From Clinic to Community

Developing a whole-system community-embedded approach to mental health and trauma with families with children aged under seven

PLATFORM
For mental health and social change
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Contents

Abstract

Aim: To test a model for improving community mental health through sharing psychosocial knowledge and supporting sense-making, and community connection alongside communities rather than in clinical settings.

Method: Using a human learning system approach to explore the use of co-production, storytelling, and relational approaches to building community-embedded mental health support.

Results: Findings suggest additional therapeutic benefits of using community-embedded approaches compared with clinic-based interventions.

Conclusion: Further research would develop the evidence base to support the implementation of trauma-informed community-led approaches and examine the long-term benefits of building community assets.

Keywords: Adverse Childhood Experiences, Community Adversity, Community Healing, Mental Health, Neighbourhood Psychologist, Poverty, Relational Health, Community Trauma, Adverse Community Experiences, Resilience, Neighbourhood Psychologist.

Introduction

The poverty and mental health cycle

Research into childhood adversity in Wales brings the link between adult mental health outcomes and early years toxic stress into sharp focus (Addis et al., 2021; Welsh Government, 2021).

The well-meaning 'one in four' mental health mantra suggests an indiscriminate distribution according to our biology or individual resilience. However, this does not account for the way that mental health is largely influenced by the social, economic, and physical environments in which people are born, live, work, and play (WHO, 2014; WHO, 2022). Mental health is fundamentally about social health.

Therefore, there is a growing need to get it right for families by addressing the social determinants of mental health. These are the broad range of social and environmental conditions that affect our physical and mental health, such as the provision of safe housing and healthy foods; opportunities for employment and education; healthcare services; non-toxic air and water; and neighbourhoods in which families can live without fear of violence or discrimination (WHO, 2014).

The social determinants of mental health do not just refer to suitable housing, accessible education, having enough money and good childcare. It is about our relational needs too. Therefore, safe and supportive relationships which scaffold emotionally healthy development with family, friends, communities, and ourselves are key.

Growing up in poverty is a powerful determinant of our mental health because it can affect children's access to many health-promoting conditions. The chronic stress from living in impoverished and unhealthy conditions can overwhelm children's stress response systems, causing toxic stress (Garner et al., 2012). Toxic stress affects a child's brain development and increases the risk of developing poor physical, behavioural, socio-emotional, cognitive, and mental health (Shonkoff et al., 2012). A large majority of brain development happens in the early years, with 75% of relational health problems starting before adulthood (Centre on the Developing Child, 2007; Kim-Cohen et al., 2003).

Toxic stress can also lead to a range of chronic illnesses in adulthood, including heart disease, substance abuse, and depression (American Academy of Paediatrics, 2018). However, families can be powerful buffers against toxic stress. Research shows that having consistent, caring adults who are positive, nurturing, and responsive can protect a child from the harmful health effects of toxic stress

(National Academies, 2016).

Poverty is as much a cause of poor mental health as it is a consequence of poor mental health (Ridley et al., 2020). Being in a constant state of threat or overwhelm can impact parents' ability to be emotionally available to their children, and it can also impact their own mental health. Our ability to make decisions and our behaviours also play a vital role in helping people to avoid and escape poverty.

A Joseph Roundtree systematic review examining the relationship between socioeconomic status and psychological, social, and cultural processes which underpin decision-making confirms this impact (Sheehy-Skeffington & Rea, 2017). They found that experiencing or growing up in poverty affects people's lifelong decision-making. People living in poverty make decisions focused on addressing present stressful circumstances, often at the expense of future goals. Therefore, we need both a poverty-informed approach to mental health and trauma as much as a mental health and trauma-informed approach to poverty.

Limitations of clinic-based approaches

Accessibility

Our dominant approach to addressing these mental health issues is still a pathogenic, reductionist, individualistic, and clinic-focused approach. In the current approach, without ecological resilience, money, transport, or support to attend hospital or clinic appointments those most in need, particularly children, are likely not part of our clinical assessment of how we could do things better. No research or evidence-based practice exists for those who do not attend clinics (Gregory, 2018).

Public knowledge of relational health

There is also a specific knowledge base that people require to engage with trauma-informed mental health support. It is important that people can soothe and self-regulate before they are able to engage with shame-based trauma memories. People currently do not have the necessary attachment and trauma psychoeducation. A recent study found that 90% of the population believe that depression is caused by a chemical imbalance rather than largely by our social circumstances (Moncrieff et al., 2023). This suggests that most people seeking mental health support are not equipped with the knowledge or skills base to engage effectively or prudently in that support.

Home and community circumstances

Furthermore, there is also little point in providing clinical intervention without addressing the circumstances in which the distress and trauma were created in the first place. Following a neuroscience understanding of cognitive processing, we need to be regulated so that we can relate to others and be able to reason (Barfield, Gaskill, Dobson, & Perry, 2011). However, when people and their circumstances are not healthy enough, when they are in a dysregulated state, they are unable to take up opportunities for intervention effectively, especially when those interventions rely on our cognitive ability (the ability to reason), such as talking therapy.

It is, therefore, not a prudent use of public resources to provide intervention without also addressing the root causes of someone's distress and the threats that exist within their circumstances. This is only likely to result in their return to services for additional support. In recognition that a clinic-based approach is no longer fit for purpose, a step change is required (National Assembly for Wales Commission, 2018; Cobner, Daffin, & Brown, 2019).

Understanding and responding to complexity

There is increasing recognition that current understandings of and approaches to public sector delivery do not enable people to respond effectively to the complex challenges of the world, especially in today's world. The Together for Mental Health strategy (Welsh Government, 2012) broadly highlighted the right themes and areas that needed to be addressed to achieve its outcomes. However, an independent evaluation has shown that there have been significant barriers to its implementation and change (Lock, Puntan, & Lewis-Richards, 2022).

People's lives are complex, and our public services are complex systems too. Building on the Cynefin Framework for decision-making (Snowden, 2002), complexity theory helps us understand what complexity is and how complex systems operate. Snowden and Boone (2007) proposed the Cynefin Framework as a sense-making framework to help people understand what kind of problem they are facing and provide direction to the type of solutions that might be best applied.

Mental health is complex, with many determining factors to consider, yet clinicians are taught in clinical training to apply reductionist approaches to complex problems. Rather than respect and understand complexity, we try to reduce it. This happens frequently in public service but especially in healthcare. We take an individual and we silo out their problems. Our current operating systems are not effective in rejoining as a whole; instead, they offer complicated solutions to complex problems. This is often why patients and clinicians alike often become frustrated when a suggested intervention doesn't live up to what it said it would do.

Emergent practice does not mean that interventions are not evidence-based or that there is no knowledge to frame decision-making and practice. Medical professionals are well versed in understanding that there is no one-size-fits-all solution, and they are familiar with using guidance, such as National Institute of Health and Care Excellence (NICE) guidelines, to inform their clinical decision-making. This is why the term 'practice' is used and why reflective practice is core to medical training and continuing professional development.

In complexity, everything exists in relation to everything else, and relationships are the operating principle. This is why upscaling often fails. We cannot upscale relationships as they are unique to place. Therefore, complexity interventions, which are robust enough to accommodate a place-based relationally informed approach and include patient choice and multidisciplinary team decision-making, are required. Co-production and 'service user' involvement must be at the heart of service delivery and intervention decision-making. This is where the need for trauma-informed, community-embedded, place-based approaches comes from.

The power of connection, co-production, and knowledge

Although it is difficult to change a family's economic circumstances, practitioners can play a critical role in addressing social determinants of mental health through effective screening and coordination of care and intervention (Francis et al., 2019). We now know that it is our current as well as our histories of connectedness, rather than our experiences of adversity, that is a better predictor of our current functioning (Perry & Winfrey, 2021). This makes relational health a key determining factor as well as a powerful healing tool.

By focusing on safe, stable, and nurturing relationships that buffer adversity and build resilience, we are on the cusp of a paradigm shift that could reprioritise clinical activities, rewrite research agendas, and realign our collective advocacy (Garner et al., 2021). Driving this transformation are advances in developmental science which inform a deeper understanding of the way early childhood experiences, both nurturing and adverse, are biologically embedded and shape outcomes in health, education, and economic stability across the life span.

Place-based systems transformation for relational and mental health

It is increasingly acknowledged that resilient, healthy children develop best in resilient, healthy families and communities. Trauma-informed community development understands the impact that trauma, adversity and poverty have on emotional health. Therefore, a focus should be put on creating the conditions that foster things like agency, security, connection, meaning and trust. This is in recognition that the stresses of living with inadequate access to economic and educational opportunities, or a lack of opportunity itself, contribute to experiences of community-level adversity. Chronic exposure to individual and community trauma, such as humiliation, distrust and loneliness, is detrimental to our physical and psychological health. As a result, a number of psychosocial ecological approaches or place-based strategies are emerging. Such approaches recognise that these issues sit within complex networks within which relationships are key (Cobner, Daffin & Brown, 2021). With such complex problems, practice needs to be built together using principles of co-production, respecting culturally relevant knowledge, expertise, and leadership.

To get better outcomes for children, it is important for parents to be emotionally available and provide a nurturing, safe and secure environment. Deep poverty gets in the way of this since stressful circumstances can compromise parents' ability to be

emotionally available to their children while also compromising their own relational and emotional health (Bywaters & Skinner, 2022). To support parents, it is necessary to think about the whole family in a joint poverty and relational health approach, and this is the aspiration of the Embrace project.

Current support systems for children and their families have created life-transforming initiatives for hundreds of thousands of children. Yet, as the world has grown more complex and demanding, our current approach cannot keep up. Therefore, solving the mental health crisis is not about more access to one-to-one therapy, counselling or mental health services. Instead, it's about creating psychosocially healthy communities.

Our current approach to mental health and poverty provision puts the problem on the person and asks, 'What's wrong with you?'. However, when we understand that our mental health is created by the circumstances that we live in, then it makes more sense to explore these issues through the lens of 'What happened to you?' or 'What did you not get that you should have?' (Perry & Winfrey, 2021). Trauma-informed community development understands the impact that trauma, adversity, and poverty have on emotional health – recognising that the stresses of living with inadequate access to economic and educational opportunities, or a lack of opportunity itself, contribute to experiences of community-level adversity. We therefore need to take a whole systems approach to addressing these issues and create psychosocially or relationally healthy circumstances in which everyone can thrive.

A system is "a set of things people, cells, molecules interconnected in such a way that they produce their own pattern of behaviour over time" (Harries, Wharton & Abercrombie, 2015). What this means is that a system is made up of relationships and that change is, therefore, inherently relational. All of these components need to work together to produce a new pattern of responding, which in turn aims to support the system work in a more relationally healthy way. To make a long-term sustainable difference, individual organisations and services will each only ever be able to provide part of the solution.

Storytelling for mental health and systems change

Our emotions are created through an interaction of neurological and social constructs (Feldman Barrett, 2018). Our circumstances therefore shape our emotions and sense of the world. Re-making or making sense of ourselves, our emotions and our experiences is a key part of trauma recovery as well as good mental health (Herman, 2024).

A narrative approach views a problem as separate from the person and assumes people possess many skills, abilities, values, commitments, beliefs, and competencies that will assist them to change their relationship with the problems

influencing their lives. Narrative therapy is a collaborative and non-pathologising approach to therapy and community work that privileges people as the experts in their own lives. Narrative therapy approaches consider the broad context of people's lives particularly in the dimensions of diversity such as class, race, gender, sexual orientation, and ability.

Aims

Drawing on the existing work by the ACES Hub, Public Health Wales, and other local trauma-informed movements, the focus of this pilot project was to explore how to move adverse childhood experiences (ACE) awareness into practice and action at a hyper-local level alongside residents and key stakeholders of the neighbourhood. To come alongside residents to understand together how to support their communities to be relationally healthy, adversity and trauma-informed, infused and healing (Pinderhughes, Davis, Williams, 2015; TED, 2016; Triesman, 2021).

The aim was to test a model for improving community mental health through sharing psychosocial knowledge and supporting sense-making, and community connection alongside communities rather than in clinical settings.

The community-led project partnered with parents from the local area to explore how community ownership and connection could build wellbeing and resilience. The model aimed to support parents to develop skills to tell their own story, make meaning from their experiences, gain psychosocial knowledge to improve their mental health and wellbeing, as well as to build healthy connections and relationships with each other.

This pilot explored ways to:

1) Co-develop a place-based approach to understanding need and improving community wellbeing and resilience in Bettws.
2) Provide support and services that are human-rights focused, non-violent, trauma-informed, community-led, healing and culturally sensitive.
3) Set in motion a self-healer's movement (adult peer-to-peer support network)

Method

Following a 12-month development and scoping phase, the pilot ran over 12 months. The model was piloted with a project worker and a Community (Neighbourhood) Clinical Psychologist, working alongside families with children aged seven and under. A human learning system approach was used to explore the use of co-production, storytelling, and relational approaches to building community-embedded mental health support. Thematic analysis methodology was used to analyse the results.

Participants

Participants were parents recruited from two primary schools who had children under the age of seven and lived in the local area. Two groups of parents were formed, each connected to their respective school: one in a Welsh medium primary school (Group 1) and another in an English medium primary school (Group 2).

Fifteen parents signed up to the project (Group 1 = 6 and Group 2 = 9). All participants self-identified as women. No participants dropped out over the course of the project. Most parents attended every session, and no one missed more than one session in a row. For some sessions, additional parents were present because participants in the core groups invited their friends. One of those invited became a lasting member in Group 2 and is therefore included in the data analysis from session five onwards.

In both groups, the parents decided how often they would meet over the course of the project. It was agreed from the start that sessions took place once a month over twelve months. The groups also received a voucher as compensation and thanks to them for taking part.

A Community-Embedded Trauma Healing model

The model used has three core parts: 1) enhancing relational and mental health understanding, 2) supporting the development of meaning-making, storytelling, and collective action skills, and 3) supporting reflection on learning, taking action and sustaining change. The sessions were framed around storytelling, which involves four core processes: coming together, learning together, creating together, and healing together. The following content plan was drawn up to allow for ten sessions per group, with flexibility to allow for co-production on an ongoing basis.

Overview of session learning plan

Whilst the project was a coproduced endeavour, to help participants and stakeholders understand what this could involve, a suggested overview was created with the caveat that it would be led by the groups once they were formed. The following outline for session content (see table 1) was drawn largely from the research on relational health (Perry & Winfrey, 2021; Garner et al., 2021), self-compassion (Neff, 2023), attachment (Bowlby, 1953), trauma healing (Rothschild, 2021; LePera, 2021), complexity (Lowe, Wilson & Boobis, 2016) and social action therapy (Holland & Kilpatrick, 1993; Holmes, 2010). Wherever possible, NICE guidelines were also followed, particularly those related to post-traumatic stress disorder (2016).

Table 1. List of suggested session content

Session	Suggested Content
1	Introductions, welcome, safe space, and consent
2	Getting to know each other, trust building, ground rules/expectations, and introduction of start kit
3	Toxic stress and its role in our health
4	Limitations of the current approach to health
5	Trauma, relationships, self-compassion
7	Making sense of it all
8	Sense-making and action for change
9	Sharing and reflecting on the project learning
10	Endings, next steps, closure, and celebrations

Evaluation process and data collection

The project captured data on an ongoing basis using Human Learning Systems (HLS) principles. HLS is an approach to public services management that embraces the complexity of real-world contexts and enables us to work effectively in that complexity by putting people first. This learning approach places relationships at the heart of the learning process and incorporates the principles of co-production, which allows facilitators to respond appropriately to the strengths and needs of the participants.

Qualitative responses from parents were captured at the end of each session using the following questions:

1) What's been tough,
2) What's been good,
3) Reflections between sessions/before starting and
4) Forward thinking/the future.

The group facilitators conducted and recorded the responses from the participants as agreed within the group. Thematic analysis was used to understand the data collected over the course of the pilot.

Findings

There were five main themes identified: connection, mental ill health, child exposure to trauma, childcare, and cost of living. These are outlined in more detail below.

Connection

Parents shared that they experience disconnection in their lives, which occurred in different ways. Many spoke about difficult relationships with their parents who had mental health difficulties of their own. This has meant that in their adult lives, these parents were not close to their parents or did not speak to them anymore. Several were not in work, meaning their opportunities to be part of a community were limited. Parents also discussed struggles with schools and described difficult relationships between themselves and the school. Many parents shared that their own children had additional learning needs or social-emotional difficulties, which would be a strain on their ability to be connected.

> *"Talking and the company of others was good. It was nice to be around other mums."*

A common theme shared across individuals in the groups was that they enjoyed attending sessions and they gained from the group setting. This indicates that it is likely to be an importance source of connection not often available to the parents elsewhere.

> *"It helps having the same people there it's like a core group".*

Mental ill health

Parents highlighted that the systems which are meant to support them are impossible to navigate, especially whilst living in poverty. Parents talked about needing systems to support them to break the cycle of poverty and poor mental health. Yet, current systems were complicated and difficult to access with long waiting times. All of this took more mental energy and effort, which parents feel they do not have because they are already overloaded.

> *"I have experienced the [health] centre and I always felt I had to hold back, and don't say anything. With the Embrace sessions I feel I don't need to hold back on what I want to say".*

Whilst parents had a good awareness of the links between poverty and mental health, there was a substantial gap in knowledge about what mental health is. There was a strong belief in the debunked chemical imbalance theory of mental health. Awareness of this information caused a lot of concern for some parents who were receiving medication. There was a feeling of being exposed or lied to. Some parents felt the information provided was wrong, demonstrating how strongly held and important this narrative is to families. Parents recognised that it is incredibly hard and sometimes seemingly impossible to change their circumstances.

> *"I learnt how to self-reflect and look at how what I was doing had an impact."*

There was a sense of loss of hope and hopelessness at this explanation of poor mental health. At the same time, many other parents felt the information made sense and was useful to them.

> *"Embrace for me helps me see things in a different way it allows me to open up and share my trauma in a safe and completely understanding environment it shows me how mental health works and how I can then use it to accommodate to my life."*

It is clear there are some misconceptions about what antidepressant medication does and what mental health is. This is a complex issue that requires sensitivity to address.

Child exposure to trauma

A high number of parents felt passionately about how they protect their children to make sure they do not experience the same childhood trauma. Many parents identified how relationships with primary caregivers were challenging when they were children and how these relationships are still challenging today. They pointed out that young carers are included in the broader conversation around adverse childhood experiences. Some parents experienced caring for family members as a child and shared how they felt this was an adverse experience for children. There were discussions around the systems that we live and grow in and how certain systems that should be there to support families are impossible to navigate. Parents asked that for any future projects that a version to help their children understand these things and to support them to help their children have these things would be their hope.

Childcare

For one of the groups childcare was a barrier to participation. The parents were unable to attend the group if children were not allowed. The group agreed to change the day and time to try to accommodate parents, but it was not possible to do this for everyone. There were a number of parents with babies who had no one else to have their children for them. It was agreed that children under 12 months were able to attend. Had this accommodation not been made, parents would not have been able to access the group. Having their children present appeared to serve as a protective factor as well. It allowed the parents to feel safe in the space and gave them a common shared experience to organise their gathering around, but also a way for parents to dip in and out of difficult conversations. Children appeared to be a co-regulation calming strategy for parents, which allowed them to remain engaged in the group space.

> *"The group helped me to socialise and improved my mental health. Normally I struggle in groups, but this helped me to overcome that. I felt safe."*

Cost of living

Concerns around money were raised often. Parents explained how lack of money causes them stress and worry and impacts on their mental health. It also means they are not able to provide for their children in the way that other people are able to, which created feelings of shame. It was possible to see how this was a vicious cycle; not feeling financially secure was keeping the cycle of poor mental health going. The impact of this could be seen across the generations. Many also shared that they had their own mental health diagnoses or difficulties alongside financial stresses, which make it difficult for them to be emotionally available to their own children, family, and friends. Parents shared that the group helped them understand they were not the only ones with their struggles.

> *"I had a really bad 12 months and if it wasn't for the group I wouldn't have left my house."*
>
> *"The group really helped me when I was feeling down and going through tough times."*

Discussion

An evolution in understanding mental health

Parents appeared to be acutely aware of the links between poverty and mental health. This link has likely been highlighted against the backdrop of COVID-19 and the cost-of-living crisis. The Mental Health Foundation and the Centre for Mental Health have also issued a series of responses highlighting these links, as have McDaid and Kelly (2022) and Davie (2022). As such, the broader social context has provided a real-world example which informed the psychosocial education being provided to parents in the group sessions.

Benefits of psychosocial education and creating community peer support

There were clear misconceptions about what antidepressant medication does, so there is an opportunity for parents to benefit from further psychoeducation within local primary care and GP health providers. Parents valued the understanding they gained from learning about the threat system and seeing their reactions through this lens. This knowledge appeared to help parents make sense of and externalise their responses to stress. Rather than feeling that there was something wrong with them, parents were able to see their reactions rooted in the social context and their circumstances. The importance of connection and building a shared space were a strong theme throughout the project. Parents shared stories of applying this new understanding amongst one another outside of the group in their community and helping each other to apply this thinking in their everyday interactions. They reported that the shared space and trust within the group had increased their capacity to do this.

Accessibility to coproduced community-embedded support

Parents stated that they preferred learning information and having discussions in groups rather than one-to-one sessions. They took comfort from being with each other and from the shared nature of their experiences and challenges. Connecting in a space that was familiar to them with staff they were familiar with also helped to create a sense of safety and trust. Parents reported that they valued the group being a safe space for them. They also reported that childcare was an issue in accessing clinic appointments, and they valued being able to attend the group with their children. It was observed that the children may have provided a sense of safety for some parents, allowing them the opportunity to dip in and out of the content as and when they needed to by focussing on their children.

Impact of project duration on emotion regulation

Research suggests that it can take up to ten sessions to feel safe enough to engage in therapeutic work because of how the body's threat response works (Perry & Winfrey, 2021). For people who have a hyper-alert or dysregulated threat response, learning to feel safe can be an extra challenge. Following neuroscience, people benefit from 'dosing' their exposure to 'threats' such as meeting new people. The body learns through multiple brief exposures whether something is safe or not. Unlike in a 50-minute therapy session, the individual is unable to engage and then disengage in a dosing way, whether that is through leaving the room, going to make a cup of tea, smoking a cigarette, or just changing the subject to talk about something safe, like a television programme. Instead, flooding often occurs as a result of the intense exposure that overloads a person's threat response system. For some people, this process can be re-traumatising and harmful (NICE, 2018; NPTMC, 2017).

The benefit of the Embrace project's design is that it partners with a network of support and a group that already meets weekly. This meant that there were multiple opportunities for group attendees to interact with each other and with one of the group facilitators outside of the specific Embrace sessions. Additionally, group facilitators were also mindful of the impact of the sessions on parents. Groups were able to go at their own pace and to take breaks as they needed. For one group, this meant allowing their young children to stay in the session with them. Children acted as a coping strategy for parents, allowing them to engage in topics and presenting them with a means to move away from distressing conversations to attend to their child's needs or to provide a distraction, for example, through play. This could suggest that parent-child interactions acted as a regulating activity within the group.

Limitations and further considerations

A notable limitation of the current findings is that the project has only been running for ten sessions. Therefore, there are benefits that this evaluation is unable to capture because the length of the project is too short. Similar projects have suggested that a much longer period is required to embed this new approach (Participatory City Research Team, 2023). Self-reflection themes from parents support the need for more time together – it took four to five sessions for parents' responses to shift from mostly 'anxious' related remarks to 'connection' and other positive remarks about their participation in the group. Matrics Cymru, 2017) guidance suggests 14-30 sessions for moderate to severe traumatic stress-related issues.

Parents' suggestions for further improvement

Firstly, the length of the project was also directly suggested by parents as an area for further improvement. Both groups called for an increase in the number of sessions and the duration of each session. An hour wasn't seen as long enough to connect and cover the content – by the time the group really got into a topic, the time was ending. Secondly, consideration of space and technology was highlighted. In some cases, parents were unable to engage with video resources because the audio or visuals were unclear in a group setting. Future sessions would benefit from exploring ways to present which complement the group size or room size to improve parents' experience.

Finally, parents reflected that the monthly group sessions meant there were quite a few weeks between groups, so they were not always able to recall information when they needed to. Parents also expressed enthusiasm about sharing snippets of the learning with more people but said that it was challenging to remember specifics. Following this feedback, parents would benefit from being provided with accessible printed resources to take away from future sessions. It is hoped that this would contribute to learning about how best to disseminate ideas beyond the group, which is an area that will be developed into future iterations of the project.

Conclusion

Whilst there are limitations with the present pilot findings, the current model would indicate support for further exploration of the value of a community-embedded approach compared with clinic-based interventions.

Community-embedded interventions appear to produce several additional benefits, including supporting connection, feelings of safety and trust, and the added value of creating community and social assets. Highlighting feedback from parents, we would recommend that the pilot is run for much longer in additional studies and that there is a post-group follow up of six months to a year. At the time of writing, this data was not yet available for this pilot.

Finally, we recommend the inclusion of ongoing evaluation mechanisms throughout to support continuous learning and understanding of the community assets and benefits that are generated. This, alongside enhanced support for the parents to apply the knowledge more practically to their parenting, could enhance the current approach further.

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References

Addis, S., Wey, T., Toll, E., & Hopkins, J. C. (2021). *What Works to Prevent Adverse Childhood Experiences (ACEs) at the Community Level?*. The Adverse Childhood Experience (ACE) Support Hub of Wales.

American Academy of Pediatrics. (2018). *ACEs and toxic stress*.

Barfield, S., Dobson, C., Gaskill, R., & Perry, B. D. (2012). Neurosequential model of therapeutics in a therapeutic preschool: Implications for work with children with complex neuropsychiatric problems. *International Journal of Play Therapy*, *21*(1), 30. https://doi.org/10.1037/a0025955

Berger, J. G., & Johnston, K. (2015). *Simple habits for complex times: Powerful practices for leaders*. Stanford University Press.

Bettws Early Learning Community. (2019). *What are we learning?* https://bettwselc.org.uk/what-are-we-learning/

Bowlby, J. (1953). Some pathological processes set in train by early mother-child separation. *Journal of Mental Science*, *99*(415), 265-272. https://.doi.org/10.1192/bjp.99.415.265

Bywaters, P., & Skinner, G. (2022). The Relationship Between Poverty and Child Abuse and Neglect: New Evidence. Nuffield Foundation and University of Huddersfield.

Cobner, R., Daffin, J., & Brown, S. (2021). The landscape of poverty. *The Psychologist*. https://www.bps.org.uk/psychologist/landscape-poverty

Center on the Developing Child (2007). *A Science-Based Framework for Early Childhood Policy.* https://developingchild.harvard.edu

Daffin, J., Thomas, R., & Parry, S. (2022). Unlocking the System: Place-based ways of working with children, their families and a neighbourhood psychologist in Bettws, Wales. *Number 357–September 2022 Special Issue: Public Health and Prevention, Part Two Edited by David Harper, Olga Luzon & Tony Wainwright*, *357*, 37.

Davie, E. (2022). *Poverty, economic inequality and mental health*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/wp-content/uploads/2022/07/CentreforMentalHealth_PovertyMH_Briefing.pdf

Feldman Barrett, L. (2018). Seeing fear: it's all in the eyes?. *Trends in neurosciences*, *41*(9), 559-563. https://doi.org/10.1016/j.tins.2018.06.009

Foden, M. (Host). (2018, December 1). Episode 1 - About the Clock and the Cat (No. 1) [Audio podcast episode]. In *The Clock and the Cat Podcast*. https://markfoden.com/clockcat/2018/12/episode-1-introduction

Francis, H. M., Stevenson, R. J., Chambers, J. R., Gupta, D., Newey, B., & Lim, C. K. (2019). A brief diet intervention can reduce symptoms of depression in young adults–A randomised controlled trial. *PloS one, 14*(10), e0222768. https://doi.org/10.1371/journal.pone.0222768

Garner, A. S., Shonkoff, J. P., Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics, Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*, *129*(1), e224-e231. https://doi.org/10.1542/peds.2011-2662

Garner, A., Yogman, M., & Committee on Psychosocial Aspects of Child and Family Health. (2021). Preventing childhood toxic stress: partnering with families and communities to promote relational health. *Pediatrics*, *148*(2). https://doi.org/10.1542/peds.2021-052582

Gregory, E. (2018). Evidence submitted to the *Mind Over Matter*. National Assembly for Wales. CYPE Committee. Wales.

Harries, E., Wharton, R., & Abercrombie, R. (2015). Systems Change: A guide to what it is and how to do it. New Philanthropy Capital.

Herman, J. (2024). Truth and Repair: How Trauma Survivors Envision Justice. Basic Books. USA.

Holland, T. P., & Kilpatrick, A. C. (1993). Using Narrative Techniques to Enhance Multicultural Practice. *Journal of Social Work Education*, *29*(3), 302–308. https://doi.org/10.1080/10437797.1993.10778826

Holmes, M. (2010). The emotionalization of reflexivity. *Sociology*, *44*(1), 139-154. https://doi.org/10.1177/0038038509351616

Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of general psychiatry*, *60*(7), 709-717. https://doi.org/10.1001/archpsyc.60.7.709

LePera, N. (2021). *How to Do the Work*. Hachette.

Lock, K., Puntan, L., & Lewis-Richards, M. (2022). *Review of Together for Mental Health and Talk to me 2 Strategies*. Cardiff: Welsh Government, GSR report number 26/2023. https://www.gov.wales/review-together-mental-health-and-talk-me-2-strategies

Lowe, T., Wilson, R., & Boobis, S. (2016). The Performance Management of complex systems–enabling adaptation. *Edinburgh: performance management association—performance measurement and management: new theories for new practices*. https://www.researchgate.net/publication/304355200

McDaid, S., & Kelly, P. (2022). *Tackling poverty for good mental health.* https://www.mentalhealth.org.uk/explore-mental-health/blogs/tackling-poverty-good-mental-health

Moncrieff, J., Cooper, R. E., Stockmann, T., Amendola, S., Hengartner, M. P., Plöderl, M., & Horowitz, M. A. (2023). The serotonin hypothesis of depression: both long discarded and still supported?. *Molecular Psychiatry*, *28*(8), 3160-3163. https://doi.org/10.1038/s41380-022-01661-0

National Academies of Sciences, Engineering, and Medicine. (2016). *Parenting Matters: Supporting Parents of Children Ages 0–8*. The National Academies Press. https://doi.org/10.17226/21868

National Institute of Health and Care Excellence. (2016). *Major trauma: assessment and initial management*. https://www.nice.org.uk/guidance/ng39

National Psychological Therapies Management Committee & Public Health Wales, (2017). Matrics Cymru: Guidance for Delivering Evidence-Based Psychological Therapy in Wales.

Neff, K. D. (2023). Self-compassion: Theory, method, research, and intervention. *Annual review of psychology*, *74*, 193-218. https://doi.org/10.1146/annurev-psych-032420-031047

National Institute of Health and Care Excellence (2018). Post-traumatic stress disorder guideline [NG116] Published: 05 December 2018.

Perry, B. & Winfrey, O. (2021). What Happened to You? Conversations on Trauma, Resilience and Healing. Melcher Media. Ophrah Books.

Pinderhughes, H. Davis, R. & Williams, M. (2015). *Adverse community experiences and resilience framework: A framework for addressing and preventing community trauma*. Preventions Institute.

Ridley, M., Rao, G., Schilback, F. & Patel, V. (2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. Science, 370(6522), eaay0214. https://doi.org/10.1126/science.aay0214

Rothschild, B. (2021). *Revolutionizing trauma treatment: Stabilization, safety, & nervous system balance*. WW Norton & Company.

Sheehy-Skeffington, J., & Rea, J. (2017). *How poverty affects people's decision-making processes*. Joseph Rowntree Foundation. https://discovery.ucl.ac.uk/id/eprint/10186609/

Shonkoff, J. P., Garner, A. S., Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232-e246. https://doi.org/10.1542/peds.2011-2663

Snowden, D.J. (2002). Complex Acts of Knowing: Paradox and Descriptive Self-Awareness. *Journal of Knowledge Management*, *6*(2). 100-111. https://doi.org/10.1108/13673270210424639

Snowden, D. J., & Boone, M. E. (2007). A leader's framework for decision making. *Harvard business review*, *85*(11), 68. https://www.systemswisdom.com/sites/default/files/Snowdon-and-Boone-A-Leader's-Framework-for-Decision-Making_0.pdf

TED. (2016, June 8). Trauma informed community development | *Paul Abernathy* [Video]. YouTube. https://www.youtube.com/watch?v=kcbu58p0fbA

Triesman, K. (2021). A treasure box for creating trauma-informed organizations. Therapeutic Treasures Collection.

Welsh Parliament. (2020). Mind over matter: Two years on. October, 2020. Welsh Parliament CYPE Committee.

World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. World Health Organization.

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. World Health Organization.

Participatory Research Team (2023). Places to Practice: Building Participatory Practices in Barking and Dagnam through the every one every day initiative. https://www.participatorycity.org/places-to-practise

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