About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

About this Response

This response was jointly led for the British Psychological Society by:
Dr Siobhan Higgins CPsychol, Division of Clinical Psychology and the Faculty of Children, Young People and their Families

With contributions from:
Dr Nicola Cosgrave CPsychol, Division of Clinical Psychology
Dr Janie Donnan, Division of Clinical Psychology
Dr Nicola Doherty CPsychol, Division of Clinical Psychology Northern Ireland
Dr Aiveen Higgins CPsychol, Division of Clinical Psychology
Roweena Rossiter CPsychol AFBPsS, Division of Clinical Psychology
Dr Lisa Shostak CPsychol AFBPsS, Division of Clinical Psychology

The Committee would welcome written submissions by 8 December 2017 on current research into ‘adverse childhood experiences’, the extent of the evidence linking them to negative outcomes in later life and relevant educational, social and health interventions, as well as the extent to which this research is supported and used by Government.

Specifically:

The evidence-base (including overseas experiences) for the link between adverse childhood experiences and long-term negative outcomes, and any gaps in that evidence base, as well as data on which specific adverse childhood experiences produce greatest adverse impact;

1. Comments:

Healthy social and emotional development in babies and toddlers is important as it is the “building blocks for healthy behaviour and educational attainment” (NICE 2012) and helps to prevent behavioural problems and mental illness (Felliti et al, 1998).

The Society aims to provide information on some of these risk factors which are termed “Adverse childhood experiences”. However, this is of course a complex and multifaceted topic. Unfortunately it is not possible to provide reliable estimates for the prevalence of poor social and emotional development in babies and toddlers nor exhaustive information on the factors that are thought to influence it. Being exposed to more than one risk factor may have an increased impact on a young child. Research from the Centre for Longitudinal Studies (CLS), using data from the Millennium Cohort Study (MCS), (Sabates and Dex, 2012) examined “the associations of multiple risks to deficits in developmental outcomes at three and five years of age for children born in 2000 to 2001” (15, pg. 3). It found that “analyses of MCS children’s outcomes at ages three and five suggested that being exposed to two or more risks in first years of life is likely to disadvantage children’s cognitive and behavioural development as they grow up. The greater the number of risks experienced by the child, the greater the problems that the child will face during the life course.”(15, pg. 22). There is a cumulative impact of ACEs with the more you experience resulting in more adverse outcomes later in life. Those who report four or more at greatest risk; individuals who had at least four ACEs are more than twice as likely to be current smokers or heavy drinkers, and almost six times as likely to drink problematically.
as those with no ACEs (Hughes et al., 2017). Individuals with 4 or more ACEs live on average 10 years less than individuals with no ACEs. It is critical to note that should these individuals have children; their problems will represent the ACEs of future generations, establishing an intergenerational cycle. Almost half of the general population in England have reported at least one ACE, but over 8 per cent reported four or more (M. A. Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014). In the Welsh population, 47 per cent of the population had one or more ACEs and 14 per cent had 4 or more ACEs (Public Health Wales, 2015).

It is important to remember that not all babies or toddlers with certain risk factors will have poor mental health, as the NICE guidance states: “these indicators can be used to identify groups of children who are likely to be vulnerable. However, not all of these children will in fact be vulnerable – and others, who do not fall within these groups, could have social and emotional problems.” (NICE, 2012). In the following response we will aim to outline the evidence base for a number of specific groups/ACEs. We would like to be clear this is not an exhaustive list and that the examples given are offered based on the strength of the evidence/research base in those areas/specific groups.

The social and emotional development of babies and toddlers can be influenced by a wide range of different factors. Having a healthy social and emotional development includes a healthy attachment which is defined as “a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually” (NICE, 2012). The NSPCC (Hogg, 2012) sets out the different kinds of attachment relationship in its report ‘Prevention in mind’. Attachment can be secure, which “enables the child to feel safe, secure and protected” (6, pg. 13), or insecure. There are three categories of insecure attachment: ambivalent, avoidant and disorganised, and in these cases children “may have experienced inconsistent or insensitive care and therefore are not able to rely upon their relationship with their primary caregiver” (6, pg. 13). It is insecure attachment, particularly disorganised attachment that can lead to problems with a baby or toddler’s development.

There is no reliable data available on parent-baby attachment despite this being an area of intense and ongoing interest.

Brofennbrenner’s Ecological Theory of Development (Bronfenbrenner & Morris, 1998) offers a useful way to conceptual the environments and opportunities where a child may be vulnerable to adverse experiences. The microsystem of the family and particularly maladaptive parenting practices can impact the child at multiple points of development. There is strong evidence that young children of parents with mental health difficulties, particularly parents who are anxious or who struggle with their mood during pregnancy expose their children to “toxic stress” in utero (Berens, Jensen & Nelson, 2017; Kinsella & Monk, 2009;)

Research indicates that experience of traumatic events in childhood can have a profound adverse impact on brain development leading to both physical and behavioural changes as the child tries to adapt to environmental stressors. If trauma occurs over a prolonged period, it can rupture the child’s internal stress system which then contributes to physical and mental health problems over the life course (Kalmakis & Chandler, 2015), making children more vulnerable to difficulties with emotional regulation from birth and is often linked to difficulties with cognition such as problems with attention and focus in early and later childhood (see Berens, Jensen & Nelson, 2017; Graignic-Philippe et al, 2014). The child’s first and immediate environment are their early interactions with their parent. Having a positive relationship with a parent who can reflect on their baby’s inner world, recognise and attend to their baby’s cues, physical and psychological needs, respond in a sensitive manner that is in-tune with and matches the needs of the young child in a warm, caring and positive way is fundamental in laying the foundations for future psychological health and wellbeing. Therefore need to intervene really early, and interventions should aim to increase parental sensitivity. We know that for very young children relationships can mediate the effects of maltreatment/ACEs (McCrorry & Vising, 2015). Therefore healthy relationships with carers are key, and interventions should aim to improve sensitivity and increase secure attachments (Felitti et al, 1998; NICE, 2012).

There are a number of factors which may negatively influence a parent’s capacity to parent in a reflective, sensitive, warm and attuned manner. This may include parents who have mental health difficulties themselves. Others may have had their own experiences of trauma, coercive, neglectful or misattuned parenting, which may make recognising and responding to a child’s individual cues and needs more problematic (Lyons-Ruth & Block, 1996).

**Children with parents who have mental health problems**

The social and emotional wellbeing of a baby or toddler can be affected by whether the mother has a mental health problem herself, often due to the effect on the mother-baby relationship (NICE, 2014; National Collaborating Centre for Mental Health, 2014; NICE, 2012) “…. emotional distress and problems during...”
pregnancy, childbirth and the postnatal period warrant particular attention because of the longitudinal impact these difficulties have on the developing fetus and newborn baby, effects which are often mediated through the woman’s disrupted relationship with her infant.” (2, pg. 209) For example, postnatal depression can have serious and long term effects on babies: “Failure to treat (perinatal depression) promptly may result in a prolonged, deleterious effect on the relationship between the mother and baby and on the child’s psychological, social and educational development.” (11, pg. 1) There is evidence that postnatal depression “may be associated with lower cognitive and language achievements” in young children (10). Cognitive development is not impaired in all babies and children of mothers with postnatal depression, but “appears limited to those children whose mothers find it difficult to maintain sensitive and active engagement with the infant” (11, pg. 2).

Children who experienced maltreatment
There are risks to babies’ and toddlers’ mental health associated with the experience of being in care, as mentioned in the NICE guidance on looked after children and young people: “Evidence suggests that frequent moves...can adversely affect the ability of babies and very young children to form healthy attachments that lead to healthy emotional and physical development.” (NICE, 2010) “The absence of a permanent carer at such a young age can jeopardise children's chances of developing meaningful attachments and have adverse consequences for their long-term wellbeing.” “Very young children can become closely attached to foster care families and can experience great distress if moved to a new placement.”

“Decisive action is of key importance to the wellbeing of very young children who come into the care of local authorities. The majority are from families where parents are struggling with issues such as domestic violence, substance abuse, alcohol abuse and mental health problems, often in combinations.” Many looked after children have suffered abuse or neglect, which can be very damaging to their development, wellbeing and attachment relationships (NICE, 2014). “A substantial number of children and young people are placed in local authority care as a result of maltreatment.... Many children suffer combinations of different forms of abuse and neglect and, as a result, experience the kind of care-giving in which key nurturing experiences are missing. In maltreated children, the child's primary attachment figure (usually the parent) is likely to be unavailable at times of need and may also be the cause of extreme fear and distress.

Experiences of child maltreatment, whether in looked after children or others, can have very serious effects on a young child's development: "There is strong evidence of the harmful short- and long-term effects of child maltreatment. All aspects of the child's health, development and wellbeing can be affected.” (NICE, 2009). There is now evidence to suggest that children who have been maltreated have a latent vulnerability for developing future mental health problems meaning they are at elevated risk (McCrory & Vising, 2015).

Children who become ‘Looked After’ by the local authority
Care is a vital part of our child protection system. Most young people in care say that their experiences are good and that it was the right choice for them (Beihal et al, 2014). But more needs to be done to ensure that all children in care are healthy and safe, have the same opportunities as their peers and can move successfully into adulthood.

Children's early experiences have a significant impact on their development and future life chances. As a result of their experiences both before and during care, looked after children are at greater risk than their peers. Children in care are 4 times more likely than their peers to experience mental health problems and 34% of care leavers were not in education, employment or training at age 19 compared to 15.5% of the general population (https://www.nspcc.org.uk/preventing-abuse/child-protection-system/children-in-care/statistics/).

Children with Learning Disabilities
Learning disabilities (LD) both global and specific as neurodevelopmental conditions, such as Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) are lifelong conditions whose impact and limitations can often wax and wane at different points in the life span. The health and social inequalities experienced by children and young people with LD have been well documented over a number of years. The Foundation for People with Learning Disabilities (2002), Emerson and Hatton (2007) and Public Health England (2015) found that they have higher rates of emotional, behavioural, mental and physical health problems, experience higher rates of poverty, bullying, emotional, physical and sexual abuse than ‘typically’ developing children and young people, yet less access to services and support. Higher rates of learning difficulties, disabilities, neurodevelopmental conditions and communication difficulties are found in “vulnerable” populations such as Looked After Children, emotional, behavioural and mental health populations (Emerson and Hatton, 2007) and in the Criminal Justice System (Talbot, 2007, DH and Bradley
2009a, 2009b, Bryan 2012), yet frequently go unrecognised in schools, mental health, care, criminal justice settings (Simonoff et al., 2006, Emerson and Baines 2010; Talbot 2007).

The impact of these adverse childhood experiences feed on into adulthood for people with LD, with the health and social inequalities paralleling those in childhood, with reduced quality of life, poorer physical and mental health, over-medication, significantly lower life expectancy than non-disabled people.

**Children with physical health conditions**

Physical health difficulties and some physical health treatments should be considered as “adverse childhood experiences” as these can have a significant impact on emotional, physical, social, cognitive and behavioural development and functioning with a significant, negative impact on peer relationships, education and later employment (BPS, 2015). Yet these are often not given due consideration in the current ACES literature in spite of evidence that CYP with physical health conditions are a patient group who are particularly vulnerable to developing mental health difficulties: 10%-37% of CYP with physical health conditions at risk of developing psychological and behavioural difficulties which impact on their emotional, social, and educational development; and occupational opportunities (Hysing et al, 2007, Kush & Campo, 1998). This risk is increased if the central nervous system is involved e.g. following brain injury.

**Specific examples:**

**Babies and Children with Cardiac (Congenital Heart) conditions**

Research has identified a significantly increased risk and incidence of psychological difficulties for both children with congenital heart disorders and their parents (McCusker et al 2007, Volker-Shachinger et al 2000). Infants with CHD have an increased risk of feeding and sleeping difficulties (Lobo 1992); parents of children with CHD report reduced quality of life; children with CHD are reported to be more withdrawn, engage in fewer activities and possess more social problems than their peers (Casey et al 2010) and older children / adolescents are reported to be at risk of developing significant psychological difficulties such as anxiety and depression (Spurkland et al 2008). Up to 42% of adolescents with Complex CHD meet DSM (American Association Diagnostic and Statistical Manual for Mental Disorders, 1994) criteria for psychiatric problems, typically anxiety disorder and dysthymic disorder (5). One third were rated as having serious dysfunction. 19% of adolescents with CHD had significant psychological symptoms, most with internalising disorders (e.g. anxiety and depression) (DSM IV). 11% of children experience significant behaviour disturbance that persists more than two weeks after surgery, 93% of pre-school children display increased anxiety/aggression after hospitalization (BPS, 2013).

Children with chronic health conditions e.g. cardiac difficulties and cystinosis are at risk of falling behind at school and struggling with peer relationships. Shillingford et al (2008) found children with CHD had 3 to 4 times the incidence of inattention and hyperactivity compared to their peers with 50% receiving some form of academic support; 15% have statements of special educational needs, 30% need specific reading support and 26% need specific help with mathematics. Munoz et al (2008) reported that neonates exposed to hypoxic events, e.g. through cardiac arrest or bypass, develop marked memory problems in later life. Early identification and management of these difficulties e.g. through cognitive and neuropsychological assessment by psychologists embedded within medical teams, can help foster resiliency and ensure schools and other relevant agencies introduce appropriate resources to support learning and prevent further impact on quality of life for these children (McCusker, 2007).

**Babies and Children with Cancer**

Children with cancer are more likely to experience a range of psychosocial dysfunction, which present in different ways dependent on the age and developmental stage of the child but include low mood and anxiety, trauma related distress, concerns about body image procedural distress and problems with adherence with treatment, somatic complaints difficulties in sustaining peer relationship (isolation/separation), worries about the future.

Over long-term cancer treatment, children can develop a specific profile of cognitive deficits including difficulties with motor skills, processing skills, abstract reasoning, attention and other executive functioning. Cognitive difficulties are more widespread and complex when a child has undergone radiotherapy to the brain and spine and/or has had a brain tumour and cognitive difficulties are usually more profound with greater treatment and when treatment starts when they are younger. A cancer diagnoses can also be associated with subtle difficulties with social and emotional development as a consequence of spending extended periods in hospital and/or in isolation and having a life limiting illness can have a significant impact on attachment and bonding. Furthermore, a long term stay in hospital (e.g. for up to and beyond a year) impacts on the child’s academic development, peer relationships, loss of social support network for families (especially if living a long way from hospital), family relationships, ability to care for other children in family and maintain adequate
income through working. Specific appearance related concerns associated with the medical condition and its
treatment (e.g. scarring, weight gain due to steroid use and hair loss) can also lead to significant
psychological distress.

**Medically related Trauma**

Admission to ICU is comparable to other life-threatening events and meets DSM IV criteria for a traumatic
stressor (Kazak et al 2006). Research has demonstrated that around one third of children (and parents of
children) who are admitted to ICU demonstrate symptoms of PTSD after discharge from ICU and 1 in 10 go
on to develop clinically significant PTSD (Colville 2008). Psychological interventions designed to intervene
early to reduce distress and increase coping help children, young people and families make sense of their
experiences and can significantly reduce the risk of trauma from PICU admission or surgical treatment (e.g.
Kazak et al 2006). The NICE Guidelines on PTSD (NICE, 2005) recommend screening those at risk of PTSD
one month after their experiences. These CYPP would not meet criteria for referral for CAMHS until they
met the threshold for diagnosable PTSD resulting in more costly and time consuming psychological therapy
that could have been managed and prevented at an earlier stage.

**PREMATURE BIRTH AS AN ACE**

The impact of being born early and/or being born sick. The physical and psychological impact of these can
have long lasting physical and psychosocial impact. The impacts are on the infant itself as well as the family
system, thereby causing further impact on the infant. Longitudinal studies such as the CHIP studies carried
out by the Belfast group highlight the LT and ongoing impact as a result of being born with a congenital heart
defect, resulting in poorer educational ad psychosocial outcomes, increased chance to still be living at home
and to be unemployed as adults (Doherty et al 2016; Doherty et al 2009, McCusker et al, 2009). Conditions
that lead to brain injury around the time of birth such as hypoxia-ischemia, stroke and intracranial
haemorrhage are leading causes of neonatal morbidity as well as lifelong morbidities such as cerebral palsy
(Wu et al, 2006).

Premature birth is considered a potential adverse childhood experience (ACE) which may challenge the
infant’s mental health (IMH) and wellbeing (Sanders & Hall, 2017). The NNU experience can be experienced
as toxic by both infant and parents, leading to dysregulation of the hypothalamic-pituitary-adrenal axis and
poorly controlled cortisol secretion (Sanders & Hall, 2017). Moreover, NNU hospitalisation and the biological,
environmental and psychosocial factors associated with this environment have the potential to interrupt
bonding and attachment between the infant and parent(s). This can have repercussions for cognitive, social
and emotional aspects of development (Weatherston & Browne, 2016; Browne, Martinez & Talmi, 2016;
Lopez-Maestro et al., 2017).

In the USA, psychosocial programme standards for families in NNUs have been agreed by a working group
of professional organisations and service user/carers (Hynan & Hall, 2015). There is a clear rationale for
interventions addressing IMH as well as family and staff wellbeing within NNUs. Early intervention is
paramount for this specific type of ACE for prevention of IMH difficulties and their long-term sequelae, both
individual and intergenerational. IMH approaches advocate prevention, promotion, intervention and treatment
in support of early mental health and socio-emotional development using a relationship-based, reflective
stance (Browne et al., 2016). Given that babies and parents may experience inpatient admission to NNU as a
traumatic or “toxic” stress, a trauma-informed care approach is also advised (Sanders & Hall, 2017).

**Poverty**

Outside of the immediate family and a further social layer external to the child’s experience of parenting and
family relationships, is the influence of health, education and social care. It is also important to consider the
risks and poor outcomes of adversity and poverty. Children from poorer backgrounds lag at all stages of
education. Poverty is also associated with a higher risk of both illness and premature death. Children born in
the poorest areas of the UK weigh, on average, 200 grams less at birth than those born in the richest areas.
Children from low income families are more likely to die at birth or in infancy than children born into richer
families.

They are more likely to suffer chronic illness during childhood or to have a disability. Poorer health over the course of a lifetime has an impact on life expectancy: professionals live, on average, 8
years longer than unskilled workers. Children living in poverty are almost twice as likely to live in bad
housing. This has significant effects on both their physical and mental health, as well as educational
achievement.4 Fuel poverty also affects children detrimentally as they grow up (http://cpag.org.uk/content/impact-poverty).
A further layer to influence experiences in early childhood links to funding for services and provision to support families and agencies to provide intervention in the early years. Although there is some provision to support Infant and Early Years Mental Health in the UK however, it is not appear to be a routine offer in CAMHS services across the country; is often a challenge for CAMHS commissioners to support given the impact of austerity and clinical needs for children and young people with more obvious clinical risks which may require more intensive input such as those with eating disorders and those who self-harm.

Recent posts in Infant Mental Health and Early Years have been supported by initiatives such as Future in Mind. In some parts of the UK, the clinical offer is often linked to funding from charities such as PIP UK (http://www.pipuk.org.uk) the NSPCC (e.g. LIFT https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/new-orleans-intervention-model/new-orleans-intervention-model-referrals) or the Big Lottery (e.g. PAIRS http://www.leaplambeth.org.uk/info-for-parents/leap-services-for-parents/parent-and-infant-relationship-service-pairs). An example of services provided in London for Looked After Children is detailed here (https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2016/reports/Moriarty-et-al-2016-Mapping-report.pdf). There does not appear to be one clear model of provision and service delivery. There appears to be a mix of clinical psychology, child psychotherapy, therapeutic social work and/or health visiting with special interest and training in early parenting providing intervention in the early years. It is a developing area of research and practice. What we understand about area is constantly evolving however, there appears to be a gap in translating even current knowledge to practice and available provision for infants and young children.

The external layer of Brofenbrenners ecological model highlights the importance of public attitude and policies. There appears to be a developing awareness of the importance and impact of developmental neuroscience; early parent-infant relationships and mental health in the early years. It is a developing area of research and practice. What we understand about area is constantly evolving however, there appears to be a gap in translating even current knowledge to practice and available provision for infants and young children.

Which adverse childhood experiences produce worst outcomes?
It is not true to say that all young children will have poor outcomes when exposed to adversity. It remains unclear which ACEs could be considered most powerful or to create the worst outcomes, however there is recognition that the more ACEs the baby or young child is exposed to, the higher the risk of poor outcomes.

Support in government:
- 1001 Critical Days
- Health Child Programme
- Increase in funding to Perinatal Services. NHS England has committed to fulfilling the ambition in the Five Year Forward View for Mental Health, so that by 2020/21 there will be increased access to specialist perinatal mental health support in all areas of England, allowing at least an additional 30,000 women each year to receive evidence based treatment, closer to home, when they need it. This includes the right range of specialist community and inpatient care. A phased, five-year transformation programme, backed by £365m in funding, is underway to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness. With this increase in funding there is also a recognition of the importance and focus on early relationships between the parent and child to support develop development and minimise future psychological difficulties for the child. e.g. http://www.londonscn.nhs.uk/publication/perinatal-mental-health-service-for-london-guide-for-commissioners/

Perinatal mental health has attracted a lot of attention and NHS England has just released a call for people to apply for Wave 2 funding in this area. However in Northern Ireland there is an absolute lack of services across the board which means that needs aren’t met which means that mothers, babies and extended families suffer. What we see is the intergenerational impact of ACEs which pregnancy, delivery and having a small baby often reigniting difficulties for the mothers (and fathers) from their own ACEs and setting the path for a whole new generation to be thus affected. There was a RQIA (Regional Quality Insurance Authority) report in Northern Ireland making excellent recommendations about psychological support in each neonatal unit and each trust area for perinatal services but these have as yet to be implemented and there is no knowledge of any funding following these recommendations.

Even with these developments, it is unclear how these proposals translate into practice and how local services are implementing some of the recommendations of these documents both in terms of services, clinical skills, staffing and service evaluation.
2. Comments:

The Early Intervention Foundation Published a review of what works to support parent child interaction in the early years (July, 2016). In their review of available interventions to specifically to address difficulties in the parent infant relationship with aims to promote parental sensitivity and reflective functioning/how parents viewed and responded to their child, only five interventions were identified as having the strongest levels of evidence and impact. These include Family Nurse Partnership, Family Foundations, Child-Parent Psychotherapy, Infant-Parent Psychotherapy and Child First. Only 5 interventions were identified for promotion by the foundation as they were based on a clear logic models, had an explicit evaluation framework and were linked to validated measures. Other interventions highlighted as “promising” include Watch, Wait and Wonder, Toddler-Parent Psychotherapy and Circle of Security.

One of the challenges of the literature and why interventions are promoted by the foundation as many clinical interventions are often based on proxy measures, the impact is often difficult to measure routinely.

However the evidence base to support parent-infant relationships, infant mental health and attachment is developing. More research needed with interventions that have clear and explicit evaluation & logic models, include randomized control trials (RCTs) and involve follow up as part of their evaluation. In five to ten years' time, the evidence base of what we know works for children to address parent-infant interaction in the early years could look very different.

Children who present with behavioural difficulties in the early childhood

Evidence for parenting programmes with a strong influence of social learning theory such as Triple P, Incredible Years. (EIF, 2016) However there are often high rates of attrition and children who may be most in need i.e. the children with additional adverse experiences (such as mental health problems e.g. lower socio-economic status, domestic violence) can often struggle to engage and may not attend.

In the NICE guidelines on conduct disorder and anti-social behaviour they term interventions offered to the first group described- those whose risk of developing a conduct disorder is significantly higher than average, as evidenced by individual, family and social risk factors- as selective prevention. Recommendations include classroom-based emotional learning and problem-solving programmes for children aged typically between 3 and 7 years in schools which are intended to:

- increase children's awareness of their own and others' emotions
- teach self-control of arousal and behaviour
- promote a positive self-concept and good peer relations
- Develop children's problem-solving skills.

It is suggested that the programmes should typically consist of up to 30 classroom-based sessions over the course of 1 school year. It is interesting to note the individual, as opposed to multi-modal, nature of this sort of intervention. Such approaches would presumably be most likely to succeed if the main reason that the child was at risk of offending was because of their individual difficulties in emotional recognition, self-control, and problem-solving, rather than if there were significant family and social factors creating the risk.

Children whose Early experience involves a stay on neonatal units

While the evidence base in the USA is encouraging for early interventions for this specific group of vulnerable infants and their families, there is a lack of UK intervention-based research. Longitudinal intervention-based studies would allow us to ascertain what the most effective early intervention are for these infants and their families.

In Northern Ireland there are promising programmes including Tiny Gym introduced to the Northern Trust by TinyLife which combines physio intervention programme and social support. Infant massage for all babies including those born sick and born early has demonstrated efficacy (See International Association of Infant Massage) and also research efficacy (Tierney et al, 2008).

Interventions for children with parents with mental health difficulties

There is preliminary evidence that parent-infant psychotherapy is a promising intervention for children whose parents have a mental health difficulty (Barlow, Bennett & Midgley, 2015), particularly when it is combined with
Interventions that include video feedback interventions such as Video Interaction Guidance (VIG) or Video intervention to promote positive parenting (VIPP) NICE 2015

### Children with developmental difficulties, LD and ASD

There is a range of evidence available, but we fail to make use of it (Gore et al. 2014 Early intervention for children with learning disabilities: making use of what we know. Tizard Learning Disability Review, Vol. 19 Issue: 4, pp.181-189


The Project found that children and young people with LD and challenging behaviour are at greater risk of social exclusion, deprivation, physical harm and abuse. They are also more likely to be placed in costly residential placements. Their families and carers are at greater risk of physical and mental health issues, increased financial burden and reduced quality of life. Delivery of early interventions for children was inconsistent across the UK, with a glaring lack of local support for children and their families.

The authors found Positive Behavioural Support, an early behavioural intervention, to be the most effective evidence-based intervention for supporting children with learning disabilities and challenging behaviour. This was echoed by the NICE guideline findings and recommendations (2015) *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*.

The authors also found that early screening of children with learning disabilities for risk factors associated with the development of challenging behaviours allowed for earlier intervention and reduced the likelihood of challenging behaviours developing later in life.

The Early Intervention Project looked for services who illustrated the provision of early evidence based interventions – see *Paving the Way: Early intervention for children with learning disabilities whose behaviours challenge*. [http://pavingtheway.works/](http://pavingtheway.works/)

### Children with physical health conditions

As mentioned above, there has not been enough consideration given to the impact of physical health conditions and their treatments within the ACES literature in spite of the significant impact these can have. With regards to evidence for supporting the psychological health and wellbeing of babies, children and families living with a physical health condition, there is a growing evidence base supporting the clinical effectiveness of psychological interventions such as Cognitive Behavioural Therapy, Motivational Interviewing, Acceptance and Commitment Therapy and Family Therapy for a number of medical conditions (Sansom-Dalget et al, 2012; BPS, 2009; Fonagy et al, 2015; NHS Education for Scotland 2015; Kashikar et al 2013; Fisher et al 2014; Spirito & Kazak 2006). Some condition specific standards and guidelines specifically recommend the provision of psychological and other psychosocial interventions as part of overall holistic care to prevent the development of psychological distress and mental health difficulties e.g. SIGN Guidelines on the management of diabetes (SIGN, 2010); SIGN guidelines on the management of asthma (SIGN, 2011); and the NHS Commissioning Paper on Paediatric Intensive Care Transport Service (2012/2013).

Specific Examples: Early identification and management of cognitive difficulties associated with conditions like congenital heart disease, cancer and neurological difficulties e.g. through cognitive and neuropsychological assessment by psychologists embedded within medical teams, can help foster resiliency and ensure schools and other relevant agencies introduce appropriate resources to support learning and prevent further impact on quality of life for these children. Early psychological intervention, and overall psychologically informed practice, for expectant parents who are aware that their child will be born with a specific genetic syndrome, or some form of disability benefit from on-going psychological support to help reduce stress, promote coping, prevent post-natal depression, maximise positive bonding and optimise infant brain development.
Interventions for children who have experienced maltreatment

When children have been deemed by Children’s Social Care to be experiencing significant levels of neglect or abuse, a decision is made as to whether the children can remain in the household or need to be removed immediately. If they are remaining in the household, this should be because there is a belief that change can occur, AND because considerable resources are going to be used to support that change occurring. Unfortunately, in many CSC departments, limited resources and lack of in-house methodologies for creating change mean that families are actually in effect monitored rather than intervened with, whilst they continue to struggle. This can mean that the children continue to experience significant harm for prolonged periods, and then are ultimately removed anyway, thus disrupting their initial attachment relationships and frequently creating internal narratives of unlovability and lack of safety in interpersonal relationships (Taylor and Shostak, in press).

Where there are external services available, for example from the voluntary sector or the NHS, families may be referred to these services, e.g. for input around domestic violence, or parenting skills, or individual therapy for an issue that is affecting their parenting such as drug use or depression. But this approach of making referrals and then monitoring whether they are ‘complied with’ fails to acknowledge that it is unlikely that any one would fail with the parenting task (to the extent of their children becoming subject to child protection proceedings) without there being a whole host of factors that are getting in the way of them being able to understand the impact of their current parenting, or being able to engage with change interventions (Taylor and Shostak, in press).

As we say when training staff to work in this field “if it was simple, they’d have done it already”. This is a complex area where simply making referrals to different agencies for the obviously identifiable ‘problem behaviours’ without a good multi-level formulation is unlikely to create change. Access to good psychological formulation around the reasons for neglect or abuse should greatly increase the likelihood of being able to develop multi-modal intervention plans with a reasonable chance of success. Multi-Systemic Therapy-Child Abuse and Neglect (MST-CAN; Swenson et al., 2010), Signs of Safety (Bunn, 2013) and FAMILY (Rostock et al., 2017) are all examples of approaches that attempt to co-develop a complex multi-level formulation of the reasons why a family is struggling in order to develop a multi-level intervention package and with a good evidence base at being able to intervene effectively.

As regards attachment the NICE guidelines, specifically related to case of observed difficulties in attachment, recommend that if there are concerns for children who have experienced maltreatment both child and parents should be offered an attachment based intervention for at least 10 sessions, which promotes parental understanding of their child’s cues and behaviours, to help them to respond positively to their child’s cues and feelings and managing their feelings when caring for their child. If a child has experienced physical, emotional abuse or neglect or has been exposed to domestic violence the family should be offered an attachment based intervention like parent-child psychotherapy, which involves an exploration of the relationship between the “emotional reactions of the parents and their perceptions of the child” and the “parents’ own childhood experiences”, on a weekly basis for 1 year (NICE, 2017).

In thinking about how we might prevent young people being born into environments where they are at high risk of maltreatment it is worth noting the work of Pause (www.pause.org.uk). Innovative projects such as Pause involve psychologically trained staff trying to help understand what motivates decisions to conceive or at least not take measures to prevent conception, and provides multi-modal interventions as appropriate to that particular woman. Initial evaluations of Pause in Hackney and Southwark have been positive, and by the end of the year seventeen teams will be in operation across England (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625374/Evaluation_of_Pause.pdf).

For children who are in foster care:

NICE 2017 recommends that children under 5 who have been abused or neglected who are in foster care should offer foster cares intervention that improves how they foster their child when upset, improve their understanding of what their child’s behaviour means, how to respond positively to cues and expressions of the child’s feelings, behave in ways that are not frightening to the child, improve how they manage their feelings when caring for their child.

Children who have been maltreated who remain at home or who are in foster care require input from multiple agencies including social care, mental and physical health, and education. Services need a model of joint responsibility and partnership and pooled budgets. There is very little available for very young infants and services could target this population to do preventative and early intervention. Services should be aiming to increase carer (both biological parents and foster carers should access interventions) sensitivity to enable
real early intervention. Evidence from the USA indicates some wrap around early intervention approaches can be successful in preventing reoccurrence of abuse and improve mental health outcomes for LAC. The New Orleans Model (NIM) is being implemented as part of an RCT in England and Scotland. Funded by pump priming money from the DfE and supported by the NSPCC, they are currently running an RCT in two sites (Glasgow and London) due to finish in 2021. The model represents an innovative way to implement a treatment programme. It has required buy in from the judiciary because the cases sit under the jurisdiction of the family courts, and typically courts do not preside over treatment. It is a service where adults and children receive comprehensive assessment and treatment for mental health and behavior, and the agencies involved share information and decision making. Findings from the USA indicate an increase in permanency for the children, reduction in incidents of maltreatment in the family home, and importantly an improvement in children’s mental health. If evidence from the UK trial repeats these findings then the model could get rolled out within the UK. This would represent a ground changing shift in the way services are delivered to this population, and by intervening so early could completely change the trajectories for these children. Similar models would be the FDAC-family drug and alcohol courts.

Where children are placed away from home, there are clear correlations between the outcomes for them and the stability of the out-of-home placement. Interventions aimed at supporting and maintaining alternative care placements such as KEEP (Knibbs et al., 2016; Roberts et al., 2016) and AdOPT (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585177/AdOpt_parenting_programme_evaluation.pdf) are frequently based on the same core approaches as group parenting programmes, but with additional components to reflect the differences in parenting a child with a history of disrupted attachments and neglect and abuse. Approaches such as MST and FAMILY have also been used to support foster and adoptive caregivers, and although there is not a separate evidence base regarding their effectiveness with this group, there is good reason to assume that these approaches could be effective in maintaining alternative care placements (Taylor and Shostak, in press).

Summary:
There are few programmes offered in infancy and/or during early childhood that have been monitored longitudinally. As a result, it is difficult to say with confidence which interventions will minimise the effects of adverse child experiences in later life. The evaluations linked the NIM may provide longer term evidence in the future. Another programme that is attempting to intervene early with high risk populations in the early years the “A Better Start” programme funded by The Big Lottery https://www.abetterstart.org.uk/content/programme. The intervention provides a number of interventions to 5 national sites of high risk; and address the known risk factors in childhood including specific programmes for social and emotional development. The programme will be externally evaluated and follow a cohort over time and will allow opportunities for a longitudinal evaluation. https://www.abetterstart.org.uk/content/about-evaluation

We assume that given the impact on the child’s developing brain it is of vital importance to intervene in the early years when there can be maximum impact (e.g. McCrory & Vising, 2015). There are a number of programmes which help ameliorate outcome. They cannot always address the circumstances in which a family find themselves but they can certainly help buffer the impact. Early screening, neurodevelopmental follow up of vulnerable groups (e.g. those born sick and early, those involved within the care system) and specific interventions is essential to good outcome, but there is a paucity of this on a clinical level.

The extent to which local and national government policies for early-years intervention reflect that evidence-base, and the challenges involved in disseminating, accessing and using the latest evidence, as well as the opportunities for intervention suggested by the evidence but not currently being implemented;

Comments:
1001 Critical Days https://www.1001criticaldays.co.uk/ is an explicit endorsement of the importance of early infant relationships, an acceptance of the recent advances in developmental neuroscience, how early infant experience and relationships with key adults support cognitive and psychological development, as well as
laying the foundations for longer term outcomes in later childhood and as adults. The services offered by and linked to PIP® are parent-infant psychotherapy. Clinicians are child psychotherapists and clinical psychologists with specialist training in parent-infant psychotherapy http://www.pipuk.org.uk/.

The recent development and extension of the CYP-IAPT programme to offer training and services for parents with children aged 0-5 is another recognition and opportunity to develop both the CAMHS and third sector workforce to offer therapeutic interventions in the early years.

As highlighted above, Early Intervention Foundation (EIF) has provided a very robust summary of the available therapeutic interventions for infants and young children that have a clear logic model and evaluation framework. It is unclear how the recommendations offered by the EIF and interventions promoted reflect clinical services offered for infants and early years.

However, apart from the services supported by PIP®, there appears to be little linking between services across the UK. Services appear to operate independently, offering different interventions and using different measures to monitor outcomes. However, even as the EIF document suggests, new evidence continues to develop. It will be important for clinical services to remain flexible and open in both their staff make up, training objectives and provision in order to provide clinical services that are linked to the evidence base as it emerges over time.

**Learning disability and neurodevelopmental disorders**

Evidence does get into policy- BUT there is a major gap in implementation. E.g. the Chief Medical Officer’s Annual Report 2013: Our Children Deserve Better: Prevention Pays has detailed analysis, synthesis and recommendations especially for was for early intervention and prevention to reduce health and social inequalities. Drawing on Marmot, (2010), the Chief Medical Officer identified the need for the use of “Proportionate universalism”

“…. to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage”. (Chief Medical Officer Annual Report, 2013, quoting Marmot: Fair Society, Healthy Lives, 2010).

Given the multiple Adverse Childhood Experiences a higher proportion of children and young people with LD and their families/carers will experience, and the health and social inequalities, “proportionate universalism” seemed appropriate and welcome. In reality, there is little evidence of implementation of this and other policy.

More attention is needed to monitor policy implementation and outcomes, celebrate and share success, and hold services to account where they do not implement

**Children with physical health conditions**

There is a lack of due consideration given in local and national government policies for early years intervention that considers the impact of physical health conditions and their treatments, in spite of these difficulties being evidenced in key documents e.g. Kings Fund (2012); National Services Framework (2008); National Delivery Plan (Scottish Government) 2009; BPS FCYP (2015) and in condition specific standards and guidelines specifically recommend the provision of psychological and other psychosocial interventions as part of overall holistic care to prevent the development of psychological distress and mental health difficulties e.g. SIGN Guidelines on the management of diabetes (SIGN, 2010); SIGN guidelines on the management of asthma (SIGN, 2011); and the NHS Commissioning Paper on Paediatric Intensive Care Transport Service (2012/2013). Furthermore, the importance not only of being able to provide evidence based psychological therapies but also to ensure overall that families are cared for by a psychologically informed workforce who recognise the impact of physical health difficulties and their treatments (and recognise these alongside the other ACES literature) is essential in promoting psychological wellbeing and maximise emotional, social, behavioural and cognitive difficulties. Psychosocial mental health practitioners (e.g. Paediatric psychologists) embedded within medical specialties can provide consultation, teaching, training and supervision to clinical and medical staff and teams to increase their understanding of the psychological factors influencing a child or young person’s presentation; and work at a systemic level to promote the relationship between families and the wider systems they are involved in within the hospital setting. This includes teaching and training around the management of common difficulties that clinical and medical staff encounter (e.g. Child in Mind, 2002, NHS Education for Scotland, 2010). Front line workers such as GP’s, Health Visitors, School Nurses, and Teachers in addition to Pediatricians and hospital based Nurses are well placed to identify psychologically vulnerable children and families early. All of these workers could benefit from awareness raising and training in initial identification and psychological first aid. Psychosocial staff are also well placed to advise on service development such as transition and the development of psychological aspects of care pathways and
teaching/training to multi-disciplinary staff to promote psychological well-being and prevent the development of mental health difficulties. Early intervention and prevention ameliorates the secondary burden of chronic health conditions and has implications on trajectory of mental health, school attendance & future employment (BPS 2015).

The support and oversight of research into adverse childhood experiences and relevant interventions, including how research priorities are identified and funded, and the extent to which current interventions are reviewed and contribute to the evidence-base;

4. Comments:

Evidence base of specific therapeutic interventions in early years for the general population is immature, yet developing. As mentioned, there have been challenges with the literature highlighted above. With the advent of CYP-IAPT services for 0 to 5s and discussions between clinical psychologists linked to the Infant Mental Health and Early Years Network, a number of measures have been agreed which are linked to a logic model of intervention to support parent-infant interaction in the years. It is hoped that psychologists linked to the Infant Meant Health and Early Years network, based in some of the newer and established clinical teams for early years can take a lead in the use of outcome measures contribute to the emerging evidence base.

Children with learning disability, the support is low for specialist LD research, as LD and neurodevelopmental disorders are often exclusion criteria in other studies. There then becomes a vicious cycle- lack of research lead to lack of evidence, maintain disability-blindness and institutional discrimination. Researchers and would-be researchers often give up. It is important to build in diversity to research, including LD, not use as an exclusion criteria (Equality Act and responsibilities for reasonable adjustments).

Children with physical health conditions

There needs to more consideration given to physical health difficulties (and their treatments) as adverse childhood experiences; and research should focus on psychological interventions and other strategies (e.g. teaching to ensure all staff work in a psychologically informed way) to promote psychological wellbeing and minimise impact of these difficulties on emotional, social, behavioural and cognitive development. Research needs to focus on gathering the evidence for promoting psychological adjustment and coping with physical health difficulties and their treatments e.g. strategies and interventions to promote bonding and attachment, promote adherence and coping, reduce distress etc. rather than focusing on the rate of mental health difficulties associated with physical health conditions which is often the focus. The former will provide much richer evidence on how to actually ameliorate difficulties and reduce the impact of adverse childhood experiences.

However as the evidence base is increasing over time with more robust and systematic evaluation of clinical interventions in the early years that are based on well-defined logic models, it is likely that the research evidence will improve both in its quantity and quality. As highlighted previously, research that is based on RCTs and which involves both short term and long term follow up will be important to consider. It will be important for practitioners and policy makers alike to be flexible and adaptable as the evidence grows and there is more knowledge about what works best for whom.

Mechanisms for bringing together the collection, communication, application and review of evidence to ensure interventions are evidence-based.

5. Comments:

- NICE guidelines. For e.g. children with attachment difficulties; socio and emotional development; looked after children
- EIF Early Intervention Foundation
- BPS documents such as: What Good Looks Like for Babies and Pre-School Children
- ChiMat – National Child and Maternal Health Intelligence Network News

For children with learning disability - more co-produced innovation and evaluation. Joint sharing of innovation, evaluation e.g. Challenging Behaviour B-NSG national bi-annual meetings. March 2016, the
theme was early intervention and prevention for children, young people and adults with LD. In addition to keynotes and workshops, there was an exhibition of posters focussing on sharing good practice.

2 areas which have co-developed practice, and have been seeking systematic research funding (so far unsuccessfully, apart from small charitable grants):


Children with physical health conditions.

There is already some evidence available that can be collated to address some of the above. The Paediatric Psychology Network UK would be happy to help advise on appropriate terminology for literature reviews, systematic reviews and meta-analysis which collate this evidence. The PPN UK would also be happy to provide consultation on appropriate research questions to help gather evidence on psychological interventions and strategies that promote psychological adjustment and reduce the potential negative impact of physical health conditions (and their treatments), as highlighted as a key focus in the answer to the previous question.

It will also be important for local communities and devolved nations to gather its own data on ACE’s & outcomes, given the unique history and the legacy.

Perinatal mental health has attracted a lot of attention and NHS England has just released a call for people to apply for Wave 2 funding in this area. However in Northern Ireland there is an absolute lack of services across the board which means that needs aren’t met which means that mothers, babies and extended families suffer. What we see is the intergenerational impact of ACES which pregnancy, delivery and having a small baby often reigniting difficulties for the mothers (and fathers) from their own ACES and setting the path for a whole new generation to be thus affected. There was a RQIA (Regional Quality Insurance Authority) report in Northern Ireland making excellent recommendations about psychological support in each neonatal unit and each trust area for perinatal services but these have as yet to be implemented and there is no knowledge of any funding following these recommendations.

Recently the NICE guidelines around attachment and children who are adopted, in care, or at high risk of going into care came out and comments were invited. Please note that if any single group has been most exposed to ACES it is this group. While they add value and should improve outcomes for children – they did not come with funding -….there is no provision for training for staff (specialist interventions are indicated in the guidelines).

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