Turning Training into Practice: Does Infant Mental Health Training Influence Practice?

Lucy Kerrigan

Table of Contents

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1. Introduction

1.1. Background

1.1.1. Attachment and Infant Mental Health

Attachment theory and its application to children's behaviour was first conceptualised in the 1960s (Ainsworth, 1964; 1968; Bowlby, 1969). Both Bowlby (1969) and Ainsworth (1982) described attachment as being the relationship between the caregiver and infant which is fundamental for the infant's survival and development. During infancy, the child is entirely dependent on their caregiver to protect them. Thus, when the infant feels a sense of danger, they will respond in specific ways to seek proximity to their caregiver such as crying. Over time, the infant builds mental representations about themselves and their attachment figure in response to whether their needs have been met by their caregiver; termed as 'internal working models' (Bowlby, 1980). Hunter, Glazebrook and Ranger (2020) highlights evidence which suggests that parents who are better able to sensitively notice and respond to their infant's cues are more likely to develop a secure attachment (Sunderland, 2016). This is where the infant is confident that their caregiver will be available and responsive to their needs and becomes a secure base from which they can safely explore their environment (Grossman & Grossman, 2020). Hunter, Glazebrook and Ranger (2020) conclude that when an infant is securely attached to their care-giver, repeated sensitive and responsive interactions will build an internal working model that they are loving and worthy of care. However, if an infant and caregiver are living in an environment which is highly stressful for extended periods of time, this will inevitably impact on the parent-infant relationship and in turn, the infant's development. Therefore, the early care-giving environment is vital for positive social and emotional development (Groh et al., 2017).

As such, Infant Mental Health concerns how well an infant develops emotionally and socially during their first two years of life. It is during this critical period, the first 1001 days of babies' lives, where interactions from caregivers shape their rapidly growing brains. During this period, connections in their brains are being created at a rate of 1 million per second (Durkan, Field, Lamb & Loughton, 2016; Leach, 2018; Schore, 2001). Thus, an infant's direct experience will also influence their neurological development,

which reinforces the notion that the quality of their early interactions provides a foundation for later physical and mental health outcomes.

1.1.2. Service Context

Despite the evidence regarding the importance of early and good quality parent-infant interactions, there is little mental health provision for children aged 2 and under. The Parent Infant Partnership UK (PIP UK) published their 'Rare Jewels' report which describes parent-infant relationship teams as being 'rare jewels' in the current mental health system (Hogg, 2019). The report provides recent statistics on the current provision of infant mental health services, highlighting that there are only 27 specialised parent-infant relationship teams currently operating in the UK. This is surprising considering there are almost 200 Clinical Commissioning Groups (CCGs) in England (Hogg, 2019). Thus, there are parents and their infants living in areas where Infant Mental Health services do not exist; limiting the necessary provision of early intervention.

Furthermore, most Child and Adolescent Mental Health Services (CAMHS) in England are commissioned to be an aged 0-18 service, however in reality, young children are not accessing the service. Hogg (2018) suggests that this is likely due to CAMH services focussing on older children and therefore, CAMH CCGs are over-looking the early social and emotional needs of infants, despite the extensive research on the importance of early relationships on later functioning. Moreover, some areas in England do not commission mental health services for parents and their infants at all. Data collected through the 'Rare Jewels' report's Freedom of Information exercise found that 42% of CAMH CCGs do not accept referrals for children 2 years and below (Hogg, 2019). This is not only detrimental to both the child and their family who need support, but also leads to high societal costs due to the likely need for a more extensive clinical intervention later in the child's life (Durkan et al., 2016; Hogg, 2019).

In NHS England's Long-Term Plan (2019), the Government proposed that by 2023/24, children and young people (aged 0-25) will have increased access to mental health services, with a focus on peri-natal services. Furthermore, the 1001 Critical Days report, a cross-party manifesto, proposed a vision that parents and their infants in every local area will have the appropriate, holistic, access to services during their first two years of life; especially for at-risk families (Durkan et al., 2016). However, this is still in progress and remains a challenge within the current context of political austerity.

Within this context, it is vital for the current child and family workforce to offer an effective service for parents and their infants. Both The 1001 Critical Days and the Rare Jewels reports recommend that practitioners who work with families and their children must have expertise and receive high quality training in Infant Mental Health and attachment as standard (Durkan et al., 2016; Hogg, 2019). Specifically, they must have the skills required to promote and support positive early relationships, and to feel able to confidently identify, signpost or intervene when babies' emotional well-being is at risk. As such, current Infant Mental Health teams are best placed to deliver this.

1.1.3. The Service – Little Minds Matter: Bradford Infant Mental Health Service

Little Minds Matter (LMM): Bradford Infant Mental Health Service is a specialist, multi-disciplinary team which aims to support and strengthen the relationship between parents or carers and their babies (aged 0-2). LMM offers specialist one-day 'Infant Mental Health Awareness' training to professionals who are already working with families in order to offer up-to-date research and best practice in infant neurodevelopment, and attachment theory, and aims to promote responsiveness and sensitivity in parenting.

One distinct challenge in delivering training is ensuring that it is effective; namely, that professionals' learning transfers into their practice (Broad & Newstrom, 1992; Kirkpatrick, 1983). Therefore, it is vital that the training offered is effectively evaluated, as the quality of the service being offered is central to effective service delivery during a time of limited resource (Ham, Berwich & Dixon, 2016).

1.2. Aims

Overall, there is a limited provision of infant mental health services in the UK despite the evidence base outlining that the quality of care a child receives in their first two years of life provides a foundation to their later mental and health wellbeing (Durkan et al, 2016). As such, it is vital for professionals in child and family services to be well-equipped with up-to-date infant mental health knowledge in order to provide an informed and effective service for families.

As such, this SEP aimed to evaluate the training provided by LMM to further understand its effectiveness, more specifically, the usefulness of training to professionals' roles and whether practitioners implement their learning from the training into their practice. Findings from this evaluation will in turn, contribute to and inform the re-commissioning of the service, as it is not currently statutory; vital for the continuing development of Infant Mental Health providers.

1.3. Commissioning

This SEP was commissioned by Dr Matthew Price, Principle Clinical Psychologist and Infant Mental Health Pathway Lead. Matt has led in the development of LMM which was first piloted in March 2018 by the National Lottery Community Fund as part of the Better Start Bradford Project. Then, in June 2018, the service was funded until August 2021. As the service is newly run, evaluation of its effectiveness is fundamental.

2. Method

2.1. Design and procedures

A qualitative methodological design was used to explore whether professionals implemented their learning from the training into their practice. A qualitative methodology was most appropriate due to its intention to capture knowledge from human experience (Sandelowski, 2004). Short (10-15 minute) semi-structured telephone interviews were conducted to capture examples of professionals implementing their learning.

Evaluation forms are routinely collected by the service prior to, immediately following and at 3-month follow up after the training. The data from these forms are mixed methods (qualitative and quantitative) and the relevant data was used to supplement the main aim of the SEP.

2.2. Participants and Recruitment

Participants were recruited via email from LMM's mailing list, in which professionals are invited to sign up to following their attendance to the training. The mailing list is used to inform professionals of service updates, newsletters, events and the annual report.

Participants who attended the training only (and had not previously accessed the service for consultation) were invited to participate in a telephone interview via an opt-in email (see Appendix B). There were 344 professionals in total who were invited to participate; the recruiting emails were sent out systematically at up to 20 emails at a time. The emails were sent by Dr Matthew Price and included the evaluator's contact details for professionals to enquire about their participation.

The initial sample size aim was between 7 and 10, as this was considered sufficient data for the qualitative methodology (Tracy, 2019). However, only 4 participants were recruited. As the routinely collected follow-up evaluation form included a specific question asking whether the training influenced their practice, the 36 participant responses which were already collected were included to supplement the data collected from the interviews. Therefore, 40 participant responses were included in the analysis altogether.

Analysis of the routinely collected follow-up evaluation forms was not initially considered to be the primary method of data collection because, at the start of the project there was limited uptake of professionals who had completed them. Therefore, it was hoped that by inviting professionals to provide verbal feedback to an independent evaluator, it would give them the opportunity to provide more rich and detailed examples which a written evaluation form would be difficult to capture. Alongside this, by using a more personal approach, it was hoped that this would increase their response rate.

2.3. Measures

2.3.1. Interview Schedule

The telephone interview schedule was developed in collaboration with the Commissioner and Assistant Psychologist in LMM. See Appendix C for the interview

schedule. The interview schedule was developed using Kirkpatrick's Training Evaluation framework (Kirkpatrick, 1983). See Table 1 for a summary of his four-level model.

Table 1. Kirkpatrick's Training Evaluation Four-Level Model (Kirkpatrick, 2007).

Level	What's being evaluated?	What does this measure?
Level 1	Reaction	Participants engagement, how they reacted and how well it was received.
Level 2	Learning	Measuring what participants have and have not learned; including how the training has developed their skills, knowledge and confidence.
Level 3	Behaviour	Helps to understand how well participants apply their training; what are they doing?
Level 4	Results	Analysis of results and outcomes

Kirkpatrick's (1983) model is a widely used framework to evaluate training as it is applicable to any organisational setting (Rajeev, Madan & Jayarajan, 2009). This model has also been evaluated a lot, and overall, the literature suggests that it is useful for framing the different points at which evaluation takes place, however, it has been criticised for over-emphasising trainees' reactions. Critiques suggest reaction responses have a low correlation with the application of learning (Alliger & Janak, 1989; Holton, 1996). As such, the model will be used for the interview process but for the purpose of reporting this SEP, the emphasis will be placed on the 'learning' and 'behaviour' levels.

2.3.2. Evaluation Form

As described, a follow-up evaluation form which professionals completed between August 2018 and March 2020 was used to supplement the data from the individual interviews. The form included the main question: 'In what way, if any, has

attending the Infant Mental Health Awareness training impacted upon your practice? See Appendix D.

2.4. Data Analysis

The telephone interviews were audio-recorded and transcribed. The transcriptions were analysed using Braun and Clarke's (2006) thematic analysis six-phase framework. See Figure 1 below.

Figure 1. Braun and Clarke's (2006) six-phase framework of Thematic Analysis.

As previously stated, data was collected from two sources (spoken interviews and written evaluation forms). As the verbal data was transferred into a written transcript, it meant that the evaluator was able to easily amalgamate the data from the evaluation forms. Thus, all data was analysed in written format using Thematic Analysis (Braun & Clarke, 2006). Thematic analysis is flexible in its approach as it can be used to analyse most types of qualitative methods of data collection (Braun & Clarke, 2006). Thus, there was no concern in the validity of the data by amalgamating it from two qualitative sources. However, Braun and Clarke (2006) highlights that the flexibility and absence of concise guidelines can also be a critique of the analysis (Antaki, Billig, Edwards & Potter, 2002).

Nowell, Norris, White and Moules (2017) summarise in their paper about the trustworthiness of Thematic analysis; that it is useful in exploring the perspectives of different participants, where similarities and differences can be highlighted (Braun & Clarke,

2006). Nowell et al., (2017) also highlight that it is useful in summarising key features of a large data set.

However, Nowell et al., (2017) also argues that thematic analysis can lead to inconsistencies when developing themes (Holloway & Torres, 2003). Tracy (2019) suggests that consistency and cohesion can be increased by explicitly reflecting on one's personal stance in relation to the research topic; and Guba and Lincoln (1989) proposes conducting credibility checks. These will be discussed below.

2.5. Personal reflections

I previously worked in an Infant Mental Health service as an Assistant Psychologist, therefore, I chose this SEP as I have a clinical interest in this area. I was particularly interested in evaluating the training strand, as the service I previously worked in did not routinely deliver training to professionals working in local Child and Family services. It is important to note that I have not had any personal experience of accessing Infant Mental Health services and I have not previously delivered Infant Mental Health training. Considering this, it is likely that my personal stance will have limited bias in the findings.

2.6. Credibility checks

The credibility of a study is addressed when there is an alignment between participants' views and the evaluators' representation of them (Guba & Lincoln, 1989). Alongside prolonged engagement with the data, the themes were discussed in supervision with the commissioner to ensure the themes were credible. Overall, the themes were consistent with the commissioner's experience of previous professionals' feedback and there were no stark differences of opinion. In our discussions the most time was spent clarifying the specificity of themes, as the examples that a lot of professionals gave were quite specific. This was managed by reviewing the data separately, and then reviewing it again together over multiple supervision meetings. This method worked well as it allowed both the commissioner

and evaluator to 'zoom out' from the data and assess it with the other party's questions in mind.

2.7. Ethical considerations

This project sought ethical approval by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC -19-004). This was granted on 16th April 2020. Ethical approval to include analysis of data from the routinely collected follow-up evaluation forms, was granted on 4th September 2020. The SEP was also approved by the Research and Development Department at Bradford District Care NHS Foundation Trust. The main ethical issues and how they were addressed are outlined below:

2.7.1. Consent

Participants were emailed the Participant Information Sheet in the recruiting email to ensure they gave fully informed consent to participating in the study. As the interviews were conducted over telephone, verbal consent was sought. See Appendix E for the Participant Information Sheet and Appendix F for the Consent form.

2.7.2. Confidentiality

Before the interview, participants were reminded of confidentiality and the anonymised storage of data. Participants were also reminded that they could withdraw their data up to 7 days following the interview, at the point of transcription.

2.7.3. Risk of distress

The nature of the clinical work in infant mental health is potentially distressing, therefore there was a small risk that the interview may trigger distress when reflecting on the participant's experiences. Participants were reminded that they could terminate the interview at any time, if they wished to. At this point, it may have been appropriate to signpost them to consult with the Little Minds Matter team or seek clinical supervision within their service. It was the participant's responsibility to co-ordinate this.

Moreover, the evaluator was a Psychologist in Clinical Training and could support the participant in managing their distress during the interview if this arose. The evaluator conducted interviews with sensitivity and aimed to seek supervision if they felt their own experiences impacted on their response to the participants; which may potentially have biased the findings.

2.7.4. Safeguarding procedures

If the participant disclosed that they or others are at risk of harm, appropriate services would be informed.

2.7.5. Bias of findings

To reduce potential bias in the findings, participants were reminded prior to the interview that the evaluator was not a part of the Little Minds Matter team and works independently from them; therefore, they were encouraged to be as honest as possible.

3.Results

The results are divided into two parts; Part 1 presents the demographic information about the professionals who participated, and Part 2 explores the follow-up learning from the training.

3.1. Part 1 – Demographics

Overall, from November 2018 to March 2020, 344 professionals attended the Infant Mental Health Awareness full day training. From these, a total of 40 (11.63%) professionals provided follow up feedback about how the training has influenced their practice. Out of these, 4 professionals provided verbal feedback through interviews and 36 completed a follow-up evaluation form. Those who completed the interviews had not previously completed the evaluation form.

Figure 3 provides an overview of the proportion of professionals who attended from each professional group.

See Appendix G for a more in-depth overview of the participants' professional titles, grouped into professional roles. Professionals from the Early Years and Development sector were the highest represented group. It is interesting to note that 22.5% of feedback was provided from non-clinical professionals. These professionals support in the running and facilitation of the Better Start Bradford projet, the wider organisation, thus, indirectly supporting families.
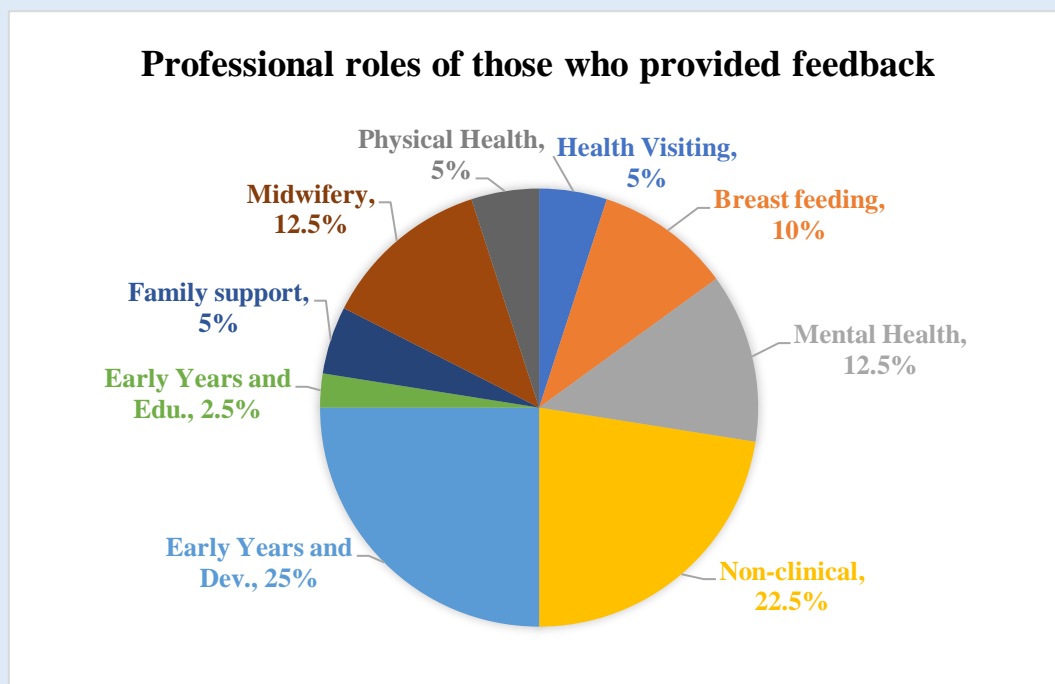
Figure 3. The proportion of professional groups who provided follow-up feedback.

Appendix H provides further detailed demographics regarding gender, ages, ethnicity, qualifications and the organisations in which professionals work, with regards to who attended the training.

3.2. Part 2 – The influence of training on practice.

Before reporting the longer term follow up findings about how the training influenced professionals' practice; the routinely collected quantitative pre and post training data will be compared and presented in a summary, to support the overall context of the results about professionals learning from the training.

3.2.1. Immediate follow-up

Firstly, all 344 professionals who attended the training rated the 'usefulness' of their training to their practice. Figure 4 provides an overview of the responses.

Figure 4. Professionals' rating of the training's usefulness to their role.

Additionally, professionals rated their knowledge and understanding prior to and immediately following the training across four evaluated domains: 'infant mental health', 'babies brain development', 'attachment' and 'parent-infant relationships'. All professionals reported an improvement in their knowledge and understanding across all four domains. Also, when professionals were categorised into relevant professional groups, this improvement was fairly consistent across the different groups. See Appendix I for the statistical analysis of these findings.

3.2.2. Longer term follow-up

With regards to the longer-term follow-up data, all professionals who provided feedback reported that the training influenced their practice.

Table 3. shows the themes and sub-themes that emerged from professionals' descriptions about how the training influenced their practice. The three main themes and related sub-themes are below.

1. Improved awareness, knowledge and skills – through **therapeutic work** with families, in **indirect work** through providing consultation and supervision, or **sharing knowledge** with families in an accessible way.

2. Improved confidence and consolidation in skills – identified through the concept of '**holding the baby/child in mind'** when working with both professionals and families, or in **parent-infant observation skills** with families.

3. Linking with local services – either through **networking** and meeting professionals from local services or **improved professional support networks** with LMM in referring families or accessing consultation.

Table. 3. Themes identified about the influence of training on clinicians' practice.

Theme	Sub-theme	Examples
Improved awareness, knowledge and skills	Therapeutic work	"I never really paid attention to how the baby can be affected, so when working with pregnant mums now, I look at everything with the baby in mind." (Participant 14)
	Sharing knowledge with families	"Since the training, we have been looking at providing information for families on brain development." (Participant 34).
	Indirect work	"I have never had input on early brain development in this detail; it enabled me to draw upon this when working with school staff, i.e. helping them to understand why some older children might act differently, and how this relates to their early years." (Participant 26).
Improved confidence and consolidation in skills	Holding the baby/child in mind.	"I feel more confident informing parents about the importance of holding the baby in mind" (Participant 17).
	Parent-infant observation skills	"I'm much more aware that I watch what is going on… so commenting on interactions like 'look how beautifully you get a smile when you look into his eyes and you're talking to him, look how he's really looking at you', really talking about the bond between the two of them" (Participant 3).
Linking with local services	Networking	"It was a good opportunity to network and meet other professionals from other services." (Participant 21).
	Improved professional support networks	"I'm organising consultations for staff with LMM to ensure the topic of parent-infant relationships is on our forefront when working with families." (Participant 11).

4. Discussion

The aim of this Service Evaluation Project was to explore whether the Infant Mental Health training influenced professionals' practice, and if so, how?

From the 344 professionals who attended the training from November 2018 to March 2020, all professionals reported that the training was useful to their practice. They also reported an improvement in their knowledge across all four evaluated domains; 'infant mental health', 'babies brain development', 'attachment' and 'parent-infant relationships'. This improvement was also fairly consistent across all professional groups .

Furthermore, 40 professionals provided follow-up feedback through a combination of individual interviews and evaluation forms about how they are implementing their learning from the training into their practice. All professionals reported that the training had influenced their practice in some way, summarised as gaining improved awareness, knowledge and skills, improved confidence in consolidation of skills, and providing an opportunity to link with local services.

These are important and worthy findings as they fulfil the training aims to upskill professionals to feel more equipped and confident to provide early intervention to parents/carers and their infants. As such, the findings suggest that LMM is also fulfilling national governmental aims outlined by 1001 Critical Days political manifesto report (Durkan et al., 2016) and the Rare Jewels report (Hogg, 2019). Both of these recommend that high-quality training should be delivered to the child and family workforce in order to offer the most effective service possible within the current climate of austerity. Although Infant Mental Health services like LMM should not be viewed as the resolution for the current challenges for the health and care system (Hogg, 2019), it is promising to learn that the training offer is being positively implicated in child and family practice. As such, this is increasing the likelihood of professionals contributing to the strengthening of parent-infant relationships when families are living in adversity, and in turn, supporting positive social and emotional infant development during their critical period (Groh et al, 2017; Durkan et al., 2016).

4.1. Strengths and Limitations

There are distinct limitations identified. Firstly, difficulties arose in recruitment which led to the data being a mix of individual interviews and evaluation form feedback. Whilst the use of one method is preferred, it was felt that 4 interviews did not provide sufficient richness in the quality of the data (Tracy, 2019). However, as the evaluation forms remain completely anonymous, the possibility of social desirability bias was reduced. Additionally, as the feedback was a combination of written and verbal, participants were therefore given the opportunity to provide feedback in a method of their choice.

Possible reasons for a small sample size should be noted; during the data collection between May – July 2020 we were amidst a global pandemic which largely required significant changes to professionals' working, where a large proportion of community professionals were required to work from home. Thus, responding to the evaluator's email invitation to provide feedback may not have been a priority for them at that time. If there were not time restrictions, it might have been more appropriate to wait before recruiting, so that professionals would feel more settled into their new remote working routines.

Secondly, there should be consideration of potential positive bias in the findings. Although the inclusion criteria for participants required that they had not accessed the service for consultation, some local services appear to have built good working relationships with LMM and so may be biased in the feedback that they offer. However, this may have been more problematic if the sample was wholly from interviews where participants may have been more inclined to offer socially desired information. Instead, the sample was from a combination of written and verbal feedback, which arguably, provided an opportunity for professionals to share honest negative implications from their learning.

A further limitation is with regards to the likelihood of capturing participants' negative or 'average' experience of the training, as all feedback collected was of a positive nature. Evidence suggests that people are sometimes reluctant to provide negative feedback (Levy et al., 1995) which will affect the generalisability of the findings. However, the service actively seeks feedback from their trainees, which is valuable for obtaining the most useful information about their performance possible (Levy et al., 1995). Due to this limitation, future evaluation could build on the existing SEP to consider how to capture more perspectives of professionals' experience of the training, and whether professionals' practice has changed in other ways?

5. Conclusion and Recommendations

Overall, this SEP achieved its aims of exploring the usefulness and impact of training on professionals' practice. As such, the following recommendations have been made:

1. LMM should continue to offer the Infant Mental Health Awareness training across Bradford as all professionals who provided feedback found the training useful to their role and implemented their learning into their practice in some way.

2. The training should also continue to be offered across all professionals who work in child and family settings in Bradford.

3. To consider further evaluation to build on the existing SEP about how best to capture more perspectives of professionals' experience of the training (inclusion of neutral and negative experiences), and to consider whether professionals' practice has changed in other ways?

6. Dissemination of this evaluation

This SEP has been, and aims to be, disseminated in the following ways:

- A presentation of the SEP at the Clinical Psychology Doctorate Programme at the University of Leeds as part of the SEP Conference.

- A summary of the findings in an email to all professionals who participated.

- A presentation of the SEP at LMM Open Day for professionals.

- Preliminary findings were included in the Annual Report presented to the service's Clinical Commissioning Group.

- Aim to write an article for publication.

7. References

Ainsworth, M. D. (1964). Patterns of attachment behaviour shown by the infant in interaction with his mother. *Merrill-Palmer Quarterly of Behaviour and Development*, 51–58.

Ainsworth, M. D. (1968). Object relations, dependency, and attachment: A theoretical review of the infant mother relationship. *Child Development*, 40(4), 969–1025.

Ainsworth, M. D. (1982). Attachment: Retrospect and prospect. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behaviour*. Basic Books.

Alliger, G. M., & Janak, E. A. (1989). Kirkpatrick's levels of training criteria: Thirty years later. *Personnel psychology*, *42*(2), 331-342.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings.

Bowlby, J. (1969). *Attachment. Attachment and loss: Vol. 1. loss*. Basic Books.

Bowlby, J. (1980). *Loss: Sadness & depression. Attachment and loss* (Vol. 3, (International psycho-analytical library no.109)). Hogarth Press.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2), 77–101.

Broad, M. L., & Newstrom, J. W. (1992). *Transfer of Training: Action-Packed Strategies to Ensure High Payoff from Training Investments*. Corporate and Professional Publishing Group, Addison-Wesley Publishing Co., Reading.

Durkan, M., Field, F., Lamb. & Loughton, T. (2016). *The 1001 critical days: the importance of the conception to age two period: a cross party manifesto*. London: DH. https://www.nspcc.org.uk/globalassets/documents/news/critical-days-manifesto.pdf.

Groh, A. M., Fearon, R. M. P., Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., & Roisman, G. I. (2017). Attachment in the early life course: Meta-analytic evidence for its role in socioemotional development. *Child Development Perspectives*, 11(1), 70–76.

Grossmann, K., & Grossmann, K. E. (2020). Essentials when studying child-father attachment: A fundamental view on safe haven and secure base phenomena. *Attachment & Human Development*, 22(1), 9–14.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.

Ham, C., Berwick, D., & Dixon, J. (2016). Improving quality in the English NHS. *London: The King's Fund*.

Hogg, S. (2019). *Rare Jewels: Specialised parent-infant relationship teams in the UK*. Parent Infant Partnership, UK. https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/

Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing*. Wiley-Blackwell.

Holton III, E. F. (1996). The flawed four-level evaluation model. *Human resource development quarterly*, *7*(1), 5-21.

Hunter, R., Glazebrook, K., & Ranger, S. (2020). The Leeds Infant Mental Health Service: early relationships matter. *Journal of Reproductive and Infant Psychology*, 1-14.

Kirkpatrick, D. L. (1983). Four steps to measuring training effectiveness. *Personnel Administrator*, *28*(11), 19-25.

Leach, P. (2018). Transforming Infant Wellbeing – Research, policy and practice for the First 1001 critical days. Routledge.

Levy, P. E., Albright, M. D., Cawley, B. D., & Williams, J. R. (1995). Situational and individual determinants of feedback seeking: A closer look at the process. *Organizational Behaviour and Human Decision Processes*, *62*(1), 23-37.

NHS England. (2019). *The NHS Long Term Plan.* https://www.longtermplan.nhs.uk/

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, *16*(1), 1609406917733847

Rajeev, P., Madan, M. S., & Jayarajan, K. (2009). Revisiting Kirkpatrick's model–an evaluation of an academic training course. *Current science*, 272-276.

Sandelowski, M. (2004). Using qualitative research. *Qualitative health research*, *14*(10), 1366-1386.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22(1–2), 7–66.

Sunderland, M. (2016). *What every parent needs to know: Love nurture and play with your child*. DK.

Tracy, S. J. (2019). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. John Wiley & Sons.

24

8. Appendices

Appendix A – Self Appraisal form

Appendix B – Recruiting email

Appendix C – Interview Schedule

Appendix D – Follow-up evaluation form

Appendix E – Participant Information Sheet

Appendix F – Consent form

Appendix G – Professional roles

Appendix H – Further demographic information

Appendix I - Quantitative analysis of pre and post training data

8.1. Appendix A: Self Appraisal Form (removed)

8.2. Appendix B: Recruiting Email

Email 1: Email to professionals re telephone interview

Subject: invitation to provide feedback about Infant Mental Health Awareness training

Dear colleague,

Thank you again for attending our Little Minds Matter Training; we hope that you found it beneficial.

As you know, your feedback is extremely important to us. We would like to invite you to speak with Lucy Kerrigan, Psychologist in Clinical Training, who is independent from the team to share your feedback on whether the training has influenced your practice. This can be conducted over the telephone, remotely via virtual means, or face-to-face if necessary once lockdown restrictions relax to allow this. All feedback will be anonymised and will help us to shape our future training offer.

Please see attached the Participant Information Sheet and Consent Form, detailing the study. If you decide to take part in the study, you will be required to read these prior to your interview.

If you would like to know more information or participate, please contact Lucy Kerrigan via email: umlck@leeds.ac.uk.

Thank you for your time. We look forward to hearing from you.

Best wishes,

Dr Matthew Price
Principal Clinical Psychologist - Infant Mental Health Pathway Lead
Little Minds Matter: Bradford Infant Mental Health Service
Bradford District Care NHS Foundation Trust

8.3. Appendix C: Interview Schedule

Interview Guide

Thank you for agreeing to take part in the evaluation of our training. We really value your input.

I will start by summarising the main points covered in the participant information sheet. I will then go through the consent form and ask for your verbal consent in participating in this study.

A summary of the participant information sheet is as follows:
- *Both your personal information and your interview will be kept strictly confidential. However, it is our duty of care to inform appropriate services if you disclose that you or others are at risk of harm. Any necessary steps for safeguarding purposes will remain your responsibility.*
- *Your interview will be audio recorded and will be deleted following transcription of the data.*
- *You can withdraw your data up to seven days after the interview.*
- *Results of the study may be published in a journal article, but you will not be identified in any report or publication.*

Do you have any questions?

In order to gain your verbal consent to participate in the project, it is also necessary to audio record our discussion of this. This is where I will talk through the consent form that you were sent in the initial email and ask you if you agree.

Are you happy for me to start the audio recorder?

Audio recorder is on now.

Do you confirm that you have read and understood the information sheet explaining this project, and that you have had the opportunity to ask questions about the project?

Do you agree that the data collected from yourself will be stored and used in relevant future research in an anonymised form?

Do you understand that relevant sections of the data collected during the study may be looked at by auditors from the University of Leeds or from regulatory authorities where it is relevant to your taking part in this evaluation project? Do you give permission for these individuals to have access to your data?

Do you give your consent for audio recordings of the interview to be made? Do you understand that this is for the purposes of analysing the information you provide in the interview to allow for the anonymous reporting of the feedback? Do you understand that any person hearing the tape will keep the information confidential, and that recordings will be stored under secure conditions?

Finally, do you agree to take part in this service evaluation project?
Will you inform me if your contact details change during the project, and if necessary, afterwards?

Thank you very much.

I'm not part of the Little Minds Matter team and work independently from them. We hope that this will allow you to describe your experience as fully as possible.

We will spend approximately 15 minutes discussing whether the training has impacted on your practice.

Do you have any questions before we start?

1) *What is your job role?*

2) *When did you attend the Little Minds Matter training?*

3) *What are the key points you remember learning from the training?*

4) As a result of the training, has anything changed about your practice?
   *(Prompt depending on profession, for example in your work with
    infants and/or their families? Or other professionals working with families)*

   If yes, do you have a specific example?

   If no, why do you think this is?

5) Would you recommend the training to a colleague?

   If yes, is there anything that could improve it further?

   If no, what would make it more likely for you to recommend it?

6) Is there anything else you would like to tell me about your experience of the training?

7) Do you have any other questions for me?

Thank you for your time.

8.4. Appendix D: Follow-up Evaluation Form

8.5. Appendix E: Participant Information Sheet

Participant Information Sheet

The title of the service evaluation project

Turning Training into Practice; Does Infant Mental Health Training Influence Practice?

Ethical approval

Ethical approval has been given by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC -19-004).

Invite to participate

You are being invited to participate in a service evaluation project for the Little Minds Matter: Infant Mental Health Service.

Before you decide whether to take part in providing verbal feedback to inform the evaluation, it is important for you to understand why the evaluation is being conducted and what your participation will involve. Please take time to read the following information carefully. You are welcome to ask further questions if you wish. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

The purpose of this service evaluation project is to evaluate the training work stream of the Little Minds Matter service. The Infant Mental Health Awareness training session will be evaluated. The results of the evaluation may be used by the service to discuss the work they do with external organisations.

To build on the feedback that you gave before and after the training, you are invited to participate in a semi-structured telephone interview. This interview will take up to 15 minutes and will involve a discussion regarding whether your clinical practice has changed since having received the Infant Mental Health training.

Recording of interviews

To ensure that the analysis and findings are accurate and of a high quality, it is necessary to audio record your telephone interview.

The audio recordings of our telephone interview will be used only for analysis. No other use will be made of them and no one outside the project will be allowed access to the original recordings. They will be deleted immediately following transcription of the data. All audio recordings will be stored on a private and secure university computer drive.

Why have I been chosen?

All practitioners who attended the Little Minds Matter full day training, signed up to their mailing list, and not used their consultation services have been invited to participate in this evaluation.

Do I have to take part?

It is entirely up to you whether to take part in this evaluation project. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw up to a week following your interview. Withdrawing will not impact on any future support you may seek from the Little Minds Matter service.

What do I have to do?

You will be asked to participate in one telephone interview, which will take up to 15 minutes. You will be asked questions which are opened ended and will ask you to draw on your experiences of attending the infant mental health training and whether this has influenced your clinical practice.

What are the possible disadvantages and risks of taking part?

The nature of the clinical work in infant mental health is potentially distressing, therefore there is a risk that the interview may trigger distress when reflecting on your experience.

If this occurs, it may be appropriate to signpost you to consult with the Little Minds Matter team or seek clinical supervision within your service. Please note, it will be your responsibility to co-ordinate this.

What are the possible benefits of taking part?

This evaluation will help the service to better understand the value of its training offer and how this might be improved for future attendees. The results will also be used by the service to discuss the work with external organisations.

Use, dissemination and storage of data

Findings from the project will be:

- included in the 2019-2020 Little Minds Matter Annual Report
- shared with commissioners and senior stakeholders within Bradford District Care NHS Foundation Trust and Better Start Bradford
- shared as a poster at a Better Start Bradford "Knowledge Café"
- shared as a poster at the University of Leeds Service Evaluation Project Poster Conference.

It is also hoped that the project will be published in a journal article.

What will happen to my personal information?

The data will be identifiable until the seven-day withdrawal window has ended. Following this, the data will be fully anonymised.

Prepared on the Leeds D.Clin.Psychol.Programme, 2020

All data will be stored on a private university computer drive and will be deleted following publication of the project.

There are limits to anonymity:

- anonymised quotes will be used with identifying details changed so that no-one else can identify them.
- it is our duty of care to inform appropriate services if you disclose that you or others are at risk of harm. Any necessary steps for safeguarding purposes will remain your responsibility.

For further information about the University's use of personal data, please see: https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf. A copy of this University Research Participant Notice guidance has also been sent to you via email with this Participant Information Sheet.

What will happen to the results of the service evaluation project?

All the contact information that we collect about you during the evaluation will be kept strictly confidential and will stored separately from the data collected through your telephone interview.

As mentioned previously, the results will be disseminated through several means, and likely be published. As a participant, you will not be identified in any report or publication.

What type of information will be sought from me and why is the collection of this information relevant for achieving the service evaluation project's objectives?

Who is organising / funding the project?

The evaluation will be conducted on behalf of the Little Minds Matter, Infant Mental Health Service. The interviewer will be a Psychologist in Clinical Training, independent of the Little Minds Matter Service, completing a Service Evaluation Project as part of the Doctorate in Clinical Psychology training programme at the University of Leeds.

Contact for further information

Lucy Kerrigan, Psychologist in Clinical Training at the University of Leeds will be conducting the Service Evaluation Project and facilitating the telephone interviews. Lucy is contactable via email on: umlck@leeds.ac.uk.

Lucy is supervised to conduct this project by Ciara Masterson, Academic Tutor. Ciara is contactable by email on: c.masterson@leeds.ac.uk.

You will be given a copy of this information sheet, and if appropriate, a signed consent form to keep.

Thank you for taking the time to read through the information.

8.6. Appendix F: Consent Form

<div align="center">Consent Form</div>

Consent to take part in the Service Evaluation Project – 'Turning Training into Practice; Does Infant Mental Health Training Influence Practice?

I confirm that I have read and understand the information sheet dated 30/03/20 explaining the above research project and I have had the opportunity to ask questions about the project.
I agree for the data collected from me to be stored and used in relevant future research in an anonymised form.
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
I give my consent for audio recordings of the interview to be made. I understand that this is for the purposes of analysing the information I provide in the interview to allow for the anonymous reporting of the feedback. I understand that any person hearing the tape will keep the information confidential, and that recordings will be stored under secure conditions.
I agree to take part in the above research project and will inform the lead evaluator should my contact details change during the project and, if necessary, afterwards.

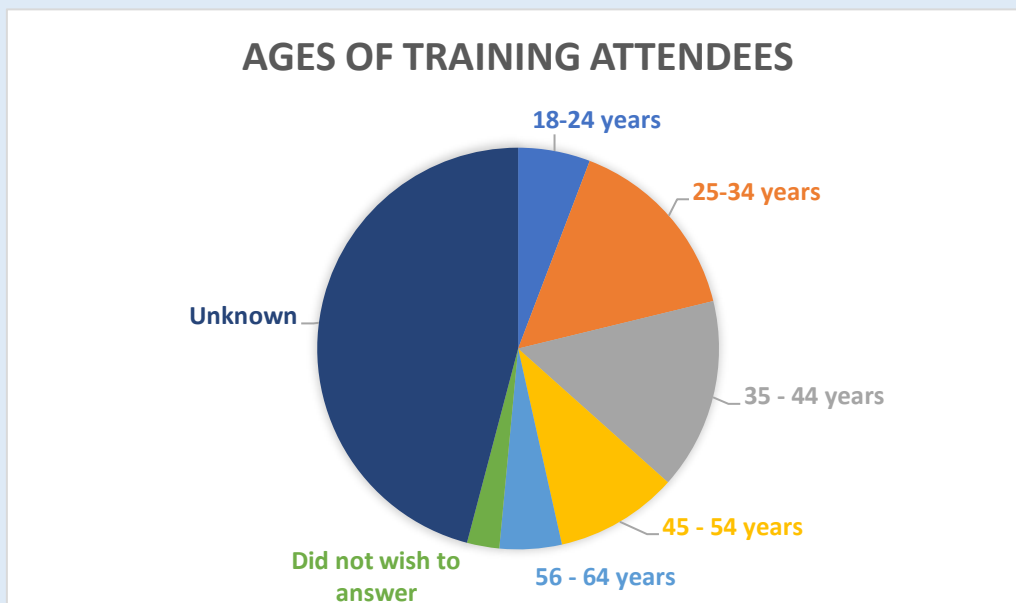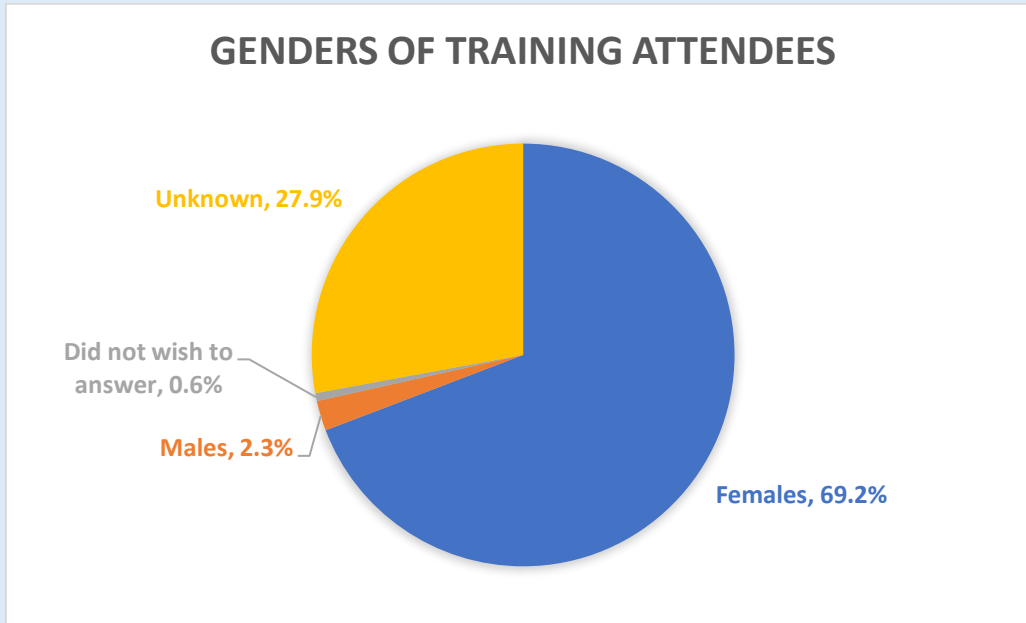|	
Date	
Name of participant	
Name of evaluator	
Electronic Signature (by evaluator but verbally agreed by the participant)	

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8.7. Appendix G: Professional roles

A table outlining the specific roles of professionals and category they were grouped into for the purpose of analysis.

Service type	Professional role
Breast Feeding	Breast Feeding Support Worker
	Breast Feeding Support Service Team Leader
Midwifery	Community Midwife
	Student Midwife
Mental Health	Perinatal Worker
	Perinatal Co-ordinator
	CAMHS Primary Mental Health Worker (PMHW)
	Adult Mental Health Services Care Co-ordinator
Early Years and Development	Educational Psychologist
	Education Audiology Officer
	Hearing Impairment Team
	Infant Feeding Co-ordinator
	Sensory Service – Specialist early years practitioner
	Specialist Therapeutic Key Worker Inclusive Education
	Paediatrician
	Language Development Programmes Manager
	Pregnancy and Post – Project Manager
	ICAN co-ordinator
Early Years Education and Childcare	Storyteller
Family Support	Neighbourhood Engagement Worker
Non-clinical staff	Better Start Bradford (BSB) Community Project Officer
	BSB Programme Facilitator
	BSB Programme Co-ordinator
	Liaison and Diversion Project Worker
	BSB Project Co-ordinator
	Little Minds Matter Administrator
	BSB integration and change officer
Physical Health	Neonatal Staff Nurse
	Neonatal Senior Sister
Health Visiting	Health Visitor

8.8. Appendix H: Further demographic information.

Here, further demographic information is included for professionals who attended the training.

GENDERS OF TRAINING ATTENDEES

- Unknown, 27.9%
- Did not wish to answer, 0.6%
- Males, 2.3%
- Females, 69.2%

AGES OF TRAINING ATTENDEES

- 18-24 years
- 25-34 years
- 35 - 44 years
- 45 - 54 years
- 56 - 64 years
- Did not wish to answer
- Unknown

The ethnicity of training attendees:

Ethnicity of professionals who attended	Percentage
Pakistani	11.6%
White English/Welsh/Scottish/Northern Ireland/British	43.3%
Indian	2.9%
Mixed White and Black Caribbean	2.6%
Other Asian	1.7%
Mixed white and Asian	0.9%
Caribbean	0.9%
Bangladeshi	0.6%
White Irish	1.2%
Any other mixed/multiple ethnic background	1.2%
African	1.7%
Any other ethnic background	0.9%
White Polish	0.9%
Chinese	0.6%
Other black	0.3%
Other white	0.3%
White Czech	0.3%
Don't wish to answer	0.3%
Unknown	27.9%

Qualification of professionals who attended	Percentage
(Young) Apprenticeship NVQ3	2.33%
5 or more GCSE's (A*-C), CSEs or O-levels	2.61%
Advanced Apprenticeship	0.29%
AS or A-level International	1.45%
Baccalaureate or BTEC	0.29%
Bachelors degree 3 – 5 years	25%
Doctorate	0.58%
Foundation Degree	6.69%
GNVQ Intermediate Level NVQ 2	1.74%
Higher National Certificate/Higher Diplomas, Higher education Diploma	6.40%
Less than 5 GCSEs (A*-C), CSE or O-Levels	1.45%
Masters Degree (taught/research) or Postgraduate Qualification/Doctorate	17.73%
NVQ 4/5	1.45%
Other	0.58%
None of these	0.29%
I do not wish to answer	1.16%
Unknown	29.94%

The Bradford Child and Family services and organisations in which the training attendees work in:

Organisations which professionals work in	Percentage
Baby Steps	2.3%
Midwifery	5.2%
Family Action Perinatal Support	2%
Better Start Bradford	12.2%
HAPPY	2%
Bradford Doulas	1.2%
Little Minds Matter	1.2%
Talking Together	2%
Health Visiting	4.4%
Early Years Practitioner	1.7%
Breast Feeding Support	1.2%
ICan Early Language Dev.	0.3%
Innovation Hub	0.3%
HENRY	1.5%
ESOL Plus	0.3%
Bradford Trident	0.3%
Adult Service	0.6%
Other	22.7%
Unknown	39%

8.9. Appendix I: Quantitative analysis of the pre and post training data

Included here is the detailed quantitative analysis collected from the evaluation forms distributed before and immediately following the training.

Quantitative Findings

Overall, professionals who attended the training reported significantly more knowledge and understanding in all areas focussed upon. These include infant mental health, babies' brain and development, attachment theory and parent-infant relationships.

Using a repeated measures t-test, the following was found:

> On average, trainees reported significantly more knowledge and understanding in **infant mental health** following the training (M = 7.07, SE = .12) compared to the beginning of the training (M = 4.6, SE = .12), $t(365)$ = -19.48, p = .000.

> Similarly, they also reported having significantly more knowledge and understanding in **babies brain development** at the end of training (M = 7.05, SE = .13) compared to the beginning (M = 5.04, SE = .12), $t(365)$ = -17.24, p = .000.

> Trainees described having more knowledge and understanding in **attachment theory** at the end of training (M = 7.52. SE = .13) compared to the beginning of the training (M = 5.98, SE = .12, $t(366)$ = -13.44, p = .000.

> Trainees also reported more knowledge and understanding in **parent-infant relationships at** the end of the training (M = 7.41, SE = .13) compared to the beginning (M = 5.88, SE = .11), $t(365)$ = -13.72, p = .000.

14 participants completed the questionnaire at the beginning, but not at the end. Using a repeated measures t-test, the findings showed that:

> Those who did not complete the questionnaire at the end, did not report significantly different baselines scores to those in **Infant mental health knowledge** (M = 4.5, SE = .66), compared to those who did complete the questionnaire at the end (M = 5.29, SE = .42), $t(13)$ = -1.32, p = 2.09.

> Similarly, when considering the baseline scores in trainees reported knowledge and understanding in **babies brain development,** those who did not complete the questionnaire at the end of the training (M = 4.8, SE = .66) did not report significantly different scores to those who did (M = 5.8, SE = .47), $t(13)$ = -1.74, p = .10.

> There was not a significant difference in baseline scores in trainee's knowledge and understanding of **attachment theory** for those did not complete the questionnaire at the end of the training (M = 5.57, SE = .57), compared to those who did (M = 7.14, SE = .44), $t(13)$ = -.30, p = 0.2.

> Moreover, there was not a significant difference in trainees baseline knowledge of **parent-infant relationships** for those who did not complete the questionnaire at the end of training (M = 5.46, SE = .55) compared to those who did (M = 7.00, SE = .51), $t(12)$ = -2.38, p = .04.

However, the mean baseline scores for all domains are higher for the group of trainees who completed the evaluation forms both before and following the training. Thus, practitioners who only completed the forms at the beginning and not at the end, generally do not report having more knowledge in the training domains.

Further Breakdown of knowledge and understanding amongst the different professions who participated:

Midwives: (N = 33)

Midwives reported more knowledge and understanding in **Infant Mental Health** at the end of the training (M= 7.76, SE= .23) compared to the beginning of the training (M = 4.82, SE = .32), $t(32)$ = -10.56, p=.000.

Midwives also reported more knowledge and understanding in **Babies Brain Development** at the end of training (M = 7.82, SE =.20), compared to the beginning of the training (M= 5.00, SE = .30), $t(32)$ = -9.61, p = .000.

Additionally, they reported having more knowledge and understanding in **Attachment** at the end of the training (M = 8.36, SE = .17) compared to the beginning (M =6.15, SE = .31), $t(32)$ = -8.50, p = .000.

Finally, they also reported having more knowledge and understanding in **Parent and Infant Relationships** following the training (M = 8.27, SE = .18) compared to the beginning (M = 6.30, SE = .29), $t(32)$ = -7.82, p = .000.

Health Visitors: (N = 22)
Health Visitors also reported significantly increased understanding in the four domains:

They reported significantly more knowledge and understanding in **infant mental health** following the training (M= 8.00, SE = .30), compared to the beginning (M=6.33, SE = .33), $t(19)$ = -4.66, p = .000.

Similarly, Health Visitors reported significantly more knowledge in **Babies Brain Development** following the training (M= 8.09, SE = .28), compared to the beginning (M= 6.34, SE=.36), t(21) =-5.08, p = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (M= 8.29, SE = .29) compared to the beginning (M = 6.74, SE = .34), $t(20)$ = -5.02, p = .000.

Health Visitors also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.27, SE = .26), compared to the beginning (M = 6.88, SE = .301, $t(21)$ = -4.71, p = .000.

Breast feeding: (N = 8)

Interestingly, breast feeding did not report significantly different scores before and after training in the domains.

They reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.25, *SE* = .16) compared to the beginning (*M* = 4.88, *SE* = .74), *t*(7) = -3.50, *p* < .05.

Breast feeding workers also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 6.88, *SE* = .35), compared to the beginning (*M* = 4.76, *SE* = .16), *t*(7)= -3.48, *p* <.05.

However, they did not report a difference in their knowledge and understanding of **Attachment theory** at the end of training (*M* = 7.38, *SE* = .18) compared to the beginning (*M* = 6.38, *SE* = .56), *t*(7) = -1.87, *p* = .10. Although, the mean scores indicate that there was an increase in rating.

Similarly, they also did not rate a significant difference in their knowledge and understanding in **Parent-Infant Relationships** at the end of the training (*M* = 7.38, *SE* = .26), compared to the beginning (*M* = 6.13, *SE* = .66), *t*(7) = -2.24, *p* = .06.

Neonatal Care: (N=23)

Neonatal care professionals reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.70, *SE* = .32) compared to the beginning (*M* = 4.78, *SE* = .31), *t*(22) = --9.48, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 7.83 *SE* = .32), compared to the beginning (*M* = 5.35, *SE* = .36), *t*(22)= -8.3, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 8.00, *SE* = .27) compared to the beginning (*M* = 6.43, *SE* = .29), *t*(22) = -10.31, *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.00, SE = .27), compared to the beginning (*M* = 6.17, *SE* = .27, *t*(22) = -9.35, *p* = .000.

Mental Health Professionals: (N= 46)

Mental Health professionals reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.41, *SE* = .21) compared to the beginning (*M* = 4.45, *SE* = .32), *t*(45) = -12.11, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 6.81 *SE* = .25), compared to the beginning (*M* = 4.25, *SE* = .33), *t*(45)= -10.99, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 7.80, *SE* = .21) compared to the beginning (*M* = 5.92, *SE* = .31), *t*(45) = -6.88, *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 7.64, *SE* = .21), compared to the beginning (*M* = 5.55, *SE* = .30, *t*(45) = -8.77, *p* = .000.

Social Care: (23)

Social Care professionals reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.40, *SE* = .27) compared to the beginning (*M* = 5.61, *SE* = .39), *t*(22) = -5.27, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 7.61 *SE* = .28), compared to the beginning (*M* = 5.87, *SE* = .42), *t*(22)= -5.87, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 8.22, *SE* = .23) compared to the beginning (*M* = 6.96, *SE* = .36), *t*(22) = -5.14, *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.00, *SE* = .25), compared to the beginning (*M* = 6.72, *SE* = .41, *t*(21) = -4.12, *p* = .000.

Family Support: (N= 32)

They reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.41, *SE* = .24) compared to the beginning (*M* = 4.76, *SE* = .28), *t*(31) = -9.28, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 7.44 *SE* = .26), compared to the beginning (*M* = 5.10, *SE* = .33), *t*(31)= -7.27, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 8.22, *SE* = .23) compared to the beginning (*M* = 6.96, *SE* = .36), *t*(22) = -5.14, *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 7.94.00, *SE* = .17), compared to the beginning (*M* = 5.77, *SE* = .25, *t*(29) = -9.57, *p* = .000.

Early Years and Development: (N=46)

They reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.70, *SE* = .15) compared to the beginning (*M* = 4.98, *SE* = .31), *t*(45) = -9.08, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (M = 7.85 SE = .17), compared to the beginning (M = 5.67, SE = .33), t(45)= -7.44, p = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (M= 8.2, SE = .17) compared to the beginning (M = 6.52, SE = .31), t(45) = -6.00, p = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.20, SE = .17), compared to the beginning (M = 6.52, SE = .30, t(45) = -5.87, p = .000.

Foster Carers: (N=4)

Foster Carers reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (M= 7.50, SE = .29) compared to the beginning (M = 3.25, SE = 1.31), t(3) = -3.09, p =.05.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (M = 8.25 SE = .48), compared to the beginning (M = 5.00, SE = .82), t(3)= -4.33, p < .05

However, foster carers did not report a significant difference in their knowledge and understanding in **Attachment** following the training (M= 8.50, SE = .50) compared to the beginning (M = 7.75, SE = .85), t(3) = -1.19, p = .32.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 7.75, SE = .48), compared to the beginning (M = 4.25, SE = .94, t(3) = -5.42, p <.05.

Physical Health (N= 11)

Physical Health professionals reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (M= 7.36, SE = .31) compared to the beginning (M = 4.27, SE = .68), t(10) = -4.84, p =.001.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (M = 7.72 SE = .33), compared to the beginning (M = 3.81, SE = .74), t(10)= -6.57, p = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (M= 8.10, SE = .28) compared to the beginning (M = 5.63, SE = .81), t(10) = -3.69 , p = .004.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.00, SE = .33), compared to the beginning (M = 5.36, SE = .69, t(10) = -4.70, p = .001.

Early Years Education & Childcare (N=14)

They reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 8.50, *SE* = .27) compared to the beginning (*M* = 5.50, *SE* = .56), *t*(13) = -5.14, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 8.50 *SE* = .34), compared to the beginning (*M* = 5.86, *SE* = .58), *t*(13)= -4.98, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 8.64, *SE* = .41) compared to the beginning (*M* = 6.14, *SE* = .57), *t*(13) = -5.11 , *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 8.64, SE = .29), compared to the beginning (*M* = 6.07, *SE* = .51, *t*(13) = -5.39, *p* = .000.

Non-clinical staff (N=36)

Non-clinical professionals reported that their knowledge and understanding in **Infant Mental Health** was significantly higher following the training (*M*= 7.69, *SE* = .17) compared to the beginning (*M* = 5.31, *SE* = .33), *t*(35) = -8.14, *p* =.000.

They also rated themselves as having significantly more knowledge and understanding in **Babies Brain Development** at the end of the training (*M* = 7.64, *SE* = .20), compared to the beginning (*M* = 5.64, *SE* = .36), *t*(35)= -7.84, *p* = .000.

They also reported significantly more knowledge and understanding in **Attachment** following the training (*M*= 8.03, *SE* = .14) compared to the beginning (*M* = 6.33, *SE* = .33), *t*(35) = -5.90 , *p* = .000.

They also reported more knowledge and understanding in **Parent-Infant Relationships** following the training (M= 7.92, SE = .17), compared to the beginning (*M* = 6.53, *SE* = .24, *t*(35) = -8.15, *p* = .000.