Written evidence submitted by Thrive FTC (EYI0040)

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Summary

- This submission responds to the Science and Technology Committee's inquiry, specifically in examining the quality of the existing evidence-base for specific early-years interventions that aim to address Adverse Childhood Experiences (ACE's) and minimise their effects in later life
- The aim of our submission is to establish Thrive's credibility in supporting neurodevelopment, both typical and disrupted, and to stimulate our involvement in research to better understand the long-term impacts of our intervention
- Thrive trains caring adults to support children as life unfolds and repairs disrupted development that results when a child's social and emotional needs have not been met. ACEs studies have already drawn a link between disrupted neurodevelopment and poor life outcomes
- The Thrive Approach is a well-established intervention, with application in early years, childhood and adolescence. It is both a universal and a targeted approach. It is used in early years settings, mainstream and independent schools, special schools, alternative provision, families and community settings
- Through online tools, training and mentoring, the approach supports practitioners to learn about the social and emotional development relevant to a child's age; in addition to understanding a child's challenging behaviour as communication. Every child gets a personal plan with simple, practical ideas and advice for the practitioner or parent/carer about how to be and what to do to implement the plan. The results are easily monitored
- Online assessment gives a baseline, monitors progress and provides us with our evidence base. At present, evidence produced by our assessments is mainly used by schools in preparation for their Ofsted inspections to demonstrate the impact of the intervention on attainment and behaviour
- The Thrive Approach provides protective development, and both identifies and addresses the neurobiological disruptions that result from ACEs. A pathology of the presenting trauma is not required, instead moving towards good mental health and wellbeing rather than putting focus on diagnosing causes of poor mental health, although the result is the same. A standpoint is taken that adults are doing the best they can with the resources they have available to them at that time and by providing adults with ways to be with children and with strategies, their effectiveness can be dramatically enhanced
- The Thrive Approach helps settings to achieve the recommendations in the NICE guidelines for social and emotional development in early years
- Currently, the evaluation of our own data is focused on our childhood work. There is potential to exploit our data further, particularly in areas where children have progressed through early years, childhood and then adolescent settings. The data set for these children may not be large, but likely to lead to meaningful insight

We would welcome involvement in research to compare Thrive outcomes with those from different interventions, in addition to comparison with children from the general population.

What is Thrive?

1. The Approach was developed in 1994 by a small group of specialists that included psychotherapists, teachers, Ofsted inspectors and social workers. It is currently in use in 1,748 settings (Children's Centres, early years settings, primary schools, secondary schools, pupil referral units and alternative provision). More than 30,000 staff have received Thrive training in the UK, ensuring more than 330,000 children and young people have access to the Thrive Approach. There are more than 3,000 current Licensed Practitioners in England and Wales. By the end of this academic year, an additional 1,500 Practitioners will have completed training. The Thrive Approach is informed by developments in neuroscientific research, and underpinned by a theoretical base in child development theory, attachment theory, Transactional Analysis, creativity, play and the arts. At the heart of the Approach lies the understanding that children's behaviour and skills, or skills deficits, represents a form of communication of underlying need. Following assessment, strategies and activities can be delivered by anyone who has received the right training.

2. Thrive is an intervention and comprises software diagnostic assessment which devises action plans to address social and emotional development needs. These needs can be 'right-time' (a child or young person working at the right developmental age) or 'reparative' (developmental age is below chronological age). The approach is universal, with children working below their social and emotional development age referred to a Thrive practitioner for specialist, targeted, reparative support.

3. Right-time support requires very little training, so that support can be provided to children by anyone who has attended an induction session and has access to TOL (Thrive-Online). Thrive is simple to understand and provides easy to use sets of age-appropriate activities and ways to be with children, so that children and families are not pathologised or stigmatised. For example, a practitioner dealing with an angry outburst will rely on the training and modelling they received to know how to validate how the child is feeling, attune to the child's emotions, provide safe containment to help the child feel that the emotions are survivable and then to help the child learn how to regulate their stress response. A child must have this done for them by a caring adult before they can do it for themselves. Normally, this development happens in the first eighteen months of age and needs repetition to be secure enough. A practitioner can support reparative development of the stress management system if this has been missed, and disrupted neurodevelopment can be caught up.

4. Reparative support is delivered by practitioners who have successfully attended intensive training. Practitioners include: learning support and teaching assistants, behavioural support specialists, occupational health therapists, educational psychologists, social workers, teachers, head teachers, foster carers, adopters, medical professionals and therapists. They specialise in Thrive early years, childhood or adolescent interventions. Licensed Practitioners can also provide support to families, including carers in implementing the child's action plan.

5. After a baseline assessment, progress can be monitored by carrying out further screenings to show progress.

The Relevance of Thrive to Adverse Childhood Experiences (ACEs)

6. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE's) study established that adverse childhood experiences disrupt neurodevelopment, which leads to social and emotional cognitive impairment. The study showed that this impairment was strongly related to adoption of high risk-behaviours, disease and social problems, leading to early death. This is conceptualised as the ACE pyramid.

7. The Thrive Approach identifies disrupted neurodevelopment (referred to as 'interruptions' in the Thrive Approach), using modern online software assessment tools. Groups of children can be screened, in addition to individual screening. The Thrive pyramid overlaps at the first three layers of the ACE pyramid, except that in Thrive, the first layer typically contains adverse childhood experiences and every-day life events. Both adverse and typically 'normal' events, such as the arrival of a new baby or moving area away from a supportive network, have the potential to disrupt neurobiology. These events can impact on social and emotional development to the extent that learning is not available and accessible, leading to social, emotional and cognitive impairment.

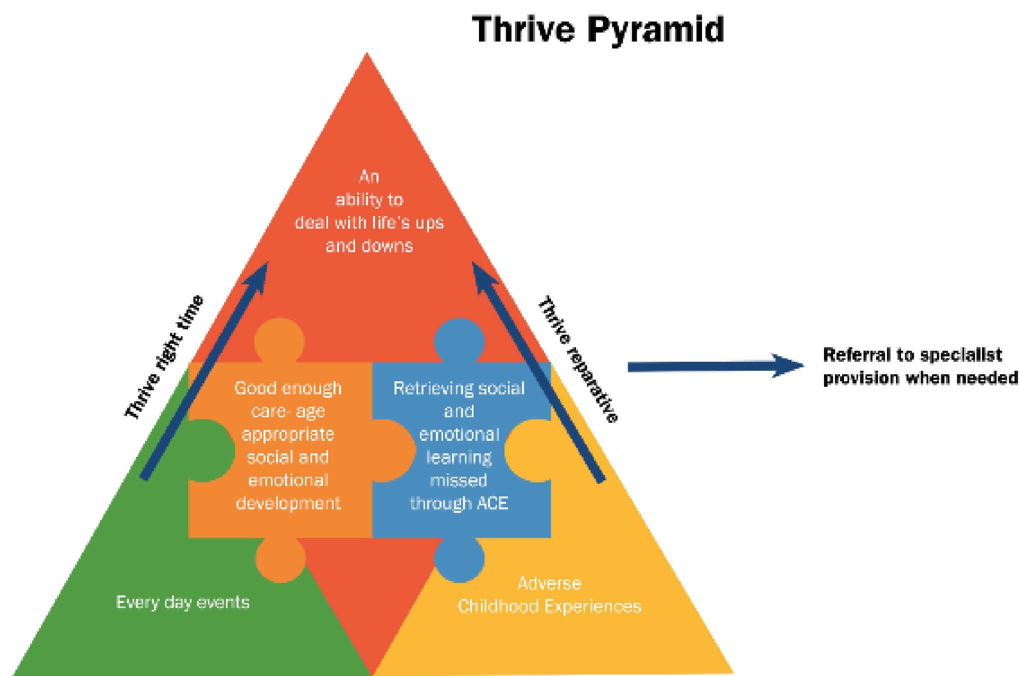
8. In the Thrive model, the presence of a protective factor is also shown, in the form of a Thrive-trained caring adult. As a result, assessing or identifying alternative sources of compensatory protection is not required as 'good enough' support is provided by Thrive-trained staff.

9. Good enough right time support meets the developmental needs of the child, appropriate to their chronological age, through repetition of activities that help form and myelinate neural connections. Neurobiological disruptions are addressed in the same way, but by using strategies and activities that are carefully chosen to compensate for the disruptions. If the disruption is conceptualised as a hole, repetition of the activities and strategies will close it.

10. The significance of the Thrive Approach as an early years intervention is that all activities are right time, no development has yet been missed. This period just before birth and up to 18 months of age is when the child's stress management system is being developed. It is this system that will go on to provide the core of the resilience that will be required in the face of both every day and adverse experiences that the child and adult will be exposed to in the future.

11. Therapists tell us that children find it difficult to grow out of a mental health diagnosis when what they often need is some health giving help. The Thrive Approach does not rely on a scarce supply of costly professionals, but harnesses the natural social sentience of humankind and communities; adults will do the best with the resources they have available to them. With some supportive strategies, a caring adult close to a child is the person best placed to provide what that child needs, unless referral to specialist services is indicated.

12. There is evidence that trained and supported staff are as effective as a therapist, but are non-stigmatising. Whilst the Thrive Approach is complementary to more formal interventions, it works alongside children as their lives are unfolding, rather than clocking-up and taking a tally of adverse events before a threshold for intervention is achieved.



The Relevance of Thrive to NICE Guidelines

13. There are five recommendations made in the NICE guidance for social and emotional wellbeing in early years:
    1. Strategy, commissioning and review
    2. Identifying vulnerable children and assessing their needs
    3. Antenatal and postnatal visiting
    4. Early education and childcare
    5. Delivering services

14. The Thrive Approach aids those that need to act to meet the recommendations set out above, by: supporting the need for universal and integrated strategies, identifying vulnerable children and assessing their needs, providing a high quality social and emotional service that builds children's capacity to learn, and providing opportunities for families to be involved.

15. Thrive is an effective method of addressing health inequalities, ensuring healthy child development and readiness for school. The Thrive Approach identifies children at risk or showing signs of social and emotional behavioural problems, an indicator of disrupted neurodevelopment. It is both a universal and targeted approach. It can work alongside early help provision and is complementary to therapy and mental health treatment. The assessment process highlights when referral to other services is indicated.

16. The intervention is structured, targeted and evidence-based. Online assessment tools provide a method of monitoring progress and outcomes. It works well when implemented as a 'services around the child' approach, to avoid multiple assessments, and provides a common language and continuity of support. Information can be shared, and training is accessible to multi-

disciplinary teams. Families and carers are involved with action plans and there is specific family-focused training in the Family Thrive for Parents and Carers course and in the Thrive at Home for Adoptive Parents and Long-term Foster Carers course. Due to the additional needs of Looked After Children (LACs), this is a specialist type of Thrive practitioner.

17. The Thrive Approach helps staff see and understand children in a new light, supporting the development of positive interactions. Practitioners commonly report the transformational impact of training in understanding a child's social and emotional needs.

Quality of the Evidence Base for Specific Early Years Interventions

18. Our understanding is that the evidence base for specific early years interventions is, as yet, underdeveloped. Research we have previously been, or are currently, involved in centres on interventions at childhood or adolescent stages. One current round of research aims to capture evidence for a new early years project, but no work has yet been undertaken on our existing data set. There is potential to map our progress to datasets held by others so that longitudinal studies can be explored. Where children have been involved in Thrive settings at early years, childhood and adolescent ages, it may be possible to assess the long-term impact of early years work. We would welcome involvement in this research.

19. The NSPCC report, 'How safe are our children' (https://www.nspcc.org.uk/globalassets/documents/research-reports/how-safe-children-2017-report.pdf - indicator 17), provides a comprehensive review of child protection. The report notes that the proportion of UK children on a child protection plan or register is higher than a decade ago, and that emotional abuse has increased as the reason for a child to be on a child protection plan or register in the last five years. These children will be experiencing the adverse events that lead to disrupted neurobiology. The report details statistics about looked after children, trafficked children, those with protection plans and on registers, referrals to social services and violence towards children. The report calls for further evidence to count every child that has been abused.

20. Worryingly, the Children's Society Good Childhood Report, 2017 (https://www.childrenssociety.org.uk/the-good-childhood-report-2017 - Page 5, para. 7), found that one million children have seven or more serious problems in their lives. It would be insightful to map the subjective wellbeing of these children to include type of intervention as a variable, to test if being involved has an impact on subjective wellbeing. To our knowledge, this has not been done with our data.

21. The NICE guidelines for social and emotional wellbeing in early years (https://www.nice.org.uk/guidance/ph40/chapter/appendix-d-gaps-in-the-evidence) identified several gaps in evidence, which includes the amount of evidence available on the effectiveness of different methods of delivering early interventions and, furthermore, the lack of evidence on differential impact (such as the impact on particular ethnic groups and on children whose parents have mental health problems). Whilst this report was published in 2012, we are not aware of these gaps being filled.

22. The Department for Health's report, Future in Mind (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Child

rens_Mental_Health.pdf 4.6, page 31) highlights the benefits of evidence based parenting programmes in intervening early for children with behavioural problems. Furthermore, the report adds that universal services, including Sure Start Children's Centres, play a key role in preventing mental health problems, which work best when they operate on a whole-system basis. The report calls on Public Health England to strengthen its work on core attributes that underpin mental health and resilience.

23. We note that the green paper, Transforming Children and Young People's Mental Health Provision, (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf - 118 Page 31) has recognised that babies with insecure or disorganised attachment issues are at greater risk of encountering a range of emotional and behavioural problems. The green paper notes that this is a particular issue for looked after and previously looked after children who have experienced disruptions and other adverse childhood experiences. We also note that the paper sets out that appropriately trained and supported staff achieve results comparable to those achieved by therapists. The report confirms the evidence gaps noted here.

24. The Thrive Approach is driven by research in the fields of neuroscience, attachment theory and child development theory. Our logic for change is to take modern advances in theory and science, to interpret this in to ways to be with children and strategies to implement. These are shaped in to high quality training to model the activities and ways to be so that people working with children can copy and integrate them in to their own contact with children. This transformational practice is under constant review, with materials and software being developed in systematic ways. We are actively seeking out involvement in addressing research gaps, both to better understand the effectiveness of our intervention and to further inform the development of our practice.

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