



ALL BABIES COUNT

Prevention and protection
for vulnerable babies

Chris Cuthbert
Gwynne Rayns
Kate Stanley

NSPCC 
Cruelty to children must stop. **FULL STOP.**

Contents

FOREWORD	4
EXECUTIVE SUMMARY	5
FROM EVIDENCE TO ACTION	
1. IMPERATIVE: One chance <i>for</i> a generation	11
2. INSIGHT: Maltreatment in pregnancy and infancy	19
3. IMPACT: Effective and promising practice	33
4. IMPETUS: One chance <i>in</i> a generation	41
ANNEXES	
A Glossary	52
B Method and acknowledgements	54
C Four nations policy calls and policy context	55
D Notes and references	65

Foreword

Over recent years, there has been an explosion of new research and understanding about the significance of pregnancy and infancy in laying the foundations for child development. This new knowledge underpins an emerging political consensus around the importance of 'early intervention' to help children get the best possible start in life.

Based on extensive research, consultation and original analysis, this report adds new dimensions to the case for early intervention. It shines a light on the disproportionate vulnerability of babies to abuse and neglect; and it provides the first estimates of the numbers of babies affected by parental problems of substance misuse, mental illness and domestic abuse.

The causes of abuse and neglect are complex. And the consequences of early adversity can cast a very long shadow, affecting children's physical and emotional health, their learning and their capacity to form positive relationships throughout their lives. Failure to act early comes at great cost, not only to individuals but to society at large.

Babies are almost entirely dependent on their immediate caregivers. A parent's capacity to respond appropriately to the emotions and needs

of their babies has a profound impact. Becoming a new parent is a major transition; there are times when every parent feels under pressure and may struggle to cope with the stresses and responsibilities of their role. But, for very young parents, or parents facing additional challenges in their lives such as mental illness and domestic abuse, this can be a particularly difficult time.

Evidence shows it is possible to prevent abuse and neglect and that pregnancy and infancy offer a unique window of opportunity to work effectively with families at risk. Our review of practice showcases some of the most successful and promising interventions. Working with our partners, the NSPCC is committed to developing, delivering and testing pioneering models of intervention to improve outcomes for vulnerable babies. But the scale of the challenge is formidable and we need to ensure that effective programmes are made available to all babies who need support.

Of course, there are no quick fixes. Translating the rhetoric of early intervention into real change on the ground will take hard work and determination. But I hope this report will make a substantial contribution, setting out the key building blocks to deliver the vision of a society where every baby is safe, nurtured and able to thrive.

Andrew Flanagan
Chief Executive

Executive Summary

IMPERATIVE: One chance for a generation

All babies need to be safe, nurtured and able to thrive. The early care they receive provides the essential foundations for all future physical, social and emotional development. Whilst most parents do provide the love and care their babies need, sadly too many babies suffer abuse and neglect.

The emotional abuse, neglect or physical harm of babies is particularly shocking both because babies are totally dependent on others and because of the relative prevalence of such maltreatment:

- **45 per cent** of serious case reviews in England relate to babies under the age of 1 year¹
- In England and Wales, babies are **eight times** more likely to be killed than older children²

Original analysis conducted for this report³ estimates for the first time the numbers of babies living in vulnerable and complex family situations. In the UK, an estimated

- **19,500 babies** under 1 year old are living with a parent who has used Class A drugs in the last year
- **39,000 babies** under 1 year old live in households affected by domestic violence in the last year
- **93,500 babies** under 1 year old live with a parent who is a problem drinker
- **144,000 babies** under 1 year old live with a parent who has a common mental health problem

Early adversity casts a long shadow. Recent neurological and psychological research highlights more clearly than ever before how critical pregnancy and the first years are to a baby's development, providing the essential foundations for all future learning, behaviour and health. Put simply, if we don't act early, we risk storing up problems for the future.

Prevention is possible. Pregnancy and the first year are critical times in shaping the template for later parenting of a baby and any subsequent children. Pregnancy is a 'magic moment' when parents are uniquely receptive to support, motivated by the desire to do the best for their child. This is a time when a parent may be more open to receiving help and acknowledging his or her struggles. And there is a growing body of evidence about interventions that can transform

a vulnerable baby's life chances. It is vital we act now to ensure every vulnerable baby is safe, nurtured and able to thrive.

INSIGHT: Maltreatment in pregnancy and infancy

Simple, singular explanations of child maltreatment fail to do justice to the complexity of real families' lives. However, research suggests that the primary caregiver-child relationship and the parents' capacity to provide love, care and nurture are of major importance. At the heart of any strategy for intervention should be work to support the development of a secure attachment between baby and caregiver, strong family relationships and quality parenting. Additional pressures on parents from factors such as mental illness, domestic abuse and substance abuse can adversely affect their capacity to be good parents. These factors need to be addressed alongside work to support attachment and parenting.

The promotion of secure attachment and reflective functioning can play an important role in prevention of abuse and neglect. These approaches emphasise the importance of sensitive caregiving, in which parents learn to understand their baby's communication and behaviours in light of their emotional states and stages of development. But in addition parents need the behavioural skills and resources to provide adequate care.

Services which address problems faced by parents, such as domestic abuse, substance abuse (including alcohol) and mental illness, will not automatically lead to improvements in the care of babies. Such services need to be combined with work which *explicitly* aims to promote secure attachment, positive relationships and good parenting.

IMPACT: Effective and promising practice

There is good evidence that intervention during this life stage *can* make a real difference to children's lives, though there is still much to be learned and significant opportunities for innovation and for increasing the impact of existing measures.

Primary prevention services, such as those delivered by health visitors and children's centres, provide critical information and advice to help parents manage the stresses involved in the transition to parenthood. There is good evidence to suggest that both antenatal education and hospital-based education programmes can

play a significant role in promoting positive models of parenting and providing constructive coping strategies. This is particularly true when programmes look beyond a purely medical model and address the wider issues and transitions families face. Providers of parenting information and advice are finding ever more creative means of reaching and supporting their target audiences.

Secondary prevention services are targeted at families thought to be at elevated risk, before maltreatment occurs. Programmes like the Family Nurse Partnership have a good evidence base and work with vulnerable families across pregnancy and the first two years of life.

Tertiary prevention is concerned with preventing the recurrence of abuse once it has taken place, and with minimising the harms caused. Therapeutic models of intervention such as parent-child interaction therapy have a strong evidence base. Findings from serious case reviews

highlight the need to improve the rigour and consistency of pre-birth risk assessments.

NSPCC is collaborating with partners in the delivery and testing of four new programmes relating to pregnancy and babies, outlined in the boxes below. They have been carefully selected on the basis of the new learning and increased impacts we believe they can deliver. They are focussed on:

- using the unique opportunities of this life-stage for engagement with parents
- tackling parental risks
- promoting secure parent-infant relationships and setting a template for effective parenting.

Preventing Non-Accidental Head Injuries in Babies

NSPCC is beginning work with up to 12 hospitals across the UK to deliver and test a new primarily hospital-based education programme for parents of all newborn babies, employing DVD and other resources. This programme draws inspiration from research in Buffalo, NY in the US, which shows it is possible to prevent non-accidental head injuries (NAHI) through parent education.

The DVD will be introduced to parents by midwives. It prepares them for the immediate days and weeks after birth, suggesting ways to cope with pressures such as crying and sleeplessness and highlighting in particular the dangers of shaking an infant. Parents also receive an information leaflet and signposting to support services including help lines and a dedicated website.

The programme will reach parents of 80,000 newborns over 2 years. It aims to reduce the incidence of NAHI, raise awareness of the dangers of shaking a baby, increase parental confidence and understanding, and increase the use of positive coping strategies.

Pregnancy, Birth and Beyond

NSPCC is working with leading experts on the development, delivery and testing of a new parent education programme for vulnerable expectant parents. The programme consists of eight group-based sessions on parenting, including two taking place after birth. The programme focuses on setting the template for good parenting and helping at-risk parents manage the major transition to parenthood. The contents of the programme are aligned with the topics of a new expert framework developed by the Department of Health in England.

The programme will be delivered in eight locations across the UK. A rigorous evaluation study will examine whether the programme is successful in engaging and retaining at risk families, and its cost effectiveness compared to routine antenatal education

Minding the Baby

Minding the Baby is an intensive home visiting programme for vulnerable and at-risk first time mothers under 25 and their babies. Originally developed by leading experts at Yale University, the programme combines health and social work support and is delivered in the home from the third trimester of pregnancy until the baby reaches the age of 2. The programme is distinctive from other home visiting services, in that support is provided jointly by advanced social workers and nurses.

The programme aims to promote better physical and mental health and attachment among babies, mothers and their families. Minding the Baby is based on attachment theory and places particular emphasis on enhancing parents' 'reflective functioning'.

The service will be delivered in England and Scotland and a robust independent evaluation study will measure the efficacy of the programme and its fit with UK delivery systems.

Parents Under Pressure

The Parents Under Pressure (PUP) programme works with parents receiving drug or alcohol treatment who have a child under 2 in their full time care. Originally developed in Brisbane, Australia, the programme has been successful in reducing the risks of child abuse among methadone-maintained parents of children aged 2–8. PUP is a twenty week programme delivered in the home. It is underpinned by an ecological model of child development and targets multiple dimensions of family functioning. PUP Therapists work with mothers and fathers to help them develop parenting skills and safe, caring relationships with their babies. They also report any signs of child abuse or neglect to children's services.

NSPCC is providing this programme to families in 10 locations across the UK. A robust independent evaluation study will measure the efficacy of the programme and its fit with UK delivery systems.

As well as measuring the impact of programmes, it is important to be able to understand *how* they work. Many of our new services work with complex families who need to be engaged and held in consistent relationships which deliver effective change. This requires a shift away from traditional didactic models of intervention, towards interventions centred around the relationship between the practitioner and the family. To achieve the full potential of evidence-based interventions, we need to understand how they fit into existing systems, and how they can be taken to a scale where they can reach all those who stand to benefit. Understanding real world delivery systems and local contexts is vital if we are to take innovation out of the laboratory and make a real difference on the ground.

“Improving children’s outcomes depends on systematising evidence-based interventions”

Michael Little⁴

IMPETUS: One chance *in* a generation

NSPCC’s strategy reaffirms our core mission of ending cruelty to all children. **We have made pregnancy and babies a key priority.** We are taking forward an important programme of work, developing, delivering and evaluating new frontline services to support the most vulnerable babies and their families.

Our vision is simple:

We believe that every baby in the UK should be safe, nurtured and able to thrive

Based on our analysis of the evidence, we believe there are a number of principles that should guide service provision during this critical life stage:

Every baby needs love, care and nurture

- The quality of parent-infant interaction is paramount.
- Interventions that foster secure attachment can prevent abuse and poor parenting.
- Parents’ capacity for reflective functioning (or ‘keeping the baby in mind’) is likely to be instrumental to their ability to provide effective care.
- Physical punishment of babies is ineffective and unacceptable.

Services need to ‘think family’

- Both adults’ and children’s services need to take into account the whole family context.
- Adults’ services need to consider their clients as parents. When addressing parental problems such as mental illness, substance misuse and domestic abuse, we need to ensure that parents are supported to fulfil their parenting role and that children get the help they need.
- Dads and father figures have a profound impact on families and should share centre stage in strategies for intervention.

It’s never too early

- Promoting informed choices and resilience *pre-conception* creates the conditions for families to thrive.
- The *antenatal* period is a vital stage in child development and in preparation for parenthood.

Prevention: we must do all we can to stop abuse before it starts

- *Primary*: universal service providers, such as midwives, health visitors, children’s centre workers and GPs, play a crucial role in health promotion, identification of risk and delivery of support that can prevent maltreatment in the first place.
- *Secondary*: targeted services that support specific vulnerable groups or address risk factors such as domestic abuse, substance abuse and mental illness can help to prevent abuse and neglect.

It’s never too late: we must stop abuse happening again

- Children’s services have a crucial role in helping to avoid the recurrence of abuse and to minimise the short and long term harms to children.
- Therapeutic support for children who are abused may also act as a means of prevention for the next generation.

Improving life chances for the most vulnerable babies cannot be achieved by any one agency on its own. Progress will require focus, open collaboration and determination to persevere in the face of set-backs.

We call on UK Governments to **guarantee** that services are available to ensure every vulnerable baby is safe, nurtured and able to thrive

Prevention and protection are everybody’s business

By working together we can transform the life chances of the most vulnerable babies

Governments across the UK have shown foresight in recognising the need for early intervention to ensure every baby gets the best possible start in life. The eminent authors of several important reviews⁵ have consistently highlighted the importance of early intervention and prevention. But we now face a decisive moment. The true test will be whether, in the face of economic and fiscal challenges, there is the leadership and resolve to translate the rhetoric of early intervention into real and sustained change on the ground.

The building blocks

So how can we get there?

There are no quick fixes. But there are concrete steps we can take that could deliver a transformation in systems and in support for vulnerable babies. Based on what we have learnt by listening to professionals, families and other organisations, we set out below the four key building blocks which we believe need to underpin the delivery of our vision.

	What success looks like...
1. Clear focus, clear accountability	<ul style="list-style-type: none"> • Widespread understanding of the importance of pregnancy and the first year of a child's life amongst the public, professionals and policy makers. • Raised awareness of Article 19 of the UN Convention on the Rights of the Child and what it means for babies. • The UK Government and Devolved Governments in Scotland, Wales and Northern Ireland ensure that necessary resources are available to support vulnerable babies. • Central and local government are held to account for the provision of high quality services and the achievement of improved outcomes, through performance management, inspection, evaluation and client feedback.
2. Integrated policy, integrated practice	<ul style="list-style-type: none"> • A seamless policy framework that bridges: <ul style="list-style-type: none"> • prevention and protection • health and children's services • maternity and child health services • adults' and children's services. • Services tailored around families' needs, not the other way around. • 'No wrong door' to support: contact with any service opens up access to a broader system of support. • All professionals recognise prevention and child protection as their responsibility and have the confidence to act decisively.
3. World class commissioning, world class services	<ul style="list-style-type: none"> • Local areas are equipped to capture and address local needs: <ul style="list-style-type: none"> • building a clear and comprehensive picture of needs (one that cuts across agency boundaries) and setting local priorities • identifying effective and promising services; monitoring and reviewing impacts; and responding effectively. • Innovation in service design and delivery. • Visible improvements in the quality and effectiveness of services. • Development of a rigorous evidence base about what works and what does not. • Proven interventions are taken to scale.
4. Professional capacity, professional capability	<ul style="list-style-type: none"> • Evidence-based methods are integrated into universal services. • The key professions attract and retain high quality talent. • Local staffing shortages are remedied. • Core practitioners have the skills and confidence to work intensively with complex families. • Practitioners have access to evidence-based tools and resources to underpin assessment and decision making, including tools for pre-birth assessment. • The commitment and responsibilities of practitioners are matched by quality supervision, freedom to exercise professional judgement and opportunities for development and progression.

“We join our voice to those who say that a crisis is an opportunity: it is a time to plan to do things differently”

Professor Sir Michael Marmot

1. IMPERATIVE:

One chance *for* a generation



1. IMPERATIVE:

One chance for a generation

There is a compelling rationale for focussing on pregnancy and babies in any strategy concerned with prevention of abuse and neglect. This chapter sets out the five key planks of our case.

The moral case

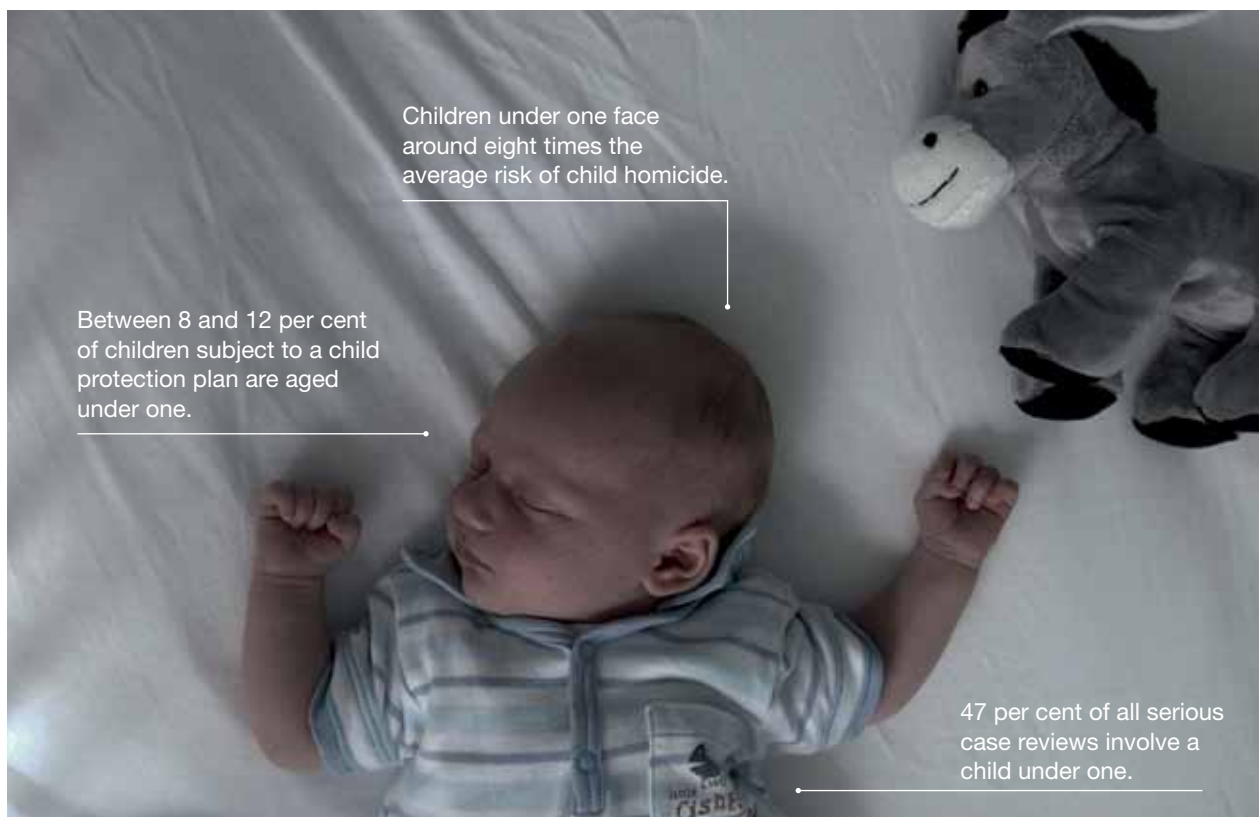
The UN Convention on the Rights of the Child enshrines our collective commitment to ensuring that all children, even the most vulnerable, are properly cared for and protected from harm. Maltreatment cases involving infants under one are particularly shocking, both because of the relative frequency with which they occur and also because of the total dependence and vulnerability of the babies concerned. Heart-rending cases like that of Baby Peter Connelly make shocking headline news. And whilst thankfully still rare, the publication of serious case reviews shows that the cases which hit the headlines are not entirely isolated.

Under-1s are a key group of concern for child protection services:

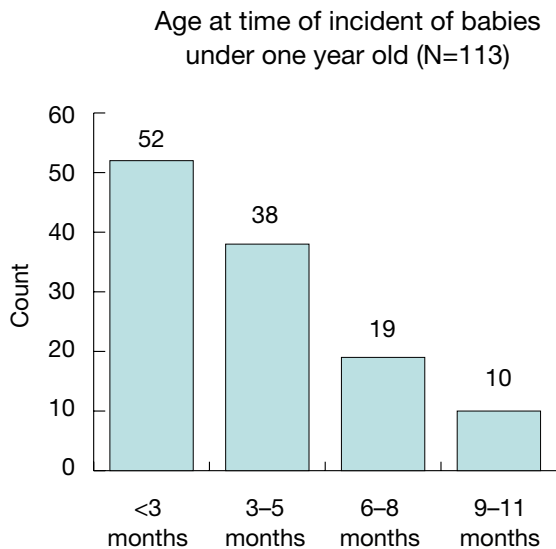
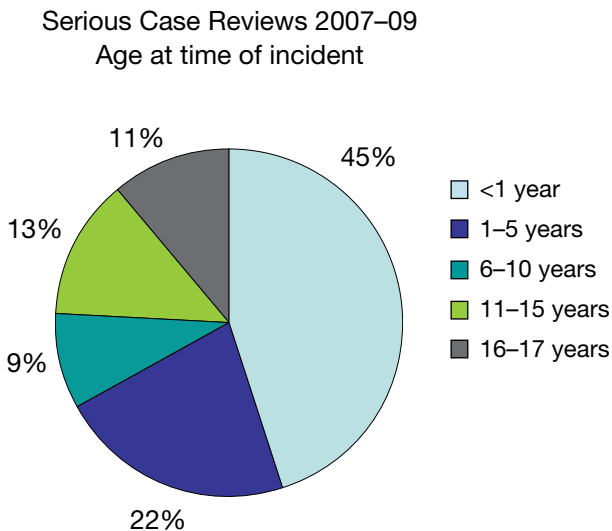
- Almost a half (45 per cent) of all serious case reviews in England involve a child under 1, and a substantial proportion of such cases involve babies of three months or younger.⁶
- Between 8 and 12 per cent of all children subject to a child protection plan are aged under 1.⁷
- In both England and Wales, neglect is the most common category of abuse for under-1s subject to a child protection plan, followed by emotional abuse, physical abuse, multiple abuse and sexual abuse.⁸

Compared to all children under 18 in England, boys and girls under 1 are:

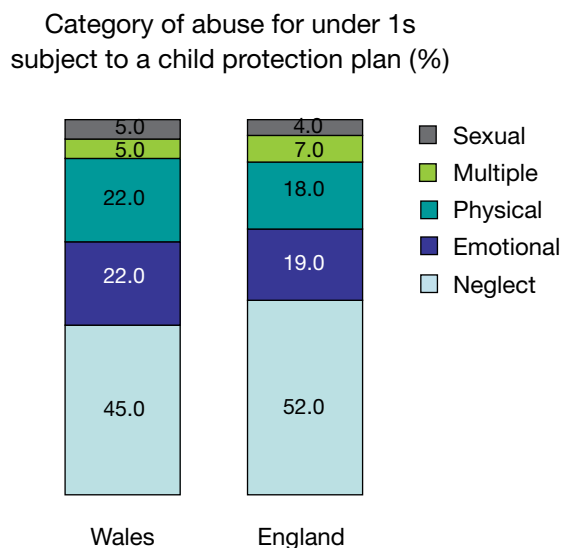
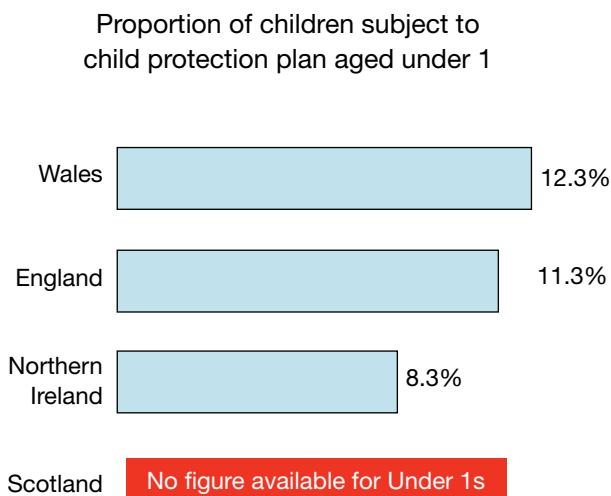
- nearly three times as likely to be subject to a child protection plan due to physical abuse.
- over two times as likely to be subject to a child protection plan for neglect.
- 1.3 times as likely to be subject to a child protection plan for emotional abuse.



Almost a half of serious case reviews involve babies under 1⁹



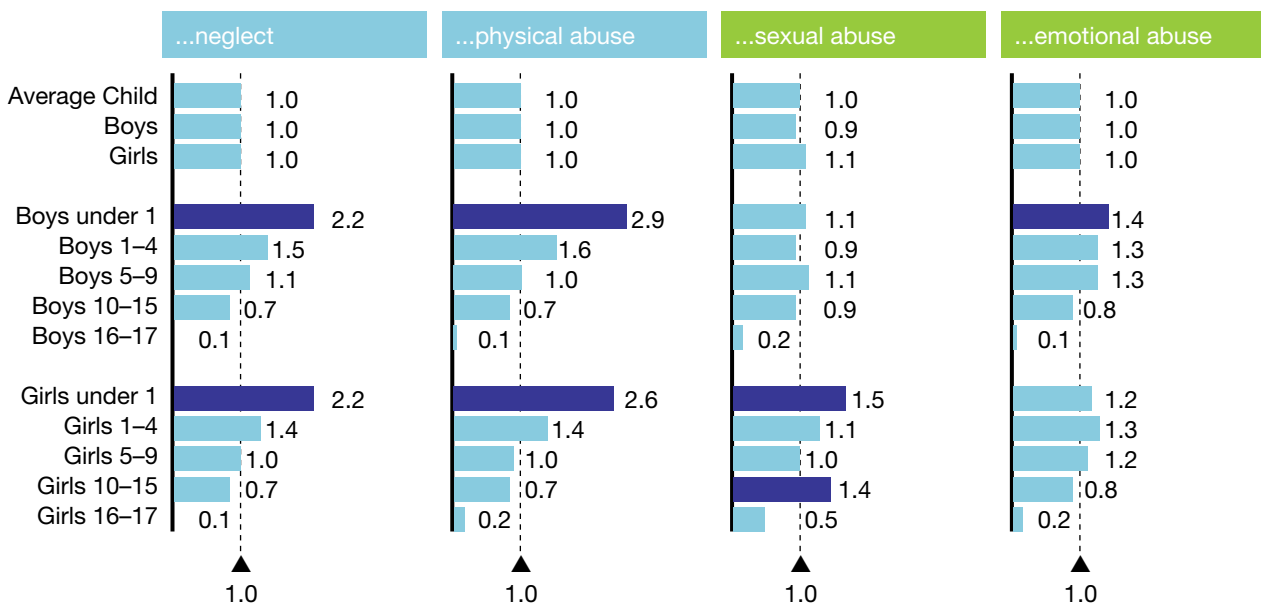
Neglect is the most common category of abuse¹⁰



Breakdowns by category of abuse not available for Northern Ireland and Scotland

Under 1s are at high risk of all types of abuse¹¹

Odds of being subject to children protection plan by age and gender, compared to the odds for all children under the age of eighteen (England only)



Data in England show that girls under 1 have higher than average odds of having a child protection plan in place concerning sexual abuse. Experts from the Centre for Exploitation and Online Protection (CEOP) have recorded an increase in the number of babies and very young children being abused and in the volume of images and video being shared online. Their intelligence suggests the average age of child abuse imagery may be going down.

In England and Wales, under-1s face around 8 times the average risk of child homicide.¹² The risk is greatest in the first three months and perpetrators are almost always parents. There is as yet no definitive explanation for this high incidence, though frailty and total dependence are important. The very real demands and stresses placed on a family by a newborn baby are almost certainly a factor.

Non-accidental head injury (NAHI) is the most common cause of infant death or long term disability from maltreatment.¹³ It represents one of the most severe forms of child abuse, with 13–30 per cent mortality rates and significant neurological impairments in at least half of the survivors.¹⁴

This tragic picture in the UK is consistent with available data from other European countries, where infants are also more at risk of fatal injury, physical abuse and neglect than older children,

indicating that it is essential to intervene early to prevent child maltreatment, death and disability.¹⁵

The prevention case

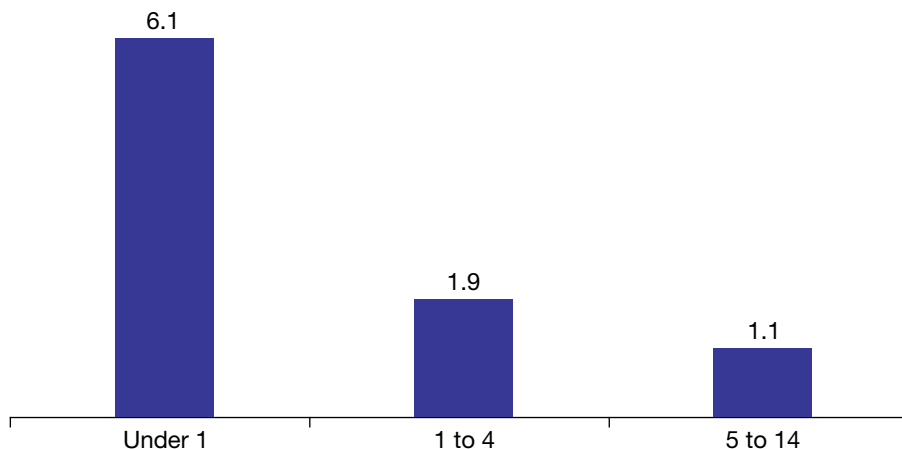
The immediate harms of maltreatment during infancy make a compelling moral case for intervention in their own right, but there is also an important case in terms of child development and the longer term impacts of children's earliest experiences. Or as eminent psychiatrist, Sir Michael Rutter, has put it: *"the circumstances of early childhood can cast a long shadow"*.¹⁶

Pregnancy and the first year are a critical stage in child development, providing the essential foundations for all future learning, behaviour and health. Adverse prenatal and postnatal experiences can have a profound effect on the course of health and development over a lifetime. Child abuse or neglect and general trauma, including witnessing violence, alter normal child development and, without intervention, can have lifelong consequences.¹⁷ We now have evidence that such early adversities also make adults more vulnerable to stress and stress-related conditions such as cardiovascular disease and substance abuse.²⁰

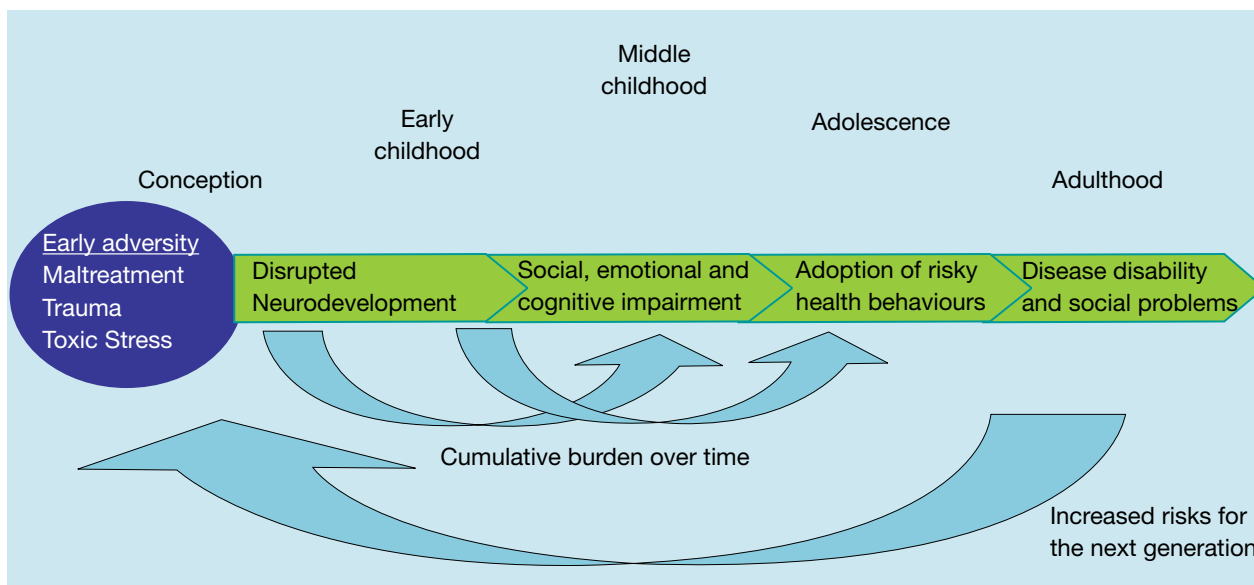
Recent neurological research has highlighted stress in early childhood, showing that while it can be growth-promoting if the stress arises in

Under 1s are a priority group in other countries¹⁸

Across the OECD, risk of death by maltreatment is highest for under Ones ¹



Early adversity accumulates over the life course and can pass between generations¹⁹



the context of stable and supporting relationships – such as meeting people from the safety of a parent’s arm – it can also be ‘toxic’ to developing brain architecture and physical health.²¹ So-called ‘toxic stress’ is associated with strong and prolonged activation of the body’s stress response systems in the absence of the buffering protection a supportive adult can provide. Stressors include recurrent child abuse or neglect, severe maternal depression, parental substance abuse or domestic abuse. Under such circumstances, persistent elevations of stress hormones and altered levels of

key brain chemicals disrupt the architecture and chemistry of the brain.

From early infancy, children naturally reach out for interaction through such behaviours as babbling, making facial expressions and uttering words, and they develop best when caring adults respond in warm, individualised and stimulating ways. In contrast, when the environment is impoverished, neglectful or abusive, the result can be a lifetime of increased risk of impairment in learning, behaviour and health.²²

Accumulating evidence from the fields of developmental psychology and neuroscience indicates that not only can early failures in parental care have a compromising and enduring impact on the ability of children to cope with stress, they can also impact upon the parenting abilities of those children when they themselves become adults.²³

The economic case

Whilst moral and social justice arguments are prominent in the rationale for focussing on early intervention, there is also a compelling economic case. The analysis of Nobel economist James Heckman²⁴ is increasingly cited in favour of the case for intervening early in the life course. Heckman's modelling of the rates of return on investment in human capital suggests a smart investor would focus attention on the early years, when returns are greatest.

Heckman's thesis has been further developed by Doyle²⁵ who argues that because 'skill begets skill', early investment raises the productivity of later investment, literally shifting the curve to the right: *"The economic argument for early investment does not therefore preclude later investment; rather it argues that there are dynamic complementarities to be gained from investing at different stages of the life cycle, starting as early as possible"*. Ironically, as was demonstrated by Sir

Michael Marmot's review on health inequalities,²⁶ current patterns of public investment during childhood are heavily skewed in favour of the later stages of childhood.

The opportunistic case

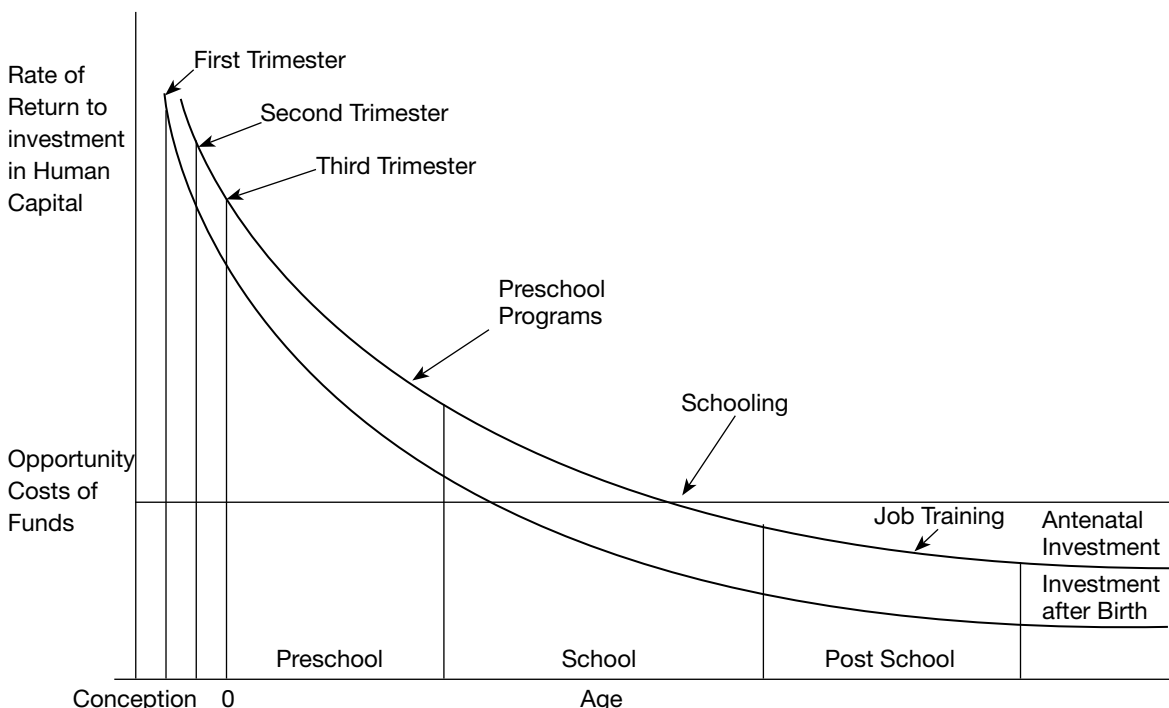
Becoming a parent – particularly for the first time – is one of the most profoundly important life events most of us experience. The transition to parenthood can be a source of great joy, but may also cause great anxiety.

Babies do not arrive with a user manual. They change our lives profoundly, and the total dependence of a newborn baby can be a daunting responsibility.

Pregnancy and the birth of a baby is a critical 'window of opportunity' when parents are especially receptive to offers of advice and support. This is a time when the vast majority of parents want to do the best for their child. It provides an opportunity to help parents get off on the right foot, and crucially to help set the pattern for effective parenting later on.

This early period is a time when families expect to have contact with professionals such as health visitors and midwives, and this contact offers an opportunity to engage families constructively in change.

Heckman's modelling of the rates of return on investment in human capital



Rates of return to human capital investment setting investment to be equal across all ages

Assessment of postnatal attachment in mothers²⁷

%	England	Wales	Scotland	NI	Total
Usually when I am with the baby, I am very/a bit impatient	7.6	7.0	7.7	7.1	7.6
When I am caring for the baby, I am very/fairly incompetent and lacking in confidence	2.8	3.2	3.0	2.6	2.8
Regarding the things that I/we have had to give up because of the baby, I find that I resent it quite a lot/a fair amount	2.1	2.2	2.0	1.1	2.0
When I am caring for the baby, I get feelings of annoyance or irritations almost all the time/very frequently	1.3	1.3	1.4	1.7	1.4

Despite all of the challenges, most parents make the transition to parenthood successfully. However, all families need some support to learn how to develop and be sensitive and responsive in their parenting practices.

Some families face additional challenges that can negatively impact on attachment. These include poverty, relationship conflict, domestic abuse, mental illness and substance abuse. Such families will require additional more intensive and coordinated support if they are to get off on the right tack.²⁸

Across the UK, a small proportion of parents of babies report feelings of impatience with their baby, incompetence in their parental role, resentment or irritation. Although these figures are small in percentage terms, these parents are likely to require significant support to be able to provide the sensitive care their babies need.

The effectiveness case

The good news is that there is evidence that intervention during this life stage can make a real difference. What is more, programmes such as the Family Nurse Partnership have demonstrated that well-crafted and evaluated interventions can deliver substantial savings.

Chapter 3 of this report reviews some of the best-evidenced programmes relating to pregnancy and the first years, providing a compelling case that it is possible to prevent abuse and neglect. It also highlights significant opportunities for innovation and increased impact, underlining the importance of investment in new approaches that address key gaps in current services and practice.

2. INSIGHT:

Maltreatment in pregnancy
and infancy



2. INSIGHT: Maltreatment in pregnancy and infancy

Simple, singular explanations of child maltreatment fail to do justice to the complexity of real families' lives. Drawing from a rich and extensive literature, this chapter sets out a framework to guide our understanding of the intricate multi-level processes associated with maltreatment. This framework for understanding maltreatment and our analysis of the most important markers of risk and protection underpins our overall strategy for response.

Causes and consequences of maltreatment in infancy

Following the work of scholars such as Bronfenbrenner and Belsky, **ecological** approaches – which highlight different levels of influence on an individual's development – are now widely

accepted as the most satisfactory explanatory model of maltreatment to date. The ecological elements of our framework can be applied across different stages of childhood, but here they are used to highlight the drivers of maltreatment *specifically* during pregnancy and infancy.

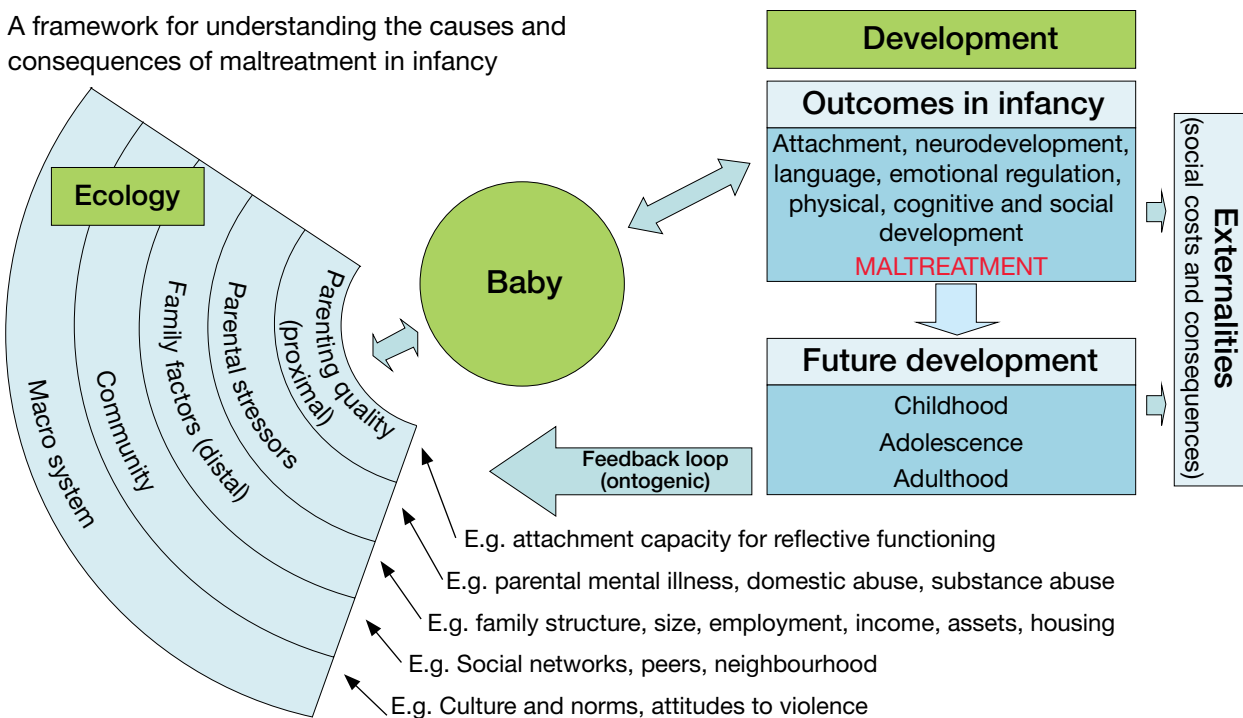
At the heart of the model is the relationship between the primary caregivers and the child. Later in this chapter we consider key constructs such as attachment and parental reflective functioning. We also examine the role of key stressors which can affect parents' capacity to provide adequate care, namely parental mental illness, domestic abuse, and drug and alcohol misuse.

Public health approaches are important in understanding the social patterning and social determinants of maltreatment.²⁹ We know for example that child abuse is higher where there is social deprivation and that poor parents are more likely to deploy physical punishment and authoritarian parenting. These approaches draw attention to population-level causes of maltreatment such as levels of poverty and inequality and social norms that tolerate violence.

Our framework also draws and integrates work from the **developmental** (or transactional) tradition

There are multiple interacting levels of influence on the dynamics of child development³⁰

A framework for understanding the causes and consequences of maltreatment in infancy



associated with authors such as Cichetti. This work emphasises the dynamic nature of child development, recognising both *continuities* (e.g., the cumulative nature of risk and protective factors) and also significant *discontinuities* (e.g., the possibility of leaving ‘at risk’ status as a result of improved circumstances, or the unexpected onset of adversity in children previously considered at low risk).³¹

Relevant here also is the concept of ‘ontogeny’, which is concerned with the childhood histories of abusive parents. The hypothesis that the nature and quality of parenting are transmitted between generations is common to several highly influential theoretical perspectives, even if they differ in views about the precise mechanisms for transmission.³² Both retrospective and prospective

studies now provide evidence of how patterns of parenting (both positive and harmful) can be passed between generations.

However, it remains indisputable that parenting experienced by one generation is by no means *inevitably* repeated in the next.³³ Further research is required to better understand why some parents repeat the parenting they experienced while growing up, whereas others do not.

A growing body of research is helping to pinpoint the factors during pregnancy and infancy which can be thought of as markers of risk for – and protection against – maltreatment. The figure below plots the key known markers of risk and protection during pregnancy and infancy against the different levels of our framework.

Level	Markers of risk	Markers of protection
Ontogenic	<ul style="list-style-type: none"> • Parent experienced maltreatment as a child 	<ul style="list-style-type: none"> • Parent experienced secure attachment
Child	<ul style="list-style-type: none"> • Age • Premature birth • Physical or mental disability • Test positive for AOD • Low birth weight • Male (for physical abuse) • Race 	<ul style="list-style-type: none"> • Good temperament • Good fit with parent
Parenting quality	<ul style="list-style-type: none"> • Does not enjoy parenting • High (unrealistic) expectations • Not satisfied with the child • Views child as difficult • Not understanding role as caregiver • Lack of knowledge of child development • Hostile/aggressive parenting • Smoking during pregnancy • Biological or genetic factors 	<ul style="list-style-type: none"> • Parent experienced secure attachment as child • Capacity for ‘reflective functioning’
Parental stressors	<ul style="list-style-type: none"> • Substance abuse • Stress in family environment • Parental conflict and domestic abuse • Parental mental illness 	<ul style="list-style-type: none"> • Supportive significant other person in the home

Level	Markers of risk	Markers of protection
Family factors	<ul style="list-style-type: none"> • Low income • Financial stress • Young age of mother • Low maternal education • Large household size • Unmarried 	<ul style="list-style-type: none"> • Space between pregnancies • Low number of children
Community	<ul style="list-style-type: none"> • Lack of social support 	<ul style="list-style-type: none"> • Social support
Macro-system	<ul style="list-style-type: none"> • Cultural values that support violence 	<ul style="list-style-type: none"> • Cultural value of protecting children

Adapted from Scannapieco and Connell-Carrick, K. (2005) *Understanding child maltreatment*.

Large-scale surveys on which much of the key empirical analysis has been undertaken can often struggle to capture the diverse experiences of particular sub-groups of families. These limitations of traditional survey research mean additional strategies are required to capture and reflect the experiences of babies born into different family circumstances, including amongst others: specific ethnic minority communities, non-English speakers, those living in institutions (young parents in care or parents in the criminal justice system) or in temporary accommodation, frequent movers (such as gypsies and travellers), parents with learning difficulties, and parents with marginal legal or social status (such as failed asylum seekers or sex workers). Researchers such as Hedy Cleaver are forging the way in capturing greater insights about the experiences of minority and vulnerable groups, but there is an urgent need for more research in this area.

This report does not provide space to fully examine the literature on each of the individual risk and protective factors highlighted in the table above. Instead, we recommend that the interested reader refer to other works (such as that of Scannapieco and Connell-Carrick) which devote themselves to providing a very detailed and extensive account of risk and protective factors.

Here, we firstly focus on the relationship between the primary caregiver and the baby. The remainder of this chapter then sets out current key issues in relation to three key stressors which can distort parents' ability to provide effective care to their babies: mental illness, domestic abuse and substance misuse. Understanding the state of

debate around these questions is important to our review and to the prioritisation of intervention strategies and policy recommendations in this report.

The couple relationship

Strong and stable relationships are at the heart of family life. The quality of relationships at home makes a big difference to the whole family, but they particularly affect children in their formative years.³⁴

When a couple has a baby, it is one of the most significant transitions of their adult lives.³⁵ In turn the quality of the couple relationship has a deep impact on parents' capacity to bond with their new baby and provide sensitive care.

Parents' capacity to provide love, care and nurture

“The struggle to understand the mother-infant bond [...] touches us so much because it holds so many clues to how we became who we are”³⁶

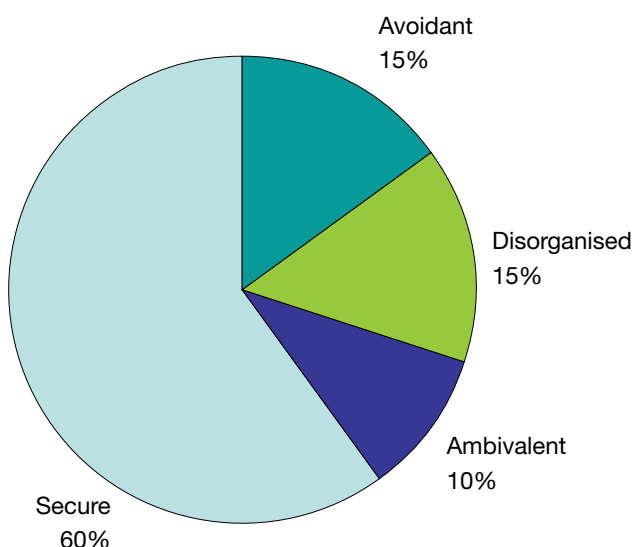
Attachment theory

Attachment theory has had a profound impact in reframing how we think about rearing children. John Bowlby's pioneering work³⁷ started from an evolutionary perspective which recognised the universal human need to form close bonds of affection. Bowlby's theory described a behavioural system which serves to ensure the safety of babies during a period of acute vulnerability and dependence. It described how infants become attached to adults who are consistently sensitive and responsive in social interactions with them. With the security of knowing his primary caregiver is emotionally available, the child grows in the confidence to explore the world around him.

Evolution, it was argued, uses the early attachment relationship as a signalling system to the newborn about the kind of environment he might expect. An environment where caregivers lack the time and resources to devote attention to the infant is far more likely to necessitate later use of violence to ensure survival. Attachment theory also introduces the idea of 'internal working models' which are developed in response to parental caregiving and which will guide the individual's feelings, thoughts and expectations in later relationships.

Mary Ainsworth translated theory into practice, developing the strange situation procedure (SSP), a clinical assessment devised to measure how infants respond to the experience of separation from their mother. The chart below illustrates the approximate distribution of the four main attachment types across general population samples.³⁸

Distribution of attachment types across the general population



Securely attached infants are confident their caregivers will be emotionally available. In the SSP, the secure infant becomes distressed during separation, seeks contact with the parent on their return, is able to be comforted, and finally resumes exploration of the novel environment. Securely attached children generally have better social skills and are more empathetic and responsive. A number of effective interventions (such as the Nurse Family Partnership) seek to promote sensitive caregiving and secure attachment as mechanisms to prevent abuse and neglect.

In **avoidant attachments**, the child shows little, if any, distress at the parent's departure during the SSP, and on the parent's return they avoid close contact, seeming to prefer playing on their own. Attachment theory explains this behaviour as the consequence of consistent rejection by the parent, particularly at times when the infant showed distress. As a result, the child has no confidence that when they seek care they will receive a helpful response.

Insecure-ambivalent attachment is characterised by the infant becoming extremely distressed at the parent's departure in the SSP, but remaining inconsolable when the parent returns. The theory here is that these infants have experienced unreliable or inconsistent care from the parent, leaving them feeling anxious about the parent's availability, and that the expression of their needs has to be maximised in order to get a response.

Insecure-disorganised attachment refers to the bizarre behaviours (including momentary freezing) shown by some children on their mother's return in the SSP. This behaviour is thought to be the consequence of the infant's exposure to frightening or inexplicable behaviour on the part of the parent, who is also paradoxically the person on whom the infant depends.

Disorganised attachment patterns are particularly likely when parents:

- have unresolved losses or have themselves suffered traumatic experiences, including childhood abuse³⁹
- have serious affective disorders, including depression⁴⁰
- are active alcoholics or heavy users of hard drugs⁴¹
- are maltreating.⁴²

It is therefore not surprising that the majority (typically around 80 per cent) of maltreated infants are classified as disorganised in their attachment behaviour. However, by no means all 'disorganised' children have been maltreated.⁴³ Studies following up disorganised infants have found elevated risks of a range of adverse

outcomes, including aggressive behaviours, mental disorders, school behaviour problems and other psychopathologies.⁴⁴

There is now a substantial body of empirical research showing associations between infant-parent attachment security and measures of psychological, behavioural and even reproductive development. Associated outcomes identified in the literature include self-esteem, cognitive abilities, persistence in solving problems, peer relations, romantic love and age of menarche.^{45,46,47}

Research has also demonstrated how parents' memories and organisation of their own childhood experiences are an important predictor of the attachment groups that their own children will fall into. For example, Mary Main found that in 76 per cent of cases there was a match between assessments of a parent's attachment status and that of their children.⁴⁸

In Patricia Crittenden's dynamic maturational model (DMM),⁴⁹ attachment is seen as a theory about protection from danger and the need to provide a reproductive partner. As a developmental theory, it is focused on the interactive effects between genetic inheritance, maturational processes and individual experiences. This important model views patterns of attachment both as a description of interpersonal behaviour and also a basis for diagnosing psychopathology.

Reflective functioning

Parental reflective functioning (or mentalisation) refers to the capacity to envision mental states (thoughts, feelings, needs, desires) in oneself and others – in other words, to 'keep the baby in mind'. These processes have been linked to a range of positive outcomes in both parents and children,⁵⁰ most importantly secure attachment.

The critical insight from this approach is that **understanding mental states is the key to understanding behaviour, in oneself and others**. Reflective functioning refers not only to the capacity to recognise mental states, but also to link mental states to behaviour in meaningful and accurate ways. A reflective individual has a sophisticated internal working model of emotion and intentions which facilitates affect regulation (the ability to maintain positive feelings and regulate stress levels) and productive social relationships.

Reflective functioning is an essential life skill at the core of parenting. A mother's reflective skills determine whether her child learns from her by default or by design. This depends on her capacity to think about and see the links between events,

her infant's behaviour, feelings and knowledge, and then to respond appropriately. In essence this means she has the ability to *think, link and respond* to her infant appropriately.⁵¹

For example, when a baby cries, a mother with strong reflective functioning skills, intuitively wonders what the crying means. She looks for links between the crying and what has happened. She wonders what the baby may be thinking and feeling, reflects on this, considers various possibilities and selects an appropriate response. At the other end of the spectrum, a mother who is insensitive or 'missattuned' may interpret her infant's cries as manipulation and decide to respond by ignoring her baby. The baby learns that crying does not get the response sought and adapts its behaviour in order to preserve the relationship with the mother.

Parents abused in childhood often lack the ability to separate out their own feelings from those of their child. As a consequence, they interpret their infant's behaviour through the lens of their own histories of trauma – what Selma Fraiberg famously described as "ghosts in the nursery".⁵²

The available evidence suggests that poor capacity for reflective functioning by parents puts a child at increased risk of abuse because of the way it impacts on parents' ability to provide adequate love and care for their baby. The good news is that models of practice are emerging which harness insights from reflective functioning and offer the possibility of fostering secure attachment and preventing many poor developmental, health and social outcomes that have plagued high risk families.

Parental stressors

We review below the role of three key 'parental stressors' (mental illness, substance misuse and domestic abuse) on outcomes for babies. NSPCC's analysis of 130 serious case reviews for infants (published since the beginning of 2008 in England) found that 94 involved one or more of these three parental stressors. It should be emphasised that these factors are not determinants of abuse – they are risk factors. Each of these parental stressors can affect babies in three main ways:

- through physical impacts as a result of exposure during pregnancy
- through the direct impact of witnessing parental stressors first hand as a baby
- through the effects of parental stressors on parenting

Mental illness

Mental illnesses affect a substantial proportion of women of childbearing age and their partners. The impacts on children and the family can vary considerably according to the specific condition, its severity, the timing of onset and its duration.⁵³ Below we consider evidence on maternal depression, on mental illness in fathers, and on serious mental illnesses.

Maternal depression

Maternal depression, characterised by a prolonged period of low mood and a profound loss of interest and enjoyment, is the most common mental health condition. The emotional swings experienced by many mothers shortly after childbirth should not be confused with major depression. Depressive symptoms include difficulty sleeping and concentrating, loss of appetite, feelings of worthlessness and guilt, and low energy.

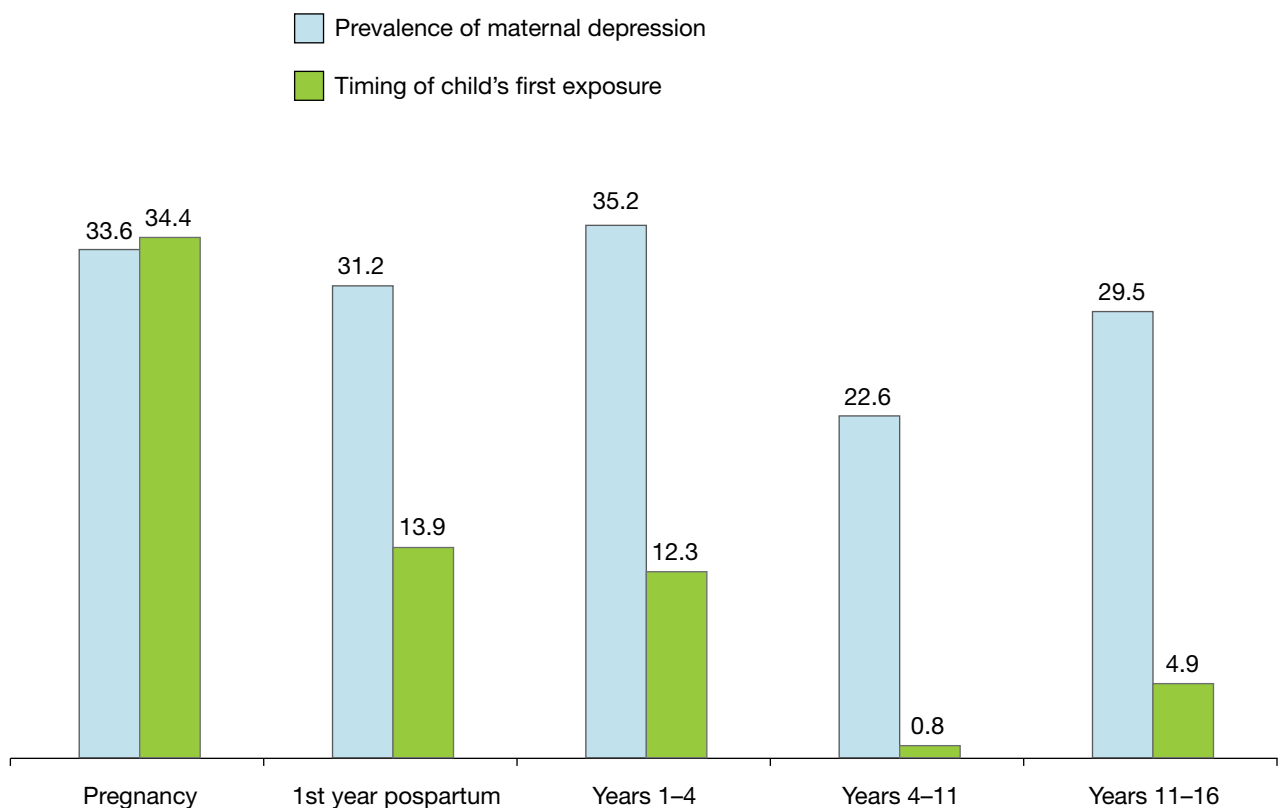
Compared to older children, very young babies are especially vulnerable when mothers experience depression because of their total dependence and the frequency of care they require. Deep depression is debilitating, making it difficult for mothers to provide routine care and maintain nurturing relationships with their children.

There is considerable awareness of the prevalence of 'postnatal depression'. Consistent with other developed countries, it is estimated that around 14 per cent of mothers in the UK experience postnatal depression.⁵⁴ There is very limited information on rates of maternal depression between different ethnic and cultural groups. However, international research suggests that prevalence rates do not vary significantly across cultures.

Symptoms of anxiety and depression are frequent during pregnancy. Indeed some studies suggest they are more common in late pregnancy than in the postnatal period.⁵⁵ Longitudinal research⁵⁶ with a large disadvantaged cohort of mothers in South London illustrates that despite the focus on postnatal depression, the prevalence of depression is also high *during pregnancy* and even *beyond the first year after birth*. Indeed this research suggests that in terms of the child's first exposure to maternal depression, the antenatal period is critical.

The risks of poor outcomes are greatest when depression *begins early*, is *long lasting* and *severe*. However, studies documenting poor developmental outcomes for the children of mothers with declining or low levels of depression suggest caution against too narrow an approach to the targeting of support.

Prevalence of maternal depression and timing of child's first exposure to depression (South London Study)



Rates of maternal depression are higher among mothers with previous histories of depression and those experiencing other stress factors such as social isolation, lack of confiding relationships or financial hardship.⁵⁷ Having the care of three or more young children increases the risk of depression in women.⁵⁸ Data from the UK and overseas suggest that whilst children from low income households face particularly high levels of exposure to maternal depression, it is in fact present across the income distribution.⁵⁹

There is a growing body of evidence that maternal depression during pregnancy may affect brain development in the foetus. 'Foetal programming' is a concept that describes the foetus' physiological adaptation to the intrauterine environment in which it develops. These prenatal physiological adaptations may render the offspring vulnerable to the development of health problems later in life. Recent research has found that antenatal depression can be linked to the silencing of a gene that regulates the production of stress chemicals. Over-production of stress chemicals in pregnant women can reduce foetal growth and poses risks of premature labour. Antenatal depression has also been linked to altered immune functioning in the baby after birth. Antenatal anxiety at 32 weeks' gestation has been linked to behavioural and emotional problems in the child at age 4 (even after a range of controls including postnatal anxiety).⁶⁰

Seminal research in the 1980s with depressed mothers living in conditions of high adversity found elevated levels of maternal insensitivity. Two types of insensitivity in parenting styles have been highlighted, typified by 'intrusive and hostile' communication at one extreme, and 'withdrawn and disengaged' at the other.⁶¹ In turn, the infant of the depressed mothers in these studies showed high rates of distress and avoided social contact. Studies with lower risk samples have shown less marked disturbance in the contacts between depressed mothers and their infants, though there is still evidence of reductions in maternal responsiveness, particularly in cases where depression persists.⁶² Recent research has found that the adverse effects of maternal depression on child attachment were reduced when the mothers themselves were securely attached.

There is accumulating evidence of the long term impacts of maternal depression. We know that women who have suffered from postnatal depression are twice as likely to experience future episodes of depression over a 5 year period, implying continued or recurrent vulnerability among the dependent children concerned.⁶³ Halligan's longitudinal analysis of a sample of families in Cambridge found that maternal

withdrawal during early interactions predicted elevated levels of cortisol at age 13 among the children of postnatally depressed mothers.⁶⁴

Fathers

Whilst researchers and practitioners have made enormous strides in understanding maternal depression, until relatively recently there has been a dearth of work around fathers and depression. Fathers matter both because of the *direct* impacts of their depression, and because of their *indirect* (potentially 'buffering') role in relation to maternal mental illness.

A recent study has found that the prevalence of paternal depression is around 4 per cent during the first year after birth (compared to 14 per cent among mothers).⁶⁵ The peak time for paternal depression is between 3 and 6 months after birth.⁶⁶ By the time a child reaches 12 years of age, two fifths of mothers and a fifth of fathers had experienced depression.⁶⁷

A recent systematic review identified low relationship satisfaction as a key element of a father's depression when his partner had depressive symptoms.⁶⁸ Between 24–50 per cent of new fathers with depressed partners were depressed themselves.⁶⁹

Research has found that fathers experiencing depression have less involvement with their children⁷⁰ and higher rates of 'infant directed negativity'.⁷¹ Severe depression in fathers has been associated with high levels of emotional and behavioural problems in their infant children, particularly boys.⁷²

A common shortcoming of interventions with depressed mothers may be their failure to engage with fathers, not least since fathers can sometimes 'shield' infants from the adverse effects of chronic maternal depression. However, many depressed new mothers report that their partners don't understand their illness and are unable to provide the emotional and practical support they need. There is clearly then, considerable opportunity to both improve the support provided to depressed fathers, and to capitalise on their potential to provide better emotional support and care to their partners and children.

Serious mental illnesses (SMIs)

SMIs (such as schizophrenia and related psychoses, and affective disorders) can pose significant challenges to parenting and risks to dependent children, particularly when mothers lack insight into their disorder and are acutely unwell.

In 1–2 per 1,000 births, the mother develops a psychosis that requires hospital admission.⁷³ The relative risk of a woman being admitted with postnatal psychotic illness in the month after birth is approximately 22 times the risk women face in the two years before pregnancy. The first three months after childbirth are when we see the peak lifetime prevalence for psychiatric disorders and hospital admissions for women. 50 per cent of maternal infanticides also occur within this first three month window.⁷⁴ In 90 per cent of maternal filicide cases, maternal psychiatric illness was documented. However, the majority of child homicides in the first 24 hours are not associated with mental illness.⁷⁵

Outcomes for babies whose mothers have SMIs are less well studied than for those whose mothers suffer mild-moderate depression or anxiety. This may be to do with lower fertility rates in this group and because many babies of women with SMIs are taken into care. We also know that these babies have a greatly increased risk of developing SMIs themselves.

The peak age of onset of **schizophrenia** among women is in their 20s, coinciding with the main reproductive years.⁷⁶ The condition affects around 4 in 100,000 of the population. Development of babies may be adversely affected during pregnancy because of a range of factors associated with chronic schizophrenia, including poor attendance at antenatal appointments, unhealthy lifestyles, poor nutrition, smoking and the effects of both prescribed and illicit drugs.

Once the baby is born, research has found that mothers with schizophrenia can experience a range of problems in caregiving, including lack of emotional warmth and intimacy, remoteness, attention deficit, impaired maternal sensitivity and responsiveness to an infant's cues, self absorption and intrusiveness.⁷⁷ Intrusive interactions can interfere with an infant's activities and lead the baby to avoid contact with the mother. Consequently, the infant may internalise an angry and protective coping style. Early experiences with mothers suffering from SMIs may interfere with infants' regulation of emotion and attention, with cognitive and memory function and with the ability to make self/other distinctions. These impacts may continue to exert direct effects on children's lives over a decade later.

Women with a diagnosis of schizophrenia are significantly more likely to have higher scores on perceived risk of harm to their babies compared to mothers with a diagnosis of psychotic depression.⁷⁸ Around half of mothers with schizophrenia receiving inpatient psychiatric care in the postnatal period do not retain custody of their babies.⁷⁹ Mothers who lose custody of their

children may grieve for several years and are often not supported adequately when this occurs.

Affective disorders, characterised by dramatic changes or extremes of mood, include bipolar I ('manic-depressive psychosis') and bipolar II (recurrent episodes of depression with at least one episode of hypomania). Symptoms of mania include persistent and abnormally elevated mood. Because of the dis-inhibition associated with mania and hypomania, women are vulnerable to exploitation (including rape) and risk-taking behaviours (high numbers of sexual partners).

Denial of pregnancy poses the risk of a host of problems, the most serious among them being neonaticide. Neonaticide is also associated with dissociative symptoms, dissociative hallucinations, depression and suspicion of early trauma in isolated, rigid family structures. Women who deny their own pregnancy are often young, fail to manifest symptoms of pregnancy and fail to attend antenatal clinics, a situation frequently complicated by their families' collusion in denying the pregnancy.⁸⁰

Domestic abuse

The term 'domestic abuse' aims to capture the breadth of abusive behaviours that can operate within an intimate relationship. It includes sexual, emotional, psychological and financial abuse as well as the physical violence which has been the traditional focus of attention.

Although official Home Office figures for England and Wales⁸¹ suggest there has been a long term decline in overall rates of 'domestic violence' since its peak in the mid-1990s, latest data still show that 7 per cent of women and 4 per cent of men reported being victims of domestic violence in the last year. These figures fail to do justice to the complexity and breadth of domestic abuse. Digging beneath the headline figures, it is clear from the data that women are disproportionately the victims of severe physical abuse and rape. However, official figures are poor at eliciting other emotional and psychological aspects of abuse or at fully capturing their dynamics, including the ways in which conflict may escalate or decline at different stages in a relationship.

The transition to parenthood is a major life change and can place considerable stress on the couple relationship.⁸² In fact, it is during pregnancy and immediately after childbirth that many women first experience domestic abuse. As well as creating new strains, pregnancy and the birth of a child may intensify existing sources of conflict such as low income, unemployment and other financial worries.

International research suggests 4–8 per cent of all pregnant women are victims of domestic abuse.⁸³ One study suggested rates of domestic abuse (severe to moderate violence) increase after birth compared to the antenatal period.⁸⁴ The same study found that 40–50 per cent of women who experienced physical abuse also experienced sexual assault. Other research of physical abuse during pregnancy suggests that injuries are more frequent during the late second and third trimesters.⁸⁵

New analysis undertaken for this review of the *Psychiatric morbidity survey*⁸⁶ estimates for the first time the number of under-1s living with a parent who reports domestic abuse. This analysis suggests that around 33,000 babies under 1 in England, equivalent to around 39,000 in the UK, are living in a family where there is domestic abuse.

Markers of risk for domestic abuse during pregnancy include low socio-economic status, low levels of support, first-time parenthood, unexpected/unwanted pregnancy, young

parenthood, unmarried parents, limited education, and alcohol misuse.^{87,88}

Domestic abuse is associated with poor physical health outcomes including sexually transmitted infections, miscarriages, antepartum haemorrhage, preterm labour, neonatal death and low birth weight babies.⁸⁹ Victimization has also been linked to unhealthy diet, breastfeeding difficulties and severe postnatal depression.⁹⁰

According to many women, the mental stress of abuse is far worse than the physical effects of beatings and the impacts on self-esteem often lead to dependence on the abuser and social isolation from potential sources of informal and formal support.⁹¹ For example, one study found that abused women were 1.8 times more likely to delay prenatal care compared to women who were not abused.⁹²

There is now increased understanding that the consequences of heightened maternal stress during pregnancy as a result of domestic abuse extend to the foetus – and later to the newborn

Oregon healthy start research⁹³

This study compared infant health outcomes among families affected by domestic abuse against those in families not affected. All differences reported below are statistically significant. Several of these factors are markers of risk for child maltreatment.

After controlling for demographic variables, families experiencing domestic abuse at 3 months of child rearing were over 2 times (OR= 2.29) more likely to have child maltreatment confirmed by the state.

%	DA N=144	Non-DA N=992
Infant born low birth weight	5.3	.08
Infant born with medical problems	8.8	3.7
Mother smoked during pregnancy	30.7	17.4
Mother chose not to breastfeed	54.4	34.9
Mother had difficulty bonding with infant	25.4	13.2
Mother smoked at 12 months	28.1	16.0
Others at home smoked at 12 months	56.1	29.5
Infant received poor or fair nutrition at 12 months	24.6	13.4
Infant not linked to primary health care provider at 12 months	7.0	2.5
Infant immunisations not up-to-date at 12 months	16.7	7.0
Infant missing regular well-child check-ups at 12 months	14.0	5.9

South Carolina study:⁹⁴ domestic abuse and mothers' potential for child abuse

- Casanueva and colleagues sought to examine the links between domestic abuse and women victim's child abuse potential (CAP) specifically during pregnancy. They recruited samples of abused and non-abused pregnant women in South Carolina prenatal clinics.
- The research showed that women abused during pregnancy had more than 3 times the odds of having a very high CAP score, elevated to the point where they were of clinical concern.
- These elevated scores were in good part due to the abused women's higher levels of distress (they were more likely to report feelings such as being fearful, misunderstood or isolated) and problems with others (they were more likely to report other people had damaged their lives in some way – e.g., making them unhappy or causing them pain).
- Importantly, abused women were similar to non-abused women in their responses to questions about perceptions of their children (including items such as 'I have a child who is bad') and parenting beliefs
- Because abused women view their children and parenting in a similar manner to non-abused women, but their relationship problems with adults (especially the violence perpetrator) and their high levels of distress (likely to be due to the violence in their lives) place them at heightened risk of abusing their children, intervention strategies aimed at improving their adult relationships and dealing with their elevated levels of distress (such as mental health counselling and treatment) appear to be appropriate.

child. Once the baby is born, she faces three main risks: observing traumatic events, being abused herself, and being neglected.

Infants as young as one year old can experience trauma symptoms as a result of witnessing domestic violence.⁹⁵ Symptoms may include eating problems, sleep disturbances, lack of normal responsiveness to adults, mood disturbances and problems interacting with peers and adults. Clinical reports indicate these babies often have poor health, poor sleeping habits or irritability, and exhibit high rates of screaming and crying.

Little is known about the father-child relationship in the context of domestic abuse, and much of the research in the UK has focused on the father's position as an 'attack' on the mother-child relationship. In this light the father is seen as directly and indirectly undermining the mother-child relationship, either because he disempowers the mother in her parenting by controlling her behaviour (distancing her physically and emotionally from her child), or because he insists that the mother prioritises his own needs over those of their child.

Emerging research⁹⁶ highlights the violent father's role in the context of attachment and emotional security theory (EST), suggesting that further research is required to understand the

infant's need for security and the impact of this on father-child attachment processes. We need to understand more about the development of infant attachment processes in families where attachment with the maternal caregiver is disrupted.

Complex causes of domestic abuse

The **feminist perspective** highlights two critical factors in understanding the causes of domestic abuse: the unequal position of women in a particular relationship (and in society), and the social acceptance of violence to resolve conflict.⁹⁷ From this perspective, violence is seen as a strategy in conflict. Relationships full of conflict, especially those in which conflicts occur about finances, jealousy and women's gender role transgressions, are more prone to violence. Violence is frequently used to resolve a crisis of male identity (for example, where a man is dealing with social expectations of manhood that are unattainable), and at times is provoked by poverty or an inability to control women. This perspective strongly rejects the idea that violence is the product of 'out of control' anger and the notion that anger management will somehow 'fix' the problem.⁹⁸

In seeking to understand the prevalence of abuse during pregnancy, **evolutionary theorists** highlight the concept of 'paternal uncertainty'.

For a sexually jealous man, pregnancy, instead of serving as a marker of his own reproductive fitness, raises doubts about paternity and suspicions of infidelity.

Some women in abusive relationships may believe that becoming pregnant will make their partner more sympathetic and less likely to abuse them. However, pregnancy can lead to just the opposite effect, because the sexually jealous man may see the pregnancy as evidence of his worst fears coming true.

Psychological approaches seek to understand how abusive patterns of behaviour within intimate relationships (such as inordinate jealousy, impulse and emotional regulation deficiencies) develop and how these behaviours may trace their aetiology to exposure to early violence and trauma.

Substance misuse

Substance misuse is a serious mental health disorder involving the persistent use of alcohol or drugs despite the negative consequences.⁹⁹ Parental substance misuse can harm children's development both *directly* – through exposure to toxins in utero and through the effects of withdrawal at birth – and *indirectly* – through its impact on parenting capacity. In this section we firstly review the evidence around harmful patterns of drinking during pregnancy and the first year, before going on to look at illicit drug use.

Problem drinking

It has been estimated¹⁰⁰ that 1.3m children under 16 in England are affected by parents whose drinking is classified as either 'harmful' or 'dependent'.¹⁰¹ However, there is no available breakdown of these figures by age of the children affected. New analysis of the *Psychiatric morbidity survey* in England commissioned specifically for this review suggests that:

- around 79,000 babies under 1 in England are living with a parent who is classified as a 'problematic' drinker ('hazardous' or 'harmful'). This is equivalent to 93,500 babies in the UK.
- around 26,000 babies under 1 in England are living with a parent who would be classified as a 'dependent' drinker. This is equivalent to 31,000 across the UK.

The riskiest period for drinking in pregnancy is around the time of conception and during the first trimester,¹⁰² when the foetal central nervous system is developing. However over half of pregnancies are unplanned and often women do not realise they are pregnant for weeks or months

and they continue to use alcohol, potentially causing harm to the foetus.

All four jurisdictions of the UK advise pregnant women to avoid alcohol, but recommend that if they do choose to drink, they should drink no more than one to two units once or twice a week after the first three months of pregnancy. The percentage of women in the UK drinking alcohol during pregnancy decreased from 61 per cent in 2000 to 54 per cent in 2005. Older mothers and those from managerial and professional backgrounds are more likely to drink before and during pregnancy.¹⁰³ White people are more likely to report drinking in the past week than people from ethnic minorities, though these established patterns may be becoming less clear cut for second generation ethnic minorities and those in mixed households.¹⁰⁴ Among mothers who drink during pregnancy, consumption levels are generally low, though there is a group of around 2 per cent who drink more than seven units per week on average.

It is generally assumed that illegal recreational drugs have the most damaging impacts on brain development and function. In fact, extensive research indicates that alcohol is one of the most dangerous neurotoxins that can affect the brain during the period between conception and birth.^{105,106}

Foetal alcohol syndrome is a serious medical condition associated with high levels of alcohol exposure during pregnancy. It is characterised by foetal growth restriction (with subsequent low birth weight, reduced head circumference and brain size), central nervous system problems (including cognitive dysfunction, or learning difficulties, and neurological abnormalities), a cluster of distinctive facial abnormalities, and failure to thrive (where the child remains below the 10th centile).¹⁰⁷ Maternal alcohol dependency poses serious risks to the unborn and requires professional management and monitoring as sudden cessation of heavy drinking is potentially dangerous to the mother (because of seizures) and may cause distress to the foetus.¹⁰⁸

A number of longer term adverse outcomes have also been identified. Analysis of the New Zealand cohort study¹⁰⁹ has shown that at age 15, children with at least one problem-drinking parent were more likely to experience psychiatric problems including mood disorders, depression, anxiety, substance misuse and behaviour problems. Prevalence rates of the psychiatric problems were between 2–4 times higher for children of problem drinking parents, than among children of other parents.

Problematic drinking by parents is also associated with negative features of parenting (such as low warmth and high criticism), though the relationship is complex and influenced by the presence of additional risk and protective factors. Parenting capacity can be damaged when parents become increasingly focussed on their drinking and become less loving, caring, nurturing, consistent or predictable.¹¹⁰ Alcohol misuse is also considered to be a risk factor in cases of injury and death due to co-sleeping.

Infants living in families where both parents are drinkers have been found to experience higher rates of insecure attachment. Paternal problem drinking has been associated with low levels of sensitivity during interactions (higher negative affect, low positive engagement and low sensitive responding). Paternal drinking may also influence the maternal-infant relationship. As well as the influence of a mother's own problem drinking on the quality of interaction with her child, family conflict and maternal depression have also been linked to maternal sensitivity.¹¹¹

Illicit drugs

The influential *Hidden harm*¹¹² report estimated that between 250,000 and 350,000 (2–3 per cent) of children under 16 have a parent who is a problematic drug user, but provided no breakdown by age of the children affected. The National Institute for Clinical Excellence estimates that around 3 per cent of pregnancies (or 20,000 women a year) will involve a substance abusing mother.

New analysis of the *Psychiatric morbidity survey* commissioned specifically for this review suggests that:

- around 43,000 babies under 1 in England are living with a parent who has used an illegal drug in the past year. This is equivalent to 51,000 across the UK.

- around 16,500 babies under 1 in England are living with a parent who has used Class A drugs in the past year. This is equivalent to 19,500 across the UK.

In more deprived areas, anonymous screening studies have indicated that rates of illicit drug use by mothers may be even higher. For example, one study of 807 pregnant women in an inner-London clinic¹¹³ found that 16 per cent of them had taken one or more illicit substances. A positive test for cannabinoids was found in 14.5 per cent, with smaller numbers testing positive for opiates (1.4 per cent), poly-drug use (1 per cent), cocaine (0.4 per cent) and alcohol (0.2 per cent).

Illicit drug use during pregnancy affects both the mother and the developing foetus, as most drugs cross the placenta. Research has charted a range of adverse consequence associated with drug misuse during pregnancy. These include spontaneous abortion, congenital malformations, placental abruption, low birth weight, poor growth development and premature delivery.¹¹⁴ Drug-using mothers themselves are at elevated risk of contracting HIV and hepatitis C and B, which can be passed to the foetus. Indeed, recent analysis has shown that substance misuse during pregnancy is associated with increased mortality risk for both the mother and her child.

Neonatal abstinence syndrome (NAS) is the most commonly reported adverse effect of dependent drug use during pregnancy.¹¹⁶ NAS refers to a group of drug withdrawal symptoms which can occur in babies born to mothers dependent on certain drugs (opioids, benzodiazepines, alcohol and barbiturates). The majority of infants born to dependent mothers (60–90 per cent) will show varying symptoms of NAS, which may include irritability symptoms (fairly continuous high-pitched crying, easily startled, hyperactivity, inability to settle or sleep) and gastrointestinal symptoms (poor feeding ability, regurgitation and vomiting, poor weight gain etc.).

Mortality risk associated with perinatal drug and alcohol use in California ¹¹⁵			
Odds ratios after controlling for confounders			
Maternal mortality risk		Post-neonatal death mortality risk	
Cocaine use	2.15	Poly-drug use	2.01
		Other drug/alcohol use	1.79
		Amphetamine use	1.77
		Cocaine use	1.43

It would be misleading to suggest that all parents who are drug abusers present a danger to their children.¹¹⁷ However, a study of 268 serious case reviews in England found that 22% involved parental drug misuse and 22% involved parental alcohol misuse.¹¹⁸ Drug-using fathers outnumber drug-using mothers by 2:1. However, research evidence is overwhelmingly concerned with maternal drug use. Increased attention needs to be paid to the effects of paternal drug use and the parenting needs and capacities of drug using fathers.¹¹⁹

Multiple parental problems

Professor Marion Brandon's groundbreaking analysis of serious case reviews¹²⁰ has highlighted the high degree of overlap between the 'toxic trio' of parental risk factors (mental illness, domestic abuse and substance misuse) in these tragic cases of child death and serious injury. Less is known about the overlap of these different parental stressors across the whole population, and less still about patterns of co-morbidity specifically during pregnancy and a baby's first year. Further research and investigation are needed to better understand the clustering and interaction of complex parental risk factors and their impacts on outcomes for babies.

3. IMPACT:

Effective and innovative practice



3. IMPACT:

Effective and innovative practice

This chapter focuses primarily on the evidence about ‘what works’ and ‘what is promising’ in preventing maltreatment during pregnancy and the first year.

There is limited systematic and comprehensive data at a national level on the availability of interventions (beyond those which are centrally funded or administered). What information does exist tends to be held in local level plans. To help ground our review, we have also consulted with groups of recent parents about their own views and experiences of the services they received.

The following review of ‘what works’ is not intended as an exhaustive compendium of all of the wide range of intervention models that aim to prevent maltreatment of babies. Rather, it aims to showcase two types of interventions:

- a) those demonstrated to be **effective** in research studies and systematic reviews which apply high levels of evidentiary rigour

- b) those innovative and **promising** programmes which meet the design principles for effective programmes (see below), but have not yet demonstrated effectiveness through full scale research trials

The principles of effective programmes¹²¹

Programme design and content is: theory driven; of sufficient dosage and intensity; comprehensive and actively engaging.

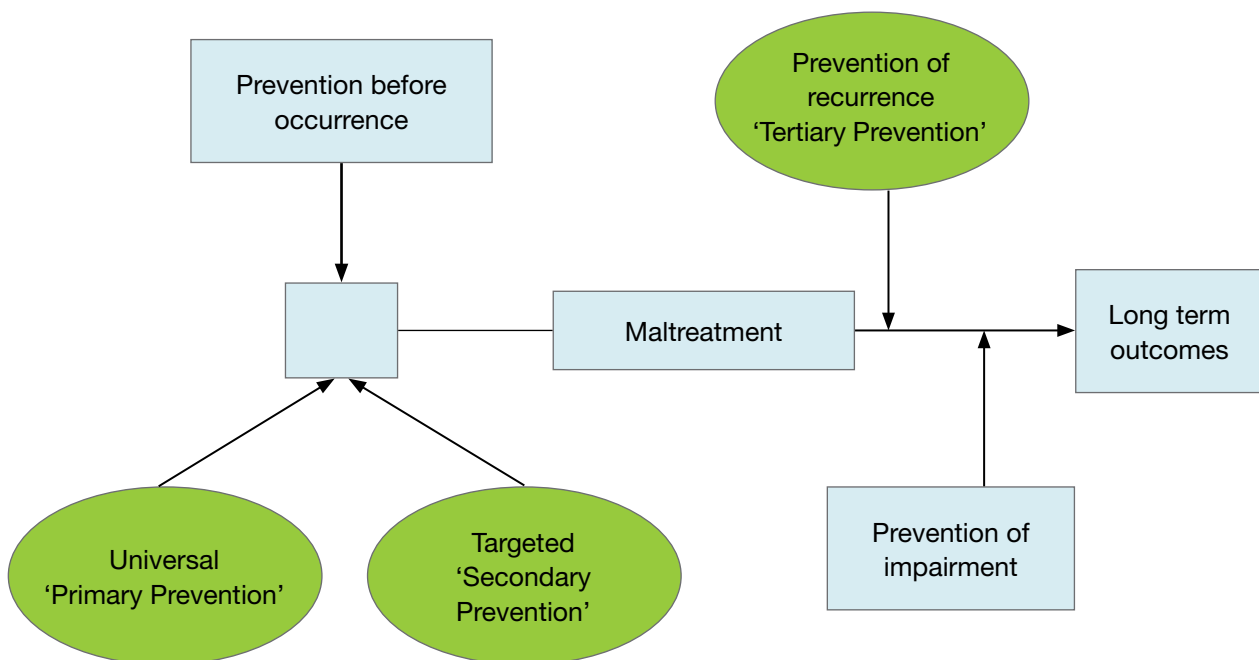
The **programme is relevant**: it is developmentally appropriate; appropriately timed; socio-culturally relevant.

The **programme is delivered** by well qualified, trained and supportive staff, and focussed on fostering good relationships.

Programme assessment and quality assurance is in place and well documented. There is a commitment to evaluation and refinement.

In presenting the findings from our review, we have drawn upon the Harriet McMillan’s framework for prevention from *The Lancet* which distinguishes different levels of prevention of maltreatment as set out in the figure below.¹²²

A framework for prevention



Primary prevention

There is a long and distinguished tradition of primary prevention in all four nations of the UK. Universal **midwifery and health visiting** services play a critical role in health care and promotion as well as in identifying and responding to additional needs and risks that families may face. **Sure Start children's centres**, initially targeted at the most deprived areas, expanded to serve over 3,000 local communities across England, providing a significant injection of additional infrastructure and resource for family support. Alongside general practice, Sure Start and Flying Start programmes across the UK are the backbone of primary prevention support.

Professor Brazelton's concept of **'touchpoints'** is helpful in thinking about key moments of opportunity for preventive intervention during pregnancy and the first years of a baby's life.¹²³ Touchpoints refer to predictable stresses related to a child's developmental surges and tend to be characterised by the parents' passionate desire to do well for the child.

Antenatal education that focuses on the transition to parenthood, with a focus on the relationship between partners and the development of a positive parent-infant relationship, shows promising results in terms of both parent and child outcomes.¹²⁴ It also has an important role to play in creating social support for parents. Current provision of antenatal education in the UK is highly variable and there is limited high quality research addressing its effectiveness. A recent systematic review found that antenatal education tends to be heavily medicalised in its contents, so missing opportunities to address the psychological and social impacts of the transition to parenthood (e.g., pressures placed on the adult relationship) and to set the groundwork for effective parenting. Current provision is generally perceived to be directed at women, limiting the participation of men. There is also very little research on the efficacy of antenatal education with vulnerable and at-risk populations (such as parents with learning difficulties or care leavers).

NSPCC is developing and testing a new parent education programme – **Pregnancy, Birth and Beyond** – for vulnerable expectant parents in eight areas across the UK

Recognising the central role of the couple relationship – and the specific challenges which the transition to parenthood can present to couples – providers such as One Plus One, Relate

and the Tavistock Centre for Couple Relationships offer important relationship support at both primary prevention and more targeted levels.

Hospital-based parent education programmes to prevent non-accidental head injuries have shown promising results in research overseas, but require further assessment before wider replication.¹²⁵ A study in Buffalo, NY in the US, in which all parents of newborns were shown a short film highlighting the dangers of violent infant shaking, found a 46 per cent decrease in the incidence of abusive head traumas between the study period and the 6 year period before the programme's introduction.¹²⁶ The immediate days and weeks after childbirth are a critical period when stresses such as sleeplessness and infant crying mean some parents struggle to cope, with potentially disastrous consequences for the newborn.

NSPCC is developing and testing a new primarily hospital-based parent education programme employing DVD, to prepare parents of newborns for the immediate days and weeks after birth. The DVD suggests ways to cope with pressures such as infant crying and warns of the dangers of violent infant shaking.

As well as the provision of rational information about the dangers of shaking babies, this is a critical window of opportunity for conveying information that can help foster sensitive caregiving and secure attachment, such as information about brain development, the understanding of 'baby states', and the suggestion of strategies for coping with the psychological and social dimensions of the transition to parenthood.

Across both pregnancy and the first year, **community support groups** such as the Community Mothers model or groups delivered by the National Childbirth Trust (NCT) can play a protective role, providing parents with access to social networks as well as practical information and advice. However, more needs to be done to expand the reach of successful services among those parents facing the most acute adversity.

Secondary prevention

Secondary prevention refers to interventions targeted at vulnerable groups, prior to the occurrence of maltreatment. This section first considers some more general programmes before

looking at interventions targeted at the particular problems of parental mental illness, domestic abuse and substance abuse.

The **Nurse Family Partnership (NFP)** programme developed by Professor David Olds in the US has been rigorously evaluated over the course of almost thirty years.¹²⁷ It is an intensive structured home visiting programme targeted at vulnerable first-time young mothers and their families. The programme is grounded in self-efficacy, ecology and attachment theories. It aims to improve health outcomes for mother and baby, promote competent and responsible parenting, and improve parents' economic self-sufficiency by helping them to plan for the future, including planning subsequent pregnancies and finding work. Programme delivery is by nurses who visit the family from early in pregnancy until the child reaches the age of 2.

Home visiting programmes are not uniformly effective. NFP has been highlighted in *The Lancet*¹²⁸ as the home visiting programme with the best evidence base for preventing child maltreatment. The programme has achieved the following outcomes across three separate randomised control trials:

- improvements in women's prenatal health
- reductions in children's injuries
- fewer subsequent pregnancies
- greater intervals between births
- increases in fathers' involvement
- increases in employment
- reductions in need for welfare and food stamps
- improvements in school readiness

Longitudinal follow up at age 15 showed that, compared to the control group, children visited by family nurses had:

- 48 per cent fewer substantiated cases of child abuse and neglect
- 59 per cent fewer arrests
- 90 per cent fewer adjudications as a 'person in need of supervision for incorrigible behaviour'

There is also good economic evidence for the programme, demonstrating high rates of return on investments in this intervention.¹²⁹

There are now 52 teams across 57 local authority areas in England, two sites in Scotland and one site in Northern Ireland delivering the Family Nurse Partnership (FNP, as the programme is called in the UK). The Government has committed to expand the reach of the programme from 6,000 to 15,000 families by 2015. Given the evidence base for this programme, opportunities for further

learning should focus on specific programme enhancements or examining how FNP can best work with particular vulnerable client groups. For example, Professor Harriet McMillan from McMaster University in Canada is collaborating with NFP to develop and test enhancements to better address issues around domestic abuse. With the demonstrated power of this programme to improve outcomes amongst disadvantaged populations, further testing and research with specific vulnerable groups whose children are known to be at elevated risk of maltreatment (such as women offenders and mothers with learning difficulties) would be desirable. The Department of Health in England is currently working with two local areas to develop and test a new group-based version of the programme for lower risk families.

The Brazelton **neonatal behavioural assessment scale (NBAS)**¹³⁰ provides a framework for evaluating infant development and early parent-child relationships. NBAS is a tool that provides an interactive, strengths-based way of understanding the baby's social and emotional development. NBAS (and its lighter touch sister assessment NBO) have been evaluated and found to increase maternal sensitivity and reduce the likelihood of serious postnatal depression.

Video Interaction Guidance¹³¹ (originally developed in the Netherlands) is being used in several NSPCC sites. This is a promising approach which aims to promote mindfulness and sensitive caregiving by helping parents to identify their own patterns of interaction and reinforce positive aspects of parenting.

The **Circle of Security** is an innovative intervention programme designed to alter the developmental pathway of parents and their young children. It teaches caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress). It presents caregivers with a simple structure for considering the ways in which their 'internal working models' (their representation of their children) influence their cognitive, affective and behavioural responses to their children. The goal is to provide language that gives caregivers awareness and understanding of the non-conscious, problematic responses they sometimes have to their children's needs. Further research is required to demonstrate the effectiveness of this programme in the UK.

Minding the Baby is a pioneering programme which has been developed by leading experts at Yale University.¹³² The programme combines clinical social work with advanced practice nursing and infant mental health care. It delivers weekly home visiting to highly vulnerable mothers (including a high proportion of poor ethnic minority

and immigrant women) from pregnancy until the child reaches the age of 2. The focus of each team is to enhance attachment relationships by developing ‘reflective functioning’ capacities in parents, and supporting positive parenting behaviours, child health and safety, maternal health and child development. This is a rigorously grounded and highly innovative programme which, as yet, has only undergone small scale testing. Initial results are promising, but the programme requires further testing to demonstrate its efficacy and effectiveness in different settings.

NSPCC is replicating and rigorously evaluating the Minding the Baby programme in a small number of locations in the UK

Parental mental illness

There are two main forms of intervention strategies for mothers experiencing depression: biological and psycho-social. In practice, the use of antidepressant medication (the ‘biological’ approach) for preventive purposes has been limited, in part due to concerns that harmful effects of the drugs can pass directly through the placenta or into the infant through breast milk.

Systematic reviews have shown that **cognitive behavioural therapies** (CBT) can be effective in reducing depressive symptoms, but contrary to what is frequently assumed, reducing mothers’ depressive symptoms alone does not necessarily lead to improvements in parenting and children’s development.^{133,134} Because healthy brain architecture is built by positive interactions with responsive caregivers over time, short term therapies of low intensity that focus solely on mothers may be effective at reducing depressive symptoms, but there is limited evidence that on their own they improve child outcomes. Interventions should focus not only on the treatment of maternal symptoms, but also maternal functioning, mother-infant interactions, the child’s social environment and the child’s physical, emotional, social and intellectual needs.¹³⁵

Effects of maternal mental illness on children occur early and can be long lasting, so it is important to identify and treat those at risk as early as possible. The **antenatal period** is the paramount time for prevention. Although mother-infant attachment disorders are most often encountered in the postnatal period, they may be detected, and therefore explored, during gestation to address and resolve hostile feelings before delivery.¹³⁶ Successful interventions to prevent

maternal depression before it occurs have been more elusive than effective treatments. The author of a recent systematic review remarked that “*The development and testing of more successful models for prevention of maternal depression, particularly for women who are at increased risk for the disorder, should be an important policy priority*”.

Rigorous research by Toth and Chicchetti¹³⁷ has demonstrated the efficacy of **toddler-parent psychotherapy** in reorganising attachment in the young offspring of mothers with major depressive disorder. This intervention focuses on the development of more positive representational models of self and of self in relation to others as a means of promoting improvements in maternal sensitivity, responsiveness and attunement.

In terms of serious mental illness, the pioneering Channi Kumar Mother and Baby Unit at the Bethlem Royal Hospital in South London is a 12-bed unit where women suffering the onset or relapse of severe mental illness following childbirth are admitted with their babies.¹³⁸ The multi-disciplinary team of psychiatrists, psychologists, nurses, occupational therapists, social workers and nursery nurses combine treatment of the mother’s mental illness with work to promote her relationship with her baby and develop parenting skills. This includes the use of video interaction work where the psychologists support mum to interpret baby’s cues and enhance sensitive caregiving.

Domestic abuse

Whilst there is extensive epidemiological evidence on the *negative consequences* of domestic abuse both for the adult victim and dependent children, far less is known about what works *to address* domestic abuse. A large amount of current practice is based on poor or no evidence.¹³⁹ Interventions may variously be focused on the perpetrator, the adult victim (overwhelmingly female) or dependent children. Outcomes sought include reducing recurrence of abuse, ensuring safety, health and mental wellbeing of victims, preventing harm to children and reducing child conduct problems and symptoms of trauma. A range of different intervention approaches have been deployed, though rarely do these take an holistic approach addressing the breadth of these outcome domains. Below we review what is known from recent reviews of the evidence in this field, though despite the significance of pregnancy and the first year of a child’s life, few of the studies address outcomes for the baby and the links to maltreatment.

Interventions for abused women

There have been a range of studies of **advocacy-based interventions** delivered in different locations including refuges, women's own homes, antenatal clinics and community settings.¹⁴⁰ A systematic review by Professor Gene Feder,¹⁴¹ found that intensive advocacy services – particularly for women who have actively sought help from professional services – can reduce abuse, increase social support and quality of life, and lead to increased usage of safety behaviours and access to community resources. Continued severe abuse or re-victimisation was the outcome most resistant to advocacy. Evidence of effectiveness was also weaker among women still in abusive relationships.

Individual therapeutic interventions have shown promise in addressing psychological conditions in women such as depression, post traumatic stress disorder and low self-esteem. For example, **cognitive trauma therapy**¹⁴² combines CBT-based treatment with empowerment strategies such as building assertive communication skills, managing unwanted contact with former partners and identifying potential perpetrators to avoid re-victimisation. Two randomised controlled trials of this intervention have shown sustained improvements in women's mental health outcomes.

However, there is limited evidence that such adult-focused interventions directly impact on outcomes for dependent children or indeed on the quality of parenting and attachment.

Support for children affected by domestic abuse

Child-parent psychotherapy¹⁴³ – developed by Professor Alicia Lieberman in San Francisco – has been positively evaluated in work with 3–5 year old children and their mothers who had experienced marital violence (where the perpetrator was no longer living at home). This therapy is aimed at improving the parent-child relationship, at helping both parent and child better modulate their feelings, and at helping the parent understand the child's experience so that the parent can become more effectively protective. The intervention consists of weekly joint child-parent sessions interspersed with individual sessions for mothers over the course of a year. Children in the intervention group had significant reductions in PTSD after the intervention and there was also a significant reduction in children's behaviour problems. PTSD symptoms were also reduced for the mothers. These positive outcomes for both mothers and children remained significant at a 6-month follow-up.

Perpetrator programmes

The best-known intervention for perpetrators is the Domestic Abuse Intervention Programme, developed in Duluth, Minnesota. The Duluth approach is based on a feminist paradigm and centres around the 'power and control wheel', which illustrates how male perpetrators use physical, emotional and financial abuse to control female victims. The intervention is a 28 week education programme which focuses on stopping an offender's use of violence, rather than fixing relationships. It aims to help the perpetrator understand that acts of violence are a means of controlling his partner's actions, thoughts and feelings. It educates participants through the use of group dialogue, aiming to increase the willingness of each to change his abusive behaviour by examining the negative effects of that behaviour on his relationship, his partner, his children and himself. The Duluth approach has been heavily criticised by Dutton and Corvo¹⁴⁴ because of its rejection of a psycho-therapeutic component to intervention and its rejection of the role that early trauma and abuse may have played in the development of the perpetrator's abusive behaviour.

A rigorous systematic review in the *Journal of the American Medical Association*¹⁴⁵ found only one good quality evaluation of interventions for perpetrators¹⁴⁶ and even this intervention did not reduce violence in the intervention groups compared to the control group. There is clearly a need to build the evidence base around effective interventions for perpetrators.

Substance abuse

Despite the increasing numbers of pregnant women with substance use disorders, research on treatment is limited.¹⁴⁷ Substance use in pregnancy is a key public health issue not only because of the associated negative foetal and infant outcomes, but also because it is preventable and can be remedied or at least attenuated.¹⁴⁸

There is a wide range of public health information available from the health service and independent bodies warning of the dangers of smoking, drinking alcohol and using illicit drugs during pregnancy. Survey evidence in England showed almost three-quarters of mothers who drank during pregnancy received advice about drinking, usually from midwives.¹⁴⁹ There have also been specific campaigns aiming to address issues such as foetal alcohol syndrome.

Pregnancy is a crucial opportunity for **screening** and intervening with substance misusers, with childbirth a potential motivator towards

behaviour change in the interests of the unborn child. Screening pregnant women for alcohol use is of great importance because even at low levels of consumption, the consequences of alcohol consumption can affect the developing foetus. The **T-ACE** was developed and tested as a screening instrument for 'at risk' drinking in pregnant women and is considered acceptable to patients and scientifically reliable.¹⁵⁰ It is also important to establish an accurate picture of a woman's drug use during pregnancy, to understand what support needs to be provided, to assess risks to the unborn child, and to consider appropriate interventions. Methods of assessment include gathering histories, completing drug diaries, assessing drug-related harm, assessing motivation to change, and toxicology tests. It is also important to prepare drug-dependent parents for the possibility that their baby might develop NAS and to communicate this information to them sensitively.¹⁵¹

Brief Interventions are a promising approach to identifying problematic drinking, involving short one-to-one discussion sessions where the participant discusses their drinking patterns and receives advice and information. Research¹⁵² suggests that one in eight participants significantly reduces alcohol intake following this straightforward intervention, which can be delivered by para-professionals following a two day training course run by Alcohol Concern.

Once parental substance abuse has been identified, it is critical that treatment services are available and that professionals know where to direct their clients to for help. The Department of Health's alcohol needs assessment research project (2005) suggested only 1 in 18 alcohol-dependent people were receiving treatment from a specialist service.

We have been unable to identify any examples of effective programmes working with substance-abusing parents specifically during pregnancy and the first year. However, working with methadone-dependent mothers with children aged 2–8 in their full time care, the **Parents Under Pressure (PUP)** programme has achieved positive impacts in a randomised control trial. PUP is a manualised home-delivered programme which is underpinned by an ecological model of child development and targets multiple dimensions of family functioning.

NSPCC is delivering and rigorously evaluating the Parents Under Pressure programme with substance-misusing parents of children under 2 in 10 areas across the UK

The **Vulnerable Infants Project (VIP)** in Scotland is a joint midwifery/social work service based in the Princess Royal Maternity Hospital. It provides liaison between maternity, paediatric, primary care, social and addiction services. The women can be referred antenatally with more intensive input after delivery. VIP provides vulnerable women with education, child care, and care and support for health and social wellbeing. It also promotes good parenting. The main objective of the service is providing support when the woman and baby leave hospital. The project is led by a clinical midwife specialist with two additional midwives, two social work services project workers and a pool of social work services sessional staff. Support is available for up to 12 weeks after birth.

Tertiary prevention

Tertiary prevention refers to interventions which come into effect once child maltreatment has occurred and which are concerned with preventing the recurrence of abuse and minimising the longer term harms and impairments associated with abuse. A recent systematic review¹⁵³ of interventions following physical abuse found that many interventions that are currently used have not been well-studied. However, there have been a number of research studies which suggest the potential positive impacts of rigorously designed assessment and intervention strategies as well as of parent-focused therapeutic interventions.

There are a number of circumstances when practitioners should consider the need for a comprehensive **pre-birth risk assessment**,¹⁵⁴ including when:

- previous children have been removed because they have suffered harm
- where a person who 'poses a risk to children' (previously known as a Schedule 1 offender) joins the family
- concerns exist regarding a parent's capability to protect and parent (particularly where parents have severe mental illness or learning disabilities)
- alcohol or substance abuse is thought to be affecting the unborn baby
- the parents are very young and a dual assessment is required of the parents' own needs as well as their ability to meet the baby's needs

The aim of pre-birth risk assessment is to identify the level of anticipated risk and determine whether this risk can be successfully managed either through an interagency child protection plan or a detailed package of support. There is a pressing

need to develop a rigorous framework and tools for pre-birth assessment based on the latest scientific evidence from across the full range of relevant disciplines. This work should be carefully evaluated, including careful examination of how best it can be administered.

Assessment following the identification of abuse supports the goal of securing safe, nurturing permanent placements for abused and neglected children, which is a primary responsibility for children's services. In practice some children go back and forward between birth families, in which they experience neglect and abuse, and temporary foster placements, or move from foster placement to foster placement. Improvements to the assessment and interventions available at the earliest stage will reap long term dividends in improved outcomes for children and reduced burden on services.

The **New Orleans intervention model (NIM)** was developed by Professor Charles Zeanah. In this model, every child found by the courts to have been maltreated receives a detailed assessment of each attachment relationship, and interventions are provided to address the needs which are identified. There is a time limit of 15 months for a decision to be made by the courts regarding a permanent placement for the child. The attachment assessments and outcomes of any interventions feed into this decision. An evaluation has shown that since the introduction of the programme, there is an increased freeing for adoption but that, for those children who do go back to their birth families, there is a significant reduction in maltreatment both for those children and for subsequent siblings.¹⁵⁵ A 7 year follow-up of 80 children exposed to the intervention has shown that on virtually all measures their mental health is similar to the general population. This intervention has shown considerable promise in an overseas setting, but further evaluation is required to determine whether this approach could fit with UK systems and to test its effectiveness.

The NSPCC is working with NHS and local government partners in Glasgow to replicate and rigorously evaluate the NIM model in Scotland.

Parent-child interaction therapy (PCIT) aims to strengthen the parent-child bond, decrease harsh and ineffective discipline control tactics, improve child social skills and cooperation and reduce child negative or maladaptive behaviours. PCIT has been positively evaluated in several randomised control trials for use with children aged 3–6.¹⁵⁶ Therapists coach parents during interactions with their children, helping them

learn to follow the child's lead in play (child-directed interaction – CDI), decrease the negative aspects of their relationship with the child and develop positive communication skills. By learning CDI skills, the parent is taught to give labelled praise following positive child behaviour and to avoid commands and criticism because these verbalisations often draw attention to negative behaviour. After the first session, at least half of each session is spent coaching the parent in CDI skills using a 'bug in the ear' wireless communication device. Once parents have mastered CDI, they are then introduced to the skills involved in parent directed interaction.

Child/infant-parent psychotherapy (CPP), discussed in relation to domestic abuse earlier in this chapter, is a treatment for children aged 0–5 who have been exposed to the traumas of physical abuse, neglect, sexual abuse and exposure to parental domestic abuse. CPP examines how the trauma and the caregiver's relational history affects the caregiver-child relationship and the child's development trajectory. Targets of intervention include parents' and children's maladaptive representations of themselves and each other, and interactions and behaviours that interfere with the child's mental health.

In rigorously conducted trials, this intervention has achieved substantial increases in secure attachment (in contrast to no increases in the control) and significantly few infants were classified as disorganised post-intervention.

What is striking about the most promising and effective interventions is the rigour with which they have been developed and the painstaking attention that has been paid to building the evidence base to ensure that they make a real difference to children's lives.

It is important to stress that it is not only the programme content, but also the skills and behaviours of practitioners in engaging and working with vulnerable families that have been found to make a big difference to outcomes.

But evidence based interventions alone are not sufficient, if they are not carefully built into systems and taken to a scale that means they can reach all those who stand to benefit.

“Improving children's outcomes depends on systematising evidence-based interventions”

Michael Little¹⁵⁷

4. IMPETUS:

One chance *in* a generation



4. IMPETUS:

One chance *in* a generation

Momentum is gathering fast. Research evidence continues to accumulate. And there are signs of an emerging political consensus: **it is possible to prevent abuse and neglect and pregnancy and the first year of a baby's life offer a critical window of opportunity** to make a real and lasting difference to vulnerable babies' lives.

NSPCC's new strategy reaffirms our core mission of ending cruelty to all children. It also shines a light on the critical life stage of pregnancy and a baby's first year. The evidence for action is compelling. NSPCC is determined to work with others to do all we can to improve outcomes for vulnerable babies.

Our vision is simple

We believe that every baby in the UK should be safe, nurtured and able to thrive

This bold ambition cannot be achieved by any one agency acting alone. Based on what we have learnt from research and our consultation with families, practitioners and experts we describe below a set of guiding principles and the key building blocks towards delivery of this vision.

Guiding principles

Every baby needs love, care and nurture

- The quality of parent-infant interaction is paramount.
- Interventions that foster secure attachment offer potential to prevent abuse and poor parenting.
- Parents' capacity for reflective functioning (or 'keeping the baby in mind') is likely to be instrumental to their ability to provide effective care.
- Physical punishment of babies is ineffective and unacceptable.

Services need to 'think family'

- Both adults' and children's services need to take into account the whole family context.
- Adults' services need to consider their clients as parents. When addressing parental problems such as mental illness, substance misuse and domestic abuse, we need to ensure parents are supported to fulfil their parenting role and that children get the help they need.
- Dads and father figures have a profound impact on families and should share centre stage in strategies for intervention.

It's never too early

- Promoting informed choices and resilience *pre-conception* creates the conditions for families to thrive.
- The *antenatal* period is a vital stage in child development and preparation for parenthood.

Prevention: we must do all we can to stop abuse before it starts

- *Primary*: universal service providers, such as midwives, health visitors, children's centre workers and GPs, play a crucial role in health promotion, identification of risk and delivery of support that can prevent maltreatment in the first place.
- *Secondary*: targeted services that support specific vulnerable groups or address risk factors such as domestic abuse, substance abuse and mental illness can help to prevent child abuse and neglect.

It's never too late: we must stop abuse happening again

- Children's services have a crucial role in helping to avoid the recurrence of abuse and to minimise the short and long term harms to children.
- Therapeutic support for children who are abused may also act as a means of prevention for the next generation.

A decisive moment

Governments across the UK have shown remarkable foresight in recognising the need for early intervention to ensure every baby gets the best start in life. But we now face a decisive moment. Despite what we now know about the importance of pregnancy and the first years of life, Professor Sir Michael Marmot's review¹⁵⁸ demonstrated that patterns of public investment in children's services are heavily skewed towards later childhood. The true test of government mettle will be whether, in the face of economic and fiscal challenges, there is the resolve to translate the rhetoric of early intervention into real and sustained change on the ground.

We call on UK Governments to guarantee that services are available to ensure every vulnerable baby is safe, nurtured and able to thrive

The building blocks

So how can we get there?

There are no quick fixes. But there are concrete steps we can take that could deliver a transformation in systems and support for the most vulnerable babies. Below we set out the four key building blocks which we believe need to underpin delivery of this vision.

	What success looks like...
1. Clear focus, clear accountability	<ul style="list-style-type: none"> • Widespread understanding of the importance of pregnancy and the first year of a child's life, amongst the public, professionals and policy makers. • Raised awareness of Article 19 of the UN Convention on the Rights of the Child and what it means for babies. • The UK Government and Devolved Governments in Scotland, Wales and Northern Ireland ensure that necessary resources are available to support vulnerable babies. • Central and local government are held to account for the provision of high quality services and the achievement of improved outcomes, through performance management, inspection, evaluation and client feedback.
2. Integrated policy, integrated practice	<ul style="list-style-type: none"> • A seamless policy framework that bridges: <ul style="list-style-type: none"> • prevention and protection • health and children's services • maternity and child health services • adults' and children's services. • Services tailored around families' needs, not the other way around. • 'No wrong door' into support: contact with any service opens up access to a broader system of support. • All professionals recognise prevention and child protection as their responsibility and have the confidence to act decisively.

<p>3. World class commissioning, world class services</p>	<ul style="list-style-type: none"> • Local areas are equipped to capture and address local needs: <ul style="list-style-type: none"> • building a clear and comprehensive picture of needs (one that cuts across agency boundaries) and setting local priorities • identifying effective and promising services; monitoring and reviewing impacts; and responding effectively. • Innovation in service design and delivery. • Visible improvements in the quality and effectiveness of services. • Development of a rigorous evidence base about what works, and what does not. • Proven interventions are taken to scale
<p>4. Professional capacity, professional capability</p>	<ul style="list-style-type: none"> • Evidence-based methods are integrated into universal services. • The key professions attract and retain high quality talent • Local staffing shortages are remedied. • Core practitioners have the skills and confidence to work intensively with complex families. • Practitioners have access to evidence-based tools and resources to underpin assessment and decision making, including tools for pre-birth assessment. • The commitment and responsibilities of practitioners are matched by quality supervision, freedom to exercise professional judgement and opportunities for development and progression.

1. Clear focus, clear accountability

In this report we have sought to demonstrate the urgent need for action to secure improved outcomes for vulnerable babies. Achieving this goal will require focused action and clear responsibility for delivering results.

In England, the Coalition Government has called for voluntary, community and private sector organisations to play a greater role in the delivery of public services. This vision of a ‘Big Society’ characterised by a surge of voluntary action and increased local self determination appears to have struck a popular chord. The big question is how this goal will be translated into change on the ground and whether it can deliver improved outcomes for vulnerable babies up and down the country.

For the NSPCC, our role in preventing the abuse and neglect of babies is clear. In this report we have aimed to shine a light on the experiences of babies, exposing their vulnerability to maltreatment and highlighting the things that we know can protect them. We are also developing, delivering and evaluating innovative programmes,

generating new approaches to protecting babies from harm so that more babies are able to thrive.

But we cannot act alone to prevent maltreatment.

Prevention and protection are everybody’s business
By working together we can transform life chances of the most vulnerable babies

So what role can Governments play?

The UK Government and Devolved Governments in Scotland, Wales and Northern Ireland must ensure that necessary resources are available to support vulnerable babies.

Despite the encouraging pronouncements about the importance of early intervention, the future of funding for vulnerable babies remains uncertain.

Over a number of years from 2011 there will be substantial cuts across public services and to the welfare state. Inevitably these challenges will have implications for children, including babies. The

choices we make today will have consequences that last a lifetime for vulnerable babies.

IN ENGLAND

In England, the Government has made an important commitment to increase the numbers of health visitors by 4,200 by 2015.

However, reforms to welfare announced in 2010 mean that the package of financial support available to lower income families in the first year of a baby's life will reduce by up to £5,500 from April 2011.¹⁵⁹ Overall, local government is facing grant cuts of 28 per cent¹⁶⁰ and the impact of reforms and cuts to public services remain uncertain.

From 2011, the Government is funding many services for children in England through the Early intervention grant, wrapping up a wide range of funding streams into one. Funding for Sure Start children's centres is included in this grant and is no longer ring-fenced. In 2011/12, the Early intervention grant is worth almost 11 per cent less than the funding streams it replaces and local authorities have been grappling with how to distribute the reduced pot. There are mixed results for the fate of Sure Start children's centres, with some closures and consolidations announced.

Now is the time for Governments across the UK to show they are serious about prevention and early intervention

The rights of the baby

As we approach the twentieth anniversary of the UN Convention on the Rights of the Child¹⁶¹ (UNCRC), it is timely to reflect on how effective we have been as a society in meeting the needs of vulnerable babies in the UK.

The UNCRC, which came into force in the UK in 1992, enshrines a set of fundamental rights of children, including Article 19 which requires governments to protect children from all forms of maltreatment. The Convention is a powerful lever for holding governments to public account for their progress in improving outcomes for children.¹⁶² It also provides a shared language and metrics

for the diverse organisations seeking to drive improvements in children's wellbeing.

Whilst the articles of the Convention can in general terms be applied to all ages of children, the specific interests and needs of babies are not captured. Given the high rates of maltreatment and lack of voice of babies, there is a strong case for an agenda which seeks to articulate and promote the specific 'rights of the baby'. Raising awareness of the vulnerability of babies and the important opportunities for prevention could help drive broad change in attitudes and behaviours at a number of levels. NSPCC is keen to work with other interested organisations to explore how the Convention could provide stronger enforcement of babies' rights to protection from maltreatment.

IN WALES: Rights of Children and Young Persons Measure, 2011

This landmark piece of legislation imposes a legal duty on Welsh Ministers to have due regard to the rights and obligations in the United Nations Convention on the Rights of the Child (UNCRC) and its Optional Protocols in exercising any of their functions. This ground breaking legislation, unique within the UK was passed by the National Assembly for Wales with cross-party unanimous support in January 2011 and received royal assent in March 2011.

2. Integrated policy, integrated practice

"Instead of 'doing things right' (i.e., following procedures) the system needed to be focussed on 'doing the right thing'"

Professor Eileen Munro¹⁶³

We believe the role of good policy is to create the conditions and systems that allow professionals to 'do the right thing'. Vulnerable babies often live in complex family situations. As we have seen from earlier chapters of this report, their needs tend to cut across different systems and service structures. Our systems need to be robust and provide specialist expertise where that is necessary. But they also need to be flexible

enough to tailor support around the changing and multifaceted needs of vulnerable families.

To really transform outcomes for vulnerable babies, we need a seamless policy framework that bridges:

- different levels of prevention and protection
- health and children's services
- maternity and child health services
- adults' and children's services.

Considerable attention is currently being paid across the four nations to the 'early intervention' agenda. This attention is important and timely as there remains some degree of confusion in policy and practitioner circles about what the term 'early intervention' actually means and how it can be delivered in practice. The term has been variously used to refer to intervention:

- *early in the life course* (as in our own focus on pregnancy and babies)
- *prior to the onset of a problem* (implying 'primary prevention' or a universal public health approach)
- *as early as possible after the identification of risk* (implying 'secondary prevention', a targeted form of intervention, which could as easily be applied to an older person as to a child).

We advocate use of Harriet McMillan's clear model of prevention set out in her paper on prevention of maltreatment¹⁶⁴ (see Chapter 3 of this report). For so long as the policy framework remains ambiguous, it will be hard for local areas to develop integrated and seamless systems spanning the spheres of prevention and protection. And without the 'join' at a conceptual and policy level, it is likely that actual services will continue to operate in silos, despite the laudable efforts of policy makers to increase budgetary flexibility as a means to drive integration.

Critical role of health services

Because of its role in the provision of maternity and wider primary care services to families, the health sector is vitally important to efforts to prevent maltreatment during pregnancy and the first year. Health is also important in terms of the provision of specialist adult services (such as drug and alcohol treatment, accident and emergency and psychological services), though frequently these services have been seen to struggle to recognise fully their clients' role as parents.¹⁶⁵

It is vital that children's health policy is driven at a government level by intensive collaboration between health officials and their counterparts in other areas responsible for early years, safeguarding, families and child poverty.

And, even within health services themselves, provision of continuity of care to new families can be difficult as families navigate the transition from maternity services to child health. Of course, the best practitioners always work hard to make the transition as smooth as possible for families. However, systems and policy need to work hard to support this to happen routinely.

IN SCOTLAND: A Pathway of Care for Vulnerable Families (0–3)

The pathway supports a consistent approach to meeting the needs of pregnant women, children and families, recognising the range of agencies involved. In line with Getting it Right for Every Child (GIRFEC), the role of *named person* (i.e. a central point of contact for children and families) is assumed by midwives from conception, and then transferred to public health nurses / health visitors.

In addition to the 'universal journey', the Pathway highlights particularly high-risk groups, such as families where there are substance misuse issues or domestic abuse, and suggests approaches to enhance the universal pathway.

IN WALES: Flying start

Flying Start is a flagship early years programme to provide intensive support to children aged 0–4 years in some of the most deprived areas in Wales. The programme includes the following entitlements: health visiting, childcare, parenting support and language and play programmes. It aims 'to make a decisive difference to the life chances of children aged under 4 in the areas in which it runs'.

‘Thinking family’

The policy framework needs to support adults and children’s services to work together in the best interests of the whole family.¹⁶⁶ In particular, it is important that adults’ services consider their clients as parents and ensure they are supported to fulfil their parental responsibilities. Services working with different family members need to be aligned, giving a consistent message and working towards the same outcomes. Professionals need to be able to provide tailored and joined-up support around the whole family. Only when there is coordination between different professionals, is it possible to build up a full picture of the family’s needs in order to provide coherent and timely intervention.

IN NORTHERN IRELAND: Family support hubs

There has been regional investment to develop ‘family support hubs’. These are networks of agencies (voluntary, community and statutory) at a local level who work directly with families who do not meet the threshold for statutory social work support.

Fathers

Much recent policy exhorts the inclusion of fathers in maternity care and emphasises the need to engage dads in parenting programmes. However, research has noted the difficulty in translating the rhetoric into real changes on the ground,¹⁶⁷ and there remains the dual challenge of managing the demands from dads very keen to be involved while also working actively to reach out to the much smaller groups who may be resistant or reluctant to get involved. And, of course, it is vital to identify those fathers who truly cannot be involved because of the dangers that they pose to mother and baby.

At the sharp end of practice, analysis of serious case review (SCR) data refers to ‘invisible men’ in families where children have been killed or seriously harmed. Numerous studies suggest that assessments do not purposefully consider men, to assess either the risks they pose or the strengths they may bring to family life (including as a ‘buffer’ against the neglect or abuse perpetrated by the mother).

A recurrent finding from SCRs is that child protection practice concentrates on mothers and their ability to protect the child, regardless of who is the perpetrator of abuse.

Policy and practice needs to play particular attention to step-fathers (married or not) and the impacts they can have on family relationships and dynamics.

3. World class commissioning, world class services

Local areas are best placed to understand local needs. Ensuring every vulnerable baby receives the support he or she needs, requires all areas to have the capacity to:

- build a clear and comprehensive picture of local needs (one that cuts across agency boundaries) and set local priorities
- identify effective and promising services; monitor and review impacts; and respond effectively

Previous research by the Cabinet Office and Department of Health¹⁶⁸ has identified significant challenges in commissioning to meet the needs of minority vulnerable groups. Weaknesses in commissioning include poor needs assessments, lack of knowledge-sharing between agencies and sectors, and poor incentives to focus attention on the most excluded families or on efforts at prevention.

Devolution means that different funding frameworks operate in England, Northern Ireland, Scotland and Wales. Over time, devolution and localism seem likely to generate greater geographic divergence. This will raise challenges but also creates opportunities to better tailor services to local needs. In England, the Coalition Government has said it wishes to devolve greater power to the local level. This will involve less ring-fencing of budgets and substantially fewer monitoring requirements.

Joint needs assessments are vital to systematically building up a picture of the numbers of vulnerable babies and families in a local area and the challenges that they face. Only when there is a shared and transparent picture of local needs can we make informed decisions about the services that are required in a particular area. Only when we have this picture, can we genuinely move towards a more preventative system of support, addressing emerging problems before they reach crisis point.

Better local data on key outcomes, such as those listed below, will be vital to driving an improved match between needs and provision of services.

Sizing the problem: key outcome indicators for babies

- Infant morbidity and infant mortality
- Numbers of children under 1 subject to a child protection plan (or equivalent) and category of abuse
- Antenatal and infant exposure to parental relationship conflict
- Antenatal and infant exposure to parental mental illness
- Antenatal and infant exposure to domestic abuse
- Antenatal and infant exposure to poverty, debt and unemployment
- Antenatal and infant exposure to temporary/poor housing/homelessness
- Teenage conception rates
- Rates of rapid subsequent childbearing among at risk families
- Social and emotional skills of teenagers

IN ENGLAND

The **Healthy child programme** provides an integrated policy framework for families from pregnancy to age 5. It emphasises the importance of evidence-based practice. Within the universal offer, the programme describes a progressive model of provision in which those with additional or complex needs can expect to receive more intensive support.

The Department of Health's **PREview** tool provides commissioners with a systematic and innovative way of using existing routine data to stratify the child population according to future need and outcomes to inform the allocation of preventive resource matched to need.¹⁶⁹

Joint strategic needs assessments are a hugely important vehicle for commissioners, which offer the potential to capture needs of vulnerable babies and their families.

At national level, there is only a partial picture of the provision of targeted and specialist interventions to prevent maltreatment, and no detailed assessment of how well current provision of services matches need. Although the Centre for Excellence in Outcomes for Children and Families performs an excellent job in sharing good practice between different local areas of the country, there is no consistent national system for rating the effectiveness of interventions which commissioners can use as a yardstick to inform their investment decisions.

World class services

As we have seen from Chapter 3, there is an increasing body of evidence that we can make a difference to the lives of vulnerable babies. But of course there are still gaps and significant opportunities to improve services and impacts for vulnerable families. We need to ensure we have the necessary infrastructure to develop and evaluate new programmes and methods of working that can address key gaps in practice.

The most successful programme developers have adopted a scientific approach to intervention development. Prevention science^{170,171} suggests that several stages of development are necessary to be confident that an intervention is effective, as in the figure over the page.

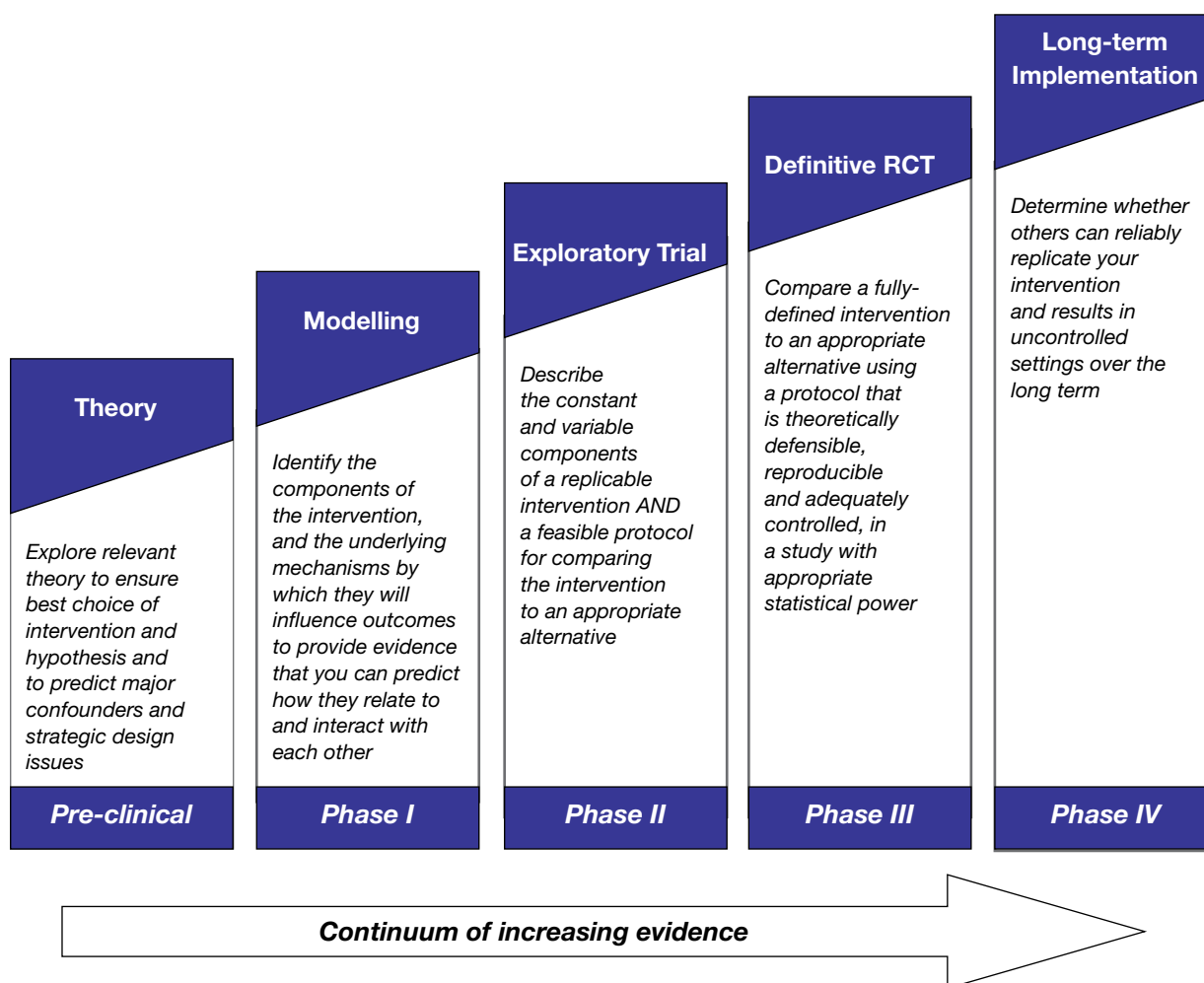
Where we do have data about the effectiveness of services, we must use it. Rigorously developed interventions, which have strong evidence of their effectiveness, should be promoted and scaled up to reach all vulnerable families who stand to benefit. Taking interventions to scale is a resource intensive and highly skilled enterprise and there is an urgent need to develop the infrastructure to support and build the capabilities of those who develop successful programmes. A good example of this kind of approach is the work of the Impetus Trust, which provides intensive capacity-building support to small charities developing evidence-based programmes to improve readiness for school.

IN NORTHERN IRELAND

The Public Health Agency and DHSSPS have supported the introduction of a package of evidence based interventions, including:

- Family Nurse Partnership
- Roots of Empathy
- Incredible Years
- Triple P
- Mellow Babies

MRC framework for development and evaluation of complex interventions



4. Professional capacity, professional capability

Maternity services can – and do – play a key role in prevention, looking beyond the traditional medical role, and supporting parents in the social and psychological transition to parenthood. Recent NICE guidelines¹⁷² provide suggestions for ensuring that some of the most vulnerable women are engaged earlier in pregnancy and are helped to get the most out of the available support.

Universal midwifery and health visiting services are absolutely critical to ensuring the health and wellbeing of new babies and their families. They also play critical public health and safeguarding roles – promoting good health and positive parenting, identifying additional needs (such as physical or emotional health problems), and detecting the risk of harm to babies.

The health visiting workforce is ageing and there has been consistent lobbying from professional bodies to increase the numbers of health visitors. In England, the Coalition Government has

announced its commitment to raise the number of health visitors by 4,200. However, there also needs to be investment in supporting the continuous professional development and initial training of health visitors, providing them with access to the latest research and practice that will help them to undertake their very demanding roles. We should draw out the learning from evidence-based programmes and ensure that evidence-based methods are integrated into universal services.

A number of recent reviews¹⁷³ point to continued variability in levels of awareness and knowledge among key health professionals (such as GPs, accident and emergency staff, health visitors and midwives) about issues during the perinatal period including:

- child protection
- emotional breakdown and mental illnesses
- domestic abuse
- substance misuse
- infant mental health

- attachment and child development
- partnership-based approaches such as promotional interviewing.

Practitioners need access to evidence-based tools to support them in the difficult decisions that they have to make. Early identification of needs, including assessment of family resources and risks, is critical to efforts to prevent maltreatment. However, at present in the UK there is no rigorously validated and consistently applied model for pre-birth risk assessment, meaning that opportunities to prevent poor parenting and abuse are potentially being missed.¹⁷⁴ When assessing parenting capacity it is critical that the wider family context, including parental factors such as mental illness, substance abuse and domestic abuse, are taken into consideration.¹⁷⁵ Assessment must not focus simply on the mother, but examine the situation of all family members, including fathers.

Once a baby has been born and a risk of harm has been identified, assessment decisions need to be made swiftly so that attachment formations are not disrupted.¹⁷⁶ However, there is evidence of delays in decision-making (so called ‘assessment paralysis’) by social workers and in the courts. This may be compounded by the tension between the Children Act (1989) which emphasises parental rights (the presumption that children are generally best cared for within the natural family) in situations where there is a conflict of interest between needs of the child and the wishes of the parent.

Parents who lose custody of their babies may grieve for several years and are often not supported adequately when this occurs. Loss of custody should be reconceived as a trigger for targeted prevention, since many parents will go on to have further children, and without the right intervention are likely to go on to repeat their abusive patterns of parenting.

In children’s social care, there is an urgent imperative to strike a better balance between the need for rigorous management of risk on the one hand, and being able to form relationships with children and families on the other. We support the sentiments of Professor Eileen Munro’s highly influential review, which seeks to enable social workers to exercise greater professional judgment, not least by highlighting the importance of using research evidence to help them reach sound decisions. But there must also be substantial investment in improving the knowledge and skills of social workers from initial training through to continuous professional development.

Working with vulnerable babies is one of the most complex and challenging jobs in the world. It is also one of the most essential. It is vital we support our dedicated professionals to do this difficult job to the highest possible standard.

* * *

With these key building blocks in place, we firmly believe it is possible to achieve our vision of a society where every baby is safe, nurtured and able to thrive.

The challenges we face can be surmounted. But achieving our vision will require focus, open collaboration and the determination to stick with it in the face of set-backs.

Change will not come overnight. But change is within our grasp.

ANNEXES



ANNEX A:

Glossary

Affective disorders: A mental disorder characterised by a consistent, pervasive alteration in mood, affecting thoughts, emotions and behaviours, such that people have difficulty regulating emotion, including depression and bi-polar disorder.

Attachment is the theory of affect regulation and personality development in the context of close relationships. The most important tenet of the theory is that an infant needs to develop a relationship with at least one primary caregiver for social and emotional development to occur normally. Attachment patterns develop in early relationships and interaction with the primary caregiver, which lead to the development of 'internal working models' that then inform the way an individual feels about him/her self and relations with other people.

Cognitive behavioural therapy (CBT): A type of psychotherapy (or talking therapy), based on the theory that psychological symptoms are related to the interaction of thoughts, behaviours, and emotions. In CBT the therapist and patient will work on identifying and directly changing thoughts and behaviours that may be maintaining symptoms.

Early intervention: This is a contested term (see Chapter 4 for a fuller discussion)

Ecological approach is one that recognises that there are different levels of influence on an individual's development (i.e., individual, family, community and societal levels). The approach is characterised by an emphasis on the interaction between these domains, rather than the processes and properties of one domain.

Infant mental health: The study of mental health (emotional and psychological well-being) as it applies to infants and their families, including optimal social, emotional and cognitive development of infants and their families in the first 3 years of life.

MARAC: Multi-agency risk assessment conferences – voluntary meetings to share information between different agencies working with high risk domestic abuse cases.

Mentalisation refers to the process of thinking about how feelings affect us and other people. It examines the ability of a parent to experience and respond to their child as an individual being with their own personality, traits, strengths and sensitivities, rather than just in terms of their physical characteristics or behaviour.

Ontology is concerned with the childhood history of abusive parents and the intergenerational transmission of abuse and poor parenting.

Perinatal refers to the period around the time of birth, specifically from 22 weeks pregnancy to 7 days after birth.

Postpartum: Of or occurring in the period shortly after childbirth.

Post traumatic stress disorder (PTSD) is characterised by the development of stress responses following either one extreme traumatic event, or a series of ongoing chronically abusive experiences. It typically involves responses that include fear, helplessness, disorganised or agitated behaviour. Symptoms include persistent re-experiencing of the traumatic event, avoidance of stimuli associated with the trauma, numbing of emotions or symptoms of increased arousal. For diagnosis of PTSD, the symptoms have to be present for more than one month, and impact on a person's ability to function normally.

Prevention:

Primary prevention: Intervention at a population level which takes place before maltreatment has occurred.

Secondary prevention: Targeted intervention which takes place before maltreatment has occurred.

Tertiary prevention: Intervention after maltreatment has occurred which aims to prevent recurrence of abuse and to prevent impairment to the child.

Problematic drug user: A person characterised by the use of multiple drugs, often by injection, and is strongly associated with socio-economic deprivation and other factors that may impact on parenting capacity. Problematic drug use is typically chaotic and unpredictable (*Hidden harm 2003*).

Public health approach refers to an overall framework within which to understand the delivery of health services. It is a means of understanding and drawing attention to population level causes of maltreatment and social norms such as social deprivation and poverty.

Puerperal psychosis: A psychotic reaction in a woman following childbirth.

Reflective functioning: The essential human capacity to understand behaviour in the light of underlying mental states and intentions.

Schizophrenia: The mental state in which an individual is unable to distinguish reality from imagination. It is characterised by the presence of a group of psychotic disorders including delusional and distorted thinking, hallucinations, disorganised speech and behaviour.

Serious mental illness (SMI) includes schizophrenia and related psychosis, and extreme forms of affective disorder.

Strange situation procedure (SSP): A diagnostic tool to measure attachment behaviour in young children aged between 9–18 months. It examines the balance between the child's exploratory and attachment behaviours when the attachment figure is present and absent in the room and during the reunion event.

Touchpoints refer to predictable stresses related to a child's developmental surges. These tend to be characterised by the parents' passionate desire to do well by the child.

Transactional approach emphasises the dynamic nature of child development and the factors which influence the child as she grows. The focus is on a developmental approach.

UN Convention on the Rights of the Child 1989 is a declaration of human rights ratified by members of the United Nations. It recognises the primacy of the best interests of the child, and the right of a child to grow up in a family environment, in an atmosphere of happiness, love and understanding. It recognises that a child by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

ANNEX B:

Methods and acknowledgements

This report is based on an intensive process of research and consultation including the following key strands of activity:

- Focused literature reviews, including drawing on systematic reviews
- Expert consultations and interviews
- Expert practitioner workshops
- Policy mapping and workshops
- Service visits
- Secondary analysis of *National psychiatric morbidity survey* by Dr Victoria Manning at the Institute of Psychiatry, KCL
- Practitioner discussion forum
- Consultation and focus groups with vulnerable parents

Many individuals and organisations have given their time and expertise in very many different ways to support the compilation of this report. We are hugely grateful to them all for their generosity and insights:

Graham Allen MP, House of Commons
Tam Baillie, Children's Commissioner for Scotland
Professor Jane Barlow, University of Warwick
Professor Jay Belsky, University of California
Chiku Bernardi, Impetus Trust
Kate Billingham, Department of Health
Adrienne Burgess, Fatherhood Institute
Dr Harry Burns, Chief Medical Officer for Scotland
Professor Marian Brandon, University of East Anglia
Professor Hedy Cleaver, Royal Holloway
Rosemary Cook, Queen's Nursing Institute
Professor Peter Cooper, University of Reading
Isabella Craig, Department for Education
Dr Crispin Day, King's College London
Professor Mark Dias, Pennsylvania State University
Professor Gene Feder, University of Bristol
Polly Fergusson, Welsh Government

Maggie Fisher, Netmums
Professor Peter Fonagy, University College London
Dr Melanie Gill, Mindful Policy Group
Professor Vivette Glover, Imperial College London
Dr Carolyn Harper, Public Health Agency, NI
Dr Susanna Hawthorne, Cambridge University
Barbara Hearn, National Children's Bureau
Wendy Herbert, Health Visiting Review, Wales
Dr Ann Hoskins, NHS North West
Dr Amanda Jones, NE London NHS Foundation Trust
Professor Alison Kemp, University of Cardiff
Professor Kathleen Kiernan, University of York
Dr Penelope Leach, Mindful Policy Group
Dr Michael Little, Dartington Social Research Unit
Claire McCarthy, 4Children
Penny Mansfield, One plus One
Sam Mason, Department of Health
Professor Harriet McMillan, McMaster University, Canada
Professor Lynne Murray, University of Reading
Professor David Olds, University of Denver
Pamela Park, Parenting UK
Dr Susan Pawlby, Institute of Psychiatry, King's College London
Dr Heather Payne, Welsh Government
Claire Phillips, Department of Health
Honor Rhodes, Tavistock Centre for Couple Relationships
Ann Rowe, Department of Health
Professor Lois Sadler, Yale School of Nursing, Yale University
Hilary Samson-Barry, TurningPoint
Dr Trudi Seneviratne, Institute of Psychiatry, King's College London
Professor Arietta Slade, Yale Child Study Center
Professor Stephen Scott, Institute of Psychiatry, KCL
Dr Sheila Shribman, Department of Health
Professor Sarah Stewart-Brown, Warwick University
Professor Colwyn Trevarthen, Edinburgh University
Baroness Claire Tyler, Relate
Dr Angela Underdown, University of Warwick
Dr David Utting, Consultant
Professor Harriet Ward, Loughborough University

Particular thanks to Sally Knock, Holly Bentley, Lorriann Robinson, Claire Lilley, Phillip Noyes and Julie Taylor as well as very many other colleagues from the NSPCC who have contributed to this report.

ANNEX C:

Policy context and calls in the four nations

We're calling on all governments in the UK to ensure the right support is in place for babies.

ENGLAND

Policy calls in England

In Westminster, we are calling on the government to:

1. Ensure resources are available to support vulnerable babies

- Cutting services that support families during pregnancy and infancy is a false economy. Investment in early intervention will save the UK taxpayer money in the long run.
- Redirect funding in order to increase the Early Intervention Grant by at least one per cent year on year to ensure all services that help babies are sufficiently resourced.

2. Give commissioners at a local level the powers and responsibility to ensure the right services are in place to protect vulnerable babies and prevent abuse at the earliest opportunity

- Use the NHS mandate to send a clear signal to the NHS Commissioning Board of the Government's priority to prevent abuse and protect the most vulnerable babies.
- Require Joint Strategic Needs Assessments to capture the needs of vulnerable babies and families at risk.
- Make local Health and Wellbeing Boards responsible for providing support for the most vulnerable babies and their families, including support to address parental risks (such as mental illness, domestic abuse and substance abuse), promote secure attachment and prevent abuse.
- Require Health and Wellbeing Boards to assess the needs of vulnerable babies and families at risk in Joint Strategic Needs Assessments.
- Give Directors of Public Health clear accountability for local delivery of outcomes for vulnerable babies.
- Encourage and equip Local Safeguarding Children Boards to monitor local provision of services and support.

3. Review the services available to families and take action to fill the gaps

- Commit to a biannual central Government review of the early intervention services currently available for families and use this to deliver a clear action plan to address gaps.

Policy context in England

Maternity services

- ***The healthy child programme (DH, 2009)***
Universal preventative service for health in the early years, providing families with a programme of screening, immunisation etc. Supersedes and replaces the child health promotion programme from 2008.
- ***Public service agreements (DH and HM Treasury, 2008–2011)***
PSA 19: Ensure better care for all, including percentage of women who have seen a maternity healthcare professional by 12 completed weeks of pregnancy.
- ***The NHS Neonatal Taskforce (DH, 2008)***
Produced a set of standards for neonatal care, and a commissioning framework. Now disbanded.
- ***Maternity matters (DH, 2007)***
Elaborates on how the maternity module of the *National service framework for children, young people and maternity services* is to be implemented.
- ***Facing the future (DH, 2007)***
Review into the role of the health visitor. Made seven recommendations.
- ***National guidelines for maternity services liaison committees (DH, 2006)***
Incorporates Standard 11 of the National Service Framework for children, young people and maternity services.
- ***The national service framework for children, young people and maternity services (DH, 2004)***
A 10-year programme that aims for longterm and sustained improvement in children's health. Standard 11 focuses on maternity services.

Families and parents

- ***Supporting families in the foundation years (DfE, 2011)***
The government's vision for the services that should be on offer for parents, children and families in the foundation years.
- ***Teenage pregnancy strategy: beyond 2010 (2010, launched 1998)***
Aimed to cut the under-18 pregnancy rate in half by 2010, and increase the number of teenage parents in education, training or employment in order to reduce their risk of long term social exclusion. Included Sure Start Plus.
- ***The children's plan: building brighter futures (DCSF, 2007)***
10 year plan to support families and children under each of the DCSF's strategic objectives. Progress report published in December 2009. Among other things it put in place child death overview panels in all local safeguarding children boards.
- ***Every child matters (DCSF, 2004)***
The foundation for work with all children and young people. Has five key aims and builds on universal health and education services. Broad safeguarding rather than narrow child protection focus, and emphasis on prevention.
- ***Sure start (DCSF, 2004)***
Programme to deliver the best start in life for every child, bringing together a range of services. Coalition Government pledged to refocus the programme.
- ***Information for parents: The pregnancy book and Birth to five (DH)***
Distributed to women at their antenatal appointments and after mother and baby have returned home.

Safeguarding

- ***Munro review (2010)***
Independent review of child protection and social work.

- **Abolition of National Safeguarding Delivery Unit (2010)**
Cross-departmental unit established in 2009 to ensure the implementation of the Laming report recommendations following the Baby P case. Abolished following the announcement of the Munro review. The Government's Chief Adviser for Child Safety resigned following its abolition and there appear to be no plans to appoint a new Chief Adviser.
- **Review of national strategies: early years foundation stage (DfE, 2010)**
2008 strategy setting common standards for learning, development and care for children from 0–5 years. Covers all early years settings. Now under review and proposals to make curriculum voluntary being considered.
- **Early intervention: securing good outcomes (DCSF, 2010)**
Makes the economic case for early intervention, including pre-birth.
- **Working together to safeguard children (2010)**
Guidance for practitioners responsible for safeguarding and protecting children.
- **Public service agreements (DH and HM Treasury, 2008–2011)**
PSA 13: Improving child safety, including preventable child deaths as recorded through child death review panel processes.
- **Every child matters: staying safe action plan (2008)**
Includes several aspects of specific relevance to the under-1s, e.g., postnatal classes made available to parents in a similar way to antenatal ones.

Child health and health inequalities

- **Achieving equity and excellence for children (DH, 2010)**
Consultation on the implications of NHS Reforms for services for children and families.
- **Maternity and early years: making a good start to family life (DH, 2010)**
Includes various commitments, such as consulting on new entitlements for women to access maternity services early in pregnancy.
- **Strategic review of health inequalities (the Marmot review, 2010)**
Discusses of how pre-birth factors influence long term health inequalities. Says 25 per cent of all deaths under the age of 1 could be avoided.
- **Together we can end violence against women and girls (Home Office, 2009)**
Strategy which proposed placing an obligation on health professionals to report female genital mutilation in pregnant women.
- **Healthy lives, brighter futures: child health strategy (DH and DCSF, 2009)**
Long term strategy setting out what children and families can expect from child health services in their areas, from birth through to the age of 19.

Key legislation

- **The Children, Schools and Families Act 2010**
Contains provisions about effective information sharing in local safeguarding children boards (LSCBs) and strengthens the evaluation of serious case reviews.
- **The Safeguarding Vulnerable Groups Act 2006**
Introduced a single list for those barred from working with children.
- **Domestic, Crime and Victims Act 2004**
Offence of causing or allowing the death of a child created.
- **The Children Act 2004**
Led to the establishment of LSCBs.

SCOTLAND

Policy calls in Scotland

In Scotland, we are calling on the Scottish government to:

- 1. Place the promotion of healthy infant mental health and development at the heart of the National Parenting Strategy, ensuring there is a focus on securing positive parent-child attachment**
 - The Scottish government's planned National Parenting Strategy provides an opportunity to embed attachment and permanence in the Scotland-wide approach to supporting positive parenting, which research suggests will help prevent abuse and maltreatment.
- 2. Review the level and consistency of early years services across Scotland, highlighting good practice as well as gaps in provision**
 - There are areas of good practice across Scotland, but there is no national picture about what's available, what's effective, and how these interventions match need. A national overview of what works well and where gaps exist will help drive the early years agenda forward, encouraging the development of innovative services.
- 3. Incentivise the reallocation of resources AT A LOCAL LEVEL towards effective and evidence-based early interventions, so the aims of the Spending Review can be realised LOCALLY**
 - We welcome the Scottish government's emphasis on early intervention in the 2011 Spending Review, and the creation of an Early Years Change Fund. It is vital that this prioritised spend is invested in evidence-based interventions which can influence wholesale service change. Budgetary and service-planning mechanisms must support long-term investment in programmes that have been shown to protect babies and prevent abuse.

Policy context in Scotland

Maternity services

- **Refreshed framework for maternity care (2011)**
This framework has been produced by the Maternity Services Action Group and will be followed by an outcomes focussed implementation plan in 2012.
- **Modernising nursing in the community (on-going)**
One of the key work streams is public health nursing (0–5).
- **Keeping childbirth natural and dynamic (2009)**
A programme which aims to promote multi-agency working and implementation of care pathways.

Families and parents

- **Pre-birth to three – positive outcomes for Scotland's children and families (2010)**
This guidance seeks to support and inform early years practice across Scotland.
- **The early years framework (2008)**
Aims to shift the focus from crisis management to prevention, early identification and intervention. Focus on supporting parents and the antenatal period.

- ***Getting it right for every child (2006)***
Framework to help coordinate children's services. It is the foundation for work with all children and young people, including adult services where parents are involved. Builds on universal health and education services. Broad safeguarding and wellbeing rather than narrow child protection focus. Emphasises joint responsibility of all agencies. The Scottish Government has indicated its intention to put GIRFEC on a statutory footing from 2012.
- ***Early Years Framework Parenting Task Group report (2008)***
Looked at a number of interventions to target risk before conception and during pregnancy.

Child protection

- ***National guidance for child protection (2010)***
Revised national guidance, replacing the previous guidance from 1998. It sets child protection within the wider context of the early years framework, GIRFEC and the UNCRC.
- ***Protecting Children and Young People: Framework for Standards (2004)***
Sets out what each child in Scotland can expect from professionals and agencies to ensure that they are adequately protected and their needs met.
- ***Children's charter (2004)***
Sets out what children and young people need and expect to help protect them when they are in danger of being, or already have been, harmed by another person.
- ***Significant case reviews (SCRs)***
There is no system in place for national analysis of SCRs, hence the proportion of cases involving under-1s is unknown. In 2010, a working group recommended on-going biennial analysis, and retrospective analysis from 2007 on, although this has yet to take place. This agenda is being led by the Scottish Government and the Multi-Agency Resource Service (MARS).
- ***Child death review responsibilities***
Child protection committees (equivalent of LSCBs elsewhere in the UK) are not responsible for these. Rather, the duty is on the procurator fiscal, as for all unexpected/suspicious deaths.
- ***Child protection register***
In contrast to the position in England and Wales, this has been maintained in Scotland.

Child health and inequalities

- ***A pathway of care for vulnerable families 0-3 (2011)***
This has been developed by NHS Quality Improvement Scotland and seeks to support a consistent approach to meeting the needs of pregnant women, children and families. The guidance covers the period from conception to age 3.
- ***A new look at Hall 4 – the early years (2011)***
This guidance concentrates specifically on the early years and includes a reinstatement of a 24-30 month review for all children.
- ***New national standard personal child health record***
Launched 2010.
- ***Towards a mentally flourishing Scotland (2009)***
One priority area is 'Mentally healthy infants, children and young people'.
- ***Equally well (2008)***
Report of the Ministerial Taskforce on Health Inequalities. Includes a focus on early years.
- ***Better health, better care (2007)***
Includes under-1s in section on 'Best possible start'.

Key Legislation

- ***Protection of Vulnerable Groups (Scotland) Act 2007***
Allows for a scheme which will replace current disclosure system.
- ***Protection of Children (Scotland) Act 2003***
Aims to prevent unsuitable people working with children.
- ***Mental Health (Care and Treatment) (Scotland) Act 2003***
NHS Boards have a duty to provide services to allow mothers in hospital with postnatal depression or other perinatal mental disorder to be placed with their children under one year old, where clinically appropriate.
- ***Children (Scotland) Act 1995***
Provides legislative underpinning for children's services. Sets out parental rights and responsibilities and includes a duty on local authorities to safeguard and promote welfare of children in need. The Scottish Government has signalled its intention to review the Act at some point during this parliament.

WALES

Policy calls in Wales

In Wales, we call on the government to:

1. **Ensure the commitment to safeguarding through early intervention continues and that investment in the early years is strengthened.**
2. **Acknowledge the critical role of universal midwifery and health visiting services in ensuring the safeguarding of babies through joined-up thinking and an evidenced-based approach to policy development and implementation.**
3. **Develop and implement a strategy to highlight the vulnerability of babies and the prevention of non-accidental head injuries.**

Policy context in Wales

Maternity services

- ***A Strategic Vision for Maternity Services 2011***
The Vision is of a service that promotes pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity and respect.
- ***The National service framework for children, young people and maternity services (2005)***
Promotes choice, breastfeeding, services for pregnant women from disadvantaged or minority groups and communities and better birth environments. Includes children pre-conception. Has seven core aims which have their origins in the UNCRC.
- ***Investing in a better start: promoting breastfeeding in Wales, 2001***
Committed to substantial investment in the promotion of breastfeeding as a way to improve health outcomes for children.

Families and parents

- ***Integrated family support services 2010***
Integrated Family Support Service (IFSS) have been established via the Children and Families Measure and are tasked with the delivery of family focussed services to meet the particularly complex needs of all family members in a holistic approach for the best outcomes for both children and adults.
- ***Families first (2011)***
The Families First programme underpins delivery of the Child Poverty Strategy. It aims to integrate services to deliver low tier bespoke support to individual families aimed at lifting them out of poverty.
- ***Child poverty strategy (2010)***
Vision for tackling child poverty and improving outcomes for low income families. The Welsh Government is clustering early intervention initiatives under the banner of child poverty, as this is a key policy focus.
- ***Sexual health and wellbeing for Wales (2009–2014)***
Working paper setting out action to reduce conception rates in girls under 16.
- ***Fulfilled lives, supportive communities (2007)***
10 year strategy aimed at local authorities who have responsibility for strategic planning, provision of services to meet needs, assessments and care management and for safeguarding vulnerable adults and children.
- ***The Flying start initiative (2007)***
The Welsh Assembly Government provides a specific grant to local authorities to provide additional support to deprived 0–3 year olds and their families.
- ***National service framework on adult mental health (2005)***
Key action 39 focuses on the needs of vulnerable children and young people whose parents/guardians have mental health problems.
- ***Adult mental health services for Wales: equity, empowerment, effectiveness, efficiency (2001)***
10 year vision which states, “High quality pre-school education and support for parents ... may offer mental health promoting benefits.”
- ***Sex and relationships education in schools (2010)***
Sexual health education is not currently statutory in Wales. It is taught as part of the PSE curriculum.

Safeguarding

- ***Review of the serious case review process (2011)***
A new framework for undertaking reviews has been published. It places emphasis on the continuous process of reviewing and learning.
- ***All-Wales child protection procedures (2008)***
Sets out multi-agency procedures and guidance on safeguarding for all individuals and agencies working with children and young people.
- ***Safeguarding children: working together under the Children Act 2004***
The equivalent in Wales of Working together.

Child health and health inequalities

- ***Fairer health outcomes for all (2011)***
Reducing inequalities in health strategic action plan for Wales.
- ***Community nursing strategy for Wales, 2009***
The aim of this document is to describe and make recommendations for a service that can provide holistic, seamless care with a nursing workforce that is flexible, adaptable and knowledgeable and able to achieve a balance between generic and specialist skills at the point of need.

- ***Our healthy future (2010)***
The strategic framework for public health. Covers pre-birth health.
- ***Children and young people: rights to action (2004)***
Sets out seven core aims for children and young people in Wales and reflects the Assembly's rights-based approach to policy. The Welsh equivalent of *Every child matters*.

Key legislation

Wales shares the majority of its legislation related to children and young people with England. Since December 2008, the Welsh Assembly has responsibility for making laws (Assembly measures) for matters relating to child protection and safeguarding. Key legislation such as The Children Act 2004 is applicable.

- ***The Children and Families (Wales) Measure, 2010***
Places a duty on Welsh Ministers to publish a strategy to reduce child poverty. It introduced '*Integrated family support services/teams*': multi-agency teams bringing together a range of professionals to work directly with families to protect and support vulnerable children (currently being piloted).
- ***Rights of Children and Young Persons (Wales) Measure, 2010***
Legislation that places a duty on Ministers to have regard in their decision making to the rights and obligations enshrined in the UNCRC.
- ***Mental Health (Wales) Measure, 2010***
Supports the provision of mental health services at an earlier stage for children and young people.

Forthcoming legislation

- ***Children and Young Persons (Wales) Bill***
It will build on the Rights of Children & Young Person's Measure and expand the role of the Children's Commissioner for Wales.
- ***Social Services (Wales) Bill***
This Bill will provide a coherent Welsh legal framework for social services.
- ***Domestic Abuse (Wales) Bill***
This bill will place a duty on relevant public sector bodies to have a strategy in place to tackle domestic abuse and violence against women.
- ***Public Health (Wales) Bill***
Possible introduction of legislation to build on the Welsh Government's policy document *Fairer Health Outcomes for All*.

NORTHERN IRELAND

Policy calls in Northern Ireland

In Northern Ireland, we are calling on the Executive to:

1. Provide adequate Resources

- To ensure adequate funding continues to be put into early intervention and frontline services working with babies, including both universal health visiting services and more targeted evidence-based programmes such as the Family Nurse Partnership.

2. Raise awareness and skills

- Develop, through the Department of Health, Social Services and Public Safety (DHSSPS) and Public Health Agency (PHA), a strategy which tackles the vulnerability of young babies and helps parents cope with the pressures and responsibilities of new parenthood. This should include access to training and continuous professional development for those working with vulnerable families during pregnancy and infancy, such as GPs and health visitors.

3. Review early intervention and prevention programmes

- Identify where there are gaps in current service provision and measure the effectiveness of any current programmes.

Policy context in Northern Ireland

Maternity and health services

- **Maternity review (2010)**
Includes considerations of service provision, quality and safety of services, workforce issues.
- **Healthy Futures 2010–2015 (2010)**
Focus on health visitors and school nurses within integrated children's services. Contains a specific theme that is relevant to children under one.

Families and parents

- **Families matter: supporting families in Northern Ireland (2009)**
Strategy targeted at early intervention and preventive services to support families to protect themselves from abuse and neglect.
- **Care matters: a bridge to a better future (2007)**
Implementation and action plan for children in care and families on the edge of care.
- **Strategic direction for alcohol and drugs 2006–2011 (2006)**
Addresses substance misuse in Northern Ireland. Children, young people and families are identified as a 'key theme' within the strategy. Policy focuses on prevention and treatment.
- **Regional hidden harm action plan (2008)**
Addresses drug and alcohol misuse through a multi-agency approach.
- **The school age mothers' programme (2004)**
Supports young girls to remain in compulsory education and continue with their education if they choose to remain in school beyond this.

- **Teenage pregnancy strategy (2007)**
Currently under review.
- **Reform implementation programme (2008)**
Significant and extensive programme of reform of frontline services, resulting in the creation of Gateways teams and Family intervention teams.
- **Children and young people – our pledge (2006)**
10 year strategy including commitments to prevention and early intervention. Followed review of safeguarding done in response to Laming’s report.
- **Tackling violence at home (2005)**
Specific areas are relevant to the physical abuse of children. Policy areas identified for the 2010 action plan include regional roll out of MARACs and roll-out of the routine domestic violence enquiry to A&E Departments.

Safeguarding

- **Early years 0–6 strategy (2009)**
Aims to improve the provision and quality of services to the youngest children, their parents and families.
- **Toner inquiry (2009)**
Identified serious concerns about co-operation and management of sex offenders in the community. Five children under 12, including a baby died.
- **Safeguarding children: a cross-departmental statement on the protection of children (2009)**
A policy statement setting out a safeguarding policy framework across government which explains the government’s safeguarding agenda and identifies gaps and new actions to close these gaps.
- **Child protection standards (2008)**
Eight child protection standards for all statutory provided services, and a framework of best practice for third sector organisations and practitioners.
- **Independent inquiry into the deaths of Madeline and Lauren O’Neill (2008)**
No child under one involved, but identified areas of concern about the interaction of mental health services with child protection systems and made recommendations. Guidance on risk assessment has since been published.
- **Co-operating to safeguard children (2003)**
Inter-agency child protection guidance, which covers Area Child Protection Committees and Child Protection Panels.

Key legislation

- **Children (NI) Order 1995 and underpinning regulations**
- **Safeguarding Board (Northern Ireland) Act (2011)**
Makes interagency co-operation statutory and establishes a case management review process. SBNI will replace the Regional Child Protection Committee.
- **Criminal Justice (Northern Ireland) Order (2008)**
Public Protection Arrangements (similar to MAPPAs) placed on a statutory footing.
- **The Safeguarding Vulnerable Groups (Northern Ireland) Order (2007)**
Established safeguarding arrangements to strengthen protection for children in workplace situations.

ANNEX D:

Notes and references

- 1 Department for Education (2010) *Building on the learning from serious case reviews: a two year analysis of child protection database notifications 2007–2009*.
- 2 Smith, K. (ed.) et al. (2011) *Homicides, firearms offences and intimate violence 2009/2010: supplementary volume 2 to Crime in England and Wales 2009/2010*, London, Home Office.
- 3 Manning, V. (2011) *Estimates of the numbers of infants (under the age of one year) living with substance misusing parents*, NSPCC.
- 4 Little, M. (2010) *Proof Positive*, Demos.
- 5 Department for Education (2011) *The Munro review of child protection: final report*; HM Government (2011) *Early intervention: smart investment, massive savings – the second independent report to Her Majesty’s Government*, London, Department for Work and Pensions and Department for Education; Field, F. (2010) *The foundation years: preventing poor children becoming poor adults – the report of the independent review of poverty and life chances*, London, HM Government; Deacon, S. (2011) *Joining the dots. A better start for Scotland’s children*. Edinburgh: Scottish Government; Burns, H. (2007) *Health in Scotland 2006: Annual report of the Chief Medical Officer*. Edinburgh: Scottish Government; Christie, C. (2011) *Report on the future delivery of public services in Scotland*. Edinburgh: Scottish Government.
- 6 Department for Education (2010) *Building on the learning from serious case reviews: a two year analysis of child protection database notifications 2007–2009*.
- 7 DHSSPSNI (2008) Children Order Statistical Bulletin 2008; Social Services Statistics Wales (2007–08); DCSF (2009) Referrals, assessments and children and young people who are the subject of a child protection plan, England, year ending 31 March 2009.
- 8 DCSF (2009) Referrals, assessments and children and young people who are the subject of a child protection plan, England, year ending 31 March 2009.
- 9 Brandon, M. et al. (2009). Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007–2009 Research Report DFE-RR040
- 10 Welsh Assembly Government (2010) Number of children and young persons on the child protection register at 31 March by age. Report 024713, Cardiff Stats Wales; “correspondence with the Department of Education” in relation to Department for Education (2010) Children in Need in England, including their characteristics and further information on children who were the subject of a child protection plan (Children in needs census, final) year ending 31 March 2010 London: Department for Education; Source: Table 1.1 in: Waugh, Iain and Fitzpatrick, Manny (2011) Children order statistical tables for Northern Ireland 2009/10 (PDF). Belfast: Department of Health, Social Services and Public Safety (DHSSPS).
- 11 Analysis of Department for Education (2010) Children in Need in England, including their characteristics and further information on children who are subject to a child protection plan
- 12 Smith, K. (ed.) et al. (2011) *Homicides, firearms offences and intimate violence 2009/2010: supplementary volume 2 to crime in England and Wales 2009/2010*, London, Home Office.
- 13 Sidebotham, P. and Fleming, P. (2007) *Unexpected death in childhood: a handbook for professionals*. Chichester: Wiley.
- 14 Dias, M. (2005) ‘Preventing abusive head trauma among infants and young children: a hospital based parent education programme’, *Pediatrics*, 115 (2005): e470–e477.
- 15 World Health Organisation (2007) *Preventing child maltreatment in Europe: a public health approach*.
- 16 Rutter, M. et al. (1998) *Antisocial behaviour by young people*.
- 17 Scannapiecco, M. (2005) *Understanding child maltreatment: an ecological and developmental perspective*.
- 18 UNICEF (2003) A league table of child maltreatment deaths in rich nations
- 19 Adapted from Harvard Center on the Developing Child (2009) *The Childhood Roots of Health Disparities*, and Barlow, J. (NSPCC Conference Paper) Setting the scene: a public health approach to child protection.
- 20 Felitti, V.J. (2002) *The relationship of adverse childhood experiences to adult health: turning gold into lead*.
- 21 Shonkoff, J.P. (2007) *A science based framework for early childhood policy*, Center on the Developing Child, Harvard University.

- 22 Shonkoff, J.P. (2007) *ibid.*
- 23 Baradon, T. (2010) *Relational trauma in infancy: psychoanalytic, attachment and neuropsychological contributions to parent-infant psychotherapy.*
- 24 Heckman, J.J. and Masterov, D. (2004) Skills policies for Scotland. Institute for Study of Labour. Discussion Paper 1444.
- 25 Doyle, O. et al. (2007) Early childhood intervention: rationale, timing and efficacy. UCD Geary Institute discussion paper series.
- 26 Marmot, M. (2010) *Fair society, healthy lives: strategic review of health inequalities in England post-2010.*
- 27 Dex, S. and Joshi, H. (eds) (2004) Millennium cohort study first survey: a user's guide to initial findings.
- 28 Department of Health (2008) *The child health promotion programme.*
- 29 World Health Organisation (2007) *Preventing child maltreatment in Europe: a public health approach.*
- 30 Scannapieco and Connell-Carrick, K. (2005) Understanding child maltreatment. An ecological and developmental perspective; Belsky, J. (1980) Child maltreatment: an ecological integration.
- 31 Scannapieco, M. and Connell-Carrick, K. (2005) *Understanding child maltreatment: an ecological and developmental perspective,* OUP.
- 32 Belsky, J. et al. (2009) 'The intergenerational transmission of parenting', *Developmental psychology*, 45(5): 1201–1204.
- 33 Belsky et al. (2009) *ibid.*
- 34 DCSF (2010) Support for all. The families and relationships green paper. HMSO.
- 35 Balsky, J. and Kelly, J. (1994) *The transmission to parenthood: how a first child changes a marriage.* Vermillion: London.
- 36 Karen, R. (1994) *Becoming attached: first relationships and how they shape our capacity to love,* OUP.
- 37 Bowlby, J. (1969) Attachment and loss.
- 38 Murray, L. (2006) *Attachment and mental health: background paper for conference on early development, attachment and social policy,* University of Cambridge.
- 39 Ainsworth, M. and Eichberg, C. (1991) 'Effects on infant-mother attachment of mother's unresolved loss of an attachment figure or other traumatic experience', in Parkes, C. et al. (eds) *Attachment across the lifecycle.*
- 40 Radke-Yarrow (1991) 'Attachment patterns in children of depressed mothers', in Parkes, C. et al. (eds) *Attachment across the lifecycle.*
- 41 O'Connor M.J. (1987) 'Disorganised attachment in relation to maternal alcohol consumption', *Journal of consulting and clinical psychology*, 55: 831–6.
- 42 Carlson, V. et al. (1989) 'Disorganised/disorientated attachment relationships in maltreated infants', *Developmental psychology*, 25(4): 525–31.
- 43 Howe, D. et al. (1999) *Attachment theory, child maltreatment and family support: a practice and assessment model.*
- 44 Howe, D. et al. (1999) *ibid.*
- 45 Lyons-Ruth, K. (1996) 'Attachment relationships among children with aggressive behaviour problems: the role of disorganised early attachment patterns', *Journal of consulting and clinical psychology*, 64: 64–73.
- 46 Simpson, J.A. et al. (1996) 'Conflict in close relationships: an attachment perspective', *Journal of personality and social psychology*, 71(5): 899–914.
- 47 Belsky, J. (2010) *Infant attachment security and timing of puberty: testing an evolutionary hypothesis.*
- 48 Karen, R. (1994) *Becoming attached.*
- 49 Crittenden, P. (2005) 'Attachment theory, psychopathology and psychotherapy: the dynamic-maturational approach', *Psicoterapia*, 30: 171–182.
- 50 Fonagy et al. (2002) *Affect regulation, mentalization and the development of the self.* New York Other Books.
- 51 Slade, A. (2006) Reflective parenting programmes: theory and development. *Psychoanalytic Inquiry*, 26: 640–657.
- 52 Fraiberg S. et al. (1975) Ghosts in the nursery: a psychoanalytic approach to the problems of impaired infant-mother relationships, *Journal of the American Academy of Child and Adolescent Psychiatry*, 14(3): 387–421.
- 53 Shonkoff, M.D. et al. (2009) *Maternal depression can undermine the development of young children,* Working Paper 8, Harvard University Center on the Developing Child.
- 54 Murray, L. et al. (in press) 'Effects of postnatal depression on mother-infant interactions and child development', in Wachs, T. and Bremner, G. (eds) *Handbook of infant development.*
- 55 Heron, J. et al. (2004) 'The course of anxiety and depression through pregnancy and the postpartum in a community sample', *Journal of affective disorders*, 80: 65–73.
- 56 Pawlby, S. et al. (2009) 'Antenatal depression predicts depression in adolescent offspring: prospective longitudinal community based study', *Journal of affective disorders*, 113: 236–243.
- 57 Miller, L.J. (2002) 'Postpartum depression', *Journal of the American Medical Association*, 287: 762–765.
- 58 Brown, G.W. et al. (1978) *Social origins of depression,* Tavistock.

- 59 Matijasevich, A. et al. (2009) 'Differentials in income-related inequalities in maternal depression during the first two years after childbirth: birth cohort studies from Brazil and the UK', *Clinical practice and epidemiology in mental health* 5: 12.
- 60 O'Connor, T.G. et al. (2002) 'Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years', *British journal of psychiatry*, 180: 502–8.
- 61 Field, T.M. (1984) 'Early interactions between infants and their postpartum depressed mothers', *Infant behaviour and development*, 7: 517–522.
- 62 Campbell, S.B. et al. (1995) 'Depression in first time mothers: mother-infant interaction and depression chronicity', *Developmental psychology*, 60: 349–357.
- 63 Cooper, P. and Murray, L. (1995) 'The course and recurrence of postnatal depression', *British journal of psychiatry*, 166: 191–5.
- 64 Halligan, S.L. et al. (2004) 'Exposure to postnatal depression predicts elevated cortisol in adolescent offspring', *Biological psychiatry*, 55: 376–381.
- 65 Dave, S. et al. (2010) 'Incidence of Maternal and Paternal Depression in Primary Care', *Paediatrics and adolescent medicine*, 2010 (184).
- 66 Paulson, J.F. and Bazemore, S.D. (2010) 'Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis', *Journal of the American Medical Association*, 303(19): 1961–1969.
- 67 Dave, S. et al. (2010) 'Incidence of Maternal and Paternal Depression in Primary Care', *Paediatrics and adolescent medicine*, 2010 (184).
- 68 Wee, K.Y. et al. (2010) 'Correlates of ante and postnatal depression in fathers: a systemic review', *Journal of affective disorders*. Fatherhood Institute Research Summary (2010) Fathers and postnatal depression.
- 69 Goodman, J.H. (2004) 'Paternal postpartum depression, its relationship to maternal postpartum depression and implications for family health', *Journal of advanced nursing*, 45(1): 26–35.
- 70 Roggman, L.A. et al. (2002) 'Getting dads involved: predictors of father involvement in early head start and with their children', *Infant mental health journal*, 23(1–2): 62–78.
- 71 Sethna, V. et al. (2009) 'The impact of paternal depression in infancy: a mechanism for the intergenerational transmission of risk', *European psychiatry*, 24(1): 236.
- 72 Rachmandani, P. et al. (2005) 'Paternal Depression in the postnatal period and child development: a prospective population study', *The Lancet*, 365(9478): 2201–2205.
- 73 Kumar, R. et al. (1995) 'Clinical survey of a psychiatric mother and baby unit', *Journal of affective disorders*, 33: 11–22.
- 74 Kendell, R.E. et al. (1987) 'Epidemiology of puerperal psychosis', *British journal of psychiatry*, 150: 662–73.
- 75 D'Orban, P.T. (1979) 'Women who kill their children', *British journal of psychiatry*, 134: 560–71.
- 76 Leung, A. and Chue, P. (2000) 'Sex differences in schizophrenia: a review of the literature', *Acta Psychiatrica Scandinavica*, 401: 3–38.
- 77 Manning, C. and Gregoire, A. (2006) 'Effects of parental mental illness on children', in O'Keane, V. (ed.) *Psychiatric disorders and pregnancy*.
- 78 Howard, L.M. et al. (2004) 'Predictors of parenting outcome in women with psychotic disorders discharged from mother and baby units', *Acta Psychiatrica Scandinavica*, 110: 347–55.
- 79 Kumar, R. et al. (1995) 'Clinical survey of a psychiatric mother and baby unit', *Journal of affective disorders*, 33: 11–22.
- 80 Spinelli, M. (2006) 'Infanticide and child abuse', in O'Keane, V. (ed.), *Psychiatric disorders and pregnancy*.
- 81 Home Office (2009/10) *Homicides, firearms offences and intimate violence*.
- 82 Belsky, J. (1990) *Patterns of marital change across the transition to parenthood*.
- 83 Gazmararian, J. (1996) *Prevalence of violence against women*.
- 84 Geilen, A. (1995) *Interpersonal conflict and physical violence during the childbearing year*.
- 85 Walsh, D. (2002) *Violence during pregnancy*.
- 86 Manning, V. (2011) Estimate of the numbers of infants (under the age of one year) living with substance misusing parents, NSPCC.
- 87 Jasinski, J. (2004) *Pregnancy and domestic violence*.
- 88 Saltzman, L.E. et al. (2003) *Physical abuse around the time of pregnancy*.
- 89 Sharps P. et al. (2007) *IPV and the Childbearing year*.
- 90 Jasinski, J. (2004) *Pregnancy and domestic violence*.
- 91 Antoniou, E. (2008) *Correlation of domestic violence during pregnancy with depression*.
- 92 Dietz, P.M. et al. (1997) *Delayed entry into prenatal care: effect of physical violence*.
- 93 McGuigan, W. (2007) The impact of domestic violence on infant health factors and child maltreatment. The APSAC Advisor.
- 94 Casanueva, C.E. and Martin, S. (2007) 'Intimate partner violence during pregnancy and mothers' child abuse potential', *Journal of interpersonal violence*, 22(5), 603–622.
- 95 Bogat, G.A. (2005) *Trauma symptoms among infants exposed to interpersonal violence*, CAB.

- 96 Cummings M. et al. (2010) *Marital conflict and children: an emotional security perspective*, London, The Guilford Press.
- 97 Jewkes, R. (2002) 'Intimate partner violence: causes and prevention', *The Lancet*, 359.
- 98 Walsh, D. (2002) *Violence during pregnancy*.
- 99 American Psychiatric Association *Diagnostic and statistical manual of mental disorders – text revision (DSM-IV) 4th Edition*, Washington DC.
- 100 Prime Minister's Strategy Unit (2003) *Alcohol Harm Reduction Project – Interim Analytical Report*.
- 101 The World Health Organisation distinguishes between 'hazardous drinking' (drinking above recognised sensible levels, but not yet causing harm), 'harmful drinking' (such drinking where it causes harm) and 'alcohol dependence' (includes in addition symptoms of dependence).
- 102 Coles, C. (1994) 'Critical periods for prenatal alcohol exposure: evidence from animal and human studies', *Alcohol health research world*, 18: 22–9.
- 103 NHS Information Centre (2007) *Infant Feeding Survey 2005*.
- 104 Joseph Rowntree Foundation (2009) *Drinking in the UK: an exploration of trends*.
- 105 National Scientific Council on the Developing Child (2006) *Early exposure to toxic substances damages brain architecture*.
- 106 Welch-Caerre, E. (2005) 'The neurodevelopmental consequences of prenatal alcohol exposure', *Advances in neonatal care*, 5(4): 217–229.
- 107 Drugscope (2005) *Substance misuse in pregnancy: a resource book for professionals*.
- 108 Drugscope (2005) *ibid*.
- 109 Lynskey, M.T., Fergusson, D.M. and Horwood, L.J. (1994) 'The effect of parental alcohol problems on rates of adolescent psychiatric disorders', *Addiction*, 89: 1277–1286.
- 110 Cleaver, H. (1999) Children's needs – parenting capacity. *The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*. TSO.
- 111 Eiden, R.D. et al. (2002) 'Mother-infant and father-infant attachment amongst alcoholic families', *Developmental psychopathology*, 14(2): 253–78.
- 112 Advisory Council on Misuse of Drugs (2003) *Hidden harm: responding to the needs of problem drug users*.
- 113 Sherwood, R.A. et al. (1999) 'Substance misuse in early pregnancy and relationship to foetal outcome', *European journal of pediatrics*, 158: 488–92.
- 114 Greenough, A. et al. (2005) 'Effects of substance abuse during pregnancy', *The journal of the Royal Society for the promotion of health*, 125(5): 212–213.
- 115 Wolfe, E.L. et al. (2005) 'Mortality risk associated with perinatal drug and alcohol use in California', *Journal of perinatology*, 25: 93–100.
- 116 Drugscope (2005) *Substance misuse in pregnancy: a resource book for professionals*.
- 117 Cleaver, H. et al. (1999) *Children's needs: parenting capacity*, HMSO.
- 118 Brandon, M. et al. (2010) *Building on learning from serious case reviews: a two year analysis of child protection database notifications 2007–09*. London DfE
- 119 Whittaker, A. (2009) *Parental problem drug use*.
- 120 Brandon, M. et al. (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*, DCSF RR023.
- 121 Barlow (2009) *Safeguarding children from emotional maltreatment*; Small et al. (2009) *Evidence informed programme improvement*.
- 122 MacMillan, H.L. et al. (2009) 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, 373: 250–66.
- 123 Brazelton, T.B. and Sparrow, J. (2003) *Touchpoints model of development*.
- 124 Schrader-McMillan, A. et al. (2009) *Birth and beyond: A review of evidence about antenatal education*.
- 125 MacMillan, H.L. et al. (2009) 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, 373: 250–66.
- 126 Dias, M. et al. (2005) 'Preventing abusive head trauma among infants and young children: a hospital based parent education programme', *Pediatrics*, 115 (2005): e470–e477.
- 127 Olds, D. (2006) 'The nurse family partnership: an evidence-based preventive intervention', *Pediatrics* 8: 318–326.
- 128 MacMillan, H.L. et al. (2009) 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, 373: 250–66.
- 129 Aos, S. (2001) *The comparative costs and benefits of programs to reduce crime: a review of research findings with implications for Washington State*.
- 130 Brazelton, T.B. (2011) *Neonatal behavioural assessment scale*, 4th Edition. MacKeith.
- 131 Kennedy, H. (2011) Video interaction guidance. A relationship-based intervention to promote attunement, empathy and wellbeing.
- 132 Slade et al. (2005) *Minding the Baby. A reflective parenting program. Psychoanalytic Study of the Child*, 60: 74–100.

- 133 Shonkoff, M.D. et al. (2009) *Maternal depression can undermine the development of young children*, Working Paper 8, Harvard University Center on the Developing Child.
- 134 Murray, L. et al. (in press) 'Effects of postnatal depression on mother-infant interactions and child development', in Wachs, T. and Bremner, G. (eds) *Handbook of infant development*.
- 135 Manning, C. and Gregoire, A. (2006) 'Effects of parental mental illness on children' in O'Keane, V. (ed.) *Psychiatric Disorders and pregnancy*.
- 136 Spinelli, M. (2006) 'Infanticide and child abuse' in O'Keane et al. (ed.) *Psychiatric disorders and pregnancy*.
- 137 Toth, S.L. (2006) 'The efficacy of toddler-parent psychotherapy to reorganise attachment in the young offspring of mothers with major depressive disorder: a randomised prevention trial', *Journal of consulting and clinical psychology*, 74(6).
- 138 Pawlby, S. (2009) 'Enhancing the relationship between mothers with severe mental illness and their infants' in Barlow, J. (ed.) *Keeping the baby in mind*.
- 139 Feder, G. et al. (2009) *How far does screening for domestic (partner) violence in different health care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria*, HTA.
- 140 Sullivan, C. et al. (2002) 'Findings from a community-based program for battered women and their children', *Journal of interpersonal violence*, 17: 915–36.
- 141 Feder, G. et al. (2009) *How far does screening for domestic (partner) violence in different health care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria*, HTA.
- 142 Kubany, E.S. et al. (2004) 'Cognitive trauma therapy for battered women with PTSD', *Journal of consulting clinical psychology*, 72: 3–18.
- 143 Lieberman, A.F. (2006) 'Child-parent psychotherapy: 6 month follow-up of a randomised controlled trial', *Journal of the American Academy of Child and Adolescent Psychiatry*, 45: 913–18.
- 144 Dutton, D.G. and Corvo, K. (2006) 'Transforming a flawed policy: a call to revive psychology and science in domestic violence research and practice', *Aggression and violent behaviour*, 11: 547–483.
- 145 Wathen, C.N. and MacMillan, H.L. (2003) 'Interventions for violence against women: scientific review', *Journal of the American Medical Association*, 289(5): 589–600.
- 146 Dunford, F.W. (2000) 'The San Diego navy experiment: an assessment of interventions for men who assault their wives', *Journal of consulting and clinical psychology*, 68: 468–476.
- 147 Fischer, G. (2000) 'Treatment of opioid dependence in pregnant women', *Addiction*, 95: 1141–4.
- 148 Flannery, W. et al. (2006) 'Substance use disorders in pregnancy', in O'Keane V. (ed.) *Psychiatric Disorders and Pregnancy*.
- 149 NHS Information Centre (2007) *Infant Feeding Survey 2005*.
- 150 Flannery, W. et al. (2006) *ibid.*
- 151 Drugscope (2005) *Substance misuse in pregnancy: a resource book for professionals*.
- 152 Heather, N. (2006) *Health interventions for problem drinkers*, London Alcohol Concern.
- 153 Montgomery, P. et al. (2009) *Systematic reviews of interventions following physical abuse: helping practitioners and expert witnesses improve the outcomes of child abuse*, DCSF.
- 154 Calder, M.C. (2003) *Assessment in childcare*.
- 155 Zeanah, Larrieu, Heller et al. (2001).
- 156 Chaffin, M. et al. (2004) 'Parent-child interaction therapy with physically abusive parents: efficacy of reducing further abuse reports', *Journal of consulting and clinical psychology*, 72(3): 500–510.
- 157 Little, M. (2010) *Proof positive*, Demos.
- 158 Marmot M. (2010) *Fair society, healthy lives: strategic review of health inequalities in England post-2010*.
- 159 Family & Parenting Insititute (2011) *Babies bear the brunt*.
- 160 Parker, S. (2011) *Next localism: new local government network*.
- 161 United Nations (1989) *Convention on the Rights of the Child*.
- 162 United Nations (2009) *Convention on the Rights of the Child: concluding observations 2008*.
- 163 Department for Education (2011) *The Munro review of child protection: final report*.
- 164 MacMillan, H.L. et al. (2009) 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, 373: 250–66.
- 165 Cabinet Office (2007) *Reaching out – think family: Analysis and themes from the families at risk review*.
- 166 Cabinet Office (2008) *Think family: improving the life chances of families at risk*.
- 167 Taylor, J. (2001) *Engaging with fathers: practice issues for health and social care*.
- 168 HM Government (2010) *Inclusion health: improving the way we meet the primary health care needs of the socially excluded*.

- 169 Department of Health (2010) *Currency options for the healthy child programme: transforming community services*.
- 170 Flay, B. et al. (2005) 'Standards of evidence: criteria for efficacy, effectiveness and dissemination', *Prevention Science*, 6(3): 151–75.
- 171 Medical Research Council (2000) *A framework for development and evaluation of RCTs for complex interventions to improve health*.
- 172 NICE (2010) *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*.
- 173 Gilbert, R. et al. (2009) 'Recognising and responding to child maltreatment', *The Lancet*, 373(9658): 167–180.
- 174 Ofsted (2011) *Ages of concern: learning lessons from serious case reviews*.
- 175 Cleaver, H. et al. (1999) *Children's needs – parenting capacity: the impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*, TSO.
- 176 Seneviratne, G. (2006) 'Parenting: mentally ill mothers and babies', in O'Keane, V. (ed.) *Psychiatric disorders and pregnancy*.



Registered charity numbers 216401 and SC037717.
Photography by Jon Challicom and istock, posed by
models

NSPCC 
Cruelty to children must stop. FULL STOP.