NATIONAL CHILDREN'S BUREAU

COMMUNITY FUND

Nurturing healthy minds together:

Exploring how services and parents can work in partnership to support the social and emotional development of under fives.

Full Report – June 2020

Authors: Dr Stephanie Smith with Sarah-Jane James, Keith Clements, Ava Berry, Claire Dorris and Dr Gayle Munro

Contents

Foreword 3
Executive Summary 4
Background to the (rapid) literature and policy reviews 11

1. Literature review 13
Need and nature of the problem – mental health and wellbeing in the under 5s 16
Parental knowledge of infant mental health 21
Sources of information, support and what works 23
What increases the effectiveness of interventions? 31
Parental experiences of support 35
Models of parental engagement – how can we best involve parents? 39

2. Public policy analysis 45
Overarching policy 45
Health services 46
Health visiting and infant health promotion 48
Early education and childcare 49
Family support and social care 51
Detail of relevant policy in the four nations of the UK 54
England 54
Northern Ireland 67
Scotland 74
Wales 78

Policy review discussion 82

Implications for research, policy and practice 84

Appendix 1: Evaluated early years' interventions, focusing on wellbeing and mental health 89

Foreword

Across the UK, there is widespread agreement on the need to increase investment in mental health support at the beginning of a child's life to improve long-term wellbeing.

Accessible and well-resourced services are important but they are not the whole answer.

The small, day-to-day interactions between babies and very young children and their parents and carers can make the greatest difference. So building parent's capacity and confidence on how to increase positive, attuned and responsive interactions with their children can reap mental health benefits for both. Sharing what might traditionally have been seen as 'specialist' knowledge on brain development with families is an important way of enabling them to reach their full potential and identify their own needs for support and advice.

In June 2019, we began working together to explore the evidence base for emotional well-being for children from conception to reception, and learn how parents were engaged in service design. Our experience, working with and for families and policy makers across the country, told us that things could and should be better and we were delighted that The National Lottery Community Fund supported us to explore the issue further across the UK.

This report was completed in March 2020, just before the onset of COVID-19. The pandemic has had an unprecedented impact on the lives of everyone across the world. In the UK, each of the four nations are taking their own approach to lockdown, a phased return to a 'new-normal' and to recovery.

The necessary restrictions on freedom and subsequent changes to daily lives, as well as the economic impact, has been challenging for many families – particularly the most vulnerable. Babies are arriving into this world without the support of their wider family circle, and many parents and children are struggling with their emotional wellbeing. While the full extent of their mental health needs will only become clear in time, it is likely to increase.

Now is the time to seize every opportunity to bring conversations around infant mental health and authentic parental engagement to the forefront of the minds of decision-makers, commissioners, researchers and practitioners across the UK. It is imperative that we don't cut corners and roll back on commitments, but instead we learn together, invest in the child and parent relationship and build a better future.

Anna Feuchtwang Chief Executive
National Children's Bureau

Jackie Brock CEO Children in Scotland

Owen Evans CEO Children in Wales

Executive Summary

Background

In 2019, the National Children's Bureau (NCB) received funding from The National Lottery Community Fund to explore the published literature and policy developments around prioritising and supporting the emotional wellbeing and mental health of very young children – from conception to reception. The research and policy team at NCB undertook a rapid review of the literature around:

- The extent and nature of mental health support needs in under 5s
- Interventions offered by different providers for families of children aged 0-5 years
- Experiences of families of early years' interventions/programmes
- Models of parental engagement
- Parental knowledge of the social and emotional needs of 0-5 year olds

The review focuses mainly on UK-based literature, but also draws upon relevant international publications. The search approach included academic databases, reference lists of journal publications, and grey literature, e.g. relevant governmental and non-statutory reports from across the four nations.

The review of the literature is followed by an analysis of those public policies which focus on support for social and emotional development and mental health from conception to age 5 across England, Scotland, Northern Ireland and Wales.

Need and nature of the problem

We do not have the evidence to reliably estimate how many under 5s are at risk of mental health problems, but routinely collected data can provide a tentative indication of the proportion of children at risk. Current data published in 2018/19 suggests that 7.5% of 2 year olds in England are not developing as expected in terms of personal and social skills (as measured by the Ages and Stages Questionnaire). In 2018, over one in ten (11.7%) 5 year olds in England are not currently achieving their expected personal, social, and emotional learning goals (as measured by the Early Years Foundation Stage Profile). There are differences in the measurement of personal, social and emotional development across the four nations.

Latest prevalence data published in 2018, found that one in eighteen (5.5%) 2-4 year olds in England have a diagnosable-level mental health problem. However, only 0.8% of 0-5 year olds in England are in contact with secondary mental health services, which suggests a significant gap between need and provision. There is no comparable prevalence data currently available for Northern Ireland, Scotland or Wales.

Parental knowledge of infant mental health

The majority of parent believe the development of social and emotional skills in early childhood are crucial. However, there are some enduring misconceptions about the concepts of mental health and mental illness. Higher levels of parental knowledge is associated with improved outcomes and positive parenting behaviours. In particular, increased levels of parental mentalization (the ability to understand the mental states

(thoughts, wishes, beliefs, and feelings), and underlying behaviours of oneself or others) is associated with the ability to respond appropriately to infants' emotions and feelings. Parental knowledge of mental health is mediated by cultural, contextual and psychological factors – an important consideration when planning and delivering programmes.

Sources of information, support and what works

In the UK, there is an intention to provide a broad ecosystem to support the emotional wellbeing of babies, infants and their families. However, despite the range of support on offer, consistent provision of services and take-up is often low. As well as the variety of service providers, there are also hundreds of existing interventions and programmes, delivered at different tiers and for different levels of need. The overall evidence base for existing interventions needs further development, and many programmes that are widely used in the UK have yet to receive an established evidence base. There also appears to be more interventions focused on 0-3 year olds, and fewer targeted at families with children aged between 3-5 years. It is a potential concern that support for social and emotional development may tail off beyond three years when children enter nursery and their first year of schooling.

The strength of the evidence is currently weakest for universal interventions, although fewer of these are available and/or evaluated. The strongest evidence exists for intensive targeted programmes, such as weekly parent-infant psychotherapy and year-long home visiting support. There are few magic bullets or quick wins. In terms of impact on outcomes, even if an intervention is found to be effective for parents (e.g. increasing their knowledge and confidence, positively affecting their mental health), it is not sufficient to assume that children will automatically benefit too. However, it is also important to consider that there may be longer-term benefits for children not captured at immediate follow-up. Where possible, evaluations should try to include a follow-up in early and later childhood.

What increases the effectiveness of interventions?

Several common factors contribute to the effectiveness of interventions, these include:

- Grounded in supporting the parent-infant relationship
- Increase parents' and professionals' knowledge of infant mental health, acknowledging the capacity to implement this knowledge
- Resourced to support effective parental engagement
- Delivered by practitioners with specialist early years expertise
- Consider the impact of other stressors
- Offered within the context of a multi-disciplinary setting/partnership
- Integrated with other services within the local area
- Respond to local need and address inequalities

Parental experiences of support

Engaging with interventions to support infant mental health can be a daunting experience and parents may face several logistical and emotional barriers. Moreover, parents who are reluctant to engage with services are generally more disadvantaged

and vulnerable in a range of ways. However, once trust is established, parents value the support and can notice the positive impact on their own mental health, as well as their child's. It is important to remember that not all approaches will work for all families and their children. Strategies to boost engagement include multiple communication channels, well-integrated services, tailored support offers for disadvantaged and vulnerable groups (e.g. peer-to-peer outreach support), and delivery through universal vehicles such as Children's Centres.

Models of parental engagement

Some of the roles that parents have led within early years and/or mental health services include peer-to-peer support, as parent champions, by taking an active role in their children's treatment, and collaborating with commissioners and practitioners on issues of wider service design and delivery. Effective parental engagement models often include the following conditions:

- Built on mutual trust
- Include opportunities for learning and development
- Asset-based – i.e., respect the value of parents' knowledge, skills and lived experiences
- Culturally responsive and respectful
- Collaborative – parents have an equal voice
- Interactive
- Embraced by senior leaders across the organisation
- Embedded in all strategies
- Sustainable via sufficient resources and infrastructure

Public policy review

The analysis of public policies across the four nations of England, Northern Ireland, Scotland and Wales explored the priorities and approaches of each of the governments in relation to four areas of public policy that are most central to early years: health services; health visiting and infant health promotion; early education and child care, and; family support and social care; as well as any overarching policies on infants, children and families.

The policy review suggested that early intervention is preferred and also highlighted a gap regarding parent/carer involvement in early intervention approaches, which were largely seen as commissioned services.

Whilst there are variations in detail and delivery, in all four nations there are two main contact points between families of young children and public services. These are:

- Universal health promotion led by health visitors, with targeted interventions for those with additional needs;
- An offer of state-funded pre-school education;

The following priorities have been pursued to varying degrees in all four nations, potentially impacting on the range or quality of support families can expect to see now or in the future:

- Improving access to and provision of both perinatal mental health services, and, child and adolescent mental health services
- A move towards integrated commissioning and service delivery;
- Developing the role of early education in promoting social mobility; and
- The recognition of the value of prevention and early intervention to support families who are struggling.

Whilst these universal offers and common priorities may offer opportunities to drive this agenda forward, there are some potential disadvantages in current policies and approaches.

- Whilst the prioritisation of perinatal mental health is welcome, for example, focussing on clinical interventions could limit the reach of support. In this report, we have highlighted some of the barriers, inherent in delivery of support as a specialist clinical service. Such a delivery model does not address issues highlighted in the literature review around parents being informed and empowered to get support when they need it and addressing the needs of the wider family.
- The expansion of Child and Adolescent Mental Health Services across the four nations means that in each of the respective NHS systems there will be significant focus on children and young people's mental health. However, the extent to which this appears to explicitly address the mental health of infants and young children is variable and sometimes unclear.
- Recognition of the role that early education can play in supporting social mobility is likely to mean better access for those who have most to benefit from this service across a wide range of outcomes. However there are two factors which may stymie the contribution of early education, including the free entitlements, to young children's social and emotional development. Firstly, the qualifications of the workforce do not appear to reflect the evidence on the need for knowledge and awareness around mental health highlighted in the literature review or the evidence on the impact qualifications have on quality more generally. Secondly, whilst early years curricula refer to social and emotional development, accountability measures may encourage a narrower focus, on numeracy and literacy, for example.

There are also differences between the four nations in how similar services and initiatives are being delivered, investigation of which could extract crucial learning to inform change in this area:

- A range of models for health visiting are being deployed across the four nations. This diversity provides an opportunity for learning on key implementation issues such as the targeting of additional support, the balance between home visits and other forms of contact, and which evidence-based interventions can be delivered effectively by professionals who may not specialise in mental health.
- It is notable that a range of approaches have been used across the four nations in describing and targeting parenting support. In developing interventions that are able to reach those who will most benefit, and ensure parents maintain a sense of control, it will be important to draw on lessons from these different approaches in terms of service user experience.

- There are also notable nuances in the various approaches to strategic integration and partnership working. The overarching children and young people's strategies in the devolved nations have differences in emphasis, for example, with Northern Ireland seeing a focus on rights and Wales seeing a focus on prevention. The scope of more focussed cross-cutting initiatives could also be an area of interest. Northern Ireland is the only part of the UK to have a multi-agency Infant Mental Health Framework. England, by comparison, is notably lacking in formal policy on strategic integration, although there are potentially encouraging developments such as the establishment of Integrated Care Systems by the NHS.

There is a welcome acknowledgement of the importance of promoting mental health, alongside recognition of the importance of social and emotional development in the early years, evidenced in a range of polices across the UK. The extent to which this addresses the mental health of infants and young children, as opposed to that of new mothers and older children, is inconsistent across the four nations and may require further development. Delivery models and the role of respective agencies in addressing this agenda do not appear to facilitate support that empowers parents. There is scope to better engage and equip universal services such as health visiting and early education to improve awareness of mental and social and emotional development. Policies generally promote the provision of mental health services and (particularly in England) family support in a clinical or overly targeted way which may discourage parents to seek support when they need it. Whilst there are elements of the policy landscape in each of the four nations that may help to tackle these weaknesses, the bigger picture suggests that support based on the strengths highlighted in the review of the literature is likely to be more the exception than the rule.

Implications for research, policy and practice

The findings set out in this rapid review suggest a number of gaps in the literature, as well as several considerations to take forward into policy and practice. The key implications are discussed at the end of this report but the recommendations are summarised here:

Improve the systems for measuring and responding to infant mental health

- Include a mandatory assessment of emotional wellbeing at the 2-2.5 year review and review ways to streamline measurement across the four nations.
- Make it an urgent priority to gather up-to-date robust prevalence data across all four nations.

Increase screening opportunities and service provision for children aged 3 to 5 years

- Health visiting services should offer at least one face-to-face visit between ages 3-5 years to identify any mental health needs (in particular focusing on emotional difficulties) that may prevent a successful transition into primary school.

Increase knowledge, skills and confidence to support infant mental health – for the public and practitioners

- Develop and deliver an impactful public awareness campaign to dispel common myths about infant mental health that is culturally responsive and sensitive, and which promotes the use of a common and accessible language.
- Increase the knowledge, confidence and skills of universal early years' practitioners, including health visitors, GPs and midwives by including a mandatory training module in social and emotional development as part of their core training. This should include training on how to measure emotional wellbeing using appropriate screening tools.
- Increase the knowledge, confidence and skills of staff working in early education settings through the UK, developing minimum qualifications and standards for the early education workforce. A mandatory training module in social and emotional development should form part of this core training, and particular focus given to supporting the transition between early education settings and the first year of primary school.

Value fathers and partners of women

- UK governments should review their policies and statutory guidance to reflect the importance of engaging fathers in improving child health outcomes, particularly social and emotional development. Paternal outcomes should be measured when evaluating the impact of an initiative or service designed to impact on parental and child health.
- Local areas and services should outline how they include fathers and partners of women in their local service provision, including how they will address the barriers to men accessing services and engaging in opportunities for parental involvement.

Prioritise consistency of relationships and the development of trust within all services designed to support parental and infant mental health

- Provide more investment in frontline, universal services to enable continuity of care for midwives, health visitors, GPs, therapists, where possible. Evaluate organisational processes and policies that focus on staff supervision and retention.

Ensure all universal interventions include a strong, evidence-based educational component

- Boost the effectiveness of universal interventions by including a strong educational component that has been co-developed by parents and has proven effectiveness.

Conduct longer-term follow-ups to assess impact of interventions into later childhood

- Government to provide adequate funding streams to ensure the feasibility of longer-term follow-up for studies of infant mental health interventions.

Build in robust processes for ongoing monitoring and evaluation of programmes

- Conduct a review of the monitoring and evaluation processes of existing programmes, with the ambition to ensure all programmes have a robust evaluation system in place within the next 5 years.

Provide a personal support offer for all families

- Conduct a review of the range of services available in local areas – by level of need, target population, mode of delivery, etc. and work towards the provision of varied local support offers. This should include urgently increasing access to specialist mental health support via Child and Adolescent Mental Health Services for parents with children under age 5 and as well as Parent-Infant Teams.

Address health inequalities to make the most impact on child outcomes

- Local areas must prioritise addressing population health inequalities through the provision of sufficient universal services, with staff trained in identifying and engaging vulnerable and at-risk groups. Outreach programs, including those led by parents themselves, such as Parent Champions and peer-home visiting programs, should form part of the strategy for reaching groups of families that are hard to engage.

Increase the number and quality of opportunities for parental engagement

- Increase the frequency and quality of opportunities for parental engagement in infant mental health programmes, developing and implementing these in accordance with established engagement principles.

Background to the (rapid) literature and policy reviews

In 2019, the National Children's Bureau (NCB) received funding from The National Lottery Community fund to explore the published literature and policy developments around prioritising and supporting the emotional wellbeing and mental health of very young children – from conception to reception. The research and policy team at NCB undertook a rapid review of the literature around:

- The extent and nature of mental health support needs in under 5s
- Interventions offered by different providers for families of children aged 0-5 years
- Experiences of families of early years' interventions/programmes
- Models of parental engagement
- Parental knowledge of the social and emotional needs of 0-5 year olds

The review focuses mainly on UK-based literature, but also draws upon relevant international publications. The search approach included academic databases, reference lists of journal publications, and grey literature, e.g. relevant governmental and non-statutory reports from across the four nations.

The review of the literature is followed by an analysis of those public policies which focus on support for social and emotional development and mental health from conception to age 5 across England, Scotland, Northern Ireland and Wales.

Structure of the (rapid) literature and policy reviews

The remaining structure of this report is as follows:

- **Introduction**
    - Including an introduction to infant mental health and the role of attachment

- **Need and nature of the problem - mental health and wellbeing in the under 5s**
    - A summary of the latest literature in relation to indicators of poor mental health in the under 5s and the prevalence of infant mental health disorders

- **Parental knowledge of infant mental health**
    - How do parents view mental health?
    - Links between parental knowledge and outcomes
    - Impact of culture, education and poverty on levels of parental knowledge

- **Sources of information, support, and what works**
    - Sources of support for infant mental health
    - Examples of evidence-based interventions offered at different levels of need

- **What increases the effectiveness of interventions?**

    - A reflection on common factors that contribute to positive outcomes

- **Parental experiences of receiving support**
    - Use of services and informal sources of support
    - Parental experiences of home visiting and psychotherapy interventions
    - Barriers to engaging families in early years' support

- **Models of parental engagement – how can we best involve parents?**
    - Examples of parental engagement models – peer-to-peer support, parent champions, other participation and engagement initiatives

- **Public policy analysis**
    - Summary of the priorities and approaches of the governments of the four nations in relation to four areas of public policy that are most central to this agenda: Health services; health visiting and infant health promotion; early education and child care, and; family support and social care; as well as any overarching policies on infants, children and families
    - Overview of the policies of the governments of the four nations in more detail with a stated aim of improving social and emotional development and mental health (including related aims such as improving perinatal mental health, attachment and infant wellbeing)
    - Discussion of policy review

- **Implications for research, policy and practice**
    - Outlines a number of recommendations and implications based on the latest research evidence

1. Literature review

Promoting the development of positive mental health in pregnancy and early childhood is one of the key components for ensuring wellbeing throughout the life course[1] - equipping children with the necessary skills to form secure relationships, and interact with society later in life. However, our understanding of the mental health of children under 5 years still lags far behind our knowledge of older children and adults[2].

What is infant mental health?

There is a variety of overlapping terminology when it comes to infant mental health (IMH). Language can vary between disciplines, which increases confusion amongst professionals and the public alike. Terms such as emotional resilience, wellbeing, social, emotional and cognitive development, attachment security are often used interchangeably. All of these are facets of mental health in the early years – and central to this is the quality of the parent-infant relationship. The generally accepted definition[3] from 'Zero to Three' encompasses all of these factors and describes 'infant mental health' as a characteristic of the child[4]:

"The young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations" (Zero to Three, 2001)

However, we do need to be mindful of the language we use to describe IMH. Northern Ireland's Infant Mental Health Framework[5] recommends the need to use language that is consistent and accessible for everyone, including policy makers, practitioners and especially for parents and wider community. Some individuals and groups will be averse to certain terminology and we need to be aware of the stigma attached to certain terms. The idea of an infant has associations of innocence, beginnings, hopes for better futures, and for some, this may not fit with their ideas of mental health and its negative connotations including maladjustment and major mental illness.

There is, however, an ongoing need to educate the public – shifting the narrative so that IMH is seen as an essential aspect of human growth and development, and a recognition that mental health needs are present from conception to through to adulthood.

---

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686928/best_start_in_life_and_beyond_commissioning_guidance_1.pdf

[2] Lyons-Ruth, K., Todd Manly, J., Von Klitzing, K., Tamminen, T., Emde, R., Fitzgerald, H., Paul, C., Keren, M., Berg, A., Foley, M. and Watanabe, H. (2017). The worldwide burden of infant mental and emotional disorder: report of the task force of the World Association for infant mental health. *Infant Mental Health Journal*, 38(6), pp.695-705.

[3] Zeanah, C. H. (Ed.) (2018). *Handbook of Infant Mental Health Fourth Edition*. New York, NY: Guilford Publications.

[4] Zero to Three (2001). *Definition of infant mental health*. Washington, DC: Zero to Three Infant Mental Health Steering Committee.

[5] https://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf

This review aims to keep the language of mental health as consistent as possible, preferring to use the term 'infant mental health' and 'infant mental health problems' as far as possible.

What is infancy?

As well as unpicking what we mean by mental health, it is also important to consider what we mean by the term 'infant'. In paediatrics, infancy usually refers to the first year of life. Whereas, in infant mental health, there is a tradition that 'infant' refers to the first 3 years. Some researchers have argued that focusing disproportionately on birth to 3 years "*begins too late and ends too soon*"[6]. Therefore, prenatal experiences should be included within a conceptualisation of IMH and the upper age limit should be extended from 3 to 5 or so years. The period from conception to reception will be the focus of this literature review.

Role of attachment

The quality of the relationship, also known as the attachment, between infant and primary caregiver is central to developing good IMH. A secure attachment during infancy is significantly associated with positive social and emotional development throughout the life-course, whereas an insecure attachment can increase the risk of later mental health problems. The key timeframe for establishing and cementing a secure attachment to the primary caregiver is between 0-3 years[7]. It is also recognised that the blueprint for IMH begins during the mother's pregnancy, and the choices and experiences of the mother during the prenatal period can have a significant impact on both maternal and IMH.

The majority of parents are able to form secure attachments with their children naturally, without any additional support or training from others. They respond to their child in a warm, sensitive and responsive way the majority of the time, for example, picking up their child when they cry, and holding and reassuring them. As a result, the child feels confident that their attachment figure will be available to meet their needs; they have a safe base to explore their environment, and seek the attachment figure in times of distress[8]. Approximately 60% of the general population is securely attached[9].

While securely attached children learn to effectively manage their feelings and emotions through sensitive and responsive caring, a significant proportion of parents (about 40%) struggle to respond sensitively to their child's needs[10], contributing to an insecure attachment. There are two main types of insecure attachment (although some researchers distinguish three or four) – avoidant and disorganised attachment. An 'avoidant attachment' style is characterised by the parent consistently responding to their child's distress in insensitive or 'rejecting' ways, such as ignoring or becoming

[6] National Research Council & Institute of Medicine. (2009). *Preventing mental, emotional and behavioural disorders among young people: progress and possibilities*. Washington, DC: National Academics Press.
[7] https://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf
[8] Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology*, 24(3), 415.
[9] Andreassen, C., & West, J. (2007). Measuring socioemotional functioning in a national birth cohort study. Infant Mental Health Journal, 28(6), 627-646.
[10] Andreassen, C., & West, J. (2007). Measuring socioemotional functioning in a national birth cohort study. Infant Mental Health Journal, 28(6), 627-646.

annoyed with them. About 25% of infants learn to minimise expression of their needs and emotions, and in return, may avoid or ignore their caregiver[11]. Other parents can be inconsistent and unpredictable when it comes to showing love and affection, displaying what is known as 'disorganised attachment'. They may be overwhelmed by their own, or their child's needs and emotions, so they respond harshly or amplify the child's distress. In response, either the infants learn to exaggerate the expression of their emotions in an attempt to engage their parent/caregiver, or they simply do not learn a way to manage their distress and feelings. This type of attachment experienced by about 15% of the infant population[12]. A disorganised attachment, in particular, is consistently associated with insensitive and inappropriate parenting, including child maltreatment[13].

Circumstances that limit parents' ability to engage sensitively and positively with their child include high levels of ongoing stress, mental health problems, and attachment insecurity in their own childhoods. Attachment-based interventions therefore typically target parents experiencing difficulties that may limit their ability to care for their children in an appropriate and sensitive way[14].

Whole child approach

As well as the fundamental role of parents/carers, is also important to recognise the role of other structures and systems that collectively influence infants' development, including other family members and friends, educational settings, health and social care services, and the wider community. The Infant Mental Health Framework[15] proposes a 'whole child' approach, where IMH is "everyone's business". The whole child approach recognises the collaborative role of services, working together in order to provide the most efficient and effective support for children and families.

[11] Ibid
[12] Ibid
[13] Van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants and sequelae. Development and Psychopathology, 11, 225–249.
[14] Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions, Development and Psychopathology, 18, 623–649.
[15] https://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf

Need and nature of the problem - mental health and wellbeing in the under 5s

In recent years, there has been growing recognition of the importance of early identification of IMH problems and the potential to prevent costly downstream interventions. As a result, all children in England have an assessment between the ages of 2 and 5 years. The Ages and Stages Questionnaire (ASQ)[16] and the Early Years Foundation Stage (EYFS)[17] profile are regularly used in health and early years' settings.

It is not possible to provide an accurate estimate of how many babies and toddlers have poor social and emotional development or are at risk for developing mental health problems in later childhood. However, population data on child development, including from ASQ and EYFS can give an idea of how many infants may have a vulnerability to poor mental health.

Vulnerability to poor mental health – at 2 years

From 2015, all children in England became eligible for a Healthy Child Programme (HCP) development review, delivered as part of the universal health visitor service. The review takes place around the time of the child's 2nd birthday and offers an opportunity to capture infant's development in relation to social and emotional wellbeing (assessed as personal-social skills), as well as other indicators of healthy child development, including communication, gross motor skills, fine motor skills, and problem solving. The Ages and Stages Questionnaire (ASQ-3™)[18] was chosen as a suitable tool, backed by research data, in which to generate a population measure of child development outcomes. The tool is rated acceptable for use in practice by parents and professionals[19]. ASQ-3™ is not a screening tool, but it can provide an objective measurement of child development and can help to identify children who are not developing as expected. Developmental delays identified at this stage are associated with poorer longer-term outcomes, including mental health and general wellbeing.

In terms of data returns, local authorities submit their data to Public Health England every quarter, on a voluntary basis. The latest data from Q4 of 2018/19 published in July 2019[20] found that 92.5% of children in England were at or above the expected level in personal-social skills, which is higher than the previous year Q4 2017/18. This means that as an average, 7.5% of 2 year olds in England are not developing as expected in the area of personal and social skills. Of note, the latest report also found significant area-level

[16] Squires, J., Bricker, D.D. and Twombly, E., 2009. Ages & stages questionnaires. Baltimore, MD, USA: Paul H. Brookes.
[17] https://www.gov.uk/early-years-foundation-stage
[18] Squires, J., & Bricker, D. (2009). Ages & Stages Questionnaires®, Third Edition (ASQ®-3): A Parent-Completed Child Monitoring System. Baltimore: Paul H. Brookes Publishing Co., Inc.
[19] Kendall, S., Nash, A., Braun, A., Bastug, G., Rougeaux, E. and Bedford, H., 2019. Acceptability and understanding of the Ages & Stages Questionnaires®, as part of the Healthy Child Programme 2-year health and development review in England: Parent and professional perspectives. Child: care, health and development, 45(2), pp.251-256.
[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818439/2018-19_Q4_-_FINAL_Child_Development_Statistical_Commentary.pdf

variations across local authorities and rates of expected development in personal-social skills ranged from 62%-100%.

ASQ data is also collected from parents in Scotland as part of the Scottish child health programme at the 27-30 month child health review. Latest data from 2017/18, published in April 2019[21] showed that 5% of children undergoing a 27-30 month child health review had a concern recorded about their emotional and behavioural development (as measured by the Strengths and Difficulties Questionnaire, SDQ[22]) and 4% had a concern recorded about their personal and social skills (measured by the ASQ-3TM[23]). Concerns regarding the emotional/behavioural domains were highest for children living in the most deprived areas of Scotland and/or who were a looked after child at the time of their review. As has been seen in the English data, there were also small decreases over time in the proportion of children recorded as having a concern about their emotional/behavioural development in most NHS Board areas.

It is important to consider whether these 'declines' reflect genuine declines in the proportion of young children with delayed development in social/emotional/behavioural domains. It may be that any decline is a result of changes in how children's development is being assessed within the 2 year/27-30 month reviews, the quality of the data recording, or the thresholds used by Health Visitors to identify a 'concern'[24].

Vulnerability to poor mental health – at 3-5 years

There is data on the vulnerability to poor mental health at 3-5 years from the Growing up in Scotland longitudinal study[25] that assessed children's social, emotional and behavioural characteristics at entry to primary school (between 3-5 years). Using the parent-report SDQ[26], this study found that the majority of children (over 80%) do not present with any social, emotional or behavioural difficulties at the point of entry to primary school[27]. Conduct problems were found to be the most prevalent and emotional problems the least evident. Between 5% and 12% of children have behaviour that places them within the abnormal range on any subscale indicating severe difficulties. These proportions broadly match the expected SDQ scores taken from community populations[28].

In terms of the timing of incidence, issues associated with hyperactivity/inattention were considerably more likely to have been present at age 3 and persist through to school entry. Emotional difficulties, in contrast, had a greater likelihood of developing

[21] https://www.isdscotland.org/Health-Topics/Child-Health/Publications/2019-04-09/2019-04-09-Child-Health-27m-review-Report.pdf

[22] Goodman, R., 1997. The Strengths and Difficulties Questionnaire: a research note. Journal of child psychology and psychiatry, 38(5), pp.581-586.

[23] Squires, J., & Bricker, D. (2009). Ages & Stages Questionnaires®, Third Edition (ASQ®-3): A Parent-Completed Child Monitoring System. Baltimore: Paul H. Brookes Publishing Co., Inc.

[24] https://www.isdscotland.org/Health-Topics/Child-Health/Publications/2019-04-09/2019-04-09-Child-Health-27m-review-Report.pdf

[25] https://growingupinscotland.org.uk/

[26] Goodman, R., 1997. The Strengths and Difficulties Questionnaire: a research note. Journal of child psychology and psychiatry, 38(5), pp.581-586.

[27] Bradshaw, P. and Tipping, S., 2010. Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school. Edinburgh: The Scottish Government.

[28] Normative data from British samples is available at www.sdq-info.com

between pre-school and entry to primary school[29]. This highlights the importance of early screening and identification and tailored transition processes between early years educational settings and primary school to minimise further deterioration in IMH.

Of note, there is an ongoing pilot programme in Northern Ireland which is testing the feasibility of a new 'three year health review' as part of the Early Intervention Transformation Programme[30], a government initiative aiming to improve outcomes for children and young people across Northern Ireland. The new health review will give parents an additional chance to meet with a health visitor to talk about their child's social and emotional development and any particular concerns they may have. The review uses the parent-completed social and emotional version of the ASQ, abbreviated to ASQ:SE2[31] which asks parents to comment on how their child responds to strangers or interacts with friends, sleeping habits and expressing feelings. The findings of this pilot will give a much needed wider picture of young children's social and emotional development across Northern Ireland.

Vulnerability to poor mental health – at 5 years

The Early Years Foundation Stage (EYFS) profile[32] includes the measurement of personal, social and emotional development, and similar to the ASQ, it could be used as a proxy for vulnerability to poor mental health at age 5. Children are said to be achieving a 'good level of development' (GLD) if they achieve at least the expected level by the end of the reception year (age 5) within the following areas of learning – personal, social and emotional development, physical development, communication and language, mathematics and literacy. According to the 2019 EYFS Handbook[33], the area of personal, social and emotional development covers self-confidence and self-awareness, managing feelings and behaviour, and making relationships – important facets for maintaining positive mental health throughout life and providing resilience against adverse life events.

According to the latest data return published in October 2018[34], the percentage of 5 year olds in England achieving at least expected on the three different components of the EYFS personal, social and emotional development learning goals is 88.3% (88.9% for self-confidence; 87.9% for managing feelings and behaviour; 89.7% for making relationships). This means that currently in England, 11.2% of 5 year olds are not meeting expected goals in personal, social and emotional development. While most 5-years olds show healthy development in terms of social and emotional skills, a substantial minority do not.

[29] Bradshaw, P. and Tipping, S., 2010. Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school. Edinburgh: The Scottish Government.

[30] https://www.health-ni.gov.uk/articles/early-intervention-transformation-programme

[31] https://agesandstages.com/products-pricing/asqse-2/

[32] https://www.gov.uk/early-years-foundation-stage

[33] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/790580/EYFSP_Handbook_2019.pdf

[34] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748814/EYFSP_2018_Main_Text.pdf

A similar tool is also used in Wales – the Foundation Phase Profile[35] that assesses personal and social development, well-being and cultural diversity, as well as language, literacy and communication skills, mathematical development, and physical development. Since 2012, data collection merged what was previously known as the Early Years (3-5 years) and Key Stage 1 (5-7 years) together[36]. This means that population-level indicators of social and emotional development for early years specifically are currently not available for Wales. However, the development of an Early Years Development and Assessment Framework (EYDAF) and the Healthy Child Wales Programme will facilitate the future collection of data for all children between the ages of 2-3 years[37].

Prevalence of infant mental health disorders

For some young children, problems can escalate into diagnosable-level disorders, including behavioural, emotional and hyperactivity disorders. Behavioural disorders are most common and include diagnoses such as Oppositional Defiant Disorder (ODD). Behavioural disorders present as repetitive and persistent patterns of disruptive and violent behaviour that exceed age-appropriate societal norms. Emotional disorders in infants manifest as fear or sadness which are in excess of the levels expected in young children and which affect daily functioning. Hyperactivity disorders are characterised by developmentally inappropriate patterns of inattention, impulsivity and hyperactivity. These symptoms are marked, persistent and cause problems in more than one setting. Less common disorders include issues with sleeping, feeding and toileting which are of a level that justifies a referral to specialist services and which cause significant distress that impacts on the child's daily functioning.

It is very difficult to determine the true prevalence of infant mental health disorders as very few research studies have used reliable and structured diagnostic interviews to assess their presence. Prevalence rates are also difficult to determine because of a lack of awareness and the inherent difficulties in assessing and diagnosing young children. There is also some debate about whether it is possible, or even necessary, to classify psychiatric disorders in very young children[38].

Other than the latest English prevalence study (discussed below), there have only been six research studies published outside UK, which found varying rates of disorders in the early years. How much of this variation represents actual place-based differences vs. measurement and other differences remains unclear. A 2006 review paper[39] combined the data from four US studies and reported a mean prevalence of psychiatric disorders in 2-5 year olds (n=1,021) of 19.5% (range: 14-26.4%). A 2007 Danish study[40] of 1.5 year

---

[35] https://gov.wales/sites/default/files/publications/2018-03/foundation-phase-profile-handbook-revised-september-2017.pdf

[36] https://statswales.gov.wales/Catalogue/Education-and-Skills/Schools-and-Teachers/Examinations-and-Assessments/Foundation-Phase

[37] https://gweddill.gov.wales/docs/dcells/publications/150916-early-years-outcomes-framework-en.pdf

[38] Carter, A.S., Briggs-Gowan, M.J. and Davis, N.O. (2004). Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology and Psychiatry*, 45(1), pp.109-134.

[39] Egger, H.L. and Angold, A., 2006. Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of child psychology and psychiatry, 47(3-4), pp.313-337.

[40] Skovgaard, A.M., Houmann, T., Christiansen, E., Landorph, S., Jørgensen, T., CCC 2000 Study Team, Olsen, E.M., Heering, K., Kaas-Nielsen, S., Samberg, V. and Lichtenberg, A., 2007. The prevalence of mental health

olds (n=211) found mental health problems in 16-18% of their sample. The final prevalence study[41], conducted in Norway of 4 year olds (n=995) estimated a population rate for any psychiatric disorder to be 7.1%.

The latest mental health prevalence data for England from 2017[42] used the parent-rated Development and Well-Being Assessment (DAWBA)[43] tool to assess for a range of infant mental health problems in a large population-based sample of 1,463 2-4 year olds. The survey found that one in eighteen (5.5%) young children had an identifiable disorder at the time of interview, with higher rates in boys (6.8%) than in girls (5.5%). The most common disorders reported were Oppositional Defiant Disorder (ODD), Autism Spectrum Disorders (ASD), sleeping disorder, and feeding disorder.

It is important to compare these findings with the number of infants who are receiving treatment from mental health services. The Mental Health Bulletin report for 2017/18 indicates that only 0.8% of the 0-5 year population in England (1% of boys and 0.5% of girls) is in contact with secondary mental health services[44], despite children and adolescent mental health services (CAMHS) nominally being a service for 0-18 year olds. When we compare these figures to the latest prevalence results, this suggests that the majority of young children who have a diagnosable-level disorder are not receiving treatment. Furthermore, a recent Freedom of Information request conducted by the PIPUK[45] found that in 42% of Clinical Commissioning Group (CCG) areas in England, CAMHS will not accept referrals for infants aged 2 years and under. Provision is also lacking in the devolved nations of the UK. There is an urgent need to address the reasons for these disparities.

In terms of prevalence data on IMH problems for the rest of the UK, there is a lack of similar data for Northern Ireland, Scotland, or Wales. To best of our knowledge, Northern Ireland does not have a recurring population-wide survey that measures the mental health and wellbeing of children and young people. Scotland does have a children and young people's mental health prevalence survey[46], but this only includes findings for 4-12 year olds as a collapsed group. There is no Scottish prevalence data for children under 4 years, or any separately reported data for 4 year olds. There is also no comparable infant mental health prevalence data for Wales. Welsh estimates were modelled based on 2004 English prevalence findings[47], but it was only possible to estimate rates in 5-16 year olds as the 2004 prevalence study did not include children under 5 years in their sample. Without latest prevalence data, it is impossible to know whether services are set up to support the population need. A representative survey of IMH that includes all Four Nations is highly recommended.

---

problems in children 1½ years of age–the Copenhagen Child Cohort 2000. Journal of child psychology and psychiatry, 48(1), pp.62-70.

[41] Wichstrøm, L., Berg-Nielsen, T.S., Angold, A., Egger, H.L., Solheim, E. and Sveen, T.H., 2012. Prevalence of psychiatric disorders in preschoolers. Journal of Child Psychology and Psychiatry, 53(6), pp.695-705.

[42] https://files.digital.nhs.uk/A5/B0F9A8/MHCYP%202017%20Preschool.pdf

[43] Goodman, R., Ford, T., Richards, H., Gatward, R. and Meltzer, H., 2000. The development and well-being assessment: Description and initial validation of an integrated assessment of child and adolescent psychopathology. Journal of child psychology and psychiatry, 41(5), pp.645-655.

[44] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2017-18-annual-report

[45] https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/#fullreport

[46] https://www.scotpho.org.uk/media/1168/scotpho131219-mhcyp2013-fullreportv2.pdf

[47] http://www.publichealthwalesobservatory.wales.nhs.uk/child-profile-wales-report

Parental knowledge of infant mental health

Parents' knowledge of social and emotional development is an important contributing factor to the quality of the parent–infant relationship. An awareness and knowledge of infant's social and emotional needs can lead to enhanced environments for development and learning, improved parent-child interactions, and improved child development. Furthermore, parents who have an understanding of mental health are more likely to want to engage with services and be accepting of their support.

How do parents view mental health?

A survey of 1,533 mothers conducted by the Early Intervention Foundation in 2015[48] highlighted that parents believe the development of social and emotional skills are crucial. The survey found that 98% of mothers agreed or strongly agreed that social, emotional and language skills are just as important to young children as literacy and numeracy. In addition, 80% of mothers agreed or strongly agreed that investing in social, emotional and language skills for children aged 0-5 would improve their long-term prospects, as well as the potential for cost savings. Evidently, enhancing these skills as part of their child's development is seen as crucial by parents.

However, another survey of 543 parents/carers conducted by Young Minds in 2018[49] highlighted some enduring misunderstandings. In their survey, almost all parents who responded (99%) understood that mental health fluctuates throughout life, and that anyone can experience mental health problems. However, some parents/carers – about 20% are using the words 'mental health' to mean the same thing as 'mental illness'. It is important to continue the delivery of public awareness campaigns to reduce stigma and dispel common misconceptions about mental health.

Links between parental knowledge and outcomes

A recent systematic review by Peters and colleagues (2019)[50] considered the literature around how parents perceive and use knowledge of infant mental health. Higher levels of maternal knowledge of child development, including social and emotional development, were found to be associated with improved developmental outcomes and more positive parenting behaviours[51,52]. There is also evidence that higher levels of parental mentalization (the ability to understand the mental states (thoughts, wishes,

---

[48] Axford, N., Barlow, J., Coad, J., Schrader-McMillan, A., Sonthalia, S., Toft, A., Wrigley, Z., Goodwin, A., Ohlson, C. and Bjornstad, G., 2015. The best start at home: What works to improve the quality of parent-child interactions from conception to age 5 years? A rapid review of interventions. Early Intervention Foundation.
[49] https://youngminds.org.uk/media/2152/amplified-insights-survey-2018.pdf
[50] Peters, J., Skirton, H., Morgan, J. and Clark, M., 2019. How do parents perceive and utilize knowledge of their infant's mental health? A systematic review. Journal of Child Health Care, 23(2), pp.242-255.
[51] Seo SJ (2006) A study of infant developmental outcome with a sample of Korean working mothers of infants in poverty: Implications for early intervention program. Early Childhood Education Journal 33(4): 253–260.
[52] Stoiber KC and Houghton TG (1993) The relationship of adolescent mothers' expectations, knowledge, and beliefs to their young children's coping behavior. Infant Mental Health Journal 14(1): 61–79.

beliefs, and feelings) and underlying behaviours, of oneself or others) are associated with the ability to correctly attend to infant's emotions and feelings[53].

Impact of culture, education and poverty on levels of parental knowledge

Cultural context is also pivotal to infant care and development and can affect how parents respond to their infant's mental health. Appropriate parenting is often culturally mediated and can differ across cultural groups. For example, desirable and undesirable attachment behaviour differs depending on mother's cultural background[54]. Parental awareness and knowledge of mental health is also influenced by socio-economic circumstances. Data from a South African study[55] found that maternal knowledge of perinatal and IMH correlated with mother's education levels, as well as cultural, contextual, and psychological factors. Furthermore, it is not just parental knowledge of IMH that is important for healthy child development; it is the ability of parents to put this knowledge into action. Parents who are worn down by the stress and trauma of poverty are less likely to have the emotional resources to do what they may know is best for their child[56].

These research findings support the use of interventions that include a strong educational component in order to best support healthy cognitive and emotional development. However, it is also important that these are context-appropriate interventions, and take account of culture and other social and economic influences.

[53] Turner JM, Wittkowski A and Hare DJ (2008) The relationship of maternal mentalization and executive functioning to maternal recognition of infant cues and bonding. British Journal of Psychology 99(4): 499–512.
[54] Harwood RL (1992) The influence of culturally derived values on Anglo and Puerto Rican mothers' perceptions of attachment behavior. Child Development 63(4): 822–839.
[55] Bain, K. and Richards, J., 2016. Mothers' perinatal and infant mental health knowledge in a Johannesburg township setting. Journal of Child & Adolescent Mental Health, 28(2), pp.71-95.
[56] Richter, L. M. (2003). Poverty, underdevelopment and infant mental health*. Journal of Paediatrics and Child Health, 39(4), 243–248

Sources of information, support and what works

Where do parents look for support for mental health?

A Young Minds survey of parents/carers (n=478)[57] found that parents are most likely to find information about mental health (not specifically infant mental health) through professional support (rated by 76% of participants), via online resources (67%), or from books (50%). Nevertheless, 36% of parents said they would find it difficult to access information that can *trust* about taking care of their child's mental health.

A 'broad' ecosystem to support the emotional wellbeing of babies, infants, families

In terms of professional support, there is currently a wide range of supportive services on offer for parents and their infants across the UK. Services include:

- Midwifery
- Universal health visiting
- Parent-infant relationship teams
- Perinatal mental health services
- i-CAMHS (infant)/CAMHS teams
- Public health
- Social care
- Children's centres
- Voluntary and third sector providers
- Nurseries and childminders

However, it is important to note that the provision of these services is inconsistent and often lacking in certain areas across the UK. There is a particular concern about the decline of universal health promotion services. For example, the recent closures of Children's Centres due to funding cuts. This is especially notable in the context of infant mental health, as research by Oxford University and the DfE has shown a beneficial impact of these services for the most disadvantaged families when they have secure funding and staffing levels in place[58].

Furthermore, a Freedom of Information request by the NSPCC (completed by 32 local authorities) estimated around 38% of mothers are not receiving their antenatal health visit before their child is born[59]. Couple this with latest 2018/19 data from Public Health England, which showed that approximately a quarter of new parents are also missing out on their 12 month health visitor contact – and there is a building picture inconsistency around health visiting[60]. NSPCC attribute the drop in visits to local authority budget cuts in England and fewer health visitors. They launched a campaign: 'Fight for a Fair Start', calling on the Government to ensure all parents receive a

[57] https://youngminds.org.uk/media/2152/amplified-insights-survey-2018.pdf

[58] Sammons, P., Hall, J., Smees, R., Goff, J., Sylva, K., Smith, T., ... & Smith, G. (2015). Evaluation of children's centres in England (ECCE). Strand 4: The impact of children's centres: studying the effects of children's centres in promoting better outcomes for young children and their families. London: Department for Education.

[59] https://www.bbc.co.uk/news/health-49099950

[60] https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

minimum of five face-to-face visits undertaken by the same health visitor to identify perinatal mental health problems more quickly[61].

More intensive and specialist support for the parent-infant relationship is also lacking. Research from Parent Infant Foundation found only 27 parent-infant teams existing in the UK and that 42% of areas in England do not accept referrals for children aged two and under although provision is intended to extend from birth[62].

There is an urgent need to improve the provision of both universal and specialist services that impact on infant and parental mental health, as well as address barriers to take-up and parental engagement.

Involving fathers

There is good evidence that the engagement of fathers is highly beneficial for children's social and emotional development – and benefits seen when parents are together or separated. Having an actively involved father is associated with (but not limited to) positive impacts on cognitive development[63], vocabulary skills[64] and fewer behavioural problems[65]. Furthermore, engaging fathers has the potential to benefit the entire family through multiple pathways – by directly promoting the fathers' wellbeing; by strengthening the fathers' knowledge and capacity to support their partner's wellbeing; via improved maternal health behaviours; and by promoting their children's mental health and development[66].

However, despite national policy advocating for health professionals to promote engagement with fathers, this is not consistently evident in practice. Fathers are more likely to be overlooked or inadvertently excluded by services supporting children[67]. This was also evident when reviewing evaluation studies, which most often included mothers and/or reported on maternal outcomes only. For this to change, we need to identify and acknowledge what it is that makes father-inclusive practice difficult to achieve, which will likely include a myriad of personal, organisational, strategic and societal factors[68].

Types of interventions/programmes

As well as a variety of service providers, there are also hundreds of existing interventions and programmes to promote and support mental health and wellbeing in the early years, delivered at different tiers and for different levels of need – from

---

[61] https://www.nspcc.org.uk/what-we-do/campaigns/fight-for-a-fair-start/

[62] https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/#fullreport

[63] Sethna, V., Perry, E., Domoney, J., Iles, J., Psychogiou, L., Rowbotham, N. E., Stein, A., Murray, L., & Ramchandani, P. G. (2017). Father–child interactions at 3 months and 24 months: Contributions to children's cognitive development at 24 months. Infant Mental Health Journal, 38(3), 378-390.

[64] Cabrera, N. J., Karberg, E., Malin, J. L., & Aldoney, D. (2017). The magic of play: Low-income mothers' and fathers' playfulness and children's emotion regulation and vocabulary skills. Infant Mental Health Journal, 38(6), 757-771.

[65] St George, J., & Freeman, E. (2017). Measurement of father-child rough-and-tumble play and its relations to child behaviour. Infant Mental Health Journal, 38(6), 709-725.

[66] Bateson, K., Darwin, Z., Galdas, P. and Rosan, C. (2017) Engaging fathers: Acknowledging the barriers. Journal of Health Visiting, 5 (3). pp. 126-132. ISSN 2050-8719 http://eprints.whiterose.ac.uk/111579/

[67] Ibid

[68] Bateson, K., Darwin, Z., Galdas, P. and Rosan, C. (2017) Engaging fathers: Acknowledging the barriers. Journal of Health Visiting, 5 (3). pp. 126-132. ISSN 2050-8719 http://eprints.whiterose.ac.uk/111579/

universal interventions offered to all families, to specialist services for those with identified difficulties. Although the case for early intervention has been well made, the overall evidence base for the programmes available to support social and emotional health needs further development[69]. Furthermore, some programmes that are widely used in the UK have yet to receive an established evidence base[70].

As part of this review, we have gathered a selection of evaluated interventions and programmes for policymakers and other stakeholders to consider when planning services. The full table is in Appendix 1. The table includes thirty interventions/programmes, structured by level of need:

- ***Universal*** – this level includes interventions/programmes that have been developed for the whole population, i.e. not identified on basis of risk and are available for all. These include interventions centred around health promotion and/or prevention.
- ***Targeted-selected*** – this level includes interventions/programmes targeted at individuals or population sub-groups on the basis of an increased risk of developing problems, e.g. possible risk factors could include economic hardship, single parenthood, young parents, recent migrants, asylum seekers or refugees, and/or ethnic minorities.
- ***Targeted-indicated interventions*** – this level includes interventions targeted at individual children (and/or parents/carers of children) on the basis of detectable signs or symptoms for developing a mental health disorder.

The table does not include evidence for specialist/Tier 4 interventions, e.g. mother-baby units. For ease of presentation, interventions are assigned to one level, although it is acknowledged that some interventions operate across different levels of need.

There is also some notable variation in the age range of available interventions. Of the interventions included in the review, the majority of interventions - around two-thirds focused on 0-3 years only, and a smaller proportion were specifically targeted at families and infants aged up to 5 years. This gap in service provision is something to bear in mind. It is a potential concern that social and emotional development beyond three years may be less supported when the child enters nursery and first year of schooling. Linked to this concern, early years teachers/services may not have the same level of knowledge of infant mental health as professionals such as health visitors.

Evidence of effectiveness

Many of these interventions and programmes have received an 'evidence rating' from the Early Intervention Foundation (EIF). EIF is an independent charity and one of the Government's 'What Works' centres. Their guidebook provides an overview about the effectiveness and cost-benefits of over 100 early years' programmes[71]. The interventions and programmes listed in Appendix 1 have been assigned an evidence score, influenced by the EIF's chosen evidence rating (where available), and the review author's discretion if the programme has not yet been considered by EIF.

[69] Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). Foundations for life: What works to support parent child interaction in the early years. London: Early Intervention Foundation.

[70] https://guidebook.eif.org.uk/about-the-guidebook/other-programmes

[71] The Early Intervention Guidebook website https://guidebook.eif.org.uk/

High-quality evidence refers to interventions which have received at least one high-quality evaluation, e.g. from a positive randomised controlled trial (RCT). Interventions with ***preliminary evidence*** include those that have been evaluated with at least 20 participants and evidence of improvements have been found for at least one child outcome. Interventions where the ***evidence-base is still to be confirmed*** include those where some testing of impact is underway but no reliable evidence has been achieved yet. Lastly, interventions where there is ***currently no effective evidence*** include those that have had a high-quality evaluation, but there were findings of no effect, or negative effects. The table includes a mix of evidence from the UK, US and other settings.

The strength of the evidence is currently weakest for specific universal interventions, e.g. universal parenting programmes, although fewer of these are available and/or have been evaluated. The strongest evidence exists for more intensive targeted programmes, such as weekly parent-infant psychotherapy and year-long home visiting support. There are few magic bullets or quick wins – the majority of effective interventions are relatively intensive, require facilitation by skilled practitioners and take time for families to establish and build up trust. In terms of impact on outcomes, even if an intervention is found to be effective for parents (e.g. increasing their knowledge and confidence, impacting positively on their mental health), it is not sufficient to assume that their children will automatically benefit too. However, it is also important to consider that there may be longer-term benefits for children that are not captured at immediate follow-up. Where possible, evaluations should try to include a follow-up in early and later childhood.

An important caveat on 'evidence ratings'

It should be noted that EIF's 'evidence ratings' have predominately been influenced by high-quality, often academic research designs including RCTs, but they do not currently account for the variability created when these programmes are implemented in real-life settings (see Chapter 4 of the Parent Infant Foundation's toolkit[72]). For example, even the best-evidenced intervention is unlikely to result in beneficial change if parental engagement is poor, staff are not properly trained and supervised, and the intervention is delivered in an inaccessible venue and manner. And the reverse could also be the case, i.e., just because an intervention has not yet received the highest level of evidence – if it is supported by the right infrastructure and is engaging and appealing for parents, then positive benefits may be seen for children and families. If we take the case of infant massage, for example, EIF has given it an evidence rating of 'no effect' for low-risk families, however practitioners have commented that infant massage can be a useful vehicle through which to identify parents who may be struggling and encouraged to receive further support[73].

Examples of evidence-based interventions - universal

Family Foundations

The **Family Foundations** programme is a 10-week universal, group-based intervention for couples expecting their first child. Parents attend five sessions prior to the birth and then reconvene for four additional sessions when the baby is 4-6 months old. The programme teaches strategies to support the transition to parenthood and establish

[72] https://parentinfantfoundation.org.uk/foundation-toolkit/
[73] Ibid

positive family routines, as well as coaching on how to respond more sensitively to their child, enhance children's emotional security, and discourage unwanted child behaviour.

The programme has a robust evidence base, from two RCTs[74,75]conducted in the United States. In terms of impact on IMH outcomes, these studies found that children were better able to soothe themselves at 10 months[76] - an indication of attachment security. Longer-term follow-up also found improved behaviour at age three[77] and improved prosocial behaviour at school at age seven, as rated by teachers who had no knowledge of the children's participation in the programme[78]. Although evidence of effectiveness only comes from the US to date, the programme is available in a few sites across England.

Incredible Years Parents and Babies

The **Incredible Years** is a comprehensive suite of parenting and classroom management groups with a well-established portfolio of evidence across its interventions[79]. The group-based Parents and Babies programme aims to promote a positive attachment between parents and their babies aged 0-12 months. It is suitable for all new parents and is delivered via 2-hour group sessions over the course of 8-10 weeks. Content includes becoming a new parent, developmental milestones, temperament differences, safety and building a positive parent-infant relationship. Facilitators use video clips of simulated real-life scenarios to support learning, with group discussions, problem solving and practice skills with babies in the group. A service evaluation in Wales found significant short-term increases in parental mental health and parenting confidence but did not measure parent-baby interaction[80]. An RCT is ongoing in the UK.

Examples of evidence-based interventions – targeted-selected

Family Nurse Partnership

The **Family Nurse Partnership (FNP)** is a targeted, regular home visiting support for first-time single mothers (aged 24 years and below), starting during the mother's pregnancy and lasting until the child's second birthday. Specially trained nurses/midwives conduct the visits (supported by a local team of supervisors and quality support officers) and provide mothers with information about child development and strategies for supporting their child's and their own needs. FNP has a significant evidence base – from

[74] Feinberg, M. E., & Kan, M. L. (2008). Establishing family foundations: intervention effects on coparenting, parent/infant well-being, and parent-child relations. Journal of Family Psychology, 22(2), 253.
[75] Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: effects on coparenting, parenting, family violence, and parent and child adjustment. Prevention Science, 17(6), 751–764.
[76] Feinberg, M. E., Kan, M. L., & Goslin, M. C. (2009). Enhancing coparenting, parenting, and child self-regulation: Effects of family foundations 1 year after birth. Prevention Science, 10(3), 276–285.
[77] Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. (2010). Effects of a transition to parenthood program on parents, parenting, and children: 3.5 years after baseline. Journal of Family Psychology, 24, 532–542.
[78] Feinberg, M. E., Jones, D. E., Roettger, M. E., Solmeyer, A., & Hostetler, M. L. (2014). Long-term follow-up of a randomized trial of family foundations: Effects on children’s emotional, behavioral, and school adjustment. Journal of Family Psychology, 28(6), 821.
[79] http://www.incredibleyears.com/research-library/
[80] Evans, S., Davies, S., Williams, M. and Hutchings, J. (2015). Short-term benefits from the incredible years parents and babies programme in Powys. *Community Practitioner*, 88(9), 46-49.

five high-quality RCTs conducted in the United States[81,82,83], Germany[84], and the Circle of Security Netherlands[85], showing consistent evidence for improved attachment security and responsiveness and increased sensitivity within mothers. It is a good example of a relatively low-cost intervention with robust evidence of long-term benefits for children and parents.

FNP launched in the UK in 2007 because of the promising findings from the three US RCTs. It started as a small pilot in ten local authorities in England, and positive results from its first feasibility study[86] resulted in a rapid rollout of the programme in 2009. FNP is available throughout England (take-up in 80 local areas), Scotland and Northern Ireland. However, the recently completed Building Blocks trial[87] - the largest trial of FNP to date (involving over 1600 first-time teenage mothers in England and Wales), did not replicate the benefits seen in previous RCTs. It concluded that there were no additional short-term benefits of the intervention compared with usual care. However, it also noted that impacts on the quality of the mother-child interaction might be observed at a later date. Because of this UK trial, the FNP National Unit is investigating methods to further target the programme based on disadvantage, increasing its reach amongst the most vulnerable young mothers and improving the range of clinical outcomes collected as part of the programme.

Mellow Groups

Mellow Groups programmes are established group-based UK programme for high-risk families, e.g. due to poverty, social isolation, and depression. There are modified versions for different groups, such as families of 1-4 year olds ('Mellow Parenting'), pregnant mothers and partners ('Mellow Bumps/Mellow Dads to be'), and parents with new babies ('Mellow Babies'). The Mellow Groups programmes are manualised parenting programmes that are focused on attachment and relationships, and use a mixture of reflective and practical techniques to support parents. **Mellow Parenting** takes place over 14 weekly sessions of about five hours each and has a positive evaluation study[88] conducted with 70 families in Scotland. Positive post-intervention effects were found for mother-child interaction, maternal wellbeing, and child

---

[81] Olds, D. L., Henderson, C. R., Tatelbaum, R., and Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics, 77*,16-28.

[82] Kitzman, H., Olds, D. L., Henderson, C. R., Hanks, C., Cole, R., Tatelbaum, R., ... & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: a randomized controlled trial. *Jama*, *278*(8), 644-652.

[83] Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., ... & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*, *110*(3), 486-496.

[84] Jungmann, T., Ziert, Y., Kurtz, V. & Brand, T. (2009). Preventing adverse developmental outcomes and early onset conduct problems through prenatal and infancy home visitation: The German pilot project "Pro Kind". European *Journal of Developmental Science, 3*(3), 292-298.

[85] Mejdoubi, J., van den Heijkant, S. C., van Leerdam, F. J., Heymans, M. W., Hirasing, R. A., & Crijnen, A. A. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. *PloS one, 8*(10), e78185.

[86] Barnes, J. (2009). Nurse-family partnership programme. Second year pilot sites implementation in England – The infancy period. Available at: http://www.iscfsi.bbk.ac.uk/projects/files/Second_year.pdf

[87] Robling, M., Bekkers, M., Bell, K., Butler, C., Cannings-John, R., Channon, S., ... & Torgerson, D. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): A pragmatic randomised controlled trial. The Lancet, 387(10014), 146–155, http://dx.doi.org/10.1016/S0140-6736(15)00392-X

[88] Puckering, C., Cox, A., Mills, M., Rogers, J., Mattsson, M., Maddox, H. & Evans, J. (2013). The impact of intensive family support on mothers and children: Mellow Parenting programme.

development. These improvements were also maintained at one-year follow-up, and in some cases magnified. A small RCT[89] of 20 mothers also found significant improvements in maternal depression and in parent-infant interaction following the **Mellow Babies** programme. There is no formative evidence of impact for **Mellow Bumps**, but there is some qualitative support of parent's experiences of the programme[90,91]. Parents viewed the intervention as helpful and it appeared to support the development of prenatal attachment relationships.

Circle of Security

The **Circle of Security (COS)** intervention in an attachment-based parent reflection model and aims to increase attachment security among socially disadvantaged children between the ages of 1-5 years. It uses video-feedback to initiate discussions on parent-infant interactions, helping parents reflect on how children communicate and consider how to meet their needs. It exists as a group intervention and an individual home visiting intervention. In its group format, it is delivered by psychologists to small groups of parents over a course of 20 sessions, each lasting 90 minutes. The sessions make use of videotaped segments of each parent interacting individually with their child, which facilitate dialogue between the parents. COS's most rigorous evidence comes from a study conducted in the USA in 2006[92] which found the intervention to be associated with a decrease in disorganised attachment and an increase in attachment security. There are many UK-based facilitators but it is unclear where the programme is offered on a regular basis, other than in Westminster, England.

Examples of evidence-based interventions – targeted-indicated

Infant-Parent Psychotherapy

Infant-Parent Psychotherapy (IPP) is an intensive psychodynamic intervention aimed at increasing parental sensitivity and child attachment security. The EIF has rated IPP has having a high-quality evidence base[93]. It is delivered via weekly hour-long therapy sessions with parents and infants (<6 months) for a period of 12 months or longer, by practitioners with a Master's (or higher) qualification in psychology or social work. The intervention aims to help parents reflect on past and/or present experiences, which may be influencing their view of their infant and relationship with them, paying particular attention to the unconscious and non-verbal aspects of communication between parent and infant. IPP has good evidence from two RCTs conducted in the US in 1991[94] and 2006[95], and has been found to improve infant attachment security and

---

[89] Puckering, C., McIntosh, E., Hickey, A., and Longford, J. (2010). Mellow Babies: A group intervention for infants and mothers experiencing postnatal depression. *Counselling Psychology Review*, *25*(1), 28-40.

[90] Birtwell, B., Hammond, L. & Puckering, C. (2013). 'Me and my Bump': An interpretative phenomenological analysis of the experiences of pregnancy for vulnerable women. *Clinical Child Psychology and Psychiatry,* 1-21

[91] Breustedt, S. & Puckering, C. (2013). A qualitative evaluation of women's experiences of the Mellow Bumps antenatal intervention. *British Journal of Midwifery*, 21 (3), 187-194.

[92] Hoffman, K.T., Marvin, R.W., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security Intervention. Journal of Consulting and Clinical Psychology, 74, 1017-1029.

[93] Asmussen, K., Feinstein, L., Martin, J. and Chowdry, H., 2016. Foundations for life: What works to support parent child interaction in the early years. London: Early Intervention Foundation.

[94] Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. Child Development, 62, 199–209.

[95] Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology, 18, 623–649.

increase levels of maternal empathy. IPP is not currently delivered in the UK –most likely due to the significant resources required to deliver this type of intervention. However, there are similarities with the 1:1 psychotherapy approaches available from parent-infant relationship services.

Watch, Wait and Wonder

Watch, Wait and Wonder is an 'infant-led' parent-infant psychotherapy programme for mothers who are experiencing difficulty bonding with their young child (10-30 months old). [96]. It can be conducted one-to-one or in groups by any suitably qualified practitioner who has attended a Watch, Wait and Wonder training and is receiving appropriate, ongoing supervision. The intervention is delivered on a weekly basis, for an average of 14 sessions during which the parents are encouraged to play with their baby in a way that follows the baby's lead. The parent is then invited to explore the feelings and thoughts that were evoked by what they observed and experienced during the play session. The intervention aims to enhance parental sensitivity, mentalization and responsiveness, the child's sense of self and self-efficacy, emotion regulation and the parent-infant relationship. Watch, Wait and Wonder has evidence from a Canadian study[97] which found several improvements in child IMH outcomes, including improvements in attachment security, emotion regulation and cognitive development.

[96] Asmussen, K., Feinstein, L., Martin, J. and Chowdry, H., 2016. Foundations for life: What works to support parent child interaction in the early years. London: Early Intervention Foundation.
[97] Cohen, N.J., Muir, E., Lojkasek, M., Muir, R. Parker, C.J., Barwick, M., & Brown, M. (1999). Watch, Wait and Wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. Infant Mental Health Journal. 20, 429-451.

What increases the effectiveness of interventions?

After reflecting on a number of different interventions, we have identified some common factors that are likely to be contributing to the effectiveness of these interventions and driving the processes of change. This is not an exhaustive list, but some of the common themes include:

Grounded in supporting the parent-infant relationship

The main theoretical approach underpinning many infant wellbeing programmes is attachment theory. The logic model/theory of change that drives many effective interventions is primarily centred on improving attachment security. Examples with a robust evidence base include Family Foundations, Family Nurse Partnership, and Infant-Parent Psychotherapy. There are two aspects to the promotion of positive relationships within infant wellbeing programmes: an educational component that teaches responsive and supportive interactions between parent and child, and the modelling of a supportive, nurturing relationship between practitioner and parent. Promotion of secure attachment has benefits for both infant and adult – supporting healthy cognitive and emotional development in infants, improving the bond between parent and child, and also developing and reinforcing core life skills of the parent. Furthermore, when this leads to successful and sustained changes, the benefits will come full circle. Based on interactions with their parents, the children can become healthy, responsive parents themselves[98].

Increase parents' and professionals' knowledge of infant mental health, acknowledging the capacity to implement this knowledge

As well as educating about the nature of secure attachment, effective interventions also contain a component that increases knowledge of mental health, such as recognising and regulating emotions – both within the parents themselves and with others. Interventions that contain a specific focus on emotion regulation include Family Foundations and Triple P. For parents, emotion regulation can be taught via interactive learning and strengthened through feedback mechanisms such as video-feedback. For older infants, these core skills can be introduced via play-based approaches, as used in Child Parent Psychotherapy sessions.

It is also important that educational components are tailored to maximise the implementation of this knowledge. This includes making sessions accessible and interactive for vulnerable or disadvantaged parents and a recognition that different delivery mechanisms may be needed.

Resourced to support effective parental engagement

In order for interventions to be effective, they need to be well resourced to enable practitioners to develop a secure and trusting relationship with families. Trust is at the heart of attachment. The reason that a family has been referred to a service in the first place, may be the very thing that makes it so hard for them to engage. Resource includes sufficient duration of the intervention, frequency and consistency of location and practitioner, as well as being mindful of caseload and group sizes in the case of group-based programmes. The majority of effective interventions are relatively intensive

[98] https://developingchild.harvard.edu/resources/three-early-childhood-development-principles-improve-child-family-outcomes/

– taking place for at least three months and up to a year, and across multiple sessions with qualified and skilled professionals.

Delivered by practitioners with specialist early years expertise

It is important for stakeholders to understand that work to protect and promote infant mental health requires specialist expertise. Work with babies is very different from work with older children[99]. The PIPUK Rare Jewels report (2019) highlights the need for practitioners working in this area to have a knowledge and understanding of early child development, ability to understand pre-verbal cues and infant emotions, recognise signs of distress, and be able to support parents (without judgment) to provide sensitive, responsive and appropriate care that their babies need to thrive. They note it is skilled work that requires specialist expertise[100]. Furthermore, routine training in parent-infant relationships is not currently offered as part of the core training for many professions, including midwifery, health visiting and clinical psychology. These skills are accessed and developed through additional training. The exception to this is child psychotherapy, where core training covers perinatal and early infancy work, and indeed high-quality evidence has been found for interventions led by child psychotherapists, such as Infant-Parent Psychotherapy. Training includes supervised weekly observation of infants and their caregivers from birth until their second birthday.

Consider the impact of other stressors

Another important factor is the degree to which programmes take a holistic approach, looking at myriad reasons behind a family's contact with services (or lack of contact), and offering an individualised programme of support. Effective programmes are often offered in welcoming environments, with either the option to be held within the home environment and/or an accessible and calming community space. It is also important to consider stress levels within the practitioners themselves, having responsive supervision, support, ongoing skill development, to manage their own stress so they can help their clients most effectively.

Offered within the context of a multi-disciplinary setting/partnership

Interventions with evidence of effectiveness, e.g. Infant-Parent Psychotherapy, Watch, Wait and Wonder, Circle of Security, and Mellow Parenting are often delivered within the context of a multi-disciplinary specialised parent-infant relationship teams, or parent-infant teams for short. It may well be that the context of where effective interventions are being delivered is driving some of the positive outcomes, as well as the highly-skilled staff that work in these settings.

These services are known locally by different names such as a PIP, an Infant Mental Health Team, parent-infant mental health service, early CAMHS, or an early attachment team. These types of services typically include family support workers or key workers, infant mental health practitioners (at band 6 or 7), specialist health visitors and service managers and administrators, and other types of specialist therapists such as play therapists. These services generally work at two-levels – they offer direct service provision to families and they are also expert advisors and champions for parent-infant relationships, supporting and developing the local workforce through training, consultation and/or supervision. According to Rare Jewels report[101], there are only 27

---

[99] https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/#fullreport
[100] Ibid
[101] https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/#fullreport

specialized parent-infant relationship teams currently in operation across the UK. Although, awareness of their value is growing and increasing number of new services are being commissioned, most families do not live in an area where they can access a parent-infant service.

Integrated with other services within the local area

It is also important for services to be aware of and to work in partnership with all of the related professionals and services who support families with babies and infants - especially if they are not immediately accessible within the service framework, i.e. work within the same setting as a specialised parent-infant service. This includes strengthening links with health visitors, GPs, children's centres, midwives, perinatal mental health teams and many others.

Respond to local need and address inequalities

It is also important to bear in mind that what works best will also depend on local factors such as geography, transport links, population need, and the level of resourcing of other services in the region[102]. Services should be designed so that they can support the needs of the local population. The Parent Infant Foundation suggest a way to commission for local need which includes taking account of the prevalence of insecure attachment across the general population and making adjustments for local indices of need, including area-level deprivation, prevalence of adverse childhood experiences (ACEs), migration status, etc. (see Chapter 3 of the Parent Infant Foundation toolkit[103]). Previous research has estimated the prevalence of disorganised attachment (the attachment style most closely associated with poor child outcomes) to range from 15% to 48%[104,105] depending on other associated risk factors including levels of family poverty, history of maltreatment, maternal substance misuse, and parental mental ill health. The research notes that the need is likely to be even higher in communities affected by other forms of trauma, such as in Northern Ireland and in those with insecure immigration status or other communities particularly affected by harassment and discrimination. Where it exists, local survey data regarding the prevalence of ACEs within the local community may help commissioners adjust how many families could benefit from more intensive interventions, as well as screening and early identification.

Reflections from service commissioners

Some of the parent-infant teams in the UK, such as Anna Freud Centre team and OXPIP are well established – having been in existence for over 20 years. There also appears to be some momentum to commission new services around the country and the Parent Infant Foundation conducted a series of interviews with commissioners (from Leeds, Tameside and Glossop, and Croydon)[106] to understand what works in terms of setting up and sustaining a specialised parent-infant relationship team. Several themes were

---

[102] Ibid

[103] Ibid

[104] . Van IJzendoorn, M., Schuengel, C. & Bakermans-Kranenburg, M. (1999) Disorganized attachment in early childhood: A metaanalysis of precursors, concomitants and sequelae. Development and Psychopathology, 11, 225-249

[105] Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. & Van IJzendoorn, M. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. Development and Psychopathology. 22 (1), 87-108

[106] https://parentinfantfoundation.org.uk/foundation-toolkit/

highlighted in these interviews, which overlap with some of the common factors outlined above:

- ***Importance of sector knowledge*** – local leaders having a good understanding of social and emotional development and the role of early relationships and attachment
- ***Strategic commitment to early years*** – sector commitment to giving children the best start in life and a whole-system approach to achieving this goal
- ***Partnership working*** – a collaborative approach to working between commissioners and between services
- ***Flexibility and foresight***– being adaptive to changes, persistent attitude and seizing opportunities to grow and develop services

Parental experiences of support

Engaging with interventions to support infant mental health can be a daunting experience and parents may face several logistical and emotional barriers. Moreover, parents who are reluctant to engage with services are generally more disadvantaged and vulnerable in a range of ways, such as low-income families, ethnic minorities, men, families with young or LGBTQ+ parents, and those with existing mental health problems. Part of the reason why these groups can be 'harder to reach' is because they are often underrepresented in existing service provision. In addition, many of the barriers to participant engagement, such as the lack of awareness, accessibility and acceptability, are likely to disproportionately affect disadvantaged and vulnerable families who have often been exposed to multiple adversities and have complex needs.

Use of services and informal sources of support

The 'Growing up in Scotland' (GUS) longitudinal study published a report in 2011[107] focusing on parental service use in the early years (n=3755). Early years' service use was defined as direct contact (in-person) with a range of statutory or voluntary agencies in order to seek information, advice, support or treatment. The study found that 41% of respondents were 'low service users' when their child was aged 10 months (using four or fewer services) and a similar proportion (43%) were in this category when their child was 4 years old (using three or fewer services). Although low service use at 10 months did not appear to be a strong predictor of later low service use, which suggests that respondents were not stable in their levels of usage.

Less than half of mothers (45%) attended antenatal classes and given these classes are a universal provision for all expectant mothers; the variation in uptake is notable. There is however, clear variation in the proportions of first-time mothers and other mothers who attend antenatal classes: 57% of first-time mothers attended compared with 14% of mothers who already had other children. Factors connected to low service use at 10 months were lower household income and lower maternal educational qualifications. This suggests that it is mothers in more disadvantaged circumstances, who formal services traditionally find more difficult to reach, who are generally less involved with a full range of services when their child is 10 months old.

Many families (almost two-thirds) who were not engaging with formal support reported medium or high levels of informal support (defined as receiving help, childcare support, information and advice from family and friends). This may explain why they did not feel the need to engage with professional services. However, the study also found a small minority of parents (14%) who were unsupported, both formally and informally. Unsupported respondents were more likely to have lower educational qualifications, live in households where nobody was in employment, and to live in urban areas – all known risk factors in terms of isolation and lowered help-seeking behaviours.

[107] Mabelis, J. and Marryat, L. (2011). Growing Up in Scotland: Parental service use and informal networks in the early years, Edinburgh: Scottish Government

Parental experiences of home visiting interventions

A qualitative study conducted in England in 2007[108] explored the perceptions of women about the value of intensive home visiting in pregnancy and the first year of their babies' life. In-depth interviews were conducted with 20 women who had been identified as being 'vulnerable' (e.g. <17 years of age, living in poverty, history of mental health problems). The study found that most women had initial concerns about committing to a weekly hour-long visit and negative preconceptions about health and social care professionals. These included worries about being judged as an unfit mother and the risk of their losing child. Despite these initial concerns, participating women reported to greatly value the relationships they established with their home visitors and identified a number of ways in which they had benefitted. These included increased confidence, improved mental health, improved parenting skills, improved relationships with others, and changes in their attitudes towards professionals. These findings highlight that the therapeutic relationship between the home visitor and parents is central to the success of this intervention, and therefore, the need for home visitors to have the necessary skills and qualities to establish such positive relationships.

Parental experience of psychotherapy interventions

A qualitative evaluation of parent-infant psychotherapy written in 2007 by Jane Barlow[109] described the findings from 21 in-depth interviews with mothers who had received treatment from a parent-infant psychotherapy service in England. The evaluation found the majority of participants to value the service and perceived the intervention as having a significant positive impact on their own mental health and relationship with their baby. A number of women, however, experienced anxieties related to the need to terminate the service when their baby was two years of age, and a significant minority also experienced difficulties in establishing a 'working relationship' with the therapist, and were left with ambivalent feelings about the therapy. Difficulties in terminating therapy may also be related to attachment issues and the initial reason for the psychotherapy referral. Parents should be empowered to access a different therapist if the professional assigned to them is not suitable for them. Although this type of intervention may not be an appropriate means of supporting all parents, if parents are given a choice of therapist and engaged with supportive discusssions around endings/discharged, then it is possible to have a positive experience of psychotherapy.

Barriers to engaging families in early years' support

A 2019 Early Intervention Foundation report[110] suggested that there are three main types of barriers to accessing early years' support. These include:

- ***Awareness barriers*** – lack of knowledge on the availability of local support services or a lack of recognition of the need for support
- ***Accessibility barriers*** – such as time, cost and location of interventions and thresholds for accessing them
- ***Acceptability barriers*** – including feelings of personal failure for accessing support and stigma – e.g. a history of parenting services being associated with

[108] Kirkpatrick, S., Barlow, J., Stewart-Brown, S. and Davis, H., 2007. Working in partnership: user perceptions of intensive home visiting. Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect, 16(1), pp.32-46.

[109] https://warwick.ac.uk/fac/sci/med/staff/barlow/wifwu/research/oxpip_paper_-_jimrh_-_march_2007.doc

[110] https://www.eif.org.uk/report/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review

parental failure, rather than a positive support service. Also, the stigma around men accessing mental health support or being seen as an equal partner in parenting.

The GUS report[111] also found that the group format of certain interventions is also off-putting for some mothers. This may stem from a lack of confidence in their ability as a parent. In the group format, some mothers may believe that their parenting skills will be assessed and discussed by other mothers. Thus, rather than a source of support, such groups are considered a source of scrutiny and stress which they would prefer to avoid.

Respondents in the GUS parenting study were also asked about the specific barriers for accessing different types of early years' support, these included:

Barriers to attending antenatal classes

- Mothers had already attended in previous pregnancies or reported existing knowledge
- Main reasons for first time mothers' non-attendance were because the group format was off-putting and not knowing where classes were held

Barriers to attending mother-toddler groups

- Respondents not keen on group format or feeling shy or awkward about attending
- No groups available or accessible in the local area
- Lack of time is a key factor, particularly for mothers who had returned to work

Barriers to accessing childcare

- Mothers would rather look after child themselves
- Cost
- Lack of availability or choice in the local area

Need to target and engage vulnerable families

It is clear that the success of many early years programmes relies on the voluntary participation of parents in the classes/groups/services, and the evidence also implies that the parents who service providers and policymakers most want to reach, and those most in need, are the hardest to engage. Parents who are reluctant to engage with services, and/or who have low levels of informal support, are generally more disadvantaged in a range of ways. Strategies to engage families and drive recruitment include[112]:

- ***Multiple communication channels***
- ***Well-integrated services***
- ***A personal offer*** targeted at disadvantaged and vulnerable groups who may be resistant to traditional formats
- ***Delivered through universal vehicles*** *such as Children's Centres to identify such groups and to enable trust to develop (e.g. through programs such as Parent Champions or peer home visiting)*

[111] Mabelis, J. and Marryat, L. (2011). Growing Up in Scotland: Parental service use and informal networks in the early years, Edinburgh: Scottish Government
[112] https://www.eif.org.uk/report/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review

In conclusion, not all approaches will work for all families and their children. The key appears to be targeting appropriate interventions for different groups of families, so that everyone can access the help and support that is best suited to their needs.

Models of parental engagement – how can we best involve parents?

There are a number of models of parental engagement and involvement that have been trialled across the Four Nations. Parental engagement/involvement can happen at various levels or tiers within service design, delivery and/or promotion. Examples include person-centred conversations, involvement in care plans/decisions on treatment, attendance at service user conferences or groups, peer-to-peer initiatives and coproduction activities. However, very few parental engagement programmes and initiatives have undergone an independent evaluation to consider the barriers, facilitators and potential outcomes of these approaches.

Some of the roles that parents have led within early years and/or mental health services include:

- **Peer-to-peer support**, leading/co-delivering programmes (e.g. Empowering Parents, Empowering Communities, EPEC programme)
- **Parent champions**, engaging their local communities in services (e.g. Parent Champion programmes)
- **Other participation and engagement initiatives**, such as parents taking active roles in their children's treatment (e.g. through a shared decision making initiatives such as Power Up for Parents); or collaborating with commissioners and practitioners on issues of wider service design and delivery (e.g. NHSE England's Amplified programme)

Peer-to-peer support

Peer-to-peer support is an increasingly common feature across health, education and social care programmes, although there are fewer examples focusing on infant social and emotional development. Methods range from informal volunteer support, befriending, and more structured and intensive individual and group-based support. There is also a convincing rationale and evidence-base for why peer-to-peer support programmes lead to positive benefits within mental health and early years services[113,114,115]. Peers with shared characteristics and common experiences may have greater credibility and influence. This may manifest through the process of mutual identification and increased trust that may boost engagement, improve support and accelerate the process of change. Research has also found that peer supporters themselves benefit from improved health and child development knowledge, confidence, community status and employment opportunities[116].

[113] Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, (27)4, 392–401.
[114] Cupples, M.E., Stewart, M.C., Percy, A., Hepper, P., Murphy, C., & Halliday, H.L. (2011). A RCT of peer-mentoring for first time mothers in socially disadvantaged areas (the MOMENTS Study). *Archives of Diseases in Childhood*, 96, 252–258.
[115] Stolzenberg, R., Berg, G. & Maschewsky-Schneider, U. (2012) Healthy upbringing of children through empowerment of women in a disadvantaged neighbourhood: evaluation of a peer group project. *Journal of Public Health*, 20, 181–192. doi: 0.1007/s10389-011-0460-0.
[116] Thomson, S., Michelson, D., & Day, C. (2015). From parent to 'peer facilitator': a qualitative study of a peer-led parenting programme. *Child: care, health and development*, 41(1), 76-83.

A good example of a peer-led programme for improving social and emotional wellbeing in the early years is the Empowering Parent, Empowering Communities (EPEC) programme. EPEC is a manualised universal offer programme that has been co-produced by parents and parenting practitioners. There are three group programmes, two of which are available for parents of children under 5 years (Our Baby and Us, 0-1 year; Being a Parent – 2-11 years; and Living with Teenagers, 11-16 years). Groups are co-facilitated by two trained and accredited parents and consist of eight two hours sessions for between 8-12 parents. They take place in a community location, e.g. children's centre, schools. Parent peer facilitators receive ongoing supervision and further training. EPEC has a strong evidence base, with five outcome evaluations showing positive benefits, including a robust RCT conducted by Crispin Day and colleagues in 2012[117]. The RCT found improvements on a number of outcomes including improvements in children's behaviour problems, parenting skills and achievement of parenting goals. A separate evaluation of the facilitators found it increased the parenting and group work skills, knowledge and confidence of the parent group leaders[118]. Furthermore, findings from a qualitative study of the parent peer facilitators[119] showed strong endorsement of the EPEC programme manual, structured training and continuing supervision, and wider personal gains, such as social status/capital and employment opportunities help to reinforce the parent facilitators' role commitment. Finally, facilitators emphasised the important value of a cohesive 'family' identity among EPEC staff and service users.

Parent Champions

A 'Parent Champion' programme is based on the premise that parents are more likely to trust other parents when it comes to choosing support services. Parent champions are typically parent volunteers who give a few hours a week to talk to other parents about a particular local service(s) and encourage take-up, e.g. free early education entitlements, wellbeing initiatives, and dietary interventions. As examples, this type of role exists across all 'A Better Start' sites, and since 2007, Coram Family and Childcare have supported a national network of Parent Champions (now with 50 Parent Champion schemes across England)[120], centring around early years' education and home learning. The role was created to predominately support harder to reach parents who often miss vital information about how to access local family services.

A parent champion role can include:

- **Talking with other parents** about their experiences of using the service(s), offering support, advice and information
- **Answer questions** about how they themselves and their children felt about using the service(s) and how they dealt with any issues faced
- **Raise awareness and promote** the benefits of using the service(s)

---

[117] Day, C., Michelson, D., Thomson, S., Penney, C., & Draper, L. (2012). Evaluation of a peer led parenting intervention for disruptive behaviour problems in children: community based randomised controlled trial. *BMJ*, 344, e1107.
[118] Day, C., Michelson, D., Thomson, S., Penney, C. & Draper, L.(2012b) Empowering parents, empowering communities: a pilot evaluation of a peer-led parenting programme. *Child and Adolescent Mental Health*, 17, 52–57. doi: 10.1111/j.1475-3588.2011.00619.x
[119] Thomson, S., Michelson, D., & Day, C. (2015). From parent to 'peer facilitator': a qualitative study of a peer-led parenting programme. *Child: care, health and development*, 41(1), 76-83.
[120] https://www.familyandchildcaretrust.org/parent-champions-national-network

- **Improve access** to services for parents, especially those from harder to engage groups
- **Transforming services**, by influencing service design and delivery, feeding in to evaluations

This approach has been found to be beneficial for both families and the volunteers involved. An evaluation report of the Family and Childcare Trust's Parent Champions pilot conducted by Coram in 2014[121], found Parent Champions to be effective in communicating with parents and their intervention increased the take-up of local children's services. 57% of parents became engaged with services after communication with a Parent Champion and 43% of parents became regular users of the service or activity recommended. Parents also reported additional impact as a result of the Parent Champion support, including an increased awareness of local services and increased parenting confidence.

In terms of the Parent Champions themselves, Coram's evaluation[122] found a number of significant gains in personal development and soft skills, including increases in knowledge, confidence, and transferable skills, increased employability, and feelings of self-efficacy from the opportunity to help others and give back to their community. With regard to increasing successful implementation, the research[123] found that schemes led by staff who had experience in volunteer recruitment and management were more effective than those that did not, and strong leadership skills were influential in progressing start-up of Parent Champion schemes in local areas. With appropriate support and guidance, Parent Champion schemes have demonstrated the potential to be an effective and low-cost method of spreading awareness and increasing take-up of local services.

Other participation and engagement initiatives

Parental engagement approaches are well established within education settings. There are a few routes to developing parent voice within school settings; common approaches include Parent-Teacher Associations (PTA), Parent Councils and Parent Forums. Some early year's education settings have also developed methods for parents to have an active role in their children's learning and development. Examples include encouraging parents to read and talk with their children at home, i.e. promotion of the home learning environment, inviting parents to participate in activities in the early years setting such as joint book reading, or literacy/numeracy programmes to improve the parents' own skills. Several studies have found parental engagement in early years' education settings to be associated with pupils' success at school[124,125] and current evidence is of moderate quality[126]. On average, parental engagement programmes

---

[121] https://www.coram.org.uk/resource/parent-champions-final-report
[122] https://www.coram.org.uk/resource/parent-champions-final-report
[123] Ibid
[124] Manning, M., Homel, R., & Smith, C. (2010). A meta-analysis of the effects of early developmental prevention programs in at-risk populations on non-health outcomes in adolescence. *Children and Youth Services Review*, 32(4), 506-519.
[125] Grindal, T., Bowne, J. B., Yoshikawa, H., Schindler, H. S., Duncan, G. J., Magnuson, K., & Shonkoff, J. P. (2016). The added impact of parenting education in early childhood education programs: A meta-analysis. *Children and Youth Services Review*, 70, 238-249.
[126] https://educationendowmentfoundation.org.uk/evidence-summaries/early-years-toolkit/parental-engagement/

evaluated to date have led to a positive impact of approximately four additional months' progress over the course of a school year. However, there does appear to be some variation in effectiveness between approaches, and ongoing monitoring and evaluation of approaches is essential.

There are similar models used to engage parents in CAMHS settings, with practitioners and parents collaborating in their children's treatment plan. Parental engagement in mental health services may include processes for involving parents in treatment decisions, providing a platform for sharing their opinions, participation in games and role-play within the sessions, and activities to follow-up in the home setting[127]. Indeed, parental engagement is particularly important for paediatric healthcare given the critical role that parents/carers often play in obtaining and facilitating attendance in treatment. Research evidence has also demonstrated consistent improvements in child outcomes when parents are involved in treatment[128] and that without parental engagement; it is less likely that any progress made during sessions will transfer to the home setting[129].

One example of a parental engagement approach is shared decision making whereby there is a genuine collaboration between children, their parents/carers and practitioners, e.g. reviewing all available treatment options, considering the pros/cons, and agreeing treatment goals. In this approach, all members of the triad are involved in the treatment planning (as developmentally appropriate), and agreed decisions are made by all parties. In order for this approach to be effective, practitioners needs to share up-to-date clinical information about their condition and options available, as well as making time to discuss progress on an ongoing basis[130]. There is some evidence that shared decision making can enhance patients' motivation, self-esteem, self-management and some cognitive outcomes[131]. However, there is still a gap in the research literature in terms of the implementation of parental shared decision making in children's mental health services, and a large-scale cluster randomised trial is currently testing the feasibility of a web application – Power Up for Parents, which aims to support parents/caregivers and promote their involvement in CAMHS decisions[132].

Importantly for this review, there is a lack of evidence about the implementation of parental engagement approaches when it comes to infant wellbeing and mental health, or at least a lack of evaluated programmes. A lack of data may also be reflective of some of the challenges that parents have reported in terms of actively participating in their child's mental health treatment. Examples of reported challenges include feeling blamed, judged and not listened to by practitioners, not feeling supported by the formal health system, and feeling dissatisfied with service provision in general[133]. Quite

[127] Karver MS, Handelsman JB, Fields S, Bickman L (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research*, 7(1), 35–51.
[128] Dowell KA, Ogles BM (2010). The effects of parent participation on child psychotherapy outcome: A meta-analytic review. *Journal of Clinical Child and Adolescent Psychology*, 39(2), 151–162.
[129] Karver MS, Handelsman JB, Fields S, Bickman L (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, 26(1), 50–65.
[130] https://www.corc.uk.net/media/1606/shared-decision-leaflet-4web.pdf
[131] Shay, L. A., & Lafata, J. E. (2015). Where is the evidence? A systematic review of shared decision making and patient outcomes. *Medical Decision Making*, 35(1), 114-131.
[132] https://www.annafreud.org/parents/research-and-involvement/power-up-for-parents/
[133] Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013). Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services. *Journal of Child and Family Studies*, 22(6), 854-868.

understandably, these factors may put some parents off from having any further engagement with services outside of (and within) routine appointments.

Although there is some indication that parental engagement may be beneficial to their children's outcomes, there are some important caveats to hold in mind, as highlighted in a recent review of parental engagement in children's mental health services[134]. Firstly, parents must feel that they have a right to decide the degree to which they want to be involved. Secondly, attempts to improve parental engagements must ensure that families do not see such efforts as coercive or intrusive. In addition, there may be rare instances when it is not ethical and/or safe to involve parents in their child's treatment and so engagement needs careful planning and monitoring.

In terms of parental collaboration with commissioners and practitioners on issues of wider service design and delivery, there are a few examples from mental healthcare services, although none with a visible evidence and evaluation base. One programme currently in motion is the Young Mind's 'Amplified' programme[135] – funded by NHS England. The programme includes a training element for professionals - masterclasses and toolkits to build the knowledge, skills and confidence around participation with children and families; as well as increasing the amount of participation opportunities at individual, organisation, local and national levels. The programme has been gathering examples of good participation practice, which includes Greenwich CAMHS, where the commissioning team work alongside a Youth Commissioners Programme, embedding the views of children and families in the commissioning of services. However, the Amplified survey of 414 professionals suggests that there are significant cultural and structural shifts to overcome when it comes to involving children and families in issues of governance[136]. For example, mental health professionals report that they are not as confident when it comes to involvement in service improvement and local transformation, they frequently feel challenged by lack of time and resources, and require more buy-in from senior management in order to implement participation opportunities with success.

Essential conditions for successful parental engagement programmes

When it comes to understanding the essential conditions for parental engagement, it is worth returning to the education literature, where parental engagement models are arguably more established than in healthcare settings. As an example, the Dual Capacity-Building Framework for Family-School Partnerships (version 2)[137] lists a series of 'essential conditions', split into 1) process conditions, i.e., at the parent-practitioner level, and 2) organisational conditions. It is not a blueprint for engagement initiatives, as they should be tailored to the particular contexts in which they are carried out. However, the authors promote their framework as a compass, laying out the goals and conditions necessary to move towards effective parental engagement efforts that lead to positive outcomes for children and services.

---

[134] Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review*, 18(2), 133-150.

[135] https://youngminds.org.uk/youngminds-professionals/our-projects/amplified/about-amplified/

[136] https://youngminds.org.uk/media/2152/amplified-insights-survey-2018.pdf

[137] https://www.dualcapacity.org/

Essential conditions for parental engagement – parent/practitioner level

- Built on mutual trust
- Include opportunities for learning and development
- Asset-based – i.e., respect the value of parents' knowledge, skills and lived experiences
- Culturally responsive and respectful
- Collaborative – parents have an equal voice
- Interactive

Essential conditions for parental engagement – organisation level

- Embraced by senior leaders across the organisation
- Embedded in all strategies
- Sustainable via sufficient resources and infrastructure

2. Public policy analysis

Overarching policy

Given the wide range of services involved in promoting young children's social and emotional development (see sections below), initiatives to bring these together under one set of goals and outcomes have an important role in making improvements in this area. They may help to facilitate, in particular, the creation of the interdisciplinary and integrated services that the literature review suggests are most successful. The three devolved administrations all have current, overarching (i.e. covering all public services) strategies for children and young people including the early years which are underpinned by legislation. This contrasts to England where the Every Child Matters agenda[138], introduced by a previous administration, now exists only as general duties in statute with no supporting activities or guidance.[139] The overarching strategies in the devolved nations are:

- *Wellbeing of Future Generations Act* (2015) in Wales, which commits key partners to a prevention agenda, focused on physical and mental wellbeing, equality and public involvement
- *Getting it Right for Every Child* framework in Scotland, parts of which were underpinned by legislation in 2014, takes a rights-based approach to child wellbeing. Scotland also has an overarching Early Years Framework, although this is now over 11 years old. Support for quality improvement across the early years and children's workforce is provided by the Children and Young People's Improvement Collaborative. The National Parenting Strategy (2012) aims to strengthen the support offered to parents across Scotland[140].
- The *Children and Young People's Strategy* in Northern Ireland is underpinned by the Children's Service Cooperation Act 2015. The Northern Ireland administration has also prioritised infant mental health, being the only part of the United Kingdom to have an overarching infant mental health framework and workforce development plan, and to use social and emotional development as the indicator for demonstrating children's progress at age three.[141]

The overarching policies of the three devolved administrations include some key common elements:

- supporting national and local government working together to support the emotional wellbeing of young children;
- enabling local areas to integrate service provision to meet local need;
- focussing on reducing poverty and inequality whilst improving health outcomes, including mental health; and
- valuing the perspectives of children and families by seeking to involve and consult them on some level.

---

[138] HM Government (2003) *Every Child Matters.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272064/5860.pdf

[139] Department for Education (2010) 'Reform of children's trusts' https://www.gov.uk/government/news/reform-of-childrens-trusts . [Accessed 6/2/2020]

[140] Scottish Government (2012) National Parenting Strategy https://www.gov.scot/publications/national-parenting-strategy-making-positive-difference-children-young-people-through/

[141] Public Health Agency (2016) *Infant Mental Health Strategy.*

Health services

Maternity and Perinatal Mental Health Services

The literature review makes clear the link between mental health of mothers and their children and the range of evidenced based clinical interventions available. Investment in specialist, evidenced-based interventions for mothers has the potential to improve the lives and experiences of many children and families.

In recent years, perinatal mental health has been a priority in terms of expanding access to and provision of services for the NHS in all four nations. In England, specialist community perinatal mental health services have been available in all 44 NHS areas since April 2019, and work is underway to begin offering mental health assessment and signposting for fathers and partners of women accessing mental health support.[142] In Northern Ireland, despite the establishment of mother and baby units being identified as a priority since 2013[143], at the time of writing, none have opened.

Beyond this, however, the exact 'offer' and availability of clinical services has been hard to gauge through the policy review. Whether particular interventions are used will depend on the professional judgement of those making referrals or treating patients, waiting lists and other variables.

Child and Adolescent Mental Health Services

In addition to those aimed at parents or delivered to parents and infants together, some clinical interventions may be delivered to young children. There has been a range of activity in recent years to reform how children and young people's mental health needs are met, including commitments across the four nations to improve provision of Child and Adolescent Mental Health Services (CAMHS):

- The English Government allocated £1.4bn to be spent on improving children and young people's mental health services over five years from 2015 to 2020. Complex trauma mental health services for children are being developed in selected areas. There are also plans to pilot designated leads for mental health in schools and new Mental Health Support Teams attached to schools. [144] However there are no equivalent measures proposed for early years settings and many CAMHS do accept referrals for children aged under five.[145]
- Wales has objectives around decreasing the percentage of children in need with mental health problems and improving access to CAMHS.[146]

---

[142] NHS England (2019) 'Specialist mental health support for new mums available in every part of England' https://www.england.nhs.uk/2019/04/specialist-mental-health-support-for-new-mums-available-in-every-part-of-england/

[143] Health and Social Care Board (2013) *Transforming Your Care: strategic implementation plan*

[144] Department of Health and Social Care and Department for Education (2018) *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*

[145] PIP UK (2019) *Rare Jewels Specialised parent-infant relationship teams in the UK*

[146] Welsh Government (2016) *Together for Mental Health: Delivery Plan: 2016-19.* https://gov.wales/sites/default/files/publications/2018-12/mental-health-delivery-plan-2016-to-2019.pdf

- Scotland has also committed to a variety of measures to extend support for children and young people's mental health. The current mental health strategy (2017-2027) commits to promoting evidence based approaches to prevention and early intervention for children and young people, deliver co-ordinated pathways for support for children's mental health and fund improved provision of CAMHS services.[147] Additionally the Children and Young People's Mental Health and Wellbeing Programme Board, set up in response to recommendations from the 2019 Children and Young People's Mental Health Taskforce is seeking to enhance community based mental health support and crisis support for children and young people, amongst other measures.[148]
- A recently concluded 10-year strategy for children and young people in Northern Ireland included measures to reduce CAMHS waiting times. The draft successor strategy emphasises the need to prevent mental health problems from occurring as well as providing services when they are needed.[149]

Integration

There is a strong evidential basis for joined up working between a range of services in the early years to promote social and emotional development. This is described in the literature review in terms of the benefits of interdisciplinary partnership and integration of services. Integration of services that contribute to health outcomes is a key plank of health reform in all four nations, which has a different emphasis depending on the jurisdiction in question:

- The NHS Long Term Plan (2019) heralded a move to new arrangements for commissioning and delivering all NHS Services in England. Central to this is the formation of 44 Integrated Care Systems across the country formed of NHS commissioners and providers and partner agencies, including local authorities. This integration agenda is supported at community level by Primary Care Networks, led by groups of GP practices and incorporating a range of community nursing and therapeutic services.[150]
- Northern Ireland have commissioning arrangements between health, social care, and public health, supported by strategies from the Department of Health and Public Health Agency.[151]
- The Public Bodies (Joint Working) (Scotland) Act 2016 set out requirements for the integration of health and social care services across Scotland to ensure that people have access to the support they need and care feels seamless. The extent to which children's services have been integrated within local Integrated Joint Boards varies across the country, although the national drive is towards full integration over time.[152]

---

[147] Scottish Government (2017) *Mental Health Strategy 2017-2027.* https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/6/

[148] https://www.gov.scot/groups/children-and-young-peoples-mental-health-and-wellbeing-programme-board/

[149] Department for Education (NI) (2017) *Draft Children and Young People's Strategy 2017 – 2027* https://www.education-ni.gov.uk/consultations/children-and-young-peoples-strategy-2017-2027

[150] NCB (2019) *The NHS Long Term Plan: Briefing for the children and young people's sector*

[151] E.g. Department of Health, Social Services and Public Safety (2012) *Strategy for Maternity Care in Northern Ireland* (2012-2018); Public Health Agency (2014) *Making Life Better: a Whole System Strategic Framework for Public Health.*

[152] Welsh Government (2017) *Flying Start parenting support: guidance*

- *A Healthier Wales* (2018) sets out a long-term vision of a 'whole system approach to health and social care', one which is focused on health and wellbeing and preventing illness. Primary care clusters of 3-15 per region will continue to develop models of seamless partnership working.[153] In addition, Health Boards, local authorities and the third sector are required to collaborate to support resilience and attachment through the early years. Local pathways should integrate and not duplicate with perinatal mental health services.[154]

Health visiting and infant health promotion

Health visitors will be a key partner in any programme to improve the social and emotional development of young children. The literature review highlights the benefits of interventions that can be delivered at settings convenient to new parents, including in the home. It also highlights the importance of professionals in universal services and parents themselves developing knowledge of infant mental health, something that could be supported through and enhancement of a standard service such as health visiting.

A universal health visiting offer exists in all parts of the UK, sitting within respective universal child health promotion programmes, with targeted interventions focused on those with additional needs.

For all of these offers, the relevant guidance makes some reference to family functioning, attachment or mental health of the mother or child. This varies between the nations, as does the number of visits/contacts/reviews:

- England mandates five health and development reviews from pre-birth to around 2 - 2.5 years.[155]
- In Northern Ireland there are 7 'key contacts' from conception to the age of 4, one of which is the sharing of messages around social, emotional and behavioural development to be delivered in early years and group settings at age three. [156]
- In Scotland there is a concentration of checks (8 in total) within the first year of life, in addition to 3 reviews between 13 months and 4-5 years.[157]
- Wales offers a minimum of 8 reviews from birth to age five.[158]

Some recent developments have indicated an increasing recognition of the role that health visitors can play in supporting mental health:

- The Solihull Approach, a universal parenting intervention, emphasises emotional containment, reciprocity and behaviour management. Training in the approach is now widely offered to health visitors (and other practitioners across the health and social care sector) within Northern Ireland to ensure wider practice is informed by an awareness of infant mental health.[159]

---

[153] Welsh Government (2018) *A Healthier Wales: our Plan for Health and Social Care*
[154] Welsh Government (2017) *Flying Start parenting support: guidance*
[155] Department of Health (2009) *Healthy Child Programme – Pregnancy and the first five years of life*
[156] Department of Health, Social Services and Public Safety (2010) *Healthy Child, Healthy future: A framework for the universal Child Health Promotion Programme in Northern Ireland*.
[157] Scottish Government (2015) *Universal Health Visiting Pathway in Scotland: pre-birth to pre-school*
[158] Welsh Assembly Government and NHS Wales (2016) *An overview of the Healthy Child Wales Programme*
[159] Public Health Agency (2016) *Infant Mental Health Framework*

- In England, recent Select Committee Inquiries have drawn attention to a range of implementation issues, including excessive health visitor caseloads and the need for an additional review at age 3 – 3.5 years.[160] There was also a recommendation for Government to consult with experts to determine if an assessment of social and emotional development prior to the fifth mandated check should be required. Whilst these recommendations have not been taken up by Government, reviews of government strategy on the first 1001 days by an Inter-Ministerial Group, and of the Healthy Child Programme by Public Health England may provide an opportunity for this agenda to be furthered.[161]
- In Scotland a new Universal Health Visiting Pathway[162] was introduced in 2015, which outlines the Scottish Government's home visiting offer to all families. To help deliver this service, the Scottish Government committed to recruiting an additional 500 Health Visitors by 2018. A national evaluation of the Universal Health Visiting Pathway is currently underway, with preliminary findings expected summer 2020.

Early education and childcare

Early education, as a universal offer based in regulated settings, provides an important opportunity for direct work with children to support their social and emotional development. The UK has accepted that early years education for preschool children enhances all-round development for children[163], and each country has an offer of state-funded early education entitlements. The entitlements of all 3-4 years olds are as follows:

- Scotland offers 16 hours per week (due to increase to 30 hours per week during term time by August 2020);
- England offers 15 hours per week;
- Northern Ireland offers 12.5 hours a week term time; and
- Wales offers 10 hours per week term time.

Each country has an aspect of the early year's curriculum focusing on social and emotional development, with an emphasis on strong relationships and each child having a key worker. There is also high value placed on working in partnership with parents and acknowledging them as the child's first educator.

Better understanding of mental health may be further embedded in early years' settings through partnership working health services. Relevant activities include:

- An Integrated Review takes place in England at age two for children identified as needing further support in their development at their early education progress

[160] House of Commons Health and Social Care Committee (2019) *First 1000 days of life: Thirteenth Report of Session 2017–19*

[161] Department of Health and Social Care (2019) *PHE priorities in health and social care: 2019 to 2020: Letter from Health Minister Steve Brine confirming Public Health England's (PHE) role and priorities for the financial year 2019 to 2020.*

[162] Scottish Government (2015) Universal Health Visiting Pathway in Scotland: Pre Birth to Pre School https://www.gov.scot/publications/universal-health-visiting-pathway-scotland-pre-birth-pre-school/

[163] Sylva, K et al (2004) *The Effective Provision of Pre-School Education (EPPE) Project: Findings from Pre-school to end of Key Stage1*. London: Department for Education and Skills

check at age two. An Integrated Review brings together health and early education professionals in a coherent way.[164]

- Northern Ireland conduct a '3-plus Integrated Review'; a review carried out in the preschool setting, by a health visitor at age three. The ASQ-SE (Ages and Stages Questionnaire – Social and Emotional) tool is used to assess social and emotional development and aims to identify any issues and address them before the child starts school. The linking of a named health visitor to each preschool encourages health-education collaboration. Parents complete the questionnaire at home, then attend the meeting with the health visitor and their child. Preschool staff also input to ensure a holistic approach.[165]
- Plans in England to introduce designated leads for mental health in schools, although no equivalent has been developed for early year's providers or pre-school children.[166]
- Scotland has a developmental and wellbeing check at the 27 -30 month check using ASQ 3 with a focus on social and emotional development.[167] [168]

Whilst there is a clear recognition social and emotional development in this area of policy, the way development and attainment is measured within early years curricula may lead to this being deprioritised – particularly in England – where there are arguably clearer expectations about progress in other areas of child development. Furthermore, in the UK, not all staff working in an early education or childcare setting have to have a qualification in early education and childcare. This is in spite of evidence that staff's level of qualification can be a key determinant of quality of early education.[169,170] Minimum qualification requirements tend to relate to management of settings, paediatric first aid and adult/child ratios and there is variation in approach between the four nations.

Social mobility

Administrative data[171], including that cited in the literature review, shows that scores for social and emotional development are typically lower in deprived areas, and amongst those in low income households. Research also shows that disadvantaged children are less likely to access nursery provision but that they benefit significantly from high-quality pre-school experiences. [172]

A commitment to social mobility across the four nations has led to the universal early education entitlements for 3-4 year olds offer being extended for disadvantaged two

[164] NCB (2015) *The Integrated Review: Supporting materials for practitioners working with young children*
[165] Department of Health, Social Services and Public Safety (2014) *Early Intervention Transformation Programme*
[166] Department of Health and Social Care and Department for Education (2018) *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*
[167] https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2015/10/universal-health-visiting-pathway-scotland-pre-birth-pre-school/documents/00487884-pdf/00487884-pdf/govscot%3Adocument/00487884.pdf
[168] Guidance on 27 -30 month check https://www.gov.scot/publications/scottish-child-health-programme-guidance-27-30-month-child-health-review/pages/3/
[169] The Economist (2012) *Starting well Benchmarking early education across the world* http://graphics.eiu.com/upload/eb/Lienstartingwell.pdf
[170] Sylva, K et al (2004) op cit
[171] Department for Education (2018) *Early years foundation stage profile results: 2017 to 2018*
[172] Sylva, K et al (2004) op cit

year olds. England have also extended the early education offer to 30 hours for working parents of 3-4 year olds.

Early language and literacy development has been a key focus within the Department for Education in England, since 2017. There are myriad government programmes seeking to improve language and literacy outcomes in disadvantaged children, including a Home Learning Environment campaign. Although these initiatives provide an opportunity for engaging with some of those families most in need, the extent to which they act specifically on the link between early communication skills and social-emotional development is less clear.

Similarly in Scotland, there are many programmes and initiatives designed to prevent the development of a poverty related attainment gap at the earliest stage, many of which have an emphasis on family learning and the home learning environment.[173][174]

Family support and social care

The literature review highlights the association of young children's disorganised attachment with various adverse experiences. Some of these, such as serious parental mental ill health, substance misuse and maltreatment may trigger child protection measures from children's social care. Targeted support for parents to avoid the need for such interventions and help families move on from difficulties will be a key part of any strategy to promote the social and emotional development and mental health of young children.

Each of the four nations have their own legislative frameworks for children's social care services:

- The Children Act 1989 provides the legislative framework for children's social care services in England. Section 17 provides the framework for children 'in need' who require support from professionals to support their wellbeing, and this could be used for children requiring support with their mental health. Guidance describes an offer of 'Early help' for families, which should be offered as a preventative measure for families who are struggling.[175]
- The Children (Northern Ireland) Order 1995 provides the legislative framework for Northern Ireland's child protection system. Families Matter (2009) provides the strategic direction for supporting parents, recognising that the family is the primary environment within which the wellbeing of the child is nurtured.
- The Children (Scotland) Act provides the framework for child protection in Scotland. The Children and Young People (Scotland) Act 2014 provides more of a wellbeing framework including requiring local authorities to develop a Children's Services Plan. Guidance states that plans must be prepared with a view to

---

173 https://www.peeple.org.uk/sites/www.peeple.org.uk/files/Scottish%20policy%20and%20the%20home%20learning%20environment_2.pdf

174 https://education.gov.scot/improvement/Documents/FamilyLearningFrameworkApril18.pdf

175 HM Government (2018) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

securing children's services that fulfil both priorities of prevention and early intervention.[176]

- The Social Services and Well-being (Wales) Act 2014 aimed to transform how children's and adults social care is delivered, including encouraging a renewed focus on prevention and early intervention. The latest expectations regarding the delivery of support for families through social care are laid out in the Families First programme guidance, published in 2017. The aim is to provide a model of effective early assessment which brings together a range of agencies to support families.[177]

The focus on family support and parenting support in the early years contrasts greatly across the four nations. It is a significant focus in Wales through Families First and Flying Start. In England, holistic work with families is highly targeted at those with multiple problems that cause cost to the taxpayer (for example, the Troubled Families Programme) or where children are at risk of being taken into state care. In Scotland the National Parenting Strategy seeks to strengthen the support offer for parents and make it easier for them to access this support.[178] There are some excellent examples of family support services from across the four nations, focused on prevention and early intervention:

- Introduced in 2014, Flying Start in Wales is funded and available in targeted areas supporting all families to give children aged 0-3 years a 'Flying Start in life'. The scheme aims to provide intensive support services for children and their families. The focus of the programme is on promoting language, cognitive, social and emotional skills, physical development and the early identification of high needs.[179]
- Families Matter (2009) underpins work with families in Northern Ireland and offers early intervention family support services on a universal offer. 'Group based antenatal care and education' is a new approach to antenatal care based on the Centring Pregnancy model and combines antenatal education classes with health checks in six group sessions delivered by a midwife. The education component is based on the Solihull parenting programme, which includes a full session on infant mental health, attachment and relationship building.[180]
- The Scottish Government's Mental Health Strategy 2017-2027 includes a range of actions relevant to mental health in the early years including the roll out of targeted parenting programmes for parents of 3- 4 year olds with conduct disorder.[181] The Family Nurse Partnership[182] for young mothers in Scotland offers an intensive family support programme of visits from pregnancy through to the child's second birthday. It is based on a programme developed in the US which has been shown to improve outcomes for mothers and children, including mental health.

---

[176] Scottish Government (2016) *Statutory Guidance on Part 3 (Children's Services Planning) of the Children and Young People (Scotland) Act 2014*
[177] Welsh Government (2017) *Families First Programme Guidance*
[178] https://www.gov.scot/publications/national-parenting-strategy-making-positive-difference-children-young-people-through/
[179] Welsh Government (2017) *Flying Start parenting support: guidance*
[180] Department of Health (2009*) Families Matter: Supporting Families in Northern Ireland. Regional Family and Parenting Strategy.*
[181] Scottish Government (2017) *Mental Health Strategy 2017-2027*
[182] Scottish Government (2016) *Pregnancy and Parenthood in Young People Strategy*

In England, *Working together to safeguard children* (2018)[183], lays out expectations for local authorities to deliver the aforementioned 'Early help' services to children and families at risk of needing formal interventions from social care under the Children Act 1989. The emphasis on, and availability of, early help is particularly relevant to parenting and young children's mental health. It will come into play in cases where, for example, there is no evidence of abuse or neglect, but parents are starting to struggle and this may be impacting on the child's emotional development.

Children's centres[184] have been one of the central locations where families are able to access early help services in England, although many have closed in recent years due to cuts in funding. In recent years concern has been raised by a range of stakeholders about the increasingly limited availability of early help services and a broader range of early intervention services[185].

[183] HM Government (2018) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

[184] Children's centres aim to improve outcomes and reduce inequalities through access to health services, parenting support and outreach services and research on their benefits is strong http://www.ox.ac.uk/news/2015-12-18-childrens-centres-improve-parenting-skills-disadvantaged-families;

[185] Sammons and Hall, 2015 All Party Parliamentary Group for Children (2018); Action for Children, NCB, NSPCC, The Children's Society and Barnardo's (2019)

Detail of relevant policy in the four nations of the UK

England

Health services

The NHS Long Term Plan, published in January 2019, set out the priorities of the NHS in England from 2019-23.[186] Chapter three of the long term plan included a dedicated 10-page section called: "A strong start in life for children and young people." The Children and Young People's Transformation Programme will oversee the delivery of the children and young people's commitments in the Plan. It includes a focus on children and young people's mental health. There is a commitment to funding for children and young people's mental health services growing faster than both overall NHS funding and total mental health spending Commitments include:

- All children experiencing crisis will be able to access crisis care 24 hours a day, seven days a week through NHS 111
- Development of complex trauma mental health services for children in selected areas
- Extending current service models to create a comprehensive offer for 0-25 year olds that delivers an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model.

The long term plan also heralded a move to new arrangements for commissioning and delivering all NHS Services in England. Central to this is the formation of 44 Integrated Care Systems across the country formed of NHS Commissioners and Providers and partner agencies, including local authorities. This integration agenda is supported at community level by Primary Care Networks, led by groups of GP practices and incorporating a range of community nursing and therapeutic services (with health visiting remaining the responsibility of local authorities).

The report, *Future in Mind*[187], was published by the Children and Young People's Mental Health Taskforce in March 2015 It presented a number of recommendations for improving children's mental health and was accepted by the Government. This included promoting resilience, prevention and early intervention in childhood. It stressed the importance of healthy pregnancies, nurturing childhoods and support for families to achieve this, and it also makes the link between parental and child mental health. It also recommended enhancing existing maternal, perinatal and early year's health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour. They wanted to ensure parents had access to evidence based programmes of intervention and support. It also recommended learning from the 0-2 year old early intervention pilots from 2015.

---

[186] NCB (2019) *The NHS Long Term Plan: Briefing for the children and young peoples' sector*
[187] Department of Health and NHS England (2015*) Future in Mind: Report of the Children and Young People's Mental Health Taskforce*

The Government allocated £1.4bn to be spent on improving children and young people's mental health services over five years from 2015 to 2020[188]. However, there is some evidence that this money has not been invested in mental health services as expected.[189] NHS England has also committed to working with partner organisations to ensure that it reduces the impact of postnatal depression, through earlier diagnosis, better intervention and support.

In December 2017, the Government published *Transforming Children and Young People's Mental Health Provision: a Green Paper*.[190] This set out plans to support schools to appoint mental health leads and create mental health support teams to provide early intervention for school aged children. No equivalent was included for early year's providers, and there were no plans for working with families of young children around their mental health.

The Maternity Transformation Programme[191] forms NHS England's Response to the 2016 Better Births review, which highlighted two fifths of parents in England had no access to perinatal mental health services. The programme is being delivered by Local Maternity Systems, formed of a range of providers and commissioners serving areas of approximately a million people. Improving access to perinatal mental health services is one of the work streams of this programme. In April 2019, NHS England announced that specialist community perinatal mental health services were available in all 44 NHS areas in England. A brief description of the current offer is included in the intervention tables below. Work to expand the scope of these services, as per the commitments in Long Term Plan, include:

- Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties or a personality disorder diagnosis to benefit an additional 24,000 women per year by 2023/24, in addition to the extra 30,000 women getting specialist help by 2020/21
- Expanding the scope of specialist perinatal mental health services so that they are available from preconception to 24 months after birth (care is currently provided from preconception to 12 months after birth)
- Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions
- Offering mental health assessment and signposting for fathers/partners of women accessing mental health support evidence-based assessment for their mental health and signposting to support as required
- Increasing access to psychological support in maternity settings.
- Maternity outreach clinics will join up maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

---

[188] Department of Health and Social Care and Department for Education (2018) *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*

[189] Frith, E (2016) *Progress and challenges in the transformation of children and young people's mental health care*

[190] Department of Health and Department for Education (2017) *Transforming Children and Young People's Mental Health Provision: a Green Paper*

[191] NCB (2019) *The NHS Long Term Plan: Briefing for the children and young people's sector.*

Health visiting and infant health promotion

How is mental health reflected in the relevant policy?

Health visitors are responsible for the delivery of services, with parental mental health, the parent-child bond, and the emotional development of young children being a feature of their remit. Five health visitor reviews are mandated by law and there is currently a ring-fenced budget for public health, which finances health visiting.

The funding for public health services delivered by local authorities, including health visiting services, is financed by a ring-fenced public health budget. In 2018/19 the total public health grant was £3.215bn.

The HCP sets out the good practice framework for a wide range of recommended programmes and interventions for children and young people aged 0-19, and two documents (published in 2009) relate to the early years specifically:

- *Healthy Child Programme – Pregnancy and the first five years of life (HCP 0-5)*
- *Healthy Child Programme: the two year review*

The HCP is based on progressive universalism, to promote optimal health and wellbeing and additional services for those with specific needs and risk factors. Two core priorities of the HCP include helping parents develop a bond with their child and to identify problems in their children's development. Parent feedback should be part of clinical governance, with services accessible, visible, understandable and popular with parents, particularly among disadvantaged families. Co-located and multidisciplinary services are also considered to be key.

In relation to mental health, *Pregnancy and the first five years of life* emphasises:

- parenting support for all parents
- increasing professionals understanding of attachment, positive parenting, maternal mental health, and responses to risk factors
- promoting the social and emotional development of children
- integrated service provision, including HCP teams in GP and children's centres and maternity services
- Focus on vulnerable children and families.

Health visiting is the statutory vehicle for delivering the core requirements of the HCP 0-5 (which are set out in the 'HCP Schedule' within *Pregnancy and the first five years of life*). The HCP is explicit in that universal health visiting services must assess mental health needs and prepare mothers and fathers for the transition to parenthood. They may also provide universal support services to support emotional and psychological health in parents and infants, which include: parenting support, aadditional support and monitoring for infants with development problems and topic-based groups. Higher risk groups (for example, parents experiencing domestic abuse or serious mental illness) should also have access to more intensive interventions and referrals to specialist input.

The infrastructure requirements of the HCP state that processes for the health visiting 4-5-6 service model provides an evidence-based framework which intends to enable health visitors to maximize their contribution to the HCP 0-5. The model outlines the four levels of service available: Community; Universal Services; Universal Plus; and Universal Partnership Plus. It also describes the remit of the five mandated health and

development reviews. Each review has a different remit, and the emotional and mental health of children and parents, and parent-child bonding are a theme throughout.

The model also presents the six 'early year's high impact areas'. They are considered to be key opportunity areas which provide the biggest impact in improving outcomes for children and families, using the universal reviews and key contact points to improve health. The high impact areas are: transition to parenthood, maternal mental health, breastfeeding, healthy weight and nutrition, improving health literacy and the two year check.

In March 2015, a rapid review of the evidence base for the HCP was conducted to ensure the programme remains up-to-date. Local authorities took over full responsibility from NHS England for commissioning public health services for children up to the age of five (under the Health and Social Care Act 2012). Public Health England have since published guidance to help local authorities implement their duties. Regulations were also introduced to mandate the delivery of the five universal health reviews to all families with babies, before their child reaches 2.5 years, as described in the HCP 0-5.

The Two Year Review is one of the key health and development checks of the HCP 0-5. The *Two Year Review* document gives supplementary guidance on content and process, and its priorities include: emotional development, communication skills, support for positive relationships with families, obesity prevention and supporting mothers and fathers to develop self-efficacy and support change.

To what extent?

In 2012, the National Institute for Health and Care Excellence (NICE) published public health guidance on social and emotional development in the early years. It explains how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. It does not cover clinical treatment. It advocates a life-course approach with a focus on the most vulnerable, and the provision of both universal and targeted services. It makes clear that commissioning early year's services is a cross-government responsibility. The guidance also discussed the need to involve parents and to further the evidence-base around improving the social and emotional wellbeing of young children. The HCP 0-5 policy and guidance documents broadly reflect the NICE guidance. Its remit and the ring-fenced public health budget indicate the government's intention to prioritise mental health promotion of young children and parents. However, workforce and implementation issues mean that many children are not in receipt of their mandated checks, meaning opportunities for early intervention are being missed.

Figures from Public Health England 2018-19 show 77 per cent of children received a 12-month review by the age of one, compared to 75 per cent the previous year.[192] Research by NSPCC found that antenatal visits are inconsistent, with an estimated 38 per cent of families not receiving a health visit before the mother gives birth. NSPCC attribute the drop in visits to local authority budget cuts and fewer health visitors. They launched a campaign: 'Fight for a Fair Start', calling on the Government to ensure all

[192] Public Health England (2018) *Health Visitor Service Delivery Metrics 2017/18 Annual Data Statistical Commentary*; and, Public Health England (2019) *Health Visitor Service Delivery Metrics (Experimental Statistics) Quarter 4 2018/19 Statistical Commentary*

parents receive a minimum of five face-to-face visits undertaken by the same health visitor to identify perinatal mental health problems quickly.

NHS Digital Workforce Statistics show that the number of health visitors has fallen by over 20% since service commissioning transferred from NHS England to local government.[193] The Institute of Health Visiting (IHV) found that almost half are working with caseloads of more than 400 children each. IHV recommend a maximum caseload of 250 children per health visitor to ensure parents and children receive optimum care.[194]

Recent Select Committee Inquiries[195] have drawn attention to these issues and call for more strategic leadership from central government. The Government refused to commit to a national strategy on the early years or on early intervention. Instead, the Government continued to support a variety of nationwide programmes to address the issues raised, stating that local areas are best placed to choose which models they use to support families.

The Health and Social Care Select Committee Inquiry on the First 1000 Days highlighted not all children are receiving their five mandated reviews, and called for the reduction of health visitor case-loads, and an additional mandated review at 3 – 3.5 years to ensure that potential developmental problems are identified and addressed before starting school. It also recommended that all reviews are carried out by a health visitor, including one home visit. Other recommendations highlighted the need for interventions to focus on the health of the whole family, and to examine how this impacts on the physical and mental health of the child. Continuity of care and improved links between health visiting and primary care were flagged as necessary, as was the provision of pre-conception support to parents who are planning a pregnancy.

Government responded that they had no plans to introduce an additional mandated contact for all children aged 3 to 3.5 years of age, but confirmed they are working with Public Health England to modernise the HCP with an initial focus on the first 1000 days and the early years. The refresh of the HCP is intended to link the health visitor and school nurse 4-5-6 service model which Public Health England are undertaking.

The Science and Technology Committee Inquiry (2018) *Evidence-based early years intervention* made several recommendations around health visiting, similar to the Health and Social Care Inquiry. In addition, it highlighted the needs of children who have experienced adverse childhood experiences (ACEs). Government responded by stating they will continue to develop the evidence-base on early intervention and research areas relevant to ACEs, including parent-child attachment, parental conflict and parenting programmes, through its support of the Early Intervention Foundations (EIF).

The Science and Technology Committee Inquiry also called for Government to consult with the Institute for Health Visiting and child development experts to determine if the HCP 0-5 should include assessment of social and emotional development prior to the

---

[193] Institute of Health Visiting (2018) *Written evidence from the Institute of Health Visiting to the parliamentary Health and Social Care Committee inquiry into the First 1000 Days of Life*

[194] Institute of Health Visiting (2018) *Three years on from a move to local authority commissioning in England, what has changed? Results from a Survey of English Health Visitors*

[195] Education Committee (2019) *9th Report – Tackling disadvantage in the early years;* Health and Social Care Committee (2019) *First 1000 days of life: Thirteenth Report of Session 2017–19; and,* Science and Technology Committee (2018) *Evidence-based early years intervention: Eleventh Report of Session 2017–19.*

fifth mandated review. Government responded that social-emotional development can be assessed at the same time as personal-social development at the two year review. However, the provisional Public Health Outcomes Framework (recently open to consultation) does not require local areas to provide data on social-emotional development, only on communication skills and personal and social skills, using the Ages and Stages Questionnaire (ASQ-3). Assessing social-emotional development would entail practitioners using an additional assessment such as the ASQ-SE or other, which is not a current requirement.

As the responsibility for supporting the mental health of young children falls across Government departments, it was encouraging to see the establishment, in July 2018, of the Inter-ministerial Group on Family Support. The group, led by Andrea Leadsom MP, was tasked with identifying gaps in support and services for families from when a child is conceived up to the age of two. Andrea Leadsom MP led a backbench debate on the Inter-Ministerial Group on Family Support and shared findings from parents and professionals who want health visitors to provide greater levels of support to new parents and their babies, particularly where parents are struggling to form a secure bond, as well as better levels of breastfeeding support and post-partum care. The group have also evidenced the need for greater support for dads, same-sex parents, non-English speaking parents and better availability for couples counselling and targeted services for new parents, such as debt and housing advice. The Inter-Ministerial Group also recommend a clear and cohesive vision from central government, in this case focused on the period from conception to age two, and with specific ministerial responsibility for the '1,001 critical days'.

In July 2019, the Department of Health and Social Care published *Advancing our Health: prevention in the 2020s*. This document confirmed that local authorities will continue to commission health visiting services but emphasised that the NHS and local authorities need to work together for 'collaborative commissioning' in order to embed the prevention agenda and deliver joined up care. The document also stated that modernisation of the HCP will improve support for perinatal mental health, and social and emotional development of babies and young children.

All three Select Committee Inquiries have urged the Government to prioritise funding for the early years. It is imperative that any modernisation of the HCP be sufficiently resourced. The public health grant was originally introduced in 2013 when responsibility for public health services transferred from the NHS to local government. When responsibility for services for children aged 0-5 years was also moved to local government, the annual equivalent of £0.9bn a year of funding was added. However, the total value of the public health grant has declined (in real terms) since 2015/16[196] and there is concern in the sector that cuts to the public health grant are having a major impact on services, such as health visitors.

There is a planned moved towards 100% business rate retention which is being piloted by some local authorities. In the financial year ending 2020, local authorities will receive a £3.134 billion public health grant, ring fenced for their public health duties for all ages. Local authorities piloting business rates retention will not receive the grant from the government.

[196] The Health Foundation (2019) *Invest in public health now, or store up problems for the future*

The one year Spending Round taking place in September 2019 will set departmental day-to-day spending budgets for 2020/21, and the Local Government Financial Statement is due December 2019. A multi-year Comprehensive Spending Review is now due for 2020 and will largely determine whether a refreshed HCP can deliver on its intentions.

Early education and child care

Summary

The social-emotional development and mental health of babies and young children is the explicit intention of a range of early education curriculum and childcare policies, particularly from 2011 onwards. Ofsted's 2019 inspection materials include grade descriptors that recognise the importance of secure and strong relationships in infancy and the need for providers to promote resilience and the social-emotional development of young children. However, the realisation of these aims is largely dependent on the quality of the early year's workforce. Its necessity is recognised by Government but issues around workforce quality remain, as outlined in the 2019 Education Committee Inquiry *Tackling Disadvantage in the Early Years.*

The Department for Education's current focus on social mobility could become a potential enabler of strong mental health in the early years, if parents and all early years' professionals are supported to understand and talk about the links between strong language and communication skills and good mental health and emotional development. There is a need for the promotion of a common narrative and language around mental health in the early years, and for parents and professionals to be supported to become confident talking about the subject. This will help bring to light the critical importance of mental health in the early years and its relationship to healthy child development over the life course. It will also help support and enable the work of early year's professionals.

How is mental health reflected in the relevant policy?

The Childcare Act 2006 placed increased responsibilities on local areas, including to improve the health and wellbeing and reduce inequality for local children; and to provide early childhood services (defined as childcare, learning, family support, and early intervention).

The Allen report (2011) provided strong impetus for the provision of high-quality pre-school education for two-four year olds as a key example of effective early intervention. High-quality early education promotes the social and emotional development of current and future generations of babies and children. Subsequently, the Education Act 2011 amended the Childcare Act 2006 by extending the duty on all English local authorities to provide free early education to eligible two year olds (looked after children and families receiving out-of-work benefits). This was due to evidence that children from disadvantaged backgrounds are less likely to access nursery provision, but high quality early education from age two can improve social and cognitive outcomes.

Providers of children's services[197] are required to follow the Early Years Foundation Stage (EYFS). The EYFS Statutory Framework is a written document that sets the standards for the learning, development and care of children from birth to 5 years old. The EYFS has undergone revisions since it was first published in 2007, notably

[197] All schools and Ofsted-registered early years providers must follow the EYFS. This includes childminders, preschools, nurseries and school reception classes.

accommodating the recommendations of the Tickell Review in 2011. There are now three prime areas within the EYFS, which are understood to be the foundations on which further learning develops. They are: communication and language, physical development and personal, social and emotional development. The personal, social and emotional development area of learning is the most relevant to mental health. It covers the importance of developing positive attachment relationships in the early years, learning to manage feelings and developing confidence in their own abilities.

All areas of learning are connected and child development from birth to age five a holistic process that necessitates play-based learning. Children are assessed at the end of the year that the child reaches age five, and this assessment is known as the EYFS Profile assessment. Children are assessed against the 'Early Learning Goals', and there are two or three early learning goals within each area of learning.

As outlined in the EYFS Statutory Framework, it is intended that four guiding principles shape the practice of early education settings, one of which is positive relationships. This reflects the evidence of the importance of secure early attachment to primary care-givers which are vital for the healthy emotional development of young children. This is also reflected by the statutory requirement for a key person to be assigned to each child, specifically to meet their needs and to work closely with parents/carers. This requirement falls under the 'safeguarding and welfare requirements' of the EYFS.

The 'unique child' principle is important in ensuring that provision adapts its approach to the needs of individual children. This means that more vulnerable groups of children, for example, children exposed to parental drug or alcohol problems or mental ill-health or children who have experienced abuse, should receive support that is appropriate and targeted to their particular needs. Considerate and sensitive responses from warm, caring adults working within early year's settings can help children learn to feel emotionally safe and secure.

The current EYFS outlines the need for a statutory *Progress Check* to take place at age two, and states that a written summary of each child's development against the prime areas must be provided to their parents. The check is intended to be a key opportunity for the early identification of needs and risk factors, including mental health needs and risks, and a targeted plan should be put in place. Where a child's progress is less than expected, an Integrated Review can be arranged. An Integrated Review brings together health and early education professionals in a coherent way.

The EYFS Profile is the final assessment a child undergoes in the final term of the year in which they reach age five. The child's level of development is assessed against the early learning goals. For the 'Personal, Social and Emotional Development' area of learning, there are currently three early learning goals:

1. Self-confidence and self-awareness
2. Managing feelings and behaviour
3. Making relationships.

Schools must share the results of the Profile with parents to give them a well-rounded picture of their child's development. The Profile is also shared with Year 1 teachers to help inform a dialogue between reception and Year 1 teachers around the child's learning and development needs and readiness for Year 1. The Profile is used as the official indicator of 'School Readiness' (1.02i) within the Public Health Outcomes Framework.

The new Ofsted Education Inspection Framework (EIF) will come into effect in September 2019, and sets out how Ofsted inspects a range of settings, including early year's settings registered with Ofsted and maintained nursery schools. The EIF has been revised in order to assess the quality of teaching by putting the focus on the curriculum instead of excessive data collection. Another way it varies from the previous inspection framework is by separating the original judgement for 'Personal development, behaviour and welfare' into two separate judgements: 'Behaviour and attitudes' and 'Personal development'.

Within 'Personal development', providers will be judged as to whether their wider work and their curriculum develop children's character – including their resilience, confidence and independence – and whether they help children keep physically and mentally healthy. In the *Early Years Inspection Handbook*, a provider rated as 'good' will promote and support children's emotional security, including by implementing a key-person system to enable children to form secure attachments. This includes staff responding to babies in a sensitive, stimulating and responsive way. One of the three grade descriptors for an 'outstanding' personal development judgment is teaching children the language of feelings, thereby helping them to develop their emotional literacy. Another revision to the grade descriptors is in relation to the area 'Behaviour and attitudes'. Specifically, that inspectors are looking for providers to take appropriate action to support children when they struggle with regulating their behaviour. Importantly, this area also includes a grade descriptor for 'good' providers around the importance of relationships: that relationships among children, parents and staff reflect a positive and respectful culture, and that children feel safe and secure. The grade descriptors for an 'outstanding' 'Behaviour and attitudes' judgement promote respect for others; confidence in social settings; recognition of the impact of behaviour on others; high motivation for cooperating and joining in; positive attitudes to play and learning; high levels of self-control and support from staff when children struggle with this.

To what extent?

The Department for Education's focus since 2017 is on young children developing early language and literacy skills, with support targeted at the most vulnerable children. Both verbal and non-verbal communication skills are essential components for healthy emotional self-regulation and emotional expression. Successful communication necessitates an understanding of another's perspective, intentions and broader mind-set and talking about people's feelings, needs and wishes fosters empathy[198].

The breadth of speech, language, communication and literacy programmes throughout the country as well as the Department's public campaign to improve the Home Learning Environment are all laudable though would do better to make explicit the potential benefits to be gained to child mental health as a result. Parent-child interactions also help nurture secure attachment, the cornerstone of emotional development and mental health in young children. This was acknowledged in the Education Committee's report that states parental engagement and involvement in the home learning environment is crucial to children's development.

Communicating this understanding to parents and professionals (through enablers such as the Home Learning Environment Campaign and other Government initiatives) and

[198] Early Intervention Foundation (2018) EIF maturity matrix: Speech, language and communication in the early years

promoting the understanding and use of a common narrative[199] and language around mental health in the early years would further both parents' and professionals' capacity to help nurture strong social and emotional skills in young children. It could also be made clearer to parents and professionals that language problems in young children can sometimes be indicative of underlying poor mental health, and vice versa[200].

Fortunately, Early Intervention Foundation's speech and language maturity matrix is one new tool that helps local areas understand that speech, communication and language is a necessary building block of a range of child outcomes and that the development of these skills helps support the development of social and emotional skills, including talking about and expressing feelings.

Also, the recent Prevention green paper states that speech, language and communication skills are an important indicator of children's wellbeing, and commits the Department for Health and Social Care and Public Health England to working with the Department for Education to support health professionals to play a full part in the Home Learning Environment campaign. Different government departments working together and collaborative partnerships between health, early education and other early years professionals is very much at the heart of the NICE public health guideline on social and emotional development in the early years, and was the vision set by the jointly published *Supporting families in the foundation years* document. Seeing more of a joined-up approach with cross-departmental responsibility for the social-emotional development and mental health of young children is welcome and necessary.

It is very encouraging to see Ofsted's acknowledgement of the importance of strong attachments between babies/children and adults in their 2019 Early Years Handbook, although it would have been stronger to have 'teaching children the language of feelings, and helping them to develop their emotional literacy' as a grade descriptor for 'good' providers not solely 'outstanding' providers, under the Personal Development judgement.

The Government have invested £3.5 billion in early years education entitlements in 2019/20, and have acknowledged that *high-quality* early years education has a significant and long-term impact on child development. Despite this, the Education Committee report *tackling disadvantage in the early years* (2019) concluded that it was still necessary to make several recommendations related to the quality of the workforce. The report highlighted that the Government' 30 hours funded childcare entitlement policy for eligible three and four year olds is actually entrenching quality rather than closing the disadvantage gap, and urged Government to review the policy. The Government responded by stating their belief that work is the best route of poverty and the 30 hours policy incentivises work and is critical to the social mobility agenda.

The Government response acknowledged that some in the early year's sector are calling for parity between early year's teachers and school teachers with qualified teacher status (QTS), and recognises the long-standing challenges to recruiting and

[199] Parent Infant Partnership (PIP) UK have developed two infographics describing a common framework and narrative around the emotional wellbeing of children from conception to age two. The infographics were developed following consultation with the early years' sector. The importance of using shared language and speaking with a consistent voice was highlighted.

[200] Early Intervention Foundation (2018) EIF maturity matrix: Speech, language and communication in the early years; National Institute for Health and Care Excellence (2012) Social and emotional wellbeing: early years https://www.nice.org.uk/guidance/ph40

retaining graduates in the sector. Government believe a focus on professional development across the wider early year's workforce will improve quality, and have chosen not to emphasise graduates. This is despite the *Effective Pedagogy in Early Years* (2002) study highlighting the importance of qualified staff in the early years. This study was referenced in Ofsted's 2019 *Education Inspection Framework: Overview of research* document that states "while the most highly qualified staff provided the most direct teaching, they were also the most effective in their interactions with the children. Furthermore, less qualified staff were significantly better pedagogues when they were supervised by qualified teachers" (Siraj-Blatchford et al, 2002).

If early education settings are not consistently led by high-quality staff, children will be significantly less likely to realise their full learning and development potential. This includes their social and emotional development and potential for strong mental health, as intended by the range of early years policies discussed in this paper.

Family support and social care

The Children Act 1989 provides the legislative framework for children's social care services in England. It gives these services, delivered by local authorities, a clear role in preventing the impairment of children's mental health or social, emotional and behavioural development[201]. How local authorities and social workers carry out this role is largely determined by a range of other factors including more detailed statutory guidance, local practice, available financial resources and the latest priorities of national government (All Party Parliamentary Group for Children, 2018).

The Westminster Government last set out its vision for children's social care in the 2016 white paper, *Putting Children First*[202] . This focussed mainly on structural changes to deliver more consistent quality in children's social care as a whole, rather than discussing in any detail the types of outcomes sought for different groups of children. Where the aims of social care services are explored, this is framed in terms of keeping children safe, and where children have to be taken into state care, ensuring those individuals are well prepared for adult life. The priorities for reform set out in 2016 (which have all since been implemented to some degree) can briefly be described as:

- Establishing clearer standards of the knowledge and skills social workers should have
- Amending regulation and guidance so that there is less prescription about the processes carried out by children's social care with individual children
- Supporting greater learning across local authority areas
- Shifting the emphasis of the inspection regime so that it supports improvement and learning
- Improving the use of data and evaluation to plan services

As part of supporting greater learning between local authorities, the white paper made reference to the (already launched at the time) Children's Social Care Innovation Programme (SCIP).[203] The programme aimed to "test innovative ways of supporting vulnerable children and young people" through funding of £200 million distributed to

[201] See, in particular, Sections 17, 47, 31, 105 of the Children Act 1989

[202] Department for Education (2016) *Putting children first Delivering our vision for excellent children's social care.* London: The Stationary Office

[203] Department for Education (2019a) 'The Children's Social Care Innovation Programme'. https://innovationcsc.co.uk/innovation-programme/ [Accessed 25/07/2019]

local projects 2014 – 2020. Most of these projects focussed on work with older children and their families.

The priorities set out in the 2016 white paper largely reflect the recommendations of a government commissioned review[204] .One notable recommendation which was not taken forward was the creation of a duty on local authorities and other services to set out an 'early help offer'. Early help in this context refers to support provided to families before they reach the threshold for statutory intervention under the Children Act, as a means to improving outcomes and avoiding the intrusion in to family life and bureaucracy involved in making a statutory social care intervention. Whilst a new duty has not been created, the most recent iterations of the relevant statutory guidance, *Working together to safeguard children*, place great store on the importance of effective early help.[205]

The emphasis on, and availability of, early help is particularly relevant to parenting and young children's mental health. It will come into play in cases where, for example, there is no evidence of abuse or neglect, but parents are starting to struggle and this may be impacting on the child's emotional development. *Working together* lists 11 circumstances where professionals should be particularly alert to the need for early help. Most of these relate to situations which would only apply to older children but also include children who are: "disabled and or have specific additional needs" or "in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse"

In recent years concern has been raised by a range of stakeholders about the increasingly limited availability of early help services and a broader range of early intervention services. A survey of over a thousand social workers carried out by NCB in 2017 found that two thirds of those surveyed thought that thresholds for early help had risen in the preceding 3 years.[206] Analysis of local authority spending statistics has found that spending on wider early intervention had fallen by an average of 49%% between 2010-11 and 2017-18.[207]

One key mechanism supporting the delivery of wider early intervention (which may include aspects of early help) to families is children's centres. Children's centres are a single place, or group of places, where early years services are provided for young children and their families. Children's centres aim to improve outcomes and reduce inequalities through access to health services, parenting support and outreach services. Children's centres support families facing a wide range of challenges, including parental relationships, issues with child behaviour and budgeting.[208] The vast majority of their activity is accounted for in supporting children aged under 5.[209] They have been shown to be effective in improving maternal health and child behaviour.[210] There has, arguably,

---

[204] Munro, E (2011) *Munro review of child protection: final report - a child-centred system*
[205] HM Government (2015, 2018) *Working together to safeguard children.*
[206] All Party Parliamentary Group for Children (2018) *Storing up trouble: A postcode lottery of children's social care.*
[207] Action for Children, NCB, NSPCC, The Children's Society and Barnardo's (2019) *Children and young people's services: Funding and spending 2010/11 to 2017/18.* Watford: Action for Children
[208] Department for Education (2013) *Sure Start children's centres statutory guidance*. London: The Stationary Office
[209] Action for Children (2019) *Closed Doors: Children's Centre Usage between 2014/15 and 2017/18.* Watford: Action for Children
[210] Sammons, P., Hall, J., (2015) *The impact of children's centres: studying the effects of children's centres in*

been a lack of clarity from national government since 2015 around expectations of local authorities and children's centre regarding the scale, scope and quality of provision.[211] This, combined with reduced local authority budgets may have contributed to the number of active children's centres having fallen by between a sixth and a quarter since 2010.[212]

The National Audit Office (NAO)[213], Committee of Public Accounts (PAC)[214] and HCLG Committee[215] have raised concerns about the financial sustainability of children's social care in England. Whilst this concern may have been brought into focus by local authorities' reduced spending power, unexplained increases in the number of children taken into care or made subject to child protection plans have also been noted. Indeed, the rate of children being taken into care has been steadily increasing over the past decade, and now accounts for over half of spend on children's social care. The NAO and PAC also point to variations between local authorities which are only partly understood.

Government initiatives in children's social care have most recently focussed on attempts to understand what can help to prevent children needing having to be taken into care. The *Strengthening Families: Protecting Children* programme, launched in 2018, aims to roll out three interventions developed as part of the SCIP (see above) across 20 English local authority areas.[216] These projects were selected on the basis of their propensity to reduce the need to take children into care. The Government-sponsored What Works Centre has also been asked to carry out research into this issue. Some development work in broader social care remains, for example with the trailing of social workers having delegated budgets (What Works Centre for Children's Social Care, 2019).[217]

---

promoting better outcomes for young children and their families

[211] This stems primarily from the delay and ultimate cancelation of consultation on the future of children's centres, originally announced in 2015, since which time inspections of Children's Centres by Ofsted have been suspended.

[212] Action for children (2019) quote official figures reducing from 3,632 designated children's centres in April 2010. This had fallen to 3,096 in August 2018 (The August 2018 figure includes linked sites) and estimates by the Sutton Trust of 1,000 closures since 2009.

[213] National Audit Office (2019) *Pressures on children's social care.* London: NAO

[214] Committee of Public Accounts (2019) *Transforming children's services: Eighty-Eighth Report of Session 2017–19.* London: House of Commons

[215] Housing, Communities and Local Government Committee (2019) *Funding of local authorities' children's services: Fourteenth Report of Session 2017–19*. London

[216] Department for Education (2019b) 'Strengthening families, protecting children (SFPC) programme'. https://www.gov.uk/guidance/strengthening-families-protecting-children-sfpc-programme [Accessed 25/07/2019]

[217] What Works Centre for Children's Social Care (2019) 'Safely reducing the need for children to enter care'. https://whatworks-csc.org.uk/research/reports/reducing-the-need-for-children-to-enter-care/ ; 'Projects'. https://whatworks-csc.org.uk/research/research-projects/ [Accessed 01/08/

Northern Ireland

Overarching policy

Established in 2015, the Children's Services Cooperation Act (2015) seeks primarily to facilitate statutory and other organisations to work together to support the wellbeing of children and young people. The Act also legislates for the pooling of funding across departments, and states that any new strategic documents must acknowledge the Act and requirements therein. Departments and statutory organisations have a legal obligation to work together to support young children's emotional wellbeing, and to facilitate other children's service providers to do the same.

The Draft Programme for Government[218] is the overarching framework for Northern Ireland, setting out the key outcomes which the NI Executive want to achieve for everyone in Northern Ireland, alongside indicators by which we can demonstrate progress towards these. Giving children the best start in life is the main desired outcome for children, and will be measured by the % children reaching the appropriate stage of development in their immediate preschool year, which is assessed using the Social and Emotional version of the Ages and Stages questionnaire at age three. This aims to give some measure of the emotional wellbeing of young children, facilitate prevention and early intervention, and allow planning of services to be based on needs. However, there remains a significant gap in our knowledge of the state of young children's emotional wellbeing.

The Executive Office's 10-year Strategy for Children and Young People[219], expired in 2016 and provided the overall strategic direction for work to improve children's lives. Young children's emotional health aligned to the outcome 'Children and young people are healthy'; indicators to measure progress focused on reduction of waiting times for appointments at CAMHS, with drivers for change focused on increasing capacity across CAMHS services, particularly with a focus on preventative measures, establishment of crisis response teams and extension of access to school counselling programmes. Since then, the Department of Education has taken overall responsibility for children and young people's issues, and in 2017 released for consultation a Draft Children and Young People's Strategy 2017 – 2027[220], with an overall aim of "*Working together to improve the well-being of children and young people living in Northern Ireland, delivering positive, long-lasting outcomes.*"

The draft strategy aligns its desired outcomes to the pillars of wellbeing set out in the Children's Services Cooperation Act (2015). Outcome 1 states 'Children and young people are physically and mentally healthy'. For the first time, the mental health of children has been placed strategically alongside physical health. The need to invest in prevention and early intervention in terms of young children's emotional wellbeing is recognised, rather than intervening when mental ill-health has arisen in later years; this is an important step towards recognising 'parity of esteem' for physical and mental health.

---

[218] NI Executive (2017) *Draft Programme for Government*

[219] Office of the First and deputy First Minister (2006) *Our children and young people – our pledge. A ten year strategy for children and young people in Northern Ireland 2006-2016*.

[220] Department for Education (NI) (2017) *Draft Children and Young People's Strategy 2017 – 2027* https://www.education-ni.gov.uk/consultations/children-and-young-peoples-strategy-2017-2027

Infant Mental Health Framework

The Infant Mental Health Framework[221] was developed in 2016, in collaboration with a range of stakeholders, to bring a strategic focus to the critical role of the early years, the development of a strong attachment with a primary caregiver, and the early development of resilience in wider child outcomes. The framework has three key themes:

1. Evidence and policy: Ensuring policy and practice is informed by the most up to date evidence on child development and the early years
2. Workforce development: ensuring all practitioners working with young children and their families have the knowledge and skills to support positive infant mental health.
3. Service development: ensuring appropriate services are available to support all new parents and their family, covering both universal preventative services as well as specialist interventions.

Recommendations from the Framework have implications right across early years, health and social care practice for expectant parents and families with young children. Initial priorities include:

- Developing opportunities for sharing of good practice among practitioners in relation to supporting good infant mental health.
- Building skills and knowledge of IMH across all areas of practice, including building IMH information into core undergraduate studies and rolling out training in the Solihull Approach widely to build a baseline knowledge, as well as offering specialist training (e.g. Tavistock Masters/ Diploma in psychoanalytic therapy).
- Reviewing the perinatal care pathway and identifying gaps to improve targeted service development for those at increased risk during the antenatal and postnatal period.

The Early Intervention Transformation Programme[222] (led by Department of Health) is a cross-departmental programme, including philanthropic funding, aimed at embedding early intervention evidence and approaches across services for children and families. There are four work streams, one of which is focused on the early years, aiming to give children the best start in life by supporting parents and enhancing early intervention support and services. NCB were commissioned to complete a number of literature reviews to ensure that service development was fully informed by evidence of what works and of need. Examples of the services developed with a role in supporting infant mental health include:

- **Group based antenatal care and education:** this new approach to antenatal care is based on the Centring Pregnancy model and combines antenatal education classes with health checks in 6 group sessions delivered by a midwife. The education component is based on the Solihull parenting programme, which includes a full session on infant mental health, attachment and relationship building.

---

[221] Public Health Agency (2016) *Supporting the Best Start in Life: Infant Mental Health Framework for Northern Ireland.*

[222] Department of Health (2014) *Early Intervention Transformation Programme*

- **3-plus integrated review:** A 3 year child review, carried out in the preschool setting, by a health visitor. The ASQ-SE tool is used to assess social and emotional development, and aims to identify any issues and address them before the child starts school. The linking of a named health visitor to each preschool also encourages health-education collaboration. Parents complete the questionnaire at home, then attend the meeting with HV and their child. Preschool staff also input to ensure a holistic approach.

Health Services

There are numerous health-focused strategic documents, from both the Department of Health and Public Health Agency, which lay the groundwork for supporting young children and their families. The strategies all agree on the critical importance of the early years in developing strong emotional wellbeing, importantly taking a whole child approach and seeking to understand the child within the context of the family and wider community across the life-course.

Overview of Northern Ireland health and Social Care Structure

Department of Health: Department with responsibility for health and social care (which is integrated in Northern Ireland).

Health and Social Care Board: responsible for commissioning health and social care services across NI, managing resources and performance, and service improvement.

Health and Social Care Trusts: 5 of these across NI, responsible for service delivery across health and social care. Hospitals, health centres, residential care homes etc. are managed by the Trusts, and a range of health and social care services are delivered to the community.

Public Health Agency: Primarily a health promotion role, with shared responsibility with the Health and Social Care Board to deliver an integrated commissioning plan for health and social care.

Strategy for Maternity Care in Northern Ireland[223] lays out the maternity pathway for straightforward pregnancies and identifies the following prioritised outcomes for children and families:

- give every baby and family the best start in life;
- effective communication and high-quality maternity care;
- healthier women at the start of pregnancy (preconception care);
- effective, locally accessible, antenatal care and a positive experience for prospective parents;
- safe labour and birth (intrapartum) care with improved experiences for mothers and babies; and
- appropriate advice, and support for parents and baby after birth.

[223] Department of Health, Social Services and Public Protection (2012) *A Strategy for Maternity Care in Northern Ireland (2012-2018)*

Infant Mental Health isn't specifically referenced in this strategy, however there is some discussion on the need for specialist perinatal support, and additional care for new parents who have experienced previous mental health difficulties. Healthy attachment is particularly noted. The mother's emotional wellbeing should be discussed at each meeting, and healthcare professionals should be aware of the signs and symptoms of maternal mental health issues. Skin to skin contact should be encouraged immediately and separation of the mother and baby is not recommended in the first hour after birth. The emotional attachment of mother and baby should be assessed and encouraged at home visits and group-based parenting programmes should be offered. The strategy also clearly states that a knowledge of a strong parent-child attachment relationship in the first years of life should *'inform provision of antenatal education and postnatal support'*.

It is important to note that there are currently no specialist mother and baby units in Northern Ireland. This has been repeatedly highlighted as a significant gap for many years, with 'Transforming Your Care: strategic implementation plan' (2013) calling for this as a priority. Lack of such provision results in new mothers with serious mental ill-health being separated from their babies in the early days after birth. This can have a significant impact on attachment and on both mother and baby mental health.

Health visiting and infant health promotion

Universal Health Promotion programme

The *Healthy Child, Healthy Future* framework (HCHF)[224] sets out the features of the Universal Child Health Promotion programme, and aims to improve parent-child interactions, increase school readiness, reduce the likelihood of serious illness occurring in later life, and provide better short and long term outcomes for children at risk of social exclusion. The framework utilises a universal early screening and surveillance approach to identify early social, emotional and developmental issues, and to provide early intervention where necessary. Despite being targeted specifically at the early years, the impact these years have on the school-age child is critical.

The UNOCINI Thresholds of Need Model (DHSSPS, 2008) identifies the following levels of need:

Level 1: all children in NI

Level 2: vulnerable children with additional needs or at risk

Level 3: children with complex needs

Level 4: critical or high risk children, in need of safeguarding or with enduring needs.

While the HCHF programme is based on the principles of progressive universalism, with core services primarily aimed at level 1 children, with additional allowances for those children requiring specialist support. Strong parent-infant attachment is a primary

[224] Department of Health, Social Services and Public Safety (2010) *Healthy Child, Healthy future: A framework for the universal Child Health Promotion Programme in Northern Ireland.*

outcome of the HCHF programme, and services are based on the strong evidence around child development and neuroscience. A whole-child approach, strong integrated working and a focus on parenting support provide the core principles of the programme

Within the HCHF framework, the universal preschool programme is the core offer for conception to 4 years old. Delivery professionals include midwives, health visitors, GPs and school nurses. Key contacts include:

- First contact with GP (info given on folic acid, lifestyle choices & maternity care options)
- 12 weeks to full term: various pre-natal care, assessment and support locations and practitioner vary depending on trust area.
- Birth to 14 days: hospital and home support from medical staff and Health Visitor
- Up to 2 years: periodic home visits & immunisation schedule
- 2-2 ½ year health review at home by Health Visitor
- 3 year delivery of key messages around social, emotional and behavioural development in early years and group settings
- 4 year record review by health visitor
- School nursing services (4 years onwards)

Role of Heath Visitors

The critical role of Health Visitors in improving early childhood developmental outcomes has been recognised by the Northern Ireland Review of Health Visiting and Healthy Futures 2012-2015.[225] In particular, the review notes the following in relation to infant mental health:

- Health visitors have a strong promotion role in relation to infant mental health and supporting parents' understanding of attachment and child development
- Perinatal mental health issues should be core knowledge for all antenatal and postnatal care practitioners, who should also be aware of NICE guidance on maternal mental health and have the skills to assess and identify concerns.
- Health Visitors should be trained to deliver parenting programmes which include content around attachment, bonding & child development

The Healthy Futures 2010-2015 'The contribution of health visitors and school nurses in NI'[226] also highlights that health visitors should play a role in identifying attachment and bonding issues and assessing child development and maternal mental health. The Solihull Approach is now widely offered to health visitors (and other practitioners across the health and social care sector) to ensure wider practice is informed by an awareness of infant mental health.

In 2013, a breastfeeding strategy[227] was released by the Department of Health. This strategy aims to improve the health and wellbeing of both mothers and babies through

[225] Department of Health, Social Services and Public Safety (2012) *Northern Ireland Review of Health Visiting and Healthy Futures 2012-2015.*
[226] Department of Health, Social Services and Public Safety (2010) *Healthy Futures 2010-2015: The contribution of health visitors and school nurses in NI*
[227] Department of Health, Social Services and Public Safety (2013) *Breastfeeding- a great start. A strategy for Northern Ireland 2013-2023.*

promotion of the importance of breastfeeding, not just for physical health but for emotional wellbeing. Alongside nutritional benefits, the strategy highlights the role of breastfeeding in bonding and attachment, contributing to a strong and nurturing relationship between mother and baby. In delivering this aim, support is prioritised to build skills in nursing, midwifery and health visiting professions to promote and support the breastfeeding experience.

The Whole System Strategic Framework for Public Health[228] takes a life course approach to health and wellbeing, hence one of its key themes is 'Giving every child the best start'. This theme identifies the following long term outcomes:

- Good quality parenting and family support
- Healthy and confident children and young people
- Children and young people skilled for life

In particular the framework recognises the critical roles that parenting and family support play in the healthy physical, social and emotional development of children. The implementation of an Infant Mental Health training plan was one of the key first actions, alongside the roll-out of Family Nurse Partnership, implementation of the breastfeeding support strategy, and promotion of universal health and maternity services. Since then, the Infant Mental Health Framework has been developed (discussed above) and these actions, and others, further developed.

Early education and childcare

The Early Years (0-6) Strategy[229] sets out the Department of Education's priorities to support young children's physical and emotional development in the early years through delivery of quality early years provision. Priorities include:

- Encouraging parental involvement in education as their child's first educator
- Ensuring equity of access for all children, including those with additional needs, to good quality early years provision that enhances their development

Throughout the strategy, opportunities are identified to enhance social development alongside physical development, such as playing in small groups, collaborating with friends on tasks, or engaging with adults. The strategy also aims to support and raise awareness of the importance of the home learning environment in developing positive social and emotional skills.

Alongside this, the Curricular Guidance for Pre-School Education[230] identifies the activities and opportunities that will support young children's social, emotional and physical development. In regards to personal, social and emotional development, the Guidance identifies a number of ways in which young children can learn to build relationships, understand their emotions, self-regulate and build self-esteem. This includes:

- Creating a culture where children feel safe and supported

[228] Public Health Agency (2014*) Making Life Better: a Whole System Strategic Framework for Public Health*
[229] Department of Education (NI) (2010) *Early Years (0-6) Strategy*
[230] Council for Curriculum, Examinations and Assessment (2018) *Curricular Guidance for Pre-School Education.*

- Establishing daily routines and supporting children to be independent (e.g. in dressing, registering themselves as present in the morning, washing their hands, getting their own snack)
- Providing flexible play opportunities so that children can create their own activities.

Family support and social care

The Children (Northern Ireland) Order 1995 provides the legislative framework for Northern Ireland's child protection system. It sets out the principal statute governing the care, upbringing and protection of children and is underpinned by the UNCRC. It affects all those who work with and care for children, whether parents, paid carers or volunteers. The following principles are reflected in the Children's Order and should underpin all strategies, policies, procedures, practice and services relating to safeguarding children and young people.

- The child or young person's welfare is paramount.
- The voice of the child or young person should be heard.
- Parental responsibility and help for families to stay together.
- Partnership – recognising that safeguarding is a shared responsibility.
- Prevention through the introduction of timely supportive measures.
- Responses should be proportionate to the circumstances.
- Protection – Children should be safe from harm.
- Evidence-based and informed decision making.

Families Matter

Families Matter[231] provides the strategic direction for supporting parents, recognising that the family is the primary environment within which the wellbeing of the child is nurtured. The strategy stresses the need to ensure parents have the skills and resources to best support their child, and highlights the importance of both physical and mental health and wellbeing. While recognising that not all families will have the same level of need, and that services for children, young people and families will be required across all tiers, the strategy prioritises the availability of universal tier one support to impact positively on all children and young people, therefore reducing the need for higher tier services.

Key themes for the delivery of services include:

- Availability of information for both parents and service planners
- Universal access to services
- Family and parental support, including parental education
- Working together across agencies and communities

The Department of Health is in the process of developing a new, fit for purpose Family and parenting support strategy to reflect changing priorities.

[231] Department of Health, Social Services and Public Safety (2009) *Families Matter: Supporting Families in Northern Ireland. Regional Family and Parenting Strategy.*

Scotland

Overarching policy

Since 2008 policies relating to children in Scotland have been informed by the Getting it Right for Every Child (GIRFEC) agenda.[232] This was underpinned in legislation by the Children and Young People (Scotland) Act 2014.This sets out an ambition to promote the wellbeing of every child by ensuring that they are:

- Safe - protected from abuse, neglect or harm at home, at school and in the community.
- Healthy - having the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices.
- Achieving - being supported and guided in learning and in the development of skills, confidence and self-esteem, at home, in school and in the community.
- Nurtured - having a nurturing place to live in a family setting, with additional help if needed, or, where this is not possible, in a suitable care setting.
- Active - having opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development, at home, in school and in the community.
- Respected - having the opportunity, along with carers, to be heard and involved in decisions that affect them.
- Responsible - having opportunities and encouragement to play active and responsible roles at home, in school and in the community, and where necessary, having appropriate guidance and supervision, being involved in decisions that affect them.
- Included - helping to overcome social, education, physical and economic inequalities, and being accepted as part of the community in which they live and learn.

The Early Years Framework[233], published in 2008, sets out the Scottish Government's vision for the early years and a strategy for achieving this through transformational change. It describes "an approach which recognises the right of all young children to high quality relationships, environments and services which offer a holistic approach to meeting their needs. Such needs should be interpreted broadly and encompass play, learning, social relationships, and emotional and physical wellbeing."

It defines the early years as pre-birth to age 8 and outlines ten elements of transformational change:

- a coherent approach;
- helping children, families and communities to secure outcomes for themselves;
- breaking cycles of poverty, inequality and poor outcomes in and through early years;

---

[232] Scottish Government (2019) *Getting it right for every child (GIRFEC)* https://www.gov.scot/policies/girfec/principles-and-values/ [Accessed 29/8/2019]

[233] Scottish Government (2008) *The Early Years Framework* https://www.gov.scot/publications/early-years-framework/

- a focus on engagement and empowerment of children, families and communities;
- using the strength of universal services to deliver prevention and early intervention;
- putting quality at the heart of service delivery;
- services that meet the needs of children and families;
- improving outcomes and children's quality of life through play;
- simplifying and streamlining delivery;
- effective collaboration.

It suggests that national and local government work together to deliver the outcomes. This would include more help to develop parenting skills within antenatal and postnatal care and developing the capacity needed to deliver this and a renewed focus on 0-3 as the period of a child's development that shapes future outcomes. No additional investment was announced alongside the publication of the Framework. It is now almost 12 years old and requires updating.

Realising the Ambition, published in 2020, provides national guidance on early learning and childcare provisions as outlined in the Children and Young People (Scotland) Act 2014[234]. The guidance seeks to support practitioners who are delivering ELC across Scotland, with an emphasis on building the knowledge, capabilities and confidence of early years practitioners to support high quality early learning and childcare services.

Health services

The Scottish Government's Mental Health Strategy 2017-2027[235] includes a range of actions relevant to mental health in the early years including

- the roll out of targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder (Psychology of Parenting Programme)
- Introduction of a Managed Clinical Network to improve the recognition and treatment of perinatal mental health problems.
- Improved provision of services to treat child and adolescent mental health problems.

The Perinatal and Infant Mental Health Programme Board was established in April 2019 to support these actions and develop a clear direction of travel for Scotland. Key priorities include increased capacity, staff, lived experience input, and infant mental health.

The Best Start: Maternity and Neonatal Care Plan (2017) outlines a five year plan to redesign maternity and neonatal services with the needs of women, babies and families in mind[236]. The plan emphasises the need for support to follow an approach that is person-centred and relationship-based.

---

[234] https://education.gov.scot/media/3bjpr3wa/realisingtheambition.pdf

[235] Scottish Government (2017) *Mental Health Strategy 2017-2027*

[236] https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland-9781786527646/

Health visiting and infant health promotion

The Universal Health Visiting Pathway[237] presents a core home visiting programme to be offered to all families by Health Visitors as a minimum standard. The Pathway is based on several underlying principles. These are:

- Promoting, supporting and safeguarding the wellbeing of children
- Person-centeredness
- Building strong relationships from pregnancy
- Offering support during the early weeks and planning future contacts with families
- Focusing on family strengths, while assessing and respectfully responding to their needs.

The programme consists of 11 home visits to all families - 8 within the first year of life and 3 Child Health Reviews between 13 months and 4-5 years. The visits incorporate continuous assessment and identification of child/family health/mental health and wellbeing needs and sharing of information about attachment and health and wellbeing. The 27-30 month check has a broad focus on early child development, physical health, parental health and wellbeing, and wider issues including home learning environment, childcare and finance. Screening for post-natal depression is also carried out at key points.

Early education and childcare

Realising the Ambition, published in 2020, provides national guidance on early learning and childcare provisions as outlined in the Children and Young People (Scotland) Act 2014[238]. The guidance seeks to support practitioners who are delivering ELC across Scotland, with an emphasis on building the knowledge, capabilities and confidence of early years practitioners to support high quality early learning and childcare services. The Scottish national curriculum, Curriculum for Excellence[239] starts at age 3. The expected outcomes across the whole curriculum age range include a range of expectations around understanding and managing, emotions and mental health. No specific expectations are set out in this regard in terms of the level of knowledge and skills children should attain ('benchmarks') during Early Level (age three to primary one).

The funded entitlement to early education and childcare is being expanded from 600 hours per year to 1140 hours by August 2020. This applies to two year olds who are looked after and those whose parents are on certain benefits as well all three and four year olds. An Early learning Quality action plan[240] was published in 2017 to ensure that this can be done whilst also driving improvements in quality and adherence to the curriculum. This includes commitments around qualification level and continuing professional development of the workforce, the use of the latest evidence on child development, and sharing of good practice between providers.

---

[237] Scottish Government (2015) *Universal Health Visiting Pathway in Scotland: pre-birth to pre-school*

[238] https://education.gov.scot/media/3bjpr3wa/realisingtheambition.pdf

[239] Education Scotland (2019) What is Curriculum for Excellence? https://education.gov.scot/education-scotland/scottish-education-system/policy-for-scottish-education/policy-drivers/cfe-building-from-the-statement-appendix-incl-btc1-5/what-is-curriculum-for-excellence [Accessed 29/8/2019]

[240] Scottish Government (2017) *Expansion of early learning and childcare in Scotland: Quality Action Plan*

Family support and social care

The National Parenting Strategy (2012) aims to strengthen the support offered to parents across Scotland[241]. It sets out a range of targeted commitments, including positive parenting for all and support for those with additional challenges (one parent families, kinship care, families with parents in prison etc).

The Children and Young People (Scotland) Act 2014 required that a "Children's Services Plan" is produced every three years by each local authority and its relevant health board, to plan children's services within the local authority area. The first set of plans were produced in 2017, and the second set are due in April 2020. The guidance states that children's services should:

- safeguard, support and promote the wellbeing of children in the area concerned
- ensure that the appropriate action is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent needs arising,
- is most integrated from the point of view of recipients, and constitutes the best use of available resources.

Taken together, these aims should support the delivery of Getting it Right for Every Child in practice.

[241] Scottish Government (2012) National Parenting Strategy https://www.gov.scot/publications/national-parenting-strategy-making-positive-difference-children-young-people-through/

Wales

Overarching policy

The Wellbeing of Future Generations Act 2015 informs all policy making and decision making by public bodies. Each public body must carry out sustainable development. This means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action. The action a public body takes in carrying out sustainable development must include:

a. setting and publishing objectives ("well-being objectives") that are designed to maximise its contribution to achieving each of the well-being goals, and
b. taking all reasonable steps (in exercising its functions) to meet those objectives.

The Act established public service boards across wales to coordinate and involve the public this activity. The wellbeing goals[242] include:

- A healthier Wales: A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.
- A more equal Wales: A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances).
- Involvement: The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

Flying Start[243] is the Welsh Government targeted Early Years programme for families with children under 4 years of age in some of the most disadvantaged areas of Wales. The core elements of the programme are drawn from a range of options that have been shown to influence positive outcomes for children and their families. These include:

- Free quality, part-time childcare for 2-3 year olds;
- An enhanced Health Visiting service;
- Access to Parenting Support;
- Speech Language and Communication.

Health services

The reorganisation of NHS Wales, which came into effect on October 1st 2009 created single local health organisations that are responsible for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system that existed previously. A Healthier Wales, published by the Welsh Assembly Government in 2018 following a cross-party parliamentary review.[244] It sets out a long term future vision of a 'whole system approach to health and social care', which is focussed on health and wellbeing, and on preventing illness.

It is underpinned by the national design principles of prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating

[242] Welsh Government (2017) *Guide to the Future Generations Act*
[243] Welsh Government (2012) *Flying Start strategy: guidance for local authorities*
[244] Welsh Government (2018) *A Healthier Wales: our Plan for Health and Social Care*

and predicting poor health and wellbeing. There is a notable focus on voice and empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them. A transformation Programme has been established to take this work forward, supported by a representative National Transformation Board. The programme works to support and identify innovation locally, scaling to a regional and then national level. From 2018 primary care clusters of 3-15 per region will continue to develop models of seamless local partnership working, working closely with Regional Partnership Boards to promote transformational ways of working, so that they are adopted across Wales. This aims to be the key driver of change in health and social care at regional level.

Together for Mental Health[245] is the Welsh Government's 10 year strategy to improve mental health and well-being. Published in October 2012. The latest delivery plan that has been published covers the years 2016-19. Priority area 5 of the strategy is to ensure children have the best possible start in life which is enabled by giving parents / care givers the support needed. Objectives within the delivery plan[246] include:

- Health boards and Public Health Wales NHS Trust to ensure women are offered good information and support when planning a pregnancy as well as during pregnancy, through birth and post-natal.
- Health boards to ensure that there is an accessible community perinatal service in every health board area in Wales.
- Educational and training programmes are in place across Wales to improve awareness and management of perinatal mental health problems.
- Ensure that all women who are identified as having serious mental health problems such as a psychosis or bipolar disorder are offered appropriate support by services when planning and during every pregnancy.

The delivery plan also includes an objective that Health boards, local authorities and third sector collaborate to support and promote resilience and positive attachment during infancy and early years through existing family programmes, including Families First and the Team around the Family approach, Flying Start, Integrated Family Support Teams and by utilising third sector experience. This is to be evidenced through agreed local pathways in place to provide services that integrate not duplicate with perinatal mental health and a decreased percentage of children in need with mental health problems.

These objectives sit alongside a range of others aimed at improving access to specialist mental health services for children and adults and preventatives support through primary care and school.

Health visiting and infant health promotion

The Healthy Child Wales Programme[247] sets out a universal service model supporting the health and development of children aged 0-7. From pre-birth to age five its delivery is led by health visitors. Its aims are:

---

[245] Welsh Government (2016) *Together for Mental Health Delivery Plan: 2016-19.*
[246] Ibid.
[247] Welsh Government/NHS Wales (2016) *An overview of the Healthy Child Wales Programme.*

- To deliver key public health messages from conception to 7 years, so that families are supported to make long term health enhancing choices.
- To promote bonding and attachment to support positive parent-child relationships resulting in secure emotional attachment for children.
- To promote positive maternal and family emotional health and resilience.
- To support and empower families to make informed choices in order to provide a safe, nurturing environment.
- To assist children to meet all growth and developmental milestones enabling them to achieve school readiness.
- To support the transition into the school environment.
- To protect them from avoidable childhood diseases through a universal immunisation.
- To ensure early detection of physical, metabolic, developmental or growth problems through an appropriate, universal screening programme.

The health visiting component of the programme includes 8 visits from birth to age 5, plus a home visit from 28 weeks gestation if the mother is expecting their first child or there is a particular vulnerability identified. A 'family resilience assessment' is carried out five times across the course of the programme. There are three levels of support – universal, enhanced and intensive. At universal, the many focus areas of this activity include:

- Promotion of sensitive parenting
- Secure infant attachment and bonding
- Perinatal mental health

At enhanced level they also include:

- Emotional and psychological issues
- Parenting support programmes, including assessment and promotion of parent-baby interaction
- Child development & speech and language

The Flying Start health programme[248] offers support in addition to the HCWP, in terms of the regularity and number of interventions provided (it involved 13 home visits). Another difference is that health visitors are able to refer to or call upon the support of a multidisciplinary team of other professionals, both health and non-health who can work collaboratively to meet the needs of the child and their family. Included among the many themes of support from the universal offer upwards are:

- social and emotional development and impact on brain development
- secure infant, attachment and bonding;
- supporting and understanding childhood behaviour;
- perinatal mental health;
- parental emotional health and wellbeing.

Early education and childcare

Foundation Phase Nursery[249] (FPN) is part-time (a minimum of 10 hours a week during school terms) education for 3 and 4 year old children before they enter compulsory education at the age of 5. Local authorities are required to provide an FPN place from the term after a child's 3rd birthday. Some children will receive five terms, some four

[248] Welsh Government (2017) *Flying Start: health programme guidance*

[249] Welsh Government (2018) *Foundation Phase provision for three- and four-year-olds: Guidance for local authorities in Wales.*

terms and some three terms, depending on when they were born. The Welsh Government has committed to providing 30 hours of government funded early education and childcare for 3 and 4 year old children of eligible working parents for up to 48 weeks of the year. The Childcare Offer is currently being tested and must include at least 10 hours early education).

The Foundation Phase Framework[250] is the developmental statutory curriculum for 3 to 7 year olds in Wales. The seven Areas of Learning within the Foundation Phase Framework are:

- Personal and Social Development, Well-being and Cultural Diversity
- Language, Literacy and Communication Skills
- Mathematical Development
- Welsh Language Development
- Knowledge and Understanding of the World
- Physical Development
- Creative Development.

As part of the wellbeing element of 'personal and social development, wellbeing and cultural diversity' area of learning, it is stated that children should be given opportunities to:

- value and contribute to their own well-being and to the well-being of others
- be aware of their own feelings and develop the ability to express them in an appropriate way
- understand the relationship between feelings and actions and that other people have feelings
- demonstrate care, respect and affection for other children, adults and their environment

Family support and social care

The Social Services and Well-being (Wales) Act 2014 aimed to transform how children's and adults social care is delivered, including encouraging a renewed focus on prevention and early intervention. It replaces the legal framework for supporting children need as set out in part 3 of the Children Act 1989.

The latest expectations regarding the delivery of support for families through social care are laid out in the Families First programme guidance, published in 2017.[251] The programme was developed by the Welsh Assembly Government and delivered by local authorities and partner agencies. It focuses on meeting needs through early intervention and family support, with the intention of preventing problems escalating. It involves systems to assess and support whole families, rather than individuals. The programme promotes greater multi-agency working to ensure families receive joined-up support when they need it. As part of the programme, Joint Assessment Frameworks for Families (JAFFs) have been developed. As of 2017, there is a JAFF in place across all local authorities. The aim of these is to provide a model of effective early assessment which brings together a range of agencies. They are either used in the initial referral process or as part of a subsequent assessment process. It incorporates the commissioning of specific services and interventions, including family support, Health (including mental

[250] Welsh Government (2015) *Foundation Phase Framework.*
[251] Welsh Government (2017) *Families First Programme Guidance*

health) and parenting support. The guidance stresses that the current range of services may not be sustainable, and parenting and support for young people should be priorities going forward.

The guidance states that: "Provision of a range of support for pregnant and new parents should be designed to help parents understand the importance of early relationships to the health and wellbeing of their baby and promote attachment and responsiveness" and that "Parents are more likely to respond positively to parenting support interventions if they feel they are partners in the process". It sets out an expectation that local authorities commission a range of formal and informal, group, individual and relationship support. 'Flying Start Outreach' introduced from 2014, requires local authorities to identify children living outside these areas who would also benefit from the programme.

Guidance[252] states that every family with a Flying Start child must be offered formal parenting support at least on an annual basis and be made aware of the different services available locally to support their parenting role. This should cover the antenatal period to age 4 and be clearly articulated in a plan showing what support (both formal and informal) is available for parents at each stage of a child's development. It stresses that all support for parents should be based on up-to-date knowledge and a sound evidence-base of what works for good outcomes for children and parents. Lists are provided of:

- Approved, evidence-based structured group parenting programmes
- Suggested structured group-based parenting support
- Suggested one-to-one parenting support
- Suggested informal drop in support

The work of local services is complemented by the national campaign, *Parenting. Give it time*[253], this includes resources for both parents and practitioners aiming to promote positive parenting that does not involve physical punishment. It includes signposting to a range of different support services. A Government-sponsored Bill to remove the common law defence of reasonable punishment is currently before the Welsh Assembly.[254]

Policy review discussion

Whilst there are variations in detail and delivery, in all four nations there are two main contact points between families of young children and public services. These are:

- Universal health promotion led by health visitors, with targeted interventions for those with additional needs;
- An offer of state-funded pre-school education;

[252] Welsh Government (2017) *Flying Start parenting support: guidance.*
[253] https://gov.wales/parenting-give-it-time [Accessed 27/8/2019]
[254] Welsh Government (2019) 'Abolishing the defence of reasonable punishment of children: overview' https://gov.wales/abolishing-defence-reasonable-punishment-children-overview [Accessed 27/08/2019]

Looking more broadly across the range of support families of young children may need to draw on, there are a number of political priorities that have been pursued in recent years. The following priorities have been pursued to varying degrees in all four nations, potentially impacting on the range or quality of support families can expect to see now or in the future:

- Improving access to and provision of both perinatal mental health services, and, child and adolescent mental health services
- A move towards integrated commissioning and service delivery;
- Developing the role of early education in promoting social mobility; and
- The recognition of the value of prevention and early intervention to support families who are struggling.

The precise extent to which these priorities are actually translating into the availability and quality of services is hard to ascertain through this policy scoping alone. This is particularly true of the devolved nations, where research and reports scrutinising the implementation of policies appeared to be less readily available.

Furthermore, whilst these universal offers and common priorities may offer opportunities to drive this agenda forward, there are some potential disadvantages in current policies and approaches.

- Whilst the prioritisation of perinatal mental health is welcome, for example, focussing on clinical interventions could limit the reach of support. Above, we have highlighted some of the barriers, inherent in delivery of support as a specialist clinical service. Such a delivery model does not address issues highlighted in the literature review around parents being informed and empowered to get support when they need it and addressing the needs of the wider family.
- The expansion of Child and Adolescent Mental Health Services across the four nations means that in each of the respective NHS systems there will be significant focus on children and young people's mental health. However, the extent to which this appears to explicitly address the mental health of infants and young children is variable and sometimes unclear. Whether these priorities in relation to CAMHS bear fruit for this agenda will depend on the extent to which the needs of younger children are properly considered in implementation and whether learning from initiatives aimed at older young people is translated across a wider age range.
- Recognition of the role that early education can play in supporting social mobility is likely to mean better access for those who have most to benefit from this service across a wide range of outcomes. However there are two factors which may stymie the contribution of early education, including the free entitlements, to young children's social and emotional development. Firstly, the qualifications of the workforce do not appear to reflect the evidence on the need for knowledge and awareness around mental health highlighted in the literature review or the evidence on the impact qualifications have on quality more generally. Secondly, whilst early years curricula refer to social and emotional development, accountability measures may encourage a narrower focus, on numeracy and literacy, for example.

There are also differences between the four nations in how similar services and initiatives are being delivered, investigation of which could extract crucial learning to inform change in this area:

- A range of models for health visiting are being deployed across the four nations. This diversity provides an opportunity for learning on key implementation issues such as the targeting of additional support, the balance between home visits and other forms of contact, and which evidence-based interventions can be delivered effectively by professionals who may not specialise in mental health.
- It is notable that a range of approaches have been used across the four nations in describing and targeting parenting support. In developing interventions that are able to reach those who will most benefit, and ensure parents maintain a sense of control, it will be important to draw on lessons from these different approaches in terms of service user experience. In particular, this could look at the experience of stigma or being 'judged'.
- There are also notable nuances in the various approaches to strategic integration and partnership working. The overarching children and young people's strategies in the devolved nations have differences in emphasis, for example, with Northern Ireland seeing a focus on rights and Wales seeing a focus on prevention. The scope of more focussed cross-cutting initiatives could also be an area of interest. Northern Ireland is the only part of the UK to have a multi-agency Infant Mental Health Framework. England, by comparison, is notably lacking in formal policy on strategic integration, although there are potentially encouraging developments such as the establishment of Integrated Care Systems by the NHS.

In conclusion, there is a welcome recognition of the importance of promoting mental health, alongside recognition of the importance of social and emotional development in the early years, evidenced in a range of polices across the UK. The extent to which this addresses the mental health of infants and young children, as opposed to that of new mothers and older children, is inconsistent across the four nations and may require further development. Delivery models and the role of respective agencies in addressing this agenda do not appear to facilitate support that empowers parents. There is scope to better engage and equip universal services such as health visiting and early education to improve awareness of mental and social and emotional development. Policies generally promote the provision of mental health services and (particularly in England) family support in a clinical or overly targeted way which may discourage parents to seek support when they need it. Whilst there are elements of the policy landscape in each of the four nations that may help to tackle these weaknesses, the bigger picture suggests that support based on the strengths highlighted in the literature review is likely to be more the exception than the rule.

Implications for research, policy and practice

The findings set out in this rapid review suggest a number of gaps in the literature, as well as several considerations to take forward into policy and practice. The key implications are outlined below, along with a series of linked recommendations.

Improve the systems for measuring and responding to infant mental health
Current estimates suggests that ~12% of 5 year olds are at risk for a later mental health disorder. However, this evidence relies on proxy measurement and tools such as the ASQ-3 used in the 2-2.5 year review do not assess emotional wellbeing in any level of detail. There is also disparity in terms of the measurement tools employed across the

four nations, as well as differences in the timing of assessments for social and emotional wellbeing.

- **Recommendation** – include a mandatory assessment of emotional wellbeing at the 2-2.5 year review and review ways to streamline measurement across the four nations.

The latest prevalence study of mental health disorders in 2-4 year olds estimated the current prevalence to be in the region of 5.5% in England, but comparable data is lacking across the rest of the four nations.

- **Recommendation** – make it an urgent priority to gather up-to-date robust prevalence data across all four nations.

Increase screening opportunities and service provision for children aged 3 to 5 years
When considering vulnerability to poor mental health, research found that hyperactivity/inattention difficulties were more likely to have started by age 3 and persist through to school entry. Emotional difficulties, in contrast, had a greater likelihood of developing between the period of pre-school and entry to primary school (i.e., between 3 to 5 years). This highlights the need for early screening and identification, and tailored transition processes between early years educational settings and primary school to minimise further deterioration in infant mental health. This is particularly important in England where the last mandated health visitor check is required at 2-2.5 years.
Regarding interventions, there appears to be more interventions focused on 0-3 year olds with fewer targeted at families with children aged between 3–5 years. In addition, a qualitative evaluation of parent-infant psychotherapy[255] found that a number of women experienced anxieties related to the need to terminate the service when their baby was two years old.

- **Recommendation** - health visiting services should offer at least one face-to-face visit between ages 3-5 years to identify any mental health needs (in particular focusing on emotional difficulties) that may prevent a successful transition into primary school.

Increase knowledge, skills and confidence to support infant mental health – for the public and practitioners
Data suggests there are prevailing misunderstandings amongst parents when it comes to mental health. We need to build on existing educational campaigns to increase public knowledge and reduce the stigma associated with mental health – shifting the narrative so that infant mental health is seen as an essential aspect of human growth and development.

- **Recommendation** – develop and deliver an impactful public awareness campaign to dispel common myths about infant mental health that is culturally responsive and sensitive, and which promotes the use of a common and accessible language.

Effective interventions are often delivered by highly skilled practitioners with specialist knowledge and expertise. However, core training in parent-infant relationships and infant mental health is not currently mandated for many frontline professions, including

[255] https://warwick.ac.uk/fac/sci/med/staff/barlow/wifwu/research/oxpip_paper_-_jimrh_-_march_2007.doc

GPs, midwifery and health visiting (it is usually accessed via additional training) and in the UK, nursery staff are not required to have training in child development. It is vital that we increase the knowledge base of professionals delivering universal interventions as part of their core training.

- **Recommendation** – increase the knowledge, confidence and skills of universal early years' practitioners, including health visitors, GPs and midwives by including a mandatory training module in social and emotional development as part of their core training. This should include training on how to measure emotional wellbeing using appropriate screening tools.
- **Recommendation** – increase the knowledge, confidence and skills of staff working in early education settings through the UK, developing minimum qualifications and standards for the early education workforce. A mandatory training module in social and emotional development should form part of this core training, and particular focus given to supporting the transition between early education settings and the first year of primary school.

Value fathers and partners of women

There is good evidence that the engagement of fathers is highly beneficial for children social and emotional development – and benefits seen when parents are together or separated. Despite this, fathers are more likely to be overlooked or inadvertently excluded by services supporting children. This was evident when reviewing evaluation studies, which most often included mothers and/or reported on maternal outcomes.

- **Recommendation –** UK governments should review their policies and statutory guidance to reflect the importance of engaging fathers in improving child health outcomes, particularly social and emotional development. Paternal outcomes should be measured when evaluating the impact of an initiative or service designed to impact on parental and child health.
- **Recommendation** – local areas and services should outline how they include fathers and partners of women in their local service provision, including how they will address the barriers to men accessing services and engaging in opportunities for parental involvement.

Prioritise consistency of relationships and the development of trust within all services designed to support parental and infant mental health

The quality of the relationship, also known as attachment, between infant and primary caregiver is essential to developing good infant mental health. The logic model/theory of change that drives many effective interventions for positive infant mental health is primarily centred on improving attachment security. In order for interventions to be effective, they need to be well resourced to enable practitioners to develop a secure and trusting relationship with families. Trust is at the heart of attachment. The reason that a family has been referred to a service in the first place, may be the very thing that makes it so hard for them to engage. Once trust is established within a therapeutic relationship, parents value the support and can notice the positive impact on their own mental health, as well as their child's.

Research shows that women participating in an intensive home visiting programme reported to greatly value the relationships they established with their home visitors and identified a number of ways in which they had benefitted. These included increased confidence, improved mental health, improved parenting skills, improved relationships with others, and changes in their attitudes towards professionals. These findings

highlight that the therapeutic relationship between the home visitor and parents is central to the success of this intervention, and therefore, the need for home visitors to have the necessary skills and qualities to establish such positive relationships.

- **Recommendation –** provide more investment in frontline, universal services to enable continuity of care for midwives, health visitors, GPs, therapists, where possible. Evaluate organisational processes and policies that focus on staff supervision and retention.

Ensure all universal interventions include a strong, evidence-based educational component

Evidence suggests that parental knowledge of mental health, in particular knowledge of infant mental health, child development and that recognising and regulating emotions is associated with positive child outcomes. It is important that all universal interventions include a strong educational component that has been co-developed by parents and has been tested for evidence of effectiveness.

- **Recommendation** – boost the effectiveness of universal interventions by including a strong educational component that has been co-developed by parents and has proven effectiveness.

Conduct longer-term follow-ups to assess impact of interventions into later childhood

Many programmes delivered in the UK have yet to receive an established evidence base. Some of the null findings may be due to any benefits not being captured at immediate follow-up. Where possible, we need to resource evaluations so that they can include a follow-up into early and later childhood.

- **Recommendation** – Government to provide adequate funding streams to ensure the feasibility of longer-term follow-up for studies of infant mental health interventions.

Build in robust processes for ongoing monitoring and evaluation of programmes

It is also important to stress, that evidence of effectiveness is not a replacement for an ongoing evaluation. The fact that an intervention has evidence from a rigorous evaluation conducted at one time and place does not mean it will be effective again. A one-off evaluation is not a replacement for ongoing monitoring and evaluation systems and therefore this needs to be built in to all existing interventions.

- **Recommendation** – conduct a review of the monitoring and evaluation processes of existing programmes, with the ambition to ensure all programmes have a robust evaluation system in place within the next 5 years.

Provide a personal support offer for all families

Not all approaches to supporting infant mental health will work for all families. It is important that there are a variety of different services on offer in local areas so that families can be supported to choose a tailored support offer that includes treatment and other participation opportunities.

- **Recommendation** – conduct a review of the range of services available in local areas – by level of need, target population, mode of delivery, etc. and work towards the provision of varied local support offers. This should include urgently increasing access to specialist mental health support via Child and Adolescent Mental Health Services for parents with children under age 5 and as well as Parent-Infant Teams.

Address health inequalities to make the most impact on child outcomes
Latest data from the Scottish child health programme collected in 2017/18[256] showed that concerns recorded around children's emotional/behavioural development were highest for children living in the most deprived areas of Scotland and/or were a looked-after child at the time of their 27-30 month child health review.
Common markers of disadvantage have also been linked with low service up-take, including receipt of both formal and informal support[257]. It is important to recognise that engaging with interventions to support infant mental health can be a daunting experience and parents may face several logistical and emotional barriers. Moreover, parents who are reluctant to engage with services are generally more disadvantaged and vulnerable in a range of ways.

- **Recommendation** – local areas must prioritise addressing population health inequalities through the provision of sufficient universal services, with staff trained in identifying and engaging vulnerable and at-risk groups. Outreach programs, including those led by parents themselves, such as Parent Champions and peer-home visiting programs, should form part of the strategy for reaching groups of families that are hard to engage.

Increase the number and quality of opportunities for parental engagement
Although parental engagement opportunities are an increasingly common feature across health, education and social care programmes, although there are fewer examples focusing on infant social and emotional development. It is important for parents to have access to a variety of different engagement models and that these are developed and implemented according to established engagement principles, such as the Dual Capacity-Building Framework for Family-School Partnerships.

- **Recommendation** – increase the frequency and quality of opportunities for parental engagement in infant mental health programmes, developing and implementing these in accordance with established engagement principles.

[256] https://www.isdscotland.org/Health-Topics/Child-Health/Publications/2019-04-09/2019-04-09-Child-Health-27m-review-Report.pdf
[257] Mabelis, J. and Marryat, L. (2011). Growing Up in Scotland: Parental service use and informal networks in the early years, Edinburgh: Scottish Government

Appendix 1: Evaluated early years' interventions, focusing on wellbeing and mental health

Level of need	Intervention Name	Brief Summary	Age range for delivery	Delivered in UK	Strength of evidence base for IMH outcomes
Universal (available for all parents and infants)	Family Foundations	10 x group-based educational sessions	Pregnancy – 4/6 months	Yes	High quality
	Incredible Years Parents and Babies Programme	Group-based parenting support programme, available for all parents	0-12 months	Yes	Preliminary
	RECAP (Reaching Educators, Children, and Parents)	Year-long social skills programme, delivered in schools	4-5 years	No	Preliminary
	Kindness Curriculum	Mindfulness-based social skills training, delivered in schools	4-5 years	No	Preliminary
	Universal health visiting, Healthy Child Programme 0-5 (HCP 0-5) in England	5 x home reviews for all parents	Pregnancy- 2/2.5 years	Yes	TBC
	Infant massage	Community-delivered small group intervention for mothers and babies	6-8 weeks	Yes	No effect
Targeted-selected (for families/infants with increased risk)	Family Nurse Partnership (FNP)	Home visiting support for young mothers (aged <24 years)	Pregnancy- 2 years	Yes	High quality
	Nobody Slips Through the Net (KfdN - Keiner Fallt Durchs Netz)	Intensive home visiting support for at-risk mothers	0-1 years	No	Preliminary
Targeted-selected (for families/infants	Mellow Parenting	Group-based programme for at-risk families, using	1-4 years	Yes	Preliminary

Level of need	Intervention Name	Brief Summary	Age range for delivery	Delivered in UK	Strength of evidence base for IMH outcomes
with increased risk)		video feedback, workshops and discussions			
	Circle of Security (group)	Group-based programme for at-risk families, using video feedback, workshops and discussions	1-5 years	Yes	Preliminary
	Circle of Security (individual)	As above, modified to be delivered as individual home-visiting intervention	1-5 years	No	TBC
	VIPP/VIPP-SD (Video-feedback Intervention to Promote Positive Parenting-Sensitive Discipline)	VIPP is delivered in the home to at-risk families, videotape clips of parent-child interactions are used for discussion and learning	0-5 years	No (NHS trial currently being conducted)	TBC
	Baby Steps	Group-based parenting intervention for at-risk families, six sessions and two home visits	Pregnancy-3 months	Yes	TBC
	Mellow Bumps/Mellow Dad to be	6-week targeted antenatal programme for mothers at risk of depression	Later stages of pregnancy (20-30 weeks)	Yes	TBC
	Mellow Babies	14-week targeted group-based day programme for mothers experiencing depression	<1 years	Yes	TBC
Targeted-selected (for families/infants with increased risk)	Family Action's Perinatal Support Project	Targeted home visiting programme, trained volunteer befrienders support mothers with depression and anxiety	Pregnancy-1 year	Yes	TBC

Level of need	Intervention Name	Brief Summary	Age range for delivery	Delivered in UK	Strength of evidence base for IMH outcomes
	Families and Schools Together (FAST) Baby	Group-based intervention for children at risk of behavioural problems, involving infants, schools and local community	3-11 years	No	TBC
	Parents under Pressure	12 x home-based educational programme for parents who misuse substances, teaching mindfulness, managing emotions	0-8 years	Yes	TBC
	Social Baby	16 x targeted home visiting sessions for mothers at risk of depression	Pregnancy-6 months	Yes	No effect
	Maternal Early Childhood Sustained Home-visiting (MECSH)	Targeted home visiting service for mothers experiencing psychosocial distress	Pregnancy-2 years	Yes	No effect
Targeted-indicated (for families/infants with identified need)	Empowering Parents Empowering Communities	Peer-led parenting programme, eight 2-hour sessions targeting disadvantaged families with a child exhibiting behavioural difficulties	2-11 years	Yes	High quality

Level of need	Intervention Name	Brief Summary	Age range for delivery	Delivered in UK	Strength of evidence base for IMH outcomes
Targeted-indicated (for families/infants with identified need)	Infant-Parent Psychotherapy (IPP)	Weekly psychodynamic therapeutic intervention for parents and infants with insecure attachment and/or have experienced trauma	<6 months-2 years	No	High quality
	Child-Parent Psychotherapy (CPP)	Weekly psychodynamic therapeutic intervention for parents and children with insecure attachment and/or have experienced trauma	3-5 years	No	High quality
	Child First	Year-long home-based support programme which integrates IPP/CPP with other activities	6-36 months	No	High quality
	Toddler-Parent Psychotherapy (TPP)	Weekly psychodynamic therapeutic intervention for parents and toddlers (20 months) with insecure attachment and/or have experienced trauma	2-3 years	No	Preliminary
	Watch, Wait and Wonder	'Infant-led' parent-infant psychotherapy for mothers who are having difficulty bonding with their child	10-30 months old	Yes	Preliminary
	Anna Freud Centre Parent Infant Project (PIP)	Parent-child psychotherapy programme for families with mental health problems and high levels of social adversity	<12 months	Yes	TBC
	Attachment and Biobehavioural Catch-up (ABC)	Coaching intervention for parents identified as	0-2 years	No	TBC

Level of need	Intervention Name	Brief Summary	Age range for delivery	Delivered in UK	Strength of evidence base for IMH outcomes
		having neglected their child			
	NAMAL (Hebrew acronym for Let's Make Room for Play)	Group-based educational sessions for families with/at high risk of PTSD. The sessions centre around teaching play skills to improve resilience and emotion regulation	2-6 years	No	TBC
	Baby Triple P	Mix of group-based and individual follow-up, eight sessions in total, targeting attachment, improve support and coping	0-12 months	Yes	TBC

NATIONAL CHILDREN'S BUREAU

United for a better childhood

The National Children's Bureau brings people and organisations together to drive change in society and deliver a better childhood for the UK. We interrogate policy, uncover evidence and develop better ways of supporting children and families.

Let's work together: 020 7843 6000 | info@ncb.org.uk

London: 23 Mentmore Terrace, London, E8 3PN

Belfast: The NICVA Building, 61 Duncairn Gardens, BT15 2GB

Part of the family
NATIONAL CHILDREN'S BUREAU

National Children's Bureau is registered charity number 258825 and a company limited by guarantee number 00952717. Registered office: 23 Mentmore Terrace, London E8 3PN.