

Grasping the nettle: early intervention for children, families and communities

A practice guide to the challenges and opportunities in supporting children, families and communities through early intervention, based on effective local, national and international practice.



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Foreword

Early intervention is a force for transforming the lives of children, families and communities, particularly the most disadvantaged. Its importance today in terms of policy and practice owes as much to its economic sense, as well as the social and personal benefits that it can generate.

Since our joint call for evidence of effective local practice in early intervention at the beginning of the year, we have been overwhelmed by the response; over 100 submissions have already been received and more are coming in by the day. In parallel, we commissioned a rapid review of international experience to build a solid base of evidence. By teasing out and distilling the key messages from this wealth of evidence of 'what works', including research findings, this practice guide aims to support local authorities and their partners in improving the quality of life for the children, families and communities that they serve.

Ultimately, tough decisions need to be taken at a national and local level in the best interests of children, families, communities and the long-term prosperity of the country. Not only does this guide identify specific interventions proven to work, but, in a number of examples, it also includes information on the costs of effective interventions at project level. This knowledge should assist both national and local policy-makers in helping decide where to allocate scarce resources and thereby achieving better value for money, especially during times of austerity.

Whilst celebrating the considerable progress made by local areas in recent years and highlighting innovations that have been developed at home and abroad, this guide guards against complacency by focussing on a number of key areas for development. In order to sustain improvements, it is vital that these areas are acted on with urgency.

Our thanks go to Simon Bird and Martin Rogers for pulling the evidence together for this report, with guidance from June Statham (Institute of Education); to George Hosking and Ita Walsh of the Wave Trust for producing the evidence of effective international practice; and, most of all, to those who submitted examples of local practice considered by C4EO's validation process. C4EO's Expert Group has also provided invaluable advice throughout.

We share the Coalition Government's belief "that strong and stable families of all kinds are the bedrock of a strong and stable society", and very much welcome its decision to set up an independent expert review on early intervention chaired by Graham Allen, MP for Nottingham North. We hope that this practice guide will support the important work of the commission.



Christine Davies CBE
C4EO Director



Kim Bromley-Derry
Chair, C4EO Early Intervention Expert Group
(Immediate Past President, ADCS)

Executive Summary

Background

The growing interest in early intervention as a policy issue reflects the widespread recognition that it is better to identify problems early and intervene effectively to prevent their escalation than to respond only when the difficulty has become so acute as to demand action. It is better for the individuals concerned, their families and society more broadly; it avoids a lot of personal suffering, reduces social problems and generally, it costs less than remedial action – so early intervention is nothing new. What has changed is that our knowledge and understanding of human development, especially in childhood, has grown to the point that we can now identify many more problems earlier; some we can even anticipate, or clearly predict a risk factor. Practice has also developed to enable us to intervene more effectively to address many of these problems. Such developments are continual, but we appear to have reached a tipping point where our knowledge and practice have progressed sufficiently to make the policy question not whether we should invest in early intervention, but how can we not do so?

To reflect its strategic importance, early intervention became the latest cross-cutting theme in the Centre for Excellence and Outcomes' (C4EO's) programme of work, with a joint call for evidence with ADCS (Association of Directors of Children's Services) to help build the knowledge base and support local areas in learning from each other about effective approaches. Over 100 submissions have been received (with more coming in), which have been subject to C4EO's validation process to assess their impact and their potential for replication in different contexts in other local areas. About a quarter of the submissions met C4EO's criteria for effective practice, and most of these are summarised in this publication.

C4EO, through its Expert Group on Early Intervention, also commissioned the Wave Trust to undertake a rapid review of international experience of early intervention. As with the local practice examples, evidence of effective practice from abroad has been distilled into case studies for inclusion in this publication. Running alongside both of these main sources of evidence are key findings and messages from academic research.

Definition of early intervention

For the purposes of this practice guide, the following definition is used: "intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Early intervention may occur at any point in a child or young person's life".

Main findings

The most striking message is that early intervention clearly works – when it is an appropriate intervention, applied well, following timely identification of a problem; and the earlier the better to secure maximum impact and greatest long term sustainability (both as early in the child's life as possible and/or as soon as possible after a difficulty becomes apparent). The wealth of effective local, national and international practice showing evidence of improvements in outcomes and the quality of life for many children and families gives cause

for optimism, and encouragement to replicate local innovations more widely. Indeed, some of the examples describe practice that has already spread widely (often internationally) from its local origins.

A clear need has been identified for more research into the effectiveness and the relative cost-effectiveness of early intervention strategies, but several characteristics emerge as common to a number of the successful examples described. These are reflected in five 'golden threads', which are described in chapter 2, and form the headings for the thematic chapters that follow. Where possible, these golden threads need to be taken together, when they constitute a coherent strategy for systemic change.

Five golden threads

- The best start in life
- Language for life
- Engaging parents
- Smarter working, better services
- Knowledge is power.

Energetic and visionary leadership, inspired by a strong sense of moral purpose, is critical. This needs to be underpinned by understanding the compelling economic and social case for early intervention, combined with well planned and robust commissioning arrangements.

The role of health services, children's centres and schools in delivering and supporting effective early intervention cannot be underestimated – from early pregnancy and support for families with young children, throughout childhood and adolescence. If we are, as a nation, to 'close the gap' for vulnerable children, young people and their families, the active engagement of local health commissioners, providers and schools in both identifying need at the earliest opportunity and helping meet these needs is crucial.

The well-developed approaches of Sweden and the Netherlands, which lead both the UNICEF and OECD league tables for child well-being, warrant closer scrutiny. Given these two countries' positions of strength and what we now know about the significant impact that parenting has on a child's development, together with research on early brain development, in this country "what is needed is a whole society attitude shift to parenting akin to those achieved with seat belt wearing and drink driving. Instead of parenting being seen as a private matter which must not be invaded, it should be celebrated as a matter where achieving high standards is in everyone's interest, and it is socially acceptable for everyone to recognise they are able to learn" (Wave Trust 2010).

Of all the potential areas for intervention, it is in the combination of early years development, including language and communication skills, and parenting support that the most significant impact could be made. The Coalition Government has already declared its commitment to supporting families, especially those with multiple problems, and refocusing resources towards an increase in the number of health visitors. The potential benefits of extending this commitment to the development of a coherent, strategic approach to early parenting, early child development and successful language acquisition would be huge, for a relatively modest step. A good foundation could be achieved through relatively low cost public education and making best use of the National Year of Speech, Language and Communication planned for 2011.

The best start in life

Far more is known now than even a few years ago about the extent to which a child's early development, including before birth, lays the foundation for their future life. But little of this knowledge is applied systematically to ensure that all children get off to the best start; too much is still left to what is often referred to as the 'accident of birth'.

Most parents are largely unaware of the conditions that promote early brain development and some members of the workforce know less than they might. Traditional, cross-generational support networks are often weaker than they were as a result of changes in society. So universal services, such as children's centres and schools, are more important in transmitting the knowledge and information to ensure a good early start – but many of the most vulnerable don't even make it to children's centres without significant encouragement.

Key messages:

- There is now compelling evidence to show that what a child experiences during the early years (starting in the womb) lays down a foundation for the whole of their life, which needs to be reflected in policy and practice, both at a national and local level.
- Children's centres lie at the 'hub' of a continuum of support for children, families and communities with additional needs, but require an effective outreach strategy to ensure that interventions target and support the most vulnerable in the community.
- Despite the significant benefits of breastfeeding having been clearly illustrated, breastfeeding rates in England are among the lowest in Europe. Effective local initiatives, such as in Blackpool, are needed to achieve and sustain significant improvements.
- Complementary action is needed to dramatically increase the current low proportion of hospitals in England (less than one in 10) accredited under the Baby Friendly Hospital Initiative, a set of standards developed by UNICEF and the WHO (World Health Organisation) to promote breastfeeding.
- More needs to be done to promote the use of peer support: volunteers from the community (including local parents) who are trained to work alongside professionals, but whose similar life experiences bridge the 'approachability gap'.

Language for life

The ability to communicate is an essential life skill which underpins a child's future development, but more children struggle than is commonly recognised. Yet awareness of the importance of language and communication skills and the creation of language rich environments for young children remains generally inadequate – not only with many parents, but also amongst policy-makers, commissioners of services and service providers. The practice examples describe a range of approaches for improving this and it is encouraging that a high proportion of language difficulties can be remedied with the right support – though for some it appears that this needs to be done by the age of 5½,¹ and many early years staff and primary teachers report a lack of confidence in meeting these needs.

Key messages:

- The scale of children affected is considerable: up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime.
- As there is insufficient understanding amongst policy-makers and commissioners nationally and locally, and sometimes parents and families themselves, raising awareness of the importance of language and communication skills and creating language rich environments is urgently needed.
- With the right support, many children with language delay go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by the age of 5½ (which appears to be a critical age). Effective support or intervention in the early years is vital to improving persistent disorders and speeding up the resolution of difficulties linked to social disadvantage.
- A skilled and confident workforce is critical, with the ability to identify communication problems at an early age, and distinguish between transient and persistent difficulties so that appropriate interventions can be put in place. Yet many early years staff feel inadequately equipped to help these children and over 60% of primary teachers lack confidence in their ability to meet children's language needs.
- Effective local practice was characterised by a large scale training programme and dissemination of information to equip staff and parents alike in successfully targeting early intervention and support, resulting in marked improvements in children's learning and achievement, practitioners' confidence and parental feedback. Other key characteristics included the effective use of data, not least to track progress, building capacity through sharing the knowledge of specialist staff, and strong parental engagement.
- The National Year of Speech, Language and Communication 2011 should be fully exploited.

Engaging parents

We know how important good parenting is to successful outcomes, from a child's early development through to them achieving independence – including the crucial acquisition of language and communication skills. But, again, our national approach to parenting support is far from systematic, with the inevitable consequence that many children and young people experience problems that are largely avoidable, and which blight their lives – and those of their parents and families – often escalating into more serious situations that may require expensive intervention.

Effective intervention with children depends not only on the *fact* of involving their parents, and sometimes wider family, but also on the *way* of doing so. The examples in this publication repeatedly demonstrate the importance of engaging parents in a collaborative approach, building on their strengths and taking account of their views and experiences.

They highlight the need to recognise the problems that families themselves often face and to develop strategies that build confidence and capacity to enable parents to properly fulfil the crucial role they play. They illustrate the vital part that outreach work often plays in making contact with families who would otherwise miss out on services, but who can often be successfully drawn into both universal or specialist (targeted) provision.

A key feature of several examples is the use of peer support: volunteers from the community who are trained to work alongside professionals, but whose similar life experiences bridge the 'approachability gap' that often prevents the take up of support. To some extent, this is also a way of addressing an issue identified previously in the *Narrowing the Gap* guidance,² that many professionals still lack confidence in working with parents, and receive inadequate training to help them. Most parents need support of some kind at some time, and 'normalising' parenting support would greatly widen the reach of the benefits it brings.

Key messages:

- Parents are the most significant influence on children, and parenting has profound consequences for their future lives, so it is important to persuade parents that engaging in their child's development can make a difference, and to build positively on their existing strengths and actively involve them in decisions.
- Disadvantage is not a block to good parenting but low levels of literacy and numeracy and confidence are obstacles, and self-perception contributes to parents' motivation to change – so it is particularly important to persuade such parents to engage with support services by convincing them that they can bring real and lasting benefits to their children.
- As most parents need support of some kind at some time and effective parenting support does help improve parenting; systematic parenting support should be rolled out across the UK.
- A whole society attitude shift to parenting is needed: parenting should be celebrated as a matter where achieving high standards is in everyone's interest, and it is socially acceptable for everyone to recognise they are able to learn, rather than being seen as a private matter which must not be invaded.

Smarter working, better services

The quality of leadership will be key in determining both how far there is a shift of emphasis towards early intervention, and how effective it will be. There needs to be a clarity of purpose, and a determination to make improvements, *because it's the right thing to do*. Commissioning provides a robust, credible and objective way of making decisions about the use of scarce public resources so that they have maximum positive impact on the lives of children and families. Effective commissioning starts with a strategic understanding of how the whole system works and how the total resource is being used. A key to success is understanding that early intervention requires a reorientation of the system at all levels.

The importance of agencies working in partnership to meet the needs of children and families lies at the heart of recent changes in approach to service development and delivery. Many of the examples of effective early intervention arise explicitly from such practice, either in the form of multi-disciplinary teams working with children and families – often making use of the CAF (common assessment framework) to determine the action to be taken – or, in some

cases, through one group of highly trained professionals supporting colleagues from other disciplines in the identification of need, facilitating a joint approach to resolving them. Staff in all settings need to have an increased understanding of the principles of early intervention, of how they can identify early difficulties, of how they should respond, and of the role of others. Some interventions, particularly those involving outreach or intensive support, require changes of practice to enable services to be offered out of 'normal' hours in order to meet families' needs. These often involve specialist staff working closely with colleagues from other agencies, with a lead professional or key worker providing consistent support.

The problems experienced by some children and families will respond to a single intervention, others will require longer term support; some will be complex and may even cross generations. It is, therefore, essential that a continuum of support is available with the capacity to meet specific needs at a particular time. Creating and sustaining such provision requires a high level of interagency collaboration, as well as good communication with families.

Key messages:

- When resources are scarce, and the workforce feels under pressure, there is a tendency to defend (or at least cling to) the *status quo* which can make innovation and change harder to implement; but it is only by doing things differently that better outcomes will be achieved. Energetic and visionary leadership, combined with effective joint commissioning, is therefore critical in delivering whole system change.
- Effective commissioning applies evidence of what works to improve outcomes for local people and will become increasingly important as budgets are constrained. It provides a robust, credible and objective way of making decisions about the use of scarce public resources so that they have maximum positive impact on the lives of children and families.
- As some children and families need ongoing support, while others may have their needs met sufficiently by an 'earlier' intervention to prevent later interventions, a continuum of services is needed to identify the most appropriate intervention to match specific needs at a particular point.³
- Considerable progress has been made in inter-agency working, but there is still much more to do. Key characteristics of effective integrated working that need to be in place everywhere include having a shared vision, clear understanding of needs and identification of gaps, sharp focus on improving outcomes for children, young people and families, clear and consistent messages communicated to staff and families, and an underpinning integrated workforce development strategy. Time needs to be invested to build trust, strong relationships and, ultimately, to secure buy-in from all agencies.
- To overcome the inconsistencies and confusion about the CAF (Common Assessment Framework) process, it should be developed into *the* standardised tool for conducting assessments for children's additional needs, and for developing and agreeing on a process through which agencies work together to meet those needs.
- Evidence suggests that professionals in all kinds of settings may lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged. Continuing investment in developing workforce skills and capacity is essential to effectively engage with parents.

Knowledge is power

Many have observed that we frequently fail to make effective use of the data we already gather, let alone gather and use systematically what would help us to make real progress. Existing data, well used and interrogated, would often highlight needs earlier. And asking the right questions would often lead to more effective forms of intervention. The recent Ofsted review of Special Education Needs and Disability observed that, “What consistently worked well was rigorous monitoring of the progress of individual children and young people, with quick intervention and thorough evaluation of its impact” (p 6).⁴ It is the progress, or lack of it, being made by children that often signifies the existence of a problem.

Whilst the practice examples in this publication illustrate data being used effectively, the international examples show how much we have to learn from other countries. It is vital that staff at all levels are able to recognise objectively the value of their work, and to both measure and question their practice against objective criteria assessing its impact.

Key messages:

- Evidence suggests that the use of data is a systemic weakness. In short, if we cannot provide evidence to show that an intervention is having a positive impact, how can we justify funding it? Evidence should be used as an integral part of the process and as an aid to innovation. We can learn much from international experience in this area.
- International research suggests that the most successful programmes tend to share common characteristics: they target specific populations; they are intensive; they focus on behaviour; they include both parents and children; and they stay faithful to the programme.
- Effective local practice is characterised by clarity of purpose; interventions are informed by a comprehensive evidence base; there is a clear analysis of local needs, including feedback from children, families and practitioners; and, critically, there is a baseline to enable the intervention to be tracked at key stages following its implementation to measure impact on outcomes.
- Sufficient analytical capacity within children’s services needs to be addressed as a workforce development priority (both nationally and locally).

Where is it best to invest?

When resources are scarce, priorities must be clearly established, as it is particularly important to allocate them where there can be confidence of achieving significant impact and good value from the investment. Some of the examples described achieve impact through a targeted focus on specific areas of need across population groups, others target specific groups and achieve broader benefits. Both approaches can deliver excellent value.

Key messages:

- The temptation to cut back on investment in early intervention in times of austerity needs to be resisted, for short term financial gains can lead to long term costs. The challenge is not, therefore, deciding whether to maintain spending on early intervention, but working out how to get better value out of the money already being invested.
- The powerful body of research (home and abroad) showing that what a child experiences during the early years (starting in the womb) lays the foundation for the whole of their life, makes a compelling case for prioritising investment in this area.
- In general, targeted approaches tend to be judged more cost effective than universal approaches. Yet there is little comparative evidence to determine which approach might be most 'cost effective'. The evidence suggests that it is unlikely to be a question of one or the other. What is needed is a range of interventions able to provide support at different levels of need.
- Spending should be prioritised on children's centres and early years (in particular breastfeeding initiatives and the Nurse Family Partnership); speech, language and communication needs; parenting programmes; targeted family support; and young people on the edge of care.
- Three of the recommended interventions – Nurse Family Partnership, Incredible Years and Multi-Systemic Therapy – are among the 11 'Blueprint' programmes identified by the Center for the Study and Prevention of Violence at the University of Colorado which meet high standards of effectiveness, as part of a review of 800 early intervention programmes.
- The OECD suggestion that expenditure on children should be regarded as if it were an *investment portfolio*, and be subjected to a continuous iterative process of evaluation, reallocation and further evaluation to ensure child well-being is actually improved, poses a formidable but necessary challenge to this nation. Learning from international experience in particular can be invaluable in helping us to move forward, though, ultimately, tough decisions need to be taken at a national and local level in the best interests of children, families and, indeed, the long-term prosperity of the country.

Conclusion

This practice guide provides inspiration for action, at many levels. Families themselves, including their children, would doubtless be encouraged to discover the range of activities and interventions that are in use to address the needs and problems many of them experience. But as awareness grows of the successful efforts being made, so too will demand for their greater availability. This demand will also increase amongst practitioners, as recognition spreads that many of the families with whom they are involved could have been helped earlier, if better systems existed to identify problems before they escalated. The scale of intervention required would have been lower.

This presents policy-makers, locally and nationally, with some real challenges – particularly at a time when resources are significantly constrained. Ways must be found to enable the systematic development of earlier interventions, which will bring both social and financial benefits, without neglecting those already ‘in the system’.

This publication demonstrates what could be done by describing what already is being done in many, but not in all areas of the country. The challenge to be met is drawing together key elements into a strategic approach that will extend those possibilities. Bold action is urgently needed to bring this about.

Areas for Action – for all those with responsibility for policy and practice

1. There is a need for more public information about the crucial importance of the early stages of child development. Official publications and pronouncements should emphasise far more directly how simple changes in how parents relate to their young children can bring permanent benefits.
2. There should be a major effort to increase breastfeeding rates, promoting the benefits to the baby, which go on into later life; emphasising the positive aspects for mothers, and countering negative perceptions.
3. Parents’ and professionals’ awareness of the importance of language skills needs to be more actively promoted. The forthcoming National Year of Speech, Language and Communication should be made a key focus, upon which further progress can be built. Existing health checks at age two should include a specific emphasis on language development, to detect early signs of possible delay.
4. Workforce development plans need to ensure that everyone working with children and families, especially disadvantaged groups, receive adequate training on language development, engaging and working with parents, and the value and uses of research and data (particularly to analyse need, for early identification).
5. Opportunities should be explored to make best use of skilled, but scarce, specialist staff (notably speech and language therapists) through training and support for other practitioners to ensure early identification of potential difficulties, offering more widespread and sustained support in meeting needs.
6. Opportunities should be created to promote the use of trained peer support (including local parents) working alongside professionals – to convey positive influences from their own experience and encourage local families’ full use of advice and practical help from local services and agencies.
7. Positive parenting should be publicly celebrated, alongside recognition that most parents need some support at some time. Systematic support should be encouraged nationally, but with particular emphasis on meeting the needs of the most disadvantaged. Parents should be engaged as early and as positively as possible, ideally before their babies are born, with helpful information from the outset about the importance of their role, and the local services available.
8. Further progress is needed to ensure that in every local area there is a continuum of support for the many families whose needs vary over time, with children’s centres and schools at its heart. Children’s centres should be strongly encouraged to develop effective outreach strategies to draw in isolated and ‘hard to reach’ families.

9. In order to consolidate use of the Common Assessment Framework (CAF), rapid progress should be made in making it the standard mechanism for conducting assessments and accessing additional support for both children and families.
10. Intervention programmes should be aligned to whole system change and have a clear purpose, be informed by a comprehensive evidence base and analysis of local needs, and include baseline data to enable evaluation of impact at key stages.

C4EO's next steps

- The body of evidence in this report should contribute to the independent expert review on early intervention set up by the Government and chaired by Graham Allen, MP.
- Continue to build a body of evidence of excellent local practice which is both (a) effective in closing the gap for vulnerable children, young people and their families and (b) cost effective.
- Working with ADCS and LGID (Local Governance Improvement & Development) continue to gather evidence from local areas which are redesigning services around whole system change, with early intervention at their heart.
- Undertake in depth studies of those local areas which seem to have reduced the demand for acute services (such as reduced rates of offending and re-offending, the proportion of children entering care), better understanding what is 'making the difference' in those localities.

1. The policy context

“No child’s future should be predetermined by the decisions or mistakes of his or her parents, and I firmly believe that every child should have the chance to succeed, regardless of their background. Intervening earlier with troubled families can not only prevent children and their parents falling into a cycle of deprivation, anti-social behaviour and poverty but can save thousands if not millions of pounds in the longer term.

“This review [independent commission to be chaired by Graham Allen MP] demonstrates the importance the Government places on improving early intervention, we want to learn from the areas already pioneering a successful approach to tackling troubled families early and build on local good practice.”

Sarah Teather, Minister of State for Children and Families

Early intervention: Key to giving disadvantaged children the opportunities they deserve, Department for Education Press Notice, 28th July 2010

Background

Early intervention has become a hot topic, attracting widespread international, national and local interest from policy-makers, practitioners, academics, think tanks and others from around the globe, as is illustrated throughout this publication. In short, the case for early intervention rests on the growing body of evidence demonstrating what happens when children and young people’s emerging difficulties are *not* spotted and addressed, coupled with promising evidence about the difference that programmes and approaches can make if delivered well. It is clear that in some cases, without identification, assessment and help, children’s problems become entrenched and then spiral and multiply, causing significant long term damage for them and for others around them, and creating major financial costs for a wide range of public services far into the future.⁵ Early interventions, according to the Nobel Prize winning economist Professor James Heckman of the University of Chicago, “promote schooling, raise the quality of the workforce, enhance the productivity of schools and reduce crime, teenage pregnancy and welfare dependency. They raise earnings and promote social attachment. Focusing solely on earnings gains, returns to dollars invested are as high as 15-17%... a rare public policy initiative that promotes fairness and social justice and at the same time promotes productivity in the economy and in society at large” (Heckman 2006).⁶

An estimated 20-30% of children and young people have additional needs at some point in their lives.⁷ This could be for a limited period, or on a longer-term basis. It is this group for whom targeted support within universal settings – principally schools, children’s centres and primary health care – will be most appropriate. The ‘Every Child Matters’ programme led to the introduction of a new framework for integrated working within children’s services designed to change the way that services are delivered, and to shift the focus so that children’s needs are identified early, assessed and result in appropriate, timely support. These issues are covered in more depth in chapter 6.

Coalition government priorities

In May 2010, the Coalition Government published its programme.⁸ The section on families and children opened by stating, “The Government believes that strong and stable families of all kinds are the bedrock of a strong and stable society” (HM Government 2010). Key commitments include:

- Taking Sure Start back to its original purpose of early intervention, increase its focus on the neediest families, and better involve organisations with a track record of supporting families.
- Refocusing funding from Sure Start [children’s centres] peripatetic outreach services, and from the Department for Health budget, to pay for 4,200 extra Sure Start health visitors.
- Investigating a new approach to helping families with multiple problems.

In a major speech hosted by Barnardo’s on the 17th June 2010, the Deputy Prime Minister Nick Clegg set out his vision of how the Government can help give children the best start in life. The speech recognised “the importance of early intervention; the importance of helping families prevent problems, rather than just trying to pick up the pieces once it’s already too late”.⁹ He also announced the establishment of a Ministerial Childhood and Families Task Force. Chaired by the Prime Minister and with senior Ministers represented on it, the Task Force aims to complete its review by the autumn, ahead of the next public spending review.

On the 28th July 2010, the Secretary of State for Work and Pensions, Iain Duncan Smith, and Minister of State for Children and Families, Sarah Teather, announced that the Government would be setting up an independent commission on early intervention to be chaired by Graham Allen, MP for Nottingham North. Mr Allen has pioneered early intervention in Nottingham and collaborated with Iain Duncan Smith. In 2008, the two MPs published a powerful report on early intervention calling for a “cross-party consensus” on the subject.¹⁰ The independent commission will report by the end of January 2011 on the issue of best practice and provide an interim report on funding. A final report on funding will be produced by May 2011.

C4EO’s cross-cutting work on early intervention

Due to its strategic importance and building on a wealth of evidence from the national programme on ‘Narrowing the Gap’ (led by the Local Government Association), early intervention became the latest cross-cutting theme in C4EO’s programme of work to support local areas in improving outcomes for children, young people and families. On the 28th January 2010, C4EO and the Association of Directors of Children’s Services (ADCS) made a joint call for evidence of effective local practice in early intervention to help build the evidence base and support local areas in learning from each other about effective approaches. Since then over 100 submissions have been received and are continuing to be sent in. These submissions have been subject to C4EO’s validation process to assess whether they do indeed work and their potential to be replicated in different contexts in other local areas. About a quarter of the submissions met C4EO’s stringent criteria for effective practice, most of which are summarised in this publication.

In order to complement the effective local practice examples, and expand our knowledge and understanding of what works, C4EO (through the Expert Group) commissioned the Wave Trust to undertake a rapid review of international experience of early intervention.¹¹ It should be acknowledged that, whilst there is much to learn from international experience, there are

economic, social, legislative, political and cultural differences which need to be taken into account. As with the effective local practice examples, evidence of effective practice from abroad has been distilled into case studies and included in this publication. Running alongside both these main sources of evidence are key findings and messages from academic research and a summary of the policy framework.

To drive the early intervention programme forward, and to challenge conventional thinking and practice, C4EO assembled an Expert Group chaired by Kim Bromley-Derry, Immediate Past President of ADCS, and made up of academics, think tanks, the third sector, national organisations and local areas at the cutting edge of practice in early intervention (see Appendix I).

Definition of early intervention

For the purposes of this practice guide, the following definition is used: “intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Early intervention may occur at any point in a child or young person’s life”.

Structure of this practice guide

Chapter 2 summarises the five ‘golden threads’ that emerge from an analysis of the effective local practice examples, supported by research findings and international experience of what works. These golden threads are analysed in more depth in the subsequent five chapters.

Each of these five chapters follows the same format, starting with a background section, including relevant research findings and policy issues, and followed by effective international practice (where applicable), effective local practice validated by C4EO and a conclusion pulling together the main implications. The final chapter aims to assist policy-makers in deciding where to allocate scarce resources and thereby achieve better value for money.

2. Five golden threads

“These golden threads have to be taken together, applied universally and pursued relentlessly to achieve significant change. In other words, they are not a ‘pick and mix’ list but a recipe for whole system change. These are the keys to change, are of interest to everyone but in particular are essential reading for those responsible for leading and managing services, especially Directors of Children’s Services (along with their partners...) and other leaders across the children’s sector.”

Narrowing the Gap – final guidance year 1, January 2008

From the analysis of effective practice, supported by research findings and international experience of what works, five ‘golden threads’ of essential practice became apparent.

Like those from ‘Narrowing the Gap’, these golden threads need to be taken together and, in so doing, constitute a coherent strategy for systemic change. Energetic and visionary leadership, combined with effective joint commissioning, is critical in delivering whole system change. ‘Cherry-picking’ the golden threads may yield improvements but the impact will be far more limited than if they were applied together. Thus the golden threads are more than the sum of their parts.

- **The best start in life** – the science of early brain development, established over decades of neuroscience and behavioural research, helps illustrate why child development – particularly from birth to five years – is a foundation for a prosperous and sustainable society. Later interventions, although important, are considerably less effective where good early foundations are lacking.
- **Language for life** – research shows that up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime. With the right support, however, many children with language delay go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by the age of 5½, go on to perform within normal limits.
- **Engaging parents** – parents are the most significant influence on children, and parenting has profound consequences for their future lives, so it is important to persuade parents that engaging in their child’s development can make a difference, and to build positively on their existing strengths and actively involve them in decisions. Disadvantage is not a block to good parenting but low levels of literacy and numeracy and confidence are obstacles, and self-perception contributes to parents’ motivation to change – so it is important to persuade such parents to engage with support services by convincing them that they can bring real and lasting benefits to their children.

- **Smarter working, better services** – some children and families need ongoing support, while others may have their needs met sufficiently by an ‘earlier’ intervention to do not require later interventions. A continuum of services is needed to identify the most appropriate intervention to match specific needs at a particular point.¹² Children’s centres in particular lie at the ‘hub’ of a continuum of support: often where emerging difficulties can be first spotted, or where children, young people and their families will themselves first ask for help, and often the most appropriate setting within which the extra help children need can be delivered.
- **Knowledge is power** – evidence and data is used as an integral part of the intervention process and as an aid to innovation. There is clarity of purpose through clearly stated aims. Interventions are informed by a sound evidence base, from local, national and even international sources. There is a clear analysis of local needs, including feedback from children, families and practitioners. Critically, a baseline is established at the point at which the intervention is first implemented, enabling the intervention to be tracked at key stages, to measure the extent to which it is delivering its stated aims and making a significant impact on outcomes.

Each of these golden threads is explored in turn in the following chapters.

3. The best start in life

“Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.”

Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010 (The Marmot Review), February 2010

Background

There is a powerful body of evidence to show that what a child experiences during the early years lays down a foundation for the whole of their life. A child’s physical, social, and cognitive development during the early years strongly influences their school-readiness and educational attainment, economic participation and health.¹³ Development begins before birth when the health of a baby is crucially affected by the health and well-being of their mother. Low birth weight in particular is associated with poorer long-term health and educational outcomes,¹⁴ and the evidence also suggests that maternal health is related to socioeconomic status.¹⁵ Disadvantaged mothers are far more likely to have babies of low birth weight. The literature on ‘foetal programming’ demonstrates that in-utero environments affect adult health.¹⁶ It has been shown, for example, that when human foetuses have to adapt to a limited supply of nutrients, they permanently change their structure and metabolism. These ‘programmed’ changes may be the origins of a number of diseases in later life, including coronary heart disease and the related disorders of stroke, diabetes and hypertension.¹⁷

Socially graded inequalities are present prenatally and increase through early childhood. Maternal health, including stress, diet, drugs, alcohol and tobacco use during pregnancy, has significant influence on foetal and early brain development. The biological effects of birth weight on brain development interact with other influences associated with socio-economic factors to influence cognitive development. Lower birth weight, earlier gestation and being small for gestational age are associated with infant mortality. In a study of all infant deaths in England and Wales (excluding multiple births), deprivation, births outside marriage, non-white ethnicity of the infant, maternal age under the age of 20 and male gender of the infant were all independently associated with an increased risk of infant mortality. A trend of increasing risk of death with increasing deprivation persisted after adjustment for these other factors.¹⁸

The first year of life is crucial for neuro-development to provide the foundations for children’s cognitive capacities.¹⁹ There is good evidence to show that if children fall behind in early cognitive development, they are more likely to fall further behind at subsequent educational

stages.²⁰ The evidence also shows that the development of early cognitive ability is strongly associated with later educational success, income and better health.²¹ The early years are also important for the development of non-cognitive skills such as application, self-regulation, resilience and empathy. These are the emotional and social capabilities that enable children to make and sustain positive relationships and succeed both at school and in later life.²²

Science of early brain development

The science of early brain development, established over decades of neuroscience and behavioural research, helps illustrate why child development – particularly from birth to five years – is a foundation for a prosperous and sustainable society. This has been summarised²³ in the following five basic concepts by the Center on the Developing Child based at Harvard University, a multi-disciplinary collaboration of scientists and scholars from many universities designed to bring the science of early childhood and early brain development to bear on public policy decision-making.

- **Brains are built over time.** The basic architecture of the brain is constructed through an ongoing process that begins before birth and continues into adulthood. Early experiences affect the quality of that architecture by establishing either a sturdy or a fragile foundation for all of the learning, health and behaviour that follow.
- **The interactive influences of genes and experience shape the developing brain.** Scientists now know that a major ingredient in this developmental process is the 'serve and return' relationship between children and their parents and other carers in the family or community. Young children naturally reach out for interaction. In the absence of such responses – or if the responses are unreliable or inappropriate – the brain's architecture does not form as expected, which can lead to disparities in learning and behaviour.
- **The brain's capacity for change decreases with age.** The brain is most flexible, or 'plastic', early in life, and as the maturing brain becomes more specialised to assume more complex functions, it is less capable of reorganising and adapting to new or unexpected challenges. By the first year, the parts of the brain that differentiate sound are becoming specialised to the language the baby has been exposed to; at the same time, the brain is already starting to lose the ability to recognise different sounds found in other languages. Although the 'windows' for language learning and other skills remain open, these brain circuits become increasingly difficult to alter over time. Early plasticity means it is easier and more effective to influence a baby's developing brain architecture than to rewire parts of its circuitry in the adult years.
- **Cognitive, emotional, and social capacities are inextricably intertwined throughout the life course.** Emotional well-being and social competence provide a strong foundation for emerging cognitive abilities, and together they are the bricks and mortar that comprise the foundation of human development. The emotional and physical health, social skills, and cognitive-linguistic capacities that emerge in the early years are all important prerequisites for success in school and later in the workplace and community.
- **Toxic stress damages developing brain architecture, which can lead to life-long problems in learning, behaviour, and physical and mental health.** Scientists now know that chronic, unrelenting stress in early childhood, caused by extreme poverty, repeated abuse, or severe maternal depression, for example, can be toxic to the developing brain. In the absence of the buffering protection of adult support, toxic stress becomes built into the body by processes that shape the architecture of the developing brain.

Research into the origins of violent behaviour

In four decades of research into the origins of violent behaviour, Professor Richard Tremblay of the University of Montreal has found solid evidence that the most aggressive and violent adolescents did not become more violent in their adolescent years; they were already very violent at age 6.²⁴ In fact comparisons at age 3 show they had much higher levels of violence than other children of the same age, and maintained that higher level of violence for the next 10-15 years: at age 2½ years the 17% most aggressive toddlers are already 10 times more aggressive than the 32% least aggressive.

Tremblay has also followed the developmental trajectories from 60 months to 17 years and found that the most aggressive at age 3 are most likely to be the most violent adolescents. While all children tend to show reduced levels of aggression from ages 2-3 onwards, and some dip significantly after age 6, the most aggressive continue to stand out from the crowd. Those who have not learned to control their aggressive reactions by the time they enter the school system enter a vicious circle of negative interactions, where rejection from their peers, because of their aggressive behaviour, leads to more aggression.²⁵

The factors underlying the striking early differences in levels of aggression include the quality of the prenatal and postnatal environments, and gene-environment interactions. Tremblay brings a new perspective to the gene-environment by introducing the scientific term 'epigenetics'.²⁶ Epigenetics is now suggesting the environment, especially during pregnancy and very early childhood, activates or silences good and bad genes crucial for mental well-being and social adaptation. These studies also indicate that inadequate perinatal environments are not only silencing or activating a few specific genes, but thousands of genes may be affected by maternal stress, inadequate nutrition, obesity, diabetes, alcohol and tobacco use. The prenatal factors that eventually lead to obesity, cardiovascular problems and cancer may also lead to serious mental health problems throughout an individual's life. Tremblay argues that a substantial increase in resources to support pregnant women, pre-school children and their families would produce major rewards in prevention of mental illness and the improved health of the next generation.

Breastfeeding

Breastfeeding is one of the most effective ways to ensure child health and survival, according to the World Health Organisation (WHO). It states that a lack of exclusive breastfeeding during the first six months of life contributes to over a million avoidable child deaths each year, and strongly recommends exclusive breastfeeding for the first six months of life. At six months, other foods should complement breastfeeding for up to two years or more. In addition, breastfeeding should begin within an hour of birth; breastfeeding should be 'on demand', as often as the child wants day and night; and bottles or pacifiers should be avoided. Breast milk is the ideal food for newborns and infants. It gives infants all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses – such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breastfeeding also benefits mothers. The practice when done exclusively often induces a lack of menstruation, reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity. Breastfeeding contributes to a lifetime of good health. Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of overweight, obesity and type-2 diabetes.²⁷

The 2005 Department of Health Infant Feeding Survey²⁸ shows that, in England, only 32% of women in the routine and manual socioeconomic groups breastfeed beyond six weeks, compared with 65% in managerial and professional groups. Breastfeeding rates in England

are amongst the lowest in Europe. Less than a fifth of English mothers are still breastfeeding their babies after the recommended six months compared with 80% of mothers in Norway and 72% of mothers in Sweden. A shortage of midwives and overcrowded maternity units are said to be contributors to the problem. Fewer than one in 10 hospitals in England has achieved Baby-Friendly Hospital Initiative (BFHI) status, a set of standards developed by UNICEF and the WHO, such as helping women to start breast-feeding within half an hour of birth and to breastfeed exclusively for the first six months. This compares to 100% of hospitals in Sweden and 64% in Norway.

The scope for improvement is considerable. This is a societal 'habit' influenced by culture. A 2004 Northern Ireland Department of Health report²⁹ captured the main reasons for this by observing that social and cultural influences play an important role in a mother's decision to breast or bottle feed her baby. Many young people either have no knowledge of breastfeeding or are subjected to negative images of breastfeeding by the media which tends to portray bottle feeding as less problematic. Many young mothers lack access to key sources of information and advice on breastfeeding such as antenatal classes, peer support programmes, friends, family and other social support networks. Although many women have access to community midwives after discharge from hospital, research evidence suggests that young first time mothers in particular may lack assertiveness and are, therefore, reluctant to ask for information or advice on issues such as breastfeeding.

The report cites research highlighting that young women from low income areas are least likely to breastfeed for a number of reasons including embarrassment, lack of role models which portray breastfeeding in positive circumstances, fear of pain, misconceptions that their babies will not gain sufficient weight from breastfeeding alone, and exposure to a bottle feeding culture which promotes the use of formula milk. The provision of tokens for free formula milk may also act as a disincentive for young and low income mothers to breastfeed their infants.

Several studies referred to the beneficial impact on breastfeeding of early skin-to-skin contact, beginning ideally at birth, between baby and mother (or father),³⁰ Moore et al (2007),³¹ a Cochrane review, found statistically significant and positive effects of early skin to skin contact for breastfeeding and breastfeeding duration. Higher levels of maternal affection and maternal attachment behaviour and shorter crying times by infants were also observed. Bull et al (2004) found evidence from review-level literature that rates of breastfeeding could be improved by home visiting programmes.³²

Effective international practice

1. Spotlight on Sweden

The countries of Scandinavia consistently lead international comparisons in terms of child welfare and general well-being.³³ Recognising the value of prevention and early intervention programmes, in the last 20-30 years, these countries have increased investment in such channels.^{34 35}

Delivery

A comparison of societal child welfare between the UK and Scandinavia shows marked differences in a range of factors. Maternity healthcare services in Sweden are accessed by the vast majority of pregnant women, who typically have 11 individual contacts, mostly with midwives. 99% of all maternity healthcare clinics offer parenting education in groups to first-time parents, with 60% allowing repeat parents to participate. Additional support in the form

of specialised groups is provided to those mothers with particular needs, for example young mothers, single mothers and those expecting twins.

99% of all families make use of the child healthcare services in Sweden. They have an average of 20 individual contacts, primarily with nurses. Parents are invited to join parent groups when the child has reached the age of 1-2 months. In Stockholm County for example, 61% of all first-time parents participated in at least five sessions in 2002.³⁶ Parent education accounts for around 8-10% of midwives' working time; 65% of midwives received regular professional training on the subject, and 72% were instructed by a psychologist.³⁷

Impact

At 2.5 per thousand live births, the infant mortality rate in Sweden was the lowest in the EU in 2005 and half that in the UK. Sweden also performs well on a number of health indicators from later life; the country has the third lowest mortality rate in the EU from cancer and circulatory diseases, amongst the lowest rates for deaths due to chronic liver disease and smoking related causes, and has the highest life expectancy in the EU for men (and the third highest for women). Sweden, moreover, has the third-lowest rate of teenage pregnancies in the European Union at 1.6%, compared to 7.1% in the UK.

	SWEDEN (2005)	UK (2005)
% Of Live Births To Mothers Under 20 Yrs	1.6	7.1
Infant Mortality (rate per 1,000 live births)	2.5	5.1
Smoking (% daily smokers aged 15 and over)	15.9	25.0
Alcohol (annual pure alcohol litres per person)	6.9	11.4
Adult Obesity (% of population)	10.7	23.0
Smoking Related Deaths (age standardised per 100,000 popn)	195.5	244.9
Chronic Liver Disease Deaths, Under 65 Yrs (per 100,000 popn)	4.0	9.5
Cancer Deaths, Under 65 Yrs (age standardised per 100,000 popn)	56.0	67.5
Circulatory Disease Deaths, Under 65 (age standardised per 100,000 popn)	31.9	43.3

These figures strongly imply a well-resourced and highly professional healthcare service in Sweden, with a major focus on prevention, and starting at the very beginning of life with emphasis on breastfeeding (98% of Swedish mothers begin breastfeeding compared with 79% in the UK). In addition, long periods of maternity and parental leave support attention to the needs of the child in its earlier months. All maternity hospitals have Baby-Friendly Hospital Initiative status (developed by UNICEF and the World Health Organisation), compared to less than 10% in the UK, and early parent training is provided for a high proportion of the population. From such a solid beginning, Sweden is able to improve the quality of life through helping to avoid many preventable illnesses, and is enabling the country to save money on both the healthcare and non-healthcare costs of those illnesses.

2. Kraamzorg, Netherlands

The system of maternity care, 'kraamzorg', in the Netherlands is unique. No other country in the world provides such support, where a professional maternity nurse looks after a mother and her new born baby during the first days after birth. The nurse shows parents how to care for their newborn baby e.g. how to breastfeed properly, and how to bathe him/her. In the case of a home birth the nurse will be there after the birth to help clean up.

Aim

Kraamzorg is a universal postnatal service in the first 8-10 days after the birth of the baby, provided through a compulsory health insurance system. The purpose of 'kraamzorg' is to aid the recovery of the mother and provide her with advice and assistance to care for her newborn. The goal is to get the mother swiftly back on her feet to independently care for her baby and return to daily life. Kraamzorg is the reason why, in normal circumstances, hospital staff release mothers from their care within hours of giving birth in the Netherlands.

Delivery

Every pregnant woman in the Netherlands has the right to kraamzorg but the hours to which she is entitled vary depending on her particular circumstances. Kraamzorg is part of the basic health insurance package in the Netherlands, though for some parents a small individual contribution per hour of care is due.

Impact

While the maternity nurse is looking after the mother, she keeps a special diary called a 'kraamdossier' to make notes about the health and progress of the mother and baby. This book is used for reference by the doctor, district midwife and health clinic. When the nurse is due to leave, she will inform the district nurse at the health clinic, who will then be responsible for ongoing help, support and guidance in looking after the baby. The health clinic is responsible for providing routine healthcare and checking the development of children from birth until they start primary school at the age of 4. It keeps the kraamdossier on the child after the kraamzorg period is over.

3. 'Community Mothers' Programme, Ireland

The Community Mothers Programme (CMP) grew out of the Early Childhood Development Programme designed in Bristol and piloted in Ireland in 1988. In its evolved form, it is being delivered to nearly 1,200 parents each year in the Greater Dublin area. It operates mainly in disadvantaged neighbourhoods and is offered to both fathers and mothers – first-timers and some second-timers – of children from birth to 24 months.

Aims

It aims to aid the development of parenting skills and improve parents' confidence and self-esteem, through advice and support on a range of family issues from breastfeeding through toddler groups to goal-setting. The delivery method is a monthly family visit when parents – mothers and fathers alike – are encouraged to set themselves goals for the month ahead. The approach supports the parents' own ideas and acknowledges they usually want to do what is best for their child.

Delivery

'Community Mothers' are recruited, trained and supported by family development nurses. Each full-time family development nurse runs a team of 18-20 Community Mothers, enabling them to support 100-120 families at any one time. Family development nurses are in turn supported by a programme director who offers specialist support, education and management in the development, implementation and maintenance of the programme. 'Community Mothers' visit parents monthly in their own homes, armed with a set of strategies focusing on health care, nutrition and overall child development. They typically spend upwards of 13 hours each month on their visits to between 5 and 15 families, and receive nominal expenses.

An important aspect of the approach is for the Community Mothers to reflect the ethos of the community they intend to visit. The programme trains experienced, volunteer mothers from the local community. It is not costly or intensive, and offers benefits to the mothers visited, volunteers and, ultimately, to the wider community.

Impact

Using a randomised controlled approach, the programme was evaluated when the children were 1 years old. Both intervention and control groups received the standard support from local public health nurses and invitations to attend for primary immunisations and a development assessment. The programme was found to have significant beneficial effects: children in the intervention group scored better in terms of immunisation, cognitive development and nutrition, and their mothers scored better in terms of nutrition and self-esteem than those in the control group.³⁸

Evaluation when the children were aged 8 found a persistence of superior parenting skills among programme families. Children whose mothers were in the CMP were more likely to have better nutritional intake, read books and visit the library regularly, and to have higher levels of self-esteem; mothers were more likely to oppose smacking, have strategies to help them and their children to deal with conflict, enjoy participating in their children's games, eat appropriate foods and express positive feelings about motherhood. The benefits also extended to subsequent births: children were more likely to complete their primary and MMR immunization and to be breastfed. There were indications that just 12 contact hours in the first year of a child's life can make a difference.

4. Nurse Family Partnership, United States

Aim

The Nurse Family Partnership (NFP, or known as the 'Family Nurse Partnership', FNP, in England) is an evidence-based programme that helps transform the lives of vulnerable young mothers pregnant with their first child.

Delivery

Each mother served by NFP is partnered with a health visitor in the second trimester of her pregnancy and receives ongoing home visits continuing through to her child's second birthday. Early and sustained contact allows time for any critical behaviour changes needed to improve the health of the mother and child.

Impact

Three randomised controlled trials have been conducted in the US since the programme was

first started in New York in the 1970s. NFP has been shown to deliver multi-generational outcomes that reduce the cost of long-term social service programmes. For instance, the following outcomes were observed in one of the randomised controlled trials:

- 48% reduction in child abuse and neglect
- 56% reduction in emergency room visits for accidents and poisonings
- 59% reduction in arrests at child age 15
- 67% reduction in behavioural and intellectual problems at child age 6
- 72% fewer convictions of mothers at child age 15
- 83% increase in labour force participation by the mother at child age 4
- 20% reduction in months on welfare.

A systematic review of the costs and long-term benefits of the Nurse Family Partnership found US costs just over \$9,000 per child, but an average benefit of more than \$26,000 per child, based on the longer term outcomes of the Elmira trial up to the time children were 15 years old.³⁹ A second study by the same team⁴⁰ found that crime reduction was an important contributor to the benefit. Crime is expensive for victims, for the state which has to investigate, prosecute and fund sentences, and for those who offend in terms of reduced earnings potential.

The programme is voluntary and in the first wave of test sites in England has been taken up by 87% of the families who have been offered it. After promising early findings (though substantial site variability was observed)⁴¹ the programme is now being tested across England.

Effective local practice

1. Early notification of pregnancy, Lancashire

Aim

In Lancashire, following the identification of high numbers of infant deaths and injuries, a task group based on the network of 16 children's centres looked at how professionals could support prospective parents from the early stages of pregnancy, with a particular focus on those considered to be potentially vulnerable.

Delivery

The task group agreed to take forward an early notification process – a simple notification form completed by a midwife with the mother at the antenatal booking clinic and forwarded to the children's centre and health visitor, giving the children's centre permission to contact the mother.

Children's centre staff have been involved in direct negotiations to move existing community health services into children's centres as a result of the partnership developed between the organisations. In October 2009, 21 antenatal booking clinics began across community venues in central Lancashire, 16 of which are in children's centres, resulting in 64 hours of midwifery time delivered in children's centres.

Impact

As a result, Lancashire reports that families now receive more and better support earlier, across the county, which covers three NHS Primary Care Trusts (PCTs) and seven Acute

Trusts. In the period April – August 2009, 430 early notifications were received in one locality, which were distributed to 16 different children’s centres. Communication improved between all the relevant services and a simple mechanism to enable effective information sharing is now in place. The families identified as highly vulnerable are offered support before their baby is born and report feeling better supported. This partnership approach also frees midwives up to concentrate on their clinical role, because they know the relevant services will offer the other kinds of support the family needs. It has also been found that the families who start to go to children’s centres before their child is born are more likely to continue to do so afterwards, helping to ensure they get the extra help they need, examples of which include Citizens Advice Bureau, Jobcentre Plus, housing advice, debt advice and Job Search.

Overall, 430 vulnerable families received targeted support from 16 children’s centres at a cost of £5,400.

2. Breastfeeding Initiative, Blackpool

Aims

In Blackpool, a partnership between children’s centres and PCTs was established to reach out to young mothers from disadvantaged areas who are less likely to breastfeed. The aim was to achieve improved standards within the 12 children’s centres across Blackpool that would support breastfeeding, and ensure that parents are given the correct health information and support to encourage breastfeeding. The partnership embarked on the Children’s Centre Baby Friendly Accreditation as a vehicle for achieving and sustaining these improved outcomes for young mothers and their babies.

Delivery

The children’s centres have been developed to welcome breastfeeding, ensuring that staff can direct queries about breastfeeding to both professional and voluntary sources, and set up support groups. The PCT provided training to staff and the children’s centres promoted the ‘Be a Star’ campaign aimed at increasing the profile of breastfeeding to young women.

A breastfeeding policy was developed across all children’s centres and this is displayed at each centre. The policy provides clear guidance on how centres can support breastfeeding. Breastfeeding support groups were developed across Blackpool’s children’s centres to ensure that parents were able to access groups in their local community. All information given at children’s centres is impartial, evidence-based and free from commercial influence.

A children’s centre in the south of Blackpool has been able to accommodate breastfeeding peer volunteers; this has further strengthened the working partnership between children’s centres and the PCT. Peer volunteers provide a home visiting service to support breastfeeding mothers who request the service after discharge from hospital.

The first satellite milk bank centre in the UK was set up within a children’s centre in Blackpool. This has enabled mothers who want to donate breast milk to have easy access to milk storage. Breast milk is collected by Wirral Hospital, treated and donated to babies on the neonatal units across Lancashire.

High standards are maintained through staff being trained in the Baby Friendly modules which enhance their knowledge about the benefits of breastfeeding and what is available to support breastfeeding mothers. A regular assessment is conducted by the PCT to ensure that individual children’s centres meet the Baby Friendly requirements for accreditation.

Impact

As a result of the initiative, the breastfeeding initiation rates in Blackpool increased from 42% in 2006/07 to 49.4% in 2007/08 and 56% during 2008/09, far exceeding the set target of a 2% rise in breastfeeding rates per year. Blackpool is one of a small number of local areas in the country to have achieved stage 1 of the Children's Centre Baby Friendly accreditation, and is aiming to achieve full accreditation by 2011.

Overall, 903 vulnerable young mothers received targeted support at a cost of £29,811 or £33 per mother per year. This indicates a social return on investment of £1.56 for every £1 invested, and estimated savings to the Department of Health of £57,500 over a two-year period.

3. Child Development Programme, Darlington

The Child Development Programme is a resource pack designed for parents and carers of children aged three to five, to use in the home with support from early years settings.

Aim

The primary aim was to 'narrow the gap' between the low-achieving children and their higher-achieving peer group. As children in part-time nursery education spend only 6.5% of their time within the setting and, recognising a parent's role as their child's 'first and most enduring educator', it was felt that a programme that used research evidence on child development, and that would support parents to promote their child's learning and development, would be key to success and to improving outcomes for children.

Delivery

The programme offers structured physical activities; targets thinking skills and the development of pre-requisites for literacy and numeracy; and also provides, in the manual, a chapter on healthy eating. It is equally applicable for children of all abilities, whether they are the most gifted or children with significant learning or physical difficulties. It provides the framework for early learning experiences that, according to feedback from the children themselves, their parents and carers and the staff in the settings, are challenging, enjoyable and show measurable achievement.

The initial pilot took place in two Early Years Foundation Stage (EYFS) settings, with the majority of assessments carried out by the University of Durham. As the programme has been rolled out, the EYFS advisory teachers or practitioners have assessed the children. At the outset, children were assessed using a standardised developmental checklist, to establish a baseline in physical development, thinking and language skills. They were then re-assessed to measure the impact of the programme after six months.

The programme is contained in a resource pack, which contains all of the equipment and instruction necessary for implementation. It is supported with a DVD that demonstrates the activities and the approach parents and carers should use with their children. In addition, there are extension activities available on an interactive website.

Initial training was provided for parents and practitioners within the early years setting. It is a holistic programme with essential information about child development, brain development and the importance of taking into account gender differences in the development of physical, communication, social and perceptual skills. Training also included information on how parents and carers could use the programme, and the support provided by practitioners in the setting and local authority.

As a result of highly successful pilots, the decision was made to roll out the programme to all children's centres and offer universal training, with the wider early years team supporting implementation in settings. Use of the programme continues to be extended. Currently seven settings are implementing the programme, with three more due to begin in September 2010. The programme is being successfully used by children's centres in Darlington to engage vulnerable and 'hard to reach' families by early years practitioners working individually with parents in their home.

Impact

The results from the pilot were extremely positive and validated by independent developmental assessments, as well as evidenced by Darlington local authority data. Improvements in pupils' achievement have been sustained as the programme has extended. Through the programme, gains have been achieved for some of the most vulnerable children, whilst extending the capabilities of the most able children. Another notable success of the programme has been the high level of parental involvement which has exceeded anything that had been tried before.

The programme was delivered at a cost of £107 per institution.

Conclusion

The powerful body of research (home and abroad) showing that what a child experiences during the early years (starting in the womb) lays the foundation for the whole of their life, makes a compelling case for prioritising both investment and, arguably more important, a shift in government policy in this most critical area. It has even been suggested that, "despite current policy's far reaching positive implications, a 'golden thread' is missing: a recognition in the underpinning framework of the importance of relationships in every young child's development. Relationships in the early years remain on the sideline in current policy with no recognition of the fundamental role that attachment and familial relationships play in bringing about children's well-being and reducing the likelihood of many physical and psychological problems. The five Every Child Matters outcomes made little reference to a child's relationships" (CSJ 2008).⁴² Similarly, it has been suggested that there needs to be a "simple, broad-based media campaign, centred around the concept of a 'Neuron Footprint' to put awareness of the brain's development during the early years at the heart of the nation's thinking on all aspects of family, social and other influences on our young children" (CSJ 2008).⁴³ The thrust of this suggestion is reinforced in Chapter 5 which focuses on parents as the most significant influence on children, with profound consequences for their future lives.

Notwithstanding the above, there are some positive developments, as reflected in the roll out of the highly successful Nurse Family Partnership programme, although the substantial site variability of its implementation in this country to date suggests that careful monitoring to assure quality and fidelity to the programme is needed. It is important to note, however, that the full cost savings from the United States are unachievable in England, since England already has universal health visitor services, albeit at a lower level of intensity. Additionally, the effective practice examples featured in this chapter show that local areas are embracing key messages from both the research and international experience. Lancashire has shown that making simple changes, through its early pregnancy notification, can lead to potentially significant benefits. The breastfeeding initiative in Blackpool, with its focus on quality standards (including in relation to health information) and the use of peer volunteers, has resulted in marked improvements in breastfeeding rates. The Community Mothers Programme in Ireland, meanwhile, gives an insight into how the vast (yet largely

untapped) resources of the wider community can benefit the baby, parents, volunteer and community; in this case, for no more than 12 contact hours in the first year of a child's life.

Key messages

- There is now compelling evidence to show that what a child experiences during the early years (starting in the womb) lays down a foundation for the whole of their life, which needs to be reflected in policy and practice, both at a national and local level.
- Children's centres lie at the 'hub' of a continuum of support for children, families and communities with additional needs, but require an effective outreach strategy to ensure that interventions target and support the most vulnerable in the community.
- Despite the significant benefits of breastfeeding having been clearly illustrated, breastfeeding rates in England are among the lowest in Europe. Effective local initiatives, such as in Blackpool, are needed to achieve and sustain significant improvements.
- Complementary action is needed to dramatically increase the current low proportion of hospitals in England (less than one in 10) accredited under the Baby Friendly Hospital Initiative, a set of standards developed by UNICEF and the WHO (World Health Organisation) to promote breastfeeding.
- More needs to be done to promote the use of peer support: volunteers from the community (including local parents) who are trained to work alongside professionals, but whose similar life experiences bridge the 'approachability gap'.

4. Language for life

“Early intervention means making a prompt intervention to support the child and family. In addressing SLCN [speech, language and communication needs], there is strong clinical opinion about the value of early intervention and the danger of its absence. If a child receives the right help early on, he or she has a better chance of tackling problems, communicating well and making progress. If a child does not benefit from early intervention, there are multiple risks – of lower educational attainment, of behavioural problems, of emotional and psychological difficulties, of poorer employment prospects, challenges to mental health and, in some cases, of a descent into criminality.”

*The Bercow Report
A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs, July 2008*

Background

Although awareness of the importance of language and communications skills has been raised in recent years – through a combination of the activities of some very effective voluntary sector bodies, academic researchers and government-sponsored enquiries (in the UK and abroad) – it remains generally inadequate. Publications that have been influential are *The Cost to the Nation of Children’s Poor Communication, I CAN 2006*⁴⁴ and *The Bercow Report, A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs, DCSF 2008*⁴⁵ – all of which draw attention to the number of children who have speech, language and communication needs (SLCN), the difficulty many families have gaining access to often patchy provision of support, the difference that support can make, and the cost (to the individual, families and the nation) of the failure to provide it in a timely and effective manner.

Scale of children affected

Research cited in the I CAN report shows that up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime.

Children with persistent language disorders are five times more likely than their peers to be classified as having learning disabilities, and the same patterns can occur in children with transient difficulties without appropriate support. There is growing evidence of undetected communication difficulties amongst children with behavioural, emotional and social difficulties, and children with an early diagnosis of language or communication difficulties who do not receive appropriate support are more likely to have poorer emotional health and to develop mental health problems. One study⁴⁶ has shown that only 50% of young people with language difficulties remained in full-time education post-16 compared with 75% of their peers and an American survey⁴⁷ found that men with speech difficulties were eight times more likely to be unemployed. 50% of the UK prison population has literacy difficulties,

compared with 17% of the general population, and 35% of offenders have only basic level speaking and listening skills.

But with the right support, many children with language delay linked to social disadvantage go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by age 5½ (which appears to be a critical age)⁴⁸ go on to perform within normal limits. Yet early years staff feel inadequately equipped to help these children,⁴⁹ and over 60% of primary teachers lack confidence in their ability to meet children's language needs.⁵⁰

Costs to the nation

The costs – not only personal, educational and social, but also economic – of failing to meet these needs adequately are high. The I CAN report describes an American review of early intensive language support programmes showing significant academic gains, reduced need for special education, improved health, higher employment and earnings for families. A cost benefit analysis showed long-term benefits and returns that ranged from 4:1 to 17:1 (*i.e.* \$4-17 benefit/saving for every \$1 spent). It also points out that no such cost benefit analysis has been done of similar programmes in the UK, and that “too little is known about the relative cost effectiveness of different approaches” (I CAN 2006, p 11). The 2004 Audit Commission report on youth justice⁵¹ included a fictional case study of a 15 year-old (‘James’s story’) reflecting a real life situation; it describes and costs a series of interventions from concerns about speech and language development at age 6 to a second custodial sentence by age 15 (total cost £153,687), and compared this to the cost of alternative strategies assuming the avoidance of crime (£43,243) – a cost benefit of £111,444 (which doesn’t include the wider societal costs of anti-social behaviour and crime).

Bercow Report

The Bercow Report recommendations included a research programme to enhance the evidence base and inform delivery of better outcomes for children with SLCN, including the cost effectiveness and efficiency of different interventions and models of collaboration. This has been commissioned from the Centre for Educational Development, Appraisal and Research (CEDAR), University of Warwick.⁵²

The Bercow Review highlighted the extent to which the ability to communicate underpins a child's social, emotional and educational development, and the fact that there is insufficient understanding of this amongst policy-makers and commissioners nationally and locally, professionals and service providers, and sometimes parents and families themselves. The previous government published an action plan, *Better Communication*,⁵³ in response to the review, including the development of the Every Child a Talker initiative, establishment of a Communication Council, the appointment of a Communication Champion and a National Year of Speech, Language and Communications (to be held in 2011).

Bercow's other recommendations aimed to ensure that early identification and intervention are recognised as essential; that a continuum of universal, targeted and specialist services, delivered by an appropriately skilled and supported workforce, is created around families that need them; that health services and children's services, including schools, work together in support of children and young people with SLCN through more and better joint working; and that there is greater consistency and equity in provision of support for SLCN. On publication of *Better Communication*, Directors of Children's Services were sent a ministerial letter urging them to think how local services could improve the lives of children with SLCN, including the possibility of a member of the Children's Trust Board being nominated to lead on speech, language and communication.

Key requirements

I CAN identified a number of key requirements, many of which were echoed by Bercow. These include the importance of communication skills being emphasised in guidance to early years settings and schools; the importance of interactions between parents/carers and their children, the early linguistic environments of young children (in the home and in early years settings and schools), and the value of practitioners/teachers working with parents to develop children's communication skills. Given the 'critical age' for resolving language difficulties, effective support or intervention in the early years is vital to improving persistent disorders or speed up the resolution of transient difficulties. And a skilled and confident workforce is vital, with the ability to identify communications problems at an early age, and distinguish between transient and persistent difficulties so that appropriate interventions can be put in place.

The examples of effective local practice outlined below illustrate a number of approaches to these issues.

Effective local practice

1. I CAN Early Talk, Kent

In 2004, concern about the number of children with severe speech, language and communication needs requiring a specialist unit place in a primary school, rather than attending their local primary school, and the research evidence underpinning the I CAN Early Talk model, led to a joint partnership agreement with I CAN to develop Kent's first specialist Early Talk centre.

Aim

The aim was to offer a targeted, multi-agency approach to supporting young children with severe speech, language and communication needs, so that they could participate in everyday activities and attend their local primary school – empowering parents as co-educators in a programme that could be delivered in a nursery, children's centre or home. Local needs analysis between the speech and language therapy service and specialist teaching service indicated that 10-12 children a year in the Ashford district had severe speech, language and communication needs that would benefit from an intensive specialist approach to enable them to access the Foundation Stage Curriculum.

Delivery

The Ashford Better Communicators Service established a virtual team including a Speech and Language Therapist (SLT), a Learning Support Assistant, a children's centre teacher, an Early Years Special Educational Needs Coordinator (SENCO), and staff from a nursery based in a children's centre. A referral pathway was established to identify the four children who enter the service every two terms. A joint assessment by the SLT and Early Years SENCO follows identification, and targets are set in partnership with the parents. Parents receive regular support from the virtual team and a dedicated parents' support group. After two terms, the child returns to his/her home nursery and the virtual team continues to offer the child and parents targeted support, including support in making the transition to the Reception class and follow-up support until the end of the Reception year.

Impact

In 2008-09:

- 92 per cent of the children supported attended their local primary school and made good progress, rather than requiring specialist language provision
- 70-80 per cent demonstrated an increase in their understanding and use of language
- only one child out of 12 needed a statement of Special Educational Need
- some children's scores increased so much they were no longer classified as having a disorder
- parents reported a very high satisfaction rate
- all the children supported made progress above expectation, with a positive impact on their progress in other areas of the Early Years Foundation Stage Curriculum
- home nurseries reported an increase in their capacity to support children with severe speech, language and communication impairments.

The success of the programme has led to the development of a peripatetic approach in another part of the county, and to a new partnership between the Council, NHS and I CAN to roll out the full Early Talk model in three other areas of Kent.

The programme was delivered to 37 children at a project cost of £46,300, indicating a social return on investment of £1.37 for every £1 invested.

2. Language for Life Reception Project, Blackburn with Darwen

The Reception Project was one strand of a three-year project across Key Stages 1, 2 & 3 in Blackburn with Darwen schools. It was developed collaboratively with mainstream staff, advisory teachers and specialist speech and language therapists.

Aims

It aims to:

- identify the language levels of all children entering the reception year
- increase the knowledge and skills of teachers and support staff
- raise the language levels of all the children in the year group through provision of universal, targeted and specialist provision
- identify children whose language skills are significantly below the level needed to access the curriculum and provide them with appropriate interventions, and those whose language skills are well developed to ensure that they can be stretched to reach their full potential
- support the smooth transition of children with identified speech and language needs into Key Stage 1.

Delivery

All Reception children are screened for their level of understanding using the British Picture Vocabulary Scale (BPVS) and the Derbyshire Language Scheme: Rapid Screening Test (DLS: RST).

The BPVS assesses a child's understanding of vocabulary, while the RST assesses a child's ability to process different amounts of information. This test involves the child following simple instructions of increasing length and information using everyday objects.

There are particular arrangements for those for whom English is an additional language (EAL), with assessments in the home language helping to establish whether there is a language/vocabulary delay or whether it is purely an EAL issue.

By enhancing the language learning environment, *all* children can be supported to develop their language skills further within the mainstream classroom. The Vocabulary Box is a targeted intervention intended for children who have a gap of more than one year between their actual age and their vocabulary age equivalent, or who are below a 4 word level of understanding, or are entering school with a vocabulary age of below 3 years.

Children who are targeted for direct intervention are reassessed on the British Picture Vocabulary Scale (BPVS) and 'ratio gains' calculated at the end of the summer term. This provides one way of measuring the children's progress and highlights any remaining language difficulties as they transfer into Year 1. Over a hundred Foundation Stage staff have been trained in the delivery of specific language assessments, and the language screening of nearly 3,000 Foundation Stage children within 37 mainstream infant schools has improved outcomes for many children. It identified children with, or at risk of, language delay, with appropriate interventions tracked and monitored on school provision maps. The majority of Blackburn with Darwen staff in reception classes have received training on how to scaffold their language interactions and enhance the language facilitation and teaching within continuous provision, and have been coached in the delivery of The Vocabulary Box.

Impact

Outcomes have improved, both for children receiving targeted interventions and for cohorts as a whole, leading Ofsted to describe the project as an excellent example of a school-based project which, when "introduced in the most challenging primary schools has shown outstanding improvements in attainment and progress from Foundation Stage to Key Stage 2, significantly bridging the gap between pupils with SEN and all pupils." (Ref No 889 January 2009).

3. Language for Life Strategy, Nottinghamshire

Aims

The strategy draws together the collaborative practice developed over a decade through joint working between children's centres, the local authority and NHS with the aim of developing language-rich environments for *all* children aged 0-7 and to enable early identification and support for children with speech, language and communication difficulties.

Aims of the strategy include:

- provision of a framework for the early identification and support of children with early language delay
- support for parents in understanding and strengthening their role in their children's language development
- provision of continuing professional development (CPD) for practitioners working with children and families to embed improvement of language-rich environments.

Delivery

A key feature of the strategy is the support of other practitioners by the speech and language therapy (SLT) team, in particular training of the health visitor team to enable them to include a language screen of every two year-old as part of the Healthy Child Programme 2-2½ year

development check. Each children's centre has a language lead, SLT provision and a Home Talk worker – an early years practitioner with training and support from the SLT who supports families of children with delayed language development. All parents are talked through a leaflet appropriate to their child's level of language development to encourage their support, and a range of support/intervention is available – from an invitation to children's centre activities to promote language-rich environments to a programme of visits by a Home Talk worker or referral to the NHS SLT service.

Impact

There has been a substantial increase in referrals of children of two years and under to the SLT service as early identification strategies improve. The vocabulary of a cohort of children in 18 nursery classes rose dramatically after practitioner training and mentoring: the cohort's average standardised scores on the British Picture Vocabulary Scale (BPVS) rose from 43 in 2007 (before training) to 67 in 2009 (a score of 50 is the age-standardised average), while the percentage scoring below 25 fell from 30% in 2007 to 6% in 2009.

Building capacity in the early years workforce has led to a reduction in the specialist SLT input from an initial two days a week per children's centre to one day a week per children's centre in the 30% most disadvantaged areas and half a day a week in the other 70% of centres.

4. Every Child a Talker, Barking and Dagenham

Aims

The aims were to:

- improve early language development, initially for children in targeted settings, but eventually across the whole LA
- establish Early Language Lead Practitioners (ELLPs) in 32 targeted settings, providing expertise and support to other practitioners in their own and linked settings, and to parents to develop their skills in the development of early language
- increase practitioner knowledge and understanding of children's early language development and how to support it
- increase parental understanding of and involvement in their children's language development.

Delivery

Two Early Language Consultants (ELCs) delivered an intensive, innovative, well-researched training programme to develop 32 Early Language Lead Practitioners (ELLPs) in school nursery and reception classes, children's centres, day nurseries and pre-schools. The ELLPs then delivered training and support to their Early Years Foundation Stage (EYFS) teams (341 practitioners). Training and support was also extended to parents/carers, childminding development officers, childminders, play and communication workers and newly qualified teachers.

Impact

The number of children ahead of the level expected for their age in four targeted areas of communication development almost doubled (20% to 37%). There was an increase in confidence in parents/carers in encouraging their children's communication development across all five topics evaluated; 93% of participating parents reported an improvement in their child's speech and language development. Results have shown an increase in

confidence, knowledge and skills in all ELLPs and EYFS practitioners in supporting early language development and identifying communication difficulties: confidence ratings of ELLPs more than doubled, and practitioners' ratings increased across all settings following the training. Pre-training, ELLPs were observed to use an average of six key skills (in timed observations); post-training they used an average of 11.

5. Talk Matters, Leicester City

Publication of foundation stage profile results nationally showed that the achievement gap between children and young people in Leicester and the rest of the UK at 11 years (Key Stage 2) and at 16 years in GCSE performance, was apparent at the foundation stage, demonstrating the need to intervene early. Indications that as many as 70% of Leicester's children were below national averages in communication, language and literacy development (CLLD) at the end of the foundation stage highlighted the severity of the problem.

Aim

The clear aim is to improve children's communication skills, which impacts on children's health, educational attainment and economic success into adulthood.

Delivery

The Talk Matters strategy is being delivered through children's centres and operates at three levels:

1. Community – raising awareness of the importance of interacting with children to support their communication and language development; ensuring that all providers and practitioners have appropriate training and resources; ensuring a range of community development activities that support language-rich environments.
2. Family – ensuring that all families: receive good information and guidance during pregnancy and early childhood on how to promote their child's communication skills from birth; understand the stages of communication development and are encouraged to engage in all areas of their child's learning; have access to resources that promote good communication and know where to get help early if they think their child needs it.
3. Child – every child has assessments of their communication development at 9 and 24 months; receives the earliest possible intervention once a difficulty is identified; has access to language rich environments from birth to 5 years; experiences positive daily interactions with a carer if they attend a Leicester early years setting.

A universal, multi-agency, city-wide approach to developmental screening at 9 and 24 months is being piloted that can be implemented by a range of professionals. A coherent suite of four age-related preventative activities are being delivered in all children's centres to help ensure that parents get the right information to keep them talking to their babies from birth, instead of intervening when something goes wrong. The aim is to have all early years practitioners trained to the Speech and Language Communications Framework (SLCF) universal level, and every setting to have one person trained to an enhanced level.

Impact

For the second year running, percentage improvements in CLLD have increased in excess of agreed targets. Outcomes for children are improving, with an increase from 27% at a good level of achievement in 2006 to 44% in 2009.

Conclusion

Research cited in the I CAN report illustrates the scale of children affected and the multiple risks they face: up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication disability and low attainment, mental health issues, poor employment or training prospects and youth crime. It is, therefore, a cause for considerable concern that, despite awareness of the importance of language and communication skills being raised in recent years, it remains generally inadequate. This was reinforced by the Bercow Report which highlighted the fact that there is insufficient understanding of this amongst policy-makers and commissioners nationally and locally and sometimes parents and families themselves. A National Year of Speech, Language and Communications, to be held in 2011, is most timely and should be fully exploited to address this shortcoming.

What is crucial is that, with the right support, many children with language delay go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by age 5½ go on to perform within normal limits. Yet early years staff feel inadequately equipped to help these children,⁵⁴ and over 60% of primary teachers lack confidence in their ability to meet children's language needs.⁵⁵ This undoubtedly warrants national attention and action. There is, however, encouraging evidence emerging from a variety of local areas. Significantly, all five effective local practice examples featured in this chapter targeted support during this 'window' involving a large scale training programme and dissemination of information to equip staff and parents alike. The impact of these effective interventions has been hugely successful, as evidenced by marked improvements in children's learning and achievement, practitioners' confidence and parental feedback.

Key messages

- The scale of children affected is considerable: up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime.
- As there is insufficient understanding amongst policy-makers and commissioners nationally and locally, and sometimes parents and families themselves, raising awareness of the importance of language and communication skills and creating language rich environments is urgently needed.
- With the right support, many children with language delay go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by the age of 5½ (which appears to be a critical age). Effective support or intervention in the early years is vital to improving persistent disorders and speeding up the resolution of difficulties linked to social disadvantage.

- A skilled and confident workforce is critical, with the ability to identify communication problems at an early age, and distinguish between transient and persistent difficulties so that appropriate interventions can be put in place. Yet many early years staff feel inadequately equipped to help these children, and over 60% of primary teachers lack confidence in their ability to meet children's language needs.
- Effective local practice was characterised by a large scale training programme and dissemination of information to equip staff and parents alike in successfully targeting early intervention and support, resulting in marked improvements in children's learning and achievement, practitioners' confidence and parental feedback. Other key characteristics included the effective use of data, not least to track progress, building capacity through sharing the knowledge of specialist staff, and strong parental engagement.
- The National Year of Speech, Language and Communication 2011 should be fully exploited.

5. Engaging parents

“One message that came out loud and clear from this work was the importance of the influence that parents have on the lives of their children. The best parents can protect their children from the disadvantages associated with poverty or chaotic living arrangements, while other parents need more support to give their children a good start in life. Tailored, joined up services, with the family at the centre, can give struggling parents a network of support in bringing up their children to be happy, safe and well.”

Kim Bromley-Derry, Chair of the National Family Intervention Strategy Group
Letter to Secretary of State, 18th March 2010

Background

It is generally accepted that parents, and parenting, are the primary – both in the sense of the first, and the most significant – influence on children, with profound consequences for their future lives. There is now far greater understanding of the importance of the early development of children in determining later outcomes. Hence the recent upsurge of interest in supporting parents in their vital role, particularly those for whom external intervention and support is necessary in order to achieve that end. This may be to compensate for perceived lack of skill (however caused) in their parenting abilities, or to assist in dealing with particular difficulties arising in some children; or, quite frequently, a combination of the two.

In its programme for government, the Coalition Government commits to encourage shared parenting from the earliest stages of pregnancy – including the promotion of a system of flexible parental leave; and put funding for relationship support on a stable, long-term footing, and make sure that couples are given greater encouragement to use existing relationship support.⁵⁶ As Statham and Smith have observed, “there are relatively few interventions focussed on relationship support, or on reducing parenting stress (*Mellow Parenting* is an exception), despite the fact that disharmonious relationships and parenting stress are known to be important factors in relation to child outcomes” (Statham and Smith 2010).⁵⁷

Good parenting

According to the classic review of research literature on the impact of parental involvement by Professor Charles Desforges,⁵⁸ “the most important finding is that parental involvement in the form of ‘at home good parenting’ has the most significant positive effect on children’s achievement. In the primary age range, the impact of different levels of parental involvement is more significant than differences associated with variations in the quality of schools... Differences between parents in their level of involvement are associated with social class, poverty, health and also with parental perception of their role and their levels of confidence in fulfilling it” (Desforges 2003).

The Effective Provision of Pre-School Education Project (EPPE)⁵⁹ was the first major European longitudinal study of a national sample to look at the impact of different types of pre-school experience on children’s later progress. It found a strong relationship between a child’s intellectual skills and their family background characteristics on entry to pre-school. This reduces (though is still strong) by the time children enter primary school – indicating that

pre-school provision can reduce, but not eliminate, the effects of social factors. It also found that the quality of the home learning environment was only moderately associated with mothers' educational level, and observed that "what parents do with their children is more important than who parents are... Young mothers with few qualifications can improve their children's progress..." (Institute of Education 2003). EPPE's findings are consistent with American research findings⁶⁰ that family characteristics have a greater impact on outcomes than pre-school factors, but the effect of attending pre-school is greater than the effect of social disadvantage. The EPPE research concluded that both the quality and quantity of the pre-school experience are influential and these and the home learning environment "can be seen as more susceptible to change through policy and practitioner initiatives than other child or family characteristics, such as SES [socioeconomic status]" (Institute of Education 2003).

Another study⁶¹ concluded that self perception is closely linked to the motivation to change, and that parents' literacy and numeracy are key components of influence on children's educational achievements, particularly at the lowest parental literacy and numeracy levels. Since major economic disadvantage, poor psychological wellbeing and lack of civic participation are concentrated among those with the lowest literacy and numeracy levels, the study suggests that policy-makers should focus their attention on these groups, not only encouraging participation in courses but also acknowledging the highly disadvantaged contexts in which many parents live.

Parenting programmes

The former DfES funded Parenting Early Intervention Pathfinders (PEIP) from 2006-2008, in which 18 local authorities (LAs) each implemented one of three parenting programmes (selected as having a sound evidence base for their effectiveness) with parents of children aged 8-13 years: Incredible Years, Triple P and Strengthening Families, Strengthening Communities. Evaluation of the pathfinders⁶² found that there were high levels of positive gains for parents and children; parental course completion rates were good; the training successfully improved parents' mental well-being and parenting skills and the behaviour of their children. The three programmes produced comparable improvement outcomes but cost effectiveness varied between LAs using the same programme, indicating the importance of local policy and organisational factors. Other findings included the value of local parents (with appropriate training) acting as peer facilitators, the low recruitment of fathers (12% of participants), the wide range of minority ethnic groups (23.9% of the total) accessing courses, and the proportion of boys (66%) and children with statements of special educational needs (17.7% – six times higher than the population as a whole). Some schools were very positive, and were involved in the identification of families, the provision of premises and of staff as facilitators.

Main recommendations were that systematic parenting support should be rolled out across the UK, and that any of the three programmes in the project may be selected. Specific recommendations included that, given the multiple differences between the three programmes yet the similarity of outcomes, other courses might be equally effective, and priority should be given to finding and evaluating alternatives. Parents should be recruited for programmes by all means possible, and decisions should be made in partnership with parents. Courses should be appropriate to the development stage and needs of children and families and set within a coordinated system of care in which there is a range of support options. Particular attention should be given to involving fathers. Funded crèche provision, contact between sessions, transport and refreshments were important to engaging and retaining parents with social and community support being important to aid the continued mutual support of groups after courses end.

There are now a great many parenting programmes. The Children's Workforce Development Council (CWDC), in partnership with the National Academy for Parenting Research (NAPR),

has developed a Commissioning Toolkit⁶³ of such programmes, which currently lists 122 examples, 114 of which have been evaluated and rated by NAPR. NAPR gathers and evaluates evidence on parenting practice, refines and develops courses for use by practitioners, and is running eight research projects into 'what works' in various aspects of parenting support. These include reducing youth offending, helping children achieve, interventions for 'hard to reach' families and factors contributing to successful foster placements.

Characteristics of successful interventions

Several national agencies have also been involved in the collection and dissemination of evidence on effective practice. Notably, the former Government commissioned a review of the international evidence,⁶⁴ which concluded that early *and* later interventions work in practice; early interventions produce better and more durable outcomes, but late intervention is better than none. It identified a number of characteristics of successful interventions: a strong theory base and clearly articulated model of change; measurable, concrete objectives as well as overarching aims; close attention to getting, keeping and engaging parents; multiple access/referral routes; more than one method of delivery; group work, where parents can benefit from social aspects of working with peers, and individual work where problems are severe or parents are not ready/able to work in a group (often including home visits and tailored one-to-one support); appropriately trained, skilled and supported staff; a focus on specific parenting skills; 'cognitive' interventions for changing beliefs, attitudes and self-perceptions.

It identified the need for more comparative, rigorous and robust research, including randomised controlled trials wherever possible, and concluded with some key findings relevant to national policy: parenting support benefits families; many parents need support at some point, and efforts to 'normalise' access to support seem likely to generate strong benefits and increase take up, especially at critical points for early intervention. Results repeatedly show that it is difficult for stressed families to benefit from parenting programmes whilst facing multiple disadvantage, so policies that reduce everyday stresses (including poverty, unemployment, poor health, housing and education) will support parents in caring for their children.

The Youth Justice Board (YJB) has published a source document⁶⁵ of international evidence on parenting support within the youth justice context and guidance on key elements of effective practice,⁶⁶ summarising the evidence from the source document into messages for practice. These include the fact that research convincingly demonstrates that parenting support can provide an effective mechanism for preventing and reducing youth offending and anti-social behaviour; that working with parents is almost certainly a prerequisite for effective intervention with young people who are offending or at risk of it; that interventions can be effective at all stages – both early and later intervention have been found to have positive outcomes; that most successful work in this field takes a strengths-based approach, building on families' own understanding of 'what works' and their existing skills and abilities, not focusing solely on problems, risk factors and deficits in parents' skills and circumstances. It summarises the legislative framework for parenting support, including parenting orders, and highlights the recent growth in voluntary sector work with parents in this context.

The National Institute for Health and Clinical Excellence (NICE)⁶⁷ has published guidance⁶⁷ on parent training/education programmes in the management of children with conduct disorder (serious behaviour problems which can affect a child's development or interfere with their ability to lead a normal life) aged 12 years or younger. This recommends group-based programmes, only recommending individual-based programmes where families' needs are too complex for such an approach, and says all programmes should: be based on principles of social learning theory; include ways of improving family relationships; offer enough

sessions to be helpful (usually 8-12); help parents identify their own goals; include role play, with homework between sessions to apply learning in the family situation; be given by people who are suitably trained, skilled and supported; follow the programme's manual to ensure consistency.

Many of the above features are apparent in the effective practice examples below.

Effective international practice

1. Roots of Empathy

Roots of Empathy (ROE) is a parenting programme for school children aged 3 to 14, currently being delivered with great success to over 50,000 children per year in 2,000 classrooms in Canada (where it first started), USA, Australia and, for the last two years, in the Isle of Man. It will be introduced in Northern Ireland this year.

Aims

The programme teaches young school-children how to parent babies in the first year of their lives, by bringing parents and an infant into the classroom over a 9-month period. Children who may never have experienced nurturing, attuned parenting at home, are exposed to 9 months of an excellent role model, with potentially significant effects on their future parenting attitudes and skills. Its fundamental goal is to break the intergenerational cycle of violence and poor parenting. Its specific aims are to foster the development of empathy; to develop emotional literacy; to reduce levels of bullying, aggression and violence; to promote children's good social behaviours; and to prepare students for responsible and responsive parenting.

Roots of Empathy prepares schoolchildren for parenthood through literal hands-on experience of how to handle and interact with a real-life baby. There is a strong focus on abuse prevention, the view being that children are never too young to learn about shaken baby syndrome, sudden infant death syndrome, foetal alcohol spectrum disorder and the dangers of second-hand smoke. It has also been identified as an anti-bullying programme; because children are taught to understand how others feel and are encouraged to take responsibility for their actions and inactions, good social behaviours rise and incidents of bullying and aggression fall.

Delivery

In a classroom setting, children share in nine monthly visits with a neighbourhood parent, infant, and trained instructor. The instructors conduct 18 further visits without the family. Babies are aged 2-4 months at the beginning of the programme and about 1 year at the conclusion, a period of enormous growth and development. Over this time, the students learn how to see and feel things as others see and feel them, and understand how babies develop. Children who may never have experienced loving, caring or empathic parenting in their own lives have nine months of exposure to, and indeed sharing in, parenting of that nature.

As the programme progresses, the students become attached to 'their' baby as they observe the continuum of the infant's development, celebrate milestones, interact with the baby, learn about an infant's needs and witness its development. The programme also has links to the school academic curriculum. Students use maths skills to measure, weigh and chart the development of their baby. They write poems for the baby, and read stories that tap

emotions, such as fear, sadness, anger and shyness. School children on the programme learn to relate to their own feelings, as well as recognise these same emotions in others.

Impact

A series of research evaluations at the University of Vancouver have found that, compared with control classrooms, children in the Roots of Empathy classrooms had increased understanding of emotions; increased perspective taking; increased good social behaviours such as helping, sharing, cooperating, being kind and trustworthy; and decreased aggression and bullying. The children also show more responsible attitudes to pregnancy and marriage. The hope is that they will become more competent parents who will be less likely to abuse their children.

2. Every Family Initiative, Australia

Evidence from household surveys of Australian parents show that parenting problems are common. For example, Sanders et al⁶⁸ found that a large number of parents from diverse socioeconomic backgrounds reported that their children had significant behavioral and emotional problems. 29% of parents of 2-12 year-olds had significant conduct problems and 9% of children met diagnostic criteria for oppositional defiant disorder. More concerning was the high prevalence of coercive or ineffective parenting practices, with over half of parents reporting using practices such as smacking and 70% reporting shouting and becoming angry with their children.

Aims

In an effort to forestall the development of mental health problems in children, an initiative known as *Every Family* was implemented as a population level intervention known as the Triple P – Positive Parenting Programme. Triple P is a behavioural family intervention based on social learning principles. Originally developed in Australia in the 1970s and now used widely in a range of countries and situations, it is a programme known for its standardised training and accreditation processes and is one of the few evidence-based public health interventions for parenting.

Delivery

The programme targeted parents of 4-7 year old children who were making the transition to primary school in South Brisbane. All five levels of the Triple P system of intervention were employed including a local mass media strategy, a primary care strategy targeting general medical practitioners, and three more intensive levels of parenting intervention delivered by a range of other service providers from the health and education sectors.

Impact

A computer assisted telephone interview (CATI) of a random sample of households in each community was conducted at pre-intervention and after two years of intervention to assess programme outcomes. Survey results showed that in Triple P communities:

- more parents had completed a Triple P programme and had greater awareness of it
- there were significantly greater reductions in the number of cases of clinically elevated and borderline behavioural and emotional problems as assessed on the Strengths and Difficulties Questionnaire (SDQ)

- there was a greater reduction in the prevalence of parental reports of depression, stress and coercive parenting.

The researchers conclude that if the intervention effects achieved were replicated across Australia there would be 31,199 fewer children entering school with significant psychological or social problems.

3. Incredible Years

Aims

The Incredible Years parent, teacher, and child training programmes are a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat conduct problems in young children. The programmes were developed in the 1980s by Carolyn Webster-Stratton, a Canadian educational psychologist with a public health nursing background.

Delivery

The programmes target children aged 2 to 12 who exhibit or are at risk of conduct problems. Trained facilitators use interactive presentations, videotape modelling and role-playing techniques to encourage group discussion, problem solving and sharing of ideas.

The parent training component teaches parents interactive play and reinforcement skills, non-violent discipline techniques, logical and natural consequences, problem solving strategies; addresses family risk factors such as depression, marital discord, poor coping skills, poor anger management and focuses on ways to further their children's academic and social competence.

The teacher training component focuses on strengthening teachers' classroom management skills. It seeks to help teachers encourage and motivate students, promote students' social behaviour and cooperation with peers and teachers, teach anger management and problem solving skills, and reduce classroom aggression.

The child training component, known as the Dina Dinosaur curriculum, emphasises skills related to developing emotional literacy, having empathy with others or taking their perspective, making and keeping friends, managing anger, solving interpersonal problems, following school rules, and succeeding at school. It is designed for use as a 'pull out' treatment programme for small groups of children who exhibit conduct problems.

Impact

There have been numerous randomised controlled trials in various countries validating the programmes' effectiveness. The parent training has been shown to reduce conduct problems and improve parenting interactions; these improvements have been sustained up to 3 years after the intervention. The teacher training component has been shown to improve children's behaviour in the classroom (improvements include less hyperactivity, antisocial behaviour, and aggression and more social and academic competence) and teachers' classroom management skills. The child training component resulted in significantly improved social skills and positive conflict management strategies with peers, in addition to reduced child behaviour problems at home and school.

4. Harlem Children's Zone, New York

Harlem Children's Zone (HCZ) is a holistic approach to rebuilding a community so that its children develop high expectations and progress on to college and the labour market. Harlem has suffered from generations of economic deprivation, leading to high crime rates, high unemployment and worse health outcomes for its almost entirely black residents. HCZ is a not for profit organisation that began in 1970 as a small agency working to prevent truancy. In 1997, the agency began a network of programmes for a 24-block area. By 2007, the Zone Project had grown to almost 100 blocks, and today the organisation serves more than 10,000 children and more than 7,400 adults.

Aim

The aim of the project is to create a 'tipping point' so that children are surrounded by an environment of college-orientated peers and supportive adults. The project website states that, "For children to do well, their families have to do well. And for families to do well, their community must do well. That is why HCZ works to strengthen families as well as empowering them to have a positive impact on their children's development."

Delivery

A wide range of services are provided for children aged 0–18 and their families. The 'pipeline' begins with The Baby College, a series of workshops for parents of children aged 0–3 where they learn parenting skills, including the importance of reading to young children. The pipeline goes on to include programmes for children of every age through to college, such as the Harlem Gems pre-school programme. The network includes in-school and after-school social health and community building services, in addition to Promise Academy schools. Part of the programme includes training Harlem Peacemakers, who are placed in the elementary schools and academies to train young people who are committed to making their neighbourhoods safe for children and families. There is a 'Fitness and Nutrition Centre' offering free classes to children in karate, fitness and dance, an obesity programme and an asthma initiative due to the very high levels of children in the area with asthma caused by poor housing.

Impact

This approach has achieved outstanding success, especially in driving up educational achievements. In 2009, 87% of Promise Academy 8th graders performed at the standard grade level in maths, compared with an estimate of only 7% among black 8th graders nationally. A very recent evaluation by Harvard University found that the Promise Academy students outperform the typical white student in New York City in maths. The overall budget for 2009 was over \$66 million, an average of \$5,000 per child. Only one third of this comes from government, with the majority coming from charitable donations or from individuals.⁶⁹

Effective local practice

1. Families and Schools Together (FAST) – Save the Children

In 2008, Save the Children identified the need for a more effective approach to engaging parents in supporting their children's success in school – particularly very disadvantaged families. They commissioned external research⁷⁰ to review the evidence on existing provision to determine which programmes had greatest impact on children's development and

educational achievement, and to highlight the components of an intervention strategy most likely to engage low income and isolated families.

Families and Schools Together, a well established and highly regarded American programme which is being used in a number of local authorities, was found to fit Save the Children's wider parental engagement programme principles and the two organisations developed a partnership in 2009 with the aim of extending access to the FAST programme across the UK.

Aims

FAST is an eight-week, family programme designed to build protective factors to increase child well-being and enhance children's resilience. Its aims are to: enhance family functioning; prevent children from experiencing school failure; and reduce the stress that families experience from daily life.

Delivery

FAST trainers co-produce programme adaptations with locally representative teams to facilitate direct delivery of the programme to children and families whilst protecting the core components of the programme. Facilitators always include at least 25% local parents or young people, depending on the age range of the target group. School-based groups can serve up to 40 families at a time, divided into 'hubs' of up to ten families, to foster quality engagement and support. Each team has at least four members per hub: one to three parent partners, an older child from the school, a school partner and community-based partner(s) from health or social work. There are three sequenced stages: community outreach; a universal participatory and experiential eight-week curriculum to build relationships between parents and children, parents and schools, and parents and other parents within the community; and, after 'graduation', 22 monthly parent-led meetings to maintain the family networks that have been developed and identify community development goals.

Each of the eight weekly sessions includes six key elements: a meal shared as a family unit; family communication games played at a family table; time for parents to talk with other local parents; a self-help parent group; one-on-one parent-child time; and a fixed lottery that lets every family win once, followed by a closing game. These core components aim to strengthen the bonds within and between families, and between families, the school and the community.

Impact

Parents and teachers are given post-programme questionnaires, which are sent to the FAST project at Middlesex University for analysis against a number of objectives. The most recent outcome evaluation (June 2010), based on evidence from eight local authorities, shows, for example: improvements in family expressiveness, family relationships and parent-child relationships; 77% responded that they are now more able to support their child in education; 91% of parents agreed/strongly agreed that the FAST team had empowered them through the way they ran the programme; and 100% felt that the team had provided information, support and resources, supported them in decisions, and respected them as individuals.

2. Barnardo's Community Mums and Dads Programme, Reading

Aims

The Barnardo's Community Mums and Dads Project (CMD) was commissioned by Reading Borough Council in March 2008 as part of a three-year strategy aimed at strengthening

communities through mobilising resources within the community itself. It aims to support families to prevent crisis intervention within their lives from other services; enable vulnerable families to access services in their local community; improve parenting skills and increase families' confidence and understanding of their child's development; and develop capacity within the local community.

Delivery

The project, located in Southcote children's centre, is managed by a Barnardo's project worker. The programme is being delivered with the help of volunteers from the local community, who have undergone structured training provided by Barnardo's head office and the project. CMD is evidence based, designed around the University of Bristol's Childhood Development Programme.

The project works with 'hard to reach' families around parenting, health and emotional well being. It is a friendly, informal and confidential home visiting programme in which local volunteer mums and dads offer useful ideas, reassurance and information 'as one parent to another'. Community mum/dad knows first hand the realities of being a parent and can offer a 'friendly listening ear'. Whilst she/he shares her/his own experiences, and those of other parents, she/he firmly believes that parents are the experts on their own children.

Impact

Progress was evaluated against a range of criteria; 28 of the 34 families demonstrated significant improvement in their situation.

The CMD programme has strengthened the children's centre's capacity around early learning, family support, health and support into employment through reaching out to socially excluded parents/families. The volunteers have reported that the training and work experience with Community Mums and Dads have enabled them to gain employment, gain essential experience to get into training/careers in social care and given them personal satisfaction. CMD volunteers help children's centres run activities/groups for families, for example a 'first time mums' group at Southcote children's centre; the programme is devised by participants with the volunteer mums and includes discussions around topics such as health, parenting and potty training, and talks from invited speakers on issues of concern such as speech and language, weaning and breastfeeding.

3. Parents as First Teachers Programme, Islington

Aims

'Parents as First Teachers' (PAFT) is a parenting programme delivered largely in the home which aims to engage parents in supporting their child's learning and development. Offered through a nursery school and children's centre, the programme aims to: better identify vulnerable families; engage families, including fathers, with their children's development and learning, increasing both their knowledge and self confidence as parents; engage 'hard to reach' families who were unlikely to access services by attending the centre; improve early identification of special educational needs and other needs, and support families to access specialist services such as speech and language therapy as early as possible; and support families in stopping small difficulties becoming more serious.

Delivery

Staff in the nursery school and children's centre attend the recognised PAFT five day training course before delivering the programme, which is offered universally and has no formal

referral process, so is non-stigmatising. It is carried out largely in the home, making it very accessible to families. Visits are monthly, or more frequent if required, and last for around an hour. They include developmental information appropriate to the child's age including what to expect now and in the near future; an activity linked to a particular aspect of development using cheap household materials; sharing a book and a rhyme with the family and information on specific parenting 'issues' linked to the child's age and stage of development. Staff share what they observe about the child with the family and ask for their observations. Staff plan and record the visit using simple pro-formas provided by the programme which includes checking against developmental milestones. Concerns about the child's development are shared with the family. The practitioner, with the family's consent, may then refer the family to a more specialist service such as speech and language therapy.

Families are recruited through a mixture of word of mouth, active promotion through the centre and recommendations from other professionals, most significantly the health visiting team who identify families they judge would most benefit. The programme is open to any family living in the area immediately around the children's centre who are about to have a baby or have a child under three. Informally, it is possible to target more vulnerable families through recommendations from other professionals.

Impact

Most of the children in the programme show at least good progress towards developmental milestones. Where there is delay, advice or referral is offered: a number of families have accessed the clinical psychology service, and others have begun to use other resources and facilities. The consideration of developmental 'milestones' with families meant both that practitioners and parents were able to identify possible difficulties early, and parents had a clearer understanding of why they may need extra support.

Over the last year, the programme has supported 60 families at a cost of £17,550, equating to £292 per family.

Conclusion

The research evidence, international experience and effective local practice are as one in their core message: good parenting is crucial to good outcomes for children and young people, and effective parenting support *does* help improve parenting, leading to improved outcomes not only for children but for parents and families. Moreover, disadvantage is not a block to good parenting but low levels of literacy and numeracy and confidence are obstacles, and self-perception contributes to motivation to change – so it is important to persuade parents that engaging in their child's development can make a difference and to build positively on their existing strengths. This includes involving them in decisions, including identifying their own goals. Many parents need support at some point, and normalising access and including peers as facilitators help recruitment. Continuing investment in developing workforce skills and capacity is essential to effectively engage with parents, an issue that is explored more in the next chapter. More and better research, including randomised controlled trials (see Empowering Parents, Empowering Communities example in chapter 7) and comparative studies, is still needed.

Further and perhaps deeper insights can be drawn from the international experience both within this chapter and chapter 3. Roots of Empathy, which was developed in Canada and is currently being delivered to over 50,000 children per year in a range of countries, is a shining example. As a parenting programme for school children as young as 3 years old, its aim is truly intergenerational: children who may never have experienced nurturing, attuned

parenting at home, are exposed to 9 months of an excellent role model, with potentially significant effects on their future parenting attitudes and skills.

The well-developed approaches of Sweden and the Netherlands, which lead both the UNICEF and OECD league tables for child well-being, warrant closer scrutiny. In Sweden, parenting education is taken very seriously: 98% of all maternity clinics offer parenting education in groups to first-time parents; and 60% allow repeat parents to participate. The Netherlands, too, treats parenting as a priority, with support offered to all families: a national network of youth and family centres was created to provide advice and help on parenting at neighbourhood level; and community schools and other facilities offer advice and support on parenting. Given these two countries' positions of strength and what we now know about the significant impact that parenting has on a child's development, together with research on early brain development (see chapter 3), the UK would benefit from "what is needed is a whole society attitude shift to parenting akin to those achieved with seat belt wearing and drink driving. Instead of parenting being seen as a private matter which must not be invaded, it should be celebrated as a matter where achieving high standards is in everyone's interest, and it is socially acceptable for everyone to recognise they are able to learn" (Wave Trust 2010).

Key messages

- Parents are the most significant influence on children, and parenting has profound consequences for their future lives, so it is important to persuade parents that engaging in their child's development can make a difference, and to build positively on their existing strengths and actively involve them in decisions.
- Disadvantage is not a block to good parenting but low levels of literacy and numeracy and confidence are obstacles, and self-perception contributes to parents' motivation to change – so it is particularly important to persuade such parents to engage with support services by convincing them that they can bring real and lasting benefits to their children.
- As most parents need support of some kind at some time and effective parenting support does help improve parenting, systematic parenting support should be rolled out across the UK.
- A whole society attitude shift to parenting is needed: parenting should be celebrated as a matter where achieving high standards is in everyone's interest, and it is socially acceptable for everyone to recognise they are able to learn, rather than being seen as a private matter which must not be invaded.

6. Smarter working, better services

“Now is a good time to reflect on the immense efforts made in the last five years to integrate universal and more specialist services for children and young people. We have come a long way and seen massive investment in our schools and early years settings and increased attention paid to preventative services and early intervention. But there is much more to do – we have not yet achieved what we set out to do, to provide a seamless continuum of services from the universal to the specialist, designed and tailored to the needs of the child, rather than professional silos.”

Marion Davis, President, Association of Directors of Children’s Services (ADCS)
Expect the Unexpected, ADCS Presidential Reception, London, 15th April 2010

Background

‘Every Child Matters’ led to the introduction of a new framework for integrated working within children’s services designed to change the way that services are delivered, and to shift the focus so that children’s needs are identified early, assessed and result in appropriate, timely support. The central plank of this agenda was interagency collaboration at all levels of accountability, “Radical reform is needed to break down organisational boundaries” (DfES 2003).⁷¹

Leadership

The quality of leadership will be key in determining both how far there is a shift of emphasis towards early intervention, and how effective it will be. When resources are scarce, and the workforce feels under pressure, there is a tendency to defend (or at least cling to) the *status quo* which can make innovation and change harder to implement; but it is only by doing things differently that better outcomes will be achieved. Many of the examples in this publication describe interventions which bring the greatest benefits to disadvantaged groups, but have significant secondary benefits to society more broadly – not least, financial savings further down the line. Some require changes in work practices, others depend for their success on engaging the community more broadly; all require committed leadership to bring them about, both nationally and locally.

There needs to be clarity of purpose, and a determination to make improvements, *because it’s the right thing to do*. The practice examples described constitute a powerful body of evidence for refocusing the efforts of services towards better identification of vulnerable groups and individuals. And for more effectively engaging them in the process of heading off or reducing problems, rather than just ‘picking up the pieces’ when something has gone seriously wrong – often at considerable cost, both human and financial.

Commissioning

Commissioning is the central function of local areas as it decides how best to use resources in the public interest. Effective commissioning applies evidence of ‘what works’ to improve outcomes for local people and will become increasingly important as budgets are reduced. It provides a robust, credible and objective way of making decisions about the use of scarce public resources so that they have maximum positive impact on the lives of children and

families. Effective commissioning starts with a strategic understanding of how the whole system works and how the total resource is being used. Despite the progress made in recent years, it is still very evident that there are children and families slipping through the system until problems escalate and high cost services are needed. Powerful professional groups, traditional service configuration and weak leadership can all conspire to hinder radical change.

Commissioning has four steps, which for early intervention and prevention means:

1. **Understanding** and persuading people that the system needs to change by using local and national evidence of what works to reduce the need for high cost, last resort services. This evidence should be supplemented by analysis of the costs of different parts of the existing system and remodelling work and tested through stakeholder engagement including the views of children, young people and parents. Commissioners will also need to have fruitful relationships with all local schools and develop a shared agenda on early intervention and prevention. A key to success is understanding that early intervention and prevention require a reorientation of the system at all levels – from governance, leadership and strategy to the behaviour of all frontline practitioners and the way they work with families, using an appreciative approach to the Common Assessment Framework (see below).
2. **Planning** – developing and agreeing strategy and plans for action with stakeholders including service users, service providers (from all sectors) and elected members. The key to success is for the planning process to include agreement of change so that action follows words. Increasingly, commissioners have developed and agreed commissioning standards, which include requirements for all practitioners to work preventatively. They have also developed and agreed a commissioning policy that makes clear their attitude to the provider market, specifications, performance measurement and management, outsourcing and to competition, all with a bias towards what will make prevention easier.
3. **Doing** – having decided how to commission change, whether through behaviour change, system and process change or by changing provider leadership or by outsourcing to a new or existing freestanding service provider, then strategic commissioning teams need to lead and manage change at all levels in the system.
4. **Reviewing** by measuring and managing performance of the system, of groups of children and individuals and the contribution of each service provider and then taking immediate remedial action by working with providers including schools.

Universal services

Universal services and settings – principally schools, children’s centres and primary health care – play critical roles in ensuring children’s needs are identified early. Often they are the places where emerging difficulties can be first spotted, or where children, young people and their families will themselves first ask for help. They are also often the most appropriate setting within which the extra help children need can be delivered. A key finding from a recent report commissioned by the former DCSF was that professionals working in schools and early years settings need better preparation to enable them to identify when children may need extra help or are at risk of harm, and to have the confidence to act on their concerns.⁷²

CAF (Common Assessment Framework)

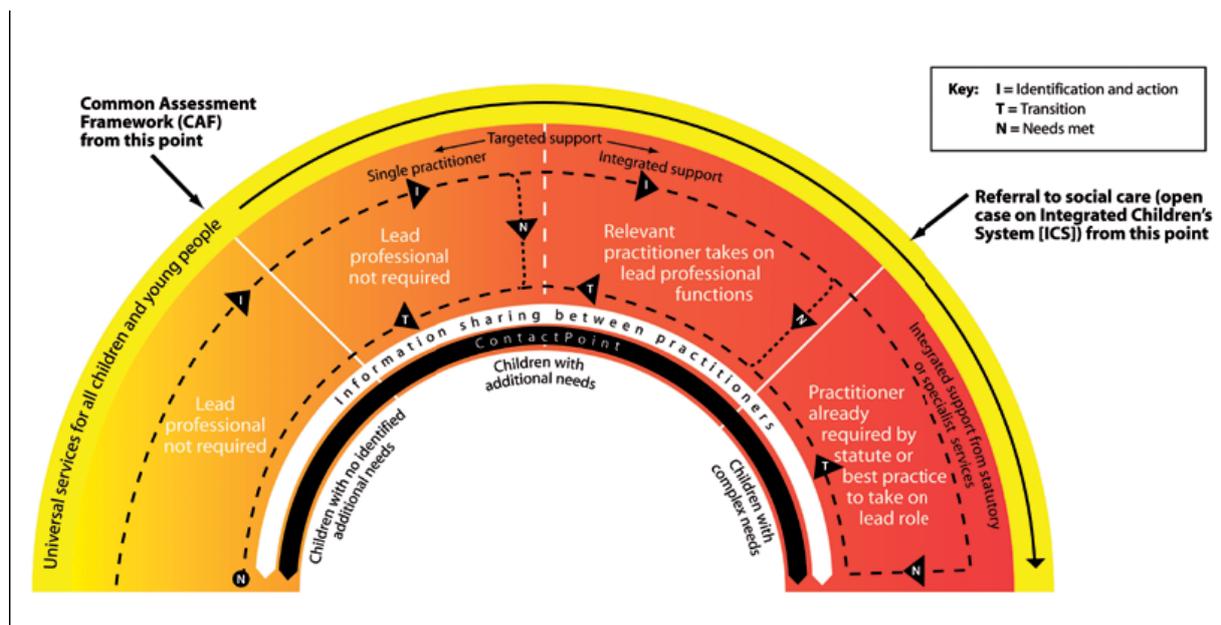
The Lead Professional, Team Around the Child (TAC) and, most notably, the Common Assessment Framework (CAF) are examples of multi disciplinary programmes that require change in the behaviours of all practitioners, crossing professional boundaries and requiring high levels of cooperation and trust between services. The challenge for commissioners now is to mainstream these processes and behaviours, challenging services, where there is insufficient evidence that they improve outcomes.

The CAF is a standardised approach to conducting assessments of children's' and families additional needs, and for developing and agreeing on a process through which agencies work together to meet those needs. It aims to enable early identification of needs, leading to planned and co-ordinated provision of services for children, young people or their families with additional needs. Children and families experience a range of needs at different times in their lives. However, while all children and young people require access to high-quality universal services, some of them also benefit from targeted support to address additional needs which may relate to education, health, social welfare or other areas. An estimated 20-30% of children and young people have additional needs at some point in their lives. This could be for a limited period, or on a longer-term basis. It is this group for whom targeted support within universal settings will be most appropriate.⁷³

A range of research studies, as well as inspection reports, have found that the CAF is being used variably across agencies and localities. The Local Authorities Research Consortium (LARC), involving over 20 local areas and led by NFER (National Foundation for Educational Research), recently found that, "despite the successes of the CAF process in supporting improved outcomes, it was clear, that there were inconsistencies and confusion about the CAF process (namely, the use of the pre-CAF assessment, the information recorded on CAF forms, the format of TAC meetings and/or the role of the lead professional). There is a need, therefore, for national bodies to support local areas to implement and embed the CAF process uniformly and to investigate the long-term impact of the process on outcomes for children, young people and families" (NFER 2010).⁷⁴

Continuum of services

The overall message from the recent research review conducted for the former DCSF (as cited above) was that it is inappropriate to view earlier intervention as an alternative to later intervention, when difficulties have become established. The problems in many, if not most, situations where children have additional needs, are multi-faceted and may persist and be intergenerational. It is unrealistic to believe that they can be easily resolved simply by being identified at an early stage. Many children and families are likely to need continuing support, and interventions at a number of points. Rather than looking upon earlier intervention as an alternative to later intervention, a better model would be a continuum of services that are appropriate at different stages in the life course of problems, with the pertinent issue being to identify the most appropriate intervention to match specific needs at a particular point. Some children and families may need ongoing support, while others may have their needs addressed sufficiently by an 'earlier' intervention to not require later interventions.⁷⁵



The diagram above, often referred to as 'the windscreen', illustrates the continuum of needs and services, and where the CAF and the lead professional role fit. It is expected that the majority of CAFs will be undertaken within universal services. The benefits of providing intervention from an earlier stage in a child or young person's life will, for some, be prevention of the need for longer term involvement with specialist services, while for others it should provide a smoother transition into these services. 'The windscreen' illustrates how a child or young person with additional needs can be supported earlier and, if necessary, through the transition into the more specialist services such as social care and child and adolescent mental health services (CAMHS). It shows that children and young people do not simply go to the right of the windscreen and remain there. It is important to note that there are children and young people who access targeted and specialist services from time to time for support or treatment. However, this may only be for a short period of time before their case is closed or they are discharged from the service. It is important for specialist services to remember that any child or young person should have the relevant support in place when they no longer require their services. This will ensure that the individual can continue to be supported at a low level to prevent any further intervention being required from specialist services.

Multi-disciplinary working

Nurturing and sustaining strong relationships both between agencies and with families themselves are absolutely fundamental to the success or otherwise of integrated working. Indeed, in a comparison of European systems, two themes appeared repeatedly and cross-nationally as the basis for effective integration: working together with other agencies and maintaining a focus on the family as a whole. The interrelationship between the two was noted since a focus on the family as a whole means that a wider network of services is likely to be involved. Professional time was the most important resource, as time was needed to develop effective working relationships with other professionals. The factors that facilitated good inter-disciplinary and inter-agency work point to a professional and managerial culture that values the development of good working relationships both with families and with other professionals.⁷⁶ In his progress report on child protection in England of last year, Lord Laming presented a mixed picture of the quality of multi-agency collaboration, "despite considerable progress in interagency working, often driven by Local Safeguarding Children Boards and multi-agency teams who strive to help children and young people, there remain significant problems in the day-to-day reality of working across organisational boundaries

and cultures, sharing information to protect children and a lack of feedback when professionals raise concerns about a child. Joint working between children's social workers, youth workers, schools, early years, police and health too often depends on the commitment of individual staff and sometimes this happens despite, rather than because of, the organisational arrangements. This must be addressed by senior management in every service" (Laming 2009).⁷⁷

Partnership with families

There is a risk that children's centres, schools and health services marginalise those who are already disadvantaged, because these children or their families are less able or willing to access the provision offered. This needs to be mitigated by effective outreach strategies and finding out what kinds of support and help such families would value and use.⁷⁸ A number of studies have summarised the characteristics of services that parents and children in need of support value and take up. These are services which are easily accessible, have practitioners who are approachable and responsive and are culturally sensitive. They attend to strengths as well as needs and focus on supporting both child and parent.⁷⁹ A review of international approaches to parenting support notes a distinction between parenting programmes and support services with a 'go-structure', whereby the worker goes to the family, and those with a 'come-structure', whereby the parent must *come* to the service. 'Go-structure' approaches were reported to improve access to hard-to-reach populations, as they were able to overcome factors such as parents' inertia, uncertainty, lack of confidence or fear of rejection, which could deter them from accessing services.⁸⁰

A significant body of evidence has built up around the 'Family Partnership Model' developed and pioneered in practice by Professor Hilton Davis of the Centre for Child and Parent Support at King's College London.⁸¹ The basic principle of this model is that services should be based upon the concept of *partnership* with families with the quality of the professional's relationship with the client(s) at the heart of the delivery. However, at the end of its first year, the 'Narrowing the Gap' programme reported that there was more evidence of services feeling confident in listening to children and young people, and in encouraging them to participate, than there was with families and parents. It seems that professionals in all kinds of settings may lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged. It was suggested that professionals, including teachers, should be encouraged to go out more and talk to people – parents especially – because face to face communication is always more effective in building relationships than letters and leaflets. Gaining trust through health services attached to children's centres, for example through family nurse partnerships or targeting intensive health visiting, is a well-known means of building strong relationships with parents when their children are very young.

Earlier in the year, the Children's Workforce Development Council (CWDC) published 'The common core of skills and knowledge'⁸² for the children's workforce that includes working in partnership with children, young people, families and carers. It is based on good communication being central to working with children, young people, families and carers. It helps build trust, and encourages them to seek advice and use services. It is key to establishing and maintaining relationships, and is an active process that involves listening, questioning, understanding and responding. To build a rapport with children, young people, their parents and carers, it is important to be respectful, understanding and honest. People become engaged when relationships are continuous and their lives improve as a result.

Effective local practice

1. Integrated Locality Working, Southend

Aims

From 2004, the children's partnership piloted 'multi-agency clusters', with multi-professional teams working with clusters of schools. The aim was to improve outcomes for children, young people and their families by providing speedier and more effective multi-agency responses, focus support on the whole family and improve joint working relationships between services, schools and agencies.

In January 2007, learning from the 'multi-agency clusters' informed the next stage of development, the aims of which were to: further strengthen early intervention and prevention and to become even sharper at matching provision to the levels of need of children and families; reduce the level of referrals to acute services, particularly children's social care; secure buy-in for a single assessment (CAF) and a single point of contact to enable families to tell their stories once and to enable better matching between assessment of need and multi-agency services provided.

Delivery

To achieve the above aims, a model was developed which focused strongly on shared, multi-agency processes, supported through co-location of staff. The model includes a relatively simple four-staged process of intervention, delivered through three localities. This enables services to target and plan provision to meet the needs of individual children and young people through integrated processes ensuring effective ways of identifying and reducing children and families at increased risk.

The approach to the CAF, within an easy-to-understand and well communicated model, is the most significant factor in making the difference. The CAF is the only assessment tool used in Southend to identify additional needs. In January 2007, all other referral mechanisms were collapsed into the CAF framework, thus making the use of CAF mandatory to access any form of additional support.

All children whose needs cannot be met within their universal setting have a CAF undertaken in partnership with them and their parents/carers, which identifies additional needs and strengths. Young people's views are fundamental to the assessment process; additional supporting tools have been designed to ensure that the voice of the child is heard, regardless of their age and ability. Families agree a lead professional and the assessment identifies the level of support required. Depending upon the level, children and families will either be supported by Stage 2 Team around the Child and Family (TACAF) or Stage 3 Children and Family Panel. The way of working builds upon the family's strengths and aspirations rather than the professional's needs and wishes. TACAF operates as a supportive team; parents and young people have the opportunity to discuss their needs with key practitioners and play an active role in the delivery of support to their family. There is a recognition that support is delivered in partnership with the parents/carers, acknowledging their key role in improving outcomes for their family. If after three months no significant impact on desired outcomes has been achieved, a further discussion will take place with the family, as they may require a more intensive sustained support package via the Children and Family Panel (Stage 3).

Impact

Between 2007 and 2009, the model has led to 29% of cases successfully moving down and 8% moving up (only half of which have needed specialist services) through the staged model of intervention. Over the same period, there have been significant reductions in referrals to social care (and corresponding savings) from 647 to 480 cases.

2. Family Support Model, Warrington

Aims

The aims were to develop a model for integrated working which would show evidence of the impact on outcomes for children, young people and their families, and provide practitioners with clear procedures for integrated working so that the CAF, role of the lead professional and information sharing would become part of day-to-day working practices.

Delivery

The model was developed as a direct result of two pilot studies; the first, in 2004-05, being on information sharing and assessment (ISA), and the second on the CAF. The first pilot involved a multi-agency group of frontline practitioners, and focused on challenges in multi-agency working, using real-life case studies to explore the issues. The group identified a number of barriers, such as a lack of common language. It was evident that these barriers affected the quality of services being delivered, including services being slow to react, resulting in uncoordinated support for those children showing early signs of additional needs.

Findings from the first pilot influenced the second pilot on the CAF which ran in 2005-06. This involved two high schools, a primary school and a children's centre, alongside all partners working within these settings (e.g. health, Connexions). The findings from the pilot were very positive and helped to shape the current family support model.

The model has three distinctive features: assessing a child's level of need before and after multi-agency intervention, thereby creating a baseline to track progress; an 'information hub'; and support to practitioners through the use of Service Allocation Meetings (SAMs). The 'information hub' enables practitioners to request background information from the CAF, social care, education, children's centres and Connexions databases. Between February 2006 and December 2009, there were 3,322 background searches. There is strong buy-in from universal services, with the largest portion (38%) of searches being requested by children's centres.

SAMs are regular meetings where practitioners who have completed a CAF but who are not confident to identify needs or services, can consult a multi-agency panel of professionals. Based on the information in the CAF and the ensuing multi-agency discussion, recommendations are made on how best to support a child or family. No final decision is made until the family is consulted. In addition, each care plan used as part of the model is subject to discussion with parents and children, to ensure the process is working for them.

SAMs are found to be an important resource for practitioners, particularly those working in schools, as they offer regular opportunities to seek advice and guidance from a range of agencies. Over 70% of all CAFs discussed at SAMs come from schools, who are also the largest portion (24%) of lead professionals engaged in Warrington's family support model.

Impact

The model is having a positive impact with more than 50% of children and young people showing a decreasing level of need due to early intervention, which is mirrored by children and families reporting that they feel the model has had a positive impact on their lives.

In 2008-09, 529 families were supported through the model at a total cost of £158,000 and a net cost per family of £6.00 per week.

3. Building Bridges, Family Action

Aims

Inspired by research and in partnership with a number of local areas (Lewisham, Hackney, Southwark, Luton, Newham, Tower Hamlets, Coventry) over the last decade, Family Action has been delivering its 'Building Bridges' service which aims to intervene early in meeting the needs of families where parents have severe and enduring mental health problems.

Children of parents with mental ill-health are twice as likely to experience a childhood psychiatric disorder. Evidence shows that the risk of significant harm to the child resulting from a parent's mental health can be mitigated where the adult is supported to gain insight into their mental health problems, parent positively and prioritise family tasks.

Delivery

The starting point for the service is families' perceptions of their needs and the issues they want to address. It is delivered by professional family support workers (qualified to NVQ Level 3) who, under the supervision of a qualified social worker, make home visits to assist with practical issues as well as provide emotional support; staff are available at times when other services are not, such as night-time, weekends and bank holidays. They aim to help members of the family improve their relationships with each other; to help parents access and coordinate their relationships with other agencies and professionals, and to promote better communication between these agencies about the needs of the whole family: the adult as parent or carer and the separate, related needs of the child.

Activities are wide-ranging: engaging children in the family in an understanding of their parent's/parents' mental health problems; helping a parent manage their child's challenging behaviour which could otherwise increase parental stress; accompanying parents and their children to children's centres so they gain confidence to use these services regularly (this is very important to parents with mental health problems who can feel different and stigmatised and often need to be supported to use universal services).

Impact

An evaluation indicated the service is having significant impact on improving outcomes for vulnerable children and parents. As a result of the support provided, there have been reductions in the number of parents experiencing mental health problems and in turn the need for acute hospitalisation and children being taken into care. Evidence from one health visiting area suggested that the intervention of Building Bridges had contributed to halving the number of vulnerable families on their caseload.

Over the course of one year, 40 families can be supported at a cost of £3,500 per family. Over two years, the estimated savings to: the Department for Education and local authority are £114,400; the Department for Work and Pensions are £158,400; and the NHS are £67,200.

4. Springboard Project, Blackpool

Aims

The aims of the Springboard Project were to improve outcomes for 60 families at a high threshold of need and for the multi-disciplinary team to act as change agents within their own agencies.

Delivery

Initially, a virtual team was established made up of professionals from a wide range of services. In the second year, the project was extended into new locality teams staffed by key workers (who could be drawn from any practice group) and police officers with access to a central team of 'specialists', including education, substance misuse and mental health practitioners. The locality teams work in family homes on a 365-day basis; staff contracts were changed to enable them to meet the needs of families all year round.

The locality teams ensure that each family has a family assessment, based on looking at each individual's needs and building on the strengths of the family; a key worker to coordinate services and be the main point of contact for the family and the professionals working with them; and access to a commissioning budget to enable things to be done differently.

It is important to note that Springboard did not develop and operate on its own, but was part of a wider effort to promote better collaboration at all stages of the family work process. Thus in August 2006 the 'budget holding lead professional' pilot project was initiated, which assisted the development of the CAF and the TAC model. In 2007, the parenting team was established offering intensive parenting input to families which were experiencing difficulty. This is accomplished through the Positive Parenting Programme and Webster Stratton programmes (see chapter 5). Training on helping parents to develop their parenting skills is now being offered to a wider staff group for which parenting is not normally a core part of the service.

Impact

An evaluation by Salford University indicated that the project has resulted in significant improvements for the children and families concerned since it was first introduced, including major reductions in recorded domestic violence incidents (74%), children placed in care (88%) and family involvement with services concerned with child protection (80%). Long term savings for services have been identified. Due to the success of the project, the decision has been taken to mainstream this approach and it is currently being rolled out across Blackpool.

5. Targeted Family Support, Exeter/Action for Children

Aims

Action for Children's Intensive Family Support project aims to improve outcomes for vulnerable children and families through a continuum of services embedded in a universal service. The Exeter project was established as an exemplar of this approach.

Delivery

The project is based on two children's centres and offers a wide menu of universal and targeted services alongside intensive case work provided by the project social workers. This

range means staff can work to ensure families are offered, and take up. Access to services at different tiers of need. The team is led by a qualified social worker, and all staff have received extensive training, including in the Webster Stratton Incredible Years approach (see chapter 5), and the family workers team have also had training in attachment/bonding.

There is a service level agreement with the local authority's children's department enabling the centres to deal with referrals from the local authority in relation to children in need, looked after children and child protection. However, the universal nature of the project means that there is flexibility for the staff to construct service packages across the span of universal and targeted provision, in line with the needs of the whole family. For example, parents who might be finding their parenting role particularly challenging, or where there were safeguarding concerns identified, could be bridged into the universal parenting groups, in addition to receiving a tailored case work response. The resulting diversity of parent group membership was achieved without any apparent evidence of a sense of stigma for anyone. Group members interviewed as part of an independent evaluation characterised their parenting capacity in very similar terms.

The emphasis of the project is on bridging families into universal services, if they had previously *only* been in receipt of a targeted service. The converse is also true, in that staff are alert to the potential change(s) in the circumstances of a child or family. A striking feature of practice in the project is that the groups are open to and used by a range of families, including those with very complex needs and those with low level additional needs.

Impact

An independent evaluation found that families using the centres had a high level of need upon entry to the service, which, following support, had led to positive outcomes for them.

6. Family Intervention Projects

Family Intervention Projects (FIPs) provide intensive support to families with multiple social, economic, health and behaviour problems. Intervening early alongside services working more efficiently with vulnerable families is central to the Government's commitment to unlock social mobility and tackle child poverty, which contributes to the Coalition Government's commitment to investigate a new approach to support families with multiple needs. Recently published official statistics,⁸³ covering services in England up to March 2010, indicate that FIPs have been broadly successful in effectively engaging and improving outcomes for these families and the wider community:

- 4,870 families received an intervention up to 31 March 2010 and 3,518 between 1 April 2009 and 31 March 2010 (a measure of service capacity).
- 93% of families were either still receiving a family intervention on 31 March 2010 or had exited for a successful reason between 1 April 2009 and 31 March 2010 (a measure of service effectiveness).
- A total of 914 families exited the intervention between 1 April 2009 and 31 March 2010. 51 families were excluded from the analysis because they provided both positive and negative reasons. Of the remaining 863 families:
 - 79% (678 families) left for a successful reason (e.g. formal sanctions had been lifted)
 - 11% (95 families) left for a reason that cannot be counted as a success or a failure (e.g. family moved away, child taken in care)

- 10% (90 families) left for an unsuccessful reason (i.e. the family refused to engage).
- For each of the four 'domains' that were identified between 2-4 key relevant measures of family outcome were combined and a percentage reduction in risk calculated against each outcome (measures of service outcomes). There was, on average, a:
 - 47% reduction in the number of families experiencing risks associated with poor family functioning, including poor parenting, marriage, relationship & family breakdown, domestic violence or child protection issues
 - 47% reduction in the number of families involved in anti-social behaviour and crime
 - 34% reduction in the number of families with health issues including mental or physical health and drug or alcohol problems
 - 34% reduction in the number of families with education and employment issues.

The effective local practice examples below illustrate how to overcome some of the inherent difficulties in interagency working and develop successful partnerships with families.

Conclusion

Energetic and visionary leadership, combined with effective joint commissioning, is critical in shifting emphasis towards early intervention, and delivering effective whole system change. There needs to be a clarity of purpose, and a determination to make improvements, *because it's the right thing to do*. Moreover, staff in all settings need to have an increased understanding of the principles of early intervention, of how they can identify early difficulties, of how they should respond, and of the role of others.

Evidence from a variety of sources – in particular Lord Laming and NFER – and comment from the ADCS President have reached the same conclusion: considerable progress has been made in interagency working, but there is much more to do. The need for a continuum of services is not in dispute, as, even with early identification, many children and families are likely to need continuing support and interventions at various stages in the life course of their situations. However, while there is a consensus on the model for best supporting children and families, some areas seem to be struggling to make it a reality for those which it is designed to serve.

The effective local practice examples featured in this chapter offer some pointers for overcoming barriers to working across organisational boundaries and cultures. First and foremost, they all embraced a key message from the literature: they invested time to build trust and strong relationships. It is no coincidence that the first two examples succeeded in developing an effective model for interagency working on the back of pilot projects with practitioner involvement and a mandate to reality check the task ahead, which, in the Warrington example, involved real-life case studies. Schools and children's centres, moreover, were central to the pilots, as well as the work that flowed from them. Indeed, evidence from the effective local practice contained not just in this chapter but the whole of this practice guide strongly suggests that children's centres in particular lie at the 'hub' of a continuum of support. This brings with it the added benefit of removing a sense of stigma for vulnerable children and families, as in the case of the Building Bridges project and targeted family support project in Exeter, both run by the third sector in collaboration with local statutory agencies.

The inability to invest the time needed to build trust, relationships and effective interagency working, and, ultimately, to secure buy-in, may go some way to explaining the inconsistencies and confusion encountered in the use of tools to promote interagency working, notably the CAF. Another reason is that CAF has not yet developed into *the* standardised tool for conducting assessments for children's' or families additional needs, and for developing and agreeing on a process through which agencies work together to meet those needs. Thus the approach developed by Southend is instructive, as it made the CAF the only assessment tool used to identify additional needs; all other such tools were collapsed into the CAF, thus making the use of CAF mandatory to access any form of additional support. Not surprisingly, therefore, Southend cited its approach to the CAF, within an easy-to-understand and well communicated model, as the most significant factor in making the difference.

The challenges posed by interagency working represent only one side of the coin; the other side is working with parents and families. Research has shown that the interpersonal qualities of the practitioner are the strongest determinant of whether or not people engage with interventions. It is suggested, therefore, that services should be based upon the concept of *partnership* with families with the quality of the professional's relationship with the client(s) at the heart of the delivery. There is also evidence that professionals in all kinds of settings may lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged. 'The common core of skills and knowledge', which includes working in partnership with children, young people, families and carers, updated by the CWDC earlier in the year, is timely and provides a firm foundation for addressing this key area for development. Having common skills across the workforce is important to effective delivery, but it is also important to cost-effective delivery, since without this there is risk of duplication or even conflicting interventions.

Developing a collaborative approach that integrates the views and strengths of parents and families, rather than imposing solutions, was a common characteristic of all five effective practice examples featured in this chapter and of the FIPs (Family Intervention Projects). Two of these – Building Bridges and the Springboard Project in Blackpool (now mainstreamed due to its success) – centred on visiting families in their homes and being available at times when other services are not: night-time, weekends and bank holidays. In the case of Blackpool, this involved changing staff contracts so that the needs of families could be met 365 days of the year.

Key messages

- When resources are scarce, and the workforce feels under pressure, there is a tendency to defend (or at least cling to) the *status quo* which can make innovation and change harder to implement; but it is only by doing things differently that better outcomes will be achieved. Energetic and visionary leadership, combined with effective joint commissioning, is therefore critical in delivering whole system change.
- Effective commissioning applies evidence of what works to improve outcomes for local people and will become increasingly important as budgets are constrained. It provides a robust, credible and objective way of making decisions about the use of scarce public resources so that they have maximum positive impact on the lives of children and families.
- As some children and families need ongoing support, while others may have their needs met sufficiently by an 'earlier' intervention to prevent later interventions, a continuum of services is needed to identify the most appropriate intervention to match specific needs at a particular point.
- Considerable progress has been made in inter-agency working, but there is still much more to do. Key characteristics of effective integrated working that need to be in place everywhere include having a shared vision, clear understanding of needs and identification of gaps, sharp focus on improving outcomes for children, young people and families, clear and consistent messages communicated to staff and families, and an underpinning integrated workforce development strategy. Time needs to be invested to build trust, strong relationships and, ultimately, to secure buy-in from all agencies.
- To overcome the inconsistencies and confusion about the CAF (Common Assessment Framework) process, it should be developed into *the* standardised tool for conducting assessments for children's additional needs, and for developing and agreeing on a process through which agencies work together to meet those needs.
- Evidence suggests that professionals in all kinds of settings may lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged. Continuing investment in developing workforce skills and capacity is essential to effectively engage with parents.

7. Knowledge is power

“Knowledge is power – power to do good – but only if you share it...In the past I would contend, too much of what passed for evaluation of any particular process or project was often not much more than a measurement of quantity – how many young people were signed up for this or that particular scheme, for instance – rather than a thoughtful analysis of what each individual may or may not have gained from the project. Did it have a life-changing impact for them? How did it improve their life chances?”

“So we have to be smarter, we have to think about how children have actually benefited (or not) from our policies and investment; about the timeliness of interventions, and whether departments and agencies have done as much cross-cutting work as they can. In the coming years, all of our interventions must be targeted on the people who will benefit most, and provided in the way that will help them best. So I am really switched on to good practice. Where is it? And how do we learn from it? How do we discover the best models for public services in times like these?”

Tim Loughton

Parliamentary Under-Secretary of State for Children and Families

Speech to C4EO ‘Excellence and Evidence – Making the Difference’ Conference
29th June 2010

Background

Ensuring that reliable and relevant evidence is used systematically to design, develop, implement, evaluate, cost, commission and decommission early interventions is vitally important, particularly in the current economic climate. We can learn much from international experience. In short, if we cannot provide evidence to show that an intervention is having a positive impact, how can we justify funding it? This seems to be a systemic weakness, since as recently as 2008 the ‘Narrowing the Gap’ programme pulled no punches on the use of data, “Unfortunately, the programme suggests there are sometimes difficulties or deficits at every stage of the process...first, the right data is not always available, and when it is it can’t always be accessed in a timely fashion. Nor is it always sufficiently reliable or presented in a way that makes it easy to use...Second, the programme found that sufficient analytical capacity isn’t always present within children’s services” (*Narrowing the Gap* 2006). It went on to suggest that steps are needed to raise awareness in children’s services about how to gather and use data to inform their work, and about the benefits of having analytical expertise on hand to help with this.

These weaknesses are echoed in the lessons drawn from the C4EO validation process used to assess the submissions for effective local practice in early intervention.

Those interventions which are judged to be effective practice by C4EO tend to use evidence as an integral part of the process and seem to perceive it as an aid to innovation. First, there is clarity of purpose through clearly stated aims, namely, stating precisely what the interventions are seeking to achieve. The interventions are informed by a comprehensive

evidence base, from local, national and even international sources. In parallel, there is a clear analysis of local needs, including feedback from children, families and practitioners. The most successful interventions tended to undertake a developmental stage, through piloting the approach and making adjustments in light of this early experience. Critically, efforts are made to establish a baseline: the point at which the intervention was first implemented. This enabled the intervention to be tracked at key stages following its implementation to measure impact on outcomes and whether it was delivering its stated aims. There is also evidence of feedback from children, young people and families.

Action for Children and the New Economics Foundation have produced a helpful practice guide⁸⁴ to commissioning that addresses some of the issues highlighted above. It can be used alongside the nine-step commissioning framework⁸⁵ and other resources available as part of the Commissioning Support Programme.⁸⁶ Action for Children and the New Economics Foundation argue that universal and targeted services have a better chance of preventing problems from occurring in children's lives if they are supported by commissioning decisions that are made with longer-term improvements to children's outcomes and wider social benefits in mind. In light of the current recession and predicted public sector spending cuts, it is more important than ever to commission services that provide value for money. Published in tandem with *Backing the Future*,⁸⁷ the guide is designed to illustrate how the call for governments to back the services that make a difference to children's lives can be supported by improvements to commissioning practices. The parameters that are set when services are commissioned determine the scope a provider has to design services that will have a significant impact on children's lives and a lasting impact on the communities in which they live.

It is common for the rhetoric around commissioning to be focused on 'outcomes' while in practice there is still more of a focus on 'outputs' in tender documents. This is in large part encouraged by national measurement frameworks, such as National Indicator Sets, which, on balance, contain more output indicators than outcome indicators. A careful distinction between outcomes and output indicators is important, because measuring 'success' on the basis of outputs alone can be misleading. 'Turning the Curve' is a toolkit based on the concept of outcome-based accountability (OBA).⁸⁸ OBA is a conceptual approach to planning services and assessing their performance that focuses attention on the results – or outcomes – that the services are intended to achieve. It takes a number of years to achieve some outcomes. In measuring the effectiveness of an intervention it may, therefore, be more appropriate to measure intermediate outcomes or the distance travelled towards an outcome.

Successful programmes

A number of research institutes have reviewed the evidence about the results from a vast array of programmes, which can help to inform policy-makers in deciding which programmes to select. For example, in a review⁸⁹ of 800 violence prevention and early intervention programmes, the Center for the Study and Prevention of Violence at the University of Colorado identified just 11 'Blueprint' programmes, which meet high standards of effectiveness. These 11 programmes include Multi-Systemic Therapy (see Islington example below and chapter 8), Nurse Family Partnership (see chapters 3 and 8) and The Incredible Years (see chapters 5 and 8), which are being tried out in this country in different local areas.

Common characteristics of successful programmes

Research by the Washington State Institute for Public Policy⁹⁰ suggests that the most successful programmes tend to share some common characteristics:

- **They target specific populations.** For example, the Family Nurse Partnership programme targets low-income, first-time single mothers and has been shown to be effective. Trials of the programme in the USA with lower need populations have shown the benefits are less.
- **They are intensive.** Programmes with strong impacts on child welfare outcomes tend to provide intensive services, meaning a high number of service hours, often coupled with a requirement for a high level of engagement from participants. For example, the Homebuilders® model of intensive family preservation services provides 24-hour staff availability to families in crisis, small staff caseloads, home-based counselling and services, and short programme duration (four to six weeks) with a high number of service hours.
- **They focus on behaviour.** Effective programmes are likely to take a behavioural approach (as opposed to an instructional approach), such as coaching parents one-on-one during play sessions with their children.
- **They include both parents and children.** Many successful programmes take an approach that acknowledges the central role of the parent-child relationship in child outcomes.
- **They stay faithful to the programme.** Some successful programmes have demonstrated the importance of maintaining adherence to the programme model. When looser criteria have been applied the results have not been so good or may even make matters worse.

Evaluation Checklist, Harvard

The Center on the Developing Child at Harvard University (see chapter 3) has produced a guide to help prepare decision-makers to be better consumers of evaluation information, which is summarised below. It is organised around *five key questions* that address both the substance and the practical use of rigorous evaluation research.

1. Is the evaluation design strong enough to produce trustworthy evidence?

Evaluations that randomly assign children to either receive programme services or to a no-treatment comparison group provide the most compelling evidence of a programme's likely effects. Other approaches can also yield strong evidence, provided they are done well.

2. What programme services were actually received by participating children and families and comparison groups?

Programme designers often wish to see a model set of services, but children or families who are enrolled in 'real' programmes rarely have perfect attendance records and the quality of the services received rarely lives up to their designers' hopes. Knowing the reality of programme delivery 'on the ground' is vital for interpreting evaluation results. At the same time, sometimes a comparison group is able to access services in their community that are similar to those provided as part of the intervention. If so, then differences between the services provided to the programme and contrast groups may be smaller than would exist in a community where those services are not available.

3. How much impact did the programme have?

The difference between the outcomes for children and/or families who received services versus those of the comparison group are often expressed as 'effect sizes'.

4. Do the programme's benefits exceed its costs?

A key 'bottom line' issue for any intervention is whether the benefits it generates exceed the full costs of running the programme. This covers how costs and benefits are determined and what they mean for a programme that is being considered for implementation.

5. How similar are the programmes, children and families in the study to those in your constituency or community?

Programme evaluations have been conducted in virtually every state and with children of diverse ethnicities and socioeconomic backgrounds. Knowing how the characteristics and experiences of comparison-group children compare to the characteristics and experiences of children in your own constituency or community is important for determining the relevance of any evaluation findings.

Cost effectiveness

As indicated by the evaluation checklist developed by Harvard, establishing whether an intervention is cost effective is an important factor (see chapter 8). The OECD⁹¹ suggests that expenditure on children should be regarded as if it were an *investment portfolio*, subjected to a continuous iterative process of evaluation, reallocation and further evaluation to ensure child well-being is actually improved. In general, effective early interventions are strongly advocated as cost effective in the long run given their potential to avoid a range of social problems later on⁹²; to decrease the chance of needs "escalating to the next level" (Regional Centres of Excellence, 2008⁹³); and to reduce "failure demand" when a problem isn't resolved and "bounces back" (Bartlett, 2009⁹⁴). However, the literature concludes that the effects and/or savings take time to filter through the system, given the time lag between early childhood and adolescence^{95 96}. There is also a general lack of studies and no agreed methodology to calculate potential financial savings from preventative services.⁹⁷ As a result, the literature finds that it is difficult to produce evidence to convince commissioners.

C4EO has developed a model to help assess the cost of effective interventions at a time of reducing resources. A new Microsoft excel based template is now available to help local authorities: <http://www.c4eo.org.uk/costeffectiveness/default.aspx>

Effective international practice

1. Alberta Initiative for School Improvement (AIS), Canada

AIS is a bold approach to supporting the improvement of student learning and performance by encouraging teachers, parents, and the community to work collaboratively to introduce innovative and creative initiatives based upon local needs and circumstances. Teachers are given considerable scope to conduct research projects on issues relevant to their individual schools and districts.

Aim

The aim of AISI is to improve student learning through initiatives that enhance student engagement and performance and reflect the unique needs and circumstances of each school authority.

Delivery

All projects (over 1,700 to date) report their progress online to parents and fellow professionals. As part of the initiative, professionals also make links with projects across the state researching similar issues in a drive to help ensure findings are shared and disseminated.

Two areas of focus for research projects have been assessment for learning and student-led enquiry – professionals working in these areas have come together to share their project findings and best practice and are now leading the discussion on how to improve practice across schools through an online forum and professional events.

Support is provided to school authorities, through working directly with local AISI coordinators to meet project requirements and to continually improve upon their projects. The AISI website - <http://www.education.alberta.ca/aisi> - is a one-stop shop for all information about AISI. The contents include background information; a clearinghouse of AISI projects and promising practices; and supporting documents for planning and implementing AISI projects.

Annual report

AISI projects require an annual report. The final annual report includes a summative evaluation for all the years that the project was funded. The annual report includes:

- Results achieved in relation to baseline and targets for quantitative and qualitative measures.
- Description of evidence of success achieved or description of quality measures.
- Actual expenditures and expense percentages in relation to the original budget estimates.
- Responses to open-ended questions. The open-ended questions for the final (summative) report focused on the following areas:
 - student learning outcomes achieved
 - other project goals achieved
 - lessons learned
 - effective practices (including parental involvement) that demonstrated the greatest impact on student learning and educational practices
 - sustainability and integration
 - summary statement of project results including conclusions and implications for continued improvement in student learning.

Data analysis

Four analyses are performed on project data to determine success:

1. Results that met or exceeded annual **targets**.
2. Results that improved over the **baseline**.
3. Magnitude of improvement through **effect size analysis**.
4. Relative effects of various project categories through **meta-analysis**.

Impact

Independent research has shown statistically significant improvements in student performance across socioeconomic groups, arising specifically from these projects on collaborative discipline-based enquiry along with assessment for learning.

Effective local practice

1. Evaluation of Parenting Programme, Southwark

Aims

Empowering Parents, Empowering Communities (EPEC) aims to improve the parenting and the mental health of children outcomes in Southwark through courses run by trained parent volunteers. It is being evaluated by the Institute of Psychiatry using a multi-centre randomised controlled trial (RCT) and an observational matched cohort control study, and the evaluation is on the International Standard Randomised Controlled Trial register⁹⁸ (a widely-used registration system, with links to the World Health Organisation international trials search programme).

Delivery

The research is guided by three hypotheses, which underlie the aims of the programme: that parents attending EPEC groups will report greater reductions in children's problems compared with those in control groups; that they will report less stress and greater confidence in their own parenting skills by the end of the intervention compared with the controls; and that they will rate the peer-led groups as being acceptable in teaching them about positive parenting skills. Half of the parents in the RCT arm of the study take part in the intervention (i.e. attend the EPEC programme) immediately (the intervention group); the other half do so after about 10 weeks (the control group). Parents in the matched control cohort may or may not take part in the EPEC programme (depending on their willingness), and are recruited through advertisement (they must not be receiving any other parenting support). All the parents are asked to complete questionnaires at the beginning and end of an 8-week period. The target number of evaluation participants is 80 in the RCT arm (40 in each group) and 160 in the observational arm.

The programme is open to parents in Southwark who are experiencing difficulties in managing the behaviour of a child aged between 2 and 11. They must be able to read and write English, to commit to attending the weekly EPEC groups and must be living with the child (who must have no significant developmental delays). The programme ("Being a parent") comprises eight two-hour sessions delivered over consecutive weeks in local schools and community centres by pairs of peer facilitators, who are recruited from local communities and reflect the ethnic diversity of parents attending the groups. Each group

includes 6-12 parents, who are given handouts which summarise the weekly session content and corresponding homework activities.

Impact

The child outcomes (parent reported) are measured in three ways: the Strengths and Difficulties Questionnaire, 25 items under five scales – emotional problems, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour (caring for others); the Eyberg Child Behaviour Inventory, a 36-item scale measuring problem behaviours and their frequency; and the Concerns about My Child Questionnaire, parental identification and assessment of their child's problem behaviours. The parent outcomes (self-reported) are measured by the Parenting Stress Index, 36 items under three scales – parental distress, difficult child and parent-child dysfunction; the Arnold-O'Leary Parenting Scale, a 30-item measure of parenting competencies; and a modified version of the Training Acceptability Rating Scale to assess the value to parents of the EPEC training.

The evaluation is taking place from January 2010 to June 2011. Although still early days, with no formally published results yet, an article about the EPEC programme in *The Guardian*⁹⁹ included some promising preliminary figures from the evaluation.

2. Adolescent Multi-Agency Support Service (AMASS), Islington

Aims

Following a successful pilot that was characterised by a very high investment in evaluation, Islington developed an Adolescent Multi-Agency Support Service (AMASS) to support families to enable young people aged 10-16 to remain at home or in foster placement, and to improve outcomes for young people.

Delivery

Islington historically had a high number of looked after children, with many being placed out of borough away from their local community. An external audit highlighted that many had major behavioural difficulties in the home, school and community which parents and professionals were struggling to manage prior to entry into care.

AMASS was launched in 2007, using approaches from Multi Systemic Therapy (MST), an American intervention designed to help adolescents seen to be at risk of offending (see chapter 8 for a detailed description). However, the Islington service diverges in several ways from MST, most distinctly in its joint delivered intervention with social workers, and the co-located wraparound multi-agency team that supports the family. AMASS delivers a six-month, high intensity parent/carer empowerment intervention with assertive outreach to the young person around education and positive activity. Of the young people in the programme, 23% had statements of special educational need, almost all had previously been referred to CAMHS, four had been referred for inpatient treatment and two had been sectioned under the Mental Health Act.

Impact

The University of Bedfordshire was commissioned to undertake an evaluation¹⁰⁰ of the work of AMASS; there has also been continual internal evaluation. The majority of primary outcomes are measured through data sharing with partner agencies; secondary and tertiary outcomes are measured through interviews with parents/carers before and after intervention. An extended cost offset analysis is being conducted to consider the impact of AMASS and avoidance of care placements.

The University of Bedfordshire report summarised, “AMASS is a high quality service, dealing with a very challenging group of young people...The qualitative and quantitative data provided strong indications that it was succeeding in reducing the use of care and improving family functioning for many of the families worked with” (Brodie et al, 2009, p 4).

Results so far have shown many positive outcomes. Between June 2007 and June 2010, AMASS worked with 66 families. Of these, 35 completed all phases of the intervention, 17 are still in the programme and the service was withdrawn from 14 for various reasons. Of the 35 completed cases, 28 were home stability packages. After one year, 26 remained at home; after three years, 21 remained at home or within family. Of six fostering stability packages, four remained stable after one year; after three years, three of the six remained stable.

71% of the young people were still engaged in some form of education one year on from the start of an intervention, and only 14% have been subject to exclusion following the end of intervention (43% before).

Over a one-year period, the number of young people entering care fell from 38 to 14, a reduction of 63%. The University of Bedfordshire estimates that each £1 invested in the service produces a saving to the residential care system of £1.46, with reduced future costs the saving per £1 invested is estimated at £1.80. In 2009/10, 38 families were supported at a cost of £780,000, equating to £20,526 per family. Estimated savings to the local authority over 1 year are around £372,188 through preventing young people entering care, with savings set to increase to £522,000 as the cost of the service reduces. A revised staffing model is to be implemented in 2010/11 to achieve the full savings identified by the University of Bedfordshire.

3. Using data to make a difference to young children’s outcomes, Southwark

Aim

Southwark Transition and Assessment Record (STAR) is a universal assessment and record keeping system. It builds on work previously done with reception classes (‘Making a big difference’), and focuses on developing the use of data in settings to inform strategic planning. It was introduced through targeted and time-limited support from early years consultants in selected ‘lead’ schools and settings in each locality in Southwark, from which practice is extended through mentoring and buddy networking.

Delivery

New materials were piloted to support the learning and development requirements of the Early Years Foundation Stage (EYFS), and schools in each locality were identified for intensive support in their introduction; interrogation of the 2007 Foundation Stage Profile data identified 12 schools with more than 20% of children scoring in the lowest 20% range, and a higher proportion scoring below the threshold. Headteachers and senior managers were engaged to support the approach, which involved analysis and review of qualitative and quantitative data, with support for practitioners from early years consultants. Continuing professional development (CPD) needs and resources were identified, and staff were helped to use data to identify the most vulnerable children, and agree new tasks for each term to improve quality and outcomes. The consultants used specific, detailed guidance on how to interrogate and contextualise the data, and work centred on three key questions: What does your data analysis tell you about how well children are learning and achieving? What do the data and monitoring evidence tell you about improvement priorities for 2008-09? What does data tell you about any additional team development and provision requirements for 2008-09?

The Head of Early Learning and Achievement made monitoring visits to the 12 schools, school improvement partners carried out close monitoring and reviews with early years colleagues, and data reviews were held each term with the EYFS Regional Advisor from National Strategies.

This one year period of intensive support has led to schools now having common assessment materials to support the statutory requirements of the EYFS Profile, which provide a consistent approach to formative and summative assessment and influence planning and practice. The new materials support how Southwark Council collects and analyses data, and the system determines how support and advice is offered at management level in schools, and informs strategic planning – with data analysis becoming an integral part of new initiatives to improve outcomes. A different set of schools received intensive support the following year.

Impact

Outcomes in one school, written up as a case study, improved particularly dramatically: for example, emotional development results rose from 11% to 93%, language for communications and thinking from 30% to 86% and numbers as labels for counting from 70% to 95%. But the project's success was apparent across the borough, with improvements ranging from 5% to 50%. The work was repeated in 2008-09 in a further 14 schools and results again improved; Southwark's overall results improved by 9% from 2007 to 2009.

Conclusion

Having the capacity to marshal and use evidence to inform all stages of implementing interventions is vitally important, especially in the current economic climate. How else can we discern whether an intervention is having a positive impact or not? The evidence, including from the C4EO validation process itself, points to a systemic weakness in the use of data. It is in this area that we have most to learn from international experience, as is evident from all the international case studies featured in this publication. Typically, they involve randomised controlled trials (RCTs) to test the difference between the outcomes for children and/or families who received services versus those of the comparison group who did not. While it needs to be acknowledged that the application of RCTs is not appropriate to certain interventions, for example on ethical grounds, there is considerable scope to extend their use to interventions in this country. Not only do they help gauge the effectiveness of an intervention but they also help to shed light on its cost effectiveness. Therefore the inclusion in this chapter of a multi-centre RCT of the 'Empowering Parents, Empowering Communities' programme in Southwark is timely.

Sufficient analytical capacity within children's services needs to be addressed as a workforce development priority (both nationally and locally), not least because it calls into question the value for money of the very interventions aimed to support children and families, particularly the most vulnerable. Such a response could consider the powerful 'bottom-up' model successfully pioneered in Alberta, Canada in relation to school improvement and pupil performance, whereby teachers are provided with support and advice and encouraged to conduct research projects on issues relevant to their school, and share and disseminate the findings online with other teachers *and families*. If applied to England and beyond schools, this could trigger a quantum leap in empowering practitioners and help to mobilise families to take greater responsibility for their own well-being on an unprecedented scale. Knowledge of 'what works' would be easily accessible to every citizen, through the power and popularity of the internet and social networking sites, rather than being a repository for a select few. This

offers the potential for the most vulnerable and disenfranchised in society to be transformed from passive recipients of largely state intervention to informed and engaged citizens.

Key messages

- Evidence suggests that the use of data is a systemic weakness. In short, if we cannot provide evidence to show that an intervention is having a positive impact, how can we justify funding it? Evidence should be used as an integral part of the process and as an aid to innovation. We can learn much from international experience in this area.
- International research suggests that the most successful programmes tend to share common characteristics: they target specific populations; they are intensive; they focus on behaviour; they include both parents and children; and they stay faithful to the programme.
- Effective local practice is characterised by clarity of purpose; interventions are informed by a comprehensive evidence base; there is a clear analysis of local needs, including feedback from children, families and practitioners; and, critically, there is a baseline to enable the intervention to be tracked at key stages following its implementation to measure impact on outcomes.
- Sufficient analytical capacity within children's services needs to be addressed as a workforce development priority (both nationally and locally).

8. Where is it best to invest?

“Although there is a temptation to cut back on investment in early intervention in tough financial periods, the experience of countries like Finland in the 1990s suggests that governments often regret, with hindsight, the long-term costs of making such short-term savings. The challenge being grappled with in the best systems around the world is not, therefore, deciding whether to maintain spending on prevention, but working out how to get better value out of the money already being invested.”

Power in People's Hands: Learning from the World's Best Public Services
Cabinet Office, July 2009

Background

This relatively short, final chapter pinpoints those areas which the evidence from the earlier chapters suggests are having the greatest impact on improving the lives of children, families and communities, especially the most disadvantaged, and, over time, saving money as a result of fewer costlier interventions further down the line. The aim is to assist policy-makers in deciding where to allocate scarce resources and thereby achieve better value for money. It should be recognised that some of these priority areas interlock, for example breastfeeding can be a distinct area in its own right (as in the case of the Blackpool initiative) or it can be subsumed into a wider approach (as in the case of the Nurse Family Partnership). Similarly, children's centres work across a range of areas, some of which may also be distinct in their own right, for example support for speech, language and communication needs. Thus the priority areas highlighted below can be configured according to different combinations.

In its recent first-ever report¹⁰¹ on child well-being in its 30 member countries, the OECD shows that average public spending by OECD countries up to age six accounts for only a quarter (24%) of all child spending, rising to 36% during the middle third and rising again to nearly 41% during the last third. Nobel Prize winning economist Professor James Heckman of the University of Chicago proposes a developmental model of investment during childhood that shifts this pattern of spending: investment in children should be most intensive during early childhood and should taper off as children age. Heckman's model is based on compelling evidence from a range of disciplines, the essence of which has been summarised in chapter 3. Taking up this theme, the OECD notes that, “country spending profiles examined are not consistent with the theory and evidence on child well-being. In contrast, there is little or no obvious rationale for why so many governments place the weight of their spending during the period of late childhood” (OECD 2009).¹⁰² Consequently, the OECD argues that spending on young children is more likely to generate positive changes and, indeed, is likely to be fairer for more disadvantaged children. It also notes that, “The UK stands out as increasing early investment in recent years, but reinforcement of this trend for disadvantaged older children is also needed” (OECD 2009).¹⁰³

In general, targeted approaches tend to be judged more cost effective than universal approaches; and there is some evidence that within targeted programmes, such as the Nurse Family Partnership and the Incredible Years parenting programme (both featured below), cost effectiveness is likely to be greater for the individuals with higher levels of need. As Statham and Smith¹⁰⁴ point out, an intervention targeted on specific ‘at risk’ individuals,

such as the Family Nurse Partnership, costs relatively little (£30 million was allocated to develop the scheme over three years in 20 sites).

Each of the five main chapters in this practice guide is now revisited in the same order as they appear in the body of this guide. Drawing on research findings and effective international, national and local practice, including, where available, information on costs of effective interventions at project level, it is suggested that spending in the specific areas below warrants priority. Three of the recommended interventions – Nurse Family Partnership, Incredible Years and Multi-Systemic Therapy – are among the 11 ‘Blueprint’ programmes identified by the Center for the Study and Prevention of Violence at the University of Colorado to meet high standards of effectiveness, as part of a review of 800 early intervention programmes.¹⁰⁵

The best start in life

Priority area 1: Children’s centres and early years

As the effective practice examples show, children’s centres lie at the ‘hub’ of a continuum of support: often where emerging difficulties can be first spotted, or where children, young people and their families will themselves first ask for help, and often the most appropriate setting within which the extra help children need can be sourced and delivered. The prevalence of children’s centres is illustrated by the fact that they feature extensively throughout this practice guide. And the most effective practice examples from both home and abroad, together with key research findings, strongly indicate that **outreach** is an essential factor in ensuring that interventions target and support the most vulnerable in the community.

The following examples appear to be most effective and provide financial returns for the efficient investments.

Breastfeeding Initiatives

As noted in chapter 3, the significant benefits of breastfeeding have been clearly illustrated. Yet breastfeeding rates in England are among the lowest in Europe. This was the focus of the effective practice example in Blackpool where 903 young mothers from disadvantaged areas were helped to adopt breastfeeding throughout 12 children’s centres. This partnership between the PCT and children’s centres led to a 16% increase in Blackpool’s breastfeeding rates over a three-year period at a cost of £29,811 or £33 per mother per year. This indicates a social return on investment of £1.56 for every £1 invested, with estimated savings to the Department of Health of £57,500 over a two-year period.

Nurse Family Partnership (NFP)

Developed in the USA, the NFP programme provides intensive visitation by nurses to low-income, at-risk young women bearing their first child; the nurses continue to visit the home for two years after birth. A systematic review¹⁰⁶ of the costs and long-term benefits of the NFP programme identified costs at just over \$9,000 per child, with an average benefit of more than \$26,000 per child (i.e. \$17,000 net benefit per child), based on the longer term outcomes up to the age of 15. In 2009, a follow-up study¹⁰⁷ indicated that the programme has a major effect on the future criminality of the mothers who participate in the programme, reducing crime outcomes by 38.2%. NFP also reduces the future crime levels of the youth by 15.7% compared with similar youth who did not participate in the NFP programme. In addition to crime outcomes, the NFP programme has been shown to reduce child abuse and neglect and increase educational test scores.

The programme is voluntary and in the first wave of test sites in England has been taken up by 87% of the families who have been offered it. After promising early findings¹⁰⁸ the programme is now being tested across England. It is important to note that the full cost savings from the United States are unachievable in England, since the latter already has universal health visitor services, albeit at a lower level of intensity.

Language for life

Priority area 2: Speech, language & communication needs

As noted in chapter 4, research shows that up to 10% of children have a long-term, persistent communication difficulty, and upwards of 50% have transient difficulties on entry to school, and that there is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime. However, with the right support, many children with transient difficulties go on to catch up with their peers, and those with a pre-school history of persistent disorders that can be resolved by age 5½ go on to perform within normal limits. The costs – not only personal, educational and social, but also economic – of failing to meet these needs adequately are high. I CAN cite an American review of early intensive language support programmes showing significant academic gains, reduced need for special education, improved health, higher employment and earnings for families. A cost benefit analysis showed long-term benefits and returns that ranged from 4:1 to 17:1 (*i.e.* \$4-17 benefit/saving for every \$1 spent).

The 2004 Audit Commission report on youth justice¹⁰⁹ included a fictional case study of a 15 year-old ('James's story') reflecting a real life situation; it describes and costs a series of interventions from concerns about speech and language development at age 6 to a second custodial sentence by age 15 (total cost £153,687), and compared this to the cost of alternative strategies assuming the avoidance of crime (£43,243) – a cost benefit of £111,444 (which doesn't include the wider societal costs of anti-social behaviour and crime).

All five effective local practice examples featured in chapter 4 targeted support during the age 5½ 'window' involving a large scale training programme and dissemination of information to equip staff and parents alike. The impact of these effective interventions has been hugely successful with evidence of marked improvements in children's learning and achievement, practitioners' confidence and parental feedback.

The I CAN Early Talk effective local practice example in Ashford, Kent, has been costed by C4EO. The programme resulted in 92% of the 37 children with complex language needs supported being able to attend their local primary school without the need to access specialist language provision at a project cost of £46,300, indicating a social return on investment of £1.37 for every £1 invested.

Engaging parents

Priority area 3: Parenting programmes

As noted in chapter 5, parents are the most significant influence on children, and parenting has profound consequences for their future lives. The former DfES funded Parenting Early Intervention Pathfinders (PEIP) from 2006-2008, in which 18 local authorities (LAs) each implemented one of three parenting programmes with parents of children aged 8-13 years,

selected as having a sound evidence base for their effectiveness: Incredible Years, Triple P and Strengthening Families, Strengthening Communities. Evaluation of the pathfinder¹¹⁰ found that there were high levels of positive gains for parents and children; parental course completion rates were good; the training successfully improved parents' mental well-being and parenting skills and the behaviour of their children; the three programmes produced comparable improvement outcomes; cost effectiveness varied between LAs using the same programme, indicating the importance of local policy and organisational factors.

The National Institute for Health and Clinical Excellence (NICE) appraisal on conduct disorder in children states that programmes should be clinically effective and cost effective (see also chapter 5). In the UK it has been estimated that the cumulative cost to public services of children with troubled behaviour is 10 times that for other children (£70,019 compared to £7,423). The mean extra cost is more than £15,000 a year, of which families themselves bear a third (mainly through reduced earnings); education services bear a third; health services and the benefit system each bear 15% and social care services bear 6%.¹¹¹ By contrast, a full cost effectiveness analysis of the Incredible Years basic parenting programme in the UK concluded that it "improves child behaviour...at a relatively low cost and was cost effective compared with the waiting list control. This parenting programme involves modest costs [an average of £1,344 per child] and demonstrates strong clinical effect, suggesting it would represent good value for money for public spending" (Edwards et al, 2007).¹¹²

This was reinforced by a very recent study¹¹³ of the same programme conducted in four urban areas in the Mid-Eastern region of Ireland, which, through using the primary outcome results from a randomised controlled trial, showed that the parenting programme significantly reduced behavioural problems among children throughout the sample, with a long-run rate of return that compares favourably to more intensive and costly alternatives. The study also observed that other benefits, such as improvements in educational attainment and associated increases in productivity and earnings capacity, reductions in substance abuse, benefits to victims of reduced crime and benefits accruing to the parents as a result of the programme, are likely to push these returns higher.

Smarter working, better services

Priority area 4: Targeted family support

Research carried out for Action for Children by the New Economics Foundation (see also chapter 7) estimated that in its Caerphilly Family Intervention Project and East Dunbartonshire Family Service – targeted interventions designed to catch problems early and prevent them from recurring – between £7.60 and £9.20 worth of social value was generated for every pound invested. In these cases the increased returns to the state were mainly generated by reductions in costs associated with increased tax revenue; decreased benefit payments; reduced costs of crime and anti-social behaviour; reduced health costs for children; and the reduction of long term costs such as specialist education and care provision.¹¹⁴

C4EO has costed two family support services validated as effective local practice featured in chapter 6. The first is the Family Support Model in Warrington which was delivered to 529 families in 2008-09 at a total cost of £158,000 and a net cost per family of £6.00 per week. During this period, 57% of families supported showed a reduction in the level of need. The second example is the Building Bridges service delivered by Family Action which supports children and families where parents have severe and enduring mental health problems. Over the course of one year, 40 families can be supported at a cost of £3,500 per family. Over two

years, the estimated savings to: the Department for Education and local authority are £114,400; the Department for Work and Pensions are £158,400; and the NHS are £67,200.

Knowledge is power

Priority area 5: Young people on the edge of care

Multi-Systemic Therapy (MST) was developed to provide scientifically validated, cost-effective, community-based treatment for young people aged 10 to 17 with serious behaviour disorders who are at high risk of out-of-home placement. Rigorous evaluation and replication in clinical and community settings in the United States mark it out as a particularly effective intervention for adolescents with conduct disorders. MST views individuals as living within a complex social network encompassing individual, family, and extra-familial (peer, school, neighbourhood) factors. MST uses the strengths in each young person's social network to promote positive change in his or her behaviour. The overriding purpose of MST is to help parents deal effectively with their child's behavioural problems; help them cope with family, peer, school and neighbourhood problems; and reduce or eliminate the need for out-of-home placements. To empower families, MST also addresses identified barriers to effective parenting (e.g. parental drug abuse, parental mental health problems) and helps family members build an indigenous social support network involving friends, extended family and neighbourhoods. Despite its high cost, MST has been demonstrated as a cost-effective treatment for decreasing the antisocial behaviour of violent and chronic juvenile offenders. MST cost approximately \$3,500 per young person in one replication site in South Carolina, which compared favourably with the average cost of the State's institutional placement at approximately \$18,000 per young person for a time period of about 59 weeks post referral.¹¹⁵

Against this backdrop Islington has developed the Adolescent Multi Agency Support Service (AMASS) which enables young people to remain at home or in foster placement, through utilising some of the approaches common to MST. The Islington service differs from MST in several ways, most distinctly in its jointly delivered intervention with social workers, and the co-located wraparound multi-agency team that supports the family. As noted in chapter 7, an evaluation by the University of Bedfordshire has validated the effectiveness of the service in terms of reducing the use of care and improving family functioning for many of the families supported. For the age group directly supported by the service, the number of young people aged 10 to 16 entering care fell from 63 in 2006/07 to 40 in 2007/08, a reduction of 36%; and, over the same period, the number of young people entering residential care fell from 38 to 14, a reduction of 63%. The University of Bedfordshire estimates that each £1 invested in the service produces a saving to the care system of £1.46, with reduced future costs the saving per £1 invested is estimated at £1.80. In 2009/10, 38 families were supported at a cost of £780,000, equating to £20,526 per family. Estimated savings to the local authority over 1 year are around £372,188 through preventing young people entering care, with savings set to increase to £522,000 as the cost of the service reduces.

Conclusion

This chapter has sought to provide a steer for both national and local policy-makers in deciding where best to allocate scarce resources, especially in the current economic climate, since "investment in proven interventions...is the prudent way to ensure positive outcomes for children and their families" (Utting 2004, p 95).¹¹⁶ By drawing on a combination of international evidence, mainly from the United States and, to a lesser extent, Scandinavia, and effective local practice, a small cluster of areas and interventions emerges as spending priorities: children's centres and early years (in particular breastfeeding initiatives and the

Nurse Family Partnership); speech, language and communication needs; parenting programmes; targeted family support; and young people on the edge of care. This cluster strikes a balance between intervening early and recognising the reality of still needing to support vulnerable older children, young people and families.

Key messages

- The temptation to cut back on investment in early intervention in times of austerity needs to be resisted, as governments often regret, with hindsight, the long-term costs of making such short-term savings. The challenge is not, therefore, deciding whether to maintain spending on early intervention, but working out how to get better value out of the money already being invested.
- The powerful body of research (home and abroad) showing that what a child experiences during the early years (starting in the womb) lays the foundation for the whole of their life, makes a compelling case for prioritising investment in this area.
- In general, targeted approaches tend to be judged more cost effective than universal approaches. Yet there is little comparative evidence to determine which approach might be most 'cost effective'. The evidence suggests that it is unlikely to be a question of one or the other. What is needed is a range of interventions able to provide support at different levels of need.
- Spending should be prioritised on children's centres and early years (in particular breastfeeding initiatives and the Nurse Family Partnership); speech, language and communication needs; parenting programmes; targeted family support; and young people on the edge of care.
- Three of the recommended interventions – Nurse Family Partnership, Incredible Years and Multi-Systemic Therapy – are among the 11 'Blueprint' programmes identified by the Center for the Study and Prevention of Violence at the University of Colorado to meet high standards of effectiveness, as part of a review of 800 early intervention programmes.¹¹⁷
- The OECD suggestion that expenditure on children should be regarded as if it were an *investment portfolio*, and be subjected to a continuous iterative process of evaluation, reallocation and further evaluation to ensure child well-being is actually improved, poses a formidable but necessary challenge to this nation. Learning from international experience in particular can be invaluable in helping us to move forward, though, ultimately, tough decisions need to be taken at a national and local level in the best interests of children, families and, indeed, the long-term prosperity of the country.

Appendix I

Membership of Expert Group

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This is a practice guide to the challenges and opportunities in supporting children, families and communities through early intervention, based on effective local, national and international practice.

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