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Networks of care for the most vulnerable

Refugees and asylum seekers, women in prison, military families, kinship carers and families in poverty

(With contributions from Home-Start UK and Kinship)

Foreword

In this supplement to the July issue of the International Journal of Birth and Parent Education, we have invited authors with very different kinds of experience to write about some of the most vulnerable families in the UK as they make the transition to parenthood. We hope our authors' insights into the challenges facing many families in our communities will be valuable in helping everyone working in the first 1000 days to understand better how relevant, respectful and compassionate care can be provided.

This supplement is introduced by Alison Morton, Chief Executive from the Institute of Health Visiting in the UK. Alison discusses the role of health visitors and the importance of a whole system approach to child health that prioritises the earliest years of life. She concludes with an invitation to work together to maximise resources and so ensure the best start in life for all our children.

Home-Start is an international organisation whose primary focus is on supporting families in their own homes. While Home-Start's trained volunteers encounter all of the problems of modern-day living in their work, the cost-of-living crisis has led to a substantial increase in the number of families who need their help because of the impact of poverty. **Peter Grigg,** CEO, describes Lauren's story and how she was supported.

Laura Abbott is an academic who has carried out extensive research into the experiences of incarcerated pregnant women and those newly released. She presents a case-study of Jenna's experiences to illustrate the complexity and distress of being a pregnant woman in prison and the need for better practice ideas to be implemented.

There are over 140,000 children being looked after by kinship carers in England and Wales; these are primarily grandparents, but also aunts, uncles and cousins. The call to care may come when least expected as described by **Louise Sims** and **Lydia Yeomans** of the charity, Kinship, in their case study of Stacey. They call for more research into the needs of this highly marginalised group of carers.

Women serving in the military, or who are the partners of those serving, face regular disruptions in their lives, as do their children. They also live with the dangers of warfare and the ever-present threat of severe injury or death. Psychologists, **Olivia Wilkinson** and **Mercedez Coleman**, describe their efforts to understand the challenges women face and why they do or do not access perinatal mental health services.

Chris and **Kathy van Straaten** worked for over three decades in the Church of England to support refugees and asylum seekers. Many of these were women and many arrived in the country either pregnant or with very young children. As a vicar, and as a vicar's wife, Chris and Kathy had unique opportunities to talk to new mothers outside of the often intimidating environment of governmental offices. They provide pointers to good practice based on an understanding that asylum seekers want what all parents want – namely to feel safe and to be able to look after their children.

Mary Nolan
Editor, International Journal of Birth and Parent Education
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Child health – the smartest of all investments

Alison Morton
Chief Executive from the Institute of Health Visiting, UK

Across the globe, numerous countries are in the throes of general elections which present a moment in time for everyone to reflect on who they will trust to lead their nation into the future. The case will be made for high profile priorities like the economy, national security, employment and engineering infrastructure. Having spent my whole career dedicated to child and family health, and through our work at the Institute of Health Visiting, I have been using every opportunity to influence policymakers to prioritise our 'human infrastructure' – especially our babies and children, who represent our future - alongside their parents, caregivers and the services that support them in the formative earliest years of life.

WHY PRIORITISE THE EARLIEST YEARS?

We are fortunate to live at a time when we have more evidence than any other generation on the importance of the earliest years of life (Black et al., 2016). It is during this time of rapid growth that babies' brains are shaped, and the foundations for lifelong health are laid. Where children are born and live, whether they are rich or poor, their exposure to environmental risks, and the support that they receive from their families, communities and the services around them, can all make a big difference to their health and life chances (Marmot et al, 2020).

Investing in the earliest years of life is not only the right thing to do, it also makes sound economic sense. Health economists have estimated that the cost of 'lost opportunity' from failing to intervene with preventative action in early childhood is £16.13 billion per year in England (The Royal Foundation, 2021). This amount is conservative and does not include the significant lifetime costs for the full range of preventable health conditions that have their roots in early childhood and can be mitigated through early intervention.

Many nations have responded with policies for early childhood. 'Giving every child the best start in life' is a policy strapline in England. However, it remains an unachieved goal and in recent years we have seen child health deteriorating and inequalities widening across the country, exacerbated by disinvestment in public health services.

WE KNOW ENOUGH ABOUT 'WHAT WORKS' TO MAKE A DIFFERENCE NOW

Building healthy people requires a whole system response with action to address the wider determinants of health, like poverty and environmental factors. In the UK, our preventative public health service is led by health visitors, who are registered Specialist Community Public Health Nurses and systematically and proactively reach every family from pregnancy and through the early years.

The importance of a service that sees all babies and young children in-person, as citizens in their own right, cannot be underestimated as they are invisible to other services unless their caregivers reach out. Seeing a baby or child interacting with their family in their home environment provides valuable insight into their world, as well as the risk and resilience factors that can impact on health and wellbeing.

In contrast to the medical model that is predominantly focused on interventions once a need has been recognised, health visiting is focused on 'health creation'. This involves searching for health needs that may be unknown, ignored or hidden. Health visitors are a critical 'health workforce' owing to their vigilance, clinical skills and application of a breadth of knowledge of public health. They are trained to assess families in context and spot deviations from the norm across physical and mental health, working to prevent and identify problems early.

When babies, children or families with additional needs are identified, the intensity of support will be proportionate to the level of need and risk. Health visitors and their team members can provide additional targeted and specialist support directly (for example, for mild to moderate perinatal mental health problems, or infant feeding issues), and also play an important role in connecting families to other support services. UNICEF UK (2022) described the universal role of the health visitor as 'the backbone of early years services across the UK' and the 'safety net around all families'.

Health visitors only provide part of the solution – 'It takes a village to raise a child'. Some excellent examples of targeted support for families in the greatest need are showcased in this journal supplement. Let's work together to maximise our resources and unite in our call for prioritisation of the 'best start in life' for all children.

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Supporting families during their time of need

Peter Grigg
CEO, Home-Start UK

Home-Start was established in 1973 by Margaret Harrison who believed that supporting a family was best done in their own home where support can be shaped to their particular needs. She thought that if parents received support and friendship from another trained volunteer parent, they would be better equipped to learn to cope with the many difficulties life can bring and would, in turn, be able to give their children the best possible start to their own lives. Her idea took root in Leicester, spread across the UK and is now a movement around the world with 22 countries on five continents providing Home-Start support for families.

Keywords: Home Start, home visiting, relationships, families, poverty, support

In the UK in the 50 years since Home-Start was founded, 1.5 million children and their parents have been supported to overcome challenges and build a brighter future. We are currently supporting over 43,000 families including almost 79,000 children. Our distinctive relational, compassionate, non-judgemental support is delivered through weekly home-visiting, providing a consistent, reliable, trusting relationship with a volunteer who builds on existing family strengths. In communities across the UK, 180 Home-Starts provide universal and targeted group work for families with a range of needs.

RELATIONAL, COMPASSIONATE SUPPORT

Parenting young children can be the most delightful joy, and it can also be lonely, frustrating, heartbreaking and overwhelming. At Home-Start, when our trained volunteers spend time with families, we find it is the simple things – like a conversation or time together – that can have the most profound effect on a parent's ability to cope. We do not see our role as to 'fix' anything but to stand alongside families to build their strength and confidence and to empower sustainable change.

> 'With the help of a Home-Start volunteer, the impossible becomes possible'
>
> (Parent)

Supported by expert staff, the 9,000 or so current Home-Start trained volunteers are matched with families following their referral and an initial assessment of needs. Support might be brief or can last for many months depending on family circumstances and what they want to achieve in their time with Home-Start. Emotional and practical support are core to the Home-Start offer with a consistent, trusted relationship being forged – a rare occurrence for some parents. Together the volunteer and family identify and build on what's going well. Their time together - between one and two hours per week - can take many forms. It might provide space for parents to focus on their own health needs – whether emotional or physical - attend appointments or have space to reflect and heal. Or it might provide an opportunity for a parent to play with their child with another pair of hands to help where there are multiple children or children with additional needs. For some parents, learning how to play, and cook and feed a family, and how to budget might feature. The support offered is as unique as the family. Research to date has demonstrated positive outcomes for families receiving Home-Start support, with over 90% of parents reporting improvements in wellbeing and coping, and diminished feelings of isolation (Warner, 2021). Improvements in parenting and child behaviour are also reported (Hermanns et al., 2013).

The work of Home-Start has broadened in the last decade or so to move beyond purely home-visiting support. While this is still the core service, our delivery beyond that is determined by the needs of local communities, other sources of support available in local areas, funding and capacity. Universal and targeted group work is the offer provided by most Home-Starts.

EXAMPLES OF GROUP ACTIVITIES ACROSS THE HOME-START NETWORK

- Drop-ins
- Stay and Play
- Infant feeding groups
- Groups for dads
- Groups for parents with mental health challenges
- Parent-child interventions
- School readiness programmes

Many Home-Starts have their own premises from which to deliver group support, while others might be based within children's centres, family hubs, or other community settings such as libraries, church halls and preschools.

Like many valuable services, Home-Starts do not work alone. Knitted into the local fabric, Home-Starts connect with and work alongside maternity services, health visiting, nurseries, social services, housing associations, perinatal mental health teams, speech and language services and other vital support. Referrals can work in many directions and where families have the support of a multi-agency team around them, Home-Start features as a part. A recent evaluation (Gentry et al., 2018) of one Home-Start's offer to local families has highlighted its value to the wider services landscape, including health and social care, and also to the volunteers themselves.

In recent years, there has been an increase in referrals of families where multiple and complex needs exist, including families receiving social care interventions, families where there are significant parental mental health needs, and significant educational and developmental needs in children. The rise in statutory service thresholds has meant that many Home-Starts have had to increase their staff teams and consider carefully what level of support volunteer-led provision can safely and realistically be expected to offer. Health and local authority funding is diminishing, with less funding being available for valuable voluntary sector partners, leaving many Home-Starts with challenging decisions to make about their offer and sustainability.

THE IMPACT OF POVERTY

When parents feel isolated and lack support around them, nurturing a family can feel a real struggle. For far too many, parenting can be a lonely experience (Co-op, 2018). In recent years, the main, but not exclusive reason for referral to Home-Start has been for parental mental health issues, financial difficulty and support for lone parents. Of course, these problems do not exist in isolation and often compound each other. Over the past year, we have seen a 15.7% increase in the number of families receiving support from Home-Start with increased financial vulnerability often driving this.

The Covid-19 pandemic exacerbated the strain on families, particularly for the third of families living in poverty in the UK (Little Village, 2021). The latest report from the Joseph Rowntree Foundation (2024) shows that not only is poverty increasing but so is deep poverty, with over a million children experiencing destitution. Child poverty means parents can't afford the basics of food, clothing and shelter and this situation makes it much harder for parents to manage the everyday strains of parent-child relationships.

For young families, the rate of fuel poverty is above the national average with 26% of single parent households affected and 17% of couples with children (Dept. for Energy Security & Net Zero, 2022). Fuel poverty impacts children in distinct ways. As part of

LAUREN'S STORY

I'd been struggling with my daughter Layla's meltdowns. Layla has additional needs and I found it hard to go out of the house with her. My Home-Start volunteer, John, encouraged me to take Layla out and told me not to care what people think. He built up my confidence to the point where I can now take Layla shopping by myself. If she does have a meltdown, I'm able to manage it.

Home-Start has helped my family in so many ways, from giving me confidence and supporting me to be a better parent, to helping us get by with food and other essentials. The cost of living crisis really affected my family. It was stopping my husband, Will, a lance corporal, from being able to travel home on weekends because we couldn't afford the fuel, and that was affecting Layla.

We'd cut back to the point where there was nothing left to cut back on. We were surprised at Christmas thanks to support from Waitrose and John Lewis, through their partnership with Home-Start. Bags and bags of lovely food arrived and Christmas gifts – including a surprise for Will and me. But the biggest thing it did for us was remove all stress and guilt. We were able to enjoy Christmas and we managed to make the food last all month!

We were so thankful to have been given this special experience that gave us a little break from having to struggle to cover the bills. We're trying to manage the rising costs as much as we can. Will has taken on a second job as a doorman, so that we can cover the travel costs of him coming home at weekends, as well as buy food and heat our home.

I'm in a much better place than I was a year ago. I no longer need Home-Start support now. I'm thankful Home-Start was there to help me through some pretty tough times.

their evidence review, the National Centre for Social Research (2023) has shown that:

- respiratory problems are twice as prevalent in children who live in a cold homes;
- food insecurity in childhood is associated with cognitive impairments
- and impaired motor skills development and school readiness.

Meanwhile, data from abrdn (a global investment company) Financial Trust's Financial Impact Tracker Action for Children reveals that families who struggle to meet their energy bills will cut back on other areas of expenditure such as food, leisure and clothing – all of which affect children's welfare. In 2022, there were an estimated 3.26 million households living in fuel poverty in England (GOV.UK. 2024). This is an increase from 3.1 million in 2021 and doesn't take into consideration the cost-of-living crisis that hit households throughout the winter of 2022-23 and beyond.

The impact of poverty and how Home-Start has been able to offer support to families are described in Lauren's story.

HOME-START'S VISION

Home Start's vision is to shape a country where all children have the best possible start in life and we want to make sure that no parent or family feels alone in the critical task of raising children. There is strong evidence for the value of preventative, peer-led support for families in the early years. These years are full of challenge and opportunity, vulnerability and growth, with the best start for life requiring nurturing relationships, an enriching home environment, and parents who are supported to fulfil this essential role. Home-Start is there for parents when they need us most because childhood cannot wait.

FOR FURTHER INFORMATION

www.home-start.org.uk

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Meeting the needs of pregnant women and new mothers in prison

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There are 12 women's prisons in the United Kingdom and six have Mother and Baby Units (MBU) attached. Approximately 5% of the total prison population consists of women (Abbott, 2018). The heightened vulnerability of pregnant women within prison environments is well-documented, with increased risks of miscarriage and pregnancy complications (Davies et al., 2022; 2020; Bard et al., 2016; O'Keefe & Dixon, 2015). The experience of pregnancy within the confines of a prison environment is marked by isolation, fear and feelings of loss (Abbott et al., 2023). There are also opportunities for the experience to be transformative should a woman be granted a place on an MBU with her baby (Abbott, 2018). However, for women who are separated from their babies, they endure a disenfranchised grief and are at risk of psychological harm (Abbott et al, 2023b).

Keywords: prison, pregnancy, motherhood, Lost Mothers, Criminal Justice System

In the UK, inquiries by the Ombudsman into two newborn baby deaths (baby Brooke Powell and baby Aisha Cleary) and the suicide of a postpartum woman (Michelle Barnes) within prison settings have raised considerable alarm, prompting regulatory responses (Prison and Probations Ombudsman (PPO), 2022; 2021). Following these numerous investigations, all pregnancies occurring in prisons are now categorised as 'high risk' (NHS England, 2022; MBRRACE-UK, 2021). Recent regulatory amendments introduced by the Sentencing Council demonstrate the imperative of factoring in perinatal women's health during sentencing and of advocating for prioritisation of community-based alternatives to prison, particularly for pregnant and postpartum women (Sentencing Council, 2024).

Specialist midwives provide maternity care for women in prison with support from psychological and health care services. Pregnancy and Mother and Baby Liaison Officers (PMBLOs) are Prison Officers who provide additional support to women who are pregnant, have babies with them or who have been separated from their babies. The Lost Mother's project (www.lostmothers.org), funded by the Economic and Social Research Council in collaboration with the charity, Birth Companions (2021; 2019), seeks to explore the dynamics between incarcerated women, midwives, health visitors, social workers, and Criminal Justice System (CJS) staff when decisions are made about separation of newborns from their mothers. Initial findings reveal that women often lack crucial information, feel disempowered and emotionally distraught, yet appreciate the additional support provided by midwives and PMBLOs (Abbott et al., 2024).

VULNERABILITIES OF PREGNANT WOMEN IN PRISON

Pregnant women in prison face a multitude of specific vulnerabilities that heighten their risk for adverse health outcomes. A majority of women in prison come from backgrounds of deep trauma and many have subsequently abused drugs and alcohol. A large number have been Looked After children and have experienced homelessness and domestic violence (Baldwin & Epstein, 2017). Substandard living conditions in prison compound risks for women, with inadequate nutrition and hygiene facilities posing significant threats to maternal and fetal health (Abbott et al., 2024; Capper et al., 2023). Separation from family and support networks deprives pregnant women of essential emotional and practical support, exacerbating feelings of isolation and stress. Women who are separated from their babies describe this trauma as 'heartbreaking' and 'the worst thing that has ever happened to me' and are especially vulnerable to mental ill health requiring specialist support.

THE NEEDS OF PREGNANT WOMEN IN PRISON

Limited access to antenatal education, resources and support services, coupled with increased risk of mental health issues such as depression

Best Practice Ideas

1. **Accessible Antenatal Care:** Ensuring pregnant women in prison have access to comprehensive antenatal care, including regular check-ups, screening, and medical interventions to address health concerns or pregnancy complications.
2. **Mother and Baby Units (MBUs):** Including Mother and Baby Units within prisons, but also providing more units outside prisons so that mothers and infants can reside together, with access to specialised support and services tailored to their needs.
3. **Parenting Support Programs:** Offering programs that equip incarcerated women with knowledge and skills to care for their infants, promote positive parent-child relationships, and prepare for reintegration into the community.
4. **Mental Health Support:** Providing access to mental health support services for incarcerated women perinatally, addressing psychological stress, anxiety, and depression associated with incarceration and motherhood.
5. **Continuity of Maternity Care:** Ensuring continuity of maternity care for pregnant women and new mothers separated from their babies, including access to breastfeeding support, postnatal care, and maternal-infant bonding interventions.
6. **Staff Training:** Providing comprehensive training for prison staff on the needs of pregnant women and new mothers, including recognising signs of distress, promoting maternal-infant bonding, and facilitating access to support services.
7. **Holistic Reintegration Support:** Implementing programs for pregnant women and new mothers on release from prison, addressing housing, employment, healthcare, and family reunification to promote successful community reintegration and reduce recidivism.

and anxiety, underscores the need for tailored healthcare interventions and support programs to address the unique needs of pregnant women in prison (Pitfield et al., 2023; Dolan et al., 2019). Specialist midwives who are expert in prison midwifery can now provide individualised care tailored to the needs of the prison population. This has not always been the case and until recently, prison midwifery was frequently an add-on to the community workload and often left women without midwifery cover during periods of sickness or annual leave (Abbott et al., 2023a). Abbott et al. (2024) describe how the prison system itself is 'institutionally thoughtless' regarding the needs of pregnant women in prison. A scoping review by Capper et al. (2023) found that there is an urgent need for a standardised approach to nutrition for pregnant incarcerated women worldwide, emphasising the importance of prioritising and providing an adequate diet to safeguard the health of both women and their babies. Access to education programs, childbirth classes, and breastfeeding support services help to empower pregnant women with the knowledge and skills needed for a healthy pregnancy and childbirth experience. Additionally, pregnant women in prison need access to mental health support services to address the psychological stress, anxiety, and depression often associated with incarceration during pregnancy. Opportunities for maternal-infant bonding, including skin-to-skin contact and breastfeeding support, are crucial for promoting positive maternal-infant relationships and infant development. Finally, pregnant women in prison need help to maintain connections with their families and support networks, as well as assistance with reintegration into the community post-incarceration to ensure continued access to healthcare and support services for themselves and their infants.

WHAT CARE CAN BE PROVIDED?

Midwives are the lead professionals caring for pregnant women and new mothers in prison. The Prison Midwives Action Group (PMAG), set up to support midwives who work in prisons, enables best practice to be shared. In some prisons, there is a multi-disciplinary team of psychologists, mental health nurses, social workers, obstetricians, PMBLOs and peer supporters. Charities such as Birth Companions provide additional support and antenatal education in some prisons. When a woman is on the main prison wings, the environment can be noisy and frightening but Mother and Baby Units are usually much calmer with a team of expert staff, including early years practitioners, available for support.

MOTHER AND BABY UNITS

Mother and Baby Units (MBUs) represent a vital resource within the prison system, with six such units established nationwide (Abbott et al., 2023b; Powell et al., 2020). These units offer accommodation for women and their babies, providing a nurturing environment until the child reaches 18 to 20 months of age. However, they are often far from the woman's home making it difficult for other children to visit. Staffed by early years practitioners, MBUs offer specialised support, fostering maternal-infant bonding and attachment and promoting positive parenting skills. Despite being situated within the prison premises, MBUs are typically separate from the main prison population, affording women the

Case Study: Jenna's Journey Through Pregnancy in Prison

Background
Jenna was sentenced to prison for 12 months for the first time for a non-violent crime. Her entry into the prison system coincided with the discovery of her pregnancy. As a first-time mother, Jenna faced an array of daunting challenges and fears, compounded by the stress and isolation of incarceration.

Initial Challenges
The initial period in prison was particularly stressful for Jenna. Not knowing what to expect and trying to navigate her new environment while pregnant added to her anxiety. She attempted to hide her growing pregnancy bump, fearing the reactions of others and the potential consequences of being visibly pregnant in prison.

Living Conditions
Jenna's experience was marred by poor living conditions. The food quality was inadequate, causing her to lose weight at a time when proper nutrition was crucial. She heard horror stories from other women about giving birth in their cells because they couldn't get medical help in time. These stories amplified her fears about her own pregnancy and impending childbirth.

Emotional and Physical Strain
The physical discomfort of being pregnant in prison was relentless. Jenna found it difficult to sleep comfortably and couldn't eat when she wanted to. She often felt scared and lonely, locked up for long periods with limited support. Her family lived two hours away, making frequent visits nearly impossible and adding to her sense of isolation.

Support Systems
Despite the harsh environment, Jenna found some solace in the support provided by the Pregnancy Mother and Baby Liaison Officers (PMBLOs), a compassionate midwife, and other women in similar situations. This network offered her emotional support and practical advice, though it couldn't fully alleviate her fears and discomfort.

Concerns About the Future
One of Jenna's greatest fears was the uncertainty surrounding her ability to stay with her baby after birth. She desperately wanted a place in a Mother and Baby Unit, but there was no guarantee she would get one. The possibility of being separated from her baby at birth was a constant source of anxiety. This fear prevented her from forming a strong emotional bond with her unborn child, as she worried it might make any potential separation even more painful.

Emotional Toll
The emotional toll of her situation was immense. Jenna often cried at night, hiding her tears from others to avoid being placed on suicide watch. The loneliness and sadness she felt were profound, and she struggled to maintain her mental health under such trying circumstances.

Conclusion
Jenna's case highlights the profound challenges faced by pregnant women in prison. Her story underscores the need for better support systems, improved living conditions, and more humane policies to ensure that pregnant inmates receive the care and consideration they deserve. The support from PMBLOs, midwives, and fellow women was invaluable, but systemic changes are crucial to address the broader issues faced by women like Jenna.

opportunity to engage in educational or vocational activities while also caring for their babies. Importantly, infants in MBUs are not considered prisoners and may enjoy day visits or overnight stays with family members outside the prison. However, in cases of poor behaviour on the Unit, women may be temporarily or even permanently separated from their babies, who are placed in community care. Overall, the presence of MBUs has the potential to be transformative for both women and babies, offering a supportive environment conducive to positive maternal and infant outcomes.

TRANSITION INTO COMMUNITIES

When pregnant women leave the prison environment and re-enter communities, a seamless transition is crucial. Access to continued healthcare, mental health services, and community support helps ensure a smooth reintegration for both the mother and child. Collaboration between prisons and community resources is therefore essential for sustained care post-release.

BEST PRACTICE IDEAS:

Best practices involve a holistic approach that combines maternity care, mental health support, and educational programs. Creating a supportive community within the prison, fostering empathy among staff, and facilitating family connections can positively impact the experiences of incarcerated pregnant women. Implementing trauma-informed care practices is

key. There are already some prisons providing excellent facilities and team-working, and charities such as Birth Companions are leading the way in how to support and care for women involved in the criminal justice system.

BIRTH COMPANIONS

Birth Companions works to improve the lives of women and babies who experience inequality and disadvantage. It provides services for women and babies, and works to create positive change in the maternity, criminal justice, social care and immigration systems.
birthcompanions.org.uk

CONCLUSION

Recent inquiries into newborn baby deaths and maternal suicides within prison environments have underscored the urgent need for regulatory responses and improved healthcare provision. Ultimately, a concerted effort is needed to ensure that pregnant women in prison receive the necessary care and support to navigate their pregnancies safely and with dignity.

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Becoming a family through kinship care:
Thinking beyond the dyad

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Kinship care has become a significant permanence option for children who have been neglected or abused; yet systems of support for and understanding of this form of family life are embryonic. There is no available data that gives us an accurate and robust understanding of kinship care across the UK. It is a family practice and a way of raising children that has been overlooked for decades, marginalised both within policy development and child welfare research. This article uses a case study to illustrate some of the common challenges for families.

Keywords: kinship care, family life, grandparent care, sibling care

Readers of this Journal understand that the first 1000 days of life for a child are vitally important. This focus on the beginnings of infancy rightly highlights both the profound needs of the baby and young child and the developmental opportunities that exist at this stage in the life-course. The IJBPE recognises the needs of caregivers and draws attention to parental support for new families as they embark on family life together. We were delighted to be asked to contribute to this edition and to have the opportunity to highlight the distinct needs of kinship families. Those first 1000 days of family life in kinship care arrangements urgently need our collective and careful attention.

It is important to say from the beginning that kinship families are families like any other. Throughout history and across the world, grandparents, aunts, uncles, sisters, brothers, cousins, and close friends have always provided parenting care to children. Economic, cultural, and practical reasons shape how family life and child raising are organised. Throughout Africa, Asia, the Pacific, and Latin America, the responsibility for raising children is commonly thought of as a shared endeavour, including both close and distant relatives. In many cultures, children are routinely raised by kin for significant periods of time alongside or instead of their birth parents. Kinship care for many communities is considered the norm.

It is estimated that there are over 140,000 children currently being raised in kinship arrangements in England and Wales (Office for National Statistics (ONS), 2021). Over half of children in kinship care arrangements are growing up in households headed by grandparents whilst nearly a quarter are growing up in households headed by a sibling (Wijedasa, 2015). Most arrangements - an estimated 95% of all kinship families in England - are made privately within families (Farmer et al., 2021). In these informal arrangements, families work out between themselves how care for the child is to be managed, including who has what responsibility. In most arrangements, the legal relationship between the child and their birth parents is not altered.

Economic, cultural, and pragmatic reasons underpin kinship arrangements around the world. For some families, arrangements are made at a time of crisis, as a consequence of bereavement, parental ill health or to protect children from abuse. Families may seek to protect children by arranging for alternative care within their network. Kinship care arrangements can also come about due to direct intervention by children's services. In England, the law imposes a duty on the local authority to safeguard the welfare of children and a duty to promote, where possible, the upbringing of children within their family network.

Government data and research are showing an increased emphasis on kinship care in both local authorities and the courts in England and Wales (Harwin et al., 2019). Kinship care is the most prevalent form of non-parental care for children who are unable to live with their parents . The following example is an anonymised case study. It highlights how arrangements can happen in an unplanned way and at a time of family crisis. Some details have been changed to preserve anonymity.

Case Study: Stacey

Stacey has been approached by social services as a possible kinship carer for her sister's unborn child. Her sister, Lucy, is eight months pregnant and has a history of chronic mental ill health and drug and alcohol addiction. Lucy had concealed her pregnancy, but health issues have led her to seek medical support. A pre-birth child protection conference has identified significant safeguarding concerns, and the local authority is seeking a care order. The plan is for the child to be removed at birth into alternative care whilst a parenting assessment is undertaken of Lucy. Stacey has had no contact with her sister for five years and did not know she was pregnant. Stacey is a 22-year-old single woman who rents a studio flat and works full-time as a shop-assistant for a high street clothing company. Both Stacey and Lucy spent time in foster care as children. Home life was often chaotic and unsafe. Both sisters are estranged from their birth family. As a former Looked After child, Stacey has had help to secure a tenancy and has been supported through college and on entering the workplace. The past few years represent the most sustained stable period of her life.

What will the first 1000 days hold for Stacey and the baby? Stacey's situation may seem dramatic, but it is not unusual. She is being asked to step in and undertake the parenting of her niece, but also to accept the possibility that the baby may be returned to the care of Lucy. Becoming a family through kinship care can be shocking and life changing. Kinship carers can take on the care of young children at any time of the day or night because a birth mother has been admitted to hospital, or a social worker has asked them to care for a child because the child is considered at risk if left at home. Carers might not have much time to think through all the implications. Complicated feelings of ambivalence and loss can reverberate through relationships (including between the child and their carer) and be felt over many years.

Kinship care can be a source of difficult feelings within family relationships. Parents may feel resentful of the kinship carers or simply not understand why they cannot care for their own children. Lucy may challenge Stacey's position as the primary carer. Stacey may need support in those first 1000 days and at different times to establish and maintain a clear sense of authority as the primary carer that allows her to safely care for the child. In the context of complex psychological and intra-family issues, support really matters and '… the timely provision of appropriate support to families or carers, is vital' (Simmonds, 2019:5).

Stacey will have to undertake a huge psychological adjustment in a very short period. Practical matters will be difficult. She may have to consider leaving her job. In our recent survey, 86% of kinship carers reported being either forced out of work or having to reduce their hours because of taking on the care of a child (Kinship, 2023). We have been calling for the government to introduce statutory paid leave through our #ValueOurLove campaign. In tandem, we are working with a range of employers to develop the Kinship Friendly Employer scheme. In September 2023, Tesco – the UK's largest private-sector employer – granted colleagues who have a Special Guardianship Order (SGO) to care for relatives' children equal rights with colleagues who adopt, giving them both 26 weeks' leave in full.

Poverty and financial hardship have become a defining feature of kinship families in the UK. Furthermore, poverty is often a consequence of becoming a kinship carer – many carers are living on a fixed income, such as universal credit or a pension (Kinship Care Parliamentary Taskforce Report, 2020). The highest prevalence of kinship care is in the poorest 20% of areas (Wijedasa, 2015).

> Financial hardship is a defining feature of kinship familes

Stacey's housing situation is precarious. Difficult and challenging situations for kinship carers can include overcrowding with carers and children having to share beds or sleep on sofa beds. In the Wijedasa study (2015), over three quarters (76%) of the children in kinship care were living in households considered deprived on at least one dimension of deprivation (employment, education, health and disability, housing). In 2020, Professor Joan Hunt provided an overview of UK research for the Parliamentary Taskforce Report into Kinship Care. Her review of the literature showed that.

- Kinship carers are poorer and in worse health than any other group raising children.
- Many children in kinship care have needs that are as great as those entering other forms of substitute care.
- For carers caring for children in the context of parental abuse and neglect, support needs and challenges can be significant, including complex psychological and intra-family issues.

What support is there for Stacey? The answer to that question is we don't know. There is no available data that gives us an accurate and robust understanding of

kinship families, their support needs and the support available. This is in stark contrast to other areas of children's social care, such as fostering and adoption. The lack of data and research maintains kinship families' invisibility to policymakers and practice systems. What we can say, with confidence, is that systems of support and understanding of this form of family life are embryonic.

Things are changing. The Department for Education (DfE) in England published the first ever National Kinship Care Strategy in December 2023. This recognition of kinship care as a distinct and valuable element not only within children's social care but also in wider society, represents a milestone moment. Kinship families need all of us to broaden our lens and consider the diversity and complexity of family life outside of the parent child dyad.

Kinship – The Kinship Care Charity
Kinship supports kinship carers as they care for their children, helping families through the challenges of family life, sharing in their accomplishments, and helping them access support. We help professionals understand kinship families and improve support for them. And through our research and campaigns we make sure kinship care is understood and government knows what changes are needed.
For more information, visit: https://kinship.org.uk/

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The perinatal experiences of military families:
Barriers and facilitators to accessing mental heath services

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The perinatal period is a time of monumental change, whether a family is welcoming their first baby or whether they already have children. Adjusting to pregnancy and parenthood can feel difficult in most circumstances. Navigating this period in a military context can make things even more challenging. This article discusses some of the unique challenges faced by military families in accessing perinatal mental health support, vital not only for the person experiencing distress to recover, but for the healthy emotional development of their children. Recommendations for best practice are discussed in relation to existing literature and a service evaluation conducted by the North Yorkshire and York Perinatal Mental Health Service.

Keywords: military families, child development, perinatal mental health, best practice

Specialist perinatal mental health teams are commissioned to treat mental health difficulties in the perinatal period and exist across the UK. They specialise in the mental health of women and birthing people in the context of parenting and can offer support with the parent–infant relationship. Around 1 in 5 women will develop a perinatal mental health condition (World Health Organisation (WHO), 2022). Perinatal mental health teams generally offer support during pregnancy and up to the child's first birthday.

THE IMPORTANCE OF EARLY CHILDHOOD

The 1001 critical days refer to the time from conception to a child's second birthday (Burlingham et al., 2024). The experiences that children have during these first years shape brain development (Tierney & Nelson, 2009). Babies and young infants are learning and developing constantly. They rely on their caregivers to provide a secure base from which to explore and learn about the world.

Children who are securely attached are more able to turn to their parents when they need help, solve problems independently, trust the people who care about them and tend to feel better about themselves throughout their lives (Circle of Security International, 2022). Perinatal mental health difficulties, including depression and PTSD following birth-related trauma, can have detrimental impacts on the parent–child relationship (Erikson et al., 2019), and the child's development of a healthy attachment. Given the challenges faced by military families, and the impact of these on mental health, it is important to know whether families are accessing specialist perinatal mental health services and what the barriers and facilitators to access are.

THE MILITARY EXPERIENCE

There are approximately 174,000 young people living in the UK who have a parent serving in the British Armed Forces, with the number of personnel making up the armed forces just over 188,000 as of April 2023 (Gov.UK, 2023). Serving personnel have been found to be at an increased risk of developing mental health problems due to the unique nature of their roles and the impact that these roles have on their everyday lives (Goodwin et al., 2015). However, the psychological toll of military service does not stop at the serving person. Partners of serving personnel are also at an elevated risk of mental health adversity due to feelings of isolation, relationship inequality and limited opportunities to develop self–

identities (Hendrix & Murphy, 2021). They may be stationed away from family and wider support networks (Senior et al., 2023). Children whose parent(s) are serving or ex–serving may face long periods of separation from their parent, and frequent moves of home and school. Military families also face unique stressors in comparison to the general population because of the psychological impact of war and combat. All these stressors are likely to play a role in the development of mental health problems in the perinatal period, already a sensitive time for mental health.

WOMEN SERVING IN THE MILITARY

Women currently make up 11.7% of the UK regular forces (Ministry of Defence, 2023), with this figure set to rise to 30% by 2030 in line with the Government target to increase female representation. Women face unique challenges within the military. Until as recently as 1990, they were automatically discharged on becoming pregnant, and only since 2018 have women been able to serve in all combat roles including infantry and special forces units. Female service members are more likely to experience sexual harassment, bullying and physical assault (Hendrix et al., 2021).

WHAT WE KNOW ALREADY

Research into the perinatal experiences of serving personnel, veterans and the partners of serving personnel is relatively limited, particularly within the UK. The barriers that exist for military partners have been found to differ considerably from the barriers identified for women in the general population in terms of accessing mental health support. For example, in a U.S. study conducted by Lewy et al. (2014), 26% of military partners cited concerns that their medical information may not be kept confidential as a barrier to seeking mental health support compared to only 4% of the general population. Nineteen percent of military wives cited 'negative opinions of the community' as a barrier compared to only 5% of the general population.

More recent research comes from Nguyen et al. (2023) in the United States who found five barriers and three facilitators to military partners accessing perinatal mental health care in the U.S. The barriers included stigma, the impact on the service member's career of having a family member with a mental health problem, lack of support, accessibility, and practical and logistical concerns. Facilitators included a vigorous support structure. Participants identified their husbands and other family members as their primary pillars of support; however, they also noted that flexibility and understanding on the part of their partner's commanders were important. Finally, encouragement to seek help was a facilitator along with practical and logistical help.

Research into U.K specific populations is yet to be conducted. A service evaluation (unpublished) carried out by the North Yorkshire and York Perinatal Mental Health Service (Tees, Esk and Wear Valley NHS Foundation Trust) found that military personnel and their dependents made up 4.8% of referrals in 2021- 2022 and that personnel had a significantly higher acceptance rate into the Perinatal Mental Health Service than their civilian counterparts. We explored the barriers and facilitators to military women accessing our service and found the following themes.

BARRIERS TO ACCESSING PERINATAL MENTAL HEALTH SERVICES

Stigma
Women identified that attitudes held within the military were a barrier to accessing mental health support.

Attitudes in the army are a big barrier and a problem.

Timeliness and accessibility
Some women identified that being posted overseas could act as a barrier to accessing timely support. Women often do not know where they will be stationed when they return home and therefore cannot access the perinatal specific support that they need.

The risks of seeking support
Another barrier to women accessing support was the idea that their children might be removed by social services or that they themselves might end up in an inpatient facility. There was also a belief that seeking perinatal mental health support could impact the service career of their husbands and partners.

Seeking help affects your partner's job.

Understanding the significance of perinatal mental health
Women spoke of the lack of specific training given to military doctors and the impact of this on seeking support.

Military doctors are not trained in perinatal mental health.

FACILITATORS TO ACCESSING PERINATAL MENTAL HEALTH SERVICES

Connection to others and relationships
Women described their relationships with family and friends as facilitators to seeking support.

My family encouraged me to go for it and have support there if I need it.

When women had had previous contact with civilian mental health services, this made seeking support easier. Relationships with staff within the perinatal team were important - women valued being involved in decision making and having their experiences and feelings validated.

Tips for best practice

• Record military status
The recording of demographic data is an important first step in understanding who is accessing your service. This data can then be used to compare military access rates to the general population in your town / county. Having open and curious conversations during assessment can ensure that military status is asked about and recorded. Knowing how military families are already accessing your service could then lead to evaluating your service. Where are referrals coming from? How are those who are accessing it, experiencing it?

• Understand the importance of connection
Military populations are frequently stationed away from their family and friends. Connection to others is a key component of good mental health and this is particularly true in the perinatal period. Supporting military personnel or their partners to feel connected to other people in the perinatal period is of particular importance. Could your service link in with local charities who offer support for military families? Could your service facilitate peer support groups for military families in your area?

• Understand the risks of seeking support
A unique barrier hindering military families from seeking support for perinatal mental health difficulties is the belief that this will affect the serving member's career. Mental health services can help women to feel supported by liaising with the military and advocating for their needs.

• Training
Keeping up-to-date with training around mental health in the military can be helpful for clinicians who may not be from a military background themselves.

CONCLUSION

Military families face unique challenges that can affect mental health. It is important to remember this in the perinatal period, a time of change, with its own vulnerability to the development of mental health problems. Clinicians and support services, both statutory and lay, need to be aware of the barriers that exist for military families in accessing perinatal mental health support so that we can provide timely and appropriate care and ensure that 'military children' are given the best possible start in life.

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The situation facing asylum seekers and refugees in England,

with particular reference to new mothers and mothers of small children

Chris and Kathy van Straaten

The authors have lived in five countries, so are familiar with having to adapt to new environments and particularly with struggling with a new language at the same time. Chris has recently retired as a vicar. Both authors have been involved for some years as volunteers at a centre for asylum seekers and refugees run by a Christian church in Hull. The content of this article is gleaned from what they have seen and learned of facilities provided in Hull and in different parts of England.

Keywords: refugees, asylum seekers, centres, depression, isolation

Having volunteered for many years at a facility for asylum seekers and refugees in Hull in the North of England, our main perception is how patchy facilities in England are. Asylum seekers and refugees are moved around the country at the whim of the Home Office, and they may well arrive in a new town or city without even a coat. If they have applied for asylum, they will be given accommodation, free heating and meals, plus a small weekly allowance (for instance, those put up in hotels currently receive just £8 per week). Accommodation varies in quality; people are often fearful of other residents; some complain of bedbugs, and the food provided by the hotels is not popular. Asylum seekers and refugees are very much reliant on welcome centres provided by charities and churches, but these are few and far between, run largely by volunteers, and they vary in what they can offer. Sometimes there is help with legal advice and support from the Red Cross, nurses and Migrant Help, as well as language lessons and hand-outs of food, toiletries and second-hand clothing. But these facilities are only available if refugees and asylum seekers are fortunate. For instance, when I visited a centre in Croydon, I was told that some of their clients walked to the centre from their hotels near Heathrow, a distance of between 15 and 20 miles!

Migrant Help

This charity exists to protect people affected by displacement and exploitation, helping them thrive as individuals and recover from their trauma. It supports those most in need and least likely to find support elsewhere, whilst aiming to bridge community gaps and bring services and support together.

For more information, visit https://www.migranthelpuk.org/

WE PROVIDE INDEPENDENT ADVICE

One of the main benefits of these centres is the possibility of meeting people who speak their own language. The importance of meeting fellow countrymen and women cannot be over-estimated. Isolation and loneliness are a huge issue for asylum seekers and refugees; being able to chat freely to others in the same situation is immensely encouraging, quite apart from all the information that can be exchanged. Virtually all asylum seekers and refugees long to be in touch with home, and some centres help clients to top up their mobile phones.

Women often feel far more isolated than men. Because of social customs, they often do

not visit the centres run for them, or feel ill at ease there. They may well not be comfortable speaking to men, and may struggle to attend language classes. If they have small children, they will be preoccupied with them, and may not leave their accommodation much at all. As a result, their ability to speak English usually lags far behind that of the men.

STRESS AND DEPRESSION

In our experience, many asylum seekers and refugees suffer from stress and/or depression. This has several causes:

1/ Whatever caused them to leave their family and country in the first place - political turmoil, persecution for religious or political reasons, threats of gangster violence, abuse by family members (for example, a woman we know had her house and daughter set on fire by her husband's family).

2/ The stress of their journey to this country (for instance, one couple lost their two sons in the chaos of the journey and didn't even know whether they were alive; fortunately, after some weeks the Red Cross was able to locate the boys in Greece and they were eventually reunited).

3/ The uncertainties of their asylum claim. People arrive in the UK often believing that they will be welcomed with open arms, so discovering the real attitude of the Home Office is devastating. Interviews and appeals, usually with little legal support, are traumatising. The ordeal of refugees and asylum seekers can last for years, with no certain outcome, while they live in fear of deportation and of being thrown out of their accommodation with little notice. Official forms are often impossible to understand and threatening in tone, and Migrant Help (the Go-to organisation recommended and funded by the government) is overwhelmed. We know of some asylum seekers waiting 20 years for an answer to their claim. One was told to travel from Hull to Croydon on her own for a hearing and was so anxious that she made herself ill and couldn't go. Many asylum seekers and refugees are on anti-depressants and show signs of acute stress, for example, picking at their skin until it bleeds. Because of their isolation, women are particularly prone to stress.

PREGNANCY, CHILDBIRTH AND COPING WITH YOUNG CHILDREN

There is still a belief amongst some asylum seekers and refugees that getting pregnant and giving birth in the UK may help their claim to asylum. Loneliness and vulnerability lead some women to start relationships which may be short-term and leave them pregnant. They may then find themselves on their own if the father of their child disappears.

Asylum seekers and refugees are advised early on to register with a GP, and it appears that most pregnant women do manage to access the NHS and to have their babies in hospital. Of course, language is usually a problem. They can - if they realise it - ask for the free services of an interpreter when they have a GP or hospital appointment. Normally these interpreters are not present but are on the phone, and vary in their language ability, especially as regards medical terms. Google Translate on mobile phones is extremely helpful, especially as you do not have to write anything, but can just speak into the phone. Often, if there is a husband or partner, he may be of help in explaining things to medical personnel.

When women are pregnant, especially with a first child, or have small children, this is the time when they will particularly miss their extended families and feel even more vulnerable than normal. We know of one woman who insisted on having her birth videoed as her in-laws back home wanted proof that she hadn't deceived them when she told them that she was pregnant. Often, the NHS in their area will know little or nothing of the customs surrounding childbirth that the expectant mothers are used to. Women's anxiety about giving birth in a British hospital will increase in the likely case of lacking fluency in English; Kathy can vouch for this having twice given birth abroad and being afraid that during labour her language ability might desert her completely.

> Pregnant refugee and asylum seeking women particularly miss their extended families

Once the baby arrives, women will have to cope with midwives and health visitors who can be intimidating. The new mothers may well be living some distance away from other asylum seekers they know and not able to afford bus fares. Men often leave women to get on with things largely on their own, regarding birth and babies as 'women's stuff'.

A new mum needs equipment: nappies, bottles, probably formula milk, a pram, bedding, baby clothes, etc.. If she is lucky, she will get help from a refugee centre, and she should receive Child Benefit. Because of the nature of their situation, asylum seekers and refugees are vulnerable to theft; we know of several

instances when parents fortunate enough to have been given a bicycle or pram, have found themselves stranded when these were stolen.

Mothers of small children soon face the stress of confronting a strange education system and of choosing nurseries and schools for their children. (And, of course, the children may well have to change schools if the family is moved.) Small children may have a difficult time going to nursery or school if they are not able to speak any English. One couple we know asked us to interpret between them and the school when their son started attending nursery at the age of three, having never been away from his parents before and not being able to communicate with or understand the teachers or children. As a result, he was aggressive at the beginning. Fortunately, he soon settled down, learned English and began teaching his mother!

HOW CAN WE BE OF HELP?

- Use Google Translate on your mobile phone if you want to communicate; you can just speak into your phone, and the phone produces a fairly accurate translation.
- Be aware of cultural issues. A male volunteer at a centre may well smile at a Muslim woman but should not touch her, even to shake hands. Women appreciate sanitary products being donated, but may well not use tampons.
- Find out where your nearest centre for refugees and asylum seekers is and see what they might appreciate in the way of donations: toiletries, household goods (eg crockery, pots, curtains, towels, clothes, especially small size men's clothes). And of particular value are bicycles. If you have one lying in the garage unused, it could be of great value to a refugee, enabling him/her to get about and do the shopping. Often refugee centres can refurbish bikes needing some work done on them.

FINALLY, AND MOST IMPORTANTLY

- Remember that asylum seekers and refugees are PEOPLE, just like us, wanting just the same things for themselves and their families: to feel safe and to be able to look after their children. Try not to feel intimidated or to avoid them if they speak a different language or are in a group. Even centres which are there to help refugees often end up processing applicants rather than welcoming people. Stressed, grim-faced volunteers, speaking loudly to try to make themselves understood, will be off-putting to timid refugees, already feeling ill at ease in an environment with rules they don't understand. A smile, valuing them as people will always help greatly!

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