

NSPCC Scotland Policy, Practice and Research Series

Infant Mental Health: The Scottish Context

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NSPCC Scotland and Infant Mental Health

Supporting infants and their parents is a key priority for the NSPCC. This is reflected in the services we provide and in our influencing work. Our All Babies Count campaign was launched in November 2011 (<http://allbabiescount.nspcc.org.uk>). Working with partners, over the next few years we are committed to developing, delivering and testing pioneering models of intervention to help ensure that all babies have the best start to life. In Scotland we are testing the effectiveness of infant mental health interventions within two services, the New Orleans Intervention Model (NIM) and Minding the Baby, in Glasgow and East Ayrshire respectively.

In partnership with NHS Greater Glasgow & Clyde, Glasgow City Council we are undertaking the first UK pilot of the New Orleans Intervention Model. We will test the effectiveness of specialist infant mental health services as part of an integrated model of support and assessment for young children (from birth to 5 years) and their families, where the children are in foster care. With Scottish Government funding, a randomised control trial of the intervention is being carried out by the University of Glasgow.

Minding the Baby is an intensive home visiting programme for high risk first time pregnant women and their families delivered by a team which includes a specialist children's nurse and an NSPCC registered social worker. Delivered in the home from the third trimester of pregnancy until the baby reaches the age of two, the programme aims to promote positive physical health, mental health, life course and attachment outcomes in babies, mothers and their families. It is based on theoretical frameworks drawn from attachment theory and current understanding of infant brain development.

Based on the learning from these and all our services we seek to achieve cultural, social and political change – influencing legislation, policy, practice, attitudes and behaviours so that all children in Scotland have the best protection from cruelty.

1. INTRODUCTION

1.1 Aims

Over the past few years the Scottish Government (SG) has made a priority of mental health in the early years, including infant mental health.

The purpose of this briefing is to:

- provide an overview of national infant mental health policy since devolution;
- consider whether agreed objectives have been achieved, and identify gaps;
- present NSPCC Scotland's views about what more needs to be done to meet the needs of infants at risk.

We welcome feedback on this briefing. You can contact us at: Scotland@nspcc.org.uk

1.2 The Policy Context

The preparation of a new Mental Health Strategy for Scotland (2012-2015), combined with plans for a Children's Services Bill, provides a good opportunity to assess the state of play in relation to infant mental health in Scotland.¹ The need for 'critical action' in this area was highlighted by the 2008 Review of the National Programme for Improving Mental Health & Wellbeing.² This called for the roll-out of evidence-based universal and targeted programmes for children and their families from pre-birth to age five.³

It is a clear advance that infant mental health is now firmly embedded in Scottish public policy. Its promotion forms part of the current national mental health strategy, *Towards a Mentally Flourishing Scotland* (2009).⁴ The overarching policy framework for this is provided by GIRFEC (2006)⁵ the integrated interagency approach for improving outcomes for children, and the linked social policy frameworks for the Early Years (2008)⁶, health inequality and child health (*Equally Well*, 2008, HALL 4, 2011)⁷, and poverty (2008, 2011)⁸. These have been developed by more focused strategies and action plans such as the *Early Years Parenting Task Group* (2008)⁹, *Pre-birth to three* (2010)¹⁰ and *A Pathway of Care for Vulnerable Families 0-3* (2011)¹¹.

Each of these areas of social policy has been informed by evidence about attachment and infant brain development.¹² They are also rooted in a social model of mental health, and an understanding that social, economic and geographic inequalities in the birth and life circumstances of children significantly amplify the risk factors including the risk of mental health problems.

1.3 The importance of infant mental health

When we talk about infant mental health care we mean interventions which:

- improve and enhance the wellbeing of the mother and of the baby and promote the mother-infant bond;
- take into consideration the psychosocial aspects of pregnancy;
- promote good early parent-child interactions and attachment;
- support the problem-solving skills of the parents;
- involve fathers and mothers.¹³

We know that health inequalities have their origins before birth. More than a quarter of babies in the UK are born into families with multiple problems. These early adversities can have a cumulative effect on babies' developmental outcomes, often with life long effects. Scotland is a very unequal society, with high levels of poverty and disadvantage. A third of children in Glasgow live in poverty (34%, Scotland 19%) and in 2009 almost half were from families with very young children (ages 0 – 4years).¹⁴ Nearly 60% of women giving birth in the city live in the most deprived circumstances and almost 17,000 families were classed as vulnerable in 2008, using Health Plan Indicator data.¹⁵

We also know there is a higher incidence of maltreatment in infancy than in any other year in the life cycle. A growing number of 0-2s in Scotland require compulsory measures of supervision for safety and welfare reasons. This age group is the single largest subject to Child Protection Orders, and infants less than 20 days old comprise the largest sub-group¹⁶. According to the Children's Reporter, the reasons are usually complex, but tend to involve domestic violence, parental substance use and parents, for a range of reasons, being unable to provide a safe and stable environment.¹⁷

Human infants are physically and developmentally immature at birth. The first weeks and months of life are a time of rapid brain development; babies are acutely attuned to those who care for them, and this intimate social interaction plays a crucial role in their early emotional, social and cognitive development. At this stage the effects of early adversities on the developing brain can be profound and enduring.¹⁸ This is especially the case for those parts of the brain involved in memory functioning, stress responses, attention, language, planning and social interaction.^{19 20} The Infants Suffering Significant Harm study found that by the age of three, almost half of infants who had suffered maltreatment in the first six months of life had developmental problems or showed signs of behavioural difficulties, with speech problems and aggression prominent.²¹

And we know a great deal about the longer term outcomes. Maltreated children have a higher incidence of mental health problems including conduct disorders²², and suffer poor educational attainment, with consequences for their future livelihoods. Between a third and 90% of children who offend have been found to have some form of past or current maltreatment.²³ Individuals who suffered early maltreatment are also significantly overrepresented within the population of adult offenders²⁴ and drug and alcohol abusers.²⁵

In Scotland we have a public health approach to caring for children and protecting them from harm. It is an approach founded on a continuum of support for children and families, from universal services through to targeted support for those who need it.²⁶ Preparing and supporting new parents to care and interact with their babies, and to form strong healthy attachments is the fundamental building block. Research shows that healthy parent-child attachment is the most important protective factor for infants, and that the quality of the parent-child relationship is a strong predictor of outcomes for children.²⁷

Infant mental health care, comprising primary, secondary and tertiary interventions, should be an essential part of our universal service provision. Improving attachment is central to promoting good mental health and wellbeing for all babies. Where infants have experienced maltreatment the evidence shows that recovery can be rapid if safe nurturing care is achieved early enough, ideally in the first year of life. The benefits of this can be intergenerational.^{28 29} Early identification and support is essential and our universal early years professionals - midwives, health visitors and GPs - are crucial role in this.

¹ A separate analysis of Child Protection Orders (CPOs) in Edinburgh in 2006-07 found that 60% of all children subject to CPOs were under 2 years old. Just under one third were newborns (30%).

In Scotland the body of evidence referred to has guided policymakers towards the need for 'preventative spending' and a commitment to shift resources towards promotion, prevention, early detection and help.³⁰³¹ Research points towards the need for greater emotional support and care for all women during pregnancy, but particularly for those living with known, and often multiple adversities.³² It has also produced an emphasis on parenting. For the 0-3 age group this means helping parents give the sensitive, responsive and consistent care needed to promote good parent-child attachment and healthy infant development.

All this is already policy. The test of our national frameworks, strategies and policies is whether we are actually identifying and responding effectively to the needs of our most vulnerable infants and families. This is a challenge at any time, but particularly in a time of fiscal austerity.

To assess our progress, it is helpful to retrace the policy journey since devolution.

2. INFANT MENTAL HEALTH IN POST DEVOLUTION POLICY

Table 1 - Infant Mental Health: Policy Timeline 1999-2009

Year	
2000	Scottish Executive commissions a Needs Assessment and strategic review of children's & young people's mental health.
2001	A National Programme for Improving Mental Health & Wellbeing (the 'National Programme') is established by the Scottish Executive.
2001	The Vulnerable Infants Project (VIP) at the Princess Royal Maternity Hospital, Glasgow is established with short-term Scottish Executive funding.
2002 – 2005	Report of the Audit & Review of Child Protection. A 3 year Child Protection Reform process is undertaken.
2003	The SNAP Needs Assessment Report is published. It presents a strategic vision for child & adolescent mental health services.
2003	Improving Infant Mental Health (Early Years) is one of the 6 priorities of the National Programme Action Plan for 2003-2006.
2004	HeadsUpScotland, the National Project for Children's and Young People's Mental Health is launched.
2005	The Mental Health of Children & Young People: A Framework for Promotion, Prevention, and Care (FPPC) is published. Its purpose is to help local agencies plan and deliver integrated services.
2005	Strategic Review of the CAMH Workforce.
2005	HeadsUpScotland appoints a Short Life Working Group on Infant Mental Health.
2006	A 3-year National Infant Mental Health Project is created as part of the National Programme. Its remit is to develop training for frontline staff working with children.
2006	The Short Life Working Group on Infant Mental Health delivers its report, in two parts.
2006	Delivering for Mental Health, the Scottish Executive's mental health delivery plan, is published.
2006	Getting It Right for Every Child (GIRFEC) is introduced.
2005-2006	The National Programme funds research into the effect of the Mellow Babies intervention.
2007	Infant Mental Health: A Guide for Practitioners is published. Produced by HeadsUpScotland's Short Life Working Group, it presents models of good practice and guidance to inform the work of public agencies.
2006-2008	NHS GG&C pilots inequalities sensitive practice within its maternity services, as part of a Scottish Executive funded programme.
2009	The Early Years Framework is published.
2008-2009	The Scottish Parliament Health & Sport Committee Inquiry into CAMHS investigates progress in implementing the 2005 Framework for Promotion, Prevention and Care, three years into a 10 year implementation plan.

2.1 Phase One: The National Programme and HeadsUpScotland

The mental health of children in infancy and the early years has been the subject of national policymaking since the early years of devolution.

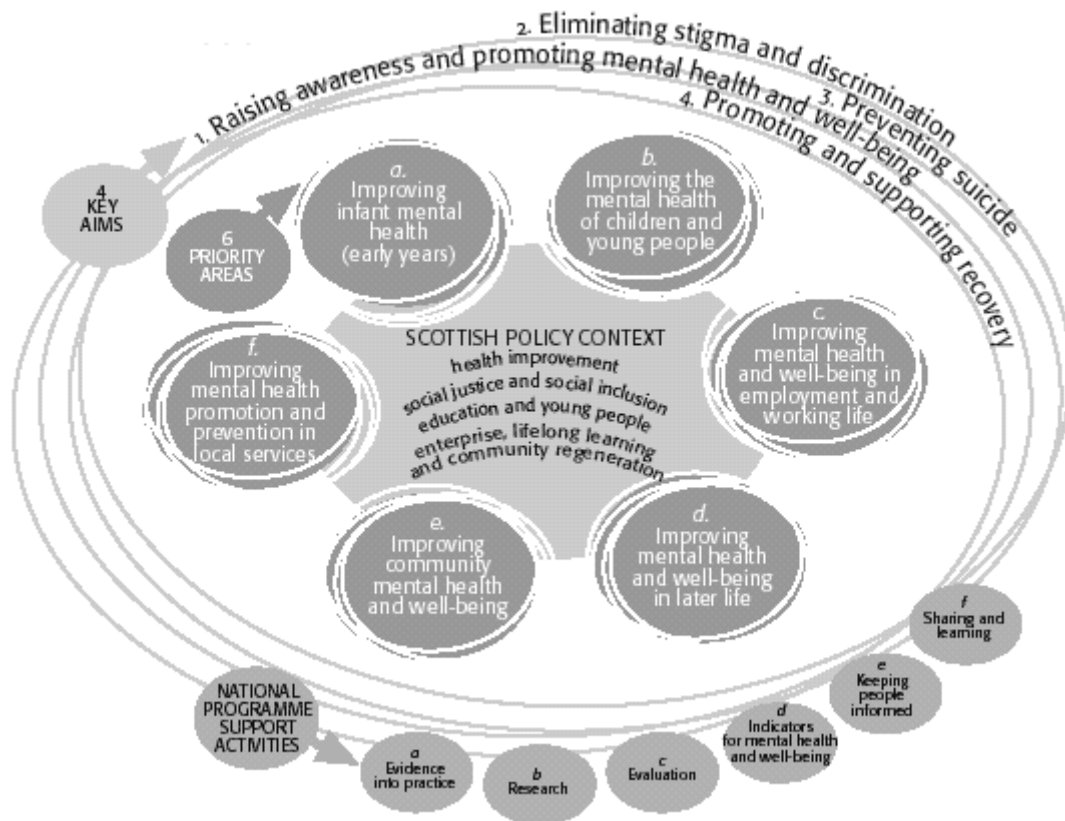
A national needs assessment of children and young people's mental health was commissioned by the first Scottish Executive (SE) as part of the Scottish Needs Assessment Programme (SNAP).³³ The National Programme for Improving Mental Health & Wellbeing, was created by the SE in 2001, with 'Infant Mental Health (Early Years)' one of its 6 priorities.³⁴ The position of infant mental health within the National Programme is shown graphically in Figure 1, below. At around the same time, the Vulnerable Infants Project at Glasgow's Princess Royal Maternity Hospital was established with SE funding.²

The challenge set for the Infant Mental Health work-stream of the National Programme was how to integrate mental health promotion and prevention into the work of Early Years services. The following were identified for action: ante-natal care; parenting programmes; identification & early intervention on post-natal depression; targeted home visiting, and support in the community, through family centres and playgroups.³⁵ A number of local infant health mental projects across Scotland were supported by the National Programme at this stage.³⁶

Work on infant mental health became the responsibility of HeadsUpScotland, the national project created by the National Programme in 2004, to lead developments in child & adolescent mental health. The Scottish Needs Assessment Programme (SNAP) report, published the previous year, had presented a strategic vision for child and adolescent mental health services.³⁷ Helping local agencies implement the SNAP report was one of the key functions of HeadsUpScotland. To assist with this, A Framework for Promotion, Prevention and Care, appeared in 2005.³⁸ It was designed to be used by local agencies, particularly NHS Boards in Scotland, as a planning and audit tool (see below). A parallel strategic review of the CAMH workforce addressed the capacity issues around implementation.³⁹ It recommended doubling the size of the NHS based CAMHS workforce by 2015, and identified the education, training and skills development needed to deliver an appropriate pattern of services.

² This joint midwifery/social work service meets the needs of pregnant women with social problems including addiction issues, providing liaison between maternity, paediatric, primary care, social and addiction services. Women are referred ante-natally with more intensive input after delivery.

Figure 1: Infant Mental Health and the National Programme, Phase One, 2003-2006.



Source: Scottish Executive (2003) Annexe 1.

The SNAP Needs Assessment (undertaken 2000-2003) was led by an Expert Group chaired by Dr Graham Bryce, Child & Adolescent Psychiatrist at Yorkhill NHS Trust. It provides a national overview of child and adolescent mental health provision. The needs assessment exercise involved NHS Boards, local authority social work services, and occupations working with children and young people across a range of services Scotland-wide. Importantly, children, young people and their parents also participated.

The SNAP report adopted the following basic principles:

- **Mental health promotion is the responsibility of everyone in contact with children;**
- **children's rights form a core value of mental health services;**
- **work on prevention, treatment and care should be needs-led;**
- **we need to main-stream mental health into children's services;**
- **a coherent combination of promotion, prevention, intervention & care is needed;**
- **children's services should speak to each other & work as intelligent networks.**

The SNAP proposals were in tune with the approach adopted in Health for All Children (*HALL 4*) which recommended a holistic approach to child health. *HALL 4* called for screening and surveillance with an emphasis on health promotion, primary prevention, and targeted active intervention with vulnerable families. It also emphasised the need for enhanced health promotion work to inform and educate parents about their child's development and needs so that they can seek the right help when they need it. *HALL 4* also highlighted the need to draw more effectively on the range of regular contacts that children and families have with other professionals, in childcare and education, supported by clear routes for liaison, consultation and referral to health professionals when there are concerns.

In summary, the SNAP Report recommended:

- That mental health ‘promotion, prevention and care’ should be integral to all agencies working with children and young people. Continuing efforts be made to find ways of integrating more fully with the wider network of children’s services, including settings like schools.
- Both a comprehensive whole population approach and targeted specialist services for those with emerging or established mental health difficulties.
- A sustained commitment to building capacity, to overcome the ‘significant mismatch’ between current levels of need and capacity to meet this. This must include development of learning opportunities, contexts for consultation and evolving arrangements for joint working and referral, underpinned by adequate time and resources for workers to achieve these.
- The reshaping, refocusing and increasing of the capacity of NHS specialist CAMHS, moving ‘the centre of gravity’ towards universal services and early intervention, *and improving services to the most vulnerable young people* (our emphasis).
- A strategic review and development plan for the CAMHS workforce to address training needs and recruitment difficulties.
- That NHS Scotland and local authorities make clear, effective arrangements for driving change and securing long term development in this area.

The Mental Health of Children & Young People: a Framework for Promotion, Prevention & Care was produced at a time when development work towards GIRFEC and the Integrated Assessment Framework was already underway. It is the key reference document for all local agencies tasked with implementing improvements in infant, child and adolescent mental health.

The Framework applies from birth to 18 years (and beyond this for some vulnerable groups). Within this context it identifies the key elements of a strategy to promote infant mental health, ante-natally and in the first months of life. It carries forward the public health approach of the SNAP Report by addressing the continuum from primary protection (mental health promotion), secondary prevention (early identification & treatment), to tertiary intervention (support, treatment and care for children experiencing mental health difficulties). It sets out the range of activities involved within universal children’s services; community based services and targeted interventions for those children most at risk of developing mental health problems. This includes children who have experienced or are at risk of abuse or neglect, including children who are or have been looked after and accommodated. It links these to outcomes, and identifies the key multi-agency staff involved in delivery (see below).

The Framework was intended to be taken forward through integrated children’s services planning processes, and as part of community planning, with the aim of all the elements being introduced in each local area by 2015. The then Scottish Executive committed itself to this timescale (in 2006).⁴⁰ It also promised to publish milestones to track progress towards this by early 2007. The SNP administration elected in 2007 also committed itself to full delivery by this date.⁴¹ Community Planning Partnerships and Community Health Partnerships have a responsibility to plan and implement local mental health plans for different life stages with a link to Single Outcome Agreements and NHS targets. They must also develop local mechanisms to measure and monitor progress and outcomes.⁴²

Infant Mental Health initiatives

The two principal infant mental health initiatives taken forward as part of the National Programme and HeadsUpScotland were the creation of a three-year National Infant Mental Health Project (NIMHP), hosted by the Scottish Institute for Human Relations, and a Short Life Working Group on Infant Mental Health, charged with producing guidance.

The aim of the NIMHP (2006-2009) was to embed, as part of the professional culture of people working with early years and their families, an understanding and appreciation of the importance of infant mental health. Its training programmes for frontline staff are now offered nationwide.³

The remit of the Short Life Working Group on Infant Mental Health (2005-2006) was to carry out an evidence review of measures to support good infant mental health and to recommend a strategy to ensure the best outcomes for all babies in Scotland.⁴³ The report it delivered was in two parts. The first of these, an evidence review and proposals for a national strategy, was received by the SE but never published. The second, A Practitioner's Guide to infant mental health, was published by HeadsUpScotland in 2007.⁴⁴ This valuable document considers how the approach and principles of the 2005 Framework can be applied to services for infants and their parents.

Infant Mental Health: A Guide for Practitioners (2007)

The Guide was prepared by the Short Life Working Group on Infant Mental Health, whose members came from health, early education, social services and the voluntary sector. It was chaired by Christine Puckering, Consultant Clinical Psychologist at the Royal Hospital for Sick Kids, Glasgow. Based upon a review of the evidence for infant mental health interventions undertaken by Christine Puckering and Jane MacQuarrie, the Guide made recommendations for best practice at each stage of a public health approach.

Primary and Secondary Prevention:

- **awareness raising and pre-pregnancy education:** good public education for all, education for parenthood within the school curriculum, including teenagers who will go on to become very young parents.
- **training and staffing:** to ensure a common core of knowledge and understanding of infant mental health across disciplines and agencies, including voluntary and statutory sectors.

Tertiary Interventions:

- **working with infants, parents and carers:** providing additional support and more intensive therapeutic interventions for some families.

The Guide gives an account of the variety of interventions and practices in current use and examines the evidence for their effectiveness. Its key recommendations are summarised in Table 2.

³ See <http://www.sihr.org.uk/IMHProj.htm>

The National Programme also funded research into promising interventions. One such was the Mellow Babies intervention to improve mother-baby interaction where mothers are experiencing post-natal depression. With the support of the Programme, a small waiting list controlled trial of a 14-week Mellow Babies group intervention was undertaken involving 17 mothers and infants in the Coatbridge area.^{4 45}

Other related initiatives were funded by the Scottish Executive within the timeframe of the National Programme. The Multiple and Complex Needs Initiative within the Health Service was one of these. This enabled, for example, NHS Greater Glasgow & Clyde to pilot inequalities sensitive practice within its maternity services.⁵ A user engagement survey was carried out with women dealing with a range of factors in their lives, including domestic violence, mental health problems and substance misuse. The survey examined features of ante-natal and post-natal care and support relevant for maternal and infant mental health.⁴⁶

2.2 Phase Two: The Early Years Framework

HeadsUpScotland was credited with playing a positive role in helping mainstream children's mental health into local services.^{6 47} However, mental health in the early years was identified as an area of weakness and the Review of the National Programme, carried out in 2008, called for it to be made a 'critical priority' in the next phase of work.⁴⁸ This conclusion was supported by a review, in the same year, of early years parenting programmes across Scotland. It found that although half of all Scottish local authorities had or were developing parenting strategies, and a variety of parenting programmes were in use in various parts of Scotland, very rarely was infancy the primary focus for parenting support, and few areas had a coherent multi-agency approach to supporting parents from family planning through conception, pregnancy, birth and beyond.⁴⁹

By this stage plans for the implementation of GIRFEC were being taken forward by the new SNP administration. Within the overall GIRFEC approach, mental health in infancy and the early years was advanced as part of the Early Years Framework (2009).⁵⁰ Its renewed focus on the 0-3 age group was linked directly to both child protection concerns and broader issues of economic and social inequality. As part of the Early Years Framework, both the Scottish Government and COSLA signed up to actions to improve infant mental health. These included:

- moving to a parenting model of ante-natal and post-natal support to promote parenting skills and attachment;
- building the capacity of universal services through mental health training for front line professionals, and CPD for early years workers.

An additional political impetus was provided by the outcome of the parliamentary committee Inquiry into Child and Adolescent Mental Health Services (CAMHS). Conducted by the Scottish Parliament's Health & Sport Committee during 2008-2009, the Inquiry looked at the state of CAMHS provision in Scotland and investigated progress to date in implementing the *2005 Framework for Promotion, Prevention and Care*, three years into a 10 year implementation plan. Ten NHS Boards and 7 local authorities submitted evidence.⁵¹

The Committee's Report strongly criticised the lacklustre performance of public agencies in implementing the national strategy for the mental health & wellbeing of children. It concluded that

⁴ This was funded through the National Programme Small Research Projects Initiative 2005-06.

⁵ This was funded through the Scottish Executive's Closing the Gap Opportunity Fund.

⁶ HeadsUpScotland was funded until 2008, when the National Programme ended. For the policy transition after the election of the SNP Government, in May 2007, see Health Scotland (2008) *A review of Scotland's National Programme for Improving Mental Health and Wellbeing 2003 – 2006*. (Edinburgh: Health Scotland), 45.

mental health and wellbeing 'seems not to have been a priority amongst those responsible for delivering the policy', and called on the Scottish Government 'to hold NHS boards, local authorities and responsible officers to account in ensuring that they give this issue the consistent and sustained priority that it requires.'⁵²

Since then, there has been a concerted push to implement the 2005 Framework as part of the Early Years agenda. The Minister for Public Health & Sport set out the government's response to the Committee Inquiry in a letter dated 31 Aug 2009. In response to the concerns raised during the Inquiry:

- the previous approach to reforming public health nursing-health visiting was abandoned and a new approach adopted, led by the Modernising Board for Nursing in the Community.
- new national guidance on HALL 4 was issued which emphasised the degree of flexibility Health Boards retain over the number of contacts health visitors have with babies in their first year, including determination of the Health Plan Indicator.
- there was a renewed drive to increase capacity within CAMHS teams. A national HEAT target was introduced to reduce waiting times for access to CAMHS to within 26 weeks by March 2013.

The changes represented by two recent major reviews of the health visiting and midwifery professions⁷, have been accompanied by structural change within government. The Child and Maternal Health Division of the Scottish Government has been combined with the broader Children's Policy areas dealing with early years and early intervention. The rationale is to achieve closer working between the range of partners and policy areas responsible for improving outcomes for children, with health, education and social care services all accountable to the Minister for Children and Young People.

There has also been a heightened focus on evaluating the effectiveness of interventions and measuring changes in children's outcomes. Recent developments here are:

- The development of a framework of mental health indicators for children and young people (2009-2011) to inform future decision-making (although there are still significant data gaps for the early years).
- The development of a new national dataset, based upon the updated Scottish Woman Held Maternity Record (SWHMR)⁵³ to help with service improvement in relation to inequalities.

3. THE 2005 FRAMEWORK AND INFANT MENTAL HEALTH

3.1 Where are we?

We are now almost three years away from the target date (2015) for implementing the *2005 Framework for Promotion, Prevention and Care* at local level.

The table below records some of the main national policy initiatives of the 2009-2011 period mapped against the recommendations of the *2005 Framework*, and the *2007 Infant Mental Health: A Guide for Practitioners*.

⁷ Midwifery 2020: Delivering Expectations (2010) sets out a vision for the midwifery profession. It is the result of a four nations, UK-wide collaborative programme involving the four Chief Nursing Officers and the Royal Colleges. Available at: http://www.midwifery2020.org/documents/MW2020_EXEC_SUMMARY_MS_WEB.pdf

Table 2 – Recommendations and Action Taken
The Framework for Promotion Prevention and Care (2005)
Infant Mental Health: A Guide for Practitioners (2007)
 (lead agencies/professions in brackets)

Recommendation	Action
<p>Involving expectant parents & prospective adoptive parents in developing the resources & services designed to help them (NHS midwifery services NHS CAMHS, social work services)</p>	<p><i>National Guidance on reducing inequalities in antenatal health care</i> was published in January 2011 to accompany the Refreshed Framework for Maternity Services.⁵⁴ Developed by a sub-group of the Maternity Services Action Group in the context of Equally Well and GIRFEC, the 3 main themes are improving access to antenatal healthcare services, improving the assessment of health and social need, and ensuring equity in the quality of care for women and their babies.</p>
<p>The 2007 Guide for Practitioners advised:</p> <ul style="list-style-type: none"> • imaginative approaches to raising awareness of infant mental health with future and expectant parents • NHS Boards should explore the possibilities for utilising existing commercially backed websites and online baby or parenting sites. • An infant mental health DVD could be produced and given away by health visitors to every new mother. • Adoption of a parenthood syllabus as part of Personal & Social Development within the Curriculum for Excellence. This could involve imaginative use of programmes such as <i>Baby Think It Over</i> (in which pupils care for a computerised model baby for 72 hours), and electronic gaming technology. • Some excellent existing audio-visual resources are recommended for use, such as the Solihull Approach materials. 	<p><i>A Scottish Antenatal Parent Education Pack</i> was launched by NHS Scotland in summer 2011 supported by a national training programme for facilitators.⁸ Developed by NHS Education for Scotland (NES), NHS Health Scotland, and NHS Quality Improvement Scotland (NHS QIS) it is hoped that the pack will help professionals deliver consistent, evidence based antenatal education to all pregnant women and their partners.</p>
<p>Training of primary care staff so they are equipped to:</p> <ul style="list-style-type: none"> • support parents in basic understanding of attachment, • identify risk factors for babies • ensure that parents' own mental health needs are assessed and met (particularly mothers with antenatal or postnatal depression), • know how to access specialist advice and support for parents/babies; • be able to refer direct to specialist NHS CAMHS (NHS CAMHS, NHS midwifery services, social work services, CPD coordinators, pre-school and childcare providers, childcare partnerships). 	<p>The <i>Towards a Mentally Flourishing Scotland Action Plan (2009-11)</i> commits NHS Health Scotland and its partners, to improve the competencies of frontline staff so that they have the knowledge and skills to support infant mental health, with a particular focus on inequalities.⁵⁵</p>
<p>Training of staff in child care settings along similar lines, so that they have a basic understanding of mental and emotional health and development, an understanding of protective factors and how to nurture these, of risk factors and what specialist advice and support is available, referral protocols and pathways for CAMHS.</p>	<p>As part of the <i>Refreshed Framework for Maternity Care (2011)</i>:</p> <ul style="list-style-type: none"> • A Staff Governance Standard has been developed, for use in workforce planning by NHS Boards. This aims to ensure that NHS staff have the competencies and knowledge to be able to support maternal and infant mental health sensitive to inequalities.⁵⁶ • Key Quality Indicators and Outcomes for Maternity Care have been developed that place a focus on inequalities and complex needs. • The Maternity Services Action Group has undertaken related work⁹ as part of its role in supporting local implementation of the Refreshed Framework. It has developed a logic model for improving maternal and infant mental health and emotional wellbeing outcomes and, through this work stream, it has made recommendations for improving maternal and infant wellbeing (Sept 2011).⁵⁷ This is discussed below.
<p>Training so that the staff of adult mental health services are aware of the potential impact on dependents or young siblings.</p>	

⁸ This is delivered through the Scottish Multi-professional Maternity Development Programme. See <http://scottishmaternity.sitekit.net/welcome.html>

⁹ The Maternity Services Action Group was established by the Scottish Government as a time limited group to support the practical implementation of policy across maternity services in Scotland.

The 2007 Guide for Practitioners advised:

- Common core training provided to all staff likely to work with new families to provide a coherent approach across social work, early years, health and education. Workers across the voluntary and statutory sectors are all in a position to deliver messages and support for infants and their families
- Infant mental health be made part of the core curriculum for all courses for public health nurses, undergraduate doctors, midwives, child care and child mental health professionals.
- Standards and core competencies for multi-disciplinary infant mental health training be developed.
- Post qualification training in identification of 'at risk' families be made available to all midwives, public health nurses, GPs, child mental health and child care and education professionals.
- Joint training in, e.g. the Solihull Approach, should be encouraged for the frontline staff who see the majority of mothers-to-be, e.g. midwives, health visitors/public health nurses.
- Joint training for frontline staff delivering perinatal services, so that they can deliver the right messages about the significance of early infant communication, and support for parents to help them understand the capacities of their babies as they grow and change. Training, staffing and awareness raising and pre-pregnancy education also apply here
- Universal services offered by Tier 1 & 2 professionals should have access to specialist consultants from CAMHS for case consultation, supervision and referral as necessary. These professionals would all be expected to have completed the HeadsUpScotland module in Infant Mental Health.

In 2010 Education Scotland produced *National Guidance and Multi-media Resources, Pre-birth to Three: Positive Outcomes for Scotland's Children and Families*.⁵⁸ The Guidance and resources are intended to support the continuing professional development of all early years staff. They incorporate key evidence and information on pre-birth and infant brain development, and the importance of pregnancy and the early months and years. This is delivered in the context of the government policy commitment to early intervention and a focus on promoting evidence-based practice. The guidance sets out the importance of attachment, attunement and transitions. Multi-media resources disseminated through the Education Scotland's Early Years website include filmed conversations with experts in infant brain development including Suzanne Zeedyk, Maria Robertson and Robin Balbernie.⁵⁹

Development and delivery of universal parenting programmes

- To give parents a basic understanding of mental and emotional health & development, an understanding of their own contribution to this, an understanding of protective factors and how to nurture these.
- To increase parents' confidence and coping skills in dealing with their child's behaviour
- To support parents by advising them how to access advice and support.

(SureStart workers, NHS Primary Care team, voluntary sector, NHS CAMHS staff).

In addition to the *Scottish Antenatal Parent Education Pack*, the Scottish Government plans to introduce a *National Parenting Strategy*. This will be consulted on during 2012 alongside the proposed Children's Services and Children and Young People's Rights Bills.

The 2007 Guide for Practitioners advised:

- Brazelton NBAS be demonstrated to parents before discharge from maternity units to raise their understanding of the competence of their babies and the primary significance of relationships from the early days of life. To be completed weekly by parents for first month of life and reviewed by the health visitor.
- Baby massage be offered to all mothers.
- Health visitors should make particular efforts to engage father in the early weeks.
- Public support for the Bookstart initiative should be maintained.
- Health visitors should have available copies of infant mental health DVDs to supply to all new mothers.

Provide support for individual children & families including targeted parenting support

- Key workers have a full understanding of attachment and how to support this.
- Parents have a basic understanding of protective factors, and feel supported in coping and gaining confidence.

(NHS Primary Care team, family centres, social work services, NHS CAMHS)

The 2007 Guide for Practitioners advised:

- Antenatal classes, particularly for vulnerable families, should be offered, e.g., through Family Learning Centres or Sure Start Centres at around 20 weeks gestation concentrating on infant capabilities and parental responsiveness.
- There is no strong evidence that home visiting programmes have specific advantages.
- The Sunderland Infant Programme has been shown to be of value as has Mellow Babies. Both require further evaluation but can be recommended as promising models.

The Scottish Government is committed to a national roll-out of the *Family Nurse Partnership* programme. An initial pilot was established in Edinburgh in 2009, followed by a second, in Tayside, in 2011. An evaluation of the Edinburgh pilot, which is investigating the transferability of FNP's within the Scottish context, is underway. An interim report of the evaluation was published in July 2011.⁶⁰

In 2011 the Scottish Government introduced an *Early Years Action Fund* (£6.8m) distributed through Inspiring Scotland. This is supporting a range of individual interventions that promote maternal and infant mental health by supporting parents and their children in their crucial first year of life (see Appendix A).

The Scottish Government is introducing an *Early Years Change Fund* (£50m over 4 years, as part of the 2011 Spending Review) as a mechanism for promoting preventative spend.

The Scottish Collaboration for Public Health Research and Policy (SCPHRP) Early Years Working Group led by Dr Rosemary Geddes has reviewed the evidence for early years interventions, including parenting programmes, paying close attention to those put into practice in Scotland.

The *Psychology of Parenting Project* has been led by the NHS Scotland Psychology Directorate since 2010. It aims to improve the availability of high quality evidence based parenting programmes for families with young children with elevated levels of behavioural problems.⁶¹ A review of current evidence in parenting programmes has been undertaken and a scoping exercise of current practices in the delivery of evidence based parenting across Scotland. "This established that, while many practitioners were trained in the content of these packages, this did not consistently translate into groups being offered to parents. At local level there is often a range of hurdles between training and delivery which present challenges to service and individual clinicians. The project therefore set about developing a dissemination plan capable of addressing the barriers that are inevitably encountered when evidence-based programmes require to be scaled up and delivered, with fidelity, in real-world settings."

Specialist child mental health services

- Recognised the very important role of specialists in supporting the 'mental health capacity' of the wider network of children's services
- Highlighted the need to increase capacity of specialist CAMHS practitioners in Scotland.
- The need to incorporate an understanding of mental health in the training of all professionals who work with children and young people.
- Practitioners who contribute to specialist CAMHS include: psychiatric nurses, child and adolescent psychiatrists, clinical psychologists, forensic psychiatrists and psychologists, social workers, psychotherapists (including child, analytical, systemic/family, cognitive behavioural), creative therapists (including art, music and drama), play therapists, liaison teachers, speech and language therapists, occupational therapists and dieticians.

The Guide for Practitioners recommended:

- An infant mental health coordinator be appointed in each NHS Board.
- A specialist infant mental health training module be commissioned to equip specialist CAMHS professionals from a variety of disciplines.
- Universal services offered by Tier 1 & 2 professionals should have access to specialist consultants from CAMHS for case consultation, supervision & referral, if necessary.

Efforts have been made to improve capacity and children's access to specialist CAMHS services by expanding the workforce, and introducing national monitoring of staffing.⁶²

Following a review (2005) the Government provided NHS Boards with additional funding for CAMHS: an extra £2m in 2008-09, £3m in 2009-10, and £3.5m in 2011-12, which has increased the number of specialists employed.

CAMHS was a priority within the 2009 National Delivery Plan for Children & Young People's Specialist Services in Scotland. The SG allocated £32m over 3 years for delivery of the plan. A commitment was made to make available funding for CAMHS development to 2011.⁶³

Performance management and service improvement targets are being used as a driver for change. A HEAT target introduced to deliver access to specialist CAMHS within 26 weeks by March 2013, targets for reducing waiting times for CAMHS and for increasing the provision of CAMHS inpatient beds, as well as the published standards for integrated care pathways for CAMHS.

Experts in CAMHS have been brought together to act as local, regional and national champions for child mental health services.

The Scottish Government Mental Health Directorate has set up a Psychological Interventions Team. This supports the delivery of HEAT waiting times for access to psychological therapies by increasing the capacity of the workforce to delivery psychological therapies and interventions.

3.1 Local Implementation

Many of the national initiatives supporting implementation of the *2005 Framework* for infants are fairly recent. The Maternity Services Action Group adopted an innovative approach, for public policy, by considering maternal and infant mental wellbeing in tandem. Some of its recent recommendations for improving maternal and infant mental wellbeing (see Appendix B) reiterate previous advice from the Short Life Working Group on Infant Mental Health (see above).

And while this strategic level work at national level is important, the test of this is whether, and to what extent, the *Framework*, including the advice contained in the *Guide for Practitioners*, and all the subsequent guidance, is being implemented locally. As noted above, this was the subject of sharp criticism in 2009. The parliamentary inquiry into preventative spending, also in 2009, heard that locally, resource pressures continued to be a major barrier to systemic change towards early intervention in the early years; these pressures have intensified and will continue to do so.⁶⁴

How to effect transformational change in service provision in the early years, and in the context of budget cuts, is the crux of the proposed Children's Services Bill. It is also central to the discussion around infant mental health. One weakness has been the patchy nature of infant mental health

initiatives at local level, with projects and pilots often dependent on short term funding linked to the latest national policy programmes.

The *2005 Framework* sought to shift the centre of gravity of CAMHS towards these universal services. One of the greatest challenges for improving maternal and infant mental health is the major gap that exists in our universal provision.

Children in Scotland have highlighted the absence of universal service provision for the 0-3 age group; from around 6-8 weeks of age, when universal health surveillance by health visitors ends, until the child becomes eligible for pre-school education, following its third birthday.⁶⁵ While the Chief Medical Officer instructed Health Boards, in 2010, to reinstate a universal health check at 24-30 months, there are few signs of this being delivered comprehensively.⁶⁶ Across Scotland as a whole, investment and policy for this age group is described as 'limited and piecemeal' and falling far short of the best European standards. As discussed below, the absence of specialist CAMHS therapeutic support and issues around our universal health surveillance for young children, forms part of this wider picture of neglect.

3.2 What needs to happen?

Here we share our thoughts on the way forward, building upon the recommendations of the Short Life Working Group on Infant Mental Health (2005-06).

Universal Services - infant mental health capacity

Capacity: Universal Workforce Planning and Caseload Management

Practitioners in primary and secondary care – midwives, health visitors, community nurses, GPs - are the critical workers for infants and toddlers at risk. Scottish Government policy regards health visitors and public health nurses as the vital links with parents, with a frontline role in providing parenting support and information, tailored to the needs of individual families.

Yet arguably we have not invested enough in this valuable workforce.

Where we have universal services, the evidence is that the staff who work with infants and parents are stretched to the limit. Between 2009 and 2010 health visitor numbers fell in 7 out of 14 Health Boards.⁶⁷ In NHS Lothian numbers declined by 25%, reflecting a shift towards public health nursing.⁶⁸ Concerns about excessive health visitor caseloads continue to be highlighted.⁶⁹ The 2008 review of the health visiting workforce in NHS Greater Glasgow reported capacity overwhelmed by the scale of need, measured in levels of child vulnerability.⁷⁰ When we talk about capacity, we need to acknowledge that the issues are not just about staffing levels, but also the service model and status of the profession, the nature of its role and relationship to others, and the level of skill and qualification, which have all seen major change – and major uncertainty - over the past decade.^{71,72}

A good indicator of these capacity issues is the actual coverage, or reach, of child health surveillance, which is a universal service. Recent research shows that the actual take-up of child health reviews is variable, declines with child age, and is lowest amongst the most deprived groups with the highest needs. Amongst the most deprived families take-up of the 39-42 month review was just 78%.⁷³ The remedy to the 'Inverse Care Law'⁷⁴ operating here is resource-intensive: it requires 'robust efforts...to assess their (the children's) needs and engage them and their families with appropriate and sensitive services.'⁷⁵

The aim should be to provide the best care to all families through a supportive, highly skilled and well trained workforce, with a higher level of support for the most vulnerable families. To achieve this requires a significant investment in health visiting in Scotland, both in numbers and skills, to fine tune our universal service delivery ('progressive universalism').

- The health visitor workforce must be expanded, in a planned programme of increased recruitment and training, to achieve caseload levels optimal for the support of vulnerable children.
- We need to enrich the skills of health visitors, equipping them with skills to assess parenting needs in the community, together with an understanding of attachment and interventions to promote it.
- Accompanying this should be a framework of regular clinical supervision for health visitors working with high risk families.

The *2005 Framework* highlighted that, in addition to competencies, *time* for staff to support new parents and babies is an important factor in achieving desired outcomes. More recently, the *2011 National Guidance on Reducing Antenatal Health Inequalities* recognises that staff need support, supervision, time and resources to enable them to work effectively with women who have multiple and complex health and social care needs.⁷⁶ We need to ensure that our workforce planning and development incorporate this principle. In particular, the distinction often made between 'frontline' and 'back office' staffing is unhelpful here.

- We need to review our administrative and support systems so that health visitors can spend a greater proportion of their time with families.

Service Design: Health & Social Care

New models of working are required that prioritise the needs of high risk groups, with more integrated and multi-disciplinary models of working between health and social work professionals. The supervision model used in two of the NSPCC's services – the home visiting programme *Minding the Baby* and the Glasgow Infant and Family Team (GIFT – part of the New Orleans Intervention Model) – could be replicated within mainstream services. In both these cases an infant mental health service is delivered by multi-disciplinary health and social care professionals.

Delivering a higher level of support to the most vulnerable families requires attention to service design, to ensure that support is attuned to the realities of life for families and communities, and that it really reaches those that it should. The needs and views of families and the realities of their lives as service users must inform service design. In developing community programmes we need to think about mobilising the whole community in providing a nurturing environment for children and families.

Infant Mental Health within the Core Curriculum of Early Years Occupations

We would like to see an audit of progress in terms of instating infant mental health as a core topic within the curriculum and post qualification training of all children's services occupations. Services to children under three years are generally provided by general practitioners, health visitors and paediatricians. It remains a concern that those health professionals who have contact with all children under three, generally are not trained in infant mental health. This applies to general practitioners (see below) as well as to health visitors, and midwives.⁷⁷

As recommended by the *2007 Practitioners' Guide*, specialised training for tier 1 & 2 staff is needed, for example, in the use of structured tools for identification, and in the evaluation of the

parent-child relationship, using a variety of means. We need to set targets for delivering specialised training to Tier 1 & 2 universal services staff, and monitor progress in delivering this.

We would suggest that the meta analysis of effective interventions in infant mental health by Bakermans-Kranenberg (2003) gives good guidance as to what is likely to be effective.⁷⁸

There are examples of research being conducted around Scotland aimed at improving practice in this area. It is important that this type of work is funded and that we share and disseminate learning more systematically, as the Playfield Institute does within NHS Fife.⁷⁹¹⁰

More specifically, we would suggest that the Scottish Government considers introducing a target for up-skilling social workers in Scotland. We should aim for a proportion of social workers to have advanced clinical post-graduate training. This target could be aligned with planning for the roll-out of Children and Family Centres, as set out in the SNP Government's election manifesto. The NSPCC is engaged in early discussion with Scottish universities about the development of advanced clinical skills-based training for multi-agency child protection practitioners, including social workers.

While the focus of early intervention work is on the universal workforce, an equally important issue is the ongoing skills development of those in contact with young children either at the threshold or within the child protection system. Recent research found, for example, that decision-making by child protection social workers is still insufficiently informed by current knowledge of attachment, early childhood development, and the long term impact of maltreatment on life chances.⁸⁰ This has implications for the quality of support social workers are able to provide to carers of looked after children, who are coping with children whose attachment relationships are commonly insecure or disorganised. As highlighted by Furnivall, training and support in attachment is required by all those caring for young looked after children, including foster and kinship carers and adoptive parents, residential and early years staff.⁸¹

Training Issues: The Adult Services Workforce

It is also vitally important that adult services and children's services work together to identify and address child mental health. In particular, in families where there are parental mental health issues; domestic abuse; or substance misuse, these issues act as stressors which can impact negatively on infant and child mental health. Therefore it is imperative that adult services are alert to the needs of children in these families, including infants, and that, where necessary, services are provided which specifically look at parent-child attachment and the promotion of infant mental health and development.

This principle should be extended to the work of services in other settings such as prisons. Very high numbers of prisoners, both male and female, are parents. Intervention with this group, ante-natally and post-natally, has great potential for helping children, and is also associated with less recidivism in parents.

Ante-natal Education

Maternal and infant mental health is part of the syllabus of the new national antenatal education pack. The aim is to reduce the incidence of poor attachment between mothers and babies and improve parental awareness of the importance of responding to their baby's needs, keeping them

¹⁰ The Playfield Institute was established by NHS Fife in 2005 in response to the 2003 Scottish Needs Assessment (SNAP) report. Part of its remit is to share good practice in infant, child and adolescent mental health.

close, smiling, interacting, touch, stroking and communicating, and the positive effect this has on mind, brain and emotional development of their baby.

As recommended by the Maternity Services Action Group⁸² the new national ante-natal education curriculum needs to be evaluated so that we know how these aspects are being delivered across Scotland, how effectively infant mental health is being promoted to expectant parents, and whether we are improving our delivery of antenatal education where it is most needed. There is also a need to develop the evidence base around psychosocial antenatal interventions for vulnerable expectant mothers and incorporate the learning into practice across Scotland.

Specialist Care

The *2005 Framework* recognises the essential role of CAMHS specialists in supporting the wider 'mental health capacity' of early years and children's services.⁸³ The integration of specialist and universal services is essential for the latter to perform its role in early intervention. The current tendency is to regard these as separate, with a division at national level between CAMHS and Early Years. This needs to be addressed.

It is important that CAMHS professionals are equipped, and have the time and capacity, to provide specialist advice and support to the universal services working with infants and young children, including case consultation, supervision and referral and the provision of learning opportunities.

At the moment mental health provision for the 0-3 age group is a major gap that needs to be addressed. We believe all CAMHS services should have a responsibility to include the needs of infants in the overall pattern of services, with the emphasis on attachment and parent-child relationships. This might best be achieved by introducing a HEAT target requiring CAMHS provision for this group.

We also need to invest in developing high level diagnostic and therapeutic skills within CAMHS specialists to improve capacity to meet children's needs. It would be helpful to set targets and measure progress towards this.

Advanced training in specialised services should include the evaluation of parent-child relationships using a variety of means (interview, questionnaire and observation and the availability of effective interventions at the earliest age.

Scottish Government

National leadership and coordination

We would like to see a heightened focus on the direction and coordination of infant mental health services within the existing national monitoring arrangements for CAMHS. However we recognise that this cannot be the sole responsibility of mental health structures. We strongly believe that addressing infant health will have a significant impact on the Scottish Government's broader stated commitments to early years and prevention. Developments in all these areas must have a shared recognition and commitment, and there is a need for much stronger coordination between the structures for mental health and the early years.

This shared national leadership and coordination role needs to embrace every tier of service provision, spanning promotion, prevention and care. It is particularly important that there is a national lead given the numerous and ongoing processes of change at the moment combined with budget reductions.

Part of this leadership role should be to maintain an overall focus on improvement and outcomes in infant mental health care. A major concern raised in the 2009 CAMHS Inquiry was the robustness of reporting arrangements for holding to account the Chief Officers of Health Boards and local authorities. Broader concerns have been raised about the 'unwieldy and complex' overlapping frameworks of indicators used to measure and monitor outcomes.⁸⁴ Infant mental health currently sits within several linked and overlapping social policy frameworks, and within the remit of a range of different Taskforces and Working Groups.¹¹ Each has its own framework of indicators and outcomes designed to drive improvement and monitor outcomes. We need an overview of where infant mental health sits within existing performance management and improvement frameworks and a way of ensuring that targets, indicators and measures are effective.

National Parenting Strategy

The promotion of infant mental health and a commitment to meet the needs of the most vulnerable infants should be placed at the heart of the National Parenting Strategy. At the same time we acknowledge that, while parenting support is valuable, on its own it is insufficient as a method of correcting for poverty, multiple disadvantage and adversity.⁸⁵ A holistic approach to economic and social policy is needed.

¹¹ Amongst others these include the Early Years Taskforce, the Equally Well Taskforce, the Maternity Services Action Group, the Modernising Board for Nursing in the Community.

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- ⁸² Maternity Services Action Group Improvement Subgroup, Maternal and Infant Mental Wellbeing Project Summary of Recommendations, 9 Sept 2011.
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- ⁸⁴ Davidson, E, (2009), *Single Outcome Agreements* (Edinburgh: Centre for Research on Families and Relationships).
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APPENDIX A

RELATED INFANT INITIATIVES SUPPORTED BY THE SCOTTISH GOVERNMENT EARLY YEARS ACTION FUND (INSPIRING SCOTLAND AWARDS, AUTUMN 2011 - £6.8m).

You First

Barnardo's Scotland will deliver You First which is a 20-week programme for new parents aged under 21 with a baby under the age of one. The programme uses a mix of hands-on practical and group work to help improve parenting skills and support parents to access other services within their communities. In addition to gaining improved parenting skills, parents are supported with financial planning, budgeting, preparing healthy meals and are supported to attain a Bronze Youth Achievement Award. You First Programmes would be delivered in conjunction with Health Boards across Inverclyde & Renfrewshire; Lanarkshire; Forth Valley Ayrshire & Arran; Tayside; Grampian; and Highland.

Ayrshire Project

The Breastfeeding Network will provide women in Ayrshire with information and support to believe that breastfeeding is a realistic option for them and their families and to support them to have a positive breastfeeding experience. They will provide peer support in the local maternity hospital followed by intensive, proactive, support by phone, text and in the home, to help the mum and baby get off to a good start with breastfeeding. On-going community mother to mother support in breastfeeding and parenting choices will also be offered in **local breastfeeding centres by trained peer supporters.**

Circle - Solo Early Years Project

Circle will expand its existing model of tailored interventions for children affected by parental substance misuse. Circle can provide 1:1 support with parenting, hands-on support to improve the home environment and supported play. Circle will provide practical and emotional support and encourage engagement with specialist services when appropriate. In addition families will be supported to link to training and employment opportunities to tackle family poverty. Services would be built on Circle's existing work in Edinburgh, West Lothian, North and South Lanarkshire.

The Hub

CrossReach will bring together a range of activities into a hub for families in Glasgow. This Hub would offer, play sessions, parenting programmes, health services, Book Bug, benefits and housing advice, support for children with a parent in prison or whose parents misuse alcohol or drugs. Additional tailored activities might include postnatal depression counselling, speech and language support, healthy eating support and support to stay in mainstream education. Families may be isolated, experience poor physical and/or mental health and have difficulties in coping with everyday tasks.

Mellow Bumps with Teenage Mums to Be

Mellow Parenting will be providing training and support to staff in teenage pregnancy units to deliver the Mellow Bumps programme to young mothers-to-be in Glasgow, Paisley and the Lothians. Mellow Bumps is a six-week group-based ante-natal programme designed to support families with additional health and social care needs, to help them enjoy pregnancy and to begin to develop a strong relationship with the baby.

Early Years Programme

The National Deaf Children's Society (NDCS) is the national charity dedicated to creating a world without barriers for every deaf child. 90% of deaf children are born to hearing parents with little or no prior

experience of deafness, so they desperately need help from the start in understanding deafness and supporting their deaf child.

NDCS will develop invaluable resources to help parents understand how to communicate with their deaf baby or toddler **from birth** through to starting school, so they can get the best start in life. The initiative will involve delivering courses for parents on a range of topics including communication methods, family sign language courses and parenting a deaf child, as well as hosting family weekend events and developing peer to peer support between parents. Initially, the work will be focused on areas of greatest population density in Scotland, with an ambition to roll out the programme across Scotland.

Young Voices for Choices

Young Voices for Choices will provide independent advocacy support for children with physical disabilities from **pre-birth to 8** - ensuring each child's needs/views and where possible their voice is heard, listened to, and taken seriously. Our advocacy support will be offered to families at key transition times in the young person's life -home to hospital and vice versa, nursery to school for example. We will support each young person and their families to access the services they are entitled to and to understand what is happening at a pace they are comfortable with. This can be with medical care planning, education, where they live. Our aim is that if advocacy support is there as early as possible before issues reach crisis point, we can ensure that each young child gets the best possible start in life.

Ruchazie

Quarriers will extend their Nursery and Family Centre in Easterhouse, Glasgow, doubling the nursery's capacity for **0-3** year olds, and to increase the outreach and centre-based family support. The centre improves a vulnerable child's attachment to their parents, increases parental engagement and delivers increased confidence. Parents and carers develop a better understanding of their child's needs and are more confident in their child caring responsibilities.

Scottish Child Minding Association - Community Childminding

SCMA will expand their Community Childminding service for **0-3** year olds into Fife and Stirling. This service works with local authorities to support families experiencing a temporary time of crisis to prevent situations deteriorating to a point where more substantial intervention is required. Crisis situations may be around substance issues, birth of child, domestic abuse, mental or physical health problems. The primary focus is on providing a safe and nurturing environment for the child but informal engagement through advice and signposting also takes place.

Smart Play Network - Play on Wheels

Play on Wheels is a mobile service, bringing play resources and play sessions to hard to reach communities in deprived areas. They will deliver free play and **baby play** sessions to children in Dundee and Fife, targeting areas of multiple deprivation and those with limited access to play opportunities. They will work closely with family centres, nurseries and primary schools and Health visitors. Themed play boxes will be made available on loan to practitioners working with young children and workshops will be delivered to develop skills of parents and practitioners to provide quality play in these areas.

Glasgow Project

In addition Stepping Stones for Families will expand their Family Health and Wellbeing project (currently delivered in Molendinar Family Learning Centre) to parents and children aged 0-5 years in the most deprived areas. Most activities will be carried out in 5 centres through 1:1 work and group work. Groups cover topics such as healthy eating and parenting, 1:1 work focuses on the family's specific needs and provides advice, information and opportunities for building confidence and self esteem.

YWCA Scotland - Teen Parent Project

Based on the existing Teen Parents pilot project run in Levenmouth by Fife Gingerbread. YWCA Scotland and Fife Gingerbread will expand the project to Kirkcaldy (managed by Fife Gingerbread) and Livingston (managed by YWCA Scotland). Activities will be a mix of individual and group activities and weekly visits to identify needs of each family. The project will provide advice on child development, health, behavioural issues and parenting and will act as a bridge to other services.

APPENDIX B

MATERNITY SERVICES ACTION GROUP – HEALTH IMPROVEMENT SUBGROUP MATERNAL & INFANT MENTAL WELLBEING PROJECT Summary of recommendations and action required

Recommendation	MSAG Action	Relevant links in logic model
1. There should be coherence and consistency between the Parent Education Curriculum and the wellbeing components of the Curriculum for Excellence.	MSAG Chair to write to the SG policy lead for Curriculum for Excellence and the NHS Education Scotland (NES) lead for Parent Education Curriculum to highlight this.	Link 1: Promote healthy relationships and sexual wellbeing to adolescents; Link 2: Parent education and parenting skills programmes
2. Parent Education and relevant parts of the Curriculum for Excellence should be integrated into Scottish Government's wider parenting strategy.	MSAG Chair to write to SG lead for parenting strategy development highlighting this recommendation.	Link 2: Parent education and parenting skills programmes
3. The partnership that developed the new Parent Education Curriculum (HS, NES and HIS) should ensure that its implementation and effectiveness, in terms of short and medium term outcomes, is robustly evaluated.	MSAG Chair to request that Health Scotland (HS), NES and Healthcare Improvement Scotland (HIS) work together to ensure a robust evaluation takes place.	Link 2: Parent education and parenting skills programmes
4. The use of equipment that allows physical or face to face contact between mother and infant (such as soft baby carriers, and parent facing buggies) should be promoted.	MSAG Chair to request that HS lead on action relating to this recommendation via their parent education resources, social marketing programmes, and other campaigns.	Link 2: Parent education and parenting skills programmes
5. Preconception care should be provided by sexual health staff, general practice, maternity care and specialist mental healthcare providers in order to improve their identification and care for women who are planning a pregnancy and are at particular risk of poor mental health related outcomes.	MSAG Chair to write to the SG Director Children and Families Directorate recommending that a review of policies and guidance is undertaken to ensure that action in relation to women's reproductive health is consistent, comprehensive and effectively represented.	Link 4: Preconception and antenatal care
6. All interactions between antenatal service providers and pregnant women should be used to promote mental wellbeing using strengths and asset based approaches, as well as to assess risk and need.	MSAG Chair to recommend that NES ensures that skills and approaches that maintain and improve an individual's mental wellbeing are incorporated into learning and education programmes for maternity care staff and in the new programmes for the early years workforce.	Link 4: Preconception and antenatal care; Link 5: Inequalities sensitive practice

<p>7. Staff providing postnatal care should be suitably skilled to be able to identify and respond to signs of mental health problems, and appropriate systems and pathways should be in place to allow appropriate referral where necessary.</p>	<p>MSAG to discuss whether robust training, support and referral pathways between maternity staff and appropriate specialist services are in place across Scotland and make recommendations to SG as appropriate.</p> <p>There are systems in place in Scotland for referral to perinatal mental health services however MSAG should discuss whether these are sufficiently robust or whether further recommendations are warranted. There are clinical practice guidelines in England and Wales that recommend a stepped care model.</p>	<p>Link 6: Postnatal care; Link 7: Develop key competences</p>
<p>8. Postnatal social support (which might include peer support) is anecdotally very important but this is not yet reflected in highly processed evidence. There is evidence, however, that new mothers most at risk of poor outcomes do not access group based support.⁸⁵</p>	<p>MSAG Chair to recommend that Modernising Nursing in the Community Group consider evidence and current practice relating to postnatal support and make recommendations to SG.</p>	<p>Link 6: Postnatal support</p>
<p>9. Interdisciplinary training in maternal and infant mental health and wellbeing should be available for all staff providing maternity care, including managers, and should incorporate shared definitions and guidance, and focus on the important contribution of maternity care to promoting and maintaining maternal and infant mental wellbeing. This should include maternal and infant attachment.</p>	<p>MSAG Chair to request that NES facilitate this interdisciplinary training. To support this NES should develop a short, evidence informed, working definition of attachment, along with guidance on how maternity care can assist its promotion.</p>	<p>Link 7: Develop key competences</p>
<p>10. Effective assessment using the GIRFEC practice model should be integral to maternity care practice.</p>	<p>MSAG to write to SG GIRFEC lead highlighting the need for nominated executive leads in every NHS Board to be fully aware that GIRFEC applies to antenatal care.</p>	<p>Link 7: Develop key competences; Link 8: Quality of care and communication</p>
<p>11. Continuity of carer(s) and the development of trusting relationships should be provided for all women and ensured for the safe care of women with complex health and social care needs⁸⁵</p>	<p>MSAG Chair to request that HIS lead the development of evidence informed definitions of continuity of care and carer that cover the antenatal, intranatal and postnatal periods, and present the implications for maternity services in Scotland to SG for consideration.</p>	<p>Link 8: Quality of care and communication</p>

<p>12. The quality of the intranatal experience is important, regardless of mode of delivery, and can influence a mother's mental wellbeing, how well she bonds with her infant, and how she approaches and deals with future pregnancies and births. Highly processed evidence does not reflect this, but the subgroup believe that further exploration is merited.</p>	<p>MSAG Chair to request that HIS review the findings of the national patient experience survey (Spring 2012) in terms of the intranatal experience and the impact of this on women's mental health and wellbeing.</p>	<p>Link 8: Quality of care and communication</p>
<p>13. New technologies (e.g. texting, social media) should be used as mechanisms for improving continuity of care and ongoing postnatal support.</p>	<p>MSAG Chair to request that HIS consider the potential of new technologies as mechanisms for improving continuity of care and carer as part of their response to recommendation 11 above.</p>	<p>Link 8: Quality of care and communication</p>

(2) Scotland has its own police and police educational systems while Northern Ireland has come closer to England and Wales in recent years. 10. European police science and research bulletin. NSPCC/Metropolitan Police, London. Heaton, R. & Tong, S. (2015), "Evidence-based policing: from effectiveness to cost-effectiveness"™, Policing, published online, September. Hinton, M. S. (2006), The state on the streets, Lynne Rienner, Boulder, CO/London. Society is formed of a series of hubs of influence and interest, and a stable social order works so that all hubs are satisfied. Norm violation is a habit that creates its own normative order. The resources we already hold prove that we are able to accumulate them and turn them into general well-being. The National Society for the Prevention of Cruelty to Children (NSPCC) is a charity campaigning and working in child protection in the United Kingdom and the Channel Islands. Contents. 1 History. It did not change its title to "Royal Society for the Prevention of Cruelty to Children" or similar, as the name NSPCC was already well established, and to avoid confusion with the Royal Society for the Prevention of Cruelty to Animals (RSPCA), which had already existed for more than fifty years. In 1891, the League of Pity was founded to allow children to learn about the NSPCC and support fund-raising initiatives.[3]. The Scottish Government is responsible for child protection in Scotland. It sets out policy, legislation and statutory guidance on how the child protection system should work. Further reading. Child protection plan register statistics Our series of factsheets pulls together the most up-to-date statistics on children who are the subject to child protection plan or on a child protection register for each of the UK nations. For further reading about the child protection system for Scotland, search the NSPCC Library catalogue using the keyword/keywords "child protection"; "child protection services"; "child law"; "social policy"; "Scotland". If you need more specific information, please contact our Information Service. S