Transforming Scotland

In A Generation

An Implementation Plan
for Fiscal Sustainability

Summary Report

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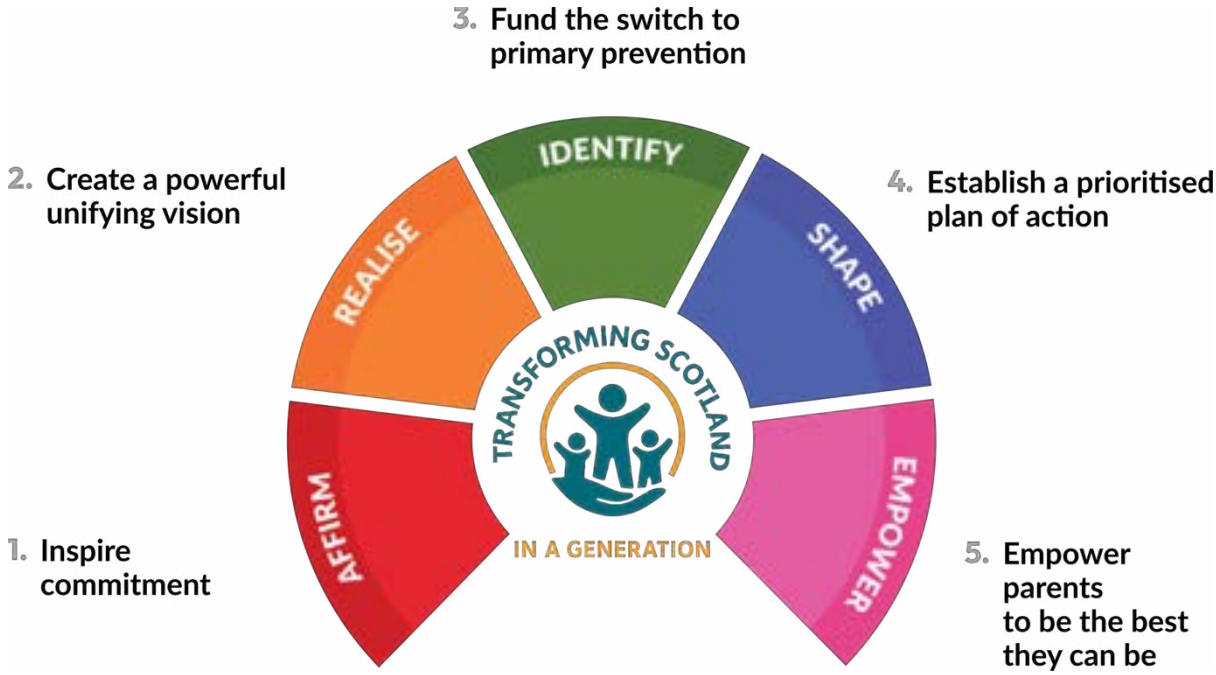
The A.R.I.S.E. Local Area Transformation Blueprint

How Transformation is Delivered Locally



Part 2a: Summary Report May 2026

This document is part of a three-part series. Part 1 (Executive Summary) and Part 2b (Full Report and Evidence) are available separately.

Report of the Cross-Party Commission of Inquiry into Preventing Adverse Childhood Experiences

Chair
Sir Harry Burns

Vice-Chair
George Hosking OBE

Foreword

Sir Harry Burns, Chair of the Commission

For over twenty years I have argued that the most important determinants of Scotland's health, and of the burden carried by our public services, lie not in our hospitals or schools, but in the conditions of life experienced by children in their earliest years. As Chief Medical Officer for Scotland, I saw at close range the human cost of untreated early adversity. As one of those who worked alongside Campbell Christie in the years before his Commission reported, I shared the conviction he expressed in 2011: that without a decisive shift to prevention, demand on our public services would in time exceed our capacity to meet it. Fifteen years on, that warning has become fiscal reality.

When I was approached to chair this Commission, I accepted because I had become convinced that the obstacle was no longer evidence but implementation. The science of early childhood development is no longer disputed. The economic returns to early intervention are no longer marginal. Cross-party political support for prevention is no longer contested. What has been missing is a practical means by which Scotland's leaders can translate this consensus into measurable change at scale.

Over four years, the Commission has examined this question with the rigour it demands, taking evidence from thirty authoritative voices in the prevention science community and reviewing hundreds of research papers and written submissions. The input from Scottish practitioners was notable in emphasising the same points from their years of practical experience as those made by the academic experts.

What distinguishes this report is not its diagnosis but its prescription. The Commission has set out a structured implementation architecture, the ARISE Blueprint, through which local areas can progressively reallocate a small proportion of existing expenditure from low-return reactive services to developmental primary prevention. It requires no new government funding and is consistent with the Scottish Government's Public Service Reform Strategy and Population Health Framework, providing a means through which the ambitions of those frameworks can be delivered in practice.

I have spent my career meeting the adults whose lives were blighted before they even reached school. The Commission's recommendations will not reach all of them. But they will reach the next generation, and the generations after that, if Scotland's leaders have the courage to act on what this report sets out.

Sir Harry Burns

George Hosking OBE, Vice-Chair of the Commission

This report rests on two streams of expertise: the developmental science presented in its chapters, and the methodology of cost re-engineering and public-service reform – a field I have practised for more than four decades, as a finance director at Unilever, a strategy consultant to BP across Europe, and an adviser to UK national and devolved governments. The ARISE Blueprint is the application of that methodology to Scotland's public services.

In my work with local authorities, NHS Boards and central government across the UK, I have heard, time and again, the same response to the case for prevention: "George, we agree with you. But we can't afford it." This report exists because we can now change that narrative. Scotland does not lack evidence, nor commitment. What has been missing is a practical means of implementation that works within existing financial constraints.

I have led 29 cost re-engineering programmes across Western Europe, including five BP subsidiaries. In almost every case the project began with local leaders telling me that every possible penny had already been saved, and that I would not succeed. In every case, by identifying root causes and matching spend to the value it delivered, it proved possible to restore both performance and fiscal sustainability, without new external funding.

The same principle applies here: the pressures on Scotland's public services are not separate problems but different manifestations of common root causes occurring in the earliest years. The cross-party consensus that established this Commission – 128 of 129 MSPs, including all party leaders, backing the 70/30 objective – is more than a credibility marker. Transformational change requires a view longer than any one Parliament, and cross-party backing is the structural condition under which it will succeed. Scotland already has that condition, provided party leaders stay true to those assertions.

The ARISE Blueprint provides the route. Local systems can progressively reallocate a modest proportion of existing expenditure from low-return reactive services to high-return developmental primary prevention, without additional government funding. The Scottish Government's Public Service Reform Strategy and Population Health Framework already require this shift; Audit Scotland has confirmed the current trajectory is unsustainable. The question is not whether change is needed, but how quickly our leaders will deliver it.

The Commission has done its work. With the right will and leadership, I have absolute confidence that Scotland can make this shift. What is now needed is the green light from those with the authority to act.

George Hosking

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Transforming Scotland In A Generation

Part 2a · Summary Report - Introduction

Scotland faces a structural fiscal crisis driven in large part by preventable harm. This document sets out what causes that harm, what the evidence shows about how to prevent it, and what Scotland's leaders can do to act on that evidence. The Commission of Inquiry has reached a clear and consistent view: the tools exist, the returns are exceptional, and the cost of continued inaction is one Scotland can no longer afford.

This summary supports rapid understanding of the Commission's findings, why they matter for Scotland, and the action now required. These findings are particularly relevant in the context of growing pressures on Scotland's public services.

The document follows on from Part 1, the Executive Summary of *Transforming Scotland in a Generation*, and acts as a bridge for those who wish to explore the full evidence base in Part 2b, Full Report and Evidence.

The document brings together three main elements:

First, it sets out the **Commission's Recommendations**. These provide the strategic direction and practical steps required to shift Scotland from managing the consequences of harm to preventing its root causes.

Second, it provides a **Summary of each of the 22 sections of the Full Report**. These one-page summaries are designed to help readers navigate the full body of work, identify the sections most relevant to their role, and locate the detailed evidence and analysis in the full report if they wish to go deeper.

Finally, the document includes **four key sections with abbreviated versions of the full evidence in the main report**:

Section 3: Scotland's Hidden Architecture of Dysfunction
Section 15: Secure Attachment
Section 19: A.R.I.S.E. – The Local Area Transformation Blueprint
Section 22: The Financial Case for Developmental Primary Prevention

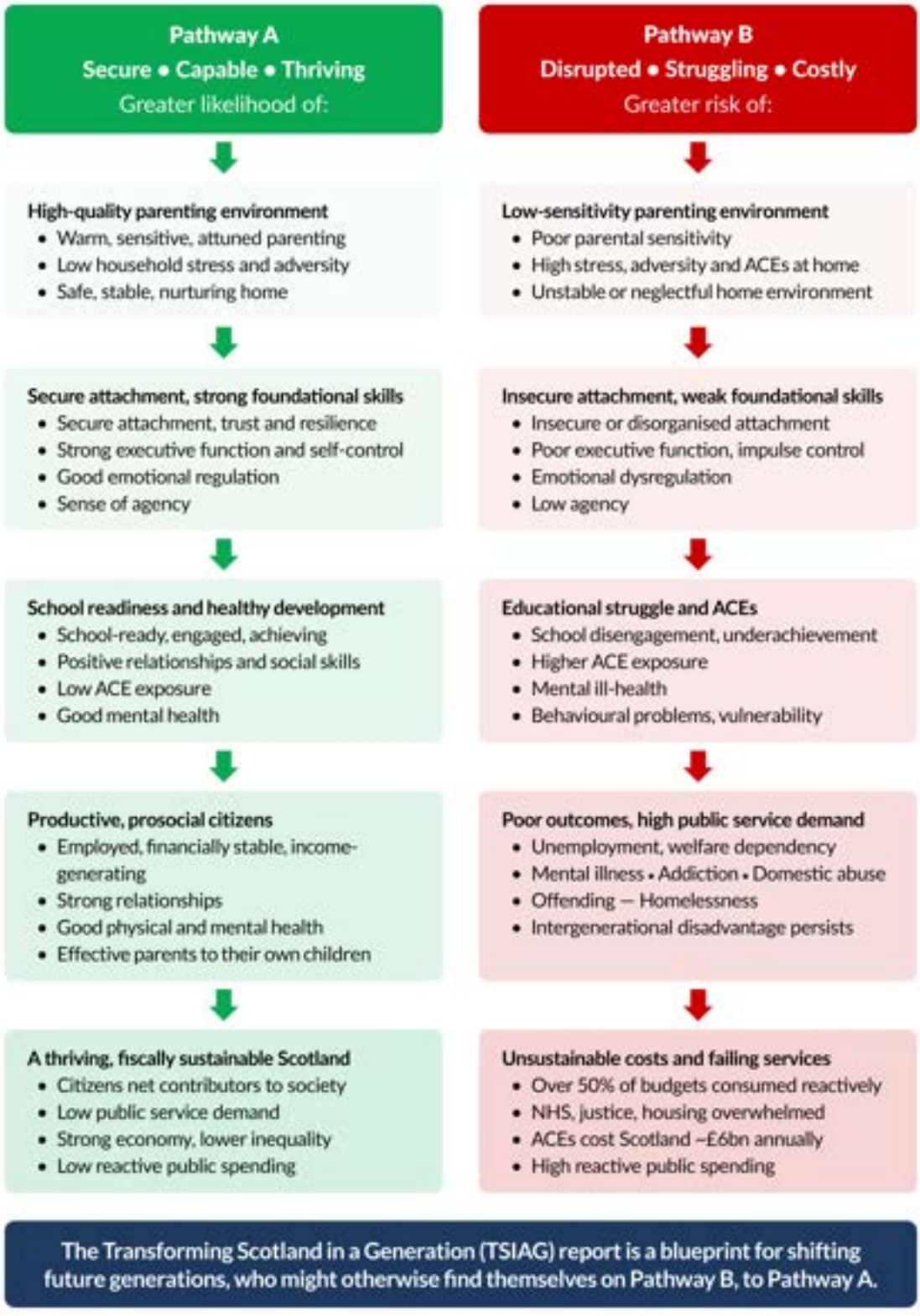
This summary sits alongside the full report, which provides the complete evidence base, detailed analysis and supporting references. This shorter document enables Scotland's leaders, practitioners and partners to engage with the Commission's findings at pace, so that the recommendations can be discussed and acted upon without requiring every reader to work through the full report.

This report sets out how Scotland can reduce long-term demand across public services by addressing the developmental root causes of social harm, funded through a reallocation of 4 to 6% of existing spending. This creates a clear opportunity to build a nation where every child can flourish.

Scotland's Two Developmental Pathways

Children's developmental trajectories follow a continuum but tend toward one of two broad pathways, strongly influenced by early parenting quality. The consequences extend across wellbeing, social outcomes and public expenditure.

The relationships shown below are statistical, not deterministic. Individual outcomes vary; some who experience significant early adversity still flourish. But at population level, the patterns are strongly associated with very different outcomes and long-term demand on public services.



Recommendations

The Commission makes 5 overarching recommendations that set the strategic direction for shifting from managing the consequences of social harm, to preventing its root causes. These are supported by 15 enabling recommendations that specify the practical steps required to implement them effectively.

Together they constitute a mutually reinforcing implementation system. The overarching recommendations are numbered 1 to 5. The enabling recommendations are numbered as subsets of the overarching recommendation they support.

Taken together, these recommendations set out a practical programme to shift Scotland from reactive spending to prevention-led reform, within existing resources.

No other intervention offers the combination of scale, impact and fiscal return identified in this report.

1. Reallocate resources to prevention

In alignment with the Public Service Reform Strategy and Population Health Framework, Scotland should progressively reallocate 4–6% of statutory expenditure from low-payoff reactive spending into high-payoff developmental primary prevention over 4 to 5 years, shifting the focus of public services from reducing symptoms to addressing root causes.

1.1. *In support of Key Recommendation 1, the Commission of Inquiry recommends that prevention strategies in Scotland are designed on the basis that sustainable prevention requires both system redesign and intentional shifts in how communities support families, and that both actively share responsibility for children's wellbeing and outcomes.*

1.2. *The Commission of Inquiry recommends that Scotland's main statutory agencies, including local authorities, the NHS, Police Scotland and Community Planning Partnerships, are mandated to prioritise the systematic identification, understanding and prevention of the key root causes, and especially the common root causes, of their most concerning and/or expensive social responsibilities.*

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2. Embed the developmental pathway as the guiding framework

Embed the developmental pathway from parental sensitivity to secure attachment to the 4 foundational skills of executive function, self-control, emotional self-regulation and sense of agency as the guiding framework within Scotland's transformation agenda.

2.1. *In support of Key Recommendation 2, the Commission of Inquiry recommends that, as the highest priority, reallocated funds from low pay-off reactive spending should*

be invested in the following areas of developmental primary prevention:

- *Supporting the capability and confidence of parents, parents-to-be and potential future parents, on a universal basis, to understand how to exercise sensitivity in response to a baby's signals and needs;*

- *Fostering the development of secure attachment as widely and robustly as possible in future generations of Scotland's children, through universal support to parents;*

- *Promoting the widespread capability of pre-school children, and children up to and including age 7, to practise as natural behaviour the four key foundational skills of:*

    a. *Executive Function*
    b. *Self-Control*
    c. *Emotional Self-Regulation*
    d. *Sense of Agency*

2.2. *Prevent ACEs by addressing their root causes, not only treating trauma after the fact. Shift decisively from a predominantly trauma-response model to a trauma-prevention model, systematically addressing the family and relational conditions that generate ACEs before harm occurs.*

2.3. *Make communities central delivery platforms for Developmental Primary Prevention. Embed prevention within communities by supporting accessible, relationship-based local infrastructures (e.g. family hubs, community parenting supports, peer models), investing in the training of community members as peer supporters, and recognising communities as essential partners in prevention rather than adjuncts to statutory services.*

2.4. *Invest in the development of specialist parent-infant mental health services across all health board areas, recognising their essential role in addressing severe and complex relational and mental health difficulties during the first 18 months of life.*

2.5. *Conduct careful early pregnancy assessments for the toxic trio – addiction, domestic violence and mental health issues - plus prior parental ACEs. Those mothers or fathers showing signs of these should receive high quality support to deal with these issues as early as possible in the pregnancy.*

2.6. *Address the attainment gap by recognising it as a developmental gap shaped by early experience, and by adopting a play-based, relationship-centred approach from ages 3 to 7 that builds the four foundational capacities - executive function, self-control, emotional self-regulation, and sense of agency - before formal academic expectations are applied.*

3. Establish universal parenting support

Establish universal, evidence-based parenting support from pregnancy to the beginning of school, with additional support for parents and carers with related issues, proportionate to need.

3.1. Provide universal parenting support, delivered through accessible community hubs, using programmes or approaches which reliably enable good parental sensitivity, build parental confidence, foster secure attachment, and embed the four foundational skills.

3.2. Develop and embed preparation for parenthood in Scottish secondary education for all young people aged 14 to 16. This should include: understanding of infant communication, parental sensitivity and serve-and-return interaction; the nature and importance of secure attachment, and how it is fostered; the four foundational skills; the developmental roots of aggression and violence; and how parenting practices can prevent or foster all of these; the harms of harsh, inconsistent, or neglectful parenting; and the realities of parenthood.

3.3. Develop Full-Service Children's Centres or integrated family hubs in every community, co-locating health visiting, early years education, family support, and parenting programmes with stable, well-trained staff supported by appropriate career structures.

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4. Reduce child poverty through integrated developmental and economic strategy

Reduce child poverty through an integrated strategy combining structural economic support with robust relationship-centred developmental investment.

4.1. Rebalance poverty prevention strategy to place greater emphasis on relational health risks - including parent-child relationship quality, parental mental health and family stress - alongside continued direct action on poverty and inequality.

4.2. Recognise and pursue the enormous opportunity to break the intergenerational cycle of poverty by tackling its root causes, resulting in enhanced educational attainment, workforce participation and productivity, a higher proportion of tax-contributing citizens and fewer citizens excluded from productive participation.

4.3. Ensure cross-departmental coordination between housing, health, and social care establishes housing policies that actively support, and do not undermine, child development priorities.

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5. Build the enabling infrastructure for sustained prevention

Build the enabling infrastructure required for sustained prevention, including planning structures, strengthened workforce capability, community partnership, continuity of relationships and relevant outcome reporting.

5.1. *Treat transformation of the Early Years Workforce as an essential enabler of the opportunity to transform Scotland, recognising that this is integral to delivering the Developmental Primary Prevention pathway and closing the poverty-related attainment gap. This should include raising professional status, pay, training quality, and career pathways to reflect the developmental importance and complexity of work with children from conception to age 7.*

These 5 overarching and 15 enabling recommendations are supported by a series of thematic recommendations on reducing all Adverse Childhood Experiences (with particular attention to Child Sexual Abuse and Domestic Violence/Abuse); making community involvement more powerful; strengthening early years policy; improving Educational Achievement, closing the Attainment Gap; developing Workforce policies; and Data collection.

1. Why Scotland Must Change

Section Summary

Scotland stands at a crossroads. After decades of progress in public health and social policy, a convergence of fiscal, demographic, and operational pressures demands transformational change. This section sets out why that change is urgent; later sections show how it can succeed - laying the foundations for delivering goals such as reducing child poverty, fulfilling 'The Promise', and closing the attainment gap, while repairing Scotland's fiscal strength as a nation.

The scale of the challenge is stark. Scotland's fiscal deficit of £22.7 billion (10.4% of GDP) in 2023–24 grew by nearly £4 billion in 2024–25. Both deficits were more than double the UK average. **Health and social care costs are rising faster than economic growth. The working-age population is shrinking, while the number of over-65s is growing. Local authorities face a £1 billion funding gap; NHS Boards report structural deficits.** Audit Scotland has concluded that "radical change is urgently needed" and that "reform should prioritise prevention."

The 2019 Scottish Health Survey found that 71% of Scottish adults had experienced at least one Adverse Childhood Experience (ACE), with 15% reporting four or more. People with four or more ACEs face dramatically elevated risks. ACE-related harm costs Scotland over £6 billion annually; insecure attachment creates further costs. Both are preventable.

Taken together, these pressures are not isolated challenges but the predictable consequences of a system that intervenes too late, after harm has already occurred.

Yet **much of this economic burden is preventable. Scotland currently spends less than 2% of local area statutory budgets on primary prevention, and perhaps less than 1% on developmental prevention affecting children's social and emotional wellbeing.** This Commission recommends reallocating 4 to 6% of statutory budgets over time to developmental primary prevention, using the A.R.I.S.E. Blueprint set out in Section 19.

The conditions for transformation have never been more favourable. International research shows high returns from such investments. The Scottish Government's 2025 Population Health Framework commits to shifting from reactive to preventative investment, while the 2025 Public Sector Reform Strategy calls for moving resources upstream to prevent harm before it occurs.

These landmark policy commitments create an unprecedented opportunity; this Commission's A.R.I.S.E. Blueprint (Section 19) provides the practical route through which these ambitions can be delivered at scale, within existing resources. The potential prize is a nation where every child can flourish.

2. A New Path - Tackling Root Causes

Section Summary

When societies face serious problems, the natural instinct is to treat visible symptoms. If violence in society rises, we call for more police on the street. If a pipe leaks, we mop the floor. If children misbehave in schools, we punish and seek to suppress the behaviour. These responses bring temporary relief but rarely resolve the underlying problem. Unless root causes are identified and addressed, issues return - often bigger and more costly than before.

History demonstrates that lasting progress comes when societies stop patching over crises and instead remove the conditions that cause them. The breakthrough in tackling cholera came not from more hospitals but from John Snow identifying a contaminated water pump in 1854 Soho and persuading authorities to remove its handle. Smallpox was eradicated not through better treatments but through vaccines that addressed viral transmission at source. The principle is consistent: invest upstream, where problems originate, rather than pouring resources downstream, where symptoms are costly and resistant.

Many of society's most damaging problems are not separate, isolated issues, but different branches of the same tree, fed by common roots. The science of Adverse Childhood Experiences shows this vividly: abuse, neglect, and household dysfunction dramatically increase risks of addiction, violence, chronic disease and mental illness in later life. What seem like different problems share the same drivers. This explains why reactive spending is so costly: prisons, hospitals, social care, and addiction services are all paying for the effects of the same root causes. Without tackling those causes, demand will continue to grow.

If shared root causes drive multiple social harms, the most efficient solution is to address those causes as early as possible. This is the essence of **developmental primary prevention**. The earliest years of life - from conception to age three - are uniquely sensitive. During this period, a baby's brain forms more than a million new neural connections per second, based on its experiences of life during this period. This critical early years' experience lays the foundations for attachment, self-regulation, executive function, and a sense of security. Strong foundations make children more likely to succeed in school, form healthy relationships, and enjoy good mental and physical health throughout life. Weak foundations increase risks of addiction, violence, chronic illness, and poor outcomes across every domain.

The Commission recommends that Scotland's main statutory agencies - local authorities, NHS, Police Scotland, Community Planning Partnerships - be mandated to prioritise the systematic identification, understanding, and prevention of the key root causes of their most costly responsibilities. Where causes lie outside single responsibility, agencies should work in partnership to support effective prevention. **This is what Scotland's Public Service Reform Strategy and Population Health Framework have committed to.**

The Commission's recommendations provide the implementation architecture to support those frameworks.

3. Scotland's Hidden Architecture of Dysfunction

Section Summary

A comprehensive analysis of Scotland's most expensive social problems reveals a unifying insight with major implications for policy and public spending. **These problems are not discrete issues requiring separate solutions. They are different manifestations of a common underlying developmental architecture that begins with the quality of early caregiving.**

Evidence identifies a clear developmental pathway. When parents provide **sensitive, attuned caregiving** during infancy, children develop **secure attachment:** a fundamental sense of safety and trust in relationships. This secure base enables the development of four foundational skills:

- **executive function** (the brain's management system for working memory and goal-directed behaviour).
- **self-control** (the capacity to regulate impulses and delay gratification).
- **emotional self-regulation** (the ability to manage emotional responses appropriately).
- **sense of agency** (the belief in one's ability to influence outcomes).

Children who travel this positive pathway enter school ready to learn, form healthy relationships, and navigate life's challenges.

In our Inquiry we found a remarkable volume of research linking deficits in these four skills to high level of public agency costs. The chart below on poor executive function is mirrored by similar charts for the other three skills.

Every line on the chart represents firm research evidence of significant association

When parental sensitivity is absent or inconsistent, children are more likely to develop insecure attachment, which undermines all four foundational skills. Adverse Childhood Experiences (ACEs) interact with this pathway in multiple ways: they undermine parental capacity, damage the parent-child relationship, and create toxic stress that impairs brain development. Over half of individuals with four or more ACEs nonetheless develop secure attachment when protective factors are present – see Positive Childhood Experiences later in this report - but dose-response relationships are striking.

This developmental pathway helps explain why deficits in the four foundational skills, insecure attachment, and ACEs consistently predict dysfunction across ten major domains: poor mental health, domestic violence, violence, antisocial behaviour, addiction, educational failure, employment struggles, poor parenting, relationship difficulties, and physical health problems. **Each dysfunction traces back to the same developmental origins.**

Local authorities spending on educational support, behavioural interventions, and youth justice are often addressing symptoms of the same underlying cause in the same individuals. NHS Boards treating mental health conditions, addiction, and trauma-related disorders are managing downstream consequences of early developmental deficits that could have been prevented more effectively and at lower cost.

This reframes Scotland's fiscal challenge entirely. Rather than facing ten separate cost pressures, Scotland faces a systemic problem where **the same root causes generate multiple expensive consequences across every public service domain. This creates the opportunity to reduce demand simultaneously across multiple public services** through reallocating a small percentage of reactive spending toward developing these skills during the critical early years.

The Commission recommends that reallocated funds be invested in

1) Universal support for parental sensitivity, secure attachment and the four foundational skills.
2) Community initiatives based on Washington State's Self-Healing Communities Model.
3) Universal parenting support through family hubs, with services for targeted needs.
4) Play-based skill development for pre-school children.

Through such high financial return prevention investment, reactive demand will be reduced, and the goals of the Public Sector Reform Strategy and Population Health Framework will be met.

This section appears in fuller form on pages 38–46.

4. What Works: Evidence And Insight

Section Summary

The evidence base for developmental primary prevention is extensive and compelling. Research from neuroscience, economics, and public policy converges: investing in the developmental foundations of life delivers greater returns than any other social intervention.

Harvard's Center on the Developing Child demonstrates that brain architecture is shaped by early 'serve-and-return' relationships between children and caregivers, 80% of brain growth occurring before age three. This is the period when fundamental neural pathways for learning, emotional regulation, and stress response are established. Toxic stress from neglect, violence, or chronic adversity disrupts this critical wiring, with lifelong consequences. Interventions during this window deliver exponentially greater returns than remediation later in life.

The economics are compelling. **Nobel Laureate James Heckman's research shows annual returns of 7–13% from investment in early childhood. Delaying intervention until school is, in Heckman's analysis, 'too little, too late';** the period of optimal return is through to age three.

The precedent exists. The Netherlands' 'Every Opportunity for Every Child' strategy (2007) restructured early years support through integrated Youth and Family Centres in every community. By 2011, this system reached 95% of children, with measurable improvements in early detection and collaboration. The core principles endured across electoral cycles.

UK evidence reveals remarkable cross-party consensus. From the Centre for Social Justice (centre-right) to the Allen Review (Labour) to the 1001 Critical Days All-Party Parliamentary Group, conclusions are unanimous: early years intervention is both economically essential and socially transformative. The 1001 Days Inquiry concluded that *'tackling child maltreatment and infant mental health should be no less a priority than defence of the realm.'*

Scottish evidence reinforces these findings. Alan Sinclair's foundational analysis showed that effective early years' spending requires not new money but reallocation from less efficient reactive budgets. Growing Up in Scotland showed inequalities are entrenched by age three. Audit Scotland has said repeatedly: preventive investment is essential to fiscal sustainability.

Scotland now stands at a pivotal moment: the Public Sector Reform Strategy and Population Health Framework explicitly prioritise prevention; the UNCRC incorporation creates binding legal obligations to protect children from harm; and the economic case is compelling.

The Commission therefore recommends that Scotland prioritises pregnancy to age three as its primary prevention window; makes parental sensitivity and secure attachment for children core national outcomes; and systematically reallocates spending upstream.

As Eglantyne Jebb said 100 years ago: 'The world can be revolutionised in one generation according to how we deal with the children'

5. Oral Evidence And Formal Written Submissions

Section Summary

Oral evidence gathered from 30 leading international and Scottish experts, plus formal submissions responding to questions posed, produced a remarkable convergence of scientific research, professional expertise, and frontline experience. Seven major themes emerged:

First, the perinatal period - pregnancy and the first postnatal year - was identified as the single most powerful window for prevention, with parental mental health difficulties liable to create cascading risks across the family (Sections 12 to 15, Pregnancy to Secure Attachment).

Second, large-scale research demonstrated that relational health risks (ACEs, parental mental health, family stress) are more predictive of adverse child outcomes than social health risks (poverty, food insecurity) alone - a finding that reframes Scotland's approach to inequality as requiring a two-pronged approach (see Section 10 'A Fairer, More Prosperous Scotland').

Third, parental sensitivity and secure attachment emerged as the developmental foundations upon which all other interventions depend, with video analysis approaches consistently highlighted as effective (see Section 14 on Parental Sensitivity, Section 15 on Attachment).

Fourth, self-control, self-regulation, executive function, and sense of agency at age 3 were shown to be stronger predictors of life outcomes than poverty, and to be modifiable early in life (see Sections 16, 'Developing the Four Foundational Skills' and Section 17 'Attainment').

Fifth, ACEs and child maltreatment were identified as the most important preventable causes of later psychopathology and system demand (Sections 6 to 8 'ACEs' and Section 9 'Violence').

Sixth, community-based approaches were recognised as essential platforms for prevention at scale - not optional additions to professional services but foundations upon which sustainable transformation depends (see Section 18, 'Community Power').

Seventh, progressive universalism - universal support for all families with flexible escalation to more intensive intervention - was endorsed as the model most likely to achieve reach without stigma (see Sections 19 on 'Local Area Transformation' and 21 'Providers and Professionals').

In written evidence Scottish practitioners described what works, why, and in what conditions. The consensus was clear: the earliest years are decisive; parental sensitivity and secure attachment are foundational; ACE prevention must replace trauma response as the dominant paradigm; communities are critical delivery platforms; integration across services is essential.

The challenge is not discovering what works but implementing it in 32 local authorities and 14 NHS Boards. The convergence between what international experts recommend and what Scottish practitioners support is striking. The Commission's recommendations do not require a leap of faith; they simply ask Scotland to act on what its own professionals already know.

The convergence between what international experts recommend and what Scottish practitioners support is striking. The Commission's recommendations do not require a leap of faith; they simply ask Scotland to act on what its own professionals already know.

Doing what both practitioners and experts recommend is the route to fiscal sustainability.

6. Adverse Childhood Experiences 1: Child Sexual Abuse

Section Summary

Child sexual abuse (CSA) affects approximately 1 in 5 girls and 1 in 7 boys before they reach adulthood, yet remains significantly underreported, with an estimated 400,000 incidents occurring annually in the UK compared to c. 50,000 known to authorities. Over half of reported CSA offences in 2023 were committed by children under 18. Online abuse is rising sharply: Police Scotland recorded 2,055 cyber-enabled sexual crimes against children in 2023–24, a 21% increase on 2022–23.

The consequences of CSA are severe and lasting. Survivors face elevated risks of depression, PTSD, substance misuse, and suicide that persist across the lifespan. CSA is associated with obesity, sexual health difficulties, low mental well-being, and relational problems including dating aggression. The betrayal of trust, particularly when abuse is perpetrated by family members or trusted adults, creates distinct patterns of psychological harm. Based on Home Office estimates for England and Wales, CSA may cost Scotland in the region of £1 billion annually.

This section adopts a public health framework for CSA prevention, and four target groups: potential perpetrators, children and young people, communities and families, and situations where abuse might occur. Evidence from 17 years of implementation in Wales demonstrates that this approach, when supported by strong leadership and effective statutory-voluntary collaboration, has been shown to deliver measurable impact.

Scotland has established significant infrastructure for responding to CSA, including the National Trauma Transformation Programme, the Scottish Redress Scheme for survivors of historical abuse, and the Bairns' Hoose model for child-centred multi-agency response. The Scottish Government's National Child Sexual Abuse and Exploitation Strategic Group, independently chaired by Professor Alexis Jay from January 2026, provides a coordinating mechanism for national action.

Detailed recommendations emerging from the CSA evidence include:

- Expanding pre-offence support services to prevent abuse before it occurs
- Investing in community-based prevention, including family safety planning programmes and integration of CSA awareness into parenting support
- Adopting a dedicated national CSA action plan comparable to those in England and Wales
- Investing in professional training to equip practitioners to identify and respond confidently to CSA
- Improving data collection to monitor prevalence and measure progress

Child Sexual Abuse can be prevented. With sustained political commitment and adequate resourcing, Scotland can be a leader in protecting children from sexual abuse.

7. Adverse Childhood Experiences 2: Domestic Violence And Abuse

Section Summary

Domestic violence and abuse (DVA) is one of the most damaging forms of adversity, with profound consequences for victims, children who witness it, and future generations. One in four Scottish women will experience DVA in their lifetime; one in ten Scottish children are affected. In 2023-24, 45% of child protection planning meetings involved domestic abuse concerns. UK Home Office analysis suggests DVA costs Scotland c. £6 billion annually.

The consequences cascade across development. During pregnancy, DVA increases risks of miscarriage, premature birth, and low birth weight, while epigenetic research shows that stress can permanently alter gene activation - effects that may transmit to grandchildren. Children exposed to DVA face heightened risks of anxiety, depression, aggression, educational failure, and adult relationship difficulties. In children under five, threat to the mother produces more symptoms of aggression, fear, and hyperarousal than any other trauma type, underscoring why DVA is particularly damaging for young children.

The **intergenerational transmission is striking:** witnessing intimate partner violence (IPV) in childhood is one of the strongest predictors of later violent behaviour. Each additional ACE raises the odds of perpetrating IPV by approximately 51%.

The Commission identifies **three priority strategies. First**, education on the harms of DVA beginning by ages 9 to 10. By age 13 to 14, 34% of schoolchildren have already witnessed family abuse, 45% in dating relationships have been victimised, and 25% have perpetrated abuse. Education is most effective when it targets boys and girls, acknowledging bidirectional violence in teen relationships while addressing the gendered nature of adult DVA.

Second, perpetrator programmes would benefit from a shift to trauma-informed approaches (TI), which significantly outperform Duluth approaches in reducing violence and controlling behaviours. TI programmes explore childhood adversity, educate perpetrators about its effects on their brains and behaviour, and model healthy relationships.

Third, promoting secure attachment represents an important primary prevention strategy. Research shows that a very high proportion of domestic violence perpetrators have insecure/ disorganised attachment. Insecure attachment is linked to anger dysregulation, jealousy, dependency, and reduced empathy, thus creating vulnerability to violence when relationships are under stress.

Scotland's current approach remains predominantly reactive. The Commission therefore recommends rebalancing toward prevention: recognition of secure attachment as a primary prevention strategy for domestic violence and abuse, education from age 9 to 10 onwards, and trauma-informed perpetrator programmes. Domestic violence and abuse are not inevitable. If we tackle their root causes, they can be stopped.

8. Adverse Childhood Experiences 3: The Wider Picture

Section Summary

Scotland has high levels of ACEs. The 2019 Scottish Health Survey found 71% of adults had at least one Adverse Childhood Experience; 15% reported 4 or more. The survey did not include neglect. The cost of ACEs to Scotland is estimated to exceed £6 billion p.a.

The mental health consequences are severe. Maltreated children are more likely to develop psychiatric disorders, with conditions emerging earlier, and with greater severity. All forms of maltreatment sharply increase risks of depression and anxiety. Many abused children develop PTSD. Maltreatment may account for up to 40% of prevalent mental health conditions.

Child maltreatment nearly doubles the risk of violent outcomes in later life. The intergenerational "cycle of violence" is well documented: over 20% of abused or neglected children can become abusive or neglectful parents. Witnessing intimate partner violence (IPV) has the strongest and most direct impact on violent behaviour.

The relationship of ACE count to poor outcomes is among the most consistent findings in public health. Attempted suicide rates rise from 1% for those with zero ACEs to over 18% for those with 4 or more. Males with six or more ACEs are 46 times more likely to become injection drug users compared to males with zero ACEs.

The **educational impacts are particularly striking. Children with 4 or more ACEs are around 32 times more likely to experience learning and behavioural problems than children with none.** Learning and behavioural difficulties were observed in 51% of children with four or more ACEs, compared with just 3% among children with none. These outcomes are not primarily matters of motivation or capability but of altered neurodevelopment driven by chronic stress.

Yet prevention can be effective. **The Commission identified five enabling actions** to underpin the shift from trauma response to trauma prevention. **First**, recognising and healing prior generation trauma: trauma-informed approaches can help parents address their own histories and enhance their capacity for sensitive caregiving. **Second**, addressing parental substance abuse through timely, stigma-free access to treatment integrated with whole-family support. **Third**, educating the public about ACEs and NEAR science (Neuroscience, Epigenetics, ACEs, and Resilience), building collective understanding and responsibility for child wellbeing. **Fourth**, strengthening professional recognition of ACEs through training for all professionals working with children and families. **Fifth**, adopting a whole-system public health approach with cross-sector collaboration coordinated through family hubs and shared data systems.

Achieving the Commission's 70/30 target could avert 350,000 to 400,000 cases of mental disorder in Scotland over a ten-year period. This reinforces the case for prioritising developmental prevention.

9. Aggression And Violence

Section Summary

Although Scotland has made remarkable progress in reducing non-sexual violence, with recorded incidents falling by 50 to 60% since its peak in the mid-2000s and homicides halving, violence remains a defining feature of too many lives. In 2023 to 2024, there were approximately 71,000 recorded incidents of non-sexual violence, with domestic abuse incidents stubbornly high at 63,867 in 2023-24 and rising since then.

Sexual violence presents a more alarming picture. Total recorded sexual crimes have more than doubled from around 6,000 in 2005-06 to nearly 15,000 in 2024-25. Rape and attempted rape have more than tripled. Even allowing for improved reporting, this strongly suggests a serious rise in a very troubling form of harm. Sexual violence shares developmental roots with other aggression, including insecure attachment, empathy deficits, and poor self-regulation, but has distinct features relating to sexuality, consent, and gender stereotypes.

The economic costs are substantial. Using a methodology that captures the full range of consequences, the total cost of all violence to Scotland could be between £5 and £10 billion annually. The lifetime cost of a single prolific offender, in 2026 costs, is around £2 million or more. Most significant is the intergenerational cost: today's violence seeds tomorrow's.

Richard Tremblay's groundbreaking research has fundamentally challenged conventional wisdom. Physical aggression is not something children learn; it peaks in toddlerhood, with 1 in 4 social interactions by 24-month-olds involving physical aggression. The developmental task is learning to inhibit it. Most children succeed by age 6. A small minority, about 3 to 5%, do not. **That minority, identifiable very early, accounts for the majority of serious violence.**

Why some children fail to learn is strongly linked to the quality of early caregiving. Children who experience sensitive, responsive care develop the capacity to regulate emotions and, by twelve months, display empathic concern for others' distress. In the absence of such caregiving, children develop insecure attachment, may respond to stress with aggression, and fail to learn alternatives. The Dunedin Study found that **children with poor self-control at age 3 were 4.5 times more likely to be convicted of a violent offence by age 21.**

Scotland’s pioneering work in public health, and the Violence Reduction Unit's creative approach, have inspired international replication. But current approaches intervene after problem patterns have developed. A root cause approach would complement this, intervening to support parental sensitivity, addressing trauma in parents, and enabling children to develop empathy and self-regulation before negative patterns become entrenched.

Given that the cluster of high-risk children, from whom prolific violent offenders will emerge, is identifiable at age 3, the scope is there to intervene before the behaviour becomes settled.

Redirecting even a small proportion of high-risk trajectories would save countless future tragedies and yield cost savings measured in hundreds of millions of pounds.

10. A Fairer, More Prosperous Scotland: Reducing Poverty And Inequality

Section Summary

Tackling poverty and inequality is a moral imperative for Scotland. With 24% of Scottish children living in relative poverty and stark inequalities visible across public systems, the commissioners strongly support action on both issues. The question is not whether to act, but how to act most effectively.

Three major studies: the Millennium Cohort Study (19,500 children), Bethell et al. (131,774 children), and Bellis et al. (7,047 adults), all found that relational factors have about 1.8 times the impact of material factors on child outcomes. Bellis found that being in the least deprived economic quintile with four or more ACEs produced worse life outcomes than being in the most deprived quintile with zero ACEs. **Poverty matters, but the decisive variable is relationships.**

The Baby's First Years experiment gave 1,000 low-income US mothers either $333 or $20 per month for four years. Despite a cumulative $15,000 difference, the study found limited evidence of improvement in wellbeing, parenting stress, or child health outcomes. Income alone can relieve hardship and succour those in distressing circumstances; it is morally right to provide this support. But both UK history and recent research show it cannot transform developmental trajectories. Strong relationships shape stress responses, build secure attachment, and develop the core capabilities for success in life, buffering against poverty.

As our and James Heckman's research show, addressing in the early years the soft skills gap in disadvantaged children offers a viable route to lifting future generations out of poverty.

The evidence points to a two-pronged strategy: structural supports (housing, transport, food security) that reduce material stress, combined with relationship-centred interventions that build parenting capacity and strengthen early bonds. Neither alone is sufficient; both together are essential. But the evidence consistently indicates that building relational capacity is the more powerful lever.

The investment case is compelling. Nobel laureate James Heckman demonstrates returns of 7% to 10% annually on early skill development. The Perry Preschool and Abecedarian projects showed returns of 7:1 or higher. Self-Healing Communities achieves cost-benefit ratios of 8:1 directly, and 35:1 including indirect benefits. The cost of ACEs to Scotland is estimated at over £6 billion annually; redirecting a small proportion of existing budgets from crisis services to early prevention can fund transformation at no additional net cost.

Sweden demonstrates that this integration works at national scale. Through Family Centres that combine easy access support with relationship-building, universal parenting support, and employment policies that build agency, Sweden achieves infant mortality close to half that of the UK, teenage birth rates close to one-fifth, and substantially lower adult obesity.

Align Scotland's compassion with the evidence, and the prize is not only reduced child poverty but transformed life chances for every child. The 70/30 objective, and much more, is achievable.

11. Preconception: The Evidence Base For Preparing Future Parents

Section Summary

The preconception period represents a window of opportunity that is often overlooked in child development strategy. This section presents evidence demonstrating why, for many issues, interventions during childhood and adolescence, before young people become parents, offer higher leverage for improving future outcomes than interventions in pregnancy or after birth.

The case for earlier intervention is compelling. About 47% of UK pregnancies are unplanned, with pregnancy typically recognised at 4 to 7 weeks gestation, by which time the embryo has entered a highly vulnerable phase of development. For Foetal Alcohol Spectrum Disorder (FASD), even brief exposures before pregnancy is recognised can cause irreversible damage. FASD prevalence in the UK is estimated at 3 to 5%, representing the most common non-genetic cause of learning disabilities, with 90% of affected individuals meeting criteria for at least one mental disorder.

Because future parents are shaped by their experiences during childhood and adolescence, **this period offers a unique opportunity to strengthen the capabilities that shape good parenting.** Childhood self-control strongly predicts parenting quality decades later: children in the lowest quintile were 2.5 times more likely to become harsh or inconsistent parents. Secure attachment predicts relationship satisfaction and better emotion regulation in adult partnerships.

A central argument of this section is that not all prevention belongs in the same developmental window. Foundational neurodevelopmental capacities – attachment security, executive function, stress regulation – are shaped primarily in the earliest years. Relational, behavioural, and role-based capacities - partner choice, conflict patterns, parenting knowledge, substance use norms – develop throughout childhood and adolescence, and it is during these years they are most amenable to influence.

For relational and behavioural capacities, schools are the natural delivery platform: universal reach, sustained contact across adolescence, and a legitimate curriculum context for relationship education, emotional literacy, and parenting preparation. Health services address biological risk. Schools address relational and behavioural risk. Both are necessary; neither alone is sufficient.

The opportunity is generational: the primary beneficiaries are children not yet born, but the opportunity to shape their life chances lies in the development of today's children and young people before they become parents.

12. Pregnancy: The Evidence Base for Protecting Development Before Birth

Section Summary

Pregnancy represents a period of extraordinary vulnerability and opportunity. Between conception and birth, the developing foetus undergoes rapid neurological and physiological development that establishes the foundations for lifelong health. **The intrauterine environment, shaped by maternal stress, nutrition, substance exposure, and the quality of support the mother receives, programmes the child's stress response systems and brain architecture in ways that persist across the lifespan.**

Pregnancy is unique in the developmental timeline because it represents a period of exceptionally high contact between families and health services. Nearly all pregnant women attend multiple antenatal appointments, providing systematic opportunities for screening, support, and early intervention. Yet critical risks, including maternal mental health problems, domestic violence, and substance use, are frequently undetected or inadequately addressed. **Research demonstrates that families at serious risk of causing harm to their children before the first birthday can typically be identified during pregnancy through four key risk factors:** parental substance misuse, intimate partner violence (IPV), parental mental health problems, and prior parental experience of adverse childhood experiences (ACEs).

The mechanisms through which maternal stress affects foetal development are now well understood. When mothers experience chronic stress, more cortisol may cross the placenta. This can alter the development of the foetal brain and future stress responses. Research estimates that more than one million children in the UK currently suffer from neurodevelopmental disorders exacerbated by prenatal stress, anxiety, and depression, and that early intervention addressing emotional wellbeing before and during pregnancy could prevent a significant number of cases from reaching diagnosis level.

Perinatal mental health problems affect 10 to 15% of women, yet health services identify fewer than half. Maternal depression in pregnancy more than doubles subsequent risk of child maltreatment. Though paternal depression is also associated with an increase in child abuse risk, paternal mental health has been substantially neglected. Domestic violence frequently begins or escalates during pregnancy, with effects on children through both direct stress programming and disrupted mother-infant attachment.

A recent large trial demonstrated that **integrated screening for risk boosted detection rates and treatment initiation and was associated with reductions in subsequent child maltreatment reports.** Scotland's antenatal system is the most universal point of contact with families at risk but is currently under-used as a prevention platform.

Systematic assessment for the four risk factors, linked to clear referral pathways and proportionate support, would transform screening and support in pregnancy into a cornerstone of the prevention architecture this report recommends.

13. Birth To 18 Months: Attachment Formation Through Responsive Caregiving

Section Summary

The first 18 months represent the period during which the fundamental architecture of emotional regulation, relationship formation, and lifelong mental health is established. Secure attachment, formed through consistent, sensitive, responsive caregiving, is the central mechanism through which early experience shapes development. It is not simply about parental warmth but represents the process through which infants acquire capacities for emotional regulation, develop internal working models that shape all future relationships, and establish the neurobiological foundations for stress management and mental health.

Recent evidence has sharpened understanding of this period's critical importance. The foundation of the prefrontal cortex, governing impulse control, problem-solving, and emotional regulation, is shaped most significantly during the "fourth trimester" (the first three months post birth), even though this brain region does not reach full maturity until ages 25 to 30.

Research demonstrates **that infants who experience adversity and lack relational support during their first two months, but later enter healthy environments, often have worse outcomes** than those who experienced healthy environments initially but later encountered adversity. Early deprivation in those crucial months is not fully compensated by later enrichment.

The mechanisms are well understood. **"Serve-and-return" interactions, repeated thousands of times, build neural connections and regulatory capacities.** Infants gradually transition from complete dependence on caregivers for emotional regulation (co-regulation) to internalising these capacities as self-regulation. Responsive caregiving also programmes the stress response system to be appropriately reactive rather than chronically dysregulated.

Multiple factors can disrupt attachment formation: postnatal depression (affecting 10 to 15% of mothers), paternal depression (5 to 10% of fathers, associated with an increase in child abuse risk), birth trauma, continuing substance use, ongoing domestic violence, parental histories of unresolved trauma, and social isolation. However, none of these associations is deterministic; with effective support, secure attachment can still be formed.

The evidence points toward a proportionate universalism approach with three levels of support: universal support to promote parental sensitivity in interactions with babies up to 18 months; targeted enhanced support for families facing prior ACEs, addiction, domestic abuse, mental health issues or poverty; and specialist parent-infant mental health services across all health board areas to address severe and complex difficulties.

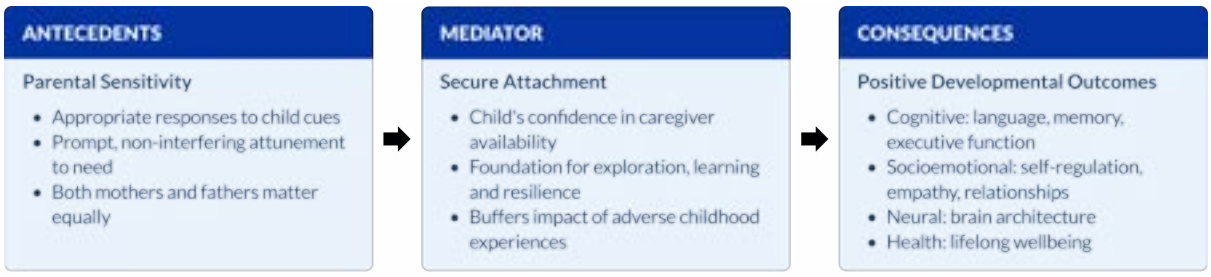
Parental sensitivity in the first eighteen months is the keystone. It builds the secure attachment and four foundational skills (executive function, self-control, emotional self-regulation, and sense of agency) that prevent Scotland's costliest dysfunctions across a lifetime. There is no higher-return investment Scotland can make.

14. Parental Sensitivity And Attunement

Section Summary

This section presents the scientific evidence establishing parental sensitivity and attunement as the primary mechanisms through which secure attachment develops. Whilst Section 13 on Birth to 18 Months addressed when and where early relationships form, and Section 15 on Attachment will examine what secure attachment is and why it matters, this section focuses on how secure attachment develops, the specific parental behaviours and interactions that create the foundations for healthy child development.

While we do not exclude the impact of other factors such as mind mindedness – see 14.2.2 in the Full Report And Evidence - or infant irritability, the core causal pathway is clear.



Every connection shown represents robust research evidence of significant association

Key Findings

1. **Parental sensitivity predicts child outcomes with comparable effect sizes for both parents** across cognitive and socioemotional domains. Both parents matter.
2. **The quality of parenting influences measurable brain development** in typically developing children, not just in cases of severe neglect or abuse (Bernier et al., 2016; Dozier & Bernard, 2017).
3. Specific dimensions of sensitive parenting are identifiable and measurable: appropriateness (responding to child's actual needs), promptness (timely responses), and non-interference (respecting child's ongoing activity) (Pons-Salvador et al., 2025).
4. Evidence-based interventions exist and achieve substantial improvements in outcomes. Circle of Security, Video Interaction Guidance (Kennedy & Sked, 2008; Svanberg, 2009), and the Solihull Approach provide multiple pathways for enhancing parental sensitivity across different contexts and populations.
5. Parent-Child Psychological Support (PCPS) a universal prevention programme with a 30-year evidence base, is scalable and highly acceptable. In Ballymun, Ireland, PCPS achieved 71% participation largely through word-of-mouth referrals, demonstrating that evidence-based universal prevention can engage families at scale.
6. PCPS delivers transformational outcomes. It raised secure attachment from c. 50% to 74.5%, halved insecure and sharply reduced disorganised attachment, and over 9 years avoided any child removals into care among 2,200 families, while reducing parental stress and increasing parental confidence (Jornet-Melia et al, 2025)

15. Secure Attachment

Section Summary

Secure attachment is the emotional bond formed between infant and primary caregivers through consistent, sensitive, responsive caregiving. It represents the fundamental developmental process through which infants acquire the capacity for emotional regulation and develop internal working models of themselves and others that shape all future relationships. It establishes the neurobiological foundations for stress management and mental health. A securely attached child develops the beliefs that "I am worthy of care," "Others are reliable," and "The world is fundamentally safe."

Attachment is a neurobiological process, not merely a psychological one. During the first two years, the right hemisphere develops more rapidly than any other brain region, driven by right-brain-to-right-brain communication between infant and caregiver. When a caregiver senses distress, mirrors the child's feeling, and calms them through tone and touch, both brains enter synchrony: heart rates slow, cortisol levels fall, oxytocin rises. Repetition teaches the infant that arousal and fear are survivable states that can be brought back to calm. When such repair is missing, the over-activated stress response leads to long-term vulnerability.

Research consistently identifies attachment security as one of the strongest protective factors across the life course. The Minnesota Longitudinal Study found securely attached infants show better social competence, emotional regulation, peer relationships, and mental health through to adulthood. Attachment security in infancy also predicted the quality of caregiving individuals provided to their own children decades later.

These benefits do not occur through a general protective effect, but via development of four foundational skills: Executive Function, Self-Control, Emotional Self-Regulation, and Sense of Agency. These skills are the proximal determinants of future academic success, mental health, relationship quality, and social functioning. Insecure attachment undermines them, leading to cascading vulnerabilities and, in turn, to Scotland's most costly social problems.

Disorganised attachment, found in 10 to 15% of low-risk samples but 40 to 80% in high-risk populations, deserves particular attention. It arises when the caregiver is simultaneously the source of comfort and the source of fear, and **predicts the most adverse outcomes** including dissociative symptoms, aggression, and conduct problems.

Strikingly, **parents' own attachment histories predict the attachment they form with their children** with c. 75% accuracy, but parents who have processed their own trauma can achieve "earned security" and form secure attachments with their infants despite ACEs. A meta-analysis found that improving parental sensitivity produces medium-to-large effects on child attachment security, an effect size stronger than many cost-effective medical treatments.

Secure attachment is foundational infrastructure for human development. It is also Scotland's most undervalued asset, and its most economically essential. This is not soft social policy. It is hard preventive economics.

This section appears in fuller form on pages 47–55.

16. Developing The Four Foundational Skills

Section Summary

When we ask what enables a child to thrive, the answer lies not primarily in IQ or family circumstances but in **four interconnected foundational skills: Executive Function, Self-Control, Emotional Self-Regulation, and Sense of Agency. These skills are more powerful predictors of life outcomes than intelligence or economic background.** Children who develop strong self-control by age five go on to have better health, higher incomes, more stable relationships, and lower involvement in crime three decades later, regardless of IQ or family income. Executive function predicts academic achievement better than intelligence. Children who can regulate their emotions experience fewer mental health problems and show greater resilience. Those with a robust sense of agency are better equipped to overcome disadvantage and hardship.

The evidence is clear: these skills are not innate talents that some children possess and others lack. They are capacities developed through experience and can be strengthened by well designed interventions. This presents both an opportunity and an obligation for policymakers. **The skills do not develop in isolation. They emerge from and depend upon secure attachment, sensitive caregiving, freedom from toxic stress and ACEs, quality play experiences, language development, and addressing socioeconomic disadvantage.** Programmes that build skills whilst ignoring these foundations will produce limited results. Children cannot develop executive function when their stress response systems are chronically activated.

The evidence demonstrates that well-designed interventions can enhance all four skills across the developmental span. **During the preschool years (ages 3 to 5), and up to age 7, play-based approaches** that exercise executive function **are highly effective**, and Scotland's expansion to 1,140 hours of funded early learning and childcare creates an unprecedented opportunity, though quality matters far more than quantity. In the primary school years, social-emotional learning curricula show consistent effects, and intensive interventions for children with significant difficulties can produce lifelong benefits.

The economic case is compelling. Cost-benefit analyses estimate returns of £4 to £17 per pound invested, from improved educational results, reduced special education costs, higher employment and earnings, reduced crime, better health, and reduced welfare dependency.

Eleven key principles emerge from the evidence:

1) start early but recognise it is never too late;
2) children with the weakest initial skills benefit most;
3) quality matters far more than quantity;
4) relational quality is foundational;
5) integration trumps isolation;
6) play is the key to early learning;
7) mind and body are inseparable;
8) parent engagement amplifies effects;
9) quality workforce knowledge and support are critical;
10) reducing ACEs and toxic stress is essential;
11) the foundational skills develop together

Benefits cascade to academic achievement, behaviour, wellbeing, future contribution to personal and public finances, and reduced demand on public services.

17. Closing The Attainment Gap: The Critical Role of Play

Section Summary

When children from disadvantaged backgrounds begin school a year behind their peers, we fail both those children and Scotland. Despite significant investment, the poverty-related attainment gap persists. **This section proposes that closing the gap requires understanding it as fundamentally a developmental gap** and addressing it through play-based provision that builds the four foundational skills before formal academic accountability is applied.

The gap visible in P1 literacy and numeracy is not primarily inability to memorise letters or to count. It **is a gap in the capacities that make formal learning possible: executive function, self-control, emotional self-regulation, and sense of agency. These capacities develop primarily through relationships and play** rather than formal instruction.

Play is not an alternative to developing these capacities; it is the primary mechanism by which children aged 3 to 7 develop them. Engaging in complex play teaches children the functions that enable all later learning: attention, planning, remembering rules, managing disappointment, negotiating conflicts, experiencing being agents who can solve problems.

International evidence strongly supports play-based approaches. Countries that prioritise play and delay formal schooling achieve better outcomes. Scotland ranked 12th in Europe in PISA 2022. Estonian children ranked 1st and Switzerland 3rd. These countries show both better academic outcomes and much better performance by their most disadvantaged children.

Scotland's own guidance, Realising the Ambition, recognises that play is the primary method of learning in the early years. Yet teachers report feeling caught between this developmental guidance and accountability for demonstrating progress in literacy and numeracy from P1. In that tension, accountability wins, play and attainment lose out.

The Commission recommends that Scotland adopt a statutory kindergarten stage for ages 3 to 7, characterised by play-based pedagogy and relationship-centred practice, with formal academic accountability applied from P3/P4 once foundations are built. The Early Development Instrument (EDI), used successfully in Australia, would complement SNSA* by measuring developmental readiness, telling us not just that children are behind but why.

Crucially, quality kindergarten depends on quality practitioners. Countries achieving the best outcomes treat early years work as a prestigious profession; Scotland's training and pay levels lag far behind. (*Scottish National Standardised Assessments)

Workforce transformation is not an additional cost. It is the investment that closes the attainment gap, restores Scotland's educational reputation internationally, and would enable us to reach the outcomes the best-performing European countries now achieve.

Scotland has the policy framework in 'Realising the Ambition'. It has the international evidence. What it now needs are the skilled practitioners to deliver on both.

18. Community Power: The Self-Healing Communities Model

Section Summary

Community capacity is not a peripheral supplement to statutory services but foundational prevention infrastructure, central to delivering the transformation envisaged throughout this report. Statutory services alone cannot achieve whole-system prevention at population scale. By autumn 2025, approximately 630,000 individuals, one in nine of the Scottish population, were on at least one NHS waiting list. Social care assessment waiting lists had grown 30% in a year, with nearly 8,000 people waiting for an assessment. This structural gap between demand and capacity cannot be closed through conventional services alone, however well-funded.

International evidence demonstrates that community-based approaches provide the missing foundation. **The Self-Healing Communities Model, developed in Washington State, offers compelling proof.** Over 18 years, counties that adopted it saw sustained reductions across child abuse and neglect, family violence, youth violence, substance abuse, school dropout, teen pregnancy, and youth suicide, at **a cost of $3.4 million per year generating direct savings of $27.9 million: an 8:1 return,** before indirect benefits. These gains occurred because the conditions that burden statutory services share common roots in adverse childhood experiences, compromised attachment, and absent foundational skills. When communities address root causes, benefits cascade across problems simultaneously.

Community-based support also reaches populations that statutory services cannot: families below referral thresholds, those who distrust statutory agencies, and those who fall through gaps in overstretched systems. Positive Childhood Experiences research reinforces this. Adults reporting six or more positive childhood experiences, including trusted non-parent adults and a sense of belonging, showed dramatically better mental health outcomes even among those with high ACE scores. Many of these experiences occur outside the family, pointing to the importance of community conditions in supplementing what families alone can provide.

The Commission's Parenting Advisory Group proposed Family Hubs in every community, co-locating health visiting, early years education, family support, and parenting programmes in accessible, non-stigmatising spaces. Alongside these, trained Community Parents, experienced local parents who visit homes to support challenged families, offer a proven, cost-effective model with demonstrated improvements in parental sensitivity and maternal wellbeing, drawing on Ireland's experience. New Zealand's SKIP initiative demonstrates how national infrastructure can enable and sustain community-led parenting improvement at scale.

The Commission recommends that Scotland rolls out a national network of Self-Healing Communities based on the proven Washington State model, establishes integrated Family Hubs in every community, and invests in training Community Parents as peer supporters for families where extra support would help.

These are not adjuncts to statutory services. They are the platform through which prevention reaches the families statutory services cannot reach. On the Washington State evidence alone, they deliver an 8:1 return on direct investment.

19. A.R.I.S.E. – The Local Area Transformation Blueprint

Section Summary

The A.R.I.S.E. Blueprint is the mechanism through which the recommendations in this report can be implemented in practice across Scotland's local systems.

Scotland's current investment in developmental primary prevention is extremely low. While prevention is widely referenced in policy, **our best estimate is that less than 1% of NHS Board, local authority, police and justice spending is devoted to developmental primary prevention: support delivered before damage occurs,** and focused on parenting, secure attachment and social-emotional development. This is not a criticism of any agency; it reflects structural patterns in which the vast majority of resources are absorbed by existing need.

The Public Sector Reform Strategy and Population Health Framework represent a decisive commitment to shift resources from reaction to prevention. Both acknowledge that despite decades of aspiration, this has not yet happened at scale. What has been missing is a means to fund prevention without new government money, and a shared implementation process.

A.R.I.S.E. provides a structured method through which local authorities and the NHS can identify opportunities to reallocate 4 to 6% of current expenditure from lower-return reactive services to higher-return prevention, without requiring new government funding.

The approach has five stages. AFFIRM inspires commitment through a senior leader discovery process. **REALISE creates a shared vision** that engages leaders, staff, communities, third sector, media and private sector around a common purpose. **IDENTIFY** uses the SABER process **to map reactive spending and locate reallocation opportunities. SHAPE develops a prioritised, costed action plan. EMPOWER supports parents** through Family Hubs, home-based help and the Self-Healing Communities approach, **building the parental sensitivity and secure attachment that foster the foundational skills which reduce demand on services.**

Each component draws on approaches that have been successfully implemented, often repeatedly, in both UK and international settings. The cost re-engineering steps would be phased and have been applied in over two dozen complex organisational transformations.

The Netherlands achieved cross-party support for similar prevention-focused approaches and consistently ranks first in UNICEF assessments of child wellbeing. Applying an evidence-led approach, such as that adopted there, would yield durable improvements in child wellbeing. Doing so while simultaneously improving public finances would be a double prize.

Success will be measured when parents report increased confidence, early indicators such as secure attachment, children in care and school readiness improve, and demand for reactive services falls. By grounding change in evidence, local ownership, and cross-sector and cross-party alignment, and designing the solution to survive electoral cycles, Scotland should be on the way to a prosperous future, in which the goals of The Promise, reducing child poverty, and closing the attainment gap are all delivered.

This approach is consistent with the Population Health Framework and Public Service Reform Strategy, enabling local areas to reallocate resources and so to reduce demand simultaneously across multiple services, at low cost.

This section appears in fuller form on pages 58–64.

20. Housing First

Section Summary

Housing is a foundational determinant of family wellbeing and child development. Housing stress compounds family difficulties and undermines the developmental environment children need. Critically, housing policies that concentrate disadvantaged families in areas of multiple deprivation create what Professor Ted Melhuish described as "ghettos of disadvantage" that are associated with poor parenting and increased risk for children.

Youth homelessness represents a population at extreme risk. Research indicates that 70 to 80% of homeless youth have ACE scores of four or more. Family breakdown accounts for 40 to 50% of cases, with young people fleeing abuse, rejection following parental repartnering, or pushed out when child benefit ceases. The mental health consequences are severe: young people in hostels are 8 times more likely to suffer mental illness than the general population; those on the streets, 11 times more likely.

Homelessness has its own self-perpetuating cycle: childhood adversity leads to homelessness, which leads to adult instability, which leads to compromised parenting, which increases the next generation's ACE exposure. Homelessness is not only an outcome of adversity but a risk factor for the next generation. The Self-Healing Communities Model approach (Section 18) and ARISE Blueprint (Section 19) address these root causes through strengthening family relationships and preventing ACEs.

The **Housing First** model, which treats stable housing as a foundation rather than a reward for compliance, has proven effective. Finland remains the only European country to have substantially reduced homelessness, down 50% since 2010. UK pilots of Housing First achieved 75 to 90% tenancy retention after 12 to 24 months, substantially exceeding traditional approaches.

The economic case is clear. Prevention of youth homelessness would yield a net annual benefit of over £500 million. Family mediation costs £1,000 to £2,000 per case vs £20,000 or more for crisis intervention. However, while Housing First reduces acute service use, it does not reduce future demand. That requires upstream prevention. **The highest return would come from coupling Housing First with early prevention of ACEs and improving family relationship skills.** Housing First improves individual outcomes; early prevention improves population outcomes and long-term fiscal sustainability.

Housing First addresses the crisis when it arrives; developmental primary prevention reduces the volume of crisis that arrives in the first place. Together they are how Scotland ends homelessness, rather than manages it.

21. Providers And Professionals

Section Summary

Programmes and policies achieve their effects through relationships between professionals and families. The quality of those relationships, and therefore the practitioner's skills, training, time, and support, are primary determinants of whether interventions succeed or fail. This makes the workforce the mechanism through which outcomes are generated.

Health visitors are uniquely trusted professionals delivering universal support, but workforce pressures are undermining this role: caseloads routinely exceed 200, student numbers have significantly declined since 2017, and for some "role drift" toward reactive safeguarding erodes time for primary prevention. Critically, a family assessed as low risk shortly after birth can deteriorate significantly within eighteen months, through postnatal depression, domestic abuse, or a change of partner, making reduced visiting of apparently "green" families (in the traffic light system) a hidden transfer of risk rather than a safe efficiency saving. Training gaps in attachment, infant mental health, and developmental trajectories were reported.

There is an early years' workforce gap between Scotland and Nordic countries, where 50-80% of staff hold degrees, salaries reach £30,000-£45,000, and turnover is 5-10%. In Scotland, c.30% have degrees, salaries are £22,000-£30,000, and turnover 15-25%. Workforce capability is needed to deliver the improvements in developmental outcomes on which long-term system transformation depends.

Full-Service Children's Centres co-locating health visitors, early years education, family and parenting support produce better outcomes through improved collaboration, communication, and continuity. Staff report preferring this way of working. Cost-benefit analysis suggests £1 invested yields £1.50 to £3 in savings.

Systematic engagement with fathers, currently overlooked, is essential as father-infant attachment independently predicts child outcomes.

Professional training in attachment, child development, and trauma-informed practice should extend to all adults who encounter children, not just specialists. The National Trauma Training Programme has trained over 80,000 people, but only 40% report sustained practice changes. Training must be embedded through ongoing supervision and coaching.

Delivering developmental primary prevention at scale could be strengthened by 1) lower health visitor caseloads; 2) re-engagement of GPs with preventive child health; 3) an early years workforce supported by stronger qualifications, pay, and status; 4) integrated Family Hubs in every community; 5) systematic engagement of fathers; and 6) relationship-based training embedded through ongoing supervision.

Build the enabling infrastructure required for sustained prevention, including planning structures, strengthened workforce capability, community partnership, continuity of relationships, and outcome reporting aligned to prevention.

22. The Financial Case For Developmental Primary Prevention

Section Summary

Scotland cannot afford to continue on its current path. The Scottish Fiscal Commission projects a £2.6 billion resource funding gap by 2029–30. NHS Boards and local authorities are struggling to balance their budgets or needing loans or emergency funding. The question is not whether Scotland can afford developmental primary prevention; it is whether Scotland can afford not to invest in evidence-based approaches that reduce demand.

The annual costs of inaction are huge. Adverse Childhood Experiences cost Scotland over £6 billion p.a.; violence and aggression £5 to £10 billion; domestic abuse £2 to £3 billion; and child poverty £2.4 billion. The Christie Commission estimated that 40% of local public expenditure addresses failure to intervene early enough. Yet we estimate less than 1% of statutory budgets is spent on developmental primary prevention, the route to cutting excess demand.

The returns from early intervention are high. Nobel laureate James Heckman's analysis of high quality, comprehensive birth-to-five programmes found 13% annual returns. The Washington State Self-Healing Communities Model achieved 8:1 returns. RAND Corporation reviews found returns of $1.26-$17 per $1 invested. The Royal Foundation/Deloitte analysis calculated that prioritising early childhood could generate £45.5 billion annually UK-wide; pro-rata for Scotland, £3.7 billion, exceeding the projected funding gap.

Glasgow illustrates the message with striking clarity. Starting in 2016, when 1,469 of the city's children were in care at a cost of c.£95 million per year, Glasgow invested in a prevention programme centred on intensive family support, increased health visiting, and relationship-centred practice. By the end of 2025 the number of children in care had fallen by 62% and cumulative savings in Children's Services had reached £33.4 million by 2025/26. These savings do not include the financial benefits to education, health, and justice services. This reflects the economics of good early years prevention: the earlier we invest in families, the greater and more sustained the returns.

Our proposition is not increased total spending but redirection. Reallocation of 4% to 6% of statutory budgets from low-return reactive spending to developmental primary prevention would represent £1.5 to £2.2 billion annually. Based on 4:1 average returns (see section detail), this would in time generate £6 billion plus per annum. The ARISE Blueprint (Section 19), based on tested and proven means, provides a practical methodology to identify savings and reallocate resources that previous prevention strategies lacked.

Every year of delay another cohort is created which will be a drag on the public purse, rather than contributors to it. Of course the ideas we have presented must be studied, tested, challenged. But **excessive delay is the enemy of fiscal sustainability.**

The Christie Commission (2011) warned that Scotland was on an unsustainable path. Fifteen years later, that warning has become fiscal reality. The choice now is between a managed transition towards prevention and unmanaged service collapse.

This section appears in fuller form on pages 65–72.

The following pages contain the ‘extended’ versions of 4 key sections of The Transforming Scotland in a Generation Report:

These are abbreviated versions of the complete sections to be found in Part 2b 'Full Report and Evidence'.

They are described as 'extended' to distinguish them from the one-page summaries earlier in this report.

Scotland's Hidden Architecture Of Dysfunction

Many of Scotland's most costly social problems stem from the same underlying root causes: specific developmental deficits formed in early childhood.

Seeing Dysfunction Through a Different Lens

These problems are treated as separate but are in fact interconnected outcomes of shared developmental causes.

Scotland spends billions of pounds every year managing a set of problems that, from the outside, look entirely separate from one another. Mental health services respond to depression and anxiety. Child protection teams respond to abuse and neglect. Schools manage disruptive behaviour and attainment gaps. Criminal justice services respond to violence and addiction. NHS Boards treat the physical consequences of chronic stress, obesity, and substance misuse. Social care supports families in crisis.

These are treated as different problems, requiring different specialists, different budgets, and different strategies. When outcomes do not match good intentions, explanations can include rising levels of demand, or insufficient capacity within the system responsible for that problem.

What this analysis reveals is that this diagnosis misses a key insight in its foundational assumption. Scotland's most costly and persistent social problems are not separate conditions. **They are separate expressions of the same underlying condition**: a set of developmental deficits formed in the earliest years of life that compromise the foundational human capabilities on which all later functioning depends.

This shared foundation is what this section calls **Scotland's hidden architecture of dysfunction**. It is hidden because it is not visible in any single service's workload. No NHS board, no local authority, no prison service sees the full picture of what a single developmental deficit costs across a lifetime. The costs are distributed across agencies, domains, and decades, making the common root invisible to any system looking only at its own demand. But it is there, consistently identified by independent bodies of research across different countries, methodologies, and populations.

The same developmental failure that fills Scottish prisons also fills Scottish mental health waiting lists, produces Scotland's attainment gap, and drives Scotland's domestic violence statistics.

It is one problem presenting in many forms in many places.

The Developmental Pathway: How Early Caregiving Shapes Life Outcomes

Early caregiving shapes life outcomes through a clear developmental sequence: parental sensitivity, secure attachment, and the four foundational skills.

The evidence identifies a clear causal sequence from early caregiving to adult outcomes. It operates through three interconnected mechanisms, each of which is necessary for the next.

First: Parental Sensitivity

The sequence begins with parental sensitivity: the capacity of a parent or carer to read and respond appropriately to an infant's signals and emotional states. **This is not a vague quality of warmth or good intentions. It is a specific, observable, and teachable behaviour,** and it is the mechanism through which infants learn whether the world is safe, whether their needs will be met, and whether relationships can be trusted. When caregiving is sensitive and consistent, it creates the conditions for what follows.

Second: Secure Attachment

Consistent sensitive caregiving produces secure attachment: a fundamental sense of safety and trust established in the first year of life. Secure attachment is neurologically formative. It shapes the developing brain, particularly the prefrontal cortex responsible for self-regulation and executive function. A securely attached infant has a stable platform from which to explore, learn, and develop the capabilities that will determine their outcomes across every domain of later life.

Where caregiving is absent, inconsistent, or frightening, secure attachment is much less likely to form. Insecure attachment, particularly the disorganised attachment that results from frightening or unpredictable caregiving, disrupts the neurobiological foundations on which everything else depends. This is not irreversible: intervention at any point can mitigate risk. But it establishes a trajectory, and the earlier the disruption, the more foundational the deficit.

Third: The Four Foundational Skills

Secure attachment enables the development of four capabilities that are foundational to functioning across every domain of life:

- **Executive function:** the brain's management system for working memory, cognitive flexibility, and goal-directed behaviour
- **Self-control:** the capacity to regulate impulses and delay gratification
- **Emotional self-regulation:** the ability to manage emotional responses appropriately

- **Sense of agency:** the belief in one's capacity to influence one's own outcomes

Children who develop these four capabilities through secure attachment and sensitive caregiving enter school ready to learn, form healthy relationships, manage setbacks, and navigate life's challenges. They require minimal support from public services and contribute positively to their communities.

Children whose early caregiving is absent, inconsistent, or frightening are more likely to develop insecure attachment, and those who develop insecure attachment are significantly more likely to show deficits in all four capabilities.

Those deficits do not remain localised. They cascade across every domain of life in which the foundational skills are required: which is to say, every domain.

It is important to note that the pathway is not deterministic. Protective factors, including the presence of one supportive adult in an otherwise adverse environment, can buffer developmental risk. Insecure attachment does not guarantee poor outcomes; secure attachment does not eliminate all risk. But the dose-response relationships documented across the research are clear: the more compromised the developmental pathway, the greater the probability of poor outcomes across multiple domains.

Adverse Childhood Experiences (ACEs): A Second, Overlapping Pathway

ACEs form a second major pathway to poor outcomes, overlapping with but distinct from the developmental pathway.

The developmental pathway described above is not the only route from early childhood to poor life outcomes. A substantial body of evidence, built over three decades and associated particularly with the work of Felitti, Anda, and colleagues in the United States, and with Professor Mark Bellis and colleagues in the UK and Wales, identifies Adverse Childhood Experiences as a major and partially independent causal force.

ACEs include abuse, neglect, and a range of household adversities: domestic violence, parental mental illness, substance misuse, parental incarceration, and family breakdown. Research consistently demonstrates dose-response relationships between ACE exposure and poor outcomes across health, mental health, education, employment, and criminal justice: the same domains affected by the developmental pathway. Each additional ACE measurably increases risk. Those with four or more ACEs face substantially elevated probability of poor outcomes across virtually every domain examined.

The two pathways overlap substantially. Parents who themselves experienced ACEs are more likely to struggle with the sensitivity and consistency that produce secure attachment, and children without secure attachment are more vulnerable to the harms that ACEs cause.

Investing in parental sensitivity and secure attachment therefore reduces both pathways simultaneously: it makes ACEs such as abuse and neglect less likely to occur, and it builds the relational resilience that buffers children when adversity does strike.

However, the overlap is not complete. ACEs can co-occur with loving, attentive parenting. A parent's imprisonment, a severe episode of postnatal depression, domestic violence perpetrated against rather than by a primary carer, or a family member's addiction: any of these can constitute significant adversity in a child's life while leaving the quality of the primary caregiving relationship substantially intact. In such cases the developmental pathway may remain largely undisturbed, though not entirely so, while ACEs impose their own direct biological and psychological harms through toxic stress and trauma.

The Commission takes both pathways seriously. However, the developmental pathway is emphasised here because it offers the most direct and scalable route to effective prevention.

The full report addresses ACEs in dedicated sections 6, 7, and 8, and the interventions recommended throughout, from universal parenting support in the earliest years to the Self-Healing Communities approach, are designed to reduce ACE exposure and build the resilience that mitigates their impact.

How the Architecture Manifests: Across Systems, Across Lifetimes

Developmental deficits drive demand across multiple public systems simultaneously, and across decades of the affected person's life.

Both pathways described above manifest across at least ten major domains of social dysfunction. The three illustrations that follow focus on the developmental pathway, tracing how deficits in attachment and foundational skills drive demand across systems.

Mental Health

Chronic early adversity produces lasting changes in the brain regions responsible for emotional regulation and stress response. Deficits in each of the four foundational skills are independently associated with higher rates of depression, anxiety, and

serious mental illness. Insecure attachment, particularly disorganised attachment, increases the risk of psychopathology from childhood through to old age.

> Scotland's mental health crisis is not primarily a crisis of resources or referral pathways. It is, in substantial part, the downstream consequence of developmental deficits formed years before any mental health service was ever involved.

Domestic Violence

Domestic violence is one of the clearest illustrations of the hidden architecture at work. Perpetrators show significantly higher rates of both attachment insecurity and disorganised attachment than the general population across multiple independent studies (Buck et al., 2012; Holtzworth-Munroe et al.,1997; McLellan and Killeen, 2000; Spencer et al, 2020). The converse is true. It is much less common in people with secure attachment.

The mechanism is understood: **insecure attachment is associated with dependency, jealousy, impaired empathy, and lower thresholds for anger arousal**, creating acute vulnerability when intimate relationships come under stress.

Research by Brodie et al. (2018) and others shows that anger mediates the pathway from attachment insecurity to abusive behaviour, with perceived criticism, emotional disinterest, or threatened abandonment triggering escalating responses in those whose early caregiving did not build the regulatory foundations needed to manage relational threat.

Each of the four foundational skill deficits also contributes directly:

- **Impairments in executive function** are linked to increased intimate partner violence perpetration, with reduced inhibition and cognitive flexibility observed among perpetrators (Romero-Martinez et al., 2023).
- **Low self-control** strongly predicts perpetration, as self-regulatory failure during conflict escalates violent impulses (Finkel et al., 2009).
- **Poor emotional self-regulation** correlates significantly with psychological, physical, and sexual perpetration across a meta-analysis of 22 studies (Maloney et al., 2023).
- **Reduced sense of agency** is overrepresented among perpetrators, correlating with higher aggression and lower treatment responsiveness (Spencer et al., 2022).

The ACE dose-response adds a further dimension: while 2 to 3% of individuals with no ACEs become perpetrators, this rises to approximately 14% among men with five or more (Anda et al., 2006).

Educational Failure

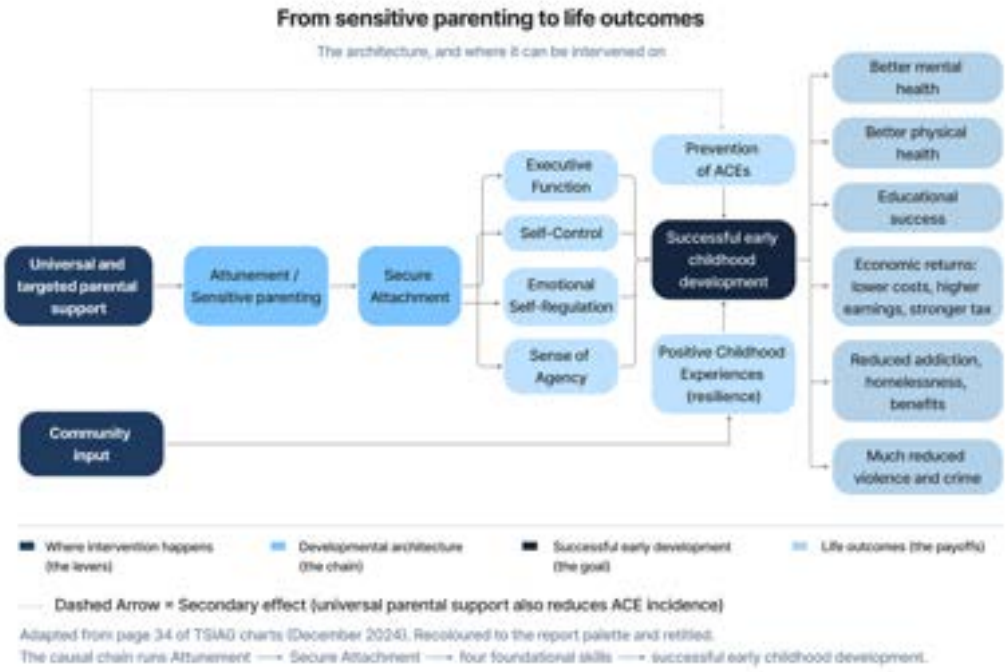
The classroom is where the developmental pathway first becomes visible to the state. Children who have not developed secure attachment, and the four foundational skills it enables, arrive at school already at a structural disadvantage that no teacher, however skilled, can quickly reverse.

Each of the four foundational skill deficits also contributes directly:

- **Executive function deficits** mean they struggle to remember and follow classroom rules, maintain attention, and adapt to the demands of structured learning (Calkins & Howse, 2004).
- **Poor self-control** is associated with the regulatory deficits characteristic of ADHD, with consistent links to poorer academic outcomes and more frequent behavioural problems (Vernon-Feagans et al., 2016; Eisenberg et al., 2000).
- **Emotional regulation difficulties** are strongly linked to lower academic performance (Robson et al., 2020).
- **Low sense of agency,** measured as external locus of control, predicts lower academic achievement (Micomonaco & Espinoza, 2019)

Children entering school without these foundational capabilities become the high-cost, high-need cases that strain educational budgets for years. The attainment gap that Scotland is rightly concerned about is, in substantial part, a developmental gap that opened years before any child crossed a school threshold.

The same pattern holds across every other domain examined: addiction, antisocial behaviour, employment failure, relationship breakdown, poor parenting, and poor physical health all trace back, through the same pathways, to the same foundational deficits. The implication is not that these problems are identical, or that the developmental pathway is the only relevant factor.



It is that a shared causal structure creates the possibility of a shared preventive strategy. And it has one further consequence that the next section addresses directly.

The Cascade Effect: One Person, Many Systems, Many Years

A single untreated child, grown up, draws simultaneously on mental health, justice, education, social care, and housing services — for decades.

A critical feature of this architecture is that its costs do not fall on one service at one time. They fall on multiple services simultaneously, throughout an individual's lifetime.

A child who enters school without adequate executive function does not simply struggle academically. They also present behavioural challenges that consume teacher time, social difficulties that draw on pastoral support, and an elevated risk of future mental health problems, substance use, and criminal justice involvement. By adolescence, the same young person may be generating demand on educational support, child and adolescent mental health services, and youth justice simultaneously. By adulthood, the costs have spread further: NHS treatment, addiction services, social care, employment support, housing, and the criminal justice system may all be involved, often at the same time, across decades.

This cascade effect explains why Scotland's current approach, managing each dysfunction separately within its own service silo, is both ineffective and fiscally unsustainable. Local authorities spending on educational support, behavioural interventions, family services, and youth justice are frequently addressing the consequences of the same underlying cause in the same individuals across their lifetimes.

The Christie Commission's finding that 40% of Scottish local public spending could have been avoided through prevention, equivalent to approximately £12 billion annually, is not surprising once this cascade is understood. Each system sees only its own portion. None sees the shared developmental source.

> Each of these problems is addressed separately, by different agencies, with different budgets. All of them share the same developmental roots.

What This Means: The Fiscal and Policy Implications

Because multiple costly problems share a common cause, prevention at that source reduces demand across all systems simultaneously.

The hidden architecture has a direct fiscal implication. Scotland does not face ten separate cost pressures requiring ten separate increases in funding. It faces a single systemic problem that generates ten categories of cost simultaneously.

The **policy implication is equally direct**. Because Scotland's most costly social problems share a common foundation in the developmental pathway from parental sensitivity to secure attachment to the four foundational skills, investment in that foundation reduces demand across all domains simultaneously. Supporting parental sensitivity in pregnancy and early infancy reduces the probability of insecure attachment. Supporting secure attachment reduces the probability of foundational skill deficits. Reducing those deficits reduces demand on mental health services, criminal justice, education support, addiction services, social care, and the NHS, not sequentially but in parallel, and not in one generation only, because the same pathway is also the mechanism of intergenerational transmission.

The good news is that Scotland's Public Service Reform Strategy and Population Health Framework both reflect exactly this understanding, committing to a decisive shift toward prevention and early intervention. Making the hidden architecture visible to policymakers and budget holders provides the conceptual map that explains why that shift will work, and where the highest-leverage investment lies. The remaining sections of this report set out the evidence, the economics, and the practical mechanisms for doing so.

A note on poverty: Poverty can be a significant exacerbating factor in the ten dysfunctions, but its role is more complex and deserves a section on its own. For this, please read Section 10: 'A Fairer, More Prosperous Scotland: Reducing Poverty and Inequality' in Part 2b 'Full Report and Evidence'.

Key Recommendations

The evidence points directly to early parenting support and secure attachment as the highest-leverage investment priorities for prevention.

The evidence in this section supports two foundational recommendations, which are set out in full in the Commission's recommendations chapter and repeated here for ease of reference.

Key Recommendation 2: Priority investment areas for developmental primary prevention

Embed the developmental pathway from parental sensitivity to secure attachment to the four foundational skills of executive function, self-control, emotional self-regulation, and sense of agency as the guiding framework within Scotland's transformation agenda.

In support of this overarching goal, the Commission recommends that, as the highest priority, reallocated funds from low-payoff reactive spending should be invested in:

1. Supporting the capability and confidence of parents, parents-to-be, and potential future parents, on a universal basis, to understand and practise sensitivity in response to a baby's signals and needs;
2. Fostering the development of secure attachment as widely and robustly as possible in future generations of Scotland's children, through universal support to parents;
3. Promoting the widespread capability of pre-school children, and children up to and including age 7, to develop as natural behaviour the four foundational skills of executive function, self-control, emotional self-regulation, and sense of agency.

Key Recommendation 3: The central implementation pathway for universal parenting support

Establish universal, evidence-based parenting support from pregnancy to the beginning of school, with additional support for parents and carers with related issues, proportionate to need.

Secure Attachment

Secure attachment is the primary developmental mechanism through which early caregiving shapes life outcomes and long-term public cost.

1. What Secure Attachment Is, and Why It Matters

Secure attachment explains how early caregiving shapes a child's emotional world, relationships, and capacity to manage stress.

Secure attachment is the emotional bond formed between an infant and their primary caregivers through consistent, sensitive, responsive caregiving. It is the foundational developmental process through which infants acquire the capacity for emotional regulation, develop internal working models of themselves and others that shape all future relationships, and establish the neurobiological foundations for stress management, social competence, and mental health.

Bowlby's foundational insight was that human infants are biologically predisposed to form strong emotional bonds with caregivers as a survival mechanism. But the quality of that bond, determined by the caregiver's sensitivity and responsiveness to the infant's signals, shapes something far more significant than proximity-seeking behaviour.

It shapes the internal working models through which children interpret all subsequent experience: whether the world is safe, whether others can be trusted, and whether they themselves are worthy of care.

A securely attached infant acquires a set of foundational beliefs, not through instruction but through thousands of repeated interactions in the first 12 to 18 months of life: that distress signals are noticed and responded to, that comfort is reliably available, and that exploration is supported. These beliefs, largely operating outside conscious awareness, become the lens through which all later relationships are experienced.

This section is the evidential centre of the report's argument. **Secure attachment** is not a peripheral concept in child development. It **is the primary mechanism through which early caregiving shapes the four foundational skills** that determine outcomes across every domain of later life: educational attainment, mental health, relationship quality, employment, and engagement with public services. Understanding it is essential to understanding both why Scotland's social problems take the form they do, and what the most effective strategy for addressing them would be. (The caregiving behaviours through which secure attachment is built — parental sensitivity — are examined in detail in Section 14 in Part 2b Full Report and Evidence.)

2. How Secure Attachment Works: The Neurobiological Reality

Secure attachment operates through neurobiological processes that regulate stress, build resilience, and shape brain development.

What feels like love at the surface is, at a physiological level, the precise regulation of stress hormones, heart rate, and brain chemistry. Modern neuroscience confirms what Bowlby could only hypothesise: attachment is a neurobiological process, not merely a psychological one.

Allan Schore's research describes the caregiver as an external regulator of the infant's immature nervous system. During the first two years, the right hemisphere, the seat of emotion, bodily awareness, and empathy, develops more rapidly than any other brain region, and this development is driven by right-brain-to-right-brain communication between infant and caregiver. When a caregiver senses distress, mirrors the child's feeling, and calms them through tone and touch, both brains enter synchrony: heart rates slow, cortisol levels fall, oxytocin rises. Repetition of this process teaches the infant that arousal and fear are survivable states that can be brought back to calm.

This is co-regulation: the caregiver's nervous system temporarily stabilises the infant's, gradually enabling the infant to develop independent self-regulation. When co-regulation is consistently available, the infant's stress response system calibrates toward resilience. When it is absent or unpredictable, the stress system becomes over-activated, producing long-term vulnerability to anxiety, impulsivity, and physical ill health.

Ed Tronick's Still-Face Experiment captures this mechanism vividly. When a mother freezes her expression and withholds response, even briefly, her baby first tries to re-engage, then turns away and cries. Even brief relational breaks activate the child's stress circuitry. Consistent repair restores equilibrium; consistent absence of repair does not.

Colwyn Trevarthen's research at the University of Edinburgh complemented these findings, identifying what he called communicative musicality: a rhythmic, turn-taking dance of emotion through which infants learn that feelings can be shared and coordinated. Through these exchanges of facial expression, voice, and movement, infants and caregivers build the neural foundations of empathy, language, and meaning.

The neurobiological conclusion is direct: **sensitive, responsive caregiving is a neurodevelopmental intervention. Its absence is a neurodevelopmental risk.** Programmes that support parental sensitivity are not supplementary to public health strategy; they are public health strategy at its most effective.

3. Attachment Patterns: Secure, Insecure, and Disorganised

Attachment patterns are adaptive responses to caregiving that carry profoundly different developmental and economic consequences.

Mary Ainsworth's Strange Situation procedure, a standardised laboratory assessment of infants aged 12 to 18 months, established the empirical classification of attachment patterns. These patterns are not personality traits, and they do not reflect infant temperament. They are relationship-specific strategies that infants develop for managing distress based on their caregiving experience.

The standard classification, developed through Ainsworth's original work and extended by Main and Solomon in 1986, identifies four patterns: secure, and three forms of insecure attachment (avoidant, resistant or ambivalent, and disorganised). In summary form, attachment is often presented as a two-way split between secure and insecure. In analytic form, the four-way split shown on the following page is used. Disorganised attachment is presented prominently in this section, and given its own descriptive paragraph below, because its developmental and economic consequences differ markedly from the other insecure forms.

Secure attachment (approximately 60 to 65% in low-risk samples) Secure attachment develops when caregiving is consistently sensitive and responsive. Securely attached infants use their caregiver as a base for exploration, seek comfort when distressed, and return to exploration once soothed. They have learned that distress is manageable and that comfort is reliably available.

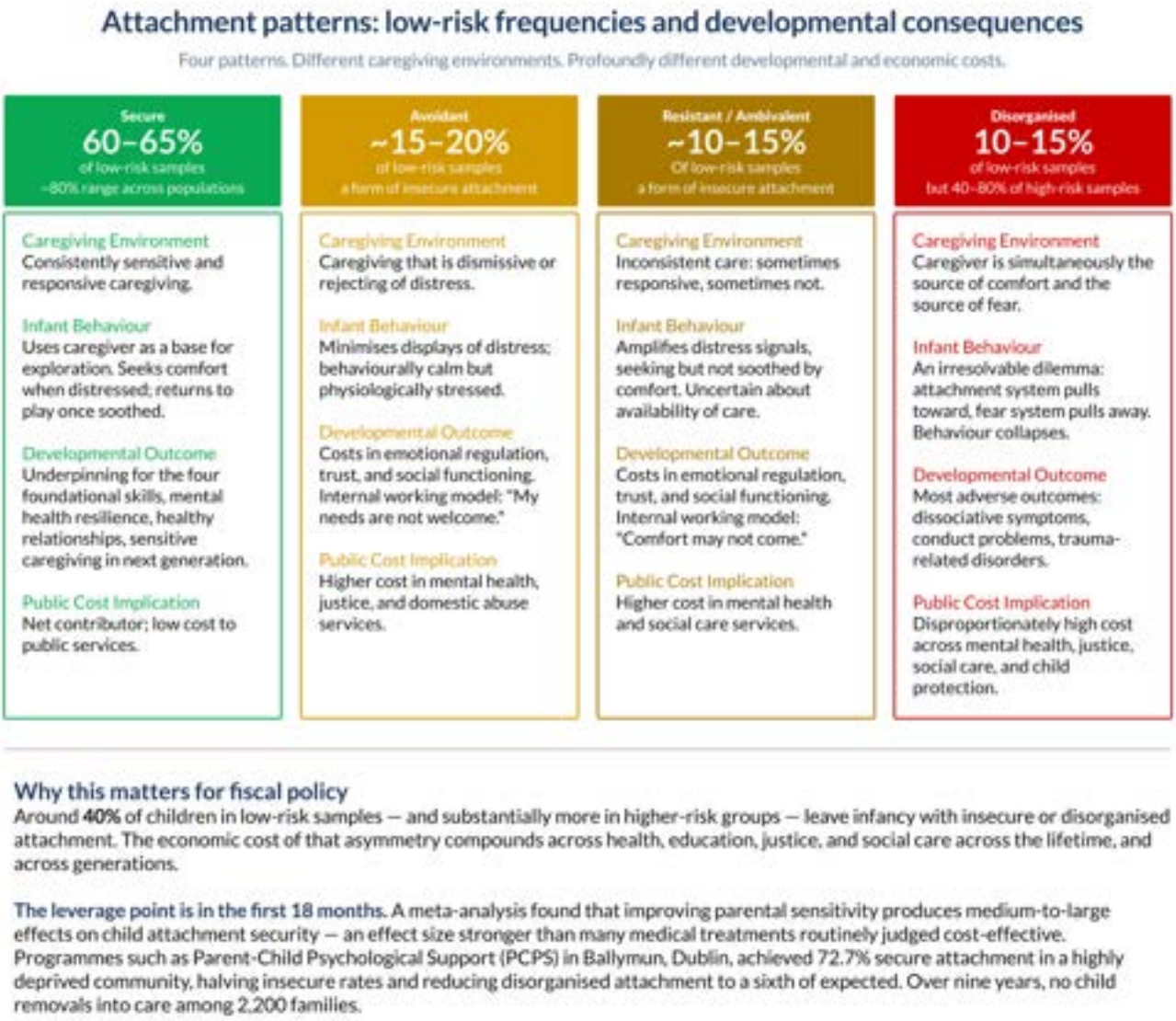
Insecure attachment (approximately 35 to 40% in low-risk samples; substantially higher in high-risk populations) Insecure attachment takes three forms. Avoidant infants (around 15 to 20% of low-risk samples) minimise displays of distress, having learned that expressing need leads to rejection or dismissal; they are, however, physiologically stressed even when behaviourally calm. Resistant or ambivalent infants (around 10 to 15%) amplify distress signals, having experienced inconsistent care that makes them uncertain whether comfort will be provided. Both patterns represent intelligent, adaptive responses to caregiving environments, but they exact costs in the domains of emotional regulation, trust, and social functioning. The third form, disorganised attachment, is described separately below because it is qualitatively different from the other two and warrants particular attention.

Disorganised attachment (approximately 10 to 15% in low-risk samples; 40 to 80% in high-risk populations) Disorganised attachment can rise to 40 to 80% in high-risk populations including maltreated children and families involved with child protection services. It represents the most significant developmental risk. It arises when the caregiver is simultaneously the source of comfort and the source of fear, an irresolvable dilemma for the infant whose attachment system drives them towards the caregiver in distress while their fear system drives them away.

Disorganised attachment predicts the most adverse developmental outcomes: dissociative symptoms, conduct problems, emotional dysregulation, and vulnerability to trauma-related disorders.

It is found in 40 to 80% of the highest-risk populations, those that most burden Scotland's public services.

Disorganised attachment typically arises from frightening, frightened, or severely neglectful caregiving, often linked to unresolved parental trauma or loss. The infant exposed to such caregiving enters adulthood with not only emotional wounds but altered neurobiological and psychological functioning that creates ongoing vulnerability across every life domain.



4. Life Course Evidence: What the Research Shows

Longitudinal evidence shows that secure attachment predicts outcomes across relationships, mental health, and economic participation over the life course.

The Minnesota Longitudinal Study of Risk and Adaptation, which has followed participants from birth into adulthood, provides the most comprehensive evidence linking infant attachment security to long-term outcomes. Key findings are unambiguous.

Social competence and peer relationships:

Infants classified as securely attached at 12 to 18 months were rated by teachers as **significantly more socially competent, empathic, and prosocial throughout childhood** compared to insecurely attached peers, with associations remaining significant after controlling for socioeconomic status, maternal education, and child IQ.

Emotional regulation:

Secure attachment predicted **superior emotion regulation capacities** across development, including better modulation of emotional arousal, faster recovery from distress, and more adaptive coping under stress. Securely attached infants showed better self-regulation throughout childhood and adolescence, measured through teacher ratings, laboratory assessments, and physiological indicators.

Romantic relationships and parenting:

Attachment patterns in infancy predicted the quality of romantic relationships in early adulthood. Most remarkably, **attachment security in infancy predicted the sensitivity of caregiving that individuals provided to their own children decades later,** demonstrating that the effects of early attachment extend not only across a lifetime but into the next generation.

Meta-analytic evidence synthesising results across multiple longitudinal studies confirms the clinical picture. A meta-analysis by Groh and colleagues examining 127 samples found that secure attachment significantly predicted lower externalising problems — aggression and conduct difficulties — and lower internalising problems, including anxiety and depression. Whilst effect sizes may appear modest in isolation, they represent substantial population-level impacts, and the effects compound over time through the multiple developmental pathways they set in motion.

The economic evidence is equally consistent. A systematic review of 44 high-quality economic evaluations concluded that parenting interventions designed to strengthen the early caregiving relationship represent good value for money, with benefit-cost ratios for preventive programmes of between $6.48 and $17.18 per dollar invested over the long term, and cost savings to society of up to $29,000 per family over 25

years. These returns flow directly from the developmental gains that secure attachment produces.

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5. System Consequences: What Insecure Attachment Costs

Insecure attachment drives sustained demand across multiple public service systems, creating significant long-term cost.

The effects of insecure attachment do not remain within the family. They ripple through every public service system that Scotland operates.

Children who cannot trust adults are harder to teach. Pupils who cannot regulate emotion disrupt classrooms and absorb teacher time. By adolescence, difficulties spill into mental health referrals, substance misuse, exclusion, and police contact. Adults who developed insecure attachment are significantly more likely to experience mental illness, to perpetrate or experience domestic violence and to become parents whose own children will develop insecure attachment.

The Christie Commission's estimate that 40% of Scottish local public spending is preventable finds one of its root causes in early attachment disruption. Individuals who develop insecure attachment are at much higher risk of generating costs across multiple service systems simultaneously throughout their lifetime. Three domains illustrate the breadth of that impact.

Addiction:

Insecure attachment, particularly anxious and disorganised forms, is strongly associated with substance misuse and dependence. The pathway is direct: where early caregiving fails to build the capacity to manage emotional distress, substances become a means of self-regulation for the overwhelming states that secure attachment would otherwise have equipped the individual to handle. Individuals with insecure attachment show greater vulnerability to alcohol and drug dependence, with the dose-response relationship between ACEs and addiction reflecting the progressive disruption of the attachment system by accumulated adversity.

The Scottish Health Survey's finding that 71% of adults experienced at least one ACE captures the scale of the population exposed to this risk.

Domestic violence and abuse:

Of all the downstream consequences of insecure attachment, domestic violence and abuse (DVA) is among the most serious and the most costly: to victims, to children who witness it, and to the public services that respond. Research measuring attachment styles in domestic violence perpetrators found that insecure attachment and disorganised attachment were significantly over-represented among perpetrators (Buck et al., 2012; Holtzworth-Munroe et al.,1997; McLellan and Killeen,

2000; Spencer et al, 2020). The mechanism runs directly through the developmental pathway this section describes: insecure attachment produces internal working models in which relationships feel inherently threatening, and where criticism, disinterest, or emotional withdrawal triggers disproportionate arousal that overwhelms regulatory capacity. Scotland's estimated annual cost of DVA of c. £6 billion (Home Office, 2019) represents, in significant part, the downstream consequence of early relational failure. The evidence base is examined in full in Section 7 of the Full Report and Evidence.

Poor parenting:

Of all the downstream consequences of insecure attachment, this is the most significant for long-term public expenditure, because it is the mechanism through which each generation's attachment difficulties become the next generation's.

Parents' own attachment histories predict the attachment security they form with their infants with approximately 75% accuracy. Insecurely attached parents are more likely to provide inconsistent, less sensitive caregiving; those with unresolved trauma are at risk of the frightened or frightening behaviour that produces disorganised attachment in their children. A meta-analysis by Madigan et al. (2019) found that around 21% of parents with documented histories of maltreatment went on to perpetrate some form of maltreatment toward their own children. The cost is not borne once. It compounds.

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6. Intergenerational Transmission: The 75% Finding

Attachment patterns are typically transmitted across generations, but this cycle can be interrupted through effective intervention.

One of the most striking findings in attachment research is that parents' own attachment histories predict the attachment security they form with their own infants with approximately 75% accuracy (van IJzendoorn, 1995). This intergenerational transmission does not occur through genetic inheritance, but through the psychological mechanisms parents bring to caregiving.

The Adult Attachment Interview, developed by Mary Main and colleagues, assesses adults' current states of mind regarding attachment through a structured interview. Critically, classification is based not on what happened in childhood but on how the person currently thinks and talks about those experiences: their coherence, reflectiveness, and emotional integration. A parent with an autonomous, secure state of mind, whether because their own childhood was secure or because they have processed earlier adversity, is far more likely to provide sensitive caregiving and form a secure attachment with their infant.

Parents with unresolved trauma or loss are most likely to transmit disorganised attachment. This occurs through frightened or frightening behaviour toward their infants: looming suddenly, dissociating during caregiving, or responding to infant distress in ways that reflect their own unprocessed fear rather than the infant's need. The infant then faces the impossible situation that defines disorganised attachment.

However, **transmission is not inevitable**. Parents who have processed their own trauma can achieve what researchers call **earned security** and form secure attachments with their children despite adverse childhood histories. This is the foundation of the case for therapeutic intervention during pregnancy and early infancy: addressing unresolved parental trauma breaks the cycle before it begins.

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7. Policy and Intervention: What Can Be Done

Levels of secure attachment in the population can be boosted through early support for parental sensitivity, delivering lifelong developmental and economic benefits.

The evidence establishes that attachment patterns are not fixed by biology. They are plastic responses to caregiving environments, and they can be shifted through well-designed intervention. A meta-analysis found that **improving parental sensitivity produced medium-to-large effects on child attachment security, an effect size stronger than many medical treatments routinely judged to be cost-effective.**

The Parent-Child Psychological Support programme (PCPS), delivered in Ballymun, Dublin, provides the most directly relevant demonstration. Working in a highly deprived community, the programme achieved 72.7% secure attachment through just six structured clinic visits, compared with rates of 48 to 51% typically found in comparable low-income populations.

It halved levels of insecure attachment and strikingly reduced disorganised attachment. In the families who attended at least 3 clinic visits, based on van IJzendoorn's studies of low SES populations, one would have expected to find 48 with disorganised attachment. In the Ballymun study there were 8.

Over nine years the programme avoided any child removals into care among 2,200 families, where 10 would have been the norm. Preventing even a single care placement avoids costs ranging from tens of thousands to several hundred thousand pounds depending on placement type, while the associated developmental benefits reduce demand across health, education, justice, and social care across a lifetime.

The workforce implications are substantial. Scotland's health visiting, midwifery, early years, and family support services touch families at the critical developmental window, but current provision often fails to translate evidence into practice: health visitors

receive insufficient training in attachment; services remain fragmented; investment priorities favour downstream interventions. Making attachment literacy a core competency across all child- and family-facing professions and embedding reflective supervision to sustain the relational quality of practice, is among the most cost-effective investments Scotland could make.

Data from the Growing Up in Scotland study confirm that early emotional attunement predicts later school readiness and mental wellbeing more strongly than socioeconomic status alone. Attachment-aware school approaches, now in use in parts of Scotland including Fife and North Ayrshire, are demonstrating that the educational consequences of insecure attachment can be mitigated through relational rather than punitive responses to difficult behaviour.

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8. Conclusion: Foundational Infrastructure, Economically Essential

Secure attachment is foundational infrastructure for human development and a critical lever for reducing long-term public expenditure.

Secure attachment is not a soft concept in social policy. It is the neurobiological and psychological mechanism through which early caregiving shapes the four foundational skills that determine life outcomes across every domain. It is the primary causal link between the quality of care a child receives in infancy and the costs that child eventually generates, or avoids generating, across health, education, criminal justice, and social care systems throughout their lifetime.

The causal chain is unambiguous: parental sensitivity creates secure attachment; secure attachment provides the foundation for executive function, self-control, emotional self-regulation, and sense of agency; those four skills determine outcomes across all life domains. The burden of preventable reactive cost that Scotland currently carries stems in substantial part from funding the consequences of insecure attachment that could have been prevented during the critical early years, when intervention is most effective and least costly.

Every secure attachment Scotland creates in infancy is a long-term investment reducing future demand across all service systems while substantially improving a child's life chances.

Secure attachment is Scotland's most undervalued asset.

This is not soft social policy. It is hard preventive economics.

The A.R.I.S.E. Local Area Transformation Blueprint

A practical, evidence-based mechanism enabling local areas to strengthen fiscal sustainability by redirecting resources from reactive services to developmental primary prevention, without requiring new money.

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1. The Implementation Gap

The shift to prevention has lacked a practical mechanism for reallocation at scale. A.R.I.S.E. is how a local authority and NHS Board would implement the shift in practice. This would include a guided process bringing together local NHS Board, local authority, and key partners to map current reactive spending and identify where reallocation is both feasible and safe.

Scotland's Public Service Reform Strategy and Population Health Framework both commit explicitly to shifting resources from reactive spending toward prevention. Both acknowledge that, despite decades of aspiration, this shift has not happened at scale. What has been missing is not commitment or evidence. It is a practical mechanism: a means to fund prevention without new government money, and a shared process for making the transition at local level.

The reason for the persistent gap is structural. We believe **less than 1%** of combined NHS Board, local authority, police, and justice spending in Scotland is currently devoted to developmental primary prevention. **The vast majority of public expenditure is absorbed by services responding to existing need, leaving minimal capacity for upstream investment even when leaders want to make it.** Incremental adjustments within current budgets have not been sufficient to shift this pattern.

The A.R.I.S.E. Blueprint exists to close this gap. It is the implementation architecture that the Government's own policy frameworks require but have so far lacked.

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2. What the A.R.I.S.E. Blueprint Is

A.R.I.S.E. is a structured process to reallocate existing resources to prevention without new funding.

A.R.I.S.E. is not a programme. It is a structured, five-stage process that enables any local authority and NHS Board partnership to do one thing well: move a proportion of existing expenditure from low-return reactive services to high-return developmental prevention, without new government funding and without undermining statutory obligations.

Every component of A.R.I.S.E. has been successfully implemented, many times, in both UK and international settings. The cost re-engineering elements, which identify and redirect spending from reactive to preventive use, have been applied in more than two dozen complex organisational transformations.

The Blueprint draws directly on four years of Commission inquiry with leading global experts, and on the experience of Scottish and international pioneers who have demonstrated that major transformation is achievable within existing resource envelopes. **Glasgow has already shown, over a decade and at scale, that the shift from reactive spending to preventive family support is not only achievable but financially self-sustaining.**

The Netherlands has pursued similar prevention-focused approaches with cross-party support and consistently ranks first in UNICEF assessments of child wellbeing. This Blueprint provides a structured implementation pathway that Scotland could use to lead European practice.

A.R.I.S.E. is not a proposal for new spending. It is a mechanism for deploying existing spending differently, progressively redirecting 4 to 6% of current budgets from low-return reactive activity to high-return developmental prevention.

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3. The Core Logic

The Blueprint provides a structured process to redirect resources from low-return reactive services to developmental primary prevention.

The rationale for this approach is straightforward. The structure of the problem is clear. Scotland's most costly social problems share common developmental roots, and the public services addressing their consequences absorb the overwhelming majority of available budgets. Prevention, though universally endorsed, remains a marginal activity.

- The constraint is real. The Scottish Government faces significant fiscal pressures and cannot fund a new prevention infrastructure on top of existing reactive spending.
- The solution is reallocation. **Scotland does not need new money to fund prevention. It needs to redirect 4 to 6% of existing statutory budgets** from services that generate poor long-term returns to developmental primary prevention that can generate returns of **4:1** on conservative assumptions. As Section 22 demonstrates, this reallocation would produce annual value **of £5 to £7 billion over the medium term.**

- The mechanism is the A.R.I.S.E. Blueprint. It provides the structured process through which local partnerships can identify redeployable reactive spending, build the shared commitment required to redirect it, develop a costed action plan, and implement the preventive services that will reduce demand. This is what the Public Service Reform Strategy and Population Health Framework are asking local areas to do. The A.R.I.S.E. Blueprint provides the means to do so.

Buckminster Fuller used the trim tab to illustrate the principle of strategic leverage. The captain of an ocean liner does not push the bow of the ship to turn it, nor wrestle with the great rudder at the stern. He turns a wheel on the bridge, with no more effort than turning a steering wheel on a car. That small movement turns a small rudder, which turns the great rudder, which turns the entire ship. A modest, well-placed human action moves something vast, because the system is designed to amplify it. Parental sensitivity and secure attachment are trim tabs in human development: modest, well-directed investment in them produces disproportionately large effects across childhood outcomes, across the four foundational skills, across intergenerational transmission, and across long-term public expenditure.

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4. The Five Stages

A.R.I.S.E. is a continuous cycle of five stages that transforms area outcomes in partnership with the local community.

A.R.I.S.E. proceeds through five stages that form a continuous improvement cycle. **Each stage builds on the previous one. Together they take a local partnership from initial exploration to sustained implementation.**

AFFIRM Inspire Commitment

- **Purpose:** To enable senior leaders to make an informed, freely chosen decision about whether to embark on the transformation journey.

- **Mechanism:** A structured discovery process in which typically two officers each from the local authority and the NHS Board explore the evidence, the methodology, the A.R.I.S.E. approach, and the track record of proven models such as Parent-Child Psychological Support and the Self-Healing Communities approach. Conversations are evidence-rich, forward-looking, and focused on potential rather than past performance.

- **Outcome:** A clear, conscious partnership decision. Those who proceed do so with genuine shared ownership. Those who do not have made an informed choice. Either way, AFFIRM ensures that no local area enters the Blueprint journey without understanding what it involves.

REALISE Create a Unifying Vision

- **Purpose:** To build a shared vision of the future that will guide every resource decision, every professional interaction, and every community engagement for the next generation.

- **Mechanism:** Six groups of stakeholders, senior leaders, all staff, third-sector partners, community members and parents, local media, and private sector supporters, are engaged in structured workshops that balance evidence with lived experience. The process is facilitated by a neutral convener ensuring that evidence rather than organisational status shapes the outcome.

- **Outcome:** A vivid, commonly held picture of the future that is specific enough to guide resource decisions and robust enough to survive changes in leadership or political composition. The shared vision is the foundation on which all subsequent stages rest: it determines where attention, effort, and money flow. Experience shows that where a genuinely shared vision is built at this stage, subsequent implementation accelerates substantially, and fragmented agencies begin acting as one system.

IDENTIFY Fund the Switch to Prevention

- **Purpose:** To locate the 4 to 6% of existing spending that can be progressively redirected from low-return reactive services to developmental primary prevention.

- **Mechanism:** A structured five-step analysis:
  1. selecting the agencies whose budgets are most relevant;
  2. assembling a cross-sector steering group with decision-making authority;
  3. disaggregating current expenditure by activity type to distinguish primary prevention, secondary prevention, and reactive spending;
  4. evaluating the costs and benefits of specific spending lines; and
  5. identifying waste reduction opportunities.

  An important element is identifying which staff currently absorbed in reactive activities can be retrained in developmental prevention. This is not a cost-cutting exercise; it is a return-on-investment analysis applied to public service budgets.

- **Outcome:** A detailed financial map showing where current money is locked in reactive services, which spending lines generate poor long-term returns, and where reallocation would produce the highest prevention gains. This analysis is the financial foundation of the whole Blueprint.

SHAPE Establish a Prioritised Plan of Action

- **Purpose:** To translate the financial analysis from IDENTIFY into a jointly owned, time-sequenced delivery plan.

- **Mechanism:** Armed with an understanding of the nature and composition of low-return reactive spending across agencies, and the potential personal and societal benefits of specific forms of developmental primary prevention, a guided process takes place in which reshaped expenditure budgets are formulated. Costs and benefits are compared and ranked from high to low payoff, and also by potential flexibility. Similar skills and resources are grouped. Resource transfers are identified, human resource implications addressed, timing assessed, and formal commitments secured. The outcome is a plan with Gantt charts, milestones, responsibilities, and accountability structures.

- **Outcome:** A costed, prioritised, cross-agency action plan with clear accountability for implementation. SHAPE is the moment when vision acquires a timetable and a budget. Without it, even excellent analysis from IDENTIFY remains unimplemented.

EMPOWER Enable Parents to Be the Best They Can Be

- **Purpose:** To translate the strategy into sustained change in everyday life: in homes, clinics, nurseries, and communities.

- **Mechanism:** EMPOWER activates three mutually reinforcing strands, phased according to local capacity.
    - **The first builds communities that nurture,** applying the principles of the Self-Healing Communities approach pioneered in Washington State, where an annual investment of $3.4 million generated direct savings of $27.9 million by reducing child maltreatment, family violence, youth substance misuse, and school dropout.
    - **The second establishes Family Hubs and home-based support** through which the core pathway of parental sensitivity, secure attachment, and the four foundational skills is fostered, delivering universal, non-stigmatising parenting support through health visiting, midwifery, and evidence-based programmes such as PCPS, with proportionate additional help for families at higher risk.
    - **The third equips health visitors, social workers, early-years practitioners, and educators** with shared training, language, and reflective supervision, so that every professional contact reinforces the same message: support is available, and it works.

- **Outcome:** A coherent, multi-level support structure that reaches every family. Parents report increased confidence. Early indicators, secure attachment, school readiness, children in care numbers, improve. Demand trajectories begin to reduce. Reactive services experience measurable pressure relief.

The Trim Tab Principle:

The trim tab principle is described on page 58. Parental sensitivity and secure attachment are its application to human development: a small, well-placed input that produces a large, system-wide effect.

In fiscal terms:

Reallocation: Approximately **£1.2 to £1.8 billion annually redirected** from reactive spending to developmental primary prevention.

Conservative return: 4:1, generating £5 to £7 billion in annual value over the medium term.

No new money required.

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5. Funding and Feasibility

Reallocation is feasible, underpinned by careful analysis of benefit to cost ratios for both reactive and preventive spending.

The 4 to 6% reallocation at the heart of A.R.I.S.E. is a progressive shift, not a one-off transfer. Applied to Scotland's combined NHS, local authority, and Police Scotland budgets, it represents approximately **£1.2 to £1.8 billion annually redirected** from reactive spending to developmental primary prevention. On a conservative 4:1 return assumption, this generates **annual value of £5 to £7 billion** over the medium term.

The reallocation is financially feasible for three reasons.

- **First: Targeted reallocation.**
  The IDENTIFY and SHAPE stages of A.R.I.S.E. are specifically designed to **locate reactive spending with poor long-term returns** that can be progressively reduced without compromising statutory obligations. Not all reactive spending is equivalent: crisis interventions that generate repeat demand, late-stage remediation with limited evidence of impact, and institutional placements that family support could have prevented are all candidates for redeployment.

- **Second: Early returns.**
  Some prevention investments generate rapid returns. Glasgow's decade-long shift toward family support over care placements reduced children in care by 62% and generated cumulative savings of £33.41 million in Children's Services alone, demonstrating that reallocation within existing budgets can be self-sustaining rather than requiring upfront investment.

- **Third: Structured Action Plan.**
  The Commission recommends that the Scottish Government require each local area to produce, within 18 months, a costed Local Prevention Action Plan identifying specific reactive expenditure lines to be progressively reduced alongside corresponding developmental preventive investments to be strengthened.

  Transparent reporting would enable disciplined transition and allow national comparison of progress. This recommendation is consistent with the Government's own Public Service Reform Strategy and requires no additional legislation.

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6. What Success Looks Like

Success is a long-term shift in outcomes, reducing demand and closing inequality gaps.

The five stages of A.R.I.S.E. have each been successfully implemented before in practice, in different combinations and contexts. Bringing them together into a single, sustained transformation requires something beyond methodology: strong and committed leadership, a genuine willingness to make difficult decisions, and the resilience to follow through processes that will at times be challenging.

This is not a simple undertaking. It is, however, a deeply rewarding one, and the evidence is unambiguous that the outcomes it produces, for children, for families, and for the public finances, justify the effort.

The following is what that journey looks like, as results accumulate over time.

- **In the short term:**
  Parents report increased confidence and support. Rates of **secure attachment**, self-control, emotional self-regulation, and **school readiness** begin to improve in communities where EMPOWER has been active. Schools notice the difference in their intake**. Children in care numbers fall**, as Glasgow has demonstrated. Scotland's commitment to care-experienced young people through The Promise shifts from aspiration toward a deliverable set of outcomes.

- **In the medium term:**
  The **inequalities** affecting the most disadvantaged children begin visibly to **narrow**. The demand trajectories that currently drive NHS Board and local authority **budget pressures begin to reduce**. Schools report more positive relationships with primary school pupils. Mental health waiting lists stabilise. Educational attainment gaps narrow. Youth violence and justice referrals decline.

- **Over the longer term:**
  The intergenerational transmission of developmental adversity is interrupted. Children who developed secure attachment and the four foundational skills become parents better equipped to provide sensitive caregiving to their own children. **The compounding that currently drives demand across services in the wrong direction begins to compound in the right direction instead.**

By grounding change in evidence, local ownership, and cross-sector and cross-party alignment, the A.R.I.S.E. Blueprint supports continuity across electoral cycles rather than dependence on them. The goals of **reducing child poverty, delivering The Promise, and closing the attainment gap** all require this kind of sustained, intergenerational commitment. The A.R.I.S.E. Blueprint provides the architecture within which that commitment can be built and maintained.

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7. Conclusion

A.R.I.S.E. provides the practical means to implement the transformation the Public Sector Reform Strategy and Population Health Framework call for and Scotland needs.

Everything that precedes this section in the report, the evidence on developmental pathways, attachment, the four foundational skills, the costs of reactive spending, the returns on prevention, the proof of concept from Glasgow and from international examples, leads here. The evidence is sufficient and the case is clear. What has been missing is the implementation mechanism.

A.R.I.S.E. provides it. It is practical. It is grounded in more than two decades of successful implementation experience. It requires no new government money. It works within existing statutory frameworks and alongside existing services. It can begin in

any local area where a local authority chief executive and an NHS Board chief executive choose to work together toward a shared vision of what their area could look like in a generation.

The choice Scotland faces is not between A.R.I.S.E. and the status quo. The status quo is already failing. The choice is between managed transformation and unmanaged deterioration. A.R.I.S.E. is how managed transformation begins.

The Financial Case for Developmental Primary Prevention

Scotland's fiscal pressures are driven in large part by preventable early adversity, and can only be addressed through reallocation to developmental primary prevention.

The Argument in Brief

Scotland faces a structural fiscal challenge driven by preventable costs that efficiency savings alone cannot resolve.

Scotland's public finances face a structural problem that efficiency savings cannot solve. Health and social care spending already absorbs more than 37% of the total Scottish budget, NHS boards are borrowing to remain solvent, and the Scottish Fiscal Commission projects a **£2.6 billion** resource funding gap by 2029-30. Demographic pressures will widen that gap further.

A substantial, and largely unremarked, driver of these pressures is the long-term cost of adverse childhood experiences. This is estimated to cost Scotland more than **£6 billion** annually, affecting areas such as health, education, justice, and social care, with further billions attributable to domestic abuse, violence, and poor mental health. **These costs are not static. They compound**, because adversity in childhood impairs the capacities needed for healthy adult life, and because those impairments tend to carry through to the next generation.

Fifteen years ago, the Christie Commission estimated that 40% of Scottish local public spending was accounted for by interventions that could have been avoided through earlier preventive action, equivalent today to approximately **£12 billion** annually. **Fifteen years on, that warning has not been acted upon at scale, and the pressures Christie described have intensified.**

This section makes the case that a progressive reallocation of **4 to 6%** of statutory budgets, from low-return reactive expenditure to developmental primary prevention, is not merely desirable but fiscally necessary. **It requires no new money.** The returns, on conservative assumptions anchored in European and UK evidence, are at least **4:1** on invested funds. Glasgow's decade-long experience demonstrates the proposition is achievable at scale. The question is no longer whether Scotland can afford to make such an investment. The consequences of not doing so would be dire.

What Developmental Primary Prevention Is, and Why It Works

Developmental primary prevention strengthens the early-life capabilities that determine long-term outcomes and costs.

Developmental primary prevention is not the same as health promotion or early help in general. It refers specifically to spending that actively supports the emotional, cognitive, and relational development of children from before birth, strengthening the capacities on which all subsequent learning and wellbeing depend.

The most critical of these are secure attachment, and the four foundational skills: executive function, self-regulation, emotional literacy, and a secure sense of agency.

These capabilities are not acquired automatically. They are formed through sensitive, consistent caregiving in the first years of life, mediated by secure attachment between child and parent or carer. Where caregiving is compromised, by poverty, parental mental health difficulties, trauma, or relationship breakdown, these foundations are at risk. Children who do not develop them are significantly more likely to struggle in school, experience mental health difficulties, become involved in the justice system, and place sustained demand on public services across their lives.

The developmental science is clear, and the economic implications are direct. **Every pound that prevents the formation of these deficits avoids a much larger stream of future costs.** Nobel laureate James Heckman demonstrated this formally, showing that returns on investment in birth-to-five programmes reach 13% per annum, declining progressively as the age of intervention rises. The developmental window of earliest childhood is, in purely economic terms, the highest-return point of leverage available to any government committed to improving outcomes.

‘Every dollar spent on high quality, birth-to-five programs for disadvantaged children delivers a 13% per annum return on investment.’
James Heckman

Critically, the relationship between adversity and developmental deficit is not confined to a single generation. Research confirms that around 21% of parents with histories of maltreatment go on to perpetrate some form of maltreatment toward their own children. Each year without preventive investment means another cohort entering adulthood with impaired capacity for parenting, employment, and relationships, with consequences that bear on the public purse for decades.

The Evidence Base: What Returns Can Be Expected

Extensive international and UK evidence demonstrates strong and consistent returns from early intervention.

The evidence on returns to early intervention is now extensive, methodologically robust, and consistent in direction.

- The RAND Corporation's review of twenty rigorously evaluated early childhood programmes found returns to society ranging from **$1.26 to $17** for every $1 invested, with the range reflecting differences in programme quality and follow-up period rather than uncertainty about whether early intervention works.
- The Perry Preschool Programme at 40-year follow-up generated **$17 per $1** invested.
- UK Social Return on Investment studies showed an average of £3.65 per £1.
- Washington State's Self-Healing Communities Model generated direct annual savings of **$27.9 million** from an annual investment of **$3.4 million**, an 8:1 return, rising to 35:1 when broader taxpayer benefits were included.
- A 2024 analysis by the Royal Foundation and Deloitte estimated that prioritising early childhood could generate at least **£45.5 billion** annually in value for the UK economy, of which around **£3.7 billion** would be attributable to Scotland on a population basis.

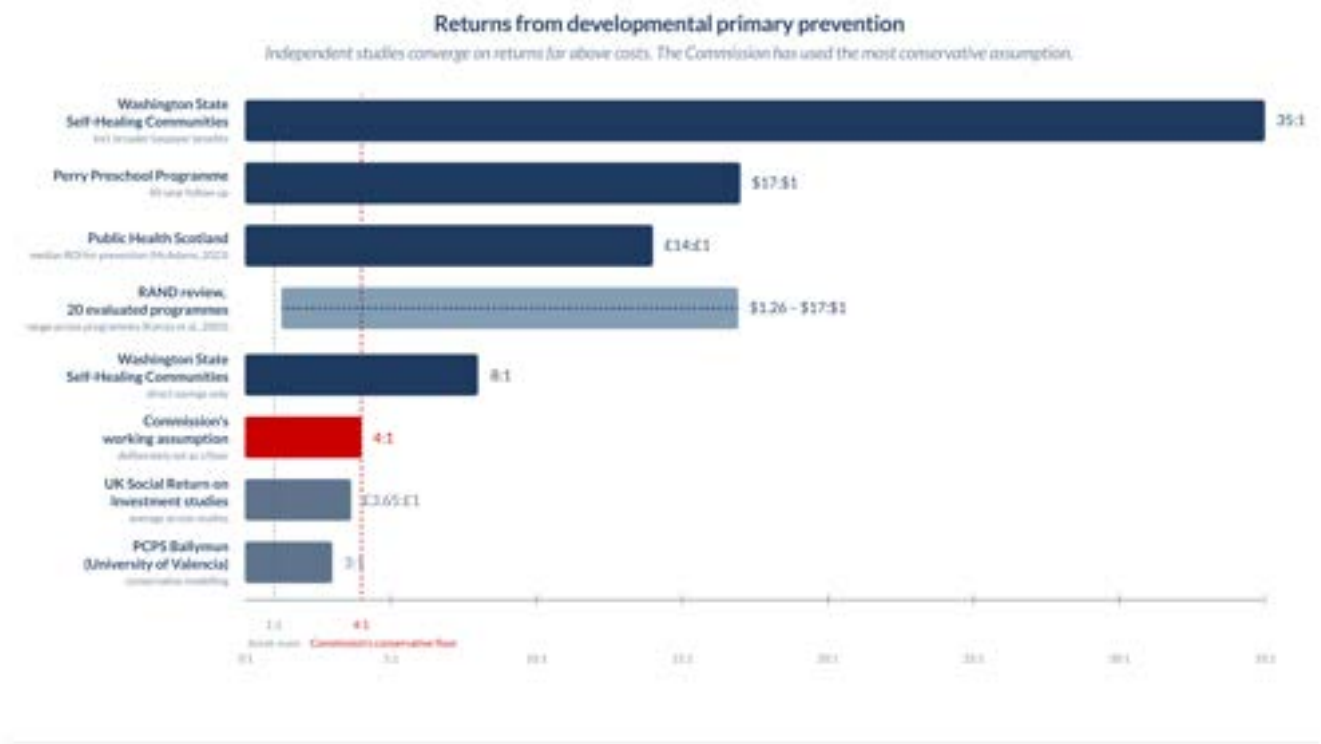
At programme level, the Parent-Child Psychological Support programme (PCPS), developed at the University of Valencia, delivers an introductory visit and six structured clinic visits at a cost of approximately £900 per family annually. In the Ballymun site in Dublin, it achieved 72.7% secure attachment in a highly deprived community, produced insecure attachment levels half the typical level in low SES communities and where, based on van IJzendoorn's studies of low SES populations, one would have expected to find 48 children with disorganised attachment, in the Ballymun study there were 8.

Over nine years it avoided any child removals into care among 2,200 families, where 10 would have been the norm. Conservative modelling across downstream benefit domains suggests a return of at least 3:1 on programme costs, with every prevented care placement avoiding annual costs of tens of thousands to several hundred thousand pounds depending on placement type.

The most directly relevant European evidence comes from Rosholm et al. (2021), a meta-analysis of ten randomised controlled trials conducted in Denmark, a country that already invests substantially in children's services. Even in that high investment context, well-designed early interventions continued to generate strong returns, empirically underpinning the 4:1 benefit-cost ratio assumed elsewhere in this section, with cost-standardised effect sizes substantially larger for children under five than for older age groups. This demonstrates that early intervention works not because it fills a vacuum but because it targets the developmental mechanisms, parental sensitivity and secure attachment in the first years of life, at the point where they are most responsive to support.

Drawing on these Danish effect sizes and applying the Heckman/Cunha framework for translating early childhood effect sizes into long-run economic returns, the Commission's working assumption of a 4:1 return on invested funds sits comfortably within the range the evidence supports. It is a floor, not a central estimate: it lies below the median return for public health intervention (prevention) identified by Public Health Scotland (£14 per £1 invested) and well below the Washington State ratios. The Commission has used it precisely because it is conservative and defensible.

On that basis, a reallocation of 4 to 6% of statutory budgets, representing approximately £1.2 to £1.8 billion annually, would generate an annual return of £5 to £7 billion over the medium term. More than half of this is likely to come from ACE reduction alone.



Across studies that vary in design, country, era, and population, the direction is the same. The Commission's working assumption of 4:1 sits below every substantial study cited in this section, and well below the Public Health Scotland median for prevention. Reallocating **4 to 6%** of statutory budgets — approximately

The Intergenerational Multiplier

Early intervention delivers compounding benefits across generations, making all current estimates conservative.

None of the cost-benefit analyses reviewed in this section accounts for the intergenerational multiplier: the fact that preventing adversity in one generation simultaneously reduces the probability of its transmission to the next.

A child who develops secure attachment because their parent received support will be better equipped to provide sensitive caregiving to their own children, extending the benefits of the original investment across multiple generations without additional cost.

This means that **all stated returns in this section are conservative by construction**. The true long-term value of early investment is substantially higher than any single-generation analysis can capture, and every year of delay carries a double cost: the compounding benefit that prevention would have generated is forgone, and the compounding harm that prevention would have averted is locked in.

Proof of Concept: Glasgow

Glasgow demonstrates that large-scale prevention-led reform is achievable and delivers measurable financial returns.

Glasgow's experience over the decade from 2016 to 2025 provides the most directly relevant available evidence that this transition is achievable, at scale, in a Scottish context.

In January 2016, Glasgow had **1,469** children in care, at a rate of 135 per 10,000 children. By the end of 2025, following a sustained commitment to trauma-informed, strengths-based family support, intensive early intervention through the Glasgow Intensive Family Support Service, and expanded health visiting and Family Nurse Partnership provision, that number had fallen to **558**, a **62% reduction**, at a rate of 50 per 10,000 against Scotland's current average of 117. Admissions of children under five, the group this report identifies as the highest-priority developmental window, fell by 60%.

The financial returns were substantial and grew every year. Cumulative savings within Children's Services reached **£33.41 million** by 2025-26. Reduction in out-of-authority placements alone generated **over £15 million**, reinvested directly into family support. These figures capture only Children's Services; the wider returns to education, health, and justice have not been quantified.

The savings were not achieved through rationing or by raising thresholds. The Care Inspectorate confirmed that children receiving wrap-around support experienced a very positive impact on their wellbeing and improved family relationships. Earlier intervention produced better outcomes at lower cost. This is the logic of developmental primary prevention in practice.

The Reallocation Proposition: What Is Being Asked

The proposal is not new spending but a disciplined reallocation of existing resources toward higher-impact investment.

The Commission recommends no new spending. The proposition is reallocation: the progressive redirection of 4 to 6% of existing statutory budgets from expenditure that generates poor long-term returns toward developmental primary prevention.

Not all reactive spending is equivalent. The Commission's A.R.I.S.E. Blueprint includes a framework for identifying spending that addresses symptoms rather than causes, generates repeat demand, or could be replaced by earlier, more effective intervention. Institutional placements that family support could have prevented, emergency responses that community capacity could have made unnecessary, and late-stage remediation with limited evidence of impact are among the categories from which reallocation may be achievable.

The transition is not simple. Reallocation requires sustained political commitment, workforce development, and a willingness to accept that returns accumulate over time rather than within a single budget cycle. Some returns, as Glasgow demonstrates, materialise quickly. Reduced care placements generate savings within the current budget year. Improved school readiness produces benefits within five to six years. The full intergenerational cascade takes longer. But the Washington State evidence shows that annual savings at many times the level of costs are achievable within eight to twelve years.

The objection that this investment requires upfront resource that Scotland cannot currently afford misunderstands the proposition. **The upfront resource already exists. It is currently committed to reactive services that address consequences rather than causes.** The question is not whether to spend the money, but how to spend it more effectively.

Three factors make the current moment uniquely favourable for prevention-led reform:

First: fiscal imperative

NHS boards and local authorities are under pressures that make transformation no longer optional. The alternative to managed reallocation is unmanaged deterioration.

Second: implementation architecture

The A.R.I.S.E. Blueprint provides the practical methodology for identifying and redirecting spending that previous prevention strategies lacked.

Third: political foundation

This Commission of Inquiry was established in response to the 70/30 campaign, which in 2022 secured the support of 128 of 129 MSPs, including all party leaders at Holyrood, for the ambition of reducing child maltreatment by 70% by 2030.

The evidence gathered during four years of inquiry has demonstrated that the developmental pathway to achieving that ambition is also the pathway to transforming Scotland's social, economic, and health outcomes more broadly. That cross-party foundation for sustained commitment is a political asset Scotland has not previously possessed.

Addressing Common Objections

'We cannot afford the upfront investment.'

The Commission does not recommend new spending. The money already exists within statutory budgets; it is currently committed to reactive services that address consequences rather than causes. Moreover, some prevention investments generate returns within the current budget cycle: diverting a young person from secure care saves £4,500 per week immediately, and reduced care placements generate savings within months of families receiving earlier support.

'The evidence is American and will not transfer.'

The most rigorous cost-benefit analyses are American, but the underlying mechanisms are universal. Sensitive caregiving produces secure attachment; secure attachment produces the four foundational skills; those skills determine outcomes across every life domain. These developmental processes do not vary by nationality. Scotland has its own evidence: the Scottish Violence Reduction Unit's contribution to major reductions in violent crime, and Glasgow's decade of verified results in children's services, both demonstrate what prevention achieves in a Scottish context.

'Returns take too long to materialise.'

Returns begin within electoral cycles. Reduced care placements, fewer A&E attendances, improved school readiness scores, and better early standardised assessment outcomes are all measurable within three to five years of investment. What takes longer is the full cascade of benefits as supported children become productive adults. The intergenerational multiplier is, in this respect, an argument for urgency rather than delay: every year of inaction means another cohort of children whose difficulties will bear heavily on the public purse for decades; and another year in which the compounding benefits of wise strategic prevention are pushed further into the future.

'Prevention cannot be targeted precisely enough.'

The evidence supports universal approaches with progressive escalation for those with greater need, not narrow targeting. The PCPS programme achieved 71% participation precisely because it was universal, while directing the 25% of families who needed it to more intensive support earlier and therefore more cost-effectively than crisis referral would have allowed.

Conclusion

Developmental primary prevention offers the most credible path to restoring fiscal sustainability in Scotland.

Scotland's fiscal pressures are real, serious, and worsening. They cannot be resolved

through further efficiency savings within existing service models, because a substantial portion of those pressures is generated by the long-term consequences of preventable early childhood adversity. Managing consequences more efficiently is not the same as reducing their occurrence.

The evidence is unambiguous. Developmental primary prevention, targeted at the formation of parental sensitivity, secure attachment, and the four foundational skills in the earliest years of life, consistently generates returns that substantially exceed costs, even on the most conservative assumptions. Glasgow demonstrates at scale and over time that the transition from reactive to preventive spending is achievable and financially self-sustaining.

A progressive reallocation of 4 to 6% of statutory budgets, not new money but better deployment of existing resources, would, on a conservative 4:1 return assumption, generate annual value of £5 to £7 billion over the medium term. This is not a marginal social policy argument. It is the most credible available path toward a sustainable balance between Scotland's public service needs and the resources available to meet them.

The financial case is clear. The implementation architecture exists. The political will is present. What is now needed are those prepared to deliver. The children whose lives that choice will shape are already being born.

Note: All references appear in Part 2b - Full Report and Evidence. Early readers may get these on request from ghosking@wavetrust.org

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ISBN-13: 978-0-9551615-5-1

Citation: Hosking G. and Lalla M. (2026). *Transforming Scotland in a Generation: An Implementation Plan for Fiscal Sustainability. 2a. Summary Report*. Transforming Scotland in a Generation Commission

Acknowledgements

The Commission gratefully acknowledges three organisations whose contributions made this report possible. Cameron Consultants funded the four years of work on which it rests. WAVE Trust synthesised the evidence and wrote the report, in continuous collaboration with our Commissioners. Coglateral.ai designed and produced the final document.

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