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UNDERSTANDING AND SUPPORTING MENTAL HEALTH IN INFANCY AND EARLY CHILDHOOD

A TOOLKIT TO SUPPORT LOCAL ACTION IN THE UK

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PEDAL
PLAY IN EDUCATION DEVELOPMENT AND LEARNING

ABOUT US

The **Centre for Research on Play in Education, Development, and Learning (PEDAL)**
is based in the Faculty of Education at the University of Cambridge. We conduct world-leading research on childhood and mobilise knowledge to help to improve children's lives and life chances.

UNICEF, the United Nations Children's Fund, is mandated by the UN General Assembly to uphold the UN Convention on the Rights of the Child (UNCRC) and promote the rights and wellbeing of every child. Together with partners, UNICEF works in over 190 countries and territories around the world, including here in the UK, focusing special effort on reaching the most vulnerable and excluded children, to the benefit of children everywhere. UNICEF has a specific role in providing advice and assistance to governments around the world in matters relating to children's rights.

Here in the UK, **the UK Committee for UNICEF (UNICEF UK)** is a registered charity that raises funds for UNICEF's global work, advocates for change for children, and works with over two million children through our Child Friendly Cities and Communities programme with local authorities, our Baby Friendly Initiative in hospitals and health centres, and our Rights Respecting Schools Award network of 5,000 schools.

UNICEF UK's Early Moment's Matter Campaign highlights the needs of babies and young children. UNICEF UK is asking the UK Government to commit to a Baby and Toddler Guarantee – to ensure that the rights of every one of our youngest citizens are met, and future generations are able to reach their full potential.

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This report should be referenced as:

Hogg, S. and Moody, J. (2023). *Understanding and supporting mental health in infancy and early childhood– a toolkit to support local action in the UK*. UNICEF UK.

SUPPORTING BABIES' AND YOUNG CHILDRENS' MENTAL HEALTH

This toolkit will help partners in local areas to develop whole-system approaches to support babies' and young children's mental health.

Being mentally healthy is a positive state that enables us to enjoy life and deal with challenges and not just the presence or lack of diagnosable conditions. Mental health will be experienced differently from one child to the next but broadly, being mentally healthy in infancy and early childhood[a] enables babies and young children to understand and manage emotions, to experience nurturing, meaningful relationships, and to explore, play and learn. Being mentally healthy in this life stage also enables children to develop the capacities to be mentally healthy throughout life.

Early moments matter. The mental health of babies and young children is important now, and critical for their future health and development. Many services have a role to play in supporting babies' and young children's mental health, and there are many assets and existing services in our communities that can be mobilised to give children the best start in life.

It can be harder for professionals to work together to promote and protect babies' and young children's mental health because mental health in this life stage is not well understood. Babies' and young children's needs – which present differently to older children and young people – are often overlooked[1].

This toolkit aims to support service leaders across sectors (including health, early education, and family support), commissioners and other decision makers in their work to develop whole-system approaches that ensure babies and young children are mentally healthy now and are supported to develop the capacities they need to continue to be mentally healthy throughout their lives.

[a] Babies and young children are children from birth to the age of five. We refer to this period of life as "infancy and early childhood." It is recognised that what happens in pregnancy, and even before conception also shapes babies' and young children's mental health.

Specifically, the document aims to help partners from different sectors, services, and professions to have reflective local discussions through which they:

- develop a deeper, shared understanding of mental health in infancy and early childhood, and the factors that influence it
- appreciate the importance of a multi-sector and whole-system approach to promoting mental health in infancy and early childhood
- reflect together and have constructive discussions about the needs of babies and young children in their area, and what more might be done to respond to these needs.

Through these discussions, local partnerships can build the foundations required to inform better decisions and action, and ultimately better outcomes for babies, young children, their families, and communities.

This toolkit is not a comprehensive "how to guide", rather a source of information, frameworks and prompt questions to support and guide local discussions. It might be used in meetings or workshops where local partners are developing needs assessments and strategies[b]. Taking time to have reflective discussions together on the topics in this toolkit can help local partners to develop a deeper shared understanding of local communities' needs, their local services and care pathways, and their goals and objectives.

The toolkit can be used in its entirety, or as stand-alone sections (for example, someone interested in the workforce might use **Part 6** to support local workforce analysis). Some diagrams are available as stand-alone resources to aid their use in local meetings, presentations and reports. In addition to questions and frameworks, the document contains links to other useful resources.

This toolkit and the definitions within it have been developed with valued input from a range of academics, policymakers, and professionals with the aim of describing mental health in a way that overcomes common misconceptions and misunderstandings and is relevant across professional boundaries. It will not work perfectly for everyone, as concepts around mental health are deeply related to personal experiences, professional understanding and community values. Local systems may decide to adapt the frameworks included here to suit their needs and the needs of the communities they work with.

This toolkit aims to provide a starting point for conversations across the sector. Babies, children and families have so far not been directly engaged in the production of this report, but should be engaged in co-producing mental health definitions, needs assessments and strategies in their local communities. For **examples of participatory engagement in this age group see Part 7.**

[b] These might be local mental health, maternity, early years, infant feeding, or Family Hubs & Start for Life strategies.

HOW TO USE THIS TOOLKIT

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Part 1 describes, in brief, why the mental health of babies and young children matters now, and for their future outcomes. It contains links to other resources to help you make the case for action in your local area.

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Part 2 discusses why it is important that local partners develop a shared understanding of mental health and suggest some reasons why this might be difficult. Use this section, and the prompt questions within it, as the basis for discussions about how your local partners understand and describe mental health in infancy and early childhood, and how this might impact joint efforts to improve outcomes for babies and young children.

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Part 4 depicts a socio-ecological model of mental health, describing how mental health results from the complex interplay between many individual and environmental factors. This section presents case studies, prompts for discussion, and interactive exercises. It might be used to help local partnerships to understand the many different ways in which they can promote and protect mental health, including the role that different services, across sectors, can play.

Part 5: Securing a whole-system approach 58

Part 5 describes what a whole-system approach to supporting babies' and young children's mental health might look like and the characteristics needed in local areas to achieve this. It contains links to frameworks and toolkits that you can use to assess and strengthen local partnerships in your area.

Part 6: Workforce analysis 68

Part 6 describes the workforce competencies and support required to effectively support babies' and young children's mental health. It contains a brief checklist which can be used for local self-assessment.

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Part 8 is a glossary that describes key concepts relating to mental health in infancy and early childhood. This might be shared locally to help professionals from different backgrounds to engage in discussions and develop a shared understanding.

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PART 1: THE CASE FOR ACTION

This section of the toolkit describes why the mental health of babies and young children matters now, and for their future outcomes. It contains links to other resources to help you make the case for action in your local area.

Being mentally healthy

All children, including babies and young children, have a right to the best possible health and development – including mental health[c] - as set out in the UN Convention on the Rights of the Child (UNCRC)[2, 3]. **It is important that the mental health of babies and young children, and their current experiences, are valued in their own right**.

Getting things right for babies and young children ensures they are healthy, free from prolonged stress and distress, and having a good life, from the start. **The earliest years of life also provide the foundation for later development. What happens during this time can have a significant impact on children's future health and happiness, and therefore the health and happiness of our society.**

During pregnancy and the first years of life the brain is developing more rapidly than at any other period in life and is particularly susceptible to environmental influences[4]. **This is a unique period of opportunity and vulnerability, when a child's experiences can have long-lasting consequences.** Physiological systems, such as how the body responds to stress, are shaped during this period. Babies and young children also develop important capacities, such as language and emotional regulation, during this time[5]. These systems and capacities are the foundations for later functioning, learning and development.

When children are mentally healthy in infancy and early childhood, they develop capacities that support mental health throughout life. For example, when babies have sensitive, nurturing relationships with caregivers

[c] Article 6 of the UNCRC highlights the States parties' obligation to ensure the survival, growth and development of the child, including the "physical, mental, moral, spiritual and social dimensions of their development".

who co-regulate their emotions, this supports them to build self-regulation skills, which are key to being mentally healthy throughout life[6].

Mental health in infancy and early childhood also plays an important role in children's wider development and a range of later outcomes. For example, if young children can regulate their emotions, feel safe to explore, and can make friends, they are more likely to be able to learn, engage and achieve in early education and in school. The ability to regulate behaviours and emotions, and to develop healthy relationships, which develop in infancy and early childhood , are strongly associated with good physical health, healthy behaviours and socio-economic outcomes[7].

Supporting babies and young children to be mentally healthy increases the likelihood of a child achieving their full potential and contributing to society and decreases the risk that they will need to rely on a range of public service support throughout life. Therefore, investing in mental health during infancy and early childhood brings economic returns through increased contributions to the economy and reduced public spending. Researchers have calculated that in England, £16 billion per year is spent on remedial action to address issues that result from a lack of high-quality interventions in infancy and early childhood[8].

Factors that can cause poor mental health early in life – such as a lack of stable, nurturing care and/or exposure to significant adversity[d] – also increase the risk of a range of other poor outcomes in childhood, and mental and physical health problems later in life[9]. **Paying attention to, and being curious about a baby or young child's mental health can help us to identify concerns about their relationships, wider health, development, and safety and to act to address these issues quickly.**

[d] Nurturing relationships can "buffer" children from the impacts of adversity. External adversity in the absence of a nurturing relationship is particularly likely to impact on babies' and young children's mental health.

Useful resources

Case for investment and action in the earliest years

- **Big Change Start Small** (The Royal Foundation Centre for Early Childhood, 2021) sets out the economic case for investment in early childhood.
- **Early Moments Matter: Guaranteeing the best start in life for every baby and toddler in England** (UNICEF UK, 2022) brings evidence around the investment case in early childhood, including recent local data on services that support babies and young children.
- **Early Moments Matter for every child** (UNICEF, 2017) makes the global case for investment.
- **First 1001 Days Evidence Briefs** (First 1001 Days Movement, 2021) set out the case for action in pregnancy and the first two years of life, and provide a compelling case for national and local decision makers across the UK.
- **The best start for life: a vision for the 1,001 critical days** (Department for Health and Social Care, 2021) outlines the importance of this life stage, and six areas for action to improve health outcomes of all babies in England.

The science behind early childhood and mental health

The **Havard Centre for the Developing Child** has a number of papers unpacking the science of early childhood and mental health:

- InBrief: Early Childhood Mental Health
- InBrief: The Foundations of Lifelong Health
- Health and Learning are Deeply Interconnected in the Body: An Action Guide for Policymakers
- Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health Are Deeply Intertwined
- The Foundations of Lifelong Health Are Built in Early Childhood

The **Encyclopedia of Early Childhood** also has a range of useful information and articles, including this piece on why mental health matters for young children.

PART 2: REFLECTING ON WHAT MENTAL HEALTH MEANS IN INFANCY AND EARLY CHILDHOOD

This section discusses why it is important that local partners develop a shared understanding of mental health and suggest some reasons why this might be difficult. Use this section, and the prompt questions within it, as the basis for discussions about how your local partners understand and describe mental health in infancy and early childhood and how this might impact joint efforts to improve outcomes for babies and young children.

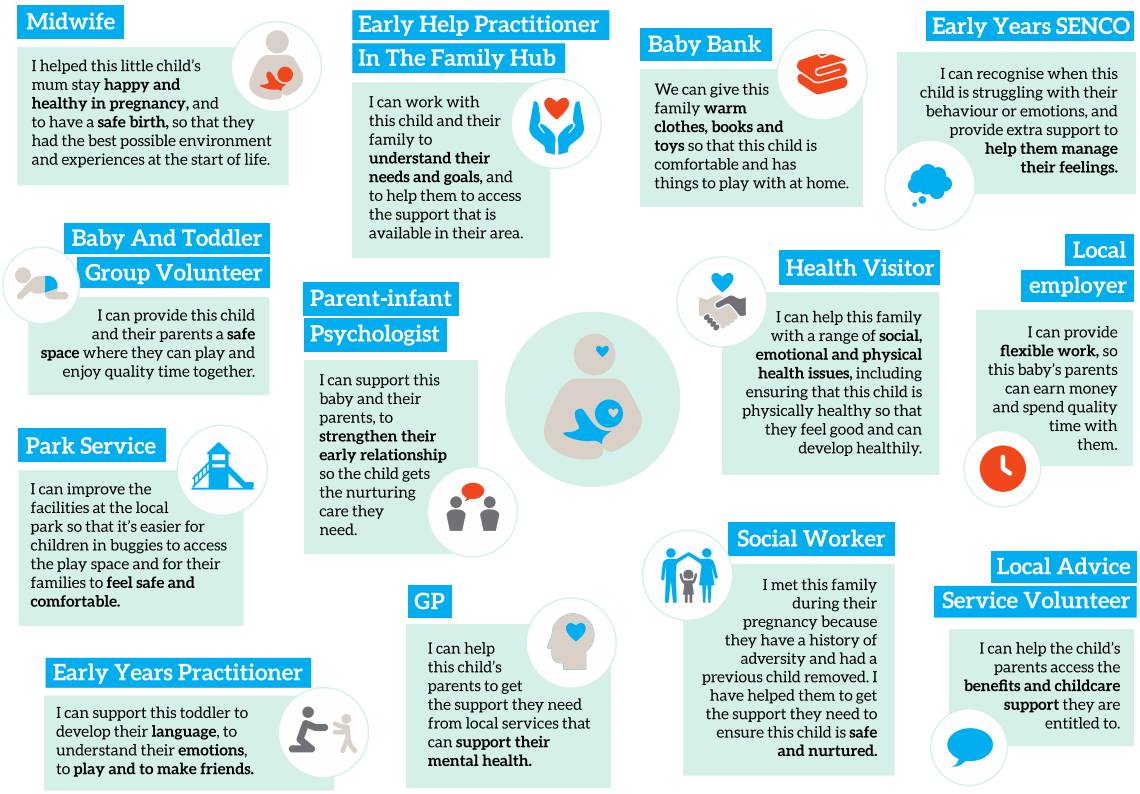
A shared understanding of mental health is an important foundation for a whole-system response

Many different policies and services have a role, alongside families and communities, in supporting babies and young children to be mentally healthy and have the best start in life. In the UK this includes, but is not limited to: maternity services, health visiting, perinatal mental health, parent-infant relationships, children's mental health, early education and care, social care, GPs, child protection services, and voluntary sector services. Between them, these services offer a range of prevention, promotion, early intervention and therapeutic support. Since being mentally healthy is the result of a complex interplay of many factors, no single service could or should be accountable to prevent, detect and address all mental health problems alone.

A whole-system approach is needed which harnesses the skills, expertise and resources of different professionals and services in a coordinated way to support mental health in infancy and early childhood – this is discussed in more detail in **Part 6** of this toolkit.

How the whole system promotes mental health in early childhood

Some of the local services that ensure babies and young children are mentally healthy.



Understanding babies' and young children's mental health requires us to overcome common misconceptions and misunderstandings about mental health

Mental health in babies and young children is not understood as well as that of older children. Often professional training – even for those working in mental health services – does not cover mental health in infancy and early childhood[10]. Babies' and young children's needs – which present differently to older children and young people – are often overlooked[11].

It can be harder for policymakers, commissioners and practitioners across sectors (including health, education, and wider community support) to work together to promote and protect babies' and young children's mental health. This is partly because professionals have different views on what mental health means in infancy and early childhood. There can also be a "baby blind spot"[12] in local mental health strategies and services, particularly evident in the COVID-19 pandemic response[13].

Professionals from different services or sectors, and from different regions, can understand mental health in different ways, use different language to describe it, and use different theoretical underpinnings to support their work[14]. Without the foundation of shared understanding, it is harder to develop integrated approaches. Services can be fragmented, synergies are not realised, and

opportunities to support babies, young children, their families and their relationships can be missed. This toolkit aims to help to address these issues.

Language used for aspects of mental health in infancy and early childhood

Mental health is a complex and multifaceted issue, and many people understand different things when they hear and use the term "mental health". Every person – including practitioners working with families - grows up within communities and cultures that shape their expectations and experiences, including their understanding of mental health.

Concepts around mental health have been developed with adults in mind, and sometimes do not work when applied to infancy and early childhood. It can be harder for adults to keep babies' and young children's mental health in mind, particularly as they are not able to verbally articulate their own feelings.

Research for this document identified three common reasons why people struggle with the concept of babies' and young children's mental health:

Common misconception	New understanding
1. Mental health is often mistaken to mean mental health problems or diagnosable disorders. This framing makes it difficult to understand babies' and young children's mental health because generally, it is not possible or appropriate to diagnose the mental health conditions that occur in older children and adults in the same way in infancy and early childhoode.	**Mental health is not just about the presence or lack of diagnosable conditions.** As the framework *Being and becoming mentally healthy in infancy and early childhood* in **Part 3** describes, being mentally healthy is a positive state, involving the ability to understand and manage emotions, to function well and to build meaningful relationships**.** Everyone has mental health that sits somewhere on a complex continuum and can move up and down that scale at different points in their life. Adopting a positive model of mental health makes it easier to talk to families about mental health: Whilst it may be difficult to discuss the idea of poor mental health in a baby or young child, the ambition for children to be happy and healthy will resonate with most families.
2. Mental health is often misconstrued as something located in an individual – as an innate strength or deficit. This framing makes it difficult to understand babies' and young children's mental health, which is usually shaped by their environment and relationships.	**Mental health for all people – especially in infancy and early childhood – is the result of a complex interplay of internal and external factors.** The socio-ecological model of mental health in **Part 4** shows how mental health is shaped by protective and risk factors at many levels including individual characteristics, relationships and wider environmental factors and social circumstances.
3. People can be concerned that suggesting babies and young children may need support to be mentally healthy wrongly labels a child, or that it is deterministic.	Describing a baby or young child's mental health is not the same as describing a deficit or a problem. Understanding mental health is about what is happening for a child and in their world, and how grown-ups and services can support them. Identifying mental health concerns in infancy and early childhood is not the same as diagnosing a child with a life-long condition. While some early regulation, emotional or behavioural problems may indicate an increased risk of mental health problems later in life, many of these issues are transient, reflect normal variations in development, and will resolve, especially with the right support.

[e] Mental health problems, as traditionally understood, may not emerge until later in childhood, or it might be that emerging mental health problems in babies and young children look different to how they display in older children and adults. Babies and young children can experience regulation, relational, emotional, and behavioural problems. Enduring problems put children at risk of developing clinically significant mental health problems.

Suggested action

Use these reflective questions for discussion

In local strategic partnerships, such as Integrated Care Boards, Health and Wellbeing Boards, Local Maternity Systems and their equivalents in Scotland, Wales and Northern Ireland, reflect together about how you define the term "mental health". You might explore the following issues:

- Do you have a shared understanding of mental health?
- Do different professionals bring different ideas and conceptions?
- Does your concept of mental health apply to babies and young children? Is there any discomfort or misunderstanding about the idea of babies' and young children's mental health?

PART 3: A FRAMEWORK TO DESCRIBE MENTAL HEALTH IN INFANCY AND EARLY CHILDHOOD

This section sets out a framework that captures the different elements of mental health in infancy and early childhood. You might adopt or adapt this to develop a shared understanding of mental health in your local area.

Mental health in early childhood has two components: BEING and BECOMING mentally healthy

The framework over the page provides a way to describe mental health in early childhood, which captures what it means to be mentally healthy now, and the capacities that young children develop to enable them to be mentally healthy in the future. It also describes the different emotional, social and behavioural elements of mental health. Whilst it is useful to consider these three different elements of mental health, they may overlap and be intertwined – for example, emotions often manifest themselves as behaviours, and behaviours may depend on social context. There is also significant interdependence between different elements.

Often the drive to improve services for babies and young children is focused on future outcomes, such as school readiness or the prevention of later mental health problems. This framework includes a clear space to consider their mental health in its own right and to capture what is being done to promote wellbeing and reduce stress and distress for babies and young children in the here and now, as well as laying strong foundations for the future.

Being and becoming mentally healthy in infancy and early childhood

	BEING	BECOMING
	This aspect of babies' and young children's mental health is how they are NOW, which might be described as their **wellbeing.** It describes their present-day thoughts, feelings, emotions and experiences. Being mentally healthy in this sense involves babies and young children feeling safe and good about themselves and the world around them, experiencing sensitive responsive care from a reliable caregiver(s), and being able to explore and play in a way that is appropriate to their level of development.	This aspect of the mental health of babies and young children is related to their **development** of different capacities that enable them to be mentally healthy. It might be called social, emotional and behavioural development. Being mentally healthy in this sense involves babies and young children developing abilities that will help them to be mentally healthy in the future.
EMOTIONAL ELEMENTS	Experiencing a range of emotions as appropriate responses to events and the environment but overall, **being** content, at ease, and feeling safe.	**Becoming** able to express, understand, and manage a range of emotions
SOCIAL ELEMENTS	**Being** engaged in meaningful, safe, caring relationships with others (including both with adults and, as the baby grows, with peers). Trusting they will be cared for.	**Becoming** able to form and maintain safe, satisfying and trusting relationships, including – as children get older - the ability to play with others and form friendships.
BEHAVIOURAL ELEMENTS	**Being** able to enjoy childhood. Exploring, learning, and playing in a way that is appropriate to them.	**Becoming** able to navigate the world, and work towards goals. Developing independence, confidence, and agency. Becoming able to cooperate and play with others to achieve shared goals.

Young children's mental health & development is dependent on nurturing care which includes their physical health and nutrition, responsive caregiver relationships, safety and security, and early learning - including sensory, motor, cognitive and language skills.

Babies' and young children's unique personalities, identities, needs, experiences, and ages will shape what being mentally healthy looks like for them and the support they need. Due to rapid development in infancy and early childhood what mental health involves will vary greatly at the different stages of development.

Babies' and young children's mental health depends on the core elements of nurturing care that include good health, adequate nutrition, responsive caregiving, safety and security, and opportunities for early learning[15], as set out in UNICEF's Nurturing Care Framework[16].

The Nurturing Care Framework, WHO and UNICEF (2018)

Mental health exists in the context of relationships. In very young babies, both the being and becoming elements of mental health are dependent on the presence of adults who can provide sensitive responsive care, and support babies to play and learn. For example, having an adult who can receive, understand, and co-regulate a babies' emotions – such as soothing them when they cry – will improve their emotional state now and support the development of emotional regulation.

As Donald Winnicott famously described, it is only by seeing the baby and their relationships with caregivers together as a unit that one can really understand the baby and their experiences[17]. Focusing on the quality of the parent-child[f] relationship may be the best way for professionals to understand and support babies' mental health. As children get older, they become able to experience and regulate emotions more for themselves and are subject to more influences beyond their relationship with their primary caregiver (although caregivers and close family members continue to play a key role in scaffolding the young child's emotional experiences throughout childhood[18]).

[f] In this case, parent refers to whoever is the child's primary caregiver(s) are, which is typically but not always their parent.

Being mentally healthy is dependent on other sensory, motor, cognitive and language capacities and competencies that develop in early childhood (and throughout life). For example, language contributes to being able to understand and manage emotions and communicate feelings[19]. Executive functions, such as attention control and behavioural inhibition, are important in managing social interaction and emotional regulation[20]. The relationship between mental health and cognitive functions can be bidirectional: to make use of executive functions a baby and young child needs to feel safe and secure, as emotional regulation or relational problems may impact their ability to focus and their levels of impulsivity[21].

Supporting a child's good physical health, development, and nutrition is vital for their mental health[22]. Adequate nutrition affects children's wellbeing now, their early brain development[23] and the likelihood that they will be mentally healthy in the future[24, 25]. Physical health problems can negatively impact a child's mental health[26]. Later in life, there are also significant comorbidities between mental and physical health problems[27].

Developmental conditions, developmental delay, neurodivergence, disability and ill health will affect what being mentally healthy looks and feels like for different babies and young children. Some diagnoses and disorders may also make it more difficult for children to be mentally healthy without additional support or adaptations. All babies and young children need acceptance for who they are, with their own different profiles, strengths and needs, regardless of diagnosis, disability, and individual characteristics. Being mentally healthy should be about being supported to feel and function well in a way that is appropriate to the individual child.

An example
Autism and mental health

I am an autistic toddler. I am happy engaging in solitary rather than cooperative play. I need professionals to understand my strengths and needs, to be able to understand and support me to be mentally healthy. Being autistic can make it harder for me to be mentally healthy in certain situations and environments, especially those designed for neurotypical children. I feel extremely anxious around unfamiliar people and in new places. With the right understanding, adaptations and support, I can feel at ease. I do not tend to use words or make eye contact to communicate my feelings. I need grown-ups to be attuned to the cues I give and the ways I show how I am doing.

Suggested action

Use and adapt this framework to define mental health

Review this framework with leaders from across maternity, health visiting, mental health, early education, family support and children's social care in your area.

- Does it provide a way of describing mental health that all providers can relate to?
- Could you work together, and with families, to develop your own definition of what being mentally healthy means?

Examples of being 'mentally healthy' in early childhood

Showing, in italics *how children are supported by adults* in their lives.

I am two days old. *When I cry, my grown-up holds me skin-to-skin. Breastfeeding quickly calms and comforts me.* This makes me feel safe, secure and loved.

I am 9 weeks old. When I'm feeling calm and alert, I open my mouth wide, *my grown-up notices and does the same with his mouth.* I smile at him, and he smiles backs, this helps me to feel connected and to develop a sense of myself.

I am four months old. Getting my nappy changed and cutlery clanging in a drawer can make me cry. I also cry when I'm feeling hungry, uncomfortable, or poorly. When I cry, *I'm soothed and comforted quite quickly by the grown-ups around me* who can help me to feel calmer and safer.

I am six months old. who is curious about the world around me. I enjoy picking up or touching things that interest me. I most like chewing on my toys and find it funny when my dog wags his tail.

I am 14 months old. I seek out connections and feel good when I experience *care and love from the grown-up close through eye contact, cuddles and smiles.* Knowing that I have the support of those close to me helps me to gain a sense of security and confidence to explore my world in the way I want to. When I am taken to playgroup, I crawl back to my caregiver if there is something I'm not sure about. After a *quick cuddle,* I'm ready to go again!

I am two-and-a-half. I can get frustrated when I have to do something I don't want to. Today I cried and lay down on the ground because I didn't want to walk home from the park. My *grown-up understood* that I was tired and sad to be leaving the swings. *They gave me a cuddle, told me I'd done a great job walking so far, and reminded me that we could come back to the park tomorrow.* This helped me feel calmer, I stopped crying, continued walking for a little while, and then asked to be carried the rest of the way.

I am 18 months old. I know *the grown-ups around me love me because they smile and laugh at things I do, they give me hugs, and lots of encouragement when I'm trying new things.* I feel happy, safe, and relaxed when I'm at home with my family.

I am nearly three. I feel capable of trying new things, even when they're tricky. I used to push and hit when I got cross, but now I can breathe deeply and keep going. With the *encouragement of the grown-ups around me,* I know I can try, try, try again.

I am three. I have a favourite friend at nursery who I like playing cars with. Sharing is something I'm still learning to do, but most of the time I'm able to take turns playing with our favourite cars. She makes me laugh when she pulls funny faces.

I am four. Sometimes I feel worried when trying out new things. I started Reception a few months ago. I was able to tell my grown-ups at home and my nursery key worker that I was feeling scared. *They helped me feel less nervous by listening to what was worrying me,* and we found some ways to make me feel more excited to start school. In the beginning, I still cried when I had to leave my grown-ups, but *my friends and new teacher were kind and comforted me* so I quickly felt more settled and happier at school and formed new relationships.

I am four-and-a-half. I love using my imagination. I enjoy being with other children at school but I'm happiest when I'm playing on my own and creating whole new worlds with my action figures. I'm really good at building towers for my figures to jump between. It can be hard to build the towers, so I need to be calm and careful to make them balance.

PART 4: A SOCIO-ECOLOGICAL MODEL OF MENTAL HEALTH IN INFANCY AND EARLY CHILDHOOD

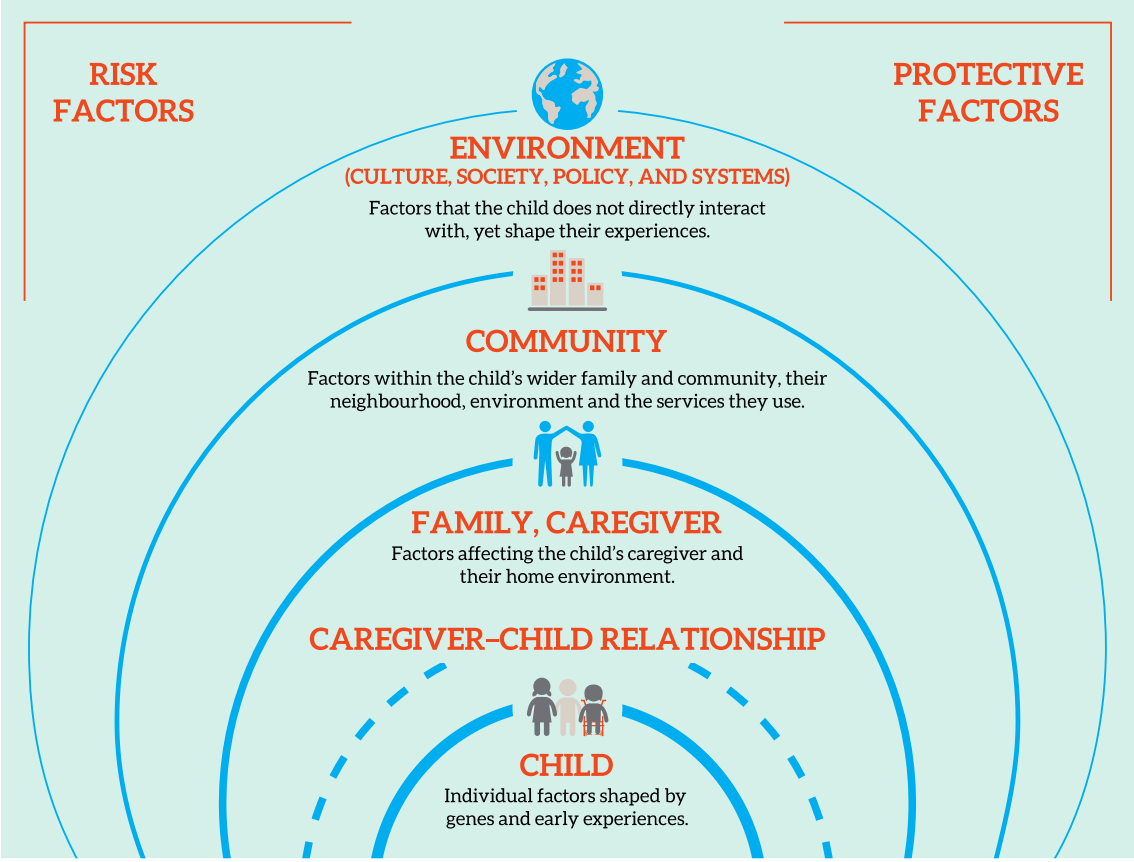
This section depicts a socio-ecological model of mental health, describing how mental health results from the complex interplay between many individual and environmental factors. This section presents case studies, prompts for discussion, and interactive exercises. It might be used to help local partnerships to understand the different ways in which they can promote and protect mental health, including the role that different services, across sectors, can play.

Mental health is impacted by a complex system of factors that act at different levels

Mental health occurs as a result of a complex interplay between many individual and environmental factors, such as a baby or young child's own capacities and characteristics, the quality of their relationships, and the communities and environments and society they live in. Understanding the different factors that influence mental health is important to identify how different organisations and services can be involved in promoting mental health in local systems.

This socio-ecological model describes the levels of a baby or young child's world, that each shape (and interact to shape) their mental health from pregnancy through childhood. This model illustrates the importance of networks of people and structures that surround a child safeguarding their wellbeing and supporting their optimal development as outlined in UNICEF's Global Mental Health and Psychosocial Support (MHPSS) Framework[28], and UNICEF's State of the World's Children report[29]. This toolkit highlights relationships as a distinct level because they are so critical to mental health in this age group[30].

A socio-ecological model of mental health in infancy and early childhood



The spheres of influence on babies' and young children's mental health and development are dynamic and evolve throughout pregnancy and childhood. They also interact with one another. For example, a child's individual characteristics may shape their experiences ("nature" influencing "nurture") which can in turn influence their wellbeing: Some children have a propensity to cry excessively early in life, which can make it harder for parents to provide sensitive and responsive care, particularly if they are also experiencing other factors such as poverty, which place them under considerable stress[31].

At each level of a child's world there are **RISK FACTORS** that can reduce the likelihood that a child will be mentally healthy, and **PROTECTIVE FACTORS** that are likely to promote mental health or mitigate the effects of risks[g]. Examples of risk and protective factors can also be found in **UNICEF's global multi-sectoral operational framework on mental health**. None of these

[g] Risk factors in childhood can be known as adverse childhood experiences (ACEs). Sometimes this term refers to 10 specific risk factors, and in other cases it can be used more broadly to describe different sorts of adversity. More detail is given in the key concepts section.

factors are deterministic, but they do increase or decrease the likelihood of a child being mentally healthy. The extent to which risk and protective factors influence a child's wellbeing and development depend on factors such as their exposure, context, and timing. Different factors may affect children differently depending on their characteristics, circumstances and context, and developmental stage.

To support babies' and young children's mental health and development, local systems should work together to reduce risk factors and build protective factors at all levels of a child's world. Some risk factors can be modified through interventions, in other cases, support can be targeted to mitigate the impact of risk factors on children's mental health – this might be called secondary prevention or early intervention.

Experiencing an accumulation of different risk factors is a strong predictor of poor outcomes[32,33]. Research shows that understanding which children face a number of different risk factors is a better way to predict poor outcomes than identifying any single risk. Therefore, it is important that local systems do not consider risk factors in isolation, but understand which children and communities are facing multiple forms of adversity. This requires services to work together and share information.

The following part of this toolkit will expand on each level of the socio-ecological model, describing more about risk and protective factors, and giving examples of interventions which can promote babies' and young children's mental health.

Useful resources

Socio-ecological models of mental health

- UNICEF's Global Multisectoral Operational Framework and Brief on the Social Ecological Model, aim to support developing prevention, promotion and treatment programmes to improve the mental health and psychosocial wellbeing of children, adolescents and their caregivers globally.
- NSPCC's All Babies Count: Protection and Prevention of Vulnerable Babies (2011) and the Harvard Centre for the Developing Child's Foundations of Lifelong Health report (2010) both contain versions of socio-ecological models of early child development.

Suggested action

Use these questions to think about how you can catalyse a whole-system response to babies' and young children's mental health.

- What local structures and partnerships should lead work to improve babies' and young children's mental health and development?
- Do these structures and partnerships bring together all the relevant partners who act at different levels of a child's world? If there are gaps, how might this be addressed?
- As you read this section of the toolkit, consider which organisations have data about the risk and protective factors affecting babies and young children in your local area? Are there ways to share and analyse data to understand which babies, families and communities are experiencing an accumulation of risk factors?

Level 1: the influence of child-level factors

The likelihood that a child will be mentally healthy now and, in the future, can be influenced by characteristics of the individual child, such as:

- biological factors (e.g. genetics)
- physical factors(e.g. birthweight, or presence of a disability)
- psychological factors (e.g. cognitive ability, temperament, or neurodivergence)[34].

Each child's individual characteristics shape the world around them – for example, adults might respond differently to babies depending on their temperament, gender, or appearance. Individual characteristics can also mediate how other factors in the world affect a child. A child's genes, for example, may influence how sensitive they are to adversity and how responsive they are to support[35].

Individual characteristics can be the product of genes, babies' environment in utero, postnatal early experiences or a combination of these things. A child's biology can be influenced by their environment even before birth[36]. For example, maternal stress during pregnancy can influence the baby's developing brain and body, shaping how they respond to stress and increasing the likelihood of mental health problems later in childhood[37, 38].

Babies' and young children's developing brain and body, including their stress-response systems, are shaped by their early environments. This can influence their ability to deal with challenging sititatons, and can increase the risk of later mental health problems. Babies and young children whose environments are repeatedly harmful or threatening to them (for example, if they are exposed to violence and/or significant adversity), and who do not have nurturing relationships, experience prolonged periods of intense stress and distress. This is known as **toxic stress** and can create **latent vulnerability,** which means a greater risk of experiencing challenges later in life[h].

Local health services including maternity and neonatal services, health visitors, GPs and voluntary sector services, can play a critical role in reducing risk factors in the child, through, for example, ensuring more women have healthy pregnancies. These services can also put support in place to mitigate the impact of individual risk factors on children's relationships and development, as illustrated by the case studies below.

[h] Toxic Stress and Latent Vulnerability are explained in the **key concepts** section. There are excellent resources on these issues produced by the UK Trauma Council.

Examples of interventions to address factors influencing individual children

An example with some evidence of impact
Newborn Behavioural Observation

The Newborn Behavioural Observations (NBO) system is a tool designed to help parents and practitioners observe babies together. By reflecting together on babies' signs, movements and responses to stimuli, practitioners and caregivers can learn more about who babies are and what they like and dislike. Observing behaviours can show the babies' strengths and the kind of support they need. It may, for example, help professionals to offer individualised guidance to parents whose babies may be more sensitive and harder to soothe.

Professionals from a range of backgrounds can be trained to use the NBO, which can be used with babies between birth and three months old. Some examples of NBO use include:

- A neonatal nurse in a NICU with a baby and parents before discharge
- A health visitor on a home visit to carry out the new birth visit
- A midwife or maternity support worker as part of postnatal care
- Psychologists working with families in the early years.

Results from evaluation show that the NBO has benefits for parents and for babies, including those facing a range of challenges, and it can strengthen important parent-infant relationships.

An example with some evidence of impact

FICare – supporting babies in Neonatal Intensive Care

Babies who are premature or unwell after birth may have to spend time in Neonatal Intensive Care (NICU). This can have an impact on the emotional health of both the parents and the babies.

Family Integrated Care (FICare) enables parents to be partners in their babies' care in NICU. The programme aims to facilitate collaboration between parents and the NICU staff, to promote parent-infant interactions, and to build parent confidence. Parents are taught and supported to care for their baby in the NICU, including feeding, bathing, administering medicines and tracking growth. Parents also take part in medical rounds which helps them understand and participate in care decisions for their baby.

Research suggests that babies cared for under the FICare model in NICU have less stress and better health outcomes compared to those cared for primarily by staff, and that FICare decreases parent stress and improves breastfeeding rates. A randomised control trial in Canada found that babies who had experienced FICare had fewer internalising and externalising behaviour problems at 18 months.

An example of putting this into practice

UNICEF UK Baby Friendly neonatal programme

The Baby Friendly Neonatal programme helps professionals to provide sensitive and effective care and support for parents enabling them to make an informed choice about feeding and so improve the short- and long-term health and wellbeing outcomes for all babies, including the most vulnerable. Around 1 in 7 babies born in the UK each year are admitted onto neonatal units, meaning that many parents are adapting to parenthood in a highly technical environment with the anxiety and stress that comes with having a premature or sick baby.

Supporting parents to build a close and loving relationship with their baby is complex, and the Baby Friendly standard of involving 'parents as partners in care' on the neonatal unit has started to change the culture from seeing parents as visitors to valuing them as true partners in their baby's care. The Baby Friendly standards have been successful in supporting health professionals to overcome many of these barriers, thus enhancing the parent-baby relationships. These include:

- Unrestricted access for parents to be with their baby
- Supporting families to provide comforting touch at any time, including during procedures
- Prolonged skin contact/kangaroo care
- Positive touching/holding
- Talking/singing/reading to the baby.

Level 2: The influence of the caregiver-child relationship

Nurturing relationships, particularly the relationship between the child and their parents or primary caregiver(s)[i], are arguably the most significant protective factor for the mental health of babies and young children. Children need at least one adult who can provide consistent, sensitive, responsive, and appropriate care to enable them to be mentally healthy[39].

Sensitive, responsive, consistent relationships support current wellbeing and future development in several ways: these relationships help children to learn how to experience, manage and understand their emotions, and feel safe and secure to explore the world around them[j]. Early relationships provide a

An example
Infant feeding and mental health

Alice (Mum to Alfie 3 months old) suffered with anxiety during a very difficult pregnancy. Alfie was born prematurely and spent several weeks in the neonatal unit. Both high levels of maternal stress in pregnancy, and premature birth are known **risk factors** for later mental health problems.

Alice was encouraged to offer Alfie lots of skin-to-skin care and was supported to breastfeed. Skin-to- skin can help facilitate breastmilk production and breastfeeding. It also builds closeness and bonding for parent and baby. These are **protective factors** known to help mental health through reducing stress, supporting parent-infant relationships.

For more information see:

- The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards.

[i] Primary caregivers are typically children's parents, but in some cases babies and young children may be in the care system or may spend significant periods with other family members, other trusted adults or childcare professionals. Cultural differences also influence who cares for child, in collectivist cultures, a child might be cared for by a wider network of family and friends.
[j] The examples on page 20 show *in italics how grown-ups support* babies' and children's mental health.

template for children's expectations in later relationships. These relationships also help young children to develop their sense of self and support the development of language and cognitive functions[40,41,42]. Alongside providing sensitive, nurturing care, caregivers can support early wellbeing and development through engaging in stimulating activities with babies and young children (such as play and book sharing), practicing responsive feeding in infancy (and making the most of mealtimes for connection for young children), and through using consistent, sensitive, and non-harsh approaches to discipline[k].

Sensitive, nurturing relationships can "buffer" babies and young children from external adversity in the world around them. For example, a tiny baby in a home where there is overcrowding and conflict between adults, whose parent can hold them close and soothe them, may not experience the same level of toxic stress as a result of this environment compared to a baby who doesn't receive this responsive care[l]. Conversely, a baby in a home free from violence may still experience high levels of toxic stress if he or she does not have a caregiver able to help him to feel safe and secure, and to respond when he cries or is hungry.

As a child gets older, they experience more of their own world directly, rather than mediated through the interactions with their caregivers. Babies and young children also have relationships with other adults and peers beyond their primary caregivers, and these wider networks grow and become more significant as they get older. However, relationships with parents and other primary caregivers continue to be important to mental health across the early years.

Most parents want to do the best for their child, but when they experience stress, particularly in the absence of support, this can make it harder for them to provide their babies with the nurturing care they need. Local systems can support early relationships by reducing the pressures and stresses on parents and improving their capacity to provide sensitive nurturing care[43].

Parenting support should be made available to **every** parent/caregiver including mothers, birthing parents, and fathers; foster carers and others playing the caregiver role such as grandparents and kinship carers. Adopting common

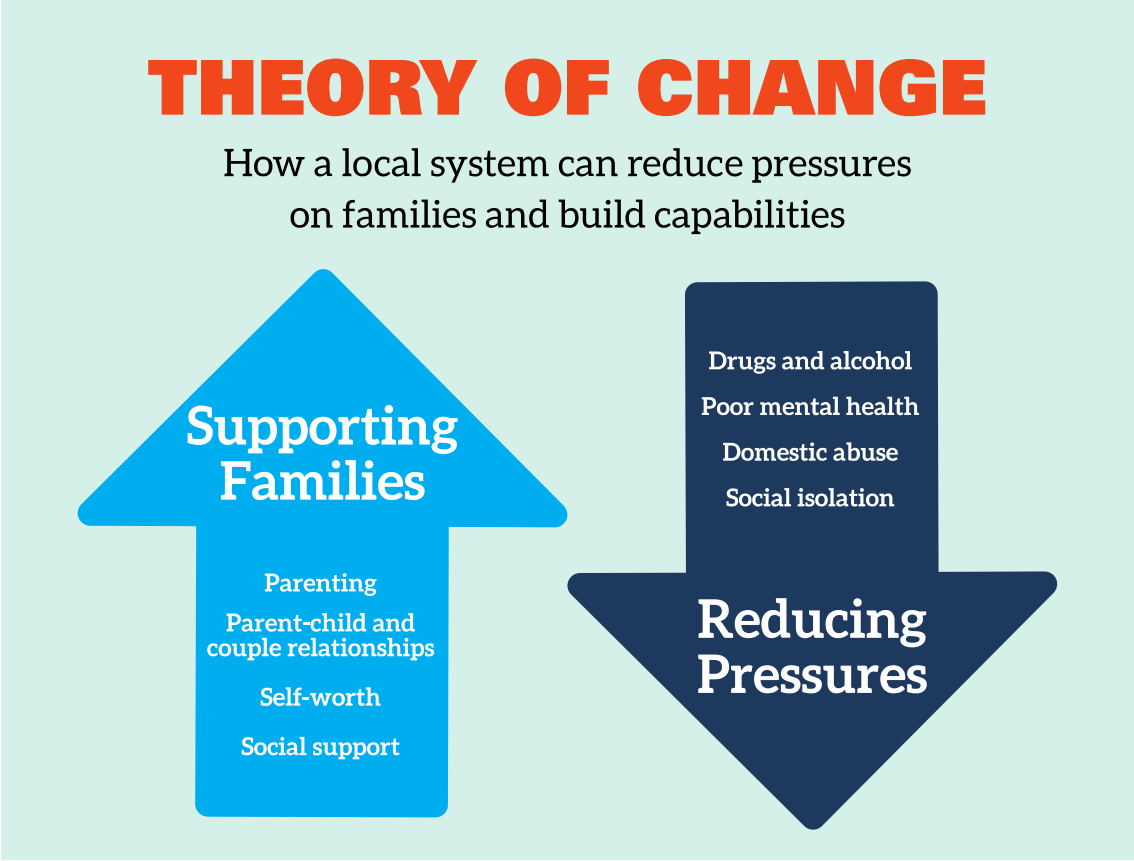
[k] Sensitive discipline refers to responding to a child's behaviour and setting rules and boundaries in way that is sensitive to the child's needs. It also involves explaining commands, prohibitions or refusals to the child, and in doing so, paying attention to the perspectives and feelings of other people who might be harmed by the child's behaviour.

[l] It should be acknowledged that if the parent/caregiver in this scenario is experiencing trauma and distress it may be harder for them to be attuned and responsive to their babies' needs.

language and approaches to supporting early relationships across services will mean parents get consistent and reinforcing messages from different universal, targeted and specialist services. **Part 5** discusses a whole-system approach in more detail.

Whilst stresses on adults impact early relationships, evidence suggests that sometimes addressing these stress factors is not sufficient to improve children's outcomes, and services need to attend directly to the quality of early relationship as well[44,45,46]. Universal services like maternity services (including midwives) and health visiting can do a lot to promote sensitive, nurturing relationships. Some families experiencing complex and persistent challenges may need specialist help, such as that provided by specialised parent-infant relationship teams. In some cases, if a parent cannot provide the care that babies need, child protection services may need to intervene and remove the child from the family temporarily or permanently.

Reducing pressures and building capabilities



This model from the Blackpool Better Start Strategy shows how a local system can reduce pressures on families and build capabilities.[47] Other factors to consider to reduce pressures and support families include access to safe housing, adequate food, employment, financial literacy, and others.

Examples of interventions to support caregiver-child relationships

A local example
Five to Thrive – Universal information for parents

Five to Thrive is an approach that helps practitioners across different services to deliver a consistent, science-based approach to parents and families, and to reinforce positive interactions between adults and children. The approach centres around five key activities, which are seen as the "building blocks for a healthy brain". These are: Respond, Engage, Relax, Play and Talk.

KCA Training provide face-to-face and online learning for practitioners to understand and apply the Five to Thrive approach, alongside a range of resources such as printed, online and digital guides, posters and other tools which can be shared with parents.

Since 2014, KCA has licensed the use of Five to Thrive to more than 50 different organisations from top tier local authorities to individual nurseries and schools.

An example with some evidence of impact
Targeted support for early relationships

The Healthy Start, Happy Start research study tested the impact of a targeted intervention where health visitors used video feedback to support parents to interact with their babies and toddlers in a sensitive and responsive way.

The study used an intervention called Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) over six home-based sessions. VIPP-SD involves practitioners filming parents playing with their children and providing focused feedback. Robust research shows that VIPP-SD supports both parent-infant relationships and infant mental health.

Targeted support for early relationships (continued)

The programme was offered to families with children aged between one and two who were exhibiting some behavioural problems as part of a randomised control trial.

Follow up studies five months and two years after the intervention found that children in families who received VIPP-SD had lower levels of behavioural problems[a]. A five-year follow up is now looking at whether this impact has been sustained.

A local example
Specialised support for early relationships

Leeds Infant Mental Health Service is a small, multidisciplinary specialised parent-infant relationship team. The team is led by a consultant clinical psychologist and includes a Family and Systemic Psychotherapist, and infant mental health practitioners from a range of professional backgrounds, such as health visiting and social work. All are highly trained with specialist expertise in supporting early relationships. The team offer a range of direct therapeutic support to families experiencing persistent difficulties in early relationships, as well as specialist consultation, reflective case discussions and training to the wider workforce across the city. Caregivers and professionals are positive about the service.

Families who use the service directly often have difficulties in their early relationships, as well as additional concerns such as parental mental health problems, unresolved loss/trauma, domestic violence and social care involvement. The team are trained to deliver a range of interventions, including evidence-based manualised programmes. Each family will receive a tailored package of support that caters to their needs. For example: video-informed work, alongside Watch me play!* to support the parent-infant interactions and relationship.

*Watch Me Play is an approach that promotes child-led play, individual attention from caregivers, and talking with babies and children about their play. Caregivers are asked to provide age-appropriate toys and their undivided attention in a quiet environment for regular short times two or more times a week.

Suggested action

Mapping parent–infant/child relationship support

You may wish to do a mapping exercise with local partners to consider the quality and reach of relationship support in your local area. Questions to ask might include:

- Are professionals across universal services (maternity, health visiting, early childhood education and care) giving families information, advice and encouragement to support relationships and promote skills for nurturing, responsive care across pregnancy, infancy and early childhood?
- Is the language and approach consistent across services?
- Do professionals have access to training, advice and support to enable them to respond appropriately if they have concerns about early relationships?
- Is additional targeted support available to families for whom universal advice and support may not be sufficient or suitable? Consider families facing disadvantage and adversity; families in marginalised communities; and families where parents may not be babies' primary caregivers.
- When services are working with adults, are they asking whether they have a caregiving role and signposting or referring parents for support with early relationships where appropriate?
- Are there clear pathways to additional support when professionals or families identify concerns about early relationships?
- Is there sufficient, high quality targeted and specialist support to respond to additional needs?
- What do you know about local parents' experiences of the information, advice and support on offer? Are there opportunities to get more insights from families to improve local support?

The case study of understanding needs in Birmingham, shown on page 76, is an example of a local area who have done this sort of mapping exercise specifically for babies and toddlers. Similar work was also conducted by the Parent-Infant Foundation for Cwm Taf Morgannwg in Wales and by NSPCC in Scotland.

Useful resources

For professionals

- The Parent-Infant Foundation's Development and implementation toolkit for specialised parent-infant relationship teams (2019), and commissioning toolkit (2022) are useful resources for any local area wishing to establish a specialised parent-infant relationship team. They include information on understanding need; mapping local provision; evidence-based intervention; workforce development and measurement and evaluation.
- The Early Intervention Foundation has further resources on healthy relationship support for parents of children with behaviours that challenge.
- UNICEF Caring for the Caregiver Package (CFC) focuses on enabling front-line workers to promote caregivers' mental health. CFC provides front-line workers with skills and activities to address barriers by encouraging self-care, partner and family engagement, and problem-solving barriers to resources.

For parents

- UNICEF's Parenting Hub brings together some of the world's leading experts to support parents with helpful tips, insights and facts.
- The BBC's Tiny Happy People page has lots of ideas for parents about bonding with their baby.
- The Institute of Health Visiting has a downloadable leaflet on Making Sense of your Baby and Getting to Know Your Baby.
- The Association of Infant Mental Health has a webpage about getting to know your baby.
- Ready Steady Baby has ideas for parents about bonding during pregnancy

Useful resources

Infant feeding and early relationships

The UNICEF UK Baby Friendly Initiative is an evidence-based, staged accreditation programme which works with public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life. The programme is recognised and recommended in numerous government and policy documents across all four UK nations, including the NHS Long Term Plan and National Institute for Health and Care Excellence (NICE) guidance.

The UNICEF UK Baby Friendly Initiative supports maternity, neonatal, health visiting and children's centre services to transform their care and works with universities to ensure that newly qualified midwives and health visitors have the strong foundation of knowledge needed to support families. This is done by:

- Setting standards which provide a roadmap for sustainable improvements
- Providing training and personalised support to help services implement the standards
- Assessing progress by measuring the skills and knowledge of health professionals, and interviewing mothers to hear about their personal experiences of care.

For further information:

- UNICEF UK Baby Friendly Initiative website
- About Baby Friendly accreditation
- Relationship building resources
- Baby Friendly training courses

Level 3: the influence of family, caregivers and the home environment

Babies' and young children's caregivers – particularly their parents or primary caregivers – their homes, and immediate environments are important for their mental health. Access to adequate nutrition, stable and safe housing, and to toys and enriching environments (sometimes known as the 'home learning environment') are all protective factors at this level. Housing quality matters, not only for babies' and young children's physical health but also for their mental health. Living in a home that is too small or that is inadequately heated is associated with greater difficulties in social and emotional development[48]. Children in poverty, especially those in temporary accommodation, refugees and sylum-seeking families are particularly at risk of living in environments that put their mental health at risk.

When a child spends time with other caregivers outside the home, including formal childcare and early education settings, they are also part of this immediate environment. The quality of childcare and early education, including the relationships that children have with adults in those settings, are key to mental health for all babies and young children who use these settings. Early childhood education and care can support a child's mental health through providing the opportunity to develop relationships with trusted adults, sometimes remedying the absence of such relationships in the home environment. Evidence shows that high-quality early childhood education and care experience is related to better social, emotional and behavioural development[49,50].

Because caregivers are so important, factors in their lives also shape the world of the child for better or worse. Parental factors, such as untreated mental health problems, unresolved trauma[m], or experiencing violence in the home are all risk factors to the child's mental health, whereas parental wellbeing, family-friendly employment and positive couple relationships can be protective factors

Maternal mental health problems in pregnancy and the first year of life are known as perinatal mental health problems and can have particularly significant impacts on children's wellbeing and development if the right support is not in place. Maternal mental health problems can influence a child's developing mental health through several mechanisms, including exposure to stress hormones in the womb, and through its impact on the maternal-child relationship and interactions.

[m] This might be trauma from the parent's past, such as a history of childhood adversity. It may also be trauma relating to their journey to parenthood, including pregnancy loss or birth trauma.

Paternal mental health can also impact on a child's wellbeing and development, and there is a growing recognition of the need for mental health support for fathers and partners of the birthing parent, including through targeted services.

When mothers or birthing parents have moderate or severe perinatal mental health problems, specialist perinatal mental health services have the specific expertise required to work with parents, babies, and their families in the perinatal period. Once a child is over two, families are not eligible for specialist perinatal mental health services, but it is important that adult mental health services still recognise that people in their care may be parents or caregivers and may need support in their parenting role. In these situations, it's also important that services work together to understand and support the needs of children in the adults' care.

The extent to which factors in parents' lives influence a child's mental health in infancy and early childhood depends significantly on the extent to which parents are receiving support, and whether these factors impact the parent-child relationship and the parent's engagement with positive activities with the child. For example, when parents are mentally healthy, and when the family have toys and books at home, the parent and child are more likely to engage in play and learning activities that support the child's wellbeing and development[51,52].

Services can support babies' and young children's mental health through both providing quality mental health services to improve parents' mental health or to address other challenges in parents' lives (reducing stresses) and through support to repair and strengthen parent-child relationships and ensure the baby receives sensitive, responsive care (increasing capabilities).

Local services can support families to create the best possible world around the child by ensuring that all families can access safe, secure housing; nutritious food (e.g., via infant feeding support), access to toys and stimulating activity in and out of the house, and access high-quality and affordable childcare and early education. Integrated working between services, and with voluntary and community sector groups can ensure that support reaches the most vulnerable and marginalised communities.

Useful resources

Perinatal and parental mental health

- Prevention in Mind (NSPCC 2013) describes what perinatal mental health is and why it matters.
- The Maternal Mental Health Alliance's Resource Hub contains a range of reports and resources for local commissioners and service leaders who wish to improve support for mothers with mental health problems and their families.
- Earlier this year, the Maternal Mental Health Alliance also released a new briefing on domestic abuse and perinatal mental health.
- Dads Matter UK works with Dads and partners to support their mental health and relationships. They provide a list of resources and advice, including on access to support.
- The Institute of Health Visiting and the MMHA have produced a new interactive evidence review to support local action on perinatal mental health.
- The Royal College of Psychiatrist's Guidance CR232 sets out recommendations for the provision of services for childbearing women.
- The charity Our Time provides advice and support across the UK, including through Family Hubs, to support children and young people who have parents experiencing mental health problems.

Examples of interventions to support families and caregivers

A local example

Home-Start Camden and Islington's support for families

Home-Start Camden and Islington provides support and practical help to parents of children under five. A volunteer, who has parenting or childcare experience themselves, regularly visits a family in their own home, offering support for as long as it is helpful or needed.

Raffy* was three when his older sister was diagnosed with blood cancer. His mother became very stressed and anxious, and had to spend a lot of time looking after his sister and attending visits. Due to the pandemic, she was scared to leave the house or have any professionals enter her home, so Raffy's family became quite isolated.

Their Home-Start volunteer started supporting Raffy's mum with weekly video calls, which provided a vital outlet that allowed her to express herself and learn coping mechanisms for the feelings she was struggling with. Home-Start helped the family to mix again, starting with monthly outdoor meetups with their volunteer, and then engagement with other services like the children's centre. They also helped to secure a nursery place for Raffy, so he had more opportunities to socialise and play.

*All names have been changed.

A local example

Daniel's Den overcoming risk for families

Daniel's Den is a Brent-based parent and toddler charity that supports families and communities through parent-toddler groups and other activities. Many families who use Daniel's Den have limited space to play and access to toys at home.

'The Net' is a Daniel's Den project currently running for asylum-seeking families residing in a local hotel. Families have limited resources, living on an allowance of £8 per week and sleeping in one room.

Samaan* is a very lively two-year-old who comes to the group with his father. They are in the hotel because they are fleeing violence in their home country. Samaan and his father enjoy coming to the weekly group sessions, as well as other activities such as a community picnic. At the Net, Samaan can enjoy a selection of toys, crafts and activities and can play in a way that he can't within the confines of their hotel room.

Samaan's father has a very positive experience of the group and has also found parents from his home country to make friends with. The family can also access donated toys and clothes from families within the Daniel's Den community.

*All names have been changed.

A local example

Let's Talk Together in Hounslow – supporting early education and childcare

Let's Talk Together (LTT) is a programme to ensure early education and care settings provide an exemplary environment in which babies and young children can have meaningful conversations which support both their emotional and language development.

Practitioners are supported to reflect in detail on their interactions with babies and children and the environment they provide, learning more about how they can actively develop good communication skills using an emotionally connected {relational} approach.

LTT has been running in Hounslow for over nine years and is funded by the Early Years Education Team.

Settings also create a working action plan which includes ratings of confidence and competence of the LTT setting on different elements of the programme. Progress data on children's communication development is collected twice a year to inform planning.

Over 50 settings are involved in the programme. Regular "cluster meetings" enable LTT leads from settings to share practice and reflect on their progress.

Useful resources

Early childhood education and care

- The EIF and PEDAL Early Years Library helps early childhood education practitioners support young children's social-emotional development, by providing a comprehensive set of evidence-based strategies and activities which can be integrated into everyday practice.
- Improving the early learning outcomes of children growing up in poverty: a rapid review of the evidence (2018) contains a review of the evidence about how to support parent-child relationships and the wider home-learning environment in the early years.
- The Education Endowment Foundation has brought together a new Early Years evidence store, and toolkit to help support professionals to make decisions about the creation of learning opportunities, including personal social and emotional development.
- Early Years in Mind is a free online network for early years practitioners. The network provides easy to read and easy to use guidance on supporting the mental health of babies, young children and their families.
- Language as a wellbeing indicator (EIF, 2017) describes how language supports mental health in early childhood.

Level 4: the influence of community-level factors

A range of further factors within the child's wider family and community environment can influence mental health in infancy and early childhood. These include social factors (such as wider family and community networks), economic factors, cultural factors, and the characteristics of neighbourhoods (including access to green space, safety and security of neighbourhoods, facilities, and clean air).

Community-level factors determine whether babies and young children can access positive activities, such as a playground, play groups, and high-quality, affordable early education and childcare. They also influence whether their parents can access formal services and informal support. Young children living in poverty face increased risk factors and may have less access to the high-quality services and support that might mitigate these risks[53,54,55].

Regardless of an individual family's circumstances, the neighbourhood they live in has an independent influence on children's outcomes. For example, social factors such as safety, social cohesion and collective efficacy[n] influence early childhood wellbeing and development through their influence on parents' access to resources to support their development, parental wellbeing, and parenting behaviour[56].

Local decision-makers can strengthen community-level protective factors by considering babies', young children's, and families' needs in the design of communities, parks and public spaces, in transport policies, and in the location of services. The voices, experiences and needs of all citizens - including the youngest – should inform decisions about local infrastructure and the design of services.

[n] Social cohesion refers to the sense of solidarity and the quality of relationships in a community. Collective efficacy refer to the a shared belief that, through unified efforts, the community can overcome challenges and achieve goals.

Example of an intervention addressing community-level factors

A local example

Transforming parks to welcome children

Blackpool Better Start has invested £1.8 million into developing and improving green spaces and play resources for babies and young children across the town. During consultation with families, Blackpool parents voiced concerns about not having safe, welcoming places to for their children to play. The investment was used to improve 15 green spaces for the community.

In Revoe Park consultation with local families led to three disused bowling greens being transformed into a natural play space and a community garden being created. A disused pavilion was transformed into an Early Years Park Ranger (EYPR) Base, and regular Park Ranger and Forest School activities now take place in the community garden for babies and children. The park has become a welcoming area that local residents take pride in and value.

Before the renovation, George Banford Park's early years play zone was in a secluded location and rarely used. There was visible evidence of drug paraphernalia, equipment was often vandalised, and antisocial behaviour was common. Consultations with families, and understanding the community's needs and wants, resulted in the relocation of the early years play zone to a more accessible and visible space, and the addition of a pram park.

Suggested action

Seeing the world through babies' and young children's eyes

You might want to organise for a group of local decision makers to get out into a community(s) in your local area to consider first-hand how it is experienced by babies, toddlers and their families, to generate new insights and perspectives. Use data about your local area to focus on a community where you know families with babies and young children with higher levels of need might live.

You could perhaps hold a regular meeting in a community venue and spend an hour before the meeting exploring together. Use this opportunity to build relationships and develop new ideas together about families' experiences. During the time you could:

- Talk to families about their experiences*. What can they tell you about their communities? What do they like and not like? How do they feel in their local environment?
- Observe where babies, young children and their parents are, and where they are not? What can this tell you about families' preferences and needs?
- Try taking a buggy or pushchair with you, can you access public transport and facilities? Can you move freely around the space? What facilities are in "pram pushing" distances of where families live?
- Visit places parents with babies might go, such as the GP surgery or park, is there useful information and advice available? Would parents in this community know what other opportunities there are for them and their children to access positive activities and support nearby (particularly free and low-cost options)?
- Get down to the height of a small child (under one meter tall) and take photos of what the world looks like from that perspective (or give children cameras and ask them to do this). What new insights do you get about the built environment and public space when you see it from a child's perspective?

*Any conversations with families in the community should not just be with the adults. With help and permission from caregivers, adults can reach out to children and find out their views too.

Level 5: the influence of the wider environment (culture, society, policy and systems)

Babies, young children, and their families will be affected by regional and national policies and circumstances, and by the values and practices of their wider cultures and societies. They will be exposed to different economic, social, and environmental factors and might benefit from different support, services and social policies, depending on the region or nation they live in. While local decision makers may not determine national policies or conditions, they can nevertheless help to mitigate their impacts and support parents to take advantage of the opportunities they create.

As with every aspect of the socio-ecological model, the impact of factors in the wider environment on babies' wellbeing and development is mediated by factors at other levels. For example, the impact of the COVID-19 pandemic and resulting national lockdown policies on babies and young children varied depending on family circumstances and the presence of other protective factors, and local systems took different actions to mitigate the impact of these national policies[57,58].

A UK example

#ShapingUs campaign changing social attitudes

The Princess of Wales' #ShapingUs Campaign aims to shine a spotlight on the importance of the first five years of a child's life, to build public understanding of the importance of infancy and early childhood. The campaign hopes to generate support for focusing our collective time, energy, and resources to build a supportive, nurturing world around the youngest members of our society and those caring for them.

An example

Employment policies

Parental leave and pay policies, and their take-up by families, have an impact on babies' and young children's relationships and development. There is international evidence to suggest that take-up and length of paternity and maternity leave are associated with parental sensitivity and the quality of parent-infant relationships, with knock on impacts on children's development.

Parental leave and pay policies are determined at a national level, but local services can make decisions about their own leave, pay and flexible working policies, and can support and encourage local employers to adopt family friendly policies.

Social and cultural factors, such as expectations of children (including gender expectations), and societal views on child rearing practices and family make-up, influence children's health and development in different ways both directly and indirectly. These expectations and values may be consistent across a region or nation or may vary between communities. Babies and young children might be parented differently in different cultures, which influences their expectations and needs. For example, some babies and young children may be used to being looked after by multiple caregivers, or to being kept physically close to their caregivers and may respond differently to other experiences based on these early experiences and expectations. When a families' culture and practices differ from the expectations of their wider society, this might influence factors such as parental confidence and wellbeing.

Some models of mental health include an aspect of 'spiritual wellbeing' which can be influenced by the religious or spiritual views and practices of a child's family and community. More information on spiritual wellbeing can be found in the key concepts section of this toolkit.

Factors in the wider environment can create structural inequalities which mean that the resources and experiences necessary for to be mentally healthy are not equally distributed according to ethnicity, gender, income, geography, and other factors[59].

Poverty results in a constellation of risk factors for children, increasing their risk of poor mental health through a number of different mechanisms. Poverty

disproportionally affects babies and young children, particularly those in families where someone is disabled, there is a single parent, or who are part of a racially minoritised community[60,61]. Babies and young children from households living on low incomes, and those with parents in receipt of benefits relating to low income and disability, are more likely to have mental health problems than other children[62].

A local example

Little Village

Little Village supports families with babies and children under five living in poverty in London. The charity runs a baby bank network, collecting, sorting and passing on pre-loved clothes and equipment, and donations of new items such as nappies and mattresses, to families who are dealing with poverty. Alongside daily essentials, Little Village aims to provide appropriate pre-loved books and toys with all baby bundles, to support families with play and in book sharing and reading, which are critical for babies' and children's development.

Little Village supports parents who use the baby banks through a dedicated signposting and guidance team, who offer over the phone and in-person advice and links to other services on issues including money, benefits and housing. The charity also advocates on behalf of families with other professionals or external organisations such as local councillors, housing office and the Citizens Advice Bureau.

Many of Little Village's services are delivered by volunteers from a wide range of backgrounds. The charity's volunteering opportunities not only enable parents to support their communities and build connections, but also to build skills and experiences that might help them to secure paid work in the future.

The charity also works to reduce poverty in the UK, by working with families to share their stories and campaign for change at a systemic level.

National policies relating to employment, benefits, and housing influence child poverty levels, as do national economic conditions. Local services can help to address poverty by supporting parents to find appropriate employment and to access benefits they are entitled to. Local services can also mitigate the impacts of poverty on babies and young children, for example through offering services that reduce parenting stress; support the home learning environment and can help families to buy warm clothes and nutritious food.

Families from racially minoritised groups are affected by structural inequalities that can have significant impacts on outcomes for children. For example, Black women are significantly more likely to experience physical and psychological trauma and poor outcomes during pregnancy and birth in the UK[63], and Black children are less likely to attend early education and childcare, and are less likely to be healthy and reach their potential as a result of a range of structural factors[64,65].

Discrimination is a risk to mental health and is intersectional in nature (interacting with other characteristics such as race, gender, ethnicity, socioeconomic status, or sexual identity). Discrimination in society can impact on the stress experienced by families and on the assets available to them (for example the levels of formal and informal support they receive). Young children from racially minoritised communities and/or those who experience physical disability, illness, developmental disabilities, and/or are neurodivergent may also face multiple forms of discrimination both from peers, adults and the wider world.

Negative racial stereotypes can lead to children from racially minoritised communities developing a negative self-image, even in the preschool years[66], and children can face exclusion from peers. Services that support families with babies and young children, particularly within early childhood education and care, can support young children to develop a positive relationship with their racial identity[o, 67].

Services can be more inclusive for all children, and avoid discrimination, by adopting a neuro-affirmative approach. This involves expecting that young children will have varying needs and having the resources and capacity to cater for these needs as part of the "business as usual" operation of the service. A neuro-affirmative approach is a commitment to being inclusive; to accept that all individuals are different and that neurodivergence will exist within service

[o] The way in which parents and professionals teach children how to navigate the often contradictory messages about race, and teach them about their own racial identity is called racial socialisation.

users; and to be ready to accept, understand and adapt to the needs of each individual child.

Ultimately, addressing the core drivers of discrimination in society will be key to supporting mental health. Whilst such discrimination exists, services, communities and families can mitigate its impact by addressing discrimination or prejudice in settings and communities in their local area and supporting protective factors, such as ensuring children receive sensitive, nurturing care from caregivers who understand their needs and individual circumstances. In early childhood settings, the EYFS (2021) 'seeks to provide equality of opportunity and anti-discriminatory practice, ensuring that every child is included and supported'.

Professionals and services are also shaped by the world in which they operate. Working with babies, children and families requires individuals and organisations to reflect on their own culture, values and beliefs, and on the impact of systems of oppression such as racism, classism, sexism and ableism in order to provide diversity informed, culturally attuned services.

Useful resources

Additional reading on addressing structural inequalities

- Anna Freud Centre guidance on helping young children to think about race in the early years for both practitioners and parents supports early years practitioners and those supporting young children to understand how race and racism impacts children in infancy and early childhood, and start to think about ways to support racial socialisation during this vital period. This also includes links to further reading including 'Racial Socialisation as Resistance to Racism, the Early Years' and 'Reflecting on anti-bias Education in Action: The Early Years'.
- Anna Freud Centre have also produced guidance to support children as they develop their own identity: Supporting families from diverse communities.
- The Early Intervention Foundation have published a report on 'Improving family support services for minority ethnic families' exploring the experiences of families in accessing and receiving support and opportunities for support services to improve this.
- UNICEF report on gender inequality in early years settings
- Anna Freud Centre have produced guidance for services that support families with young children on supporting parents with learning difficulties or disabilities. They have also recently published a guide to neurodiversity in the early years.
- The Family Hubs network have also published an article with guidance and case studies on supporting Family Hubs to be accessible for parents with disabilities.
- Famly (Tembo, Benham, 2022) have published a series of articles around heteronormativity in early education and care and the importance of recognising and addressing heteronormativity in policies and practice.
- Shaddai Tembo sets out the need to think more about race and racism, LGBTQ+ equality and the role of men in early years, looking specifically at the Scottish context in: More work to do: thinking through equalities with young children in Scotland.

Understanding problems that babies and young children experience

Mental health occurs along a complex continuum, and all babies and young children will have mental health that sits somewhere on that continuum. Some babies and young children may be mentally healthy across all domains, while other babies may exhibit problems with specific aspects of mental health, such as regulation of their emotions or behaviour.

All babies and young children struggle to manage their emotions and exhibit behaviours that challenge at times. It is expected that all children might exhibit 'internalising' behaviours such as becoming withdrawn, feeling anxious, crying, or having trouble sleeping from time to time or during some phases of development. They may also sometimes exhibit 'externalising' behaviours like aggression (hitting, biting, kicking), destructiveness, temper tantrums, noncompliance and/or impulsivity. It's important that babies and young children have the care of the adults around them to respond appropriately to these difficult times. For most children these behaviours are a normal part of development or are transient problems and are not, in and of themselves, a cause for concern in terms of their mental health.

Some young children may show emotional or behavioural problems[p] that can be more significant, particularly if they are more extreme, persistent across different contexts, cause more significant distress and/or stop children being able to play, interact and learn. Babies may have regulation problems that affect sleeping or eating, lead to excessive crying, or that lead them to be very quiet, withdrawn and compliant.

Significant and persistent issues should prompt professionals to be curious about what is happening for a child and to investigate further to understand their development, their relationships, and their experiences (without stigmatising children that may not conform to the normal expectations). Professionals should be aware that a baby or young child's emotional or behavioural problems may be the result of neglect or maltreatment at home, in which case, alongside supporting the child, professionals should follow safeguarding procedures. For more information on safeguarding, please refer to NSPCC guidance.

[p] More information on mental health in under 0-4 year olds can be found in Centre for Mental Health's 2018 briefing on this age group.

Causes and persistence of problems

Problems in regulation, behaviour and emotion may be due to factors at any of the levels described in the socio-ecological model impacting on the baby or young child's immediate experiences and relationships. The same external behaviours might indicate different underlying factors in different babies or young children. While some problems may be the result of a child's biology or a developmental condition, others might be an adaptive response to situational factors and the child's experiences, but both none-the-less can cause difficulties for the child. Regular contact with children, and a holistic understanding of their development, relationships and home environment are important to addressing the nature and cause of any emotional or behavioural problems they may display.

Some problems in early childhood, such as excessive crying, may resolve as the child develops and do not indicate underlying problems in regulation. However, these problems may still have consequences for the child, for example through their impact on the developing parent-child relationship and adults' perceptions of the baby[68].

Persistent regulation, behavioural and emotional problems, as well as very passive or overly compliant behaviours, should be taken seriously BOTH because they are preventing children from thriving now, and because acting to address problems that emerge in early childhood may reduce the risk of poorer outcomes later in life. Delays in diagnosis and appropriate support for young children who have additional needs, such those who are neurodivergent or who have communication and interaction needs, can exasperate or increase the risk of mental health problems[69]. It's therefore important that babies and young children are supported to get the help they need when they need it.

An illustrative example

The need to think holistically about a child's needs

A nursery setting may find that a child regularly struggles with managing their emotions and is aggressive towards other children. There are strategies that the setting may put in place to help the child to understand, manage, and communicate their emotions and regulate their behaviour. But unless professionals across services work together to understand a child's home environment and relationships, they may miss other vital elements which will help to understand and manage their behaviour.

Understanding whether the behaviour is unique to the childcare setting or persistent in other contexts may tell practitioners more about whether the behaviour is due to the child's wider environment; individual characteristics, or an unmet need in the setting itself.

It is important to be curious about the child's home environments. Perhaps this toddlers' parents are experiencing a high level of stress which makes it harder for them to respond to their needs? Perhaps the child doesn't have a safe, secure place to sleep at home or has been exposed to abusive relationships or arguments between their parents? Perhaps the home environment is supportive and safe, but there remain emotional problems which could signal another unmet need, or neurodivergence?

Working across services to understand and address the causes of regulatory, social, emotional and behavioural problems is not only key to supporting the toddler's mental health but will also ensure that underlying issues – which might include safeguarding issues – are detected and addressed.

Prevalence of regulation, behavioural and emotional problems

The absence of consistent and effective approaches to screening and assessment makes it hard to estimate the proportion of babies and young children who are mentally healthy. The Mental Health of Children and Young People in England survey has made important progress in extending its work to include younger children (2–4-year-olds), but as this is pilot data, there remains uncertainty about prevalence. Best estimates from the international literature suggest that mental health problems in very young children are likely to be of a similar prevalence to those of older children and adolescents (10-15%)[69]. A study in Copenhagen suggested that 16-18% of 18-month-old children had mental health problems, most commonly disturbances of emotion, behaviour, eating and regulation. Parent-child relationship disturbances were found in 8% of the population[70].

The most widely used measure of child development currently used in UK health services is the Ages and Stages Questionnaire. Data provided by local authorities in England suggests that significantly fewer children are reaching the expected levels of development on the ASQ-3, falling from 84.1% pre-pandemic to 80.9% post-pandemic. The proportion of children experiencing difficulties with personal-social skills increased from 7.1% in 2018–19 to 9.2% in 2021–22[71]. These trends speak to the impact of the pandemic on young children's development and wellbeing[72].

Scenarios to support local discussions

These examples show transient or persistent issues with babies' and toddlers' emotional, behavioural and social wellbeing and development. They are provided to help local services to understand the provision and pathways of care for babies in their local area to identify gaps or opportunities. When reading each example, consider would this baby or toddlers' problems be identified? How would services understand what is happening for them? How would they receive appropriate support?

I am 9 weeks old.
I'm very quiet and subdued. My caregivers haven't shown me much interest or responded to my cries so I've stopped making as much noise. I am not spoken to and spend a lot of time in my car seat. I don't seek out eye contact with adults in the way other babies my age do.

I am 4 months old.
I cry a lot and grown-ups find it very hard to soothe me. I struggle to settle for feeds. I do not like being put down. I wake often at night and do not sleep easily during the day. My grown-up is getting very distressed about my crying and is also exhausted because we wake up so much.

I am 7 months old.
My grown-up is very anxious, particularly around food. I'm very interested in food, watching what people eat and reaching out. But my grown-up gets upset when I do that. She says things like I am not ready yet and might choke, or that my hands might be too dirty.

I am 14 months old.
I am happy playing with bricks and cars and pushing my fire engine. I don't point at things or make eye contact with grown-ups or other children.

I spend a lot of time with all the grown-ups and other children in my household and wider family who love me very much. I don't go to nursery or playgroups. My health visitor spoke to mum on the phone when I was 10 months old, and we won't see her again until I am two.

I am 18 months old.
When I get frustrated with other children, I can bite and hit. My grown-up used to take me to play groups and to other people's houses to play, but now she is so anxious about my behaviour that we stay at home a lot.

I am two. I'm just started nursery and I really don't like it. I get very distressed when we start to get ready to go and cry a lot in the car, when we arrive and when my grown-up leaves. I've started to cling onto my grown-up more at home and don't let her leave my sight – even to go to the toilet. If my grown-up goes out I cry and sob and try and get the babysitter to call her, so she does not go out as much anymore. At bedtime I'm refusing to go to sleep unless my grown-up stays with me.

I am nearly three.
I love running around, jumping and climbing. I live in a very small flat and the neighbours told my grown-ups that I am very noisy when they are trying to rest. So my grown-ups try and get me to sit still and watch TV. I love our local park, but we can't afford wellies and warm coats so we only go there on good weather days.

I'm am four. My grown-up and I have moved around a lot, and other people have lived with us at different times. At pre-school I'm very reserved and don't play much with other children. I have developed a good bond with my key worker and am very anxious to leave her, particularly if different adults come into the setting.

I am very jumpy and startle easily. When something goes wrong, like I spill my drink, I get incredibly upset and am hard to console.

I am four-and-a-half.
I am very chatty and playful and particularly love dinosaurs. I find it hard to sit still. I fidget a lot and don't focus on tasks. I struggle in circle time at pre-school because I can't wait my turn and keep talking, interrupting people, and moving around. My swimming teacher told mummy I couldn't move up to the next group because I won't follow instructions.

PART 5: SECURING A WHOLE-SYSTEM APPROACH

This section describes what a whole-system approach to supporting babies' and young childrens' mental health might look like and the characteristics needed in local areas to achieve this. It contains links to frameworks and toolkits that you can use to assess and strengthen local partnerships in your area.

To increase the likelihood that every baby and young child will be mentally healthy now, and throughout their lives, there must be a whole-system approach to drive action at all levels of a child's world, and ensures every baby, young child and their family gets the support that works for them and is appropriate to their needs[73].

There are many different models, such as the one in the table below, that describe the different elements and levels of the system that influence babies' and young children's mental health. Local systems will adopt the models that work best for them. A whole-system approach involves looking at all of these levels of the system holistically, to ensure there is a strategic and integrated approach.

This way of working (for 0–2-year-olds) has been endorsed in England through the Family Hubs and Start for Life programme guidance for local authorities which recommends cross-sector and multi-disciplinary governance structures, strategies across perinatal mental health and parent-infant relationships, and identifying shared outcomes for families to influence decision-making at the ICS level[74].

Services that support babies and young children in local areas can often be underresourced, and undervalued, and delivery is patchy regionally[75]. That is why UNICEF UK's Early Moments Matter campaign is calling for a National Baby and Toddler Guarantee, asking for the government to resource and deliver a nationally recognised suite of accessible, high-quality services for babies and young children in every area.

Continuum of support[q]

Levels of support		What this looks like in practice
Promotion	**Promotion of positive mental health and wellbeing**	There is strategic, joined-up local action to increase protective factors in the population, so that more babies and young children are mentally healthy. This would also include improving awareness and understanding of how to support babies and young children's mental health in the population and destigmatising mental health issues.
Prevention	**To address risk factors**	There is targeted support in place for families to minimise risk of and prevent mental health problems from arising, particularly for for those experiencing adversity and at greater risk of developing mental health problems.
Care	**Early intervention**	There are timely, appropriate interventions in place when babies and young children experience adversity and/or problems relating to their mental health to prevent these problems from escalating or becoming entrenched.
	Treatment or therapeutic support to treat or manage problems and reduce their impact	There is early identification, assessment, and appropriate treatment when babies and young children are experiencing problems, such as emotional, behavioural or regulation problems, or relational trauma (including abuse and neglect), to provide therapeutic support to address these issues and mitigate their impact on the child's longer-term wellbeing and development.
	Continuing Care	There is ongoing management, support and treatment to address persistent problems. This should include support for the young children and their parent(s) or caregivers.

These different levels of intervention can be used to think about how to address risk and protective factors at each level of the baby or child's world. For example, premature birth is a risk factor for mental health problems.

[q] Adapted from UNICEF '[Continuum of MHPSS needs]' model, 2019.

Primary prevention activity related to this might be action to reduce smoking and alcohol use in pregnancy, and to increase folic acid intake , so that fewer babies are born prematurely. Family Integrated Care, discussed in Part 4, is an example of early intervention or targeted support, which aims to mitigate the impacts of prematurity on the babies' wellbeing and development. Psychologists on neonatal units can provide therapeutic support, and parent-infant relationship support to families who feel that their experiences have impacted on their wellbeing and relationships.

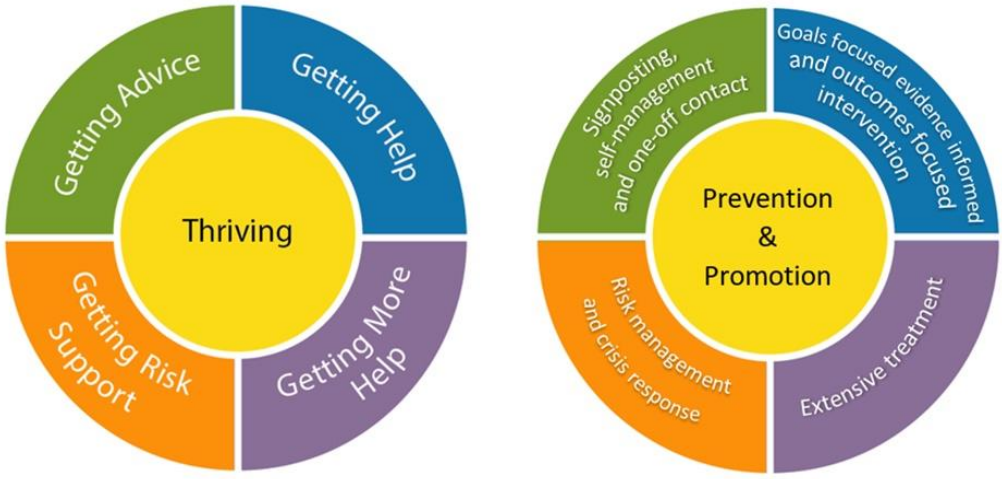
Alongside the three-tier model described above, there are other models which local areas find useful when thinking about the whole system of babies, children and young people's mental health provision. Two such models – NEST and iThrive are described in more detail below.

Adopting a trauma-informed approach across a whole system will support efforts to improve babies' and young children's mental health. Trauma-informed practice aims ensures practitioners are aware of how trauma can negatively impact individuals and communities and improves "the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use[76]". Trauma-informed practice includes 6 principles; safety, trust, choice, collaboration, empowerment, and cultural consideration.

Examples of whole-system approaches for supporting babies' and young childrens' mental health

An example
The THRIVE Framework for system change

The THRIVE Framework for system change (Wolpert et al., 2019) is an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and their families that was developed through a collaboration of the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. It conceptualises need in five categories: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support. Emphasis is placed on prevention and the promotion of mental health and wellbeing across the whole population.



The THRIVE Framework for system change, Wolpert et al., (2019)

An example
The NYTH or NEST Framework

The NEST Framework is a planning tool for Regional Partnership Boards that aims to ensure a whole-system approach for developing mental health, wellbeing and support services for babies, children, young people, parents, carers and their wider families across Wales. It was co-produced by the Together for Children and Young People (T4CYP2) network and a wide range of stakeholders.

The NEST Framework, Together for Children and Young People and NHS Wales Health Collaborative

Effective prevention, promotion and treatment of mental health in early childhood must be underpinned by a well-trained, well-resourced and well-supported workforce. **Part 7** describes the skills, capacity and support required across the workforce.

An effective whole-system approach needs to be supported by robust analysis of local need. There also needs to be clear pathways of care so families can receive timely and appropriate support as they need it. **Part 8** sets out ways that local systems can understand risk factors and needs.

Multi-sector working

Integrated work between different agencies and across sectors, at all levels of the system from strategic planning and commissioning to front line delivery, is key to improving outcomes for all children. Well-integrated early years services and systems can help ensure babies', children's' and families' needs are identified, and that they can access additional support in a straightforward and timely way. Other positive effects include: increased understanding, trust and cooperation between services; better communication and consistent implementation of services; less duplication of processes across agencies; more user involvement in shaping services; more early identification and up-stream support; and a smoother path from universal to targeted and targeted to specialist support[77]. Conversely, when services are not joined up, babies' and children's needs may be less visible and more likely to "fall though the net."

Bringing services, commissioners, and service users together to effectively create, deliver and sustain a whole-system approach to promote, protect and improve babies' and children's mental health, requires certain conditions to be in place. These include:

- Clear partnership arrangements at a strategic level with clarity of purpose, good working relationships, accountability, and the ability to drive decisions and actionr.
- Strong committed political and operational leadership.
- A good, dynamic understanding of local need based in data, insights from communities and clear feedback loops between frontline services and strategic leaders. A culture and clear processes to support sharing information across and within organisations.
- Good relationships with local communities and with voluntary and community organisations that work within then.
- A culture of learning, creativity and problem solving[78].

It is important to note that whilst promoting mental health in early childhood forms an important part of preventing mental health problems in adolescence and adulthood, it will not alone be sufficient. Some children will need repeated support throughout their lives. However, when children have effective early support, it can make later intervention even more effective[79]. An joined-up approach can ensure that children can transition between different services as they grow up (for example, moving from parent-infant relationship services to children and young people's mental health services).

[r] Partnerships to drive action on mental health in 0-5s might be part of a local integrated care board, health and wellbeing board or similar local partnership arrangements.

Examples of multi-sector working

A local example

Salford's integrated approach

In Salford there are a range of services work together to support families during pregnancy and the early years of life, and there is a whole-system approach to early help and school readiness. A network of "Salford Family Hubs" in local communities offer a range of universal and targeted support including Antenatal support, Child's Health, Early Help, Play Sessions, and Parenting support. Locality based teams are based within the family hubs and are made up of staff from various professional backgrounds including Early Help, Parenting and Health Practitioners.

Family hubs are co-produced community provision, and each one is tailored to meet the unique needs of its local community. Community Workers employed by Salford Community and Voluntary Services (CVS) help to link family and community organisations with family hubs, and to facilitate joint working. In some hubs, community groups might run the coffee and chat or stay and play groups.

The Early Years and Early Help teams in the local authority are integrated into the Family Partnership team and work closely at a strategic and operational level with the health visiting service. Training and workforce development happen jointly to prevent professionals "thinking in silos". Professionals are trained in the Five to Thrive and Solihull Models* to support the development of secure, sensitive relationships within families.

A "transformation midwife" has been recruited by the local authority to help to integrate maternity services into local work to improve infant mental health. A range of other services also work with the local authority to support families with babies and young children, these include Home-Start (which offers a Baby Bonding programme), Dad Matters (which works directly with fathers) and a Specialised Parent-Infant Relationship Team.

*The Solihull Approach works with practitioners to support emotional health and wellbeing in children and families. It brings together three core psychological constructs of containment, reciprocity and behaviour management, with the aim of helping parents understand their child's behaviour in the context of their development and the parent-child relationship.

A local example

Manchester joint working

Greater Manchester has a whole-system approach to perinatal and parent-infant mental health. This involves universal services, peer support, parent-infant mental health services, IAPT (talking therapies), perinatal and parent-infant and perinatal specialist services all working together with a shared approach and understanding.

This mothers' story shows how local services work together: Cindy* was very anxious early in her pregnancy and she was referred to the community mental health team and the Early Attachment Service (a specialist parent-infant service). Alongside working with these services, Cindy saw her midwife and health visitor regularly. Both had been trained in baby bonding, and encouraged Cindy and her husband, Andy, to reflect on and engage with their growing baby.

Cindy engaged well with services but remained anxious. The specialist perinatal mental health team diagnosed her with severe anxiety, prescribed medication and visited Cindy regularly. Her anxiety continued to worsen and the services working with Cindy all decided that she should be admitted to the Mother and Baby Unit.

Andy began to experience anxiety and low mood. He was referred to the IAPT service where he was fast tracked under the "Babies Can't Wait protocol" and received six sessions of CBT. Andy was also connected with Dad Matters (part of Home-Start) where he received one-to-one peer support sessions and antenatal group sessions with other dads-to-be.

The Early Attachment Service continued to see the family in the Mother and Baby Unit, where they worked close with the staff team and helped both parents think about their baby and about becoming parents. Cindy's midwife and health visitor also visited them in the Unit.

Manchester joint working (continued)

When the baby was born, the health visitor visited the family and supported them to get to know their baby using the NBO. After four weeks, Cindy and her baby were discharged. The Mother and Baby Unit, Specialist Perinatal Team, Early Attachment and midwifery and health visiting teams worked closely together to ensure the family were well supported at home.

The family continued to receive support from the Perinatal Team and Early Attachment Service, which provided weekly parent-infant psychotherapy. Andy was signposted to a local dad's group which he took his daughter to at the weekends.

Cindy received regular visits from the Health Visitor who registered her with a universal postnatal group called Early Start. Cindy felt welcome at the group; she made friends with other parents and learned about other activities for her family in the local area.

*All names have been changed.

Useful resources

Whole-system approaches and multi-sector working

- The Family Hubs and Start for Life programme: local authority guide includes guidance to support a whole-system approach to infant mental health, parent-infant relationships and perinatal mental health.
- The Early Intervention Foundation (EIF) maternity and early years maturity matrix has been developed as a self-assessment tool to support local areas to take a system-wide approach to improving outcomes for children and families. EIF have also developed a guide to population needs assessments for local areas and Family Hubs.
- The Working for Babies: Lockdown Lessons from Local Systems and Listening to local voices for a better recovery capture lessons from the pandemic about the characteristics of local systems which enable effective, joined-up responses to babies' and families' needs.
- Beyond Boundaries looked at local partnerships across London to understand what effective integration across early years systems and services look like for babies, young children and their families.
- The Early learning communities' toolkit provides a guide to improving children's early learning outcomes across local systems.
- Chapters 11 and 12 of Improving The Early Learning Outcomes Of Children Growing Up In Poverty: A Rapid Review Of The Evidence describe the conditions needed in services and systems to support the effective implementation of evidence-based practice and services.
- The MMHA's Mums and Babies in Mind Pathway Assessment Tool helps local partners rate their perinatal mental health offer against national standards to identify strengths and gaps where more work is needed.
- The National Lottery Community Fund's Better Start Programme have pulled together a report on Trauma-informed practice in early child development.

PART 6: WORKFORCE ANALYSIS

This section describes the workforce competencies and support required to effectively support babies' and young children's mental health. It contains a brief checklist which can be used for local self-assessment.

Supporting babies' and young children's mental health requires a workforce across statutory services, local authorities, and the voluntary and community sector with a range of skills, capacity, understanding to do this important work. All professionals working with babies, young children and their families should have a range of understanding and skills at a level appropriate to their role.

Alongside professional skills and development, it is important that professionals and volunteers have support to do their role, such as access to reflective supervision. Adequate clinical leadership and capacity for specialist supervision across services such as health visiting, maternity services and social work is key to ensuring evidence-based and person-centred practice.

The list over the page sets out some core competencies, skills and support which should exist across the workforce in every local area. Alongside skills and competencies, the list describes supervision, support and opportunities for shared learning. This grid can be used by local partners for reflection and self-assessment.

Taking a joined-up approach to professional development across different services can help ensure consistency in approach and language which benefits families. It also helps professionals understand the services in their local area so that they can signpost and refer families who need additional help.

Local example

Supporting workforce development in Cardiff

The Parents-Plus team in Cardiff is a specialised parent-infant relationship team, consisting of psychologists and early years family practitioners who offer a range of targeted and specialised therapeutic support to families with a baby or child under five. In addition, they provide a range of indirect support to build the confidence and capacity of the wider workforce. This includes:

- An Attachment, Relational and Trauma-Informed Service Community of Practice Group
- "Thinking Together" conversations – consultations to support social workers, health visitors, family support workers and childcare practitioners to reflect on how best to work with particular babies, children and families.
- Psychology-informed training for practitioners linked with the AiMH UK Infant Mental Health Competency Framework.

For more information, you can contact the team via email at Nicola.Canale@Cardiff.gov.uk

Useful resources

Workforce capabilities

- The AIMH-UK Infant Mental Health competency framework describes competencies for infant mental health practice at three different levels. Competencies are the skills, knowledge and behaviours that enable practitioners to deliver high quality care and the continuous improvement to services.
- The Competency framework for perinatal mental health was commissioned by Health Education England for all those who work with people in the perinatal period, their families and loved ones. The framework aims to build perinatal mental health capability in the workforce, by identifying the skills required and helping care teams to assess their training needs.
- The Scottish Perinatal mental health curricular framework is a framework for maternal and infant mental health which sets out the different levels of knowledge and skills required by members of the Scottish workforce to enable them to support mothers, babies and their families to have good mental health during the perinatal period.
- American organisation, Zero to Three has produced a competency framework for those working with babies and toddlers in early education and childcare.
- UNICEF EQUIP is a global training package to build capacity for enhanced Mental health and Psychosocial support. It provides guidance and tools to assess and monitor competencies in helpers to enhance training and supervision and build safe, effective, and high-quality services.

Suggested action

Workforce self-assessment

You might use the high-level workforce checklist over the page as a brief self-assessment tool to consider the skills and capacities of different parts of the workforce in your local area such as across maternity services, health visiting, early years settings, family hubs, the voluntary sector, children's services and more. Service leads might be asked to review their own services, or teams could reflect together on their own development needs. Looking across assessments completed by different parts of the workforce can help local strategic partners to consider strengths and opportunities across the system.

Workforce checklist tool

Use a simple RAG (Red-Amber-Green) rating, also known as 'traffic lighting,' to summarise current workforce capabilities related to mental health in infancy and early childhood.

To what extent do the workforce:	RAG self-rating	Comments
Understand child development – particularly social and emotional development - from pregnancy to age 5, including expected developmental milestones		
Understand how to meet the needs of children with additional needs such as physical or developmental disabilities, illness or who are neurodivergent.		
Have the knowledge and ability to implement strategies or practices, based in evidence, to promote babies' and young children's mental health in ways that are appropriate to their role (e.g. to support attuned parent-infant relationships or to support the development of young children's emotional regulation)		
Have the knowledge, skills and opportunities to "tune in" to the cues and communications of the babies and toddlers they are working with and respond sensitively and appropriately to their needs.		
Understand the importance of parent-child relationships.		
Have the knowledge and skills to observe the quality of parent-child relationships and identify any concerns.		
Have the ability to practice in a relationships-informed and trauma-informed way with both parents/carers and young children.		
Understand other services available to local parents and how to signpost or refer families for additional support as necessary.		
Have opportunities to reflect with colleagues and supervisors on what is happening for a child who is displaying emotional or behavioural problems, and what aspects of the child's environment or experiences may be playing a role in this, and what the best response might be.		
Have reflective supervision to reflect on their own wellbeing, culture, values, beliefs, feelings and behaviours, and to address issues to enable them to response in sensitive, nurturing ways to families' needs.		
Learn together with other professionals in the local area, to develop shared understanding, to benefit from each other's skills and expertise, and to build relationships that support joined-up care for families.		

PART 7: EVALUATING, ASSESSING AND OBSERVING MENTAL HEALTH IN INFANCY AND EARLY CHILDHOOD

This section discusses ways to capture the mental health of individual babies and young children, and levels of need in communities. It includes measures that might be used to understand need in your local area.

Understanding and measuring the mental health of babies and young children and the prevalence of any problems is important for identifying need at an individual level, understanding population needs to plan services and to identify trends, and measuring the impact of interventions. Measuring an aspect of mental health before and after an intervention can help to guide clinical decisions and to capture the impact of the service.

To understand mental health needs at both an individual, and a population level, information can be gathered about:

- **The child's mental health**: the child's emotional, behavioural and social competencies and the incidence of any delays or problems.
- **The caregiver-child relationship:** the quality of the parent-child relationship, the incidence of sensitive, nurturing interactions and/or the capacity of the caregiver to be attuned to their child's need.
- **Risk and protective factors in the environment:** the incidence of risk factors such as poverty or poor housing, abuse and neglect, or exposure to parental stressors such as poor mental health, violence in the home or childhood trauma. Ideally – given the impact of cumulative risk – it is helpful to know about whether children are experiencing multiple risk factors.

There are a range of tools and instruments to measure mental health in early childhood, but there are limitations to many of them.

A variety of measures are available for use in current practice, which all differ in terms of the required resource (cost, training), applicability across different age groups, the degree to which they measure needs and strengths, and accuracy in indicating risk for mental health problems. If measures are used by professionals to inform work with individual children, they should be used alongside observation and clinical judgement.

- **Children's mental health competencies and problems** in the early years are frequently measured using parent-reported questionnaires and/or observation and assessment tools administered by practitioners or researchers[80] (see the table on page 78 for some examples). These measures vary in how they are used. Some are brief screeners that focus on specific areas of development and can prompt further assessment or evaluation. Others form comprehensive checklists that help to generate a more detailed profile of the child's strengths and weaknesses. Currently, there are tensions between what measures of emotional and behavioural functioning are feasible and available use in practice, and those measures that are robust from a psychometric point of view.
    - There is a developing evidence base from other countries for the use of specific measures of child mental health in universal services (e.g., the use of the Copenhagen Infant Mental Health Questionnaire in Denmark[81]). The World Health Organization are developing a new Global Scale for Early Development, which has a psychosocial component and is intended to be a universal measure to capture children's mental health at a population level.
- **The caregiver-child relationship** is often measured using questionnaires and observation measures. A review of parent-report measures found that few had demonstrated that they assess the parent-child relationship in a reliable and valid way, with the Postpartum Bonding Questionnaire[82] having the highest ratings of reliability and validity[83]. The Mothers Object Relations Scale (MORS[s])[84,85] and the

[s] The MORS (and its short form MORS-SF) is a parent-report measure for assessing parental thoughts and feelings about their relationship with their baby. It is a validated measure that is relatively easy to use and so widely adopted. The Department for Health and Social Care in England are asking parent-infant interventions funded through the Start for Life programme to use the MORS measure. The original version is for use in parents with babies aged 6-52 weeks. An adapted version, MORS-Child, is suitable for use in children aged 2 to 4 years old.

Prenatal Attachment Inventory[86] are currently being used and tested widely in UK practice for work with babies[87].

- A number of approaches have also been developed or tested in UK health and community services. For example, the Early Attachment Observation tool was developed by the Leeds Infant Mental Health service in collaboration with Leeds Health Visiting Services[88]. The tool features three questions about the parent-infant relationship for health visitors to ask the primary caregiver, and asks health visitors to carry out a two-minute observation of the baby and caregiver interacting.
- Different measures are designed for different ages. Many of the parent-baby relationship measures work for babies in the first weeks or months of life. Other tools are required to understand and measure aspects of the relationship in young children over a year old (for example, the ASC-3 Parenting Relationship Questionnaire and the Parent-Child Relationship Scale (P-CRS)).

- **Risk and protective factors in the environment** can be measured using checklists that assess factors such as whether the parent has experienced episodes of being in care, whether the child is living in a family with inadequate housing or income, or if there is a presence of alcohol/drug misuse in the home. For example, the Maternal Vulnerability Assessment Tool developed by the Lambeth Early Action Partnership team measures social vulnerability in pregnant people, focusing on environmental factors such as social isolation, migration status, membership of underserved communities, and experience of domestic or other violence, among other parental and family factors.

Useful resources

Measuring outcomes

Measuring what matters (Blackpool Centre for Early Childhood Development, 2022) describes current use of outcome measures by Specialist Parent-Infant Relationship Services. The review highlights the lack of consensus on what to measure and how to measure it, the difficulties and tensions surrounding parent-infant relationship outcomes that could be measured and the complexities of needs being met within and between services, and key gaps in the suitability of existing measures for very young children (under 12 months).

Local example

Understanding need in Birmingham

Between December 2021 and March 2022, four professionals from Birmingham Women's and Children's NHS Foundation Trust undertook a needs assessment of parent-infant relationship (for age 0-2) help and support in Birmingham.

The work was undertaken in agreement with Birmingham and Solihull Clinical Commissioning Group (now part of the Integrated Care Board) and was overseen by Birmingham and Solihull Infant Mental Health Steering Group, a subgroup of the local Maternity and Neonatal System (LMNS) Perinatal Mental Health Board.

The work involved:

- **Understanding local population need:** gathering a wide range of local, national, and international data to understand the need for parent-infant relationship support in Birmingham.
- **Service mapping**: interviews with 23 practitioners and service managers, analysis of service data and consultation with service leaders to map current parent-infant relationship support across Birmingham.
- **Workforce analysis**: interviews with 89 local practitioners and managers about current strengths and future training needs. Research into the workforce requirements for improving parent-infant relationships.
- **Parents' views**: 45 local parents were asked a range of relevant questions.
- The work was undertaken to inform the wider network, and the operationalisation of the Trust's commitment to parent-infant relationship support. It generated 38 recommendations relating to provision in Birmingham.

A copy of the needs assessment 'Nurturing our future: holding young minds in mind' is available by request from bwc.ftbinfantmentalhealth@nhs.net

The Centre for Early Child Development's *Measuring What Matters*[89] report contains recommendations to guide the use of outcome measures. These were intended for parent-infant relationship services but are relevant across mental health services in infancy and the early years. They include:

- **Be realistic** - there is no single, easy to use measure that captures the complexity of work in this space.
- **Seek clarity** - be clear about what the primary outcome on an intervention be, and the extent to which measures can capture that outcome.
- **Capture observation** – given the "gold standard" focus on observational measures of the child and the relationship, consider committing resources to carry out observational measures.
- **Think long-term** – implement measures and use them consistently to build evidence. Give time for services to do the work, and evaluations to capture the impact.
- **Work together** – ensure a range of stakeholders (practitioners, parents, researchers, commissioners, service managers etc) are all heard and valued in the identification of measures and development.

Example questionnaire and observation tools used in the screening and assessment of 0-5-year-olds.

For a full table for comparison see unicef.uk/EYMH-toolkit.

Measure[t]	**Ages & Stages Questionnaire: Social-Emotional (ASQ:SE-2)** *Squires, Bricker, and Twombly (2015)*
Purpose	To identify and screen children's social and emotional behaviours
Scales/Items/Constructs	A total score of social-emotional development is produced from items related to self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people
Age range	1 - 72 months
Training	3 training DVDs or 18-hour seminar
Interpretation	The information summary sheet for scoring provides total scores by page, total overall score, and cut-off. A graph is used that shows whether the child's score falls below the cut-off, in the monitoring zone, or above the cut-off where further assessment with a professional may be appropriate. Guidance on score interpretation is provided, and follow-up referral considerations and actions are outlined.
Format	Questionnaire
Rater	Parent
Length	~30 items
Estimates of associated costs[u]	Starter pack including User Guide, master questionnaires and scoring sheets: £245

[t] Tools and classification systems used for diagnostic purposes have not been considered here, however examples of such approaches include the Development and Well-Being Assessment (DAWBA; Goodman et al., 2000; Goodman, 2011), the Preschool Age Psychiatric Assessment (PAPA; Egger & Angold, 2004), Diagnostic Infant and Preschool Assessment Manual (DIPA; Scheeringa, 2004), and the DC: 0-5. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Washington (Zero to Three, 2016). Screening tools for specific symptom groups (e.g., The modified checklist for autism in toddlers M-CHAT-R; Robbins et al., 2014) are also not considered.

[u] These are estimations based on advertised costs described in publications related to these measures, information provided by distributors, or other publicly available sources. Costs are likely to vary depending on the context and scale of the measure's use.

Measure	**Alarm Distress Baby Scale (ADBB)** *Guedeney and Fermanian (2001)*
Purpose	To assess relational withdrawal in infants by observing their behaviour during an interaction with an unfamiliar adult (e.g., a health visitor)
Scales/Items/Constructs	Assesses social behaviour across eight items: facial expressions, eye contact, general level of activity, self-stimulating gestures, vocalisations, briskness of response to stimulation, relationship, and attraction
Age range	0 – 24 months
Training	65 hours training w/ developers
Interpretation	Each of the eight items are scored on a 0 (no unusual behaviour) to 4 (severe unusual behaviour) scale. Total scores range from 0 to 32. Based on studies of French infants, a cut-off score has been suggested for screening purposes. If a child receives a score over the threshold, re-evaluation within two weeks to assess the stability of the behaviour is advised. If the behaviours are found to be persistent, further confirmation and investigation is recommended.
Format	Observation
Rater	Practitioner
Length	~30 items
Estimates of associated costs	~£1000 – £1600 pp for training

Measure	**Brief Infant-Toddler Social and Emotional Assessment** *Briggs-Gowan et al. (2004)*
Purpose	To identify social-emotional and behavioural problems and delays in competence
Scales/Items/Constructs	The Problem scale assesses social-emotional/behavioural problems such as aggression, defiance, overactivity, negative emotionality, anxiety, and withdrawal. The Competence scale assesses empathy abilities such as empathy, prosocial behaviours, and compliance.
Age range	12 – 36 months
Training	Recommend 4 hours of training w/ clinician
Interpretation	Scoring generates a social emotional problems total score and a social emotional competencies total score. Cut-off scores are provided in the manual. Calculations can account for premature birth. The manual emphasises that possible problems or delays identified through the measure should not be considered diagnostic and further follow-up is always necessary.
Format	Questionnaire
Rater	Parent, childcare provider
Length	42 items
Estimates of associated costs	Starter kit including the BITSEA manual, and 25 parent and 25 childcare provider questionnaires: ~£100; Scoring software: ~£75

Measure	Child Behavior Checklist (CBCL; 1.5-5) *Achenbach and Rescorla (2000)*
Purpose	To assess behavioural and emotional problems
Scales/Items/Constructs	Items relate to the following scales: emotionally reactive, anxious/depressed, somatic complaints, withdrawn, attention problems, aggressive behaviour, sleep problems
Age range	18 – 60 months
Training	Recommend individuals be trained to master's degree level
Interpretation	Subscales combine into internalising and externalising scores as well as a total problem score. Raw scores are converted to norm referenced scores. Cut-offs are used to indicate clinically significant and borderline scores which suggest that further assessment or intervention may be appropriate. DSM oriented scales (e.g. depressive problems, oppositional defiant problems) comprise items that are considered to be consistent with DSM-5 diagnostic categories.
Format	Questionnaire
Rater	Parent
Length	99 items
Estimates of associated costs	~£42 for manual, plus ~£1.30 per questionnaire and scoring sheet

Measure	Conners Early Childhood *Conners Early Childhood (1989, 1997, 2009)*
Purpose	To assess the behavioural, social, and emotional development, and developmental milestones of preschool-aged children.
Scales/Items/Constructs	Items focused on children's behaviour relate to defiant and aggressive behaviours, inattention/hyperactivity, social functioning, atypical behaviours, mood and anxiety, and sleep problems
Age range	2 – 6 years
Training	Requires training up to a master's level or qualification to practice in healthcare
Interpretation	An interpretive report can be generated for each completed assessment. In the interpretive report, individual scores are compared to a normative group. Raw scores are converted to t-scores, accounting for child age and gender. It is emphasised that information gathered through this measure should be combined with information obtained through other measures and tools before being used to aid assessment and guide intervention decisions.
Format	Questionnaire
Rater	Parent, teacher
Length	190 items
Estimates of associated costs	~£120 for manual, ~£4.50 per response booklet, and ~£215 for scoring software

Measure	**Infant-Toddler Social and Emotional Assessment (ITSEA)** *Carter, Briggs-Gowan, Jones, and Little (2003)*
Purpose	To assess a wide array of social-emotional and behavioural problems and competencies
Scales/Items/Constructs	Items relate to externalising (e.g., impulsivity, aggression, defiance), internalising (e.g., anxiety, separation distress, withdrawal), and dysregulation (e.g., negative emotionality, sensory sensitivity), competencies (e.g., compliance, attention, imitation/play, empathy, and prosociality), maladaptive behaviours, atypical behaviours, and social relatedness
Age range	12 – 36 months
Training	Recommend 4 hours of training w/ clinician
Interpretation	The subscale scores are added and averaged depending on the number of items answered. Scores are then converted to t-scores and percentile ranks dependent on child age and gender. Elevated t-scores on the internalising, externalising, and dysregulation scales identify areas "of concern". The manual provides guidance for interpretation alongside exemplar clinical cases.
Format	Questionnaire
Rater	Parent, childcare provider
Length	166 items
Estimates of associated costs	Starter kit including the ITSEA manual, and 25 parent and 25 childcare provider questionnaires: ~£200; Scoring software: ~£75

Measure	**Neonatal Behavioural Assessment Scale (NBAS)** *Brazelton (1984)*
Purpose	To provide a strengths-based, in-depth neurobehavioural assessment for newborn babies
Scales/Items/Constructs	Administered or observed items focus on habituation (sleep protection), social interactive responses and capabilities, motor system, state organisation and regulation, autonomic system, and reflexes
Age range	0 – 2 months
Training	2-day course + practice phase
Interpretation	The scale has been used as a tool for observation, assessment, and intervention. The infant's responses to the behavioural and reflex items are recorded on a standardised scoring sheet. This measure does not use norming in its scoring.
Format	Observation
Rater	Clinician
Length	53 items
Estimates of associated costs	£745 for course

Measure	**Strengths and Difficulties Questionnaire (2-4)** *Goodman (1997)*
Purpose	To assess emotional and behavioural problems and prosociality
Scales/Items/Constructs	Items relate to scales for emotional problems, conduct problems, hyperactivity, peer problems, and prosociality
Age range	18 – 60 months
Training	Free, 60-min video call with Youth in Mind offered for training
Interpretation	If the measure is completed online, the Youth in Mind website produces a technical report for professionals, a description of the scores, the level of concern, an overall impression, and suggestions for further assessment and action. A provisional banding of SDQ scores for 2–4-year-olds has been developed based on prevalence estimates in the general population and data on the distribution of SDQ scores in 2–4-year-olds. The measure can be used in initial clinical assessments, in evaluating outcomes, and as a screener. For interpretation, it is emphasised that information gathered through this measure should be combined with learning from research interviews and clinical ratings.
Format	Questionnaire
Rater	Parents, childcare provider
Length	25 items
Estimates of associated costs	Free use of questionnaire, cost for electronic scoring at ~£0.21 per questionnaire

Understanding individual needs can support early identification

Despite the challenges of measurement, approaches to early identification are needed as emotional and behavioural problems can be distressing for young children and their families in the here and now of their lives. Identifying potential problems early, and providing support, may also intercept problems before they worsen – at which point the burden to children is increased and problems become more difficult and expensive to treat.

A key goal of early identification is to identify children and families who may benefit from further follow up, support, and assessment now and in the future. There is less consensus on whether and when it is appropriate to assess young children with a view to arriving at a diagnosis. This should be considered carefully based on the best interests of the child, involve specialist input, and requires a more comprehensive approach than is considered here.

Screening of the child's mental health and development is likely to be most effective when it occurs at fairly regular intervals, as variation is normal but persistent difficulties generally indicate higher risk for more significant problems. This is why it is important that children have regular contact with skilled professionals through the early years. When services, such as midwifery or health visiting, are cut or work remotely, important opportunities to identify need can be missed.

An example
Understanding mental health need

PEDAL's UKRI-funded Helping Little Minds Thrive project will work to bridge existing gaps in the assessment of, and intervention for, mental health needs in very young children (0-4 years). A key strand of this research programme will involve working directly with families and services to develop an approach which helps professionals and families to identify mental health need right from the beginning of babies' lives.

Understanding need at a population level can shape services

At a population level, service providers and commissioners can bring together a range of information including data from the use of screening tools and assessments, together with wider statistics on risk factors, to aid understanding about local need.

When working to understand the needs of babies and young children, local partnerships need to consider:

- How to create processes and systems that enable sharing data between the different services, agencies and commissioners that work with families in pregnancy and the early years, including the possibility of using unique identifiers to enable different services to track children's service use and outcomes.
- Whether data can be disaggregated by age, so the specific needs and experiences of babies and young children are visible.
- If it is possible to capture and report data on which adults interacting with public services are pregnant or have parental responsibility, which may reveal more about the numbers of children exposed to parental stress factors.

Where local data exists, it is important to analyse it locally to understand if there are some families or communities who are experiencing particularly high levels of risk, and to map service use against need. Data about whole population need and service provision can sometimes disguise the needs of particularly underserved communities.

Capturing babies', children's and families' voices

The measures described above are not designed to capture the 'being' element of mental health (i.e. whether babies are feeling good). It is also not possible to know if what is measured reflects what matters to most babies, toddlers, and young children themselves and if they feel mentally healthy.

It is easier to capture parents' views about their own, and their child's wellbeing and development. Some services use approaches such as outcome stars to capture what families want to achieve from an intervention, and the extent to which progress is made to towards these goals.

Playing with young children, and watching them play, can enable adults to gain valuable insights into their mental health. Play-based measures are being used in research, and in some cases – such as play therapy – to guide clinical assessment and intervention.

At a population level, it is important to engage babies, children, families and their communities – including those with additional needs and from traditionally marginalised communities – to capture their insights about mental health to inform local needs assessments and decision making. Utilising participatory and ethnographic methods with 0- to 5-year-olds could enhance our understanding of children's priorities. Many individual services and local partnerships are now

doing more work with parents and children to understand their needs and priorities, and in some cases, to co-produce solutions.

Useful resources

Voice of babies and young children

The Scottish Government's **Voice of the Infant Best Practice Guidelines** provide guidance on how to take account of babies' views and rights in all encounters they may have with professionals in statutory or third sector services, or in public spaces such as shops, libraries or galleries.

Local example

Lambeth's under 5s children's voice project

The Child Friendly Lambeth partnership created a range of interesting ways to consult children and young people to underpin the Lambeth Children and Young People's Strategy, and as part of their journey to become a UNICEF UK Child Friendly Community.

They wanted to ensure that the voices of children under five were heard at this crucial stage of the programme, but recognised traditional consultation may not be appropriate. As a solution they developed the Under 5's Children's Voice Project so that this age group could share their own unique experiences of the world around them and have a say in shaping the local spaces and services that have a direct impact on their physical and mental wellbeing.

Child Friendly Lambeth developed guidelines for children's centres and early years settings, and bought and shared disposable cameras. They asked children and their caregivers to take photos of things they liked in Lambeth that are good for children and young people, places they liked to go with their families, and things that make Lambeth special. The images captured a vast range of activities and places, from play grounds and green spaces to local services, and formed part of a local display. This was a crucial part of informing the selection of priority areas for Child Friendly Lambeth which, in addition to the three mandatory areas included Place, Safety and Security, and Child Friendly Services.

Local example

A partnership approach to ensuring Early Years children are actively engaged in making Liverpool child-friendly

As part of its journey to become recognised as a UNICEF UK Child Friendly City, Liverpool City Council is collaborating with universities and academics to engage young children.

In the early stage of the programme, the University of Liverpool's School for Public Health Research's *Children, young people and families programme* hosted an event to bring together researchers across universities.

As part of the programme, the universities have been working with children and young people in the city to design a website. A key part of this work has been the focus on making sure that children in their early years are involved. Liverpool Hope University's Head of Subject for Early Childhood, Dr Cleona Boyle, co-developed a participation pack for very young children with her students. They tested the activities in the packs with children and young people in the city, and worked closely with several nurseries. The activities aimed to encourage young children's voices in innovative ways and were especially designed with the Liverpool context in mind. They included telling visiting extra-terrestrial life about what they love about their city, engaging as a secret agent with Mission Liver-Bird, and creating treasure maps showing their favourite and least favourite parts of Liverpool.

Once developed, the website will be a place where all children and young people can find out information about the programme and take part in a meaningful way. The website will involve organisations and agencies from across the partnership, and showcase the best practice that they develop.

This partnership approach between the Council and its academic partners is resulting in children and young people from all ages being actively involved and included in shaping the city's services and spaces.

Suggested action

Use these questions for discussion

As providers and commissioners, it can be useful to go "back to basics" when thinking about measurement. You could start by exploring the following questions?

- Why are you interested in measuring babies' and young children's mental health (for example, is it to improve individual service delivery, to understand population need to evaluate interventions, or something else?)
- What outcomes and experiences do you specifically do you want to know about?
- What outcomes and experiences were the services and interventions in your area designed to influence?
- What resources do you have available to capture and record measurement information, and to analyse and use it?

Based on these questions, you could review current measurement and evaluation arrangements, and consider future improvements.

PART 8: KEY CONCEPTS

This glossary describes key concepts relating to mental health in infancy and early childhood. This might be shared locally to help professionals from different backgrounds to engage in discussions and develop a shared understanding.

Adverse childhood experiences

In the mid-1990s, researchers in the USA studied the impact of 10 types of traumatic event or circumstances occurring before the age of 18 on later adult health. These ten forms of adversity were known as Adverse Childhood Experiences (ACEs), and included forms of abuse and neglect, and experience of household disfunction such as having a parent in prison. This "ACE study" was a significant piece of research that found compelling evidence linking poor adult health with negative childhood experiences[90].

A body of research demonstrates a link between ACEs and the development of a variety of later mental health problems and symptoms, encompassing PTSD, OCD, personality disorders, psychotic disorders, mood and anxiety disorders, eating disorders, sleep problems, SUDs, and suicidality[91].

The term Adverse Childhood Experiences often refers to the ten forms of adversity used in the initial ACEs study, although it can be used to refer to other forms of adversity. More recent ACE research includes factors such as historical trauma and social location[92]. A good discussion of the definition of ACEs; the impact of ACEs on outcomes, and how to use ACEs to inform practice, can be found in the Early Intervention Foundation's 2020 report, *Adverse childhood experiences What we know, what we don't know, and what should happen next*.

Attachment

A child's attachment refers to how they behave in the context of a caregiver, the extent to which they seek contact with the caregiver when they are frightened, worried or vulnerable, and whether they find such contact comforting[93]. Attachment is thought to have significant psychobiological and evolutionary functions.

Researchers observe four consistent patterns of attachment in young children, which are known as Secure, Insecure-Avoidant, Insecure-Resistant and Disorganised. These are normally apparent in the second year of life. A child might have different patterns of attachment towards different caregivers. As

toddlers, securely attached children are generally comfortable when with their caregiver, upset upon separation, and happy to explore the world around them using their caregiver as a 'secure base'. At the other end of the spectrum, children with disorganised attachment can show conflicted, disorientated or fearful behaviour towards their caregiver.

A young child's pattern of attachment is largely, if not entirely, the result of the quality of their interactions with their caregiver. Safe, sensitive, responsive care makes it more likely that children will develop a secure attachment. Insecure attachment relationships do not, on their own, indicate cause for concern, but disorganised attachment does suggest that a child has experienced relational trauma. Disorganised attachment in early childhood increases the likelihood of later mental health problems, although these are not inevitable[94].

The Anna Freud Centre's *What is Attachment leaflet* explains attachment for early years workers.

Cumulative risk

The consequences of negative or positive experiences and environments on children's wellbeing and development are cumulative. Research shows that the more different risk factors a child face and the more often the child is exposed to them, the greater the likelihood of poor outcomes later in life.

Evidence that greater numbers of risk factors predicted a greater prevalence of clinical problems was first found in Rutter's (1979) Isle of Wight Study[v] which found that no single risk factor significantly increased risk for mental health problems in young people, but the presence of two risk factors contributed a fourfold increase in the likelihood of mental health problems, and the presence of four risk factors yielded a tenfold increase.

In addition to having a cumulative effect, risk factors also cluster[95] so that if a child has one form of adversity, it may be more likely that they experience others. Children who live in poverty, or who come racially minoritised or immigrant communities, may be particularly likely to experience a number of risk factors.

Infant

The term infant is used differently by different professionals. For example, in paediatrics, infants are babies under one, but in schools infants can be children between the ages of 4 and 7. This report uses the term infancy to refer to the first two years of life, but refers to very young children as babies rather than infants.

[v] Rutter and colleagues initially identified six risk factors significantly correlated with childhood psychiatric disorders: (1) severe marital discord; (2) low social status; (3) large family size; (4) paternal criminality; (5) maternal mental disorder; and (6) foster placement.

Infant mental health

Infant mental health refers to the mental health of babies, most often from pregnancy or birth to age two (although sometimes until age three). The Parent-Infant Foundation (2020) explain that "infant mental health describes the social and emotional wellbeing and development of children in the earliest years of life"[96]. Infant Mental Health has also been defined as "an interdisciplinary professional field of inquiry, practice, and policy that is concerned with alleviating suffering and enhancing the social and emotional competence of young children"[97]. Infant mental health uses a different definition of infant to paediatrics, where infancy is the period until age one[98], or primary education, where infants are children aged between four and seven[99].

In the recent UK government guidance on Family Hubs and Start for Life programmes, infant mental health is defined as *"a baby's social, emotional, and cognitive development and wellbeing."*

Latent vulnerability

Latent vulnerability refers to the way in which a child's developing brain changes in response to early adversity. These changes can be helpful to the child in the short-term, helping them to cope and survive in the face of the adversity. However, they may make the child more vulnerable to developing mental health problems later on[100]. A child who experiences abuse or neglect, for example, may become hypervigilant. This may help them to keep safe in an abusive home, but later on it may mean that they interpret social situations as threatening and react accordingly, which will make social interactions more difficult and can impact on their ability to form enriching relationships[101].

Neurodivergent/neurodiversity

Neurodiversity describes how people experience and interact with the world around them in many different ways; there is no one "right" way of thinking, learning, and behaving, and differences are not viewed as deficits[102]. Children with developmental differences can sometimes be referred to as having special educational needs (SEN)[103], although there are other instances that may mean a child has additional needs.

Neurodiversity refers to the diversity of all people including neurotypical and neurodivergent people.

'Neurotypical' people think, perceive, behave and process information in ways considered standard or typical in the general population.

Neurodivergent people – such as autistic people, and those with neurological or developmental conditions such as ADHD or learning disabilities – are people whose brain functions and behaviours can diverge from those considered typical.

Parent–infant relationships

Parent–infant relationships are the relationships between babies and their primary caregivers[w], who are typically, but not always their parents. The quality of these relationship has a significant influence on babies' mental health and development.
The UK Government guidance on Family Hubs guidance states that parent-infant relationships "can be interchangeable with" infant mental health this is because many services that are called "Infant Mental Health" or "Parent–Infant Relationships" services do the same sort of clinical work with families.

Parent–infant relationship services

Parent-infant relationship services are services that support the relationship between babies and their primary caregiver, helping caregivers to overcome difficulties and develop capacities to provide babies with the sensitive, responsive care. These services are often known locally by different names such as a PIP, an Infant Mental Health Team, parent-infant mental health service, early CAMHS or an early attachment team.

Specialised parent-infant relationship teams (known as parent-infant teams in short) are services that meet specific criteria set out by the Parent-Infant Foundation. They are multidisciplinary teams, led by specialist mental health professionals with expertise in supporting and strengthening parent-infant relationships. These teams work with any families where there are sufficient concerns about the early relationship (as opposed to focussing only on families who meet specific criteria such as having a moderate or severe perinatal mental health condition or being in the care system). Parent-infant teams generally work at two levels: providing direct therapeutic support to families with the highest levels of need, and also using their expertise to help the local workforce to understand and support parent-infant relationships through offering training, consultation and/or supervision[104].

Perinatal mental health

Perinatal mental health problems are those which occur during pregnancy or after the birth of a child. Typically perinatal mental health refers to the mental health specifically of mothers or parents who give birth to babies (rather than fathers, adoptive mothers or non-birthing mothers in same-sex couples) but the use of the term is not consistent and, in some cases, may refer to the mental health of other new parents. In some cases, perinatal mental health problems refer to problems only in the first year after birth, although in England perinatal mental health services will work with a family until a child is two.

[w] Primary caregivers are the people who spend most time caring for the child.

Relational trauma

Relational trauma is trauma that occurs within a close relationship, typically with a parent or primary caregiver. It arises when there are significant and persistent difficulties in relationships. Relational trauma can describe abuse, neglect or other forms of severe disruption in the relationship. 'Relational poverty' refers to babies and children experiencing interactions where the caregiver does not have the capacity to think about and respond the needs of the child (for example, because they are extremely lonely or isolated or experiencing high levels of stress). Both relational poverty and relational trauma cause acute suffering for the baby, and latent vulnerability, increasing the risk of later poor outcomes. Research has shown that relational poverty in the perinatal period has a stronger impact on development than the presence of adversity. The impact of the quality of relationship with a primary caregiver diminishes as children get older, but it is still a strong predictor of functioning and development[105].

Spiritual wellbeing

Whilst it is not widely used in the UK, some models of mental health capture "spiritual wellbeing and development". Spiritual wellbeing refers to finding meaning and purpose in life, and living in accordance to, values and beliefs. For some people spirituality is about believing in and connecting to a higher being (or beings) and adopting religious beliefs. For others it is about finding a connection to the world around them, or a feeling of inner peace in other ways. Spiritual wellbeing can support mental health through helping people to find meaning, purpose and belonging, and sources of comfort, strength and hope. It can help people to make sense of experiences, and to connect with others. Babies and young children's spiritual development can be supported by helping them to reflect on themselves and the world around them; through discussions of values and ethics; and through helping them to learn about, observe and/or participate in religious practices and rituals. Young children can be encouraged to talk about, express and explore their feelings about family, nature, faith and religion through conversation and/or through play.

Toxic stress

Babies and young children can experience many kinds of stress. Toxic stress refers to "the constant activation of the body's stress response systems due to chronic or traumatic experiences in the absence of caring, stable relationships with adults"[106]. When this form of stress occurs during the earliest years of life, it is distressing for the baby or child, and can have lasting negative impacts on brain architecture and other developing organ systems. The "toxic stress response" describes the physiological and psychological response that can occur when a child experiences strong, frequent, and/or prolonged adversity without adequate adult support. This describes the mechanisms through which adverse experiences impact the developing brain and body, creating latent

vulnerability. The extent to which events lead to toxic stress, and have lasting adverse effects is determined in part by the individual's biological response (mediated by both genetic predispositions and the availability of supportive relationships that help moderate the stress response), and in part by the duration, intensity, timing, and context of the stressful experience[107].

Trauma-informed approaches

There has been a lack of consensus within the health and social care sector on how trauma-informed practice is defined[108]. However, the current working definition published by the Office for Health Improvement and Disparities defines trauma-informed practice by six key principles: safety, trust, choice, collaboration, empowerment, and cultural consideration.

When practitioners, services and policies are trauma-informed, it generally means that they:

- Recognise and understand the different ways that experiences of trauma impact on individuals, groups and communities
- Recognise and understand the signs, symptoms of trauma and how trauma influences individuals' behaviours and needs
- Work with individuals in a way that is sensitive to, and helps to overcome the impact of trauma in their lives and avoids re-traumatisation.

Services working with families in early childhood can recognise and respond to the way in which parents' or primary caregiver's experiences of trauma may impact their wellbeing, engagement with services and relationships with their babies. Understanding trauma also helps professionals to understand why it is so important to address adversity in early life.

Systems can be designed to be trauma-informed, so that all professionals have a good understanding of trauma and are trained and supported to work with individuals and families which is sensitive to the trauma they might have faced and helps them to overcome the impact of trauma in their lives. Trauma-informed systems also consider how to identify those who have experienced multiple childhood traumas, and how to put support in for families that addresses the impacts of trauma and prevents intergenerational transmission of trauma.

ACKNOWLEDGEMENTS

We are grateful to all our colleagues and partners who shaped this toolkit with us and took the time to provide insightful input and constructive challenge.

We would like to thank all the decision makers and service leads from local government, the voluntary sector and health services, and national civil servants who joined us for workshops about this toolkit. We appreciated their support and feedback.

Many members of the PEDAL team contributed to this document through workshops and discussions, we particularly acknowledge the contributions Dr Christine O'Farrelly, Prof. Paul Ramchandani, Dr Beth Barker, Morgan Healy, Emma Pritchard, Kelsey Graber and Chloe Bond, alongside Prof. Pasco Fearon from the Centre for Family Research.

Members of the UNICEF UK advocacy team who contributed to this document and review, including Claire O'Meara, David Bradley, Rebecca Jacques. UNICEF UK programme colleagues, including Shereen Fisher and Smita Hanciles from the Baby Friendly Initiative team and Kat Darling and Naomi Danquah from the Child Friendly Cities & Communities Programme. UNICEF Global Mental Health Leadership Team colleagues, including Diana Rayes, Dr Zeinab Hijazi, and Emma Ferguson.

We are grateful to all our external peer reviewers:

John Bailes, Office for Health Improvement & Disparities

Prof. Jane Barlow, University of Oxford

Hilda Beauchamp, Institute of Health Visiting

Debbie Brace, Baby Talk and Play

Dr Jonathan Campion, Royal College of Psychiatrists

Dr Nicola Canale, Parents Plus, Cardiff Parenting Services

Sorcha Ni Chobhthaigh, University College London

Alex Corgier, Home-Start UK

Sharon Fernandez, Public Health Wales

Dr Gina Gomez de la Cuesta, Play Included

Emily Hackett, Local Government Association

Elizabeth Hodgman, Local Government Association

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Dr Camilla Rosan, Anna Freud National Centre for Children and Families /UCL

Becky Saunders, What Works for Early Intervention and Children's Social Care

Mary Taylor, Family Links the Centre for Emotional Health

Flora Wilkie, Local Government Association

Many organisations and individuals have already agreed to help us to disseminate this toolkit far and wide to help those working hard to improve babies and young children's lives in the UK and beyond. Thanks to all of you who will share and use this toolkit.

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