Breakthrough
Britain

The Next Generation

A policy report from the
Early Years Commission

Chaired by Dr Samantha Callan

September 2008

THE CENTRE FOR
SOCIAL
JUSTICE

About the Centre for Social Justice

The Centre for Social Justice aims to put social justice at the heart of British politics.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our working groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Chairman: Rt Hon Iain Duncan Smith MP
Executive Director: Philippa Stroud

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Please note that all children and adults photographed have acted as models. The quotations, references and commentary on the photographs in this document bear no relation to the actual individuals pictured.

Principal photographer: Elaine Duigenan

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Preface

Whilst conducting the in-depth policy research which culminated in the *Breakdown and Breakthrough Britain* reports, the Social Justice Policy Group (SJPG) became collectively concerned about the importance of ensuring that children's experiences in their earliest years of life are laying the right foundation for their futures. Over the last decade or so we have seen dramatic increases in young people's alcohol and drug use and a greater likelihood that they will experience mental health problems. Concentrated as these and other factors are in the poorest 20 per cent of society, they conspire to make educational attainment more difficult and profoundly affect people's ability to form and maintain positive relationships. They therefore make it significantly harder for the next generation to break out of a downward spiral of disadvantage. Interrupting these cycles becomes an ever more important policy priority, but research strongly indicates that the most effective intervention strategy requires helping parents to get it right at the antenatal, postnatal and infant stages, long before such help is typically available.

As such, the significance of the early years was a thread running through the policy recommendations in *Breakthrough Britain*, especially the sections concerned with the prevention and alleviation of family breakdown and educational failure. However members of the SJPG, and especially its Chairman, Rt Hon Iain Duncan Smith MP, were aware that much more sustained policy attention would have to be paid to this area.

In the aftermath of the Social Justice Policy Group therefore, Iain Duncan Smith asked me as the former chair of the SJPG's Family Breakdown Working Group, to draw together a group of experts and practitioners in the early years field. An Early Years Commission was formed to undertake a wide-ranging consultation process which would identify not only the very best interventions but also how we might effect cultural change in this policy area so that the environment in which all children grow up is as conducive as possible to sound relational and mental health. All those involved in the Early Years Commission were extremely keen that this consultation process cut across the usual political divides (and indeed almost all of the Commission, including the chairman, have no affiliation with any political party). This report will be followed by an implementation phase which will look in closer detail at how the recommendations would be rolled out in communities across the UK for the benefit of many of our most fragile families.

On behalf of the rest of the Early Years Commission I would like to thank all those consultees who gave generously of their time and who were so enthusiastic about our aims. The members of the Commission all work full-time in other capacities, and have strong professional links with the early years sector. Despite the high demands placed on them by their 'day jobs' they were quite unstinting in their efforts to bring together the research and examples of good practice and to think through the implications of both for national policy. The Centre for Social Justice is in their debt, and I am personally enormously grateful for the sacrificial level of time and attention they have been able to give to this essential subject.

Dr Samantha Callan, *Chairman, Early Years Commission*

Foreword

We know that it is an impossible task to prescribe what every child needs from birth until three years old. Nonetheless consideration must be given to this because there is a trend in British society towards failing this important and vulnerable group, as *Breakthrough Britain*[1] and the recent UNICEF[2] report made clear. This report is not intended as a flawless map towards the perfect childhood, but instead as a guide to facilitate a more intelligent and informed analysis; a conduit for the knowledge that each of us once held deep in our own hearts and minds.

For all of us were once the age in question. What did we want? What did we get? And how did it change our idea of what we wanted? It is not always possible to think our way back through that conundrum. Fortunately we have some new tools at our disposal. There have recently been some very useful scientific advances in understanding and demonstrating the way that the brain works and is being organised during the 'early years' from birth to three years old. As Dr Bruce Perry, the child trauma expert, said at a recent conference in London, 'Experience changes adult brains. In infants it organises actual brain systems.'[3] This scientific work can help to ground us as we seek to interpret more usefully some of the difficult ideas suggested from the research into outcomes and ideals; and the theories that could link the two.

We have all been small children. Many of us are responsible for the care of them. Considering new information about these early years can evoke denial, anxiety, guilt or anger. This in turn can lead to defences which become too strong for reason, fact and considered arguments to penetrate. We hope that will not be the case with this report, because its focus is unapologetically positive; pro-parents and pro-children and therefore pro-society.

Babies and very young children have a set of emotional needs not yet determined by advertising, culture, peer pressure or money. The 'early years' are about a human being in process and therefore especially about their first experiences of becoming a person which in turn is nested in their relational

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1 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice

2 UNICEF Innocenti Research Centre (2005) *Report Card No. 6: Child Poverty in Rich Countries 2005* Florence: UNICEF

3 Perry B (2008) 'The Traumatised Child: Healing Brain, Mind and Body' Lecture London: *The Centre for Child Mental Health* June 14

experiences. From the social sciences and neuroscience, we now know that it is relationships that primarily define us. Our relational experiences in childhood dramatically impact on how we behave towards one another in all aspects of life. It is the quality of relationships that ultimately define our society.

Benjamin Fry *(Psychotherapist, BBC expert and Commission Member)*

Members of the Early Years Commission

Dr Samantha Callan, *Chairman*

Samantha Callan acts as a research and policy consultant to major UK voluntary sector organisations which aim to strengthen family life. She is also an honorary research fellow at Edinburgh University and is engaged in primary research into long-term marriage and committed relationships, a subject about which she regularly presents at national and international conferences. Working from a background in Social Anthropology and Islamic Studies, she holds Masters degrees from the universities of Cambridge and Nottingham. (Prior to completing her degree at King's College Cambridge in Social Anthropology she was accepted to read Medical Sciences.)

Dr Margot Sunderland

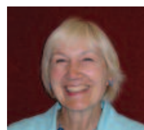
Margot Sunderland is Director of Education and Training at The Centre for Child Mental Health London, Honorary Visiting Fellow at London Metropolitan University and Child Psychotherapist with over twenty years experience of working with children and families. She is the author of nineteen books in the field of child mental health, which collectively, have been translated into eighteen languages. Her acclaimed book, *The Science of Parenting* won First Prize in the BMA Medical Book awards 2007 (Popular Medicine). The book, endorsed by one of the world's leading neuroscientists, Professor Jaak Panksepp, is the result of ten years research on the long-term effects of parent-child interaction on the brain. Margot has written and run Masters Degree programmes unique in the field of child mental health, namely MA Integrative Child Psychotherapy and MA Education: Emotional Literacy for Children.

Dr Elly Farmer

Elly Farmer is a Chartered Clinical Psychologist who works part-time for the NSPCC, assessing and treating children with sexually abusive behaviour. Her research in this role includes developing a treatment programme for children with this behaviour, and conducting a review into effective interventions for conduct problems. For the rest of the week Elly works therapeutically with adults with substance misuse problems, with a focus on the resolution of childhood trauma. Fields in which she has previously worked include children and adolescent mental health, youth offending (in HMP/YOI Feltham) and adult trauma (predominantly refugees). Her publications include journal articles on good practice in trauma-focussed therapy, and on the role of shame in anger problems.

Benjamin Fry

Benjamin Fry developed an interest in psychotherapy and other areas of personal growth during a long and varied personal treatment starting in his twenties. After a degree in physics and philosophy Benjamin studied psychotherapy at Regent's College in London. He has recently returned there to study towards a professional doctorate in psychotherapy. He wrote the book, *What's Wrong With You* and the eponymous column in *The Saturday Times* Body&Soul section; and recorded the follow-up audio book, *How to be Happy* for Hachette Audio. He is perhaps best known to the nation as the co-presenter of the BBC's groundbreaking and long running *Spendaholics* series on BBC3 in which he helps over-spenders by getting to the root of their problems. Benjamin has a private practice in Harley Street and is founder of the Happy Hour network.



Maria Robinson

Maria Robinson is an independent lecturer and adviser on early years development, with a background in health visiting, teaching and as a trained counsellor. A large part of her work is with Bedfordshire Early Years and Extended Services Department providing training to early years practitioners at all levels. The rest of her time she spends working for other authorities, educational establishments and organisations giving lectures on early development with a particular focus on emotional/attachment needs in babies and very young children. Her publications include two texts on development, the first focusing on the first year of life and the second on development from birth to eight years.

Melanie Gill

Melanie Gill is a Child Forensic Psychologist. She is one of the founders of Commonsense Associates, using radical and innovative multi-disciplinary approaches to solve psychological problems with families and children. Melanie serves on the South Downs Mental Health Act Tribunal Panel and works part-time in a GP surgery in Brighton which deals with the most deprived areas of the city. She advises The Centre for Social Justice on children and families and worked on both *Breakdown* and *Breakthrough Britain*. Recently she was on a commission examining the role of social services and child protection, chaired by Lady Butler-Sloss and Lord Laming. She regularly speaks on child and family mental health issues, including bullying, attachment, biopsychosocial problems and changing policy at conferences and on local and national radio. She is a founder of a group of child therapists, academics, media, and politicians attempting to bring more psychological understanding into society and policy making to be called 'Psycho-Politics'.

Cheryl Dobson

Cheryl Dobson is a recent graduate in Law from Edinburgh University where she took Honours courses in both Family Law and Human Rights. She is now a researcher for the Early Years Commission conducted by the Centre for Social Justice. She has a keen interest in social justice particularly in the area of family and addictions. She has previously spent time working in India with women caught up in prostitution which prompted her to complete her LLB dissertation on the subject.

Karen Bradley, *Consultant (Finance)*

Karen Bradley is a Chartered Accountant and Chartered Tax Adviser with over 15 years experience advising clients in the City of London. She has worked in the Conservative Research Department advising on economic and fiscal issues and in the Conservative Policy Unit in the run up to the 2005 General Election, where she was involved in the development and costing of a broad range of policies. She worked on the Policy Exchange paper, *Little Britons: Financing Childcare Choice* and has a degree in Mathematics from Imperial College, London.

Professor Stephen Scott, *Consultant (Psychiatry)*
Stephen Scott is Professor of Child Health and Behaviour and a Consultant Child & Adolescent Psychiatrist. He is also the head of the National Specialist Conduct Problems Clinic and the National Specialist Adoption and Fostering Clinic. He recently took up the position of Director of Research at the National Academy for Parenting Practitoners.

Executive Summary

A compelling body of research indicates that children's experiences in the earliest years of their lives strongly influence their futures across a wide range of measures. Policy is currently focused on dealing with the *consequences* of early adversity (neglect, abuse and dysfunction) which are strongly implicated in the dramatic increases in young people's alcohol and drug use and mental health problems and in youthful knife and gun crime. The most effective intervention strategy therefore requires helping parents to get it right at the antenatal, postnatal and infant stages, long before such help is typically available. Such timely support for parents could help them do an outstanding job in raising the next generation.

This report summarises a consultation process undertaken by the Early Years Commission, instituted by the Centre for Social Justice which aimed to:

- Build on the findings of two initial and far-reaching reports – *Breakdown Britain*[4] and *Breakthrough Britain*[5]
- Focus on the needs of children under three, their families and other carers
- Provide realistic recommendations to support and enhance the well-being of infants, very young children and their families

The Commission comprised a panel of experts in the early years covering psychology, neuroscience, professional practice and family policy. A wide range of views from those involved in social work, primary and secondary health care, daycare, education and mental health were elicited at evidence-gathering hearings. Well over 50 individuals and organisations made submissions and visits were made by the Commission to projects and facilities in all three mainland nations of the UK. We also conducted two rounds of polling and extensively accessed the academic literature.

4 Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice

5 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice

Why the early years matter

RELATIONSHIPS UNDERPIN BEHAVIOUR

We have been trying to address the issue of troubled children and young people for decades, with little positive change. The problem persists and appears to be growing, as illustrated by rising levels and severity of youth crime. Current government initiatives appear to be focused far more on intervention than prevention. 70 per cent of the Youth Justice Board's budget is spent on only 4 per cent of young offenders yet 92 per cent re-offend within a year of being released from costly institutions. Yet the RAND report[6] found that well-designed programmes for disadvantaged children age four and younger could produce economic benefits ranging as high as $17 (in terms of money saved on later remedial services) for each $1 spent on the programmes.

A key conclusion of our report is that these issues have been so difficult to resolve because, until now, we have never properly understood or acknowledged their root causes. We have stuck rigidly to attempts to change *behaviour* but this is an outcome or product of an individual's state of emotional and social health and well-being. So for genuine change to take place, it has to occur in these areas. Successful parenting interventions, for example, are those which concentrate on improving parent-child relationships, out of which context expectations for good behaviour can be set.

This perspective is based on the last decade's consistent and significant body of psychological and brain science research, which identifies the key component in our capacity to function as emotionally and physically able human beings as the quality of our relationships and specifically those in our earliest years. These highly reputable studies emphasise the importance of relationships on the *physical* as well as the emotional health of an individual. (Adverse childhood experiences cost the National Health Service billions of pounds in tackling severe obesity, alcohol and drug abuse, heart disease, diabetes, hepatitis and the effects of domestic violence.)

BRAIN FORMATION IS CRUCIALLY DEPENDENT ON PARENT-CHILD RELATIONSHIPS

Freud was entirely right when he said we come into the world 'not quite finished' and in the early years, the brain is still forming. Due to this period of rapid brain development, adult-infant interaction can affect the architecture and long-term chemical balance in a child's brain, for better or

6 Karoly L et al (1998) *Investing in our children: what we know and what we don't know about the costs and benefits of early childhood interventions* Santa Monica: The RAND Corporation

worse. Key stress response systems, and foundational systems for emotional regulation, kindness, empathy and concern are very immature at birth. How they will unfold is dramatically affected by the infant's relational experiences.

Without sufficient calming, soothing and emotion regulating interactions from parents and other significant adults, the stress response systems in the infant brain, which are extremely sensitive to adverse postnatal experience, can become hypersensitive. An infant can grow up unable to handle stress well and adopt a generally long-term defensive reaction to people and events. He or she can be persistently on the look out for threat, prone to anxiety, depression and anger, both in childhood and later life.

In contrast when infants are consistently met with attuned and responsive kindness, calm and compassion, the brain's pro-social systems, key for capacity for empathy and concern, develop. Hence the brain is often referred to as a 'social organ.' Infancy is both a critical window of vulnerability and also a critical window of opportunity. In short, children's brains adapt to the environment they live in.

Infants' core relational needs are for secure attachment and attuned emotional responsiveness (both to pain and joy); physical affection and physical contact; interactive and independent play, exploration and shared adventure; support and nurture for the growth of positive self-esteem through encouragement and praise and appropriate limits or boundaries. We probed the extent to which these needs are being met.

What is currently happening in the early years in the UK?

- Infants aged under one are more at risk of being killed by another person than any other age group of children under 18 in England and Wales[7]
- Up to one in ten women experience domestic violence each year – in 90 per cent of the incidents children are in the same or next room[8]
- 20 per cent of parents suffer from postnatal depression,[9] affecting their ability to meet their infant's relational needs
- The NSPCC estimates that one to two children die at the hands of their parents every week[10] (in comparison to Sweden where statistics indicate one to two children *per year* die at the hands of their parents)
- 30,000 children are on waiting lists for mental health services[11]

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7 Povey D et al (2008) *Homicides, firearms offences and intimate violence 2006/2007: supplementary volume 2 to Crime in England and Wales 2006/2007* London: Home Office
8 Every Child Matters (2003) *Green Paper CM5860* London: TSO
9 Survey conducted by the Royal College of Midwives, 2007
10 http://www.nspcc.org.uk/documents/supportingchildrenonline.pdf_wdf46259.pdf accessed 26/7/08
11 BMA Board of Science (2006) *Child and Adolescent Mental Health: A guide for healthcare professionals* Oxford: BMJ Books

- Almost half of all calls to the Parentline helpline cite isolation and loneliness as key concerns[12]
- One in two cohabiting parents split up before the child's fifth birthday (compared to one in twelve who were married before they started a family) and one in four children suffer the stress of family breakdown[13]

The Commission learned that parents struggle to give their infants the relational experiences they need for long-term emotional health for a variety of reasons. They may not understand their need to interact and so make no effort to; they may adopt unduly harsh discipline regimes or leave them for prolonged, indefinite periods without comfort. Stress in late pregnancy and postnatal depression can be disadvantageous to the infant. 'Stress chemicals' from the mother pass across the placenta to the baby who may be born highly stressed and 'fractious', difficult to soothe, feed and settle. A downward spiral ensues as the mother reacts to the unresponsiveness or perceived difficulty of her child. Premature babies are particularly vulnerable to the deleterious effects of lack of contact and relationship.

Parental conflict, domestic violence and general family dysfunction create an environment for children where soothing, calming, helping a child to find words for feelings, listening and interactive play are lacking. Parents with mental health problems can struggle to manage the demands of a family and meet the emotional needs of their infants. Drug and alcohol abuse can create families characterised by chaos, uncertainty, and lack of routine again making the meeting of very young children's relational needs haphazard at best. Very young parents, many of whom may have experienced significant parenting deficits themselves, and whose emotional world is centred more upon their own needs, may struggle to nurture their children thus ensuring the intergenerational transmission of disadvantage. Financial insecurity and the threat or reality of homelessness will also deprioritise the meeting of children's psychological needs.

Current Government policy for the early years does not support relationships

The past decade has brought with it a sea-change in children's policy and services, following the publication and elaboration of the five Every Child Matters (ECM) outcomes (to be healthy; stay safe; enjoy and achieve; make a positive contribution and achieve economic well-being) around which most children's policy is now structured. A key thread is a call for greater integration throughout service provision. Recent early years policy has focused on the

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12 http://parentlineplusforprofessionals.org.uk/index.php?id=168, accessed 23/7/08

13 Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice

wider provision of affordable, quality childcare; on standards for this childcare and on the development of a public health strategy for children ages 0-5. The Early Years Commission found that, despite current policy's far-reaching positive implications, a 'golden thread' is missing: a recognition in the underpinning framework of the importance of relationships in every young child's development.

ECONOMIC GOALS CROWD OUT THE IMPORTANCE OF NURTURE

Policy prioritises economic and academic ambitions above the essential relational needs of infants and children, so services on the ground have no imperative to provide the optimal conditions that support emotional health and prevent later dysfunction. A clear example of this lies in the widely acknowledged loss of one of the most important original goals of Sure Start, which was to help ensure that children of all backgrounds received the nurture and care from their parents which they needed to thrive. The emphasis has shifted towards helping disadvantaged parents become work-ready and enter the labour market. This has been achieved largely by making childcare provision a cornerstone offering of Children's Centres, into which Sure Start has evolved, to the extent that the 'nurturing' goals seem to have been wholly subordinated to the educational and economic imperatives described above.

There is a clear rationale for aiming to eradicate child poverty and improve academic performance for children (poverty reduces educational achievement and increases the risk of later physical and psychological dysfunction and education is of course associated with economic achievement, as well as with positive health and social outcomes) and focusing on these, highly 'visible' goals, permits relatively easy measurement of progress. However, the deeper, less perceptible factor of relationship dysfunction accounts for a much larger percentage of later life difficulties than either economic or educational disadvantage. A Canadian National Longitudinal Study following zero to six year olds concluded that if you eradicated all child poverty, there would only be a 10 per cent reduction in the number of children who were experiencing behavioural, social, educational and health difficulties.[14]

Relationships in the early years remain on the sideline in current policy with no recognition of the fundamental role that attachment and familial relationships play in bringing about children's well-being and reducing the likelihood of many physical and psychological problems, such as antisocial behaviour, substance misuse, mood disorders, and chronic diseases such as obesity, asthma and chronic obstructive pulmonary disease. None of the five ECM outcomes refer to a child's relationships; in the 25 aims underpinning these outcomes, relationships are only relevant insofar as what they must not involve (maltreatment, neglect, violence and sexual exploitation).

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14 McCain M, Mustard F (1999) *Reversing the real brain drain: Early years report* Toronto: Canadian Institute for Advanced Research

POLICY TREATS FAMILY BREAKDOWN AS INEVITABLE

Policy also communicates a tacit resignation to the reality of familial breakdown. For example the Children's Plan (2007) states that 'A significant minority of children will experience family breakdown…The support the parents and the wider family, including grandparents, can provide for the child during the family break-up is critical to that child's well-being and success.' Without mentioning intervention before break-up, the clear subtext is that family breakdown is an unavoidable fact of life that is at best managed sensitively with the needs of the child acknowledged. Reducing conflict post-separation, because of the damage it inflicts on children, is undoubtedly important but so too is reducing conflict while parents are still together.

Breakthrough Britain and this report both emphasise the need to support the adult, couple relationship, not least because of the importance for children of committed, relationally competent parents. Relationship education programmes have been shown to reduce family breakdown and improve family outcomes,[15] so there is a strong case for improving access and provision as well as normalising such programmes from their current position at the margins. (Polling for *Breakthrough Britain* showed that 60% agreed or strongly agreed that prevention of family breakdown is possible and should get significant government funding.) By leaving relationships off the broad political agenda, the Government is communicating the view that emotionally attuned, loving family relationships are neither here nor there.

THE PRINCIPLE OF INTEGRATION HAS NOT BEEN FOLLOWED THROUGH

Moreover, despite the Government's good intentions for integration of services, professional groups have described difficulties working more closely with one another, often because of different 'languages', models of working, and priorities for children. A more organic, 'bottom-up' approach to integration (for example through inter-agency and inter-professional child development training which we recommend) may help to overcome these understandable barriers. Additionally, prioritising integration has not extended to the process of policy development itself. Professionals working with children were unclear about which new policies applied to them, how to integrate their varying guidance and felt overwhelmed by the sheer number of initiatives and the speed with which they are being introduced. Many professionals are unaware of the existence of policies directly relevant to their work.

A GENUINELY PREVENTATIVE APPROACH IS LACKING

Although the five ECM outcomes are described as preventative (in the sense that if these outcomes can be achieved, difficulties will be avoided), efforts are not, for the most part, focused on improving relationships, arguably the most

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15 Carroll J, Doherty W (2003) 'Evaluating the effectiveness of pre-marital prevention programs: A meta-analytic review of research' *Family Relations* 52 105-118

effective focus for prevention. When they are considered, prevention is not focused on *early* relationships. Prevention in its purest sense means being early years focused.

In terms of trends on the ground, the health visiting service appears to be increasingly targeted at those families perceived to be 'vulnerable', and usually socio-economically disadvantaged. The flipside is a dwindling universal health visiting service. Yet, supply is in no way mirroring demand as our polling (see below) and other reports (e.g. from the Family and Parenting Institute[16]) reveal. Regular home visits from health visitors in a child's early years for all families are what people consistently express a preference for. These visits provide a non-stigmatising means of providing support, identifying where more help is needed. Health visitors could also help with parent-child and broader family relationships.

POLICY DELIVERS LITTLE GENUINE CHOICE IN THE AREA OF CHILDCARE

Recent childcare policy, acknowledging that parents often struggle to meet families' competing financial and nurturing needs, aims to alleviate this with greater amounts of affordable statutory childcare. This might meet the needs of parents who want to work more hours, and help children of parents who need to work to escape poverty, but without parallel policies that increase choice for those parents who want to spend more time with their children or use other forms of care, choice is only increased for some, and many people feel even more pressurised to return to work. The broader message communicated by this lopsided policy is that a child's time with their parents is irrelevant to their well-being and healthy development. The government's support for an increase in quality, affordable childcare is narrowly focused on the formal and subsidized state sector.

Additionally, without clear routes to parenting and relationship help for families, childcare is in danger of being used as a 'solution' to parenting struggles. Using childcare as a 'bandage' may serve to hide difficulties that could otherwise be remedied before they become an entrenched part of family life. The absence of a clear framework focusing on the relational and emotional well-being of the child affects the quality of care provided. Staff are not trained in an understanding of the nature and importance of attachment, nurturing relationships and emotionally attuned responsiveness, neither are they helped in developing the skills to promote them. Instead, we heard that in many areas poor training has led to high levels of demoralisation.

CHILDREN'S MENTAL HEALTH PROBLEMS MUST BE FULL-BLOWN FOR THEM TO GET HELP

Child and Adolescent Mental Health Services' (CAMHS) requirement for children to show an elevated degree of mental health or behavioural problems

16 Gimson S (2007) *Health Visitors: an Endangered Species* London: Family and Parenting Institute

to receive a service is completely incongruous with principles of prevention. As children in the early years rarely present with the greatest difficulties, they are mostly absent from caseloads. Early, often relational, indicators of difficulties are left to emerge into full blown problems at a later stage of development. Similarly, social workers described the priority given to safeguarding rather than preventing the need for safeguarding in the first place.

IN SUMMARY

Economic and academic concerns trump relational ones, despite the latter's crucial role in child, and later adults', well-being. Children's policy misses the importance of relationships and political thinking in general misses the relevance of high levels of relational stress and relational poverty in the early years as key underlying factors for a whole host of social problems we face today. As long as policy continues to marginalise relationships in the early years and marginalise the early years in other policy areas there will be no lasting improvement to the interrelated physical, emotional and social problems faced by both children and adults in our society.

Polling

YouGov polled 2827 expectant parents or parents (27-29 May 2008) and 2337 adults, not just parents (11-15 July 2008). We found that:

EARLY YEARS MATTER, ACCORDING TO PUBLIC OPINION

- 77 per cent of parents agreed that a lack of parental support when children are under the age of three contributes to their children getting involved in anti-social behaviour later on as teenagers
- 73 per cent of parents (and 68 per cent of adults) said that more government support for parents during their children's early years would be very effective or somewhat effective in reducing emotional and behavioural problems when those children reach adulthood
- Of those expressing an opinion, 74 per cent of parents (and 62 per cent of adults) agreed that the present government's policies concentrate too much on punishing anti-social behaviour rather than tackling the causes of behavioural problems
- 92 per cent of adults and parents agree or strongly agree that the early relationships we have with our parents while we are still babies and toddlers can strongly influence future aspects of our lives
- 97 per cent of adults said they thought the relationship between a mother and baby was very important or fairly important in the child's later development but almost as many, 96 per cent of adults, said they thought the relationship between a child's *mother and father* when they are under 3 was very important or fairly important

ON THE SUBJECT OF HEALTH VISITORS

- When parents were asked what they would support being made more widely available to help parents who experience relationship pressures after the birth of a child, the largest category of people, 53 per cent, said more help from health visitors
- When asked how helpful they thought free counselling sessions with professionals (e.g. family therapists or psychologists) would be for vulnerable parents (those likely to struggle in their role) bringing up zero to three year old children, 71 per cent of parents thought these would be helpful or very helpful but 80 per cent thought more frequent visits from health visitors would be helpful or very helpful
- 72 per cent of adults were fairly confident or very confident that health visitors are competent and well-trained. In contrast only 28 per cent had that perception of Sure Start staff, 37 per cent of social workers and 53 per cent of childcare professionals
- And if they were concerned about being able to cope with being a parent, 35 per cent of adults would prefer to go to a health visitor for help, compared with 26 per cent preferring a GP, 3 per cent Sure Start staff and 3 per cent a social worker

ON THE SUBJECT OF CHILDCARE

- 88 per cent of parents and 82 per cent of adults thought that more should be done to help parents who wish to stay at home and bring up their children in the early years (this was consistent across socioeconomic groups ABC1 and C2DE). 97 per cent agree that the Government should do more in this area
- 81 per cent of parents cited finance as the main factor in pressurising them or their partner to return to work
- 67 per cent of parents and nearly 70 per cent of adults agreed that parents are encouraged to put their children into daycare and return to work too early
- 75 per cent of parents believe that a child under three should spend a lot or all of their time with their mother and 63 per cent of respondents believe that a child under three should spend a lot or all of their time with their father
- Almost a third of all respondents stated that they did not feel that they have been or are able to spend enough 'quality time' with their children when they were or are very young
- When asked what would have been most useful as a parent of a child under the age of three, the highest response, 50 per cent, was for more child benefit. Only 39 per cent said more affordable childcare.
- When asked what they found a particular cause of stress during pregnancy, the highest percentage of people, 38 per cent, cited financial worries, significantly more than those citing fear of childbirth or fear of being able to cope with the baby

- One third of adults felt that non-familial daycare (e.g. day nurseries or childminders) was not very well or not at all able to meet all the needs of zero-to three-year-old children while they were there

Central concerns of the Early Years Commission

In the light of all aspects of our consultation process, including the above polling, our overriding concern has been to identify how best to ensure that parents, other carers and society in general, understand fully the needs of infants, the crucial importance of enriching relational experiences and how to act on this knowledge. Research and the evidence from the hearings repeatedly indicated that if an infant's relational experiences are consistently positive and their attachment needs adequately met, this dramatically protects against behavioural problems and distress in later life.

This Commission was concerned with addressing relational and emotional poverty as well as economic poverty. Longitudinal studies following infants from birth to adulthood have found that economic poverty is only one of many factors that can adversely affect emotional, cognitive and social development long term. At the heart of the many and varied influences on the infant is the family. This is where the main thrust of our recommendations are directed, so that families will be enabled to thrive, and potential breakdown or dysfunction will be prevented or, at the very least, its consequences will be alleviated. On the basis of the themes emerging from this analysis, recommendations are made which:

- are concerned with the promotion of emotionally healthy relationships;
- are family-centred, not just 'child-centred';
- treat all family relationships as important (and do not leave out the role of fathers);
- enable people and build on assets of individuals and communities (instead of making people dependent on professionals);
- are universal and specific according to whichever is most appropriate;
- emphasise that an early years focus must not disadvantage the later years;
- are preventative

In summary we recommend the following:

1. **Family Services Hubs** to be established in every community: facilities to enhance current, community-based service provision and enable a greater degree of coordination of professionals and voluntary sector providers. Such hubs would emphasise support for parents in their children's first three years. They would build on existing infrastructure wherever possible and recapture one of the most important original goals of Sure Start, which was to help ensure that children of all

backgrounds received the nurture and care from their parents which they need to thrive.

2. **Fostering of families instead of fostering children**, thus keeping children with their biological families if possible (by providing supported housing where this is a key reason for breaking up the family). Encourage older parents from the local community to act as extended family in whatever capacity is necessary (with training and back up from social services).
3. **Enhanced role for health visitors in intensive home visiting (to be available nationwide) as well as revitalization of their role in providing a universal service** which is non-stigmatising and preventative and better able to assess where nurturing deficits are occurring.
4. **Enhanced support and training for professionals to include common inter-agency training, further integration and development of children and infant mental health services, co-location of services** (partly facilitated by Family Services Hubs) **and specialised programmes of training for all professionals** whose work impacts upon children (which grounds them in the neuroscience involved in the very early years). This would, for example, make daycare facilities more child-focused, emotionally responsive and motivated to provide greater continuity of care.
5. **Relationship and parenting education with all individuals, couples and families entitled to draw down money from a personal 'budget'** to access pre-marriage, antenatal, and parenting (of 0-5s, 5-11s and teens) services. Additional streams also available for lone parents, prisoners, military and foster/adoptive parents.
6. **Early Years Internet Portal** to provide a one-stop-shop for information on funding, training, services, programmes etc.
7. **Genuine choice for families in paid work and childcare,** with a change in the rules to allow the **use of childcare tax credit to pay un-registered close relatives** (albeit at a lower rate) to reflect parents' preferences, and **location, where possible, of childcare outside Children's Centres.** This would free them up to concentrate on delivering family support services and would create a more level playing field for private, voluntary and independent sector nurseries.
8. **Front-loading child benefit** making it flexible so that a larger proportion of the child's total entitlement would be available during the first three years when parents most want to spend time caring for their children and when attachment and intensive nurture are most important. This would be linked where necessary to ameliorative services such as intensive parenting support, to greatly improve the life chances of children most likely to experience deficits in parental care.
9. **Greater integration of information and service provision across all healthcare sectors,** especially in mental and physical health and requirement to make improvements in the level of integration of services a key performance indicator in health services reviews.

10. **Simple, broad-based media campaign, centred around the concept of a 'Neuron Footprint'** to put awareness of the brain's development during the early years at the heart of the nation's thinking on all aspects of family, social and other influences on our young children.
11. **All recommendations complement or reiterate those made in the family breakdown section of *Breakthrough Britain*.** This body of policy aimed to build family stability and minimise family breakdown by encouraging healthy relationships; by drawing on community-level support and reducing dependence on the state and, of course, by focusing on the first three years of children's lives. **Transferable tax allowances** acknowledged the reality that if one spouse is not working outside the home that family requires more, not less, support from the tax system. Similarly the benefits system should not penalise low income couples who want to live together which requires **tackling the 'couple penalty'.** Finally, we called for a commitment to **increasing 'supported housing' projects** which help the most vulnerable families stay together and work together towards self-sufficiency.

Conclusion

To reiterate, although the way individuals 'behave' is important, unduly focusing on this neglects the vital role relationships play in influencing behaviour as well as in shaping the brain itself during the early years. At the point when children are most vulnerable, there is also the greatest opportunity to lay a good foundation for the future. What parents do really matters; the time they spend with their children can transform their lives for the better - they are intimately and intricately involved in shaping them, through their relationships. However we do not want to set up a false dichotomy between behaviour and relationships, but rather to shift the emphasis to the latter to enable the adoption of a truly preventative approach.

The findings and recommendations summarised here represent the culmination of an extensive ten month consultation process, drawing in some of the finest practitioners and researchers working in the early years field. This report builds on the recommendations made in *Breakthrough Britain,* which were themselves subject to much scrutiny by Commission members to establish that we were building on a sure foundation. We have at all times aimed to recommend policies which are realistic, achievable, affordable and understanding of the diversity of views and family experiences. We have also sought to work with the grain of other policy development currently being undertaken at the Centre for Social Justice on the subjects of children in care, youth and gang crime and family law. Building a coherent and interlocking body of policy was the genius of *Breakthrough Britain* and remains the goal of ongoing work. The

Commission was and remains keenly aware of the genuine and wide-ranging difficulties we will need to overcome to guarantee a better future for society's most vulnerable members – babies and young children – but we are convinced that the shifts in thinking we propose provide essential starting points.

Principles guiding our consultation process and underpinning our recommendations

- **Promotion of emotionally healthy relationships**
  Currently, short-term and surface-level policies are used with the aim of directly improving a range of Government targets which range from the eradication of poverty, the reduction of obesity, improvements in educational attainment and greater health overall. Paradoxically, turning attention away from these to focus instead on relationships is a vastly more cost-effective means of meeting these same goals, as this focus addresses the root causes of societal dysfunction in all aspects of emotional, cognitive and physical health. For example, emotional well-being drives motivation, interest and enthusiasm whatever the age or circumstances of an individual. This aside, emotionally healthy relationships are the self-stated priority of the nation, and central to living a life that feels satisfying and meaningful.
- **Family-centred, not just 'child-centred'**
  Again there is a paradox: focussing solely on the needs of the child can unwittingly work against the most fundamental need a child has – safe relationships between all of his or her family members. The child's needs are integrally bound up with the needs of the whole family.
- **All family relationships are important**
  Promoting healthy relationships between everyone is necessary – and this means not leaving out the father (or, more generally, the partner of the primary caregiver), as many previous approaches have done. This includes facilitating the father's active involvement in child-rearing and attachment. Paying attention to the roles and relationships of the 'secondary' caregiver in no way equates to impeding single-parent family structures.
- **Enabling people**
  This approach side-steps both blaming the victim and promoting victim-hood - opposing yet equally insidious and harmful messages. Whilst the former diverts attention from the wider, more powerful systemic causes of family dysfunction, the latter can call into question the power of

people to effect change in their own lives. Although starting from conflicting points, these perspectives converge to lower people's sense of self-efficacy, and so in turn, remove one of the key factors that move people out of adversity. On the other hand, policies that create opportunities for people, and facilitate their take-up, develop both individual and communal self-esteem and self-efficacy – forces that take on a life of their own in building an emotionally healthy and economically prosperous society.

- **Building on assets of individuals and communities**
  These are the factors in the environment, individual, family and wider social networks that promote resilience and capability. Not only is this approach likely to be cost-effective; it is also an essentially enabling method as it illustrates to people that the tools to achieve change are already within them or close by. It moves the focus away from 'outsourcing', instead looking for solutions in those who have the most experience of the problem. (Again, this is why the engagement of fathers is to be encouraged and facilitated wherever possible.) It does not, however, equate to removing attention from the changes that are required in statutory services. Rather, the two are symbiotically connected – statutory services can be altered with the aim of 'unlocking', building and complementing capabilities within the community.
- **Universality**
  The erosion of healthy emotional relating has occurred across social categories in the UK, whether these are defined by class, culture, geography or other difference. It is not doubted that some groups have fared worse than others, but a sole focus on these populations will fail a vast number who do not happen to be in a high-risk group. In actuality, the whole of society is at risk. Policies are required that include everyone and that aim to bring about a paradigm shift in terms of the way people treat each other, particularly their children.
- **Specificity**
  Focussing attention on all children does not necessitate fitting them all into the same category. Although all children have the same fundamental need for loving relationships, different children may be more likely to miss out on these in different ways or for different reasons. These differences are likely to be virtue of a complex biopsychosocial interaction involving factors such as socioeconomic status, family composition, cultural background, neighbourhood influences and genetic factors. Paying no attention to these dissimilarities is likely to produce ill-fitting policies that are of no help to large swathes of children. Adapting to difference can be thought about in terms of tailoring large-scale approaches to specific high-risk groups of children, or in terms of developing policies that allow individuality when approaches are applied on the ground.

- **The early years focus must not disadvantage the later years**
  Indeed a major aim of focussing on the early years is to sow the seeds for later positive relationships and emotional resiliency. In addition however, explicit attention is required to ensure that those who have lost out in their early years are given every chance to have the effects of this counter-balanced in future opportunities. A focus on the early years does not imply that intervening later is a pointless exercise, and policy must reflect this reality. As John Giedd (2002) states, 'In terms of the development of the brain, the first three years are important but so are the next 16.'
- **Prevention**
  This principle is at the heart of all others; the truth that investing in relationships at a young age prevents the growth of a web of increasingly tangled difficulties: offending, depression, anxiety, psychosis, substance misuse, domestic violence, sexual abuse, self-harm etc, all of which entail profound suffering. Needless to say, prevention brings with it huge economic savings.

Introduction to the report and background to the Early Years Commission

A society's child-rearing practices are not just one item in a list of cultural traits. Child rearing…places definite limits on what can be achieved by society.[17]

Introduction – the problem we have to address

The picture of society set out in *Breakdown Britain*,[18] emphasising the depressingly prevalent intergenerational transmission of disadvantage, was supported by robust and exhaustive findings from national and international research, for example the UNICEF report.[19] That children and young people are faring badly in 21st century Britain is evident not least in the dramatic increases in young people's alcohol and drug use. In England the average weekly consumption of alcohol for drinkers aged 11 to 13 rose from 3.4 units in 1992 to 8.2 units in 2005[20] and a survey by the Joseph Rowntree Foundation found that 25 per cent of 13- and 14-year-olds have participated in binge drinking, with this figure rising to over 50 per cent for youngsters aged 15 and 16.[21] 1 per cent of 11-year-olds had taken drugs in 1998, compared with 6 per cent seven years later. 34 per cent of 15-year-old boys and girls had taken drugs in the last year in 2005, compared with 25 per cent of girls, and 29 per cent of boys in 1998. Glue-sniffing among 11- to 15-year-olds had increased sevenfold over the same period.[22]

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17 De Mause L (2002) *The Emotional Life of Nations* New York: Karnac Books

18 Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice

19 UNICEF Innocenti Research Centre (2007) *Report Card No. 7: Child Poverty in Perspective: an overview of child well-being in rich countries* Florence: Innocenti Research Centre

20 DH (2006) *Drug use, smoking and drinking among young people in England in 2005: headline figures.* London: TSO

21 Beinart S, Anderson B, Lee S, Utting D (2002) *Youth at risk? A national survey of risk factors, protective factors and problem behaviour among young people in England, Scotland and Wales* London: Communities that Care

22 DH (2006) *Drug use, smoking and drinking among young people in England in 2005: headline figures* London: TSO

These changing patterns of drug and alcohol use may be interacting with the higher rates of mental health problems that we are also seeing in our young people. The Mental Health Foundation estimates that 13 per cent of girls and 10 per cent of boys aged 11-15 suffer from mental health problems[23] and researchers have found there to be a strong link between mental disorder and rates of smoking, drinking and cannabis use among 11- to 15-year-olds.[24] Over 40 per cent of this age group who smoked regularly have a mental disorder: 28 per cent have a conduct disorder, 20 per cent an emotional disorder and four per cent a hyperkinetic disorder such as attention deficit hyperactivity disorder (ADHD). The Children's Society report that, overall, more than a million children have mental health problems.[25]

Such problems are concentrated in the poorest 20 per cent of society. People in the poorest households are much more likely to use class A and other drugs than any other group[26] and children in families of social class V were almost three times more likely to have a mental disorder than those in social class I families. The highest rate, 21 per cent of children and young people, was found in the small group of families where no parent had ever worked.

Drug and alcohol use and mental disorder conspire to make educational attainment more difficult, and all these factors combine to make it more likely than not that young people will be unable to break out of the downward spiral of disadvantage. The purpose of *Breakthrough Britain* was to interrupt these cycles and tackle head on the findings that British young people are involved in more drug taking and binge drinking than teenagers in other European countries and appear to be the most unhappy children in Europe. This comprehensive and interlocking set of recommendations acknowledged the 'knock on' effect of such activities and traits which pervades all aspects of daily life and affects relationships, work, ability to learn and general social and cultural attitudes.

In the fields of education, psychology and sociology, we have been trying to address the issue of troubled children and young people for decades, with little positive change. The problem persists and appears to be growing, as illustrated above and also by rising levels and severity of youth crime. For example, there has been a 37 per cent increase in youth knife crime with 24,000 10- to 17-year-olds convicted or cautioned over the last three years.[27] (Although recently released crime statistics indicate a fall in violent crime[28]

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23 http://www.mentalhealth.org.uk/

24 http://www.statistics.gov.uk/cci/nugget.asp?id=853

25 www.goodchildhood.org.uk

26 Chivite-Matthews N et al (2005) *Drug Misuse Declared: findings from the 2003/04 British Crime Survey England and Wales* London: TSO

27 According to Ministry of Justice 2007 figures published in the *Daily Telegraph* (see http://www.telegraph.co.uk/news/uknews/1576076/Violent-youth-crime-up-a-third.html accessed 22/7/08)

28 Kershaw C, Nicholas S, Walker A (eds) (2008) *Crime in England and Wales 2007/08: Findings from the British Crime Survey and police recorded crime* London: Home Office

this is the first year that police statistics have been broken down to show the extent of knife crime so these statistics cannot be compared with other years. The British Crime Survey has produced specific statistics on knife crime for years and a reduction has been seen but the survey does not include under-16s, which the government acknowledges is a serious omission.[29]) During the writing of this report, over 30 young people have lost their lives through knife crime alone.

Other statistics indicating the poverty of emotional well-being include the fact that every 22 minutes a teenager in the UK tries to kill themselves;[30] one in three boys and one in four girls admit to bullying at some time;[31] and one in five girls aged between 15 and 17 have self–harmed.[32] One in ten women experience domestic violence each year - in 90 per cent of the incidents children are in the same or next room.[33]

In response, the government has produced a number of well-intentioned initiatives but they appear to be focused far more on intervention than prevention. Timely, appropriate intervention is obviously essential yet, for example, billions of pounds are being spent on the Criminal Justice system – the Ministry of Justice budget alone is set at nearly £10 billion.[34] By way of illustration of the intervention versus prevention imbalance, 70 per cent of the Youth Justice Board's budget is spent on only four per cent of young offenders.[35] This represents the cost of placing them in institutions in order to change their behaviour and yet 92 per cent re-offend within a year of being released. On the other hand, the RAND report found that well-designed programs for disadvantaged children aged four and younger could produce economic benefits rising as high as $17 for each $1 spent on the programs.[36] Referring to this statistic former presidential candidate Hillary Clinton said, 'We consistently fail to invest in what will save us money.'[37]

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29 Cherie Booth's evidence to a Home Office Select Committee as a member of Channel 4's Street Weapons commission, (investigating gun and knife crime) confirmed that exclusion of under-16s was skewing the figures as front-line staff in accident and emergency wards to whom she spoke during her investigation 'left us in no doubt that the figures are moving up'. See http://news.bbc.co.uk/1/hi/uk_politics/7484103.stm accessed 25/7/08

30 Hawton K, Houston K, Shepperd R (1999) 'Suicide in young people. Study of 174 cases, aged under 25 years, based on coroners' and medical records', *British Journal of Psychiatry* 175 271-276

31 Katz A et al (2001) *Bullying in Britain: Testimonies from Teenagers* Surrey: Young Voice

32 Samaritans and the Centre for Suicide Research (2002) *Youth and Self Harm: Perspectives* Surrey: WithSamaritans

33 Every Child Matters (2003) *Green Paper CM5860* London: TSO

34 See p225 of the 2007 Pre-Budget Report and Comprehensive Spending Review, available at http://www.hm-treasury.gov.uk/media/F/D/pbr_csr07_annexd7_172.pdf accessed 26/7/08

35 Hansard [HL] 12th June 2007 http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70612-0001.htm accessed 22/7/08

36 Karoly L et al (1998) *Investing in our children: what we know and what we don't know about the costs and benefits of early childhood interventions* Santa Monica: The RAND Corporation

37 *The Guardian* (2007) May 23

A change in emphasis – hope for the future

Perhaps it is fair to say that the issue of destructive and self-destructive behaviour in our society has been so difficult to resolve because, until now, we have never properly understood or acknowledged the conditions and root causes that give rise to such actions. In our attempts to ensure that children and young people grow up to become good citizens, we have stuck rigidly to attempts to change *behaviour*. A sound description of the type of thinking which has generally dictated policy is given in the following quotation from former government advisor Geoff Mulgan:

> *… a key role of the state is to encourage in us **behaviour** that is in our own best interests. Most people would prefer to lead more productive, healthy and socially rewarding lives. Yet sometimes everyone engages in **behaviours** that they may regret or that do them harm, or harm to those around them. There is a potential tension between, on the one hand, an agenda of encouraging 'personal responsibility' and, on the other hand, of the shaping of the determinants of personal **behaviour** by the state (our emphases).*[38]

In a similar vein, the Home Secretary, Jacqui Smith, stated in a recent article in the Times, 'I believe it is about identifying families in which you are going to intervene at an early stage, where you will expect certain behaviour and if that does not happen there will be sanctions'.[39] In our polling (the parameters of which are outlined at the end of this Introduction), of those expressing an opinion, 74 per cent of parents (and 62 per cent of adults) agreed that the present government's policies concentrate too much on punishing anti-social behaviour rather than tackling the causes of behavioural problems.

The fundamental question which must be asked, is why initiatives which depend on behavioural change alone appear to be failing. A possible answer is that a crucial point is being missed: behaviour is an outcome – the product of an individual's state of emotional and social health and therefore in order for genuine change to take place, it has to occur in the realm of personal, emotional and social well-being.

This perspective is based on the last decade's vast outpouring of psychological and brain science research, which has identified that the key component in our capacity to function as emotionally and physically able

38 Mulgan G (2004) *Personal Responsibility and Changing Behaviour: The State of Knowledge and its Implications for Public Policy* London: Cabinet Office/Prime Minster's Strategy Unit

39 Ford R, Webster P (2008) 'State will take action against parents who can't control their children' *The Times*, June 27

human beings is the quality of our relationships, particularly those in our earliest years. Any government which continues to emphasise addressing behaviour, without considering what underpins behaviour, is denying or ignoring a significant and respected body of international research emphasising instead the impact of early relationships and interactions on future well-being. Again, our polling indicates that British adults and parents understand this: 92 per cent of adults and parents, in two separate polls, agree or strongly agree that the early relationships we have with our parents while we are still babies and toddlers can strongly influence future aspects of our lives.

What is particularly troubling is that many of these research studies, which are the output of the most reputable medical, science and psychology departments from across the world, also emphasise the importance of relationships on the physical, as well as the emotional, health of an individual. Adverse childhood experiences cost the National Health Service billions of pounds. Studies indicate that where there has been no effective early years intervention, someone with adverse childhood experiences has a far greater chance of suffering from:

- Severe obesity
- Alcohol and drug abuse
- Heart disease
- Stroke
- Diabetes
- Hepatitis
- Attempted suicide
- Early death
- Risk of perpetrating or becoming a victim of domestic violence[40]

Current concerns for the nation's health provide a powerful incentive to consider that when devising governmental policy, it is vital that we take into account the research which shows the extent to which a well-functioning, moral and healthy society depends on the *relational* health of its members.

If we as a society really want to influence anti-social behaviour, address the unhappiness that promotes it and influence health in all its aspects, it is crucial that we act on the profound implications of this research. As the way people

40 Felitti V (2003) 'The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900' *Preventative Medicine* 37 268-77

Example 1: The Minnesota Study of Risk and Adaptation followed 180 infants born in poverty from age 0 to 30, and focused on risk factors for abuse and neglect. The key factor for non-perpetuation of maltreatment was *relationship*. Almost all of the abused mothers who provided adequate care were significantly more likely to have received emotional support from an alternative, non-abusive adult during childhood, and/or to have participated in a therapeutic experience for at least 6 months during some period, and/or to have had an emotionally supportive and satisfying relationship with a partner. Virtually none of the parents who perpetuated the cycle of abuse had experienced any of these forms of relationship. As the researchers said, **'We were struck by the fact that each of these change-promoting factors was a relationship experience.'**[41]

Example 2: A 2006 study found, that if parent-teenager relations are poor, the high testosterone levels of adolescence (50 times the level of a ten-year-old), were a key contributory factor in risky behaviour such as skipping school, engaging in under-age sex, lying, drinking and stealing. In contrast, when boys had a good and close relationship with their mothers, testosterone levels were positively associated with peer competence and involvement and did not result in delinquency.[42]

Example 3: 'Midnight football', a creative intervention to address delinquency in Shoreham (among other places), where teenagers play football with the local police, for example between 11pm and 2am, has been a huge success.

relate to each other strongly influences behaviour (see box above), and in light of the vital influence of the early years, we need to consider how parents relate to children and how to support them in their knowledge of the care, nurture and socialisation needs of their children. (Successful parenting interventions, for example, are those which concentrate on improving parent-child relationships, creating a context in which expectations for good behaviour can be set.)

Prevention - the recommended paradigm

Central to our consultation process therefore has been the key question – 'How do we support parents, other carers and society in general to understand fully the needs of infants and, thereby, the crucial importance of enriching relational experiences?' Our recommended paradigm is fundamentally oriented towards prevention rather than intervention. Research and evidence-gathering hearings conducted around the country repeatedly found that if an infant's relational experiences are consistently positive and their attachment needs adequately met, this dramatically protects against behavioural problems and

41 Sroufe L, Egeland B, Carlson E A, Collins W (2005) *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood* London: Guildford Press

42 Updegraff K, Booth A, Thayer SM, 2006, 'The role of family relationship quality and testosterone levels in adolescents' peer experiences: a biosocial analysis' *Journal of Family Psychology* 20 21-29

A short note on attachment theory

Whilst emphasising the importance of attachment, the Commission is aware that this theory does not explain all or even the majority of mental health and relationship difficulties and that other factors are important, many of which are described below.

We note in particular Dr Helen Barrett's comments in her book, (Barrett H, 2006, *Attachment and the Perils of Parenting* FPI)

> 'Although a large number of theories have been put forward to account for the very special quality of relationships between infants and their carers (Rajecki et al's 1978 article remains an informative and concise discussion of a number of these views while Fonagy 1999 provides an excellent comparative review of psychoanalytic theories)…the term Attachment Theory seems to have come to be used as though [it] were either the only or the most popular one in existence.' (p10)

Similarly, we are aware of the pitfalls of trying to make psychological theories accessible for policy. Barrett goes onto say that 'Among texts [on attachment theory] there is a tendency for those directed at less specialist audiences (ie. those which do not assume a basic understanding of the theory) to over-simplify or, at times to misrepresent theoretical arguments and research findings, to lack any substantial critique of the ideas they present and to present rather one-sided views which, though engaging, may be of dubious evidential status.' (p11) We have therefore been at pains to retain simplicity whilst using careful referencing to indicate the wealth of research underpinning the statements we make.

misery in later life. In contrast, if policies and interventions target behavioural issues which are 'outcomes' rather than root causes then such interventions will never be fully successful.

In short, the Commission holds the view that there needs to be a paradigm shift which focuses on relational disorders, not simply behaviour and symptoms. When behavioural problems are considered *in isolation*, the complexity of human existence is not taken into account. Such interventions are 'set up' for poor outcomes which in turn are a dramatic waste of government money and do not alleviate the misery in society. Through social science and neuroscience, we discover that relationships define us. For this reason the primary focus must be on relationships if we are to mend our broken society.

This report provides evidence-based ways forward to address today's deep social concerns. In so doing, it is not intended as a flawless map towards the

perfect childhood but as a guide to facilitate an intelligent and informed knowledge base in terms of what enables children – and ultimately society - to thrive.

Addressing emotional and relational poverty as well as economic poverty

Societal health depends on addressing relational and emotional poverty as well as economic poverty. Longitudinal studies following infants from birth to adulthood have found that economic poverty and family breakdown are only two of the factors that can adversely affect long term emotional, cognitive and social development. Without effective relational interventions, all the factors listed below have the potential to lead to dysfunctionality:

- Stress/complications in pregnancy, delivery or the perinatal period (which can adversely impact in the long term on the quality of the parent-child relationship)
- How the parent was brought up (for example if they themselves experienced repeated emotionally unresponsive or highly stressful parent-child interactions)
- Parents' mental and/or emotional ill-health
- Low parental self-esteem
- Current major stressors (e.g. poverty, family breakdown, domestic violence)
- Parental beliefs about what constitutes good parenting, which may be significantly at odds with evidence-based child development and brain science research
- Parents' lack of awareness of the psychological needs of the infant
- Parents' abuse of drugs or alcohol
- Inadequate child-care for the infant (e.g. nurseries that offer insufficient one-to-one relational time)[43]

Taking a biopsychosocial approach – what does this mean?

The question of what constitutes emotional health in infants, children, teenagers and adults is complex. In order to address this complexity, we adopted a biopsychosocial approach to our consultation and study, acknowledging the interrelatedness of physical, emotional and social factors and taking the following as 'maps' to guide our thinking:

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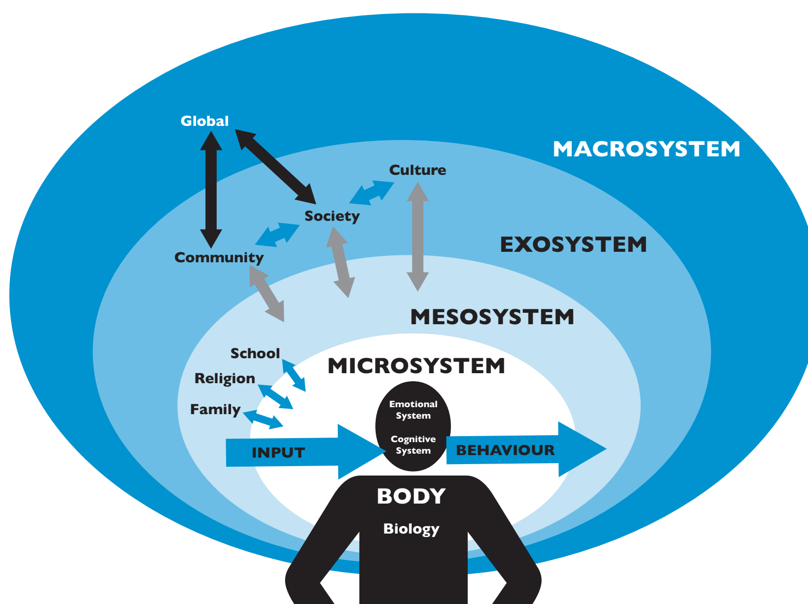
43 Sroufe L, Egeland B, Carlson E A, Collins W (2005) *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood* London: Guildford Press

- The extensive research which resulted in *Breakthrough Britain*
- Neuroscientific research on how the brain develops from foetus to three years old
- Neuroscientific research evidencing how different kinds of environmental influences in the early years can either cause long-term damage to the functioning brain or promote the pro-social systems in the brain which are key for a person's capacity for empathy, kindness and concern
- Longitudinal studies showing the enduring impact of environmental influences in the early years, for better or worse
- Cutting-edge contemporary research on the study of emotions, cognition, language, and symptomatology such as obesity, anti-social behaviour and depression
- A wide range of cost-effective interventions in the early years proven to promote long-term emotional health

From this foundational platform, we gave considerable time and thought to the impact of the most common environmental influences on children under three. In fact our work has brought a constant reminder of the multitude of factors that contribute to an infant thriving or failing to thrive over their lifetime. The variety of multidirectional environmental influences on the infant are illustrated graphically in Bronfenbrenner's Ecological Systems Theory – see diagram below:



At the heart of the many and varied influences on the infant is the family. This is where the main thrust of our recommendations are directed, so that families will be enabled to thrive, and potential breakdown or dysfunction prevented or, at the very least, its consequences alleviated. We also make recommendations to support children when they receive care outside the home. The report is pro-family, pro-children and pro-parents. As clearly stated in *Breakthrough Britain*, our aim is also to avoid the criticism often made when the needs of children are discussed – that such discussion is all about 'parent blaming'. Such a response often serves to stifle any further debate by making people defensive or reactive. Nevertheless concern about this potential outcome has not been allowed to diminish or dilute the views expressed here which are firmly grounded in evidence from research. It is undoubtedly true that our findings may make uncomfortable reading, evoking anxieties, guilt or regret. We have all been infants, many of us have been responsible for the care of them and as a result, this report may at times trigger a defensive reaction. However, for others, we think our findings will be deeply reassuring, as our aim is to enable parents to enjoy the best possible relationships with their infants – for the ultimate well-being of society as a whole.

> 'To be a successful parent means a lot of very hard work. Looking after a baby or a toddler is a 24 hour a day job 7 days a week, and often a very worrying one at that. And even if the job lightens a little as children get older, if they are to flourish they still require a lot of time and attention. For many people today these are unpalatable truths. Giving time and attention to children means sacrificing other interests and activities. Yet I believe the evidence for what I am saying is unimpeachable.'
>
> Bowlby, quoted in Barrett H (2006) Attachment and the Perils of Parenting FPI p35

The work of the Early Years Commission

The Commission comprised a panel of experts in the early years' field covering psychology, neuroscience, professional practice and family policy. A wide range of views from those involved in social work, primary and secondary health care, daycare, education and mental health were elicited in a range of different ways. Evidence was taken over four days of hearings at the House of Commons, and the Commission also made site visits to projects and facilities in all three mainland nations of the UK (Brighton, North Wales and Edinburgh). Well over 50 individuals and organisations made submissions and Commission members also conducted field interviews with several consultees and obtained illustrative anecdotal evidence.

YouGov conducted two rounds of polling for the Commission: the first round accessed the views of 2827 expectant parents or parents between the 27th and 29th May 2008, and the second accessed 2337 adults (not just parents) between the 11th and 15th July 2008. Commission members attended several academic and practitioner conferences (see list at the back of this report) and presented a paper at the First Biennial International Family Aggression Conference at the University of Central Lancashire (18th and 19th

March 2008), on the work of the Commission. Extensive use was also made of the relevant academic literatures.

Structure of the Report

- Chapter 1 considers why intervening in the early years prevents the intergenerational transmission of disadvantage and why this period matters so much for the well-being of individuals and society. It looks at the core needs of zero- to three-year-old children and what they require from their parents or primary carers in order to thrive. It also describes the long-term social, emotional and financial costs for individuals and society if these needs are not met.
- Chapter 2 examines the current direction and content of government policy on the early years and the extent to which it is addressing deficits.
- Chapter 3 focuses on the causes of the problem of why infants are not getting what they need, citing evidence we received which helps to explain why some parents struggle to meet the needs we describe in Chapter 1.
- Chapter 4 cites further evidence obtained at our hearings of how services are currently failing to make a difference in the first three years.
- Chapter 5 outlines our recommendations to assist parents and other key adults to meet the needs of society's children under three.

We have aimed to provide a coherent strategy that will:

- improve the emotional well-being of infants and their families
- improve the understanding of society in general that the early years impacts greatly on an individual's capacity for relationships, learning, work and positive daily interactions
- find cost effective, early interventions which will enable far more parents to enjoy positive and enriching relationships with their infants
- address the needs of specific groups of infants and their families who require additional help and support
- consider cost implications of the implementation of far more extensive intervention and prevention programmes for early years, in terms of savings of costs to the NHS, Education, Youth Justice and Criminal Justice systems

CHAPTER ONE

Why intervening in the early years prevents the intergenerational transmission of disadvantage

1.1. Introduction - the importance of the early years

The earliest period of human development can have lifelong impact in terms of the mental health and general well-being of individuals and wider society. It can also decisively influence the ability of the rising generation to break out of the cycle of disadvantage in which many of their parents have been caught up. The British population understands the importance of the early years. YouGov polled 2827 expectant parents or parents (27-29 May 2008) and 2337 adults, not just parents, (11-15 July 2008) and found that 77 per cent of parents agreed that a lack of parental support when children are under the age of three contributes to their children getting involved in anti-social behaviour later on as teenagers. 73 per cent of parents (and 68 per cent of adults) said that more government support for parents during these early years would be very effective or somewhat effective in reducing emotional and behavioural problems when those children reach adulthood.

1.1.1. KEY STATISTICS RELEVANT TO THE EARLY YEARS IN THE UK

- Infants aged under one are more at risk of being killed by another person than any other age group of children under 18 in England and Wales[44]
- Up to one in ten women experience domestic violence each year – in 90 per cent of the incidents children are in the same or next room[45]
- 20 per cent of parents suffer from postnatal depression making it very hard for them to meet their babies' emotional needs[46]

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44 Povey D et al (2008) *Homicides, firearms offences and intimate violence 2006/2007: supplementary volume 2 to Crime in England and Wales 2006/2007* London: Home Office

45 Every Child Matters (2003) *Green Paper CM5860* London: TSO

46 Survey conducted by the Royal College of Midwives, 2007, reported at http://www.dailymail.co.uk/health/article-451570/Post-natal-depression-hits-20pc-mothers.html accessed 23/7/08

- The NSPCC estimates that one to two children die at the hands of their parents every week (in comparison to Sweden where statistics indicate one to two children die at the hands of their parents *per year*)[47]
- Some form of foetal alcohol spectrum disorder affects more than 6000 children in Britain each year and is a leading cause of learning difficulties[48]
- Almost half of all calls to the Parentline helpline cite isolation and loneliness as key concerns[49]
- One in two cohabiting parents split up before the child's fifth birthday (compared to one in twelve who were married before they started a family) and one in four children suffer the stress of family breakdown[50]

1.2. Brain science shows the early years are about opportunity and vulnerability

Freud was entirely right when he said that we come into the world 'not quite finished'. This is because, in the early years, the brain is still forming. Key structures and chemical systems not finished at birth are established according to gene-environment interplay: 'While the functional capabilities of the mature brain can change throughout life, the majority of the key stages of neurodevelopment take place in childhood.'[51]

Due to this period of rapid brain development in these early years, adult-infant interaction can affect the actual structure and long-term chemical balance in a child's brain, for better or worse. Key stress response systems, emotional regulating systems, and foundational systems for kindness, empathy and concern are very immature at birth. How they will unfold is dramatically affected by the infant's relational experiences. Without sufficient calming, soothing and emotion-regulating interactions from parents and other significant adults, the stress response systems in the infant brain, which are extremely sensitive to adverse postnatal experience, can become hypersensitive. This means the infant can grow up unable to handle stress effectively and move into primitive fight or flight behaviours when under pressure. This defensive reaction to the world can continue long term. He or she can be persistently 'on the look-out' for threat and prone to anxiety,

47 http://www.nspcc.org.uk/documents/supportingchildrenonline.pdf_wdf46259.pdf accessed 26/7/08. Expressed as a percentage of the population per annum, 1-2 out of 9.2 million people per annum is 0.00002%, compared with 1-2 per week out of 60.7 million which is 0.00013%, 6.5 times as many.

48 National Organisation on Foetal Alcohol Syndrome estimates reported by the Department of Health, see also www.timesonline.co.uk/tol/life_and_style/health/article1837653.ece accessed 23/7/08

49 See http://parentlineplusforprofessionals.org.uk/index.php?id=168, accessed 23/7/08

50 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice

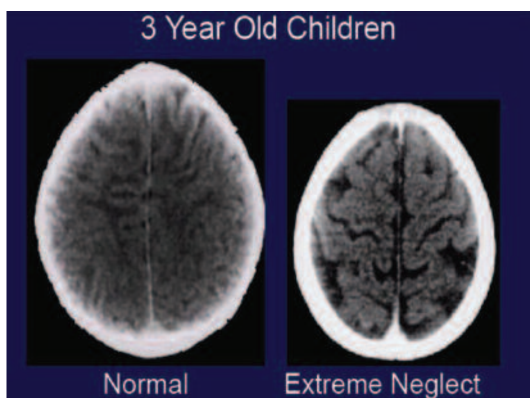
51 Perry B (2002) 'Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture' *Brain and Mind* 3 79–100

depression and anger, both in childhood and later life.[52] In short, children's brains adapt to the environment in which they live.

In contrast when infants are consistently met with attuned and responsive kindness, calm and compassion, the brain's pro-social systems develop. These systems are key to the capacities for empathy and concern. Hence the brain is often referred to as a 'social organ.' This means that infancy is both a critical window of vulnerability and also a critical window of opportunity.

> *'If [sufficient nurturing] is absent for the first three years of life and only after that a child begins to receive good attention, love and nurturing, these positive experiences may not be sufficient to overcome the [disruption to the socio-emotional brain systems] in those early years.'*[53]

1.2.1. *PROLONGED* UNCOMFORTED DISTRESS IN INFANCY CAN DAMAGE ACTUAL BRAIN TISSUE



Most people have come to accept that some parenting practices can inflict deep psychological wounds on the infant, but until recently few considered the possibility that certain forms of very stressful or impoverished parent-child interaction can damage actual brain tissue.[54] Here is a brain scan of a child who suffered severe neglect. The infant's mother was postnatally depressed and he lived for the first years of his life alone in a basement.

It is also important to remember that it is not just dramatic examples such as these that cause problems in a child's developing brain but also:

- repeated unresponsiveness and/or inappropriate reactions to a child's distress
- neglect of their need for play, to be curious and explore in order to learn and thrive

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52 Arborelius L et al (1999) 'The role of coticotrophin-releasing factor in depression and anxiety disorders' *The Journal of Endocrinology* 160 1-12; Graham Y et al (1999) 'The effects of neonatal stress on brain development: implications for psychopathology' *Development and Psychopathology* 11 545-565; Plotsky P, Thrivikraman K, Meaney M (1993) 'Central and feedback regulation of hypothalamic corticotrophin-releasing factor secretion' *Ciba Foundation Symposium* 172 59-75; Heim C et al (1997) 'Persistent changes in corticotrophin-releasing factor systems due to early life stress: relationship to the pathophysiology of major depression and post-traumatic stress disorder' *Psychopharmacology Bulletin* 33 185-192; Gunnar M, Donzella B (2002) 'Social regulation of the cortisol levels in early human development' *Psychoneuroendocrinology* 27 199-220; Kaufman J et al (2000) 'Effects of early adverse experiences on brain structure and function: clinical implications' *Biological Psychiatry* 48 778-790

53 Perry B (2002) 'Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture' *Brain and Mind* 3 79–100

54 Perry B (2002) 'Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture' *Brain and Mind* 3 79–100; Teicher M et al (2006) 'Sticks, stones, and hurtful words: relative effects of various forms of childhood maltreatment' *The American Journal of Psychiatry* 163 993-1000

- lack of sensitivity to their growing independence (albeit allied to a continuing need for protection)
- subjection to stress via inappropriate over-stimulation through parental anxiety for the child to 'achieve'

All these will also influence the way in which the brain is 'shaped'.

1.2.2. VERY YOUNG CHILDREN'S RESILIENCE IS OVERSTATED

One often hears statements such as, 'children are resilient,' or 'they'll get over it', but as one leading child trauma expert states, 'it is an ultimate irony that at the time when the human is most vulnerable… during infancy and childhood, adults generally presume the most resilience. Of course, children "get over it" - they have no choice.'[55] In the process of 'getting over it' research shows that there can be lost potential; lost capacities for intelligence,[56] kindness, concern, creativity, ability to manage life's inevitable knocks,[57] and sometimes lost brain tissue.[58]

It is not denied that some degree of stress in childhood can lead to psychological resilience. This is known as 'stress inoculation' which describes usually benign events such as taking an infant to the swimming pool for the first time. However when children suffer from *prolonged* uncomforted distress and other chronic stress states, this can lead to toxic levels of stress hormones 'cascading' over the brain. This in turn can result in cell death in some key structures in the brain.[59] Such damage can also result from verbally abusing the child, relentless criticism and name-calling.[60] In terms of the cost to society, the parts of the brain most affected are often those directly involved in social and emotional intelligence and in memory.[61]

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55 Perry B (2002) 'Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture' *Brain and Mind* 3 79–100

56 Turkheimer E et al (2003) 'Socioeconomic status modifies heritability of IQ in young children' *Psychological Science* 14 623-628

57 Steele M, Steele H, Johansson M (2002) 'Maternal predictors of children's social cognition: an attachment perspective' *Journal of Child Psychology and Psychiatry, and Allied Disciplines* 43 861-872; Pollak S (2005) 'Early adversity and mechanisms of plasticity: integrating affective neuroscience with developmental approaches to psychopathology' *Development and psychopathology* 17 735-752

58 Teicher M et al (2006) 'Sticks, stones, and hurtful words: relative effects of various forms of childhood maltreatment' *The American Journal of Psychiatry* 163 993-1000

59 Khun C, Schanberg S (1998) 'Responses to maternal separation: mechanisms and mediators' *International Journal of Developmental Neuroscience* 16 261-270; Kaufman J et al (2000) 'Effects of early adverse experiences on brain structure and function: clinical implications' *Biological Psychiatry* 48 778-790; Penza K, Heim C, Nemeroff C (2003) 'Neurobiological effects of childhood abuse: implications for the pathophysiology of depression and anxiety' *Archives of Women's Mental Health* Feb 6 15-22; Heim C (1997) 'Persistent changes in corticotrophin-releasing factor systems due to early life stress: relationship to the pathophysiology of major depression and post-traumatic stress disorder' *Psychopharmacology Bulletin* 33 185-192; McEwen B (1999) 'Stress and the aging hippocampus' *Journal of Neuroendocrinology* 20 49-70; Brunson K et al (2001) 'Long-Term, Progressive Hippocampal Cell Loss and Dysfunction Induced by Early-Life Administration of Corticotropin-Releasing Hormone Reproduce the Effects of Early-Life Stress' *Proceedings of the National Academy of Sciences of the United States of America* 98 8856-8861

60 Teicher M et al (2006) 'Sticks, stones, and hurtful words: relative effects of various forms of childhood maltreatment' *The American Journal of Psychiatry* 163 993-1000

61 Teicher M et al (2003) 'The neurobiological consequences of early stress and childhood maltreatment' *Neuroscience and Biobehavioral Reviews* 27 33-44

1.2.3. HOW GENETIC DIFFERENCES PLAY OUT DEPENDS ON ENVIRONMENT

There can be a tendency to consider that all our feelings and behaviour are governed by our genes, leading to the assumption that 'our children will turn out a certain way no matter how we raise them.' However, this is, in many ways, inaccurate. In short, genes do not and cannot override the many other influences on behaviour. Complex behaviours are the result of multiple genes interacting with multiple environmental influences. As Baker says 'Based on your genes, no one can say what kind of human being you will turn out to be or what you will do in life.'[62] Many people mistakenly think that one gene controls a behavioural disorder or personality trait but this is untrue. Temperament, personality and behavioural traits are always the result of a gene-environment interplay.

One area of physiology that is increasingly drawing attention to this gene-environment interplay is the field of epigenetics. In essence, some of our genes will be expressed in a particular way, depending on the environment in which we find ourselves. So for example, some of the genes which code for chemical activations that restore well-being after a stress reaction may be 'tuned down' by adverse parenting experiences in childhood. Similarly, genes which can place us at risk of later problems may only be 'turned on' by adverse parenting.

1.2.4. LATEST RESEARCH ON THE ROLE OF GENETICS IN INFANT MENTAL HEALTH INDICATES THAT:

- Infancy is a time of both great opportunity and great vulnerability for expressing the infant's genetic potential[63]
- There are foundational genetic systems in the brain for creativity, play, gentleness, kindness and concern, but whether or not these genetic potentials become fully expressed depends extensively on the quality of parenting and other key adult-infant interactions[64]
- We all have 'vulnerability' genes but with the right sort of adult-infant interactions in early life, these need not necessarily express themselves.

The following box gives several examples of this.

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62 Baker C (2004) *Behavioral Genetics: An introduction to how genes and environments interact through development to shape differences in mood, personality, and intelligence* New York: AAAS

63 Caspi A et al (2003) 'Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene' *Science* 301 386-389; De Bellis M (2005) 'The psychobiology of neglect' *Child maltreatment* 10 150-172; Foley D et al (2004) 'Childhood Adversity, Monoamine Oxidase A Genotype and Risk of Conduct Disorder' *Archives of General Psychiatry* 61 738-744; Fox N et al (2005) 'Evidence for a gene-environment Interaction in predicting behavioral inhibition in middle childhood' *Psychological Science* 16 921-926; Meaney M (2001) 'Maternal care, gene expression and the transmission of individual differences in stress reactivity across generations' *Annual Review of Neuroscience* 24 1161-1192; Turkheimer E et al (2003) 'Socioeconomic status modifies heritability of IQ in young children' *Psychological Science* 14 623-628

64 Panksepp J (1998) *Affective neuroscience: The foundations of human and animal emotions* New York: Oxford University Press

Example 1: A common regulatory variant in the human serotonin transporter gene (5-HTTLPR) has been associated with vulnerability for affective disorders including anxiety and depression. A ground-breaking study found that children with a variation on this gene had increased risk of behavioural inhibition in middle childhood, but *only* when their mother was suffering from lack of emotional support.[65]

Example 2: Another study looking at infants with the same genetic vulnerability found that if they were maltreated when young, their risk of depression as adults was greatly increased. If they were not poorly treated in infancy, their risk for depression in adult life was the same as those without this particular genetic variant[66]

Example 3: A variant in the gene MAOA affects enzymes key to the breakdown of dopamine and noradrenaline. Children with this variant have an increased risk of developing a conduct disorder and anti-social behaviour but *only* in the presence of childhood adversity (e.g. parental neglect, inconsistent or harsh discipline, accumulated losses, maternal rejection, physical or sexual abuse and inter-parental violence).[67]

Example 4: In some studies, variants in the DRD4 gene are associated with attention problems and lack of impulse control.[68] One study found that without the presence of excessive parental alcohol consumption, this particular variant of gene did not adversely affect the child's behaviour.[69]

Example 5: Genes for IQ potential can fail to express themselves through impoverished parent-infant interactions. Research shows that a child's genetic IQ potential does not express itself with highly stressful home environments, whereas genetic IQ potential is very influential in families where parents are not stressed with financial concerns.[70]

Example 6: Research shows that a chronic lack of physical affection in early life may adversely affect the genetic expression of oxytocin receptor binding. Oxytocin is an 'emotion chemical' in the brain which plays a key role in the social reward circuitry. In combination with other chemicals, oxytocin makes social interactions rewarding, particularly affecting the ability to feel good after being given a cuddle from an attachment figure.[71]

1.2.5. IMPOVERISHED PARENT-CHILD INTERACTIONS CAN LEAD TO INEQUALITY IN EDUCATION

It is important to recognise and acknowledge the long term effects of poor relationships between the parent and child on all aspects of the child's development including their cognitive/intellectual attainment. Inequality in education and learning opportunities is not only driven by a narrow interpretation of 'education' and the perception of the availability of 'good schools' but also, crucially, by parental attitudes towards learning, knowledge and education, including parents' attitudes to the learning habits of their

65 Fox N et al (2005) 'Evidence for a gene-environment Interaction in predicting behavioral Inhibition in middle childhood' *Psychological Science* 16 921-926

66 Caspi A et al (2003) 'Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene' *Science* 301 386-389

67 Foley D et al (2004) 'Childhood adversity, monoamine oxidase A genotype and risk of conduct disorder' *Archives of General Psychiatry* 61 738-744

68 Lynn D et al (2005) 'Temperament and character profiles and the dopamine D4 receptor gene in ADHD' *The American Journal of Psychiatry* 162 906-913; Swanson J et al (1998) 'Association of the dopamine receptor D4 (DRD4) gene with a refined phenotype of attention deficit hyperactivity disorder (ADHD): a family-based approach' *Molecular psychiatry* 3 38-41

69 Lahti J et al (2005) 'Novelty seeking: interaction between parental alcohol use and dopamine D4 receptor gene exon III polymorphism over 17 years' *Psychiatric genetics* 15 133-139

70 Turkheimer E et al (2003) 'Socioeconomic status modifies heritability of IQ in young children' *Psychological Science* 14 623-628

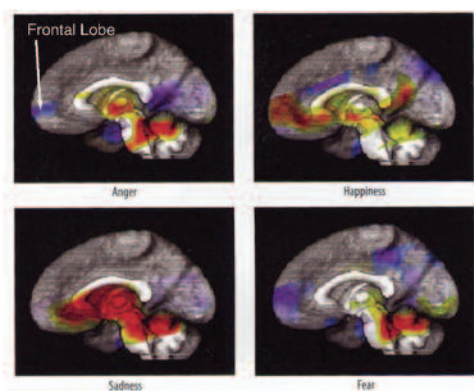
71 Fries A et al (2005) 'Early experience in humans is associated with changes in neuropeptides critical for regulating social behaviour' *Proceedings of the national Academy of Sciences of the USA* 47 17237-17240

children. The parents' relationship with their child and therefore the level and degree of their involvement in their children's education is highly influential.

Without positive parent-infant interactions right from the beginning of life, such as talking to the baby, singing songs and nursery rhymes, playing and telling stories, taking him or her out to the park and shops, visiting friends or relatives, and, later, reading aloud, teaching songs and nursery rhymes, painting and drawing, playing with letters and numbers, visiting the library, and creating regular opportunities for play, infants are at a considerable disadvantage when they reach school age. This is because these activities are all associated with higher intellectual and behavioural scores.

This attainment gap between children begins to emerge at the pre-school stage. Dr Gillian Evans, an associate at Brunel University's Centre for Child-Focused Anthropology states that this is because these simple games and tasks are not simply a means of keeping a child occupied and amused but they are tried and tested means of acquiring core literacy and numeracy skills. She further states that children who have not benefited from close parental involvement in their early years enter formal education at a real disadvantage. When children have not received an abundance of quality one-to-one interaction with a parent and where talking, sharing books and stories and songs have not been used to inspire them to delight in the written and spoken word, they can fall behind and become disillusioned and demotivated before even reaching primary school.

As in a race, certain children start first and have every opportunity to catch up if they fall behind, while disadvantaged children may start well behind the rest of the field and have few opportunities to catch up. Even if a pupil from a disadvantaged background starts ahead, he or she is more likely to fall behind eventually.[72] This trend continues to accelerate throughout the course of primary education and increases significantly by the age of ten.



Infants who are frightened, angry or stressed by adverse and/or chaotic circumstances or by unrealistic expectations cannot learn well, as their frontal lobes (higher thinking brain) are poorly activated and often adversely affected by high levels of stress hormones.[73] This brain scan shows just how powerfully the stress hormone activation from overwhelming feelings and uncomforted distress can disrupt the higher thinking brain. In this scan red hues indicate areas of increased activity and purple hues indicate regions of decreased activity. See how little activity there is in the frontal lobes when we are overwhelmed by strong emotion.[74] Educationalists consulted for the Social Justice Policy Group flagged up the marked increase in extreme emotional problems they encounter

72 Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice; Bartley M (2006) *Capability and Resilience: Beating the Odds* London: University College London Department of Epidemiology and Public Health

73 Damasio A et al (2000) 'Subcortical and cortical brain activity during the feeling of self-generated emotions' *Nature Neuroscience* 3 1049-1056

74 *The Secret Life of the Brain* New York: Joseph Henry Press

in children under their care, citing family breakdown, inadequate parenting and social deprivation as key causes. Children embroiled in such adversities will find learning difficult. As a result, those working in early years care need to be highly sensitive to children's core relational needs, self-aware and well trained in child development. When an infant feels psychologically safe and has been inspired by the parent's capacity for curiosity and exploratory nature, they are most likely to be able to make good use of their educational experiences. In other words, appropriate, high quality learning opportunities provided by parents and other educators are best supported if the emotional needs of the child are met first. Learning itself must be in a context which puts all the child's developmental needs at its heart.

1.2.6. TO SUMMARISE…

In the early years, each positive relational experience the infant receives is an important social and emotional brain-developing event.

Relational wealth (repeated positive interactions between parent and child):

- Increases brain growth (new synaptic connections, top-down, left-right brain pathways, releases brain fertilizers)
- Organises brain systems
- Develops pro-social and calming brain systems
- Regulates brain and body systems
- Decreases negative effects of stress on the brain and body

On the other hand, relational poverty and chronic relational stress in the early years take their toll.

Relational poverty (repeated relational stress between parent and child/lack of positive interactions) leads to:

- Underdeveloped brain systems badly affecting capacity for attention, learning, concentration, creativity, empathy, kindness
- Smaller brains: less sophisticated neuronal networks
- Frequent activation of alarm systems in the brain
- Possible damage to certain structures and chemicals systems in the brain

The infant brain is particularly vulnerable to repeated, stressful relational experiences. This is because systems in the brain that are key for emotional and social well-being are still being organised. As Perry states, 'In adulthood experience changes the brain but in childhood it is organising actual brain systems.'[75] This is why we must invest in children's early years if we want an emotionally healthy society.

Moreover, as stated, adverse relational experiences can block genetic potential or be responsible for serious developmental delay, particularly in the higher executive brain (pre-frontal cortex).[76] This will adversely affect the child's capacity for reflection, reasoning, empathy, concern, being stable under stress etc. In short, parents have the power to develop the brain's pro-social systems and therefore what happens during the early years has a long-term impact on overall levels of kindness versus violence and/or cruelty in society.

It is for this reason that the Commission has researched interventions directed towards enabling a far greater number of parents and families to offer their infant consistently enriching relational experiences and has considered how services can best meet both parents' and children's needs.

1.3. Zero-to-three year old children have core relational needs

Overall, despite all these disturbing facts, the brain science brings hope for a healthier, better functioning society, because it also informs us about what works in order for an infant to develop a strong sense of self and emotional and social well-being. In a nutshell, positive relational experiences lead to good mental health. The following are the core relational needs of infants:

- Secure attachment and attuned emotional responsiveness (both to pain and joy)
- Physical affection and physical contact
- Interactive play and opportunities for independent play and exploration
- Support for and nurture of the growth of positive self-esteem through encouragement and praise
- Shared adventure
- Appropriate limits or boundaries

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75 Perry B (2008) *The Traumatised Child: Healing Brain, Mind and Body Lecture.* London: The Centre for Child Mental Health June 16

76 Perry B (2008) *The Traumatised Child: Healing Brain, Mind and Body Lecture.* London: The Centre for Child Mental Health June 16

1.3.1. SECURE ATTACHMENT[77]

Secure attachment pertains to a relationship in which the infant feels loved and secure in the consistent emotional responsiveness of the other person.

Attachment is a genetically ingrained system in the brain.[78] Hence, an infant's need to feel safe and secure in the affection and emotional responsiveness of their carer is entirely natural, as is the sense of protest and panic when the satisfying of such attachment needs are threatened in some way. If a parent is to establish a secure attachment with their infant, they will be able to respond appropriately to the infant's joyful states as well as to their painful states. When a securely attached infant is distressed he or she will seek solace from the parent to whom he or she is securely attached and then will be quickly comforted. This can have a life long impact, in that the infant is consequently likely to grow up with the ability to seek solace from other people when distressed, rather than turning to alcohol, self-harm or drugs, or discharging intolerable emotional tension through anti-social and/or self destructive behaviour.

Secure attachment also develops both stress-regulating systems in the infant brain and those directly involved in social and emotional intelligence. Moreover, secure attachment in the first few years of life is strongly associated with the capacity to make satisfying relationships in later life. In contrast, insecure attachment patterns by and large result in some forms of debilitating relationship problems, especially those involving romantic partners and offspring. Insecure attachment can lead to 'loving in torment or not daring to love at all'.[79]

Insecure attachment in the early years has been directly associated with troubled behaviours, unhappy or tormented relationships and lack of emotional intelligence in childhood, teenage years and adulthood, including:

To be met in joy and to be met in pain

In our polling, 97% of adults said they thought the relationship between a mother and baby was very important or fairly important in the child's later development and 75% of parents think that a child under three should spend almost all or a lot of their time with their mother. (However, 63% of respondents believed that a child under 3 should spend a lot or all of their time with their father, so dads are considered to be very important too!)

YouGov polling (2008)

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77 As we state in the introduction, whilst emphasising the importance of attachment, the Commission is aware that this theory does not explain all or even the majority of mental health in relationship difficulties and that other factors are important, many of which are described below. See Barrett H, 2006, *Attachment and the Perils of Parenting* FPI, for a full discussion of the strengths and weaknesses of attachment theory

78 Panksepp J (1998) *Affective neuroscience: The foundations of human and animal emotions* New York: Oxford University Press

79 Armstrong-Perlman E (2005) *Personal communication*

Anecdotal evidence obtained by the Commission: 'my mother was always so busy with the five of us so if we were happy, sad or indifferent we were always treated the same. We felt like pieces in a jigsaw puzzle rather than a family of individual children. I still find it hard to know how I really feel in any given situation. This has been a big deal in my recovery from my alcohol and gambling addictions. I've found the most important thing is to get in touch with my feelings, but for me feelings didn't exist as a child. Somehow they weren't defined.'

- Depression and anxiety
- Poor self esteem
- Inability to handle stress and life's inevitable knocks
- Lack of confidence to explore and be curious
- Lack of self-awareness
- Lack of capacity for emotional regulation
- Lack of empathy and compassion
- Alcohol and drug abuse[80]

Without early intervention (or some form of therapy later in life), insecure attachment patterns are incredibly tenacious, maintaining similar characteristics in individuals over time. Insecure attachment is *not* equivalent to mental disorder but creates significant vulnerability for dysfunctionality.

1.3.2. PHYSICAL AFFECTION AND PHYSICAL CONTACT

Physical affection in the early years is essential for the development of brain and bodily systems concerned with long-term capability to be calm under stress and to handle life's inevitable knocks. We can see this from studies on humans and other mammals.[81] This is so much the case that key researchers in the field agree that if a teenager does not get enough physical affection (such as cuddles) it is a real shame, but if an infant does not, it can be a disaster.[82] Other studies have shown that if there is chronic deprivation of physical affection and other emotional needs in the first three years of life, infants develop severe deficits in social development and capacities for behavioural and emotional regulation. They also experience

80 Steele M, Steele H, Johansson M (2002) 'Maternal predictors of children's social cognition: an attachment perspective' *Journal of Child Psychology and Psychiatry, and Allied Disciplines* 43 861-872; Park L, Crocker J, Mickelson K (2004) 'Attachment styles and contingencies of self-worth' *Personality and social psychology bulletin* 30 1243-1254; Murray L et al (2006) 'Socioemotional development in adolescents at risk for depression: The role of maternal depression and attachment style' *Psychopathology* 18 489-516; Powers S et al (2006) 'Dating couples' attachment styles and patterns of cortisol reactivity and recovery in response to a relationship conflict' *Journal of personality and social psychology* 90 613-628; Meredith P, Strong J, Feeney J (2006) 'Adult attachment, anxiety, and pain self-efficacy as predictors of pain intensity and disability' *Pain* 123 146-154; Yoo H et al (2006) 'Parental Attachment and Its Impact on the Development of Psychiatric Manifestations in School-Aged Children' *Psychopathology* 39 165-174; Guttmann-Steinmetz S, Crowell J (2006) 'Attachment and externalizing disorders: a developmental psychopathology perspective' *Journal of the American Academy of Child and Adolescent Psychiatry* 45 440-451; Moss E et al (2006) 'Attachment and behavior problems in middle childhood as reported by adult and child informants', *Development and Psychopathology* 18 425-444

81 Caldji C, Diorio J, Meaney M (2000) 'Variations in maternal care in infancy regulate the development of stress reactivity' *Biological Psychiatry* 48 1164-1174; De Bellis M (2005) 'The psychobiology of neglect' *Child maltreatment* 10 150-172; Field T, Kilmer T, Hernandez-Reif M, Burman I (1996) 'Preschool Children's Sleep and Wake Behavior: Effects of massage therapy' *Early Child Development and Care* 120 39-44; Fleming A, O'Day D, Kraemer G (1999) 'Neurobiology of mother-infant interactions: experience and central nervous system plasticity across development and generations' *Neuroscience and Behavioural Reviews* 23 673-685

82 Pollak S et al (2005) 'Early experience in humans is associated with changes in neuropeptides critical for regulating social behaviour' *Proceedings of the national Academy of Sciences of the USA* 102 17237-17240

progressive developmental deterioration in cognitive functioning that can be irremediable.[83] When they were examined at 3 years of age, some infants were found to have suffered from physical growth delays, including smaller body size and head circumference, poor social skills, and delays in language development. Lack of physical affection in infancy can inhibit growth hormone: in the absence of nurturing touch the brain initiates the suppression of ornithine decarboxylase gene transcription, which is key for the activation of growth hormones.[84]

1.3.2.1. Physical affection in the early years is key for later emotional well-being

Research with other mammals found that infants who had received abundant physical affection in the early years grew up to be far less fearful and anxious. In contrast low levels of touch in infancy resulted in increased fearfulness in later life and increased stress reactivity.[85] This is due to the fact that comforting parental behaviour has a profound influence on GABA (gamma-aminobutyric acid) receptor gene expression in the infant's brain (the natural calming chemical system in the brain), thus enabling infants to be less vulnerable to developing anxiety disorders in later life.

Research shows that oxytocin activation from physical affection acts to alleviate stress and promote well-being. It can lower both blood pressure and stress hormone levels. It also regulates breathing, temperature, digestive and elimination processes and improves immune system functioning.[86]

1.3.3. INTERACTIVE PLAY

Play is a universal activity in both children and young animals, and while its value is questioned by some, especially in learning/education contexts, current neuroscientific research has demonstrated that interactive play is essential for optimal brain growth and development. This again has major implications for early years intervention in terms of enabling and encouraging parents to offer their infants lots of interactive play.

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83 Spitz R (1945) 'Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood' *Psychoanalytic Study of the Child* 1 53-74; Chugani H (2001) 'Local brain functional activity following early deprivation: a study of postinstitutionalized Romanian orphans' *Neuroimage* 14 1290-1301

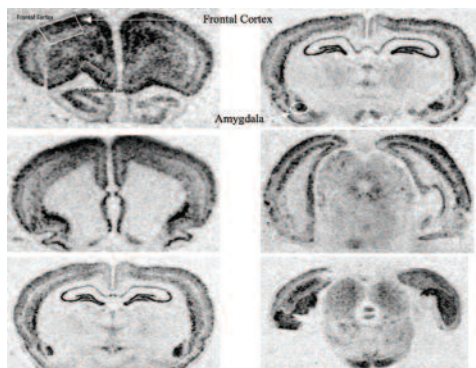
84 Khun C, Schanberg S (1998) 'Responses to maternal separation: mechanisms and mediators' *International Journal of Developmental Neuroscience* 16 261-270

85 Meaney M, Caldji C, Diorio J (2003) 'Variations in maternal care alter GABA(A) receptor subunit expression in brain regions associated with fear' *Neuropsychopharmacology* 28 1950-1959

86 Uvnas-Moberg K, Petersson M (2005) 'Oxytocin, a mediator of anti-stress, well-being, social interaction, growth and healing' *Zeitschrift fur Psychosomatische Medizin und Psychotherapie* 51 57-80

Interactive physical play releases well-being chemicals in the brain, namely opioids.[87] These are anti-anxiety and anti-aggressive molecules.

In studies with other mammals, interactive play has been shown to develop the frontal lobes. In humans this is the part of the brain key for higher functions such as reasoning, reflecting, empathy, creativity. This is due to the fact that interactive relational play releases a brain 'fertiliser' called BDNF (brain derived neurotrophic factor)[88]. This enhances the development of the brain's noradrenaline and dopamine systems. (It is these very systems that are underdeveloped in many children diagnosed with attention-deficit hyperactivity disorder or ADHD.)



This brain scan shows the effect of BDNF working on the frontal cortex (higher brain). The scan on the left shows the brain of a mammal who has received interactive play (see dark patches in the frontal lobes which indicated the release of BDNF). The mammal on the right has not received interactive relational play.

Mental and motor development of children in local authority care rose dramatically after play intervention. When children were deprived of playtime at schools, they developed ADHD-type symptoms in the afternoon.[89]

Interactive play has been found to be as effective as low doses of Ritalin without the deeply concerning side effects.[90] At the moment there are 55,000 children taking Ritalin in the UK[91] costing the NHS £28 million. A three year Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder (MTA)[92] found a substantial decrease in the rate of growth in children that had taken Ritalin over the period, with no substantial benefits.[93] Moreover, Ritalin decreases play behaviour[94] and in other mammals is associated with increased risk of drug abuse in later life.[95]

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87 Nelson E, Panksepp J (1998) 'Brain substrates of infant mother attachment: contributions of opioids, oxytocin and norepinephrine' *Neuroscience and Behavioural Reviews* 22 437-452

88 Gordon N, Burke S, Akil H, Watson S (2003) 'Socially-induced brain 'fertilization': Play promotes brain derived neurotrophic factor transcription in the amygdala and dorsolateral frontal cortex in juvenile rats' *Neuroscience Letters* 341 17-20

89 Pellegrini A, Huberty P, Jones I (1996) 'The effects of recess timing on children's playground and classroom behaviours' *American Educational Research Journal* 32 845-64

90 Panksepp J et al (2003) 'Modeling ADHD-type arousal with unilateral frontal cortex damage in rats and beneficial effects of play therapy' *Brain and Cognition* 52 97-105

91 Centre for Paediatric Pharmacy Research 2008

92 National Institute of Mental Health 2007

93 Swanson J et al (2007) 'Effects of stimulant medication on growth rates across 3 years in the MTA follow-up' J*ournal of American Academy of Child and Adolescent Psychiatry* 46 1015-1027

94 Beatty W et al (1982) 'Psychomotor stimulants, social deprivation and play in juvenile rats, Pharmacology' *Biochemistry, and Behavior* 16 417-422

95 This might seem very difficult to establish, but researchers simply put cocaine in animals' cages to see if they were either not interested, mildly interested or very interested. In one experiment, securely attached animals were not particularly interested in cocaine (they preferred chocolate), whereas insecurely attached animals showed interest in the cocaine. See Nocjar C, Panksepp J (2002) 'Chronic intermittent amphetamine pretreatment enhances future appetitive behaviour for drug- and natural-reward: Interaction with environmental variables' *Behavioural Brain Research* 128 189-203

When Ritalin was given to pre-pubescent mammals, it resulted in the death of dopamine cells.[96] This is particularly worrying as current knowledge indicates that we only have so many of these cells, which naturally start to die as we get older. We are yet to see if children given Ritalin before puberty will suffer from early Parkinson's disease (which involves death of dopamine cells) in later life.[97] Interactive play protects against the natural degeneration of dopamine cells, so may protect against Parkinson's disease in later life.[98]

1.3.4. SELF-ESTEEM, ENCOURAGEMENT AND PRAISE

Many parents do not know that there is a critical window of opportunity between two and six months where the face-processing neurons in the infant brain are particularly active. Child psychologist Daniel Stern refers to this developmental stage as 'the world of the face.' If things go right, he says, it is the most sociable time of your life. It is a crucial time for establishing the strongest foundation stones for self-esteem. You look into your mother's face and see her delighting in you, this is 'the beautiful experience of being a loved, beautiful baby in mother's mind.'[99]

However, the opposite can happen. When parents don't know about this critical period, a real opportunity for establishing a strong sense of self-esteem can be lost. Furthermore, Lier found that infants who had not developed good conversational contact with parents in the third or fourth month of life were often unable to 'use' social contact in the following year, so when people smiled at these infants, they looked blankly back.[100]

1.3.5. SHARED ADVENTURE

There is a genetically ingrained brain system in the old mammalian part of the brain called the 'seeking' system.[101] It is a system central to a person's will, motivation, curiosity and drive. (At the top of the Harvard Business Review's list of vital qualities for business success is 'a high level of drive and energy.')

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96 Moll G et al (2001) 'Early methylphenidate administration to young rats causes a persistent reduction in the density of striatal dopamine receptors' *Journal of Child and Adolescent Psychopharmacology* 11 15-24

97 Panksepp J Personal communication with Dr. Margot Sunderland Centre for Child Mental Health London 2007

98 Hyman C et al (1991) 'BDNF is a neurotrophic factor for dopaminergic neurons of the substantia nigra' *Nature* 350 230-232

99 Reid S (1990) 'The Importance of Beauty in the Psychoanalytic Experience' *Journal of Child Psychotherapy* 16 29-52

100 Lier L (1988) 'Mother-infant relationship in the first year of life' *Acta psychiatrica Scandinavica Supplementum* 344 31-42

101 Panksepp J (1998) *Affective Neuroscience: The Foundations of Human and Animal Emotions* (Series in Affective Science) Oxford University Press

Example: Research demonstrates that in order for an infant to develop good self-esteem they ideally need around six positives for every one negative comment.[102] This can be a particularly difficult challenge for many parents when the infant reaches the two-year-old stage, with all the natural defiance and boundary testing that occurs around this time. Jenner found that when there are six negatives for every one positive, the infant may move into oppositional defiance, which later can result in anti-social behaviour. The adverse effects on self-esteem and behaviour of a lack of praise in a culture of commands and criticism is well-documented.[103] In one research study, when parents were helped to engage with the child with playful and praising interactions, as well as essential limit-setting, the majority of children heading for anti-social behaviour shifted into emotional health. It is possible to shift harsh, command-based family cultures to praise-based family cultures, benefiting the mental health of both parent and child and dramatically improving quality of family life.

For the 'seeking' system to work well it needs to be activated by key adults in an infant's life. The system is like a muscle - the more it is activated, the more a child's natural curiosity and drive will develop. Lack of interactions, play opportunities and encouraging of curiosity and exploration will mean that it is far more difficult for the infant to be ready for learning and to desire knowledge when they reach school age. Although we emphasise throughout this report that meeting these needs as early as possible is best for children, the box opposite gives an example of where a slightly later intervention can have encouraging results.

1.3.6. APPROPRIATE LIMIT SETTING

Each generation begins anew with fresh, eager, trusting faces of babies, ready to love and create a new world. And in each generation some parents will dominate children until they become emotionally crippled adults who repeat in nearly exact detail …the domination that existed in previous decades. Should a minority of parents… begin to provide a somewhat more secure, loving early years …..history soon begins to move in surprising new directions and society changes in innovative ways.[104]

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102 Jenner S (1999) *The parent-child game* London: Bloomsbury

103 Bugental D, Martorella G, Barrazaa V (2003) 'The hormonal costs of subtle forms of infant maltreatment' *Hormones and Behavior* 41 237-244; Blair R (2005) 'Applying a cognitive neuroscience perspective to the disorder of psychopathy' *Development and psychopathology* 17 865-891; Forehand R, King H, Peed S, Yoder P (1975) 'Mother-child interactions: Comparison of a non-compliant clinic group and a non-clinic group' *Behaviour Research and Therapy* 13 79-84; Hoffman M (1984) 'Empathy, its limitations and its role in a comprehensive moral theory', in J Gerwirtz & W Kutines (eds) *Morality, moral development, and moral behaviour* New York: Wiley 283-302

104 De Mause L (2002) *The Emotional Life of Nations* New York: Karnac Books.

Good news for the 'seeking' system if we miss the 'early years window'

Some ground breaking longitudinal research demonstrated that if children from greatly impoverished backgrounds were given a nutritional, educational and physical exercise enriched programme between 3 and 5 years of age, they were far less likely to develop criminal or anti-social behaviour in early adulthood. Children who participated in the enrichment program at ages 3-5 years had far lower scores for anti-social behaviour at age 17 years and for criminal behaviour at age 23 years, compared with the control subjects.[105]

Anecdotal evidence obtained by the Commission further illustrates the importance of shared adventure:

> 'One of my favourite times of childhood was the things that my father would do with me that my mother would disapprove of. He would always just push a little bit at the limits of what we were used to as we grew up. He pushed us gently and it was exciting. We always had our mother to go back to when it got too much though. It's something I keep with me when I'm feeling a little out of my depth. I remember that challenges can just be part of growing up, or growing stronger.'

Discipline or the setting of developmentally appropriate, realistic and fair boundaries in toddlerhood is a real art. Yet getting it right is vital if a parent is to activate and develop the child's higher thinking brain, and maintain all the work achieved in babyhood to establish secure attachment. Some parents are wonderful with babies, but can struggle when the toddler begins to protest and challenge the parent's authority. A significant body of research indicates that trying to frighten the toddler into compliance can carry long term costs in terms of the child's emotional health (see below). Limit setting through inducing fear in the child, harshly delivered commands and unremitting criticism is strongly associated with the following:

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105 Raine A et al (2003) 'Effects of environmental enrichment at ages 3-5 years on schizotypal personality and antisocial behaviour at ages 17 and 23 years' *The American Journal of Psychiatry* 160 1627-1635

- Conduct disorders[106] /antisocial behaviour[107]
- Migraine and asthma in childhood[108]
- Bullying of other children (at the moment one in three boys and one in four girls will be a bully at some time in their school career[109])
- Coercive forms of play[110]
- Brain damage. ('We are finding that verbal abuse is devastating… These changes [to the brain] are devastating.' (Martin Teicher, neuroscientist from Harvard University in 2006)

In terms of the health of our society, how parents discipline and set limits for their children is crucial. Research shows that whilst showing them empathy facilitates moral socialisation, inducing fear through harsh discipline actually hinders it.[111] All this said, of course, nearly all parents will snap at and shout at their children from time to time. It is perfectly normal, very human and not damaging in the long term. However the point we are making is that early intervention needs to enable parents, many of whom have been brought up themselves in a harsh and critical milieu, to establish boundaries through firmness and clear consequences rather than anger, verbal attack or physical aggression.

Moreover, some children are also limit deprived. This means that they do not receive appropriate boundary setting. They act in an unacceptable way, causing hurt or damage and there are no clear consequences for their actions. As a result, they can become 'tyrants' in their own right, having inappropriate power within the family and some children end up abusing their own parents.[112]

1.4. Conclusion

This chapter has shown how the earliest period of human development can have lifelong impact in terms of the mental health and general well-being of individuals. We have described the core relational needs of zero-to-three-year-old children and what can happen if these needs are not met. As we have stated,

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106 Bugental D, Martorella G, Barrazaa V (2003) 'The hormonal costs of subtle forms of infant maltreatment' *Hormones and Behavior* 41 237-244

107 Denham S et al (2000) 'Prediction of externalizing behavior problems from early to middle childhood: The role of parental socialization and emotion expression' *Development and Psychopathology* 12 23-45

108 Siniatchkin M et al (2003) 'Migraine and asthma in childhood: evidence for specific asymmetric parent-child interactions in migraine and asthma families' *Cephalalgia* 23 790-802

109 Katz A et al (2001) *Bullying in Britain: Testimonies from Teenagers* Young Voice (p9)

110 Troy M, Sroufe L (1987) 'Victimisation among preschoolers: Role of attachment relationship history' *Journal of American Academy of Child and Adolescent Psychiatry* 26 166-172

111 Hoffman M (1984) 'Empathy, its limitations and its role in a comprehensive moral theory' in J Gerwirtz & W Kutines (eds) *Morality, moral development, and moral behaviour* New York: Wiley, 283-302

112 Omer H (2000) *Parental presence: Reclaiming a leadership role in bringing up our children* New York: Zieg Tucker

Anecdotal evidence obtained by the Commission: 'Our house was always full of strangers and weirdos. My step-father was really into the alternative music scenes and there was no difference between his endless drunken ranting meetings with his mates and our own family time in our small council house. I was always terrified of these people, and of him. There just seemed to be no limit to where home ended and the outside world began. I think that's why it seemed OK for me to sleep rough as a teenager. I just didn't really care. No-one had ever cared for me.'

in terms of developing the infant's emotional and physical brain, the early years are a time of great opportunity and great vulnerability. Each positive interaction an infant has with a significant adult can be an important social and emotional brain-developing event. Raising awareness of this is the main goal of the 'Neuron Footprint' recommendation we make in Chapter 5.

We have made the point that intervening in the early years and enabling parents to have the best possible relationship with their infants can prevent history repeating itself in terms of the levels of misery and dysfunctionality we see today. It can prevent the intergenerational transmission of disadvantage.

From its extensive research, the Commission concludes that it is a wise society indeed that invests in optimising the quality of parent-child relationships in the early years, and enables parents to address their infant's relational needs in an attuned and emotionally responsive way. The next chapter summarises the current policy approach. It is followed by two chapters outlining the evidence that we collected on the difficulties that parents face and interventions which might be directed towards strengthening those who need help with the most emotionally demanding of tasks: the raising of children.

CHAPTER TWO
Current policy – missing the golden thread?

2.1. Introduction

This chapter will describe the current Government's approach to children's policy and services in general since coming to office, and their approach to early years policy in particular. Whilst it is clear that a body of policy has been formulated with a view to providing much support to children in their early years and to their families, the Commission has had to conclude that it has not gone far enough to help bring about health and well-being in this age group and to set them on a positive life trajectory. We consider what appear to be the central themes of current policy, and find that a 'golden thread' is missing, a recognition in the underpinning framework of the importance of relationships in every young child's development.

2.2. Overall direction of current policy does not support relationships

The past decade has brought with it a sea-change in children's policy and services, following the publication and elaboration of the five Every Child Matters outcomes around which most children's policies are now structured. *Every Child Matters: Change for Children*[113] states that every child should have the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being

'Every Child Matters' documents have outlined a framework for services to work together in new ways to achieve these outcomes, and the Children's Act

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113 DfES (2004) *Every Child Matters: Change for Children* (DfES/1081/2004) London: DfES

(2004)[114] provides the legislative spine behind these changes. A key thread to the reforms is much more integration intended at all levels of service provision, and interwoven with this thread is an emphasis on greater accountability. The drive for more integration can be seen at governmental level in the recent creation of both the Department for Children, Schools and Families (DCSF) and the Children's Commissioner; and in the drawing up of the first ever Children's Plan[115] in 2007; this aims to provide a coherent 10 year strategy for how the Government will support children and families.

It can also be seen in the creation of Children's Trusts (partnership arrangements designed to bring all services for children and young people into one area) and the national provision of Sure Start Children's Centres in which services for children in their early years are designed to be in one location (or in close proximity). With regard to the early years, recent policy has also focused on the wider provision of affordable, quality childcare;[116] on the learning, development and welfare standards for this childcare, with the Early Years Foundation Stage[117] (EYFS); and on the development of an early intervention and prevention public health strategy for children aged 0-5 with the Child Health Promotion Programme: Pregnancy and the first five years of life[118] (CHPP).

This body of policy has been developed to provide a potential foundation for support to children in their early years and their families. The question that arises is whether it is sufficient to help bring about health and well-being for children in their early years and set them on a positive life trajectory. Crucially, do the priorities, outcomes and strategies embedded within policy allow this to occur? Within the central themes of current policy, we have identified some admirable aspects with far-reaching positive implications, but also what we term a missing 'golden thread'. This is a recognition in the underpinning framework of the importance of relationships in every young child's development. When policy prioritizes economic and academic ambitions above the essential relational needs of infants and children, services on the ground will not be providing the optimal conditions that support emotional health and prevent later dysfunction.

2.3. Threads and themes in current policy

2.3.1 SAFEGUARDING

One salient, constructive theme in current children's policy has been the priority given to safeguarding of children from abuse. Failures across children's services in this regard were brought to the fore in the Victoria Climbié enquiry, and

114 HM Government (2004) *Children's Act.* London: TSO
115 DCSF (2007) *The Children's Plan: Building brighter futures* London: DCSF
116 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO
117 DCSF (2008) *Statutory Framework for the Early Years Foundation Stage* London: DCSF
118 DH (2008) *Child Health Promotion Programme: Pregnancy and the first five years of life* London: DH

policy has since attempted to rectify this situation with a number of initiatives, including the guidance on widespread integration of services described above, the introduction of legislative measures mandating agencies to safeguard,[119] the provision of clear guidance on safeguarding procedures,[120] and the introduction of statutory Local Safeguarding Children's Boards. In addition social services and children's services need to be schooled in the damage to children of over-reaction as well as under-reaction to cases of suspected abuse. As we indicate in Chapter 4, the children's workforce (four million people) needs to be adequately trained in the effect on a child of unnecessary attachment ruptures. Training such as this is in line with the aims of Every Child Matters.

2.3.2. EMBEDDING FLEXIBILITY

The move towards more integrated services has been interwoven with a more flexible approach to the creation and provision of children's services, with the aim of ensuring that services more fully suit users. This approach is evident in the establishing of a Children's Commissioner, who primarily advocates for the interests of children and young people, as well as engaging children and young people more fully in the planning of services (for example, see Every Child Matters Inspection Criteria). With regard to service delivery, greater flexibility has meant more provision for outreach, 24-hour, and home visiting work, and this is now happening to some extent.

2.3.3. RECOGNITION OF THE IMPORTANCE OF THE EARLY YEARS

The Government states that 'early childhood is a time of vital importance in children's development'.[121] The recent policies outlining clear standards for the healthcare, childcare and education for the early years is testament to the government's commitment to this view (for example, those espoused within the CHPP and EYFS).

2.3.4. A FOCUS ON ECONOMIC AND ACADEMIC OUTCOMES

Given the Government's stated commitment to the early years, the question arises as to what it is that is actually perceived to be 'vitally important' in the early years for children's development. An examination of the goals, guidance, and outcomes in policy suggests that the imperative issues at hand are removing children from economic poverty and preparing them for later educational achievement.

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119 HM Government (2004) *Children's Act* London: TSO120

120 DCSF (2006) *What to do if you're Worried a Child is Being Abused*. London: DCSF.

121 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO

These two aims are closely entwined; poverty is seen as a key reason behind why children are not able to academically achieve, education is perceived as the surest means out of poverty.

Together they form the priorities for the current Children's Plan,[122] as well as more specific early years policy (for example, Choice for parents, the best start for children, 2004[123]). These are the domains in which the Government is looking for headline improvements.[124]

There is a clear rationale for aiming to eradicate child poverty and improve academic performance for children in the multitude of studies detailing the impact of poverty on reducing educational achievement[125] and increasing the risk of later physical and psychological dysfunction.[126] Education is of course associated with economic achievement, as well as with positive health and social outcomes.[127] Additionally, focusing on these goals allows for the relatively easy measurement of progress, as they are both highly 'visible' in their outcomes.

Indeed the visibility of economic and academic parameters, and their associations with negative life outcomes, may convince us that poverty and educational deficits are the root causes of these problems, and that, therefore, if they are tackled in childhood, later dysfunction will disappear. However, we argue that there is convincing evidence that the deeper, less perceptible factor of relationship dysfunction accounts for a much larger percentage of later life difficulties than either economic or educational disadvantage (see Chapter 1).

> 'Too many children's education is still being held back by poverty and disadvantage'
>
> Ed Balls (Foreword to the Children's Plan, 2007)

> 'Educational achievement is the most effective way to improve outcomes for poor children and break cycles of deprivation'
>
> Every Child Matters: Change for Children (2004)

> 'Childcare can play a role in breaking the cycle of disadvantage both directly through improving children's educational outcomes and indirectly, through supporting parental employment'
>
> Choice for parents, the best start for children (2004)

2.3.5. THE MISSING THREAD: THE CENTRALITY OF RELATIONSHIPS

Extensive research we have already detailed has demonstrated how positive and consistent emotionally attuned responsiveness from parental figures early in life has a profound impact upon a child's experience of life. This fundamental relationship is key to the child's social and emotional development, preparing her or him for healthy interactions with others, as well

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122 DCSF (2007) *The Children's Plan: Building brighter futures*. London: DCSF

123 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO

124 DfES (2004) *Every Child Matters: Change for Children* (DfES/1081/2004) London: DfES

125 Bartley M (2006) *Capability and Resilience: Beating the Odds* London: University College London Department of Epidemiology and Public Health

126 Acheson D (1998) I*ndependent Inquiry into Inequalities in Health Report* London: TSO; Marmot M, Wilkinson R (1999) *Social Determinants of Health* New York: Oxford University Press; McLeod, J, Shanahan M (1993) 'Poverty, parenting and children's mental health' *American Sociological Review* 58 351-366

127 Ross C, Wu C (1995) 'The links between education and health' *American Sociological Review* 60 719-745

as providing the emotional resiliency necessary for dealing with later life challenges. Further supporting and encouraging this process are the relationships *between* significant people in the child's life. Fundamentally, the attuned relationship with their parent coupled with the experience of loving, reciprocal relationships between family members helps the child develop an internal sense of well-being and an internalised 'safe base' from which they can explore the world around them, later to include school and peers. Hence we can see how these early relationships provide the cornerstone for those very achievements in learning and work which appear to be the driving force behind Government policy thinking.

It cannot be denied that economic disadvantage can strain the task of forging sensitive and affectionate relationships. Targeting poverty will do much to reduce later life difficulties, potentially largely because this would remove some of the strains on early years relationships. However these facts cannot detract from the centrality of human relationships in emotional well-being and in much suffering. Relationships can become detrimental for many reasons beyond those connected to poverty, and the impact of this can be seen across every domain of human experience, far exceeding those connected to educational achievement.

> 'The biggest driver of well-being is an individual's 'Set Point', their general temperament and approach to life…What determines that? Well, clearly genes are involved… but the evidence is absolutely clear now that we have overestimated the importance of genes and underestimated the importance of the early years… it is the early nurturing, more than the genes, which influence a person's capabilities in learning and memory, their response to stress and their emotional reactivity throughout life.'
>
> Professor Felicity Huppert, speaking at a seminar on 'Well-Being in the Classroom', convened by the All-Party Parliamentary Group on Scientific Research in Learning and Education.

This Government might argue that policy has gone some way to address the role of relationships in children's early and ongoing development, citing its plans to extend the length of maternity leave to twelve months and to enable a proportion of this leave to be transferred to the child's father. This move fits with the broader recognition in policy of the valuable role of fathers in the nurture and care of children in their early years. Yet, there has been criticism of these measures from those representing the interests of both mothers and fathers. According to the Equal Opportunities Commission, women are a less attractive employment prospect and men still have the most unequal rights in Europe (as mothers would have to transfer leave, it would not be automatically available).[128] They say that this large discrepancy between rights reinforces expectations that mothers will provide most of the childcare and has not challenged the negative culture in many workplaces

128 Bennett R, Ahmed M (2008) 'Equality Laws are now holding women back' *The Times* July 14

surrounding men's access to flexible and part-time working. Many families could not afford for men to take up the leave: they are usually the higher earners and the transferred leave would be paid at a rate which is far below minimum wage.

The Child Health Promotion Programme (CHPP),[129] makes the case for involving fathers in the child's health care and provides practical advice on how this can be achieved. Indeed, it goes further than attending to the father-child relationship; it speaks to the importance of sensitive and attuned parenting in general and advises health visitors to assess and refer parents on to parenting programmes if necessary. It also recommends assessment of the relationships between parents, in recognition of the important role harmony there plays in the young child's development. In a section on 'progressive' assessments for children six weeks to six months it says: 'parents in conflict should be offered access to parenting groups which address parental conflict using specially designed resources (eg. One Plus One Brief Encounters).'[130]

2.3.5.1. Relationships are on the sideline

However, despite these encouraging developments, relationships in the early years remain on the sideline in current policy. At the point of publication of this report, few practitioners we spoke to had either heard of the CHPP or felt there were sufficient resources currently available to meet its aims. Moreover, there is no recognition in overarching policy priorities, objectives or targets of the fundamental role that attachment and familial relationships play in bringing about children's well-being and in reducing the likelihood of a multitude of physical and psychological problems, such as antisocial behaviour, substance misuse, mood disorders, and chronic diseases such as obesity, asthma and chronic obstructive pulmonary disease. None of the five Every Child Matters outcomes refer to a child's relationships. Upon closer inspection of the 25 aims underpinning these outcomes, it appears that relationships are only relevant insofar as what they must *not* involve (maltreatment, neglect, violence and sexual exploitation). In parallel with each of the outcomes, parents, carers and families are expected to: promote healthy choices, provide safe homes and stability, support learning, and promote positive behaviour, and they themselves will be supported to be economically active. It seems that the existence of a nurturing parent-child relationship or broader harmonious family relationships are neither considered important outcomes in their own right, nor deemed as useful factors in the facilitation of those outcomes. If positive relationships are not identified at this level of policy, it becomes difficult for services on the ground to prioritise them.

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129 DH (2008) *Child Health Promotion Programme: Pregnancy and the first five years of life* London: DH
130 *ibid* p47

Returning to the Child Health Promotion Programme, whose guidance to health professionals working with the early years includes promoting positive relationships, we find that the national priorities that it identifies itself as focused upon do not include any regarding the parent-child relationship. Rather, these priorities are concerned with teenage pregnancy, breastfeeding, obesity, smoking and immunisation (most of which could substantially benefit from a priority being given to the parent-child relationship). At other points it emphasises 'the importance of behavioural change in improving the health of the nation',[131] ignoring the importance of the reasons behind this behaviour (that are most often relational).

In essence, although some policies exist that seek to improve the relational base a child has in his or her early years, there is no overarching framework or set of priorities that support them. Yet a mass of scientific, medical and psychological research studies clearly show that an infant's capacity to thrive in life is entirely dependent on their relational experiences. The CHPP recommends that health professionals assess insensitive parenting interactions and refer parents on to group-based parenting programmes if necessary. However there is no mandating for the provision of these parenting programmes. Neither is training in this skilled and subtle assessment a core component of current health visitors' training (let alone other health professionals who might be expected to undertake this assessment). Similarly, whilst the formation of the National Academy of Parenting Practitioners and the Parenting Fund are very welcome moves towards supporting nurturing familial relationships, it is not yet clear how they are tied to policies that impact families universally, in a way that will bring about a cultural shift in the way early years relationships are viewed and supported.

2.3.5.2. Economic factors always dominate but account for a tenth of difficulties

A second outcome of neglecting relationships in children's policy is that when relational needs rub against other more prioritised needs, such as those narrowly focused on tackling economic disadvantage, the latter take precedence This is clearly seen in current political thinking on the care of children. *Choice for parents, best start for children*[132] clearly recognises that 'The quality of these interactions between parents and children *is* more significant for child outcomes than parental income or social background'. However further on in the report, this evidence is cited more ambiguously as 'the quality of the interaction that parents have with their children *can be* as important as a parent's income or social

131 *ibid* p71

132 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO

background' [both emphases ours] and is followed by comments about the impact of poverty on children. The significance of poverty on child development is of course undeniable; however, this central part to the document appears to be the rationale for a *volte face* to take place, wherein the facilitation of nurturing relationships is no longer important in light of the need to help parents return to work. The recognition of parent-child interactions becomes meaningless. Furthermore, and most importantly, a Canadian National Longitudinal Study following zero to six year olds concluded that if you eradicated all child poverty, there would only be a 10 per cent reduction in the number of children who were experiencing behavioural, social, educational and health difficulties.[133]

2.3.5.3. Relational breakdown is treated as inevitable

In actuality, it seems that rather than focusing on promoting positive relationships where (in the family) and when (in the early years) children need them most, policy instead communicates a tacit resignation to the reality of familial breakdown. For example the Children's Plan states:

> *'A significant minority of children will experience family breakdown… The support the parents and the wider family, including grandparents, can provide for the child during the family break-up is critical to that child's well-being and success.'*[134]

The overt message of support for those experiencing family break-up is praiseworthy. However, in the absence of complementary messages regarding intervention before break-up, the clear subtext is that family breakdown is an unavoidable fact of life that is at best managed sensitively with the needs of the child acknowledged.

By leaving relationships off the broad political agenda, the Government is communicating the view that emotionally attuned, loving family relationships are neither here nor there. However, the truth is that they are right at the heart of creating well-being in the early years and beyond. The lack of priority that policy gives relationships may be one of the reasons why the UK ranked last on the 'family and peer relationships' dimension of children's well-being in the recent UNICEF study of child well-being in 21 industrialised countries[135] (in contrast with slightly higher rankings for the material and educational well-being dimensions). Yet people in the UK do not themselves accept

133 McCain M, Mustard F (1999) *Reversing the real brain drain: Early years report* Toronto: Canadian Institute for Advanced Research

134 DCSF (2007) *The Children's Plan: Building brighter futures.* London: DCSF

135 UNICEF Innocenti Research Centre (2007) Report Card No. 7: *Child Poverty in Perspective: an overview of child well-being in rich countries* Florence: Innocenti Research Centre

relational failure as inevitable. An example of this is the vast majority of young people who aspire to get married in the future and remain with one partner for life (over 80 per cent according to a recent poll[136]). Moreover the majority of parents we polled were very aware of the importance of relationships in the early years and the support they want to help with these. In essence, aspiration and evidence come together to suggest that relationships must be at the heart of early years policy.

2.3.6. ASPECTS OF POLICY ARE INHERENTLY FRAGMENTARY DESPITE CALLS FOR INTEGRATION

As noted, a strength of current child policy is the aim to bring services together to provide an holistic, communicating, effective package of support for every child. Beyond the wide-scale examples described above, there are specific attempts at integration emerging, such as the bringing together of maternity and early years public health promotion within the CHPP, and an integrated database. However, despite the Government's good intentions, professional groups have described difficulties working more closely with one another, often because of different 'languages', models of working, and priorities for children. A more organic, 'bottom-up' approach to integration (for example through inter-agency and inter-professional child development training which we recommend later) may help to overcome these understandable barriers.

> In our polling, 70% of parents felt that health visitors should be offering more help to new parents on how to bond with their babies
>
> YouGov poll (2008)

An additional problem is that, beyond the universal adoption of key principles (i.e. Every Child Matters outcomes), prioritising integration does not appear to have extended to the process of policy development itself. We spoke to professionals working with children who were unclear about which policies applied to them amongst the wealth of recent documents, and were unsure about how to integrate their varying guidance. People felt overwhelmed by the sheer number of initiatives and the speed with which they are being introduced. Most worryingly, a number of professionals were unaware of the existence of policies of direct relevance to their work – the Child Health Promotion Programme being the most notable example of this. Maybe this is an unavoidable consequence of the process of radically restructuring children's services; however confusion might be alleviated somewhat by a clear flow-chart of policy development and what is of key importance to different professionals and services.

136 Opinion Research Business poll 2000 *Young People's Lives in Britain Today*

Taking more of a bird's eye view towards Governmental policy, beyond the commendable attempts to integrate across children's services, there is what appears to be a deep fragmentation of policies and services that follows clear fault lines. These fault lines isolate people within their respective ages, ignoring both the connections between people, and between their present, past and future lives. We also received evidence suggesting that the separation of emotional health from physical health is not only an artificial divide but leads to higher health costs and negative effects on health care access and outcomes.[137]

Strong links between childhood well-being and future physical and mental health

The ACE studies (Adverse Childhood Experience studies[138]), involving 17,000 people across three generations, strongly indicate the benefits of enabling more parents to meet effectively their children's emotional and relational needs in the early years. The essence of these studies has been to match retrospectively, approximately a half century later, an individual's current state of health and well-being with the quantity of adverse events they experienced in childhood, what is termed their ACE score. These adverse events clustered around three core categories of abuse, household dysfunction and neglect.

Very simply, adults suffering from depression and struggling with addictions tended to have a high ACE score. The study concluded that if we are able to address adverse childhood experiences, prevent them where possible and offer healing relational experiences to children where it is not, the overall emotional health of society would improve dramatically. Felitti et al[139] (2003) looked at population attributable risk. They estimated that if we could successfully prevent or treat adverse childhood experiences, it could reduce societal ills to the following degree:

- 50 per cent less drug abuse
- 65 per cent less alcoholism
- 54 per cent less depression
- 78 per cent less intravenous drug abuse
- 67 per cent fewer suicide attempts

137 Levant R Heldring M (2007) 'Commentary: Health care for the whole person' *Professional Psychology: Research and Practice* 38 276-277

138 Felitti V et al (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study' *American Journal of Preventative Medicine* 14 245-258

139 Felitti V et al (2003) 'The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900' *Preventative Medicine* 37 268-77

To illustrate, mental health services are usually artificially demarcated into child and adult, reducing the potential for holistic assessment and intervention. Yet this holistic approach is most likely to reflect the nature of the problem; for example, the presence of mental health problems in adult family members profoundly impacts upon a child's development and well-being. There are some departures from this general pattern of service delivery; for example, the Parent Infant Mental Health and Perinatal Care Services in North East London NHS Foundation Trust are services aiming to provide a secure network of support around families with young children, facilitating a close bond between infant and parent. However, these 'family-centred' services are the exception rather than the rule. A political and cultural shift is needed to bring about workable, holistic services on the ground.

However, policies that are family-, rather than either child- or adult-focussed, go beyond implementing integrated services. Focusing on the interconnections between people would lead to all areas of policy recognising and adapting to the needs of the populations beyond the immediate group in question. This way, all areas of policy relevant to a child's well-being ranging from that regarding adult substance misuse services, to marriage services, to human fertilisation actually become supportive of a child's well-being.

2.3.7. EMPHASIS OF POLICY IS TO BE REACTIVE TO PROBLEMS RATHER THAN PREVENTATIVE

Turning to the connections between people's present, past and future lives, much of current policy focuses on responding to problem behaviours as they emerge in a person's life, rather than considering and intervening with the root causes appearing at a much earlier life stage. Despite all that we know about the impact of childhood experiences on later criminal behaviour and health problems (physical and psychological), the costs below suggest that the Government places most weight on responding to these happenings, rather than on preventing them. This approach shows no signs of abating; a further measure in the Children's Plan is to spend £20 million on combating antisocial behaviour through Acceptable Behaviour Contracts,[140] despite these epitomising a reactive, punishment-based response that has no evidence of efficacy.

Current UK costings relevant to early years intervention

Children's Healthcare	3 billion
Children's Services	<3 billion
Criminal Justice for under 25's	>6 billion
Criminal Justice overall	>22 billion
NHS	>76 billion

(Royal College of Paediatrics and Child Health, 2007)

140 See Section 6.2 in DCSF 2007 *The Children's Plan: Building brighter futures* London: DCSF

By way of example, research has shown how some of the root causes of anti-social behaviour can be seen in four year olds. In a study by Troy and Sroufe,[141] children were observed playing together in pairs. The children who were securely attached (meaning they had received emotionally attuned responsiveness from parental figures) brought an enjoyment and an enthusiasm to the exchanges. They were attractive play partners and empathy was very characteristic of the time they spent together. In contrast, in a pairing of an insecurely attached child with an insecurely attached child, there was bullying, victimisation, repeated rejections, verbal and physical abuse. To indicate the typical behaviour of these pairing the authors write, 'In one interaction L hit N in the stomach immediately after N indicated that her stomach was sore, and when N cried out in pain, L, with a smile on her faced, poked N again.'

Alternatively, an overarching strategy that truly recognised the links between people's experiences and well-being over their life course could enable each policy initiative designed to tackle a social problem to include a preventative dimension. This might, for example, mean obesity, antisocial behaviour, smoking and adult mental health policy and legislation all providing guidance and resources on the promotion of enriching relationships in the early years. This would be an effective implementation of the maxim 'tough on crime, tough on the causes of crime', as well as being tough on the causes of suffering in our society today.

It is not true to say the Government has ignored the principles of prevention altogether. Indeed, the five Every Child Matters outcomes are described as being preventative – the idea is that if these outcomes can be achieved, difficulties will be avoided. The prevention of children growing up in poverty and/or remaining in it for the long-term provides the impetus for much Government strategy; for example, the provision of accessible, affordable childcare is designed to increase both parental income and children's readiness for school, which both in turn reduce disadvantage. Similarly, policy guidance on breastfeeding has in mind the prevention of obesity. The major caveat however is that these preventative efforts are, for the most part, not focused on improving relationships - arguably the most effective focus for prevention. Moreover, when relationships are considered, prevention is largely focused on socioeconomically disadvantaged groups (who are by no means the only population requiring relational help) and is not focused on early relationships. In other words, it is not prevention in the purest sense of the word. Being early years, relationally focused is being preventative.

141 Troy M, Sroufe L A (1987) 'Victimization among preschoolers: Role of attachment relationship history' *Journal of the American Academy of Child and Adolescent Psychiatry* 26 166-172

2.3.8. THERE IS NO MANDATE, CLEAR FOCUS OR COHERENT STRATEGY FOR PREVENTION

The scarcity of relationship-focussed prevention may be in part due to a) insufficient political thinking around prevention in general and b) policy makers being ill-informed about the wealth of scientific, medical and psychological research on the long term effects of parent- child interaction on the brain, for better or worse (see Chapter 1). Policy makers are unaware of the evidence on root causes, and lack a clear developmental model. Instead the behaviour at hand becomes the sole focus of attention. The urgent crowds out the important, as is the case with knife crime as this report was going to print. Whatever the reason, the time is now ripe for political strategy to be driven by the truth that prevention is better than cure.

2.4. Trends 'on-the-ground'

2.4.1. TRENDS IN HEALTH VISITING.

What does all this policy translate to in the experience of families on the ground? The health visiting service appears to be increasingly targeted at those families perceived to be 'vulnerable'; this usually translates to the socio-economically disadvantaged. The flipside is a dwindling universal health visiting service. The Family and Parenting Institute recently reported that health visitors were becoming an endangered species and that numbers are in 'free-fall' but their research showed that 76 per cent of parents want health visitors and 83 per cent would like home visits from health visitors.[142] This is felt to be most acutely the case in so-called 'privileged' areas. Although we are encouraged by the recent announcement that the Nurse-Family Partnership of Professor David Olds is being piloted in the UK (an approach testifying to the importance of early years prevention, showing massive reductions in later maltreatment, drug abuse, antisocial behaviour and other negative outcomes following health visiting early on[143]), we share the concern of organisations like the Family and Parenting Institute that such services are 'only for a tiny proportion of the population'.

Yet, supply is in no way mirroring demand. Our polling showed that health visitors are the most desired source of support for new parents, with 53 per cent of parents or expectant parents saying that health visitors should be more widely available to parents who experience relationship pressures. Seventy-two per cent of

142 Gimson S (2007) *Health visitors: An endangered species* London: Family and Parenting Institute

143 Olds D (2006) 'The nurse-family partnership: An evidence-based preventive intervention' *Infant Mental Health Journal* 27 5-25

adults polled were fairly confident or very confident that health visitors are competent and well-trained. In contrast only 28 per cent had that perception of Sure Start staff, 37 per cent of social workers and 53 per cent of childcare professionals. And if they were concerned about being able to cope with being a parent, 35 per cent would prefer to go to a health visitor for help, compared with 26 per cent preferring a GP, 3 per cent Sure Start staff and 3 per cent a social worker.

Regular home visits from health visitors in a child's early years for all families are what people consistently express a preference for. These visits provide a non-stigmatising means of gaining support and help with parent-child and broader family relationships. It is equally clear that targeting more vulnerable families for more intensive support is important. However, strangely enough, it is the universality of health visiting that allows for the effective targeting of services. It affords health visitors the opportunity to assess which families are *relationally* vulnerable, i.e. those families whose ways of relating may not be optimal for the young child's development, and who may benefit from support. This support might range from a single encouraging conversation with the health visitor to a parenting group or couples therapy. If these universal visits are also frequent, intervention can become truly preventative; support is offered in a timely fashion before problems become entrenched and when 'help' is far less stigmatizing to receive.

Prevention is cost effective

In fact in our hearings it was established that early preventative intervention can be extremely cost effective for society. For example, we heard that an organisation in Oxford called OXPIP (the Oxford Parent Infant Partnership, whose work has been evaluated and has proven effectiveness) can turn around a parent-infant relationship which is going wrong in just six to twelve sessions costing only £35 per session. They pointed out that if the alternative is that the child concerned ends up in local authority care, with the huge costs to the public purse (and to the emotional well-being of the child) this implies, this is just one area where intervention could result in significant savings. Yet due to funding constraints, less that 0.5 per cent of parents have access to what OXPIP does. We believe significant progress could be made if a model like this were developed across the country. In contrast, focusing initial health visits on economically poor families risks letting many families fall through the net of preventative help. As we have made clear, socioeconomic status and relationship health do not overlap sufficiently for one to be used as a proxy for the other. (Indeed, our hearings revealed that relationship problems can frequently cluster in areas of relative prosperity: one consultee cited the example of the high rates of domestic violence in middle class areas in Chelmsford, Essex.)

2.4.1.1. Health visitors need training in infants' relational and psychological needs

One of the key points from our hearings in relation to this was the need to train health visitors differently. It was generally agreed among our experts that health visitors now need to be trained in the relational and psychological needs of the infants just as much as they are in their physical needs. Universal frequent health visitor reviews paired with further specialist help for those with relational difficulties would not only be a more effective, accurate and preventative means of support, but might also help stem the reduction in numbers of health visitors. Consultees highlighted how health visitors frequently feel 'burnt-out' struggling with problems of poverty which they are unable to fix. Alternatively, universal services could permit health visitors a balanced workload and facilitate the learning of skills which are usefully employed across their caseload.

Although the Child Health Promotion Programme is a positive development in this regard, in that it recommends some degree of universal services in the first year, and between three and five years, it heavily falters in its lack of guidance on the health visitor training requirements necessary for its implementation (as mentioned above in relation to the necessary relational training). There is also little advice on how health visitors can manage caseloads and administration in order to fulfil all the requirements. Higher expectations are being put on the profession (and our recommendations for preventative work would make more) in a context where, as the recent report from the FPI says, 'numbers are in freefall.'[144] This is not least because some primary care trusts are cutting health visiting budgets. The report says that 'in January 2007 West Kent PCT agreed to cut ten whole time equivalent health visitors in the south of the Trust out of a total of 57. It was a compromise. The original proposal had been to cut 15. This was to help them make savings of £700,000.' All of these limitations in the CHPP risk it becoming a piece of policy guidance impossible to follow.

In summary, the state of health visiting services, described in more detail in Chapter 4, highlights how a sole focus on eradicating poverty can come at the expense of tackling the more insidious and prevalent problems of relational poverty.

2.4.2. TRENDS IN CHILDCARE

Recent childcare policy acknowledges that parents struggle to meet the often competing financial and nurturing needs of their family. *Choice for parents, the best start for children*[145] cites the Repeat Study of Parents' Demand

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144 Gimson S (2007) *Health visitors: An endangered species* London: Family and Parenting Institute

145 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO

indicating that on the one hand, 63 per cent of non-working mothers would prefer to do some work or study if they had access to good quality, convenient and affordable childcare, and, on the other, 63 per cent of working mothers wanted to work fewer hours, and 44 per cent said that they would like to give up work and stay at home with their children if they could afford it. The majority of recent policy focused on alleviating this struggle of competing demands is concerned with the provision of greater amounts of affordable statutory childcare. Whilst doing much to meet the needs of those parents who would like to work more hours and helping children of parents who would otherwise not be able to work to escape poverty, this prioritises non-parental care.

2.4.2.1. Policy focuses on state-provided, non-parental childcare

Without parallel policies that increase choice for those parents who would like to spend more time with their children or use other forms of care, choice is only increased for some, and many people are left feeling ever more pressurised to return to work. The broader message communicated by this lopsided policy is that a child's time with their parents is irrelevant to the child's well-being and healthy development.

Additionally, the Government's support for an increase in quality, affordable childcare is narrowly focused on the formal and subsidized state sector. This is at odds with women's preference for informal care, and this may be a reason for the low take-up of childcare places despite a rising birth rate. This is most noticeably the case in certain ethnic minority communities (for example, Pakistani and Bangladeshi) who are particularly keen on informal forms of care for their child.[146] However, there is no governmental support for this childcare (for example, close relatives are legally able to look after children but do not receive childcare tax credit), meaning that it may well become a rarity. This is despite the large majority of this care being excellent for children: they are most commonly spending time with a consistent caregiver who displays love and affection towards them. This not only promotes healthy social and emotional development, but strengthens a bond with wider family or community members that can be a source of support throughout childhood and beyond.

In our polling 88% of parents or expectant parents thought that more should be done to help parents who wish to stay at home and bring up their children in the early years (and 97% of those agree that the Government should do more in this area). In the later poll of all adults, 82% agreed or strongly agreed with this.

67% of parents and nearly 70% of adults expressing an opinion agreed that parents are encouraged to put their children into daycare and return to work too early.

Almost a third of all parents stated that they did not feel that they have been, or are able to spend enough 'quality time' with their children when they were or are very young.

YouGov poll (2008)

146 Aston J, Hooker H, Page R, Willison R (2007) *Pakistani and Bangladeshi women's attitudes to work and family: DWP Research Report no. 458* London: DSF: TSO

The support of state-provided childcare over other forms is also undermining the viability of private, voluntary and independent childcare provision. Representatives of these nurseries described the pressures on them generated by a large increase in state childcare places which was often introduced without a rigorous audit of local demand. State provision is subsidized so existing local nurseries, obliged to charge full costs for childcare, are placed at such a disadvantage that their rolls often fall below sustainable limits and they are forced to close.

2.4.2.2. Childcare supports parents' aspirations for work but not for good relationships

Childcare is promoted without concomitant clear messages, principles and appropriate training to prioritise the healthy social and emotional development of the child. In fact childcare can be used in a fashion that is to the detriment of the child's long-term well-being. It may be used for increasingly longer periods of time by parents which research indicates can increase problem behaviour – a finding that was echoed in our consultations as Chapter 4 details.

Secondly, without clear routes to parenting and relationship help for families, childcare is in danger of being used as a 'solution' to parenting struggles. Using childcare as a 'bandage' may serve to hide difficulties that could otherwise be remedied before they become an entrenched part of family life.

The absence of a clear framework focusing on the relational and emotional well-being of the child is also impacting on the quality of the care provided. Experts referred us to the missing components of training for early years workers. Staff are not provided with an understanding of the nature and

One Surestart primary nurse commented in *Breakthrough Britain*: 'We can tell which children do long hours in the centre because their behaviour gets worse and worse throughout the day. 'Dry' children sometimes wet themselves three times in half an hour, they just become permanently tired and really should be at home.'

We also quoted research[147] which indicates that if a child is not securely attached to a primary carer when he or she enters a nursery, say at one year old, then the stress of entering such a setting can send cortisol (stress hormone) levels soaring much higher than if he or she were securely attached. This must be considered when children are being placed in nurseries to 'make good' parenting deficits.

147 Ahnert L, Lamb M E (2003) 'Shared care: Establishing a balance between home and child care settings' *Child Development* 74 1044-1049

importance of attachment, nurturing relationships and emotionally attuned responsiveness, or helped in developing the skills to promote them. Instead, we heard that in many areas poor training has led to high levels of staff demoralisation.

When staff and managers *at all levels* of early years childcare provision lack the basic understanding of the relational needs of young children at different developmental stages, other concerns take precedence and children lose out on the nurture they need. Julian Grenier, headteacher of Kate Greenaway Nursery School and Children's Centre, highlighted to us the fact that many childcare workers avoid touching infants for fear of being 'unprofessional', despite the clear benefits bound up with nurturing touch. We heard that there is a focus on auditing and paperwork in place of spending the time a child needs with a consistent caregiver. Sound relationally-based care demands an emotionally attuned caregiver, and this requires not only adequate training, but also the space to reflect on one's practice and to be supported – currently a rarity in early years childcare. If the right framework is in place, childcare could be transformed in a multitude of ways to help children on their way to finding a positive life trajectory.

Anecdotal quote obtained by the Commission from a teaching assistant in a Sussex school: 'I couldn't carry on going in to work and seeing child A back and worse than before. CAMHS had sent him back, they couldn't do anything, his mum wouldn't take him, she was too sad and beaten. His dad was a smack head. He won't talk now...at all. Nearly a third of the school was in special measures and they just cut the funds for the counsellor. I had palpitations and panic attacks, I wasn't alone. I just had to start thinking about myself and my own child.'

2.4.3. TRENDS IN CAMHS AND SOCIAL SERVICES

Despite ongoing reviews of Child and Adolescent Mental Health Services (CAMHS) leading to some significant improvements to services, such as the wider provision of outreach and 24 hour services, CAMHS appear to be considerably held back in improving the mental health of children due to the absence of a preventative framework driving service delivery. Professionals from both CAMHS and their referring services speak about the elevated degree of mental health or behavioural problems required in order for children to receive a service.

2.4.3.1. Children only get help when problems are full-blown

At the moment there are 30,000 children on the CAMHS waiting lists.[148] This is completely incongruous with the cost-effective principles of prevention. Not only is a preventative approach not mandated, the high referral criteria mean that essentially it is actively dissuaded. This is most acutely seen with reference to the early years: given that children of this age do not typically present with the greatest difficulties, they are mostly absent from CAMHS caseloads. Early,

148 British Medical Association Board of Science (2006) *Child and Adolescent Mental Health – A guide for healthcare professionals* London: BMA

often relational, indicators of difficulties are purposefully left to emerge into full blown problems at a later stage of development. Additionally the lack of integration with services for people of other ages means that even if prevention was prioritised, the focus of prevention would be constrained to a child-centred rather than family-centred level of intervention (excluding some notable exceptions of integrated services).

We found that similar problems plague Local Authority Children's Services. Social workers described the priority given to safeguarding rather than preventing the need for safeguarding in the first place. Attempting to intervene with a full-blown family problem was felt to be much more difficult than with one at an earlier stage, not simply because it was more entrenched and harmful, but also because of the high levels of defensiveness intervention at this stage frequently provoked. Interventions are lost in the overriding message they convey that the family in question is a 'problem'.

2.5. Conclusion

To summarise, there is much to commend in recent children's policy. The Government have taken steps to improve safeguarding, communication, and service accessibility. They have brought in measures that have the aim of reducing unacceptable levels of childhood poverty and educational underachievement. However, these economic and academic concerns trump relational ones, despite the latter arguably playing the most crucial part in a child, and later adult's, well-being, as the description of infant brain development in the last chapter made clear. The omission of relationships and underlying causes from an overarching policy framework can be seen within current childcare, health visiting, CAMHS and social services practices, among others. Not only does children's policy miss the importance of relationships, but political thinking in general misses the relevance of high levels of relational stress and relational poverty in the early years as being key underlying factors for a whole host of social problems we face today. As long as policy continues to marginalise relationships in the early years and marginalise the early years in other policy areas (and respond to the fallout from this in a fragmented fashion) there will be no lasting improvement to the biopsychosocial problems faced by both children and adults in our society.

CHAPTER THREE

Why some parents struggle to give their infants the relational experiences they need for long-term emotional health

3.1. Introduction

In the first chapter we described what needs to happen in the first three years of a child's life to help her or him grow into a well-functioning individual. We emphasised the importance of good relationships between parents and infants, what can happen when these are lacking and the implications for the intergenerational transmission of disadvantage. This chapter will look at the various reasons why too many infants in the UK may not be getting the relational experiences they need and these can be separated into the following five areas:

- Lack of knowledge about the importance of relationships between parents and children
- Perinatal issues
- Relational issues between parents
- Family dysfunction
- Challenges faced by teenage parents
- Financial issues

3.2. Lack of knowledge about the importance of the interactions between parents and children

A vast (and continually growing) neuroscientific and psychological evidence base exists about the importance of positive relationships between parents and infants in the early years and of family bonds overall. Yet there remains a gap between this wealth of knowledge, what many parents (and society in general) appear to understand about what this information means for the long-term emotional, social and physical well-being of both individuals and society, and its actual transfer into the day-to-day care of babies and very young children. There is a great deal of

advice for parents through the media, varied ante-natal and/or parenting classes, and from 'parenting gurus'. However, the information underpinning such advice can focus on behavioural change or establishing certain behaviours in the baby rather than taking the baby's needs for nurturing care as the starting point.

Through a lack of knowledge and understanding of the basic principles of neuroscientific and attachment theory, parents may be unaware of the risk of harm to the developing brain and future mental health[149] associated with constantly leaving a child to cry for prolonged periods when they are in genuine distress and have no established expectation that comfort will be available. (Systematic neglect like this is very different to leaving a tired baby to cry for a relatively short period at some point, usually the end, of an emotionally rewarding day where comfort is the norm.) It is not the place in this document to be prescriptive about child rearing practices, but to point to what the research says about marked and profound lack of nurture.

> YouGov polling showed that 92% of adults agree or strongly agree that the relationships we have with our parents while we are still babies and toddlers can strongly influence future aspects of our lives (the same percentage of parents agreed or strongly agreed when asked this in the earlier poll).
>
> YouGov poll (2008)

Parents can fall back on their own experiences of being parented. For the many who had caring, nurturing experiences themselves or who have been able to reflect on their experiences in terms of the needs of the baby, this 'fall back' is positive, especially if supported by knowledgeable and well-trained professionals such as health visitors as identified in our polling. In other circumstances however, where parents have had stressful, emotionally impoverished and/or abusive childhoods and who remain caught up in their own emotional distress, problematic parenting can occur.

Lack of knowledge and understanding of the needs of human babies, can lead to inappropriate expectations of the child's capabilities in either direction, i.e. parents may think that it is unnecessary to talk directly to a baby as the baby does not yet 'speak'. Conversely, parents may be too intolerant of behaviours which are developmentally typical for their children's age, such as tendencies not to sit still, to clamber onto furniture or not to share. This can lead to children being thought of as 'naughty' and an unduly punitive stance adopted.

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149 Bugental D, Martorella G, Barrazaa V (2003) 'The hormonal costs of subtle forms of infant maltreatment' *Hormones and Behavior* 41 237-244; Bergman N, Anderson G, Moore E, Hepworth, J (2003) 'Early skin–to-skin contact for mothers and their healthy newborn infants' *Birth* 30 206-207; Gunnar M, Donzella B (2002) 'Social regulation of the cortisol levels in early human development' *Psychoneuroendocrinology* 27 199-220; Gunnar M, Fisher P (2006) 'The Early Experience, Stress and Prevention Network: Bringing basic research on early experience and stress neurobiology to bear on preventive interventions for neglected and maltreated children' *Development and Psychopathology* 18 651-677

3.2.1. POTENTIAL EFFECTS ON CHILDREN WHEN EMOTIONAL NEEDS ARE NOT UNDERSTOOD – LESS THAN OPTIMAL BRAIN DEVELOPMENT AND LONG-TERM RELATIONAL DIFFICULTIES

Example 1: Placing a child in daycare where there is a deficit of one-to-one attention can be stressful for babies and infants. Research indicates that prolonged uncomforted stress or distress over a significant duration can have adverse effects on the child's developing brain.[150]

Example 2: The 30 year longitudinal Minnesota study[151] studied the mental health of infants from birth into adulthood. One of the biggest factors contributing to long-term insecure attachment, meaning a troubled or tormented relationship life, was when parents had no real psychological understanding of the infant's developmental needs.

Example 3: During the first two to three months of life the optimal relationship between mother and child is characterised by an intimate interchange of responses. If however, a mother does not realise the importance of such dialogue or is unable to respond to the baby in such a way because of her own difficulties, a pattern of emotional withdrawal can develop where the baby avoids eye contact, does not engage in vocal dialogue and does not know how to use social contact. Without effective intervention the infant's relational life becomes impoverished.[152]

3.3. Perinatal Issues

Stress in pregnancy can affect the mother's ability to meet the relational needs of her baby. Chronic levels of stress in the last three months of pregnancy can result in the transmission of excessively high levels of stress chemicals (glutamate and cortisol) through the placenta into the brain and body of the unborn baby.[153] Newborns of depressed mothers then show a biochemical/physiological profile that mimics their mothers' prenatal biochemical/physiological profile. This means that the baby is born highly stressed and may be particularly 'fractious', difficult to soothe, feed and settle. Stressed babies may also not be curious or 'playful'. This can result in the mother and baby moving into a downward spiral of stress. Often a lack of rewarding contact ensues as the mother is also influenced in her reactions by the unresponsiveness or perceived difficulty of her child.[154]

150 Teicher M, Anderson S, Polcari A (2002) 'Developmental neurobiology of childhood stress and trauma' *The Psychiatric Clinics of North America* 25 297-426; Brunson K et al (2001) 'Long term, progressive hippocampal cell loss and dysfunction induced by early life administration of corticotropin-releasing hormone reproduce the effects of early life status' *Proceedings of the National Academy of Sciences of the United States of America* 98 8856-8861; De Bellis M et al (2002) 'Brain structures in pediatric maltreatment-related posttraumatic stress disorder: A sociodemographically matched study' *Biological psychiatry* 52 1066-1078; Fumagalli F, Molteni R, Racagni G, Riva M (2007) 'Stress during development: Impact on neuroplasticity and relevance to psychopathology' *Progress in neurobiology* 81 197-217; Preston S, de Waal F (2002) 'Empathy: Its ultimate and proximate bases' *The Behavioral and Brain Sciences* 25 1-20; discussion 20-71

151 Sroufe L, Egeland B, Carlson EA, Collins W (2005) *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood* London: Guildford Press

152 Lier L (1988) 'Mother-infant relationship in the first year of life' *Acta psychiatrica Scandinavica. Supplementum* 344 31-42

153 Field T, Diego M, Hernandez-Reif M (2006) 'Prenatal depression effects on the fetus and newborn: a review' *Infant Behavior & Development* 29 445-455

154 Field T et al (2002) 'Prenatal anger effects on the fetus and neonate' *Journal of obstetrics and gynaecology* 22 260-266

- Increased levels of maternal prenatal stress appear to be associated with temperamental and behavioural problems in toddlers[155]
- Maternal prenatal stress has been found to be related to hypersensitive stress response systems in the brain which are still affecting infants on their first day at school[156]
- Research from studies with other mammals shows that high levels of stress during pregnancy is one of the risk factors for depression and vulnerability to drug use in the child's later life[157]

We received many submissions to the effect that well-trained midwives and health visitors would be particularly well placed to support mothers, their partners and/or family as the next chapter details. They could provide advice and information to help parents understand the special needs of their baby in these circumstances, thereby alleviating the general distress which can occur when a baby is seen as 'difficult' or overly demanding or unresponsive.

3.3.1. PREMATURE BABIES OFTEN HAVE UNMET RELATIONAL NEEDS

We were told at our hearings that although just under 2 per cent of babies are premature, many in this country are not getting the relational experiences they need to ensure that they are given the optimum chance to thrive in later life. It has long been assumed that premature babies are not at a stage of needing human interaction. Yet Colwyn Trevarthen has demonstrated, on film, a premature baby communicating in a four second speak-response exchange with her father. Research also shows that premature babies are vulnerable to falling behind at school in later childhood and adolescence.[158] In addition, the importance of carers' interaction with such premature babies has been identified by a range of research.[159] These studies particularly identified the benefits of contact via appropriate levels of touch for these babies, for example:

155 Gutteling B et al (2005) 'The effects of prenatal stress on temperament and problem behavior of 27-month-old toddlers' *European Child & Adolescent Psychiatry* 14 41-45.

156 Gutteling B, de Weerth C, Buitelaar J (2005) 'Prenatal stress and children's cortisol reaction to the first day of school' *Psychoneuroendocrinology* 30 541-549

157 Deminiere J et al (1992) 'Increased locomotor response to novelty and propensity to intravenous amphetamine self-administration in adult offspring of stressed mothers' *Brain Research* 586 135-139

158 Jennische M, Sedin G (2006) 'School level at 10 years of age in children who required neonatal intensive care in 1980-1989' *Acta Paediatrica* 95 1586-1593

159 Vickers A et al (2000) 'Massage for promoting growth and development of preterm and/or low birth-weight infants' *Cochrane Database of Systematic Reviews* 2; Feijo L et al (2006) 'Mothers' depressed mood and anxiety levels are reduced after massaging their preterm infants' *Infant behavior & development* 29 476-80; Feldman R et al (2002) 'Comparison of skin-to-skin (kangaroo) and traditional care: parenting outcomes and preterm infant development' *Pediatrics* 110 16-26.

- Babies experiencing appropriate (i.e. very gentle) touch were less fussy, cried less, had lower stress levels, were more easily soothed and were calmer with better muscle tone and less agitated movements
- Mothers who held their babies, rather than left them in the incubator, were less depressed and were more able to respond to their babies during the hospitalisation period
- Parents who had held their babies, rather than left them in the incubator, were more sensitive, adaptive, warm, and resourceful during social interactions at six months
- Infants who had received physical holding were more socially alert than the incubator premature babies and their Bayley developmental scores[160] at six months were higher in the mental and motor domains.
- Early maternal touch had an impact on psychomotor skills six months later

Unfortunately, there are only a few hospitals in the UK which have taken on board this research. For example, St Mary's Hospital, London (Neonatal Intensive Care Unit) employs a neonatal parent-infant interaction co-ordinator who teaches all nurses to enable parents to communicate with their premature babies and use the right, very gentle form of touch. (The wrong form can distress the infant.) St Mary's offers the only training centre in the UK for Newborn Individualistic Developmental Care and Assessment Programme (NIDCAP) – originally an American based-initiative. This is a highly collaborative approach between the staff and parents who are also helped and supported through the difficulties of caring for such vulnerable infants.

Evidence we received from Cherry Bond, a neonatal intensive care specialist nurse, suggested that such a programme would be highly beneficial across all premature baby units and that training in the needs of premature babies should be incorporated at a general level for all professionals working in the early years to raise awareness. More specific training could be offered nationally for health visitors as part of their continuing professional development.

Parents also need support once the baby is home and, again, appropriately trained health visitors could provide a crucial role here. In addition, the greater use of technology and survival rates for very premature infants means that there are implications for all practitioners working in the early years which again highlight the need for ongoing reviews of current training across the early years professions.

160 Bayley Developmental Scales measure the mental and motor development and test the behaviour of infants from one to forty-two months of age. The Scales may be used to describe the current developmental functioning of infants and to assist in diagnosis and treatment planning for infants with developmental delays or disabilities.

Premature babies pose highly complex problems for both clinicians and parents and can place enormous pressure on the mental health of parents. Research by Dr Amanda Jones, a leading parent-infant psychotherapist and Head of Parent-Infant Mental Health Services, North East London Mental Health Trust, suggests that mothers of 'prems' are at particular risk from postnatal depression. Charlotte Savins, an Arts Psychotherapist at the Royal Alexandra Children's Hospital in Brighton described the constant state of fear and depression which can pertain when children are born too early, especially when this leads to them being disabled. Insecure attachment can result (which may have been exacerbated by the level of technology often needed to support life at this early stage) potentially leading to future personality and mood disorders and other psychological problems.

The appearance of premature babies can be highly alarming to many parents and the total needs of the 'pair' (the mother and child) involved, need to be taken into account. Cherry Bond told us that the environment of many premature babies' wards has the capacity to cause psychological damage: harsh lighting and the constant noise from the complex technology used to keep premature babies breathing can cause eye problems and stress.

She described other countries, such as Sweden, where parents are helped and encouraged to 'read' their premature babies, to understand their needs and, for example, how to touch them in a very careful way, when even their first instinct might be that their baby is too delicate to be touched. A lack of touch and basic attunement with the needs of the child can seriously hamper the bonding process between a baby and her or his carer which can have a dramatic impact on the child's mental and emotional future. She challenged the current imperative to hit targets and get people 'through the system' and discharged because this does not ensure the best care, the lack of which can lead to later problems both for children's and parents' well-being.

Models of good practice also include the Trevor Mann Baby Unit in Brighton. Here Dr Ramon Fernandez told us about his research which shows a) that pre-terms stand a better chance of survival if their brains are not damaged by the experience of being repeatedly subjected to pain and b) the benefits of non-invasive procedures for testing such babies for infection and organ damage. Premature babies suffer regular 'pricking' as their blood is tested continually for potential infection: this can lead to neuron damage from pain. Awareness of potential neurological damage due to stress and pain has driven the development of new technology in the Unit; this aims to reduce the very high number of intrusive procedures which every premature baby has to go through in order for survival.

3.3.2. POSTNATAL DEPRESSION (PND) CAN HAVE LONG-TERM EFFECTS ON BABIES

A Royal College of Midwives survey suggests that around 20 per cent of women suffer from postnatal depression. For many this markedly interferes with their ability to relate in warm, playful and empathic ways with their child, as they are struggling to cope with their own emotions. Professor Lynne Murray gave evidence to the Commission and her groundbreaking research shows a number of worrying findings. For example, girls who had postnatally depressed mothers were still showing high levels of stress hormones at age 13.[161] This means a marked vulnerability to developing depressive and anxiety disorders, and to perceiving the world as threatening and difficult. Boys too potentially showed greater vulnerability than girls in later cognitive development especially if from lower socio-economic groups. Given these long-term effects, the necessity for early detection of both pre and postnatal depression is great.

Dr Amanda Jones suggests that PND should be seen as an umbrella term for a very wide variety of symptoms and problems which can already exist and are exacerbated by the fear and stress sometimes associated with birth. Dr Jones described mums' conflicting feelings during the perinatal period: many mums can feel as if they hate their baby and also feel hated by their baby (known as 'malignant transference and projection').

Resentment towards postnatally depressed mothers makes it harder for them to admit to problems. Even professionals can experience such negative feelings towards mothers in their care. Dr Amanda Jones admitted that it had taken her three sessions to overcome her resentment with a particular mum who hated her baby. For all of the above reasons she stresses that policy in this area should take into account that:

- Therapy for the mother and baby may need to be long-term
- Special consideration needs to be given to families with premature babies
- GP services need to start liaising with neonatal and psychiatric services
- Psychological knowledge and training needs to be implemented in neonatal units

Awareness of the prevalence of postnatal depression is high according to our polling. When asked what percentage of new mothers do you think suffer from post-natal depression (rather than just the 'baby blues'), 81% of parents or expectant parents thought it was more than 1 in 10 of the population, and more than a quarter said they thought it was more than 1 in 4.

YouGov poll (2008)

161 Murray L et al (2006) 'Socioemotional development in adolescents at risk for depression: The role of maternal depression and attachment style' *Psychopathology* 18 489-516

- Partner choice and involvement is paramount, the father can be decisive in overcoming PND and helping with bonding and attachment
- Relationship help for couples planning pregnancy is imperative

3.4. Relational issues between parents

3.4.1. PARENTAL CONFLICT TENDS TO INCREASE AFTER CHILDBIRTH AND, IF SEVERE, AFFECTS INFANTS' DEVELOPMENT

While many couples believe that having a baby will bring them closer together, most research suggests that couples become less satisfied with their relationship after having children.[162] Positive interactions between spouses have been shown to decrease after the birth of a child[163] while levels of conflict increase.[164, 165]

Marital and parental conflict has been associated with an array of adjustment problems in children, for instance poor peer interaction, conduct problems, ill health, depression and anxiety, low self-esteem, eating problems and poor attachment. Marital conflict that is 'intense, frequent and child-related' leaves infants feeling fearful and emotionally dysregulated.[166] Lack of resolution can be associated with further distress. The combination of hostility and detachment in parental communication is thought to be the most destructive form of parental conflict and associated with maladjustment in many areas of the family.

Due to their lack of psychological defences, infants tend to be acutely sensitive to parental conflict but are unable, because of their limited ability, to understand and manage strong emotions. As a result they often express their distress through challenging behaviour. They may then get punished for this and so a downward spiral of more distress and misconnection ensues.

Similarly parents in conflict are often unable to work cooperatively together to parent the child, especially in the area of setting limits. This can result in conflicting messages being given to the child about their behaviour. The child can then appear difficult or divisive, and conflict with the child then becomes part of the parental conflict. Such additional stress can lead to the parents being further

162 Belsky J, Pensky E (1988) 'Marital change across the transition to parenthood' *Marriage and Family Review* 12 133-156

163 Spanier G, Rovine M, Belsky J (1983) 'Stability and change in marriage across the transition to parenthood' *Journal of Marriage and the Family* 42 825-839

164 Cowan P, Cowan C (2000) *When partners become parents: The big life change for couples.* Mahwah, NJ: Erlbaum.

165 One Plus One Marriage and Partnership Research information sheet, *The transition to parenthood – the 'magic moment'* (for references and additional material see http://www. oneplusone.org.uk/ Publications/InformationSheets/TheTransitionToParenthood.pdf accessed 24/7/08)

166 Katz L, Woodin E (2002) 'Hostility, Hostile Detachment, and Conflict Engagement in Marriages: Effects on Child and Family Functioning' *Child Development* 73 636-652

unable to manage their own emotions and behaviour both with the child and with each other. In the midst of this turmoil, the stress levels in the child increase, with a prolonged and toxic effect on an infant's developing brain.

We mentioned earlier that whilst the mother and child 'pair' is an obvious place to focus attention in the very earliest stages of a child's life, the role of the father cannot be neglected. Professionals working with mothers who are struggling with mental health issues whilst trying to do the very best for their young children (and are therefore at a distinct disadvantage), emphasised the importance of partner choice from the outset. A supportive father can be a key source of help with bonding and attachment and of paramount importance in overcoming PND. Therefore *Breakthrough Britain* emphasized ensuring that couples have access to services which can help them form strong bonds with each other before they have to cope with the stressors of child rearing (see Chapter 5 for a reiteration of those recommendations).

Infants' 'Triangular Skills':

Fivaz-Depeursinge and colleagues have developed the Lausanne Trilogue technique for looking at triadic interactions between infants and both parents. They have shown that by 12 weeks some infants are responding not just to their interactions with their mother or father, but to what is going on between their mother and father. Hence parents who are out of 'sync' with each other are reflected in the infant's behaviour. In some cases, the infant's responses will map onto some combination of the parents' behaviours, so the infant will perhaps be taking a go-between role and trying to regulate the parents' behaviours even at this young age.[167]

3.4.2. DOMESTIC AND FAMILY VIOLENCE AFFECTS CHILDREN'S DEVELOPMENT

Domestic violence, i.e. between adult partners often begins or increases in pregnancy. In a time of generally heightened emotions there are often significantly higher levels of stress, which can spill over into violence far more often than is commonly appreciated.

Babies begin to feel a pain-like response at 20 weeks gestation. Dr Amanda Jones points out that assaults on pregnant mothers mean that a foetus will

167 Fivaz-Depeursinge E, Frascarolo F, Corboz-Warnery A (1996) 'Assessing the triadic alliance between fathers, mothers, and infants at play' *New Directions for Child Development* 74 27-44

possibly not only be physically hurt but also neurologically, which can lead to future behavioural and emotional problems. Infants who have heard or witnessed domestic violence often develop post-traumatic stress disorder.[168] They are often then wrongly diagnosed as having attention deficit hyperactivity disorder (ADHD), which can have similar symptomatology.

According to the United Nations Secretary General Study on Violence against Children, between 240,000 and 963,000 children are exposed to domestic violence in the UK per annum.

It must also be remembered when considering interventions that the victim of domestic violence may be unable to be protective or caring towards the children and so they have a double burden of being witness to frightening emotional and physical behavior and of not being emotionally or physically protected. Children are also affected on a psychological, physical and neurological level by abuse and violence towards them or by witnessing verbal abuse or violence towards siblings or an elderly relative, neighbours and in their wider community.[169] Browne and Herbert[170] state that 42 per cent of murder or manslaughter cases involve a domestic dispute and one third of domestic victims are children. The effect on the developing child is profound and indicators show a rise across depression and anxiety disorders, personality disorders, psychosis, addictions, violence and anger, and eating disorders. Younger children can also become the victims of older siblings who may already have established patterns of violence triggered by of their own experiences.

Unfortunately for infants and very young children exposed to domestic violence, significant aggression may become part of their own repertoire and appearing to be a stable character traits, once established. For this reason preventative work and early intervention is crucial for infants in such families. Work with the perpetrator however is just as important as for the victims so that the perpetrators do not move onto new relationships to perpetuate the cycle still further. Harsh physical discipline can also be included in the concept of family violence and yet be condoned by generational family 'values' and cultural norms.

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168 Fehon D, Grilo C, Lipschitz D (2005) 'A comparison of adolescent inpatients with and without a history of violence perpetration: impulsivity, PTSD, and violence risk' *Journal of nervous and mental disease* 193 405-411

169 Teicher M, Glod C, Surrey J, Swett C Jr (1993) 'Early childhood abuse and limbic system ratings in adult psychiatric conditions' *Journal of Neuropsychiatry and Clinical Neuroscience* 5 301-306; Teicher M et al (1997) 'Preliminary evidence for abnormal cortical development in physically and sexually abused children using EEG coherence and MRI' *Annals of the New York Academy of Sciences* 821: 160-175; Teicher M et al (2006) 'Sticks, stones, and hurtful words: relative effects of various forms of childhood maltreatment' *The American Journal of Psychiatry* 163 993-1000; Teicher M (2008) *The Neurosciencce of Neglect and Abuse*, London: The Centre for Child Mental Health, May; Teicher M, Anderson S, Polcari A (2002) 'Developmental neurobiology of childhood stress and trauma' *The Psychiatric Clinics of North America* 25 297-426

170 Browne K, Herbert M (1997) *Preventing Family Violence* Chichester: Wiley

We talked with key members of the domestic violence lobby, whilst consulting for *Breakthrough Britain* and this Commission. Notably, Diana Barran who heads the organisation, Coordinated Action Against Domestic Abuse (CAADA), emphasized the need for interagency working. CAADA has pioneered the Multi-Agency Risk Assessment Conference (or MARAC) which brings together as many as fifteen agencies around the table with the key aim of making victims and their children safe. Nationally MARACs have been used to review 12,000 cases, involving 17,000 children.

3.4.3. SEPARATION AND DIVORCE CAN IMPACT INFANT AND FUTURE MENTAL HEALTH

Some statistics:

- In our polling, 96 per cent of adults said they thought the relationship between a child's mother and father when they are under three was very important or fairly important in the child's later development[171]
- 'If you have experienced family breakdown, you are 75 per cent more likely to fail at school, 70 per cent more likely to become a drug addict and 50 per cent more likely to have alcohol problems. There is also an overrepresentation in teen pregnancy statistics of girls from broken homes.'[172]
- 'A tiny percentage of government money is spent on preventing family breakdown compared with its cost to society. Instead funding is focused on dealing with the effect of broken lives.'[173]
- Severe depression is three times higher among women and nine times higher among men who have been separated or divorced compared to stably married and single men and women[174].
- 89 per cent of securely attached one-year-olds show insecure attachment at 18 if they are from divorced families.[175]

Divorce and separation are among the most stressful life events a person can experience. This is often the case both for the person who sought the separation and for the person who was 'separated from' and whether the situation was expected or not. Although the initiating spouse often experiences a great deal of relief when the marriage is legally terminated, they might have been mourning the end of the marriage whilst it was still legally and physically

171 YouGov poll of 2337 adults, (11-15 July 2008)

172 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice

173 *ibid*

174 Bruce M, Kim M (1992) 'Differences in the effects of divorce on major depression in men and women' *American Journal of Psychiatry* 149 914-917

175 Lewis M, Feiring C, Rosenthal S (2000) Attachment over time *Child Development* 71 707-720

> Studies allow us to reach several conclusions about the consequences of divorce for adults and children. First, we know that adults and children from divorced families, as a group, score lower than their counterparts in married-couple families on a variety of indicators of well-being. Second, although selection can account for some of these differences, the evidence is strong that divorce has an impact on well-being net of selection. Third, we have a good grasp of many of the mechanisms through which divorce affects individuals. These mediators include disruptions in parent–child relationships, continuing discord between former spouses, loss of emotional support, economic hardship, and an increase in the number of other negative life events, such as relocation. Fourth, although some adults and children adjust relatively quickly to divorce, others find it hard to function long term. Fifth, a number of factors moderate the speed and extent of adjustment. For adults, protective factors include resources such as education and employment, support from a new partner, and being the spouse who initiated the divorce. For children, protective factors include the use of active coping skills, support from family and friends, and having access to therapeutic interventions. For adults as well as children, the end of a highly conflicted marriage is likely to be followed by improvements, rather than declines, in well-being.[176]

intact. A spouse who wanted the marriage to continue, in contrast, might not mourn the end of the marriage until the legal divorce is completed. Spouses, therefore, often experience the greatest degree of emotional distress at different points in the divorce process.[177]

Many parents may already come from a background of family breakdown or dysfunction, and the process of separation will exacerbate psychological distress. A heightened sense of remorse and guilt tend to be felt by at least one party, especially where there are children present. In addition, the level of physical or emotional support from the extended family and friendship networks may decline following separation.[178]

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176 Amato P (2000) 'The consequences of divorce for adults and children' J*ournal of Marriage and the Family* 62 1269-1287 citing Emery R (1994) *Renegotiating family relationships: Divorce, child custody, and mediation* New York: Guilford Press

177 *ibid*

178 Professor Paul Amato (see previous reference) qualifies this by saying that although divorce often brings about an initial decline in emotional support, people vary in their ability to reconstruct social networks following divorce, and to form new, supportive intimate relationships. Also, Dench and Ogg describe how grandparents may struggle to maintain closeness with grandchildren when their own child is not the 'parent with care'. In other words, any reduction in support they are giving to the 'parent with care' may be involuntary (Dench G, Ogg J (2002) G*randparenting in Britain: A baseline study*, Institute for Community Studies)

Ambivalence, uncertainty and confusion can lead to varying degrees of mental distress and anger in both parties as the family identity goes through this major change. Psychological aspects of separation include feelings of grief, betrayal, disappointment, failure, isolation, anger, depression and guilt. These feelings can evoke memories of earlier losses. We know that infants are greatly impacted by parental negative emotion and stress.[179] Research shows adverse effects on the child's infant's physiology, heart rate, stress hormone levels, play behaviour, sleep, eating, toileting and immune system.[180]

Maternal stress and lack of social support during pregnancy were significantly associated with lower intelligence test scores of three year olds.[181] Parental anger predicts continuation of antisocial behaviour and other behavioural problems in children over time,[182] and parental depression in the early years can lead to disruptions to the brain's stress response systems.[183] Children with frightening or frightened parents are vulnerable to suffering from stress mismanagement in later life[184] Very young children of parents with an anxiety disorder are more fearful,[185] as they are not only left struggling with their own emotional storms, but also those of their parents. Kohut and Wolf[186] referred to such infants as 'over-burdened', and argue that they can suffer from all manner of behavioural and relational problems – as well as learning difficulties – as a result.

The National Child Development Study (which has tracked around 17,000 people born in Britain during one week in 1958 over the course of their lives) has recently shown that children whose parents split up are more likely to end up without qualifications, claiming benefits and suffering depression.[187] The study's data suggest that greater social acceptance of divorce has not reduced its impact on children. When

179 Dawson G, Ashman S, Carver L (2000) 'The role of early experience in shaping behavioural and brain developmnt and its implications for social policy' *Development and Psychopathology* 1294 695-712; Hibbs E, Zahn T, Hamburger S, Kruesi M, Rapoport J (1992) 'Parental expressed emotion and psycho physiological reactivity in disturbed and normal children' *The British Journal of Psychiatry* 160 504-510

180 Field T (1994) 'The effects of mother's physical and emotional unavailability on emotion regulation' *Monographs of the Society for Research in Child Development* 59 208-227

181 Slykerman R et al (2005) 'Maternal stress, social support and preschool children's intelligence' *Early Human Development* 815-821

182 Denham S et al (2000) 'Prediction of externalizing behavior problems from early to middle childhood: The role of parental socialization and emotion expression' *Development and Psychopathology* 12 23-45; Walker L, Cheng C (2007) 'Maternal empathy, self-confidence, and stress as antecedents of preschool children's behavior problems' *Journal for Specialists in Pediatric Nursing* 12 93-104

183 Ashman S (2002) 'Stress hormone levels of children of depressed mothers' *Development and Psychopathology* 14 333-349

184 van Ijzendoorn M, Schuengel C, Bakermans-Kranenburg M (1999) 'Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae' *Development and psychopathology* 11 225-249

185 Pine D (2005) 'Face-emotion processing in offspring at risk for panic disorder' *Journal of the American Academy of Child and Adolescent Psychiatry* 44 664-672

186 Kohut H, Wolf E (1978) 'The disorders of the self and their treatment' I*nternational Journal of Psychoanalysis* 59 413-424

187 Elliott J, Vaitilingham R (eds) (2008) *Now we are 50: Key findings from the Child Development Study*, Centre for Longitudinal Studies, IOE. Available to download at http://www.cls.ioe.ac.uk/news.asp?section=000100010003&item=449 accessed 26/7/08

outcomes for this group were compared with children born in 1970, children of divorced parents in both groups were equally likely to lack qualifications, be on benefits and suffer from depression. Summarising the effects of divorce, the report says that it 'has repercussions that reverberate through childhood and into adulthood…Children from disrupted families tend to do less well in school and subsequent careers than their peers. They are also more likely to experience the break-up of their own partnerships.'

All this has major implications for policy. Although we need to help children cope with the stress of parental separation and divorce by providing effective interventions, preventing breakdown from happening in the first place was a key aim of *Breakthrough Britain*, the report which preceded this one. We said that 'Family breakdown is an expensive and painful business. Any attempt to reverse the long-term trend of increasing

One Plus One, Marriage and Partnership Research, has trained over 3,000 practitioners (especially but not exclusively health visitors) in **Brief Encounters®**, reaching well over a million families, many in deprived circumstances and the vast majority in the early years of parenting. Family practitioners (e.g. health visitors) are usually the 'turned to' person when people experience problems at home. Where underlying relationship and family issues can be identified by practitioners early on in routine practice, there is reduced likelihood of problems escalating to crisis point.

Using the guidelines and boundaries of the training, practitioners gain confidence to listen without becoming overwhelmed, to offer effective support and to make a timely referral where necessary.

Brief Encounters® training has been evaluated and has been shown to help practitioners to:

- engage with parents
- recognise signs of relationship distress at an early stage
- understand couple and family relationships better
- use active listening to respond appropriately
- encourage self help and offer support
- make a relevant referral
- use the brief intervention model across a wide range of family issues
- use time skilfully as well as work in a timely way
- be clear about personal and professional boundaries
- develop their own supportive networks (See http://www.oneplusone.org.uk/SFR/downloads/BriefEncountersInformation.pdf accessed 25/7/08)

When 2827 expectant parents or parents were polled by YouGov (27-29 May 2008) and asked what they would support being made more widely available to help parents who experience relationship pressures after the birth of a child, the largest category of parents, 53%, said more help from health visitors.

family breakdown needs to be backed by serious long-term strategies.'[188] Recommendations made in that report with particular bearing on improving outcomes for children in the early years have been reiterated in Chapter 5.

3.5. Family dysfunction

3.5..1 OVERVIEW – PARENTS' OWN EMOTIONAL DYSREGULATION STRONGLY AFFECTS THEIR ABILITY TO NURTURE

Dysfunctional families are characterised by 'emotional disadvantage' within the family. This can mean, for example, that there are poor relationships between the parents themselves and/or other members of the family; infants may have insecure attachments with their parents and there can be abuse or neglect. In some families, parents are simply unable to offer the infant sufficient emotional responsiveness to enable them to thrive. Such relational impoverishment for infants can cut across all social strata. This may be due to parents having never received emotional responsiveness themselves, or because of unworked-through trauma or loss in their own lives. Some parents are unable to cope because they are overwhelmed and isolated, suffering from a profound lack of emotional support or are under pressure to meet work demands.

Whilst sometimes appearing intact, some families have a dynamic which not only creates vulnerability in infants to a wide array of mental and physical health problems, but the very act of caring for an infant exacerbates the difficulties and pressures of the existing relationships within the family unit. Such families may also become incubators for the generational transfer of insecure attachment patterns, mental and physical ill-health and chaotic or emotionally cold lifestyles that inhibit the infant's ability to lead a fulfilling life.[189] These damaging effects can be explained on both biological and psychological levels. That said, the scale and level of the effects of such damaging behaviours can vary hugely depending on various protective factors in families' backgrounds and the surrounding environment – such as financial security, educational opportunities and supportive networks of friends or relatives.

In YouGov polling for the Social Justice Policy Group, of those expressing an opinion, 60% agreed or strongly agreed that prevention of family breakdown is possible and should get significant government funding.

(Nationally representative sample of 1500 adults polled on proposed solutions to family breakdown Apr-May 07)

188 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice

189 Felitti V (2003) 'The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900' *Preventative Medicine* 37 268-277

In terms of the infant's relational needs, parents are often too stressed to be able to offer their infant the quality one-to-one time that they need. Most research indicates that family disruption and breakdown, whether by dysfunction or parental separation, is a precursor for poor mental health in infants.

Furthermore, one of the most notable aspects of dysfunctional families is that the parents often come from backgrounds where soothing, calming, helping a child to find words for feelings, listening and interactive play were lacking, so they have no model for adequately addressing these core relational needs of their own infants.

The highest rate of people murdered in this country, in any one age group, is of those under one year of age: 26 per million of the population (or 17 individuals in 2006/2007)[190]

The stress of being a parent in a dysfunctional family often leads parents to use punitive discipline and to scream and shout as a way of discharging their emotional tension, or to use emotional withdrawal. Educationalists with whom we consulted flagged up the marked increase in extreme emotional problems they encounter in children under their care, citing family breakdown, inadequate parenting and social deprivation as key causes.

3.5.2. ABUSE AND NEGLECT AFFECT SIGNIFICANT PERCENTAGES OF CHILDREN

The NSPCC surveyed nearly 3000 young people in 2000 and found that:

- 7 per cent had been physically abused by a parent or carer
- 6 per cent had been emotionally and psychologically maltreated as children
- 6 per cent had been seriously physically neglected
- 3 per cent had been sexually abused, especially by brothers and stepbrothers
- 1 per cent had been sexually abused by a parent or carer[191]

Abused children come mainly from families where there is violence between parents and other family problems. Eight in ten physically abused children have also known domestic violence. The effect on the developing child is profound, and indicators include a rise in depression and anxiety disorders, personality disorders, psychosis, addictions, violence and anger disorders and eating disorders.

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190 Povey D et al (2008) *Homicides, firearms offences and intimate violence 2006/2007: Supplementary volume 2 to Crime in England and Wales 2006/2007* London: Home Office

191 Cawson P (2002) *Child maltreatment in the family: the experience of a national sample of young people* London NSPCC

Kids Company

Queen Mary, University of London's evaluation of Kids Company (2005 – 2008) states the following statistics based on the analysis of young people coming to one of our street-level centres.

- 84% have a history of homelessness
- 81% have a history of criminal involvement
- 82% have experienced substance misuse problems
- 83% have sustained trauma (i.e. multiple traumatic events)
- 87% have emotional difficulties and many suffer from psychiatric conditions
- 39% are teenage carers and struggling to cope
- 69% of children assessed in the schools programme have an above average stress level
- Improved anger management – 89%
- Reduced substance intake – 88%
- Improved relationships with family members – 95%
- Access to GP/NHS services – 100% (68% had not previously registered with a GP)
- Reduced criminal involvement – 90%
- Gang involvement stopped – 89%
- Sustained engagement with education – 90%
- Academic attainment – 81%
- Return to education – 91%
- Improved employability – 90%
- Engagement with work placement – 86%

What experiences have these children had?

'The biggest crisis in these children's lives is the absence of a consistent loving carer who takes responsibility for the child's well-being and for protecting the child against harm. Ideally, this should be a mother figure supported by a father figure.

Most children we meet have grown up with mothers and absent fathers. If the mother is not too distressed and too preoccupied with her own survival, then she is able to be 'attuned' to her child (i.e. sensitive to her child's emotional and practical needs). This child will grow up knowing that they have the power and the potency to engage someone else with their care. This makes the child feel important, treasured and the child understands that they exist because the mother is thinking about them, noticing them and reacting to them……

As our sense of who we are and how lovable or special we are arises from the way our parents treat us, for those who have experienced rejection or abuse, the sense of self can be very vulnerable and can lead – when stressed – to a catastrophic sense of not wanting to exist because you have not internalised a loving experience. You feel empty, meaningless, with no sense of destiny, no aspirations; you cannot create a reason for living nor develop any meaning to your life.'[192]

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192 Batmanghelidjh C (2008) *The Kids Company brainwave: Learning from vulnerable children how to care better* Unpublished manuscript

3.5.3. PARENTAL UNHAPPINESS AND EMOTIONAL ILL-HEALTH IS A RISK FACTOR FOR CHILDREN'S ADVERSE MENTAL HEALTH

Parental emotional ill-health can lead to families characterised by chaos and disorganisation, where parents may experience reality differently and interpret its meaning in ways which lead to painful and frightening responses to the infant.

Breakdown Britain cited reports suggesting that as many as 1 in 4 adults will experience some kind of mental health problem in a given year:

- Postnatal depression: 10 per cent of all new mothers
- Phobias: 1.9 per cent
- Personality disorders: 5 per cent
- Bi-polar disorder: 1 per cent
- Obsessive/ compulsive disorder: 3 per cent
- Schizophrenia: 1 per cent
- Depression and mixed anxiety: 9.2 per cent[193]

Statistics for mixed anxiety and depression have seen a significant rise in the last 10 years, in the entire population. According to the organisation Mind the prescribing of anti-depressants has risen by 700 per cent in the last ten years (some of the rise has been due to the availability of new selective serotonin reuptake inhibitors or SSRI's) and it is thought that on any one day, 33 per cent of visits to GPs' surgeries are for symptoms of depression.

Parents with mental health problems struggle to manage the demands of a family and are often unable to address the emotional needs of their infants. As we said earlier, this is because they are constantly struggling to manage their own emotions, which make it very hard for them to recognise or deal with those of their child(ren). We know that unworked-through trauma or bereavement in a parent can also have a dramatic effect on infant health. Again, this is because the parent is often not sufficiently emotionally available to offer the child the relational experiences that they need for social and emotional development. At other times, the parent's trauma or loss impinges on the child in some way. (It is common for example, for a parent who has been traumatised by their baby nearly dying, to be overly intrusive at mealtimes and unduly anxious about their infant's feeding habits.)

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193 ONS (2000) *Psychiatric morbidity among adults living in private households in Great Britain;* Meltzer H, Gatward R, Goodman R & Ford T (2000) *Mental Health of Children and Adolescents in Great Britain* London: TSO

Parental unworked-through trauma or loss is a common cause of troubling symptomology in young children e.g. eating disorders, bedwetting, soiling, school refusal. When the parent gets counselling, the child's problems often stop. Carl Jung called this phenomenon 'participation mystique'. Or as one little boy quoted by Winnicott said eloquently, 'My Mummy has a pain in my tummy.'

Mental Health Nursing, July 2004, reports that 'Patients at a London surgery can make an appointment with an independent employment advisor.' Tomorrow's People (the independent employment advisory service) advises both those with mental disorders (including stress and depression) and physical symptoms to navigate their way back into sustainable employment.

Dr Roy Macgregor, a partner at the participating surgery, said:

> 'Having an employment adviser on site, working as part of the primary care team, is a unique way of helping people regain their confidence and re-enter the work place. In the past, if a patient had asked me about getting back to work or welfare advice I would not have had the time or the knowledge to help and would have had to refer them to an outside agency. Now I can suggest to the patient that they talk to Tomorrow's People just across the hall.'

Results from first pilot

- 87% have returned to employment or are back in education or training. On average, 82% are still in work 12 months on
- The scheme has saved the practice at least five GP consultations per patient, a 20% reduction overall, representing savings of thousands of pounds (and a 74% reduction in referrals to practice counselors)
- There has been a reduction in the amount of drugs, particularly anti-depressants, prescribed to some patients[194] (19% fall in anti-depressant prescriptions after 18 months being registered with their GP)

3.5.4. PARENTAL DRUG AND ALCOHOL ABUSE SERVICES MAY NOT BE AWARE OF CHILDREN'S NEEDS

The Hidden Harm Report[195] states that 350,000 children have drug addicted parents and one million have alcohol addicted parents. We received several submissions describing how family life with a substance-abusing parent is characterised by chaos, uncertainty, and lack of routine. Tragically, in such cases, the parent's relationship can be more intense with their drug or drink than with their infant. Treatment services for adults are not under any obligation to find out if there are dependent children so certain parts of the

194 See http://findarticles.com/p/articles/mi_qa3949/is_200407/ai_n9410355 (accessed 26/7/08) and www.tomorrows-people.co.uk

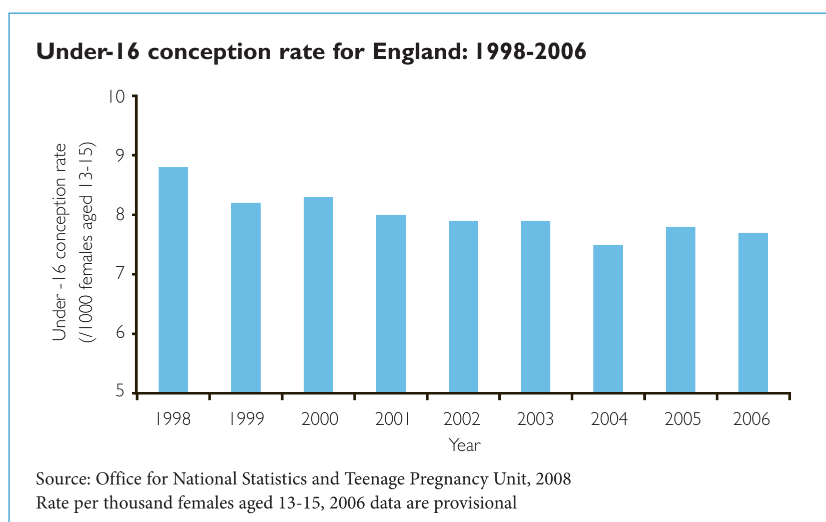
195 Home Office (2003) *Safety and Justice: The Governments Proposals on Domestic Violence* London: Home Office

system at present render children 'invisible', despite their intensely vulnerable situation.[196]

3.6. Teenage parents are still trying to achieve emotional and physical maturity

Official statistics show that 7,296 girls under the age of 16 became pregnant in England in 2006 (more than six in ten conceptions ended in abortion) and 39,003 girls aged 16 to 18. These figures represent a slight fall (of 177 and 801 girls respectively) from the 2005 figures but 2006 figures are stated as being provisional and there had been an increase in the under-16 conception rate from 2004 to 2005.[197] The Government states that progress towards reducing figures is not uniform across the country.

Under-16 conception rate for England: 1998-2006



Source: Office for National Statistics and Teenage Pregnancy Unit, 2008
Rate per thousand females aged 13-15, 2006 data are provisional

There are obviously adolescents who are able to love and care for their baby (and each other). However, teenagers are themselves going through significant psychological and physiological change with neuroscientific evidence pointing to surges in brain as well as bodily activity (with changes in sleep patterns as one simple example.)

A particular 'task' of adolescence is the gradual moving away from parents both emotionally and physically, not least as one seeks a partner for oneself. In addition, the human brain itself is not fully mature until early adulthood. All this implies that the adolescent may find that their emotional world is centred more upon their own needs and so may be unprepared for the demands of a

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196 See Professor Marina Barnard's testimony on page 56 of *Addicted Britain*, the section in *Breakdown Britain* focusing on drug and alcohol addiction as a pathway to poverty (Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice)

197 All statistics from Teenage Conception Statistics for England, 1998-2006, available to view at http://www.everychildmatters.gov.uk/_files/6D17854AF93522B6D2C32EE0A954ADA8.doc accessed 26/7/08

baby who needs their wholehearted and loving attention. Unfortunately, if parents lack emotional maturity, there is a higher risk of physical or emotional abuse of their infants.

The findings of research carried out by the Joseph Rowntree Foundation[198] of planned teenage pregnancy in areas of high poverty are particularly poignant. This study showed that for many young mothers, choosing to become pregnant was perceived to 'correct' their deprived childhoods and alter their lives for the better. Girls in the study reported 'desperately wanting a baby' from as young as nine. Their perceived lack of educational and career opportunities made the decision to start a family very young appear rational to them, and many of the young people in the study felt that their own lives had been improved by having a baby. However if many babies are being conceived by young parents partly to fill the emotional voids in their own history, some will be able to be very loving parents but others will struggle to meet their children's needs for nurture. Ironically, this research indicates that those least well prepared for parenthood by their own lost childhoods could be those most likely to start a family early and repeat a negative intergenerational cycle.

3.7. Parents' financial concerns make it hard for them to meet children's emotional needs

Where parents are struggling with poverty, debt, and poor housing (if not homelessness), they are naturally preoccupied with the stress and strain of living with these issues on a daily basis. These problems are often accompanied by a lack of educational opportunities and barriers to work including inadequate or inaccessible non-parental childcare. It is completely understandable that quality one-to-one time with an infant gets de-prioritised. If you are just 'surviving', your own and your dependents' psychological needs cannot be met.

The Early Years Commission visited a voluntary sector organisation which has a very good grasp of the need to provide vulnerable people with sustained and tailored assistance in issues like these, if they and their children are to function well as a family. Save the Family provides what it describes as a 'last chance' lifeline for families who find themselves in crisis situations, especially that of involuntary homelessness.

> In our polling, when asked what they found a particular cause of stress during pregnancy, the highest percentage of people, 38%, cited financial worries, significantly more than those citing fear of childbirth or fear of being able to cope with the baby.
>
> YouGov polling (2008)

One of the most tragic outcomes of homelessness is the family break up which occurs when children have to be taken into local authority care. Save the Family has a residential family centre which accommodates 24 homeless families until they have sufficiently accessed the support, training and advice

198 Joseph Rowntree Foundation research undertaken by Suzanne Cater and Dr Lester Coleman at the Trust for the Study of Adolescence (2006)

needed to break the homelessness cycle. Their outreach programme includes a number of community based ‘move on’ houses and ongoing support for those leaving the family centre as they look for more permanent housing. The care continues, if welcomed, once they have fully reintegrated into the wider community.

Parents are given the opportunity to undertake personal development training, acquire qualifications and, of most relevance to this report, address any inability they may have to nurture their children adequately. As such deficits are commonly a result of their own adverse childhood experiences (many parents have been in local authority care themselves), Save the Family’s work genuinely tackles the intergenerational transmission of disadvantage in a number of ways.

Other organisations working in areas of considerable deprivation and social exclusion include NCH (formerly known as National Children’s Homes and shortly to be renamed as Action for Children). Their Inverness Family Project in Scotland provides home visits to vulnerable families and parenting input incorporating aspects of both the PIPPIN (Parents in Partnership – Parent Infant Network) and Webster Stratton models.

PIPPIN is particularly relevant in this context, because its main aim is to maintain and improve the emotional health of families through one of the most critical stages in people’s lives - the period surrounding the birth of a new baby. They state that ‘Excellent training is key to this’ and so they continue to develope, test and refine rigorously tested and continue to refine their range of courses for professionals (e.g. midwives and health visitors; family and social workers; childbirth and parenting educators and counsellors; nursery nurses and childcare workers) that equip them in facilitating the early parenting process.

3.8. Conclusion

This chapter has looked across a range of reasons why parents can struggle to give their infants the relational experiences that they need for long-term emotional health. We have attempted to bring together anecdotal experience, our own polling evidence and the grassroots knowledge of voluntary sector organisations and contextualise it in the extensive academic research.

CHAPTER FOUR

Where services are currently failing to make a difference in the first three years

4.1. Introduction

The previous chapters have clearly illustrated the needs of babies and very young children and in addition have demonstrated the difficulties that parents and families may have in meeting those needs. A pervasive theme in the academic literature and emerging throughout our consultation process has been the need for well-trained, knowledgeable professionals to provide preventative information and support as well as intervention.

While there is a range of professions associated with the early years, there is a 'triad' who are potentially involved with all children, not just those identified as being 'at risk' or having some special need; these are health visitors, daycare practitioners and early years teachers. The latter are becoming increasingly involved with the under fives because of their growing participation in Children's Centres and the introduction of the Early Years Foundation Stage with its melding into Key Stage 1. As the activity of the first two categories is more focused on the first three years of children's lives, much of what is said below concerns them and how they can best be supported so that they in turn can support parents.

This chapter will look at the following areas and summarise our review of the literature and what consultees said was required to bring about a new dimension of effective provision for parents and very young children:

- The crucial role of health visitors
- Getting childcare right
- Fragmentation of services

4.2. Health visitors perform a crucial role

Health visitors in particular have long been associated with the care, support and developmental assessment of children under five and are, in the main,

viewed positively by families. In our polling we asked adults who they would go to if they were concerned about being able to cope with being a parent. Over a third, 35 per cent, said they would prefer to go to a health visitor for help, compared with 26 per cent saying a GP, 6 per cent a midwife, 4 per cent a childcare professional e.g. nursery nurse, 3 per cent Sure Start staff and 3 per cent a social worker (9 per cent said 'Other' and 14 per cent didn't know).

They are frequently seen as the main contact for families for day-to-day advice about their babies and very young children. During the hearings held for the Early Years Commission, the role of the health visitor was frequently cited as being crucial in supporting parents in meeting the needs of their children. They were described to us by the Association of Infant Mental Health as the 'agents of change to make a difference and to translate between the medical and real world'. In addition, health visitors carry out formal assessments at timed intervals within their work with children and their families.

Although their practice is influenced by the numbers in their case loads, local need and responses to pressures from both local and national initiatives as to types of interventions required, generally they carry out routine developmental assessments on all infants between seven to twelve months of age using nationally accepted criteria to assess the 'normal' development of children, thereby identifying potential delay or dysfunction. The other periods are six to eight weeks, eighteen months to two years, three years and pre-school although requirement for surveillance of the older age ranges does vary amongst authorities and depends on the practicalities of case loads. (There are also variations on which members of the primary health care team carry out the procedures.)

4.2.1. CONFUSION SURROUNDING THEIR ROLE DESPITE RECENT GOVERNMENT REPORTS

In spite of being seen as crucial for both the possible prevention of difficulties for families in their relationships with their babies as well as for assessment and intervention of existing problems, there is unhelpful confusion as to their role and responsibilities. Reports such as *Saving Lives: Our Healthier Nation*[199] set out their role as potential leaders in public health practice and in public health policy. Their role in family centred practice was also highlighted in another report published the same year – *Making a Difference: Strengthening the health visiting, midwifery and nursing contribution to health and healthcare*,[200] which

199 DH (1999) *Saving Lives: Our Healthier Nation*, CM4386 London: TSO

200 DH (1999) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* London, TSO

gave indicators for their tasks such as the expectation that health visitors would lead teams to include 'nursery nurses and other community workers' that would (for example) 'deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs.'

A more recent document published in 2001 by the Department of Health, *Health visitor practice development resource pack,*[201] described a 'new role' for health visitors with the statement that a

> *family-centred public health approach enables health visitors to reclaim their public health roots whilst providing a framework in which to maximise the impact of their family-based work* (see p8)

This latter document was one element of a national Health Visitor and School Nurse Development programme aimed at helping health visitors and school nurses to change and develop their practice. This document, similar to the 1999 reports, emphasised the health visitor in their public health role, assessing community needs as a whole as well as devising family health plans. In particular their role in assessment and monitoring of development was questioned, as the focus of a public health role is more on encouraging health promotion with a 'reduced emphasis on surveillance'.

This emphasis on health promotion as opposed to surveillance was combined with a suggested parallel reduction in the number of routine contacts. While stressing this change in focus, this document also noted the expectation that 'any screening tests are carried out to a high standard and regularly audited to assess uptake and quality'. What was particularly troubling about this document was that it scoped out a huge social, psychological and health remit for health visitors without mentioning how their training may need to be adjusted to meet the range of this public health role. Their basic training remains that of general nursing, followed by midwifery or obstetrics and then a further year to train in health visiting.

A further review, by Hall and Elliman,[202] advocated a core minimum programme for health visitor pre-school surveillance. However, at the same time, there remained a recommendation that every child should have access to a universal child health promotion programme which has now been published by the Department of Health (the CHPP extensively referred to in Chapter 2[203]).

201 DH (2001) *The Health Visitor and School Nurse Development Programme: Health visitor practice development resource pack* London: TSO

202 Hall D, Elliman D (2003) *Health of all Children* (4th Report) Oxford: Oxford University Press

203 DH (2008) *Child Health Promotion Programme: Pregnancy and the first five years of life* London: DH

Implementation of such guidance reinforces the very wide remit for health visitor practice together with a requirement for sound knowledge of infant and child development. Guidelines for health visitors in Bristol, for example, based on the Hall report, include the identification of parental concerns, maternal mood, play and language development.

Another recent report, *Facing the Future, a review of the role of health visitors*[204] yet again spoke of 'a renewed role for health visitors' and 'identified the need to reform the existing health visiting service into a fully integrated preventive service for children and families within a public health context' but also included 'early intervention and prevention' as one of the core elements of health visiting – emphasizing the need for a well-trained and up-to-date workforce.

This document also noted the continuing confusion and lack of clarity about the role of health visitors and that:

> *'Health visitors' knowledge needs updating especially in neurological development, mental health promotion and parenting….and there is a mismatch between training and service requirements.'*

Recommendations arising from this review included meeting the following needs:

1. to assess and identify existing and future vulnerability
2. to be responsible for a 'focus on the first two years of life'
3. to assemble the relevant research findings to support a 21st century child and family health promotion service
4. to bring together 'screening, early detection, health promotion, health protection and parenting support into one programme for all families'.

4.2.2. EARLY INTERVENTION IS A VITAL ASPECT OF THE HEALTH VISITOR'S ROLE

The common theme within all these reports is the emphasis on behaviour, e.g. promotion of breast feeding, anti-smoking, healthy eating, while topics such as mental health and development of children though ostensibly of importance, nevertheless seem to remain in the background. A lack of careful and detailed attention to the development of very small children is particularly troubling given the fact that at our hearings it was made clear that millions of pounds a year and untold suffering could be prevented with early screening for signs of autistic traits at four months, as intervention at this time might prevent full blown autism in many cases. For the past six years in France, paediatricians have been trained to recognise the early

204 DH (2007) *Facing the Future, a review of the role of health visitors* London: DH

autistic behaviours in babies at four months of age. Dr Stella Acquarone, founder of the School of Infant Mental Health advised us that in the UK 190 babies are born daily who, without this early intervention, will become autistic.[205] She also stated that autism alone costs the Government £236.3 million per year.

The importance of early prevention

Millions of pounds a year and untold suffering could be prevented with early screening for signs of autistic traits at four months, as intervention at this time might prevent full blown autism in many cases.

The commission was informed that in the UK 190 babies are born daily who, without this early intervention, will become autistic.

Also of concern is Professor Lynne Murray's research which she discussed in the hearings regarding the identification of postnatal depression (highlighted in Chapter 3 as being a key risk factor for a mother not being able to meet the needs of her baby, as well as being deeply distressing for the whole family). She found that health visitors did not always identify postnatal depression and recommended that they should have more training as the available training regarding postnatal depression 'is currently too patchy and haphazard'. Professor Murray also commented that that they have 'too much to do' as their remit is so wide, which works against them being able to set aside the time necessary for such sensitive appraisals.[206]

Murray's research found that health visitors were identifying less than 10 per cent of mothers with postnatal depression zero to eight weeks after giving birth and picking up a little over 10 per cent of depressed mothers nine weeks to one year post-partum. Those who did receive extra training scored more highly in helping mothers communicate with their babies and giving them an appreciation of their babies' abilities.

4.2.3. HEALTH VISITORS SHOULD BE CO-LOCATED WITH OTHER PRIMARY HEALTHCARE SERVICES

The need for health visitors to work closely with general practitioners is highlighted in the new Child Health Promotion Programme which states that 'every general practice needs to have regular contact with a named health visitor with whom to discuss individual children and families and the delivery of the CHPP'.

However we visited a GP practice serving one of the most deprived parts of Brighton, where Dr Sue Lipscombe despaired at their inability to draw on health

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205 Written submission from Dr Stella Acquarone, The Parent Infant Clinic & School for Infant Mental Health

206 In the Child Health Promotion Programme, the following are suggested as the most appropriate opportunities for screening tests and developmental surveillance, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early years services:

- By the twelfth week of pregnancy.
- The neonatal examination.
- The new baby review (around 14 days old).
- The baby's six to eight week examination.
- By the time the child is one year old.
- Between two and two-and-a-half years old.

> One GP in a busy inner city practice told us that 'Health visitors are based at Sure Start but if someone comes into the surgery weeping they want help now, not to have to go and access another service.'

visiting services when women present with postnatal depression: 'There are very few lines of referral for women suffering from PND and women struggling generally with parenting. Health visitors are based at Sure Start but if someone comes into the surgery weeping they want help now, not to have to go and access another service.' She also noted that a lot of mothers are leaving hospital without enough teaching on breast feeding and other areas of early parenting 'but there is no resource for them to tap into, whereas in the past there were health visitors.' The weight of this testimony led the Early Years Commission to go beyond the CHPP requirement for health visitors to be available to doctors, and to recommend that health visitors be available at key times in GP surgeries for mothers and parents themselves, as Chapter 5 makes clear.

Finally it should be mentioned that antenatal depression is more common than postnatal depression. One paediatrician told us that much antenatal anxiety goes unrecognised. This was borne out in our polling: when asked 'From your experience, how stressful have you (or your partner) found pregnancy to be?' a startling 49 per cent had either found it very or fairly stressful.

4.2.4. HEALTH VISITORS NEED TRAINING IF THEY ARE TO FULFIL CHPP REQUIREMENTS

Also missing from the reports and initiatives such as the CHPP are proposals regarding health visitor training – which is mentioned in only a very general way. Yet to meet the recommendations in both the 2007 health visiting report and the requirements of the CHPP, health visitors will need to have wide ranging training to include interviewing techniques, and awareness and understanding of neuroscientific research, attachment theory and relationship needs.

Debate regarding the role of the health visitor continues: consultees to the Commission described the need for clear guidance regarding their professional expectations together with a complete overhaul of their training programmes so that there is consistency throughout the UK regarding the content, length and focus of their training. However, what also has emerged from the hearings are concerns regarding the number of health visitors being appointed and trained. Child psychotherapists from the Association of Infant Mental Health told us that 'Health visiting has a very strong brand. That is what people want' and a significant literature has built up concerning the need to regenerate health visiting.[207] They also stated that there was a need for 'more health visitors, better training and better support' (for the health visitors themselves).

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207 Cowley S, Caan W, Dowling S, Weir H (2007) 'What do health visitors do? A national survey of activities and service organisation' *Public Health* 121 869-879; Cowley S (2007) 'A funding model for health visiting: baseline requirements – part 1' *Community Practitioner* 80 18-24

Staff at the Sure Start Children's Centres need to be trained in the latest findings of neuroscience and the importance of emotional regulation. They must be able to recognise when an infant is showing signs of emotional dysregulation and be able to treat it at an early stage, if they are to make any real difference in the educational and social achievement of these children. Midwives, health visitors and GPs UK-wide also need to know these latest neuroscientific findings and developments, and how to spot the early warning signs of emotional dysfunction so that they can refer appropriately.

4.2.4.1. Recognising and treating emotional difficulties whilst brains are still forming

Representatives from the Parent Infant Clinic in London said: 'We believe that midwives, health visitors and GPs together with Children's Centre staff have the potential to make a huge difference in the lives of children during their crucial early years – provided these professionals become skilled in recognising and treating emotional difficulties whilst childrens' brains are still forming.'

The Commission has therefore made specific recommendations for health visiting not least in terms of necessary additional training, which are detailed in Chapter 5.

4.2.5. HEALTH VISITORS SHOULD BE SEEN AS PART OF THE DRIVE TO REDUCE VIOLENT CRIME

However, it was not just in submissions from professionals involved in healthcare themselves who cited the importance of health visiting. Researchers of violence and gang-related crime (such as the WAVE Trust) or those who are dealing directly with the incidence and effects of violent crime, identified health visitors as necessary partners in combating its prevalence throughout society.

We visited key figures in the Justice Directorate of the Scottish Executive where they are beginning to treat violence prevention as a public health issue. The head of the Violence Reduction Unit, Detective Chief Superintendent John Carnochan, has famously stated that he would rather have a hundred extra health visitors than a hundred extra police officers. He is of the view that there has been no sustainable reduction in violent crime, that early-years intervention was especially important in tackling knife crime and that a balanced approach investing in teachers, social workers and health visitors would be more important than increased policing alone.

He has publicly said: 'What we are looking at now is the evidence and research that indicates that sometimes the skills that you lack that lead to you being violent when you grow older, those are learned within the first three years of your life.'[208] Health

208 See http://news.bbc.co.uk/1/hi/scotland/6465645.stm accessed 25/7/08

Dr Patricia Crittenden, psychologist and international expert on attachment, told us that 'We need some compromise where women can use their intelligence and still look after their children. We must change employment so women can have careers and children.'

Although this verbatim quote talked specifically about mothers, it was in the context of children needing to have parents around for example at the end of the school day, so the principle could equally apply to fathers who want to invest time in their families and sustain rewarding careers.

It was for this reason that *Breakthrough Britain* emphasised the need for far greater flexibilisation of the workplace.

visitors are in a position to deliver the very early interventions which may be necessary to help parents teach children that violence is preventable and not a fact of life. John Davidson, Head of the Violence Reduction Team at the Scottish Government, which we visited, emphasised the importance of a culture of cross-departmental consultation, which permits integrated thinking. This had been encouraged by the incoming executive and had been essential for linking public health and violence reduction. We also make recommendations for more integrated working in Chapter 5.

4.3. Government policy has to get the priorities right in childcare

Breakthrough Britain discussed the issue of childcare at some length, including the different preferences for formal and informal provision. Past and current research has identified that the context within which children grow up has changed hugely over the last 50 years, not least in terms of the rise in women who work outside the home and the corresponding increase in children spending time in daycare. For example, in 1981, only 24 per cent of mothers returned to work before their baby was a year old. Today the figure is nearer to 70 per cent, although Professor Jay Belsky puts the figure around 50 per cent.[209] As a result, almost a quarter of a million British children under three attend a day nursery full- or part-time.[210] Although Belsky contends that, contrary to popular belief, children under one are mainly cared for in settings *other* than daycare centres, there is, nevertheless, a growing trend for centres, i.e. large group care, to be used more and more for the younger age range. Many centres now accept babies from three months of age.

This Government assumes that the trend is likely to continue with numbers increasing, and in response they have set up a new initiative from the English Sure Start Primary National Strategy which is the Birth to Five Early Years

209 HM Treasury (2004) *Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare* London: TSO Statistics presented by Professor Belsky at a conference for What About The Children? WATCh? February 2006

210 *The Guardian* (2006) Feb 25

Foundation Stage (EYFS). This particular initiative builds on two current frameworks, the Birth to Three Matters Framework and the Curriculum Guidance for the Foundation Stage, and is fundamentally an integration between the two. It covers from birth to the end of the foundation stage, ultimately leading into Key Stage 1, the child's first year in 'formal' education (at 5 years). The implications of such frameworks combined with concerns over daycare briefly described later, provide an important strand for consideration of the well-being of very young children.

Many will already be familiar with the concerns that tend to be expressed and which were raised again in our hearings, particularly surrounding levels of practitioner training and qualifications, the extent to which practitioners understand infant development, and what some perceive to be the unhelpful 'formalisation' of learning within such settings.

4.3.1. MANY PARENTS WANT INFORMAL CHILDCARE AND TO DO MORE OF IT THEMSELVES

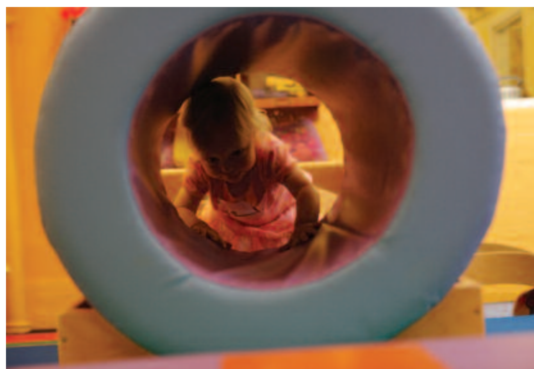
A CentreForum report states that 'a 2006 study found that many families use a combination of the two (formal and informal childcare), with 3.42 million having used formal childcare in the previous year.[211] The increase in the use of formal childcare has been most marked for couple families, for higher income families and for families living in more affluent areas. By contrast, growth in formal childcare use has been slower for single parent families, lower income families, families in deprived areas and families in London.'

Obviously it is important to understand what is driving these preferences, but if there is demand for informal childcare it is important that policy supports this to a greater extent than is currently the case. In *Breakthrough Britain*, we described the more pervasive current policy bias against family and other types of informal care and towards state-provided childcare. (e.g. close relatives, such as grandparents, are legally able to look after children but not to receive childcare tax credit.) Yet our polling and other surveys indicate that parents are not necessarily happy with the amount of time they are spending outside the home in paid work and away from their children. Seventy-five per cent of respondents believe that a child under 3 should spend a lot or all of their time with their mother and 63 per cent of respondents believe that a child under the age of three should spend a lot or all of their time with their father. Almost a third of all respondents stated that they did not feel that they were, or are, able to spend enough 'quality time' with their children when they were or are very young. When asked what would have been most useful as a parent of a child under the age of three, the highest response, 50 per cent, was for more child benefit. Only 39 per cent said more affordable childcare. Eighty-three per cent of adults agree

211 Astle J (2007) *The Surest Route: Early years education and life chances* CentreForum

or strongly agree that the government should do more to help parents stay at home to bring up their children in the early years.

As in the previous report, *Breakthrough Britain*, we are not interested in forcing women back into traditional roles, but in designing affordable and reasonable policies which will facilitate genuine choice. In that report we quoted The British Social Attitudes (BSA) Survey 23rd Report[212] which concludes that more than eight out of 10 women and men working full time would like to spend more time with their family, up from under three-quarters in 1989. The survey finds that full- and part-time employees, men and women alike, struggle in combining their job with family responsibilities. Although working hours have fallen slightly for men, an increase in hours worked by women means that, overall, the hours being worked in two-earner households have risen. At the same time, the pressures of work appear to be increasing, with both men and women expected to work harder.



4.3.2. STATE-PROVIDED CARE APPEARS TO BE MORE PRIORITISED THAN PARENTAL CARE

Many of the organisations and individuals who gave evidence to the Social Justice Policy Group noted this 'time bind' (which affects families across the socioeconomic spectrum[213]) but considered that the current government places far greater emphasis on the value of paid work outside the home and far less on the value of care provided by parents. Yet this is also at odds with preferences stated in the BSA survey and a recent EOC survey of 1,200 fathers (whose children were aged between three and 15 months) which found that almost eight in ten working dads said they would like to stay at home and look after their baby.[214]

> The Government appears to be nurturing a dependence on state-sector childcare provision despite low take-up of existing places. It is undermining the economic viability of private, voluntary and independent childcare provision

We also stated that the Government appears to be nurturing a dependence on state-sector childcare provision despite recent reports suggesting low take-up of existing places.[215] We also found that it is undermining the economic viability of private, voluntary and independent childcare provision.

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212 National Centre for Social Research (2007) *British Social Attitudes (BSA) Survey 23rd Report: Perspectives on a changing society*

213 However La Valle et al emphasise how many low-income families adopt shift-parenting strategies to manage dual-earner work and childcare, decreasing significantly the amount of time couples can spend together (La Valle I, Arthur S, Millward C, Scott J & Clayden M (2002) *Happy Families? Atypical work and its Influence on Family Life*, Bristol/York: The Policy Press/JRF)

214 Akbar A (2005) '80% of dads would rather stay at home and raise children' *The Independent* June 16

215 *The Times*, April 30 2007 'Nurseries feel the pinch as mothers stay home'

Representatives of these nurseries described the pressures on them generated by a large increase in state provision of childcare places often introduced without a rigorous audit of local demand. Recent reports indicate that supply may greatly exceed that demand.[216] State provision is subsidised so existing local nurseries, obliged to charge full costs for childcare, are placed at such a disadvantage that their rolls often fall below sustainable limits and they are forced to close.

4.3.3. QUALITY OF CHILDCARE HAS A LIFE-LONG IMPACT

In this current report we want to focus more on the knowledge that 'the quality of childcare has life-long consequences for mental health,'[217] on the grounds that the first three years of a child's life are crucial for healthy neurological development and therefore psychological stability. The yardstick of quality therefore applies across the spectrum of childcare: parental, informal and formal. Careful consideration of the evidence makes it impossible to state simplistically that home care is always good and nursery always bad. Some children with very emotionally challenged parents will be better off at nursery.

Again, in these more recent hearings some important points were made about the relative value placed on the role of parenting in comparison with paid work. The organisation What about the Children (WATCH) advocated that all mothers should have a real choice to look after their own children at least until the age of two by paying them a realistic wage for caring for their first two children (the 2008 report by Policy Exchange, *Little Britons*, also suggested the payment of homecare allowances, following the recommendation in *Breakthrough Britain* that they be given careful consideration).[218] WATCH made the point that 'there is an irony in that just at the point in history when the special value of parenting is being understood scientifically, parenting is being outsourced more than ever before. The essence of nurseries is that care is transferred from loving parents to strange adults, who are often fairly young women and relatively low-paid. Parental love is therefore discounted.'

> Anecdotal evidence obtained by the Commission: 'Every day my mother would drop me at the childcare lady in our village who wasn't a kind woman. Often we were just left to our own devices for hours on end with nothing to play with. I remember crying desperately when we were left in the morning. It's one of my first memories. I've never felt that I had a real vocation or desire to work in my adult life either and perhaps have always found jobs difficult to stomach. I wonder sometimes if these things are related. It's almost as if I was long-term unemployed from birth.'

216 *ibid*
217 Sunderland M (2006) *The Science of Parenting* London: Dorling Kindersley
218 Hakim C, Bradley K, Price E and Mitchell L (2008) *Little Britons: Financing Childcare Choice* London: Policy Exchange

Similarly, the internationally acclaimed psychologist Dr Patricia Crittenden described countries like Sweden where 'parents are protected from having to be responsible for their own children but ADHD levels are very high, there is a very high rate of break-up of relationships and the "set up" suits the parents not the children.'

This Commission acknowledges that economic demands on families, the desire in many cases of both parents to do paid work outside the home and a range of other factors, make the provision of a spectrum of non-parental childcare essential in today's society. However, we considered it important to integrate the implications of the neuroscientific research on very young children's relational needs for daycare settings, into the policy recommendations in the next chapter and outline these briefly below.

4.3.4. NEUROSCIENTIFIC RESEARCH AND IMPLICATIONS FOR DAYCARE

Submissions were made to the Commission concerning levels of stress experienced by very young children in nursery settings. These must be considered alongside the advantages for children of nursery care which are well-documented. These include improved verbal skills, the use of a wider range of words (especially for children from socio-economically deprived areas) enhanced arithmetical skills and accelerated cognitive skills. In summary, Belsky et al[219] found that attendance at child care centres improves academic achievement, at least up to 20 hours in the child care centre per week. Over and above 20 hours in the child care centre per week, academic achievement levels off and then falls again slightly. This is partly because, as this report also found, aggressive behaviour and disobedience rise with longer hours spent in nurseries and such 'externalising behaviour' is associated with reduced academic achievement.

But when we return to the issue of stress, research by Watamura et al[220] found that in child care, 35 per cent of infants (with a mean age of 10.8 months) and 71 per cent of toddlers had raised cortisol (stress hormone) levels and at home 71 per cent of infants and 64 per cent of toddlers showed decreased levels. Similarly Geoffrey et al (2006) saw cortisol levels increase during daycare whereas they decreased when children stayed at home. Research by Ahnert and Lamb[221] indicates that if a child is not securely attached to a primary carer when he or she enters a nursery, say at one year old, then the stress of entering such a setting can send cortisol levels soaring

219 Belsky J et al (2007) 'Are There Long-Term Effects of Early Child Care?' *Child Development* 78 681-701

220 Watermura S, Sebanc A & Gunnar M (2002) 'Rising cortisol at childcare; Relations with nap, rest and temperament' *Developmental Psychobiology* 40 33-42

221 Ahnert L, Gunnar M R, Lamb M E & Barthel M (2004) 'Transition to child care: associations with infant-mother attachment, infant negative emotion, and cortisol elevations' *Child Development* 75 639-650

much higher than if he or she were securely attached. Similarly cortisol levels go up with a sudden change of nursery nurse to whom the child has formed an important attachment.

Finally it is important to state that the magnitude of the daycare stress in these studies varied in that it was larger for children in low-quality daycare, there was little or no effect for children in high-quality daycare and children with difficult temperaments in daycare were more likely to exhibit a rising pattern of cortisol compared with children who were not difficult.

To summarise the implications of the above, raising the quality of daycare in a way that emphasises the importance of relationships between staff and children should mitigate some of the worst effects of being away from a primary attachment figure and allow the child to reap the benefits of daycare's advantageous aspects.

4.2.4. THERE IS A MARKED LACK OF A RELATIONAL EMPHASIS IN DAYCARE

Professor Jenny Rogers, who has contributed to the work of the All-Party Parliamentary Group on Scientific Research in Learning and Education describes how our British personality ('the stiff upper lip, a little distance and a strong emphasis on original sin'[222]) determines the way we assess and measure children from an early age.[223] She states that, in comparison with the practice in Scandinavia, Japan and Holland, 'Yes, they are observing and assessing but in a much looser way than we do.' The atmosphere when one walks into one of their nurseries is quite different. It is much more open, relaxed, with outdoor play and involving all the community. Our approach 'brings the emphasis away from relationships because the emphasis is, will the children achieve and will the results be alright?' Sally Jenkinson, an early years Waldorf Steiner education specialist also emphasised to us the need for outdoor play, the engagement of parents within the 'community of the nursery' and Steiner nursery schools' focus on the whole person of the child.

Julian Grenier, who heads the Kate Greenaway Children's Centre in Islington, London, acknowledged the potential for group childcare to be inherently problematic if children's emotional needs were not met and that

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222 Taken from the transcript from the seminar on 'Well-Being in the Classroom', convened by the All-Party Parliamentary Group on Scientific Research in Learning and Education, on 23rd October 2007 at Portcullis House. Available at http://www.futuremind.ox.ac.uk/downloads/transcript_well_being_08_v6.pdf accessed 25th July 2008

223 A Cambridge University primary school review study found British children were the 'most tested' in the world. For more details of 'The condition and future of primary education in England: The Primary Review,' based at the University of Cambridge and supported by the Esmée Fairbairn Foundation, see http://www.primaryreview.org.uk/ accessed 25th July 2008

this was especially likely to be the case if children were handed 'from one staff member to another'. The real issue, he said, was to make the nursery nurses as 'child-centred as possible'. However he did not downplay the difficult and complex demands that entailed or deny that the childcare workforce was struggling to meet these demands, given that 'the nature and level of qualifications is pretty poor, it's low paid and there is an impoverished understanding of what it is to care for someone else's children'. Again, his testimony concurred with Professor Jenny Rogers point that practitioners could be somewhat reserved with the children. 'Workers want to keep boundaries very clear, many believe they are not allowed to cuddle children and daycare settings tend to be proceduralised and routinised.'

Other consultees emphasised that small changes in childcare settings could make a big difference to the emotional well-being of children, such as continuity of hands-on care through keyworker systems rather than the latter being used for continuity of administration. In other words, key workers who kept all the records and interfaced with the parents are not providing children with ongoing and consistent attention. Nappy changing rotas where one child is changed according to the clock, by which ever person's 'turn' it is, was also cited as a potentially emotionally impoverishing experience for infants.

4.3.6. CHILDREN'S CENTRES ARE LESS ABOUT FAMILY SUPPORT AND MORE ABOUT SUPPORTING EMPLOYMENT

We spoke to committee members from the Association for Infant Mental Health who pointed out that nursery settings could be a place not only for children but also for parents, 'they could facilitate the building of parent-parent and parent-professional support networks.' We asked to what extent Children's Centres already act in this way or could evolve into providing such a setting. They and others considered that there is 'too much emphasis on getting mums back into work and affordable childcare. The original aims of Sure Start were not just educational, they were also about promoting social and emotional development. These more "nurturing" ideas which were in the initial plan for Sure Start, have gone by the wayside.'

Describing how the Government's rhetoric surrounding Sure Start had changed, one of its key architects, Norman Glass, described how in 1999 the stated aim was to

To work with parents-to-be, parents and children to promote the physical, intellectual and social development of babies and young children - particularly those who are disadvantaged - so that they can flourish at home and when they get to school, and thereby break the cycle of disadvantage for the current generation of young children.

'The original aims of Sure Start were not just educational, they were also about promoting social and emotional development. These more "nurturing" ideas which were in the initial plan for Sure Start, have gone by the wayside.'

Association for Infant Mental Health

By 2003 however, this had changed to

> *Sure Start aims to provide better outcomes for children, parents and communities by: increasing the availability of childcare for all children; improving health, education and emotional development for young children and supporting parents as parents and in their aspirations towards employment.*[224]

It was for similar reasons to this that we stated in *Breakthrough Britain*, 'To free up Children's Centres to provide more family support we recommend that childcare should be located outside community-based Children's Centres wherever possible.' We also recommended instituting Family Services Hubs with an enhanced role for health visitors, facilities at the heart of communities to enhance current, community-based service provision, a greater degree of integration of services to maximise efficiency and coordination of professionals and voluntary sector providers. Such hubs would emphasise support for parents in their children's first three years with an enhanced role for health visitors in preventing dysfunction in very young children's cognitive and emotional development. In their report to the Ontario provincial government, of a key longitudinal study tracking children from 0-6 years, McCain and Mustard[225] similarly did not propose universal daycare, but rather recommended the establishment of a network of early child development and parenting centres. Ideally linked to primary schools, the centres would include early childhood development and parenting activities, home visitation, home-based satellites and early problem identification and intervention. We go further into our recommendations for childcare in the next chapter.

4.3.7. SERVICES SHOULD SUPPORT PARENTS NOT MAKE THEM DEPENDENT ON PROFESSIONALS

To summarise much of the last section, if daycare workers are not 'tuned into' the needs of children, then where daycare is being used to compensate for parenting deficits (obviously in a small minority of cases) much potential benefit could be lost. More fundamentally though, we expressed the concern in *Breakthrough Britain* that, as one nursery nurse expressed it, "some full-time places are paid for by the local authority because the mothers cannot cope but surely the answer is not to do the job for these mums but to give them the basic skills so that they can do it themselves. Often these mums have other children and another baby on the way, we have to think longer term. The problem is that increasing numbers of the parents we see feel completely unfit for the task and

224 See http://www.bristol.ac.uk/sps/cnrpapersword/children/glass.ppt#1

225 McCain M, Mustard F (1999) *Reversing the real brain drain: Early years report* Toronto: Canadian Institute for Advanced Research

think the nursery will do a better job. But we can't be there 24/7 and those deficits are going to emerge somewhere along the line.'

It was for this reason that we recommended there be targeted assistance for parents who currently struggle to nurture their young children, such as therapeutic counselling for carers and their babies within the first two years of the baby's life eg. that provided by organisations such as OXPIP. As we stated above, if parents decide to look after their own children, most if not all of the time, the quality of the care they provide is important.

4.3.8. ASSISTANCE SHOULD BE TARGETED TO BUILD PARENTING SKILLS

Andrea Leadsom, chair of OXPIP, the Oxford Parent Infant Partnership, described how the intergenerational cycle of disadvantage can be broken by their services. 'If you as a baby did not form a bond with a caring adult, the chances are that you will not have the ability to do so yourself as an adult. It will be possible that you cannot form long-lasting relationships with other adults, or your own child, which, in turn, impacts their ability to learn how to relate.' This resonates with much that has been said earlier in this report, but diagnosing the problem is insufficient. What OXPIP's clinicians do is help parents work through their own problems from early in life. OXPIP interrupts the cycle of emotional and multiple deprivation in that two-fifths of their work is with cases referred to them by social workers concerned with child protection and their evaluations indicate that they have seen significant success in children being considered safe to return home. The costs of taking children into local authority care run into thousands each week (according to the British Association for Adoption and Fostering (BAAF)[226] the cost of foster care services in 2003/04 across the whole of the UK was £932.2 million) but OXPIP's weekly class costs £35.

> The emotional brain is largely created in the first 18 months of life, its auditory map is formed even earlier, by twelve months and synapse formation in the visual cortex peaks at three months and has finished by age two. What happens in the early years, in terms of the quality of attachment to a primary carer, and the level of stimulation, nurture and empathy an infant receives, 'permanently moulds the individual's capacity to enter into all later emotional relationships'.
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> Schore A (2000) 'Attachment and the regulation of the right brain' Attachment and Human Development 2 23-47

A key objective of this organisation and many others we spoke to, is to try to reduce families' reliance on the Government. Reliance on professionals can also be detrimental to the overall emotional health of the family unit. As the Consultant Child, Adult and Family psychotherapist (and Joint Head of Psychotherapy Services, Great Ormond Street Hospital for Children), Dr Jeanne Magagna, stated 'we have to support inadequate parents, rather than removing babies, because otherwise they will have future pregnancies' (see below). However, she expressed the caveat that

226 See http://www.baaf.org.uk/media/releases/050710report.pdf accessed 20/7/08

professionals such as GP's and health visitors, psychotherapists and paediatricians often provide *themselves* as the support to the mothers rather than using a partner, friend, father as someone to help and be a support to the mother. This 'taking the place of the father' by professionals can frequently leave the mother turning too often to the professional who is more adequate than to her partner, who may also need help to develop the capacity to create a 'couple as the cradle' for the baby's emotional life.

4.4. Fostering families, instead of fostering children

Quite apart from the difficulties children go on to experience when placed in local authority care, parents encounter significant difficulties in mourning the loss of a baby. Dr Magagna described the importance of social services taking seriously the task of helping parents whose baby is in danger of or is actually removed from them, otherwise they will perpetually have other difficulties to deal with as a result of the feelings induced by a baby being taken away. She cites Dr. John Simmonds who talks of a mother having 15 subsequent babies in such a situation and she herself has frequently seen the mother go on to have more babies who are taken away.

Building a Bridge, a relatively new fostering agency which has at its chairman, Sir Cyril Connelly of Great Ormond Street Hospital Executive Board, is developing the concept that it is useful to foster both the mother and baby together, providing both with support while a good care-giving plan can be worked out for the baby. A similar recommendation was made to us by the psychologist, Dr Patricia Crittenden. She suggested that older couples within the community who might welcome a challenge after their own children had grown up, would be willing to assist a vulnerable family. She recommended that we 'create a set of foster parents, one generation up. They can love and care for both the parents and the children as experienced parents themselves.'

4.4.1. SERVICES WHICH HELP VULNERABLES FAMILIES STAY TOGETHER

As stated in the previous chapter, Save the Family will take whole families under their care, effectively fostering them whilst they found their feet. When we visited their facility a Plas Bellin, in North Wales, we met Jane (names have been changed) whose first two children were taken into care. She herself had been fostered until the age of 16 then housed on her own with no support. She became enmeshed in an abusive relationship and had her first two children. She had them placed in care for their own protection but found it extremely difficult to cope with the emotional fallout from this decision. She became addicted

to heroin and crack cocaine. Although she moved into the North Wales area to make a new start, form a new relationship and have another baby, she returned to drugs and was on the verge of losing her third child.

In her words, 'I decided to work with social services and stop using drugs' and it was then that she was referred to Save the Family. Several months on she is clean, she has obtained qualifications and is with the father of her child who has been similarly helped by the organisation. This was a family in which repeated transgenerational failure seemed unavoidable, but tailored services working in partnership with statutory bodies have made a decisive difference. Recommendations for supporting parents which appropriate the best aspects of these models are made in the next chapter.

Save the Family does not just provide a safe haven. They teach vital skills to both parents, such as how to cook, how to budget and how to access training and employment. When families feel ready to move on they stay in touch and provide ongoing support for as long as it takes them to become completely established and financially self-sufficient.

Jane told us, 'when my other children [who were taken into care] come looking for me they'll see that I'm not a mess, I've made something of my life.'

4.5. Fragmentation of services in spite of rhetoric of integration

The need for greater integration of services came up as a recurring theme in the consultation process, especially on our field trip to Brighton. The scale of integration we were advised is necessary goes beyond inter-agency working and the need to safeguard vulnerable children, although these are to be welcomed. Respondents emphasised the interconnectedness of social and medical problems, their roots in the first two to three years of life and the compelling case for acknowledging the systemic nature of such problems (where cause and effect interact) in the way services are delivered.

It became clear to us that research on premature babies and on the effects of environmental influences and maternal health on very young children have a broad range of implications for the aetiology (study of causes) of chronic disease in later life, postnatal depression (PND), and policy to address these issues. A visit to the Royal Alexandra Children's Hospital and the Trevor Mann Premature Baby Unit in Brighton revealed cutting edge techniques and research to address the growing levels of mental and physical ill health in the UK.

4.5.1. THE ROOTS OF CHRONIC DISEASE ARE IN EARLY CHILDHOOD

Professor Somnath Mukhopadhyay (Chair in Paediatrics at the Royal Alexandra Children's Hospital) in common with other medical consultees, told us that there is much concern about disease in the community but a lack of recognition that the seeds of these illnesses are sown in the first three years at the physical *and* psychological level. There are vital physical and biochemical changes taking place in the first three years of life but 'there is an emphasis on

50 year olds where the disease has already happened but this is too late….' His research with young children has identified the subtle interplay between genetic and environmental factors in the aetiology of asthma, currently at especially high levels in the poorest 20 per cent of the population.

International research has established that babies who were small at birth and had 'poor growth in infancy may have an increased risk of adult coronary heart disease and type 2 diabetes,' especially if they gain a lot of weight in later life. An 'adverse intra-uterine environment' increases the potential for 'strokes, hypertension, obesity, osteoporosis, obstructive airways disease, reduced cognitive function, ADHD, Autistic Spectrum Disorders and poor mental health.'[227] In other words, the health, history and environment of the mother are crucial to long term effects of the health of an infant. Evidence from research links specific maternal influences with the adult health of the offspring, notably:

- The mothers own birth weight
- Maternal body composition, including fat and lean mass
- Maternal diet
- Maternal endocrine status (all of the systems regulated by hormones)

A psychotherapist, Charlotte Savins with whom Professor Mukhopadhyay works, described how very early psychological and physical influences are particularly determinative of childhood and future obesity. Not only are unhealthy patterns of food consumption engrained and metabolic abnormalities instilled, in many cases, from the mother's diet even before she becomes pregnant, but patterns are also developing in relationships. She explained that 'where children are not able to get emotional comfort from parents, they will try to get it from food.'

We also heard that interventions to address growing levels of chronic disease are often too prescriptive, especially in terms of lifestyle change. 'Contemporary public healthcare strategies are based on the concept of an individual's duty to be well, this can be liberating for those who can make effective and appropriate lifestyle choices, but oppressive for those who are powerless to make such choices,'[228] so measures to help with parental lifestyles are based on a 'one size fits all' approach. However, we heard that a flexible approach which can be modified with time and allow constant correction to best suit the needs of participants is to be welcomed. Professor Mukhopadhyay has found that many of the solutions which could help parents understand e.g. nutrition, (which is vital to the future physical and therefore psychological

219 Godfrey K (2006) 'The Developmental origins hypothesis: epidemiology' in Gluckman P & Hanson M (2006) *Developmental Origins of Health and Disease* Cambridge University Press

228 Noble R (2006) 'Developmental Origins of Health and Disease: Ethical and Social Consideration' in Gluckman P & Hanson M (2006) *Developmental Origins of Health and Disease* Cambridge University Press

health of the baby) can be found within their family. He used an example of research conducted in Dundee (the 'Healthy Living Centre' in Dundee in 2000) which revealed that – for example – as long as one member of the family at risk could make porridge, that family member could be called on to help with diet and nutrition.

This 'building on existing strengths' approach is becoming increasingly common in service delivery. The need to acknowledge the local community and the importance of kinship were emphasised to us, as was the need for an holistic approach to prevention, rather than a prescriptive approach, which should begin at the antenatal point. Professor Mukhopadhyay particularly stressed the need to listen to the individual needs of mothers in order to tailor support.

This viewpoint was reiterated by Professor Jane Barlow[229] who considers that interventions with parents should support their needs primarily and be highly flexible in terms of duration and specific programme used. She and others consider that there is no need for sophisticated screening tools, to identify families requiring interventions, just well trained GPs, health visitors, practice nurses etc. Non-stigmatising approaches were considered to be extremely important and this is where universal services score highly. If everyone is receiving e.g. relatively frequent visits from a health visitor this lowers any defensiveness of families who are struggling. If the language being used is one of 'eligibility' for a preventive service, no one family or indeed community feels singled out on the basis of what might seem to them to be their 'external appearance'.

4.5.2. THE IMPORTANCE OF PRIMARY CARE IN PREVENTION CAN BE UNDERESTIMATED

A prevailing view from the consultation process was that primary care has the key opportunity to deliver effective preventions and that these can be undertaken routinely. We talked with Dr Sue Lipscombe and other staff members in a GP practice serving one of the most deprived parts of Brighton, who described the almost universal attendance at the doctor's surgery, regardless of income, of parents with very young children. This was confirmed by other consultees, such as the paediatrician Dr Mitch Blair, Consultant Reader in Paediatrics and Child Public Health, Imperial College, who said it was 'the most disenfranchised who keep their children's vaccination and health books ("red books") close to their hearts.' He also emphasised how influential the very earliest part of a child's life was for their future health and well-being. Again, he stated that nutrition is vital from the antenatal period if not before but it is not common practice to monitor mothers' nutrition levels so many children are already born lacking in nutrients – 25 per cent of pre-school

229 *Getting it Right for Babies: An Overview of the Evidence Regarding Effective Interventions to Promote Positive Parenting in the Early Years*. Lecture for Association for Infant Mental Health 2008.

children are zinc deficient (which affects later male fertility) so regular screening should take place.

4.5.3. GETTING THE DIAGNOSIS RIGHT MAY REQUIRE LOOKING AT THEIR EARLY CHILDHOOD

Jeremy Turk, Professor of Developmental Psychiatry, at St. George's. University of London, said recently that 'The exploration of a patient's *biography* [our emphasis] is an important strategy in establishing a successful working relationship.'[230] This prevents the possible psychosocial aspects and risk factors of ill health being overlooked because 'original pathophysiological insults which may not manifest themselves till a patient is older, become secondary to more proximate determinants of human well-being, this leads to treatment of symptoms without a full understanding of their potential origins.'[231] Concentrating on the symptoms rather than on their historical antecedents, which may not be purely physical, means that measures aimed at the prevention of diseases may not be as effective as expected.

Similarly, Dr Patricia Crittenden described to the Early Years Commission how an understanding of genes, biological and developmental interplay is an essential complement to knowledge of psychological dysfunction. Conversely, as we said in the preceding paragraph, early life events determine in part the risk of later disease. The conclusion to which many clinicians with whom we consulted have come is that the importance of a patient's 'psychological history' requires that we change our method of assessment of ill health. Diagnostic absolutes would give way to a more holistic approach which ultimately gets away from intervention at the stage when there is a specific showing of 'symptoms' and moves towards interventions to prevent those symptoms developing in the first place.

4.5.4. AWARENESS AND APPLICATION OF DEVELOPMENTAL EVIDENCE AND BRAIN RESEARCH

The framework recommended to us by paediatricians like Dr Blair therefore, requires looking at mental *and* physical health needs, because as we have stated repeatedly, brain growth depends critically on nurture. He was one of many consultees who said that brain research should be emphasised in training and throughout the health profession. Similarly, there was significant consensus that what was lacking in provision for the most

230 Turk J (2008) 'How are You' CEFD Conference *Thinking about the development of health and illness behaviour in children* June

231 Felitti V et al (2006) 'The enduring Effects of Abuse and Related Adverse Experiences in Childhood' *Neuroscience* 256 174-186.

disadvantaged children was 'joined up thinking'. Dr Blair told us that 'we need to connect things up better, facilitate synergy and make it easier to work together and meet everyone's targets within Children and Young People's Partnerships. At the highest levels people agree but at the operational level we have to move beyond fire fighting.'

4.5.5. TRAINING IS FRAGMENTED AND 'INCONSISTENT'

Several consultees referred to one way in which services can be more 'joined up' such that there are elements within training programmes which are common to all the many different professionals who engage with young children and their families. We have already mentioned the need for training which

- takes into account the importance of neurological development, other aspects of mental health promotion and the role in both of parenting and
- equips professionals to better recognise perinatal depression and identify infants who are experiencing significant parenting deficits.

Consultees advised us that such training should not be limited to those stereotypically associated with the early years (such as nursery nurses and health visitors) but considered that it would be of benefit to anyone who had the power to affect the lives of children, ranging from family court judges to social workers.

We noted that the recent Conservative Party review of social workers (whose independent patrons were Lord Laming, Former Chief Inspector of the Social Services Inspectorate, and author of the report of the inquiry into the death of Victoria Climbié and the former President of the Family Division of the High Court, Baroness Butler-Sloss), made much mention of social pedagogy. This is an integral part of the child welfare system in some European countries and is a professional model that gives social workers a very different role in early intervention, prevention and educational support to vulnerable, challenging and excluded children and their families. At this point much of the social pedagogue role is already carried out in the UK by social workers in conjuction with other professionals such as health visitors and therapists, but submissions to that consultation from bodies such as the Local Government Association (LGA) advised building the best elements of social pedagogy into the single role of social workers.

One reason cited was that European social pedagogy adopts a more holistic approach and treats the social worker-child/young person relationship as a more therapeutic one. This stands in contrast with the

prevailing situation in the UK where young people often feel that social workers fail to understand the emotional needs of children in care and do not 'hear' them when they are making a coded plea for help or expressing their own concerns. The review concluded that 'there is much to indicate that child and family social work could benefit if some aspects of the role and training of pedagogy were incorporated into social work education and practice in the UK.'[232]

Although the children referred to above would be older than those who are the subject of our review, the common denominator is that higher expectations would be placed on social workers if the profession were to address fully the implications of deficits in early years service provision. Engagement with the training described above would be a *sine qua non*. The concomitant benefit to the social work profession would be to enhance their image as professionals who profoundly understand the issues with which children and families are grappling.

4.5.6. SOCIAL WORKERS EAGER TO WORK MORE PREVENTATIVELY

All the social workers we talked to expressed a strong appetite for truly preventative work. One social worker on the child protection team in Eastbourne told us that 'there is *no* [her emphasis] preventative work going on, yet every young person using the drug drop-in centre had a social worker when they were a much younger child and they had been the only positive thing in their lives. It would be good if more social workers were doing more direct work with the child,' along the lines of the social pedagogue role previously described.

The message came through clearly that these front-line professionals were well-placed to make a difference but were only able to spend their time on cases that had already developed to crisis stages. She mentioned children who had obviously suffered significant psychological harm from seeing what she described as 'domestic violence, horrendous domestic violence', but whom she was unable to refer to the local Children and Adolescent Mental Health Service (CAMHS) because they were not presenting with aggression. But, she said, we have to 'look to the long, long term, work with the children now as they'll be the parents.'

The implication of her testimony and others like it was that an awareness of the psychological impact on children of profoundly adverse experiences and training in how to help parents or other adults remedy deficits, would greatly benefit the children in their care.

232 Conservative Party Social Work Commission (2007) *No More Blame Game – the future for Britain's Social Workers* p20

We heard at our hearings that 'we tend to offer the least competent families the most complex integration of services.' When families are in need of a variety of services because they are facing multiple disadvantages, they will typically have to engage with a large number of different professionals eg. to do with child protection, school attendance, intensive parenting support etc, with some of whom they will have only a little contact.

One or two of those professionals will be better at interfacing with a particular family than others: a mother or father might feel they are far more compatible with one professional than with all or most of the others. Being able to choose which professionals actually come through the door of their home would give families a greater sense of being in control, whilst they are having to grapple with difficult and often highly personal issues.

Intervening intensively with a family may be necessary, but it involves gaining access to their private inner world. When a range of professionals are attempting to do that, it becomes very complicated for family members and the presence of the 'many' can seem highly intrusive, albeit that each specialism is necessary to the whole process.

We were advised that this dynamic requires adjusting the model such that a multidisciplinary committee should be working *behind the scenes*, supporting the one or two professionals who have been chosen by the family and who have the opportunity to work on a long-term basis, thereby building up a strong relationship. That relationship would be the conduit through which the input from other professionals could flow. This would reduce complexity at the point of service delivery to the family but not the degree of expertise available to them.

Submission from Dr Patricia Crittenden, former Director of Child Protection, Miami, Florida, US

4.5.7. INTER-AGENCY TRAINING IS ESSENTIAL FOR SHIFTING THINKING ON THE EARLY YEARS

However, it was emphasised to the Early Years Commission that this enhanced training would have far less impact if it were delivered in the usual professional silos. We received submissions from pioneers in inter-agency training, such as Dr Richard Gray, Principal Lecturer in Primary Care at Brighton and Sussex Medical School, who explained that 'as there are so many complexities in society we need many professionals to learn and work together. Within the clinical education of medical students there are various courses that a wide range of other professionals also attend. They get lessons now with midwives, nurses and pharmacists, as well as with social workers.' Although he admitted that he had met some resistance, he explained that there is a growing sense that 'every profession should be contributing to improving the whole thing: if we focus on the patient or client, our professional jealousies disappear – we must work on these principles.'

He admitted that it was hard to teach, to reach everyone at the right level, and that there was a need to support and help teachers as inter-agency training was vital for building networks which would deliver truly integrated care. However, the aim of building inter-disciplinary respect, understanding and seamless care could get lost: 'Although nearly half of medical schools in England are having inter-professional education now, it cannot be a tick-box exercise. It is about shifting cultures.'

Professionals working with families and children are often unfamiliar with issues in each other's field. While psychiatrists may discount primary care physicians' knowledge of mental health issues, primary care physicians often see psychiatrists as inaccessible, non-medical and uncommunicative. Medical school programmes can contribute to these views by emphasizing the biomedical and technical aspects of care and not giving adequate weight to psychosocial factors. The Bazelon Center for Mental Health Law website[233] describes how many primary care physicians are already somewhat sceptical about whether mental health diagnosis and treatment is evidence-based and are likely to consider treatment as outside the mainstream, more the province of social services than of medicine, or simply untrustworthy. The accuracy of this description was verified by one practitioner of homeopathy for children, Marisa Guthrie the Director of the Children's Clinic in Brighton. Equally, psychological training can ignore physiology completely.

Although there appears to be a fairly slim academic literature on the effectiveness of inter-agency training as yet[234] it is considered to be an indispensable part of inter-agency *cooperation*, which is based on the assumption that 'promoting children's well-being and safeguarding them from significant harm depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals.'[235] Government guidance for assessing children in need, eg. the *Framework for the Assessment of Children in Need and their Families*,[236] emphasises the importance of engaging appropriate professionals from a range of children and adult services in multi-disciplinary assessments in order to safeguard children and promote their welfare.

Glennie and Horwath[237] write that 'Inter-agency training has a central part to play in building and maintaining the conditions required for this sense of shared responsibility and an integrated approach to the planning, administration and delivery of services to children.' Moreover, they also recommend that for inter-agency training to be effective 'it must be *broadened* conceptually to take account of both safeguarding and promoting the welfare of children. This in turn means wider target groups from a diverse range of adult and children's services in statutory, voluntary and private settings,' and they include GPs and other healthcare professionals (such as psychologists and health visitors) in suggested lists.

Although the context for all the documents cited in the last two paragraphs is one of child protection, safeguarding children who are likely to be at risk, our

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233 http://www.bazelon.org/

234 Sebuliba D, Vostanis P (2001) 'Child and adolescent mental health training for primary care staff' *Clinical Child Psychology and Psychiatry* 6 191–204

235 DH (1999) W*orking Together to Safeguard Children*, London: DH

236 DH (2000) *Framework for the Assessment of Children in Need and their Families*, London: DH

237 Glennie S & Horwath J (2000) 'Inter-agency training: broadening the focus' *Child Abuse Review* 9 148-156 p148

consultation process revealed the view that the logic should be extended across training for all those working with early years children with a preventative rationale. Our recommendations in the next chapter have taken account of these arguments.

4.5.8.THERE IS A CASE FOR INTEGRATING MENTAL AND PHYSICAL HEALTHCARE SYSTEMS

The last section highlighted the importance of services for families and children being designed around the growing complexity of their needs through inter-agency cooperation. However, we received submissions to the effect that there should be macro-level integration of mental and physical health care systems given their aetiological interrelatedness (that is, there are common root causes to different physical and mental conditions). One in ten children have a diagnosable mental health or conduct disorder[238] and the leading causes of mortality will no longer be infectious disease but diseases of the heart, cerebrovascular diseases, cancer, chronic obstructive pulmonary disease and diabetes.[239] Developmental and environmental factors are at the root of all these sets of conditions.

Evidence from hearings, visits, conferences and consultations consistently reinforced the need to integrate approaches and deliver holistic services at a stage when preventative measures could change the outcome of biopsychosocial vulnerability. Evidence from a number of clinicians (such as Professor Mukhopadhyay, Dr Hilary Cass, Dr Amanda Jones and Professor Jane Barlow) identified the importance of co-ordinating mental and physical healthcare in a new way, to cope with factors contributing to mental ill health and chronic disease, which arise during the perinatal period and in the first three years of a child's life. As Dr Hilary Cass and Dr Ingrid Wolfe, from the newly formed National Collaborative for Children's Integrated Healthcare, state 'we need to catch up with other countries, by integrating [primary and secondary] health services for children and by building strong community-based teams of children's healthcare professionals including family GPs, paediatricians, specialist children's nurses and other allied health professionals. Such integrated teams could provide the ideal balance between access and expertise, and help to raise UK children's healthcare to be among the best in the world,'[240] but they go further in recommending that the UK lead the way in joining up mental and physical health services.

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238 Collishaw S, Maughan B, Pickles A (2004) 'Affective problems in adults with mild learning disability: the roles of social disadvantage and ill health' *British Journal of Psychiatry* 185 350-351; Meltzer H et al (2000) *Mental health of children and adolescents in Great Britain*, London: TSO

239 Vollrath M (2006) *Handbook of Personality and Health* London: Wiley

240 *The Times,* Letters to the Editor, June 28 2008

The picture that was built up over the lifetime of the Commission was that, at present, the range of healthcare (including mental healthcare) is delivered through services which are often separated in a way that fails to provide the best outcomes for children and families. Healthcare professionals themselves described a basic lack of understanding that our present diagnostic criteria and our systems are constructs derived from researchers and clinicians, which often lack integrating cultural perspectives, take little or no account of overall impairment and fail to consider a range of developmental issues or the needs of the entire family. Services artificially separate emotional and physical health which is not only costly but also becomes increasingly unsustainable from a workforce perspective. The entire system is confined within inflexible hierarchies between health, social care and mental health, despite Government policy emphasising inter-agency collaboration (see for example *Every Child Matters* 2003).

Meanwhile the rise in early onset chronic disease and mental ill health continues, with economic priorities resting on the cost of physical ill health and therefore on the medical healthcare system, despite the fact that 'psychological factors, such as health-compromising behaviours and stress'[241] are involved in morbidity from chronic disease. Dr Simon Wilkinson states that, 'brain development is dependent on continuing feedback from the environment, genes being turned on in particular contexts' and therefore attachment strategies have particular relevance in understanding the language of illness.'[242]

Throughout this report we have prioritised the importance of nurturing to achieve optimum brain development and attachment strategies which form strong relationships: the foundation for stable emotions and behaviour. We have been advised that this approach should be at the heart of understanding the nature of mental/physical and social ill health but that the organisation of services throughout the UK does not enable this to happen. Yet the findings of a range of international research such as the ACE study have '…demonstrated the connection between childhood trauma and adult pathophysiology' and are of 'direct importance to the everyday practice of medicine and psychiatry because they indicate that much of what is recognized as common in adult medicine and social behaviour has a dose-response relationship to what was not recognized in childhood. The implications for medical practice are profound and have the potential to provide a new platform upon which to base primary care medicine.'[243]

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241 Vollrath M (2006) *Handbook of Personality and Health* London: Wiley

242 Wilkinson S (2003) *Coping and complaining: Attachment and the language of disease* London: Brunner-Routledge

243 Felitti V et al (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study' *American Journal of Preventative Medicine* 14 245-258

A view typically expressed in our consultation process was that if the root of future adult disease lies in the environment, including the psychological context, in which children begin their lives then treating physical and psychological maladies in an almost wholly separate way may go a long way to explain our inability to adopt a truly preventative approach. Lando et al make the point that 'the separation of mental and physical health that exists in our healthcare belies the fact that both exist within individuals in an exquisitely integrated fashion.'[244] Understanding and recognising the importance of an individual's biopsychosocial background prioritises the relational aspects of life and focuses on emotional and relational poverty as the foundation of vulnerability, instead of purely educational and economic poverty. Flowing from that will be an emphasis on changing and improving emotional well-being.

The logical conclusion which many consultees to the Early Years Commission have come to is that there should be an integration of services based on a biopsychosocial model of health, to be initially delivered through primary care services and integrated specialist services, during the perinatal period and the first years of a child and its family's life. This has been discussed internationally but not yet implemented anywhere. (In the next chapter we describe how this might work alongside the model of Family Services Hubs.) This places the emphasis on prevention and early treatment, using a universal approach to the whole population. In turn this will lead not only to changes in inter-professional training, but also to a different and more holistic approach to diagnostics and assessment, using a 'what's the story' analysis instead of 'what's the symptom.'[245]

4.6. Conclusion

This chapter has attempted to summarise much of the evidence we obtained at our hearings concerning deficiencies in service provision intended to improve outcomes for very young children. Chapter 5 presents our recommendations for the key areas of health visiting, childcare and better integration of services, based on the expert advice we have received from health care practitioners and voluntary sector service providers, our awareness of the academic literature, as well as on the specialist knowledge of Commission members.

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244 Lando J et al (2006) 'Uniting Mind and Body in our Healthcare and Public Health Systems' *Preventing Chronic Disease* 3 Editorial.

245 Comment made by Dr Bruce Perry during his lecture, *Helping Children Reach Their Potential* Child Trauma Academy Conference 2007/ 2008

CHAPTER FIVE
Recommendations from the Early Years Commission

5.1. Introduction

From the consultation process (comprising hearings, background research and polling both of parents and the general public) described in the last two chapters, there emerged common themes which form the basis for our recommendations. These are intended to promote infants' and families' well-being during pregnancy and in the first three years in order to secure the best possible future for the next generation.

We are aware that, as our guiding principles state (see Introduction), a focus on the early years must not disadvantage the later years. Our aim in directing services towards the early years is to sow the seeds for later positive relationships and emotional resiliency. In addition however, explicit attention is required to ensure that those who have 'lost out' in their early years are given every chance to have the effects of this counter-balanced in future opportunities. A focus on the early years does not imply that intervening later is a pointless exercise, and policy must reflect this reality. Other policy groups within the Centre for Social Justice are producing policy recommendations on the subjects of youth and gang crime, family law and children in local authority care. *Breakthrough Britain* itself, the precursor to this report, looked across the full age range and at multiple causes of disadvantage and the work of this Commission is intended to build upon the recommendations it made, not to supercede them.

In the light of that we will reiterate some of the main recommendations made in that report and how they have been further refined in the light of the subsequent consultation process.

5.2. Family Services Hubs[246]

The concept of the Family Services Hub represents a significant enhancement of current, community-based service provision as well as a greater degree of integration of services to maximise efficiency and coordination of professionals in the interests of the nation's families. What we recommended in *Breakthrough Britain* is that in each neighbourhood there be a hub or 'nerve centre' of services. All of the services which we consider necessary need not be located within a single building or site in a neighbourhood, but there should be an access point to which people can go in order to be signposted onto the correct provider. In highlighting that every *family* matters – as well as every child – we wish to see a significant improvement in the range, quality and accessibility of services to every family.

> In our polling, when we asked which two provisions would be most helpful in supporting parents to have the best possible relationship with their infant, 41% of parents and expectant parents said post-natal parenting classes and 38% said the provision of health visitors trained in parent-child relationships. More than a quarter (28%) said a community support group led by parenting experts and almost one fifth said parenting classes undertaken in schools.
>
> YouGov polling (2008)

Rather than prescribe exactly how Family Services Hubs should be set up, we proposed that each local authority would be required to ensure that a well-specified list of services be delivered. An expectation would be placed on them to maximise the coordination of services and work with eg. health authorities to provide adequate training and supervision for professionals where necessary. We recommended that they co-locate services wherever practical, and work with the public, private and voluntary sectors to determine how to deliver those services. Child and adult mental health services, health visitors and social workers should ideally be co-located or closely linked with providers of relationship support.

We therefore aimed to build on the Sure Start idea of centralised access to services and outreach, be much more prescriptive about the menu of services required, (eg. the need for home-visiting programmes, parenting programmes in the infant's first year of life and therapeutic counselling for parents and their babies within the first two years such as that provided by organisations such as OXPIP) but much less prescriptive about the required infrastructure. The implications of this greater load on local authorities would, we said, need to be thoroughly thought through by an Implementation Working Party which would include appropriately senior members of the Local Government Association and leaders from within the private, voluntary and community sector. This would help to ensure that a sense of partnership permeated the development of such an initiative, and that the full potential e.g. of the voluntary sector was harnessed.

246 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice p102

5.2.1. WE SHOULD MAKE THE MOST OF EXISTING FACILITIES

Rather than a massive spend on new infrastructure we recommended that existing facilities be used wherever possible and extended where necessary. These would include (but would not be limited to) GP surgeries, Children's Centres, health clinics, Extended Schools, register offices, community centres and Citizens Advice Bureaux. In practice, Children's Centres and Extended Schools are likely to feature most prominently as Family Services Hubs, as by 2010 there are expected to be 3,500 Children's Centres and all schools will be obliged to offer extended services.

5.2.2. THE IMPORTANCE OF CHILDREN'S CENTRES AND EXTENDED SCHOOLS IN FAMILY SUPPORT

We also recommended that Children's Centres and primary schools should be the focus of as much parenting support as possible. A greatly reduced emphasis on the provision of childcare in Children's Centres would, we said, release space and resources for other services for parents. This recommendation and the whole concept of Family Services Hubs is very much in line with what was recommended to the Government of Ontario after a major longitudinal study was carried out in order to identify key ways to improve outcomes for children.[247] The report's authors did not propose universal daycare, but rather recommended the establishment of a network of early child development and parenting centres. Ideally linked to primary schools, the centres would include early childhood development and parenting activities, home visitation, home-based satellites and early problem identification and intervention.

5.2.3. FAMILY SERVICES HUBS AS THE KEY DELIVERY MECHANISM FOR RECOMMENDATIONS IN THIS REPORT FROM THE EARLY YEARS COMMISSION

It is important to remember that the original aims of Sure Start, the progenitors of Children's Centres, were not just educational and childcare-oriented, they were also about promoting social and emotional development. It is our intention to refine rather than dismiss this major policy initiative of the current Government and to revitalize the values (especially of promoting nurture and thereby breaking the dysfunctional cycle) which inspired many professionals and practitioners to engage with Sure Start in its early days. The switch in emphasis to childcare has led to many of those we spoke to becoming disillusioned – they saw the ethos of Sure Start as being concerned with helping parents do the best job possible, not with looking after their children so they could do other jobs.

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247 McCain M, Mustard F (1999) *Reversing the real brain drain: Early years report* Toronto: Canadian Institute for Advanced Research

> The National Academy of Parenting Practitioners commissioned YouGov to survey 5,551 parents with a child or children aged 16 or under to obtain their perspective on parenting services. Parents wanted services in a variety of formats, and were particularly interested in drop-in centres (67% of parents) and interactive websites (62%)
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> FPI, *2007,* Parenting Services: Parents' Perspectives: YouGov survey conducted for the National Academy for Parenting Practitioners

Serious consideration has already been given to aspects of the Family Services Hubs by bodies such as the Parent Infant Clinic and the School of Infant Mental Health. They have fully developed the concept of Emotive Care Units (ECUs) based in the community to help ensure that very young children receive what they need for optimal emotional development. Similarly there are localized models of good practice such as the Paediatric Centre set up by Dr. Amanda Jones and colleagues in North East London which provides specialist and comprehensive care at a critical stage in the life of a family, from the conception of a baby through to the baby becoming a toddler. We envisage working with experts such as these in an implementation phase to scope out more completely how hubs would operate and, for example, how they might be evolved from current Children's Centres.

5.2.4. COST IMPLICATIONS:

This recommendation is largely unchanged from the original Breakthrough Britain Report, which estimated the cost to be £86 million per annum. Further detail of how these costs were arrived at is provided in the Appendix.

5.3. Fostering families instead of fostering children

We would also like to make a further recommendation for service design in early years support. Foster care has been described as 'the most powerful, extensive and personalized intervention available to children and families.'[248] It may protect children in the short term but not promote their long-term development. It is widely known that children tend to do very badly when they are removed from their parents and placed in local authority care, and although this is not done lightly by social services, other interventions should also be considered. In earlier chapters we described the work of Save the Family, a voluntary sector organization which works (with social services) to keep families together when homelessness might otherwise necessitate placing the children in foster families until their own parent(s) can provide a stable home. Even if it is only a temporary measure, being separated from their parents can be very psychologically difficult for children who tend to have already experienced other traumas.

248 Crittenden P, Farnfield S (2007) 'Fostering Families: an integrative approach involving the biological and foster family systems' in Lee, R & Whiting, J (eds) (in press) *Handbook of Relational Therapy for Foster Children and their Families.* Washington DC: Child Welfare League of America

We therefore recommend that the work of organisations like Save the Family be replicated across the country with guaranteed, long term funding in recognition of the cost savings they deliver. Save the Family is an accredited provider of supported housing for vulnerable people through the Supporting People programme. Research has shown that for every pound spent on the Supporting People programme, £1.68 is saved through the reduced impact on health, prison and local authority services.

Finally, we would also recommend that consideration be given to placing families with other families in the community using a 'fostering families' approach. The attachment expert Dr Patricia Crittenden described to us the concept of 'generational hopping' where experienced older parents whose children have left home act as grandparents to the children and in some measure, fulfil the role of extended family members to the parents also. She has worked with Dr Steve Farnfield, a lecturer in social work at the University of Reading, to develop guidelines for social workers in this area such that, again, children are able to stay with their parents, with appropriate intervention.[249]

5.3.1 COST IMPLICATIONS:

For the supported housing model described above and assuming initial capital costs of £42.95 million and ongoing net revenue costs (taking account savings in the local authority care budget) of £75 million, this would cost £117.95 million in the first year. There would however be significant savings in costs associated with healthcare (mental and physical), criminal justice, failed tenancy, unemployment, other temporary accommodation and support services for the adults (parents) in the present and their children in the future. Further detail of how these costs were arrived at is provided in the Appendix.[250]

5.4. A revitalized health visiting profession to deliver universal and targeted services

In *Breakthrough Britain* we stated that important preventative resources are being eroded by both policy and budget cuts, that health visiting services in particular are being significantly reduced, insufficient numbers are being trained and the profession is becoming increasingly demoralised. The Family and Parenting Institute recently reported that health visitors were becoming an endangered species and that numbers are in 'freefall'. Yet 76 per cent of parents want health visitors and 83 per cent would like home visits from health visitors.[251]

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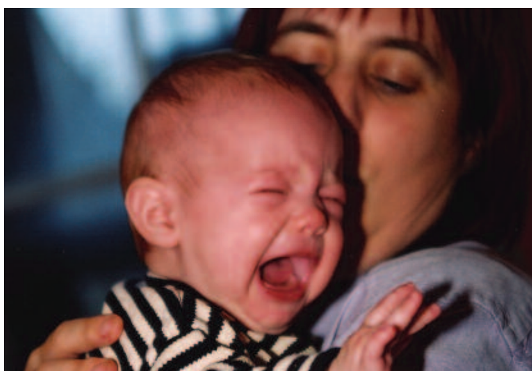
249 Crittenden P, Farnfield S (2007) 'Fostering Families: an integrative approach involving the biological and foster family systems' in Lee, R & Whiting, J (eds) (in press) *Handbook of Relational Therapy for Foster Children and their Families* Washington DC: Child Welfare League of America

250 Cost implications assessed for this report i.e. not *Breakthrough Britain* costs, have been validated by our financial consultant and all necessary caveats expressed.

251 Gimson (2007) *Health visitors: An endangered species* London: Family and Parenting Institute

As we said in Chapter 3 of this report, GPs told the Early Years Commission of their concern that there were few lines of referral for post-natal depression, for the reason that health visitors were no longer routinely attached to surgeries. Given the ramifications of postnatal depression for babies' development, the level of suffering for and pressure on whole families which it brings about and the poor rates of its detection by front-line healthcare workers, this present Commission recommends that the siting of health visitors away from GP surgeries be urgently reviewed.



The Child Health Prevention Programme states that 'every general practice needs to have regular contact with a named health visitor with whom to discuss individual children and families and the delivery of the CHPP' but we would go further in recommending that health visitors be available at key times in GP surgeries for mothers and parents themselves. Our consultation process revealed that take-up of Children's Centre services by the 'hardest to reach' is far less common than the near-universal attendance at surgeries.

5.4.1. TARGETED SERVICES SHOULD NOT REPLACE A UNIVERSAL OFFERING

We also recommended in *Breakthrough Britain* that funding be provided for intensive home-visiting during pregnancy and infancy in order to promote and facilitate family and child health, development, resilience and mental health. One such model is the Nurse-Family Partnership of Professor David Olds currently being piloted in the UK but other models exist, such as the Sunderland Infant Programme, which points to a new and very important role for health visitors, as infant mental health workers. Where it was implemented, the Sunderland Infant Programme provided intensive support and intervention with the use of video-based screening of parent-infant interaction, feedback, advice and co-operative working between health visitors and psychologists. However, this programme has now ceased because of lack of funding. The promotion of positive nurturing relationships between parents and very young children requires that sustained funding be available for a very wide range of proven interventions.

> In our polling, 68% of parents said that GPs surgeries support pregnant women fairly well or very well.
>
> YouGov polling (2008)

However we also shared the concern of organisations like the Family and Parenting Institute that such services are 'only for a tiny proportion of the population …. a strong universal offer is critical for the majority of families who also need support and parenting help from health visitors.' This was also the premise upon which the European Early Promotion Project (EEPP) was founded, that is, to provide a universal service acceptable to all families with small children, and to utilise a partnership model in professional-parent relationships.

International Models

In Canada a programme to offer telephone support to pregnant and postpartum mothers proved successful, aiming at help with smoking cessation, low birth weight, encouraging breastfeeding and recognition of depression. Proactive telephone support may (a) assist in preventing smoking relapse, (b) play a role in preventing low birth weight, (c) increase breastfeeding duration and exclusivity, and (d) decrease postpartum depressive symptomatology.

The importance of maternal nutrition and smoking is of international concern and was highlighted in this report. Missouri has also tried telephone support through its 'Baby BEEP' scheme which uses nurse-delivered individualised social support to families and biological monitoring. This proved effective in reducing not just smoking but helped with maternal stress. (Post hoc analyses of study completers suggested a four percentage-point advantage for the intervention groups over controls in producing early and mid-pregnancy continuous abstainers.)[252]

The EEPP, piloted out in several European countries, including the UK, started from the premise that an emphasis on the very early years of a child's life cannot be confined to those children who are at most risk of social exclusion. The future mental health of a much higher percentage of the population would be distinctly improved by focusing resources and attention here, and the role of health visitor needs to be protected and developed. A preventative and supportive universal home visit service has merit for its own sake. Such a programme is non-stigmatising and will also allow early identification of those needing more intensive help, with improved consequences for family well-being later on. (Effects of the intervention on children's psychological development and family adaptation were evaluated at two years of age in comparison with matched groups not receiving the intervention, using a set of questionnaires, interviews and observation methods. At 24 months there was evidence of differences in outcome favouring the intervention group, who also showed significantly higher levels of satisfaction with the intervention they had received. For example, maternal depression at 24 months among women in Finland and Greece who had received the intervention was 53-56 per cent better than those who had not.[253]

That early identification would take place through assessments of infants and very young children which would have a wider remit than an emphasis on

252 Dennid C L et al (2008) 'A Systematic Review of Telephone Support for Women During Pregnancy and Early post-partum Period' *Journal of Obstetric and Gynaecological Neonatal Nursing* 37 301-314; Bullock L, Everett K D, Mullen P D, Geden E, Longo D R, Madsen R (2008) Baby BEEP: A Randomized Controlled Trial of Nurses' Individualized Social Support for Poor Rural Pregnant Smokers, *Maternal and Child Health Journal* (In press)

253 Tsiantis J et al (2005) 'EEPP: Conclusions, Implications and Future Directions' *International Journal of Mental Health Promotion* 7 103-110

As a potential factor the recognition of post natal depression as a potential for biopsychosocial risk in infants is recognised internationally. Again the use of an accurate assessment tool has been tested internationally from Pakistan to the UK, e.g. the Edinburgh Postnatal Depression Scale was shown to have satisfactory sensitivity and specificity for detecting major depressive disorder during pregnancy in pregnant Taiwanese women.[254]

behavioural or medical issues, e.g. obesity. Assessments need to incorporate the neuroscientific implications for child development and emotional needs in their appraisal. Work would need to be done to assess different methods of developmental appraisal with the co-operation of health visitors and allied professionals, with pilot studies carried out to ascertain a general framework which could then be adapted. The pilot studies themselves should have very clear aims, objectives and time scales for evaluation.

Similarly the mother's mental and physical health after birth, including signs and symptoms of postnatal depression needs to be more clearly identified. Professor Lynne Murray presented worrying evidence that such depression is not always being detected by front-line healthcare workers such as health-visitors and GPs. Further training is necessary to enhance sensitivity to these issues for all those involved in antenatal as well as postnatal care. (The attitude of the mother could, for example, be assessed throughout the first year through play-based observation during a general discussion.)

When we polled parents, and asked them how helpful they thought free counselling sessions with professionals (e.g. family therapists or psychologists) would be for vulnerable parents (those likely to struggle in their role) bringing up 0-3 year old children, 71% thought these would be helpful or very helpful but 80% thought more frequent visits from health visitors would be helpful or very helpful.

YouGov polling (2008)

EEPP training of primary health care professionals e.g. health visitors and community nurses in the UK, led to a distinct improvement in knowledge and perceived self-efficacy, and their accuracy of need identification in families and training satisfaction was high. However the UK Government has not acted on these evaluation results to make the necessary investment to build up the type of universal health-visiting service that the programme recommends.

So this Commission reiterates the call in *Breakthrough Britain* for enhanced health-visiting, and emphasises that the promotion of families' well-being during pregnancy and in the first three years requires that more personnel and resources are needed for universal and targeted services. We also recommend that programmes or approaches (such

254 Su K P, Chiu T H, Huang C L, Ho M, Lee C C, Wu P L, Lin C Y, Liau C H, Liao C C, Chiu W C, Pariante C M (2007) 'Different cutoff points for different trimesters? The use of Edinburgh Postnatal Depression Scale and Beck Depression Inventory to screen for depression in pregnant Taiwanese women' *General Hospital Psychiatry* 29 436-441

as the partnership model used in the EEPP described above) with proven effectiveness in training professionals to better supporting parents who are struggling in the early years are given a far higher priority in funding decisions. This would be wholly consistent with an overall emphasis on treating this stage of children's lives as a strategic intervention point, likely to bring the highest rate of return on investment.

5.4.2. COST IMPLICATIONS

This recommendation is largely unchanged from the original Breakthrough Britain Report which set the cost at £135 million. Further detail of how these costs were arrived at is provided in the Appendix.

5.5. Better support and training for early years professionals

We recommended a number of system changes to the child and family workforce to enhance the effectiveness of their work. These include direct access to mental health professionals for young children, (who would have been identified by universal frontline services such as health-visitors trained in the manner described below) common inter-agency training and application of a coherent theoretical model of family support, and a more facilitative role (requiring better training) for managers.

5.5.1. GREATER ACCESS FOR CHILDREN TO BESPOKE MENTAL HEALTH SERVICES

We also recommended the further development of child mental health services (including infant mental health specialists) on the grounds that relatively few children with psychosocial problems are seen by specialists. With reference to the effect on children's mental health of their mother's post-natal depression, Dr Christine Puckering, a Consultant Clinical Psychologist and Research Fellow at the Royal Hospital for Sick Children in Glasgow (and a consultee to the Commission) writes that:

> *Child mental health services, rarely see children until after the early months when the damage may already have been done…the needs of the child require special attention and only in rare cases are infant mental health services developed. Effective intervention for parents and children will require the coordination of primary and secondary care services across the age range in combinations that may lie outside the usual multidisciplinary boundaries.*[255]

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255 Puckering C (2004) 'When a parent suffers an affective disorder: effect on the child' in M Gopfert, J Webster & M Seeman (eds) *Parental Psychiatirc Disorders: Distressed parents and their families* Cambridge: Cambridge University Press

Moreover, such specialists are needed to train and support other personnel. Services need to be available to families in their own localities, with better integration of agencies and disciplines at different levels of specialism. Services should be organised on a tiered basis to improve coordination of all services and access to higher levels of specialty. As many different services as possible should be co-located or organised closely together, including child mental health specialists, speech and language therapists, which would be facilitated by the Family Services Hubs model.

5.5.2. ADOPTION OF A FAMILY PARTNERSHIP MODEL

We also recommended that services be based upon the concept of partnership with families and that the quality of the professional's relationship with the client(s) be at the heart of delivery. The first implication of this is that careful attention will have to be given to selection and recruitment procedures to ensure that the workforce has the qualities and skills to engage families in true partnership and communicate with them effectively.

We stated that all people working with families and children – across social care, health and mental health, education and the voluntary agencies – should receive specialist training to hone their understanding of the processes of helping and promoting family well-being and the interpersonal skills required for their work no matter what their role, as suggested by the Family Partnership Model.[254] Rather than imposing solutions, the collaborative model integrates the expertise of parents with that of potential helpers.

We noted that as the use of a common model is likely to enhance inter-agency cooperation, it should not be limited to professionals' post-qualification period (and to child protection as stated earlier). Such training should be given pre-qualification in a multi-agency, multi-disciplinary setting. A final implication of this approach is that the management of all staff should be improved, and that regular, facilitative supervision be guaranteed. This will require managers to be selected for their interpersonal qualities and supervisory skills, trained to enhance these and well supported themselves.[256]

Further development of this recommendation was carried out by the Early Years Commission in the following areas:

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256 Davis H, Day C, Bidmead C (2002) *Working in Partnership with parents: the parent adviser model* London: Harcourt Assessment

257 Braun D, Davis H, Mansfield P (2006) *How Helping Works: Towards a Shared Model of Process.* London: Parentline Plus

5.5.3. CLOSER INTEGRATION OF MENTAL HEALTH SERVICES ACROSS THE GENERATIONS

Our hearings identified a need for greater co-operation and integration between services. There was concern that the impact of parental mental health on children and vice versa should be acknowledged. The problematic nature of the splitting of services was raised by several consultees, for example the international attachment expert Dr Patricia Crittenden recommended that we end the division between children, adolescent and adult mental health services and 'treat the families not just the child. Similarly adult psychotherapists must ask about the risk to any children involved and not just the adult in their care' and Dr Christine Puckering writes that 'there is also an issue about service delivery, with adult mental health services unaware of the impact of depression in parents on their children, and probably considering this outside their remit.'[258]

Co-operative working between teams who have within them practitioners who are more knowledgeable about child or adult mental health is vital. The Parent Infant Centre delegates in particular felt that: 'The current provision of mental health services to the early-years sector (babies 0-3 years old, parents, families and the professionals who serve them) is stigmatizing and inefficient'. Therefore, the impact of mental health issues in adults on the children and other family members should be acknowledged with co-operative working between the various mental health teams as a requirement.

5.5.4. SPECIALISED PROGRAMMES OF TRAINING FOR ALL PROFESSIONALS WHOSE WORK IMPACTS UPON CHILDREN IN THEIR EARLY YEARS

Our consultation process suggested that, at present the social and emotional development of children in their early years is not sufficiently understood by professionals whose work impacts upon it (directly or indirectly). We heard that professionals need to understand the underpinning neuroscience, how to recognize emotional dysregulation in children etc. Without training and understanding in all these areas, policies such as the Child Health Promotion Programme may be variably implemented across the country with professionals struggling to meet its many and detailed requirements. Training must also help foster inter-agency and inter-professional integration.

Here we outline a three-tiered model of early years training designed to address these issues:

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258 Puckering C (2004) 'When a parent suffers an affective disorder: effect on the child' in M Gopfert, J Webster & M Seeman (eds) *Parental Psychiatirc Disorders: Distressed parents and their families* Cambridge: Cambridge University Press

5.5.4.1. Additional modules to be part of core Health Visitor training covering social and emotional development in the early years, and key skills to enhance this

We recommend that health visitor training be extended to two years in order to include at least three additional modules. The first should focus on the nature of early years social and emotional development with topics here to include attachment (for example, its patterns, neuroscientific basis, influencers, effects); the impact of antenatal and perinatal depression and other mental health problems on the formation of attachment and early development together with the impact of other family relational factors; and the implications of all this for practice. The second module would focus on the assessment of familial relationships and their impact on the child, including use of validated tools designed to measure insensitive parenting as outlined in the CHPP (e.g. Brazelton or Nursing Child Assessment Satellite Training, NCAST). Health visitors should be made aware of the full provision of specialist help, and how and when to refer on. The third additional module should centre on developing specialist skills in promoting nurturing parent-child interactions through conversation with parents. Relevant skills include motivational and promotional interviewing, active and reflective listening, and brief intervention skills. For training to be maximally effective, it is likely to require a mix of instructional, questioning, collaborative and practical teaching methods.

5.5.4.2. Additional modules to be part of core childcare worker training covering social and emotional development in the early years, and key skills to enhance this

Similarly, we recommend that daycare practitioners' including childminders' training be expanded to include an additional two modules. The first should follow the same lines as that of the first module outlined for Health Visitors above (i.e. include attachment; perinatal depression and mental health problems; familial relationships and implications for practice). The other unit should focus on the skills and practices essential for childcare workers to engage in nurturing interactions with the children under their care. This would build on those topics already part of the training such as child-centred play, attending, self-care, and reflexivity skills. Training should clearly outline the appropriate extent as well as limits to worker-child interactions. Again, it is likely to be maximally effective if it employs instructional, questioning, collaborative and practical teaching methods.

5.5.4.3. Inter-professional training module on the early years to be developed and made mandatory for all relevant professional groups with indirect or direct contact with children in their early years

Many professional groups, beyond those with direct, frequent contact with young children and their parents, have the power to make decisions that profoundly influence these children's relationships and development. Good decisions and interventions need to be informed ones. In particular, they need

International training programmes

Accurate assessment of the quality of attachment between baby and caregiver is at the heart of being able to deliver an effective intervention. The international work of Dr Patricia Crittenden (The Family Relations Institute, Miami, see www.patcrittenden.com/courses) has focussed on methods of assessment derived from years of research in different cultures and contexts in relation to attachment strategies. Her Dynamic Maturational Model of attachment encompasses this research and is used throughout Europe to assess mother/infant pairs. Training courses in assessment include:

1. The Care Index: This assesses mother-infant interaction from birth to about two years of age based on a short, videotaped play interaction of 3-5 minutes. Once the coder is trained, coding of an interaction takes about 15-20 minutes. The measure assesses mothers on three scales: sensitivity, covert and overt hostility, and unresponsiveness. There are also four scales for infants: cooperativeness, compulsive compliance, difficultness, and passivity. These scales tend to be related to the maternal scales in the order listed. The scales are highly correlated with the infant 'Strange Situation'[259] assessment patterns of attachment; they differentiate abusing from neglecting, abusing-and-neglecting, marginally maltreating, and adequate pairs; can be used during intervention; can be used to assess the effectiveness of intervention.
   The procedure is easily applied to 'live' observations made by nurses, infant teachers, clinicians, and social workers.
2. Adult Attachment Interview: The dynamic-maturational approach to the Adult Attachment Interview (AAI) is both a useful research tool and also a potential guide for psychotherapists. Therapists, in particular, learn not only new ways to conceptualize disturbed development, but also ways to identify adults' distortions of the mental processing of information, particularly information relevant to disorders of feelings, thought, and behaviour

The advantage of this particular model is that it promotes the idea of and ability to change: 'maturation, occurring slowly over two decades or more, increases the probability that a wide range of experiences will influence the development of both brain and mind.'[260] Accurate assessment of potential risks allows any country to design specific programmes to flexibly apply to their own culture.

For example:

The Circle of Security (USA) intervention uses a group treatment modality to provide parent education and psychotherapy that is based on attachment theory. The programme runs for 20 weeks and is group based; it is designed to shift patterns of caregiving interactions in high risk, caregiver-child pairs to a more appropriate developmental pathway, using videotapes of parental/ child interactions. It has been designated as a 'Reported Effective Program' by the Children's Bureau Office on Child Abuse and Neglect of the US Department of Health and Human Services.[261]

The use of video feedback is also used in Holland in 'Promoting Positive Parenting.'[262] This enhances sensitive responses from caregiver to infant and reinforces positive movements. This service is also offered as adoption aftercare for every newly adopted child and family for only 100 euros per case.

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259 In 'Strange Situation' assessments a child is observed in a setting unfamiliar to them in which the physical and psychological availability of the baby's carer is systematically manipulated and he or she is introduced an unfamiliar figure. Such alterations are designed to subject the baby to mild but cumulative stress under which circumstances babies are expected to seek comfort from their attachment figure. The procedure is designed to elicit attachment behaviours from them and build up a profile of their attachment pattern.

260 Crittenden P M & Claussen A H (eds) (2000) *The Organisation of Attachment Relationships* Cambridge University Press

261 Hosking G, Walsh I (2005) *The WAVE Report 2005: Violence and what to do about it* London: Wave Trust

262 Bakermans M J et al (2003) *Promoting Positive Parenting*

to take account of how different familial relationships impact upon a child's well-being in the present and at future developmental stages.

As an aid to co-operative and integrated working, the introduction of a core training programme for all professionals working with the zero to three age range and their families is strongly recommended. This would focus on the emotional and relational needs of children and their families and between the adults.

We therefore recommend a generic training in early years social and emotional development for the following professional groups: social workers in both adult and child settings; CAMHS and adult mental health (AMH) healthcare professionals; substance misuse workers; general practitioners; judges and lawyers involved in family law; managers of childcare centres and Children's Centres and teachers involved in the Personal Social and Health Education (PSHE) curriculum. This training should include the four topics already described as part of the first module for health visitor and childcare workers (i.e. attachment; perinatal depression and mental health problems; familial relationships; implications for practice). The fourth topic, implications for practice, may be individualised for the different professional groups. In order to promote inter-professional and inter-agency collaboration, this common training should be made mandatory at a pre-qualification stage, and be delivered in a multi-agency, multi-disciplinary setting (following good practice models already in place).

5.5.5. COST IMPLICATIONS

Depending on how many additional mental health professional posts were created to increase children's access to services, this would cost between £30 million (to create another thousand posts) and £350 million (to double the existing workforce). Training costs would require further modelling to take into account all categories of professional involved, costs of training trainers and the percentage of those whose training would be publicly funded. (To give some idea of costs, training in the Family Partnership Model costs £6000 per group of 12 participants.)

5.6. Couple relationship education as well as parenting education

In the interim report from the Social Justice Policy Group, *Breakdown Britain*,[263] we quoted Penny Mansfield, the director of One Plus One, who said that

263 Social Justice Policy Group (2006) *Breakdown Britain: Interim report on the state of the nation* London: Centre for Social Justice

The evidence is compelling that stable, harmonious relationships improve the quality of life for adults and children but how do we - or indeed can we – create the conditions in which such relationships are nurtured…whilst there is ample evidence that the quality of parental relationships is a critical social factor for children, politicians, policy makers and practitioners are wary of adult relationships. Current policy mainly addresses families as individuals, ignoring the defining feature of adult life, for good and ill, interdependence.[264]

In an endeavour to 'create the conditions in which such relationships are nurtured' in *Breakthrough Britain* we proposed the development and national roll-out of nine streams of relationship and parenting education programmes, operated locally by the voluntary sector through appropriate access points (including Family Services Hubs). The first five streams – pre-marriage, antenatal, and parenting zero to fives; fives to elevens, elevens & teens – would be accessed by all families. The last four streams – lone parents, prison, military and care parents – would reach specific vulnerable families.

5.6.1. PROGRAMMES COULD IMPROVE FAMILY STABILITY AT KEY LIFE STAGES

We concluded that preventative relationship and parenting education programmes can be extremely effective. Reviews show that programmes lasting just a few hours can strengthen family relationships over a period of one to five years.[265] For example, a major study of 3,000 families in the US found that divorce rates were 30 per cent lower over the first five years of marriage amongst those who had completed a well-organised marriage preparation programme.[266] With UK family breakdown so heavily concentrated in the early years of marriage and parenthood, even modest improvements in family stability at these key stages would still prove highly cost effective. As all individuals, couples and families would be entitled to draw down money from a personal 'budget', these would be non-stigmatising programmes, open to and intended for all. It was further recommended that outreach programmes operate from Family Services Hubs so that parenting programmes can take place in a range of settings.

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264 Mansfield P (2004) 'The Missing Link in Parenting Education and Support' *One Plus One Bulletin* 8 10-11

265 Carroll J, Doherty W (2003) 'Evaluating the effectiveness of premarital education programs: A meta-analytic review' *Family Relations* 53 105-118; Moran P, Ghate D (2005) 'The Effectiveness of Parenting Support' *Children and Society* 19 329-336

266 Stanley S, Amato P, Johnson, C & Markman, H (2006) 'Premarital education, marital quality, and marital stability: Findings from a large, random, household survey' *Journal of Family Psychology* 20 117-126

5.6.2. EVIDENCE-BASED INTERVENTIONS IN LINE WITH PRINCIPLES

In terms of parenting programmes, Parent Management Training is an umbrella term for a group of interventions that we recommend below, whilst expressing one or two caveats. These parenting programmes are aimed at reducing behavioural problems in children, and in this sense they are not truly preventative. Additionally, strictly speaking, changing problem behaviour is the ultimate goal rather than building positive family relationships. However, longitudinal research suggests that they are often effective in preventing future antisocial behaviour, and that one of the ways this appears to be achieved is via their improvement of relationships.

Programmes with proven effectiveness include, amongst others, the Incredible Years Programme, Triple P, and Parent-Child Interaction Therapy. All programmes have proven effectiveness across a wide-range of populations including those experiencing multiple stressors. Parent-Child Interaction Therapy has a number of particular strengths: it can be used with children as young as two, has been found to be effective as a preventative approach in children without behavioural problems but at high risk, and directly looks at the parent-child relationship as it is being played out. We recommend that these approaches are made universally available across the UK, although not as an alternative to programmes primarily focussed on enhancing nurturing, enriching relationships at an earlier stage of development.

5.6.2.1 Examples of good practice

Some of these programmes have been mentioned already, such as OXPIP (Oxford Parent Infant Project) and PIPPIN (Parents In Partnership - Parent Infant Network) but we also heard about others such as Watch, Wait and Wonder (WWW) through Dr Shirley Gracias, the consultant in infant, child and adolescent psychiatry. The WWW approach to early intervention is a relational one which enable the parent to work therapeutically and directly with their own child. Its effectiveness has been evaluated[267] and the studies indicated that time-limited psychotherapeutic treatment for infants and their mothers can have long-lasting and wide-ranging effects. For example, when compared with another programme, at the end of treatment, 20.6 per cent of infants in the WWW group shifted to a secure attachment compared to 3 per cent in the other group. Also, infants in the WWW group made significantly greater gains in developmental assessments than infants in the other group.

The Mellow Parenting core programme is a one day a week (for 14 weeks) group programme designed to support families with relationship problems with their children under five. It combines personal support for parents with a video and direct work with parents and children on their own parenting

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267 Cohen N et al (2002) 'Six-month follow-up of two mother-infant psychotherapies: convergence of therapeutic outcomes' *Infant Mental Health Journal* 23 361–380

problems. Given our concern that everything is done to draw fathers into services it should be mentioned that there is a particular variant called Mellow Dads which is geared towards fathering. More specifically for the age groups at the heart of this report is the Mellow Babies Programme. This has been applied in a number of settings to include mothers with postnatal depression and families with child protection concerns. The Mellow Babies programme has undergone a randomized waiting list controlled trial with clinically and statistically significant effects on maternal depression and mother child interaction, and a reduction in the need for Child Protection Registration and compulsory measures of care. The programme has been shown to make a marked impact not only on the well-being of mothers but also on their interaction with their children and their children's development.[268] Engagement and attendance at groups is very high (80 per cent of families attended 80 per cent of sessions).

5.6.3. USING THE 'TURNED TO' PERSON EG. HEALTH VISITORS TO DELIVER RELATIONSHIP SUPPORT

As well as providing funding to individuals and families, enabling them to access courses and programmes, and thus building capacity within the relationship and parenting education sector, we would also like to acknowledge and recommend the more informal relationship support which health visitors could be trained to provide. In Chapter 3 we described the Brief Encounters training programme which has been shown to help practitioners to:

- engage with parents
- recognise signs of relationship distress at an early stage
- understand couple and family relationships better
- use active listening to respond appropriately
- encourage self help and offer support
- make a relevant referral
- use the brief intervention model across a wide range of family issues
- use time skillfully as well as work in a timely way
- be clear about personal and professional boundaries
- develop their own supportive networks

Therefore, in addition to what we say above about specialist training for early years professionals, an enhanced role for health visitors and the need for a greatly expanded provision of relationship and parenting education, we would also recommend that programmes such as Brief Encounters become part of the standard training which health visitors receive.

268 Puckering C (2004) 'Mellow parenting: an intensive intervention to change relationships' *World Association of Infant Mental Health* 12 1–4

5.6.4. RESTATEMENT OF THE NEED TO ROLL OUT A FULL RANGE OF RELATIONSHIP SUPPORT

In summary, the Early Years Commission reiterates the recommendations for relationship and parenting education on the grounds that these are likely to make a significant difference to the environment in which children are raised. This is in terms of the enhanced parenting skills they will afford their parents and the likely improved model they will see for their own future relationships in their parents' marriage or partnership.

5.6.5. COST IMPLICATIONS:

Again this recommendation is largely unchanged from original Breakthrough Britain Report which set the overall cost of this significant expansion of services at £187 million once full capacity within the sector had been reached. Further detail is provided in the Appendix.

5.7. Early Years Internet Portal

A range of approaches, programmes and theoretical perspectives have been mentioned in this report, representing a fraction of the national and international offering on the subject of the early years. One further recommendation which would greatly improve the ability of practitioners, local authority commissioners and parents themselves to access information about early years provision would be to set up an Early Years Internet Portal which would allow maximal integration of information.

This would provide one place for people to go, to look for information on funding, training, services, programmes etc (with links for example to the National Academy of Parenting Practitioners Toolkit. This rates parenting programmes according to their proven effectiveness and theoretical foundations, the extent to which the targeted population and recruitment strategies are made explicit and the level of specificity regarding training, supervision and implementation procedures necessary to replicate success in a new and independent setting.)

5.7.1. COST IMPLICATIONS:

An initial outlay over three years of £1.44 million is anticipated for this particular proposal with the expectation of an eventual cost-neutral situation as this would be undertaken as a private-public sector project with advertising revenue built into the business plan. Further detail of how these costs were arrived at is provided in the Appendix.

5.8. Genuine choice for families in paid work and childcare

Breakthrough Britain identified a bias in the current system away from informal care, such as has historically been provided by grandparents, other

> The most interesting element of *Breakthrough Britain* in relation to childcare is the proposal to allow parents to use the childcare tax credit to pay close relatives to care for their children even if those relatives are not registered childcare providers. This would have several technical advantages over the current system, but it would also be superior in terms of relationship goods. Not only would it potentially strengthen the relationships between grandparents and grandchildren and enable parents and grandparents to share experiences and display mutual trust towards one another. It would also, almost certainly, have a redistributive effect, since lower income grandparents are those who would most likely take advantage of such a scheme; many already perform this work for free but would be paid for it under these proposals.[269]

kin and trusted friends or indeed parents themselves. Close relatives, such as grandparents, are legally able to look after children but not to receive childcare tax credit. We recommended that there be a change in the rules to allow the use of childcare tax credit to pay unregistered close relatives (albeit at a lower rate) to reflect parents' preferences.

We also drew attention to the fact that the Government appears to be nurturing a dependence on state-sector childcare provision which appears to be at odds with women's preference for informal care. It is also undermining the economic viability of private, voluntary and independent childcare provision. Representatives of these nurseries described the pressures on them generated by a large increase in state provision of childcare places often introduced without a rigorous audit of local demand. Recent reports indicate that supply may greatly exceed that demand.[270] State provision is subsidized so existing local nurseries, obliged to charge full costs for childcare, are placed at such a disadvantage that their rolls often fall below sustainable limits and they are forced to close.

We recommended that childcare should be located outside community-based Children's Centres wherever possible, leaving these centres free to concentrate on delivering the kinds of services we have elaborated earlier for community-based services for mental and relational health. It should be a priority for every local authority to do all it can to guarantee as much choice as possible within its geographical area, providing subsidised state childcare only where necessary to meet local demand and not in competition with existing providers, such that well-performing nurseries are in danger of being priced out of business by subsidies.

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269 Brighouse H, Swift A (2007) 'The end of the Tory war on single parents?' *Public Policy Research* Sept-Nov: 186-192

270 Bennett R (2007) 'Nurseries feel pinch as mothers stay home' *The Times*, April 30

Ideally professional childcare should be available for those who want to use it but the system must not penalise those who want to look after their own children. A balance has to be struck and a strong, culture-challenging signal sent, that for those who want to spend time at home looking after their children or a close relative there is room in the system for that choice as well as for the choice to work continuously.

5.8.1. AVOIDING PRESCRIPTION BUT ADDRESSING LACK OF CHOICE

We received substantial evidence of the benefit to children of parental care in the early (first three) years. This is a contested area of research but the body of evidence about the importance of attachment and nurture for brain development is too significant to ignore when constructing national policy on this issue. Again our intention was not then and is not now to coerce or prescribe a particular way of raising children, but any Government must respect the desires of those who feel that their children need their care, and recognise that this is supported by research and is not some kind of outmoded and reactionary view of the family.

> In our polling one third of adults felt that non-familial daycare (e.g. day nurseries or childminders) was not very well or not at all able to meet all the needs of 0-3 children while they were there.
>
> YouGov polling (2008)

It must be emphasised that our policies are in no way intended to discourage primary carer parents, usually the mother, from re-entering the workplace or coerce a return to tightly prescribed roles for mothers and fathers within the family. This is not the underlying reason for the proposed change in policy. What is being addressed is the lack of choice that either the mother or father has, to be less engaged with the labour market at key points in the lifecycle of the family.

Additionally, evidence we obtained in the hearings indicated that daycare could be far more child-focused, for example by providing greater continuity of care by one person for each child. As Julian Grenier said to us, 'we need to make childcare as emotionally responsive as possible.' The kind of mandatory training we describe above, which has an understanding of the importance of adults emotionally attuning with babies and very young children for their optimal neurological development, would be essential for the widespread delivery of child-focused daycare.

5.8.2. COST IMPLICATIONS

The proposal to change the rules to allow the use of childcare tax credit to pay unregistered close relatives (albeit at a lower rate) is unchanged from Breakthrough Britain where it was costed at £1 billion. Further details are provided in the Appendix (which described likely savings when existing claimants switch from higher cost group childcare to lower cost childcare by relatives and where relatives now receiving income from childcare see a consequent reduction in their own tax credits).

5.9. Front-loaded Child Benefit[271]

The Social Justice Policy Group, in *Breakthrough Britain*, also made the recommendation proposed by Labour MP Frank Field to enable parents to have the option of drawing down larger monthly rates of child benefit in the early years, and proportionately lower rates when the same child is older. In other words, over the child's life-course parents would receive no more money in total but they could receive larger amounts of it e.g. during the pre-school or 0-3 years period, when children are most in need of parental care. In our hearings Dr Patricia Crittenden advised the Commission that we should be 'resiting the locus for ensuring a child's future good-health away from non-parental childcare and education and back into the family with services where necessary which support relational development and stable attachments.' In a similar vein, Dr Bruce Perry[272] concludes that we need to create policy and practice that capitalizes on biological realities.

This proposal would relieve the financial pressure that forces many mothers to work when they would prefer to stay at home. It would also provide an opportunity to address deficits in nurture and care, by helping parents who are currently struggling to come to grips with the many demands of parenting, thus building stronger, more sustainable families.

5.9.1. CONDITIONS ATTACHED TO RECEIPT OF FRONT-LOADED BENEFITS

We did not recommend 'testing' all parents and closely scrutinising family life. However, it is because of deficits in parental care that some disadvantaged children are entering nurseries. Therefore, we anticipated there might be some concern that funds are effectively being provided which will encourage ill-equipped parents to look after their children themselves instead of entering paid work and placing their children in daycare.

It is to address these concerns and the parenting deficits they are based on, that some conditionality would attach to the receipt of front-loaded child benefits. In *Breakthrough Britain* and this report we have emphasised the importance of intervention, where necessary, in the first three years of a child's life, for the sake of their lifelong emotional (and physical) health. The kinds of assessments, routinely carried out on all children by a revitalised health visiting profession, as already stated, would identify those parents who need help to bond with and successfully raise their child so that they will have the best start in life and be prepared, across a spectrum of measures, to enter school and be ready to learn.

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271 Social Justice Policy Group (2007) *Breakthrough Britain: Ending the costs of social breakdown* London: Centre for Social Justice p72-73

272 Perry B (2007) *Helping Children Reach Their Potential Lecture* Child Trauma Academy

When struggling parents are identified by health visitors, home-visiting, parenting support and the other remedial services would all be available. Receipt of front-loaded child benefit as described earlier, will be dependent on health visitors and other professionals being satisfied that infants and young children are making the necessary developmental progress under the care of their parents. Where parents are unwilling to engage with parenting support services to address deficits, their access to the temporarily higher level of child benefit would be affected and eventually denied. It is anticipated that only a very small percentage of parents will be required to take up these services in order to receive front-loaded child benefit.

Most children present no concerns when current developmental checks are carried out but for those who do, it is not unreasonable that some expectation be placed upon their parents to address deficits which could have severe consequences for the rest of the child's life.

We said that if this proposal were adopted we would want all parents to have the option of drawing down larger monthly rates of child benefit in the early years. If it were not possible to make this universally available in one budget, then we recommended a phased process in which the initial focus is on those families who would benefit most from such a policy. The life chances of children who might otherwise be most at risk of lacking in nurture and quality parental care could be vastly improved by providing such a measure and linking it robustly to parenting support. The consultation process the Early Years Commission has been engaged with has emphasized rather than questioned the need for such a fiscal measure and we reiterate the need for this *Breakthrough Britain* recommendation here.

In our polling 82% of adults agree or strongly agree that the government should do more to help parents stay at home to bring up their children in the early years.

YouGov polling (2008)

5.9.2. COST IMPLICATIONS:

Various take-up rates, and other variables which determine the cost to the exchequer, have been modelled simply in the Appendix. The first year up-front cost lies between £100 million and £2 billion, depending on eligibility criteria, numbers opting into the scheme, rate of benefit paid etc. If 20 per cent of mothers took up the higher level of child benefit proposed in the model (equivalent to double the amount for the first child, payable to all children under 3) then the up-front cost would be £388.5 million. Depending on how the later clawback is calculated, the cost in later years will be reduced due to families receiving a lower amount of child benefit later in the child's life.

5.10. Building further on *Breakthrough Britain* – an truly integrated approach to health and social care

This Commission has developed further the implications of the early years focus of *Breakthrough Britain* and has concluded that this requires looking carefully at the fundamental way in which our health and social care systems are organized.

International perspectives

Integrating services in the perinatal and post natal period within a biopsychosocial framework in Primary Care is advocated internationally, as is recognition of the need to embed such interventions within services that have contact with a large proportion of children and their families. However the subject is a matter of ongoing debate throughout Europe and beyond. Integrated mental and physical health has been on the agenda in the USA since 2002 when the President George W Bush announced creation of the new 'Freedom Commission on Mental Health' whose goals included the integration of services at all levels. In Michigan, the Jordan Valley Community Health Centre collaborated with local psychologists after realising that 80% of their patients had substantial behavioural health needs. The venture also opened up opportunities for interagency training at a new level. The need for services to begin in the first few years and perinatal period is now a separate subject being analysed by several countries.

Throughout this report we have prioritised the importance of nurturing and attachment in achieving optimum neurological development and forming strong relationships, which are the foundation for stable emotions and behaviour.

It was strongly recommended to us that this approach should be at the heart of understanding the nature of mental, physical and social ill-health and therefore key to organising systems of treatment. The ACE (adverse childhood experience) studies described in earlier chapters revealed the legacy of very young children's unmet psychological needs in later onset of chronic and costly health conditions. Similarly, they and similar studies found that self-harming behaviours such as alcoholism, drug abuse and eating disorders and violence towards others may be strongly rooted in early parental deficits. Without removing responsibility from adults for the results of their own actions, understanding the strong link between the psychological and the physical requires closer integration of mental and physical healthcare systems.

> 'In the context of everyday medical practice, we came to recognize that the earliest years of infancy and childhood are not lost but, like a child's footprints in wet cement, are often life-long.'[273]

In terms of the early years, paediatric provision should be closely integrated with other services, to address associated social care, mental health, and educational needs. This would be greatly facilitated by the Family Services Hubs described earlier, but it would ideally be part of a much more wide-ranging integration of the different existing systems of mental and physical health and social services.

However we were informed that the designation of services throughout the UK does not enable this to happen. Dr Hilary Cass and Ingrid Wolfe, from the

273 Felitti V, Anda RF (2008) 'The relationship of adverse childhood experiences to adult health, well-being, social function and healthcare' in Lanius R, Vermetten E (eds) *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease* Cambridge: Cambridge University Press

National Collaboration for Children's Integrated Healthcare Steering Group have described problems spanning the full spectrum of children's healthcare, from primary and community-based provision through to secondary and tertiary level care. The result is that the quality of children's services is variable, and support for children with long-term conditions remains poor. They say:

> *We continue to see failures of child protection, worsening inequalities, and inferior outcomes in the management of children's diabetes and cancer, compared to our European counterparts. These failures are in spite of unprecedented investment in the health service and a raft of policy initiatives which were intended to improve and* ***integrate*** *[our emphasis] care for children.*[274]

They describe how services are delivered by a multitude of providers, organisations, and sectors; funding streams and budgets are separate and may compete and conflict with each other; and there are differences in organisational or professional cultures, languages (different 'jargons') and agenda. Information flow within and between services has remained poor. This strongly implies that the relational emphasis which drives the early years policy recommendations described above, has to extend to the interactions between the professionals, practitioners and parents themselves.

The Early Years Commission therefore recommends that the complexity of the difficulties faced by families is met with an enhanced degree of integration of information and service provision and that improvements in the level of integration of services becomes a key performance indicator in health services reviews. The Commission was told that there are signs of a growing trend in the organisation of healthcare to integrate services but that it is very patchy and involves different services in different health authorities. We believe that the Family Services Hubs could greatly assist in an 'integration drive' particularly in early years care, because they would require and facilitate a new dimension of inter-agency working and communication.

5.10.1. COST IMPLICATIONS:

No significant cost implications are anticipated for this particular proposal which specifies the integration, not the expansion of services.

5.11. Raising awareness of the importance of nurture – the 'Neuron Footprint'

We have said a lot about the importance of professionals and practitioners having an understanding of the key role that nurture and relationships play in the emotional and physical health of our children. If the population as a whole

274 *The Times* (2008) Letters to the Editor June 28

were able to grasp the neuroscientific findings outlined in Chapter 1 this could revolutionise the way parenting and children themselves are viewed.

The science we describe has been in the public domain for several years and awareness among the bulk of the population of the *importance* of the early years is certainly well established. As we said in the introduction to this report, 92 per cent of adults and parents, in two separate polls, agree or strongly agree that the early relationships we have with our parents while we are still babies and toddlers can strongly influence future aspects of our lives. What has been missing has been the right presentation of the science as a package, both in politics and in the media.

We propose a simple campaign to put the awareness of the brain's development during the early years at the heart of the nation's thinking when considering all aspects of family, social and other influences on our young children. We centre this campaign around the concept of a 'Neuron Footprint'.

5.11.1. COMMUNICATING THE NEURON FOOTPRINT CONCEPT

In the same way that policy and society now support the notion that an individual must take responsibility for his or her contribution to global environmental problems, the campaign we envisage needs to encourage, help and qualify every contribution to neuronal pathway construction and therefore brain development in our young children. Thus we suggest appropriating the concept of a carbon footprint to offer a simple way to understand the complexity of the neuroscientific message.

The Neuron Footprint can be a concept applicable across every aspect of care for children in the early years. Every intervention could be assessed with reference to this simple, positive touchstone. It may even be possible to offer simple quantifiable guidelines, like a five star (or toe?) rating for how 'Neuron Positive' an activity might be (although this would be a heuristic guide rather than a precise calculation, unlike a carbon footprint). In common with the carbon footprint campaign, our goal will be to influence the overall direction that each individual action or choice contributes to and encourage parents and service providers to aim to be 'Neuron Positive' in their outcomes.

Thus we offer a real, positive alternative to unconstructive criticism; this approach gives parents and service providers the chance to take informed action to measure and balance their performance in the round so that no single act or omission is judged in isolation: we believe this is real life reacting to real science.

A broad spectrum media campaign would introduce the concept of 'a Neuron Footprint for every child'. Every single state-run, private or voluntary sector organisation which influences the life of young children could be encouraged to become certified as 'Neuron Positive'. Certification would be

determined by simple, practical guidelines which would be supportive rather than condemning. Training would be available across the board for all professionals and organisations so that there is a coherent underpinning set of simple principles that lead to certification as a 'Neuron Positive' practitioner or service provider.

An easy example of this will be in daycare for the young children of working parents. Different ages have different needs, with the youngest children needing dedicated attention to provide adequate attunement. A service provider with a policy of providing such attunement to infants will qualify for 'Neuron Positive' status. This will allow working mothers to know that although they are not there 'building neuronal connections' themselves with their infant, someone else who understands how and why to do so is doing it for them; hence there is a net positive result.

5.11.2. THE NEURON FOOTPRINT CONCEPT REFORMING SERVICE DELIVERY

The trickle down effect of adopting such a concept at the broad national level could be an exciting motivator for individuals tasked with overhauling existing services to make them 'Neuron Positive'. It provides a focus and useful motivating concept for management and a clear message to deliver to their clientele. It is clear, simple and 'doable' as messages can be visual, loosely quantified and tailored to any sector or activity. We would anticipate that awareness would grow among parents themselves about very young children's need for 'Neuron Positive' activities and about the simple things parents can do to help their babies brains develop to their full potential during this sensitive and vital window of opportunity. Greater awareness among service deliverers (such as health visitors and early years workers, who have received the training in neuroscience we recommend) of how to ensure that a child has an optimal Neuron Footprint will enable them to assess, albeit somewhat approximately, where individual children are on the spectrum and advise parents where appropriate and if necessary.

5.11.3. NOT A HARD AND FAST MEASURE, MORE A SIMPLE 'RULE OF THUMB'

In summary, the overall concept is as simple as the carbon footprint: what you do makes a difference, and every action contributes to the final outcome. Where this differs from the carbon footprint however is that we are not recommending some rigid form of quantification (which would be almost impossible to achieve in practice and would encourage an inappropriate target orientation). The core principle of communicating the Neuron Footprint message is to reinforce that no-one is prescriptively telling parents how to raise their children; they are merely being informed about the implications of what

they are already doing, in a way that compares this to what they might do instead. Parents can then make the choice about what to do with that knowledge to achieve the result they want, just as with the environment. At the moment of birth every parent wants to do the very best for their children, but parenting deficits in their own childhood or other disadvantages can make it very hard to follow through on that resolve.

Brown and Dench found that interventions making low-income, young mothers more aware of child development and helping them to relate to their children, were very popular.[275] Addressing parenting deficits in a way that fires the enthusiasm of struggling parents requires the communication of simple concepts, easily grasped and acted upon. 'Popularising the science' in the way we are recommending could have profound implications for greater relational health and improve a wide range of outcomes across parents' and their children's lives.

Our campaign for a positive Neuron Footprint would inform the whole population about the best choices for making the most of limited time and resources for the care of young children, and help parents and services to understand the effects of what they do. How people use that information, and how far they chose to take it will be their responsibility. The intention of the Neuron Footprint concept is to take some of the guesswork out of parenting (and service provision) and put the power for informed decision-making back where it belongs; in the hands of the people actually holding the babies.

5.11.4. COST IMPLICATIONS:

It is anticipated that this would attract a cost of £5 million for the first year of the campaign. Further detail of how these costs were arrived at is provided in the Appendix.

5.12. Conclusion and summary of recommendations

To reiterate, although the way individuals 'behave' is important, unduly focusing on this neglects the vital role relationships play in influencing behaviour as well as in shaping the brain itself during the early years. At the point when children are most vulnerable, there is also the greatest opportunity to lay a good foundation for the future. What parents do really matters; the time they spend with their children can transform their lives for the better – they are intimately and intricately involved in shaping them, through their relationships. However we do not want to set up a false dichotomy between behaviour and relationships, but rather to shift the emphasis to the latter to enable the adoption of a truly preventative approach.

275 Brown B, Dench G (2004) *Valuing Informal Care: What the mothers of young children want* London: Hera Trust

The findings and recommendations summarised here represent the culmination of an extensive ten month consultation process, drawing in some of the finest practitioners and researchers working in the early years field. This report builds on the recommendations made in the family breakdown section of *Breakthrough Britain*, which were themselves subject to much scrutiny by Commission members to establish that we were building on a sure foundation. *Breakthrough Britain* aimed to build family stability and minimise family breakdown by encouraging healthy relationships; by drawing on community-level support and reducing dependence on the state and, of course, by focusing on the first three years of children's lives.

Transferable tax allowances acknowledged the reality that if one spouse is not working outside the home that family requires more, not less, support from the tax system. Similarly the benefits system should not penalise low income couples who want to live together which requires **tackling the 'couple penalty.'** Finally, we called for a commitment to **increasing 'supported housing' projects** which help the most vulnerable families stay together and work together towards self-sufficiency.

The Early Years Commission has, at all times, aimed to recommend policies which are realistic, achievable, affordable and understanding of the diversity of views and family experiences. We have also sought to work with the grain of other policy development currently being undertaken at the Centre for Social Justice on the subjects of children in care, youth and gang crime and family law. Building a coherent and interlocking body of policy was the genius of *Breakthrough Britain* and remains the goal of ongoing work. The Commission was and remains keenly aware of the genuine and wide-ranging difficulties we will need to overcome to guarantee a better future for society's most vulnerable members – babies and young children – but we are convinced that the shifts in thinking we propose provide essential starting points.

In summary we make ten recommendations: (see Appendix for details of cost calculations if applicable):

1. **Family Services Hubs** to be established in every community, building on existing infrastructure wherever possible and recapturing one of the most important original goals of Sure Start, which was to help ensure that children of all backgrounds receive the nurture and care from their parents which they need to thrive.
   Estimated cost: £86m per annum
2. **Fostering families instead of fostering children**, thus keeping children with their biological families if possible (by providing supported housing where this is a key reason for breaking up the family). Encourage older parents from the local community to act as extended family in whatever capacity is necessary (with training and back up from social services).
   Estimated cost: £117.95 million in the first year

3. **Enhanced role for health visitors in intensive home-visiting** (to be available nationwide) as well as **revitalization of their role in providing a universal service** which is non-stigmatising and preventative and better able to assess where nurturing deficits are occurring.
   Estimated cost: £135 million in the first year
4. **Enhanced support and training for professionals to include common inter-agency training, further integration and development of children and infant mental health services, co-location of services** (partly facilitated by Family Services Hubs) and **specialised programmes of training for all professionals** whose work impacts upon children (which grounds them in the neuroscience involved in the very early years). This would, for example, make daycare facilities more child-focused, emotionally responsive and motivated to provide greater continuity of care.
   Estimated cost of increasing children's access to services: between £30 and £350 million depending on how many new posts were created
5. **Relationship and parenting education with all individuals, couples and families entitled to draw down money from a personal 'budget'** to access pre-marriage, antenatal, and parenting (of 0-5s, 5-11s and teens) services. Additional streams also available for lone parents, prisoners, military and foster/adoptive parents.
   Estimated cost: once full capacity is reached after several years, £187 million
6. **Early Years Internet Portal** to provide a one-stop-shop for information on funding, training, services, programmes etc
   Estimated cost: 1.44 million start-up costs over the first three years
7. **Genuine choice for families in paid work and childcare,** with a change in the rules to allow the **use of childcare tax credit to pay un-registered close relatives** (albeit at a lower rate) to reflect parents' preferences. **Location, where possible, of childcare outside Children's Centres.** This would free them up to concentrate on delivering family support services and create a more level playing field for private, voluntary and independent sector nurseries.
   Estimated cost of making childcare tax credit payable to un-registered close relatives: £1 billion

8. **Front-loading child benefit** to make it flexible so that a larger proportion of the child's total entitlement would be available during the first three years when parents most want to spend time caring for their children and when attachment and intensive nurture are most important. This would be linked where necessary to ameliorative services such as parenting support, to greatly improve the life chances of children most likely to experience deficits in parental care.
   Estimated up-front cost (for 20 per cent take-up): £388.5 million

9. **Greater integration of information and service provision across all healthcare sectors, especially in mental and physical health** and requirement to make improvements in the level of integration of services a key performance indicator in health services reviews.
10. **Simple, broad-based media campaign, centred around the concept of a 'Neuron Footprint'** to put awareness of the brain's development during the early years at the heart of the nation's thinking on all aspects of family, social and other influences on our young children.
    Estimated cost: £5 million in the first year

APPENDIX:

Recommendations from the Early Years Commission – Cost Implications

This Appendix gives the rationale behind the costs given for the recommendations in Chapter 5. References are given to the section number in Chapter 5 where the summary cost implications are set out.

1. Family Services Hubs

This recommendation is largely unchanged from the original *Breakthrough Britain* Report, which estimated the cost to be £86 million per annum (see section 5.2.4.).

There are two elements to the cost of this recommendation:

1. The cost of setting up and running the Family Services Hubs, and
2. Moving daycare provision out of Children's Centres.

1.1. FAMILY SERVICES HUBS

As set out in the original *Breakthrough Britain* Report, each local authority would be able to make use of existing local facilities – such as Children's Centres, health clinics and Extended Schools – the need for new infrastructure will be minimal in some places. Costs will comprise re-location & co-location of professionals and provision of new programmes. Additional central government grants would be available when new builds are deemed necessary, for the higher anticipated numbers of health care professionals (see later recommendations) and for the roll out of cost-effective voluntary sector provision described.

In order to estimate the costs of these hubs, Bromley Children's Project were asked to estimate full running costs of one multi-agency community-based family support 'hub'. Their estimate was £517,000 per annum and hence the cost to spread similar hubs throughout the country is estimated at £86 million.

1.2. COST IMPLICATIONS OF MOVING DAYCARE PROVISION OUT OF CHILDREN'S CENTRES AS PER THE FAMILY SERVICES HUB MODEL

Although private sector childcare costs are readily available – typically £5,000-8,000 per year – it is not obvious how to tease out the equivalent costs from Children's Centres. The 2006 Surestart cost effectiveness review, for example, reports that childcare comprises 18-21% of the £1,000 spent per child aged 0-4 in each catchment area per year. No details are available for how many children received childcare. However it seems highly unlikely that Children's Centre provision will prove cheaper than private sector provision. The cost of outsourcing childcare is therefore likely to be lower and hence this element of the recommendation is likely to be cost neutral.

2. Fostering families instead of fostering children

This recommendation (described above in section 5.3.) involves taking a number of children currently in care out of the care system, returning them to their families and providing accommodation and support for those families. The children suitable for this treatment are those that are in care as result of low incomes or special circumstances, not as a result of neglect or abuse.

The cost implications of this recommendation are therefore the costs of housing and supporting suitable families. However, there will be a corresponding saving of the costs currently incurred in keeping these children in care. There will also be significant savings in costs associated with healthcare (mental and physical), criminal justice, failed tenancy, unemployment, other temporary accommodation and support services for the adults (parents) in the present and their children in the future. These are difficult to quantify, although as set out in section 5.3., research indicates that for every £1 spent, a saving of £1.68 can be expected in the reduced impact on health, prison and local authority services.

2.1. CAPITAL COSTS

There may be some capital costs attached to the provision of supported housing. Initial capital costs of £42.95 million have been assumed in the cost implications, based on existing service providers' published costs e.g. those of Save the Family.

2.2. REVENUE COSTS

In order to estimate ongoing revenue costs, we looked for similar schemes. The charity Save the Family[1] currently provides a similar service to the one proposed. They spent £1.05 million in 2006 on providing accommodation for 22 families (5.5% of the 400 referrals received). Although homes could only be found for 22 families, advice and support was given to many more families of

1 http://www.savethefamily.uk.com/

the 400 referred. The cost of providing a home for each family, assuming that the majority of costs incurred in 2006 were spent on the 22 families is just under £48,000. An estimated figure of £50,000 per family per year has therefore been used in the cost implications.

To estimate the number of families who may be helped by this recommendation, we found information on the number of children in care who may be suitable for this proposal.

According to the British Association for Adoption and Fostering (BAAF)[2], there were the following numbers of children in care on 31 March 2007[3]

Number of children in local authority care at 31 March 2007	England	Wales	Scotland	Northern Ireland	Total
Total number in care	60,000	4,640	14,060	2,436	81,136
Number in foster care	42,300	3,465	4,055	1,522	51,342
Private fostering (at 31st March 2006)	980	43	N/K	N/K	N/K

According to the Department for Children, Schools and Families (DCSF)[4], 62% of children (37,200 in England) in local authority care were taken into care due to abuse or neglect:

- 4,800 children were in care in England due to acute distress,
- 6,400 due to dysfunction and
- 120 due to low income.

This means that 19% of children in care in England are in care due to family circumstances and may be suitable to be helped by the recommendation. Applying this percentage (19%) to the total number of children in foster care (60,000), gives:

- 7,981 children in England,
- 654 in Wales,
- 765 in Scotland and
- 287 in Northern Ireland.

Assuming two children in each family and a cost of family fostering of £50,000 (see Save the Family example above) per family, the cost of taking these 9,687 children out of foster care and into family fostering would be in the region of £250 million.

2 http://www.baaf.org.uk/media/releases/050710report.pdf
3 http://www.baaf.org.uk/info/stats/index.shtml
4 http://www.dfes.gov.uk/rsgateway/DB/SFR/s000741/SFR27-2007rev.pdf

Turning to the cost saving of not having the 9,687 children in care, the BAAF website shows that the cost of foster care services in 2003/04 across the whole of the UK was £932.2 million. Applying the same percentage (19%) to the cost of foster care services in the UK (2003/04 figures), the saving on current foster costs of £932.2 million would be £175 million.

This results in a net revenue cost of £75 million per annum.

3. A revitalized health visiting profession to deliver universal and targeted services

This recommendation (set out in section 5.4.) is largely unchanged from the original *Breakthrough Britain* Report which set the cost at £135 million.

According to the FPI (Gimson 2007), there are 9,000 health visitors on Band 6-7 pay scales ranging from £22 to £37k. The supply of health visitors is falling at 10% per year. Taking £30k as the average cost of recruitment and one year training, a 50% increase in health visitors would initially cost £135m. There would also be some savings due to staff replacement and substantial longer-term savings from the preventative nature of health visitor work.

Although this form of intensive support is expensive it produces savings in the form of reduced welfare and criminal justice expenditures and increased tax revenues. These exceed its costs by a factor of four over the life of the child according to an economic evaluation by the RAND Corporation[5], which found that the original investment is returned well before the child's fourth birthday.

4. Better support and training for early years professionals

There are two elements to this recommendation as described in section 5.5.:

1. An increase in the number of early years professionals, and
2. A specialised training programme.

4.1. INCREASING THE NUMBER OF EARLY YEARS PROFESSIONALS

This is largely unchanged from the *Breakthrough Britain* report.

Doubling the present stock of clinical psychologists and consultant psychiatrists would amount to the addition of a further 8,500 health professionals. This would cost an additional £350m based on an average mid Band 8 salary of £42,000. A more cautious expansion would involve an additional 1,000 mental health practitioners, based on Child and Adolescent Mental Health Services wait list of 25,000 children and a caseload of 25 children per professional.

Applying similar pay rates as for health visitors, this would cost £30m. There would also be further training costs for health professionals (the cost of training in foundation interagency skills is approximately £550 per person). In context

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5 Greenwood P et al (1996) *Diverting children from a life of crime: measuring costs and benefits,* RAND

however, the former plan represents an increase of 4% to 5% above the £7.9bn cost of public services devoted to mental health, according to a 2004 Cabinet Office review. Seen as prevention, there is potential for substantial longer-term savings.

4.2. SPECIALISED TRAINING PROGRAMMES

It is envisaged that these will be similar to the Core Family Partnership Training Course offered by the Centre for Parents and Child Support.[6] The cost of this course is £1,200 per day, per group of twelve participants lasting for five days, i.e. total cost per group of £6,000.

5. Couple relationship education as well as parenting education

Again this recommendation (described in section 5.6.) is largely unchanged from the original *Breakthrough Britain* Report which set the overall cost of this significant expansion of services at £187 million once full capacity within the sector had been reached. This comprises three elements:

- The *Breakthrough Britain* Report detailed a range of schemes costing £166m once fully operative after a few years, saying that although the savings generated by the parenting, prison and care schemes are hard to quantify, the pre-marriage, ante-natal and military schemes all pay for themselves several times over through reduced family breakdown.
- We also costed the appointment of a local authority commissioner of relationship education services in each of the 312 local councils amounting to an additional £11m. (Although in practice, local authorities may decide to combine the posts with existing local commissioners of parenting services. Local authorities can expect significant reductions in future costs resulting from these preventative programmes.)
- In 2006, Family and Parenting Institute administration comprised 5% of Parenting Fund costs. On a similar basis, the administration of a fully operative individual budget scheme would eventually cost £10m per year. A research programme at least equivalent to that of the Joseph Rowntree Foundation would cost a further £10m per year.

6. Early Years Internet Portal

An initial outlay over three years of £1.44 million is anticipated for this proposal (set out in section 5.7.). We expect that eventually the recommendation would be cost neutral as it would be undertaken as a private-public sector project with advertising revenue built into the business plan.

6 http://www.cpcs.org.uk/services.php

According to ADL Consulting,[7] an information and communication technology firm, an estimate for the cost of a portal of this nature is £480,000 per annum during the first three year design and build phase. It is envisaged that the portal would be launched in Year 4, at which point net costs will escalate to just over £1 million to cover the costs of site launch and advertising. Net costs in Year 5 will also be relatively high – around £500,000 – to take account of continued advertising spend. However, we would expect to see sufficient advertising revenue from Year 6 onwards to cover expenditure.

7. Genuine choice for families in paid work and childcare

The proposal (described in section 5.8.) to change the rules to allow the use of childcare tax credit to pay un-registered close relatives (albeit at a lower rate) is unchanged from *Breakthrough Britain* where it was costed at £1 billion.

Allowing childcare tax credit to pay close relatives is likely to encourage an increase in demand. According to HMRC, 374,000 families claimed the childcare element of the working tax credit in 2006 at an average weekly cost of £49.80. A doubling of current take-up would cost an additional £1 billion annually. The net cost of such a scheme would in reality be lower, even if particularly hard to quantify. Some savings would emerge as existing claimants switch from higher cost group childcare to lower cost childcare by relatives. Further savings emerge as relatives now receiving income from childcare see a consequent reduction in their own tax credits.

8. Front-loaded Child Benefit

This recommendation (described in section 5.9.) has no additional cost over the life of each child – every pound received early will be recouped via lower payments when the child is older – but there is a cost to the Exchequer of funding the upfront payments which will not unwind for several years. The cost implications have therefore been calculated for year one only.

In order to estimate the costs of this proposal in year one, several assumptions had to be made. These were:

- The number of children aged between 0 – 3 that would be eligible for/take up the proposal
- The additional amount to be paid each week per child

7 www.adl-consulting.co.uk

- Whether a discount would be applied to second or later children
- Whether it would be available to the families of all children aged under three or just those whose children are born after the start date

8.1. NUMBER OF CHILDREN AGED 0 -3 ELIGIBLE FOR/TAKING UP THE PROPOSAL

According to HM Revenue and Customs (HMRC), child benefit is claimed for 642,900 children aged under 12 months, 711,000 children aged between 12 and 24 months and 709,800 aged between 24 and 36 months.[8]

It is difficult to assume what take up would be and would presumably depend on the impact later in a child's life of taking up the front loading. Take up for traditional child benefit is close to 100% (98%)[9], whereas take-up for the Childcare Element of the Working Tax Credit is only 449,000 families[10] compared to 7.5 million families receiving child benefit. However, this low take-up does not necessarily reflect need for additional support, but is more likely a consequence of the difficulty of being eligible to claim.

The other issue that will affect take-up is whether front-loading is available to all or is restricted (at first) to those identified by health visitors as being in need. In this case the lower take-up rates will be relevant.

The cost of various take-up rates are given in the table below.

8.2. INTRODUCTION – TRANSITIONAL ARRANGEMENTS

The cost in the first few years of the programme will depend on whether front-loading is available to all families with children aged under three or only for new children born after the start date. Clearly, the latter option is cheaper in the first three years, but will make no difference after that time. The costing below assumes that front loading is offered to all children aged under three on the day that the scheme is introduced.

8.3. HOW MUCH EXTRA IS PAID EACH WEEK?

For this costing, an additional amount of £18.10 per week has been used, being the amount paid today to first children in the family.[11]

8.4. SECOND CHILDREN REDUCTIONS?

For costing purposes, no reduction has been applied for second children to the amount paid. Second and later children in the family currently receive £12.10 per week.

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8 Child Benefit Quarterly Statistics, August 2007, Table 3.1 http://www.hmrc.gov.uk/stats/child_benefit/aug-07.pdf

9 House of Commons Hansard, written answers 7 March 2006, col 1296W

10 http://www.hmrc.gov.uk/stats/personal-tax-credits/cwtc-apr08.pdf

11 Appendix B http://www.hmrc.gov.uk/stats/child_benefit/aug-07.pdf

Using the assumptions above – £18.10 per week extra available to all children aged three and under on the start date – the total first year cost at a range of take up rates is as per the table below:

	Number of children aged	Under 1	1 - 2	2 - 3	Total Cost £'m
	(000s)	642.9	711.0	709.8	
Take up					
	5%	30.3	33.5	33.4	97.1
	10%	60.5	66.9	66.8	194.2
	15%	90.8	100.4	100.2	291.4
	20%	121.0	133.8	133.6	388.5
	25%	151.3	167.3	167.0	485.6
	30%	181.5	200.8	200.4	582.7
	35%	211.8	234.2	233.8	679.8
	40%	242.0	267.7	267.2	776.9
	45%	272.3	301.1	300.6	874.1
	50%	302.5	334.6	334.0	971.2
	55%	332.8	368.1	367.4	1,068.3
	60%	363.1	401.5	400.8	1,165.4
	65%	393.3	435.0	434.2	1,262.5
	70%	423.6	468.4	467.6	1,359.6
	75%	453.8	501.9	501.0	1,456.8
	80%	484.1	535.4	534.5	1,553.9
	85%	514.3	568.8	567.9	1,651.0
	90%	544.6	602.3	601.3	1,748.1
	95%	574.8	635.7	634.7	1,845.2
	100%	605.1	669.2	668.1	1,942.4

The cost will therefore be between £97 million and £1.9 billion.

Depending on how the later clawback is calculated, the cost in later years will be reduced due to families receiving a lower amount of child benefit later in the child's life.

9. Building further on *Breakthrough Britain* – a truly integrated approach to health and social care

No significant cost implications are anticipated for this particular proposal which specifies the integration, not the expansion of services (as set out in section 5.10.).

10. Raising awareness of the importance of nurture – the 'Neuron Footprint'

The costs of this campaign (as described in section 5.11.) are envisaged as being similar to the Eat Less Salt campaign run by the Food Standards Agency (FSA). According to the 2007 annual accounts for the FSA[12], spending on this campaign amounted to £5.8 million in the year to 31 March 2006 and £3.1 million in the year to 31 March 2007. On this basis, a cost of £5 million for the first year of the campaign has been included in the overall budget.

12 http://www.food.gov.uk/multimedia/pdfs/annualconsolidated0607.pdf

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List of Consultees

Dr Stella Acquarone, Clinical Director, The Parent Infant Clinic & School of Infant Mental Health

Felicity Aldridge, Art Psychotherapist

Titus Alexander, Director for Learning, Novas Scarman Group

Professor Jane Barlow, Professor of Public Health in the Early Years, University of Warwick

Diana Barran, Chied Executive, Coordinated Action Against Domestic Abuse (CAADA)

Camila Batmanghelidjh, Chief Executive, Kids Company

Dr Ivona Bialis, Consultant Child and Adolescent Psychiatrist

Dr Mitch Blair, Consultant Reader in Paediatrics and Child Public Health, Imperial College

Cherry Bond, Positive Touch Specialist Neonatal Nurse

Lydia Bowles, Social worker, Child Protection Team, Eastbourne

Dorothy Bowring-Male, Steiner Birth to Three and Parenting Trainer

Dr Hilary Cass, Consultant in Paediatric Disability, Director of Postgraduate Medical Education, and Associate Medical Director at Great Ormond Street Hospital for Children and Vice Chair of the National Collaborative for Children's Integrated Healthcare

Fiona Chandler, Child & Family Psychotherapist

Professor Sarah Cowley, Professor of Community Practice Development, Florence Nightingale School of Nursing and Midwifery, King's College London

Dr Patricia Crittenden, Director, Family Relations Institute, Miami, Florida, USA

John Davidson, Head of the Violence Reduction Team at the Scottish Government

Dr Dilys Daws, Honorary Consultant Child Psychotherapist, Tavistock Clinic, Advisor to Association for Infant Mental Health

Diana Dean, Vice Chairman, What About The Children? Scientific Advisory Board

Dawn Eccleston, Health visitor specialising in inter-agency teamwork

Dr Ramon Fernandez, Consultant Neonatologist, Clinical Governance Lead, Trevor Mann Baby Unit, Royal Alexandra Children's Hospital, Brighton

Gordon Franks, Managing Director, Gordon Franks Training

Maggie Gairdner, Associate Director, Children, Young People and Substance Misuse Services, Sussex Partnership

Dr Richard Gray, Principal Lecturer in Primary Care at Brighton and Sussex Medical School and specialist in inter-agency working

Sue Gregory, Community Mental Health Worker

Julian Grenier, Headteacher, Kate Greenaway Nursery School and Children's Centre

Dr Amanda Gummer, Psychologist and Director, FUNdamentals

Marisa Guthrie, Executive Director, The Children's Clinic Brighton

Professor Roger Higgs, Professor Emeritus at Kings College London and retired GP

George Hosking, Chief Executive, Wave Trust

Richard House, Senior Lecturer in Psychotherapy and Counselling at Roehampton University

Dr Leslie Ironside, Child and Adolescent Psychotherapist, Director, Centre for Emotional Development

Sally Jenkinson, Freelance Educational Consultant

Dr Amanda Jones, Head of Parent-Infant Mental Health Services, North East London Mental Health Trust

Patricia Kennard, Practice Nurse Locality Lead, Brighton and Hove PCT

Andrea Leadsom, Chairman, Oxford Parent Infant Project (OXPIP)

Dr Susan Lipscombe, Lead GP at Park Crescent Surgery, Brighton

Catherine Lowenhoff, Nurse Consultant (perinatal and infant mental health), Vice Chair of Association of Infant Mental Health

Jeanne Magagna, Head of Child Psychotherapy, Great Ormond Street Hospital for Sick Children

Di Metson, Specialist Child & Family Psychotherapist

Baroness Trish Morris, Shadow Minister for Children, Schools & Families and Women

Professor Somnath Mukhopadhyay, Consultant and Chair of Paediatrics at Brighton and Sussex Medical School, Royal Alexandra Children's Hospital, Brighton

Professor Lynne Murray, Research Professor in Developmental Psychopathology, School of Psychology, University of Reading

Sir Denis Pereira Gray, President, What About The Children? and Chairman of the Scientific Advisory Board

Dr Bruce Perry, Senior Fellow, Child Trauma Academy, USA

Brojo Pillai, Strategy Consultant, Wave Trust

Chris Ponsford, Development Director, What About The Children?

Dr Christine Puckering, Consultant Clinical Psychologist and Research Fellow, Royal Hospital for Sick Children, Glasgow

Charlotte Savins, Arts Psychotherapist, Royal Alexandra Children's Hospital, Brighton

Dr Tom Scanlon, Director of Public Health, Brighton and Hove PCT

Dr Jonathan Sharples, Deputy Director, Institute for the Future of the Mind, Oxford University

Dr Julia Sheeran, Child and Adolescent Psychiatrist

Daniel Siegal M.D., Director Mindsight Institute, Co-Director UCLA Mindful Awareness Research Centre USA

Professor Jeremy Turk, Professor of Developmental Psychiatry, St George's, University of London

Dr Simon Wilkinson, Child and Adolescent Psychiatrist: Ullevål University Hospital, Oslo, Norway

Conferences and Events attended by the Early Years Commission

Mental Health: Mental Health in Babies and Young Children 2007: Dr David Daley, Dr Shirley Gracias, Professor Lynne Murray, Professor Sarah Halligan, Professor Jonathan Green. Association for Child and Adolescent. 7 December 2007.

Obesity, Maladaption to a Modern World: Professor Terry Wilkin. Centre for Emotional Development. 12 February 2008.

The Neuroscience of Attachment and Attachment Disorders: Key Ways of Working with Troubled Children and Teenager: Dr Margot Sunderland. Centre for Child and Mental Health, 16 February 2008.

Visit to the Violence Reduction Team, Scottish Government. February 2008

When Distress Hits the Body: Working with Psychosomatic Symptoms in Children, Young People and Adults: Dr Mitch Blair, Professor Bryan Lask, Ada Sachs, Dr Peter Shoenberg. Centre for Child and Mental Health, 1 March 2008.

Neglect and Abuse in Childhood and Adolescence: Effective Interventions and Ways Forward: Professor David Howe, Dr Margot Sunderland, Dr Martin Teicher, Jay Vaughan. Centre for Child and Mental Health. 15 March 2008.

Policy Development with a Focus on the Importance of the Early Years: Dr Samantha Callan, Dr Elly Farmer. 'Family Aggression: Causes & Consequences', First Biennial Conference of the International Family Aggression Society, 18-19 March 2008.

Getting it Right for Babies 2008: Professor Jane Barlow, Dr P.O. Svanberg, Dr Amanda Jones, Professor Colin Trevarthen. Association for Infant Mental Health. 16 May 2008.

Awakening and Addressing Attachment Needs in Troubled Children, Teenagers and Adults: Sir Richard Bowlby, Dr Dan Hughes, Jeremy Holmes. Centre for Child and Mental Health. 17 May 2008.

Study visit to Brighton comprising consultations with social worker from Child Protection Unit (Eastbourne); Professor Somnatah Mukhopadhayay and his team at Royal Alexandra Children's Hospital and the Trevor Mann Baby Unit; Dr Sue Lipscombe and staff at Park Crescent Surgery; Dr

Richard Gray and members of the Hove CAMHS (Child and Adolescent Mental Health) team. May 2008.

New Initiatives and Techniques for Work with Troubled Children and Young People: Professor Derek Bolton, Louise Bomber, Maggie Johnson and Alison Wintgems, Dr Pall Jonsson, Ann Lubbock, Richard Rose. Centre for Child and Mental Health. 7 June 2008.

How Are You? Thinking About the Development of Health and Illness Behaviour in Children: Professor Jeremy Turk, Professor Roger Higgs, Dr Simon Wilkinson, Professor Somnath Mukhopadyay. Centre for Emotional Development. 20 June 2008.

The Traumatised Child: Healing Brain, Mind and Body: Dr Bruce Perry. Centre for Child Mental Health. 21 June 2008

Child and Adolescent Psychiatry: Diagnosis Explained and Treatment Explored: Professor Jonathan Hill, Professor Declan Murphy, Dr Paul Sepping, Dr Margot Sunderland. Centre for Child and Mental Health. 5 July 2008.