Early years

A mentally healthy childhood is crucial in promoting positive social, emotional and behavioural development in children. The national strategy 'Getting it Right for Every Child' defines wellbeing in terms of eight indicators: nurtured, active, respected, responsible, included, safe, healthy and achieving. The strategy states these are the basic ingredients necessary for all children to reach their full potential. It places the child and family at the centre of all care and services. Children exposed to poor parental mental health and lifestyles are more likely to experience poor birth outcomes and poorer mental and physical health as they grow. Early intervention and preventative investment is more effective than trying to improve outcomes through interventions at a later stage of development.[22]

The early years in the context of this report includes the time from conception to nursery school age. There are just over 68,000 children aged 0-4 years living within the NHSGGC Board's boundaries. This chapter includes a description of the issues related to mental health and wellbeing in the early years, an overview of local practice and recommendations for action.

Section 1: Determinants of mental health in early years

1.1 Influences on the likelihood of developing mental ill-health are called protective and risk factors and impacts on all stages of the life course. Protective factors for wellbeing include resilience, self-esteem and the ability to cope with stress. Diet and physical activity help improve mental and physical health and are important pre-pregnancy, during pregnancy and after birth for mothers and children. Secure attachment, good parenting and a supportive environment are foundations for wellbeing.

1.2 Risk factors for this stage include parental mental ill-health, substance misuse, physical and emotional abuse. Family conflict, isolation, poverty and stressful life events including bereavement and loss also contribute to an increased risk of poor mental health.

Risk factors for children include genetic factors, low birth weight and prematurity. Many of these risk factors are associated with social disadvantage, adding to the risk of mental ill-health.

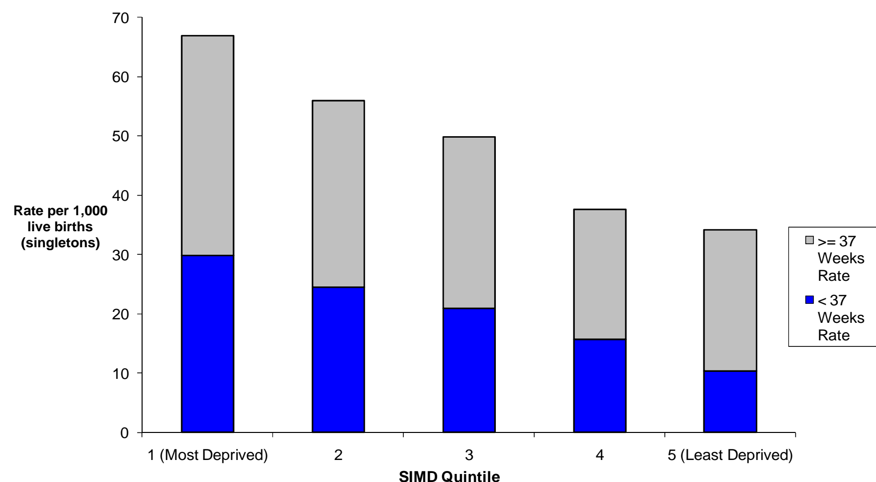
Section 2: Challenges to wellbeing in pregnancy

2.1 Poor mental health and wellbeing from preconception have health and social costs to mothers, babies, families and the wider community. Early experiences set the course for the rest of our lives.

2.2 Inequalities have a bearing on maternal health and the development of the child and his or her happiness and productivity in society. This is the start of a recurring cycle of social disadvantage for generations, which can lead to huge costs for the wider society.[23]

2.3 The greatest health inequalities are both a direct and indirect result of poverty. Low income and poverty are associated with worse physical, mental and social outcomes starting pre-birth, into childhood and throughout adult life. This is compounded by other forms of inequality such as race, gender and disability. Poorer children are three times more likely to have mental ill-heath, with higher rates of suicide or self-harm compared to children with positive mental wellbeing during childhood.[24] Of the 14,020 live births in 2009/10 in NHSGGC, 42.5% were to mothers living in the most deprived communities.[25] There were just under 750 babies born with low birth weight (excluding multiple births) in NHSGGC in 2009/10 (see Figure 3.1). The overall rate of these low birth weight babies was 66.9 per 1,000 live births in the most deprived compared to 34.2 per 1,000 live births in the least deprived. The rate of premature low birth weight babies was almost three times higher in the most deprived than in the least deprived communities. Across Scotland, there are more deaths in the first year of life in the most deprived compared to the remaining population. Infant mortality rates in Scotland fluctuate between years but are about double those of some Scandinavian countries.

Figure 3.1: NHSGGC Low birth weight babies (singleton); rate per 1000 live births by gestational age at delivery and deprivation Source: SMR02, extracted August 2011



2.4 Socially disadvantaged women frequently have unplanned but not unintended or unwanted pregnancies and are least likely to have a termination of pregnancy. It is particularly important for these women to receive advice and services to enable them to have pregnancies if and when they want to, with appropriate timing to promote optimal medical and social outcomes. Many of these women are known to or are in contact with health and social service agencies that address many aspects of their life but seldom discuss their reproductive plans. These opportunistic contacts with services provide opportunities to enable women to protect and control fertility and have pregnancies when they choose to do so. In addition, offering women who have had babies, long acting and reversible contraception before they leave hospital after giving birth is a way we can give women back some control and help them have children at a better time in their life.

2.5 Almost half the children in NHSGGC live in low-income households – defined as the proportion of children that are dependent on out of work benefits OR Child Tax Credit more than the family element (see Table 3.2). For the year 2009/10, the estimate of children living in low-income households ranges from 32% in East Dunbartonshire to 62% in Glasgow City. The national average for that year was 48%.

Table 3.2: Percentage of Children in Low Income Households by Local Authority area across NHSGGC, Source: Scottish Government, 2010a

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010
East Dunbartonshire	28%	29%	29%	31%	32%
East Renfrewshire	28%	29%	29%	31%	32%
Glasgow City	58%	58%	59%	62%	62%
Inverclyde	52%	53%	53%	55%	56%
Renfrewshire	45%	46%	46%	48%	49%
West Dunbartonshire	53%	54%	55%	57%	58%
SCOTLAND	44%	45%	45%	47%	48%

2.6 Financial security is an important social determinant of mental health and wellbeing. Many families with children living in low-income households across NHSGGC may feel this is out of their reach. Tackling child poverty is a priority for local partners and cannot be separated from the circumstances of parents or carers.[26] This work is supported by the national policy agenda, e.g. *Equally Well, Achieving Our Potential, and The Early Years Framework.*

Section 3: Risk factors

Child and family poverty

3.1 Poverty can transfer from generation to generation. Poor outcomes for babies and mothers associated with deprivation include higher maternal illness, premature labour, foetal growth restriction, low birth weight and above average birth complications.[27] Adverse life circumstances, maternal lifestyle and poor maternal mental health, are linked to income inequalities and social disadvantage.

Women with complex social problems e.g. substance misuse, homelessness, and mental health problems, are considered to be high-risk groups. High-risk women

require the support of all our services pre pregnancy, during pregnancy and beyond.

3.2 In his report for the End Child Poverty Campaign, Nick Spencer writes;
"The health of the mother has a profound effect on the health of her children. This effect is most noticeable during pregnancy but persists throughout the child's life."[27]

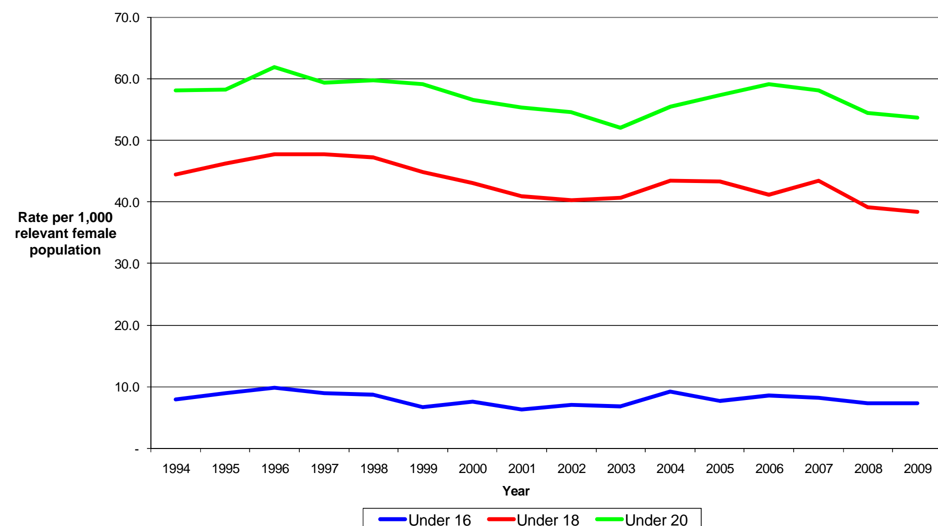
3.3 Stress and prenatal depression have an effect on physical health and brain development of the foetus. Women experiencing high levels of anxiety in pregnancy at 32 weeks may be twice as likely to have children with behavioural or emotional problems even after allowing for postnatal factors.[28] Risk factors for stress and depression in pregnancy include a prior history of depression, women living with domestic abuse, complications in pregnancy, poor social support and low income.

3.4 Mothers under 20 years are also a high-risk group. There were fewer than 2,000 pregnancies to women in NHSGGC under 20 years old in 2009, of which 58% were in the most deprived communities.[29] There were 143 pregnancies to mothers under 16 years. Women under 20 years old living in the most deprived areas are ten times more likely to continue with their pregnancy and deliver than those in the least deprived areas. There is a higher risk of depression and anxiety in teenage mothers. Risk factors for teenage pregnancy include exposure to parental separation and divorce and there is a strong association with social disadvantage. Over the past 15 years, the rates of teenage pregnancies in women under 20 and women under 16 have fluctuated (See Figure 3.3). The current rates for pregnancies in women under 20 are higher in NHSGGC compared with Scotland, 53.6 and 52.8 per 1,000 women under 20 respectively. Within NHSGGC, the highest rates for pregnancy for women under 20 years are in Glasgow City and West Dunbartonshire (63.3 and 62.1 per 1,000 relevant female populations respectively). The highest rates of pregnancy for

women under 16 years in Glasgow City and Inverclyde are 9.5 and 9.1 per 1,000 relevant female populations respectively. In comparison, the figures in both age categories for East Renfrewshire and East Dunbartonshire are well below the Health Board average (24.0 and 31.9 per 1,000 relevant population respectively for Under 20's and 2.6 and 2.9 per 1,000 relevant populations respectively for Under 16's).

Figure 3.3 NHSGGC Teenage Pregnancy Rates 1994–2009

Source: Teenage Pregnancies, year ending 31st December 2009 (published 28th June 2011) ISD Website (Maternity and Births, Teenage Pregnancy)



3.5 Child sexual abuse survivors are at higher than average risk of mental health problems, substance misuse and homelessness, risky sexual activities and sexual exploitation. For example, over 50% of young homeless people disclosed they had experienced

childhood sexual abuse when asked during the assessment process.[30]

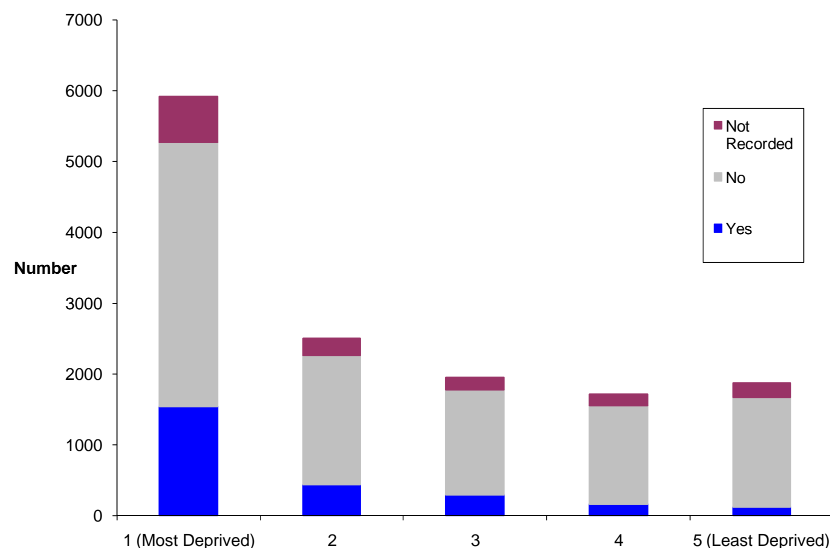
3.6 There is a relationship between stress, poverty and impact on family wellbeing e.g. social isolation and little family support, unemployment, mental health (anxiety and depression), money and housing matters all contribute to poor mental wellbeing. These effects are linked to poor attachment with the infant after birth and increased risk of suicide in the postnatal period. Maternal suicide is now the leading cause of indirect deaths after a pregnancy, leaving bereaved families to cope and increasing their risk of mental ill-health among other family members. Fortunately, these events are rare, but their effects are severe.

Smoking

3.7 Women who smoke in pregnancy are more likely to be young, single, lack support, have higher levels of stress and be living in more deprived areas with complex social needs. It is both a cause and effect of health inequalities.

3.8 Figures for Glasgow suggest that 17.5% of women booking in NHSGGC maternity units are current smokers. This means that of the 13,876 maternities in NHSGGC in 2009/10, we estimate that at least 2,475 pregnant women were smokers. This is only an estimate because in approximately 10% of women, smoking status is unknown, usually because they are not asked. Recent data suggests the proportion of unknown smokers has fallen. Pregnant smoking rates range from 5.5% to 25.9%, between women in the least and most deprived areas respectively.

Figure 3.4 NHSGGC Maternities, smoking during pregnancy by deprivation
Source: SMR02, extracted August 2011



3.9 Reducing smoking in pregnancy would have immediate benefits in birth outcomes. To illustrate this point, if we use a delivery rate of 13,860 per year and assume we can reduce the smoking rate to precisely 10%, we would expect to see about 13 fewer stillbirths per year (74 in 2009), 38 fewer miscarriages, fewer hospital admissions in pregnancy and fewer sudden infant deaths. Our nurses, midwives, general practitioners and health visitors play a vital role in reducing the number of mothers who smoke. Their intervention may be the most important single influence on a woman's health. NICE guidance stated that early results around using incentives to stop smoking were promising but that more UK research is needed about effectiveness in pregnancy. We will be hosting a randomised controlled trial in NHSGGC to look at this in the near future.

Alcohol and substance misuse

3.10 Drinking too much alcohol in pregnancy affects foetal development and is associated with adverse pregnancy outcomes. Women who abuse alcohol are more likely to suffer from poor mental health and wellbeing. Foetal alcohol harm (FAH) is the term used to describe the range of outcomes resulting from exposure to alcohol during pregnancy and incorporates foetal alcohol syndrome (FAS) and foetal alcohol spectrum disorder (FASD). Foetal alcohol harm is estimated to effect over 10,000 children and young people (0-18yrs) in Scotland

and is thought to be the most common environmental cause of learning difficulties. Foetal alcohol syndrome, the more severe form of the condition, affects between one and seven per 1,000 live-born infants, equating to an estimated 137-964 children in NHSGGC per year based on the current birth rate. FASD affects a much larger number of children and is associated with learning disability and behavioural problems including the inability to plan, learn from experience or control impulses. FAH has large economic and social costs. It is preventable but because many pregnancies are unplanned, much of the harm is done before a women herself is aware that she is pregnant.

3.11 We do not know if there is a safe level of alcohol consumption during pregnancy. The UK Chief Medical Officers advise that pregnant women and women trying to conceive should avoid drinking any alcohol and, if they choose to drink, this should be limited to one or two units once or twice per week. The Glasgow Health Commission has recommended clear messages in bars and off-licences to advise pregnant women against drinking alcohol.

3.12 Alcohol and drug intake is poorly recorded in pregnancy and health care professionals report barriers to asking about sensitive issues. Pregnant women abusing alcohol often hide or deny their addiction. Health workers are less likely to question women who are more affluent. NHSGGC is training midwives to give alcohol brief interventions to women at their booking visit as part of the HEAT targets.

Gender based violence

3.13 Women and children who experience some form of gender-based violence are at significantly higher risk of experiencing other risk factors associated with maternal and child health. Research from 2008 by Family Action and Gingerbread, revealed how domestic violence can push women into severe debt and hardship.[31] A recent UK wide NHSPCC report highlighted that 1 in 20 secondary school pupils has been sexually abused and

far more likely to self-harm, abuse drugs and alcohol, suffer from depression and experience post-traumatic stress disorder.[32] This abuse may have happened or began before secondary school. Furthermore, pregnancy itself is a risk factor for domestic abuse.[33]

Services to address these factors

3.14 NHSGGC provides a number of services aimed at addressing the determinants of ill-health in pregnant women. The redesign of Special Needs in Pregnancy (SNIPs) service will provide additional support for women with complex social needs in an equitable way across the whole board area. SNIPs midwives work with addiction, mental health staff, social and support workers. We will also implement the programme for Vulnerable Children and Families and align it with current primary care and maternity services. One of the greatest challenges facing these services is providing referral to the support needed in a time sensitive way. This is to allow for every additional day a pregnancy or new baby is exposed to adverse vulnerable circumstances, there is a significant impact on the future of that individual and their family.

3.15 We promote sensitive antenatal enquiry to identify women already accessing specialist services such as substance misuse, social work and mental health services. Comprehensive antenatal care takes into account a woman's personal social context and identifies those with additional stress and social care needs who may need further support relating to emotional and psychological wellbeing. Stresses may include a history of domestic abuse, financial worries or anxiety and depression. Findings from this enquiry are documented in the maternal handheld record which can be used as a tool to support access to other services e.g. financial inclusion (benefit maximisation, debt and potential debt support, budgeting skills), and housing services. Women with socially disadvantaged high-risk pregnancies should be considered just as vulnerable as those with medically high-risk pregnancies and have their care delivered through a consultant led obstetric service.

3.16 Maximising families' income is one element of addressing the effects of poverty on the health of women and their children. The Healthier, Wealthier Children (HWC) project aims to improve financial security for families with children living in low-income households. Health staff enquire sensitively if their patients have any money worries and can then refer them to financial advisers. Between February and May 2011, there were 1,585 HWC referrals to advice services, of which 72% (n=1,137) were from Midwives and Health Visitors. The Glasgow Centre for Population Health evaluation report for HWC will be available in March 2012.

HWC Family Case Study: Mum is in low paid work and dad is caring for three young children. Despite thinking she had received all her benefit entitlements, mum spoke to a health worker about her money worries. A HWC referral resulted in a Council Tax saving of just under £1,000. The family stress levels were significantly reduced. The family can now save for emergencies, e.g. a new washing machine. They can buy the children toys they previously couldn't afford. Mum feels more confident about looking for a better paid job.

Section 4: Children and early experiences

4.1 The relationship between secure attachment, good parenting and a supportive environment are protective factors for mental wellbeing in the early years and predictors of future health and wellbeing. Likewise

parental ill-health, family conflict and poor parenting are risk factors for mental ill-health.

4.2 Young children experience short-term stress in normal circumstances such as fear, hunger, or pain, for example, falling over and hurting their knee. Usually parents provide the support required to sooth and reassure a child. The child feels secure through this relationship. It affects how they grow and develop new relationships with others. Parents' own stress can affect their ability to support their child. It is not always easy to know the best thing to do to support your child.

4.3 Children suffering from severe neglect experience negative effects on brain development. Severe neglect includes failing to provide for basic needs or emotional support, or with inappropriate care. Neglect accounts for two-thirds of all abuse and can go unrecognised for long periods. Early neglect has been shown to predict high levels of aggression in older children and, in the long-term, can lead to attention deficits, social deficits and abnormal stress responses. This means children will find it difficult to sit still and concentrate at school, will struggle to maintain friendships, and could over or under-react to stressful situations such as getting into a disagreement. There is an association between erratic, coercive or negative parenting and problems with aggression, such as conduct disorder. In extreme circumstances, children suffering prolonged stress such as physical abuse, neglect, parental substance misuse or a mother with severe postnatal depression or mental ill-health, are more likely to develop depression, anxiety and substance misuse in later life. This is where parenting support can be an effective way to reduce the burden of mental illness in the long-term.

4.4 Support for parenting skills can bring positive outcomes for parents and children, increasing parental wellbeing and experience and enhancing long-term protective factors for children. Better Health, Better Care[34] and Towards a Mentally Flourishing Scotland[35] stress the importance of providing parenting support in order to achieve the desired goal of providing children with the best possible start.

4.5 It is possible to see some early warning signs of poor outcomes in physical and psychological domains, including language delay and disruptive behaviours. A new universal contact between health visitors and children aged 30 months is being planned. Using tools to assess aspects of social, emotional and language development, the families of children identified with language delay, emotional, conduct, attention or peer-relationship problems at 30 months will be offered further help. This work will help us to develop care pathways and preventative programmes using interventions that are based on good evidence to improve outcomes for children and families. However, as brain development is largely complete by three years of age, and change thereafter slower and harder to achieve, even earlier intervention should be prioritised.

Section 5: Parenting

5.1 NHSGGC has adopted Triple P (Positive Parenting Programme), an evidence-based parenting programme, in partnership with a number of local authorities.

5.2 Early indications from the evaluation show positive outcomes for parents e.g. reduced anxiety, depression and stress after taking part in a group. We are continuing with our robust monitoring and evaluation process to make sure we provide the most effective, appropriate and timely parenting support across NHSGGC. The roll out of Triple P takes in other areas such as Inverclyde and West Dunbartonshire.

5.3 We will also be carrying out a trial of Triple P for Baby and Mellow Bumps programmes. These group-based programmes for prospective parents aim to improve relationships between parents and children by intervening at the antenatal period. They differ in their approach, time commitment and costs. Both programmes are appropriate for vulnerable mothers, but we do not yet know how effective they are. Trained staff in community settings will run the programmes. We aim to assess whether either programme can save

money for the NHS in the long-term. The programmes will be compared in terms of (a) the quality of the mother-child relationship and (b) mothers' mental health when the baby is 6 months: both related to risk of maltreatment and child development.

5.4 It is important to provide high quality universal services to engage all parents, ensuring the majority of resources meet the needs of the most vulnerable groups.

Section 6: Parental mental health

6.1 There is a sub optimal understanding of mental ill-health affecting parents. Parents with poor mental health cope less well with parenting and as identified earlier, this can lead to poor attachment as well as long-term emotional, physical and behavioural problems in children.

6.2 The Scottish Health Survey 2008/9 showed that 15.4% of pregnant women scored poorly, indicating possible psychiatric disorder. When we apply these results to the 13,823 NHSGGC maternities of 2009, we estimate that 2,129 of the NHSGGC maternity cohort would have been expected to score poorly on this measure, indicating poor mental wellbeing. However, not all of these women would be expected to qualify for a psychiatric diagnosis.

6.3 The Growing up in Scotland report suggests about a third of mothers experience poor mental health at some point in the first four years of life. This equates to over 4,500 women each year in NHSGGC.

6.4 Children exposed to maternal mental ill-health are more likely to have poor outcomes. Children whose mothers are emotionally well have better social behavioural and emotional development. Mothers' vulnerability e.g. those who have suffered domestic violence and/or mental ill-health, makes it more likely that the child will develop poorly and be maltreated.[36-38]

6.5 Midwives, General Practitioners and Health Visitors have an important role in identifying women who are depressed before and after their babies are born and supporting them in recovery and identifying neglect in young children.

6.6 Health Visitors use the Edinburgh Postnatal Depression scale, a self-reporting tool to assess new mothers for depression in the postnatal period. Postnatal depression is relatively common, affecting 10-15% of women having a baby. Symptoms include low mood, irritability, tiredness, sleeplessness, changes in appetite, difficulty in enjoying anything, loss of interest in sex, negative and guilty thoughts, anxiety, avoiding other people, and feelings of hopelessness or suicidal thoughts. A small number of women with very severe depression develop psychotic symptoms: they may hear voices and have unusual beliefs. This equates to between 1,367 and 2,050 women per year in NHSGGC, suffering from postnatal depression and between 136 and 273 women experiencing psychosis. Research suggests 1 in 4 mothers will still be depressed by the time their child is one year old.

Section 7: Recommendations

7.1 We must recognise the importance of preconceptual and maternal health in public health and maternity planning to ensure that every child is born in the best health possible and nurtured in early life. Integrated planning should include preconception counselling, contraception advice and provision for high-risk, vulnerable groups. This includes strengthening the role of health visitors and midwives working together to detect and support those with mental health problems in the early years. Preconception care also includes youth services that promote mental health and self-esteem as discussed in the next chapter. Staff must be aware of the implications of poverty on health and what support can be provided. We will continue to support women at risk of poverty, gender based violence or who could benefit from employability advice, by recommending sensitive enquiry in services.

7.2 The evidence base should be used to target services to need. We can do this with a blend of universal and targeted services for pregnant women and young children continuing the population approach to Triple P but identifying and supporting more vulnerable families to access more intensive parenting interventions. Plans are in place to strengthen routine child health surveillance with the introduction of a new universal contact at around 30 months of age. We must ensure that there are effective ways to engage families identified as requiring more support in evidence based parenting programmes and early language development.

7.3 We will continue to prioritise the implementation of the Triple P positive parenting programme. We will use early lessons and evaluation to make seminars as attractive and useful to parents as possible and utilise parent discussion groups on specific topics. We will work with existing parents groups and organisations to support engagement with the Triple P programme.

7.4 We need to raise awareness amongst all staff in contact with pregnant women of the harms caused by smoking and alcohol in pregnancy and the effectiveness of cessation support to encourage women to access smoking cessation services as early in pregnancy as possible. We endorse the national approach to giving clear messages of no alcohol in pregnancy. We will implement alcohol brief interventions in pregnancy but it will be vital to evaluate the effectiveness of this intervention, as this is unclear. We would also like to work with licensing boards to encourage clear warnings of the harms of drinking in pregnancy in licensed premises.

7.5 We should ensure that primary mental health services prioritise pregnant women and women with very young children in need. We must aim for fast track access to support with psychological therapies before or soon after their child is born to reduce any effect on attachment or bonding.

7.6 In March 2011, the Scottish Government published their Child Poverty Strategy for Scotland, which sets out how the 2020 targets laid down by the Child Poverty Act 2010 will be met.[39] We will take action to reduce child poverty by developing local partnership strategies, which will help families, reduce their outgoings, increase their incomes and reduce the negative effects of poverty. These partnership strategies should describe clearly each agency's role in addressing child poverty.