Cynulliad Cenedlaethol Cymru | National Assembly for Wales

Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee

Y 1,000 diwrnod cyntaf | First 1,000 Days

FTD 53

Ymateb gan: Unigolyn

Response from: Individual

1. Promote and protect the health and wellbeing of children from pregnancy (for example through positive parenting, high immunisation rates and tackling smoking in pregnancy).
2. Deliver improved child health outcomes across Wales (for example prevention of obesity and the promotion of health enhancing behaviours for every child such as eating a well-balanced diet, playing actively and having appropriate weight and height for their age and general health).
3. Tackle health inequalities with a specific focus on child poverty and disabled children
   Reduce child death and injury prevention particularly in the most deprived part of Wales where infant mortality is much higher than the least deprived.
   Support effective child development and emotional and social wellbeing. Specifically interventions that are delivered outside the health service which can help to detect and address developmental delay.
4. Focus on improving learning and speech and language development through the home learning environment and access to early years provision (including child minders, preschool and day nurseries)
5. Reduce the adverse impact on the child of psychosocial issues such as poor parenting, disruptive family relationships, domestic violence, mental health issue and substance misuse through effective safeguarding.

Response

The evidence base for the domains of child health and development referred to in the ToR, relevant to the first 1,000 days, conflates of attachment, child neurodevelopment and medical foci/ parameters of health and disease. How these domains and the links between them are conceptualised and the terminology used in the ToR is disorganised. Never the less this does reflect how the evidence is understood and applied in practice. There is generally poor understanding of the causal association between the significance of the attachment relationship, the quality of early care, child neurodevelopment outcomes and lifespan potential. This has consequences for policy, service provision and health and social care practice that is costly and potentially without any benefit for the client.

Domains of child health/ wellbeing and development				
Attachment 0-12months →	Neurodevelopment 0-18 months	Public health/ medical/ health promotion	Social/ deprivation	Didactic activities
Speech/ language development		high immunisation rates	child poverty	positive parenting
psychosocial issues		smoking in pregnancy	disruptive family relationships	injury prevention
poor parenting		prevention of obesity	domestic violence	home learning environment
disruptive family relationships		well-balanced diet		improving learning
domestic violence		playing actively		
mental health issue		Height/ weight ratio		
improving learning		general health		
		child death	child death	

		smoking in pregnancy		
		mental health issue		
		poor parenting	poor parenting	
		psychosocial issues		

This response focuses on attachment and neurodevelopmental growth:

With regards to the first 1,000 days a child's attachment status reflects optimum wirings of neural pathways and is central to neurodevelopmental growth, i.e. emotional, social, behavioural and cognitive; individual higher risk for mental illness; later life, adult capacity in intimate relationships. The attachment status is an outcome of the quality of early care during the period of critical brain development (pre-birth – 18 month postnatal). There are a number of developmental tasks that the dyad (parent-infant pair) are required to achieve (most important = emotional regulation) during this time to promote secure attachment and underpins optimum developmental outcome across the lifespan. This is reliant on parental sensitivity to offspring care needs. *This is not positive parenting but a complex neurobiological process* – deficits in early parental caregiving that influence attachment and developmental progress are not addressed by didactic parenting programs.

Common interventions applied in practice that are broad, time limited (e.g. wait watch and wonder groups) or introduced when adverse outcomes are measurable in the child are of little if any benefit. Services should work with indicators of parent-to-infant risk, understand how this risk is transmitted to ensure early identification (e.g. a parents who has been a looked after child) and develop bespoke interventions that target individual need. *With regards to the first 1000 days learning, speech and language are not matters of education* as suggested in the terms of reference. These are outcomes secondary to the implicit communication between the primary caregiver and

infant that is operational from birth and dependent on parental sensitivity to the infant.

Safeguarding is not an appropriate first line approach to reduce the adverse impact of the factors listed in the ToR. This is too late and the threshold for safeguarding is very high – does not intervene at the level of risk but at the level of actual harm. The intention should be the earliest identification of risk, first through adult indicators (e.g. LAC, history of mental health problems); secondly when deficits in essential (normative) features of parental caregiving are observable.

During the first 1,000 days regardless of the problem issue, interventions should include work that specifically targets the parent-infant relationship, applied in tandem with the intervention addressing the adult. So for example, in the case of adult substance misuse, behavioural strategies and motivational interviewing respond to the substance misuse. These are not appropriate models to promote/ protect child health and development.