the scary feelings and to avoid being drawn into further retraumatising re-enactments but to understand the communication of his experience and fears, to begin to think and speak about them. I was converted.

Despite my reservations, and prejudices, the consultations became invaluable, and the feeling I could not articulate, at the time, was 'containing'. It helped me immeasurably. Since qualifying as a child and adolescent psychoanalytic psychotherapist I remain committed to using my psychoanalytic frame of thinking, I hope, in the spirit of generosity with which it was shared with me to help support others working in frontline services who undertake painstaking work with children and families.

1.4 Rationale

It is these experiences that are of interest and provide the opportunity to undertake an in-depth evaluation of the service from the perspective of children's centre practitioners. I am interested in how the service is experienced, if the identified aims have been achieved and if the Under-fives Service is accessible, and if not, to try to understand why. Do practitioners feel supported and more skilled and confident in identifying infant mental health difficulties?

I obtained the views of six children's centre practitioners who have consulted the Under-fives Service and work in four local authority children's centres within inner-city locations covered by our CAMHS service.

I hope my research will offer a valuable contribution to the ongoing development and improvement of the service. The research report may also help in the development of similar projects – a precursor to a manual of practice for an under-fives service model. I hope it will make a helpful contribution to professional knowledge in this field.

1.5 Getting established: a personal reflection

There is a tendency to dilute the term 'infant mental health' in children's centres, preferring to use the term 'emotional wellbeing'. Our Under-fives Service has been comfortable with the various titles attributed to us in different centres, such as 'Under-fives therapists', we do not want our professional qualifications to be a barrier to engagement with us. It also reveals the ambivalence of infant mental health, the societal stigma and the practitioners' own discomfort with the term, which still has negative connotations and judgements about a family's functioning.

The aim of the Under-fives Service is to be flexible, responsive, easily accessible, offer a containing presence to frontline staff and think about children's behaviour and their emotional responses. When the service launched, in 2017, I spent several months feeling under suspicion from some staff and parents in the children's centres. I had not considered my presence, the NHS presence, would evoke anxieties and perhaps resentment. I was not

invited to comment and felt infantilised, as if there solely to learn. I was to observe, listen and help to tidy up ‘the mess’ at the end of the stay and play activity sessions. I felt silenced and began to wonder if I had anything to offer. During the post-session reflective/planning discussions, my thoughts and observations were not invited and my comments only coolly acknowledged. I was an ‘unwelcomed outsider’, I began to feel deskilled and did not look forward to my weekly attendance in the universal sessions. These unconscious communications perhaps mirror some of the ambivalence families feel about professional involvement. My psychoanalytic understanding of the transference and my counter-transference helped me to tolerate the projections and think about the meanings. I wondered about the children’s centre practitioners’ feelings of inadequacy, feeling deskilled and left to tidy up the mess of the families, as well as their previous experiences of allied professionals who may flit in and out of the centre. I struggled to position myself, oscillating between being overly friendly, wanting to fit in, to be accepted, to being distant and defensively hiding behind my NHS ID badge. The badge was my armour to protect me from unwanted projections, I had felt exposed and vulnerable without it.

Much time was invested nurturing a benign and non-persecutory presence in the centres, quietly observing and chatting to the families and practitioners, getting alongside and trying not to be intrusive, but tip-toeing into the centres. This was time consuming and emotionally draining, and with the pressure of the under-fives waiting list, some doubt crept in about whether standing around was the best use of our time and if the investment was going to be worth it.

Persistence, perseverance, having a visible presence, flexibility and availability laid the foundation for integration. Tensions and unconscious professional rivalries gave way to the development of a mutually satisfying and productive relationship. It took a year before clinicians began to feel of value or competence in the centres and taken four years to embed.

The practitioners now ask for my thoughts and I now feel a valued non-member of the staff group. I wanted to be accepted and now at times I struggle to keep hold of my difference, my impartiality to remain independent. I am now expected to tidy up the messy/confusing feelings, as well as the toys, and provide some containment. When I am absent, the staff miss something about my presence, more than just another pair of hands. As McFadyen (1994) notes, the quiet presence of an interested observer can bring something together as an observational stance can help to bring networks and/or parents and professionals together in a child-centred way.

1.6 Update: January 2022

Since the launch of the Under-fives Service some of the centres have transitioned into Family Hubs. Different commissioning bodies have shown increased trends for outsourcing activities, such as the universal stay and play activity groups, and only two of the centres now host universal groups. This is a worrying trend and risks missing those very early difficulties that can be spotted by experienced children's centre practitioners in a universal group setting.

Research interviews took place during the global Covid-19 pandemic and lockdown in 2021. The interview questions did not include a specific question about the impact of the pandemic, ethical approval predated the pandemic, but this emerged in the findings.

Three of the four children's centres in this study closed, with the fourth only running with skeleton staff and no universal groups operating. There was an expectation from some practitioners that under-fives clinicians should be present and the absence of under-fives clinicians provoked some anxieties. There was a huge sense of loss experienced during the Covid-19 pandemic with government-imposed lockdowns, when centres closed and clinicians continued to offer a service from the CAMHS clinical base or online. The practitioners' emotional response is in the context of a much wider societal loss but is nevertheless worth noting, they felt a sense of loss and abandonment. The clinicians had come to represent containment, and the physical absence triggered more primitive functioning, with a return to a more 'us and them' culture. During the pandemic, the Under-fives Service continued to operate fully, but with an increase in referrals the clinicians were busy. There was defensiveness on the part of the clinicians who felt criticised by some in the centres. This perhaps reveals the fragility of the success of the service and how quickly old ideas and prejudices can resurface.

1.7 The national context

I will now outline the development of the national context of early intervention policy, including children centres and mental health, under the following:

- early intervention policy;
- development of children's centres;
- mental health.

1.7.1 Early intervention

I will describe a brief overview of the political climate and developments in early years policy. Policy directly targeted at very young children and their parents developed significantly in government policy in the 1990s and early intervention developed as a more joined-up preventative policy approach and programme. With the aim to integrate services, there has been a shift in the field of infant mental health, which include policies to support early intervention to improve health and wellbeing outcomes, with a focus on the emotional development of young children as well as the relationship between the parent/s and young child.

Political Context

> Early intervention is a public policy approach to identify and support children and their families to prevent problems developing in later life, such has poor physical and mental health, low educational attainments, crime and antisocial behaviour. (Powell *et al.*, 2021)

The Labour government (1997) first identified poverty not just in financial terms, but also introduced wellbeing and developmental opportunities. Policies were implemented to tackle and address causes of poverty, with a focus on early intervention in the early years. The government commissioned an independent review into poverty and life chances. In his report, *The Foundation Years:*

Preventing poor children from becoming poor adults (2010) MP Frank Field recommended a new policy focus that government at a national and local level should pay to children under-five and their families. He revealed that there was overwhelming evidence that the first five years of a child's life is a predictor for future outcomes and that early intervention is an effective and cost-effective way to help and support young children and families. He stated:

> The things that matter most are a healthy pregnancy; good maternal mental health; secure bonding with the child; love and responsiveness of parents along with clear boundaries, as well as opportunities for a child's cognitive, language and social and emotional development. Good services matter too: health services, Children's Centres and high-quality childcare … by the age of three, a baby's brain is 80% formed and his or her experiences before then shape the way the brain has grown and developed. (Field, 2010, p.5)

The social and emotional development of young children and the parent and young child relationship was also recognised by Graham Allen in the government publication *Early Intervention: The Next Steps* (Allen, 2011). Allen promoted early intervention to prevent the 'inter-generational cycle of dysfunction and under-achievement' (p.5). He highlighted the importance of the quality of the relationship between parents and their young children, and that all parents need to know how to 'recognise and respond to a baby's cues, attune with infants and stimulate them from the very start, and how to foster empathy' (p.57).

A similar message is conveyed in Dame Clare Tickell's 2011 governmental report pertaining to the early years. She states that the importance of a child's early experiences have a lasting effect on children's development and that solid foundations are important for good long-term outcomes for children. If help is needed 'the evidence shows that high quality early years interventions provide lasting and significant long-term effects on young children's development' (Tickell, 2011, p.4). Professor Munro's (2011) review of the child protection system also emphasised the importance of early help. Referencing the reviews from Allen, Field and Tickell, Munro recommended a statutory duty on local authorities to secure sufficient provision of local early help services for children, young people and families.

These policy documents also cite findings from neuroscience that demonstrate the impact of a range of stressors, such as structural inequality, neglect and trauma, on the developing brain (Heim & Binder, 2012). Research identifies a critical 'window' of development and highlights the value of early intervention, which is a cost-effective investment.

1.7.2 Children's centres

The 1998 Labour government introduced Sure Start Local Programmes/Children's Centres to reduce child poverty and inequalities and to improve health and education outcomes among children under five and their parents. Initially they were introduced in the most deprived areas (Bouchal & Norris, 2017).

Sure Start Children's Centres were introduced in 2003 to offer universal services and work in partnership with other services such as health. 'They should bring all the different support agencies together to offer a range of services to meet you and your child's needs, all in one place' (DCSF, 2008, p.1) to support and develop the health and wellbeing of children under the age of five. The Childcare Act in 2006 placed a duty on local authorities and health commissioners to work together to provide integrated services to improve the wellbeing of young children (Childcare Act, 2006).

In his 2010 report, Field recommended:

> Local Authorities should aim to make Children Centres a hub of the local community. They should maintain some universal services so that the centres are welcoming, inclusive, socially mixed and non-stigmatising, but aim to target services towards those who can benefit from them most. (Field, 2010, p.7)

The First 1001 Days Movement (DHSC, 2021) raises awareness of the importance of the earliest years of life, with an all-party parliamentary group to promote infant's social and emotional development, and both physical and mental health. The recent *Early Years Healthy Development Review* (March 2021) sets out a new policy, 'Start for Life', which aims to further integrate and join up support for emotional and physical wellbeing. Children's centres will transform into family hubs, a place for families to access 'Start for Life' services, such as childcare, early education and health services (DHSC, 2021).

The Childcare Act (2006) places a duty on providers to ensure that the adults looking after children have appropriate qualifications, training, skills and

knowledge. Dame Tickell points out that whilst parents have a direct influence on children's experiences, early years settings can also make a positive contribution. This is especially so as children are spending more time in such settings (Tickell, 2011, p.2).

These initiatives have placed the early years high on the national agenda. Such programmes, however, have not necessarily incorporated appropriate recognition of the mental health needs of this age group. It is important that children's centre staff receive access to specialist infant mental health training in order to raise awareness of the emotional needs of infants and can identify symptoms of distress in young children, factors that can impact on development. The importance of intervention is highlighted by Karlen Lyons-Ruth (Lyons-Ruth *et al*, 2017), who stresses, 'once early signs of mental health problems are identified, increased access to evidence-based prevention and intervention services should be a priority' (p.701). The Under-fives Service is an example of such integration. Under-fives clinicians are based in children's centres and offer consultation to all staff and anyone who is interested in and concerned about infant mental health or children's behaviour.

There is a shift in children's mental health and emotional wellbeing. It is now at the fore of the government's agenda to improve and expand NHS mental health services for children and young people. In the following section, I give a brief overview of the relevant government papers in respect of the NHS and mental health.

1.7.3 National context: mental health

A range of terminology is used to talk about mental health. The term 'mental health' is sometimes avoided because of its association with stigmatising ideas about mental illness. Some prefer to use terms such as 'psychological wellbeing' or 'emotional health' (Frederickson *et al*, 2009, p.1). Perhaps there is a diluting of the severity of the impact of untreated mental health. The impact of mental health problems on children and young people's lives can be significant. The evidence shows that children and young people with mental health problems are more likely to have negative life experiences that can impact on their life chances in adulthood.

NHS England and the Department of Health (DoH) released two publications, *Future in Mind* (DoH, 2015) and *Five Year Forward View for Mental Health* (NHS, 2016), which expressed agreement around the need for higher quality and more accessible mental health services for children and young people. Acknowledging the chronic underinvestment in mental health care across the NHS, they propose the need for investment 'to meet the significant unmet mental health needs of people and to improve their experiences and outcomes' (NHS, 2016)

> There is now a welcome national recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked. (DoH, 2015, p.8)

The government's green paper *Transforming children and young people's mental health* (DHSC, 2017) builds on *Future in Mind*. It aims to ensure that children showing early signs of distress are able to 'access the right help, in the right setting, when they need it'. It sets out the importance of 'mental health and wellbeing' for the future of children to thrive and achieve, stating that one in ten young people have some form of diagnosable mental health condition and face potential lifelong inequalities if children's mental health is untreated.

In 2017 the then prime minister said:

> Mental health problems affect people of all ages and all backgrounds. An estimated 1 in 4 of us has a common mental disorder at any one time. The economic and social cost of mental illness is £105 billion – roughly the same as we spend on the NHS in its entirety. And for children – 1 in 10 of whom has a diagnosable condition – the long-term effects can be crippling: children with behavioural disorders are 4 times more likely to be drug dependent, 6 times more likely to die before the age of 30, and 20 times more likely to end up in prison. (Theresa May, January 2017)

She concluded this is one of the burning injustices of our time and legislated for parity of esteem between physical and mental health. She also committed to improve services, setting out plans within 2015's *Future in Mind* and 2016's *Five Year Forward View for Mental Health*.

The government report *No Health without Mental Health* (DoH, 2011) highlights the importance of a good relationship between parent and child, which promotes positive outcomes in children. Children who are exposed to negative parenting, relationships and other early life adversities are at risk of mental health problems in later life.

I will discuss the prevalence of infant mental health in the literature review in Chapter 2.

Chapter 2: Literature review

2.1 Literature review strategy

The initial literature search started with books and journals relating to child psychotherapy and under-fives. I expanded my searches using electronic databases such as PsychInfo, ResearchGate, EbscoHost, Pep-web Archive and the Tavistock and Portman Library webpage. I used search terms including 'work with under-fives', 'parent–child psychotherapy', 'brief psychotherapy', 'early years policy', 'children's centres', 'outreach work', 'reflective practice', 'infant mental health', 'prevention' and 'institutional dynamics'. I also browsed through books and journals such as the *Journal of Child Psychotherapy* and the *International Journal of Infant Observation*.

The literature search did not identify any other research where psychotherapeutically informed clinicians were embedded in children's centres. Neither were there any studies where the function of an under-fives service integrated into children's centres was evaluated. The lack of studies similar to my proposed work gave me reassurance that this piece of research would contribute to the current literature and could prove useful for the future development of similar under-fives services.

The key areas identified for my literature review are:

- infant mental health
- under-fives models

- community setting
- ways of working
- theoretical perspectives
- institutional dynamics
- under-fives service during the pandemic.

2.2 Infant mental health

Early childhood is considered to be the most important developmental phase for children and is critical for a child's development and life course (Irwin *et al.*, 2007). During this phase a child develops language, the capacity to form and maintain positive relationships with others, and emotional wellbeing. Identifying mental disorders in children at an early stage is therefore important as good mental health is a foundation for lifelong emotional and physical health as well as education and economic achievement (Wave Trust, 2013).

The presence of mental disorders in early childhood has been recognised as an important area of research that has not yet received sufficient attention. Exploring mental disorders in preschool children is challenging because existing diagnostic systems are not necessarily appropriate given the rapid development that these children experience (Egger & Angold, 2006). In infant mental health, social and emotional development is nurtured in close and secure interpersonal relationships, which develop the capacity of the infant to regulate and express emotions and to explore the environment and learn (Zero to three, 2012).

There is increasing recognition of psychopathology in young children (Lyons-Ruth *et al*., 2017). Infant mental health ‘emerged as an important and visible undertaking during the late 20th century’ (Zeanah & Zeanah, 2019, p.5). Young children and infants can experience depression and other psychiatric disorders connected to attachment and trauma (Luby, 2000).

The main reasons for referrals to infant mental health clinics are difficulties in regulating behaviour, excessive crying, feeding or sleep difficulties and attachment problems, including separation anxiety (Keren *et al*., 2001). Infant mental health difficulties are often unrecognised; there is resistance to the idea that infants have ‘mental health’, with some expressing ‘puzzlement or even aversion to the term “infant mental health” (Zeanah & Zeanah, 2019, p.5).

A number of studies have emphasised the complexity of identifying psychopathology in infancy (Burnham *et al*., 2002; Chatoor, 2002). Others suggest prevalence rates similar to those for older children, ranging from 6% to 12% (Costello *et al*., 2005). Infant mental health is difficult to assess and measure compared with older children due to the unique positioning of infants resulting from the relational dependence they have to their parents (Rosenblum *et al*., 2009). With a lack of recognition, awareness, assessing and diagnosing young children (Lyons-Ruth *et al*., 2017).

The latest survey funded by the Department of Health and Social Care examined the prevalence of mental disorders in preschool children (2 to 4 year olds) in England in 2017 and the characteristics of preschool children with a mental disorder. Figures from NHS Digital reveal that of 271,998 children and

young people (2 to 19 years old) in England who were in contact with mental health services, 6,483 were aged 2 to 4 years old. One in eighteen (5.5%) preschool children were identified with a mental disorder at the time of interview, with higher rates in boys (6.8%) than in girls (4.2%). The results highlight the importance of understanding mental health difficulties in the under-five age group (NHS Digital, 2017) and the importance of early identification.

Early difficulties do not improve. If left untreated, they can have a lifelong impact on development and wellbeing, leading to mental health difficulties in adulthood (Mathiesen & Sanson, 2000; Skovgaard *et al.*, 2008). Early identification, support and intervention is important. Lyons-Ruth *et al.* highlight:

> This lack of widespread recognition of disorders of infancy is particularly concerning due to the unique positioning of infancy at the beginning of the developmental process. Both the brain and behaviour are in vulnerable states of development across the first 3 years of life, with the potential for enduring deviations to occur in response to early trauma and deprivation. (Lyons-Ruth *et al.*, 2017, p.695)

There has been a significant amount of research that identifies the importance of the quality of the parent–infant relationship. The psychopathology of children is best understood in a relational context. ‘Most problems in early years, whilst often manifest poignantly in child behaviour, are best conceptualised as relationship problems’ (Sroufe, 1989, p.70). Early experiences shape the brain and development (Lyons-Ruth *et al*, 2017).

Recent research supports Winnicott’s view ‘there is no such thing as an infant’ (Winnicott, 1960, p.587): a child only exists in relation to a parent, in the context

of a relationship, with the parent–infant relationship being the central focus of any intervention to alleviate difficulties and improve the social and emotional wellbeing of young children. Infant mental health cannot be untangled and separated off to study in isolation from relationships with parents or parental mental health. Difficulties in the parent–child relationship, as well as parental mental health, are risk factors for emotional, behavioural, eating and sleeping disorders in young children (Skovgaard *et al*., 2007; Skovgaard *et al*., 2008; Skovgaard, 2010). The idea that 'there is no such thing as individual psychopathology in infancy' (Hopkins, 1992, p.5) suggests that symptoms in the infant are best treated through supporting the parent–child relationship.

2.2.1 Attachment

Many referrals to our Under-fives Service suggest 'attachment difficulties' between parent and child. Bowlby (1951) laid the foundations of attachment theory: his investigation of the effects of separation and loss on children's development and attachment informs the work (Bowlby 1988). Babies are born unable to regulate their own arousal and are dependent on their parent for this regulation. The attachment system is triggered when there is a perceived threat to security. The aim of attachment behaviour is to re-connect with the parent to re-establish a sense of security. When the attachment system is activated, the infant signals anxiety and the mother is alerted, tries to soothe and understand the cause of distress, and responds appropriately to her infant's needs, returning the infant to a sense of security. The attachment relationship is crucial to healthy development and can provide a buffer against later difficulties, like an inoculation. It also spurs further development: if the infant feels safe, they

have a 'secure base' to return to, to scaffold them (Ainsworth, 1982; Bowlby, 1988).

Winnicott describes the importance of ordinary 'good enough' (1953, p.13) early experiences that help to build a strong foundation for healthy development, learning, relationships and the ability to regulate emotions and behaviour. Parenting that is good enough is associated with security of attachment and good social, emotional and cognitive development outcomes (Fonagy *et al.*, 2002).

Attachment research was developed by Ainsworth (1969), using observations of infant behaviour in an experimental 'strange situation'. Reunions of mother and infant, after interactions with a friendly stranger, were analysed to establish three classifications: 'Secure', 'insecure-avoidant' and 'insecure-ambivalent'. An abundance of research confirms the original findings that mothers of secure one year olds are responsive to their babies, while mothers of insecure-avoidant babies are unresponsive and mothers of insecure-ambivalent babies are inconsistently responsive (Main & Weston, 1982; Sroufe, 1979). Later a fourth attachment style was identified – disorganised attachment – discovered by Hesse and Main (2000). This results from frightening experiences, which leads to confusion and pathological defences (Fraiberg, 1982). These children show worrying signs of distress, such as hurting themselves, bizarre behaviours and 'freezing'. Children with this attachment pattern have usually experienced severe trauma.

2.2.2 Emotional regulation

Many referrals to the Under-fives Service also report behavioural and emotional regulation difficulties. Infants and young children are dependent on parents for regulation in order to understand and respond to their bodily and mental states. Mothers who are able to regulate their baby's emotions help their children learn to regulate their own emotions and develop coping strategies. Research by Slade (2008) found that security of attachment can be predicted by a mother's capacity to reflect on her child's affective experience. Mothers who are able to interpret their baby's feelings have 'mind-mindedness' (Meins, 1997). Fonagy *et al*. (1993) highlight the importance of developing parents' 'reflective self-function' and mentalisation (Fonagy, 1988) to ameliorate the impact of their own difficulties.

Cortisol arousal is triggered by a parent's absence, physical or emotional, leading to infant stress. A little 'manageable' stress is regarded as developmental as it spurs development. The infant learns that the parent will be there in time to re-establish equilibrium (Fonagy, 2002, p.37).

Research from neuroscience underlines the risks of early trauma and neglect on the developing brain (Gerhardt, 2004). Infants are highly sensitive to the emotional stress of their environment. Parental mental health difficulties may put children at greater risk of later challenges in life, including school failure and social and behavioural difficulties. This gives further validation to the emphasis in psychoanalytic theory on the significance of early experiences for later development (Balbernie, 2001, p.247).

2.3 Under-fives models

The Under-fives Service Model in the present study is based on the 'Under-fives Counselling Service' founded at the Tavistock Clinic in the 1980s (Miller, 1992) in recognition of the importance of prompt early intervention for families with babies or small children (Emanuel & Bradley, 2008, p.1):

> to answer the frequent need for brief work with parents and the baby or small children … universal troubles of infancy and early childhood: we see babies and toddlers who reveal their anxieties by refusing food, sleep or separation, who display angry, restless crying and tantrums, or who are more obviously under strain because of internal troubles like unresolved jealousy or external ones like the effects of parental conflict or loss. (Miller, 2000, p.108)

The referred patient is usually the child but he or she is seen in the context of the family (Miller, 2000): 'They are malleable and open to the world without having strong defences, are easily affected by what happens to them' (Pozzi, 2003, p.12). The therapeutic model is flexible, it adapts to the needs of families: 'It is rooted in the belief, the experience, and knowledge that early intervention has a curative, as well as preventative, effect' (Pozzi, 2003, p.11). It offers up to five sessions of psychoanalytically based interventions to families: 'The approach requires the clinician to maintain a thoughtful and observant attentiveness when seeing families, without a set structure for interventions' (Emanuel & Bradley, 2008, p.2). Consultations are also offered to staff working in nurseries, day care and community settings (Emanuel & Bradley, 2008).

> The work relies upon the knowledge that a good deal of change can be brought about in a family where the children are still very small. It is a time of naturally high-speed growth and development. It is the time when much emotional heat is generated in the family, and the potential for development in parents exists in relation to the potential for development in the baby. Interventions can be highly effective in the intimacy of the nursery. (Miller, 2008, p.39)

The Under-fives Service in this research offers assessment, up to six sessions of family/parent–child psychotherapy and consultations to the professional network and to families. Clinicians also spend time in universal group activities and participate in reflective discussions. The parental past is kept in mind with a focus on the unfolding parent–child relationship.

Many emotional difficulties are expressed in physical and behavioural symptoms (Pozzi, 2003). The Under-fives Service makes use of observation. Clinicians meet with the family and observe their interactions and the child's play. They listen closely to difficulties, making links between observations and thinking about the child's and the family's history, and put things into words, in a tactful way, in the context of an evolving understanding of the dynamics of the family and concerns about the infant's development. Parents are encouraged to think about the child's behaviour as a simple communication of feelings about the world they occupy, inviting parents to think with us about possible meanings. Parents usually experience a sense of relief and their capacity to observe themselves and their children develops. We make simple suggestions such as asking parents to be less busy, do less activities with their children, to stop and just notice them for a brief period of time each day. We

encourage parents to think about the emotional world of their children and to make links between their own emotional world/experiences and their children's behaviour, developing the idea that young children, like parents, have a mind and an internal world containing fears and worries. The aim is to develop a therapeutic alliance with parents, trusting enough, to be curious and allow us to gently challenge their perceptions and defences.

It is important to work with the parent–child relationship when treating infant and young child mental health difficulties. Addressing difficulties communicated by parents consciously and unconsciously, supporting parents to get development back on track and reduce the child's symptoms, enhancing parental sensitivity and enabling the parent to better understand and communicate with the child all help parents to provide 'a secure base for children, more able to regulate and contain the child … by helping the parent to reflect upon the children's mental states' (Slade, 2008, p.220). Parental difficulties expressed or unknown may interfere with the parent–child relationship. Ensuring a parent feels their difficulties are understood and not judged can help to alleviate and shift something and bring about a new understanding of the difficulties, helping a parent to be more receptive and nurturing to their child (Rustin, 2009a) and less blaming of the child (Pantone, 2000).

The psychoanalytic model is not unique in its focus on recognising the 'importance of helping parents to be sensitively attuned to the communications of the infant, and of promoting the parent-infant relationship' (Daws, 2009, p.xv). Approaches such as the Solihull Approach (Douglas & Brennan, 2004)

promotes reciprocity and containment of anxieties. VIG promotes sensitivity, using video reflective feedback and supporting the parent–child relationship. Group interventions such as Mellow Babies (Mellow Parenting Programme) aim to develop sensitive responses to children through video, practical advice and reflections. The Webster-Stratton Incredible Years® is a universal parenting programme aimed to prevent the escalation of behaviours through training and support.

2.4 Under-fives Service in the community setting

The Anna Freud Centre has a long tradition of working in nurseries. Anna Freud and Dorothy Burlingham (1942, 1944) established the 'war nurseries' for children who were separated from parents to not only support them physically and educationally but also psychologically and emotionally. Anna Freud studied the impact of separation on children and developed further understanding of the child–parent relationship and child development (Edgcumbe, 2000). Goldstein *et al.* (1973) drew attention to the 'psychological parent'. They focused on the importance of the psychological parent–child relationship not just the biological relationship, and showed it to be one of care and concern for a child. Their findings shaped and influenced decision making for children in the care system.

The psychoanalyst René Árpád Spitz (1945) was concerned about the detrimental impact on children's mental and physical health of separation. In James Robertson's film (1952) *A Two-year-old Goes to Hospital*, the visual images of the impact of separation on young children 'pierced defences as the spoken word cannot do' (Robertson & Robertson, 1989, p.23); it led to changes

in practice for young children in hospital. Bowlby drew from Robertson's observations of children in hospital to bring attention to the impact of separation in 'Maternal care and mental health' (Bowlby, 1951).

Since the 1980s child psychotherapists such as Dilys Daws, Cathy Urwin, Maria Pozzi, Louise Emmanuel, Janine Sternberg and Beverley Tydeman have developed child psychotherapy in the community and described the value and challenges of new ways of working. In 1985 Daws set up a baby clinic in a local GP practice. In her paper 'Standing next to the weighing scales', she illustrates the importance of being 'visible' in the practice for professionals, parents and their children in the clinic. Being hidden away in a consulting room diligently seeing many families had left the practice staff feeling she was 'absent'. This helped Daws identify the importance of informal contact with colleagues and seeing parents and children:

> I began to realise that talking about patients was as important as being shut away seeing a few, and that much of my usefulness was in sharing ideas about the problems with mothers and babies with my colleagues; furthermore, that the timing of good referrals was partly dependent on the timing of informal discussions with me. I realised I must be visible, available and receptive. (Daws, 1985, p.78)

Daws describes the challenges of where to place 'oneself' as an 'outsider consultant' and the complexity of the role of working in another organisation. The importance of maintaining some separateness from the organisation, however uncomfortable, is highlighted together with the need to develop a thoughtful presence, neither too available nor too distant. Daws describes the skills she developed of being visibly present and available:

> Standing doing nothing requires skill if it is not to be puzzling and persecuting to the people around … If I am too self-contained, it must seem that my observations are for some unexplained private use, if I am too efficiently outgoing, mothers hand me their baby books to check them into the clinic. (Daws, 1985, p.79)

With reference to his work in a school setting, Music (2007) also described the challenges of where to place oneself: he suggests it is uncomfortable and also how important it is to have 'one foot inside and another firmly in our own secure base of clinical experience, psychoanalytic traditions and professional support structures' (p.7).

Music and Hall (2008) suggest it is helpful to draw from theories of organisational dynamics as well as psychoanalytic theory to support community work. They suggest this way of working presents challenges not only to child psychotherapists but also to the organisation, with the challenges of new ideas of working and how to communicate and work together, in addition to the complexities of professional rivalries. Loshak's (2007) experience of community work also highlights these challenges and the need to let go of professional omnipotence, perhaps a response to the anxieties of being an outsider, which can create a barrier to collaborative work.

In the 1990s, Urwin established a weekly under-fours service in a community centre that aimed to be more accessible and to develop relationships with other agencies. An outreach service was offered in a community centre alongside a

playgroup. This presented challenges as many of the families attending already knew each other. Urwin states:

> It inevitably heightens competitiveness or intrusiveness, running the risk that one or both parents drop out … I found it essential to be absolutely scrupulous about boundary setting and confidentiality. (2003, p.384)

The project managed to engage hard to reach families who would not have attended a clinical setting. Urwin found that the work was successful but complex as the clinicians experienced increased anxieties triggered by the unfamiliar context of the work. She noted that clear procedures, boundaries and strong links with mainstream CAMHS were necessary to hold both the clinician and the work in the outreach setting in order to provide a 'bedrock' and a 'secure base'.

Tydeman and Sternberg have written about their experiences of developing the Tavistock Under-fives Model in a community primary care setting. They suggest an easily accessible service helps both families and professionals and provides an important 'thinking space' (Tydeman and Sternberg, 2008, p.100). The authors attribute its success to the clinicians' flexible approach and the provision of an informal and responsive service:

> The primary care milieu in itself serves a therapeutic purpose. The psychotherapeutic presence helps all the workers who are under such pressure to be more fully themselves in their work (Balint, 1993;

> Elder, 1996) having an increased ability to access their own thoughtfulness and sensitivity. (Tydeman & Sternberg, 2008, p.112)

With reference to their work in a school setting, Soloman and Nashat (2010) suggest it is having a consistent presence rather than sporadic availability, ‘dropping in’, that facilitates integration: becoming part of the fabric of the community setting creates a presence that can represent thinking about emotions and be containing for staff.

Woodhead and James have written about providing parent–infant psychotherapy in community drop-in groups. They highlight the importance of collaboration with health professionals, providing an integrated service located in a setting that families routinely visit for health checks and family support. Like Urwin and Daws, they suggest the community setting facilitates engagement and enables parent–infant relationship difficulties to be spotted early. Parents and infants have access to psychoanalytic therapeutic thinking in a more natural setting with the opportunity for a transformative experience in a ‘culture for change’ (James, 2002). Like Daws and Urwin, Woodhead and James also highlight the complexity of what appears to be a simple approach:

> Establishing an analytic frame and culture within services that are structured so that parents can drop in and drop out is complex. Responsiveness and adaptability are essential. (Woodhead & James, 2007, p.119)

Attending groups can help parents and infants who are isolated from extended family support, and those for whom difficulties are emerging in parental relationships:

> Groups are opportunities for parents and babies to rediscover the sense of belonging within a mini-community. They can be helpful for those families overwhelmed by practical preoccupations, who find specialist services stigmatising or too intense. (James & Newbury, 2010, cited in James, 2016, p.138)

Primary care is both non-stigmatising and accessible as patients are more likely to present with mental health difficulties or parent–infant relationship difficulties to their GP or health visitor than to a mental health service. It is estimated a third of all consultations with GPs are about psychological difficulties:

> If one considers, in addition, that most presentations of physical illness also have mental, emotional, or psychosocial dimensions, it is clear that GPs and their colleagues on the primary care team are by far the main mental healthcare professionals in the country. (Launer, 2018, p.8)

Infant mental health clinicians having a presence in a health centre or GP practice can release allied professionals from some of the mental health burden placed upon them. Helpful conversations with an infant mental health clinician can allow for space to think and reflect. In other community settings, ordinary conversations can help to develop knowledge of infant mental health presentations and difficulties and thus lead to more appropriate referrals to the relevant services.

Maria Pozzi (2003) discusses her experiences of the importance of the setting when working in an under-fives counselling service. She identifies the importance of providing a suitable physical setting with basic furnishings, toys and a private reliable room and also identifies the most important aspect of the setting as the 'mental setting', the therapist's state of mind. She suggests this thoughtful and observant attentiveness to the families can make up for an imperfect physical setting (Pozzi, 2003, p.33; Rustin, 2009a). What seems to be key to transformative relationships is the therapist's empathy, compassion and ability to make emotional contact with another, showing we are prepared to join others on part of their journey, positioned as neither a too distant expert or as directionless without a map (Music, 2019).

2.5 Ways of working

2.5.1 Observation

One of the key elements of under-fives work is the use of observation: 'The approach requires the clinician to maintain a thoughtful and observant attentiveness when seeing families' (Emanuel & Bradley, 2008, p.2). We draw from Bick's infant psychoanalytic observation (1968): her 'naturalistic' approach to infant observation – originally a training method for child psychotherapists – develops the capacity to learn to 'be with' and to suspend judgement and wait to see. It also provides the opportunity to develop the capacity to tolerate the uncertainty of 'not knowing' (Rustin, 2009b). To remain attentive and open with 'eyes that look with kindness, interest, and stay "in the question" and by contrast

to evil eye, the voyeuristic eye, eyes green with envy and so on, the whole range of ways of looking which involve the eye as an organ of projection rather than of receptivity' (Rustin, 2009b, p.31).

In community settings such as nurseries, psychoanalytic observational skills can be used to provide practitioners with an important perspective on the meaning of children's behaviour; it potentially informs and helps to understand children's experiences (Youell, 2005) and can provide useful insight into the functioning of a child and family or institution (Music, 2007). The capacity to observe is 'paramount in this work as in all psychological therapies' (Pozzi, 2020, p.4). Observation can be helpful in understanding more about the institution, as well as about our own and other practitioners' emotional responses. As Miller explains:

> Observers are investigating mental activity and mental states. We are asking ourselves not only to observe what appears to be happening but also to observe the effect that it is having upon us that it is having upon them. Correctly grasped, the emotional factor is an indispensable tool to be used in the service of understanding. (Miller, 2008, p.40)

Urwin (2003) also highlights the value of observational skills in the community setting. She suggests it is useful in bringing staff together from different institutions, backgrounds and trainings and for facilitating collaboration. This is also highlighted by McFadyen:

> At its simplest, an active interest in the baby, no matter how premature, fragile or disabled, provides a model for both parents and staff. The curiosity aroused in those observing the observer often seems to act as a powerful catalyst for a new kind of way of looking at the infant, and consequently a new kind of interaction … If they are able to feel emotionally contained by the unit or by one or two people working in the unit, they will be able to respond far more sensitively to their child. (McFadyen, 1994, p.64)

As Jenifer Wakelyn describes, observational approaches provide opportunities to integrate thinking about children's developmental and psychological needs in a way that can feel tolerable rather than critical or persecutory (Wakelyn, 2019).

2.5.2 Parent–infant psychotherapy

Parent–child psychotherapy can be traced back to Winnicott, who undertook consultations with mothers and infants and linked symptoms in the child to difficulties in the parents. Winnicott began to develop his embryonic idea of parent–infant psychotherapy as early as 1941 when he noted mother–infant difficulties and observed parental anxieties being projected onto the infant but presented to him by the parent as symptoms in the infant (Winnicott, 1941).

As Winnicott (1964) states, it is important to introduce the world to the baby in small doses. Infants come into being differently according to whether the conditions are favourable or unfavourable (Winnicott, 1960, p.589): the earliest anxieties relate to being insecurely held physically and psychically (1952). Winnicott (1971) describes 'the holding environment' in which a mother holds

and looks at her baby: an environment in which an infant experiences not just being physically held but also a sense of feeling protected, supported, cared for and contained. He recognised that the 'ordinary good enough mother' sensitively and sufficiently adapts to her infant's needs but also allows a degree of frustration that facilitates development, 'mother who fits in with her babies desires too well is not a good mother' (1958, p.215). The healthy mother's realistic expectations of her infant allows the expression of ordinary negative feelings and leaves the child free to develop (Pozzi, 2003).

Fraiberg too believed that there is no individual psychopathology in infancy. In her seminal paper 'Ghosts in the nursery: a psychoanalytic approach to problems of impaired infant-mother relationship' (1975), she and colleagues described ghosts or unremembered influences from the parent's past that threatened to intrude into an infant's life and bring 'mischief' (1975, p.388). The 'ghost in the nursery' maybe someone or an aspect of someone from a parent's past 're-presenting' through the child's behaviour in the parent's mind, and become a presence that can disrupt and interfere in the current parent–infant relationship. Infant–parent psychotherapy developed by Fraiberg (1975, 1980) aimed to help a parent recognise how their own 'ghosts in the nursery' may be represented in the current relationship with their infant. She identified the importance of parents gaining insight through therapeutic support to uncover these 'ghosts'. She drew from both attachment and psychoanalytic object relations theories and worked with both infant and parent together, treating the symptoms by treating the relationship. Understanding how the past influences

the present, in part, offers an opportunity to repair and improve the current relationship.

In under-fives work it is important when children present with excessive crying or tantrums to keep in mind Juliet Hopkins' statement 'there is no such thing as individual psychopathology in infancy' (Hopkins, 1992, p.5). Prevention of psychopathology in young children is achieved by helping parents to mentalise (Fonagy, 1998a) or develop 'reflective self-function' (Fonagy, 1993) to prevent the transgenerational transmission of behaviours and attachments. Research by Fonagy and colleagues found that a coherent narrative of parents' adverse early experiences was more important for the attachment pattern than the nature of the experiences themselves.

> The task of psychoanalytically informed parent–infant psychotherapy is to free the infant from the damaging, unconscious projections of the parent – to rid the nursery of its 'ghosts'. (Barrows, 1999, p.190)

By helping parents develop a narrative, links are made between past experiences and re-enactments in the present. Parents who are able to acknowledge their own experiences of being parented and the impact on them are less likely to repeat their own parents' mistakes (Main, Kaplan & Cassidy, 1985).

2.5.3 Reflective practice

Reflective practice is recognised as good practice across the helping professions. Donald Schön (1983) promoted reflective practice as a learning tool to 'reflect on action' and to build a capacity to reflect and so learn from experience. The aim is to encourage curiosity: practitioners look back upon their earlier interactions and actions to 'reflect on action':

> The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomena before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomena and the change in the situation. (Schön, 1983, p.68)

Hawkins and McMahon (2020) define reflective practice as 'the ability to continually learn from, reflect on and develop work'. Joyce Scaife suggests 'reflection is creating an explanation of the experience, reviewing the usual practice, thinking of possible ways to approach the matter in the future and making a decision about your own future action' (2010, p.2). Hawkins and McMahon (2020) propose that 'the most effective practitioners' (p.17) are those who fully engage in reflective practice.

> Values including personal, familial, ethnic, cultural, professional and organisational, impact every aspect of infant mental health. Professionals working with infants and families need training and supervision in order to meet the social and emotional needs of

> children and families appropriate to the range and scope of services provided. (Hinshaw-Fuselier, Zeanah & Larrieu, 2009, p.535)

Reflective time offers group learning opportunities and skill development by sharing observations and experiences with young children. In collaborative joint reflection, ‘to explore together generates new understanding and new knowledge’ and is also essential for promoting good teamwork (Hawkins & McMahon, 2020, p.25).

Children’s centres are full of the needs and anxieties of parents and children, which evoke strong emotions. The work is stimulating but emotionally demanding, receiving the projections of parents and children can be stressful. Reflective practice offers learning opportunities for self-reflection, emotional support and containment to practitioners: ‘Reflection … is now widely cited in the international literature as an essential element of early years policy frameworks’ (Elfer, 2021, p.2).

In reference to the school setting but also applicable to work in children’s centres, Youell states:

> To offer containment requires the adults, whatever their role, to be open to the feeling states of the children and young people without being overwhelmed by them. It requires a capacity to observe, reflect, and respond in a thoughtful way. It requires a degree of self-knowledge to be able to differentiate between what is being communicated by the child and what is one’s own feeling. (2020, p.61)

In work discussion, reflection helps to process and contain anxieties stirred from the emotional work of working in institution and caring professions and can provide a rich type of learning (Bradley & Rustin, 2008). Reflective practice is similar to work discussion in its careful consideration of emotional dynamics of the work, but unlike the work discussion model, reflective practice does not directly focus on unconscious processes.

The containment for staff provided by regular reflective consultation is crucial for the demanding work they undertake with families (Stephanopoulo *et al.*, 2011). Youell highlights the importance of containment for those providing containment. Referencing a personal communication with Gianna Williams, she cites the 'Russian Doll' model of containment, with layer upon layer holding the system together, family or institution (Youell, 2020, p.61):

> It is more than sympathetic listening. It is a process of enabling people to think about and talk through threatening or anxiety-provoking ideas with someone who can listen and think about them, returning them reframed in an emotionally more manageable way. (Dearnley & Elfer 2007, p269)

2.6 Theoretical perspectives

2.6.1 Psychoanalytic theory

A psychoanalytic frame is fundamental and informs all the interventions offered by the Under-fives Service: parent–child psychotherapy, drop-in groups, consultations and reflective groups. The aim of any therapeutic encounter is to

understand why and how the family have difficulties or symptoms of psychological or emotional disturbance, and how best to help to alleviate and free the child and family of them (Emanuel & Bradley, 2008).

2.6.2 Unconscious processes

Work with under-fives requires a good understanding of the ordinary emotional lives of infants and of projective and introjective processes in order to help parents or practitioners to recognise the ordinary developmental achievements of infants and to engage in thinking about the possible meanings of behaviour.

Melanie Klein (1955) discovered play as a child's natural communication of unconscious feelings and processes and went on to use play to understand children's anxieties and defences. Her understanding of unconscious processes in the ordinary anxieties of children informs under-fives practice today. In Klein's account of the early emotional development of an infant (1957), painful feelings (e.g., when the mother is absent) are split off and 'projected' in order to maintain a connection with good aspects of a mother's care. In typical development, the infant goes on to develop a capacity for whole object relations, as the infant becomes able to accept and integrate all aspects (good and bad) of the mother's care (1946). This achievement is seen as a move to the 'depressive position' from an earlier 'paranoid schizoid position' (Klein, 1946).

In typical parenting, a mother gives her infant repeated experiences of being responded to and gathered up, creating a sense of bodily integrity and a good

relationship that enables further development allowing the infant to thrive. Klein describes the building of a ‘good internal object’ through repeated opportunities to take in or ‘introject’ satisfying responses in which the infant’s needs are met, their projections are accepted and their distress is relieved. The good object ‘loves and protects the self and is loved and protected by the self’ (Klein, 1957, p.188).

As part of normal development, the defensive strategies of ‘splitting’ and ‘projection’ protect the infant’s immature psyche from feeling overwhelmed by psychic pain. If an infant has to rely on these defences too frequently, in the absence of sufficient good experiences, they can inhibit development. When the infant splits and projects unwanted bad feelings onto the mother so that the mother is then experienced as bad, Klein called this ‘projective identification’ (1946).

2.6.3 Containment

The concept of containment is central to psychoanalytic under-fives work (Bion, 1962, 1967). During the early years, an infant/young child needs help to make sense of emotions and raw bodily sensations. They are not equipped to process them and project them out and so they evacuate them onto the mother. If a mother is able to take in these projections and allows them to register and resonate in her without being too overwhelmed, she is able to get in contact with her infant’s distress and thus to think about it, understand it and give it meaning. This unconscious maternal thinking is called ‘reverie’ (Bion, 1962, p.36). Bion describes that through her thinking the mother performs ‘Alpha-

function' (1962, p.35), returning unmanageable anxieties into something more tolerable that can be thought about by giving shape, meaning and words to raw sensations.

Initially the mother thinks for the infant; slowly the infant learns to perform this function for him or herself. The mother's mind acts as a container for the infant and her thinking provides a sense of containment that facilitates the infant's psychological growth. In Bion's thinking, this development is accompanied by the transmission of caring feelings to the infant, not as conscious intentions and thoughts but as a 'psychical quality' (Bion, 1962) that is communicated both verbally and non-verbally. The infant who is able to internalise helpful parents, having a space in someone's mind of being understood, is able to develop his own capacity to think. This is the beginning of a solid foundation in the infant's development.

2.6.4 Early defences

Also key to under-fives work is Esther Bick's contribution to our understanding of what infants do in the absence of sufficient containment. Bick (1968) considered that the infant's first psychological need is to feel held together psychically. She describes the young infant in a primitive unintegrated state who is held together both physically and psychically by the containing function of the mother: the infant feels 'held together … by skin functioning as a boundary' (Bick, 1968, p.484). In the absence of sufficient containment, the infant develops defences in an attempt to hold the self together through muscular movements and form second-skin containment. Alternatively, the infant may focus on inanimate stimuli, such as a light, to hold their attention and

give an experience of feeling held together. This defence forms part of an infant's ordinary experience when an infant has to manage a mother's brief absence, but if there is insufficient containment, over time the infant learns to rely on these defences. The development of a sense of self is impacted and leads to what Bick (1968) termed an 'adhesive identification' or 'second skin formation' and children can appear to be pseudo-independent.

Infants who lack sufficient good-enough experiences of sensitive responsive parenting are more vulnerable and may have had to rely on self-soothing activities. In under-fives work we see children who have ADHD traits, constant movement and the muscular tension described by Bick (1968), or traits that are similar to Autistic Spectrum Disorder (ASD) difficulties. These adaptations or defences may have developed to cope in the absence of sufficient containment. The Coventry Grid has been developed to try to identify differences between attachment difficulties and ASD (Flackhill *et al.*, 2017).

> The loss of ability to regulate the intensity of feelings is the most far-reaching effects of early trauma and neglect … The aftermath trauma, certain personality traits predispose individuals to engage in less successful coping strategies. (Schore, 2001, p.210)

As Perry's research highlights, these adaptation 'states' become 'traits' (Perry *et al.*, 1995). Sharing observations of children and reflecting on behaviours in the context of relationships can help practitioners in children centres to notice and raise awareness of behaviours that may be a communication of anxiety or distress. A child who wanders around the centre on his own, seemingly happy

and uncomplaining, without seeking adult attention or support could be experiencing attachment difficulties or there may be problems in the parent–infant relationship. This reflective exploration can help to inform understanding of infant mental difficulties and challenge common misconceptions such as that problems are only expressed through defiance.

2.7 Institutional dynamics

In the service investigated in this study, the under-fives clinicians are co-located, in children's centres, so it is important to consider relevant literature to organisational dynamics.

Isabel Menzies-Lyth's classic study of a nursing practice, 'The functioning of social systems as a defence against anxieties', has been an influential contribution to the psychoanalytic understanding of organisations (Menzies-Lyth, 1959). She drew from the psychoanalytic theory of anxiety and defences, studying nursing practices that developed in response to attempts to defend themselves from painful feelings and distressing aspects of the work, resulting in the depersonalisation of patients by referring to procedures and numbers rather than to patients. To avoid emotional stress, these organisational defences can develop as between members of the organisation. However, they provided little relief to the nurses: a lack of job satisfaction led to poor staff retention. The 'social system of the hospital was built of primitive psychic defences, those characteristic of the earliest phases of infancy' (p.74).

> Given the collective demands of children and frequently being understaffed, the demands on staff were overwhelming. In the face

> of this Menzies-Lyth's argued that staff tended to manage by finding ways to avoid or minimise the children's demands. She thought they did this partly physically, removing themselves with busy practical activity, and partly emotionally, cutting themselves off and avoiding thinking too much about the children. (Elfer, 2014, p.289)

Such social defences may also become evident as self-protection for staff in under-fives settings. Defences against anxiety are a feature of working with children and their families, in children's centres as well as schools: 'unconscious dynamics are active beneath the surface in a school institution, it becomes important to bring them into consciousness and made available for thought and reflection' (Youell, 2020, p.68). Unconscious processes in the organisation, when some behaviours represent 'hidden emotions or meaning' and defences against anxiety are 'played out collectively' (Bell, 2020, p.78) and may prevent teams from working well.

Halton's 1994 paper illustrates unconscious aspects of mental activity that influence conscious activities in institutions:

> The psychoanalytically orientated consultant takes up a listening position on the boundary between conscious and unconscious meanings, and work simultaneously with problems at both levels. It may be some time before the consultant can pick up and make sense of these hidden references to issues of which the group itself is not aware. (p.12)

He explains that denial and defences against painful or anxiety-provoking feelings can appear to help staff to cope with stress, but they also disrupt the

functioning of the group and ‘hinder the organisation from fulfilling its task’ (Halton, 1994, p.12).

Bion’s (1961) thinking about unconscious group processes, defences and the impact of emotions on the capacity to think is helpful for under-fives work in children’s centres. Bion describes two types of group: the work-group is able to function, carry out its tasks and assess its effectiveness; in contrast, the basic-assumption group is anti-task, aimed at meeting unconscious needs that are rooted in anxiety and internal conflicts. These conflicts may be projected onto team members.

In helping professions, there is a tendency to deny feelings of hatred or rejection towards clients. These feelings may be more easily dealt with by projecting them onto other groups or outside agencies, who can be criticised. Halton suggests that emotional disorder interferes with the functioning of an organisation, particularly in relation to tasks that require co-operation or collective change (1994, p.15). The projection of feelings of badness outside the self helps to produce a state of illusionary goodness and self-idealisation. This black-and-white mentality simplifies complex issues and may produce a rigid culture in which growth is inhibited (Halton, 1994, p.14).

As Halton says ‘Psychoanalysis as a system of ideas has adherents, sceptics and a multitude of indifferent passers-by’ (1994, p.11). Psychoanalytic ideas can be helpful to allied professions, with the potential to bring relief to those who are in the throes of emotional work with children and families and to make

sense of the complexity of the work. Yet a child psychotherapist's arrival can be met with ambivalence and their work may be undermined. Music and Hall (2008, p.48) describe challenges posed by the dynamics of the institution as a contributing factor to the success or otherwise of work in community settings.

Obholzer and Roberts (1994) have written about the 'the unconscious at work' and the stress levels for health professionals. In an attempt to understand the impact of defences in the staff and the institution, Roberts suggests 'workers can get caught up in the institutional defences arising from shared anxieties' (1994, p.110) and this may lead to dysfunctional dynamics that impede the work towards the primary task. One example of such dysfunctional dynamics is 'a collective sense of everything good and helpful being inside the organisation, and of the outside world is harmful and dangerous … where group identity was based on being a superior alternative to another form of care' (Roberts, 1994, p. 113).

> The psychodynamic understanding of institutional process also brings a state of mind and a system of values that listens to people, encourages thought and takes anxieties and resistance into account. (Obholzer, 1994, p. 209)

2.8 Under-fives Service during the pandemic

During the Covid-19 pandemic (2020), lockdowns have led to the closure of community groups in children centres. Services that remained open, including health visiting, moved to remote working: families and children were not seen in person but via online platforms.

Humphreys and colleagues highlight how social distancing and isolation during the pandemic has been associated with increased family and interpersonal violence (Humphreys *et al.*, 2020).

Research undertaken by HomeStart, Best Beginnings and the Mental Health Foundation highlights the importance and value of community groups for parents and young children and the impact of the ongoing closure of baby and toddler groups. For families who are isolated and without support, there is an increased impact on parental mental health and an increased risk of domestic abuse. This study found that 6 in 10 (61%) parents had significant concerns about their mental health and almost 9 in 10 (87%) parents were more anxious as a result of the pandemic.

While CAMHS clinical services for the under-fives remained open throughout the lockdowns, most children's centres were closed. The report 'No one wants to see my baby' (HomeStart, 2020) highlights the importance of community groups for accessibility, support and parental mental health and the importance of under-fives clinicians' presence in community settings:

> Parents are still struggling to access essential services to help them through pregnancy and beyond, with problems including accessing face to face medical care, reduced access to health visitors and a lack of community parent and baby groups – all of which are taking a toll on parents' mental health. (HomeStart, 2020)

2.9 Literature review conclusion

Infant mental health difficulties are often unrecognised and early identification, support and intervention is important. Early difficulties do not improve; if left untreated, they can have a lifelong impact on development and wellbeing leading to mental health difficulties in adulthood (Mathiesen & Sanson, 2000; Skovgaard *et al.*, 2008). Research identifies the importance of the quality of the parent–infant relationship and the development of emotional wellbeing and concludes that psychopathology of children is best understood in a relational context.

The CAMHS Under-fives Service in this research project builds on the experiences and findings of others such as Tavistock Under-fives Counselling Service, which identified flexibility, curiosity and an informality at the core of the service (Miller, 1992; Emanuel, 2006). This research builds on child psychotherapists (Daws, 1985; Urwin, 2003; Pozzi 2003; Sternberg and Tydeman, 2008) who developed child psychotherapy in community settings to aid accessibility and engage those "who were unlikely to find their way into child and adolescent services" (Emanuel, 2008 p.136). Approachableness, visibility and informality were all at the core of their success. They highlight the importance of collaboration with health professionals and suggest providing an integrated service in the community setting facilitates engagement, enabling parent–infant relationship difficulties to be spotted and treated to early.

This study supports the view that psychoanalytic ideas can be helpful to allied professions, can bring relief and containment to those who are in the throes of

emotional work with children and families and can help make sense of the complexity of the work.

Chapter 3: Methodology

3.1 Structure of the chapter

This chapter will begin with a brief outline of the aims of the research. It will explain the design, process and steps taken to set up the project, including ethical considerations. I will outline the stages of gathering the data, including recruitment, sample size and the rationale for choosing the method used for analysing the data, and explain the stages of data analysis. I will reflect on the issues of bias and subjectivity that are considered throughout to ensure reflexivity and triangulation.

3.2 Aim of the research project

The Under-fives Service was launched in January 2017 in response to a scoping exercise of 52 local agencies to understand the lower rate of referrals into CAMHS for the under-fives population. The scoping exercise revealed that agencies felt that CAMHS was inaccessible and the agencies lacked knowledge and confidence in recognising infant and young child emotional/mental health difficulties. The Under-fives Service aimed to redress this by working directly alongside children's centre practitioners in order for CAMHS to be more accessible and improve staff's identification and knowledge of under-fives mental health.

The treatment provided by the Under-fives Service to children and their parents is not the focus of this research project; rather, it aims to explore the strengths and limitations of a newly established service using the Tavistock Under-fives

Model and to capture the views and experiences of children's centre staff who have had direct experience of working with the service. The research questions are directly linked to the aims of the service to explore the degree to which the original aims and hopes for the service are being met and to find out more about what may need to be changed.

This research title is: An evaluation of a newly established psychoanalytically informed Under-fives Service in four children's centres. The aim is to establish what are the children's centres practitioners' experiences of the Under-fives Service: what has worked well and what needs improving?

3.3 Approaching the research

During the planning and design of the project I felt daunted; my inexperience of research design and the complexity of the study meant I was unsure how I would decide upon which research methodology to use. I was excited about the project and kept in mind the aim of the research – to generate an in-depth knowledge of the children's centres' practitioners' experiences of the Under-five's Service from descriptions generated from interviews – to help me determine the most appropriate research method. This led me to qualitative research, which is rich and diverse and offers the opportunity to capture 'the complexity, mess and contradiction that characterises the real world, yet allows us to make sense of patterns of meaning' (Braun & Clarke, 2013, p.10). This made the choice straightforward and helped me to overcome the intimidation I felt regarding research methods. As a child psychotherapist, I am drawn to the idea of creating meaning and trying to understand complexity. Meaning is

central in qualitative research; therefore, the project was an exploratory qualitative study designed to give meaning and 'voice to a group of people and provide a detailed description of experiences' (Braun & Clarke, 2013, p.20).

I decided to undertake an interview study and to analyse the data using thematic analysis (Braun & Clarke, 2006). Semi-structured interviews were chosen as they are an effective method for generating rich qualitative data (Braun & Clark, 2013). The aim of the interviews was to have a conversation to facilitate participants to share their experiences and perspectives and to capture their language and concepts in relation to a topic I had determined (Rubin & Rubin, 1995). The interviews questions were prepared in advance but with an element of flexibility in the exact wording or order of the questions to allow the researcher to explore meanings in participants' views to capture a range of detailed responses. I analysed six semi-structured interviews with practitioners from four children's centres where the Under-fives Service is co-located one day a week.

3.3.1 Rationale

A pattern-based method, Thematic Analysis (Braun & Clarke, 2006), was chosen to analyse the transcribed interview data. It provides a systematic method 'for identifying, analysing and reporting patterns, themes across a data set' (Braun & Clarke, 2013, p.178), 'a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data' (Braun and Clark 2006 p.78) and 'a method which works both to reflect reality, and to unpick or unravel the surface of "reality"' (p.81).

Thematic analysis is a method of discovery that aims to reach below surface meanings to gain a deeper understanding. This fits with the aim of my research project to develop rich themes informed by the data to understand, illustrate and give voice to the experiences of the practitioners in order to inform service development and learning about the service. Using an inductive approach allows the data to speak for itself and to ensure that theoretic insights follow the observation.

Thematic analysis is described as an organic process where the researcher takes an active part in the creation of the findings. It sets out a clear step-by-step methodical analytical six-phase process to follow; the researcher's subjectivity is very much accepted as part of the process, which influences and carves out the data, creating unique individualised findings. Braun and Clarke (2006) liken this process to the work of a sculptor, who given the same tools and clay will not create the same model as another artist; similarly, each researcher with the exact same data set would create something individual.

3.4 The research setting

The research took place in an inner London CAMHS. The Under-fives Service offers community outreach in four children's centres across the boroughs. An under-fives clinician is based for one day a week in each of the four children's centres.

As described earlier, the Under-fives Service was launched in 2017 in response to reported inaccessibility of CAMHS and lower rates of referral for the under-fives to CAMHS. It is a specialist service based on the Tavistock Under-fives Model, which offers consultation, evidence-based treatments including parent–child psychotherapy and VIG, inter-agency partnership working and specialist assessments. In addition, the under-fives clinicians attend weekly universal group activities in the children's centres (stay and play/drop-in groups), work alongside practitioners, screen for early difficulties in parent–child relationships and participate in reflective groups. The under-fives clinicians are not commissioned to directly provide training but the children's centre managers hoped the practitioners would be 'skilled up' in infant/young child mental health through consultations and reflective groups and from working alongside the under-fives clinicians.

The under-fives clinicians are available to the nursery staff but, given the resource limitations, the priority is to attend the universal group activities that are open to all parents/carers and children under the age of five. Clinicians should be a visible presence, available and approachable to parents who may have concerns about their child, and should identify early difficulties in parent–child relationships, intervening as swiftly as needed.

The local authority children's centres in the study have a diverse multi-cultural population. The families speak many languages and have different religious backgrounds and beliefs. There are extremes of wealth and poverty across the boroughs, with significant child poverty in the under-fives population. Universal

activities, in the centres, are free and available to all families; parents/carers remain with their children during these activities.

Families are contacted by the children's centres following notification of a birth or a family child with additional needs who is under the age of five who has moved into the area – for example, families fleeing domestic abuse or asylum seeking. The outreach team pro-actively reach out to make contact with families and to introduce the family to the centre and the activities services in the centre. They offer a befriending service to assess the family's needs and link the family with agencies if required. Where there are concerns, families are discussed (either anonymously or with the family's consent) at a monthly multi-agency meeting that under-fives clinicians attend.

Families are encouraged to join the universal groups where there is baby massage, breast feeding advice and CAMHS Under-fives Service support. Further services in the centres include midwifery, access to speech and language therapy (SALT), housing advice, benefits advice) and domestic abuse support. One centre also provides nursery provision with government-funded places for 15–30 hours a week for children aged two to five years.

3.5 Ethical approval

The University of East London (UEL) Research Ethics Subcommittee (URES) approved this project in August 2020; URES ID registration number: 202101 (Appendix A). Ethical approval was granted by the University of East London

Research, Research Degrees and Research Ethics Committee (RRDE-formally UREC) in September 2020. It received the Tavistock Research Ethics Committee (TREC) ethical approval in June 2020.

3.6 Consent

Permission to interview children's centre staff was obtained from the local authority children's centre area manager(s) (Appendix B). Information sheets and consent forms were provided to each participant and completed in advance of the interviews (Appendix C).

Data confidentiality was maintained and data were stored on an encrypted computer. This included personal details of participants and interview recordings. Participants were made aware that information from the interviews would be transcribed and shared with my supervisory team and findings may be shared with the under-five's service to improve the service.

All data used within this study was anonymised prior to data analysis.

3.7 Recruitment

First, I consulted the children's centres area managers. They gave their consent to the study taking place in the children's centres and permission to recruit early years practitioners (Appendix B). It was agreed that the managers would not pre-select participants for the study in order to allow participants to self-select and reduce potential sample bias.

I was also given permission to present the research to the teams in each of the children's centres. Unfortunately, this was not possible due to the Covid-19 pandemic and government lockdowns; it was also not possible to present via an online platform in the early months of the pandemic as the children's centres did not have sufficient IT equipment to enable group meetings and many of the staff were isolating or absent.

Information sheets were emailed to all practitioners in the children centres (see Appendix C) with a covering letter inviting interested practitioners to contact me if they would like to discuss the project further or with any questions about the project. In total six practitioners and one manager expressed initial interest, at least one practitioner from each of the four centres.

Owing to the exclusion criteria, one of the practitioners could not be included. I then spoke with each of the remaining six participants on the telephone and discussed their requirements for an interview and also confidentiality and arranged to send them the consent form (Appendix C) to be completed in advance of the interview. All returned the consent forms promptly.

3.8 Sample

The inclusion criteria for the sample were:

- Staff were either early years practitioners or managers working in the children's centres.

- Staff who had worked in the children’s centre for a minimum of one year and had a minimum of one year’s experience of working alongside an under-fives clinician in the children’s centre.
- Staff who had experience of working alongside an under-fives clinician in the universal groups (stay and play/drop-in activities).
- Staff who had participated in the reflective groups attended by an under-fives clinician.
- Staff who had experience of co-working with an under-fives clinician.
- Staff who attended multi-agency meetings with an under-fives clinician.

Exclusion criteria:

- Staff with less than one year’s experience.
- Staff who were not available within the recruitment period.

It was important to ensure that participants had sufficient experience of working alongside an under-fives clinician and therefore a minimum of one year’s experience was added as a criteria for inclusion. I had hoped to recruit eight participants, but the impact of the Covid-19 pandemic and, for some, the lack of access to online facilities affected practitioners’ availability in the time frame for the study

3.9 Participants

Six participants from across the four children’s centres volunteered to take part in the study. All work full time. Their ages ranged between 28 and 61 years.

They have worked in the centres for between two and thirty years and have worked with the Under-fives Service for between two and four years.

Participants' roles in the children's centres were: one manager, one family navigator, three early years practitioners and one stay and play/ drop-in co-ordinator.

The participants were of mixed ethnicities: two were Black British (of African-Caribbean heritage), four were white British (two Irish, one Scottish heritage and one English). English is the first language of all participants. The participants identified themselves as one male and five female.

3.10 Data collection

Data were collected through one individual semi-structured interview with each participant. Owing to the Covid-19 pandemic, the interviews took place virtually online via Microsoft Teams as stipulated by the University of East London.

There were eight semi-structured interview questions with prompts to generate thinking whilst allowing the participants to take the lead in the direction of the conversation (Appendix D for full interview questions including prompts).

Each interview lasted 1 hour. To build rapport and speak about any anxieties the participants may have had, I began with introductions, setting out the structure of the interview and purpose of the study. I explained it was to gather participants' views to help to evaluate experiences and effectiveness of the

Under-five's Service and that it was not the participants practice or knowledge being evaluated. Some of the participants had worked alongside the researcher and it was important to speak directly to this dynamic. I acknowledged this at the beginning and, to ensure the participants felt able to give honest opinions, reminded the participants it was not the individual under-fives clinician but the service as a whole that was being evaluated and that no offence would be taken of any criticisms. I outlined confidentiality and reminded the participants that they could stop the interview at any point and also withdraw from the research up until the point when data analysis has been completed.

The semi-structured questions were used to structure and guide the interview and ensure the participants' views and opinions were captured about the Under-fives Service. The interviews were free flowing with open-ended questions and a conversational atmosphere to build up a rapport and capture unconscious associations with follow-up questions to clarify understanding and extend meaning about their experiences.

At the end of the interviews, all participants were offered the opportunity to debrief to discuss the experience of the interview with the researcher.

3.11 Data analysis: process

Braun and Clarke use six phases to analyse the data: transcription, familiarisation, coding across, searching for and reviewing themes, naming themes, and writing finalising analysis.

I will now describe step by step the data analysis process I followed.

3.12 Transcription

I transcribed the interviews twice. In the first transcription, I instinctively made minor changes, added punctuation, corrected grammar and omitted pauses, hesitation and stumbles in the spoken language. I was concerned that this potentially lost some meaning. The interviews were listened to again and meticulously transcribed using orthographic transcription (Braun & Clarke, 2013) – a verbatim transcription that includes pauses and hesitations in order to capture all possible meanings for analysis in the data. I used a notation key in the transcript. For example:

> '*….*' meaning the interviewee trailed off and didn't the finish the sentence and an '*umm*' indicates pause and hesitation.

Each participant interview was anonymised. The participants were ascribed a number; for example, participants 1 to 6 were abbreviated to P1, P2, P3, P4, P5 or P6 in this thesis. The children's centre names have been removed and are referenced as the '*children's centre*' throughout. The under-fives clinicians have been renamed '*Under-fives clinician*' to protect anonymity and confidentially of the participants and clinicians. Where a family/case material is discussed it has been anonymised and details altered to ensure it is not identifiable (see Appendix E sample transcription).

3.13 Reading the data

After I had transcribed all the interviews twice, I felt familiar with the data. I then re-read the whole data set to immerse myself in the data. I printed out hard copies and made a note of any immediate thoughts and ideas. This stage is 'observational and casual, rather than systematic and precise' (Braun and Clarke, 2013, p.205).

3.13.1 Initial codes

Coding is the process of searching through the data and noting aspects that relate to the research question. Codes are units of micro-meaning, a word or phrase which is rich, nuanced and complex and represents the 'building blocks' of the analysis (Braun & Clark, 2013). 'If you imagine your analysis is a brick-built, tiled-roofed house, your themes are the walls and roof; your codes are the individual bricks and tiles' (Braun & Clark, 2013 p.207).

I read through the data set and highlighted potentially relevant units to evoke meaning. I coded the whole data set in a process called 'complete coding'. I included all possible codes and was not selective to ensure 'patterning and diversity' in the data (see Appendix E for initial codes).

3.13.2 Theme development

I cut out each code and placed them on a board. I found this overwhelming and impractical, requiring significant space, and I was unable to leave them out over the period of time required to truly immerse myself and study the codes. To make it more manageable, I placed the codes under each of the interview

questions, ensuring they were placed with the correct question (Appendix F and G). I found it more helpful to group each code to each interview question.

I reviewed the codes to help identify patterns and began to look for themes that could represent 'some level of patterned response of meaning within the data set' (Braun and Clark, 2006, p.10). The themes are ideas that reappear throughout the data and capture something meaningful: their salience is more important than the number of times something appears. Themes work together to create patterns that fit together to create a coherent analysis.

To organise and structure the analysis, I then grouped themes according to central overarching themes that 'capture an idea encapsulated in a number of themes' (Braun & Clark, 2013 p.333) aiming to create a story that is true to the data. I then reviewed the themes, named them and re-re-read the uncoded data. I created a thematic map (Appendix H) of the central overarching themes, themes and subthemes. A subtheme catches and develops one notable specific aspect of one theme, but shares the central organising concept of the theme' (Braun & Clark, 2013, p.337). My research supervisor and I discussed the data set and the mapping.

Four overarching core themes and fifteen subthemes were identified from the data analysis.

3.14 Acknowledging subjectivity: reflexivity and reliability

3.14.1 Reflexivity

In qualitative research there is an acceptance that not all biases can be removed and that subjectivity influences the analysis. The context of identities, cultural backgrounds, experiences, training and theoretical underpinnings and so on continually influence what we see and understand.

I have a professional interest in working with families and young children and the importance and value of intervening early in parent–child relationship where there are difficulties has been a drive in my career. I have witnessed missed opportunities to intervene early and have seen the consequences for children and their families. I have the therapeutic tools to usually assist families and to help get them onto a healthier and fulfilling trajectory. My other interest is supporting staff who work in the frontline of social care. These have undoubtedly influenced the shape and design of this research. As Braun and Clark (2006) describe, the process is like the work of a sculptor, who given the same tools and clay will create a different model from another sculptor; similarly, each researcher with the exact same data set will create something individual. The human, not robotic, reality is qualitative research not a neutral exercise (Biggerstaff, 2012).

While Thematic Analysis accepts some bias, reflexivity is important in qualitative research in order to critically reflect 'on the knowledge we produce and our role in producing that knowledge' (Braun & Clarke, 2014, p.37). I am committed to working in the service and invested in wanting to develop the

service further. I believe in the value of the Under-fives Service. It offers a unique and helpful perspective to children's centre staff and families and there is a risk of researcher bias, namely skewing interpretations of the data or finding themes that may place the newly established Under-fives Service in a more positive light in order to ensure its success. Steps were taken to minimise bias through the different stages of the research process.

The Under-fives Service was originally 'a pilot', recommissioned on an annual basis. Our team's rigorous use of Routine Outcome Measures and Consultation Forms provided the commissioners with data to monitor its effectiveness. The Under-fives Service's value was acknowledged and it was given permanent funding predating the research interviews. The continuation of the service is not reliant upon the positive outcomes of the research and reduces the risk of researcher bias.

The risk of bias was discussed with my supervisors at the embryonic stage of the research. My supervisor encouraged me to keep a record of my experience, thoughts, feelings for critical self-reflection and discussion in supervision. My hope for the outcome of research and the recognition of possible bias was routinely discussed and challenged by my supervisors to ensure, as far as possible, researcher neutrality. The reflexive journal assisted and rich discussions in supervision challenged me and increased my self-awareness and reflexivity.

Another notable consideration is I am one of the clinicians in the Under-fives Service that is the subject of the research. I have experience of working in two of the children's centres and have worked alongside two of the six participants. As an insider researcher, there was a shift in my position to inhabit a dual role and the relationship with some of the children's centre practitioners. I was mindful of this complexity involved in evaluating a service that I am part of and it was important to acknowledge this role in the research. It was also important to consider not only the impact on my relationship with the practitioners but also how my role as researcher conducting the interviews may have influenced the participants and their ability to be critical of the service. I addressed this in my pre-discussion with all staff as the aim of the service is the evaluation of the service not individual clinicians. The data were consistent and similar across the centres including the two centres and practitioners I had not worked with.

> Premature conclusions that are based upon preconceived ideas and the desire for positive outcomes are not unique to insider research, but there is more potential for this to occur when the researcher is closely linked through the nature of the insider position. A useful solution is to use a 'critical friend' who can interrogate and challenge your assumptions. What is perceived as routine and familiar and 'as expected' from the researcher's point-of-view, can be new and unfamiliar to a third party. (Fleming, 2018, p.316)

The data were rigorously examined to ensure credibility. At each stage of the process quality check discussions took place in supervision in order to stay loyal to the data. For example, following my first transcription of the interviews, I re-transcribed them to ensure I had captured all the nuances since during the first transcription I had inadvertently omitted to record hesitations. Following my

initial coding, my supervisor read the transcriptions and coding and I recoded some of the transcripts to ensure consistency and neutrality.

The dual roles of being an insider researcher can be positive, ‘it enables contributions to knowledge, meaning and understanding that is directly related and relevant to practice’ (Fleming, 2018, p.312). It also gave me a unique position of understanding, a rich perspective which informed my research but did not interfere with the data.

Whilst there is criticism that prior knowledge as an insider researcher potentially contaminates the research (Mercer, 2007), equally there are limitations to being an outsider. It is argued that an outsider does not have the experience and is unlikely to be as sensitive and understanding as someone with knowledge (Merton, 1972). Participants may be more comfortable to discuss issues with someone who has inside knowledge and understanding (Fleming, 2018).

A key advantage of insider research is said to be the ‘pre-understandings’ and how such researchers ‘are often well positioned to gain an in-depth understanding’ (Fleming, 2018, p.311). My role as an active participant also gave me a deeper understanding of the challenges faced by children’s centre staff. From my attendance in the universal groups, I bore witness to the complexity of their work, the emotional strain, the need for this to be recognised and the need for support. I have included some of my thoughts from my experience in the centres’ transparently in the discussion section.

Another factor that helped to create some distance from the research was the Covid-19 pandemic and government lockdowns, which had a significant impact on the children's centres. Three of the centres closed for the duration of government lockdowns. The interviews took place during the lockdowns and created some space between the clinician who would ordinarily be in one of the centre's each week, allowing some additional space for reflection.

3.14.2 Reliability

Joppe defines reliability as:

> The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. (2000, p.1)

Reliability in qualitative research is reconceptualised as the 'dependability' or 'trustworthiness' of the methods of data collection and analysis used (Braun & Clarke, 2013, p.279). Dependability refers to the need for the researcher to account for the ever-changing context within which the research occurs (Mertens, 2005). The dependability of the research was addressed through engagement in a systematic review of the literature and being transparent and explicit about the methods used within the research process. This included an

in-depth account of the steps taken throughout the study, allowing for the replication of the process (Mertens, 2005).

3.15 Transferability (generalisability)

In quantitative research, transferability is known as 'generalisability' (Mertens, 2010). The study adhered to several steps to enable transferability of research findings. This included providing a rich detailed context of the study, context and details about each participant (e.g. background, qualifications, ethnicity, and role). Mertens (2010) also notes that the use of several cases strengthens the transferability of a study; in this research there were six participants which is an adequate number to ensure a degree of transferability.

The aim of the research is to generate insight and deep understanding how the children's centre practitioners experienced the co-location of a newly established CAMHS Under-fives Service, what is helpful and what could improve the Service. The researcher did not attempt to make generalisations from this research, but to develop a deep understanding of the views of the practitioners at a local level. However, some of the findings do have potential to be generalised to those early years' settings within a similar context to those used in this study (i.e. inner London, children centre settings).

The study captures the experiences of children's centre practitioners who work on the frontline working with under-fives and their families and have experience of working alongside the Under-fives Service clinicians. There is a range of

practitioners who work across the four inner-city children's centres in this study. Whilst there was some diversity of perspectives, there is overwhelming common ground across the data from all the participants, which gives it broader relevance and could be applied to other contexts.

The results of the study offer rich data and relevance to transfer the results of a study to a wider population in similar settings such as those working in early years settings, allied professionals who are setting up community hubs, CAMHS clinicians and child psychotherapists who are reaching out into community settings. In the context of the current development of Family Hubs that aims to integrate services such as health and social care, this research could be of interest and helpful.

The research could contribute to awareness and knowledge of the complexity of working with under-fives and families and those who work in early years may need additional training to identify infant mental health, parent–child relationship difficulties and the impact of parental difficulties on the emotional development of the child. The importance of early identification and early intervention is well documented but this research could be helpful to policy makers as a contribution to planning and design of services for the early years workforce to be sufficiently skilled and supported to deliver child-focused practice. The findings may therefore be of interest and helpful to those who are responsible for developing early years policy.

The findings of the research give further evidence to support the importance and value of outreach work in a community setting as others have highlighted before (Daws, 1985; Urwin, 2003; Emanuel, 2008) and have wider applicability. This research investigated the views of the practitioners in the children's centres, the findings provides further evidence to support the value and importance of CAMHS and in particular infant mental health is needed in community settings to work alongside agencies and the allied professionals.

3.16 Summary

This chapter has provided an overview of the methodology used to gather the data for the research study. In the next section, the results of the data are presented and discussed in relation to the research question.

Chapter 4: Findings

4.1 Structure of the chapter

This chapter will present an overview of the main findings of the research with extracts from the data. The aim of the research is to explore the strengths and limitations of a newly established Under-fives Service from the perspective of the children's centre staff and to capture their views and experiences on working with the under-fives clinicians.

The research question: What do practitioners tell us about their experience of working alongside a newly established psychoanalytically informed Under-fives Service?

The research is an explorative study to gain meaning of experiences and give voice to the children's centre practitioners. The aim is to understand the children's centre practitioners' experiences of the Under-fives Service and to explore what has worked well and what needs improving. If CAMHS is more accessible, less stigmatising and do practitioners feel better supported.

Four overarching core themes and fifteen themes were identified from the data analysis. In this chapter, I will describe and illustrate data analysis with extracts from the data transcripts.

- Presence in the children's centres
    - Accessibility
    - Expertise
    - Containment

    - Partnership and collaboration

- A different way of thinking
    - Observation
    - Reflection
    - Focus on parent–child relationship
    - Focus on play
- Learning and development
    - Re-stimulating interest
    - Gaining knowledge and understanding:
    - Gaining skills
- Organisational challenges
    - Implementation
    - Dynamics
    - Limitations
    - Impact of the Covid-19 pandemic

There are many quotes that could serve well to illustrate themes or subthemes but a decision has been made only to include one where it fits best or most closely belongs within the subtheme.

4.2 Core theme 1: presence in the children's centres

Four themes emerged from the data:

- Accessibility
- Expertise
- Containment

- Partnership and collaboration

4.2.1 Theme: accessibility

All practitioners discussed the accessibility of the under-fives clinicians in the children's centres.

> Having an under-fives clinician there and explaining what CAMHS does and is friendly seeing them in a really friendly manner in the stay and play session that is comfortable and safe for the parents and child, it was fantastic … It was a lovely way to introduce them to CAMHS to be able to tiptoe into the service in a comfortable and familiar setting, I think it's absolutely invaluable I think that's the most powerful thing that families can speak directly to CAMHS that's a game changer in my mind, mutual access. (P2)

The presence of the service in children's centres was highlighted by all participants. All described the value of an under-fives clinician's presence in the universal groups (stay and play and drop-in groups). All the participants refer to the importance and value of the 'visible presence' of the under-fives clinicians in the centres and experienced the clinicians to be more accessible and approachable to both practitioners and families. Participants also referred to the value of the under-fives clinician' working inside the centre 'on the ground', rather than shut away in an office within the centre. An ease of access and informality has helped to break down barriers for staff and families:

> When the under-fives clinician is in the drop-in, parents can see and parents can approach and ask their own questions of the

> under-fives clinician. They can ask you what your role is, what you do to have those kind of conversations. (P6)

> I really like the fact that under-fives are both available for families and professionals, so you don't get that hierarchy. (P2)

> To have somebody on the ground to actually meet with, to have a face and to be introduced and chat to the CAMHS person make such a difference. To support those families as to where get that support, that's been really supportive for families to have them within that drop-in service itself. (P5)

The participants valued the constancy and consistency of the under-fives clinicians' presence in the centres. An under-fives clinician is linked to and present in a centre each week on the same day, and this helped practitioners and families get to know when the under-fives clinician would be available for either a consultation or being present in the universal groups. The under-fives clinicians became familiar to both practitioners and families, and participants reported that it was less daunting to approach the clinician. Participants also said that if they had a query or concern about a child or family, the familiarity with the clinician enabled them to feel confident to make contact with the under-fives clinician when the clinician was not in the centre.

> It's been so easy when somebody's been there and you can just go in and catch up, but for me definitely knowing when they were in the drop-in that you can go in and seek advice see them – so easy to access. (P6)

> For parents that are really hard to reach, it was good to know which day the under-fives clinician would be in. (P3)

> Knowing there is someone, so if you have someone present with a particular issue or problems it's really easy to pick up your phone or to email a person. (P1)

Working alongside the practitioners in the universal groups enables informal access to under-fives clinicians and is preferred to the more formal consultation. It facilitates joint conversations about children and their families and sharing of information. Making time to talk to the practitioners about families is valued is by clinicians, rather than being out of sight undertaking clinical work with families. The under-fives clinicians' attendance in universal groups promotes availability, helps to break down barriers, overcomes workforce hierarchy, removes the remoteness of CAMHS and helps to demystify psychoanalytic thinking and the work of child psychotherapist.

Subtheme: destigmatising

The data identified different elements of the value of the clinician being visible and approachable. A subtheme that strongly emerged is CAMHS presence in the centre is destigmatising for families.

> The under-fives worker coming in, it breaks down the barrier and stigma, it becomes more of a face and you become more accessible and are accepted and in terms of the service and CAMHS becomes acceptable to the families. (P6)

All participants stated that a referral to CAMHS triggered anxiety for parents, who were fearful their children may be labelled and stigmatised. The participants described how the presence of the under-fives clinicians in the centre in both the universal and the targeted groups helped alleviate anxieties.

> Actually, I think a presence in the children's centre really does help to break that down because you've become more of a known quantity really. I was able to say we have CAMHS workers are in here and that for her she was then able to go ok fine and he was not going to be stigmatised by CAMHS and that really helped her that this is fine and it's a supportive service. (P6)

> Under-fives worker being in situ helped break down the barriers about mental health with families….The Under-fives therapist was really involved and really hands on so the sort of professional was that broke down barriers. (P3)

Cultural differences in attitudes to infant mental health emerged within the data. The population of the children's centres in this study is diverse, with families speaking many languages and coming from different religious and cultural backgrounds. Some participants highlighted the challenge that in some cultures and languages there is no word for mental health, and thus it could not be translated and was unexplainable. This posed challenges for practitioners to explain the CAMHS service to families or to suggest making a referral. For others, mental health could bring a sense of shame to the families.

The participants stated that many of the families would not have engaged or agreed to a referral to the CAMHS Under-fives Service without a clinician's

visible and approachable presence, which has helped to break down the fears about mental health. The participants reported observing the under-fives clinician break down barriers with families with an informal approach, getting alongside parents and children and taking an interest in them in the drop-in or stay and play sessions. The participants observed families accepting under-fives support:

> Under-fives clinician informally sitting next to families and actually just wants to listen, so that approach, it's just that ease is of chatting, to tell me about your child, I can see he is interested in such and such observing the children playing, taking note in your mind what the child playing with and starting with that conversation with the parents which has been so helpful. (P5)

> In the drop in/stay and play I saw a mum struggling with the two-year-old, in terms of the child's behaviour, and the under-fives worker was there and she had observed the child, the under under-fives clinician had a conversation with mum which then led to a referral into the Under-fives Service. (P1)

Families are able to build trust within the safety and relative anonymity of a busy universal group setting. Parents have more control and by observing the under-fives clinician's interactions and listening into conversations between parents and the clinicians, they get a sense of what clinicians offer. Parents can then approach at their own pace for an informal conversation about their children.

4.2.2 Theme: expertise

The participants described the under-fives clinician as an 'expert' and valued having 'a specialist' in the centres for both the families and the practitioners. The practitioners value the availability and presence of the clinicians in the universal groups. They are able to check in with the clinicians to discuss observations and thoughts in the reflective time.

> Families who were there in the actual drop in/stay and play session were really appreciative of having a specialist CAMHS person in the session. (P1)

> It's a professional impact, under-fives expertise, it's not just a professional impact on the practitioners but the extra support for children and families … it's been a marvellous thing and under-fives involvement and multi-agency panel meetings, part of a multidisciplinary network across the whole locality, not just serving a local community. (P4)

The participants expressed uncertainty and anxiety about infant mental health. They described feeling positioned as 'experts on children' and pressured to provide instant solutions by parents. They also described feeling worried about upsetting parents All the participants were reluctant to refer children to CAMHS and did so only as a last resort: they did not feel confident in identifying mental health difficulties and were fearful of upsetting families, even when they had concerns about a child. They felt reassured by the presence of an 'expert in infant mental health'. Practitioners' worries and anxieties about identifying

difficulties in infant/young child mental health or the fear of missing something was a repeated theme:

> Knowing that there is a specialist that deals with under-fives being there and that is a great support for us as practitioners too, a different pair of eyes, specialist eyes with a particular expertise makes a great difference and I think that was very very helpful. (P1)

> It was also supportive reassuring for the staff … I think there is still a lot of anxiety around in having the skills for that knowledge around infant mental health. (P5)

Participants are worried about offending families, which is related to the societal stigma of mental health difficulties. As a result, there is a risk that these anxieties could lead to children's difficulties being unintentionally overlooked and children may not receive the support they need. The practitioners prefer to distance themselves and outsource the arena of infant mental health/parent–child difficulties to the under-fives clinician, with the hope the clinician will undertake an observation of a child and family in the universal group, diagnose difficulties and intervene without practitioners being seen to be involved in the process.

4.2.3 Theme: containment

The participants experienced the containing presence of the under-fives clinicians in the universal groups, reflective planning discussions and consultations. Children's centres are full of anxieties and the staff are on the receiving end of many projections from parents and their children, absorbing worries, fears and uncertainties. The universal groups are open to all in the

community and everyone is welcomed. The staff running these groups occupy a unique position, front of house, ready to face whoever walks in and be prepared to provide emotional and practical support to parents and their children, no one is turned away. Some of the families are from deprived backgrounds living in poverty, isolation, homelessness, domestic abuse, fleeing violence, seeking asylum and living with mental health conditions. Some children are known to the Children's Services and are on care plans. Most but not all are there out of choice, and it is somewhere warm with a friendly, welcoming smile and where help is on hand.

> It was also supportive reassuring for to staff I think there is still a lot of anxiety around in having that skills for that knowledge around infant mental health … the under-fives clinician created an atmosphere where things are contained. (P5)
>
> The aspect of supporting staff in the particular way - it's not just a children's centre offer the offer to the professional development of staff and professional support staff and emotional support staff. (P4)

The research identified the helpful containing function of the under-fives clinician's presence for practitioners and families. The under-fives clinicians mirror the quality of the good enough mother–infant interaction in the interactions with parents, children and staff through being attentive, noticing, thinking and making a meaningful connection to understand without judgment, holding something that feels intolerable for the practitioners and families and giving voice and meaning to difficulties.

4.2.4 Theme: partnership and collaboration

Participants felt valued by the under-fives clinicians, and the clinicians sought their thoughts about families. When a referral was made to the Under-fives Service, it had felt integrated, joined-up and not separate. These themes capture a significant portion of the data set, which referenced collaboration and partnership between the Under-fives Service and the children's centres.

> It's rare that practitioners feel valued by a service, under-fives don't come in playing the big I am I know best and more qualified than you, I have status et cetera, that's not the approach or style of the under-fives clinicians. (P4)

> So helpful that working alongside, working together with the family, it didn't feel like you were off working separately on your own, it did feel like we were a team. I think we worked really well together. (P6)

> It feels embedded in the team. (P2)

Some participants described the under-fives clinicians' qualities and attitude as an important element of the success of the collaboration:

> An open and honest, friendly approach with everybody the practitioners and the families and feeling part of the team. (P6)

> Almost perfect in terms of how things can work with creativity and positive attitude it's about professional attitude. This work and this teamwork depend absolutely and the attitude of the professionals

> involved in it it's fundamental to everything we've been extraordinarily lucky having such committed under-fives clinicians' delivering it. (P4)

The findings reveal the practitioners are surprised to be treated equally and note the clinicians do not stand on the sidelines appearing aloof but 'mucked-in' with tasks, including helping to clear up any mess. Working alongside created a sense of partnership, as one participant commented, 'Under-fives don't come in playing the big I am'. The findings highlight a genuine collaboration between the under-fives clinicians and the children's centre practitioners, who feel valued and respected by the clinicians.

4.3 Core theme 2: a different way of thinking

Across all the data the core theme of experiencing a different way of thinking came to the fore. Four themes emerged:

- Observation
- Reflection
- Focus on parent–child relationship
- Focus on play

4.3.1 Theme: observation

All six participants commented on the value of the observations by the under-fives clinicians of children, parents and their interactions.

> Almost like the clinician from the under-fives had a third eye and noticed the interactions and also the non-interaction and it may have been something really subtle but we may not of picked up on. (P6)

> It was really good and really informed us and we adapted the way we worked by taking observations into consideration. (P5)

These observations helped participants feel they are more child-focused and more likely to consider potential difficulties in the parent–child relationship, rather than difficulties being located in the child, as described by the parent. The participants valued the clinicians' thoughts and contributions about children and their parents, which they described as being different to their own training.

> Our training is child development based very much looking at where children are at in their milestones … so it's a reminder to look at the whole family. (P3)

The participants valued observations that informed their thinking about a child and family, participants noted a shift in their understanding of behaviour. The practitioners are more likely to consider behaviour as a communication of meaning to be thought about and their practice is more child focused.

> Under-fives clinician's observations of what was happening in their interactions was so helpful … The reflective time which is really valuable because we talk about observations of the children

> what the children's interests have been thinking about the planning and thinking about the other perspective of what might be going on for the child of the family. (P6)

> Lots around observations about what the practitioner would've observed from the under-fives is that maybe we hadn't picked up and not picking up on for example under-fives saying I noticed that mum was doing such and such. (P5)

Participants described feeling positioned by parents as 'experts on children' and pressured to offer instant advice/solution to parents, particularly when a child was displaying challenging behaviours. Their advice was usually to leave the child to have a tantrum whilst reassuring the parent the child would recover and learn from the parent's firmness. The participants are more likely to include further observation of the child, their interactions and invite the parent to think about possible meanings for the child's behaviour before giving advice. Observations now informs the participants' planning.

> I want to know more, more about this family, what is it they are trying to tell me nonverbally … I now say let's look at the sleep routine, let's look at the feeding routine let's etc … what is concerning us about this family, what is this child trying to tell us through their behaviour and through their play. (P5)

> Input has been really useful in terms of a different perspective for making us think by saying have you thought about this or that and I think for any team having another perspective, it's a positive evolvement. (P6)

Over time participants developed an interest in the under-fives clinicians' observations, finding them informative and illuminating. Observations were incorporated into the practitioners' thinking and planning for a family. The findings suggest the practitioners adapted their observation style, influenced by the under-fives clinicians' psychoanalytic observations, with a shift from using observation against an internal checklist, which can obscure unconscious emotional communications and block emotional receptivity, to a more open to the 'here and now'. Stripping away preconceptions and giving one's whole attention to noticing has developed curiosity in the practitioners.

Practitioners found psychoanalytically informed observation has helped them to keep a child at the centre of practice. Practitioners' primary focus is to engage families, help parents manage stressors and give depleted parents some reprieve during their time in the group activities. Their approach may often be adult focused, accepting parental perception of children's difficulties and giving parenting advice and strategies. The dedication of the practitioners to alleviating families difficulties is admirable and visibly appreciated by the families. The practitioners in this study were able to acknowledge that the needs and demands of parents can obscure children's needs. Observation helped them to bring the child back into focus and to take a fresh look at the difficulties as a whole.

4.3.2 Theme: reflection

> In the reflective time having someone there from under-fives who is saying keep going, say more what is it? It's really useful to work through together because you might get stuck with something and you can't put your finger on what it is, but by asking different questions and reflecting on it, in a different way, you are able to open it up for people, different members of staff … I wanted to know more and I wanted it to continue. Teasing out was so beneficial, it was like getting me to answer my own question, my own thoughts and to dig a little bit deeper. To reflect on your own feelings and not give you an answer, that was such a positive side of it. (P5)

The participants valued the presence of the under-fives clinicians in the children's centres, providing not only a physical presence in the universal 'stay and play/ drop in' but also a presence in the planning time. At the end of each 'stay and play/ drop in' session, the under-fives clinician met with the practitioners for a 'planning/evaluation' time. The 'planning' involved discussion about children and families who had attended the session. The participants described a change in focus influenced by the under-fives clinicians' way of thinking and included not only reflections and observations of children and families but also the practitioners' emotional responses – this became known as the 'reflective time'. Several participants described the value of the reflective time and identified it as an important contribution of the Under-fives Service:

> The reflective time which is really valuable because we now talk about the clinician's observations of the children what the children's interests have been thinking about the planning and

> thinking about the other perspective of what might be going on for the child of the family … It was positive that we had that reflective time to be able to really think about a family, that concentrated time to really reflect on the families or a particular child what are the worries but it was having that space and time to think. (P5)

> With the under-fives there she enabled us to be a bit more curious than would have, we would have these thoughts but we didn't really know where to put them so it was good to take them to the reflective time. (P3)

Being part of these discussions gave the under-fives clinicians more credibility. They provided an opportunity to share and reflect on observations. Joining these ordinary conversations, sharing observations about children's behaviour and parent–child relationships created a culture of curiosity, thinking and learning about meanings. Whilst reflective ideas were rather coolly received initially, there was a distinct and observable shift in the practitioners' interest in the ideas put forward by the under-fives clinicians and over time this became known as a 'reflective' time and was valued by the practitioners.

The participants were interested in the under-fives clinicians' way of thinking about the observed interactions between parents and children in the sessions, the reflections on these interactions and the exploration of participants' thoughts.

> Particularly the questioning it was really good that was the question the circle the reflection of questioning shone through and it helped me to think better … Input has been really useful in terms

> of a different perspective for making us think by saying have you thought about this or that and I think for any team having another perspective of you it’s a positive evolvement. (P2)

> Also building up our knowledge skills, and hearing under-fives clinicians’ conversations with families, and being able to have that reflection time afterwards, is so valuable to use and use that evaluation time it has been really productive. (P5)

During the reflective time, the focus had been on planning, there had been an absence of thinking about the emotional impact of the work. Its impact was visible: staff looked emotionally drained, they exhaled loudly and fanned themselves as if to cool themselves down after the heat and demands of running the group. Exhaustion was seen as part of the job with no expectation to reflect on feelings. It had not been identified as a need but the research highlights its usefulness for the practitioners as a place to unpack their feelings. The under-fives clinicians introduced the idea, naming the exhaustion, which perhaps made it possible to think about it. The practitioners value and recognise the need to discuss the emotional demands of their work in a supportive and reflective capacity as one participant explained:

> It was positive that we had that reflective time to be able to really think about a family, that concentrated time to really reflect on the families or a particular child what are the worries but it was having that space and time to think. (P3)

Reflective time also contributed towards the practitioners development. Working alongside under-fives clinicians developed practitioners' interest in psychoanalytic ideas and unconscious meanings. In the reflective time, after initially disregarding ideas they wanted to hear more.

Reflective time requires time and trust between the under-fives clinicians and the practitioners. The consistent presence of an 'outsider' who is accepted by the practitioners is important; it can feel too intimidating for staff who are not trained or used to reflecting on their emotions in a group. Working together in the universal groups and discussing observations helped to overcome self-consciousness and developed a sense of unity, cohesion and trust. It is helpful to have a shared understanding but it also important to keep some distance, some impartiality, and not to get drawn into unhelpful group dynamics, thus being able to provide a different perspective. It is a delicate balance to strike, it requires self-reflection and supervision; having dual citizenship is challenging.

Subtheme: consultations

Outside of the group reflective time, all children's centre staff are able to request a discussion 'consultation' with an under-fives clinician. Families who attend the universal groups or nursery can also request a consultation. The practitioners all described the helpfulness of the consultations. One participant explained a consultation had led to a 'lightbulb moment' and helped the practitioner to be child-focused:

> I went to under-fives practitioner to have a consultation about this family … parents finding it really hard to manage the child's behaviour, at their wits end she was out of control, she doesn't listen or respond to them and they had run out of ideas and stuff to manage. The family often looked externally for the reasons as a cause for the behaviour but the child presented very differently in the nursery, most of things with parents talked about the child at home didn't happen in the nursery … Under-fives helped me with a thinking, I think the under-fives clinician was able to position things for me she kind of joined up lots of things, so I firmly started to put myself in the shoes of the child and perceived the world as her home, her homelife through the eyes of that child. I know I work in children's services you're meant to do that all the time but it really did, it was a lightbulb moment. (P2)

Whilst practitioners had been reluctant to engage with reflective thinking during the planning/ reflective time, the experience of sharing joint observations and thinking together stimulated practitioners' interest. The practitioners approached the under-fives clinicians and routinely began to request individual consultations.

> Professional consultations have been really useful to be able to discuss the case quite thoroughly methodically. It's really helped my own practice, it's really helped with my own thinking particularly for questioning. Really good at questioning me which is really lovely, a lovely challenge for me … She was able to pose questions for me it brought on broadened my thinking it made me a little bit more empathetic sometimes with some of the cases. (P2)

> I would have a consultation with under-fives and say what do you think it was so helpful. (P3)

Families who were hard to reach and fearful of the being stigmatised were able to request a consultation without being required to give further identifying details. This allowed anxious parents to keep control whilst gaining a flavour of a non-persecutory parent–child psychotherapy and supportive experience before committing. This helped to facilitate engagement, overcoming obstacles for families, and some children received help whose parents would not have attended a clinical setting.

> Consultations is available for families it's really valuable. For me they happen in a seamless way I can just approach under-fives clinician to talk about cases that we are working on together. (P6)

4.3.3 Theme: focus on the parent–child relationship

Another theme to emerge from the core theme of a different way of thinking is the under-fives clinicians' focus on the parent–child relationship:

> The child's experience was before this I wonder what they're thinking or feeling I wonder what's going on at home whereas before my perspective would've been about their learning … As practitioners we are very quick to label the child's behaviour we say that's going down the path maybe we need to speech and language referral I think that's what under-fives helped us to just change our practice slightly so you're looking at it holistically. Actually, the night terrors might not be it can be it maybe we can teach mum or dad or carer to do to be in tune a bit more. (P3)

Several of the participants commented on the value of the under-fives clinicians' observations and thinking about the parent–child relationship and interactions. The participants described a shift in their practice to include more observation and thinking about the parent–child relationship rather than the parent and child separately.

The practitioners avoided exploring or challenging parents' narrative about the children's 'problems', which can lead to collusion, stemming from a fear of reprisals from parents and perhaps an over-identification with the parents. There was an over emphasis on parental difficulties. The findings found the practitioners' focus has shifted to incorporate the parent–child relationship, recognising that children and their parents' mental states are inextricably interlinked. The research found this has also changed some of their practice. Participants are much more likely to be curious about reported 'challenging behaviour' and would now consider if it is connected to parents' difficulties. Practitioners would routinely undertake further observation.

> The lived experience of the child is paramount all the relationships they have all the form have an impact. (P1)

> Understanding of behaviour affecting their mental health and the effects of things that happen in the home, the things that happen in the environment the home environment has an impact on their mental health and well-being as well. (P1)

The under-fives clinicians' observations and reflections of the parent–child relationship has impacted the way practitioners think about children's

behaviour. The participants discussed a shift in their focus to pay more attention to the parent–child relationship and reported they felt more able to recognise potential difficulties in the relationship and they were more likely to seek a consultation with an under-fives clinician or make a referral to the service for early intervention work. Participants described feeling pressure to tend to parental difficulties/state of mind in isolation and separate from the child's behaviour. They described gaps in their knowledge of infant mental health and an anxiety about upsetting parents and uncertainly about how to speak to parents about possible attachment difficulties or infant mental health. They discussed feeling more aware of the impact of depression on the relationship and awareness of an infant/young child's emotional needs being overlooked from a focus on parental difficulties, such as depression and other mental health difficulties.

> Being able to see difficulties in parent–child relationship I feel more confident now. (P1)

> Wondering and been curious about what's going on at home have you moved house the child been moved to a different room was anything else happened in the family to look at what the impact might be and feeling more confident to do it, I have developed and feel more confident and more skilled to do it. (P3)

4.3.4 Theme: focus on play

Children's centres focus on play and its benefits for learning. In the centres, children have the opportunity to play with developmentally appropriate toys. The under-fives clinicians also view play as an expression of children's feelings

and thoughts, consciously and unconsciously. Working alongside under-fives clinicians in the universal group the participants observed that the clinicians put into words possible meanings of the children's communication. This has expanded practitioners' repertoire to incorporate its value as a means of communication and to help understand a child's feelings, their relationship to a parent and learning:

> Learning through play that makes a difference and mum or dad might not even know that. So the idea now very much play focus, and thinking about the meanings and commentating on the play there. (P1)

Participants have incorporated play as a tool to help improve the quality of parental attention and to develop relationships and attachments. Practitioners observe play to track possible meanings and take this into account when wondering about a family's difficulties:

> But the under-fives clinician's practice, learning through play makes it easier to connect with your child … It helps them reconnect the child between mum and child, its meaningful and sometimes parents don't realise it actually by doing that its quite significant … That attunement, the child might be saying something and you might not sure what the child is saying so you can track it through play. (P1)

> Yeah, I think the behaviour challenges …now actually I think what are you telling me right now (P6)

4.4 Core theme 3: learning and development

Professional development overwhelmingly emerged as a core theme from across data. Three themes were identified. The participants all felt they had progressed personally in their professional development, some felt it reinvigorated their interest and all described gaining knowledge and skills.

The three themes that emerged from the data are:

- Re-stimulating interest
- Gaining knowledge and understanding
- Gaining skills

> The ease of access has been very helpful for us practitioners, the under-fives worker has been responsive in the children's centre, there is a good cross-fertilisation of knowledge and also good for the families. (P1)

4.4.1 Theme: re-stimulated interest

> It's kind of drawn me back to the part of the work that I quite like which is the relationship bit. (P2)

This theme highlights small portions of the data that included participants' views in relation to feeling their interest in working with children and families had been positively impacted and had reinvigorated their interest in the work

> I have supervision regularly but talking through ideas or your thoughts with under-fives clinician at times it's like another level of supervision for me it really refreshes my practice, it gives me that extra strand in terms of my work as well. (P6)

> I had lost if I’m honest I had lost the child a little bit but under-fives dragged me back. (P2)

Practitioners felt more contained by the presence of the under-fives clinicians, less burdened and less preoccupied by parental anxieties and more able to think about meanings and understand them. Difficulties being seen, validated and understood is a powerful clinical tool in work with parents and children. It can alleviate difficulties and depleted parents can find they have the emotional capacity to manage, which usually results in a reduction of symptomatic behaviours in the child. This is perhaps similar to the participants’ experience of the under-fives clinicians.

4.4.2 Theme: gaining knowledge and understanding

> To get an idea of different roles but when somebody is in there you actually get to know more about it rather than you can go to a training and you have to implement it whereas actually if they are there regularly it becomes part of the practice and that’s valuable to be there. (P6)

The participants described how their experiences of working alongside the under-fives clinicians in the children’s centres has developed their understanding of how CAMHS works, of the role of the under-fives clinicians and of the interventions offered. They felt more confident to speak to parents about CAMHS under-fives and mental health. The research findings indicate participants had gained knowledge from working alongside the consultations

and observing change in families where a piece of parent–child psychotherapy had been undertaken by an under-fives clinician. The reflective time-generated discussions about meanings of children's behaviours, parental difficulties, unconscious processes and observations was valued by the participants:

> I have a better understanding and I have found a better understanding of where things should go and the child's behaviour … I am able to manage the case more appropriately, I've had a really good experience … I have a better understanding of the ones that should go to CAMHS. It helped me understand more about how a psychotherapist was going to work. (P2)

> Helps us as practitioners what is the under-fives role is as practitioners for us to look at what it is that the Under-five Service does and support for families. (P5)

The practitioners developed an interest in and have grasped a better understanding of infant mental health difficulties, CAMHS and the under-five service, and the role of a child psychotherapist. As a result, they feel more equipped to recognise early difficulties in the parent–child relationship, symptoms in a child and what the Under-fives Service can do to help families and their children. Importantly, they no longer accept a parent's account of the difficulties but feel they can stand back and explore, observe and talk to parents about the difficulties.

> I feel I've got a better understanding of that infant mental health, looking at the effects of when crying feeding the dynamics of what goes on in the family and for the family. (P3)

> What was really good she gave was very good clear parameters about what the service could and couldn't do and which kinda managed my expectations as well which was useful. (P2)

> I was able to pick up the phone I was able to explain to parents what CAMHS under-fives do and the benefits of doing this early on so then so then we focus on early intervention we were doing the screening early on so we could say I've noticed this and this would you mind having a conversation with mum. (P3)

Practitioners are more open to the possibility of infant mental health difficulties, recognising symptoms of infant distress as well as a deepening understanding of the contributory factors and have a better understanding of specialist services. This important development filters directly to the families who attend the children's centres.

Participants described paying more attention to parent–child interactions and felt they have an increased awareness of parent–infant mental health difficulties. Practitioners are more aware of parental pressures put on them to give immediate solutions to help parents manage and change children's behaviours. Practitioners are more likely to take time, step back, reflect and undertake further observation and consider alternative meanings for behaviours. They are less reactive and more thoughtful, feeling more confident to challenge parents perceptions of difficulties and to undertake a piece of work to improve the parent–child relationship themselves.

> I think differently now an awareness more around perhaps young children's mental health that they can struggle with that and it's

> not something that's just resigned to older children or adults in that sense. (P6)

> Changed my perspective of I was thinking straightaway about speech and language referrals or OT referrals I would never think this child's mental health or they're anxious or what's going on for them off. Under-fives helped us to be curious and to question things more with children's well-being. (P3)

4.4.3 Theme: gaining skills

> Having someone with expertise is so important ultimately for the families they are the most important but it's also been really helpful for me my professional development and knowledge for me to learn. (P1)

The practitioners described internalising this thinking and applying the new way of thinking into their practice.

> Under-fives taught me a different way with in the team as a practitioner because then afterwards I have used different bits like I use it now as a tool in my thinking and with practice … I do it in myself in my head I think what else do I need to know and it's urm yeah doublethink yourself. (P5)

Another element identified from across the data is the participants' sense of feeling more confident. They described how working alongside the under-fives clinicians in the children's centres has developed their knowledge and skills.

> Also building up our knowledge skills and hearing under-fives conversations with families and being able to have that reflection time afterwards is so valuable to use and use that evaluation time it has been really productive (P5)

> It's been so positive having under-fives and we have learnt so much from under-fives clinicians. (P3)

> It's been really valuable professionally as well as for the families. (P6)

The participants conveyed that they had developed skills from working alongside under-fives clinicians, the consultations and the reflective time. The participants reported increased confidence in recognising signs of infant difficulties and curiosity about a parent's narrative of their child's difficulties and as a result are mindful of the impact of parental difficulties on the parent–infant relationship. As participants put it:

> Being able to see difficulties in parent–child relationship, I feel more confident. (P1)

> I firmly start to put myself in the shoes of the child and perceived the world as her home world, (P2)

The skills the practitioners have identified go beyond being able to recognise parent–infant difficulties but practitioners feel more confident in their ability to offer help without referring onto another service. There is an idea that there was an outside expert but the practitioners describe their own qualities of expertise

in identifying and working with parent–child difficulties. The under-fives skills such as use of observation, containment and reflective thinking have been integrated, and these ways of thinking and working have built the practitioners' own capacity to identify need and intervene.

> I can see a child … I will be able to tell if they have a behavioural problem they might be running or they might be really quiet and I'm able to support, that child might need some support … the parents might need some support. (P1)

> I feel a little bit more grounded to deal with it now having had that professional relationship with under-fives I feel more robust in dealing with it. (P2)

> I feel more confident in saying well let's start early before things start to escalate any more let's look at what support we can offer you … We felt equipped enough ourselves to screen ourselves on the days that under-fives was not there. ..You're not having to bypass to go straight to another service when you can do that small piece of work yourself and it makes such a big difference. (P3)

Subtheme: capacity building

This subtheme captures the sense that from working alongside the under-fives clinicians the participants felt more skilled and empowered and have started to internalise and apply their understanding to practice. This has helped to build their capacity to identify children's mental health needs and intervene accordingly, without referring on to specialist services. If further help is needed,

the staff are more confident in where to refer to children and which service to contact. Practitioners now feel able to make direct contact with CAMHS.

> Within the team because if somebody does that within the team now I find that's what I do I start saying what is it what do you think tell me a little bit more what is it that you see what was the behaviour you know so I find that I do that a bit more because it then questions myself (P5)

> I've been able to work through together it's really useful because you might get stuck with something and you can't put your finger on it what it is but by asking by different questions and reflecting it in a different way is then you are able to open it up for people different members of staff. (P5)

4.5 Core theme 4: organisational challenges

The final core theme captures the organisational challenges referenced across the data by some of the participants. This core theme centres on organisational challenges and captures the challenges implementing the new Under-fives Service and the limitations and constraints of the service from the participants' perspective.

Three themes emerged from the data:

- Implementation
- Dynamics
- Limitations
- Impact of the Covid-19 pandemic

4.5.1 Theme: implementation

> I don't think we were told they were coming in without thinking how it was that going to work within the drop in/stay and play group. And I think not the whole team was part of all that early discussions, the team weren't aware of what CAMHS does and if it's done again how that whole introduction would be done within the team. (P5)

One participant described a lack of preparation for the launch of the Under-fives Service staff, who as a result felt ill-prepared, which presented challenges and impacted on dynamics. The research identified a lack of consultation prior to the launch of the service. The management of the centres were part of the discussions and decision-making process about the structure and implementation of the Under-fives Service in the centres with CAMHS consultants. This was not disseminated amongst the frontline practitioners, leaving the staff feeling unprepared and without a clear understanding and details of the working relationship. The arrival of the new service triggered resentment and frustration.

> A piece of work before actually before launching rather than launching with rather than starting with the family so rather just start with the staff … making sure that everybody really understood what the under-five service is what the role is how they would link in with children services. Because if you're working with staff in that consultation they've got to have a clear understanding of under-fives to be able to support the families. (P5)

There was an absence of thinking about the impact on the frontline staff in the universal groups, who felt they were left to manage their own feelings and also those of the families, who were equally curious and suspicious of the sudden arrival of people with their NHS badges standing around in universal groups. The staff felt left without the necessary information to explain why they were there and what the new service could offer. As identified by the research, a lack of understanding of mental health difficulties contributed to the staff feeling anxious about the presence of under-fives clinicians and this stirred some paranoia about the clinicians' motives. Some staff felt they were being spied on and the clinicians were reporting back to the management team about them.

A small portion of the data identified the challenge in the children's centres: that not all the children's centre practitioners were present and worked alongside the under-fives clinician in the stay and play/drop-in groups and on a regular basis, there was a core staff group in the groups but other team members were not consistently present. This presented a challenge to the with a gap in knowledge emerging between the practitioners (in relation to the growing knowledge of CAMHS, the under-fives role and infant mental health/ parent–child difficulties, and some internal dynamics). Some tensions emerged in one of the centres as a result, or perhaps existing tensions were unearthed:

> I think it was just that reflective time because it wasn't the same staff all the time. I think it was just thinking about having the discussion prior to the reflection time how are use them sometimes. I think planning that reflection time a bit better for us

> and actually saying on this particular day this is our reflection time this is our consultation time and using it more productively (P5)

> I found that I was having to have those discussions and that was my challenges and I think that reflected in that consultation time, no reflection on the under-fives that was the challenge for me. And that I was having to have those discussions with staff over and that was a challenge for me. (P5)

The planning time, later named reflective time, had been a long-established part of the post-drop-in/stay and play universal group, perhaps it felt commandeered by the ideas of the management team and the under-fives clinicians. Practitioners were subjected to these new ideas and had little control that impacted on the dynamics of the group. There was also an unspoken aim of the service, management to 'skill up' the practitioners through a cross-fertilisation of knowledge from working alongside the under-fives clinicians. In the absence of, or mis-communication, between management and the practitioners led to a mis-understanding about the role of the Under-fives Service, in the practitioners minds the under-fives clinicians were in the universal and discussion groups only to learn from the practitioners, which in part led to the clinicians being treated like students, feeling they had no value.

Whilst the findings clearly demonstrate the value of the under-fives clinicians' presence in the reflective time, the presence of clinicians was initially unhelpful and impacted on the dynamics within the staff group. It presented a challenge

particularly to the stable consistent members of the centres, others coming and going, it left the regular ‘senior’ attendees feeling responsible for sharing ideas discussed, as one stated.

> It got a challenge for me, I just kind of thought for me and reflected back well actually that should’ve been planned a bit better. (P5)

The under-fives clinicians joined the discussion at the end of the group, later known as reflective time, and this gave rise to further anxieties with staff feeling uncomfortable in the presence of the clinicians. Practitioners felt dumped upon, left ‘holding the baby’ and unclear about what the expectations were of them. Once the service had been agreed between CAMHS and the centre management team, it would have been helpful to meet with both the children’s centre practitioners and the management team to set out the proposed plan prior to the launch of the service to discuss the reason, purpose and aims of the service.

4.5.2 Theme: dynamics

This theme represents a smaller but significant portion of the data: one participant referred to tensions within the children’s centre staff group which presented challenges:

> But actually, it was the dynamics in the children centres staff umm I think it’s direct dynamics of the team, the knowledge and the skills of different practitioners their understanding of what that

> time was for and their understanding of CAMHS and the role and what the role actually was. (P5)

The introduction of the new under-fives clinicians from a different training background into well-established groups, each with their own strong culture and way of working, presented challenges and complexities. This was evident in some of the ways the under-fives clinicians' thoughts were initially resisted. The expectation from practitioners that clinicians' task was to be present in the group, another pair of hands to help share the work, clear up and sit and listen only to the practitioner's conversations about parents and their children. This dynamic was not helped by managers including the clinician's name on the universal group staff rota. Whilst on the one hand this was a symbolic recognition of the integration of the service, on the other hand it set up an expectation that the clinician was another practitioner, to be present in the universal groups and absence would leave practitioners short staffed and with more to do. This generated some unspoken resentment within the staff group when the clinicians were required to undertake other under-fives clinical duties, absence perhaps seen as shirking responsibilities. This is also perhaps a projection of the practitioners feeling trapped and envious of clinicians' obvious freedom.

> Think some dynamics some workers responded well to the way and the under-fives kinda worked whereas others were quiet and unresponsive. (P5)

> Making sure that everybody really understood what the under-five service is what the role is how they would link in with children services. (P5)

Following a flurry of excitement about the joint venture implementation was challenging. A period of confusion followed as practitioners passed around, unconscious and conscious, confusion about the Under-fives Service and a lack of the understanding about the purpose of the clinicians' presence in the universal groups. Practitioners felt ill-prepared to explain the service to the families who trusted them. The frontline practitioners were thrown into being unintentional hosts and the clinicians were their uninvited guests, both tried to negotiate a fit and find their place within a new way of working. The practitioners were individually warm and welcomed the clinicians but perhaps felt threatened, accompanied by a lack of clarity that led to obstacles to collaboration. The clinicians felt devalued and superfluous to need. This is complex, as discussed in the previous chapter, and is also connected to projections from the practitioners and not just inadequate planning. The clinicians' presence increased practitioners' anxieties, they felt under scrutiny and sometimes paranoid about the clinicians' motivations.

4.5.3 Theme: limitations

> It's not anything about individual support for children it's about the sustainability and capacity of your service which is limited. (P4)

The participants all value the Under-fives Service and expressed anxiety about the service being de-commissioned. The participants all commented on the limitations of the under-fives clinicians' capacity and suggest more time and additional services were required to meet the needs of the children, families and practitioners. The participants made suggestions that the service should be available in all centres, it should be expanded to include training staff in infant mental health and it should expand into other children's centres.

> It's the capacity of the service only one person one day a week it's not enough. (P6)
>
> I think to have more of you more of the Under-fives Service in the children's centre in terms of the access and availability would be fantastic but also in terms of mental health support, that's a desperate need for it for all ages so if there were more funding would help to provide more. (P6)
>
> I think we need more parenting workshops, I think training more training for all staff in infant mental health. (P1)

The CAMHS under-fives service is not in all the children centres across the borough and this inconsistency is noted by the children's centre practitioners who link with other centres.

> When we say we have CAMHS Under-fives in in our centre there was a little 'ooof' others are shocked that CAMHS are in our children's centre, they can't believe we can just speak to you and refer to you. (P2)

> I know the value for our children centre has been huge and I think it would be really helpful for other children centres to have access to your service. (P6)

There is limited capacity but there is increased demand as practitioners identify the need for an infant mental health service. The Under-fives Service has very limited resources: four part-time clinicians covering four children's centres, a total of forty-five clinical hours a week between the clinicians, including attending the centres' universal groups, consultations, multi-agency meetings and direct clinical work with children under-five who are referred into CAMHS from across the boroughs.

The need for the Under-fives Service is both recognised and valued, and the demand for psychoanalytic thinking. The practitioners all expressed a need for more under-fives time to be allocated to their centres and also highlighted the inequalities, in that other children centres do not have a clinician attached.

> I know the value for our children centre has been huge and I think it would be really helpful for other children centres. (P6)

> Developing the skills for all the staff and the knowledge of CAMHS and of infant mental health for some it is still they are aware but they don't have a full understanding of the what the role is. (P6)

> More training definitely around mental health for under-fives that would be really good CAMHS could come and present something to us. (P1)

> It's changed my practice completely way I practice … I always think that I've learnt a lot from U5s and I don't think other practitioners have had that opportunity – whether that is a training aspect. (P3)

Another highlighted the increased demand as a result of the pandemic.

> The presence of CAMHS to be here more than anything post-Covid we need it. (P1).

One practitioner also expressed frustration about the use of feedback forms for each piece of work undertaken, including consultations.

> We are in fear that the service will be taken away if we don't do the forms, if we don't capture it. (P3)

Another practitioner highlighted in one centre it was not the best session for the under-fives clinician to attend.

> It was not the right session for her to be in because she wasn't seeing the right families so sometimes it was the sessions that wasn't right. It's just didn't work as well in the xxxx centre, it's just such a shame because it was so successful in the xxxx centre. (P3)

4.5.4 Theme: impact of the Covid-19 pandemic

The interviews took place during the Covid-19 pandemic and unsurprisingly this aspect emerged across the data. Three of the children's centres closed for the universal drop-in/stay and play activity groups, one remained open for key worker/ staff children. Under-fives clinicians did not have a presence in the children's centres during government lockdowns but all clinicians remained

available for consultation to all children centre staff and families via Zoom. All meetings and parent–child psychotherapy sessions took place via Zoom during this time.

Participants appreciated the continued availability of the under-fives clinicians. One participant commented on her observations of children since the pandemic and the greater need for a presence in the centres.

> It's been really easy to access, communication is wonderful feel like I can call at any time it's been really helpful despite the lockdown the pandemic. (P2)

> The presence of CAMHS to be here more than anything post-Covid we need it. (P1)

What is striking from the finding is the anxieties provoked by the absence of the clinicians, there was a huge sense of loss experienced during the Covid-19 pandemic with government-imposed lockdowns, when centres closed and clinicians continued to offer a service from the CAMHS clinical base or online. The practitioner's emotional response is in the context of a much wider societal loss but is nevertheless worth noting. They felt a sense of loss and abandonment as the clinicians had come to represent containment, and the physical absence triggered more primitive functioning and with a return to a more 'them and us' culture. The Under-fives Service continued to fully function during the pandemic, and with an increase in referrals, the under-fives clinicians were busy. The under-fives clinicians were defensive, feeling criticised by some of the centres' practitioners for being absent. This perhaps reveals the fragility

of the success of the service, and how quickly old ideas and prejudices can resurface.

Others appreciated Under-fives Service's ongoing support, being thought about during the lockdowns, as one participant said:

> In the middle of a pandemic under-fives clinician was emailing me that's amazing and I emailed the staff to that under-fives is available if you feel like you need like a chat and it validates something about practitioners on the front line. (P4)

4.6 Summary

This chapter described the main findings of the study. Thematic analysis of the interview data identified four core themes of the experiences of the CAMHS Under-fives Service: availability and presence in the children's centre, experiencing a different way of thinking, professional development, and organisational challenges. In the next chapter I will explore the findings in connection to the research question and national contexts of early intervention and the published literature.

Chapter 5: Discussion

In this chapter I explore each of the core themes and how they interrelate with key concepts from existing literature and research in the context of the research question and identify the most important findings. I will discuss the findings in the same order presented in the previous chapter, although many of the themes overlap.

5.1 Presence in the children's centres

The findings highlight the impact and importance of the visible presence of the under-fives clinicians in the children's centre. These finding are consistent with Daws' (1985) account of the importance of being seen and 'standing around'. It is important for clinicians in the children's centres to be available, approachable and talk about our work in an ordinary non-jargonistic way, finding a shared language and meanings. It demonstrates the under-fives clinicians' interest in and the value of the practitioners' views, thoughts and expertise. The importance of this shift, which facilitates a sense of team working, concurs with Music and Hall's (2008) findings of the importance of adapting, coming out of our traditional ways of working and being visible.

As others (Urwin, 2003; Sternberg & Tydeman, 2008) have noted, in order to be accessible to all sectors of a community it is important to have a presence in community settings that families routinely frequent, such as GP surgeries and children's centres. This setting offers the opportunity for the Under-fives Service to appear more open and transparent and helps to demystify CAMHS.

The findings show that the under-fives clinicians' presence in the universal group gives the opportunity for parents to access the Under-fives Service in a more naturalistic, non-stigmatising and less threatening setting. This is particularly important for hard to reach families, those most in need, and chaotic and unstable families, who are al suspicious of specialist services, fearful of being stigmatised and unlikely to attend a clinic. A presence in the universal community setting, with its primary focus on play, is a helpful setting to see families from diverse ethnic and cultural backgrounds. The clinicians' 'light touch' approach, available but non-intrusive, being curious and interested in children's play, fostered an alliance with parents, overcoming barriers and facilitated engagement.

The finding confirms there is a mis-conception that early intervention is less complex work (Music, 2007). Centres are actually full of children and families with multiple and complex needs These families may mistrust authority figures and their children may be at risk of not receiving any help, compounding further health inequalities. Britton explains, 'a place like a clinic where problems are focused on seems threatening and even the collation of information is felt to be unwelcome. It is not surprising therefore that they shun clinics' (1981, p.174). The children's centre setting offers an opportunity for children from more chaotic families to receive some input from an under-fives clinician, either directly or indirectly through discussion between the clinician and practitioners about infant mental health and parent–child relationship difficulties. This helps to redress some inequality faced by the most deprived children who can be at least over-seen by an under-fives clinician within the universal group setting.

The flexible accessible approach allows parents to get to know and build up a rapport with the under-fives clinician and has helped families to engage in a piece of parent–child psychotherapeutic intervention in the centre, families who would ordinarily 'shun' (Britton, 1981) the idea of attending a clinic.

The findings reveal how the children's centres practitioners feel there is a workforce hierarchy and they occupy a lower status. Historically, they would not consider initiating contact with CAMHS to make a referral or discuss concerns about a child. This was beyond the parameters of their role and too anxiety provoking, instead, concerns were discussed with managers who decided the next steps. Children's centres practitioners feel undervalued and expect CAMHS clinicians, as other agencies have, to behave in a superior way towards them.

Co-location has been identified in research (Anning *et al.*, 2006) as important for collaboration. The findings in this study identify that it is not the co-location of services but more importantly a visible presence coupled with an approachable attitude that nurtures cohesion and improves information sharing. In this small sample, the practitioners experience the clinicians as being part of the maelstrom of activity in the universal groups. The approach helped to ameliorate the felt hierarchy and unify the clinicians and practitioners. These findings are in line with Daws (1985), whose experience taught her similarly 'not to disappear from sight while seeing patients' (p.8).

The findings highlight how practitioners feel reassured by having an under-fives clinician, an 'expert' in infant mental health, in the children's centres. This links to the anxieties and discomfort 'mental health' stirs in the practitioners: some doubt its existence but most feel unsure how to recognise mental health problems. The practitioners prefer to be seen as 'good' by the families and the under-fives clinicians to take up 'bad' position (Klein, 1946). This split is unhelpful and it perpetuates the stigma. It is important to ensure that all the practitioners working in the frontline with children and families are skilled and confident to recognise difficulties and to feel sufficiently supported when intimidated by families. Child psychotherapy and under-fives teams are a very limited resource and most children's centres do not have an under-fives clinician in their centres. It is therefore important that practitioners not only receive adequate training, but also continue to have access to infant mental health specialists and to be supported in identifying infant mental health difficulties. As Daws highlights, it is important to keep these ideas in the minds of colleagues, the 'task is in reinforcing this approach in my colleagues, not allowing it to be attributed only to me' (Daws, 1985, p.80).

The findings found the children's centre practitioners are expected to contain parental anxieties and strong emotions; as Britton (2015) describes, they are forced into them. The practitioners are like 'unofficial counsellors' for parents (Cottle & Alexander, 2014). They are expected to undertake the 'emotional labour' (Elfer, 2015, p.498), which takes an emotional toll of the practitioners, whose own health can be affected (Rothi, 2008). It is important to look after their emotional health for someone to contain their anxieties (Youell, 2020)) to

contain the containers (Bion, 1962), in order to manage the emotional work, to keep thinking about painful and difficult feelings, necessary to maintain child-focused practice.

5.2 A different way of thinking

A surprising finding of the research is the value of observation. Initially, some clinicians were resistant to reflecting on observations. On one occasion an observation of parent–child interaction made one practitioner feel so angry they 'reported' concerns to their manager. The practitioner had reacted to an observation of a mother, her baby and young child who regularly attended the universal group. The mother had been observed to leave her young son unattended in the outside play area without a coat during the winter. He had looked unkempt and sad, whilst the mother sat indoors with her thriving baby daughter. The contrast was stark. The practitioner reacted to the disturbing feelings, she withdrew and sat in silence. It is important to tread carefully and be sensitive to reactions, which may belong to something more primitive and unconscious. Those who work in the frontline need support to tolerate the discomfort of thinking about children's emotional worlds, which can allow new understandings to emerge. Psychoanalytic training equips clinicians to withstand and think about strong emotional responses. Such training has helped them to be aware of the projections and not react to these as if they are personal attacks on us or our thinking. It also develops our capacity to think about disturbing emotions.

Another important finding is that observation has developed a really fruitful means to engage with practitioners in an ordinary way for thinking about children's development and psychological needs, helping to overcome professional defences which can hamper remaining child-focused. Developing a joint focus is in line with McFadyen's (1994) findings in relation to work in neo-natal units. Observational approaches provide opportunities to integrate in a way that can feel tolerable rather than critical or persecutory. Thinking together as a cohesive group of professionals can help to regulate the stress and pain of accepting the reality and severity of traumas.

In the children's centres, the focus of attention is predominantly on parental need, then children's learning and behaviour. The children's centre practitioners are acutely aware and sensitive to the impact of external stresses such as housing, financial worries and domestic abuse on parents. They register who appears under strain, monitor, offer advice and direct them to specialist services if needed. They perceive children's observed or reported 'challenging' behaviour as placing an additional burden on a parent already under strain, or even a cause of parental difficulties and functioning. Their aim is to change the child's behaviour through behavioural strategies, mirroring how to manage the behaviour and so free the parent from the stress and instil confidence in parental capacities. Observation is regarded as an invaluable clinical tool by child psychotherapists and is not exclusive to child psychotherapy; other trainings now include an observational component. Neither is observation new to children's centres practitioners, who routinely incorporate it into their practice, predating the launch of Under-fives Service.

But the value of observation seemed revelatory to some participants, helping them to focus on the emotional communications of the child and on the parent–child relationship –looking with a ‘third eye’, as it were, to see not just the parent–child dyad but also the emotional exchanges and the impact on themselves.

The findings highlight that observational skills helps to ensure a child-centred approach, in keeping with Barlow and Svanberg’s findings (2009) on ‘infant-centred practice’ in the early years workforce. I suggest it is the observational technique along with space to discuss observations that is crucial in ensuring that emotional responses can be thought about to avoid acting into or an over-identification with a parent or child. This presents an ongoing challenge, and without space for reflection, it can easily and understandably slip from the practitioners’ minds as the complex work with children and families can erode the capacity to think.

Some practitioners resisted thinking, preferring to keep active. This is consistent with Elfer *et al.* (2018), who found that constant activity ‘can affect practitioners’ capacity to notice and think about children’ (p.194). It is important to keep in mind the context of the difficult emotional work faced by practitioners, who do not routinely have a place to reflect on their feelings and instead may be ‘psychologically held together by action’ (p.194). The resistances are also connected to the anxiety of upsetting parents, and a fear of negative criticism can intrude and obscure making meaningful emotional contact with children and being able to see their communications. The findings support, as others

have (Jackson, 2002; Music, 2007; Elfer *et al.*, 2018), the importance of having space to think and to reflect on observations and emotional responses so they are not defensively avoided, and to develop a culture where thinking time is routinely integrated, valued and given credibility.

Having time and space to think and reflect together on observations is identified by practitioners as a useful tool to keep the children in mind and at the centre of work with children and families. This is particularly important in the complex world of children's safeguarding and is essential for safe practice (Laming, 2003). It is well documented that anxieties are high amongst frontline staff. As one participant said, under-fives gave a 'space and time to think'. This is essential for exhausted frontline practitioners, who receive less training, are paid less, are undervalued and yet play an important role in children's safeguarding and improving outcomes for children. This is in keeping with Bower's (1995) findings that psychoanalytic contribution is valuable, providing a 'space for thinking about the meaning of what is being seen, heard and experienced' (p.xv).

It is also well documented that processing emotions has an important restorative quality that can help staff to manage the emotional demands of the work and keep curiosity about families live. In line with Jackson's (2020) findings, the reflective time 'created a space outside the heat, to reflect on their work' (p.131). The Under-fives Service got alongside children's centre colleagues, noticed and thought about the observations and feelings. As Tydeman and Sternberg suggest, 'the clinicians presence helps both the

patients and the staff, a sense of a sinking heart is diminished when it can be thought about and understood' (2008, p.113). The practitioners noted the quality of the clinicians' listening and interest in their emotional work and feelings and identified that it is this emotional quality and the capacity of the clinicians' mind that is containing. This has enabled practitioners to talk about the challenges and for these to be thought about and processed. This concurs with Dearnley and Elfer's work. It requires more than a sympathetic ear, and the space perhaps allowed the practitioners to process feelings and so guards against adopting less helpful defensive distancing behaviours to manage the work (2007).

Rather than the under-fives clinician having a third eye, as suggested, the practitioners have adapted their observation style, discovering for themselves how helpful observation is to understanding. As Lisa Miller describes: 'Correctly grasped, the emotional factor is an indispensable tool to be used in the service of understanding' (2008, p.40).

5.3 Learning and development

The findings highlight how some practitioners felt reinvigorated and that conversations with the under-fives clinicians had re-ignited an interest in the relationship aspects of the work with children and families. Organic learning has developed practitioners' knowledge and re-stimulated their interest through 'learning from experience' (Bion, 1962) rather than teaching or force-feeding psychoanalytic ideas and concepts.

The reflective space became a learning ground for practitioners, sharing observations and unpicking meanings, with new insights emerging that helped to develop their observational skills (Jackson, 2002) and reflective capacities. The practitioners even expressed some frustration, wanting to hear more of the clinicians' thoughts when the clinicians held back and to develop collaborative joint-thinking. As Daws highlighted: 'if one talks too much, reflective thought has no time to grow' (1985, p.79).

The participants clearly developed a greater understanding of the importance of the parent–child relationship, their understanding helps parents to think about their children's emotional experience through conveying understanding and managing the anxiety rather than suggesting only behavioural strategies. The integration is an important achievement for practitioners in order to keep in their minds on the child's experience and behaviour as a possible symptom of parent/family difficulty and to prevent more serious difficulties developing. Similarly, participants discovered the value of play as a means of communication and a way to tune into a child's world. It can be helpful to busy practitioners who often feel flooded with parental narratives about children. Like observation, it can help practitioners to keep a child at the centre to ensure they are seen and heard, and as Tydeman and Sternberg (2008) suggest, it is important to make links between the parent's narrative and the child's play.

The findings reveal some shift in the attitude to infant mental health difficulties. Practitioners are less resistant and more willing to think about and discuss the emotional states of children, enabling them to focus in on the child. They are more likely to be alert to difficulties and the way they are communicated, to identify problems and to refer to a specialist service. This is a significant development, and children are more likely to receive prompt appropriate specialist support and the parent–child relationship can receive the attention and thought needed.

5.4 Organisational challenges

The practitioners were frustrated by a lack of consultation, consideration and information provided to them before the launch of the Under-fives Service and the arrival of the under-fives clinicians in the centres. They felt unprepared and resentful of being landed with a new service that lacked clarity and led to misunderstanding about the purpose of under-fives Service clinicians' presence, whilst also being expected to welcome and induct under-fives clinicians into the children's centres universal groups. The misinformation led to some confusion between the practitioners and the clinicians.

The practitioners felt acutely aware of lacking sufficient knowledge about CAMHS and infant mental health and being ill-equipped to talk about the under-fives clinicians/service to families or other members of staff. There was a sense that the process felt humiliating and the lack of consultation confirmed their expectation: that they would be overlooked, disregarded and expected to manage. The under-fives clinicians' presence stirred anxieties and they were

unsure why the under-fives clinicians were there and what was expected of them. The practitioners would have found it helpful to have had some clarity prior to implementation, to have met with the Under-fives Service, to have had a presentation on the service, including infant mental health, and to set out the proposed aims and plan of the work. In the absence of open discussion with managers, the practitioners projected their feelings onto the clinicians, who felt devalued. Jackson (2008) highlights the importance of being explicit and transparent about the aims. This would have given the opportunity to allay some anxieties about the role of the under-fives clinicians and identify a shared understanding and collaborative working.

The under-fives clinicians joined the planning time, reflective time, at the end of universal group, quietly taking in from the groups They noted that contributions generated some resentment from some practitioners, who perhaps felt their time was being hijacked, generating further resentment.

The management were enthusiastic about the arrival of the CAMHS Under-fives Service in the children's centres, but there was ambivalence amongst the practitioners who work on the ground alongside the under-fives clinicians. The experience is similar to Music and Hall's (2008) experiences of working in the community setting. They found staff to 'harbour worries about anything called therapy or with psycho in its title … and our role can be undermined' (p.48).

To work towards a common understanding of new ways of working and to overcome obstacles and misunderstandings required much time and

perseverance. Trying to find a place in a children's centre is challenging, as others before have stated (Daws, 1985; Jackson, 2002; Urwin, 2003; Music, 2007). There is much in common in helping children and their parents, but there is a risk of air-brushing over of the differences between the two organisations and failing to appreciate the different expertise each brings. In an attempt to be part of the centres, to blend in, the temptation is to distance oneself from our differences, to rid us of our reputation of a superior attitude, 'the big I am'. It is important to protect our capacity to think and not to get overly caught up in the busyness and chaos of universal groups. It is important to be explicit about differences and the tensions inherent in multi-agency working and to acknowledge them, otherwise we risk losing the richness that joint-working can bring for practitioners, clinicians and the families we serve.

Practitioners who were initially resistant came to value the helpful presence of the under-fives clinicians in the universal groups: an extra pair of hands to assist with the mammoth task they faced, someone who bore witness to the emotional strain of the work, and who helped with practical tasks and emotional support. As the practitioners came to value the under-fives clinicians' presence, this also highlighted the need and put practitioners in touch with the limitations of the under-fives clinicians availability. The practitioners unanimously requested an extension to under-fives clinicians' time in the children's centres and suggested that the service should be extended into other children centres.

Despite a period of resistance, ambivalence and some resentment towards the under-fives clinicians, the findings demonstrate the practitioners valued the

presence and interventions offered by the Under-fives Service, but there is acknowledgement of the limitations of the service.

5.5 Impact of the Covid-19 pandemic

Interviews took place during the global Covid-19 pandemic and lockdown in 2021. The interview questions did not include a specific question about the impact of the pandemic, and ethical approval predated the pandemic, but this came through in the findings.

The practitioners reacted to the physical absence of the under-fives clinicians in the centre imposed by the government lockdowns. It seemed to put the practitioners starkly in touch with a sense of loss and unmet need, which was projected onto the under-fives clinicians. Much of the Under-fives Service work was unseen by the children's centres practitioners and the service continued to operate from the clinic or remotely throughout lockdowns, but for some this triggered anxieties – without the containing presence they felt perhaps unheld and resorted to more primitive states of mind.

Chapter 6: Conclusions

In this chapter I will reflect on what has been learned from the study and discuss key findings. Future research will also be considered from the findings. I will make some recommendations for the future development of under-fives work in children's centres.

The research conveys that there remains some ambivalence and disbelief of infant mental difficulties, which concurs with McFadyen's work (2021). Participants conveyed a sense of uncertainty and lack of understanding of infant mental health, worrying about offending families related to the endemic societal stigma of mental health. This research found practitioners were unsure about how to recognise mental health difficulties in children, which could lead to difficulties being missed and children not receiving the appropriate support. These elements interconnect and have a knock-on effect, compounding a societal reluctance to acknowledge the mental health needs of young children with continued parent-focused practice. This adult-focused practice loses sight of the child (McFadyen, 2021).

Whilst the findings suggest practitioners have gained knowledge in infant mental health, there remains insufficient knowledge about the impact of parental disturbance on the developing parent–child relationship and a lack of confidence in identifying parent–child difficulties. It raises the question about providing training in infant mental health, particularly the importance of an understanding of the quality of the early relationship in the development of emotional wellbeing. These research findings are in keeping with findings

from the Solihull Approach (Douglas & Brennan, 2004) that there is insufficient focus on the relationship in training or support for practitioners to integrate working with parents and their children.

Psychotherapeutic training and insight into unconscious processes, group processes, individual and institutional defences, and the use of observation helped to withstand and tolerate some of the projections from some of the children's centre practitioners without under-fives clinicians retaliating or resorting to an unhelpful who's to blame culture. It helped to focus on the meanings of the behaviours and to try to understand them. Perseverance and a thick skin are needed along with ordinary, non-jargonistic conversations with staff that simply names feelings and help to pave the way to acceptance of the new ways of working.

Further investment is required to meet the need in the centres, as well as expansion of the Under-fives Service into other children's centres to address the inequalities. Since the launch of the Under-fives Service, some of the centres have transitioned into Family Hubs; with different commissioning bodies there is an increased trend to outsource activities, such as the universal stay and play activity groups and only two of the centres now host universal groups. This is a worrying trend and risks missing those very early difficulties that can be spotted by experienced children's centre practitioners in the universal group

There is a general denial amongst the practitioners of their own need to digest feelings and have their emotional needs cared for. This may mirror general neglect of infant mental health difficulties and the position of children's centre practitioners who feel there is an early years workforce hierarchy in which practitioners' views and voices are often neglected, neither sought or valued, and reflects how parental voices can drown out children's communications. The downplaying of practitioners' own emotional needs can also lead to distancing behaviours. Anxieties are displayed through the practitioners' constant physical activity and talking as a way to deny need and to 'hold' (Bick, 1968) themselves together in the absence of psychological holding.

6.1 Key findings

Children's centre practitioners in the frontline absorb worries and anxieties from parents without routinely having a place to think about the impact on their emotions and behaviour. They can get filled up, entangled and preoccupied with parental difficulties, leaving them overly focused on parents and at risk of overlooking children's emotional needs. Practitioners are fearful of parental reprisals and in response they mobilise distancing behaviours as a defence against this anxiety (Menzies-Lyth, 1959), unconsciously denying or overlooking children's emotional needs and resulting in a tendency to pathologise children when it may be the parents who have the difficulties. Supportive reflective time is needed to keep in mind and see children's behaviours in the context of their families and that behaviours can be an adaptation to cope with parental/family difficulties. This is connected to a lack of awareness, training and a societal denial of the impact of parental difficulties

on children’s development and the parent–child relationship. This can lead to an over emphasis on changing children’s behaviour to alleviate parental distress, or a developmental focus and an absence of thinking about the emotional needs or alternative meaning of children’s behaviour.

Working alongside the practitioners, being visible and discussing observations and ideas is a more palatable way for practitioners to overcome possible obstacles and begin to hear, see and take in some of the clinicians’ ideas, generating a working alliance. These ideas began to take shape in the minds of the practitioners as they observed the clinicians’ ‘funny ideas’ in action with the families and their observations making sense. The clinicians levelled out any negative pre-judgements and expectations of superiority by having ordinary conversations about children and families and taking an interest in and valuing the practitioners’ thoughts and feelings. The practitioners’ attitude changed and invited the clinicians’ thoughts rather than resist them. The value of reflective time became evident as the practitioners, who contain so much for the families, engaged with and experienced the reflective time as a space for them to think and feel thought about.

The practitioners in this study found this new way of observing children – using psychoanalytic observation skills and reflective thinking – illuminating. Applying these new skills allowed practitioners to discover their value for a focus on children’s experiences and their relationships. They have adapted their practice to integrate these new ways of working, which has enabled them to be more mindful of children’s emotional states and more child-focused, discovering new

meanings and understanding of difficulties. The practitioners are less directive and try to help parents be more curious and receptive to their child's communications.

Children's centres practitioners are highly dedicated and valued and trusted by families. They provide a crucial link to those families who are very suspicious of CAMHS. Despite practitioners' lingering reservations, their warmth and acceptance of the Under-fives Service filtered through to the families, who accepted and responded to the clinicians' presence. Difficult to engage, highly suspicious families engaged with the clinicians, and some entered into parent–child psychotherapy. With parents reporting relief of difficulties and better relationships, it convinced those still in doubt of the benefits of the Under-fives Service in the centres.

The overall findings reveal that many aspects of the Under-fives Service are greatly valued by the children's centres and is a success. The staff came to value the presence, psychoanalytic thinking and the clinicians' interest in the practitioners. The Under-fives Service represents a place where emotions, practitioners, parents and young children can be thought about, and thinking is in the service of understanding and creating meaning, which is helpful and satisfying for the practitioners. The research suggests that in this model of service delivery the application of psychoanalytic thinking can be helpful to children's centre practitioners.

Problems in the way the service was set up highlighted useful learning for future service development. The importance of more openness and transparency regarding aims, objectives, expectations of staff during the planning phase of a service was essential to ensure that all staff feel consulted and to give a voice to frontline staff.

6.2 Limitation and strengths of the research

Given its small sample and qualitative approach, the findings of this study are not generalisable.

Another possible limitation is my role as clinician and researcher. I have been in the service since it launched and have worked alongside the participants, some of them very closely. This may have influenced what the participants said, perhaps leading to more positive feedback or avoidance of negative comments. Alternatively, my established relationship may have engendered more trust and enabled more honest opinions.

Another potential biasing factor is that it is possible that the practitioners who volunteered to be interviewed may have had a better relationship with or experience of the service than those who did not volunteer.

The Under-fives Service is embedded within children's centres and the data from this study offer a unique perspective on the views of practitioners who now have extensive experience of working with under-fives clinicians. The under-

fives clinicians' 'expertise' is borne out of a long training and experience to be able to recognise signs of infant distress. The research captures the impact of cross-fertilisation of knowledge, the changes in the practitioners' awareness of infant mental health difficulties, and their developing knowledge of parent–infant difficulties. It captures the value of joint-working and the usefulness of psychoanalytic thinking and skills for practitioner development in order to contain their anxieties and its important contribution to the development of child-centred practice.

The data provide rich insight into the intense and complex pressures affecting practitioners in children's centre. The study gives a voice to the practitioners, a group that typically do not have the opportunity to share their views in research studies. The research has provided invaluable insight into how an Under-fives Service can best function in and be established in new centres.

Another strength of this project is that it links with the current policy agenda of government, promoting the importance of early intervention and the NHS plan to offer community-based services to families. As the government has made further investment in early intervention, funding the development of Family Hubs in 2021, this research could be helpful to those planning to develop multi-agency services within a family hub (Campbell, 2021).

6.3 Recommendations for service delivery and practice

This research suggests a need for, and the value of, a space for practitioners to discuss their work, observations and emotional responses in order to continue to develop their reflective capacities. Statutory organisations and CAMHS tend to repel the most chaotic complex difficult families, those most in need of social care or mental health input to support parents in their parenting and ensure children grow up in an environment that not only meets their physical but also their emotional and psychological needs. These most deprived and at-risk families and children occupy the universal groups in the children's centres. Practitioners are expected to undertake this demanding work and should receive the appropriate recognition, status and ongoing training. They also need sufficient emotional support to ensure they do not become too overwhelmed by parental need or intimation. Both can lead to defensive coping strategies, such as distancing from emotional contact with children, which risks losing sight of a child's needs and resorting to parent-focused practice. Children's centre staff need to be supported to keep children at the centre of their practice.

Collaboration should start before introducing a service into another organisation. When planning and implementing a community service to undertake a piece of work prior to the implementation with all staff, it is important to be explicit and transparent with all the staff in the centres about the reasons behind a proposed new service, the aims and the goals of the service and explore setting joint goals to avoid misinterpretation and conflict of goals in order to develop collaboration and a commitment to joint working.

The study suggests that greater recognition among practitioners of factors that can interfere with the capacity to see the child was an outcome of the Under-fives Service. The perils of failing to see the child are well documented. This research suggests that those in the frontline need and can make use of co-working, reflection and consultation to assist in recognising the impact of parental difficulties and recognising infant mental health problems.

Under-fives clinicians need to continue to have a consistent presence in children's centres, to keep a visible profile and not to return to being out of sight, behind a closed door. We need to have the time to stand around, be visible to both the families and practitioners and to convey that we have time available for them. This is very challenging as universal groups shrink, referrals to our service increase and clinicians are over-stretched; further investment and support is needed to return to and sustain the quality of the pre-pandemic service so valued and evidenced in this research.

The conclusions I have drawn about the practitioners' experience of the service could contribute to the planning of other projects and to sharing the learning of the particular issues facing child psychotherapists when working in an outreach setting, such as a children's centre.

6.4 Recommendations for training

Whilst the findings suggest practitioners have gained knowledge and skills, there remains insufficient knowledge of the impact of parental disturbance on the developing parent–child relationship and a lack of confidence in identifying parent–child difficulties. It raises questions about providing training in infant mental health, particularly the importance of an understanding of the quality of the early relationship in the development of emotional wellbeing – and about how this training can be most effectively provided.

6.5 Recommendations for future research

This research has focused on the practitioners' experience of the Under-fives Service. It does not capture the parents' voices in regard to the informal non-clinical outreach work, that is, the work with families who are not referred into CAMHS but receive input either in the universal group or those parents who consulted with the clinician. It would be interesting to undertake further research to capture the views of the parents who attend the centres who engaged in an intervention or those who had a consultation with the under-fives clinicians to compare findings.

Observation skills and reflective practice are both highlighted as useful in the development of child-focused practice and supporting practitioner's wellbeing. It would be helpful to undertake research focusing on a child psychotherapist's contribution to the development of child-focused practice through observation and reflective practice.

6.6 Dissemination of this research

I plan to present the findings of this study to all the staff, including the managers in all the centres, revisiting the original aims of the service and creating an opportunity to present the findings of this research. The aim is to bring to the attention of the managers the usefulness of psychoanalytically informed observation skills and a space to think, a reflective time, in the development of child-centred practice as well as benefitting the practitioners' wellbeing.

I also aim to present commissioners with a synopsis of the salient findings of the research in order to raise awareness of the complexity of early intervention and the need for further investment in the Under-fives Service. For wider dissemination I am also interested in publishing the research in a peer reviewed psychotherapy journal and early years journals and to present the study at an appropriate conference.

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Appendices

Appendix A - Ethical Approval

27th August 2020

Dear Julie,

Project Title:	**An evaluation of a newly established psychoanalytically informed under 5S service in 4 children's centres**
Principal Investigator:	**Dr Jenifer Wakelyn**
Researcher:	**Julie Bithell**
Reference Number:	**URES 2021 01**

I am writing to confirm the outcome of your application to the University Research Ethics Subcommittee (URES), which was considered by URES on **Thursday 17th August 2020.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to URES. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents: http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to-Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to URES.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Microsoft Teams	Dr Jenifer Wakelyn

University of East London

Pioneering Futures Since 1898

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
URES application form	2.0	24 August 2020
Participant Information sheet	2.0	24 August 2020
Consent form	2.0	24 August 2020
Annexe 3 – Interview questions	1.0	24 August 2020
Gatekeeper letter from	1.0	24 August 2020
Gatekeeper letter from	1.0	24 August 2020
Gatekeeper letter from	1.0	24 August 2020
Gatekeeper letter from	1.0	24 August 2020

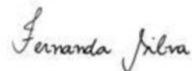
Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

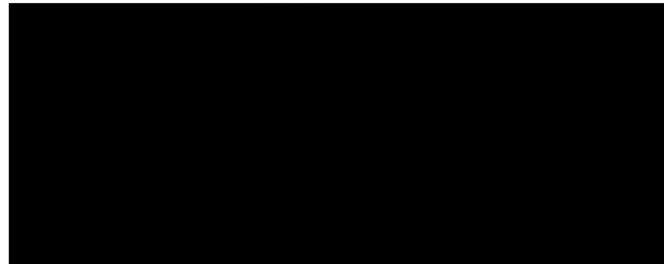
With the Committee's best wishes for the success of this project.

Yours sincerely,



Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Subcommittee (URES)
Email: **researchethics@uel.ac.uk**

Appendix B - Permissions



Friday 10th July 2020

To: Julie Bithell

Dear Julie,

As requested, I write to confirm that [redacted] and I, Senior Leadership Team at [redacted] Childhood Centre, give you, Julie Bithell, permission to interview [redacted] staff for the purpose of your research project which is entitled: An evaluation of a newly established psychoanalytically informed Under 5s Service in 4 Children's Centres. Thank you.

Yours sincerely,

Letter from [redacted]:

10th July 2020

To whom it may concern:

I am happy to give permission for Julie Bithell to interview children's centre staff who work at [redacted] for the purpose of her research project which is entitled: An evaluation of a newly established psychoanalytically informed Under 5s Service in 4 Children's Centres
Should anyone require further information please do not hesitate to contact me
Best wishes

Manager

From: >
Sent: 10 July 2020 15:59
To: BITHELL, Julie
Subject: Consent

Dear Julie,

Please see consent below:

I, Serita Kwofie, give permission for Julie Bithell; Child & Adolescent Psychotherapist in the CAMHS Under 5s Team, to interview children's centre staff who work at Cheyne Children's Centre & Holmfield House Children’s Centre for the purpose of her research project which is entitled: An evaluation of a newly established psychoanalytically informed Under 5s Service in 4 Children's Centres

Kind regards,

Our Values:

Appendix C - Information sheets for participants and consent form

University of East London

Research Integrity

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.

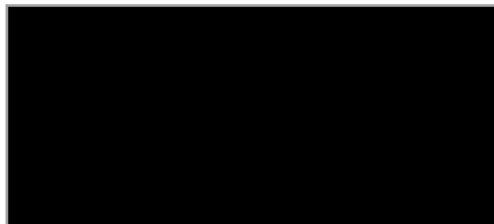
The University is committed to preserving your dignity, rights, safety and well-being and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

The Principal Investigator/Director of Studies

Jenifer Wakelyn
The Tavistock and Portman NHS Foundation Trust.
120 Belsize Lane. London. NW3 5BA.
Tel: 020 7435 7111 Email JWakelyn@tavi-port.nhs.uk

Student researcher

Julie Bithell



Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

An evaluation of a newly established psychoanalytically informed under 5s service in 4 children's centres.

Project Description

Brief history to the project:

Children's Centres were consulted in 2016 regarding infant mental health provision in the borough. The Under 5s CAMHS Service was launched in 4 children's centres ([redacted]) in 2017 in response to identified gaps/unmet need in infant mental health.

Context of the research

I am a qualified child and adolescent psychotherapist and I am undertaking this research project as part of a Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy.

Why do the research?

The research purpose is to evaluate the service to ensure it is meeting unmet need and to make recommendations for service improvement. You have been invited to take part in this research study because you work in one of the children's centres and have worked with/ or consulted the Under 5s Service.

Aim/Goal of the research:

The goal of this research is to find out from talking to children's centre staff, who have consulted and/or worked with the Under 5s Service, what their experience has been of working together in this multi-disciplinary way of working. In this interview you will be asked some questions about your experiences of working with the Under 5s Service. The interview will last for about 45 mins, no longer than 60 minutes.

The research will hopefully benefit the people in the community because if more is known about what constitutes a successful intervention or successful piece of work, then we may be able to do more to help the families that we work with. It is also an opportunity to reflect on your work with the under 5 service and to help further development of the service. You will only have to attend one interview. If you become tired or decide you do not want to take part, or continue, you may tell the interviewer and the interview will stop immediately.

The information which follows tells you what will happen if you agree to take part.

The interview will be recorded and transcribed but all personal details will be kept confidential. For example, your name will not be mentioned. Only the researchers/interviewer will have access to the interview material.

What will be required of you?

To participate in 1 interview (a maximum of one hour) with me (Julie Bithell), which will be audio recorded and transcribed by me. In view of the Covid-19 pandemic and continued social distancing the interview will take place remotely via Microsoft Teams.

Will there be any risks involved?

The research questions only invite you to share your experiences of the Under 5s Service. I hope to provide a supportive, reflective space, but talking may stir up some emotions or be unsettling. At the end of the interview I will offer you time, if you require it, to talk about how you are feeling. I have also provided details of local

counselling service should you wish to talk with someone externally. *Talking Therapies - Community Living Well can be contacted online https://communitylivingwell.co.uk/organiser/talking-therapies or Tel: 020 3317 4200.*

The views you share of you experience of the Under 5s Service will not impact on your continuing relationship with the Service. Every effort will be made to ensure that names and details are changed so you are unidentifiable. Due to the small sample size of 12 participants there is a risk that anonymity for staff is harder to preserve.

Confidentiality of the Data

What will happen to the information I give?

Due to the small sample size of 12 participants there is a risk that anonymity for staff is harder to preserve, however, every effort will be made to ensure that names and details are changed so staff are unidentifiable. Notes will be kept in a locked cabinet and any electronic data will be password protected.

The transcript of the interviews will be anonymised. Any personal details which could identify you will be removed from the transcript. Any extracts from what you say in the interviews that are quoted in published research will be anonymized. I will store information I receive from you during the interviews securely and in keeping with the Data Protection Act 2018.

All information that you share during the interview will be kept confidential where possible, unless you report feeling unsafe, such as having thoughts of harming yourself or someone else. I will share this inform[redacted] [redacted]s, Under 5s Lead, so that together we offer you help, agree upon a safety plan and contact the relevant authority.

I will also breach confidentiality if you share information which may indicate a child is at risk of being harmed or has been harmed. I will advise you to discuss with your manager and consider children's safeguarding procedures. If this is not safe I will help you to identify the appropriate person and facilitate a meeting. I will also discuss with the Under 5s Lead and notify the relevant authority.

What will happen to the results of the project?

The results will be published in academic papers and included in academic presentations. You can request to receive a summary of the results.

The data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

Location

In view of the Covid-19 pandemic and continued social distancing the interview will take place remotely via Microsoft Teams.

Disclaimer

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn up to the point of data analysis – after this point it may not be possible.

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet

Other information

UEL and The Tavistock and Portman NHS Trust are the sponsors of the research.

The research has received formal ethical approval from University of East London Research Ethics Sub-Committee (URES)

Data collected will be in accordance with the university's data policy.

University Research Ethics Sub-Committee

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Hitchens, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

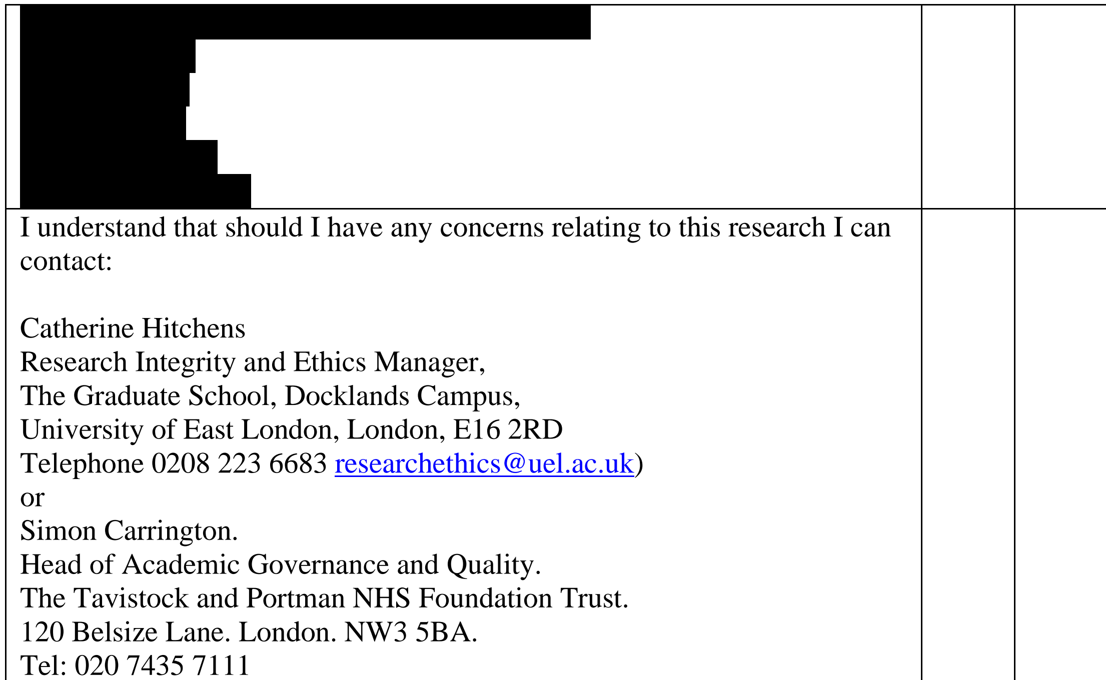
Title of Project: An evaluation of a newly established psychoanalytically informed under 5s service in 4 children's centres.

.

Name of researcher: Julie Bithell

Please tick as appropriate:

	YES	NO
I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I confirm that I understand that there is one interview and this will be audio recorded and then transcribed and analysed for the purposes of this research.		
I confirm that I understand that information I provide regarding my personal views of the under 5s service will be analysed for the purposes of the research.		
I understand that any identifiable information linked to my participation in the research will be anonymized and held securely by the researcher.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data.		
I understand views shared of my experience of the Under 5s Service will not have a detrimental impact on my continuing relationship with the Under 5s Service and that every effort will be made to ensure that comments will be anonymized.		
I understand that maintaining strict confidentiality is subject to the following limitation: Due to the small sample of size of 12 participants there is a risk that anonymity and confidentiality for staff is harder to preserve. Every effort will be made to ensure that details are changed and staff are unidentifiable.		
I understand where possible confidentiality will be maintained unless a disclosure is made that indicates that I or someone else is at serious risk of harm. Such disclosures [redacted] Jones (Under 5s Lead) and may be reported to the relevant authority		
I understand that information I provide may be used in published academic papers and in academic presentations as anonymized quotations.		
It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		
I understand that I may contact the researcher, Julie Bithell email: U0740268@uel.ac.uk Tel: 020 3317 3599, if I require further information about the research.		
I understand that should I have any concerns relating to the Under 5s Service I can contact: [redacted]		



[redacted]		
I understand that should I have any concerns relating to this research I can contact: Catherine Hitchens Research Integrity and Ethics Manager, The Graduate School, Docklands Campus, University of East London, London, E16 2RD Telephone 0208 223 6683 researchethics@uel.ac.uk) or Simon Carrington. Head of Academic Governance and Quality. The Tavistock and Portman NHS Foundation Trust. 120 Belsize Lane. London. NW3 5BA. Tel: 020 7435 7111		

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Investigator's Name (BLOCK CAPITALS)

……………………………………………………………………..

Investigator's Signature

………………………………………………………………………………………

Date: ………………………….

Appendix D - Interview questions

Semi - Structured Questionnaire

1. Which Children's Centre do you work in? How long have you worked in the children's centre? Did you work in the children's centre before the Under 5s service was launched?

2. Can you tell me a little bit about your role in the children's centre? *(Prompt: Perhaps if we could start with you telling me something about the work that you do in the children's centre)*

3. Can you tell me about your experiences of working with the Under 5s Service? (*Prompt How did you access the Under 5s Service? Did you find it easy to access the service? Can you tell me what it was like? What form of support was offered? Did you find it helpful? Was it not convenient for you?)*

4. Can you give me an example of a piece of work/ consultation that went well with the Under 5s Service….(Prompt *Perhaps you could tell me about a piece of work that you particularly enjoyed or felt happy that the Under 5s Service provided? Further prompts might include, a particular family where you felt things improved*? *Did it meet expectations?)*

5. Can you tell me about another experience you did not find helpful? *(Prompts: was it something about the Under 5s service? Why do you think it didn't go well? What could have made the experience better?)*

6. Do you understand anything different about infant or young child mental health? (*Prompt: has anything changed for you perhaps regarding young children's emotional wellbeing*?)

7. Did you feel a particular approach was taken by the person you worked with from the Under 5s service? (Prompt: *Can you say something about this type of approach taken, the types of ideas that was put forward?*

8. What do you feel would be the important things for the researcher to hear about your views about the Under 5s Service? Do you have any thoughts about the future development of this provision or the needs of the Children's Centre staff from the Under 5s Service

Appendix E - Sample transcription with initial coding

<table>
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<td>

Question 1 - Which CC do you work in, did you work in we worked in the centre did you work in the centre before then the first service was launched?

Join the service in ██████ did not work in the children's centre ██████ of the Under-fives launched. Work in ███

Question 2 – Role in CC

██████ we are first tier of early help we are split into targeted early help in our service we are the earliest point of support for families with children and families ██████

Question 3 - Experience of working U5s service

I've had really good experience of the Under-fives Service in the ████ - initially the first person I met was based in the children's centre drop -in/ stay n play session, █.
The drop-in session is led by the early years practitioner in the *stay and play session/drop-in session* and that was really interesting. I remember when I first started speaking to a couple of families who were there in the actual play session and they were really appreciative of having a specialist CAMHS person in the play session… because they felt it was less daunting to talk about some of the issues that had arisen for some of the children that were there and I remember once I started working with some of the families it was a lovely way to introduce them to CAMHS, just the word CAMHS is a little bit scary some families don't know what it is and the ones that do are a little bit daunted CAMHS for all sorts of reasons, but to be able to tiptoe into the service in a comfortable and familiar setting I think is absolutely invaluable I think that's the most powerful thing about it for me that I found about the service.

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families who were there in the actual play session and they were really appreciative of having a specialist CAMHS person in the play session

they felt it was less daunting to talk about some of the issues that had arisen for some of the children

it was a lovely way to introduce them to CAMHS

to be able to tiptoe into the service in a comfortable and familiar setting I think is absolutely invaluable I

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Then I word with another practitioner during lockdown which has been a challenge for everybody, but what I found about this part of the service the professional consultations have been really useful just to be able to share some thinking, to be able to discuss the case quite thoroughly methodically and all those words urmm It's really helped my own practice, it's really helped with my own thinking particularly for questioning – this particular practitioner was really good at questioning me which is really lovely a lovely challenge for me, in a really nonthreatening way it was really a felt like a collaborative process, she was able to pose questions for me it brought on broadened my thinking it made me a little bit more empathetic sometimes with some of the cases I was committed to. I ██████ and all of them very different, one of the cases was really challenging and it felt a bit stuck to me but it was really good to work through because the it's challenging because - the parents do not have hearing communication was a key issue was it did help me do was I've got a better understanding of the service and the workings of a psychotherapist she was able to help me prepare the family for her intervention, having established it was an appropriate case for her to work with she was able to prepare me to prepare the family because when I first started referring the family I had a very different outlook on what was possible and what they thought the intervention would look like how much it would be so it was a case of managing their expectations, I'm not sure if we got there but by the process of doing it helped me understand more about how a psychotherapist was going to work, ██████ ██████ it was a good fit the family had assumed that (name) would give him a tablet and magically five weeks later the child would be better so that it was a really good process and its been really easy to access, communication is wonderful & I feel like I can call at any time its been really helpful despite the lockdown the pandemic. I think what was really good ██████ was very good clear parameters about what the service could and couldn't do and which kinda managed my expectations awell which was useful. Coz sometimes when I work with the schools they just wanna throw CAMHS at everything as soon as soon as a child is not fitting the box sometimes they say refer to CAMHS refer to CAMHS	think that's the most powerful thing professional consultations have been really useful to be able to discuss the case quite thoroughly methodically It's really helped my own practice, it's really helped with my own thinking particularly for questioning really good at questioning me a lovely challenge for me, in a really nonthreatening way it was really a felt like a collaborative process, she was able to pose questions for me it brought on broadened my thinking it made me a little bit more empathetic sometimes with some of the cases it did help me do was I've got a better understanding of the service and the workings of a psychotherapist

as just having the conversations now I feel better able to perhaps to yep just to be able to signpost when I need to but just but just be able to manage the case more appropriately, I've had a really good experience. Very different and the [redacted] was very hands-on in the drop-in session and the second person name was much more thinking I'm not sure how hands-on she would've been as we went into a lockdown. [redacted] [redacted] the particularly the questioning it was really good that was the question the circle the reflection of questioning shone through and it helped me to think better – that's not to say that [redacted] didn't but the setting felt different it was different. Because [redacted] it's a good fit for service. Something about the thinking that is containing. Because [redacted] it's a good fitness impressed and we're allowed to have time to think we are given the time and space to think to do that kind of thinking– I feel it is embedded in the team.	she was able to help me prepare the family for her intervention it helped me understand more about how a psychotherapist was going to work, its been really easy to access, communication is wonderful & I feel like I can call at any time its been really helpful despite the lockdown the pandemic. what was really good she gave was very good clear parameters about what the service could and couldn't do and which kinda managed my expectations awell which was useful now I feel better able to perhaps to yep just to be able to signpost when I need to but just but just be able to manage the case more appropriately, I've had a really good experience.

Question 4 - Can you give an example of a piece of work or consultation that went well (15.33)	
Well there are two – there's been challenges with this particular case there have been challenges and in terms of the thresholds it's up hence part of the. Reason I went to U5s practitioner to have a discussion about it his family where the parents are both deaf, their challenges where they were finding it really hard to manage her behaviour, they said they were at their wits end and that they said she was out of control, she doesn't listen or respond to them and they had run out of ideas and stuff to manage. I'd already had a TAF for the nursery where she was you know unfortunately the family often looked sort of externally for the reasons, they looked to illness, conditions they looked to interaction with peers as a cause for the behaviour but once we had done the TAF the child presented very differently in the nursery most of things with parents talked about the child at home didn't happen in the nursery so things like they said she is a fussy eater and she can't concentrate for long periods of time that has outbursts and meltdowns and I have done a lot of TAF's they were so far apart so starkly far apart many ways and the only time that the nursery saw a change in her behaviour was when a picked her up and drop her off and usually a pick up time she became quite distressed and her behaviour became quite erratic and nothing like they recognised and so this kind of shaped my piece of work and work had to start yeah I knew it was in the family they wanted me to have one-to-one sessions with the child to fix her and I did do a couple of sessions with on my own with a child and I realised I'd need some more professional input and I think I having U5s you know you hesitate to refer to CAMHs u5s I don't know about you as a professional you really do hesitate and you do try almost absolutely everything before thinking it might be whatever.. but the two play sessions I had with her she responded really well she was only 3 ½ at the time maybe three not four and her language was age-appropriate, she did all the play things it expected to do she was quite warm and then I went to the family setting and I saw some of the behaviours that the parents were talking about and were challenged with and I knew at that point I had to speak to U5s about it. Under-fives helped me with a thinking it again I processed again I did one more session but I had a session with a parents	particularly the questioning it was really good that was the question the circle the reflection of questioning shone through and it helped me to think better Something about the thinking that is containing I feel it is embedded in the team. Under-fives helped me with a thinking it again I processed again I they were finding it really hard to manage her behaviour, they said they were at their wits end and that they said she was out of control presented very differently in the nursery

and what came through was the parents anger verging on anger and distress I knew I had to work on their relationship as well but I think was able to position things for me she kind of joined up lots of things so I firmly start to put myself in the shoes of the child and perceived the world as her home world, her Homelife through gthe eyes of that child. I know I work in children services you're meant to do that all the time but but it really did it was a lightbulb moment that this child is seeing the world very differently to her peers in the nursery and that her parents don't communicate in the same way with her, yeah I did lots of reading it prompted me to do reading about coders just to understand how they might communicate differently etc so it was really useful piece of work and in fact we haven't finished yet. It took a journey to get this kind of support so we decided is working with them now and stepped back and to the piece of work is picking them up afterwards again for ongoing support that I would not of managed this case as well without U5s. was quite fastidious about seeing the behaviour and the world from the view of the child and I felt I had got quite lost in of the parents my attention had been drawn to the difficulties of the parents they felt invisible in society and not listened too and I was on board with the plight as it was and maybe I had lost if I'm honest I had lost the child a little bit but U5s dragged me back. That resonates with me she didn't make me feel that way should make me feel tired and I think that it was very professional I had been consumed by the case and had gone down a rabbit hole and I didn't see any way out. was with them and he was with them because of the sensory loss and their experiences of society day they were bullish they know their rights and they wanted instant glory and if you don't provide that they move onto the next professional and the next practitioner and that's been a challenge and continues to be a challenge but I feel a little bit more grounded to deal with it now having had that professional relationship with U5s I feel more robust in dealing with it.	Under-fives helped me with a thinking it again I processed again I think was able to position things for me she kind of joined up lots of things so I firmly start to put myself in the shoes of the child and perceived the world as her home world, her Homelife through the eyes of that child quite fastidious about seeing

You know you do doubt yourself particularly if you've been with the family for a little while yourself sometimes even your thinking is it's not appropriate just having that other person to talk it through and there was some bits that were reassuring she was I found I was on the right track from talking it through with the Under-fives worker. Get beneath the belly of it this family have a lot of services difficulty in the parent child relationship and help in that, this family have a lot of services on board and part of the reason of having a go at the service to coordinate the team very difficult to coordinate the team because parents are professionals they curtailed professionals special therapist may move the child setting with the child from the nursery and they've had another baby during lockdown. They have a new baby now. **Question 5 - Case you didn't find so helpful (34 minutes)** The mum decided not to engage in the different case following a consultation but it was nothing to do with the service. The nursery had contacted me to say they were worried about their concerns about his presentation they were concerned that he played alongside children but not with them they were also concerned that he could be aggressive sometimes played independently they were concerned he was often absent from the setting he was only 15 hours absent from the setting I've got organised for the family to come to the play session at [redacted] and in that session he played quite well in the setting & what's the feedback from [redacted] and the mum went back to the nursery and kind of fed back and maybe a little bit of splitting maybe it needed another session or maybe a consultation to the nursery would've been helpful? I didn't quite work because the child did go on to have other issues and has gone on to be diagnosed [redacted] wasn't a panic that was in there, mum was quote spooked [redacted]. This was kind of my first time getting a referral for under fives and as I wasn't fully cognitive about what the under five service offered if it happened now I would dealing with it completely differently I would've done the preparation it's easily done a piece of just with the parents as I think I anxiety levels are through the roof for various reasons I was consumed with	the behaviour and the world from the view of the child and I felt I had got quite lost in the deafness of the parents I had lost if I'm honest I had lost the child a little bit but U5s dragged me back. I think that it was very professional I had been consumed by the case and had gone down a rabbit hole and I didn't see any way out. I feel a little bit more grounded to deal with it now having had that professional relationship with U5s I feel more robust in dealing with it. reassuring she was I found I was on the right track from talking it through with the Under-fives worker.

parents again and the parents had high levels of anxiety experience of being displaced and domestic abuse. I've done the preparation for the parents I could've easily done a piece of work with just the parents because her anxiety levels were through the roof for various reasons so many things going on for her I was concerned with the parent I would've had a different approach (39mins) Having U5s in our team meeting she is more aware of with all the other services and knows the services around iit helps all our thinking – iI say ts integrated working on the ground. **Question 6 - Do you understand anything differently about infant mental health?** Urmm he biggest difference is what I've said already said **the lived experience of the child is paramount all the relationships they have all the form have an impact** whether an hour a week or it's kind of what was said before it's honed what I already knew that **there is definitely a shift in my thinking and it's embedded and bolstered things** **I feel more robust because sometimes when you do similar work with families and talk about behaviour as communication sometimes to the families it can feel rather airy fairy but practically it's kind of giving me the confidence to continue and the confidence to tackle those pieces of work** because sometimes as navigators we get seen as very practical fixes not necessarily the thinking space and we link them to the service and we get things done what it's done for me yes **it's kind of drawn me back to the part of the work that I quite like which is the relationship bit** which is why I do it rather than other fixer, get me this get me a new house I need this where as **Feeling able to slow it down.** Some families have really thrived during lockdown and we need to really champion that we need to and we need to unpick what was it, I realise I like my family has people. Noticing and empowering parents given them it's the skills.	and the mum went back to the nursery and kind of fed back and maybe a little bit of splitting maybe it needed another session or maybe a consultation to the nursery would've been helpful? I didn't quite work because the child did go on to have other issues and has gone on to be there wasn't a panic that was in there, mum was quote spooked by **the lived experience of the child is paramount all the relationships**

	they have all the form have an impact there is definitely a shift in my thinking and it's embedded and bolstered things
Question 7 - Did you feel that a particular approach was taken by the person U5s service U5s were **quite forensic quite systematic structured I didn't feel like it was just to chat it felt like there was a process to go through and we did a process getting to know the detail** I'm not sure their approaches are similar it felt & I felt supported , **it was structured we set aside time and they were clear about the boundaries parameters about the work what they could do what was possible**. We are kept in the loop after making a referral and it did **feel like a team effort because the Under-fives practitioner was very keen to know what had gone before, iwhat may have brought things about, it felt like a team effort**	I feel more robust because sometimes when you do similar work with families and talk about behaviour as communication sometimes to the families it can feel rather airy fairy but practically it's kind of giving me the confidence to continue and the confidence to tackle those pieces of work it's kind of drawn me back to the part of the work that I quite like which is the relationship bit Feeling able to slow it down.
Question 8 - What do you feel it be important for researcher to hear? **It's got to stay - it's been invaluable to me it really has been invaluable it's kind of that bit in the jigsaw in the ██████ that was missing possibly there's nothing like else like you in the hub, the access to you is invaluable .....**	Consultations - quite forensic quite systematic structured I didn't feel like it was just to chat it felt like there was a process to go through and we did a process getting to know the detail

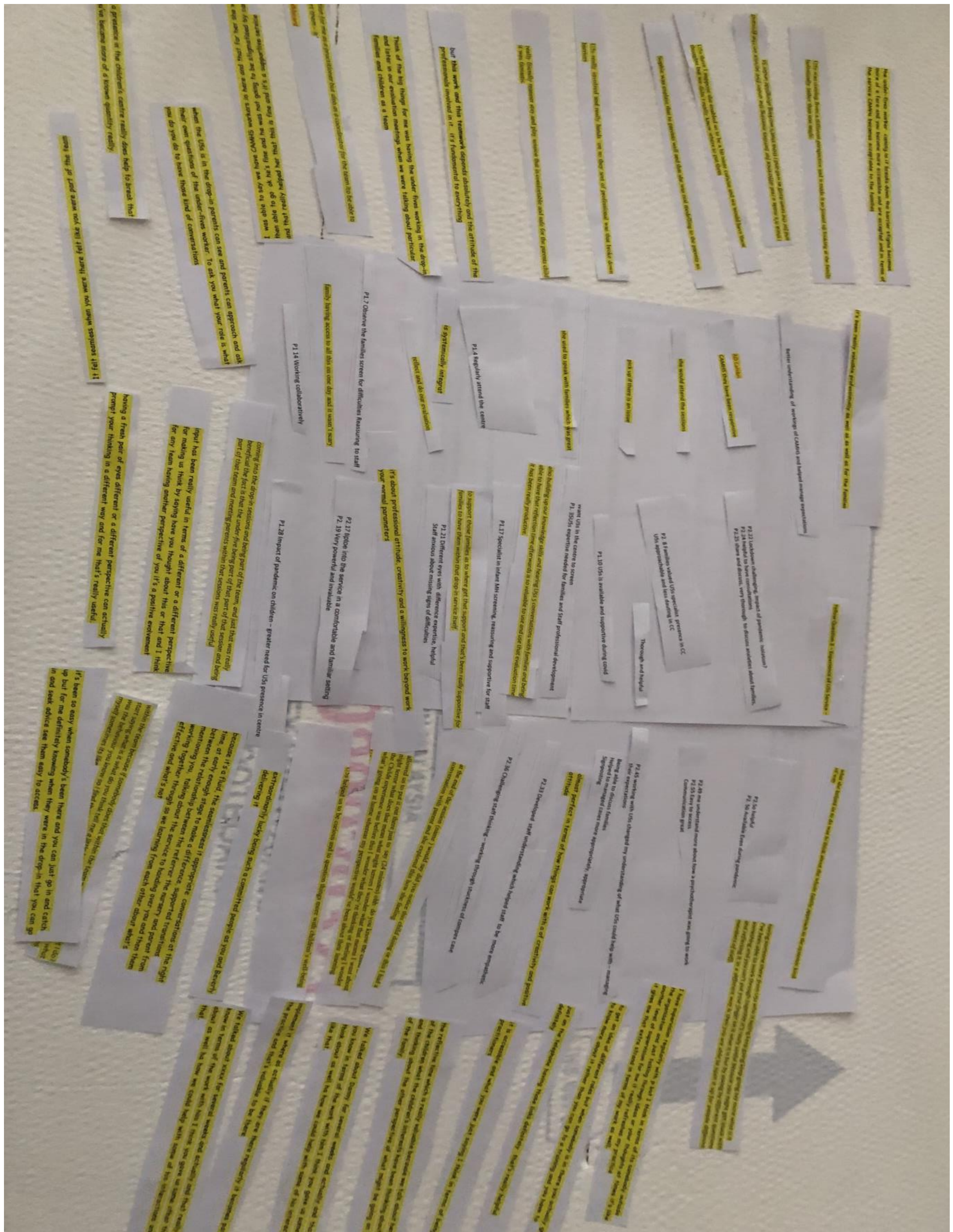
This is the view from other professionals CAMHS is this little oasis in the desert but there is a wall around it, there is a wall they know that everyone is overwhelmed but w**hen we say we have CAMHS U5s there was a little ooof a others are shocked that camhs are in** there & I think I was a bit like that but because now it's part of I don't take it for granted but **I appreciate the ease with which we can have these conversations and it's really been I have a better I have a better understanding though now and I have a better understanding of the ones that should go to CAMHS** possibly other ones possibly where we can do some work first or there is another organisation I can try alongside sometimes.	**it was structured we set aside time and they were clear about the boundaries parameters about the work what they could do what was possible** **Under-fives practitioner was very keen to know what had gone before, what may have brought things about,**
Urmm only positive I really like the fact that really the camhs are both available for families and professionals so you don't get that that hierarchy but you have to go through I like the fact **that families can speak to speak directly to Camhs and that's a game changer in my mind urrm mutual access – being based in centre having a space, I think you need designated space in the**	**It's got to stay - it's been invaluable to me it really has been invaluable it's kind of that bit in the jigsaw in that was missing possibly there's nothing like else like you in the , the access to you is invaluable …..**
	when we say we have CAMHS U5s there was a little ooof a others are shocked that camhs are in
I have a better understanding and I have found a better understanding of where things should go at the child's behaviour.	**I appreciate the ease with which we can have these conversations and it's really been I have a better I have a better understanding**

Only positive ones that should continue I really liked camhs is accessible to both families and professionals so you don't get that hierarchy that you have to go through I like the fact that the families can speak directly to CAMHS that's a game changer in my mind Mutual access based in the centre **having a space I think you need more space I think you need a designated space** and I know it's always difficult but I think families knowing that you are based there but there was a space just a practical Space designated space. It's just not feasible a conducive space would be helpful	**though now and I have a better understanding of the ones that should go to CAMHS** **Urmm only positive I really like the fact that really the camhs are both available for families and professionals so you don't get that that hierarchy** **that families can speak to speak directly to Camhs and that's a game changer in my mind urrm mutual access – being based in centre having a space, I think you need designated space in** ████ **I have a better understanding and I have found a better understanding of where things should go at the child's behaviour.** **having a space I think you need more space I think you need a designated space**

	Question 3 - Experience of working U5s service	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47	I've had really good experience of the Under-fives Service in the [redacted] - initially the first person I met was based in the [redacted] centre drop -in/ stay n play session, [redacted]. The drop-in session is led by the early years practitioner in the *stay and play session/drop-in session* and that was really interesting. I remember when I first started speaking to a couple of families who were there in the actual play session and they **were really appreciative of having a specialist CAMHS person in the play session…** because they felt it was less daunting to talk about some of the issues that had arisen for some of the children that were there and I remember once I started working with some of the families it was a lovely way to introduce them to CAMHS, just the word CAMHS is a little bit scary some families don't know what it is and the ones that do are a little bit daunted CAMHS for all sorts of reasons, but to be able to tiptoe into the service in a comfortable and familiar setting I think is absolutely invaluable I think that's the most powerful thing about it for me that I found about the service. Then I worked with another practitioner during lockdown which has been a challenge for everybody, but what I found about this part of the service the professional consultations have been really useful just to be able to share some thinking//, to be able to discuss the case quite thoroughly methodically and all those words urmm It's really helped my own practice, it's really helped with my own thinking particularly for questioning – this particular practitioner was really good at questioning me which is really lovely a lovely challenge for me, in a really nonthreatening way it was really a felt like a collaborative process, she was able to pose questions for me it brought on broadened my thinking it made me a little bit more empathetic sometimes with some of the cases I was committed to. I have had 3 consultations and all of them very different, one of the cases was really challenging and it felt a bit stuck to me but it was really good to work through because the it's challenging because - the parents do not have [redacted] [redacted] was a key issue was it did help me do was I've got a better	P2. 8 Families valued U5s specialist presence in CC U5s approachable and less dauting in CC P2.17 tiptoe into the service in a comfortable and familiar setting P2. 19 Very powerful and invaluable P2.22 Lockdown challenging, Impact of pandemic isolation? P2.24 helpful to have consultations P2.25 share and discuss, very thorough to discuss anxieties about families, Thorough and helpful P2.33 Developed staff understanding which helped staff to be more empathetic P2.36 Challenging staff thinking – working through stuckness of complex case

48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70	understanding of the service and the workings of a psychotherapist she was able to help me prepare the family for her intervention, having established it was an appropriate case for her to work with she was able to prepare me to prepare the family because when I first started referring the family I had a very different outlook on what was possible and what they thought the intervention would look like how much it would be so it was a case of managing their expectations, I'm not sure if we got there but by the process of doing it helped me understand more about how a psychotherapist was going to work, it fits in with our ██████ it was a good fit the family had assumed that (name) would give him a tablet and magically five weeks later the child would be better so that it was a really good process and its been really easy to access, communication is wonderful & I feel like I can call at any time its been really helpful despite the lockdown the pandemic. I think what was really good she gave was very good clear parameters about what the service could and couldn't do and which kinda managed my expectations awell which was useful. Coz sometimes when I work ██████ they just wanna throw CAMHS at everything as soon as soon as a child is not fitting the box sometimes they say refer to CAMHS refer to CAMHS as just having the conversations now I feel better able to perhaps to yep just to be able to signpost when I need to but just but just be able to manage the case more appropriately, I've had a really good experience.	P2.45 working with U5s changed my understanding of what U5s could help with – managing their expectations P2.49 me understand more about how a psychotherapist was going to work P2.55 Easy to access Communication great P2.So helpful P2. 56 Available Even during pandemic Better understanding of workings of CAMHS and helped manage expectations Being able to discuss families Helped to managed cases more appropriately, appropriate Signposting

Appendix F - Initial codes



Appendix G - Theme development

Question 4 Theme Development

Question 4 - Can you give me an example of a piece of work/ consultation that went well with the Under 5s Service….(Prompt *Perhaps you could tell me about a piece of work that you particularly enjoyed or felt happy that the Under 5s Service provided? Further prompts might include, a particular family where you felt things improved*? *Did it meet expectations?)*

Ease of access:
good to have ease of access and also specialist help – 1
support and reassurance, clarity for parents -1
It's really easy for me to pick up the phone or just email the Under-fives CAMHS practitioner -1
Knowing there is someone, so the do you have someone presence with a particular issue or problems so it's really easy to pick up your phone or to email a person -1
ease of access has been very helpful for you and U5s worker has been responsive, you liked it when they were in the children's centre because there is a cross-fertilisation of knowledge I think you said good for you good for your training and also good for the families
-1
I have observed I've been present in the session and they've been in the session where there has been some difficult behaviour or mum is concerned about emotionally and mentally. Ihave observed ██ step in and say they can offer an intervention 1

I was able to pick up the phone I was able to explain to parents what CAMHS Under-fives do and the benefits of doing this early on so then so then we focus on early intervention we were doing the screening early on so so we could say I've noticed this this and this would you mind having a conversation with mum - 3

if other practitioners had concerns we would straightaway say speak to U5s do the consultation so they were so valuable to us - 3

Drop in
U5s that in situ breaking down the barriers about mental health but - 3

mum was struggling with the two-year-old in terms the child's behaviour through night terrors - and U5s was there and she had observed the child U5s had a conversation with mum which led to a referral into the U5 service - 3

All my engagement has been really good within the first service - 6

Specialist knowledge

For families I think I think receiving the support and getting the support thinking about how parent/child is feeling - say if it's attachment or behaviour getting understanding why is the behaviour like that what's the meaning and also knowing what to do about it – 1

advice is helpful - 1

level of expertise your service represents in the centre – ██ 4

that level of expertise and containment - 4

talk a human being to people it's hard so lucky to have that level of practice - 4

Practitioner development

I feel a little bit more grounded to deal with it now having had that professional relationship with U5s I feel more robust in dealing with it - 2

Under-fives helped me with a thinking - 2

U5 was able to position things for me she kind of joined up lots of things so I firmly start to put myself in the shoes of the child and perceived the world as her home world, her Homelife through the eyes of that child -2

I was able to pick up the phone I was able to explain to parents what CAMHS Under-fives do and the benefits of doing this early on so then so then we focus on early intervention we were doing the screening early on so so we could say I've noticed this this and this would you mind having a conversation with mum – 3

we were equipped enough ourselves to screen ourselves so the days that U5s was not there the time - 3

U5s taught me a different way with in the team as a practitioner because then afterwards I have used different bits like I use it now as a tool in my thinking and with practice – 5

I do it in myself in my head what else do I need to know and it's urm yeah doublethink yourself – 5

Infant mental health

I had lost if I'm honest I had lost the child a little bit but U5s dragged me back - 2. reassuring she was I found I was on the right track from talking it through with the Under-fives worker -2

I think that it was very professional I had been consumed by the case and had gone down a rabbit hole and I didn't see any way out - 2

your insights and your observations of what was happening in their interactions when you were doing your sessions and how she would wanted him to be there on-screen and how she was responded to him - 6

Thinking

quite fastidious about seeing the behaviour and the world from the view of the child and I felt I had got quite lost in the deafness of the parents 2

what is concerning us about this family, what is this child trying to tell us through their behaviour and through their play – 5

It's so useful having that U5s coming in from a different angle and it's just that kind of almost like keep teasing , say more a different - 5

. I wanted to know more and I wanted it to continue. Teasing out that was so beneficial it was like getting me to answer my own question my own thoughts and to dig a little bit deeper and just for you to reflect on your own feelings and not give you an answer and that was such a positive side of it just a little bit more - 5

I want to know more I want to know more about this family what is it they trying to tell me nonverbally almost what is it we can how can we best support this child/family rather than going in and saying yes you can do this let's look at the C sleep routine let's look at the feeding routine let's - 5

you begin to think about other children as well that's a real positive when you start to begin to evaluate and plan better when other children are highlight - 5

Case consultations/reflections

they were finding it really hard to manage her behaviour, they said they were at their wits end and that they said she was out of control – 2

I would have a consultation with U5s and say what do you think it was so so helpful - 3

It was positive that we had that reflective time to being able to really think about a family – 5

that concentrated time to really reflect on the families or a particular child what are the worries but it was having that space and time to think – 5

reflective time and break that down and I think as practitioners some were at that stage and some weren't and it gave them the opportunity to have those and be part

of the discussions and then to become more aware of what children might be telling us through the play and behaviour -5

it was really interesting some of the different dynamics that came up I'm really valuable for than me - 6

Consultations is available for families it's really valuable. For me they happen in a seamless way I just come to talk to you about cases that we are working on together - 6

Pieces of work

Mother more attuned I noticed – 3

Your intervention and the integrated intervention of the centre opened this family up to the extent that this parent still phones me and update me - 4
The challenges that you identified – contained - 4
containment of anxiety
you create an atmosphere like that where things are contained - 4

you are part of our team so - 4

Support staff - 4

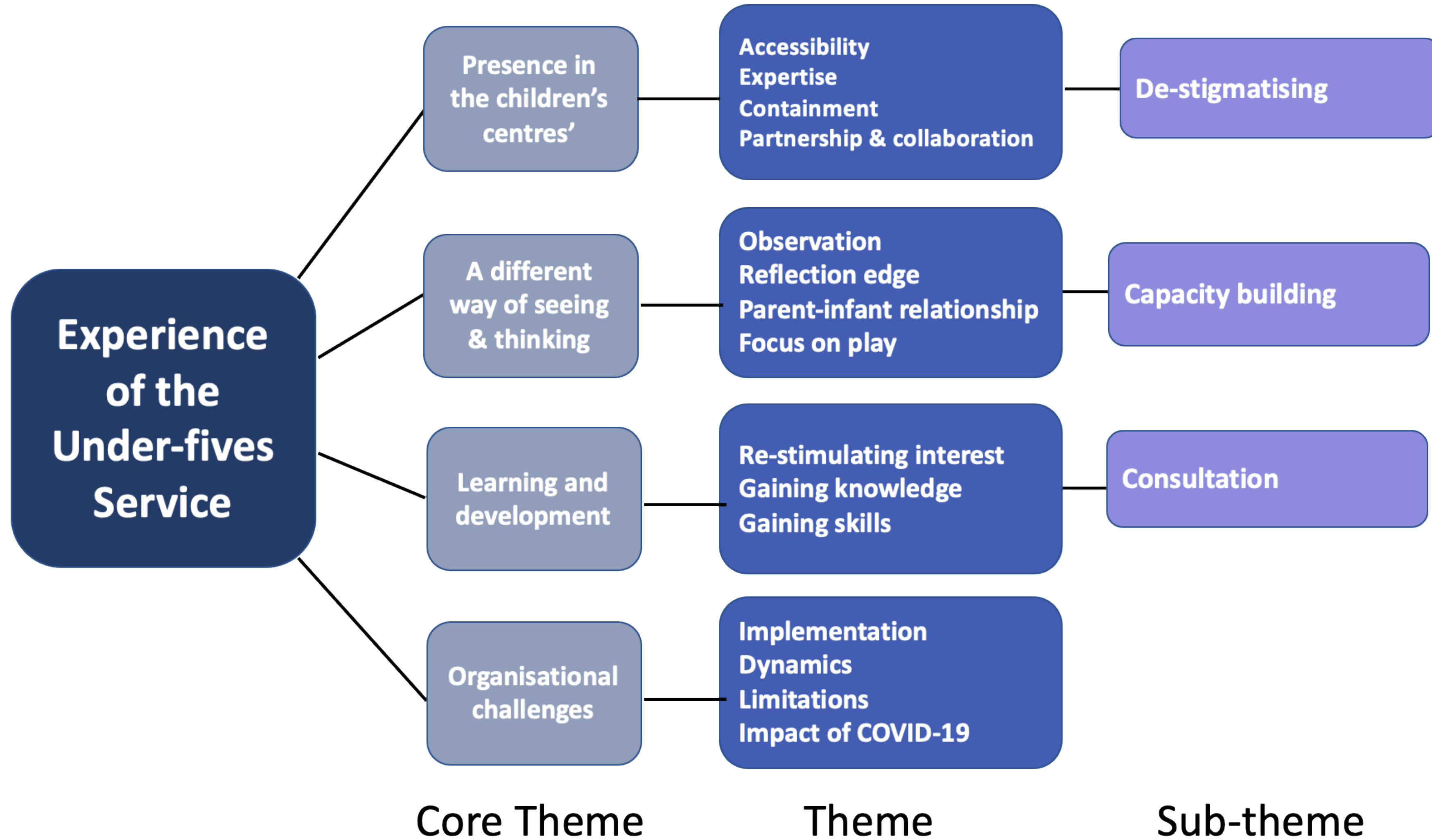
joined-up working. It was really good and so really informed us and we adapted the way we worked by taking your observations into consideration

Integrated working

helpful that working alongside working together with the family didn't feel like you were still off working separately on your own it did feel like it was a team. I think we worked really well together. - 5

but the support but the power of the supportive narrative that went on between in a triangle between the parent for us and a new and the U5s service -4

Appendix H - Thematic map


Experience of the Under-fives Service
Presence in the children's centres'
Accessibility
Expertise
Containment
Partnership & collaboration
De-stigmatising
A different way of seeing & thinking
Observation
Reflection edge
Parent-infant relationship
Focus on play
Capacity building
Learning and development
Re-stimulating interest
Gaining knowledge
Gaining skills
Consultation
Organisational challenges
Implementation
Dynamics
Limitations
Impact of COVID-19
Core Theme
Theme
Sub-theme