University of Dundee

Voice of the Infant

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Voice of the Infant Best Practice Guidelines and Infant Pledge

March 2023

Scottish Government
Riaghaltas na h-Alba

Voice of the Infant

Best Practice Guidelines
and
Infant Pledge

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Introduction

The Voice of the Infant Best Practice Guidelines and Infant Pledge have been co-produced by a short-life working group, on behalf of the Infant Mental Health Implementation and Advisory Group, which is part of the Scottish Government's Perinatal and Infant Mental Health Programme Board. Members are listed in Appendix 1.

The intention is to provide guidance on how to take account of infants' views and rights in all encounters they may have with professionals in statutory or third sector services, or in public spaces such as shops, libraries or galleries.

The term 'Voice of the Infant' is used to convey our understanding that babies have their own minds and have things to communicate from birth. The Guidelines offer suggestions about how those who work with babies and very young children* can notice, facilitate and share the infant's feelings, ideas and preferences which they have let us know about through their gaze, body language and vocalisations. The Infant Pledge (Appendix 2) sets out what infants should expect from those around them. It encourages mindful commitment to facilitate infants to express their feelings, and to consider their views, uphold their rights and take action accordingly.

This guidance is primarily written for all those who come into contact with babies and very young children through their work in community settings and nurseries, and in education, third sector, health and social services, both general and specialist. They can support infants to be active participants in these services, and inform the care and decisions that affect them. It may also be of interest to a wider audience including policy makers and families.

Context

Getting It Right For Every Child (GIRFEC) principles[1] and values should underpin all services. GIRFEC is the Scottish Government's commitment to provide all children, young people and their families with the right support at the right time. With the United Nations Convention on the Rights of the Child (UNCRC)[2] as its foundation, it provides an evidence-based consistent framework and shared language for promoting, supporting, and safeguarding the wellbeing of all children. Children's Services Plans (CSPs) provide the statutory framework for the strategic planning and delivery of local services and support for babies, children, young people, and families in each area of Scotland, so that they are delivered in a way that improves outcomes. This means identifying needs of the local population, gathering information on what kinds of support provide early help, preventing needs arising, where possible. CSP partners are required to give full consideration to the views and needs of all babies, children and families in developing their CSPs.

This sits alongside *The Promise Scotland*[3], which focuses primarily on improving Scottish services and the way that they are delivered for care experienced children and young people (see Appendix 3).

* The term 'infant' refers to babies and very young children. All three terms are used within this document.

The World Association for Infant Mental Health's *Position Paper on the Rights of Infants*[4] argues that the UNCRC "does not sufficiently differentiate the needs of infants and toddlers from those of older children". This risks their unique needs and experiences being overlooked.

Infants often have many important adults in their lives. The advice from Lansdown[5] about young children's participation in decision-making that "the most meaningful opportunities will be created closest to their immediate environments" is pertinent to the task of facilitating infant voice. Babies are particularly sensitive to their primary caregiver's emotional state and look to them to understand the world and know whether a situation is safe or not. However, it is also important to remember that while parents and carers are well-placed to give an insight into the baby's views and wishes, these may not be the same as their own.

Keeping a focus on the infant can sometimes be a challenge if the adults present have a lot to say. It is important for those around babies to be on the lookout for their communications.

Wall and colleagues[6] identified eight "pivotal" factors that can inform our approach to recognising, facilitating and understanding infant voice: Definition, Power, Inclusivity, Listening, Time and Space, Approaches, Processes and Purposes. Voice is context specific, and these factors inform how the adult-infant relationship and its inherent power imbalance can influence how we interpret and take account of what we hear and observe. The importance that adults place on infant needs and communication varies and can lead to diverse interpretations of infant voice across different contexts and social settings. These factors may also influence our own perceptions, and should be taken into account as we try to make sense of what the baby is telling us.

As we develop our practices to support the respectful facilitation of voice from the earliest age, it is helpful to focus on the four concepts described in the Lundy Model of Participation[7].

The Scottish Model of Infant Participation

All babies and young children have a right to meaningful participation, but as they may be preverbal, non-speaking or still developing language, practitioners will need to access innovative ways of facilitating this. Good practice should always address Space, Voice, Influence and Audience, which are inter-related and overlapping. They put the infant front and centre so that they are always in focus, support the use of appropriate tools and mechanisms to facilitate the capturing of their views and ensure that opportunities exist for these views to be shared with decision makers and ultimately acted upon. This requires the use of creative and infant-led approaches that go beyond relying on parents and carers as proxies for the infant voice.

As shown in Figure 1 (below), this Model of Participation is based on four concepts: Space, Voice, Audience and Influence.

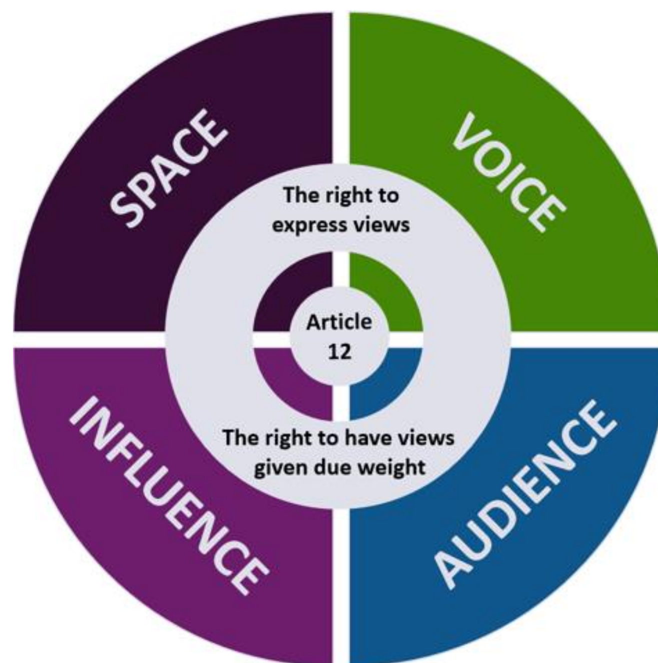

Figure 1: The Scottish Model of Infant Participation based on Article 12 of the United Nations Convention on the Rights of the Child. Adapted from Lundy (2007) and DCYA (2015).

SPACE and **VOICE** relate to the infant's right to express their views.

AUDIENCE and **INFLUENCE** relate to their right to have their views given due weight.

Key Messages for Best Practice: 1
Facilitating Infant Participation

SPACE

Babies and young children meet a range of people (Health Visitors, Family Nurses, GP's, Paediatricians, mental health, early years and social care professionals for example) in a variety of settings (home, clinic, nursery, hospital ward for example). Some physical spaces, such as baby clinics or nurseries, are designed with infants in mind and may be more likely to support their participation. Other spaces or environments may require more significant adaptation to facilitate this. Beyond the safety and comfort of the infant, it is important in all settings to consider how to optimise conditions for infant participation and communication. How the space is made baby-friendly[9] will vary according to infant age and stage, but could include providing appropriate communal space, minimising unnecessary noise and other distractions, and providing appropriate materials to promote or facilitate infant communication (for example, furniture and toys). Getting down on the floor or sitting on cushions or low chairs with infants and their carers will support communication.

We usually meet babies and young children with their parents or caregivers, whose interests and concerns may or may not be the same. These adults often bring valuable insights, for example, about the baby's character and routines. Appropriately, they may try to 'speak' for the baby. These contributions may help professionals understand an infant's experiences. However, it is also important to assess this relationship and look beyond it to see the baby themselves. Babies' communications are easily overlooked even when they are the subject of a meeting. Helping the adults to put themselves in the baby's shoes may help overcome any tensions.

As well as physical space, emotional space is needed to properly take account of the baby's perspective. Emotions felt by those accompanying the baby will be communicated to them and may stop the baby from feeling at ease, and being receptive to attempts to engage them. In therapeutic encounters, it is important to try to attend to everyone's feelings and help create this emotional space.

During home visits, it may be necessary to address these important issues with the adults. Services for babies and young children need to provide a safe and appropriate environment to support babies as they let us know about their perspective and experience, and have their voices heard.

Key Messages for Best Practice: 2
Facilitating Infant Participation

VOICE

Babies and young children have a voice that must be listened to. This voice is heard and seen in the noises and movements they make, their response to the environment and in their interactions with the people who are with them. Their silence may also represent a communication and it is important to understand this in the context of their history and relationships. Infant voice is present in how they make us feel. Eliciting the baby's voice requires close observation and facilitation. Observing and noting the baby's posture and movements, eye contact and other non-verbal communications is crucial, as is listening carefully to their vocalisations. In specialist services, it may be possible to ensure that two professionals are present, allowing one to focus entirely on the baby. Where this is not possible, space within a meeting dedicated to paying quiet attention to the baby can help to include their voice.

> *Assume that all children and young people have views and opinions about their own healthcare and actively encourage them to express what matters to them. NICE 204.1.5*[10]

Babies have things to tell us. It is our responsibility to create an environment that facilitates their communication and supports them to make a meaningful contribution. Giving information to adults and older children present about how babies communicate can help them to see and hear what is happening, and to leave a space for the baby and respond. Back and forth communication with babies is called 'reciprocal' interaction and is essential for healthy brain development.

It is often helpful for professionals and caregivers to adopt an approach of shared curiosity to infant communication. Describing aloud what the infant is doing, wondering together about what it means and being open to different interpretations is supportive of infant expression, provides feedback to the infant, and offers insights to both caregivers and professionals. Interpretations of infant communication translate 'the language of the baby' into words but will not always capture infant experience fully or without error. When babies are sleeping or 'tuned out', it can be helpful also to notice out loud their different states of consciousness.

Depending on the setting and role of the professional, a range of training, tools and techniques may be relevant to supporting infant voice and helping parents or caregivers recognise and understand their infant's communication. Some are specifically used to help parents and caregivers see and appreciate their baby's strengths and their communications about their wellbeing and needs.

Key Messages for Best Practice: 3

Facilitating Infant Participation

AUDIENCE

In clinical and early years settings, the baby has an immediate audience, and it is important that communications do not go unnoticed. The baby should be actively listened to. Professionals should acknowledge what they are seeing and hearing both to the baby and to their carer. This can be done in words that make sense to the adults or older children. Words should also be directly spoken to the infant who is more likely to understand the communication via the tone, facial expressions and movement that accompanies them. Through our words and body language, we let babies know that we are listening to them.

Audience also refers to the wider notion that everyone has a duty to respond to and share what has been learned from the baby. At a very basic level, they may let us know that the environment is unsuitable or not ideal. For example, they may cover their ears or cry if they find the room too noisy. We must take note of and act on their feedback.

Modelling to others that we value and take account of what babies tell us can be done when we meet babies and their caregivers. In clinical work, this may be followed up and reflected in our correspondence with others in each baby's network of professionals and with their parents and carers.

Further, the experiences of babies and what we learn from them about what is important should inform the development of policy and practice. Services and organisations may not have previously considered barriers to and facilitation of infant participation. Where services are routinely working with infants, explicit review is encouraged to overcome issues impeding infant access and inclusion. They should be co-producers of our services, contributing their views to design and implementation. This requires a mechanism whereby their input is formally presented to and evaluated by managers who are responsible for service development and ongoing improvement. This is discussed further in the next section (**INFLUENCE**).

Key Messages for Best Practice: 4
Facilitating Infant Participation

INFLUENCE

We have a duty to ensure that what we learn from babies and very young children is acted upon.

As outlined in previous sections, gathering and considering the views of babies and very young children about the service they receive and about the design and development of services can be challenging but must be done to ensure that their right to express their views is upheld.

Furthermore, once their views have been interpreted, they must be considered by those with the power to effect change. Services and organisations working with infants must show their commitment to being informed and influenced by their views and have a process by which relevant decision makers, that is to say those responsible for influencing change, are identified and involved in this process.

For professionals, the responsibility to consider both babies' best interests **and** to present findings about a baby's perspective when decisions have to be reached about their physical care and treatment or their emotional wellbeing, is paramount.

Given most planning and review meetings are not ideal environments for babies, it is incumbent on us to make sure that their views are made present and real to those who do attend. For example, in the Children's Hearing System, adults such as panel members, social workers and foster carers, have a duty to ensure that babies' views are considered in addition to their perceived best interests.

Taking a co-production approach means working alongside service users and/or their representatives, valuing everyone's input equally. A commitment to influence should be embedded from the start. Integral to this approach is the responsibility to feedback to those whose views have been sought. As with eliciting voice, this requires careful consideration of the context as well as the method of communication with babies and very young children.

In order that babies and very young children can be prioritised in this process, it is good practice to ensure that someone specifically represents their views about the services they are receiving. This could be formalised by nominating an Infant Voice champion or via the role of a Participation Officer who may already be in place.

In the absence of either of these dedicated roles, staff in all settings welcoming infants must take responsibility to listen and ensure their views reach the decision makers. Formalising mechanisms that facilitate this should be mirrored at every level including the development of government policy.

Special Considerations

The approach to eliciting infant voice may be more challenging in some situations. This may be to do with the infants themselves or the wider context.

As with older children, the infant's perceived views should be taken into account when making decisions about their care (for example at a Children's Hearing). However, our response should not be to a single cue but rather to the overall picture we have of the infant, which should be considered alongside the views and observations of carers and professionals. What we have learned from the infant often acts as a stimulus, promoting discussion of all the evidence we might have about them. The Best Practice Guidelines support ways to bring the infant's voice into the room, and not to make judgements in isolation.

Times of stress and distress for family members and professionals may make the task of listening to the infant voice more difficult. There are a range of factors that can make it hard to focus on the baby's perspective, which should be considered in each case.

Factors to consider include:

Infant characteristics may include prematurity, complex physical health issues, or additional physical or developmental needs, where their communication is evolving in relation to specific challenges such as hearing loss or visual impairment. In these situations, the assistance of specialists such as Developmental Paediatricians or Speech and Language Therapists may be helpful.

Family context and relationships may include stress or trauma for the family, domestic abuse, social or economic adversity, housing issues, caregiver difficulties or needs (such as mental health needs and substance use), complex family dynamics, safety or child protection issues.

Service context may include role of the service, professional training and experience, differences of perspective and resource issues.

Developmental context may include considering the age/stage of the infant in their own development journey. Areas such as sleep and crying may cause stress and challenges to parents in terms of understanding and responding to their infants in a way that fully meets their needs. These need to be considered and understood as part of the infant's normal developmental journey. Infant sleep patterns will rarely coincide with adult sleep patterns, and babies' feeding patterns, particularly for those that are breastfed, are likely to be frequent throughout the day and night and may change where there are periods of rapid growth.

Crying may be the only way that the baby can communicate their needs, and along with other cues, should be considered as a normal developmental response to making their voices heard.

In all situations, it is possible to give space to infant experience and voice. Thinking about how to co-create the right space can be done in collaboration with others in the family and the wider professional network.

A Good Practice Checklist, to help you evaluate and improve your practice, is provided on pages 12 to 13.

Good Practice Examples from multi-disciplinary professionals working with babies and very young children are presented on pages 14 to 29.

Good Practice Checklist

Is your service succeeding in facilitating babies' and very young children's participation by eliciting and supporting infant voice?

The traffic light checklist on this page and the next can be used to help you evaluate and improve your infant voice practice.

Area of Practice SPACE	Not at all	Partly	Very much
✓ Is the setting baby-friendly in UNICEF[9] terms? ✓ Is the environment free of distractions and suitably decorated for infants? ✓ Is it safe for the infant to move around? ✓ Is the infant physically comfortable? ✓ Is the lighting, sound and other stimuli in the environment at a level to prevent infants feeling overstimulated? ✓ Is there a quiet space for infants who need to sleep or rest? ✓ Are there age-appropriate toys available in waiting areas and rooms? ✓ Is there sufficient time and mental space provided to ensure that the infant's communications are listened to and reflected upon?			

Area of Practice VOICE	Not at all	Partly	Very much
✓ Do staff routinely set the scene, giving information about how infants communicate, encouraging a space for the infant and responses to their communications? ✓ Do staff take note of the infant's silence? ✓ Are efforts made to capture observations and consider what is being communicated? ✓ Are staff mindful that a caregiver's view may be different to the infant's? ✓ Do staff put the infant's communications into words to interpret what they may be experiencing? ✓ Do staff comment on the infant's emotional state? ✓ Are staff mindful of how they communicate with infants through their facial expressions, word choice, tone of voice, body language and emotions during interactions?			

Area of Practice **AUDIENCE**	Not at all	Partly	Very much
✓ Do staff acknowledge what they are seeing and hearing to the infant and their caregiver? ✓ Do staff respond directly to the infant? ✓ Do staff act on the infant's feedback about the environment and approach? ✓ Are the number of staff present considered in relation to ensuring infants are listened to but not overwhelmed?			

Area of Practice **INFLUENCE**	Not at all	Partly	Very much
✓ When making decisions about care and intervention, do staff ensure that the infant's perspective is taken into account? ✓ Do staff ensure that the experience of infants is reflected in service design and delivery? ✓ Is there a mechanism for recording what actions are taken based on what we learn about the infant's views? ✓ Does your service have a Participation Officer, Infant Voice Champion or someone appointed to represent the views of babies and very young children? ✓ Is feedback given to staff/parents or carers on how the infant's views have been acted on? ✓ Is feedback given to the infant?			

Good Practice Examples

Examples of good practice from professionals working with babies and very young children within community settings as well as universal, enhanced and specialist services are presented on pages 14 - 29. They provide a snapshot of good practice in relation to some of the ideas presented in these Guidelines. Some practitioners have provided examples written from the infant's perspective while others reflect the practitioner's approach. Each demonstrates one or more of the concepts described in the Lundy Model of Participation (SPACE, VOICE, AUDIENCE and INFLUENCE).

Vicky Armstrong (Art Therapist) and Dr Josephine Ross (Developmental Psychologist)

Art at the Start, University of Dundee and Dundee Contemporary Arts

Art at the Start supports attachment relationships for infants and their important grownups through art making. Babies' voices are vital, whether we're offering art therapy to families who need extra support for their wellbeing and attachments or running messy art sessions for babies visiting the gallery.

When baby Sam joined our art therapy group she was an equal member of the session and this showed in how we set up the session space: We laid out the room so we were all at her level on the floor and she could get comfy in the space with mats and beanbags, We thought about how she would experience the different materials, what would engage her and help her to play, and how to offer a peaceful spot if she needed a break from stimulation. It was also helpful to visit Sam and her important grownup before the session so they felt confident and welcome in this new place.

One important aspect of our role was to highlight and support baby Sam's agency. This is about her coming to know that she can make change in the world around her. When Sam made a mark with the art materials, she saw the very direct result of her own agency. We helped highlight this to her grownup, encouraging Sam's agency to be positively received. A baby is an individual with their own intentions and preferences, so we helped to draw attention to Sam's intentions by speaking directly to Sam, by thinking aloud about what Sam may be telling us, helping her grownup to notice her cues and follow her lead in the art making. Sam seemed interested in cars so we showed her grownup a way to join in by rolling cars through the paint to engage Sam in shared play. Signals from Sam like body movements, facial expressions, sounds, eye contact and attention, told us when she was engaged by an activity and wanted to play more, or when she needed to regulate by finding a quiet area or having a snuggle, or when she wanted freedom to explore. After each session we used an observation tool[11] as part of our reflection to keep Sam's perspective central, and when we evaluated the work we used observation tools to capture changes in Sam's experience and develop the service with the baby in mind.

Natasha Martens (Peep Coordinator)

Peep Project, Aberdeen City Council

Peep is a research-based adult learning programme which supports parents and carers to support their children's learning and development though play and everyday activities. In all of our sessions, we encourage the grownups to notice and recognise what their children are communicating.

Lily attended a block of baby Peep sessions with her Mum. All Peep sessions are on the floor so that we're at the children's level and a comfortable and inviting space is created with enough room for Lily and the other babies to move around and explore. Every session begins with the Hello song, singing babies' name first and then Mums'- and as the weeks went on, Lily started to anticipate and recognise when we sang hello to her, giving us all a big smile and clapping her hands.

One of the main activities we offer at baby Peep sessions, is a chance to explore treasure baskets. Treasure baskets are an opportunity for babies to make their first choices and show what their preferences are. This opportunity allows babies like Lily to choose and explore items themselves. We encourage the parents to recognise how their babies respond to the items and we model this by speaking directly to the babies with lots of eye contact and asking them questions directly. Lily was attracted to the shinier items in the basket and would often pull them out and put them to the side by her Mum so other babies couldn't reach them. Lily's Mum recognised her preference of items but also encouraged Lily to share some of her bounty with others.

Singing is a big part of our sessions, and the baby sessions include many songs that promote eye contact and touch. We encourage parents to notice their babies' reactions and to see what they like and don't like. Each week, Lily and the others are asked what song they would like to sing. After attending a couple of sessions Lily's Mum recognised that she had a preference for the more active songs. Lily gave her Mum lots of smiles and giggles when we sang *Ready And* and *Zoom Zoom*. Her Mum also recognised that Lily didn't care for the songs and activities with scarves. Lily voiced her dislike of this by trying to sit up and shrieking if the scarf touched her face. Lily's Mum heard what she was communicating and gave her a bosie (hug) instead removing the scarf.

Attending Peep helped Lily's Mum realise that Lily has a voice, likes and dislikes, and an ability to make choices. As her Mum became more confident as a parent and got to know more about Lily's preferences, she was able to share with us what type of activities Lily would enjoy at future sessions. We used this feedback to plan future sessions, including Lily and the other babies' favourite songs and activities.

Ruth Taggart (Book Bug Session Leader)

Book Bug, Aberdeen City Libraries and Scottish Book Trust

Aberdeen City Libraries shows how we value our youngest borrowers in several ways. Families are encouraged to obtain library membership for each child from birth, so that infants can borrow items in their own name. There are no fines or charges for late return of items borrowed on a child's card. All children, however young, are greeted by name and welcomed when visiting the library, and staff 'chat' with them appropriately. Everyone under five years old can take part in Bookbug's Library Challenge and attend Bookbug Sessions with their grown-ups.

Bookbug's Library Challenge awards stamps to under-5s for each library visit, until they have enough stamps to exchange for a certificate. Some staff let very young children stamp their own cards as soon as they are able to do so. For younger babies, staff make sure they can see the stamp card by holding it in their eye line and commenting e.g. "well done!"

Bookbug Sessions are thirty-minute sessions of songs, rhymes and a story, delivered by our team of trained session leaders within local libraries. The leaders and support staff at sessions aim to recognise and respond to infant voices in a variety of ways:

- As far as possible, everyone at a Bookbug Session sits on or close to the floor, so that session leaders can make eye contact with babies and very young children, and they are free to explore their surroundings as far as they are able. A small selection of board books and suitable toys are often placed within their reach, and parents and carers are encouraged to help their child explore the library space.

- Children are encouraged to make choices as to what rhyme they would like at a Bookbug Session. For those who are preverbal, these choices are given by offering physical objects such as finger puppets to represent the rhyme and paying attention to which one the child takes more interest in, either by touching or eye gaze. Session leaders verbally reinforce "oh, you have chosen...x" and value these contributions by clapping or thanking the child.

- Parents and carers are encouraged to watch for their wee one's responses, especially to more sensory or more active rhymes. This might be done subtly, by the session leader 'checking in' with the Bookbug empathy doll to model infant-carer communication, or more explicitly with messaging such as "find out where your wee one likes to be tickled" etc.

- If a baby demonstrates that they do not wish to participate, e.g. by crying or moving away, parents and carers are assured that this is okay and that they are welcome to move around and try returning for a different song!

After a Bookbug session, staff again chat to babies and very young children directly, asking if they have had a good time. For those who are pre-verbal, staff may reflect on facial expression or body language, commenting "oh, do you feel.....?" All feelings and responses are accepted!

Toni Martin (Play Worker)

PlayTalkRead (Pathways Through Play), Smart Play Network

PlayTalkRead (PTR) is the national programme and roadshow campaign for the Scottish Government's Parent Club initiative and is delivered by Smart Play Network. We have extended our activity to support early speech and language development using our strapline 'pathways through play'.

This is achieved through face-to-face parent workshops and community outreach programmes promoting the importance of play in the home learning environment for early language development. The focus is on delivering key messages to parents and carers about playing, talking, and reading with their child from birth. However the way this is done centres around listening to and responding to the cues of the infants in the room.

Magnus (18 months) attended sensory story play sessions with both mum and gran. These sessions are delivered at the infant's level either on the floor or from low level tabletops, encouraging all adults to sit close with their child, on the floor or nearby seats. All sessions are designed to be delivered with the children, ensuring eye contact and waiting for responses at infant's own pace. Skippy, a child sized puppet, accompanies the PlayTalkRead speech and language team members on all their adventures and provides a key bridge into development through the eyes of a child.

As with many session Skippy invited Magnus and his family into the room encouraging them to sit by him on the floor. Skippy is used to engaging with very young children and models behaviours such as listening and turn taking. Magnus initially was not sure of Skippy and on approach told him to "shoo, shoo" gesturing to go away but was happy to wave at him from a distance. By listening to Magnus's verbal request, and translating his facial expression and body language, the PlayTalkRead team member was able to vocalise what Magnus was telling her and Skippy "ah Magnus is not sure of Skippy". Skippy kept his distance to provide reassurance but continue to include Magnus as he went around the room introducing himself. Asking each child their name and who they have brought with them. Pointing to their parent/guardian "who is this?". Magnus replied "mum" to whom Skippy waved and then "Gangan" to whom Skippy waved. Skippy continued to go around the circle of children asking the same question. Magnus moved away from his mum and over to help Skippy wave to each of the other children and parents. As he was lifting the puppets arm to wave Magnus received positive feedback from the PlayTalkRead Team. "Magnus is kind helping Skippy to say hello" and thanking Magnus for his help. By doing this we were demonstrating how to reinforce the positive behaviours of helping and in doing so we were recognising Magnus for being courageous too. Sharing eye contact with both Magnus and his mum and gran helped his caregivers in recognising and in sharing in the delight of Magnus's achievements.

(Skippy was proud of Magnus too).

Leona Stewart (Quality Improvement Officer, Early Years)

Oakburn Early Years Centre

Oakburn Early Years Centre (EYC) provides Early Learning and Childcare for children aged 2 years to 5 years. It was opened in 2021 to support the funded entitlement of 1140 hours for eligible 2 year olds and 3-5 year olds in East Dunbartonshire. This case study exemplifies how young children's voices are listened to, respected and acted upon. It will show that voice is not just verbal communication, but expressions, actions, behaviours, choices, and silences.

In the 2 year old room this starts with practitioners spending time with the child and family during 'settling in' visits, getting to know their personality and preferences. The family complete an 'All about Me' booklet to share the child's prior learning. A care plan is used to support and review and each child has a keyworker.

The centre provides a wide range of activities, areas and resources to support the child to self-select, make choices and be free to play where and with whom they choose. Provocations to play and learn are created by practitioners, who watch and listen to the children in their play. They follow children's sphere of interest to create a 'spark' to develop curiosity. They provide opportunities and teachable moments, recording individual learning and needs through floor books, using photos of the children during play, interactions, drawings and recording what children say or do. This takes account of children who are verbal and non-verbal and supports the practitioners to attune to the children's 'voice'. The floor books are available for children to access at any point, allowing them to revisit and express their views on interactions with resources, other children and activities. Children's perspectives are listened to and the environment and resources adapted. This learning is shared with families via online journals that capture the learning moments linked to the skills they develop, alongside Realising the Ambition and SHANARRI[1] wellbeing indicators.

The practitioners and playroom environment promote independence in the children, allowing their perspectives to guide their journey through the day. Free flow is an important factor in this. Children choose when to eat snack and self-select this. They choose when to sit for lunch as a rolling lunch is accessible and they are positively encouraged to take an active role in pouring their own drinks and serving their own food. Sensitive adults are on hand to assist this. On discovering there were no cups left to have a drink a child was asked if they would like to go to the kitchen and request a clean cup. They confidently went off to the kitchen to retrieve one, returning to pour their own drink.

The children also have autonomy over where they play as they have full access to the courtyard space outside the playroom and again into the garden. They freely play alongside the older children within the setting and are encouraged to become active participants in the routines and practices in the setting, whilst being supported by knowledgeable and perceptive adults.

[1] safe, healthy, achieving, nurtured, active, respected, responsible and included

Kerry Cleland (Starcatchers Artist)

Starcatchers

Starcatchers is *Scotland's arts and early years organisation*. Since 2006 we have been exploring ways to use arts and creativity as a means of engaging and inspiring our youngest children, those aged from birth – 5 years and their parents and carers. Our work is rooted in a strengths-based children's rights approach that places the baby or young child at the heart of our practise. Understanding babies and young children's agency and engagement with the arts and artists has been an evolving process. Starcatchers Artist, Kerry Cleland reflects on her work with babies:

"When I'm with babies and very young children making connections and communicating in an honest way is about being in the moment, free of expectation and making sure my focus is reserved only for this conversation.

When 6-month-old Zara and her mum joined our group, I noticed mum wasn't so keen for baby to be out of the pram, and if she was, it was away from any mess. On her 3rd visit when mum is feeling more at ease, I encourage her to place Zara onto the sheet of giant paper on the floor and invited mum down to join us. I lie on my belly alongside Zara, being present and ready for her to lead the way. We study each other's faces. Zara shows me her tongue and I let her know that I've seen it by mirroring her. I see in her eyes that she is happy with the conversation. We're making prolonged, steady eye contact and slowly we begin to mirror one another, it doesn't take long before we both have a good idea of what this game is. The pace is set by Zara. Our conversation is as serious and important as every other one happening around us. Zara is making babble sounds and I listen like I would to any other person of any age. I then join her with matching or similar sounds and soon enough we start to vocalise together, echoing and adding, closely watching Zara's movements and signals for my next cue.

After a short while Zara reaches out for the pot of edible paint and dips her hand in, I do the same with another pot, following her pace but making sure that she's aware of my action. I acknowledge vocally that I too am interested in this new feeling, describing out loud the experience. I demonstrate a willingness for mess, letting mum see how enjoyable this is for her. Zara brings a big blob of paint up to her nose, and I copy, signalling to her and those around that this is okay. Her hand slaps down upon the paper and she reacts with excitement from the noise and the splats. I join her delight and respond positively again. This conversation ends with Zara crawling onto my knee for a well-deserved rest. Zara has had the chance to explore and converse at her own pace and on her terms with support, encouragement, and positive responses. An uninterrupted journey that she led. With each session the family attend we will ease back from our conversations with Zara and create the space for mum to continue embracing them."

Laura Henderson (Infant Massage Instructor)

Bonding with Baby

I am a Certified Infant Massage Instructor (CIMI) trained by the International Association of Infant Massage (IAIM). The association highlight that as CIMI I am the 'instructor'; parents are my 'students' and the baby is our 'teacher.' During sessions, I invite the parents to place their baby on a mat in front of them or on their legs to support face to face communication and to aid parental understanding of how their baby is responding to the massage strokes. I teach parents to understand baby's verbal and non-verbal cue and encourage parents to find their baby's state of 'quiet alert' where breathing is regular, body is relaxed and engaging, as this is the best time to learn massage together. Crying is the clearest 'no' cue that their baby will present, and massage will not take place if their baby is crying or flailing arms and legs or their eyes are darting around – at this point they need reassurance and connection to calm, prior to commencing massage. I remind parents that a sleeping baby should not be massaged as they are unable to consent to participating.

Prior to starting any massage strokes on their baby and on each new body part that is touched, I encourage parents to ask their baby's permission – by rubbing hands together and presenting flat palms to the baby's face, whilst asking "May I give you a massage?" or "May I massage your legs/stomach/chest, etc?" Massage should be built up slowly, introducing a new body part(s) weekly, at a pace that suits the individual baby. Repeated communication from the parent allows the baby to become aware of the massage routine, and if they do not wish to engage in massage at that time, they learn their 'no' cues will be respected and massage will not occur. As a CIMI, I facilitate parental observations to develop their understanding of their baby's behaviours during our weekly sessions and verbally remind them of 'no' cues whilst carrying out the massage strokes, as well as the 'quiet alert' cues which show baby is engaging and massage can proceed. Group discussions with parents allow for time to understand baby's behaviour at a deeper level and their need for love, trust and respect as the individual human being they are.

Dr Angela Lisa McLaughlin (Developmental Psychologist)

Butterfly Baby Clinic

The Butterfly Baby Clinic provides a range of support to babies and their caregivers between pre-birth and pre-school, in addition to services for early year's professionals. The following is a real case example of this work written from the perspective of the baby.

"I first met Angela with my Mummy when I was still in the womb for my first 'Developmental Portrait'. I could hear them talking about me as they watched the 3/4D ultrasound scan footage of me *in utero*. My Mummy explained that the Sonographer had moved her tummy during the scan to make me move so that she could get a better view. Angela said that when the recording began, she could see that I was in a deep sleep (state 1) because the tone in my face and body was very relaxed and still. I then heard her describing to my Mummy what she observed as I moved up in my states of consciousness in response to being moved. She pointed out how I quickly moved up through state 2 (light sleep), state 3 (drowsy), state 4 (quiet alert) and into an active alert state 5. Angela pointed out how the tone in my face and upper body had increased in response to my higher physiological arousal and highlighted how I had moved my hand towards my mouth to self-regulate and self-soothe. I could hear how impressed my Mummy and Angela were as my skills decreased my arousal and I moved down to a relaxed quiet alert state 4 before going back to sleep. Me and my Mummy were the topic of conversation as Angela asked her about what she imagined I was like as a person and what her growing relationship with me was like during the pregnancy.

Angela visited me and my Mummy at home again a few days after I was born for my next Developmental Portrait. She helped me to demonstrate all the skills and abilities that I had developed in the womb and since birth through the Brazelton NBAS[12]. I was the centre of attention as they observed my behaviours and skills. They were so impressed with how well I could self-regulate, managing my internal states by holding my hands near my face and body when I was having to work harder or taking timeout by looking away when I needed a break from the interaction. They admired how much I could communicate through my behaviours and social skills, listening to what I was saying through my body language and vocal sounds. I was also the main topic of conversation as Angela asked my Mummy about what she had learned and observed about me since birth, including my likes, dislikes and consoling preferences.

Angela came to visit me and my Mummy for Developmental Portraits until I was 3 years old. During that time she helped me to demonstrate my evolving skills, abilities, likes, dislikes, stress signs, self-regulation skills and consoling preferences through the NBAS, NBO[13] and Bayley-III[14] assessments. She also talked to my Mummy about 'Touchpoints'[15] and how these predictable periods before developmental leaps were affecting my eating, sleeping and behaviour at that time or to help her prepare for the next Touchpoint. I was always the centre of attention and conversation, even if I was sleeping. My Mummy also talked to Angela about our growing attachment relationship. I heard my Mummy say that she had learned so much about me as a person through observing my behaviours and thinking about my world. Angela also said that every baby she's met has always taught her something new and that babies have so much to tell us if we learn how to listen."

Marie Balment (Health Visitor)

NHS Grampian, Aberdeenshire Health and Social Care Partnership

This example is from my work with the Simpson family. Baby Amelia lives with her mother Nikki and father Chris. I visited the family's home to meet them for the first time 12 days after Amelia's birth in accordance with the Universal Health Visiting Pathway[16]. Amelia was reportedly delivered without complications at 39 weeks gestation, according to maternity discharge paperwork. As I arrived, I was greeted at the door by a distraught Chris. When I walked inside the pristine house, I found Amelia crying in a pram. After a restless night caused by a fractious Amelia who "wouldn't sleep in her Moses basket," Nikki was just getting out of bed and was exhausted.

Amelia's parents were upset and worried that she could be ill because she didn't appear to be satiated after feeding, cried repeatedly, and would not sleep. I watched Chris and Nikki carefully undress Amelia so that I could perform a physical examination, evaluate her feeding, and generally assess her. There were reassuringly no warning signs of physical illness or abnormalities. Amelia was awake, calm, and relaxed when I held her to check her muscle tone. Since Nikki and Chris hadn't spoken to Amelia directly since I got there, I purposefully modelled a conversation with her as I did this.

After letting the parents know that Amelia appeared to be well and following a brief period of containment, I led a discussion about what Amelia might be attempting to convey to us through her behaviour. Nikki narrated what happened overnight as we began to consider Amelia's nonverbal communication, and gradually the notion of interpreting the previous night from Amelia's perspective was introduced. We talked about safe sleeping habits and how unsettling a Moses basket must be for Amelia after spending the entire pregnancy so close to her mother, hearing her rhythmic heartbeat, and experiencing the amniotic fluid's gentle movement. Nikki and Chris both had a genuine "aha" moment at this point and exchanged bemused glances.

Nikki went on to decide that during feeds she should talk to Amelia, stroke her to make her feel soothed which might help her go to sleep afterwards. Chris noticed a head movement Amelia would make just before fussing. I chose to emphasise how helpful it was to be able to recognise this because by doing so, they could respond earlier to stop Amelia from becoming more distressed. Nikki and Chris wanted to be great parents but had been unable to acknowledge that Amelia's distress was caused by anything other than illness. Physical closeness with her mother, on the other hand, was discovered to be the key to Amelia being a more comfortable and happier baby. This was instinctive once they understood what Amelia had been trying to tell them all along.

During my subsequent home visits, Amelia was often in a sling attached to her Mum while together they did chores in the house, or I would find them feeding on the sofa while Nikki chatted animatedly to Amelia who, as the weeks passed, could hardly feed for smiling.

Sarah Jeffs (Family Nurse)

NHS Fife

Chloe is 5 and half months old and lives with her mum Sophie who enrolled onto the Family Nurse Programme when she was 15 weeks pregnant.

Sophie experiences challenges with her mental health and had worsening anxiety throughout pregnancy.

During the pregnancy phase of the programme, I used motivational interviewing skills (Open ended questions, affirmations, reflections and summaries) to explore the FNP programme with Chelsea. This helped to match the programme with Chelsea's identified needs and goals. Chelsea was really interested in baby development and really enjoyed a "Partners in Parenting Education (PIPE)" activity looking at how a baby's brain is stimulated to develop through bonding activities, nurture and love. She sang to her bump and spoke lovingly to her baby.

Chloe was born by emergency caesarean section at 40+4 weeks gestation, following an induction of labour. On our first infancy visit together, I noticed Sophie appeared to be meeting her baby's physical needs well but frequently left Chloe in the Moses basket, was quite functional and rarely spoke to Chloe. Sophie said she couldn't work out why Chloe was crying and that it was affecting her mood.

We explored an FNP activity called "What would my baby tell me if I could talk?" over several weeks. This helped Sophie to understand Chloe's behaviours and how Chloe might feel at different times. It also supported Sophie in mentalization, understanding that Chloe is an individual with her own thoughts, feeling and fears. Doing this over several visits appeared to enable Sophie to observe Chloe with a purpose – she noticed how when she was interactive and observant of Chloe, she could more easily respond to Chloe's cues and meet her needs.

On subsequent FNP home visits Sophie started to cuddle Chloe more, spoke to her in an empathetic way and became more confident in reading her cues. Sophie remarked that she was able to distinguish between a cry that said "I'm hungry" and a cry that said "I'm tired." We used PIPE to explore further parenting concepts. Through a series of fun short activities we thought about what trust means and why it is important for Chloe. Using a "demonstration doll" I was able to share different activities with Chloe and Sophie, affirming to Sophie how responsive she was being to Chloe and how much this was supporting Chloe's development. Sophie and Chloe became confident in reading books, singing nursery rhymes and playing short games. Sophie had learnt how Chloe liked a slower pace when reading books and a faster pace with singing; this built trust between them.

In subsequent visits Sophie became more loving in her interactions with Chloe, sharing loving mutual gaze and using simple activities like nappy change as an opportunity for play. Sophie was really keen to demonstrate her reciprocal relationship with Chloe, she is already looking forward to her next steps as a mum and watching how Chloe enjoys baby-led weaning.

Sarah Hallam Stewart (Change and Improvement Manager)

NHS Fife Infant Mental Health Team

Our Infant Mental Health Team aims to support and strengthen relationships between infants and their care-givers. We provide direct interventions with families and the following brief description is an example of this.

Annie, aged nine months, was referred to the Infant Mental Health Team by her Health Visitor. This was due to concerns about the impact of Annie's Mother Jill's previous trauma on Annie's emotional wellbeing. The Health Visitor commented that during her visits, Annie smiled readily at Jill, however that Annie was often strapped into her baby chair.

During an assessment session, Jill sat Annie on her knee, facing outward. Annie showed us that she was interested in the toys below her by leaning forward, as if to want to explore. Jill said "I think she wants to get down and play". Jill continued to hold onto Annie, still facing her away. Annie soon began to wriggle, demonstrating that she felt frustrated by being kept in Jill's arms. Eventually, Jill placed Annie on her tummy on the play mat. Annie's expression of uncertainty and slight bewilderment when there made her seem alone and solitary. Jill described finding it difficult to physically let Annie go and said she had a strong desire to hold her despite knowing that Annie was telling her that she was ready to play.

Annie became enlivened as she explored the toys on the mat. As Jill remained on the chair above her, it felt like something might be getting in the way of her and Annie engaging in baby led activities together. Jill smiled towards Annie as she talked. When Annie showed that she needed some interaction by becoming slightly restless, Jill picked her up and Annie quickly settled. Jill continued to hold onto Annie, who began to cry when Jill described some difficult feelings she had had that week. Jill said that she did not want to put Annie down because she felt comforted by holding her close.

Annie's Father Mark was welcomed at one of the appointments, during which Annie frequently crawled towards him happily, often making eye contact with him. Jill said that this made her wish that Annie was engaging with her instead. She shared that when Annie was really enjoying positive interactions with Mark, Jill felt overwhelmingly upset and that she would remove Annie from him so as to stop their play. Mark and Jill both shared that they worried about how this might make Annie feel.

Throughout each of the three assessment sessions, Annie was either physically attached to Jill or playing on her own. We thought together about what Annie had been telling us and wondered whether baby focused play might help Annie to communicate her desires and needs to Jill. Annie could thus be supported to enjoy pleasurable activities with Jill which did not involve Annie being either held or placed away from her. The aim was that this would encourage their relationship to develop.

Jill has agreed that a series of home visits to support Annie's and her attachment would be beneficial. This will be supported through weekly "Watch Me Play" (Tavistock model) sessions.

Elaine Watson (Speech and Language Therapist)

Wee Minds Matter Infant Mental Health Service, NHS Greater Glasgow & Clyde

I am a speech and language therapist in a multi-disciplinary infant mental health service. We bring our different perspectives to support families and people working with them to think about the infant's development, experiences and relationship needs. Our direct work with an infant and family includes supporting the infant and parent or caregiver relationship, to prevent later difficulties in mental health. For some infants, we offer support to families where there is an emerging difference in their development, to help parents and caregivers understand their infant's development and to know how to respond, as well as offering support with adjustment and acceptance of any difference to what they had expected or imagined. This is an example from my practice written from the infant's perspective:

I am 15 months old and I come to see Elaine with my Mummy, at a local nursery, in a family room. The sessions are in the morning, because I usually have a lunchtime nap. Elaine always says hello to me when we arrive, getting down to my level, face to face, and waiting to see how I respond. If I look away, Elaine will move back and let me know that it is okay if I don't want to say hello today. When I look at Elaine, she gives me a big smile. She says hello to Mummy, too, and says it is lovely to see us both again. Elaine and Mummy take me into the family room, it has interesting toys and treasure baskets of real objects on low shelves and there are mats with cushions on the floor.

Mummy and Elaine are practising some ideas that Elaine talked with Mummy about, from the Hanen More Than Words[17] guidebook. Elaine told Mummy about strategies to adapt her communication, to suit my stage and style of communication and interaction. One day I was exploring the wooden bricks, picking them up and making sounds that I like to make. I was focused on the bricks and did not look at Mummy or Elaine for a while. They were watching what I was doing and wondering what I was interested in, waiting to see if I wanted to communicate with them. I tapped the bricks together and made the sound 'dadada'. After doing that a few times, I looked at Mummy and then did it again. Mummy picked up some bricks and copied what I did, saying 'dadada'. Then I tapped the bricks together and said 'bababa'. I waited. Elaine suggested to Mummy that maybe she could try copying, to see if I noticed. I tapped the bricks again and said 'dadada', then Mummy copied. This time I looked towards her and I could see she was smiling. I did it again, to see if the pattern kept going. It did! We did that for a few more turns and then I went to do something on my own for a while, looking at the bubbles in a lava lamp. Elaine said to Mummy that she wondered if I needed a break, so they watched me from the mat. Elaine talked with Mummy about non-verbal communication and how I was showing them what I wanted by looking towards Mummy for 'again' and by moving away to show I was 'finished'. They seemed happy that I noticed when Mummy copied and I liked it when they were interested in what I wanted to do.

Mummy told Elaine that she feels she understands me more and has some ideas of how to play with me now, as previously she felt frustrated when she tried to start playing with me and I did not respond. Elaine said she wonders how it must feel for me, now Mummy is following my lead and going at my pace. Mummy said she thinks I seem calmer and I want to play with her more, too. We are coming back again next week and Elaine told Mummy she will get out the toys I liked today.

Dr Nashwa Matta (Associate Specialist in Neonatology)

Queen Elizabeth University Hospital, NHS Greater Glasgow & Clyde

In my work as a paediatrician working with medically vulnerable infants, either born preterm or with difficulties which necessitate a prolonged hospital stay, I am conscious that it is our responsibility as adults to decipher/decode the baby's behaviour, as this is the baby's language. I trust the baby to tell me how they feel, and see them as a competent, communicative human being. In trying to understand the babies in my care, and supporting others to do so, I ask colleagues not to approach the baby as 'tasks needing to be done' - like doing their medical/nursing care - but as competent human beings. When seeing families for follow up, professionals should be aware of the infant's and family's experience and I suggest their first question should be "what has this infant been through?" rather than just asking "what is wrong with this baby?"

The following practice snapshot illustrates a typical interaction, from baby Zack's perspective.

"When Dr Nashwa came to help me and my parents, she spent time standing with them and looking at me. I felt a bit scared as I hadn't seen her before; when she spoke gently and kindly to me, used my name and told me that she was interested in what I had to tell her, I felt reassured. I think my Mum and Dad did, too; they smiled at her and looked relaxed. Nashwa didn't just look at me and write things on paper, like other people in the hospital sometimes did. Instead, she spent time with us, and I was right in the middle of them all. Nashwa talked with me and my Mum and Dad; she pointed out some of my behaviours and encouraged them to observe me too. My Mum and Dad seemed to notice me in a different way: they spoke about how I startled and seemed scared when alarms went off around me. Nashwa suggested that I might need to be held and comforted. Nashwa helped my Dad lift me for a cuddle, and I started to feel calmer. I could hear my Dad's voice sounding calmer, too; I think we both liked the feeling.

Nashwa seemed to understand how tired and worried my Mum and Dad have been feeling. She told them that they are still my Mum and Dad and the most important people to me, even though I need to be in hospital right now instead of at home. Nashwa encouraged Mum and Dad to get down to my eye level so that they can look into my eyes, but to let me take a break when I need to. Nashwa helped them figure out how I show this, like when I look away, yawn or stretch out my arms and legs. Nashwa also helped Mum, Dad, and the people looking after me in hospital think about ways they could help me feel safe and settled on the ward, like finding comfy positions for me, and keeping the lights low when they can. Sometimes Mum and Dad can't lift me because of my medical condition or procedures, but because they now know that their touch calms me, they can lay their hand on my tummy, which helps me feel safe. We are all learning together."

Dr Laura Kerr (Principal Clinical Psychologist) and Rosie Simpson (Psychologist and Team Manager)

Glasgow Infant and Family Team (GIFT)

GIFT is a multidisciplinary infant mental health team working with under 5s in care. This story is an example of how we seek to represent the voice and experiences of infants. We give the infant a voice through which they narrate their own story. To do this we have to put ourselves 'in their shoes'. We draw on the information we have about them, including that presented at children's hearings and care proceedings, to understand what has happened to this baby. We also observe them closely and notice how they communicate their feelings and needs.

GIFT have found this to be a powerful tool in bringing together complex professional systems (e.g. social care, legal, health and educational agencies) to focus thought on an infant's experiences and care planning. The prompts at the end of the case example can support discussion and decision making.

"My name is Katie; I am 2 days old. Today I went straight from hospital to live with Mary and Alex. I couldn't go home with Mummy. Mummy has had lots of difficult things happen to her, which means she has grown-up problems and can't keep me safe. When Mary came to get me, Mummy was very angry and shouted at Mary and Helen. Helen is a helping person, called a social worker; her job is to keep me safe. Because Mummy was so angry, other helping people, called the police, came. Mummy held me tight; I was scared. She was crying and shouting that she would run away with me. Everyone looked worried and scared. I'm too small to understand what 'scared' is yet, but my tiny body is born with all it needs to help me try to survive. I'm flooded with cortisol, a hormone stimulated by stress. Although I won't be able to recall or talk about this later, my body will remember my fear in these early moments of life. I'm born ready to learn quickly what I can expect from grown-ups and the world.

I am now 5 months old. A big, important thing I am learning about is feelings; I need lots of help from the big people around me with this. Learning it's okay to show different feelings helps me feel safe and secure and learn to trust others. But I've already learned to stop crying when I'm in the car with the grown-ups whose names I don't know, who take me to see Mummy. I've noticed Mummy likes it when I smile, but she doesn't like it when I feel tired or grumpy or sad, so I tuck this away when we're together. Maybe it's not okay to feel grumpy or sad? Sometimes, when Mummy shouts, the grown-ups in the room go and get help. I also feel scared and worried but am too little to crawl or move away. Mummy sometimes holds me when she's angry and shouting; I don't know what to do, so I try and stay still and very quiet - this helps keep me safe. Maybe I make Mummy angry? Maybe I am bad?"

Please reflect on Katie's experience and consider some core questions which are unconsciously being asked and answered during infancy.

Am I loved/ lovable? Is the world a safe place? Can other people help and protect me? Are other people a source of pleasure or pain?

Based on the answers to these questions, we develop beliefs about ourselves and our relationships, which form the foundations for developing and long-term mental health across the lifespan.

Anne Riddell and Nikola Grant (Social Workers)

Family Assessment and Contact Service, Glasgow City Council

We complete parenting assessments to consider whether it is safe for a child to return to a parent's care, after having been removed due to risk of harm. Part of assessment is watching the parent-child relationship and the parent's ability to meet all of a child's needs in a 2 hour timeframe over a number of weeks. Normally, we observe behind a 2-way mirror.

Watching family time between a child and their parent, we are curious about their interactions. We ask ourselves a series of questions about how a child communicates their experience – for example, how do they show feelings, do they become dysregulated quickly or over minor things, how do they signal needs and to whom. We consider what behaviour can tell us, e.g. turning away can show the need for a short break from connection, or behavioural patterns, like repeatedly going to the bathroom or moving away from the parent, may communicate avoidance. We interpret their behaviour in the context of the situation. We are also interested in how a parent responds with their child, for example the tone and volume of their voice, body language, facial expressions and eye contact. We are interested in how the parent recognises the child's communication and supports them, and how the child responds – for example if they can be soothed by the parent, and how quickly. We pay particularly close attention to how the child and parent respond when they first meet and when they say goodbye, or if the parent leaves the room. We also consider how the child and parent spend time together: whether the parent or child initiates play, and how they respond to each other's overtures. We think about factors influencing the child and parent during family time, like the room we are in, the child's routines, and their state (hunger, tiredness). We also consider how the child's behaviours with parents are different to their behaviours with their foster or kinship caregivers.

Baby's experience: "Mum, Dad and I have been going for family time at the Family Centre. Mum and Dad have moderate learning disabilities and there is a lady who joins us to help Mum and Dad understand what I need. The lady speaks with Mum and Dad about my behaviours – she says they are "cues" about what I need. She says what I might say to them if I knew how to speak. The lady reminds Mum and Dad about my routine and coaches them about how they can help me. Last week, Mum was trying to feed me, but I was in an uncomfortable position, and couldn't get milk from the bottle, no matter how I tried. I was so hungry and I couldn't see Mum's face properly; I felt alone and frustrated, and I arched my back and cried. The lady pointed out to Mum that the bottle teat was empty. She helped Mum get into a position that was comfortable for both of us, and find a way to hold the bottle that helped me suck. Often I feel unsettled in family time and Mum and Dad aren't sure how to help me. Sometimes I get so upset that the lady helps me, or brings my foster carer in, and I feel better when I see her. The lady from the Family Centre came to see me in my foster home, too. I was a bit unsure seeing her in a different place, so I reached out to my carer for help and quickly felt comforted when she gave me a cuddle. Then I felt okay and could play; I played peekaboo with my carer and smiled at her."

Kasia Zych (Child Psychotherapist)

Wee Minds Matter Infant Mental Health Service, NHS Greater Glasgow & Clyde

Through different strands of our work - consultation, outreach, education and training, direct clinical work - we include infants as active participants and try to bring their perspective to life for parents, caregivers, families and professionals. We use a number of approaches including the NBO[13], Circle of Security Parenting[18] and Parent-Infant Psychotherapy. The NBO invites parents to join an observation of their baby, learning how much baby is communicating, and helping them read and understand the communications. For example, a baby may sneeze, change in colour, or turn away when they feel overwhelmed and need a break. Circle of Security Parenting helps parents understand how their child cues they need support to explore their world or to get comfort and reassurance.

In Parent-Infant Psychotherapy we use observation to help us recognise and understand the infant experience in the context of their primary relationships. We work at the infant's level, on a mat on the floor together with parents and the infant at the centre. Sometimes we describe what the infant is doing, for example, gazing at Mum's face or turning away. We invite parents to be curious about their baby's mind, "what do you think baby is thinking? What do you think baby would say now if they could speak?" We may speak directly to the infant, for example "I noticed you watching Daddy carefully when he was talking about something upsetting." All these are ways to help parents think about their baby's thoughts, feelings and intentions – a process called mentalization. This in turn enhances the baby's growing ability to understand both their own feelings and motivations, and those of others.

Example from clinical work (Parent-Infant Psychotherapy):

"Kasia took out a mat and toys she had brought for me to play with. I wanted something on a shelf but Mummy said it wasn't safe. That was hard and I shouted, cried and tried to get it. Mummy quickly got annoyed and shouted at me. Kasia suggested we pause, slow down and try to understand what happened. Mummy shrugged, Daddy looked unsure. Kasia asked Mummy about our feelings in that moment; Mummy said she felt annoyed and angry, and thought I was annoyed I couldn't have what I wanted. Kasia thought it was interesting that Mummy and I ended up with the same feelings and wondered if I had maybe communicated my feeling to Mummy. Mummy's expression changed. She looked like she recognised something. They spoke about how I let Mummy know my feelings without words, she experienced them. Mummy said she often absorbs how others feel. Kasia spoke about feelings sometimes being very strong and that they could try to think about them together. This might help Mummy and Daddy understand them better and know what to do with them. Mummy and Daddy spoke about how their feelings were looked after when they were little, and said it was hard to provide me with something they didn't experience, but they were really trying. Mummy described it as 'the curse of the generations'. Kasia shared her observations of how well Mummy and Daddy are caring for me and how hard they are working to give me what I need. It was helpful when Kasia stopped and helped Mummy and Daddy notice our feelings in the moment, and try to understand where these came from."

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Appendix 1: Members of the Voice of the Infant Short-Life Working Group

These guidelines have been produced by a short-life working group on behalf of the Infant Mental Health Implementation and Advisory Group, which is part of the Scottish Government's Perinatal and Infant Mental Health Programme Board. Members of the short-life working group are listed in the table below.

Name:	Job Titles:	Organisation:
Anne McFadyen	**Chair** Chair of the IMH-IAG and Infant Mental Health Lead for the Perinatal Mental Health Network	Scottish Government NHS National Services Scotland
Kat Masterson	**Chair** Participation Officer	Parent and Infant Mental Health Scotland
Bea Anderson	Consultant Clinical Psychologist	NHS Greater Glasgow & Clyde
Vicky Armstrong	Parent Infant Art Therapist	University of Dundee
Cathy Begley	Participation Officer	Children and Young People's Commissioner Scotland
Alex Brown	Assistant Programme Manager	NHS National Services Scotland
Sarah Hallam-Stewart	Change and Improvement Manager	NHS Fife
Rachael Hood	Design School Programme Lead	The Promise
Rhona Matheson	Chief Executive	Starcatchers
Angela Lisa McLaughlin	Developmental Psychologist	Butterfly Baby Clinic
James McTaggart	Early Years Educational Psychologist	North Highland HSCP
Joanne Smith	Policy Manager	NSPCC Scotland
Kate Wall	Professor of Education	University of Strathclyde
Elaine Watson	Speech and Language Therapist	NHS Greater Glasgow & Clyde
Eliza Waye	Manager	Home-Start Lothian
Sarah Williams	Perinatal and Infant Mental Health Lead	Home-Start Scotland

Table 1. Members of the Voice of the Infant short-life working group.

Appendix 2: Infant Pledge

The Infant Pledge

- Has been co-produced by members of the Voice of the Infant Short-Life Working Group
- Is written in simple language from the baby's perspective
- Details what a baby can expect from the adults around them
- Encourages mindful commitment to facilitate infants to express their feelings, consider their views, uphold their rights and take action accordingly
- Is a reminder it is everyone's responsibility to listen to the voice of infants

The Pledge is available as a one page sheet that can be printed and put up as a poster in places welcoming babies.

Infant Pledge

I am one of Scotland's youngest citizens. To give me the best start, so that I can thrive throughout my life, I need to be seen as a person with my own feelings and rights. I depend on adults to interpret my cues and communications so that my rights are upheld, and my voice is heard.

My relationships with the people who care for me are important and directly affect how my brain grows and develops, and how I learn to process and regulate my feelings. Safe and secure relationships and consistent care support my wellbeing now and give me better chances and outcomes in later life too.

Professionals and academics in the field of Infant Mental Health alongside organisations championing the rights and welfare of babies and very young children have come together on my behalf to create the following expectations, which they believe would help improve my life chances.

I expect that I will:

1. Be seen as a person with my own feelings and views.
2. Be seen as able to communicate my feelings and views.
3. Be able to trust my important adults to think carefully about my feelings and views and speak them for me.
4. Be supported to have secure relationships with the adults who care for me.
5. Have safe, interesting places to play and learn, and the help I need to do so.
6. Have my views valued by my family, community, and society.
7. Have a say in decisions about what happens to me.

My important adults will:

8. Have support to be healthy, including before I am born.
9. Have the information they need to make good choices for me.
10. Have the support they need to understand and meet my needs and their own.
11. Have help from people with the right knowledge and skills.

It is everyone's responsibility to:

12. Consider me and my perspective at all levels of decision making.

Appendix 3: The Promise Scotland

The five principles of The Promise Scotland are:

Voice: Children must be listened to and meaningfully and appropriately involved in decision-making about their care, with all those involved properly listening and responding to what children want and need. There must be a compassionate, caring, decision-making culture focussed on children and those they trust.

Family: Where children are safe in their families and feel loved they must stay – and families must be given support together to nurture that love and overcome the difficulties that get in the way.

Care: Where living with their family is not possible, children must stay with their brothers and sisters where safe to do so and belong to a loving home, staying there for as long as needed.

People: The children that Scotland cares for must be actively supported to develop relationships with people in the workforce and wider community, who in turn must be supported to listen and be compassionate in their decision-making and care.

Scaffolding: Children, families and the workforce must be supported by a system that is there when it is needed. The scaffolding of help, support and accountability must be ready and responsive when it is required.

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