



All Party Parliamentary Group for
Conception to Age 2 – The First 1001 Days

Building Great Britons

Conception to Age 2:

First 1001 Days All Party Parliamentary Group

February 2015



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Require local authorities, CCGs and Health & Wellbeing Boards to prioritise all factors leading to the development of socially and emotionally capable children at age 2, by: adopting and implementing a '1001-days' strategy, and showing how they intend to implement it in collaboration with their partner agencies, within 5 years. The '1001-days' strategies should be based on primary preventive principles, with particular emphasis on fostering mental/emotional wellbeing and secure attachment, and preventing child maltreatment.	



Recommendation 3

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National government should establish a '1001-days' strategy fund to support local authorities and CCGs to make a decisive switch over the next 5 years, to a primary preventive approach in the first 1001 days. Practical support should also be provided, including the measures of success.

Recommendation 4

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Hold Health & Wellbeing Boards responsible for ensuring that local authorities and CCGs demonstrate delivery of a sound primary prevention approach as outlined in Part II of this report. Promote the delivery of this through establishing scorecards (similar to Adoption Scorecards) and a joined up multi-agency inspection framework which combines CQC and OFSTED.

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Build on the 'Early Help' recommendations of the Munro Review by requiring and supporting all relevant agencies in prevention to work together to prevent child maltreatment and promote secure attachment.

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Appoint a Minister for Families and Best Start in Life with cross-departmental responsibility, drawing together all relevant departmental ministers, with a remit to draw up a '1001-days' strategy Masterplan within 12 months of the election. The Minister should either be in the Cabinet or reporting directly to Cabinet.

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Make joint inter-agency training on the importance of the early years for social and emotional development, for all professionals working with children and families in the early years, a priority in the '1001-days' strategy.

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Children's centres should become a central source of support for families in the early years with access to multi-agency teams and multiple on-site services including health visiting, GP services, housing, finance, parenting classes, birth registration, library and other community services.

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Research evidence and good local area data are necessary to ensure effective changes are implemented to services. Where data and evidence are not available, these should be prioritised and supported with appropriate funding.

PART II

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Essentials of a good local primary prevention approach

1. Good universal services
2. Central role of children's centres
3. Universal early identification of need for extra support
4. Good antenatal services
5. Good specialised perinatal mental health services
6. Universal assessment and support for good attunement between parent and baby
7. Prevention of child maltreatment

References

References will be found on line at www.1001criticaldays.co.uk/news_list.php?cat=parliament



1001 Days Foreword

The cost of failing to deal adequately with perinatal mental health and child maltreatment has been estimated at £23 billion each year.^{1,2*} As our report shows the two are closely linked and more importantly largely avoidable. That is the equivalent of more than two thirds of the annual Defence Budget going on a problem that is widespread and when unchecked passes from one poorly parented generation to the next. Tackling it should be no less a priority for our politicians and our health and social care professionals than defence of the realm.

This is not '*rocket science*.' Technically it is '*neuro-science*.' As a concept it is at last gaining wider acceptance with policy makers and clinicians brave enough to take a longer term view of how intervening early, even before a child is born, is the best way of that child growing up to be a well-rounded member of society. Poor attachment leads to poor social and physical development and behavioural problems. Often this can lead to child maltreatment and then the whole destructive cycle can be played out again by the next generation of parents who have known no better themselves. It has been calculated that as much as 80% of maltreated children could be classified as having disorganised attachment.³

Society prospers, and is an enriching environment in which to live, according to the nature of its citizens. The more our citizens are physically and mentally healthy, well educated, empathic, prosocial, hardworking and contributing to the costs of society, the better society will flourish. As there is a rise in the proportion of citizens who are damaged, physically or mentally ill, poor at relationships, antisocial, violent or criminal in their behaviour, and placing a drain on society's resources, so the quality of society worsens.

The groundwork for good citizenship occurs in the first 1001 days. A society which delivers this for its children creates a strong foundation for almost every aspect of its future. A society which fails to deliver it generates enormous problems for the future in terms of social disruption, inequality, mental and physical health problems, and cost. At its starkest, preventing these adverse childhood experiences could reduce hard drug use by 59%, incarceration by 53%, violence by 51% and unplanned teen pregnancies by 38%.⁴

No section of society is immune. Deprivation may lead to a greater concentration of affected families, middle class mothers can be just as prone to peri-natal mental health problems and the impact on their children. Certain groups, such as the families of armed services personnel, are a particularly high risk section of the population yet go largely under the radar.

The All Party Parliamentary Group (APPG) for Conception to Age 2 – The First 1001 Days, which I co-chair with Frank Field MP and which is responsible for this report, was established in 2013. It is one of the largest and most active APPGs in Parliament with substantial membership and buy-in from MPs and Lords of all parties. Our objective is to ensure that the interests and needs of families during the conception to age 2 period are represented to as many people inside Parliament and Government as possible.

To that end we produced a '1001 Critical Days Manifesto'. It has received widespread endorsement including that of the Chief Medical Officer, Royal Colleges and children's and health charities. We are urging all parties to adopt it into their own manifestos at the forthcoming election. This report provides further evidence why that is urgent and ultimately unavoidable if we are to deal sustainably with the causes and origins of so many of society's ills rather than firefighting the spiraling financial and social costs of our failure to do so.

The Government's 'Troubled Families' programme is a bold and potentially 'game changing' strategy for dealing in a more holistic, inter-disciplinary and effective way with the consequences of chaotic upbringings. It is showing promising signs



of success already and hopefully will enjoy continued buy-in across political parties and at all levels of government. The establishment of the Early Intervention Foundation by the Department for Education was another sign of a change in Government's mindset and a willingness to deal with the origin of problems not just the symptoms. Building on that, what we really need is a **'pre-Troubled Families'** programme and that is what our 1001 Days Strategy now offers.

I am enormously grateful to the panel of experts and Parliamentary colleagues who came together over several months to take evidence and question witnesses from a very impressive range of backgrounds. A short report such as this was never going to do justice to the wealth of submissions and expertise we received. Our conclusions cannot reflect the entirety of the presentations that inundated us and for that reason we have published them in full on our website. In doing so we would like to pay tribute to all those who took the trouble to provide us with such rich data and arguments. Our work has not been in isolation though.

When the Scottish Parliament asked its Finance Committee to carry out a 9-month investigation on the benefits of an early years' prevention approach, the results were summed up in the Parliament by former Scottish Health and Economics Minister Tom McCabe thus: *"We have heard evidence, stacked from the floor to the sky, that this is the right thing to do."* This message – and the need for Government to act on it – was echoed over and over again in the evidence presented to us.

A core theme (Conclusion 1) of our report is that, to deliver socially and emotionally capable children at age 2, local policies need to be based on a commitment to primary prevention. The evidence presented in this Inquiry strongly indicates that identification of need should take place before the child is harmed, not after. Thus inspection should look closely, and report on, the primary prevention measures which would deliver this result.

A second theme (Conclusion 2) is that, without intervention, there will be in the future, as there has been in the past, high intergenerational transmission of disadvantage, inequality, dysfunction and child maltreatment. This self-perpetuating system creates untold and recurring costs for society. The economic value of breaking these cycles will be enormous.

The resulting nine recommendations are practical, achievable but above all the minimum essential if we are to tackle this disease whose tentacles pervade so many aspects of what is wrong in society today.

Finally, we owe a huge debt of gratitude to three people in particular whose superhuman efforts have been essential in translating a cornucopia of evidence into this highly readable and timely report. Ita Walsh and George Hosking, from WAVE Trust, who generously provide the secretariat for the APPG, took on a much bigger task than anyone envisaged and sacrificed much sleep to edit this report in time. Clair Rees, who has just been appointed as Chief Executive of the charity PIP UK which complements our work, has helped steer the whole enterprise. I very much hope that our work results in the recognition that it deserves and that our children need.

Tim Loughton MP



Co Chairman The All Party Parliamentary Group for Conception to Age 2
and Chairman of the Inquiry Panel.

**£15 billion estimate for UK child maltreatment based on studies by Monash University in Australia and the Centre for Disease Control in Atlanta USA.¹ £8.1 billion on perinatal from the MMHA Report.²*



Acknowledgments

The Conception to age 2: first 1001 days APPG would like thank WAVE Trust and Parent Infant Partnership UK (PIPUK) for providing the joint secretariat and publishing this report.

We would like to thank the committee panel who contributed their expertise of policy and science to our inquiry including:

Tim Loughton MP

(Chairman of the Committee)

Professor Sheila the Baroness Hollins

Sharon Hodgson MP

for Washington and Sunderland West,
Shadow Minister for Women and Equalities

Paul Burstow MP

for Sutton and Cheam

Susan Ayers

Professor of Maternal and Child Health,
City University

Robin Balbernie

Clinical Director of Parent Infant Partnership UK

Sir Harry Burns

Professor of Global Health at Strathclyde University

Dr Alain Gregoire

Consultant Perinatal Psychiatrist

Kate Mulley

Director of Policy and Campaigns at Action for Children

George Hosking OBE

CEO of WAVE Trust

Councillor David Simmonds

Hillingdon's Deputy Leader, Chair of LGA Children's Board

We would also like to thank the following expert witnesses:

Dr Susan Pawlby - Kings College London, Professor Vivette Glover - Imperial College University, Ailsa Swarbrick - Family Nurse Partnership, Professor Joan Raphael-Leff - University College London, Professor Mark Bellis - Liverpool John Moores University, Chris Cuthbert - NSPCC, Professor David Shemmings - University of Kent, Dr Jonathan Sher - WAVE Trust, Karen Todd - Department of Health, Dr Liz McDonald - Chair of the Royal College of Psychiatrists' Perinatal Faculty, Judith Barac - South London and Maudsley NHS Trust, Dr Amanda Jones - North East London NHS Foundation Trust, Kathryn Grant - expert by experience, Tessa Baradon - Anna Freud Centre, Professor Jane Barlow - University of Warwick, Professor Pasco Fearon - University College London and Professor Lynne Murray - University of Reading.

A wealth of written evidence has been submitted by key education, health and social care organisations which can be found listed and downloaded separately alongside references to this downloadable report on the 1001 Critical Days website page. www.1001criticaldays.co.uk/news_list.php?cat=parliament



PROLOGUE

INFANT JOY

I have no name	Pretty joy!
I am but two days old,	Sweet joy but two days old,
What shall I call thee?	Sweet joy I call thee;
I happy am	Thou dost smile.
Joy is my name,	I sing the while
Sweet joy befall thee!	Sweet joy befall thee.

William Blake

From the moment of conception, through to birth and the first year of life every aspect of a baby's environment influences its physical, emotional and social development. In an ideal world, all children should be wanted, nurtured, loved, protected and valued by emotionally available and sensitively responsive parents. Such an environment allows the child to develop in the most optimal way, with emotional wellbeing, capacity to form and maintain relationships, healthy brain and language development leading onto cognitive development, school readiness and lifelong learning. Such children contribute to the establishment of a caring, nurturing, proactive and creative society with negligible levels of child abuse and neglect.

"Teaching parents-to-be about bonding and attachment, and the importance of holding, talking and gazing at their child, cannot be underestimated. It is possibly the single most important role that a parent has in terms of the child's emotional development yet most parents are completely unaware of how babies' brains develop or what they can do to give their baby the best start in life."

Parentscool, Written Evidence

During the antenatal period mothers and fathers can be supported to understand their essential role and what to expect physically and emotionally both ante-and postnatally as parents and as a family. The symbiotic parent-infant relationship begins at conception, and the influence of nutrition, physical and emotional health cannot be underestimated. Effective, timely, consistent and non-judgemental antenatal support means parents feel supported and prepared for their transition into parenthood and the arrival of their baby.

Experiences of labour also impact on parents' ability to provide the ideal environment for their child. Having a supportive partner provides emotional support for the mother. Midwives who are empathic and caring towards mothers, and continuity of care antenatally and during labour, can ensure families are prepared and can exercise their choices.

After the baby is born, parents can begin to put into practice what they have learned antenatally, and their understanding of their babies' needs grows with their continued nurturing relationship and their confidence in responding to their baby's signals.

"When [baby] cried & I was tired I tried to put myself in her place & understand her feelings & that crying was her only way to communicate & express her needs. It helped me calm down & look after her again but happily."

Young Mother, Oxford, Family Links, Written Evidence

Parents who are able to understand their baby's cues and tune into their baby's needs are able to provide the responses and experiences that their baby needs at different points in their baby's life in order to support the establishment of appropriate neural pathways and optimal development of their baby's brain.



INFANT SORROW

My mother groand! my father wept. Struggling in my father's hands:
Into the dangerous world I leapt: Striving against my swaddling bands:
Helpless, naked, piping loud; Bound and weary I thought best
Like a fiend hid in a cloud. To sulk upon my mother's breast.

William Blake

The importance of relationships

In difficult circumstances, mothers may groan and fathers (if they are still on the scene) may weep. A recurring message in the evidence submitted was the critical nature of relationships throughout the first 1001 days, including those between the parent(s) and professional helpers, between the professional helpers and their supervisors or line managers and, crucially, that of the couple relationship itself. As one contributor said “the quality of the couple relationship inoculates the child”.

Resilience

Although the ‘ideal’ is for every parent to have the support of a committed and loving partner, it needs to be borne in mind that a resilient, mentally, physically and emotionally strong lone parent can mean a couple relationship is no necessity for good outcomes for the parent or infant – as many single parents and their children can testify.

“The very simple story is that children who are ... treated with kindness and thoughtfulness grow up to be adults who are kind and thoughtful ... and anything that gets in the way of that very simple process needs to be addressed.”

Robin Balbernie, Clinical Director Parent Infant Partnership UK, Oral Evidence


Just as a positive environment can support optimal development for babies, so too can a negative environment disrupt development, with potentially lifelong damaging effects on the developing brain which can predispose to mental health problems, risk-taking behaviour, depression, anxiety and even violence throughout the lifespan.

“A mother's capacity to adjust to and enjoy a new baby is affected by her life before pregnancy.”

Foundation Years Trust, Written Evidence

Parents having been maltreated in childhood

A major factor which puts babies at risk is a parent having themselves been maltreated in childhood. Since a significant proportion of the population has been maltreated – 20% or more according to both national⁵ and international⁶ surveys – and many of these parents have large families, this represents a high proportion of infants potentially at risk for this reason. Maltreated mothers are at elevated risk for ante- and postnatal depression, relationship problems, being with violent partners and teenage pregnancy. Maltreated fathers are at elevated risk of committing domestic violence. Fortunately, while a minority of people who were maltreated in childhood do go on to commit abuse or neglect, the majority do not. Protective factors such as a relationship with a loving sibling, parent, grandparent or partner come into play.



"In non-traditional societies, the baggage we carry around from our infancy does not get resolved because our families are getting smaller, extended families fall away, so we have very few opportunities to work through our feelings about other baby relationships. These feelings then flare up again in pregnancy."

Professor Joan Raphael Leff, Oral Evidence

Oral evidence from Dr Susan Pawlby highlighted that women who experienced childhood maltreatment were ten times as likely to suffer from antenatal depression⁷. Parents' own childhood experiences, particularly if maltreated as a child, can often impair their ability to offer a loving, caring environment where they can respond sensitively to their baby's needs.

Maternal stress

A stressful environment for a mother during pregnancy results in production of the stress hormone cortisol. This hormone crosses the placental barrier and circulates round the foetal body, overwhelming its capacity to regulate its own stress response. Professor Vivette Glover stated in her oral evidence that the impact of stress on foetal development rises in line with the 'dose' of stress experienced. Different people find different things stressful, and triggers range from quite normal everyday things to extraordinary events. Many of the effects of prenatal stress can be helped by sensitive caregiving, especially in the first year. If the mother is well attuned to her baby and responsive to his or her needs, this can help enormously with future development. Domestic violence in pregnancy can be a source of serious stress. See www.beginbeforebirth.org for further information on stress and anxiety during pregnancy.


Domestic violence

Evidence submitted by Family Action (McCloskey et al, 2007)⁸ showed that 'Pregnant women who suffer Intimate Partner Violence have been shown to be almost twice as likely to enter antenatal care late (after the first trimester). If abused women are blocked from accessing treatment, any health conditions they suffer before and during pregnancy are likely to worsen, potentially impacting on the development of the foetus, and future development of the child.'

"Trauma, including witnessing domestic violence, in the first two years of life is especially detrimental to cognitive ability and the effects persist at 2, 5 and 8 years of age, after controlling for socioeconomic status, mother's IQ, home stimulation and birth complications (Enlow, et al., 2012)."⁹

Robin Balbernie, Clinical Director Parent Infant Partnership UK, Written Evidence

Domestic violence can have damaging effects at any point from conception, during pregnancy and in the earliest years of life. Over one third of instances of domestic violence begin during pregnancy¹⁰ and more assaults are aimed at the woman's abdomen than the more 'usual' targets of head and upper body. Not only can domestic violence impact the physical wellbeing of the mother, but the level of emotional distress, stress and anxiety can adversely impact the developing foetus. A home characterised by domestic violence is a high risk place for an infant. There is increased risk of child maltreatment in such situations (in one study, families with domestic violence were 23 times more likely to abuse their under 5-year-olds than families without)¹¹. Besides, witnessing domestic violence is as harmful to a child as being directly on the receiving end of the less serious variety of physical violence since there is no emotional refuge for a child who has one caregiver a threat and the other frightened.



“Because the emotional and mental wellbeing of infants is so strongly influenced by the relationship with their parents, the emotional and mental wellbeing of the parents can have a profound impact on the infant. So infants born to parents who suffer from depression or anxiety, who are in a dysfunctional or violent relationship or who engage in substance or alcohol misuse, are more likely to experience emotional or behavioural disturbance and subsequent mental health problems. Babies that are anxious or tense are likely to exhibit symptoms such as poor sleep patterns, difficulties with feeding, restlessness and gastric disturbance (Young Minds, 2004).”¹²

Royal College of Midwives, Written Evidence

Parental mental health problems

The mental health of both parents is one issue that is core to the emotional development of the baby. Mental health problems can range from adjustment disorder, depression, anxiety, post-traumatic stress disorder, obsessive compulsive disorder and psychotic illness. The stress of childbirth can be a trigger for mental illness; in her oral evidence Dr Liz McDonald stated that a woman is 33 times more likely to be admitted to a psychiatric ward after her first pregnancy and birth than at any other time in her life.¹³ A parent suffering from a mental health disorder or difficulty can profoundly impact the parent-infant relationship and, as a result, the child’s own emotional development and wellbeing. A baby requires a timely, consistent and sensitive response when experiencing a stressful situation and the lack of this can lead to emotional and behavioural problems throughout childhood and beyond.

Parental substance misuse

The impact of alcohol and smoking during pregnancy has been more widely recognised in recent years. However, without access to timely and effective support, many mothers find themselves unable to stop either smoking or consuming alcohol.

Smoking during pregnancy restricts the supply of oxygen and increases the likelihood of harm to the unborn baby, including greater risk of stillbirth, premature birth and a baby being born underweight. The effects also include lifelong consequences to children (e.g. increased risk of elevated aggression in teenage years, asthma and other serious illnesses). Consuming alcohol during pregnancy can also have a profound effect on the developing foetus, interfering with normal development and potentially resulting in brain damage, foetal alcohol harm or a condition called Foetal Alcohol Syndrome. Foetal alcohol harm is the largest cause of learning disability in the Western world. Excessive alcohol and/or misuse of addictive drugs during pregnancy results in some infants being born addicted and needing to face a start in life marred by the hideous suffering of withdrawal symptoms.

“Around 39% of serious case reviews relate to babies under the age of 1 and around 200,000 babies (1 in 5) are living in families with issues such as parental drug and alcohol misuse, mental illness and domestic violence. So this is an issue on a major scale.”¹⁴

Chris Cuthbert, NSPCC, Oral Evidence

Drug and alcohol misuse can also have a profound impact upon infants, through an impact on parental responsiveness, physical and emotional care, violence and trauma. At least one third of abuse perpetrated against children is done under the influence of alcohol.¹⁵



Attachment

It is the unfortunate reality for many families that one or more of the issues described above will permeate their lives and their relationships. The importance of the parent-infant relationship should not be underestimated; poor relationships during the 1001 critical days predict higher rates of physical and emotional health issues. Significantly, the character of the bond between a child and caregiver, known as attachment, is infinitely bound up in the parental ability to respond sensitively and lovingly to an infant. Secure attachment describes the young child using the caregiver as a secure base from which to explore and return and as a source of comfort when needed. About 60% of the general population have secure attachment.¹⁶ When the caregiver is inconsistently available or unresponsive, the result will be insecure attachment. There is a clear association between attachment security and children's later behavioural problems.

"Where the caregiver is chaotic with no predictable pattern, is neglectful, frightening or unsafe, the result can be 'disorganised attachment', found in 15-19% of the population.¹⁷ Disorganised Attachment Behaviour occurs when the secure base and safe haven (of the carer) is simultaneously a source of fear, terror or chronic indifference. This could be as a result of fear of or for the carer."

Professor David Shemmings, University of Kent, Oral Evidence

Disorganised attachment is a likely indicator of child maltreatment because around 80% of maltreated children could be classified as having disorganised attachment (DA).¹⁸ DA can have devastating lifelong effects on the infant, including high levels of physical and mental illness, high levels of entry into care, disruptive behaviour in preschool and school, low educational and employment achievement, poor relationship skills, and high levels of violence, imprisonment, worklessness and homelessness.



Key Statistics

The Antenatal Period

- Depression and anxiety affect 10-15 out of every 100 pregnant women.¹⁹
- Over a third of domestic violence begins in pregnancy.²⁰
- Posttraumatic stress disorder (PTSD) occurs in about 8% of pregnant women.²¹
- 1 million children in the UK suffer from the type of problems (including ADHD, conduct disorder, emotional problems and vulnerabilities to chronic illness) that are increased by antenatal depression, anxiety and stress.²²

Child Maltreatment

- 20% or more of UK adults have suffered significant maltreatment.²³
- c.50% of all maltreatment-related deaths and serious injuries involve infants under-1.²⁴
- WHO estimates child maltreatment is responsible for almost a quarter of the burden of mental disorders. Its economic and social costs are on a par with those for all non-communicable diseases (inc. cancer, obesity, diabetes, heart, respiratory diseases).²⁵
- Based on both US and Australian studies, adjusted for population, the UK annual cost of child maltreatment would be £15 billion.²⁶
- Preventing such Adverse Childhood Experiences as abuse, neglect and witnessing domestic violence could reduce heroin/crack use by 59%, violence by 51%, incarceration by 53%, and unplanned teen pregnancies by 38%.²⁷

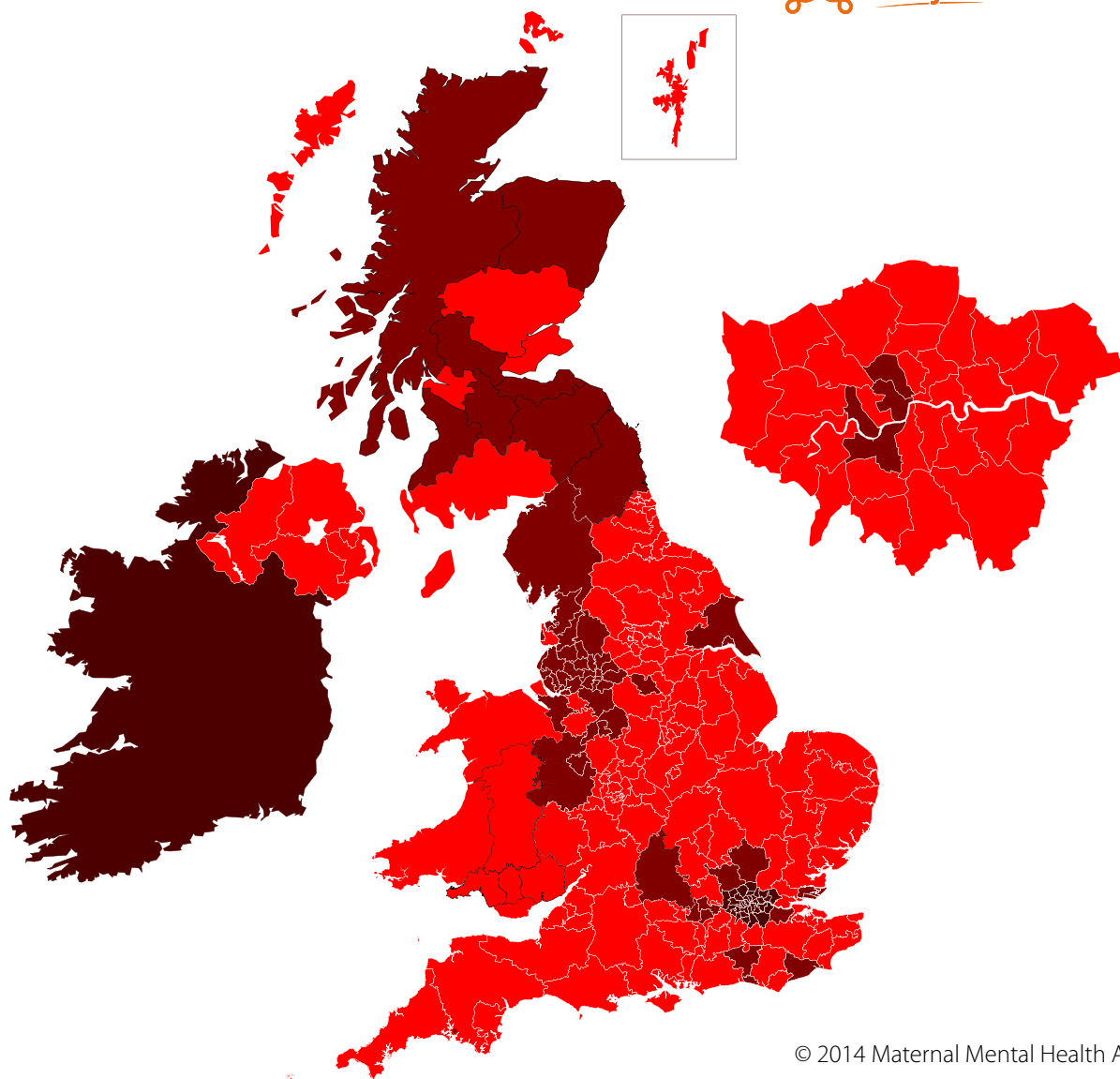
The Perinatal Period

- Mental health problems affect up to 20% of women during the perinatal period.²⁸
- About 11% of pregnant women experience some form of depression, with 3% suffering from a major depressive disorder.²⁹
- Suicide is a leading cause of death for women during pregnancy and in the year after giving birth.³⁰
- Anxiety and panic disorders affect between 2 and 4% of pregnant women.³¹
- Taken together, perinatal depression, anxiety and psychosis carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.³²
- Only 3% of Clinical Commissioning Groups (CCGs) in England have a perinatal mental health strategy.³³

Infant Mental Health

- 122,000 babies under one are living with a parent who has a mental health problem.³⁴
- Infant regulatory disturbances such as excessive crying, feeding or sleeping difficulties, and bonding/attachment problems are the main reasons for referrals to child health clinics.³⁵
- Around one-fifth of children aged 18 months have regulatory problems.³⁶
- About 15% of children have Disorganised Attachment behaviour,³⁷ which is associated with high levels of entry into care, poor relationship skills through life, high levels of disruptive behaviour in school and pre-school, school exclusion, poor physical and mental health, aggression, and entry into the criminal justice system.
- Around half (49.9%) of infants and toddlers (12-40 months) show continuity of emotional and behavioural problems one year after initial presentation.³⁸

UK Specialist Community Perinatal Mental Health Teams (Current Provision in 2014)



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LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria www.rcpsych.ac.uk/pdf/perinatal_web.pdf
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision

Disclaimer Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.



MAIN CONCLUSIONS AND RECOMMENDATIONS

Introduction

The groundwork for good citizenship occurs in the first 1001 days. A society which delivers this for its children creates a strong foundation for almost every aspect of its future. A society which fails to deliver it generates enormous problems for the future in terms of social disruption, inequality, mental and physical health problems, and cost.

We seek a cross-party commitment to prioritise getting this strong foundation for the future of our society in place. Here we set out how we think this can be achieved.

A core theme (Conclusion 1) of our report is that, to deliver socially and emotionally capable children at age 2, local policies need to be based on a commitment to primary prevention.

A second theme (Conclusion 2) is that, without intervention, there will be in the future, as there has been in the past, high intergenerational transmission of disadvantage, inequality, dysfunction and child maltreatment. This self-perpetuating system creates untold and recurring costs for society. The economic value of breaking these cycles will be enormous.

CONCLUSION 1

We want to create children who at the end of their first 1001 days have the social and emotional resources that form a strong foundation for good citizenship.

To achieve the above, the following recommendation was developed and supported by the evidence collated:

Recommendation 1

Achieving the very best experience for children in their first 1001 days should be a mainstream undertaking by all political parties and a key priority for NHS England. Recognising its influence on the nature of our future society, the priority given to the first 1001 days should be elevated to the same level as Defence of the Realm.

A recurring theme in the evidence was that if we want children to grow up with the social and emotional skills and attitudes which foster good citizens, how they are parented and related to in the first 1001 days is of paramount importance.

"The time in the womb, and the first two years of life shape the way the brain of the child develops."

Professor Vivette Glover, Imperial College London, Written Comment

"We are the first generation to have this knowledge at our fingertips. We ignore it at our peril' (Rowley, 2014)"³⁹

What About the Children? Written Evidence

Society prospers, and is an enriching environment in which to live, according to the nature of its citizens. The more citizens are physically and mentally healthy, well educated, empathic, prosocial, hard-working and contributing to the costs of society, the better society will flourish. As there is a rise in the proportion of citizens who are damaged, physically or mentally ill, poor at relationships, antisocial, violent or criminal in their behaviour, and placing a drain on society's resources, so the quality of society worsens. In the UK today there are too many citizens in the latter



category. We do not blame – they are to a large extent the product of their childhoods as, in turn, were their parents and grandparents. We do propose that decisive action be taken to ensure the proportion of good citizens rises sharply in the future.

Jane Barlow, Professor of Public Health in the Early Years, at Warwick, in written evidence, cited Marmot's 'Fair Society, Healthy Lives' which "highlighted the importance of pregnancy and the first 2 years of life ... [when] there is the biological embedding of social adversity...Both health and social inequalities have their origins in early parent-infant interaction."⁴⁰

The challenge is not simply one of providing a good experience for the majority of children. We need to recognise that, for a significant proportion of children, early life is a period of trauma and untold damage. Professor Mark Bellis provided oral evidence from the studies of Adverse Childhood Experiences (ACEs) such as abuse, neglect, and growing up in households with domestic violence or substance abuse. Comparing adults who had suffered 4 or more categories of ACE with those with none he pointed out the lifetime consequences of allowing ACEs in childhood – and the huge potential benefits to society from preventing these:

"... they are 6 times more likely to have an unplanned teenage pregnancy; 7 times more likely to have been involved in violence in the last year; and 11 times more likely to be a heavy drug user. So if we got rid of ACEs, we would see a 52% reduction in violence perpetration; 51% reduction in violence victimisation; and a reduction of close to a third in unplanned teenage pregnancies.⁴¹ If you look at Troubled Families, these adults have an average of 9 problems."⁴²

Professor Mark Bellis, Director of Policy, Research & Development Public Health Wales, Oral Evidence

Professor Kevin Browne, one of the country's leading researchers and writers on child maltreatment, also provided evidence, citing from a study he co-authored with Professor Ruth Gilbert of the UCL Institute of Child Health, and others:

"Child maltreatment ... has long lasting effects on mental health, drug and alcohol misuse (especially in girls), risky sexual behaviour, obesity, and criminal behaviour, which persist into adulthood...Child maltreatment is common, and for many it is a chronic condition...The burden on the children themselves and on society is substantial. The high burden and serious and long lasting consequences...warrant increased investment in preventive and therapeutic strategies from early childhood."⁴³

Gilbert et al. (2008) Burden and consequences of child maltreatment in high income countries, Lancet

0-2 is the peak period for both abuse and neglect in the UK.⁴⁴ The long term burden to society of early abuse and neglect was also highlighted by Robin Balbernie:

"From a life-path perspective it has been clearly demonstrated that children who have suffered early neglect and abuse are far more likely to suffer from serious illnesses when they are adults, thus taking up an excessive and disproportionate amount of health service resources (Felitti et al., 1998)."⁴⁵

"Infants who have suffered maltreatment in the context of adverse family relationships go on to become teenagers and adults who are grossly over-represented in the criminal justice system. This is not only a direct drain on resources; it also signifies a large population who are not in a position to contribute to the wider society."

Robin Balbernie, Clinical Director, Parent Infant Partnership UK, Written Evidence



CONCLUSION 2

Without intervention, there will be in the future, as in the past, high intergenerational transmission of disadvantage, inequality, dysfunction and child maltreatment. These self-perpetuating cycles create untold and recurring costs for society. The economic value of breaking these cycles will be enormous.

Research has demonstrated recurring cycles of violence, abuse, disadvantage and dysfunction, which run from generation to generation. Multiple studies have identified the factors which can cause these cycles to persist – as well as to break them. Protective factors – such as being loved or cared for by someone empathic, or family support – can help people to break free of these cycles. Nonetheless they are a major feature of our society, as was illustrated by much of the evidence we received.

“The biggest predictor of antenatal depression was the mother’s own experience of childhood abuse. Women who experienced childhood maltreatment were ten times as likely to suffer from antenatal depression.”⁴⁶

Dr Susan Pawlby, Institute of Psychiatry, Kings College, London, Oral Evidence

This particular cycle does not stop there. Antenatal and postnatal depression are strongly correlated, and postnatal depression has been shown to predict elevated levels of the harmful stress hormone cortisol in adolescents (Halligan et al., 2004),⁴⁷ higher levels of depression and emotional disorders in the child (Harvard Center for the Developing Child, paper on Depression),⁴⁸ and child conduct problems. The odds of a child developing depression by age 16 are nearly five times greater if his/her mother was depressed than if she was not (Murray et al., 2011).⁴⁹

“The real story is that there is transgenerational transmission of vulnerability and that vulnerability is transmitted through the human mind.”

Dr Alain Gregoire, Psychiatrist, Chair of the Maternal Mental Health Alliance, Oral Evidence

There is also a cycle of violence, affecting a proportion of children who suffer abuse, as shown in WAVE Trust’s 2005 report *Violence and what to do about it* and evidence submitted from WHO reports.

“Maltreatment and other adversity in childhood may cause toxic levels of stress, which impair brain development and may lead to the adoption of health-harming behaviour, poorer mental and physical health, worse educational and social outcomes throughout the life-course and intergenerational transmission of violence.”⁵⁰

WHO (2014) Investing in Children: the European Child Maltreatment Prevention Action Plan 2015-2020, Written Evidence

There is a cycle of abuse/maltreatment, and of mental disorders associated with these. Dr Susan Pawlby from the Institute of Psychiatry gave evidence that 50% of the inpatients in the Bethlem Mother and Baby Unit, which treats mothers with serious antenatal and postnatal mental illnesses, had suffered previous maltreatment;⁵¹ Dr Alain Gregoire gave evidence that 80% of women referred to his community psychiatric service with mood disorders have been maltreated in childhood.⁵²

“...the strongest predictor of maltreatment was previous maltreatment subjected to the parent and ... was a very strong indicator of poor outcomes right up to adulthood. This suggests we are talking about an intergenerational cycle.”

Dr Alain Gregoire, Psychiatrist, Chair of the Maternal Mental Health Alliance, Oral Evidence



We heard how parenting in the early years is a major transmitter of these cycles:

"Research shows that the parents who find parenting particularly difficult are those who have a childhood history of abuse or neglect."

Family Links, Factors affecting optimal development in the antenatal period, Written Evidence

"How we are treated as vulnerable infants can significantly impact on later mental health, not least on levels of empathy towards others, including one's own children (Baron-Cohen, 2012)."⁵³

What about the Children? Written Evidence

Amanda Jones, in her oral evidence, gave a graphic description of how this can occur:

"What can disturb a woman when she conceives a baby particularly is that she might not have been anticipating the reawakening of her relationship with her own past parental figure she depended upon. If there's unresolved loss and hurt and trauma in a woman's life she may have been managing until the birth of her baby, it's this that can crash through at this very vulnerable time...forgotten, or suppressed ghosts which seep into the relationship with the baby and become really disturbing for the baby... 'my baby reminds me of my mother', well, that can be pretty terrifying if you've had a very disturbed relationship with your mother, and you're not going to want to care for that baby."

Dr Amanda Jones, Consultant perinatal psychotherapist, NE London Foundation Trust, Oral Evidence

Further, these intergenerational cycles perpetuate social inequality, an issue of interest to almost all political parties.

"Maltreatment exacerbates inequality because of its health and social impacts, thereby perpetuating cycles of deprivation. Although brain development may be harmed throughout childhood, children are most vulnerable in the first three years of life, and the greatest returns will be made by investment in early child development."⁵⁴

WHO (2014) Investing in Children: the European Child Maltreatment Prevention Action Plan 2015-2020, Written Evidence

The economic value of breaking these cycles would be enormous. Taking just two areas alone, where primary preventive approaches are scarce in the extreme, perinatal mental health and child maltreatment, the estimated annual cost to the country is well in excess of £20 billion per annum.⁵⁵ The Christie Commission, set up in Scotland to examine the Future Delivery of Public Services, estimated that 'as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach'.⁵⁶

Recommendation 2

Require local authorities, CCGs and Health & Wellbeing Boards to prioritise all factors leading to the development of socially and emotionally capable children at age 2, by: adopting and implementing a '1001-days' strategy, and showing how they intend to implement it, within 5 years, in collaboration with their partner agencies.

The '1001-days' strategies should be based on primary preventive principles, with particular emphasis on fostering mental/emotional wellbeing and secure attachment, and preventing child maltreatment.

The cost of more than £20 billion for failing to intervene before harm is done is argument enough for preventive strategies to be adopted by local authorities, CCGs and Health and Wellbeing Boards.



The majority of parents in the UK bring up children who at age 2 are emotionally healthy and socially competent, have a robust ability to regulate their feelings, and can handle emotional stress or separation from parents. These children possess what is called 'secure attachment'. [See prologue for a brief explanation of Attachment]. About 60% of children develop these strong, healthy emotional bonds with their parents.⁵⁷

Regrettably, about 40% of children do not develop this set of capabilities.⁵⁸ They are both less able to handle adversity or stress, and more prone to aggression and dissociation, defiance and hyperactivity as they get older. About 20% of children are maltreated at some point in their lives and, by age 2,⁵⁹ 15% have experienced early life trauma – most commonly due to abuse, neglect, or both⁶⁰ – which leaves them very damaged and, as they grow to adulthood, much more likely to damage others. These are the children, and the families they go on to parent, who can cost society astronomical sums.

The historic British approach to looking after the welfare of children is to treat this as entirely the business of families, and for outside agencies to become involved only when problems show up that are so serious they require outside intervention. This approach is highly expensive, and does not work. By failing to identify potential problems before they happen, or immediately they begin to happen, situations of potential stress and maltreatment are allowed to grow and develop until they become very serious.

"We know that local areas struggle to know the true scale of child neglect as many do not collect statistics over and above child protection register statistics. If local areas have no accurate picture of the scale of the problem ... they are in no position to plan and commission an effective response."

Kate Mulley, Director of Public Policy, Action for Children, Written Evidence

When authorities do step in, the costs of treating the problems are very high. Because resources are scarce, thresholds are then set which positively discourage intervention at earlier, less acute, phases of the developing issue. In some local authorities 80% of referrals of children at risk are not even investigated,⁶¹ and most maltreatment is never spotted, especially when the child has responded by 'switching off' and becoming 'invisible' compared with those still hopeful enough to broadcast their distress by causing trouble. Some of these could potentially become the callous, unemotional psychopaths of the future.

"A high proportion of abusive experiences is not known to children's services. The gap between known and unknown cases of severe abuse and the overlapping with other types of maltreatment and abuse at home, in school and in the community has implications for locally-based joint strategic needs assessments and for future service planning."⁶²

NSPCC Report, Child Abuse and Neglect in the UK today, Written Evidence

The same failure to identify and respond to need occurs with perinatal mental health services. This leads to the situation that in the UK, 144,000 children under 1 live with a parent with a mental health problem.⁶³ This severely affects the life chances for the child (DfE/WAVE Trust, 2013)⁶⁴ but most of these parents are never treated and neither do they receive help to improve the relationship they have with their child.

A core problem, described by Professor Susan Ayers in evidence, is that physical health and risk factors have been prioritised in maternity care, with a relative lack of attention to women's mental health and social circumstances. Current assessment of mental health in pregnancy and after birth is minimal and assesses only depression. Many women with mental health problems during this time do not report them to a health professional, so problems can remain unrecognised and untreated (Boots Family Trust, 2013).⁶⁵



"We know that 75% of people with diagnosable mental health problems in the UK are not treated,⁶⁶ and that's reflected again in perinatal mental health services where 50% are not recognised and another 50% don't receive treatment."⁶⁷

Dr Liz McDonald, Royal College of Psychiatrists, Oral Evidence

We heard recurrently (e.g. see national map accompanying Key Statistics) how little is being done about these issues:

"Only 3% of CCGs in England have a strategy for commissioning perinatal mental health services; 60% said they have no plans; 8% didn't even reply; and 18% said they were planning to have a plan. Yet the LSE Personal Social Science Research Unit found that perinatal depression anxiety and psychosis carries a cost of £8.1 billion for each year cohort of births in the UK."⁶⁸

Dr Liz McDonald, Royal College of Psychiatrists, Oral Evidence

The solution proposed, and supported across the board by witnesses, was:

"There must be strategic commissioning of perinatal mental health care based on need. Every local area must develop and deliver a perinatal mental health strategy. There must be local clinical leadership in each area to champion the needs of women with perinatal mental illnesses. Every Health and Wellbeing Board must ensure that there is a local perinatal mental health strategy in the area, and that it is properly resourced and delivered."⁶⁹

NSPCC Prevention in Mind – Spotlight on Perinatal Mental Illness, Written Evidence

Fundamental to addressing this recommendation is that universal maternity services provide integrated physical and psychological care of women and their infants; that effective assessment of psychological and social risk is conducted early in pregnancy; and that specialist mental health midwives and health visitors are available in all maternity units. Continuity of care, such as midwifery-led or specialist family nurse care, reduces a number of negative outcomes, including preterm birth and child maltreatment, and increases the likelihood that health and social problems are detected early and adequately addressed. Continuity of midwifery care costs the same or less than other models of care (Sandall et al, 2013)⁷⁰ so could be made universally available.

Recommendation 3

National government should establish a '1001-days' strategy fund to support local authorities and CCGs to make a decisive switch over the next 5 years, to a primary preventive approach in the first 1001 days. Practical support should also be provided, including the measures of success

Delivery of the early years' primary prevention policies to create the social and emotional foundation for good citizenship, through '1001-days' strategies, is a local area responsibility. However, local authorities are going through – and will be for the next few years – extremely deep cuts in their budgets. In a 2014 study conducted for the Department of Health, by WAVE Trust, asking local authorities what stopped them investing more in prevention, the biggest reason by far was this financial environment (WAVE Trust, Prevention in Practice, 2014).⁷¹

While some forward-thinking local authorities are already making a decisive switch of resources to prevention, and report that they are saving money by doing so, the momentum to deliver such a switch in emphasis on a nationwide basis inside 5 years will not be achieved without some pump priming.



"Kick-starting investment can be a great way of catalysing change at a local level. The Big Lottery work is a good example of the kind of investment that can have a major effect on local areas, as it has helped some local areas to lever other investments locally."

Chris Cuthbert, Head of Strategy and Development for Under 1s, NSPCC, Oral Evidence

Lack of money at central Government level should not be a barrier to investment in the early years because that money will come back in time through savings in such costs as welfare, education and criminal justice, with a higher and more rapid payback than for most capital projects. It would also encourage local area investment if their preventive action enabled them to claim the resulting savings from national budgets.

"From only 1% of the budget of the Departments for Education, of Health, Justice, Home, and Communities and Local Government you get to more than we've ever spent on early intervention and prevention. This would come to about £3 billion which is huge and savings would be made to those very Departments over time".

Sharon Hodgson MP, Oral Evidence

Paul Burstow MP asked what some of the consequences have been of the Christie Commission recommendation of a shift to preventive spending in Scotland.

"The first consequence of the Christie Commission report was that the Scottish Parliament gave cross-party endorsement and prioritised preventive spending. There was a two-year Inquiry into preventive spending and it's the judgement of Scottish Parliament that government should make preventive spending a priority ... Secondly, there has also been priority given to the early years with a task force being established. This led to the establishment of the Early Years Collaborative."

Dr Jonathan Sher, Scotland Director, WAVE Trust, Oral Evidence

The Early Years Collaborative approach – bringing together regionally about 20 staff from each local area, from midwives to commissioners to CEOs – then exposing them to the evidence in favour of primary prevention, with leading expert speakers, and finally inviting all to make a pledge to ensure multi-agency collaboration and progress in their area, is one of many non-financial initiatives central government can take to encourage greater priority for prevention. It has had a huge impact in embedding a national acceptance (at local level) of the importance of primary prevention in Scotland.

"The Early Years Collaborative has set targets (to achieve, making Scotland the best place to grow up) and every local authority has set plans and set data collection plans to achieve this."

Professor Sir Harry Burns, former Chief Medical Officer, Scotland, Oral Evidence

"...[it led to] a bringing together of community planning partnerships from all authorities, health boards and others to focus on prevention for issues from still births to child development. What led to this is the understanding that there is a more efficient way of spending."

Dr Jonathan Sher, Scotland Director, WAVE Trust, Oral Evidence

When the Scottish Parliament asked its Finance Committee to carry out a 9-month investigation on the benefits of an early years' prevention approach,⁷² the results were summed up in the Parliament by former Scottish Health and Economics Minister Tom McCabe thus: "We have heard evidence, stacked from the floor to the sky, that this is the right thing to do". This message – and the need for Government to act on it – was echoed over and over again in the evidence presented to us, both at the macro level:



"There must be a period of consolidation supported by Government activity to enforce existing duties to provide early help."⁷³

Action for Children (2013), The state of child neglect in the UK, Written Evidence

... and at the micro level, for example:

"Commissioning and funding arrangements for specialist perinatal mental health services must support preventative work."⁷⁴

NSPCC Prevention in Mind – Spotlight on Perinatal Mental Illness, Written Evidence

International evidence, supplied by some witnesses, reinforced the merit of central Government playing an active, enabling role.

"Commitment of top political and government leaders is critical to ensuring that the prevention of child intentional injury is established as a priority issue and that the requisite resources, both human and financial, are made available."⁷⁵

National action to address child intentional injury (2014). What are European countries doing to prevent intentional injury to children?, Written Evidence

Both witnesses and written evidence called for this to be backed with dedicated funding:

"In addition to providing a duty on early help, local authorities need to have clear funding streams dedicated to early help. The Early Intervention Grant (EIG), valued at £2.3 billion in 2012/13, was welcomed as a way of focusing spending on prevention. However, the EIG [was] absorbed into wider local government funding from April 2013."⁷⁶

Action for Children (2013), The state of child neglect in the UK, Written Evidence

Recommendation 4

Hold Health & Wellbeing Boards responsible for ensuring that local authorities and CCGs demonstrate delivery of a sound primary prevention approach as outlined in Part II of this report. Promote the delivery of this through establishing scorecards (similar to Adoption Scorecards) and a joined up multi-agency inspection framework which combines CQC and OFSTED.

Experience tends to show that however good the intentions of central government or the commitment of individual ministers, and whatever the extent of rewriting of regulations and robustness of guidance, this does not guarantee that appropriate action actually follows through in practice. This is particularly the case when it is dependent on delivery of the service by local authorities and partner agencies and it remains a conflicting conundrum between localism and central fiat.

"It's great to have a strategy for mental health care of women at this critical time, but NICE has been saying this since 2007 and most of the country doesn't do it, and that really is unacceptable in an area where it's costing us a fortune and producing huge amounts of human suffering."

Dr Alain Gregoire, Psychiatrist, Chair of the Maternal Mental Health Alliance, Oral Evidence



A good case in point has been the current Government's reforms to the adoption system, now showing some signs of rapid progress. Undoubtedly the high profile commitment from ministers to increasing the numbers of children benefiting from adoption, and the quality and sustainability of their placements, has been hugely important. However it is the creation of 'Adoption Scorecards',⁷⁷ statutory changes to legal processes and a beefed-up inspection regime to ensure it is happening, that have transformed good intentions and ministerial speeches into hard results.

With every local authority adoption service having to lay bare its adoption record on a qualitative basis, there is nowhere to hide and it is difficult for one area to defend why it is only supporting half as many older children into adoption as the neighbouring one for example. Where there is consistent poor performance, backed up by rigorous inspection, then intervention centrally is likely to result.

"We need to ensure that central and local government are held to account for the provision of high quality services and the achievement of improved outcomes. We need to see annual progress reports so that we are able to translate the rhetoric and aspiration of early intervention into real change."

Chris Cuthbert, Head of Strategy and Development for Under 1s, NSPCC, Oral Evidence

Work should continue on new outcome measures to assess progress. DfE/WAVE Trust did innovative work on this in their report *Conception to age 2 – the age of opportunity*, as are WAVE in their Pioneer Communities project to prevent child maltreatment. Good progress is being made with perinatal mental health indicators.

"Through the Department of Health's research and development directorate, we've commissioned the National Perinatal Epidemiology Unit at Oxford University to develop and test a perinatal mental health indicator, which would reflect the mental health care a woman receives at certain critical perinatal time points - the antenatal booking, the early postnatal period, and approximately one year postnatal. The intention is that this indicator will be available for inclusion in future revisions of the NHS and Public Health Outcomes Frameworks."

Karen Todd, Maternity Services Manager, Maternity and Starting Well section, Dept of Health, Oral Evidence

Particular concern was expressed about the need for effective strategies to prevent child maltreatment – and for these to be backed up by effective delivery

"The same applies to the meaningful commitment to primary prevention of child maltreatment which absolutely has to have a strategy that has to deliver, that they're reducing maltreatment and demonstrating that they're doing it."

Dr Alain Gregoire, Psychiatrist, Chair of the Maternal Mental Health Alliance, Oral Evidence

... and for CCGs to be held responsible for that delivery.

"CCGs in areas which have been identified as having high levels of child abuse and maltreatment should be held to account if services are not commissioned to reflect the areas' need."

British Association for Counselling and Psychotherapy (BACP), Written Evidence

In the case of the '1001-days' strategy, strong partnership participation across a range of public or publicly commissioned agencies is key. It needs to be inspected on a joint inspectorate basis as is currently being developed by the DfE working with OFSTED, CQC, Inspectorate of Constabularies, HM Inspector of Probation and others for children's services.



Children affected by dysfunctional families are rarely the result of one problem. Just as with the Government's potentially 'game changing' Troubled Families programme we need a multi-agency approach to develop local '1001-days' strategies. To make sure that it is effective we need a '1001-days' strategy scorecard to report its progress transparently and a rigorous multi-agency inspectorate approach to gauge its quality.

The importance of strong inspection procedures for the 1001 days would build on the recommendations of the Munro Review of Child Protection, whose Recommendation 3 is '*The new inspection framework should examine the child's journey from needing to receiving help.*'⁷⁸ The evidence presented in this Inquiry strongly indicates that identification of need should take place before the child is harmed, not after. Thus inspection should look closely at, and report on, the primary prevention measures which would deliver this result.

Just as effective prevention needs a multi-agency approach, so it is necessary to address this with a multi-agency inspection structure. This, too, builds on Munro, in terms of both how (by whom) and where (of whom) inspection is carried out.

Concerning the 'by whom' the Review states that child protection is a complex area of multi-agency working and that the ideal solution might be multi-agency teams from OFSTED, The Care Quality Commission, and HM Inspectorates of Constabulary and Probation, who would jointly inspect the various aspects of safeguarding and child protection in each area.

In terms of where, her Recommendation 2 states: '*The inspection framework should examine the effectiveness of the contributions of all local services, including health, education, police, probation and the justice system to the protection of children.*'⁷⁹

Recommendation 5

Build on the 'Early Help' recommendations of the Munro Review by requiring and supporting all relevant agencies in prevention to work together to prevent child maltreatment and promote secure attachment.

Presaging the thrust of this report, Dame Eileen Munro's Review of Child Protection clearly states, in the section 'Sharing the provision of early help', that '*Preventative services can do more to reduce abuse and neglect than reactive services.*' The report goes on to recommend that Government place a duty on local authorities and their statutory partners to secure the sufficient provision of local early help services.⁸⁰


Munro Recommendation 10: The Government should place a duty on local authorities and statutory partners to secure the sufficient provision of local early help services for children, young people and families ... against the local profile of need set out in the local Joint Strategic Needs Analysis (JSNA).⁸¹
Munro Review of Child Protection, WAVE Trust, Written Evidence

This report repeats that recommendation, with a particular emphasis on the word 'sufficient'. This is not the case at present in any area in the UK of which we are aware. In fact evidence submitted suggested quite the opposite.

"Our child protection system is disgraceful, we wait for children to be harmed and then we intervene by creating more harm. It is unbelievable in a civilised society and it must be changed."

Dr Alain Gregoire, Psychiatrist, Chair of the Maternal Mental Health Alliance, Oral Evidence

Nor is our system of intervention considered to be effective.



“Currently our child protection system is geared towards responding to one-off incidents rather than chronic problems, towards undertaking assessments of need as a mechanism to gate keep scarce resources, and encouraging universal professionals to refer on concerns rather than taking action themselves.”

Kate Mulley, Director of Public Policy, Action for Children, Written Evidence

The scale of the problem is not small, and is a particular problem for infants. As noted in the prologue, a very high proportion of serious case reviews relate to babies under 1 and 20% of babies are living in families with domestic violence, mental illness or substance abuse.⁸²

The UK is a signatory to the UN Convention on the Rights of the Child, which states:

- Article 19:** 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.
2. Such protective measures should include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention.⁸³ *UN Convention on the Rights of the Child*

Effective prevention measures should be in place in every local authority and should be a clear statutory requirement.

“... this [is an] unacceptable (and profoundly costly) harm to our youngest children. Our actions as a society must prove that we really do find all child abuse, neglect and toxic childhood environments intolerable . . . by no longer tolerating them”.

Sir Harry Burns, former Chief Medical Officer, Scotland, Professor of Global Public Health, Strathclyde University, Written Evidence

Pioneer Communities project

WAVE Trust submitted evidence describing a comprehensive approach to the primary prevention of child maltreatment of children aged 0-2, which they propose to test in six Pioneer Communities, each of 50,000 population, over the 5 years of the next Parliament. Communities would be selected on the basis of the quality of commitment by local authorities and their Health partners to sustained delivery of a preventive approach within a rigorous, research-evaluated framework. The intention is to demonstrate that major reductions in maltreatment can be made in a short timescale, and will deliver significant cost benefits to society.

Interventions will have three main stages: 1) assessment of risk, to identify families most in need of support (e.g. due to domestic violence, or where parents were themselves maltreated as children); 2) targeted support by midwives, children's centres, health visitors and trained professionals, backed by community engagement and support; 3) monitoring and assessment of childhood aggression at age 2-3, Disorganised Attachment (children with complex and often fear-ridden responses to stressful situations, and a surrogate for serious maltreatment) at 15-18 months, Parental Sensitivity and Mentalisation (ability to understand others' feelings), followed by a second opportunity for support.

The risk analysis, carried out mainly by a boosted workforce of midwives and health visitors, will look for known risk



factors for maltreatment, and in particular (i) parents who themselves were abused as children; and then families where there are issues with (ii) domestic violence, (iii) substance abuse, or (iv) mental ill-health.

Support for families will be provided in each of these areas, through programmes with evidence or science-based underpinning. Community engagement, backed by a proven approach called Asset Based Community Development (ABCD) will have a positive focus, building community support for successful parenting with a theme such as 'Happy, Healthy Babies; Happy, Healthy Relationships'.

The project has cross-party backing from each of the three main political parties in the UK, and as of early January, thirteen local authorities in the UK had expressed interest in becoming Pioneer Communities. WHO has expressed support for the project and possible interest in taking the approach to other European countries. Management of the project would reside in a multi-agency Pioneer Partnership Board in each local area, and be backed by an already formed national Local Authority Advisory Board consisting of over 20 CEOs, Directors of Children's Services and Directors of Public Health.

Recommendation 6

Appoint a Minister for Families and Best Start in Life with cross-departmental responsibility, drawing together all relevant departmental ministers, with a remit to draw up a '1001-days' strategy Masterplan within 12 months of the election. The Minister should either be in the Cabinet or reporting directly to Cabinet.


Just as the Munro Review stressed the necessity to have effective multi-agency working at local level, so a national shift to an emphasis on prevention and ensuring that at the end of 1001 days children have the social and emotional skills that form a strong foundation for good citizenship will require good inter-departmental co-ordination at Ministerial level. Further, since support to families is the vehicle for success with this strategy, and has the purpose to give children the best possible start in life, we propose that this Minister should be called the Minister for Families and Best Start in Life.

Given, further, that driving a national shift to a philosophy of primary prevention in the early years will require dedicated leadership, and that senior Ministers in Departments such as DCLG, Education, Health and the Treasury have their hands full with other responsibilities, a Minister for Families and Best Start in Life will be able to give the time and focus that this role requires. To ensure adequate priority of support from the major ministries to what will be for them, as for local areas, a major change in historic priorities, this Minister should either sit in the Cabinet (ideally) or report directly to Cabinet. This will demonstrate the meaningful commitment of the government of the day.

"A Cabinet-level Minister for Families to lead genuine integrated, multi-professional, cross-departmental approach to service provision will need a status with sufficient power to ensure that the Department of Health, Department for Education, Social Services and most importantly the Treasury genuinely prioritise families and their role/work in raising children. The position of the Treasury and fiscal policy is key to ensuring ordinary families are supported with their work as parents in providing the close, consistent, and responsive care of their children in the first three years."

Lydia Keyte, What about the children? Oral Evidence

In the 2014 DH study of why local areas were not investing in prevention,⁸⁴ carried out by WAVE Trust, the second-highest ranking reason given after lack of money, was absence of local and national leadership. The importance of the leadership or co-ordinating role in ensuring a national switch to prevention is reflected in the advice of the World Health Organisation, in its recommendations to European governments that they switch to prioritising preventive strategies.⁸⁵



“Substantial gains in preventing child maltreatment can be made by coordinating actors in multiple sectors. Leadership to harness these strengths should be provided by national and local governments. An important first step is to develop and review any existing action plans in relevant sectors.”⁸⁶

WHO (2014) Investing in Children: the European Child Maltreatment Prevention Action Plan 2015-2020

The Prevention Action Plan also draws on WHO’s wide international experience to stress the value of robust national co-ordination, even where implementation is largely at local level:

“Action plans or policies are more effective if there is a national coordinating framework that is multisectoral and properly funded, if progress in implementation is monitored and if feedback on their impact on maltreatment is provided.” At the same time the need for local participation is also recognised: “Local authorities are critical players in implementation at the municipal level and their engagement in the development and implementation of plans and programmes is essential.”⁸⁷

In line with this advice, and the evidence provided by experts, to the Inquiry, we recommend that the Minister be given a remit to draw up a ‘1001-days’ strategy Masterplan within 12 months of the election.

Recommendation 7

Make joint inter-agency training on the importance of the early years for social and emotional development, for all professionals working with children and families in the early years, a priority in the ‘1001-days’ strategy

It is essential to a successful ‘1001-days’ strategy that all professionals, practitioners and support staff, who work with families with young children, are well qualified, emotionally skilled and understand the critical importance of very early life. Their training and preparation should include such key elements as understanding the nature of infant brain development and sensitive periods, or ‘windows’; the impact of perinatal mental health issues (including ante- and postnatal depression and anxiety); the value of attunement and secure attachment; and the intergenerational nature of many issues that arise during this period, including maltreatment.

“[There is a] ... need for a strong and capable workforce, who are trained, supported and supervised to develop strong relationships with parents, and deliver effective work to improve infant outcomes.”

NSPCC, Written Evidence

The importance of a primary preventive approach, i.e. preventing harm before it happens, should be at the core of this training. Ailsa Swarbrick, the National Unit Director for Family Nurse Partnership, stated in written evidence: “It’s very important that all practitioners understand primary prevention principles. Within the FNP national unit we did work a while ago around this, called PREview, which aims to help practitioners tailor their offer according to the factors that are evident. It would also be important that any graduated/ targeted offer is built on a strong basic/universal offer that has primary prevention focus at its core.”⁸⁸

The training should extend beyond early years’ professionals to the wider workforce, including GPs and other health professionals, schools and other services likely to come into contact with families in the early years.

“Health service commissioners and providers should encourage all midwives, health visitors and GPs to undertake regular refresher training in perinatal mental health. This should be part of the local perinatal mental health strategy.”⁸⁹

NSPCC Prevention in Mind – Spotlight on Perinatal Mental Illness, Written Evidence



Beyond specific training for professionals, there should be joint, inter-agency training to ensure all of the services that might be working with the same family share an understanding of the needs of that family:

"Multi-agency training by good quality trainers of all obstetricians; hospital and community midwives; student midwives; GPs; health visitors and student health visitors and Children's Centre staff in how to engage empathically; listen skilfully; and move away from "top-down expert" approach."

Family Links' Written Evidence

Co-ordination of and communication between services and agencies is extremely important for families in the earliest years, particularly those experiencing complex situations of suffering. These families require a multi-disciplinary approach with all involved working together.

"Professionals must work together to provide continuity of care in the perinatal period. A shared culture around infant mental health could bring a philosophy shift regarding parenting and development. Change in policy and culture of provision is needed."

Tessa Baradon, Anna Freud Centre, Written Comment

There should be clear, integrated pathways between health and other support services, including GP services, midwifery, health visiting, children's centres, voluntary sector support, infant and perinatal mental health services. Commissioning of services should specify good and appropriate supervision for practitioners. Good training on its own is not enough. It should be supported by quality clinical supervision, undertaken regularly and supported by clinically-trained professionals.

"Midwives need to have more time for reflection; there are some who have had only one session of formal supervision this year."

Earl of Listowel, Oral Comment

"To support families effectively the workforce must be effectively supported themselves in addition to their other training".

Stella Acquarone, Parent Infant Clinic, Oral Comment

In support of this, the Health Education England Mandate should prioritise reflective practice and clinical supervision for all early years' professionals:

"Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice, aiming to identify solutions to problems and improve care."

Jacque Gerrard, Royal College of Midwives, Oral Comment

Recommendation 8

Children's centres should become a central source of support for families in the early years with access to multi-agency teams and multiple on-site services including health visiting, GP services, housing, finance, parenting classes, birth registration, library and other community services.

Children's centres could and should become a central point of contact and support for families in the first 1001 days. If most antenatal care could effectively be provided within children's centres, parents would benefit from multi-agency teams and become familiar with the wide range of services that is available in multi-agency children's centres before the birth.



"Therefore more investment in excellent multi-agency Children's Centres (midwife, GP, health visitor and Children's Centre staff; birth registration; infant massage; CAB etc.) rather than cutbacks, would increase the chances of children having the best chance of healthy development, physically, emotionally, mentally and socially."

Family Links Written Evidence

Not only would this type of Children's Centre support optimal development of all children, it would allow a community of parents to develop a network of peer support.

"Using children's centres and other community settings to reduce the social isolation of parents and encourage the development of supportive community networks."

Royal College of Midwives, Written Evidence

Having several organisations based within and regularly working from one building will support integrated working, allowing for swift referral and increased information sharing.

"[I wondered] ... whether the way ahead is to try and bring many of these services around early years ... under one roof. So you've got professionals who are hot-desking, who can then refer somebody who's perhaps coming for a completely unrelated interest, or have been in an outreach service, or is a health visitor who is visiting, but where there are clearly perinatal mental health issues that can then be referenced on, signposted on to another professional."

Tim Loughton MP, Oral Comment

Often, families with the most complex lives are the least likely to access any services at all. If children's centres offered multiple services, such as birth registration and health services, it may increase the likelihood of the families most in need of support coming into contact with the services. Provided that the workforce is skilled and well qualified, support could be available for these families within children's centres.

"Many of the families experiencing the most significant problems don't access services. Those that do access services often access children's centres that are not staffed by people who have the necessary skills to address the problems that are presenting."

Professor Jane Barlow, University of Warwick, Oral Evidence

"There are a lot of nice community-based models with volunteer community mothers who work alongside children's centres. Sometimes this is a way of accessing families and bringing them back into the fold."

Professor Jane Barlow, University of Warwick, Oral Evidence

It is essential that families receive the right support, in the right place, at the right time during the 1001 critical days. If services are fragmented, or situated in areas that are not accessible to families, or stigmatising, they will simply not be supporting the optimal development of children.

"The key is to put families first, with a coherent set of services around families with a natural set of connections within the community. [It is] Important that there's coherence right up until pre-school and formal education, with a common set of objectives."

Professor Pasco Fearon, UCL, Oral Evidence



Recommendation 9

Research evidence and good local area data are necessary to ensure effective changes are implemented to services. Where data and evidence are not available, these should be prioritised and supported with appropriate funding.

Robust research evidence is vital to inform effective change and allocate limited resources efficiently. Throughout the Inquiry recurring themes arose about the importance of data and research evidence. Evidence is needed to ensure that changes implemented are effective. Data need to be available across authorities and services to facilitate detection and support of vulnerable women and children. Research is necessary to ensure appropriate tools are used for the assessment and identification of psychological and social risk.

“Better research and evidence so that we know what we are commissioning. It is the key to effective investment of restricted funds.”

Ailsa Swarbrick, Family Nurse Partnership, Oral Comment

Fundamental to this is the availability of data. If data are not available and shared across authorities, it is difficult to gauge the importance and extent of risk factors that contribute to poor outcomes – essential to inform and develop effective services.

“The NSPCC tried to analyse the exposure of babies to risk factors and were shocked to find there were no national estimates of those levels of exposure to drug and alcohol misuse, domestic abuse, et cetera. It’s crucial that when local areas develop Joint Strategic Needs Assessments they have this data if we’re going to develop the best services for vulnerable families.”

Chris Cuthbert, NSPCC, Oral Evidence

In some areas there is a notable lack of research evidence, such as on the primary prevention of child maltreatment and prevention and treatment of perinatal mental health problems. The need for more research in these areas is clear and should be prioritised for funding. Among specific topics raised in evidence, Professor Sir Denis Pereira Gray made a strong request for further research into the levels of cortisol found in children under 3 in the main settings in which they spend time.

“There is practically no research on the primary prevention of maltreatment in the UK and that’s a huge problem... The outcomes of services like the Family Nurse Partnership are better known but we don’t yet know what the ask is or what the purpose is of our universal services and how we could tweak universal services best to reduce child maltreatment.”

Professor Mark Bellis, Liverpool John Moores University, Oral Evidence



PART II: ESSENTIALS OF A GOOD LOCAL PRIMARY PREVENTION APPROACH

Introduction

Prevention is better than cure; in terms of offering help to vulnerable and stressed families in the first 1001 critical days it is also much cheaper, more effective and, since in large part this refers to reducing the chances of maltreatment, it carries an obvious ethical imperative.

Essential elements of a good local primary prevention approach should include:

1. Good universal services
2. Central role of children's centres
3. Universal early identification of need for extra support
4. Good antenatal services
5. Good specialised perinatal mental health services
6. Universal assessment and support for good attunement between parent and baby
7. Prevention of child maltreatment

1. Good universal services

Universal services are the lynchpin of early intervention, from conception onwards. They provide an early warning system for future social and emotional development and as such are the most important in terms of their contribution to a range of such adult services as social care, the judicial system and many aspects of the NHS. Because universal services are 'invisible', they carry no stigma while providing access to all families. It is therefore essential for these professions to have the right training and support and not be overwhelmed by caseloads too large to give practitioners a realistic opportunity for forming good working relationships with clients. Relationships are as much the key to interventions in the early years as they are central to the healthy social and emotional development of all infants.

"Improving infant mental health requires a workforce capable of delivering services to support families where they cannot provide the growth-enhancing environment needed. Those directly responsible for delivering early care and intervention are varied, ranging from highly specialised to those without formal education in the field."

Dr. Tessa Baradon, Anna Freud Centre

Parenting programmes to improve understanding of infant needs should be available and strongly promoted nationally because attendance results in better-skilled and more confident parents. The increasing tendency for babies to be treated as a parental 'joint enterprise' by both parents attending antenatal classes is helping remove outmoded stigma associated with needing to be 'taught' how to be parents.

This opens the door to continuing the support into the postnatal (and even 'child development') period. One example of an initiative which does just this is the Leksand approach, which is very successful throughout Sweden. After 3 years, 46 mothers and 46 fathers were still attending the original Leksand group, which continued to meet for 5 years.⁹⁰ It is now being adopted by other nearby countries. The key to its success seems to lie in the fact that, after initial professional set-up, the groups are run by the participants, and it is they who decide what they want to learn and which speakers they'd like to invite to contribute to their parenting knowledge.

Some young UK fathers are also responding very well to parenting programmes:

"I was scared of coming to a group but I've enjoyed every moment & told my mates. I've done a baby journal & I feel more bonded with my baby. I've learnt massage & I talk to him & I tell him I can't wait to meet him."

Young father, Hull, Family Links, Written Evidence



"The course has helped our relationship & given us confidence to look after our baby together. We talked about breastfeeding & decided my partner would try it as it's better for the baby & she wanted to see what it was like."

Young father, NE Lincolnshire, Family Links, Written Evidence

2. Central role of children's centres

The important role and potentially expanded contribution of children's centres is outlined in Recommendation 8.

3. Universal early Identification of need for extra support

Every mother-to-be should be able to develop a positive relationship with her midwife and ideally there should be continuity throughout the period of pregnancy to birth, followed by a planned handover to the health visitor. It is crucial that training for midwives and health visitors includes a component on emotional and mental health, including the normal course of psychological changes and altered emotional priorities of pregnancy.

Over the antenatal period midwives are in the best position to identify two different but related areas of difficulty: mental ill-health in the parents, combined with other sources of stress known to have the potential to impact negatively the mother's future relationship with her baby. Both areas of risk may require prompt remedial intervention from a range of adult mental health services and those that specifically focus on the caregiving relationship. Particular attention must also be given to identifying where abuse or neglect have occurred in the childhood of the future parents because this is a major risk factor. Specialist midwife teams have an essential part to play here by offering support and continuity to vulnerable mothers, especially those with mental health or substance abuse problems. Identifying some of the issues the most vulnerable mothers contend with can be painful and unsettling for both parties; for this reason it is essential to have ready availability of both good reflective supervision as well as a clear pathway of referral designed to engage appropriate services as soon as possible.


Professor Lynne Murray recommends:

1. Screening for parental mental health problems through the first two years
2. Routine screening for parenting difficulties which should incorporate this domain-specific perspective. Such assessments should be done in relevant age-adjusted contexts
3. Subsequent interventions should target parenting as well as parental mental health, and be domain-specific. They might need to be long-term^{91, 92}

Risk factors

Parental childhood maltreatment	Mental health issues
Domestic violence	Lack of take-up of antenatal care
Inadequate nutrition; poverty	Alcohol/drugs during pregnancy
Persistent anxiety or stress	Smoking

With adequate screening for these risks, followed by timely extra support, even the least likely parents can do very well. Pages 100-116 of *Conception to age 2 – the age of opportunity* report detail potential cost savings from a preventive approach and give actual UK case studies, e.g.



"Case 2 was of a 23-year-old mother, referred when 6 months pregnant, suffering from escalating aggression and anti-social tendencies with a diagnosis of Borderline Personality Disorder. She had lost custody of two previous children. Treatment cost £5,265. The baby is now securely attached to both mother and father and the mother is now studying 3 'A' levels with a plan to seek employment."⁹³

Conception to age 2 – age of opportunity, page 119

In this case, the baby's good start shows how best practice primary prevention services could be key to the successful reversal of a negative family cycle of living and child-rearing. In all the examples given, the absence of intervention was reliably projected to have resulted in highly expensive consequences in terms of the costs of lasting damage to parent and child and the costs to health services of dealing with these.

"Parenting is consistently affected by a whole variety of different risk factors that a family may be facing... the primary vehicle via which these risk factors have their effect on children's development is via the quality of parental care, so parental psychiatric illness, unemployment, poverty, past history of trauma are well known risk factors. The evidence is clear that these risk factors have their impact via the patterns of parent-child interaction."

Professor Pasco Fearon, UCL

4. Good antenatal services

Just as the pregnant mother protects and nurtures the foetus, so there needs to be an array of nurturing and protective services available for parents throughout pregnancy and beyond. In many ways society, in the form of service provision, now has to accept a role that once was mainly fulfilled by the extended family.

"Most antenatal depression or stress goes undetected by health professionals. We need to educate the carers of pregnant women that the pre- and postnatal environments are equally important."

Professor Vivette Glover, Imperial College

Pregnant mothers who are struggling with severe mental health problems need prompt specialised help over the perinatal period, and all those who have contact with them need to be aware of what robust mental health looks like, as well as having the skills to discover when there might be problems. If we ignore the impact of stressful pregnancy on the mother and foetus, the problem is just deferred to a time when the expense of addressing it will be far higher and the time taken to bring about change will be far longer.

5. Good specialised perinatal mental health services

In terms of the provision of specialist adult mental health services, the term 'perinatal' can span pregnancy until the infant reaches age 1.

"This perinatal time is particularly precious because it is a window of opportunity, a time when parents, especially mothers, are highly motivated to make use of help; but it's also a time of extraordinary danger if adequate help is not available. Not having a service is akin to having no A&E and neonatal care available after a bodily crisis. If a parent experiences an emotional crash with no access to help, the forming emotional life of their baby will be damaged, and this damage has long-term emotional and economic consequences."⁹⁴

Dr Amanda Jones, Consultant perinatal psychotherapist, NE London Foundation Trust, Oral Evidence

We recommend that areas formulating a '1001-days' strategy follow the recommendations of The Joint Commissioning Panel for Mental Health guidance for commissioners (http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf).



Adult mental health services are different from those that focus on the caregiving relationship, and the two approaches often (not invariably) need to work in tandem, preferably starting before the birth of the baby. There are many interventions to support the relationship between parents and their small children and generally speaking these are strength-based, can call upon a range of techniques, and are tailored to suit the circumstances. As quoted in the prologue:

“What do we know about the perinatal period? Well, what we do know is that childbirth is a trigger for serious mental illness. A woman, after she gives birth with her first pregnancy, is 33 times more likely to be admitted to a psychiatric ward than at any other time in her life. We know that women who have had a previous history of a psychotic episode in the postnatal period have a 50% chance of relapsing. So these are the women we can work with in terms of prevention.”⁹⁵

Dr Liz McDonald, Royal College of Psychiatrists, Oral Evidence

You do not have to be a ‘therapist’ to be therapeutic, and health visitors, especially with the current initiatives of ‘health visitor champions’ and their role in delivering the Family Nurse Partnership programme (as demonstrated above), are well placed to intervene from a basis of having a pre-existing relationship with the family.

6. Universal assessment and support for good attunement between parent and baby

Ensuring good attunement between parents and infants (i.e. parents being sensitive to infant cues and setting up a good ‘serve and return’ interaction in which the baby is leading) is a critical step on the pathway to good relationships between parents and babies. To some parents this comes naturally, but many can benefit from outside support. We recommend universal assessment of the quality of mother-baby interaction at 3-4 months of age, normally by specially trained health visitors. When this identifies parent-infant pairs who would benefit from support to improve attunement, this should be followed (depending on need) by either video interaction guidance or parent-infant psychotherapy.

Video interaction guidance has also been successfully used to improve sensitivity and decrease the amount of disrupted communication between mothers and babies with feeding problems; and a slightly modified version has been shown to help mothers with postnatal depression re-connect with their babies. These need to be supported by the good perinatal mental health support systems referred to above as parents are unlikely to provide secure attachment while still struggling with issues of mental health or their relationship with the child.

7. Prevention of child maltreatment

The prevention of early childhood maltreatment is a key task of primary prevention, and the first 1001 days provide the most cost-effective window of opportunity. Many situations of potential risk can be easily identified and help provided before a baby suffers or a negative response becomes embedded within the family dynamic.

Maltreatment in infancy is particularly pernicious as the quality of the environment at this stage of greatest neural plasticity can be seen as an evolved way of programming the mind for survival in future adverse conditions.

Efforts to prevent child maltreatment should include the following principles:

- Universal risk assessment in pregnancy
- Targeted support addressing the major risk factors
- A community-led universal drive to raise parenting skills and improve child outcomes
- Further assessment of parent-infant interaction during the first year
- Monitoring of changes in outcomes in the second year and beyond

“So much time and money is spent addressing individual dysfunctions whereas what should be done is to intervene meaningfully at the source. Any child who is chronically frightened will fail to thrive and achieve. Making children safe and loving them is where health and wellbeing begins.”⁹⁶

Kids Company, Written Evidence



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All Party Parliamentary Group for
Conception to Age 2 – The First 1001 Days

Conception to Age 2: First 1001 Days All Party Parliamentary Group

PERINATAL INQUIRY – EVIDENCE SESSIONS ON FIRST 1001 DAYS

Recommendations for the promotion of optimal development in the first
1001 days to give every baby the best possible start in life.



Tackling the roots of violence

