wave TRUST

Tackling the roots of violence

International experience of early intervention for children, young people and their families 2010

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PREFACE

C4EO
The Centre for Excellence and Outcomes in Children and Young People's Services provides a range of support to drive positive change in the delivery of children's services, and ultimately outcomes for children, young people and their families. C4EO supports and constructively challenges the sector by sharing high quality, up-to-date evidence and really effective practice, making it easily accessible to those who need to work in a 'low cost-high impact' environment.

WAVE Trust
WAVE has 14 years experience of international research into root causes of violence and child maltreatment and 11 years of detailed investigation of best practice in early intervention. During this time it has produced its 2005 report, *Violence and what to do about it*, which reviewed over 400 international interventions to improve outcomes for children; the 2008 report, *Working together to reduce serious youth violence* and the initial drafts of the Iain Duncan Smith and Graham Allen booklet, *Early Intervention: Good Parents, Great Kids, Better Citizens.*

Authors of the Report
The project has been conducted by George Hosking and Ita Walsh, supported by Brojo Pillai. George is an economist, accountant, psychologist and clinical criminologist. Before focusing on social issues, George had a successful career in business, first as a senior line manager in international strategy, then as a strategy consultant and corporate turnaround specialist. Following a successful career running her own business, Ita moved into strategy consulting where she became first a Director, and later owner, of an international consultancy. Brojo has been a researcher with WAVE for three years and played a major role in the design of WAVE's Preventive Strategy for local authorities. He is also a Montessori teacher.

Introduction

Context for this rapid review
Against the background of recent government guidance in England on early intervention to improve outcomes for children and young people (Early Intervention: Securing Good Outcomes for all Children and Young People, 2010), and a literature review examining early intervention to identify and support children with additional needs (Earlier Intervention: Identifying and Supporting Children with Additional Needs, 2010), C4EO determined to examine the international perspective in relation to this issue.

WAVE Trust was commissioned to carry out a rapid review of international literature relating to early intervention. This will complement a previous C4EO desk study to identify the key messages relating to early intervention and prevention from current, published (or about to be published) C4EO publications.

This review links to all Every Child Matters outcomes:

Be healthy
Stay safe
Enjoy and achieve
Make a positive contribution
Achieve economic well-being

C4EO is interested in interventions which enable effective identification of vulnerable children and families and assessment of their needs; successfully engage families at the early signs of a child or young person's problem and works in partnership with them to address this; support a strong culture of prevention; and may lead to possible cost savings. The 4 specific questions contained in the brief were:

Question 1: Identify up to 30-50 examples of good international practice of early intervention for children and families which will be useful for UK policy-makers to consider.

Question 2: What are the key messages from and implications of this international experience in terms of improving governance, strategy, processes and front-line delivery in England? This relates to both direct and indirect effects.

Question 3: What key messages from international experience will contribute to the policy framework in England, such as deregulation?

Question 4: What are the key messages on the efficient focus of early intervention and its cost-effectiveness/value for money?

Definition of terms
C4EO's working definition of the term early intervention is:

'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. Effective intervention may occur at any point in a child or young person's life'

Approach
In our research we carried out a literature search on a number of databases such as Medline, PsychInfo, Social Services Abstracts, CINHAL, ERIC and the Cochrane and Campbell Databases; we wrote to over 150 international WAVE contacts and, based on responses received and our own past experience, downloaded over 400 documents, mainly from scientific journals, referring to different aspects of early intervention in or from around 20 countries.

From these we identified more than 90 candidate Practices which were approaches worthy of consideration in a targeted 30-50 examples of good international practice which could be useful to UK policy makers. The time constraints of this rapid review have prevented us from assessing all of these, but from over 70 which were considered 47 have been selected for inclusion in this report. To

enable readers to choose the level of detail that best suits their purpose, we have taken a handbook approach and reported in up to four layers of detail on the selected 47 practices:

- the Key Messages section highlights examples of practices we found most relevant to the particular Message;
- Section 1 provides both a single paragraph description and a longer overview of each practice;
- The Appendix expands the single paragraph and 'brief overviews' by summarising the source material

Caveat

The initial database review was conducted using strict criteria for research validity. Because the resulting numbers fell significantly short of those required for our target of 30+ practices, we relaxed our research requirements for the remainder of the study. The result is that that many of the interventions referred to in this review have been validated by only a single research study, and/or one carried out by the programme originator. Although we believe the review highlights much that is good in international practice, all conclusions must therefore be considered as tentative. A step which was not part of our brief, but which we believe would add value by making the study more robust, would be a separate, systematic analysis of the quality and strength of the research evaluations of each of the studies identified. We can conduct such an analysis if requested.

Key Messages

We have drawn many messages from the research related to this survey of international experience and good international practice. It would have been easy to list twelve or eighteen such messages, from the economics of alternative approaches to early intervention, to the timing of when intervention could take place, to the identification of what works, to the implications of comparisons between countries. We have decided instead to focus here on 6 key messages, which we believe to be of over-riding significance. These are:

1) **Those who prioritise investment in the earliest years secure the best outcomes**
2) **The quality of parenting/care is the key to a successful society**
3) **There could be a major dividend from focused commitment to ensure children arrive at school 'school ready'**
4) **The impact of poor early care can be alleviated by the right experience during school years**
5) **Galvanising the community is the secret of success**
6) **Innovative approaches to social care can provide significant benefits at minimum cost**

Message 1: Those who prioritise investment in the earliest years secure the best outcomes

The scientific evidence that very early childhood experience defines later life outcomes is already well-documented. The work of the Harvard University Center on the Developing Child provides scientific underpinning for why this should be so, together with the Center's policy recommendations. We strongly recommend reading their series of 10 booklets on the science of the child's brain and how its life-long architecture is established by experiences in the early years. The booklets are available on the following website:

www.**developingchild**.**harvard**.edu

Further evidence is referred to by Richard Tremblay, in Practice 15 of this report (please see Appendix for all Practices). The findings of the emerging new science of epigenetics, which demonstrates how genes are switched on or switched off by early environmental experience, adds to the scientific evidence of the importance of the first few years.

This principle is also supported by the World Health Organisation's recommendation for babies to be exclusively breast-fed until they are a minimum of 6 months old. The WHO site:

www.who.int/en/

states (1 August 2010) – *'If all babies and young children were breastfed exclusively for their first six months of life and then given nutritious complementary food with continued breast-feeding up to two years of age, the lives of an additional 1.5 million children under five would be saved every year.'*

Practice 12, a Cochrane review which emphasises the importance of the near birth period, including birth, breast-feeding and risk assessment, observes that breast-feeding rates in England are among the lowest in Europe. OECD reports that in 2005 less than 1% of British mothers were exclusively breastfeeding at 6 months, compared with the EU average of 28%. The review by Dyson cites reasons why, and we shall return to that issue when we address governance and strategy. Practice 10, the effect of early post-natal breast-feeding support in Denmark shows that early interventions can boost breast-feeding and Practice 12 cites studies in Belarus and New Zealand with the same conclusion. We could have selected many more.

Long-term, randomised, controlled trials of Practice 11, the Nurse Family Partnership intensive home visiting programme, demonstrate a range of long-term benefits. As readers will know, this programme is now being tested in the UK with encouraging initial results. Practice 13, the Irish Community Mothers Programme, delivered to first- or second-time parents of new-born infants, is resulting in better outcomes for the children at age 8 (e.g. being more likely to read books regularly, visit the dentist and have better nutritional intake).

Practice 29, the University of Montreal Longitudinal-Experimental Study, was set up to check the validity of previous findings that physical aggressiveness and academic problems are early life predictors of adolescent delinquency. The research candidates were therefore identified from disruptive children in kindergarten, although the programme did not commence until they were aged 7. This parent training study demonstrated positive effects through school and at age 24 in significantly higher levels of high school graduation and lower levels of crime. One of the study's authors, the Professor Tremblay referred to above in Practice 15, is of the view that even better results could be achieved from much earlier intervention. He points out that the optimum time to tackle violence is when children are 3 years of age, by which time the 17% most violent children (who may account for 50% or more of future violent crime) are already showing levels of aggression ten times higher than that of the most peaceable 32%.

That aggression can be reduced in the pre-school years is shown by Practice 25, the Chicago School-Readiness Project, which successfully reduced aggression and defiance in preschoolers. Practice 23, the Incredible Years, claims the same capability.

Taking averaging rankings on 6 measures of child well-being in the 2007 UNICEF League Tables for Child Well-being,

http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf

the two countries which come top are Netherlands (average ranking 4th) and Sweden (average ranking 5th). Because all countries have some weak areas, no country scored better average rankings. Netherlands came top on Subjective Child Well-Being, second on Health and Safety, and third on both Behaviours and Risks and Family and Peer Relationships. Sweden came top on Behaviours and Risks, Health and Safety and Material Well-being. The UK's average ranking was 18th, putting it bottom of the league table, along with the United States, some way behind Hungary.

We looked at both Sweden and Netherlands, to see what might be learned from them. Practice 9 describes the Approach to Infancy and Early Childhood in Sweden, while Practice 16 captures the Dutch government's 'Every Opportunity for Every Child' programme. Both show a high recognition of the importance of focusing investment in the early years.

Sweden's strong focus on prevention starts at the very beginning of life with emphasis on breast-feeding (98% of Swedish mothers begin breast-feeding and 72% have maintained this at 6 months vs 79% and 22% in the UK). In addition long periods of maternity and parental leave support attention to the needs of the child in its earlier months. 100% of hospitals have BFHI (baby-friendly) status (compared with less than 10% in the UK) and early parent training is provided for a high proportion of the population.

The Netherland's strong commitment to prevention and the very best possible start to life, for mother and baby, begins with their unique universal Kraamzorg system of post-natal support at home for the new mother (Practice 45). This provides elevated support for mothers with challenging home circumstances, or who are having problems with breast-feeding.

The Dutch government's 2007 Youth and Family Programme *'Every Opportunity for Every Child'* calls for a focus on prevention, stating that the problems of children and families must be detected and addressed as early as possible, to prevent them from becoming more serious when they grow older. Emphasis was placed on ensuring a healthy, balanced upbringing for children before the age of four 'since this is the best way of ensuring that they do not develop problems when they grow older'. In the Netherlands all mothers are entitled to the support of a nurse for a week after the birth of their child and return home, to allow them to focus on the needs of the child while their nurse takes care of many other household duties. This supports mother-infant bonding.

Youth healthcare services were required to conduct a growth and development risk assessment for each child during its first four years, with help being given where necessary. Interventions include parenting support and provision of early childhood education programmes. Data sharing was made mandatory. Prevention of child abuse was stated to be a primary aim.

Message 2: The quality of parenting/care is the key to a successful society

A recurring theme for our research for this project was the key role, for a successful society, of good parenting. By successful society we mean one in which its citizens have good physical and mental health, children are happy and nourished while young, engage and succeed at school, and grow up to be caring, contributing, responsible citizens who generate wealth for society rather than destroy the wealth created by others. In too many cases in the UK current parenting achieves the opposite, as statistics for binge drinking, teenage pregnancies, costs of prison and youth justice, and the growth of an underclass who are long-term unemployed, demonstrate.

Parenting education and support repeatedly demonstrate much improved outcomes for both the parents and the children and the challenge of improving parenting was a recurring theme throughout the early intervention practices we found.

The list of international Practices which address parenting is extensive. A number of studies have shown Triple P to be effective in improving children's behaviour and parent-child interaction and in reducing parenting conflicts. Two studies of Triple P being delivered and/or publicised on a population wide basis, one in South Carolina (Practice 5) and one in Brisbane, Australia (Practice 7) demonstrate the positive effects of an intervention to improve parenting.

WAVE's prior research (Hosking & Walsh, 2005) has identified the crucial importance of the quality of attunement between a mother and baby in the first 18 months of a baby's life. A number of the early interventions included a focus on improving this dimension of the parent-child relationship. Practice 10 (Effect of early postnatal breast-feeding support, Denmark) shows higher breast-feeding rates being aided by parents getting to know the baby's cues and improving interactions with the baby. A main goal of Nurse Family Partnership (Practice 11) is to improve the child's health and development by helping parents to provide more sensitive and competent care.

The two Video Interactive Guidance approaches – Practice18 (Circle of Security) and Practice 20 (VIPP, Video-feedback Intervention to Promote Positive Parenting) – focus on this dimension. In VIPP 'parents are supported to become more sensitive to their child's communicative attempts and to develop greater awareness of how they can respond in an attuned way'.

An intervention which we believe is of particular strategic value is Roots of Empathy (Practice 46). This 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. The programme also fosters empathy and reduces bullying in schools.

Other early interventions whose goals centered on, or included, improving parenting skills, included Practices 13, 19, 22, 23, 29, 30, 32 and 41. Areas of child behaviour that the interventions sought to impact included cognitive development, reading and self-esteem (Practice 13), conflict management skills, social skills with peers, academic engagement, decreased noncompliance with parents at home; decreased peer aggression and disruptive behaviours in the classroom (Practice 23), decreased aggression, hyperactivity, disruptiveness and delinquency, higher levels of academic performance and high school graduation (Practice 29); drug-taking (Practices 30, 32); and child behaviour (Practices 38 and 41).

The two countries we mentioned in Key Message 1 which lead the UNICEF League Tables, and which give priority to investment in the early years, also give a high priority to improving parenting.

Sweden (Practices 9, 17) takes parenting education very seriously. 98% per cent of all maternity clinics offer parenting education in groups to first-time parents. 60% allow repeat parents to participate. Parents are invited to join parent groups when the child reaches one to two months. In Stockholm County for example, 61% of all first-time parents participated in at least five sessions.

The priority extended to the Parent Education extends to professional training. 8-10% of midwives' working time is spent on parenting education; 65% of midwives received regular professional training on the subject, and 72% were instructed by a psychologist.

The Netherlands (Practice 16) also 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. Community schools, youth and family centres and other local facilities also offer advice and support on parenting.

Another country which is taking seriously a commitment to improve parenting practices is New Zealand. Worried, like the UK, by trends in dysfunctional youth behaviour, the New Zealand Government made a policy decision that the key to healing this trend lay in the quality of family life and parenting. SKIP (Strategies with Kids, Information for Parents, Practice 2) was set up as a nationwide campaign to improve parenting, with the goal of encouraging parents and caregivers to bring up children from birth to age 5 in a positive way, as part of a loving, nurturing relationship that provides what children need. The campaign appears to be achieving many of its goals.

Corporate parenting of looked-after children

No review of parenting would be complete without including the parenting of children who need to be separated from their original families. Although these most vulnerable children amount to less than 1% of the general population, in circumstances where they are providing one third of the prison population (and have two and a half times the national average of teenage pregnancies), this 1% becomes disproportionately significant, and offers a tremendous opportunity for improvement.

Practice 40 (The Bucharest Early Intervention Project) documents the very real damage the wrong sort of institutionalisation can do to young minds. In contrast Practice 39 (Holistic approach to looked-after children, Denmark and Germany) reveals that looked-after children can thrive in care homes – provided an holistic (or pedagogic) approach is adopted. Since the supply of suitable UK foster placements is dwindling, it is very encouraging to find that a successful model for delivering this type of parenting already exists. As an example, the Petrie et al study of German, Danish and English care homes found that staff characteristics (relating to quality and commitment to the children rather than purely qualifications) accounted for 30% of the higher rates of pregnancy in the English homes. 94% of the Danish care home staff in the sample had degree level qualifications while the figure for the English homes was 20%.

Message 3: There could be a major dividend from focused commitment to ensure children arrive at school 'school ready'

If schools are to deliver the full potential of schoolchildren, it is important that children arrive at school ready, willing and able to learn – 'School ready'. In too many cases in the UK this is not the case. We hear stories from all over the country, from reception class teachers, of children arriving who are disruptive, unable to socialise with other children, unable to respond appropriately to teacher requests and even of not yet being toilet trained. These disadvantaged children are not only a challenge in themselves, they also impair, sometimes significantly, the ability to learn of the other children.

What Works in Early Years Education, a review of approaches to Early Years Education across the globe (Practice 28), cites two international comparisons of academic performance in English schools, in one case with Slovenia, in the other case with Switzerland. Though the Slovenian children started school two years later, within 9 months they had caught up on English mathematics attainment. The Swiss children started school a year later than those in England, yet the Swiss one year younger than English children performed better in maths. A study which addressed why this was the case identified the variable academic ability of children in the English reception class.

As we will show elsewhere, we believe the economic case for investment in early intervention for children with poor early years experiences, is strong. That it could also add value to the academic performance and wider school outcomes for a whole cohort in a year suggests there could be a major dividend from ensuring children arrive at school 'school ready'. The evidence from international early intervention practice suggests that much can be done to help this occur.

Head Start REDI (Practice 24) is a programme to promote the school readiness of socioeconomically disadvantaged children in Pennsylvania. Integrated into Head Start settings, it enabled children to do better than in typical Head Start classes, with gains especially in social skills, reduced aggression, language development and emergent literary skills. Also in the Head Start setting, The Chicago

School Readiness Project (Practice 25) addressed the problem that preschool can improve academic readiness *at cost of social development.* The research found that the project had a large, statistically significant impact on reducing low-income preschoolers' internalising (sadness, withdrawal) and externalising (aggression, defiance) behaviour problems.

In addition to child-readiness, the Nebraska Getting Ready (Practice 26) focuses on parent-readiness for children making the transition to school. Integrated into Head Start settings, staff are trained in how to engage parents as partners and strengthen parental confidence. Results include increased early and sustained engagement for parents, higher levels of attachment and initiative, and lower levels of anxiety and withdrawal behaviours for the children. A research study suggests the intervention is particularly effective at building children's social-emotional competencies.

HIPPY, the Home Instruction for Parents of Pre-School Youngsters, (Practice 27) is another parent-focused school readiness programme targeted at parents of preschoolers. In addition to the curriculum, books, and materials and group interaction, it provides outreach via home visits. There appears to be some evidence it improves readiness for school, academic grades and parents' involvement with their children's education.

Message 4: The impact of poor early care can be alleviated by the right experience during school years

Our research identified a number of successful practices delivered during school years (though not necessarily in school) that can alleviate the effects of children's adverse early experiences.

In an intervention delivered between ages 7 and 9, The Montreal Longitudinal study (Practice 29) took a group of boys who had been disruptive in kindergarten and, through intensive parent training (on average 17 sessions), made striking differences to the subsequent school and early adult outcomes for these children. Two-thirds of the 'disadvantage' of the disruptive kindergarten boys, compared with controls, had been removed by the time they were 24, Intervention delivered before age 7 could have yielded even better results.

KIPP schools (Practice 47) have open enrolment and take disadvantaged youth in the USA, irrespective of prior academic record, conduct, or socioeconomic background. Over 90% of students are African American or Hispanic/Latino, and more than 80% are eligible for the federal free and reduced-price meals programme. Within three years many students have gained by the equivalent of an additional year of instruction, enough to make substantial reductions in race- and income-based achievement gaps.

The Seattle Social Development Project (Practice 32) was based on strengthening children's bonding with parents and school, parent training and skills coaching for students, including problem-solving and refusal skills. Outcomes at age 21 included lower rates of delinquency and significantly higher rates of high school graduation. Practice 33 (The Second Step Programme) resulted in significant increases in fifth- and sixth-graders' Social Competence, including knowledge about empathy, anger management, impulse control, and bully-proofing, in Norway, Germany and the USA.

Reach for Health Community Youth Services (Practice 34) was focused on precocious sexual behaviour and had good results in delaying onset of sexual behaviour, reducing frequency of sex and, in particular, encouraging use of birth control. The Carrera Project (Practice 35) is an after school programme. Females in the study had significantly lower rates of teen pregnancy. Among a wide range of benefits participants were significantly more likely to have bank accounts, to have had work experience, to use word processing programmes and to use the Internet and e-mail.

Two programmes focused on addressing the risks of drug abuse. Preparing for the Drug-Free Years (Practice 30) delivers 10 hour-long sessions to parents of children in the 4th to 6th grades. Parents are reached through schools, community centres, TV marketing etc. Good family engagement is achieved and positive results have been reported. Project ALERT (Practice 31) showed success in reducing cigarette, cannabis and alcohol use compared with controls.

Message 5: Galvanising the community is the secret of success

Perhaps the most encouraging form of prevention/intervention we found could be summed up by the phrase 'galvanising community'. This approach to building functional, healthy communities shows the power of an idea adopted by a large number of citizens at the same time, and its characteristics include overcoming the challenge of reaching the most at-risk, and therefore hardest to reach, potential beneficiaries of support.

A nationwide example is the campaign (Practice 2) called SKIP (Strategies with Kids, Information for Parents), a government-funded route to transforming the way people think about parenting in New Zealand. This is reported to be enormously successful at raising the public profile of the issue in a positive manner, putting life back into the concepts that older people have wisdom and experience to contribute, and that child rearing is a community as well as parental matter. Above all, the campaign is taking the subject of parenting out of darkness into light and establishing the idea that good parenting is a learned skill – and there's nothing 'wrong' with people who engage in learning it. Materials relating to parenting come in many forms, including fridge magnets! The high profile, open style of communication the campaign fostered has resulted in the topic of parenting being common in the workplace – even of fathers. SKIP is a truly national community initiative, a benign revolution in the way people live together and raise the next generation, rather than just another parenting programme. The following comment from a community worker is typical of the feedback received: *We feel part of changing the ways parents parent in New Zealand. We feel like we are part of a social transformation that is bigger than us.*

Qualitative analysis of the campaign in a study commissioned to help understand the reasons for the extent of the success distilled the following key success factors:

- a clear, strong, collective vision focused on social change;
- genuine partnership with community;
- a culture of possibility;
- the use of social marketing to promote an agreed message;
- the idea that success breeds success; and
- a positive, universal and non-judgemental approach.

The SKIP campaign fits well with Practice 1 (The New Zealand Families Commission), which works to promote a better understanding of family issues and needs among government agencies and the wider community, encouraging debate, stimulating research and helping shape government policies.

Called 'one of the most ambitious social-service experiments of our time' by The New York Times, the Harlem Children's Zone Project is a unique, holistic approach to rebuilding a very run-down community so that its children can stay on track through to college and go on to the job market. The goal is to create a 'tipping point' in the neighbourhood so that children are surrounded by an enriching environment of college-oriented peers and supportive adults, a counterweight to the toxic popular 'street' culture that glorifies misogyny and anti-social behaviour. President Obama has called for the creation of 'Promise Neighborhoods' across the USA based on the comprehensive, data-driven approach of the HCZ Project.

Its numerous impressive achievements include virtually eliminating school-unreadiness and doubling the percentage of 'advanced' among 4-year-olds, and catapulting 100% of 3rd graders in 2 of the Academies to achieve grade level or above in the state-wide math programme. In 2009, 106 Harlem children who were engaged in the chess programme won 78 trophies.

Harvard economist Roland Fryer concluded that the students in the HCZ project had actually closed the black-white achievement gap.

Practice 8 (CIRV – Community Initiative to Reduce Violence) is a local Glasgow initiative based on the Boston Ceasefire model. This programme involves the whole community, including the police. In its first year it has successfully enrolled more than half the 700 gang members from the east end of Glasgow in a commitment to renounce violence. It has already seen violence by these youths drop by 49%, with a knock-on effect of an 18% reduction in violence among gang members who did not sign up to the initiative.

Message 6: Innovative approaches to social care can provide significant benefits at minimum cost

The Scottish Highland Region Streamlined Reaction system (Practice 37) ensures that the situations for at risk children are dealt with effectively, and in a streamlined manner, the first time they show up on the radar, thus saving the costs and consequences of children remaining in the local authority or criminal justice systems for years to come. It is a particularly innovative and interesting model of effective multi-agency working. Senior staff involved claim that the approach has led to greater cost efficiency, lower juvenile crime and less child abuse, but hard data validating these claims have not yet been received.

There are similarities between the Highland Region and the Croydon Total Place (Practice 37 refers to both) approaches of making early intervention and effective multi-agency team-work a priority. The very promising Croydon Total Place approach differs from Highland Region in being targeted at Prevention of child maltreatment rather than solely very early reaction but is still a plan of action rather than a demonstrated intervention. From our knowledge of the details of both these local authority initiatives, we conclude that an approach combining the best of both models could possibly deliver much improved outcomes for children and deliver significant cost savings.

Although the more holistic approach to looked-after children employed in Denmark and Germany ('social pedagogy', Practice 39) has already been reviewed briefly under Corporate Parenting in Message 2, it is worth mentioning here in more detail because it demonstrates so clearly the benefits available from sound corporate parenting. These include good educational and employment achievements and low levels of criminal offending and teen pregnancy among looked-after children in care homes. An interesting feature of the difference between the England and Denmark and Germany is that the sample reviewed showed it took almost double the staff-to-children ratio to deliver poor results in England than those who delivered medium results in Germany and very good results in Denmark. This fact seems to be directly linked to levels of staff qualifications. The indirect benefits of producing better results here could be enormous, in view of the fact that our current care home system provides a third of the prison population and very high levels of teen pregnancy and, therefore, re-creation of at- risk children.

The Iowa Family Development and Self-Sufficiency Program (FaDSS, Practice 43) is a very innovative zero cost programme to get families out of welfare. Created to assist Family Investment Program (FIP) families who suffered significant or multiple barriers (including drug and alcohol problems, helplessness and lack of motivation) to reaching self-sufficiency, a home visitor works closely with the family to assess family history, strengths and resources; set goals; provide support and assistance; and re-integrate families into the community. The resulting savings in FIP and income tax revenue raised enabled the programme to fulfil its basic requirement of paying for itself. Indirect benefits from parents being employed, happier and having higher self-esteem had a positive impact on all the family members and translated into further savings for the state as the 'at-risk' status diminished.

Practice 44 (the Dundee Families Project) is designed to stabilise the situation of families threatened with eviction due to bad behaviour or inability to cope. Delivered by a charity, it offers an effective model for social care in this type of situation. The programme employs a skilled work force with the remit to rehabilitate families whose antisocial behaviour has put them at risk of homelessness. The workers (and the families) needed to overcome the obstacle of a very hostile local community who had 'had enough' of these antisocial families. The re-housed families were supported in as many ways as the individual situation warranted. Three years later the local community had turned entirely positive about the families, and the children of the assisted families were very enthusiastic about what had happened. The project generates cost savings through stabilising families' housing situation, avoiding costs associated with eviction, homelessness administration and re-housing; and, in some cases, preventing the need for children to be placed in foster or residential care.

SECTION 1

Identify up to 30-50 examples of good international practice of early intervention for children and families which will be useful for UK policy-makers to consider

Using the definition provided by C4EO (see Introduction above) we invited input from our international contacts and collected what emerged from the database searches. At this point in the search, a majority of documents emerging related to the early years (0-5 years). After comments from C4EO on the emphasis on early years, we put some emphasis in the latter stages of the study in identifying interventions affecting children later in their lives. A rough analysis of the age spread of the interventions and practices identified came up with the following result:

Practices	Age of child				
	pre-natal	0 to 1	2 to 4	5 to 11	12 +
Number impacting	13	27	24	24	18

The total adds to significantly more than the 47 practices included because many impact children of more than one age group.

Structure of reporting 47 chosen approaches/interventions
In exploring differing ways of grouping the chosen approaches/practices, we considered doing so by C4EO theme, but concluded that some distinctions not included in that approach (e.g. between health in early years and parenting practices in early years, or between schools and broader community approaches) would be lost. Therefore we chose instead to organise them under the following four broad headings which we believe more easily map on to local area (local authority and primary care trust) divisions of responsibility:

A - Community Practice
B - Health and Early Parenting Practice
C - School-related
D - Social Care and Family Welfare

We open with Community Practice because some of the most interesting and successful examples of intervention approaches involved a new tendency within communities to work across all segments to achieve a better and brighter future by reversing negative patterns and practices. This development in attitude can be summed up in a statement published on the Harlem Children's Zone website:

> '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.'

Duplication
The following section provides brief overviews of each of the 47 practices. The Appendix contains a fuller (approximately one page) outline of each Practice. This conscious duplication of the information provided is part of the 'layered' approach described in the Introduction, and has been taken to suit the needs for differing depths between different users of this report.

SECTION 1 (A) Community Practice

Placing community as the umbrella under which all social interventions sit, we will open by describing 8 community approaches to early intervention:

- The New Zealand Families Commission works to promote a better understanding of family issues and needs among government agencies and the wider community. The Commission encourages debate, stimulates research and helps shape government policies.

- SKIP (Strategies with Kids, Information for Parents) is a government-funded nationwide campaign which is transforming the way people think about parenting in New Zealand, raising the public profile of the issue in a wholly positive manner and putting life back into the concept that it takes a whole village to raise a child.

- The Harlem Children's Zone seeks to rebuild a very run-down part of New York with an ambitious pipeline which begins with The Baby College (a series of workshops for parents of children ages 0-3) and goes on to include best-practice programmes for children of every age through to college. The programme is judged to have closed the black-white achievement gap in its area of New York.

- The Stop ACEs' Group in New York State has galvanised the local community to respond to the powerful research by Drs Anda and Felitti, showing that Adverse Childhood Experiences (ACEs) such as being abused or neglected, witnessing domestic violence or growing up in a household with alcoholic or drug-abusing carers has lifelong impacts on physical and mental health, economic prospects and life expectancy.

- We also include two local population-level initiatives to raise parenting standards and protect children from maltreatment: one in 18 counties of South Carolina; the other in South Brisbane, Australia. Both initiatives are based on the Triple P model, and both have produced very positive findings of the effectiveness of such a public health approach to prevention.

- CASASTART is a community based programme, delivered within the school setting in 5 cities in the United States, designed to keep high risk 8 to 13 year olds free of drug and crime involvement. The programme is voluntary, and children participate for up to 2 years. It was developed by The National Center on Addiction and Substance Abuse at Columbia University (CASA). The programme has successfully reduced violence and drug abuse.

- Based on the Boston Ceasefire model, CIRV (Community Initiative to Reduce Violence) is a Glasgow-based community and police initiative to reduce violence in the worst gang violence area of Glasgow. In its first year it has successfully enrolled more than half the 700 gang members from the east end of Glasgow in a commitment to renounce violence and has seen violence by these youths drop by 49%, with a knock-on effect of an 18% reduction in violence by gang members who did not sign up to the initiative.

BRIEF OVERVIEWS

1. Families Commission, New Zealand

The Families Commission provides a voice for New Zealand families and whānau (Maori for extended family). The family is seen in New Zealand to be 'the most powerful, the most humane, and by far the most economical system known for building competence and character' (Bronfenbrenner 1986). Established in 2004, the Families Commission is an autonomous Crown agency governed by a board of commissioners.

Activities

The Commission works to promote a better understanding of family issues and needs among government agencies and the wider community. The issues and needs that families face are believed to be different from those of just parents, or just children. The Commission is charged, under legislature, with the following functions:

- To encourage informed debate about families
- To stimulate research into families, for example by funding and undertaking research
- To help shape government policies that promote or serve the interests of families
- To promote public understanding of matters relating to the interests of families

Some of its activities include the following:

- ran multiple panels and discussion groups around the country each year
- published research on the issues of work, income and debt for families
- studied communities of whose family life little is known, such as Pacifica families
- led, with the Ministry for Social Development, a campaign to reduce family violence in NZ

Over the past 6 years the Commission has published a large number of very informative documents, capturing international research and identifying its relevance to New Zealand local and national policies.

2. SKIP – Strategies with Kids, Information for Parents, New Zealand

Also in New Zealand, SKIP (Strategies with Kids, Information for Parents) is a government-funded initiative led by the Ministry of Social Development (MSD).

The key to this programme is the way its accent on community brings the whole topic of parenting into the light and to the forefront of people's minds and speech. That the programme content is sound and well-based is almost incidental compared to this inspired, modern approach to resurrecting past community values, one of which is the idea that the whole community is responsible for its children. With SKIP, the philosophy that it takes a whole village to raise a child has stopped being mere words or a 'nice' idea. It has once more become a reality – and the community is loving it. The following comment from a community worker is typical of the feedback received:

> ***We feel part of changing the ways parents parent in New Zealand. We feel like we are part of a social transformation that is bigger than us.***

SKIP is a truly national community initiative, a benign revolution in the way people live together and raise the next generation, rather than just another parenting programme that could be interpreted as stigmatising its participants.

Summary of findings

No quantitative reviews of tangible, statistical changes have yet been published, but everybody involved is clear that the programme is a resounding success – so clear that a study was commissioned to help understand the reasons for the extent of the success. The reality is that people (parents, partners and professionals) are very enthusiastic and excited about the programme and what it means for the future of the whole nation; now even fathers can be heard discussing their parenting issues with work colleagues, which would have been unheard of before the programme, and the elders are once again taking their place as sources of wisdom and experience instead of being relegated to the position of helpless or useless.

The qualitative review analysed the programme and distilled the following key success factors:

- a clear, strong, collective vision focused on social change;
- genuine partnership with community;
- a culture of possibility;
- the use of social marketing to promote an agreed message;
- the idea that success breeds success; and
- a positive, universal and non-judgemental approach.

Whole community collaboration is a key principle, and parents report that this, together with the open communication and support they experience, is having profoundly beneficial effects not just on the behaviour of their children and their own experience of being parents, but on all their relationships.

3. The Harlem Children's Zone (HCZ), Harlem, NY, USA

Called 'one of the most ambitious social-service experiments of our time', by The New York Times, the Harlem Children's Zone Project is a unique, holistic approach to rebuilding a community so that its children can stay on track through college and go on to the job market. The goal is to create a 'tipping point' in the neighbourhood so that children are surrounded by an enriching environment of college-oriented peers and supportive adults, a counterweight to 'the street' and a toxic popular culture that glorifies misogyny and anti-social behaviour.

In January 2007, the HCZ Project launched its Phase 3, expanding its comprehensive system of programmes to nearly 100 blocks of Central Harlem. President Barack Obama has called for the creation of 'Promise Neighborhoods' across the country based on the comprehensive, data-driven approach of the HCZ Project.

Summary of major achievements to date

Of the 161 four-year-olds entering the Harlem Gems in the 2008-2009 school year, 17% had a school readiness classification of delayed or very delayed. By the end of the year, there were no students classified as 'very delayed' and the percentage of 'advanced' had gone from 33.5% to 65.2%, with another 8.1% at 'very advanced', up from only 2%.

Since their creation in 2004 and 2005, Promise Academy I and II elementary schools have done well enough to lead Harvard economist Roland Fryer to conclude that the students had actually closed the black-white achievement gap.

In 2009, the third-graders from both schools were 100 percent on or above grade level in the statewide math programme.

At PA1 the third-graders were 94 percent on or above grade level in English Language Arts, while the third-graders at PAII were at 86 percent.

In 2009, the chess programme served 106 children throughout HCZ, who went on to win 78 trophies.

4. Stop ACEs, Oneida County, New York, USA

The Adverse Childhood Experiences (ACE) studies of medical doctors Anda and Felitti in California, carried out with Kaiser Permanente and the US Center for Disease Control, provides evidence in the lives of over 17,000 middle-class Americans of the effect of early traumatic life experience on later well-being, social function, health risks, disease burden, healthcare costs and life expectancy. This research has found a powerful and consistent relationship between extent of adverse childhood experiences and these outcomes. For example, the 16% of the population who have suffered four or more categories of ACE, compared with people who have experienced none, had twice the level of liver disease, 3 times the levels of lung disease, depression and adult smoking, were 4 times as likely to have begun intercourse by age 15, had 6 times the level of alcohol abuse, 11 times the level of intravenous drug abuse and had made 14 times the number of suicide attempts.

The authors of the study conclude that 'all told, it is clear that adverse childhood experiences have a

profound, proportionate, and long-lasting effect on well-being', whether this is measured by depression or suicide attempts, by protective unconscious devices like overeating and even amnesia or by what they refer to as 'self-help attempts', the use of street drugs or alcohol to modulate feelings.

The leaders of the study have published a wide body of evidence supporting their conclusions. They argue that the findings of the ACE study suggest a credible basis for a new paradigm of primary care medical practice. One specific suggestion was for GP's treatment to begin with a comprehensive biopsychosocial evaluation of all patients. One astounding outcome of administering this evaluation to 200,000 patients was a 35% reduction in visits to doctors' offices during the following year.

Galvanized by Anda & Felitti's research, a group of professionals in Oneida, New York, called the STOP ACEs group, have drawn the community together to put an end to ACEs in Oneida.

Activities to date
The group appears to be gaining momentum with the following activities and accomplishments:

- Secured a grant from Congress to fund their work
- Begun a public dialogue around ACEs and their impact on Oneida.
- Made presentations to a wide range of stakeholders in the community
- Drawn into their Group the Health, Education and Mental Health departments of the County
- Initiated a needs analysis to understand awareness of, and services to prevent, ACEs
- Identified strategies and interventions that promote positive parenting

Four subgroups have since been created to:

- Train professionals on how to identify and tackle ACEs
- Devise community wide prevention and intervention programmes
- Promote positive parenting within the community including the large immigrant community
- Develop a sustainability plan to ensure Stop ACEs continues past its funding period

5. Population-based Prevention of Child Maltreatment, USA

In 2006, the US Centre for Disease Control and Prevention funded a 2-year population level trial of Triple P, with 18 South Carolina counties being randomly assigned to either dissemination of the Triple P system or to a 'services-as-usual' control condition. This is the first randomised study of Triple P deployed as a public health intervention and is, to our knowledge, the first randomised study of any parenting intervention deployed at population level. The following are selected extracts from the published study.

> *The prevention of child maltreatment necessitates a public health approach. Prevent Child Abuse America estimated costs associated with child abuse and neglect in the U.S. to be over $94 billion per year in 2001 dollars (Fromm, 2001). This figure likely underestimates the cost because it is based only on official reports of child abuse and neglect and does not take into account the cost of unreported maltreatment ... For example, Theodore, Chang, Runyan et al. (2005) found in an epidemiological study conducted in the Carolinas that maternal reports of physical abuse from anonymous telephone surveying were **40 times greater** than the official child physical abuse reports.*
>
> *To address the difficulties of poor population reach via evidence-based parenting programs, a public health approach to improving parenting is required. Reducing the prevalence of coercive parenting in the community requires that a large proportion of the population be reached with effective parenting strategies (Biglan, 1995).*

Primary analyses
The effectiveness of the trial was measured by its impact on 3 outcome variables: hospitalisations or emergency-room visits for child maltreatment injuries, number of child out-of-home placements, and rate of substantiated child maltreatment. A historical analysis of these variables showed there were no differences between treatment and control counties over the 5 years prior to the trial.

At the end of the 2-year trial, differential and positive effects were found in the Triple P system counties for all 3 outcome variables. For instance, child maltreatment injuries at hospitals reduced by

18.5% in treatment counties while it increased by 19.9% in control counties. Out-of-home child placements reduced by 12.2% in treatment counties while it increased by 43.9% in control counties. And while substantiated child maltreatment did increase in treatment counties, the increase was small (8.1%) in comparison with the increase in control counties (35.4%) and indeed the other 28 counties in the state which experienced similarly large increases.

The researchers estimate that in an area containing 100,000 children under 8 years of age the study results could translate annually into 688 fewer cases of child maltreatment, 240 fewer out-of-home placements and 60 fewer children with injuries requiring hospitalisation or emergency room treatment.

6. CASASTART (Striving Together To Achieve Rewarding Tomorrows)

CASASTART is a community based programme, delivered within the school setting, designed to keep high risk 8 to 13 year olds free of drug and crime involvement. The programme is voluntary, and children participate for up to 2 years. It was developed by The National Center on Addiction and Substance Abuse at Columbia University (CASA).

CASASTART operates on three levels: building resilience in the child, strengthening the family, and making the neighbourhood safer. The programme brings together key stakeholders - schools, law enforcement agencies, social services, health agencies - under one umbrella, and provides case managers to work on a daily basis with high risk children. The case managers engage with the children, develop case plans, offer counselling, make referrals e.g. to mentoring services, help parents navigate through the social/educational/legal systems, advocate for the family in court, run after school or recreation programmes, intervene to prevent eviction or utility shut-offs etc

The Office of Juvenile Justice and Delinquency Prevention funded experimental demonstrations from 1992 to 1996 in five US cities – Austin, Bridgeport, Memphis, Savannah and Seattle – to test the feasibility and impact of integrated delivery of the CASA model. It was later found that many of the youths in the programme did not receive the full specified programme – i.e. implementation was below specification in some cities.

Findings

Compared with youths in the control group CASA youths were significantly less likely to have used either gateway or strong drugs in the past month; were significantly less likely to have used gateway drugs (but not strong drugs) in the year following the end of the programme, were significantly less likely to have sold drugs, and committed significantly fewer violent (but not property) crimes in the year following the end of the programme. CASA youths had more positive peer support than youths in the control group; associated less often with delinquent peers; and felt less peer pressure to engage in delinquent behaviours.

While the results are very positive, and the programme has been commended by many reviewers (such as Blueprints), it has been evaluated in only one study.

7. Every Family Initiative, Australia

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 Program. *Every Family* is a preventive intervention designed to promote better mental health outcomes in children during the transition to school period. It is based on the Triple P-Positive Parenting Program developed by Sanders and colleagues, one of the few evidence-based public health interventions for parenting.

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.

Summary of findings to date

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 Triple P
- 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), and
- 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 transitioning to school with significant psychosocial problems.

8. CIRV (Community Initiative to Reduce Violence)

Glasgow is one of the most violent cities in Europe, with knife crime a particular problem. Gang culture is deeply ingrained in parts of the city, especially the East End. The Scottish Violence Reduction Unit (SVRU) adopted the Boston Cease Fire approach in their Community Initiative to Reduce Violence (CIRV). Ceasefire consisted of gang members involved in serious violence being subjected to a united, multi-agency front which combined the promise of multi-agency support in housing, education and training if they renounced violence and a hard response aimed at the whole gang if any of its members did not do so. These combined strategies brought a very successful period of homicide reduction to Boston.

Of an estimated 700 gang members in Glasgow's East End, 500 were invited to Glasgow Sherriff Court for gang summits where they were confronted with the effects of gang violence and offered help to turn their lives around. Gang members heard from a senior police officer, an Accident and Emergency consultant, members of their community and the parent of a victim. The senior police officer then told the gang members that if any of them - including members not present - committed an assault or murder, they would be pursued as a whole group, as in the Boston model. At the end of each session, gang members were given the freephone number of a 'one-stop shop' where they could access support in education, health services, careers advice and social services. A programme is tailor-made for each participating gang member in a bid to help them turn their life around.

Implementation of the CIRV methodology also requires communities affected by gang violence both to receive and deliver the following messages: (1) Stop the violence. We care about our young people; (2) We don't want to see them become either victims or offenders; (3) We won't tolerate violence in our community.

Results of the programme

More than half of the estimated 700 gang members participated. After the first year the programme had led to a 49% reduction in violent offending by those engaging with the initiative and an 18% reduction among gang members who declined to participate. In 2010 the two-year £5million project was extended to the north of the city, where there are an estimated 400 gang members.

Levels of gang violence in Boston rose again as the impetus was lost after the initiative was completed. Glasgow is committed to maintaining its efforts on a longer-term basis.

SECTION 1 (B) Health and Early Parenting Practice

In this section we summarise 15 interventions and approaches, grouped together because of their common focus on early years. Six are addressed under the heading of Health and nine under the heading Early Parenting Practice. Further information on each of these can be found in the relevant section of the Appendix.

HEALTH-RELATED

We have identified 7 interesting health-related practices, the first of which also encompasses early parenting practice.

- The Swedish approach to infancy and early childhood consciously puts a strong emphasis on prevention and ensuring the best possible support to parents at the beginning of a child's life, from having 100% of hospitals qualify for UNICEF baby-friendly status, through 98% of mothers initiating breast-feeding, to high levels of parenting education and support in the early years. Sweden has among the lowest rates of infant mortality and teen pregnancy in Europe. Lifetime health outcomes on measures such as deaths from circulatory disease, liver, cancer and smoking-related illnesses (see Appendix) are strikingly better than in the UK.

- The study on the effect of early postnatal breast-feeding support from Denmark demonstrates that levels of breast-feeding can be increased significantly by a well-planned intervention. We could have selected a number of other studies which showed the same conclusion.

- The World Health Organisation recommends all infants be fed exclusively on breast milk from birth to six months of age. Breast-feeding rates in England are among the lowest in Europe. 20-25% of British mothers are still breast-feeding at 6 months, compared to over 70% in Sweden, and OECD reports that in 2005 less than 1% of British mothers were exclusively breastfeeding at 6 months, compared with the EU average of 28%. Reasons cited include that fewer than 1 in 10 hospitals in England has achieved UNICEF Baby-Friendly Status compared to 100% in Sweden, 64% in Norway and 40% in Switzerland.

- Nurse Family Partnership is the most thoroughly researched and recommended early intervention in the world and since WAVE worked with its originator, David Olds, in 2006 to bring it to the UK, it now runs in this country as the Family Nurse Partnership. We have included this and an update of UK findings from initial pilot studies at the request of C4EO.

- The Community Mothers Programme (CMP) in Dublin trains experienced, volunteer mothers from the local community to visit families to provide necessary child-rearing support from the birth of a child until its second birthday. Research on the children and families at age 8 showed superior parenting skills among the programme families, children who are more likely to read books regularly, visit the dentist and have better nutritional intake. The effects also carried through to subsequent children born to the mothers.

- Centering Pregnancy is a model of group antenatal care developed at the Yale School of Public Health that has since been widely replicated. Women are engaged as active participants (e.g. measuring each other's blood pressure). With little added cost women receive 10 times more contact time. Suggested benefits include reduced preterm births, increased birth weight and increased breast-feeding initiation rate.

- Kraamzorg is a unique Dutch system of universal support for mothers for 8-10 days after they return home following a birth. Help may cover health checks (e.g. stitches clean and healing), hygiene advice, support in breast-feeding, ensuring hygiene levels in the home are high and basic household chores such as cleaning the bathroom, nursery and mother's room and taking care of meals for the mother

EARLY PARENTING PRACTICE

We identified 9 approaches and interventions aimed at improving early parenting practice.

- It is commonly said that the peak age for violent behaviour is mid-adolescence. Four decades of research by Professor Richard Tremblay demonstrate that a more accurate statement would be that while the visible consequences of violence are greatest in mid-adolescence, the peak age for aggression and violence in children is 2-3, with those children destined to be the most troublesome offenders in teenage years already distinguished at age 3 by levels of aggression 10 times higher than the most peaceable 30% of toddlers. Tremblay's research is summarised and has an important message for the most effective age of intervention to reduce violence in society.

- In 2007 the Dutch government adopted a new approach on youth and families. In policy statements very compatible with the Swedish approach to health and Tremblay's recommended approach to violence, *'Every Opportunity for Every Child'* states that the problems of children and families must be detected and addressed as early as possible, to prevent them from becoming more serious when they grow older, and calls for a focus on prevention. Emphasis was placed on ensuring a healthy, balanced upbringing for children before the age of four 'since this is the best way of ensuring that they do not develop problems when they grow older'.

- The municipality of Leksand in central Sweden has developed an innovative approach to parent groups which is now being extended to other parts of Sweden. The municipality has taken responsibility for organising parent groups and maintains the same groups from ante-natal classes through to when children are 5. The continuity this provides has resulted in a situation, five years after launch, where about half the parents were still attending the groups with as many men as women attending. This does not happen elsewhere in Sweden and is judged to be a direct result of the Leksand model. Attendance at the parent groups is high, with different social groups successfully recruited.

- Circle of Security uses edited videotapes of parents' interactions with their children to shift patterns of caregiving interactions in high-risk, caregiver-child dyads (pairs) to a more appropriate developmental pathway and to promote secure attachment. It also increases caregiver affection for the child.

- The UCLA Family Development Project sets out to break the cycle of violence, abuse and neglect among low-income families with a history of abuse or neglect. To realise these goals, a social worker begins visiting the mother's home weekly during the third trimester of her pregnancy. The goal is to establish trust and give social support to the expectant mother. After birth the visits focus on giving positive reinforcement to the mother to increase her sense of competence.

- Video-feedback Intervention to Promote Positive Parenting (VIPP) is a variation of Video Interactive Guidance (VIG) which has been developed in the Netherlands. It uses video feedback to give parents a chance to reflect on their interactions with their infant, drawing attention to elements that are successful and supporting them to make changes where desired. There have been a number of studies showing that VIPP can promote sensitivity between parents and young children, including those with attachment difficulties.

- Parents as Teachers trains and supports early-years professionals on how best to engage parents in their child's development. They develop curricula for parent education based on the latest research in child development and neuroscience and train early-years professionals to deliver these. They also supply extensive support resources both for professionals and parents, follow-up training and mentorship and annual accreditation to maintain quality. Outcome measures validate the effectiveness of the approach.

- Like Nurse Family Partnership, Incredible Years is now a well-known system in the UK. It delivers a set of three comprehensive, multi-faceted, and developmentally-based curricula for parents, teachers and children, designed to promote emotional and social competence and to prevent, reduce, and treat behaviour and emotion problems in young children. There have been numerous international and UK studies which demonstrate its effectiveness.

- The CARE-Index is a simple, versatile measure which evaluates the quality of adult-infant interaction for children from birth to 30 months. It also assesses attachment. Based on 3 minutes of videotaped play interaction occurring under non-threatening conditions, the Index assesses risk to relationships rather than demographic, medical or nutritional risks. It enables the user to differentiate abusing from neglecting, abusing-and-neglecting, marginally maltreating and adequate dyads, and also the effectiveness of interventions.

HEALTH-RELATED BRIEF OVERVIEWS

9. Approach to Infancy and Early Childhood in Sweden

In the last 20-30 years Sweden has increased investment in prevention and early intervention programmes (Killén 2000; Socialstyrelsen 1997). This commitment has been based on recognition of their value.

A comparison of societal child welfare between the UK and Scandinavia shows marked differences. Maternity healthcare services in Sweden are accessed by the vast majority of pregnant women (99 per cent), who typically have 11 individual contacts, mostly with midwives. Ninety-eight per cent of all maternity healthcare clinics offer parenting education in groups to first-time parents, with 60 per cent allowing repeat parents to participate. Additional support is provided to young mothers, single mothers and those expecting twins.

Ninety-nine per cent of all families make use of the child healthcare services, with an average of 20 individual contacts, primarily with nurses. Parents are invited to join parent groups when the child has reached the age of one to two months. In Stockholm County 61 per cent of all first-time parents participated in at least five sessions in 2002 (Bremberg 2006).

At 2.5 per cent the infant mortality rate in Sweden was the lowest in the EU in 2005, and half that in the UK. Sweden also performs very well on a number of health indicators from later life (see table in Appendix). In addition Sweden has the third-lowest rate of teenage pregnancies in the European Union at 1.6%, compared to 7.1% in the UK.

These figures strongly imply a well-resourced and professional healthcare service in Sweden, with a strong focus on prevention, and beginning at the very beginning of life with emphasis on breast-feeding (98% of Swedish mothers begin breast-feeding vs 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. 100% of hospitals have BFHI (baby-friendly) status (less than 10% in the UK) and early parent training is provided for a high proportion of the population (see also the Leksand Model in this report for an example of high population involvement including fathers). From that strong beginning it is able to improve its users' quality of life through helping them to avoid many preventable illnesses, and enabling the country to save money on both the healthcare and non-healthcare costs of those illnesses.

10. Effect of early postnatal breast-feeding support, Denmark

Duration of exclusive breast-feeding is well below the recommended level in most industrialised countries. Four months after birth, exclusive breast-feeding is seen for 45%–60% in Scandinavia. This compares to only 7% in the United Kingdom. Practical and effective intervention programmes to prolong exclusive breast-feeding are therefore needed. The aim of this Danish study was to assess the impact of a supportive intervention on the duration of breast-feeding.

Summary of findings

Mothers in the intervention group had a 14% lower cessation rate of exclusive breast-feeding during 6 months of follow-up. Similar results were seen for primipara, and multipara with previously short breast-feeding experience. Mothers in the intervention group received their first home visit earlier, had more visits and practical breast-feeding training within the first 5 weeks. Babies in the intervention group were breastfed more frequently, fewer used pacifiers, and mothers reported more confidence in not knowing the exact amount of milk their babies had received when being breastfed.

Six months after delivery 59 mothers (7.7%) in the intervention group were still exclusively breast-feeding compared to 40 mothers (4.9%) in the comparison group. In the intervention group 122 (15.6%) mothers had stopped exclusive breast-feeding during the first 5 weeks after delivery compared to 166 (20.4%) mothers in the comparison group. Corresponding numbers for multiparous mothers with previously short breast-feeding were 25 (45.5%) intervention group vs 42 (65.6%) comparison.
Conclusion: Home visits in the first 5 weeks following birth may prolong the duration of exclusive breast-feeding. Postnatal support should focus on both psychosocial and practical aspects of breast-feeding. Mothers with no or little previous breast-feeding experience require special attention.

11. Nurse Family Partnership

Nurse Family Partnership (NFP) is an evidence-based programme that helps transform the lives of vulnerable mothers pregnant with their first child. 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 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.

Summary of findings to date
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 fifteen
- 67% reduction in behavioural and intellectual problems at child age six
- 72% fewer convictions of mothers at child age fifteen
- 83% increase in labour force participation by the mother at child age four
- 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 olds (Aos et al., 2004) A second study by the same team (Aos et al., 2006) 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.

In 2006 the UK government announced that 10 demonstration sites would test the NFP in England, where it is called the Family Nurse Partnership (FNP). An evaluation was set up to document, analyse and interpret the feasibility of implementing the NFP model in England; to determine the most effective method of presenting the model; to estimate the cost of presenting the NFP model; to determine the short-term impact on practitioners, the wider service community and the children and families; and to set the groundwork for a possible longer term experimental assessment of the programme and its impacts. There are now 50 sites offering the programme in the UK.

It was decided not to focus on outcomes in this phase of evaluation, but rather to concentrate on establishing the success of the process. Nonetheless some outcome measures, such as smoking rates and breast-feeding, have been gathered. The results are highly variable by site, partly due to quality of delivery, partly to ethnic differences in the client mix.

The first two years of evaluation have taken place. Staff, clients and families are extremely positive about the programme. Key messages from the second year evaluation included:

- The FNP Programme can be delivered well in infancy, in terms of the nature of the visits and the extent to which clients are retained in the programme.
- Clients value the programme and their Family Nurse (FN) highly and report that receiving FNP is making a difference.
- Delivery in England has come close to original stretch objectives, but with substantial site variability.

- Commissioners focus on the cost of the programme, not always showing awareness of who it is intended for, what impacts might be, and the relevance of the existing evidence base from the USA (putting the programme under future funding threat).
- The cost of delivery at £3,000 per client per year appears to be approximately comparable to the USA but a substantial proportion of staff time is taken up with non-FNP activities, including professional development and mandatory NHS training.

A randomised control trial will be carried out by Cardiff University on 18 sites of FNP evaluating child outcomes, smoking in pregnancy, birth spacing and economics. Results will be available in 2013-14.

12. Importance of the near birth period, including birth, breast-feeding and risk assessment

Dyson et al (2005), in their Cochrane review of interventions for promoting the initiating of breast-feeding, comment that WHO recommends that all infants should be fed exclusively on breast milk from birth to six months of age. Breast-feeding is supported by extensive evidence for short-term and long-term health benefits, for both mother and baby.

Breast-feeding rates in England are among the lowest in Europe. 20-25% of British mothers are still breast-feeding at 6 months, compared to over 70% in Sweden, and OECD reports that in 2005 less than 1% of British mothers were exclusively breastfeeding at 6 months, compared with the EU average of 28%. A shortage of midwives and over-crowded maternity units were said to be contributors to the problem. Fewer than 1 in 10 hospitals in England has achieved UNICEF Baby-Friendly Status (a set of standards including helping women to start breast-feeding within half an hour of birth and to breastfeed exclusively for the first 6 months). This compares to 100% of hospitals in Sweden, 64% in Norway and 40% in Switzerland. Hospitals can only be designated as UNICEF Baby-Friendly when they:

- do not accept free or cheap breast milk substitutes, feeding bottles or teats, and
- have implemented 10 specified steps to encourage breast-feeding (e.g. informing mothers about the benefits, training staff to help women breastfeed, not offering dummies to infants, and ensuring mothers and babies stay together 24 hours a day while in hospital).

The UK also compares unfavourably with countries such as Netherlands and Sweden on rates of caesarean births (UK 21%, Netherlands 14%) and infant mortality (UK 4.9, Netherlands 4.6, Sweden and Norway 3.0). Given the crucial nature of the best possible start in life, the birth experience and immediate post-natal support, the perinatal experience appears to be one area where the UK could do much better. Anecdotal feedback to us from midwives with experience in both the UK and the Netherlands strongly pointed to this as one factor explaining poorer UK child outcomes.

A number of studies indicate successful approaches to promoting breast-feeding. The Dyson review referred to above showed that health education and peer support interventions can increase the number of women beginning to breast-feed. A WHO and UNICEF sponsored initiative in Belarus (Kramer et al, 2001) showed in a study of over 16,000 mother-infant dyads that infants from intervention sites were significantly more likely than control infants to be breast-fed, and more likely to be breast-fed exclusively. These children also showed lower levels of gastro-intestinal tract infections and atopic eczema. Bull et al (2004) found evidence from review-level literature that rates of breast-feeding could be improved by home visiting programmes; the New Zealand Family Commission (Dwyer, 2009) also report an RCT which increased breast-feeding (70% vs 58% for the control group).

A number of studies referred to the beneficial impact on breast-feeding of early skin-to-skin contact, beginning ideally at birth, between baby and mother (or father). (Gomez Papi 1998; Moore et al (2007). The latter study, a Cochrane review, found statistically significant and positive effects of early skin to skin contact for breast-feeding and breast-feeding duration. Higher levels of maternal affection and maternal attachment behaviour and shorter crying times by infants were also observed.

13. Community Mothers Programme (CMP), Ireland

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.

The programme trains experienced, volunteer mothers from the local community to visit families to provide necessary child-rearing support. The volunteers' motivation is to help their community with their own knowledge and experience gained through childrearing. Participation in the programme helps to increase their feelings of self-worth and their community status. It is claimed (in an unpublished thesis by Molloy (2005)) that volunteering in the CMP contributed to lifelong learning.

Summary of main findings

The children were initially monitored at age 1; one-third of the original sample group were followed up (38 in the intervention group and 38 in the control group) at age 8 (Johnson et al, 2000). It is not clear whether the smaller sample was selected (and if so, how) or whether only one third of the families could be traced. Therefore the full, long-term impact of the programme remains to be evaluated. Findings indicated that:

- Superior parenting skills persisted among the programme families
- Children whose mothers were in the CMP were more likely to read books, to visit the library regularly, to visit the dentist and to have better nutritional intake
- Programme mothers had higher levels of self-esteem and were more likely to express positive feelings about motherhood
- The effects also carried through to subsequent children born to the mothers, who were more likely to have received immunisation and to have been breastfed

14. Centering Pregnancy, USA

Centering Pregnancy is a model of group antenatal care developed at the Yale School of Public Health that has since been replicated in over 100 clinical practices in the United States and abroad. Women are engaged as active participants in this model (e.g. measuring each others blood pressure), reducing the professional-patient divide. With little added cost women receive 10 times more contact time – a significant factor in communicator public health messages. Groups often remain in contact after birth, strengthening community links.

Summary of Findings

A number of studies including at least one randomised control study of Centering Pregnancy have found that, as a model of group antenatal care, it can:

- Increase attendance rates at antenatal classes
- Reduce the number of preterm births
- Increase birth weight especially for low birth weight infants
- Increase breast-feeding initiation rate
- Increase antenatal knowledge, satisfaction with care and readiness for labour and delivery

The next intervention was a late addition and is consequently out of numerical sequence:

45. Kraamzorg, post-natal care in the Netherlands

Kraamzorg is a universal postnatal service provided in the Netherlands (via a compulsory health insurance system) in the first eight to ten days after the birth of a baby. 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 care for her baby independently and return to daily life.

The nurse shows parents how to care for their newborn baby, e.g. how to breastfeed properly, and how to bathe the baby. In the case of a home birth she will also be there after the birth to help clean up. The National Guidelines for Postnatal Care categorise kraamzorg in three levels: At the basic level support covers:

- care for mother and baby,
- regular health checks (e.g. that stitches are clean and healing, the uterus is shrinking),
- advice and instruction (hygiene, feeding etc),
- ensuring hygiene levels are high
- basic household chores which directly relate to the care of mother and baby (such as cleaning of the bathroom, the nursery and the mother's room and taking care of meals for the mother).
- support to integrate the newborn into the family

For more needy families – e.g. with large numbers of children, mental illness or communication barriers, an unstable family situation, birth of twins or problems with (breast)feeding a more comprehensive level of support is provided. In this case care may extend to looking after other members of the household (e.g. other children) and additional household tasks not directly associated with the mother and newborn.

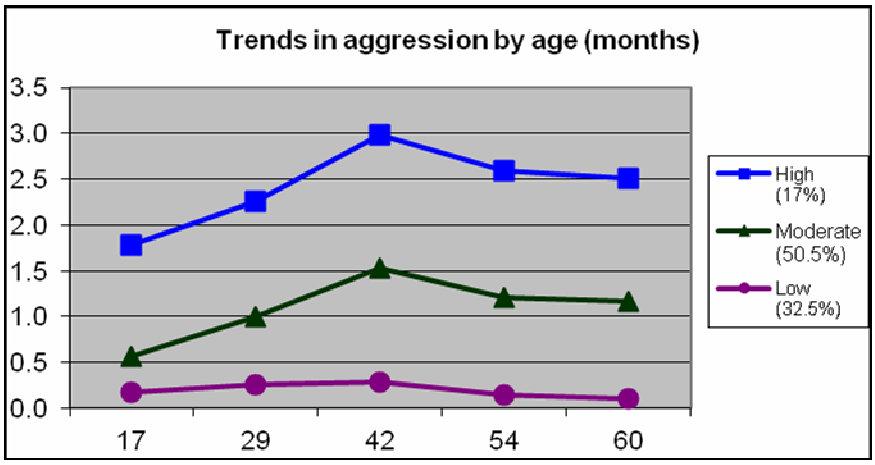
While the maternity nurse is looking after the mother she keeps a special diary called a kraamdossier to make notes about the health and progress of the mother and baby. This book is used for reference by the doctor, district midwife, health clinic etc.

When the nurse is due to leave she informs 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.

EARLY PARENTING PRACTICE BRIEF OVERVIEWS

15. Research of Richard Tremblay

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 violent adolescents did not become more violent in their adolescent years; they were already very violent at age 6. In fact comparisons at age 3 shows 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 29 months (2½ years) the 17% most aggressive toddlers are already 10 times more aggressive than the 32% least aggressive.



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. Such children need intensive interventions to help them learn alternatives to physical aggression at a time when it is developmentally appropriate, i.e. pre-school.

The factors underlying these early differences include the quality of the prenatal and postnatal environments, and gene-environment interactions. Tremblay suggests that society pays a

tremendously expensive price for not fostering the quality of early brain development in high risk children, knowing: a) that quality of this crucial organ's development ensures the quality of behaviour regulation and, b) that chronically violent youth and adults show important cognitive dysfunctions (Tremblay, 2008).

Tremblay brings a new perspective to the gene-environment by introducing the scientific term epigenetics. Epigenetics is now suggesting the environment, especially during pregnancy and very early childhood, activates and 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. He argues that a substantial increase in resources to support pregnant women, preschool children and their families would produce major rewards in prevention of mental illness and improvement in health and behaviour of the next generation.

16. Every Opportunity for Every Child

The Dutch government's 2007 Youth and Family Programme *'Every Opportunity for Every Child'* states that the problems of children and families must be detected and addressed as early as possible, to prevent them from becoming more serious when they grow older. Essentially, this calls for a focus on prevention.

Emphasis was placed on ensuring a healthy, balanced upbringing for children before the age of four 'since this is the best way of ensuring that they do not develop problems when they grow older'. Youth healthcare services were required to conduct a growth and development risk assessment for each child during its first four years, with help being given where necessary. Interventions could range from parenting support, provision of early childhood education programmes and community school activities to a youth care order. Data sharing was made mandatory.

Another principle was to confirm the family's natural role in bringing up children. Intensive use was made of the Family Group Conference approach, in which a joint plan is devised enabling families to rely on their own networks of relatives, friends and neighbours for support. Parenting support was offered to all families. A national network of youth and family centres was created to provide advice and help on parenting at neighbourhood level. Community schools, youth and family centres and other local facilities also offered advice and support on parenting.

If the safety, health or development of their children was at risk, they were to be obliged to accept help. Those reluctant to do so would, if necessary, be legally required to work with professionals to improve their parenting skills. Another principle was that undesirable situations cannot be allowed to continue. Everyone must take responsibility if there are signs that a child or family is in difficulty. Simply monitoring the situation, providing an ad hoc response or even turning a blind eye is no longer acceptable.

Prevention of child abuse was stated to be a primary aim in accordance with Article 19 of the International Convention on the Rights of the Child. 'Freedom from abuse is the right of each and every child. Prevention of such abuse is therefore the government's primary aim.'

17. Leksand Model, Sweden

The Leksand model is an innovative approach to parent groups that is now being extended to a number of other parts of Sweden. In the small community of Leksand, the municipality has taken responsibility for organising parent groups. Parents attend their first parent group before the birth of their child. Midwives are typically invited, by the municipality, to run an antenatal course for this group of parents. Rather than being disbanded at the end of the course however, the group remains intact. This is possible because although the midwife has been invited to run the sessions, they have not created the group and are not responsible for maintaining it – the municipality does this in collaboration with the parents.

The group continues to meet after birth to discuss parenting themes chosen by the parents themselves. This has continued until age 5. Further parenting programmes may be run, such as Incredible Years, by inviting professionals to deliver this to the group. The traditional professional-client roles have been reversed – it is not an Incredible Years group that parents would be attending, but a Parent Group that the Incredible Years practitioner is invited to attend. The relationships and support networks between parents is greatly strengthened in this model.

Results of the programme
In 1999–2000, parents from 91 Leksand families took part in parent group activities during pregnancy. In 2004, when the children were between 3 and 5 years old, about half the parents were still continuing, 46 women and 46 men. Because of the continuing nature of the parenting group, which men joined ante-natally, it has been found that fathers participate to about the same degree as the mothers. This is seldom if ever the case elsewhere in Sweden, strongly suggesting it is a result of the Leksand format.

Attendance at the parent groups is high, with different social groups successfully recruited. A key feature of the high level of commitment and stability in the groups is that it is also possible to introduce evidence-based programmes into these groups.

A crucial factor in the success of the model seems to be the involvement of the municipality. Midwives from the maternity healthcare services and child healthcare nurses participate but do not have main responsibility. The parents themselves 'own' the groups.

18. Circle of Security

Circle of Security is designated as a 'Reported Effective Program' by The Children's Bureau's Office on Child Abuse and Neglect of the US Department of Health and Human Services in its Emerging Practices in the Prevention of Child Abuse and Neglect project. This was initiated to identify effective and innovative programmes in child abuse and neglect-prevention around USA. Using edited videotapes of their interactions with their children, this 20-week, group-based, parent educational and psychotherapeutic intervention is designed to shift patterns of caregiving interactions in high-risk, caregiver-child dyads (pairs) to a more appropriate developmental pathway.

Summary of findings to date
Preliminary evaluation findings have been positive (Marvin, Cooper; Hoffman & Powell, 2002) suggesting that Circle of Security may have:

- Increased ordered child and caregiver strategies (ordered strategies include secure, ambivalent, and avoidant, as opposed to disorganised and insecure-other).
- Increased secure caregiver strategies.
- Increased secure child attachment.
- Increased caregiver affection, sensitivity, delight, and support for exploration.
- Decreased caregiver rejection, neglect, flat affect, and role reversal.

19. UCLA Family Development Project

The UCLA Family Development Project's mission is to break the cycle of violence, abuse and neglect among low-income families with a history of abuse or neglect. As part of that mission, the Project empowers first-time mothers' approach to parenting so it can be joyful, intimate and child-centred. This is accomplished by promoting the effectiveness and mental health of the child's primary caretaker.

Parents who have, and are still, experiencing abuse are helped to increase their own sense of efficacy and to respond effectively to the needs of their children and break the generational cycle of abuse and neglect.

The strategy to pursue these objectives is to improve the positive development of at-risk families by increasing the mother's confidence and helping her deal with pre- and post-partum depression, anxiety and potential return to drug abuse. Work with the mother is done to increase her partner and

family support and combat potential domestic abuse. This is achieved through a relationship-based home visiting programme for pregnant women at risk for inadequate parenting.

The intervention is designed to start in the third trimester and continue until the infant is 24 months old. The mission of the project is to develop the capacity of the members of a family to support each other and to recognise and meet the needs of their infant effectively. At key measurement stages and for attending mother-infant groups, participation is incentivised by small financial rewards.

Summary of Findings
In an experimental evaluation of the programme, researchers found that the Family Development Project was effective in increasing the mothers' responsiveness to their child's needs as well as the mothers' encouragement of infant autonomy and task involvement. Children in the programme were also more secure, autonomous and task-involved compared with those who did not receive the intervention.

No families dropped out before child age 2.

Mothers who did not experience the help of the intervention: had significantly more difficulty controlling their child if it was a boy as opposed to a girl, and used the least appropriate methods of control.

20. Video-feedback Intervention to Promote Positive Parenting (VIPP)

VIPP is a brief and focused parenting intervention programme that has been successful in a variety of clinical and non-clinical groups and cultures. It uses video feedback to give parents a chance to reflect on their interactions with their infant, drawing attention to elements that are successful and supporting them to make changes where desired.

Results of the programme
The evidence-base for VIPP has been building up over the last 20 years through small-scale studies in the Netherlands and the UK. Three separate studies summarise the results of this research:

1. Summarising VIPP research over the previous 10 years, Juffer et al (2007) report that interventions using video to promote sensitivity can be effective and that VIPP in particular can be effective in promoting sensitivity between parents and young children with attachment difficulties.

2. A subsequent meta-analysis (Fukkink, 2008) concluded that interventions using video feedback can increase parental sensitivity, resulting in behavioural and attitudinal changes towards children, reduced parental stress and increased self-confidence in parenting.

3. A recent DCSF review (Barlow & Schrader-MacMillan, 2009) cites evidence for the effectiveness of Video Interaction Guidance (another term for VIPP) in improving parental sensitivity.

21. CARE Index

The CARE-Index is a simple and versatile way to measure attachment for young children. Specifically, it is a method for evaluating the quality of adult-infant interaction for children from birth to 15 months (and up to 30 months using a toddler format). The adult is most often the mother; however, the procedure can be used with any adult – father, relative, health visitor or daycare provider. Assessment is based on 3 minutes of videotaped play interaction occurring under non-threatening conditions, at home or in a clinic setting.

In addition to being used for videotaped assessments, the procedure has also been applied to 'live' observations made by nurses, infant teachers, clinicians and social workers. Although such observations tend to be less reliable when video is not used, the method is reported to sharpen practitioners' observation skills and their ability to communicate both what the mother-infant dyad did, and why it should be interpreted in a particular manner.

Summary of findings to date
As a screening tool, the CARE-Index is unique because it assesses risk to relationships rather than demographic, medical or nutritional risks to individuals. It has been found to be:

- highly correlated with the infant Strange Situation assessment patterns of attachment
- able to differentiate abusing from neglecting, abusing-and-neglecting, marginally maltreating and adequate dyads
- of use during intervention
- able to assess the effectiveness of an intervention

22. Parents as Teachers, USA

Parents as Teachers is a uniquely effective capacity-building organisation that trains and supports early-years professionals on how best to engage parents in their child's development.

The organisation develops curricula for parent education based on the latest research in child development and neuroscience. It trains early-years professionals to deliver these curricula through personal visits to, and group programmes for, parents of children in their setting. It thus equips these professionals to extend their direct work with the child, to working through the parents as well.

The organisation provides extensive support to these early-years professionals through (1) a comprehensive set of resources for both the professionals and the parents they are supporting, (2) follow-up training and mentorship and (3) annual accreditation to ensure quality remains high.

Findings to Date
Research studies, including randomised controlled trials, have been conducted and supported by state governments, independent school districts, private foundations, universities and research organisations, and outcome data have been collected from more than 16,000 children and parents. Key outcomes for Parents as Teachers (PaT) include:

- PaT parents scored significantly higher than comparison parents on four of six parent knowledge scales (such as appropriate discipline, knowledge of child development)
- PaT parents read more to their children, use more techniques to support book/print concepts and have more children's books in the home
- A multi-site randomised trial showed that for families with very low income, PaT parents were more likely to read aloud, tell stories, say nursery rhymes and sing with their child
- PaT parents are more likely to initiate contact with teachers and take an active role in their child's schooling (63% vs. 37%).

23. The Incredible Years Parent, Teacher and Child Programs

Recommended in a number of UK and international reviews such as Support from the Start, Communities that Care and Blueprints, Incredible Years comprises a set of three comprehensive, multi-faceted, and developmentally-based curricula for parents, teachers and children, designed to promote emotional and social competence and to prevent, reduce, and treat behaviour and emotion problems in young children.

Summary of findings to date
A Scottish review of parenting programmes including Incredible Years (Hacker et al, 2005) including 9 evaluation studies, of which 7 were classified as RCTs, found the following conclusions from studies of Incredible Years:

- Parenting intervention has been demonstrated to improve parenting skills (use of praise, limit setting etc) and parental self-confidence
- The teacher programme has demonstrated an increase of peer- and teacher-child interaction, bonding with parents, and proactive classroom management strategies
- In relation to children, studies demonstrated an increased use of appropriate cognitive problem-solving strategies and more pro-social conflict management strategies with peers.

Children were also reported to be more socially competent and demonstrated a reduction in conduct problems at home as well as in school
- A limiting factor with this research is that Webster-Stratton (who devised the programme) has collaborated with the majority of the research studies, and therefore that objectivity may have been affected
- Further research is required to demonstrate that the intervention is effective in targeting a range of children's behavioural problems across settings

The programmes have been evaluated by independent investigators in Canada, Norway, Holland, Russia, Portugal and Scotland as well as England and Wales.

Very encouraging results were produced in a Communities That Care trial in Coventry (Manby, 2002), through Sure Start in North Wales (Bywater, 2004; Hutchings et al, 2007), and in South London with a substantial number of black and ethnic minority families (Scott et al, 2000).

SECTION 1 (C) School-related Practice

This section is broken into 3 segments: Pre-school, School and After school.

PRE-SCHOOL

The interventions in this group focus on improving young children's readiness and ability to cope with school.

- Head Start REDI is a child-development based intervention that was integrated into Head Start settings. Results show children in REDI classes do better than typical Head Start classes, with gains especially in social skills, language development and emergent literary skills.

- The Chicago School Readiness Project curricula called Emotions Matter were developed following the realisation that preschool can improve academic readiness at cost of social development. As with Head Start REDI, this programme was created for integration into Head Start settings, and the conclusion is that Head Start as a setting can be boosted by offering such curricula.

- In addition to child-readiness, the Getting Ready Project focuses on parent-readiness for the future role when their children make the transition to school. Again integrated into Head Start settings, staff are trained in engaging parents as partners and strengthening parental confidence so collaborative relations can be built.

- The Home Instruction for Parents of Pre-School Youngsters (HIPPY) is another parent-focused school readiness programme targeted at parents of preschoolers. In addition to the curriculum, books, and materials and group interaction, it provides outreach via home visits. There appears to be some evidence it improves readiness for school, grades and parents' school involvement.

- A Scottish study of 'What works in early years education' found that academic performance of children in England showed no advantage compared with those in Switzerland and Slovenia who started school 2 years later, and that issues other than school start age are significant.

SCHOOL

Although, by definition, these programmes are predominantly delivered to school-children in the school environment, there also are also some parent and teacher components included in some of them.

- The Montreal Longitudinal study was of a school-based parent training that identifies boys with disruptive behaviour in kindergarten but does not work with them until age 7. The 2-year programme then delivered showed positive impact, including lower likelihood of being involved in gangs. Follow-up at age 24 showed that two thirds of the disadvantage of these disruptive kindergarten children had been removed by this 2-year intervention at age 7-9.

- The Preparing for Drug-Free Years programme delivers 10 hour-long sessions to parents of children in the 4th to 6th grades. Parents are reached through schools, community centres, TV marketing etc, and good results have been reported.

- The Project Alert school-based anti-drug programme is delivered to grade 7 and 8 students. While the effects are fairly good, they fade over time indicating need for booster sessions. Most successful with those at highest risk. There were unclear results for younger students.

- The Seattle Social Development Project is a 3-prong intervention delivered from school, to prevent youth delinquency through teaching classroom management for teachers; behaviour management, academic support and drug-use prevention skills for parents; and problem-

solving and refusal skills for students. Age 21 follow-up showed reasonable impact on drug use, graduation rates and court charges.

- The Second Step Programme has been evaluated in Norway, Germany and the USA, and shown to result in significant Increases in fifth- and sixth-graders' Social Competence, including knowledge about empathy, anger management, impulse control, and bully-proofing.

- The Reach For Health Community Youth Services (RFH-CYS) targets 12-13 year old disadvantaged African American and Hispanic youth, delivered in school and in the community. Its aims are to prevent teen pregnancies and STD and it delivers good results, particularly for children with special educational needs.

- Roots of Empathy is an international award winning Canadian programme, now beginning to be adopted in the UK, which teaches young children how to parent babies. People tend to parent in the same style they experienced themselves as children. This programme exposes children to 9 months of experience of caring, nurturing parenting, which may affect their own later behaviour when they become parents. It also fosters empathy and can be seen to reduce school bullying

- KIPP schools is a rapidly growing American programme, grounded in high quality teaching, which takes disadvantaged youth, mainly from ethnic minority backgrounds, and closes a significant part of the black-white or poor-rich gap in educational performance.

AFTER SCHOOL

We identified one potentially fruitful after-school project.

Targeting 13-15 year olds: among girls in 6 New York City sites, the Carrera Project delayed first sex, increased the use of condoms along with another effective method of contraception, and reduced pregnancy rates for 3 years.

PRE-SCHOOL BRIEF OVERVIEWS

24. Head Start REDI (Research-based, Developmentally Informed), Pennsylvania

While Head Start children do significantly better than their counterparts on some cognitive and social-emotional indices, a 2005 study (USDHHS) showed no significant improvement on important aspects of school readiness such as oral comprehension skills, phonological awareness, aggressive behaviours, and social skills.

Head Start REDI was therefore developed in partnership with Head Start programmes to target the promotion of specific school readiness skills in the domains of social-emotional development and cognitive development. Targeted skills in the social-emotional domain include prosocial skills, emotional understanding, self-regulation and aggression control. Targeted skills in the cognitive domain include language and emergent literacy skills.

Summary of findings to date

Compared to children in usual practice Head Start classrooms, children in REDI classrooms showed increased gains in:

- Emergent literacy skills, including vocabulary growth, phonemic awareness, and letter recognition
- Social behaviour, including higher levels of positive social behaviour and lower levels of aggressive behaviour
- Learning engagement, including gains in concentration and task focus

Working memory and attention control predicted growth in emergent literacy and numeracy skills during the pre-kindergarten year, and made unique contributions to the prediction of kindergarten math and reading achievement.

25. Emotions Matter: Classroom-based Integrated Intervention (Chicago School Readiness Study)

Results of a recent US nationally representative sample suggested low-income children experienced short-term academic benefit from having attended pre-school but that their emotional and behavioural adjustment was placed at substantially greater risk in the long run (Magnusson, Ruhm, and Waldfogel, 2007). This 'trade-off' is alarming and signals the need for targeting pre-school classroom processes to support rather than compromise young children's emotional and behavioural development.

This intervention sets out to address the pressing need for effective, evidence-based interventions that can be implemented in pre-school programmes in low-income neighbourhoods.

Summary of findings to date

Compared with children in the control group, children in the intervention group on average had significantly lower scores on the BPI Internalising scale and the BPI Externalising scale scores.

On average, children enrolled in CSRP classrooms were reported by teachers to manifest significantly fewer signs of sadness and withdrawal than were children in the control group. The CSRP model of intervention also demonstrated efficacy in reducing pre-schoolers' externalising behaviour problems, including children's symptoms of aggression and defiance.

Results from the independently assessed classroom observations provided important converging evidence on this impact.

Findings were strongest for children facing lower levels of poverty-related risk.

The findings provide powerful evidence that pre-school programmes can be leveraged to provide important behavioural as well as academic intervention and support. Follow-up sub-group analyses suggest, when children in the intervention group were compared with their racial/ethnic- and gender-matched control group peers, the intervention led to significant, albeit smaller, reductions in boys' and African American children's behaviour problems as well as more pronounced improvements in the girls' and Hispanic sub-group.

Analyses are currently underway to detect whether CSRP-enrolled children sustain these improvements as they make transitions to new kindergarten classrooms.

26. The Getting Ready Project, Nebraska

Many children do not possess the social-emotional competence necessary to function effectively in a formal educational setting (Raver and Knitzer, 2002). 46% of American kindergarten teachers reported that more than half of their incoming students did not possess the basic social and emotional competencies necessary to succeed in school (Rimm-Kaufman, Pianta and Cox, 2000). 34% of teachers reported that more than half their kindergarten entrants had difficulty working independently and 30% found that more than half of children enter with difficulties working as part of a group.

We hear very similar stories of children arriving at Reception classes in schools in the UK.

This approach is designed to advance the research-base from one that focuses simply on 'child readiness' for school to one that addresses 'parent and child readiness' to engage in the schooling across the early childhood spectrum and transitions across contexts.

Summary of findings to date

Statistically significant differences were observed between treatment and control participants in the rate of change for certain interpersonal competencies (attachment, initiative and anxiety/withdrawal).

The intervention group gained three fourths of a standard deviation overall over the entire 2-year intervention period more than the control children on the DECA Attachment scale.

Significantly different rates of change were seen in children in the treatment group relative to controls in the area of *initiative* for a net gain of more than one half of a standard deviation relative to control children over two years.

In contrast, no statistically significant differences between groups over a two-year period were noted for behavioural concerns (anger/aggression, self-control or behavioural problems).

The intervention appears to be particularly effective at building social-emotional competencies beyond the effects experienced as a function of participation in Head Start programming alone.

27. HIPPY (Home Instruction for Parents of Preschool Youngsters)

HIPPY is an international programme that started in Israel and has since spread to Germany, New Zealand, Australia, South Africa, Canada and the United States. In 2007 there were 146 HIPPY programme sites in 25 states of the USA serving over 16,000 children and their families. It is a parent involvement, school readiness programme that helps parents prepare their three, four, and five year old children for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books and materials designed to strengthen their children's cognitive skills, early literacy skills, social/emotional and physical development.

HIPPY is dedicated to increasing the chances of positive early school experience among children who may be educationally at risk; empowering parents to view themselves as primary educators of their children; creating an educational environment in the home that encourages literacy; fostering parental involvement in school and community life; providing parents with the opportunity of becoming home visitors in their own community; helping home visitors develop skills and work experience needed to compete successfully for other jobs in local labour market; stimulating the cognitive development of the child; improving interaction between parents and their children; teaching parents and children the joy of learning; breaking through the social isolation of the parents.

Summary of findings

International research indicates positive impacts of HIPPY on children's school readiness when entering Kindergarten and first grade and on performance in higher grades; and also on parents' involvement with their children's education.

28. What works in Early Years Education

This summary is based on a Scottish review of international approaches to Early Years Education.

Summary of findings

Though there are at least five distinct, widely-used international approaches to early years education, there is no research base to favour one over any other.

There is evidence of the effectiveness of early years education, especially for disadvantaged children and those who suffer social, emotional or psychological disadvantage.

In the National Institute of Child Health and Development studies (NICHD, 2002, 2005) of the effects of child care from birth to 4 years 6 months, distinct benefits and risks were found to be associated with the quality, quantity and type of early care and education. Higher quality provision predicted better pre-academic skills and language, and out-of-home settings improved language and memory. However the quantity of time spent from birth in non-maternal early care and education was associated with behavioural problems which lasted throughout the primary grades. The Effective Provision of Pre-School Education (EPPE) project (Sylva et al, 2004) also found a significant relationship between higher quality provision and practice and better intellectual and social/behavioural outcomes. Part-time provision was as beneficial as full-time.

Two studies comparing the academic performance of English school-children with those in Slovenia who did not start primary school until two years later, and in Switzerland with children almost a year younger and starting school one year later, suggest no performance advantage from the earlier English start.

The POST report (2000) suggests one reason may be that the academic ability in the English reception class was much more variable. They argue that these results and other work on school starting age demonstrate that an early school starting age confers little advantage by nine years old and is less effective in ensuring educational standards than homogeneity in ability which allows the group to progress at a faster and more uniform rate. The POST report concludes that greater effectiveness in ensuring attainment might be achieved by increasing the flexibility of the school starting age.

SCHOOL BRIEF OVERVIEWS

29. The Montreal Longitudinal-Experimental Study, Montreal

The objective of this parenting skills and children's social skills treatment was to employ parent training to reduce disruptive behaviour identified in kindergarten boys of low socio-economic origin, and thereby move them off the trajectory leading from early aggressive, antisocial behaviour to later aggressive, delinquent behaviour. The intervention commenced when the boys were age 7 and lasted 2 years. Follow-up at age 24 showed that two thirds of the disadvantage of these disruptive kindergarten children had been removed by this 2-year intervention at age 7-9.

Summary of findings to age 12

By the end of primary school, the behaviour of the disruptive boys in the untreated group confirmed previous research findings, that physical aggressiveness and academic problems are predictors of delinquency that are identifiable early on in a child's development. The research also confirmed that social intervention can positively affect the social development of disruptive boys. Compared with the untreated boys, the boys who received the intensive multi-faceted treatment:

- exhibited less aggression and fighting in school,
- performed well academically more often,
- experienced fewer difficulties in adjusting to school, and
- reported committing up to 75% fewer (depending on category) delinquent acts up to three years after the end of treatment
    - major theft figures at 5% vs 19% for bicycles and 7% vs 20% for items over $10 were particularly striking;
    - minor theft at 19% vs 45% and trespass at 40% vs 62% less so.

However, no significant differences were found between the treated and untreated boys in terms of hyperactivity, prosociality and vandalism.

At age 15, those receiving the intervention were less likely than untreated boys to report gang involvement, having been drunk or taken drugs in the past 12 months, having committed delinquent acts (stealing, vandalism, drug use), and having friends arrested by the police (no specific statistics provided). Follow-up at age 24 showed lasting effects reflected in significantly higher rates of high school graduation and lower levels of criminality.

30. Preparing for the Drug Free Years (PDFY), USA

PDFY offers schools and communities a well-researched, universal parenting programme that increases protective and reduces risk factors, and ultimately decreases problem behaviours among teens.

Summary of findings to date

Evaluation studies of PDFY have addressed two major issues: 1) the success of dissemination and 2) the efficacy of the programme.

The evaluation studies to date provide promising evidence that the PDFY programme is appropriate for general and diverse populations and that it can be successfully disseminated. Most important, these studies show that PDFY improves parenting practices in ways that reduce risk factors and increase protective factors for adolescent problem behaviours.

The experimental findings are promising in several respects. The studies demonstrate the applicability of PDFY when looking at specific targeted outcomes. Data from the observations of workshop leaders show that training community members to lead workshops is effective. In addition, the studies show that most parents, once they agree to participate in the programme, will attend most of the PDFY sessions.

31. Project Alert and Project Alert Plus, USA

The programme is delivered to 7th and 8th grade students in 50 states. 'Project ALERT buys time for youth. Every year of forestalled substance use makes teens that much more mature and savvy when confronted with internal and external pressures to smoke, drink or use drugs.' But '… the positive outcomes on drug use seen in to 7th and 8th grades erode once the Project ALERT lessons are discontinued. As other studies have shown, maintaining the effects of classroom prevention efforts requires booster programs after adolescents make the transition into high school. To address this issue, RAND has developed and is currently testing a combination middle school and high school curriculum, called ALERT Plus, that aims to sustain the program's positive effects over time.'

On the face of it, the findings by RAND look very promising. However, another randomised control trial (by Stephen R. Shamblen, PhD for Pacific Institute for Research and Evaluation, Chapel Hill, North Carolina), delivering the programme to one year younger students (6th and 7th instead of 7th and 8th grades) did not find any significant improvement in their attitudes to the substances, but their Abstract does not clarify the actual findings of usage, which would need to be investigated.

Summary of findings to date
Most positive results were achieved with students who were not users of substances –

- Onset of tobacco, alcohol and marijuana use was delayed, and usage reduced.
- About 40% of students who had experimented with cigarettes did not go on to become regular smokers.
- The project led to 20% reduction in alcohol misuse by the highest-risk early drinkers.
- Effects were eroded when the lessons were discontinued, triggering the introduction of 'booster' sessions.

32. Seattle Social Development Project (SSDP)

This was a multi-year, school-based intervention that used a risk-reduction and skill-development strategy to improve outcomes for participating children and youths. The programme was guided theoretically by the social development model, which hypothesises that youths who are provided with opportunities for greater involvement with their schools and families, who develop the competency or skills they need for fuller participation with their schools and families, and for whom skilful participation is constantly reinforced, ultimately develop strong bonds with their families and schools. Further, the model proposes that these strong bonds set children on a positive developmental trajectory, resulting in more positive outcomes and fewer health-risk behaviours later in life. The SSDP was first implemented in 1981. It combined teacher, child, and parent components with the goal of improving children's bonding with their families and schools. Teachers were trained in proactive classroom management, interactive teaching, and cooperative learning, while the students themselves were provided with direct instruction in interpersonal problem-solving skills and refusal skills to avoid problem behaviours. Parents were offered courses in child behaviour management skills, academic support skills, and skills to reduce their children's risk of drug use.

The age-21 follow-up by Hawkins et al. (2005) reported that full participation students were significantly more likely to have graduated from high school; reported significantly fewer thoughts of suicide; had fewer symptoms of depression; fewer symptoms of social phobia; were significantly less likely to have sold illegal drugs in the past year; were significantly less likely to have had a court

charge; and were marginally less likely to have used alcohol, tobacco, or illicit drugs in the past month or year.

33. Second Step Programme

Significant Increases in Fifth- and Sixth-Graders' Social Competence

Two recent journal articles describe a study of the effects of the Norwegian version of the Second Step programme, *Steg for Steg,* on fifth- and sixth-grade students. The first set of findings from the study showed that the programme resulted in significant increases in social competence for both boys and girls across the fifth and sixth grades. The second set of findings showed that low-socioeconomic-status (SES) students reported greater improvement in social competence, school performance, and satisfaction with life, compared to their middle- and upper-SES peers.

The impact of Second Step has also been evaluated in Germany and in the US. A University of Washington study examined the effectiveness of Second Step in helping children resolve conflicts, avoid disputes, and behave more prosocially (Frey et al, 2005); a study by Edwards et al (2005) found significant gains by schoolchildren in knowledge about empathy, anger management, impulse control, and bully-proofing; Cooke et al (2007), in a city-wide implementation of the programme, found students showed significant improvements in positive approach/coping, caring/cooperative behaviour, suppression of aggression, and consideration of others. Nearly three-quarters of teachers reported that the Second Step programme helped their students during the implementation year, and 91.7 percent said that the Second Step programme would help their students in the future. The German study evaluated a curriculum to prevent violence in elementary schools (Schick, A., & Cierpka, M., 2005).

34. Reach for Health Community Youth Services, USA

The Reach for Health Community Youth Services Program *(RFH-CYS)* targets economically disadvantaged 12-13 year-old African-American and Hispanic youth living in urban areas. The programme combines a classroom teaching component with community service work. The intervention, as implemented, provides opportunities for middle school students to participate in service activities within their communities while simultaneously reducing early and unprotected sexual activity. The programme builds upon community-based service learning. It includes a health promotion curriculum (*Reach for Health*) that is based upon *Teenage Health Teaching Modules*. The curriculum includes information on human sexuality. The health curriculum consists of 40 core lessons that focus on three primary health risks faced by urban youth: 1) drug and alcohol use; 2) violence; and 3) sexual behaviours that may result in pregnancy or infection with HIV and other STIs.

Students spend about three hours each week providing service in community settings, such as nursing homes, senior centres, full-service clinics, and child day care centres. Under the guidance of their health teachers as well as staff from placement sites, students perform such tasks as reading to elders, assisting with meals, and helping with exercise, recreation, and arts. Students prepare for their service activities by learning more about the organisation to which they are assigned and by setting personal goals for their service learning.

Summary of findings

At follow-up six months later, reports of sexual activity were higher across the sample. However, students in the control condition showed greater increases in risk behaviour (ever had sex, recent sex, recent sex without condom, recent sex without birth control) than did their peers in the treatment conditions. In contrast, students in both intervention conditions showed increases in their use of STD protection and birth control. Also noteworthy are the findings that eighth graders and special education students showed the greatest improvement. Specifically:

- Delayed initiation of sexual intercourse
- Reduced frequency of sex
- Increased condom use
- Increased use of contraception
- Long-term: Sustained reduction in rates of initiation of sexual intercourse

- Long-term: Sustained reduction in frequency of sex

Long-Term Impact

- Delayed initiation of sexual intercourse—Follow-up when youth had reached 10th grade found that CYS+ youth were less likely than youth who received only the health curriculum to report having initiated sex or to report recent sex. Among those who had not had sex at baseline, 44% of male and 57% of female CYS+ youth had not initiated sex by 10th grade, compared to 27% of males and 47% of females who received only the curriculum.
- Reduced frequency of sex—Similarly, sexually experienced curriculum-only youth were more likely to report recent sex than were sexually experienced CYS+ youth. Among sexually experienced curriculum-only youth, 69% of males and 47% of females reported recent sex versus 45% of sexually experienced CYS+ males and 38% of sexually experienced CYS+ females.

The following two interventions were late additions, and so are numbered out of sequence.

46. Roots of Empathy, Canada

Roots of Empathy (ROE) is a parenting programme designed to foster empathy; develop emotional literacy and reduce bullying, aggression and violence. A prime goal is to teach children how to handle babies and to prepare them for responsible and responsive parenting.

Delivered to school children from ages 3 to 14, local parents make 9 monthly visits to the school with their baby, spending an hour with the children. Babies are aged 2-4 months at the beginning of the ROE programme and about 1 year at the conclusion. Children who may never have experienced loving, caring, empathic parenting in their own lives have 9 months of exposure to, and indeed sharing in, parenting of that nature. This may be an extremely important influence on their future parenting, and the perceived value of the programme has led to its being recommended by the Dalai Lama and Barack Obama, as well as WAVE Trust.

During their 9 months exposure to the parents and baby the children learn emotional literacy, human development, infant safety and how to identify with another person's feelings. Children prone to developing violent behaviour patterns are connected with emotionally satisfying parenting, through interaction with visiting parents and their babies. They learn how to see and feel things as others see and feel them, and understand how babies develop.

Research evaluations have found increased understanding of emotions; perspective taking; helping, sharing, cooperating, being kind and trustworthy; and decreased aggression and bullying.

The programme is being delivered to over 50,000 children per annum in 2,000 classrooms in Canada, USA, Australia and the Isle of Man. It will be introduced in Northern Ireland and Glasgow this year (2010).

47. KIPP Schools (Knowledge is Power Program), USA

The Knowledge Is Power Program (KIPP) is a network of public charter schools designed to transform and improve the educational opportunities available to low-income families. There are 82 KIPP schools operating in 20 different states: 16 elementary schools, 55 middle schools, and 11 high schools, with over 21,000 students.

The two original KIPP schools were set up in Houston and the Bronx, Texas Education Agency has recognised KIPP Academy Houston as an 'Exemplary School' and New York City Department of Education rates KIPP Academy New York as the highest performing public middle school in the Bronx.

KIPP schools enrol all interested students, space permitting, irrespective of prior academic record, conduct, or socioeconomic background. Over 90 percent of KIPP students are African American or Hispanic/Latino, and more than 80 percent of KIPP students are eligible for the federal free and reduced-price meals programme.

KIPP schools share a core set of operating principles known as the 'Five Pillars', These are:

- High Expectations
- Choice & Commitment
- More Time
- Power to Lead
- Focus on Results

Achievement levels of KIPP students are often substantially higher than those of schools serving similar populations of low-income, minority students, despite having lower average ability than comparative schools at school entry. A recent independent evaluation by Mathematica reported that, three years after entering KIPP schools, many students had benefited from the equivalent of an additional year of instruction, enough to make substantial reductions in race- and income-based achievement gaps.

AFTER SCHOOL BRIEF OVERVIEWS

35. The Carrera Project, USA

This Children's Aid Society comprehensive youth development programme is for at-risk teens who participate for 3 years or more from starting ages 13-15. The programme is provided after school at local community centres and runs for about 3 hours each week (average attendance 16 hours per month for 3 years). It is the only programme with strong evidence that, among teenage girls, it delayed sex, increased simultaneous use of condoms and other more effective contraceptives, and reduced both pregnancy and birth rates. Furthermore, the programme had very long term effects—that is, effects that lasted three years after girls joined the programme. It did not have significant positive effects on the sexual behaviour of boys.

Summary of findings to date

Philliber, Kaye and Herrling (2001) conducted a rigorous, three-year, random assignment evaluation of the CAS-Carrera programme, collecting data from 12 sites in New York City, Maryland, Florida, Texas, Oregon and Washington, where the CAS-Carrera programme was implemented for purposes of this study. 1163 teens volunteered to participate (with parental support):

- 70% of the Carrera group teens were still involved at the end of 3 years.
- At age 17, compared to the control group females, Carrera group females were 40% less likely to have ever been pregnant and 50% less likely to have ever given birth.
- Examining school preparation, programme participants, especially males, were significantly more likely than the control teens and control males to believe that the quality of their schoolwork had improved.
- On PSAT verbal and math portions, Carerra teens were significantly more likely to have higher scores than the control group, and Carrera females were significantly more likely to have higher scores on the verbal portion.
- Carrera teens were also significantly more likely to have made college visits.
- Attempts at replication have had less positive results; fidelity to programme model in terms of training, quality of delivery staff and use of programme materials appears to be the issue.
- Among girls in 6 New York City sites, it delayed first sex, increased the use of condoms along with another effective method of contraception, and reduced pregnancy rates—for 3 years.

SECTION 1 (D) Social Care and Family Welfare Practice

This section is divided into 2 segments: Social Care and Family Welfare Practice. In this instance, we have run the opening one-paragraph descriptions on from each other because the subject matter is so closely related. A violence risk-assessment approach (the Cracow Instrument) appears at the end of the Social Care section.

SOCIAL CARE

- There is good evidence for the effectiveness of Healthy Families America in preventing child maltreatment. It is a national initiative to help parents of newborns get their children off to a healthy start. While participation is strictly voluntary, outreach is included in the initiative. Crucially, the home visiting is carried out by trained Family Support Workers rather than health visitors.

- Highland Region in Scotland has set up a streamlined reaction system which ensures that the situations for at risk children are dealt with effectively, and in a streamlined manner, the first time they 'show up on the radar', thus saving the costs and consequences of children remaining in 'the system', generating public cost, for years to come. It is a particularly innovative and interesting model of effective multi-agency working. Senior staff in Highland claim that the streamlined reaction approach has led to greater cost efficiency, lower juvenile crime and less child abuse. A comparison is made with the Croydon Total Place approach, with which there are some similarities.

- The Croydon Total Place initiative has similarities with the above Highland Region approach, including team-working across agencies, single points of contact for difficult families, early identification etc, plus a number of additional ideas such as involvement of the community, proactively engaging parents and an Early Years Academy to train staff. An approach combining the best of both the Highland Region and Croydon models could deliver much improved outcomes for children as well as significant cost savings.

- The Parent Child Interaction Therapy programme is unique in its delivery of live coaching to parents (via earpiece and 1-way mirror) and has delivered good results with parents of young children where there are conduct/maltreatment issues.

- The more holistic approach to looked-after children employed in Denmark and Germany ('social pedagogy') achieves better results in all measurable outcomes than those achieved in England. Further, the study sample revealed almost twice the ratio of staff to children in England compared to Denmark and Germany. This Petrie et al study also demonstrates a strong link between the level of staff qualification and levels of teenage pregnancy.

- The Bucharest Early Intervention Project shows the negative impact of early institutionalisation, and the benefits of transfer to foster care, at the earliest possible age. These results contrast sharply with outcomes reported from Denmark (see above), and could indicate that it is not institutionalisation *per se* that is damaging, but the absence of an holistic approach to caring for children, whatever the setting. Also, exceptional care had been taken in appointing and training suitable foster families, and then working closely with them throughout the trial.

- Children are more prone to become delinquent following the divorce of their parents. The Early Development of Delinquency within Divorced Families study showed that intervention can significantly reduce delinquency in such children over time.

- The Cracow Instrument comprises a comprehensive list of empirically and theoretically validated risk factors for youth violence. Study so far indicates that this risk assessment tool is capable of revealing significant correlation between (1) scores totalled for the pre-perinatal period with (2) scores totalled for the early childhood period and (3) anti-social behaviour several years later.

FAMILY WELFARE

- The Iowa Family Development and Self-Sufficiency (FaDSS) family development and self-sufficiency programme was created to assist Family Investment Program (FIP) families with significant or multiple barriers to reach self-sufficiency. The resulting savings in FIP and income tax revenue raised enables the programme to fulfil its basic requirement of paying for itself.

- With its shift from reaction to prevention, support rather than eviction, the Dundee Families Project has been very successful (including cost-effectiveness) at rehabilitating families whose antisocial behaviour had put them at risk of homelessness, with the attendant risk of children needing to be taken into care.

SOCIAL CARE BRIEF OVERVIEWS

36. Healthy Families America, USA

Healthy Families America (HFA) is an evidence-based home visiting programme model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is the primary home visiting model designed to work with families who may have histories of trauma, intimate partner violence, mental health and/or substance abuse issues.

This is a national initiative to help parents of newborns get their children off to a healthy start. Participation in HFA services is *strictly voluntary*. HFA offers home visiting and other services to families in over 450 communities, with a ninety percent acceptance rate.

Summary of findings to date

HFA has a strong research base which includes randomised control trials and well designed quasi-experimental research. In 2006, HFA was named a 'proven program' by the RAND Corporation based on research conducted on the Healthy Families New York programmes. To date, research and evaluation indicate impressive outcomes. Reviews of more than 15 evaluation studies of HFA programmes in 12 states produced the following outcomes:

- Reduced child maltreatment;
- Increased utilisation of prenatal care and decreased pre-term, low weight babies;
- Improved parent-child interaction and school readiness;
- Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services;
- Increased access to primary care medical services; and
- Increased immunisation rates.

37. Highland Region Streamlined Reaction - A proposed pioneering model for children's services in local authorities

We identified from Scotland a local authority approach to child protection and children's and social services which could be a blueprint for more efficient (and possibly cheaper) delivery of these services in local authorities in England. The Scottish (Highland Region) approach is particularly interesting because it has been running for ten years and so there has been time to assess its impact in practice.

The interest in this model is heightened by the fact that it has many similarities to the approach proposed in the recent Croydon Total Place report on Early Intervention. Although the Croydon approach is preventive while the Scottish approach is reactive, in other respects they have striking similarities. The Croydon Total Place report concluded that very significant cost savings could be made by a switch to their intended model of working, while at the same time delivering better outcomes for children. The Scottish experience lends credibility to the Croydon conclusions and while both models lack the inclusion of an array of specific, proven early intervention projects (and both

could be strengthened by this) a fusion of the Highland and Croydon models could be a powerful blueprint for local authorities in England.

Results
Senior staff in Highland, who have been in place for the 10 years of their revised approach, report that the streamlined reaction methodology has led to greater cost efficiency, lower juvenile crime and less child abuse – further that the trend in these figures is improving at a time when some are worsening for Scotland as a whole. Some hard data has been obtained in support of these claims (see Appendix), but not as much as we would wish, and we would like to be able to investigate the underlying data in more depth. However, the claims do have similarities to the projected benefits from the similar Croydon Total Place approach.

Croydon Total Place
Similarities between this (proposed) system and the Highland Region approach include team-working across agencies, single points of contact for difficult families, early identification of problems and a determination to ensure things are right at the beginning of a child's life rather than allowing problems to develop and then addressing them expensively (and ineffectively) at a later age.

Croydon has a number of additional ideas such as involvement of the community, proactively engaging parents and an Early Years Academy to train staff.

In theory the Croydon approach should produce better results because it intervenes before harm is done to children rather than (only) reacting rapidly afterwards. McLeod and Nelson (2000) identified that this was a more effective form of intervention. The Croydon model projects net savings of £25m in 6 years from an upfront investment of £2.5m.

An approach combining the best of both the Highland Region and Croydon models could deliver much improved outcomes for children plus significant cost savings.

38. Parent Child Interaction Therapy (PCIT)
Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct-disordered young children that emphasises improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behaviour and decreasing negative behaviour.

Summary of findings to date
At least 30 randomised tests have found PCIT to be useful in treating at-risk families and children with behavioural problems.

Parent-child interaction therapy has been found to reduce future child abuse reports among physically abusive parents.

Reductions in observed negative parenting behaviours facilitated this benefit. At pre-treatment baseline, negative and positive parental responses were about equally likely to follow a child's positive behaviour. This pattern changed rapidly during PCIT, with rapid increases in positive parental responses and decreases in negative parental responses to appropriate child behaviour.

A quadratic growth pattern accounted for 70% of observed variance and virtually all change occurred during the first three sessions.

39. Holistic approach to looked-after children, Denmark and Germany
The commitment to improve care provision for UK looked-after children is reflected in numerous government initiatives during recent years. A comparison of the outcomes for children in residential homes in England, Germany and Denmark demonstrates more successful outcomes with lower numbers of staff possessing higher levels of skill and qualifications in both Denmark and Germany. These countries employ social pedagogy, an academic discipline concerned with theory and practice

of holistic education and care. This requires care homes to be staffed by people with far higher levels of qualification than is usual in the UK.

Summary of key findings from comparison

- Delivery of care is structured differently across the countries. England augments local authority provision with for-profit private care (Denmark and Germany augment with non-profit and church run organisations)
- Almost half of Danish establishments in a cross-country review provided education for residents, compared with a quarter of those in Germany and 1 in 5 English homes.
- Both Germany and Denmark had far lower ratios of care home staff to children than England
    - 2.1 staff per child in Germany; 2.5 staff per child in Denmark; 3.7 staff per child in England
- Levels of professional qualifications in care home staff varied between the countries as follows:
    - Denmark – high (94% with degree level qualifications, predominantly in pedagogy; 3% with none)
    - Germany – medium (51% with high qualifications; 2% with none)
    - England – low (20% with high qualifications; 36% with none)
- Residential care is seen as a positive alternative in Denmark and Germany, not a 'last resort' as it is in England. The proportion of all looked-after children in care homes rather than foster care was, therefore, also much higher in Germany (59%) and Denmark (54%) than in England (29%).
- Young people leave care at an earlier age (16-18) in the UK than is general in western Europe, where it is not unusual for vulnerable youngsters to remain in some form of residential care until well into their 20s.
- Qualitative and measurable outcomes for cared for children varied significantly:
    - English care homes came out bottom on: contact between the children and their families, contact between social workers and the children's families, children's contact with non-residential friends, and with the community, and staff skill in providing emotional support.
    - under-16-year-olds not attending school (Denmark 1.6%; Germany 2.2%; England 11.6%)
    - Levels of youth employment (16-18) years
        One third in some form of paid work in Denmark and German; 4% in England
    - Incidence of criminal offending
        (offences per child: Denmark 0.158; Germany 0.092; England 1.730)
    - Incidence of violence towards staff
    - Incidence of teenage pregnancy (defined as under 19 years)
        Denmark: no issue; Germany: half that of England (which is 2.5 times the national average)

Link between teenage pregnancy and qualification/quality of staff

Close analysis showed that the following 3 staff characteristics together accounted for **nearly 30%** of the variation in reported rates of pregnancies in under-19-year-olds:

- higher rates of in-service training,
- offered more fact-seeking responses to hypothetical dilemmas involving young people, and
- intended to carry on in their current post for longer.

After in-depth analysis for country issues, Petrie et al concluded:

> ***'…In the present sample, we may conclude that cross-country differences in the care population did not account for risk of teenage pregnancy; staff characteristics did.***'
>
> (Petrie et all, 2006, p.107)

40. The Bucharest Early Intervention Project

In this randomised controlled trial on 'Cognitive Recovery in Socially Deprived Young Children' Nelson et al (2007) compared abandoned children reared in institutions to abandoned children placed in institutions but then moved to very high quality, specially trained and supervised foster care.

Young children living in institutions were randomly assigned to continued institutional care or to placement in foster care, and their cognitive development tracked to 54 months of age.

The cognitive outcome of children who remained in the institution was markedly below that of never-institutionalised children and children taken out of the institution and placed into foster care. The improved cognitive outcomes observed at 42 and 54 months were most marked for the youngest children placed in foster care. These results point to the negative sequelae of early institutionalisation, suggest a possible sensitive period in cognitive development, and underscore the advantages of high-quality family placements for young abandoned children.

These results from research into looked-after children in Romanian care homes contrasts sharply with the outcomes reported from Denmark (see above) and reinforces the need for an holistic approach to caring for children, whatever the setting.

41. Early Development of Delinquency within Divorced Families

The Oregon Social Learning Center evaluated a randomised preventive intervention trial into early development of delinquency within divorced families.

Divorce can be a trigger for greater delinquency by children, due to upset, anger, sense of loss. This intervention targets the mother, after divorce, and shows delinquency can be reduced by a well-designed intervention, targeted at specific at-risk families, during this vulnerable time. The intervention:

- Identifies children of recently divorced parents as being vulnerable to delinquency
- Offers supportive intervention to newly divorced/divorcing mothers
- Focuses on parenting practices/issues relevant to divorce process (e.g. managing conflict)
- Showed a significant impact on children's subsequent delinquency

Summary of key findings

Extract from evaluation:

Delinquency exhibited a pattern of linear change with the experimental and control groups beginning to diverge at 24 months and becoming significantly different at 36 months, ($p < .05$). Overall, the fitted linear slopes indicated that the intervention significantly reduced delinquency over time and, further, the intervention operated through hypothesised mechanisms

This paper reports on an experimental test of coercion theory early onset model of delinquency. Results are from the Oregon Divorce Study-II, a randomised preventive intervention trial with a sample of 238 recently separated mothers and their sons in early elementary school. The objective was to experimentally manipulate parenting variables hypothesised to influence development of delinquent behaviours. Multiple-method assessment spanned 36 months. Because the intervention focused on parent training, we expected that any intervention effects on changes in child outcomes would be mediated by hypothesised intervening mechanisms. Linear growth models showed significantly greater reduction in boys' delinquency and deviant peer affiliation in the experimental group relative to the controls. Subsequent models demonstrated that the intervention effect on delinquency operated through growth in parenting and reduction in deviant peer affiliation.

42. Cracow Instrument (NATO Science Series)

Researchers at an Advanced Research Workshop conducted by NATO in Poland identified a comprehensive list of empirically and theoretically validated risk factors for youth violence. It is a developmental framework that covers the period from before birth up to the time when they become adults including, uniquely, the impact of interventions on reducing their risk. With some adaptation it can be used as a risk assessment tool to identify children on a pathway to violence.

Findings
While further validation is needed, preliminary data from an investigative study (Losel and Bender, 2006) shows significant correlation between (1) scores totalled for the pre-perinatal period with (2) scores totalled for the early childhood period and (3) anti-social behaviour several years later.

FAMILY WELFARE BRIEF OVERVIEWS

43. Family development and self-sufficiency program (FaDSS), Iowa

Iowa's Family Development and Self-Sufficiency (FaDSS) Grant Program was created to assist Family Investment Program (FIP) families with significant or multiple barriers reach self-sufficiency. FaDSS provides services that promote, empower, and nurture families toward economic and emotional self-sufficiency.

Participation in FaDSS is a voluntary option for people receiving Family Investment Program (FIP) benefits.

The programme itself is also required to be self-sufficient and must show net financial savings each year by the families being employed and off welfare.

Work with the children becomes a natural outgrowth and every Family Development Specialist is automatically authorised as a Mandatory Child Abuse Reporter, because they are often the first to see things happening. The programme:

- tackles the right families and is focused on doing something for them i.e. increasing their income
- generates savings (off welfare) + earnings (tax revenue);
- gives the right message to children about the importance of work; and
- 'slips in' early interventions incidentally.

Results of the programme
Its success has been such that it is now delivered in all 99 counties in the state of Iowa.

- During the financial year, FaDSS families earned total wages of $4,986,881 resulting in a FIP savings of $1,329,398.
- In FY 2009 17% of FaDSS heads of households were employed at programme entry. Of those exiting FaDSS in FY 2009 40% of head of households were employed.
- 43% of households served during the year increased their income.
- For every dollar invested in FaDSS $1.14 is returned in the form of wages and FIP savings. Every dollar earned in wages regenerates in the community five to six times by consumer spending and taxes paid.
- One in five FaDSS households has a child in the home who has survived sexual, physical, or emotional abuse. 77% of families served during FY 2009 engaged in activities to promote the health and well-being of their children, including attending school conferences, and enrolling in parenting classes.

44. Dundee Families Project, Scotland

Run by NCH Action for Children Scotland, the project provides services for families who are, or who are at risk of, becoming homeless due to anti-social behaviour. The range of services offered include: individual and couple counselling, family support and group work. The three main service types are:

- Outreach: a preventive service offered to families in their existing homes
- Dispersed tenancies
- Core: temporary accommodation offered to the most needy families in a residential block for up to four families

Summary of key findings

The great majority of families who engaged with the Project made progress. Adults identified major changes in their housing situation, facilities for children, positive changes in family relationships and behaviour. Some parents indicated difficulties in adjusting after the project's very structured support had ended, and many still had serious child care problems.

Virtually all the children and young people interviewed were very enthusiastic about the Project. Most saw the staff as helpful (they were from a stable, well-paid position with a charity, which ensured continuity) and thought their housing situations were much better. Several welcomed the attention and play opportunities. Many acknowledged changes in their own behaviour at home or school and also recognised significant improvements in their parents.

Evidence suggests that the project generates real cost savings, through stabilising families' housing situation, avoiding costs associated with eviction, homelessness administration and re-housing; and, in some cases, preventing the need for children to be placed in foster or residential care.

SECTION 2

What are the key messages from, and implications of, this international experience in terms of improving governance, strategy, processes and front-line delivery in England? This relates to both direct and indirect effects.

To reiterate the Key Messages outlined in the opening part of this report:

1. **Those who prioritise investment in the earliest years secure the best outcomes**
2. **The quality of parenting/care is the key to a successful society**
3. **There could be a major dividend from focused commitment to ensure children arrive at school 'school ready'**
4. **The impact of poor early care can be alleviated by the right experience during school years**
5. **Galvanising the community is the secret of success**
6. **Innovative approaches to social care can provide significant benefits at minimum cost**

We now address the issues of governance, strategy, processes and front-line delivery. Although stated second in the Question above, we are addressing Strategy first, as the selection of strategy drives the decisions about governance.

SECTION 2 (A) Strategy

1. Early Years Prevention as the Principle

The evidence we have found from the interventions studied overwhelmingly demonstrates that 'earlier is better' and 'earliest is best'. Even by age 3, the problems of dysfunctional early care are showing, for example in the disruptive kindergarten behaviour of Practice 29, the high levels of aggression of Practice 15, or the more than half of children entering kindergarten, identified in Practice 26, who did not possess the basic social and emotional competencies necessary to succeed in school. The programmes which are based on true prevention, such as Practices 4, 5, 7, 11 and 18, demonstrate the value of such an approach at the micro level, while the philosophy is deeply embedded in the more universal approaches of both Sweden (Practice 9) from childbirth onwards, and the Netherlands (Practices 15 and 45) in the first 4 years of life.

We already know from the meta-analysis of Macleod and Nelson (2000) that interventions before damage is done are more effective than those applied after the damage begins. This is common sense. It is easier to prevent an egg from breaking than to put it together again. The UK Government should consider making a strong public commitment to leading a shift of paradigm to early-years prevention rather than cure.

2. Shift the Mind-set re Parenting: Parenting as an open topic

Parenting in the UK is often perceived as an intensely private matter. Children are treated as, essentially, possessions of the parent, and interference from outside is seen as an unacceptable intrusion. Any suggestion of government involvement brings cries of 'the nanny state' as if nannies were ogres. The implication is that all parents can be left to do their job without outside support or advice, though for a disturbing proportion of our population this is demonstrably not true.

Contrast the situation in New Zealand, where the highly successful SKIP programme (Practice 2) has made parenting a topic people are happy to discuss on the factory production line, and the idea that there are things to learn about parenting is seen as an obvious truth rather than an insult to one's man- or woman-hood. Both Sweden and the Netherlands have universal parenting programmes.

Government may like to adopt a strategy to shift the British mind-set re parenting, such that it is generally recognised that there is a lot of valuable information which can be learned, by anyone.

This initiative could engage the public in understanding the now established principles of good parenting – the value of breast-feeding for 6 months or much longer, the importance of attunement to the cues of a baby, how to foster empathy, the explosive development of a baby's brain in the first three years and how much the parent can do to assist this, the crucial nature of the brain architecture laid down in this period, the responsibility to send a child to school, 'school ready'. Some of these facts may be known in some middle class families, but they are not widely known even among many professionals (as we know from the hundreds that WAVE Trust presents to every year).

An important contribution to this would be to encourage schools to offer programmes such as Roots of Empathy (Practice 46) which train schoolchildren in how to attune with babies, and in helping them both with information, and in adopting positive attitudes to the challenges of early child care, such as recognising that when a baby cries 'that's how it talks' (one teaching of the programme) rather than a reason to smack. (The peak age for child abuse in England is 0-1.)

3. Engage the Community

Galvanising widespread adoption of good parenting practices, and especially good early years parenting practices, especially amongst those who find this most difficult, will not happen without commitment and leadership. It will also be more difficult to achieve if it is seen to be the 'parent' (state) wagging its finger at the 'child' (the real life parent).

An alternative strategy is to make a commitment to engage local communities in leading the drive to good parenting practices. The New Zealand SKIP campaign (Practice 2) is a potential model of how to achieve this, through 'seeding' community initiatives so that there is innovation and ownership.

There are also a number of other Practices which may suggest fruitful ways forward. The Leksand model (Practice 17) is a highly successful, locally led approach, which has engaged the same parents in attending classes for over 5 years – with high male participation. This was a municipality led approach, but other forms of local leadership, by the community or the voluntary sector, may also be able to deliver this model. Practices 13 and 14 are also examples of how the community may help itself, given leadership and good implementation.

4. Create Local 'Early Years' Partnerships

The goal of engaging the community could be supplemented – or catalysed – by setting up local 'Early Years' partnerships with responsibility to empower communities, parents and families to communicate widely the importance of early years, and especially the value of breast-feeding, recognising and responding to a baby's cues (attunement), school readiness and sound parenting. These partnerships could contain GPs, health visitors, head teachers, parents, police, social workers, the faith community and others.

5. Involve Business and the Media in promoting good early years parenting

Ministers could challenge business to engage in support for good parenting, and especially good early years parenting. There are many UK businesses which sell products worth hundreds of £ millions to parents of small children, from corn flakes to soap powder. They could provide free advertising of messages on their packets, or run promotions which publicised key early parenting messages. Persil could not only wash whiter, but Promote Positive Parenting. The media could also be enrolled through ministerial encouragement, and see their influence help to transform the life chances of a couple of million children (the number being abused and neglected each year, according to the NSPCC).

Other groups which might be actively engaged in spreading the key messages include Faith Groups and the voluntary sector.

6. Choose pilot areas and create sustained change

It is unlikely that Government will choose to invest heavily in early years interventions across England without first seeing proof of the results to be achieved. They could, however, pilot intensive approaches to creating sustained change in limited geographic areas. The Harlem Children's Zone

(Practice 3), which has transformed 100 blocks of central Harlem, creating an enriching environment as an alternative to the pull of 'the street', could be trialled in run-down, deprived areas of some major cities. Innovative social care approaches such as Iowa FaDSS (Practice 43) and the Dundee Family Project (Practice 44) could be trialled, as well as many proven early interventions, perhaps driven by a local version of SKIP. Local academies or schools might trial some of the proven school approaches or school programmes which have achieved striking successes elsewhere.

SECTION 2 (B) Governance

We now address what steps in governance may support a strategy such as that above.

1. Defining responsibility

An important part of governance will be to define responsibilities. If a teacher's prime responsibility is to teach subject matter, rather than to the wider pedagogical vocation of both teaching and guiding children in a holistic manner, then someone or some agency must be made responsible for ensuring children arrive at school 'school ready'. Who might this be?

One step would be to define it as the parent's responsibility. This would require a clear definition of 'school ready' to be shared with and communicated to parents. They might be told that by age 3½ a child must have reached certain development requirements – such as the ability to sit still, to listen, to share with other children, to behave without excessive aggression. Part of encouraging attendance at early years parenting classes could be that they help parents achieve this goal.

A second part would be to monitor the child's progress, at age 3½ to 4, to determine whether it is indeed on track to be school ready. An agency such as Health would be given responsibility for assessing the child's progress. This is already government policy in the Netherlands (Practices 16 and 45) where the health clinic is responsible for providing routine healthcare and checking the development of children from birth until they start primary school, *and 'youth healthcare services are required to conduct a growth and development risk assessment for each child during its first four years, with help being given where necessary'*. In England a Joint Strategic Needs Assessment by ward, prepared by Director of Public Health, might be the mechanism to carry out this review.

A prior step must be to determine where responsibility lies for supporting parents to reach the requisite level on assessment. A later step must be to define responsibility for taking action when the child is suffering from developmental delay or there are other causes for concern such as elevated levels of aggression.

Prime responsibility for parental support prior to age 3½ to 4 might be given to Health. This would fit with the Swedish model (Practice 9) in which parent training is part of the responsibility of midwives, and where parent training follows hospital discharge. The Croydon Total Place approach (referred to in Practice 37) envisages maternity services within hospitals being transformed so that their role is widened to include holistic preparation for parenthood, with the wider needs and vulnerability of families being identified and parents directed to social networks for support. The Kraamzorg system of post-natal support (Practice 45) from the Netherlands might be explored.

There is also the alternative Leksand model (Practice 17) where it is the municipality which takes this responsibility, continuing until a child is aged 5. It might also be useful to engage the community and the third sector in supporting this process, through local Community Early Years Partnerships.

Who should be responsible when the child falls short? We suggest this requires an immediate cross-agency conference, and creation of a Child Plan as in the Highland Region Streamlined Reaction system (Practice 37). Indeed, if local areas were to adopt versions of the Highland Region or Total Place models, integrated action would automatically follow. Where such a system is not in place then appropriate responsibility would depend on the needs of the child. The Dutch 'Every Opportunity for Every Child' approach states clearly 'Everyone must take responsibility if there are signs that a child or family is in difficulty. Simply monitoring the situation, providing an ad hoc response or even turning a blind eye is no longer acceptable.' The 'everyone' in this case could be Education (e.g. compulsory pre-school education); Social Services (taking the child into care); or Health (providing additional

support to a family struggling to cope). We do commend the Highland Region approach where there is a clearly defined Integrated Services responsibility.

It must also be recognised that some children picked up in the 3½ to 4 year old development assessment might still not be school ready by age 5, or that children will arrive at school not yet ready, who were somehow not identified in or eluded the development assessment (e.g. new immigrant children, who may also have language issues). A system might exist in which there is clear responsibility for bringing such children up to speed by age 8. The evidence of Practice 28 (What works in Early Years Education) suggests these deficits can be made up with appropriate support. We suggest this responsibility might be given to Education (e.g. a joint committee of local schools); or it could be a community responsibility with funding provided to the third sector for support to close the gap. Like other forms of early intervention, it would be likely to save more money than it costs.

The earliest of all earliest interventions might be to catch schoolchildren before they become parents, and to teach them the essentials of caring, loving nurturing of small babies. Education and schools could be encouraged to include programmes such as Roots of Empathy in their curriculum. Feedback from the Isle of Man primary schools which have been doing so for the last two years is very positive.

2. Requiring information

Certain information will need to flow if the strategy is to be sustained successfully. In a system committed to early years prevention and/or children arriving at school 'school ready' it will be appropriate to have a system which provides information locally of children who are not on track, or are at risk of not being on track in the future.

Three possible points in time for data to be collected and shared are perinatal, 3½ to 4 year old development assessment, and on arrival at school.

Both the Croydon Total Place and WAVE's own Early Prevention Strategy for local authorities envisage formal assessment of families at the time of pregnancy or birth. Croydon would have this be carried out by maternity staff in hospitals; WAVE envisaged the information being supplied by GPs or health visitors, using either the CARE Index (Practice 21) or Cracow Instrument (Practice 42). It would be useful to have such data, even if anonymised, to show areas of need for intensive parenting support. The Kraamzorg system (Practice 45) also offers a unique and effective method for collecting and documenting this information, and using it for subsequent support.

The Development Assessment could be providing information to whichever local inter-agency structure takes responsibility for rapid reaction to the identified shortfall, and possibly also to local schools with an interest in monitoring and supporting initiatives to improve school readiness.

Finally the school itself would be reporting findings of the extent and nature of school unreadiness on arrival, as this information would be essential both to monitor the effectiveness of school preparation activities, and to inform the design of what is needed at local level.

Attendance at, and the proportion of families who have attended, five parenting classes might be valuable information to gather, to monitor success with the goal of transforming attitudes to parenting.

While the current coalition government does not favour a very target-oriented approach to governance, it would be appropriate to define what is expected in terms of, for example, local breast-feeding rates, effective early prevention, attendance at parenting classes and subsequent school readiness. Once the expectations are defined, information would be supplied to capture the match between reality and expectation.

3. Early Years Structures

Appropriate structures will be needed to support the strategy. A commitment to a strategy of early prevention would call for a concomitant commitment to establish that maternity hospitals should be 100% UNICEF Baby Friendly – see Practices 9 (Approach to Infancy and Early Childhood in Sweden) and 12 (Importance of the near birth period, including birth, breast-feeding and risk assessment).

Local Community Early Years (LCEY) partnerships could be created on a smaller scale, community (rather than local authority area) basis, involving GPs, health visitors, schools, parents, police, the faith community, third sector and business, with responsibility for communicating the importance of early years and the core messages referred to above. These LCEY partnerships might also be engaged with the Joint Strategic Needs Assessment for their ward or community, and take some responsibility for initiatives to address the gaps identified.

There should also be encouragement for effective local community structures, such as the highly effective Harlem Children's Zone (Practice 3). Their mantra 'For children to do well, their families have to do well. And for families to do well, their community must do well' could inform these structures. The challenge is to determine which organisations should represent the community, and how they should be supported. HCZ has a series of innovative and effective structures such as Baby College, Harlem Gems, Promise Academy, Peacemakers and TRUCE. One possibility is to fund and reward groups on the basis of the results they deliver in areas such as breast-feeding, parent training and school readiness.

Here it could be important to give people the belief that they can change their local community. The LCEY partnerships could be charged with sharing success stories and inspiring local commitment and innovation, as well as adoption of proven interventions.

Another question to address is, what are the optimum structures to deliver the interventions identified to be the most effective? WAVE's prevention strategy lists interventions such as Family Nurse Partnership, Roots of Empathy, Video Interactive Guidance, Circle of Security, Family Checkup, Incredible Years, Triple P. Many others candidates might be proposed on the basis of this research: Parent-Child Interaction Therapy, post-natal breast-feeding support, Community Mothers, the several US school-readiness programmes. Should they all be left to the voluntary sector and, if so should they be funded by reward for their impact on school-readiness? Or, like Family Nurse Partnership, should they be part of the NHS? Should the NHS's current spending of 3-4% of its budget on prevention be increased to reflect the wisdom of a more preventive approach?

As raising quality standards is a vital step on the route to achieving optimum outcomes (see point 5 below) and in view of the vital nature of nurturing experiences in the earliest years, it would be appropriate to set up a structure to train, evaluate and monitor the standards of day-care providers in charge of very young children.

4. Later Years Structures

Structures are also needed for later years. Whatever emphasis is given to improving the early years experience of children there will still be a generation of older children in need of ongoing support.

Consultation with, and involvement of, the community could encourage joint school/community and after-school programmes to educate older children on the dangers of drugs, alcohol and unprotected sex. These joint school/community structures could also explore the introduction of proven interventions such as (if they are judged suitable) the Montreal training, SSDP, Second Step, Preparing for the Drug Free Years, Reach for Health and Carrera. Community programmes such as the local equivalent of the Harlem Children's Zone and Stop ACEs would also rely on wide community involvement. Government might consider means to support initiatives such as KIPP schools for disadvantaged areas.

There is scope in local authorities for structures which better encourage effective inter-agency co-operation. The Integrated Services structure of Highland Region (see Appendix, Practice 37) may offer a model of an integrated structure that has proven successful over 10 years of use.

A structure to measure population-wide mental health outcomes periodically, by age group, could be useful to inform Strategy and priorities for delivery of services across the whole population.

5. Quality Standards and Training

Another important aspect of governance relates to training and quality standards. The value and importance of quality was a recurring theme throughout our research. The success of the Nurse

Family Partnership (Practice 11) is put down to the high quality of its training and supervision, which nurses who have transferred report is far above what they previously experienced as health visitors in the NHS. Tremblay (Practice 15) suggests society pays heavily for not fostering the quality of early brain development in high risk children. Parents as Teachers (Practice 22), which achieves high levels of parental involvement in their children's development and schooling, emphasises quality as a key component of its training.

The Highland Region Streamlined Reaction approach (Practice 37) is built on a core of quality. The key figure in their Integrated Services set-up, who safeguards both the speed of response to a signal of problems with a child, and the quality of the subsequent reaction, is the QARO (Quality Assessment and Review Officer). The QARO is a registered Social Worker but with a responsibility to be independent and manage the Quality Assessment function; he/she also prepares, chairs and summarises conclusions of the inter-agency Child's Plan meeting.

There could be value in creating a provision for multi-agency post qualification training, covering such issues as:

- What signs indicate need for more support
- What are the good parenting basics
- What support is
- What actually works as intervention
- How to deliver together

Of particular importance is the quality of pre-school care and education. National Institute of Child Health and Development studies (NICHD, 2002, 2005) of the effects of child care from birth to 4½ years found distinct benefits and risks associated with the quality, quantity and type of early care and education. Higher quality provision predicted better pre-academic skills and language (Practice 28).

Practice 39 (Holistic approach to looked-after children, Denmark and Germany) suggests a link between teenage pregnancy rates in Care Homes and qualification/quality of staff. The far poorer outcomes for children in care in the UK, compared with those in Denmark, are seen to be essentially because of the British practice of staffing care homes with larger numbers of lower quality staff, even though this is no more cost-effective.

Other Practices which emphasise quality of training or service delivery include 1, 2, 36 and 40. In addition there are examples of early intervention which lack of time prevented us from including in our study, which also demonstrate the power of quality. A prime example is the KIPP (Knowledge Is Power Program) schools which operate in 20 states in America, which have done much to close the black-white gap in outcomes (Practice 46).

We conclude this point with a quotation from the Center for the Developing Child at Harvard University. While their comments refer to North America they are just as applicable to England:

'The essence of quality in early childhood services is embodied in the expertise, skills, and relationship building capacities of their staff. The striking imbalance between the supply and demand for well-trained personnel in the field today indicates that substantial investments in training, recruiting, compensating, and retaining a high quality workforce must be a top priority for society. Responsible investments in services for young children and their families focus on benefits relative to cost. ***Inexpensive services that do not meet quality standards are a waste of money.*** *Stated simply, sound policies seek maximum value rather than minimal cost.*'

6. Care Homes for Looked-After Children

Care Homes in England have a particular responsibility. On the one hand they are looking after the most damaged and most abandoned children in society. Society owes these children a duty of care – and the experience of Denmark shows it is possible to have a Care Home system which delivers excellent outcomes for children. On the other hand, their current methods of operating in the UK

deliver appalling outcomes, from exceptionally high rates of teen pregnancy (with consequent recurring cost to society) to a massive contribution to the prison population. Moreover we deliver at this level with what is not even a cost-efficient system (Practice 39).

It would be appropriate for a government committed to a strategy of early prevention to require Care Homes to meet the standards of school-readiness at pre-school and school entry ages set for the rest of society, and also to ensure children at age 11 and 16 achieve standards comparable with children who are not in care. This would not be achievable with current approaches to care – which are overdue for overhaul anyway, as demonstrated by reports such as the Centre for Social Justice (Breakthrough Britain: Couldn't Care Less, 2007) and The House of Commons appointed Children, Schools and Families Committee on Looked-after Children (2009).

SECTION 2 (C) Processes

1. Communications

A core process in delivery of a strategy of early prevention would be communication of important messages to the central parties who have a role to play. This could be done through a set of information and communication programmes.

What is needed here 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 (even at the cost of accepting millions of children being abused and neglected, Cawson et al, 2000), 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.

The general public / parents

Government could deliver a national communication programme to make parents, health professionals and especially newly pregnant women aware of the importance of:

- avoiding stress and toxic substances during pregnancy
- the near-birth experience
- breast-feeding
- how to recognise and respond to a baby's cues
- the need to attune with and stimulate infants from the very start
- how to foster empathy
- the sensitive period for emotional development in the earliest 18 months and the particular need during that period to avoid
    - stress
    - domestic violence
    - physical abuse
    - neglect
- the general importance of the first 3 years of life, including frequent talking with a baby
- all the things that would make a difference: looking, smiling, engaging
- whom to turn to for help, and where to find them

They could also engage the general public in understanding the value of these principles, and that these actions will make a real difference to outcomes for their children

Breast-feeding

The 2005 Department of Health Infant Feeding Survey (DoH, 2005) shows that in England 32% of women in the routine and manual socio-economic groups breastfeed beyond six weeks, compared with 65% in managerial and professional groups. The scope for improvement is considerable. This is also a societal 'habit' influenced by culture. A 2004 Northern Ireland Department of Health report captured the main reasons for this:

'Social and cultural influences play an important role in a mothers' decision to breast or bottle feed her baby...many young people either have no knowledge of breast-feeding or are subjected to negative

images of breast-feeding 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 breast-feeding 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 breast-feeding. Research highlights 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 breast-feeding in positive circumstances, fear of pain, misconceptions that their babies will not gain sufficient weight from breast-feeding alone, and exposure to a bottle feeding culture which promotes the use of artificial milk. The provision of tokens for free artificial milk may also act as a disincentive for young and low income mothers to breastfeed their infants.'

A challenge for government is to replace the current negative influence of both media and commercial interests with a partnership to achieve high rates of UK breast-feeding. A good start would be to convert the levels of UNICEF baby-friendly hospitals from less than 10% to 100%, as a demonstration of intent.

School readiness
An information campaign would need to be designed to teach people precisely what school-ready is and to make clear that this is now a parental responsibility. In addition to providing advice on how 'school readiness' can be achieved (e.g. through offering parenting classes and additional 'in home' support for those in greatest need) this would make it clear that failure to comply could mean removal of the child from home, and financial penalties.

A national parenting campaign
A campaign to promote interest in parenting, for parents of children of all ages, could be launched, similar to SKIP in New Zealand. It might be said that we have had, in England, the National Family and Parenting Institute, the National Academy for Parenting Practitioners and Parenting UK; how would an English SKIP be different?

The key difference is that the first three of these were not known to the general public, and they were organisations for professionals rather than directly for parents. The purpose of an English SKIP would be to engage the parents themselves, as well as the local community groups who would be the local promoters of improved parenting.

2. Children's Centres

Children's Centres could potentially play a valuable role in the development of parenting skills, and preparation for school readiness. They might, for example, be used to initiate, host and support the LCEY partnerships and local implementation of best practice interventions.

3. Systems of local support

Raising standards of parenting around the country requires the support and engagement of many local people who are inspired by the potential value of better parenting practices across the country. This support could take many forms. We could adopt interventions such as Harlem Children's Zone (Practice 3) and the Community Mothers Programme (Practice 13), ensuring we follow successful Irish implementation methods and not those tried unsuccessfully in the past in England.

A population-based approach to improved parenting might be considered, using interventions such as Triple P (Practices 5 and 7) or Incredible Years (Practice 23). This might require, say, a Community Development working group responsible for public health initiatives for the population. This group might also be responsible for ensuring support to vulnerable families in the neighbourhood, using innovative low cost approaches such as the Dundee (Practice 44) and Iowa (Practice 43) welfare approaches described in detail in the Appendix.

4. Classes for early years parenting in schools

Schoolchildren are taught grammar, mathematics and sometimes algebra and French in school – all useful subjects. They are not taught how to be parents. A review of alleged parenting classes in south London secondary schools, carried out by WAVE in 2004, found the classes being delivered appeared to be aimed more at 'pregnancy scaring' than at educating future parents. The fact that the participants and non-participants were not pre-evaluated for knowledge and attitudes made it impossible to assess the impact. However, the students who received the classes were found in the follow-up evaluation to hold less evolved attitudes than the non-participating group.

There is a place for children to be taught how to parent, with a particular value in teaching them how to raise babies in their first year, how to attune with them, and how to foster empathy. As noted above, Roots of Empathy does this for school children.

5. Training and quality control for early years staff

A fundamental need if we are to have cost effective early years provision is that the government and local authorities set and maintain high standards of training, performance and quality control for early years staff working with children and families. Many of their training needs, from knowledge of the architecture and development of the infant brain, through the crucial nature of attunement to acquiring the ability to form a caring empathic relationship with clients, are common. A national system to train such professionals to a high standard, and to monitor subsequent performance, could usefully be established.

It may also be necessary to provide special training for providing professional help to parents, or directly to children, to help them achieve school ready status.

In this context it is worth registering that good salaries and realistic staff ratios are essential for effective work with high-risk families.

SECTION 2 (D) Front-line Delivery

1. Health visitors

Health visitors could be an underutilised asset – and therefore a promising resource – in a strategy of early years prevention. In some parts of the country they meet almost 100% of new mothers. As such they could be an ideal resource to spot need in the first few months after birth. However, there must be enough of them, and training in how to identify and respond must be arranged. Croydon proposes to use a 'light touch' tool, the Strengths and Difficulties Questionnaire, to allow health visitors to fulfil exactly this role. They will also use them to follow up warning signals, such as a family missing immunisation appointments.

While already part of their responsibility, a review might be made of how health visitors could better promote breast-feeding. Danish health visitors, after specialist training, have been successful in reducing rates of cessation of exclusive breast-feeding after 6 months by 14% (Practice 10).

2. Midwives

One early intervention practice which we began to explore was the difference in perinatal experiences between the Netherlands and the UK. Time ran out before we had gathered sufficient hard information to include this in our list of Practices. Anecdotal feedback to us from midwives with experience in both the UK and the Netherlands strongly pointed to the difference between the relatively high quality of perinatal experience in the Netherlands and the contrasting experience in the UK as one factor explaining poorer UK child outcomes.

The Croydon Total Place report records many Croydon mothers speaking emotively about their bad experiences with midwives. Is this another arena where quality and training in the UK has been allowed to slip below norms of the better countries on the continent? Or is this a feature of workloads? Either way the comments bear out our (limited) research findings.

Croydon also saw midwives as offering an opportunity. They say:

'We will transform how maternity services feel within the hospital setting. Instead of delivering narrow contacts – midwifery check-ups or scans – maternity services through Croydon's local hospital (whether provided in the hospital building or out in the community) will be characterised by holistic preparation for parenthood.'

They also link midwives, with other health staff, to the opportunity to develop parenting support groups:

'We will use imaginative ways to support and grow networks of parents, especially for the most isolated, led where possible by parents themselves ... Midwives and health visitors, working in partnership with other hospital staff, will use these conversations with parents to spot potential need, particularly around maternal mental health and relationship stress, and will seek to respond appropriately. Early warning signs – such as missing appointments – will be followed up.'

With or without the Croydon preventive strategy approach, midwives can play a positive role in identifying at risk children and could be used to administer the CARE Index or Cracow Instrument.

3. Local parenting groups

Here we can do no better than recommend adoption of the Swedish approach of encouraging universal engagement in parenting groups, beginning ante-natally and continuing after birth. Even the Dutch government recognises it can learn from Sweden, commenting in 'Every Opportunity for Every Child' that *'evidence from other countries, such as Sweden, shows that offering parental support to all parents as an integral part of youth healthcare reduces the incidence of child abuse.'* An ideal structure may be the Leksand model, with its wide social span, high engagement of fathers and continuing engagement of participants.

4. Community plus school working parties

Schools and the local community, including the third sector, could work together in partnership to deliver proven interventions targeted at issues such as teenage pregnancy, drug and alcohol use, and involvement with deviant or criminal peers. This process might be initiated by the Community Development working group suggested above.

For example the Reach for Health Community Youth Services (Practice 34) approach increased use of contraception. At a time when comparison students reported a 9% increase in recent sex without birth control pills, rates decreased by 8% among youth who had undergone the full RHCYS programme. The Carrera Project (Practice 35) also showed higher rates of contraceptive use and reduced teenage pregnancy.

5. Proven early interventions

Local authorities could be encouraged to introduce a range of proven interventions. The Healthy Families America (Practice 36), for example, might be trialled as a complementary programme to Family Nurse Partnership, being offered across a less restrictive range of families in need of support Research in the USA suggests it is effective at reducing child abuse and improving parent-child interaction and school readiness. Other potential early interventions have been listed elsewhere in this report. Parent-Child Interaction Therapy (Practice 38) has been found to be especially effective in changing the behaviour of abusive parents.

SECTION 3

What key messages from international experience will contribute to the policy framework in England, such as deregulation?

Given the scope and speed of this rapid review, the following represent first thoughts for discussion rather than considered proposals.

1. Policy Framework for Early Years

Given that 'earlier is better' and 'earliest is best', a national policy framework for Early Years could be established. This might emerge from the Cabinet Office Review of Early Intervention, to be chaired by Graham Allen MP. Such a framework could include a set of guidance statements for local authorities, GP commissioning consortia and individual communities on what they are expected to deliver in terms of a healthy start in life for children

Possible components could include a 'Right from the Start' objective with relevant national and local indicators; a national policy steer on how to achieve these targets at local authority level. Another possibility is a National Early Intervention Agency to drive and inform the implementation of best early intervention policy around the country.

2. Health Policy Framework

The coalition Government is establishing a new policy framework for Health. For an early intervention strategy to succeed it will be important to lay down policy guidelines which integrate fluently the Early Intervention agenda with the Health agenda.

The new plans for the NHS provide for The Health Secretary, through the Public Health Service, to set local authorities national objectives to improve population health outcomes. It would be appropriate for these objectives to include:

- measures relating to key early years health improvements
- achievement of social and emotional wellness suitable to support school readiness
- need defined proactively not only reactively (i.e. response to illness) but including a strong recognition of the value of prevention.

New 'Health and Wellbeing Boards' are to be established within local authorities. These will undertake 'joining up the commissioning of local NHS services, social care and health improvement'. These boards, to be established by April 2012, will 'allow local authorities to take a strategic approach and promote integration across health, adult social care and children's services. They could be an appropriate body to drive integrated early years strategies at local level.

Another change is that HealthWatch England will be created as a new, independent consumer champion within the Care Quality Commission. The current local involvement networks – LINks (created in 2007) are to be replaced by, or will change into, local HealthWatches. The framework could allow for representatives of the Early Years, charged with representing the interests of young children, to be automatic members of each local HealthWatch.

In a similar way the local Directors of Public Health (DPH), to be jointly appointed by local authorities with the Public Health Service, should have included in their policy responsibilities the achievement of Early Years, school-readiness and other early intervention targets.

The DPHs 'will be responsible for health improvement funds allocated according to relative population health need'. As with the Public Health Service. it will be important that DPHs recognise fully that 'need' includes prevention.

Thought needs to be given to how GP commissioning consortia do not become overly influenced, in setting priorities, by the vocal demands of the older middle classes (such as the authors of this paper) at the expense of the needs of the less articulate under 5s from disadvantaged backgrounds. This can only be guaranteed by a policy framework which clearly sets out the responsibilities of the GP

consortia in this respect. Andrew Lansley has laid down the policy principle *'no decision about me, without me'*; that principle calls for a methodology within it that protects the inarticulate.

3. Workforce Development Policy Framework

The lessons from our Practices that quality is a key contributor to effective delivery suggests that early years settings might require, say from 2014, employing someone with Early Years Professional Status (EYPS) on site. The requirement would be a degree in early childhood studies (not a diploma or NVQ) ***or*** substantial experience backed by an intensive specialist training.

This requirement would be particularly relevant in Care Homes for Looked-after Children, especially if in support of a strategic decision to move from a low quality, high staffing model to a lower staffing, high quality model, with specified performance deliverables, including school-readiness.

In the interim, a short course for all key professionals on what is good parenting, what works and how to promote and support it, could be devised and delivered from 2011.

Supporting aspects of such a Workforce Development Framework would be to establish training and salary structures which recognise the challenge and importance of early-years staff and especially staff engaging with multi-problem families. Training in parent engagement would be appropriate.

4. Policy Framework for Families

A permanent Family Commission might be set up to serve the interests of families and charged with creating a shift in the mindset of families towards parenting. It might, for example, run national good parenting information and enrolment campaigns and support local ones. It could produce high quality information, and materials such as DVDs that local communities can use. Positive use could be made of the various internet social networking sites to get the messages across.

Such a Commission could also increase understanding of the needs and perspectives of the family unit in England, e.g. by panels around the country each year, or by commissioning research to fill gaps in knowledge, or by ensuring government policy is family-friendly.

A review might be carried out of the connection between families on welfare benefit and early intervention. For example benefit could be made dependent on attendance at parenting sessions. There could be a general policy of providing holistic support to get vulnerable families off welfare.

Policies could also be developed to encourage eventual self-sufficiency. For example the response to higher income after support in getting off welfare could be for the income gain to be (compulsorily) invested in savings rather than resulting in a higher rent for social housing.

5. Policy Framework for Communities

An appropriate policy framework may be introduced to encourage the development of community organisations which support the overall strategy, e.g. in the delivery of ongoing parenting classes from ante-natal to school readiness (e.g. as in the Leksand model).

This might include shifting some policy responsibilities – and funding – from the state to the community or not-for-profit sector. This could be done, for example, within the commitment to a national campaign to promote positive parenting. There could be funding, such as with the Lottery Fund, to stimulate grassroots innovation. Encouragement could be given to the idea of community as a small place with local actors (rather than the local authority) as in the Harlem Children's Zone and President Obama's 'Promise Neighbourhoods'.

6. Social Work Practices

Social Work Practices are social worker-led organisations commissioned by, but independent of, the local authority, that provide the social work services for an agreed group of children. They discharge the statutory duties and responsibilities of the local authority in relation to these children. Though set

up as a pilot experiment in six areas by the previous government, the approach is not necessarily incompatible with the philosophy of the current government.

One policy approach to these could be to establish them on the basis of a total shift to a therapeutic model, with rewards either (a) reflecting good quality salary structures, but without a profit element, or (b) based on a share of the cost savings arising from delivery of families and children engaging positively with their roles as citizens, with identifiable cost savings to local and national government.

It would be essential that these groups are given training on the key components of good parenting, interventions, support and best practice. This should emphasise working with families in daily lives and not on the form-filling systems.

Local groups could combine to offer high quality provision as in the KIPPS schools or Harlem Promise Academies.

SECTION 4

What are the key messages on the efficient focus of early intervention and its cost-effectiveness/value for money?

The key message re the efficient focus of early intervention, as recorded above in this document, are that earlier is better and earliest is best. While we do not argue against the value, or effectiveness, of many later interventions, the evidence is overwhelming that for *optimal* effectiveness intervention should be focused on the earliest years, and ensure that children arrive at school 'school ready'.

In terms of assessing cost-effectiveness and value for money, we have taken two complementary approaches. First we looked at the evidence specifically from our 47 Practices. We also look at the results of a number of independent reviews which we came across during our research, or which we knew of beforehand.

Evidence from the 47 Practices

Time and budget did not allow an independent review of cost-effectiveness in these practices, and little hard evidence emerged during our review. Nuggets stand out. Nurse Family Partnership has been evaluated by RAND and found to payback four times its cost (in the USA). Croydon Total Place's claim that for an up-front investment of £2.5 million in an area of 50,000 population they expect returns – after allowing for the up front costs – of £8 million in 3 years and £25 million in 6 years sound bold. Highland Region's 'streamlined reaction' model bears out that the switch to a preventive or very early rapid reaction model could deliver an improved service while saving money. The Iowa FaDSS programme is by its very structure defined to be cost-effective – and is reported to be successful. The ACE work of Anda and Felitti achieved a 35% reduction in visits to doctors' offices, over a year, by conducting a comprehensive biopsychosocial evaluation of all patients. The health benefits of improved breast-feeding are well known.

These apart, while reviews of several interventions claimed them to be cost effective (e.g. Community Mothers, Triple P, Centering Pregnancy, Dundee Families Project) we uncovered little hard cost benefit data. This does not mean the claims are invalid; only that they are as yet unsubstantiated.

Independent reviews

Reviews from Canada, the Netherlands, New Zealand, USA and the UK all emphasised the critical importance of investment in the earliest years to avoid serious consequences later. According to Tremblay (2009) the new science of epigenetics suggests:

> ***'…the environment, especially during pregnancy and very early childhood, activates and silences good and bad genes crucial for mental well-being and social adaptation'***

Tremblay (2006) said the origins of high levels of violence in adolescents can be traced back to their high levels of aggression at age 3 – the most effective (and cost-effective) age to tackle aggression:

> ***'We probably pay a tremendously expensive price for not fostering the quality of early brain development in high risk children'***

Similar messages come from the New Zealand Families Commission (2009) and the UK/North American work of Piquero, Farrington, Welsh et al (2009)

The most compelling support comes from the National Scientific Council on the Developing Child at Harvard. In a series of working papers they identify:

> ***'… the critical impact of a child's 'environment of relationships' on developing brain architecture during the first months and years of life'***

and cite new evidence that these relationships shape brain circuits and lay the foundation for:

- later academic performance,
- mental health and
- inter-personal skills

Another paper states that early emotional development lays the foundation for later academic performance, mental health and the capacity to form successful relationships.

A further paper suggests that exceptionally stressful experiences early in life may have long-term consequences for a child's learning, behaviour, physical and mental health. Significant adversity early in life can permanently alter a child's capacity to learn and to adapt to stressful situations. The authors suggest how policies could be shaped to minimise the disruptive impacts of toxic stress on young children.

A later paper suggests that the foundations of many mental health problems that endure through adulthood are established early in life through the interaction of genetic predispositions and sustained, stress-inducing experiences. [Note: the peak age for child abuse in the UK is 0-1.] The authors state:

> ***'This knowledge should motivate practitioners and policymakers alike to address mental health problems at their origins, rather than only when they become more serious later in life'***

Evidence that investment in the 0-3 period can be highly effective
In a 2000 review of international evidence of what works in parenting support, Moran et al concluded that early interventions produced better and more durable outcomes than later interventions.

A number of international reviews such as Regalado & Halfon (2001), who reviewed 312 publications from MEDLINE and PsychoINFO, a Dutch meta-analysis by Bakermans-Kranenburg, van IJzendoorn & Juffer (2003) of 70 early prevention studies and a review of 28 prevention experiments by Tremblay and Japel (2003) have concluded that early childhood interventions can have significant positive effects in such areas as promoting optimal parent/child interaction, parents' understanding of child temperament, management of excessive infant crying, changing insensitive parenting, improving attachment security, disruptive behaviour and cognitive skills. Tremblay and Japel comment:

> ***'early and intensive preventive interventions can have the desirable impact which it appears to be so difficult to achieve with disruptive elementary schoolchildren and juvenile delinquents'***

Alink, Mesman et al (2009) also found in a sample of 117 mother-child dyads that parental sensitivity can be taught and that sensitivity reduces aggression in the infant. The New Zealand Families Commission report that 'A number of rigorous, evaluative, controlled longitudinal studies demonstrated that high quality early childhood education and parenting programmes can contribute substantially to school-readiness, improved educational performance and increased economic success in adulthood (Heckman, 2006a; Karoly, Kilburn, & Cannon, 2005; Schulman & Barnett, 2006)'.

The Harvard Center on the Developing Child in its brief on Early Childhood programme effectiveness concludes

> ***'Effective interventions are grounded in neuroscience and child development research and guided by evidence regarding what works for what purpose. With careful attention to quality and continuous improvement, such programs can be cost-effective and produce positive outcomes for children'***

They conclude with these messages for policy makers:

- The basic principles of neuroscience and the process of human skill formation indicate that early intervention for the most vulnerable children will generate the greatest payback ...

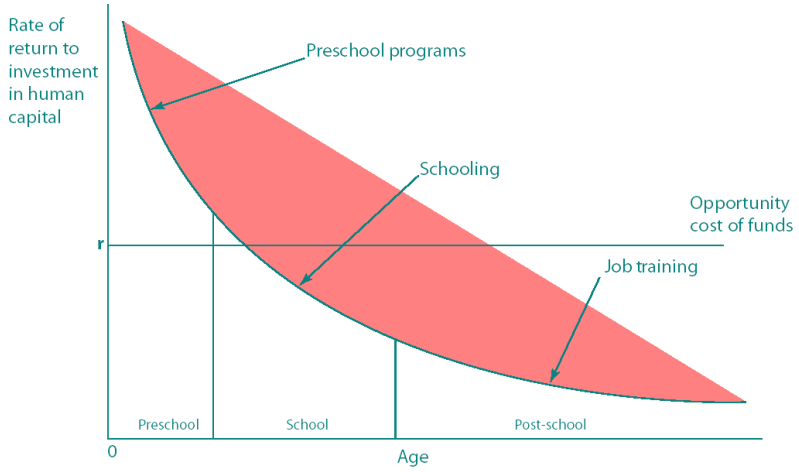
extensive research indicates that investment in high quality interventions will generate substantial future returns through increased taxes paid by more productive adults and significant reductions in public expenditures for special education, grade retention, welfare assistance, and incarceration.

- Long-term studies show that model programmes for three- and four-year-olds living in poverty can produce benefit-cost ratios as high as 17:1 and annualised internal rates of return of 18% over 35 years, with most of the benefits from these investments accruing to the general public. While it is not realistic to assume that all scaled-up early childhood programmes will provide such handsome returns, it is likely that benefit-cost ratios still will be considerably greater than 1:1.

- The essence of quality in early childhood services is embodied in the expertise, skills, and relationship-building capacities of their staff. The striking imbalance between the supply and demand for well-trained personnel in the field today indicates that substantial investments in training, recruiting, compensating, and retaining a high quality workforce must be a top priority for society. Responsible investments in services for young children and their families focus on benefits relative to cost. Inexpensive services that do not meet quality standards are a waste of money. Stated simply, sound policies seek maximum value rather than minimal cost.

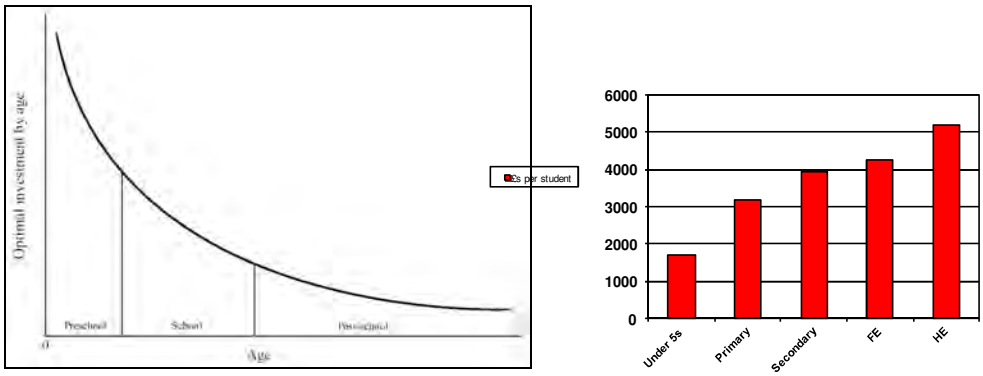
The message stated visually

This case has been made visually and perhaps it is useful to look at this before examining the arguments themselves. The Nobel Prize winning economist Professor James Heckman, in work conducted for the Scottish Government, estimated the return on capital from money spent on children at different ages. The graph below shows the relative rates of return:



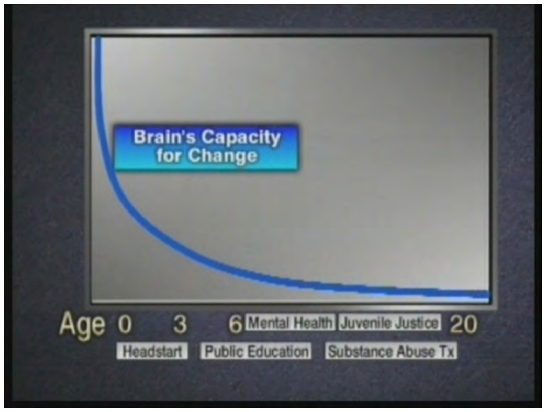
Rates of return to human capital investment initially setting investment to be equal across all ages

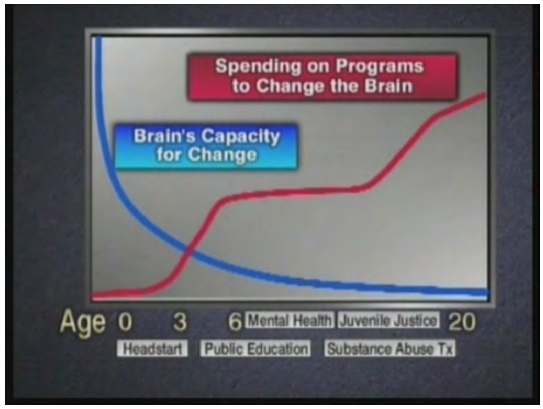
The opportunity costs of funds shown in the graph was notional rather than actual. Based on this analysis Heckman recommended that the optimum curve of investment for Government (including local government) should look as in the left-hand graph below.



Actual investment follows the pattern in the right-hand graph – the opposite of that recommended.

A similar point, but based on a different science, is made by Dr Bruce Perry whose field of research is the infant brain. He compares the malleability of the brain with patterns of spending to change it. While his data comes from America, UK patterns are unlikely to be very different.





The Heckman Economic Case

(The following summary was provided by John McLaren, an economist at Glasgow University who worked closely with Professor Heckman.)
The economic case revolves around:

- the past and current waste of economic potential through unemployment, caused by the lack of success of government interventions later in life, typically post compulsory schooling age

- the demographic squeeze on the working population that will hit most developed countries in the next 20-30 years, i.e. 'the major threat to long-term fiscal solvency in advanced countries' (IMF, 2009).

The basic future economic argument comes down to how to deal with a working age population that is shrinking as a share of the population and where the dependency ratio is steadily rising.

The answer to this problem will partly come from the (unpopular) need to increase the age of retirement. Other not very effective methods include: increasing the birth rate and increasing net inward migration.

The most effective way to reduce the dependency ratio is to get more of the existing population into employment. In particular, numbers who are unemployed or on incapacity benefit need to be reduced. Recent shares of these are unsustainable. This cannot be done through investments post compulsory schooling, which have consistently failed, but rather through early-years investment strategies.

These proven strategies are based on what Professor Heckman describes as the 'learning begets learning' principle: that the earlier good practice is instilled in a child/pupil, the longer that good practice reaps returns (working like a compound interest rate). This also helps explain the ineffectiveness (and waste of money) of later interventions, which have to fight against ingrained patterns of behaviour. Even if they worked, which by and large they don't, they would only be effective from the age of 16, rather than 5, so much of the learning potential will already have been missed.

The educational claims of such interventions are not that they will make great advances in the cognitive (IQ) abilities of children but that, usually unmeasured, non-cognitive abilities will be improved (e.g. time-keeping, application, behaviour and interactions with other staff/ customers etc). Often it is precisely these qualities that business leaders complain job applicants lack, arguing that the specific skills can be instilled so long as the basic qualities of application are there.

Increasing weight of evidence over the last 20 years suggests that the situation described above has always been the case and that policy should move from late to early intervention. That case is made all the more urgent with the coming demographic crunch which allows little scope for 'wasted' human resources.

The Financial Case

Evidence from Cost-Benefit Analysis shows that High Quality Early Years Investment provides a high return on original government investment, despite undervaluing many of their indirect benefits. Evidence from education based interventions identifies early years investment as having the greatest potential, including improvements in skills and follow through into improved employment records.

However the greatest financial benefits of early years intervention come in reductions in criminal behaviour. The principle behind this is the same as for education. In the sense that 'learning begets learning' so too does 'good behaviour begets good behaviour'. The attraction of this is that, unlike with the benefits of employability the state starts to reap a reward much earlier as often children who are still at Primary School can cause costly problems, both inside and outside the classroom.

The baby boomer generation effect that is now ending allowed for wastage in human resources to be possible due to the overall expansion of the workforce. The reversal of that trend makes a continuation of similar wastage impossible to sustain in the future and investment in early years intervention an economic imperative.

The RAND evaluation

The RAND Corporation has carried out two significant reviews of the economics of early intervention (Karoly, Kilburn, and Cannon, 2005; Kilburn and Karoly, 2008).

Kilburn and Karoly identify that seven of nine analyses in their 2005 review found benefit-cost ratios greater than 1, implying that the benefits outweighed the costs, with a range between $2 and $17 in benefits for every dollar invested. They also observe that some of the variation in benefit-cost ratios reflects that many evaluations do not capture long-term benefits. The highest benefit-cost ratio is for the Perry Preschool Project, which has followed participants until age 40. They also observe that a spectrum of different types of early childhood–programmes can generate payoffs, citing as examples the large-scale Chicago Child-Parent Center programme, HIPPY and the Abecedarian programme.

The authors conclude that cost-benefit analysis and rate-of-return calculations have provided evidence that early childhood programmes have the potential to save government money in the long run and produce benefits for society as a whole. The costs savings for government could be large enough to not only repay the initial costs of the programme but also to possibly generate savings to government or society as a whole *multiple times greater than the costs* (Karoly, Kilburn, and Cannon, 2005). These findings moved early childhood policy from being strictly a social-service policy and philanthropic endeavour that might benefit only participating children and families to be considered an economic-development strategy.

Both on theoretical grounds and given findings from empirical analyses, including cost-benefit analysis, economic research promotes a reorientation of child and human services toward investment and prevention, in contrast to the current approach of attempting to 'treat' poor outcomes that manifest themselves later in the life cycle. Implementing such an approach would require a fundamental rethinking of the way in which nearly every human service is delivered, ranging from child-protective services to health care to education (Halfon, DuPlessis, and Inkelas, 2007; Yach et al, 2004). Shifting toward a paradigm in which resources are invested in early human capital might produce better outcomes, save taxpayers money, and improve the quality of life.

Washington State Institute for Public Policy (WSIPP)

The Washington State Legislature directed the Washington State Institute for Public Policy (WSIPP) 'to calculate the return on investment to taxpayers from evidence-based prevention and intervention

programmes and policies.' Since WSIPP was first set up in 1983 they have conducted thousands of evaluations and identified many hundreds of programmes which produce positive outcomes.

WAVE Trust

WAVE Trust has been carrying out analyses of what policies would be required to effect a 70% reduction in child maltreatment in the UK by 2030, and the possible costs and benefits associated with such a commitment. This policy was endorsed by the Liberal Democrat Party in their General Election Manifesto and is also supported by Iain Duncan Smith.

A mathematic model has been developed which explores one possible way to approach this challenge. Further information can be supplied on request. The major unresolved issue in the model, as it currently stands is whether it works to apply sequential programmes to families. If this were done, would the impacts be cumulative or would they cease to have an effect after the first one or two interventions? We have interviewed many international experts to gain opinions on this. All that we can conclude at the moment is that opinions are divided (with a slight majority of the view that the effect would be cumulative). However, this approach does not appear to have been tried anywhere in the world. It would be interesting to test a version of this approach in a limited pilot area.

To summarise its results, in its present form, the model suggests we can reduce the risk of child maltreatment in the UK by 70% within 16 years, at a total cost of £97 billion (i.e. £6bn p.a.). This is probably an underestimate. However, these costs are only about 1.4% of the areas of expenditure which arise from dysfunction created, in part at least, by child maltreatment. An assumption of a 12% reduction in the targeted areas of costs, which seems reasonable given what is known about the links between maltreatment and subsequent life outcomes, would be worth £1 trillion (£50-60bn p.a.).

Action for Children / New Economics Foundation

The Backing the Future report produced by Action for Children and New Economics Foundation (2009) lays out the programme for a National Prevention Strategy. This is costed at £620 billion with projected benefits of £1.5 trillion. The major difference from the WAVE model is the very much higher investment in universal services assumed in Backing the Future.

Even assuming the higher level of costs of the Backing the Future model and the lower level of benefits of the WAVE model, investment in scale in early intervention is judged to be cost effective. We are ***not*** suggesting that this is politically feasible at the present time, but the ideas might be piloted in limited geographic areas.

Croydon Total Place

Both the WAVE and Backing the Future evaluation are based on the assumption that substantial new investment would be necessary to make a significant impact on early years prevention. It is possible that this is too pessimistic an assumption. The Croydon Total Place project concluded that much of current Children's Services and Social Services are being conducted in a manner where costs are not invested where they have the appropriate impact on outcomes. Our meetings with local authority staff around the country do not suggest that Croydon is likely to be atypical. As stated above, Croydon estimate that they can realise net savings of £8m in 3 years and £25m in 6 years from an upfront investment of £2.5m, in an area of 50,000 population, through a switch to a prevention strategy.

International experience of early intervention for children, young people and their families

APPENDIX

SECTION 1 (A) Community Practice

1. Families Commission, New Zealand

The New Zealand Family Commission states that well-functioning families foster the development of socially engaged and successful young people who contribute to the wellbeing of wider society. Well functioning families are inextricably linked with economic productivity and flourishing workplaces. When intimate relationships are healthy, adults in the work force contribute measurably more to their workplace than those whose family relationships are stressed. By contrast dysfunctional families impose costs on society in the form of supporting distressed children, paying for mental health services, and providing benefit support. They quote 'The family is the most powerful, the most humane, and by far the most economical system known for building competence and character.' (Bronfenbrenner 1986)

At the same time, there has been a significant change in most western societies toward focusing on individuals rather than family groupings. It is argued that individuals are increasingly focused on themselves and their own wellbeing to the detriment of the wellbeing of the family as a whole. While there is a strong and enduring argument that families are essentially private, and that the state should not interfere in their affairs, it is increasingly recognised that families are not able to perform all the functions they did in the past. Education, health care, and other functions are now outside the arena of the immediate family. The interface between families and public policy is therefore of great importance.

In order to inform policy making in New Zealand and elsewhere, a body of evidence is needed that is based on sound research and on the identified issues and needs of families. The Families Commission has as its mandate the tasks of listening to families, of developing a sound knowledge base, and of advocating for families. The Families Commission is charged with providing that sound knowledge base. Its functions are:

Listening
'being in touch with families and whänau'
The Commission collects information from families and whänau about key issues and seeks to understand these issues from their perspective. The Commission runs a number of panels around the country each year where they discuss the factors that bring families together in those specific communities. Themes that emerge from the panels inform research priorities.

Research
'grounded and concrete evidence'
The Commission undertakes research and builds specific expertise on family and whänau issues. It engages with organisations working with families and whänau to collect their experience of the issues and needs. The Commission identifies areas where a lack of knowledge poses an impediment to family-friendly policy making, and commissions research to address those areas. For 2010/11 areas of priority for the Commission's Research Programme include

- The reasons for New Zealand's high rate of teen parenthood
- Parents with complex issues who have had their children removed
- Improving the accessibility, cost and quality of out-of-school services
- Debt issues for Pacific communities

Advocate
'informed positions'
The Commission provides advice from a family and whänau perspective to decision-makers (Government, government agencies, non- government agencies and Mäori organisations) to improve

the quality and effective delivery of services and policies. This is in line with the fundamental purpose of the Family Commission, which is to undertake research and policy analysis in order to advocate for positive change for families and whānau in New Zealand.

2. SKIP – Strategies with Kids, Information for Parents, New Zealand

New Zealand has in recent years had its share of troubled youth while levels of dysfunction, including crime, have been on the rise. A policy decision was taken at government level that the key to healing this trend lies in the quality of family life and parenting. Three key research reports were employed to inform SKIP's values and messages: *The Discipline and Guidance of Children: a Summary of Research* (Smith, Gollop, Taylor, & Marshall, 2004); a 2005 report by Gravitas that analyses changes in parental attitudes towards discipline; a systems-based review of SKIP's success factors (Gandar, 2005). The result is an approach that encourages parents and caregivers to bring up children from birth to age 5 with confidence about managing their behaviour in a positive way, as part of a loving, nurturing relationship that provides what children need.

Six things children need

The approach is based around the Six Principles – six things children need to grow into happy, capable adults – as outlined by The Discipline and Guidance of Children research report:

1. **Love and warmth**
   This builds the bonds of trust, love and positive self-esteem.
2. **Talking and listening**
   Talking with children, listening to what they say and giving clear messages strengthens confident and healthy relationships.
3. **Guidance and understanding**
   Children are more likely to co-operate when they understand why we require things of them. Straightforward explanations inspire greater co-operation.
4. **Limits and boundaries**
   Rules keep things safe and fair for the whole family. They need to teach mostly 'what we do' rather than 'what we don't do'. They need to work for everyone – for children and parents.
5. **Consistency and consequences**
   Consistency involves predictability. From an early age, children learn that an action has consequences.
6. **A structured and secure world**
   Safe, supportive environments provide security and reduce conflict.

Project design for SKIP

SKIP emphasises what parents and children should do, rather than should not do. Non-judgmental, it helps and supports parents with any and all problems they may be experiencing, including e.g. with alcohol or drugs. Collaborative, the professionals working in the programme put parents in contact with other agencies as appropriate. These same professionals work in a style of true partnership, so parents experiencing problems are not left feeling inferior or that there is something wrong with them because they have problems. All involved work together to find solutions to the common problems faced by humanity in general and parents in particular. Practical issues such as identifying what type of parent one is, methods of discipline and the stage of development of a child (and what therefore might reasonably be expected) are covered in the material but, as always, as a partnership adventure rather than professionals 'talking down' to the parents.

Group activities and whole family days are thoroughly enjoyed. Emphasis on the importance of parenting and the newly re-emerging community spirit are openly celebrated with all kinds of highly visible materials, including fridge magnets, rather than hidden away as private or even shameful signs of weakness. Resources include pamphlets, postcards, DVDs and educational modules in Māori and English.

The principle that success breeds success – a central theme. Everyone involved reports being energised and excited by the recognition MSD gives them and the value placed on their work. Success is celebrated and this breeds more success, with celebrations at gatherings, through newsletters and through stories woven into SKIP's history. Those involved have been highly successful at generating excitement, which is a phenomenon referred to as 'collective effervescence'

(Westley et al. 2007:131). Patterns of intensity are often at the greatest when people are together and sharing the same ideas and, often, the energy stirred by sharing a common idea and sense of purpose is far greater than the sum of its parts. The SKIP team and those working on SKIP-funded initiatives understand this, and often leverage it to generate wider community excitement and involvement, in turn encouraging more people to get involved, perpetuating the positive cycle.

3. The Harlem Children's Zone (HCZ), Harlem, NY, USA

'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.' HCZ works to reweave the social fabric of Harlem, which has been torn apart by crime, drugs and decades of poverty.

Project design for HCZ

This programme is focused on 97 blocks of the very disadvantaged community of central Harlem. The method is described as a Project Pipeline, delivered in stages to cover all children's ages from zero through to college.

Initially, parents and potential parents attend Baby College where they learn parenting skills including e.g. the importance of reading to young children. The pipeline stages then move up through the age groups, all of which have positive-sounding names such as Harlem Gems and Promise Academy. 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. The agency has 86 Peacemakers working as teaching assistants in seven public schools, serving 2,500 students.

The philosophy behind the programme is that starting at the earliest possible age results in the best possible outcomes. For instance:

- In 2009, Baby College graduated 371 individuals
- 86% of Baby College parents who read to their children less than 5 times a week at pre-test, improved their frequency
- 92.5% of respondents said they had learned a lot from the classes

There is even a 'Fitness and Nutrition Center' called TRUCE, which offers free classes to children in karate, fitness and dance. Participants also learn about health and nutrition, and receive regular academic assistance.

Examples of achievements

1. Of the 161 four-year-olds entering the Harlem Gems in 2008-2009, 17% had a school readiness classification of 'delayed' or 'very delayed'. By the end of the year, there were no students classified as 'very delayed' and the percentage of 'advanced' had gone from 33.5% to 65.2%, with another 8.1% at 'very advanced,' up from only 2%.
2. Since their creation in 2004 and 2005, Promise Academy I and II elementary schools have done well enough to lead Harvard economist Roland Fryer to conclude that the students had actually closed the black-white achievement gap.
3. In 2009, the third-graders from both schools were 100 percent on or above grade level in the statewide maths programme.
4. At PA1 the third-graders were 94 percent on or above grade level in English Language Arts, while the third-graders at PAII were at 86 percent.
5. Part of the afterschool programme is a chess programme: one team finished second and two other teams came in third in the All Nationals for Girls in 2009 (in all the chess programme served 106 children throughout HCZ who went on to win 78 trophies).
6. In 2008-2009, the programme's karate team brought home 86 trophies, including 36 first-place trophies.

Many of the students' parents had attended Baby College and these students had therefore been in the programme since birth or shortly afterwards.

4. Stop ACEs, Oneida County, New York, USA

Oneida is a small city in Madison County, New York, with a population of 10,987 at the 2000 census. A group of professionals in the county had been exposed to the research of Anda & Felitti, and found it to:

> '…clearly demonstrate how the negative effects of abuse and neglect in childhood severely hamper mental and physical health over a lifetime including spending huge public and private financial resources'.

These professionals set up a Community Group called the Stop ACEs group with the aim of putting an end to Adverse Childhood Experiences in their community. Detail of their practical approach is shown in the main report. This appendix summarises the research background to their initiative.

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) studies of medical doctors Anda and Felitti in California, carried out with Kaiser Permanente and the US Center for Disease Control, provides evidence in the lives of over 17,000 middle-class Americans of the effect of early traumatic life experience on later well-being, social function, health risks, disease burden, healthcare costs and life expectancy. The average starting age of the subjects was 57 and all had expensive private health care plans.

The essence of the study has been to match retrospectively, approximately a half century after the fact, an individual's current state of health and well-being against adverse events in childhood, and then to follow the cohort forward to match ACE Score prospectively against doctor office visits, emergency room visits, hospitalisation, pharmacy costs and death.

The adverse reference points were grouped under the three main headings of Abuse, Household Dysfunction and Neglect. Each participant was assigned an individual ACE Score – a count of the number of categories of adverse childhood experience encountered in their first 18 years. These are: (1) emotional abuse, (2) physical abuse, (3) contact sexual abuse; (4) mother treated violently; (5) household member an alcoholic or drug user; (6) or in prison; (7) or chronically depressed, suicidal, mentally ill, or in psychiatric hospital; (8) the subject not being raised by both biological parents; (9) physical neglect and (10) emotional neglect. The scoring system took account of only one incidence in any given category, so if a subject had been raised in a household containing both an alcoholic and a drug user, this would count as one not two, etc. The conclusions to date are startling in their wide-ranging implications for physical and emotional health, and for health spending and priorities, and have been published in an extensive range of more than 60 articles (e.g. Felitti & Anda, 2009; see references for selection).

OVERVIEW OF ACE FINDINGS -- Whenever a study participant was found to score 1 on the Adverse Childhood Experience Score, there was an 87 per cent probability of more such experiences. One in six people (or 17 per cent of the sample tested) had scores of 4 or above. For this category, compared with people with no ACEs, they had twice the level of liver disease, 3 times the levels of lung disease, depression and adult smoking, were 4 times as likely to have begun intercourse by age 15, had 6 times the level of alcohol abuse, 11 times the level of intravenous drug abuse and had made 14 times the number of suicide attempts.

The most common contemporary health risks (smoking, alcoholism, illicit drug use, obesity and high level promiscuity) are widely known to be harmful and yet are difficult to give up. This can be because they are experienced as personally beneficial. In other words, unhealthy behaviours may be soothing submerged pain.

The relationship between ACE Score and depression is borne out by analysis of prescription rates for anti-depressant medications, now 50-60 years after the fact. It appears that depression is common and has deep roots, usually going back to the developmental years of life.

The authors of the study conclude that 'all told, it is clear that adverse childhood experiences have a profound, proportionate, and long-lasting effect on well-being,' whether this is measured by depression or suicide attempts, by protective unconscious devices like overeating and even amnesia or by what they refer to as 'self-help attempts', the use of street drugs or alcohol to modulate feelings. They say that these are misguidedly addressed solely as long-term health risks, 'perhaps because we physicians are less than comfortable acknowledging the manifest short-term benefits these 'health

risks' offer to the patient dealing with hidden trauma.'

Using teen pregnancy and promiscuity as measures of social function, Ace Score has a proportionate relationship to these outcomes, as it does to miscarriage of pregnancy. Job performance correlated inversely with ACE Score. The problems of alcoholism and use of IV drugs already mentioned can also be treated as markers for damaged social function as they are reflected in impaired work performance.

Arguing that the findings of the Adverse Childhood Experiences (ACE) Study suggest a credible basis for a new paradigm of primary care medical practice, the authors advocate that treatment should begin with a comprehensive biopsychosocial evaluation of all patients. One astounding outcome of administering such an evaluation to 200,000 patients was a 35 per cent reduction in visits to doctors' offices during the following year.

5. Population-based Prevention of Child Maltreatment, USA

The *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.

Project design for Triple P

Dissemination in the 9 treatment counties involved Triple P professional training for the existing workforce (649 service providers), as well as universal media and communication strategies to reach the target population of families with children aged under eight (85,000 families in any given year in the treatment counties). Providers reported delivering the intervention to between 8,883 and 13,560 families over a 2-year period.

The programme is delivered to parents rather than to children, and is based on five core parenting principles:

1. Ensuring a safe and engaging environment for children
2. Creating a positive learning environment for children
3. Using assertive discipline
4. Having realistic expectations, assumptions and beliefs about the causes of children's behaviour
5. The importance of parental self-care

Triple P works at 5 levels (from community-based to a narrow targeted focus). From a policy-making perspective, and particularly in relation to inequalities, division into 5 delivery levels of increasing intensity is key.

> Level 1: population level for all interested parents of children 0-16 years (promotion of parenting style through media, parenting tip sheets, TV programmes, newspaper columns, radio announcements etc.)
> Level 2: brief early intervention strategy for parents of children with mild behavioural/developmental issues. Delivered through primary care services (1-2 consultation sessions, tip sheets, videotaped programmes)
> Level 3: more intensive early intervention strategy, targeting parents of children with mild to moderate behavioural/developmental difficulties (involves 4 sessions providing active skills training for parents)
> Level 4: group or self-directed parent training programme for parents of children with more severe behavioural/developmental difficulties (involves 8-10 sessions of intensive work with parents, offered as three separate delivery approaches)
> Level 5: enhanced programme, individually tailored. Aimed at whole families with persistent childhood behavioural problems and where other sources of parental family stress are present

Findings

A number of studies have shown Triple P to be effective in improving children's behaviour and parent-child interaction and reducing parenting conflicts. Studies have also shown:

- Improvements in disruptive behaviour to be maintained for up to two years after intervention
- The intervention to be effective within a range of settings (standard, self-directed, telephone-assisted, group and enhanced intervention) and with several different family types

Use as a public health intervention
Triple P has been implemented at the population level before, for example in Australia where families in 20 areas across Brisbane, Sydney and Melbourne participated in a population trial of Triple P called the Every Family initiative (Sanders *et a*l, 2008). However the U.S. Triple P System Population Trial is reported to be the first study of its kind to randomise communities to condition, implement Triple P as a prevention strategy, and then demonstrate positive impact on multiple population indicators of child maltreatment.

6. CASASTART (Striving Together To Achieve Rewarding Tomorrows)

CASASTART is a community based programme, delivered within the school setting, designed to keep high risk 8 to 13 year olds free of drug and crime involvement. The programme is voluntary, and children participate for up to 2 years. It was developed by The National Center on Addiction and Substance Abuse at Columbia University (CASA*), a national organisation that brings together under one roof all the professional disciplines needed to study and combat all types of substance abuse. CASA's staff includes medical, legal and other professionals in communications, criminology, economics, education, epidemiology, government, history, journalism, medicine, psychology, public health, public policy, social work, sociology and statistics.

Project design
CASASTART operates on three levels: building resilience in the child, strengthening the family, and making the neighbourhood safer. The programme brings together key stakeholders - schools, law enforcement agencies, social services, health agencies - under one umbrella, and provides case managers to work on a daily basis with high risk children. Each case manager serves 15 families. These case managers work closely with teachers, police officers, social service agencies, charities and so on to organise services and support that would help to counteract the factors that make the child vulnerable to substance abuse and juvenile crime. The case managers engage with the children, develop case plans, offer counseling, make referrals e.g. to mentoring services, help parents navigate through the social/educational/legal systems, advocate for the family in court, run after school or recreation programmes, intervene to prevent eviction or utility shut-offs and so on. Case conferences are held at least bi-monthly to discuss individual clients, with representation from the different agencies involved, and sometimes parents as well.

The Office of Juvenile Justice and Delinquency Prevention, and other agencies and foundations funded experimental demonstrations from 1992 to 1996 in five cities—Austin, Texas; Bridgeport, Connecticut; Memphis, Tennessee; Savannah, Georgia; and Seattle, Washington—to test the feasibility and impact of integrated delivery of the CASA model.

The outcomes of the programme were assessed using three main measures:

Surveys of youths and caregivers. In person interviews in the home at baseline, at the end of the programme period and 1 year after the end of the programme.

Data on officially recorded criminal activity. Annual records were collected from the police and courts in participating cities on the youths' officially recorded contacts with the criminal justice system.

Data on school performance and attendance. Records were collected from the schools on grades, promotions, and the percentage of scheduled days youths attended.

Findings
Compared with youths in the control group 1 year after the end of the programme, CASA youths were significantly less likely to have used either gateway or strong drugs in the past month; were significantly less likely to use gateway drugs in the year following the end of the programme (but no less likely to use stronger drugs in that year) were significantly less likely to have sold drugs, both in the past month and at any time; and committed significantly fewer violent crimes (but not property crimes) in the year following the end of the programme.

In terms of risk factors, one year after the programme ended, CASA youths had more positive peer support than youths in the control group; associated less often with delinquent peers; and felt less peer pressure to engage in delinquent behaviours.

7. Every Family Initiative, Australia

Evidence from household surveys of Australian parents show that parenting problems are common. For example, Sanders et al found that a large number of parents from diverse socioeconomic backgrounds reported that their children had significant behavioural 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.

Positive parenting programmes based on social learning principles to teach parents positive parenting skills and consistent discipline methods hold particular promise in reducing behavioural and emotional problems, and have been repeatedly demonstrated to be effective in managing children with early onset conduct problems. Despite their demonstrated effectiveness relatively few parents access evidence-based programmes, and more socially disadvantaged parents are less likely than others to be aware of or participate in such programmes, even though there is strong evidence that low income families benefit from such programmes. The high prevalence rates for both child problems and ineffective or inadequate parenting coupled with growing community concerns about children's behavioural and emotional problems in schools points to the need to develop, implement and evaluate parenting interventions that can be rolled out on a large scale in a cost-effective manner. For such an approach to be effective a public health approach is needed.

Design of programme for Triple P, Australia

The Triple P system was introduced to 10 geographical catchment areas in Brisbane intervention communities and was compared to 10 socio-demographically matched communities in Sydney and Melbourne who received care as usual.

Findings

The implementation of the Triple P system was associated with significantly greater reductions in emotional problems and psychosocial difficulties in both children and their parents, than in the Care as Usual condition. Following the intervention parents in the TPS condition reported greater reductions in SDQ total scores. This finding supports earlier reports by Zubrick et al, Heinrichs et al and McTaggart and Sanders, and confirmed that the systemic introduction of a coordinated across agency system of parenting support can produce meaningful population level effects. The intervention effects were for overall psychosocial problems and emotional difficulties, but not for conduct problems, hyperactivity and peer relationship difficulties. Nevertheless, if the 22% reduction in psychosocial problems on the SDQ total score were replicated Australia wide there would be approximately 31,199 fewer children transitioning to primary school with serious behavioural or emotional problems.

Although individual studies have previously shown Triple P interventions improve some form of parental depression, no studies have shown an impact on parental depression at a population level. Hence, findings that parental reports of depression reduced by 26% and stress reduced by 4% are encouraging. Replicating this level of reduction in depression Australia-wide would result in 72,612 fewer parents reporting high levels of depression as their children transitioned to school.

There was a 32% reduction in coercive parenting in the Triple P communities, a 14% greater reduction than in the CAU communities. If this were replicated at a whole population level this represents 98,545 fewer parents engaging in coercive parenting techniques. This finding is important as Triple P has been advocated as a child maltreatment prevention strategy. We were unable to detect population level effects favoring Triple P on parental reports of consistency and self efficacy.

The major implication from this 'going to scale' implementation of Triple P as a public health intervention is that a relatively small increase in parental exposure to an evidence based programme was associated with a significant population level reduction in problems with children and reduced parental distress at the transition to school period.

8. CIRV (Community Initiative to Reduce Violence)

Glasgow is one of the most violent cities in Europe, with knife crime a particular problem. Gang culture is deeply ingrained in parts of the city, especially the city's East End. The Scottish Violence Reduction Unit (SVRU) looked around the world for possible models of intervention to deter gang members from violence, before they end up as either a murderer or a victim.

They found a possible model in the Boston Cease Fire Project. The success of the Boston approach was grounded in one principle and two operational practices: the principle was a network based on capacity and trust, where stakeholders from the community, including pastors and street workers who were ex-gang members, were brought together to support gang members willing to give up violence.

One of the Boston practices, Operation Nightlight, was not adopted in Glasgow. The other, Operation Ceasefire, was. Ceasefire consisted of gang members involved in serious violence being subjected to a united, multi-agency front saying, essentially, 'We know who you are. We know what you do. If you cross this line – serious violence – we will come down on you hard, and it will be a multi-agency approach where you may be penalised in any area of your life– tax, litter, housing, driving'. These combined strategies brought a very successful period of homicide reduction to Boston.

CIRV Project design

In October 2008 the SVRU, with Strathclyde Police, invited 220 out of about 700 East End gang members to Glasgow Sherriff Court for a gang summit where they were confronted with the effects of gang violence and offered help to turn their lives around. At the first meeting about 100 were brought to the court by minibus with police officers on board to stop any violence. Two sessions were held - one in the morning for those aged 15 and under, and one in the afternoon for those aged 16 and over.

During a carefully scripted meeting the gang members heard from a senior police officer, an Accident and Emergency consultant, members of their community and the parent of a victim. They were also shown an interactive map which identified Glasgow gangs, their members and their territories.

The senior police officer then told the gang members that if any of them - including members not present - committed an assault or murder, they would be pursued as a whole group, as in the Boston model. The SVRU said this often had the effect of pushing gangs to police their own behaviour.

At the end of each session, gang members were given the freephone number of a 'one-stop shop' where they could access support in education, health services, careers advice and social services. A programme is tailor-made for each gang member in a bid to help them turn their life around. CIRV brings together a mentoring support service of around 80 people from community safety services, housing, careers, education, social work, health and ex-gang members.

Achievements

Within 6 weeks some 63 of the gang members who attended the initial sessions had taken up the offer of help. By December 2009, one year later, 368 had signed up – over half the estimated total East End gang members – and pledged to give up violence. Over 100 of the youths have been routed into full-time employment, work placement or training including 60 new jobs in conjunction with the UK Future Jobs Fund. Enforcement activities have been directed at those continuing to offend.

Police reported after the first year that the programme had led to a 49% reduction in violent offending by those engaging with the initiative. It also had a domino effect among gang members who refused to participate, with violent activity among the 'disengaged' falling 18%.

Community leaders described the effects as 'incredible' with one commenting 'The community are telling me they see a real difference and they feel safer'.

SECTION 1 (B) Health and Early Parenting Practice

HEALTH-RELATED

9. Approach to Infancy and Early Childhood in Sweden

The countries of Scandinavia consistently lead international comparisons in terms of welfare (Wilkinson and Pickett 2009). Recognising the value of prevention and early intervention programmes, in the last 20-30 years these countries have increased investment in such channels (Killén 2000; Socialstyrelsen 1997).

A 2008 study by Heiervang, Goodman et al, investigating children's externalising and internalising problems in both Norway and Britain, discovered that Norwegian children scored lower on all problem scales (emotional, behavioural, hyperactive and peer relationship) on the 'Strengths and Difficulties Questionnaire' according to parents as well as teachers. The prevalence of externalising disorders (behavioural and hyperactivity) in Norway was about half that observed in Britain.

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 (99 per cent), who typically have 11 individual contacts, mostly with midwives. Ninety-eight per cent of all maternity healthcare clinics offer parenting education in groups to first-time parents, with 60 per cent 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.

Ninety-nine per cent 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 one to two months. In Stockholm County for example, 61 per cent of all first-time parents participated in at least five sessions in 2002 (Bremberg 2006). Parent education accounts for around 8-10 per cent of midwives' working time; 65 per cent of midwives received regular professional training on the subject, and 72 per cent were instructed by a psychologist (Socialstyrelsen 1997).

At 2.5 per cent 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). In addition Sweden has the third-lowest rate of teenage pregnancies in the European Union at 1.6 per cent, compared to 7.1 per cent in the UK (only several Eastern European countries have a greater number than Britain). Given the poor relative life prospects for children of teenage mothers, this also contributes to better long-term outcomes in Sweden.

	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 professional healthcare service in Sweden, with a strong focus on prevention, and starting at the very beginning of life with emphasis on breast-feeding (98% of Swedish mothers begin breast-feeding vs 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. 100% of hospitals have BFHI (baby-friendly) status (less than 10% in the UK) and early parent training is provided for a high proportion of the population. From that strong beginning it is able to improve its users' quality of life through helping them to avoid many preventable illnesses, and enabling the country to save money on both the healthcare and non-healthcare costs of those illnesses.

10. Effect of early postnatal breast-feeding support, Denmark

Duration of exclusive breast-feeding is well below the recommended level in most industrialised countries. Four months after birth, exclusive breast-feeding is seen for 45%–60% in Scandinavia. This compares to only 7% in the United Kingdom. The first weeks following birth have been identified as the period when breast-feeding attrition occurs most often. The health care recommendations best supported by evidence are (1) Unrestricted mother-infant contact; (2) frequent feeding; (3) mastering breast-feeding techniques; and (4) delayed use of pacifiers. The largest effect of postnatal support is obtained by personal contact.

Project design

A community based cluster-randomised trial in Western Denmark. Subjects: 52 health visitors and 781 mothers in the intervention group, 57 health visitors and 816 mothers in the comparison group.

All health visitors in the intervention group participated in an 18-hour training course, developed for the study with inspiration from the WHO's Training Course. The main topics were effective breast-feeding technique, self-regulated breast-feeding, mothers' concern about having enough milk, parents getting to know the baby's cues and interact with the baby, common breast-feeding problems, how to acknowledge the mother's perception of the breast-feeding and address her concerns. Health visitors in the comparison group offered their usual practice.

The intervention consisted of 1-3 home visits within the first 5 weeks with the following main topics: (a) Effective breast-feeding technique and learning to know the baby, (b) self-regulated breast-feeding and interpretation of the baby's cues, (c) sufficient milk and interaction with the baby. The first visit was scheduled as soon as possible after coming home from the hospital. Primipara and multipara mothers with previously short breast-feeding experience received two additional visits in the first 5 weeks after delivery.

Findings

The primary study outcome was the duration of exclusive breast-feeding defined as a child being fed only on mother's milk. The secondary outcome was the mother's satisfaction with the breast-feeding period measured on a five-point Likert scale.

Mothers in the intervention group had a 14% lower cessation rate of exclusive breast-feeding during 6 months of follow-up. Similar results were seen for primipara, and multipara with previously short breast-feeding experience. Mothers in the intervention group received their first home visit earlier, had more visits and practical breast-feeding training within the first 5 weeks. Babies in the intervention group were breastfed more frequently, fewer used pacifiers, and mothers reported more confidence in not knowing the exact amount of milk their babies had received when being breastfed. Six months after delivery 59 mothers (7.7%) in the intervention group were still exclusively breast-feeding compared to 40 mothers (4.9%) in the comparison group. In the intervention group 122 (15.6%) mothers had stopped exclusive breast-feeding during the first 5 weeks after delivery compared to 166 (20.4%) mothers in the comparison group. Corresponding numbers for multiparous mothers with previously short breast-feeding were 25 (45.5%) intervention group vs 42 (65.6%) comparison.

Conclusion: Home visits in the first 5 weeks following birth may prolong the duration of exclusive breast-feeding. Postnatal support should focus on both psychosocial and practical aspects of breast-feeding. Mothers with no or little previous breast-feeding experience require special attention.

11. Nurse Family Partnership

When a young woman becomes pregnant before she's ready to take care of a child, the risk factors for the entire family escalate—often resulting in poverty, conflict, and despair. The transition to motherhood can be particularly challenging for many low-income, first-time mothers. Many are socially isolated, and have limited access to good parenting role models. Nurse-Family Partnership provides these parents with a relationship they can count on: a trusted, compassionate health visitor who visits them at home regularly for over two years.

Design for Nurse-Family Partnership Programme

Women voluntarily enrol as early as possible in the programme, ideally by the 16th week of pregnancy. They receive weekly or fortnightly structured home visits by a specially trained health visitor from enrolment until children are 24 months old. The curriculum for these visits is well specified and detailed with a clear plan for the number, timing and content of visits. Supervision is ongoing and careful records of visits are maintained. The programme has strong theoretical underpinnings, with the formation of a strong therapeutic relationship between nurse and mother at its heart.

Main goals

The main goals of the programme are to:

1. Improve the outcomes of pregnancy by helping women improve their prenatal health.
2. Improve the child's health and development by helping parents to provide more sensitive and competent care of the child.
3. Improve parental life course by helping parents plan future pregnancies, complete their education and find work.

The most pervasive effects of the programme, when implemented with fidelity, are those relating to maternal life course (such as fewer and more widely spaced pregnancies) and better financial status. The likelihood of child abuse and accidents is reduced, the children are likely to have improved developmental outcomes as they reach school age and there is some evidence for a reduction in antisocial behaviour in children when they reach their teens.

In 2006 the UK government announced that 10 demonstration sites would test the NFP in England, where it is called the Family Nurse Partnership (FNP). The majority of staff recruited to offer the FNP were extremely experienced. Most teams consisted of four Family Nurses and a supervisor, but some teams were a little larger.

An evaluation was set up to document, analyse and interpret the feasibility of implementing the NFP model in England; to determine the most effective method of presenting the model; to estimate the cost of presenting the NFP model; to determine the short-term impact on practitioners, the wider service community and the children and families; and to set the groundwork for a possible longer term experimental assessment of the programme and its impacts. There are now 50 sites offering the programme in the UK.

The first two years of evaluation, to this brief, have taken place. In the first year some teething problems were found, such as a higher than expected rate of attrition from the programme, but feedback from mothers, fathers, extended family, nurses was all extremely positive. All those directly involved in the FNP in the pilot sites and centrally point out that while it may appear to be an intensive version of existing UK early years health services, the actual experience is of a very new way of doing things. FNs feel they are reaching real need, using their skills, partnering clients and seeing change in them. They note how different it is to work in a structured programme, but found it extremely helpful in comparison with the professional approaches they had been used to (in health visiting and midwifery). They valued the close relationship within the FNP team, the high quality of the training and the chance to work with the whole family.

Clients value the programme and their Family Nurse (FN) highly and report that receiving FNP is making a difference. Clients were asked to indicate, on 10 point scales, the extent to which they thought that receiving the FNP programme had made a difference – first to their pregnancy and then to the way that they had cared for their baby. A score of 1 would signify that they had not learned anything new and had lots of other support, while a score of 10 would signify that FNP had 'made all the difference in the world, before being offered FNP I was not sure how I would cope'. 43% of clients rated the nurses at 10, and 80% scored them at 8-10.

Other key messages from the second year English evaluation included:

- The FNP Programme can be delivered well in infancy, in terms of the nature of the visits and the extent to which clients are retained in the programme.
- The strength of the client-Family Nurse relationship is noted by clients and FNs as the key to successful delivery, making an impact, and retaining clients in the programme.
- Despite being new to each stage of the programme, delivery in England has come close to stretch objectives, but there is substantial site variability.
- A small number of sites, with cohesive teams and strong local support, are performing at a high level, and a small number, typified by high staff turnover and ambivalent support from the wider service community, are performing less well.
- Site variation suggests local factors such as: team cohesiveness and stability, relationships between the supervisor and FNs, and the capacity of individuals assigned to integrate FNP into local services to give clear messages to commissioners.
- Commissioners focus on programme costs, not always showing awareness of who it is intended for, what impacts might be, and the relevance of the USA existing evidence base.
- The cost of delivery at £3,000 per client per year appears to be approximately comparable to the USA but a substantial proportion of staff time is taken up with non-FNP activities, including professional development and mandatory NHS training.
- Staff turnover has been high in some sites, impeding successful delivery. This may be related to lack of clarity about where FNP sits in relation to other professional opportunities for nurses

A randomised control trial will be carried out by Cardiff University on 18 sites of FNP evaluating child outcomes, smoking in pregnancy, birth spacing and economics. Results will be available in 2013-14.

12. Importance of the near birth period, including birth, breast-feeding and risk assessment

WHO recommends that all infants should be fed exclusively on breast milk from birth to six months of age. Breast-feeding is supported by extensive evidence for short-term and long-term health benefits, for both mother and baby. Babies who are not fully breastfed for the first three to four months are more likely to suffer health problems such as gastroenteritis, respiratory and ear infections, urinary tract infections, allergies and diabetes mellitus. There are also significant long-term benefits to the mother from breast-feeding.

20-25% of British mothers are still breast-feeding at 6 months, compared to over 70% in Sweden, and OECD reports that in 2005 less than 1% of British mothers were exclusively breastfeeding at 6 months, compared with the EU average of 28%. A shortage of midwives and over-crowded maternity units were said to be contributors to the problem. Fewer than 1 in 10 hospitals in England has achieved UNICEF Baby-Friendly Status (a set of standards including helping women to start breast-feeding within half an hour of birth and to breastfeed exclusively for the first 6 months). This compares to 100% of hospitals in Sweden, 64% in Norway and 40% in Switzerland. Hospitals can only be designated as UNICEF Baby-Friendly when they:

> do not accept free or cheap breast milk substitutes, feeding bottles or teats, and
> have implemented 10 specified steps to encourage breast-feeding (e.g. informing mothers about the benefits, training staff to help women breastfeed, not offering dummies to infants, and ensuring mothers and babies stay together 24 hours a day while in hospital).

The UK also compares unfavourably with countries such as Netherlands and Sweden on rates of caesarean births (UK 21%, Netherlands 14%) and infant mortality (UK 4.9, Netherlands 4.6, Sweden and Norway 3.0). Given the crucial nature of the best possible start in life, the birth experience and immediate post-natal support, the perinatal experience appears to be one area where the UK could do much better. Anecdotal feedback to us from midwives with experience in both the UK and the Netherlands strongly pointed to this as one factor explaining poorer UK child outcomes.

A number of studies indicate successful approaches to promoting breast-feeding. The Dyson review referred to above showed that health education and peer support interventions can increase the number of women beginning to breast-feed. A WHO and UNICEF sponsored initiative in Belarus

(Kramer et al, 2001) showed in a study of over 16,000 mother-infant dyads that infants from intervention sites were significantly more likely than control infants to be breast-fed, and more likely to be breast-fed exclusively. These children also showed lower levels of gastro-intestinal tract infections and atopic eczema. Bull et al (2004) found evidence from review-level literature that rates of breast-feeding could be improved by home visiting programmes; the New Zealand Family Commission (Dwyer, 2009) also report an RCT which increased breast-feeding (70% vs 58% for the control).

A number of studies referred to the beneficial impact on breast-feeding of early skin-to-skin contact, beginning ideally at birth, between baby and mother (or father). (Gomez Papi 1998; Moore et al (2007). The latter study, a Cochrane review, found statistically significant and positive effects of early skin to skin contact for breast-feeding and breast-feeding duration. Higher levels of maternal affection and maternal attachment behaviour and shorter crying times by infants were also observed.

13. Community Mothers Programme (CMP), Ireland

CMP operates mainly in disadvantaged neighbourhoods and is offered to both fathers and mothers – first-timers and some second-timers – of children from birth to twenty four months, to aid the development of parenting skills and improve parents' confidence and self-esteem. It gives advice and support on a range of family issues from breast-feeding through toddler groups to goal-setting. An important aspect of the approach is for the Community Mothers to reflect the ethos of the community they intend to visit. It is not costly or intensive (many of the volunteers had just twelve contact hours with each mother), it offers benefits to the volunteers and to the mothers visited (and, ultimately, to the wider community) and it *may* engage parents who are difficult to reach via traditional services.

Design for CMP

Community Mothers are recruited, trained and supported by Family Development Nurses. Each full-time FD Nurse runs a team of 18-20 Community Mothers, enabling them to support 100-120 families at a 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. These CMs 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.

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 will want to do what is best for their child.

Findings

The programme was evaluated in Dublin, using a randomised controlled approach in 1989-90, when the children were 1 year old. Both intervention (n=141) and control (n=121) groups received the standard support from local public health nurses and invitations to attend for primary immunisations and a development assessment. 89% percent of the sample completed the study. 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 (Johnson et al, 1993).

Evaluation (of one third of the original intake) 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, to have higher levels of self-esteem, to be 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 immunisation and be breastfed. There were indications that just 12 contact hours in the first year of a child's life can make a difference.

Evaluation of the Comprehensive Child Development Programme in the US found children's health, ability to concentrate and social behaviour were better, compared with those who received conventional postnatal care, and that they were more likely to have story books at home.

Twenty six areas of Britain are covered by versions of the Child Development Programme. A detailed

study of statistical data, across a sample of more than 30,000 children in 24 health authorities in England and Wales suggested that those families involved in the CDP had a 41% lower rate of registration on the Child Protection Register, and a 50% lower rate of physical abuse, than adjusted levels for the relevant populations in the same health authorities (Barker et al, 1992). However the First Parent Visitor Programme (FPVP), which evolved from the CDP and comprises a programme of regular home visits by a specially trained health visitor to first-time parents from deprived areas has been evaluated in the UK, with the finding that there were no differences between the target and control groups of mothers in self esteem, locus of control or depression rates.

14. Centering Pregnancy, USA

Antenatal care is typically provided on a one-to-one basis between the midwife and the family. This places an inherent limitation on the amount of time the family has with the professional, and therefore the value the family can derive from the interaction. Group antenatal care is a structural innovation to the traditional antenatal mode, permitting more time for professional-family interaction and therefore greater opportunity to address clinical as well as psychological, social and behavioural factors to promote healthy pregnancy. The group dynamic offers an empowering model of experiencing pregnancy and allows families to build mutual support networks from very early on in their pregnancy.

Centering Pregnancy is an established model of group antenatal care that has a reasonable and growing evidence base supporting its effectiveness.

Intervention Design

Delivery of Care

1. Centering Pregnancy is provided within a group space rather than within an examination room
2. Care is provided in *partnership with* a professional rather than by the professional

Content of Care

1. The mother participates in physical assessment – blood pressure, weight and heart rate monitoring occur in the group space. Health concerns requiring private consultations can still be conducted in ancillary visits or in a private room.
2. The mother participates in documentation – recording their own weight and blood pressure. Responsibility for the antenatal care record is shared between mother and professional.
3. Education runs throughout the 10 sessions with professionals covering specified topics from a structured manual. In the traditional model, education can be provider-dependent, random, dependent on patient-initiated queries, and under time pressure.
4. There are constant opportunities for community building during the ten 2-hour group sessions.
5. It is a one stop shop for relevant services (smoking cessation, nutrition counselling, labour preparation) rather than mothers having to go from one service to another.

Time Spent with Families

1. All care, education and support take place within a 2-hour period, with no need for a waiting room.
2. Providers find it fulfilling to be given the opportunity to spend time with families and have in-depth discussions with them over a 20 hour period.
3. The group schedule is decided at the start rather than being dependent on the professional's.

Evidence of Effectiveness

Grady and Bloom (2004), in a trial targeted at high-risk teenage mums, found that in comparison with two other (non-randomised) groups of adolescent mums, participants in Centering Pregnancy:

- Were more likely to attend classes (81% vs. 72%)
- Had 50% fewer cases of preterm or low birth weight births
- Had almost double the self-reported breast-feeding rate at time of discharge (46% vs. 28%)
- Were more likely to have identified a paediatric provider at hospital discharge (79% vs. 52%)

Ickovics et al (2007), in a randomised, controlled trial of 1047 pregnant women aged 14 to 25 found:

- Participants in Centering Pregnancy were 33% less likely to have a preterm birth
- Participants had significantly better antenatal knowledge, felt more ready for labour and delivery and had greater satisfaction with care
- Breast-feeding initiation was higher in Centering Pregnancy: 66.5% compared with 54.6%
- There were no differences in birth weight nor in costs associated with prenatal care or delivery

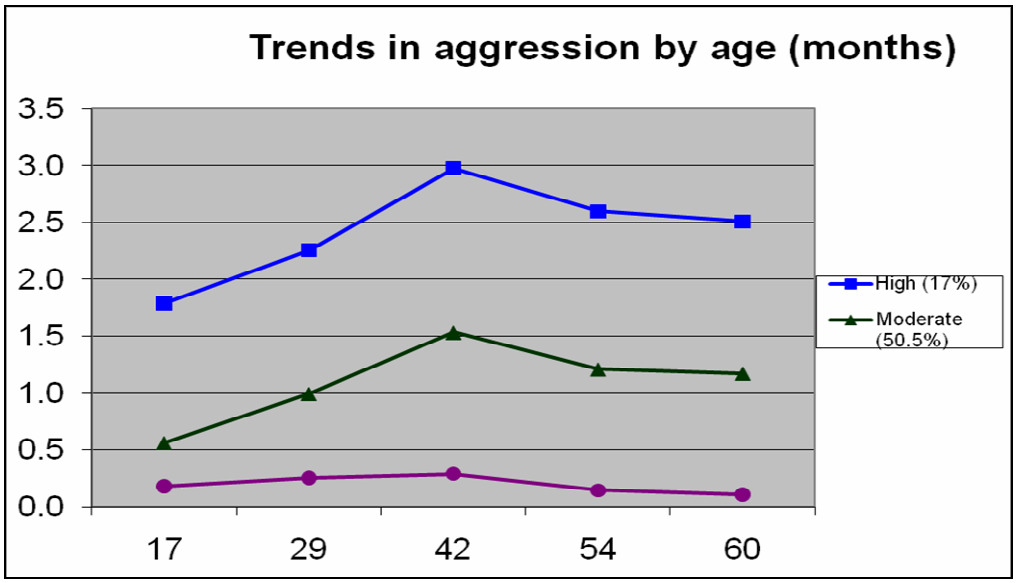
45. Kraamzorg, post-natal care in the Netherlands

This Practice can be found at the end of this Appendix, Late Additions.

EARLY PARENTING PRACTICE

15. Research of Richard Tremblay

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 (Tremblay, 2006). In fact comparisons at age 3 shows 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. The chart below, of violence at ages 17 to 60 months, shows that at age 29 months (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 (Tremblay & Japel, 2003).

Tremblay goes on to point out that so-called 'prevention programmes for aggressive elementary or high school children are, in fact, corrective interventions. Since children were using physical aggression during the preschool years, it does not make sense for interventions with school-age children to aim at 'preventing' children 'from learning to use physical aggression.' Such children needed intensive interventions to help them learn alternatives to physical aggression at a developmentally appropriate time i.e. pre-school. At best, the later interventions are attempts to help learn alternatives to aggression for children who did not learn when they should have.

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 (Tremblay, 2008). Epigenetics is now suggesting the environment, especially during pregnancy and very early childhood, activates and 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. He argues that a substantial increase in resources to support pregnant women, preschool children and their families would produce major rewards in prevention of mental illness and the improved health of the next generation.

He suggests society pays a tremendously expensive price for not fostering the quality of early brain development in high risk children, knowing: a) that the quality of this crucial organ's development insures the quality of behaviour regulation and, b) that chronically violent youth and adults show important cognitive dysfunctions.

16. Every Opportunity for Every Child

This Dutch government programme was set up 'despite our children being among the happiest in the world'. As business strategy consultants we (the founders of WAVE) found that leading companies, no matter how good, were always striving to improve. Even though the Netherlands leads the UNICEF league tables on child well-being (in which Britain came 21st), they are still committed to do even better.

The Youth and Family Programme states that the problems of children and families must be detected and addressed as early as possible, to prevent them from becoming more serious when they grow older. Essentially, this calls for a focus on prevention. Early identification, and above all, early intervention are stated to be core to their approach.

Another principle was that undesirable situations cannot be allowed to continue. Everyone must take responsibility if there are signs that a child or family is in difficulty. Simply monitoring the situation, providing an ad hoc response or even turning a blind eye is no longer acceptable.

The third principle was to confirm the family's natural role in bringing up children. Intensive use was made of the Family Group Conference approach, in which a joint plan is devised enabling families to rely on their own networks of relatives, friends and neighbours for support.

Parenting support was offered to all families. A national network of youth and family centres was created to provide advice and help on parenting at neighbourhood level. Community schools, youth and family centres and other local facilities also offered advice and support on parenting.

The problems of individual families were tackled using the 'one family, one plan' approach - an overall plan which addresses all the problems being experienced by a family, with a single point of contact for family members and care workers. As soon as two or more organisations began providing assistance to one family, they were automatically required to come together to plan a joint strategy, with one agency in overall charge. 'Children with problems often come from families with problems'. Divorcing couples were required to draw up a parenting plan containing agreements about their children's upbringing to ensure continuity of a stable home life.

Emphasis was placed on ensuring a healthy, balanced upbringing for children before the age of four 'since this is the best way of ensuring that they do not develop problems when they grow older'. Youth healthcare services were required to conduct a growth and development risk assessment for each child during its first four years, with help being given where necessary. Interventions could range from parenting support, provision of early childhood education programmes and community school activities to a youth care order. Data sharing was made mandatory.

Parents were recognised as being primarily responsible for raising their own children, and were to be given help when needed; if the safety, health or development of their children was at risk, they were to be obliged to accept help. Those reluctant to do so would, if necessary, be legally required to work with professionals to improve their parenting skills.

The overall goal of the government's anti-child abuse strategy was to protect children from all forms of abuse, in accordance with Article 19 of the International Convention on the Rights of the Child: 'Freedom from abuse is the right of each and every child. Prevention of such abuse is therefore the government's primary aim.'

The government's action plans stated that prevention would be the focus of all interventions. They stated that evidence from other countries, such as Sweden, shows that offering parental support to *all* parents as an integral part of youth healthcare reduces the incidence of child abuse. Youth and family centres were to play an important role in this. 'Parents must be given support so that inability to cope with child-rearing does not lead to child abuse.' This strategy is based on the following four goals:

1. *preventing* parents from mistreating their children;
2. *identifying* and reporting child abuse;
3. *halting* child abuse;
4. *limiting* the harmful effects of child abuse.

17. Leksand Model, Sweden

In several Swedish towns and cities, parent support is organised by the municipality in partnership with the county council and adult education organisations. The model was first developed in Leksand, in central Sweden. Parent groups start there, as in other parts of the country, within the maternity healthcare services whilst the mothers are still pregnant. The groups are run by midwives. The difference between the Leksand model and more prevalent models elsewhere is that the same groups of parents continue to meet after the baby has been born. This has been a long-standing ambition in many parts of the country, but has seldom been implemented in practice.

Project design

The reason why success was achieved in Leksand is probably because the municipality has taken a collective responsibility for the parent groups. In more prevalent models around Sweden, the responsibility for parent groups after the baby has been born lies entirely with the nurses in the child healthcare service. They have subsequently organised the groups according to the way the child healthcare services are set up, which is different to the way the maternity healthcare services are organised. It has hence been difficult to keep the groups formed during pregnancy together. In Leksand, on the other hand, the municipality has taken overall responsibility, allowing the groups to be kept together. The same groups continue to meet as the children get older and acquire younger siblings. An adult education association then organises the activities in cooperation with the parents.

There are a number of advantages with this model. The first is the way the contacts among parents are strengthened. This is one of the intentions of current parent education elsewhere but is seriously disrupted by constant changes to the composition of the parent groups. Another is that the parents can easily continue to meet and discuss themes they themselves choose, even after the children have grown beyond early infancy.

Findings

There is data from Leksand on the parent groups that started when the mothers were still pregnant with the family's first child. In 1999–2000, a first child was born in 96 families domiciled in the municipality. Parents from 91 of these families took part in parent group activities during pregnancy. The groups continued on through early infancy and the toddler years. In February 2004, when the children were between 3 and 5 years old, about half the parents were still continuing, 46 women and 46 men. These figures reflect another strength of the Leksand model, that fathers participate in activities to about the same degree as the mothers. This is seldom the case in other municipalities.

Attendance at the parent groups is high, and different social groups are being successfully recruited, suggesting the model has come to grips with problems which afflict most other parent groups. It is also possible to introduce evaluated methods that have proven effective into these groups. The Leksand model therefore constitutes an interesting alternative way of organising parenting activities.

A crucial factor in the success of the model seems to be the involvement of the municipality. Midwives from the maternity healthcare services and child healthcare nurses participate but do not have main responsibility. It is instead the parents who invite various professional groups. The parents themselves 'own' the groups.

There is a question, however, how well the model would be suited to larger municipalities. The model involves a shift of responsibility from the county council towards the municipality and part of what

works is for a single actor to have the main responsibility for parent support. There is a concern that in larger communities multiple actors would need to be involved and this would impair effectiveness.

18. Circle of Security

Sir John Bowlby concluded that the most dangerous event for baby mammals, including humans, is separation from a protective adult. Conversely, he also recognised the need for exploration as being essential to survival. His hypothesis was that when children feel safe and secure, their attachment system terminates, and their exploratory system engages. This allows for both optimal safety and the mastery of necessary skills. However, when children feel threatened, exposed, criticised, or vulnerable to attack, their exploratory system terminates and their attachment system is activated.

There is increasing evidence that an insecure attachment during infancy, especially one that is 'disorganised,' is an important component of the cumulative risk factors on a developmental pathway toward maladaptive child outcomes. These outcomes are related to social competence with peers and teachers, impulse control, conduct disorders, anxiety, depression, dissociative disorders, and other psychiatric and legal problems.

In this parent educational and psychotherapeutic intervention edited videotapes of their interactions with their children encourage caregivers to:

1. Increase their sensitivity and appropriate responsiveness to their children's signals for closeness and comfort, affect regulation, and exploration and autonomy.
2. Increase their ability to reflect on their own and their child's behaviours, thoughts, and feelings regarding their attachment-caregiving interactions.
3. Reflect on experiences in their own histories that affect their current caregiving patterns.

Project design for Circle of Security

The programme is based at Head Start and Early Head Start centers. The three major programme components are:

4. The identification and assessment of high-risk families by Head Start staff, a university-based assessment team, and Circle of Security therapists.
5. A 20-week programme of weekly, 1 hour and 15 minute sessions broken down as follows: 4 weeks of educational material focused on creating secure and emotional attachments; 15 weeks focused on specific, diagnostically-informed video review interventions with caregivers; and 1 week of review, celebration, and closure.
6. Collateral support for caregivers and children between group meetings provided by Head Start teachers and family service coordinators.

The programme is designed to:

1. Decrease risk factors among families who demonstrate disordered or insecure attachment patterns, and who show potential for resilience and the capacity to change.
2. Improve caregiver observation skills, reflective functioning, affect regulation regarding self and others, and empathy.
3. Facilitate caregivers' ability to create more secure attachments with their children.
4. Foster understanding and community support related to attachment in high-risk families.

19. UCLA Family Development Project, California

This home visiting programme was created based on previous literature and evaluations of other home visiting programmes attempted in past studies. Based on those findings, the UCLA researchers created the Family Development Project with 5 goals: 1) Decrease maternal depression and anxiety; 2) Increase partner and family support; 3) Increase responsiveness of the new mothers and increase infant security in attachment to their mothers; 4) Encourage child autonomy; and 5) Encourage child task involvement. To realise these goals, a social worker begins visiting the mother's home weekly during the third trimester of her pregnancy. During these visits, the worker's goal is to establish trust and give social support to the expecting mother. Then, the visits focus on giving positive reinforcement to the mother to increase her sense of competence. Finally, the mother receives specific interventions to increase her knowledge in parenting, family systems and infant health. As needed, she also receives referrals to other health programmes and additional contacts for support. All mothers in the study were poor, lacked social support, had histories of abuse, and potential to

return to drug abuse. Their average age was 24 years and they had, on average, only a high school education.

Project design for UCLA Family Development Project
The comprehensive approach includes:

- Pre- and post-natal health care
- Weekly home visits for the first year and then every other week for the second year
- Weekly mother-infant group (participants receive $10 per session)
- Developmental assessment at the 1 and 2 year points (participants receive $25)
- Psychiatric services where needed

When the infant is about 2 months, mothers are encouraged to join a mother-infant group to interact with others, who may share their questions and concerns. Mental health difficulties such as post-partum depression are common after birth, and a part-time psychiatrist is available to help diagnose and treat such difficulties. All of these services are available in both English and Spanish.

This 'home visiting' intervention service contrasts with the 'pediatric follow-up' contact, which included developmental evaluations, feedback on the evaluations, and referral to other services as needed, but not home visits or mother-infant group. Home visits were carried out by mental health professionals with experience in child development and family systems approaches.

Findings
In Year 1: Mothers in the intervention group were found to be more responsive to the needs of their infants than those in the control group when the baby was 12 months old. Likewise, mothers in the intervention also encouraged their infant's autonomy and task involvement and used restriction and punishment less. Children in the intervention group were described as more secure, autonomous, and task-involved than children in the control group. Mothers in the intervention group were just as likely to have depressive and anxiety related symptoms compared with the control group, but they experienced more partner and family support. Children in the intervention did not differ from the control group children on measures of cognitive functioning.

In Year 2: The intervention made a significant, positive impact during the child's first 2 years of life on:

- the mother's responsiveness to the needs of her child and the related development of his or her security of attachment;
- the mother's encouragement of her child's autonomy and the related development of his or her autonomy; and
- the mother's encouragement of her child's task involvement and the related development of his or her task orientation.
- the mother's use of more appropriate forms of control and children's positive response to these controls

20. Video-feedback Intervention to Promote Positive Parenting (VIPP)

VIPP is based on a model developed in the Netherlands by Harrie Biemans and colleagues in the 1980s. The video feedback model itself is used in a wide variety of settings – with parents and children of all ages, with practitioners in health, education and social service settings, and between adults in business settings. VIPP is a specific application of the video feedback model as an intervention to promote positive parenting. Its central concept is to use principles which promote successful early mother-infant dialogue as the framework for picking out positive moments in any communication between mother and infant.

Project design for Video-feedback Intervention to Promote Positive Parenting (VIPP)
VIPP takes the view that change can be achieved more effectively in the context of a 'coaching' relationship than 'teaching' relationship, because this is collaborative rather than prescriptive, empowering rather than de-skilling. It conveys respect for strengths and potential, rather than drawing attention to problems or weaknesses. Throughout filming and feedback sessions, parents are supported to become more sensitive to their child's communicative attempts and to develop greater

awareness of how they can respond in an attuned way. They are empowered to make an informed decision about change.

The use of the video is also of central importance both as a focus for co-constructing new possibilities and as a trigger for revealing intuitive feelings which can be the key to lasting change. It seems that the video helps troubled families uncover alternative stories about themselves. In the process of standing back and looking at themselves on screen, parents are able to analyse what they were doing when things were going 'better than usual'. In this way they can grow in an organic way into their new way of being without having to consciously remember and put in place new skills. There is a deeper level of healing that can take place when relationships are restored where further positive changes can naturally occur.

Method of delivery – core components
The process begins by helping the family to negotiate their own goals. Asking them what it is they want to change helps ensure they are engaged in the process. Adult-child interactions (e.g. a game, a conversation, reading a book together) are filmed and edited, to produce a short film or a set of short (30 second) clips focusing on the positive.

In the video feedback sessions that follow, the family and professional reviews a micro-analysis of successful moments, particularly those when the adult has responded in an attuned way to the child's action or initiative using a combination of non-verbal and verbal responses. They reflect collaboratively on what they are doing that is contributing towards the achievement of their goals, celebrate success and then make further goals for change. These reflections move very quickly from analysis of the behaviour to the exploration of feelings, thoughts, wishes and intentions.

These two visits to the family form one cycle and the family can take part in as many cycles as seems sufficient, or they wish to receive. The average number of cycles tends to be 6. The family is given the lead in thinking about their own part in interaction with their child, and deciding what areas they require support and further focus in.

All practitioners are 'supervised' in their own supported reflection through the analysis of themselves in filmed interaction. The films of the feedbacks are used in supervision focusing and building on micro-moments of attuned interaction, particularly those where they activate the client to make initiatives, then receive the client fully and respond with ideas that can be understood and used to promote positive change. This cyclical process has all the elements of effective adult learning. Many video interactive guidance practitioners state that working with VIG has fundamentally changed their interactions with clients, colleagues and in their personal lives. Turning points for parents and professionals seem to be around moments of joy which can be observed on the video and celebrated by both the professionals and the families and then again with the supervisor.

21. CARE Index

The CARE-Index has multiple uses – for screening, to help plan and deliver interventions, and as a measurement instrument. It is its use for screening that is most salient to this report.

The purpose of a screening tool is to identify risk that professionals would otherwise overlook. That is, screening tools are valuable to the extent that they identify non-obvious risk. In infancy, that is (1) covert hostility in adults and compulsiveness in children and (2) passive kindliness in mothers combined with passivity or irritability in children. In toddlerhood it is (1) a wider range of compulsive behaviour and (2) the exaggerated emotional displays of coercive children. There are other sorts of risk as well but they are more obvious (Crittenden, 2005).

Intervention design
The CARE-Index assesses adult sensitivity in a dyadic context. Assessment can be applied by paraprofessionals and carried out in almost any context (home, clinic, office, etc). It is brief, taking just 10 minutes with the dyad and 3 minutes of videotaping. On the other hand the professionals who subsequently code the videotaped interaction need extensive training; once trained however an interaction takes just 15 minutes to code.

The CARE-Index assesses the adult on three scales (*sensitivity*, *covert and overt hostility*,

unresponsiveness) and infants on four scales (*cooperativeness*, *compulsive compliance*, *difficulties*, *passivity*). The coding procedure focuses observers' attention on behaviour that expresses 'affect' (facial expression, vocal expression, position and body contact, expression of affection) as well as 'cognition' (pacing of turns, control of the activity, developmental appropriateness of the activity).

Scores for the seven scales range from 0-14, with zero sensitivity being dangerously insensitive, 7 being normally sensitive and 14 being outstandingly sensitive. Scores of 5-6 on the adult sensitivity scales suggest the need for parental education, 3-4 suggest the need for parenting intervention, and 0-2 suggest the need for psychotherapy. Although these are suggestions that should not be applied rigidly or without additional assessment, they make the two points that (1) less adequate parent-infant relationships may not be helped – and may be harmed – by parent education and (2) some very troubled relationships will not be helped by parenting interventional at all.

It is crucial to note that sensitivity as assessed by the CARE-Index is not a characteristic of an individual but of a specific relationship. Thus, the same adult could display different degrees of sensitivity with different children.

22. Parents as Teachers, USA

Leading health, education and social service organisations and professionals seek out Parents as Teachers curricula and training because of its flexibility and ability to integrate easily with other services they provide. The intervention is 'designed for professionals who will return to their communities ready to implement the Parents as Teachers model of service, either as a stand-alone programme or as part of another early childhood programme such as Early Head Start, Healthy Families America or Even Start'.

Design for Parents as Teachers

Training in the intervention is conducted via personal visits and group meetings, and focuses on screenings and community resources as well as child development and parenting information. Participants who complete training are certified as Parents as Teachers parent educators, a status that is maintained through annual recertification. Institutes are offered through the United States on an ongoing basis and on-site by special arrangement for groups of 12 or more, focusing on:

Developing curricula *that support a parent's role in promoting school readiness and healthy development of children (such as the neuroscience-infused* Born to Learn *curriculum).*
Training professionals *in health, education and social service organisations, offering providers practical, hands-on applications for parents in real-world situations.*
Advocating for children and families*, raising awareness and shaping policy around evidence-based practices that support reaching children during the critical, formative years of life.*
Setting high standards *of research and quality – committed to evidenced-based research that positively impacts children during their most critical, early years of life.*

The approach is based on the fundamental principles of the Born to Learn Institute, which prepares early childhood and human service professionals to implement the four components of a programme using the *Born to Learn Curriculum Prenatal to 3 Years*. The material covered includes:

- neuroscience research on early development and learning (prenatal through age 3)
- sequences of early childhood development
- effective instructional personal visits
- facilitation of parent-child interaction
- ideas for parent group meetings
- ways to provide connection to community resources
- service to diverse families
- red flags in areas of development, hearing, vision and health
- recruitment and programme organisation

Findings

Parents as Teachers parents demonstrated high levels of school involvement, which they frequently initiated, and supported their children's learning in the home. Ninety-five percent attended special

events at their schools, nearly 67 percent worked monthly as volunteers in the school or classroom, 75 percent participated in PTA and PTO meetings, and 67 percent communicated with their child's teachers by phone on average four times a year. Most (85 percent) parents initiated a contact with the school or teacher. About 75 percent of parents always assisted with home activities related to school work (Pfannenstiel, Lambson & Yarnell, 1996). More Parents as Teachers parents attended parent conferences than parents in the comparison group. Ninety percent of parents of Parents as Teachers kindergarteners 'always' attended parent conferences (O'Brien, Garnett & Proctor, 2002).

23. The Incredible Years Parent, Teacher and Child Programs

The programme was developed in the 1980s by Carolyn Webster-Stratton, a Canadian educational psychologist with a public health nursing background. It is aimed at parents of children aged 1-10 who have early indications of conduct disorder, or are at high risk of developing conduct disorder (defined as high rates of aggression, defiance, oppositional and impulsive behaviours). It is a behavioural-humanistic programme addressing child behaviour and the parent-child relationship. It was used in the US Head Start programme and has been used in various Sure Start initiatives in Wales. The initiative comprises a number of different interventions involving parents, teachers and children:

- BASIC Parent Training Program, targeting parenting skills and delivered in the home
- ADVANCE Parent Training Program, targeting interpersonal skills for parents, delivered in the home
- EDUCATION Parent Training Program, targeting academic skills for parents, delivered in home and school
- Teacher Training Program, targeting classroom management skills and delivered in schools
- Child Training Program, targeting social skills, problem solving and classroom behaviour, delivered in home and school.

Design of programme for Incredible years

This series of programmes addresses multiple risk factors across settings known to be related to the development of conduct disorders in children. In all three training programmes, trained facilitators use videotape scenes to encourage group discussion, problem-solving, and sharing of ideas. The BASIC parent series is 'core' and a necessary component of the prevention programme delivery.

Findings

These training programmes have been shown to affect the following risk and protective factors:

Parents

- Increased positive and nurturing parenting style.
- Decreased harsh, inconsistent and unnecessary discipline.
- Increased praise and effective discipline.
- Decreased parental stress and depression.
- Increased positive parent commands and problem-solving.
- Increased parent bonding and involvement with teachers.

Teachers

- Increased proactive and positive classroom management skills.
- Decreased harsh and critical classroom management style.
- Increased positive classroom atmosphere.
- Increased bonding with parents.

Children

- Increased positive conflict management skills and social skills with peers.
- Decreased negative behaviours and noncompliance with parents at home.
- Increased social competence at school.
- Decreased peer aggression and disruptive behaviours in the classroom.
- Increased academic engagement, school readiness and cooperation with teachers.

As well as the formal evaluations reported on the Summary page, these findings have been reflected in teacher and parent ratings, child testing and interviewing, independent observations in the home

and at school, and laboratory observations of peer interactions and interactions with parents (Webster-Stratton, 2001;Webster-Stratton & others 1997, 1998, 1999, 2001).

A weakness of the model is the reliance on studies carried out by Webster-Stratton herself; however offsetting this are three trials in the UK, all with positive results (Scott et al, 2000; Manby, 2002; Bywater, 2004; Hutchings et al, 2007).

SECTION 1 (C) School-related Practice

PRE-SCHOOL

24. Head Start REDI (Research-based, Developmentally Informed), Pennsylvania

One hundred sixty-four Head Start children (44% African American or Latino; 57% female) had been followed longitudinally. Path analyses revealed that working memory and attention control predicted growth in emergent literacy and numeracy skills during the pre-kindergarten year, and furthermore, that growth in these domain-general cognitive skills made unique contributions to the prediction of kindergarten math and reading achievement, controlling for growth in domain-specific skills.

These findings extend research highlighting the importance of working memory and attention control for academic learning, demonstrating the effects in early childhood, prior to school entry.

Project design for Head Start REDI
This project consisted of the implementation and evaluation of a developmentally based intervention programme integrated into existing Head Start programmes in order to promote the school readiness of socioeconomically disadvantaged children.

Forty Head Start classrooms were randomly assigned to the enriched intervention Head Start (Head Start REDI - Research-based Developmentally Informed) or to 'usual practice' Head Start. Using a longitudinal study design, a sample of 320 children (160 experimental group and 160 control) were assessed annually over a four-year period (pre-test at age 3; post-test at age 4; follow-up assessments at age 5 and age 6, at the end of kindergarten and first-grade, respectively). The enrichment intervention utilised brief lessons, 'hands on' extension activities, and specific teaching strategies linked empirically with the promotion of: 1) language development and emergent literacy skills, and 2) social-emotional competencies.

Findings
The following is from the Abstract of the article below by Welsh et al. At the time of writing the full article had not yet been released:

This study examined developmental associations between growth in domain-general cognitive processes (working memory and attention control) and growth in domain-specific skills (emergent literacy and numeracy) across the pre-kindergarten year, and their relative contributions to kindergarten reading and math achievement.

Path analyses revealed that working memory and attention control predicted growth in emergent literacy and numeracy skills during the pre-kindergarten year, and furthermore, that growth in these domain-general cognitive skills made unique contributions to the prediction of kindergarten math and reading achievement, controlling for growth in domain-specific skills. These findings extend research highlighting the importance of working memory and attention control for academic learning, demonstrating the effects in early childhood, prior to school entry.

The full article, when published, will discuss the implications of these findings for pre-kindergarten programmes, particularly those designed to reduce the school readiness gaps associated with socio-economic disadvantage.

25. Emotions Matter: Classroom-based Integrated Intervention (Chicago School Readiness Study)

Recent research highlights a considerable gap in academic achievement between low-income children and their more affluent counterparts as early as Kindergarten and 1st grade.

Project design for Emotion Matters

The present study evaluated the efficacy of a multi-component, classroom-based intervention in reducing pre-schoolers' behaviour problems. The Chicago School Readiness Project model was implemented in 35 Head Start classrooms, each with a matching 'sister' control site, using a clustered-randomised controlled trial design.

Results indicate significant treatment effects for teacher-reported and independent observations of children's internalising and externalising behaviour problems.

There was some evidence for the moderating role of child gender race/ethnic group membership, and exposure to poverty-related risk, with stronger effects of intervention for some groups of children (i.e. girls, Hispanics) than for others (i.e. boys, African American children),

Findings

The following is from the Abstract of the article by Raver et al (2009):

Compared with children in the control group, children in the intervention group on average had significantly lower scores on the BPI Internalizing scale and the BPI Externalizing scale scores. Results from our analyses suggest that CSRP had a large, statistically significant impact on reducing low-income preschoolers' internalising and externalising behaviour problems. On average, children enrolled in CSRP classrooms were reported by teachers to manifest significantly fewer signs of sadness and withdrawal than were children in the control group. The CSRP model of intervention also demonstrated efficacy in reducing preschoolers' externalising behaviour problems, including children's symptoms of aggression and Defiance. Results from our independently assessed classroom observations provided important converging evidence of this impact. Fewer instances of externalising, disruptive behaviour (e.g., physical and verbal aggression) were observed among children in intervention-assigned classrooms as compared with their counterparts in control-enrolled classrooms. Findings were strongest for children facing lower levels of poverty-related risk.

Results indicate that our classroom-based intervention offers a highly promising model for supporting the emotional and behavioural development of low-income preschool children exposed to a large number of poverty-related risks. Our results are consistent with emerging research on ways to build on the strengths of low-income families and the institutions that serve them (Berryhill & Prinz, 2003; Dishion & Stormshak, 2007; Tolan et al., 2004). Our findings provide powerful evidence that a key source of institutional support of children's communities, namely, their Head Start–funded preschool programmes, can be leveraged to provide important behavioural as well as academic intervention and support.

We conducted follow-up analyses of intervention impacts within each subgroup. Follow-up subgroup analyses suggest, when children in the intervention group were compared with their racial/ethnic- and gender-matched control-group peers, the intervention led to significant, albeit smaller, reductions in boys' and African American children's behaviour problems as well.

Our findings show CSRP's efficacy in reducing children's behavioural difficulty only through the end of the preschool year. Analyses are currently under way to detect whether CSRP-enrolled children sustain these improvements as they make transitions to new kindergarten classrooms the following fall.

26. The Getting Ready Project, Nebraska

This study aimed to evaluate the benefits of a multi-component child- and parent-focused intervention that addresses both home and center/school environments. The intervention was designed to improve the skills of intervention agents, through ongoing coaching and professional development, resulting in increased early and sustained parent engagement.

Project design for Parent Engagement and Child Learning Birth to Five
The study used a randomised design to evaluate the intervention's impact on key outcomes predictive of school success. Additional analyses examined: (1) child and family factors that modify the intervention effects; (2) components of the intervention, especially its timing at the ages of 0-3 versus 3-5, that affect the outcomes on children and families; and (3) the longitudinal pattern of change within each child.

220 children in 28 Head Start classrooms were involved in the 'Getting Ready' project over the 4-year study period.

Specific research aims were to: (1) evaluate the effects of an innovative, comprehensive service delivery system on child cognitive, behavioural, and socio-emotional outcomes, in comparison to the present conventional system for children under 5 years of age; (2) assess the impact of the proposed comprehensive intervention on parental engagement (i.e., warmth/sensitivity, support for child's autonomy, and active participation in learning and literacy); and (3) evaluate the extent to which child outcomes are mediated by changes in parental engagement.

Findings
The following is from the article by Sheridan et al (2010):

Statistically significant differences were observed between treatment and control participants in the rate of change over a 2-year period on teacher reports for certain interpersonal competencies (attachment, initiative, and anxiety/withdrawal). Thus, whereas the control group showed some evidence of improvement (as might be expected given their enrolment in Head Start), the intervention group gained three fourths of a standard deviation overall over the entire 2-year intervention period more than control children on the DECA Attachment scale.

Significantly different rates of change were seen in children in the treatment group relative to controls in the area of *initiative* for a net gain of more than one half of a standard deviation relative to control children over 2 years.

Preschool children in the Getting Ready treatment group demonstrated a *significantly greater reduction in anxiety/withdrawal behaviours* over time for a net benefit of three fourths of one standard deviation relative to controls.

In contrast, no statistically significant differences between groups over a 2-year period were noted for behavioural concerns (anger/aggression, self-control, or behavioural problems).

The intervention appears to be particularly effective at building social-emotional competencies beyond the effects experienced as a function of participation in Head Start programming alone. Limitations and implications for future research are reviewed.

27. HIPPY (Home Instruction for Parents of Preschool Youngsters)

Home Instruction for Parents of Preschool Youngsters (HIPPY) is a parent involvement, school readiness programme that helps parents prepare their three, four, and five year old children for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books and materials designed to strengthen their children's cognitive skills, early literacy skills, social/emotional and physical development.

HIPPY is an international programme that started in Israel in and has since spread to Germany, New Zealand, Australia, South Africa, Canada and the United States. In 2007 there were 146 HIPPY programme sites in 25 states of the USA serving over 16,000 children and their families.

Project design
All HIPPY programmes around the world follow the HIPPY model: a developmentally appropriate curriculum, with role play as the method of teaching, staffed by home visitors from the community, supervised by a professional coordinator and with home visits interspersed with group meetings as the delivery methods.

The four features of the model are:
- Developmentally appropriate curriculum
- Role play (method of teaching)
- Coordinator and home visitors (staffing)
- Home visits and group meetings (service delivery method)

A model HIPPY site serves up to 180 children with one coordinator and 12-18 part-time home visitors. Each of the four features of the model was chosen and developed in a certain way to allow participation from parents who might otherwise not get involved with their children's education. Although HIPPY is for any parent who wants educational enrichment for his/her child, the HIPPY model was designed to remove barriers to participation, due to lack of education, poverty, social isolation and other issues.

HIPPY is dedicated to:
- Increasing the chances of positive early school experience among children who may be educationally at risk.
- Empowering parents to view themselves as primary educators of their children.
- Creating an educational environment in the home that encourages literacy.
- Fostering parental involvement in school and community life.
- Providing parents with the opportunity of becoming home visitors in their own community.
- Helping home visitors develop skills and work experience needed to compete successfully for other jobs in local labour markets.
- Stimulating the cognitive development of the child.
- Improving interaction between parents and their children.
- Teaching parents and children the joy of learning.
- Breaking through the social isolation of the parents.

Examples of achievements
International research indicates positive impacts of HIPPY, both on children's school readiness when entering Kindergarten and first grade and on performance in higher grades; and also on parents' involvement with their children's education. Over 30 international research studies are cited as evidence of effectiveness on their web site; however only a small number of these are in peer-related journals. These give modest but positive support to the effectiveness of the intervention.

28. What works in Early Years Education

This summary is based on a Scottish review of approaches to Early Years Education across the globe.

Five distinct international curricular approaches were reviewed, based on a 2004 report by OECD: A) The Experiential Education approach used in the Netherlands which sees two key dimensions as necessary for high quality: emotional well-being and involvement with purpose and pleasure; B) The American High/Scope curriculum, which proposes children learn best through active experiences and following their own interests; C) The Reggio Emilia approach, whose core priority is ‘learning how to learn’; D) The New Zealand Te Whariki approach, which works from the Maori principle ‘empowering children to grow’; E) The Swedish National Curriculum which has at its core dialogue between adult and child and a focus on nurturing search for knowledge through play and social interaction.
There is no meaningful research base to support any one of these approaches against the others.

Findings
There is evidence of the effectiveness of early years education (Schweinhart and Weikart, 1997; POST, 2000; Campbell, 2001). These programmes may be of particular benefit for children who suffer social, emotional or psychological disadvantage. Currie (2001) confirmed the economic value of compensatory programmes for disadvantaged children whose mothers had the least education, were at risk of abuse or neglect or had limited proficiency in the mainstream language.

In the National Institute of Child Health and Development studies (NICHD, 2002, 2005) of the effects of child care from birth to 4 years 6 months distinct benefits and risks were found to be associated with the quality, quantity and type of early care and education. Higher quality provision predicted better pre-academic skills and language, and out-of-home settings improved language and memory.

However, the greater quantity of time from birth in non-maternal early care and education was associated with behavioural problems which lasted throughout the primary grades.

The Effective Provision of Pre-School Education (EPPE) project (Sylva et al, 2004) also found a significant relationship between higher quality provision and practice and better intellectual and social/behavioural outcomes. EPPE concluded: Children who attended pre-school outperformed children who did not on cognitive attainment, sociability and concentration; Part-time provision was as beneficial as full-time; Disadvantaged children benefited significantly from good quality preschool experiences; The beneficial effects remained evident though attenuating through ages six to seven.

Aubrey et al (1998) refer to a study looking at attainment in Slovenia where children did not start primary school until two years later than in England. When the Slovenian children had been in school for only nine months their attainment in mathematics suggested that there was no apparent benefit from the earlier start on formal education in England. Prais (1997) compared the mathematical ability of children in England and Switzerland and found that although almost a year younger and starting school one year later the Swiss children performed better. Reviewing this evidence the POST report (2000) suggests one contributory factor may be that the academic ability in the English reception class was much more variable. They argue that these results and other work on school starting age demonstrate that an early school starting age confers little advantage by nine years old and is less effective in ensuring educational standards than homogeneity in ability which allows the group to progress at a faster and more uniform rate. The POST report concludes that greater effectiveness in ensuring attainment might be achieved by increasing the flexibility of the school starting age and allowing children to remain in an early education setting for another year. An alternative is for children to be grouped with others with similar starting points and to experience a highly differentiated curriculum that allows for learning opportunities to match children's needs.

SCHOOL

29. The Montreal Longitudinal-Experimental Study, Montreal

This research by the University of Montreal was to check the validity of previous findings that physical aggressiveness and academic problems are predictors of delinquency that are identifiable early life. The research candidates were therefore identified in kindergarten, although the programme did not commence until they were aged 7. All the families were of low socio-economic status.

Project design for Montreal Longitudinal-Experimental Study

Kindergarten teachers rated the behaviour of each of the boys in their classes at the end of the school year. 1,037 boys from 53 schools who were identified as being at-risk (i.e. disruptive, hyperactive, aggressive) were selected for the longitudinal study and randomly assigned to 3 groups: the treatment group, created for the experimental study of prevention; the observation group, created for the longitudinal observational study of the social interactions of disruptive boys; and, the no-treatment, no-contact control group, for evaluating effects of the experimental study and of the longitudinal follow-up.

Parenting training programmes (on average 17 sessions each) were delivered by professionals working with individual families over a two-year period. The treatment for parents emphasised close supervision of children's behaviour, positive reinforcement of prosocial behaviour, consistent, non-abusive discipline strategies, and management of family crises. Professionals provided social skills training in the school to small groups which included disruptive boys and prosocial peers. Treatment focused on social skills to promote positive interaction with teachers, parents and peers, problem-solving and self-regulation skills. Work was carried out with the teachers of the treated boys as well.

Post-treatment, behaviour was assessed annually (from age 9 to age 12) by teachers, peers, mothers and the boys themselves. For all of the boys, ratings were obtained on a number of indicators: educational achievement, fighting behaviour, overall school behaviour and performance, delinquent behaviour, mothers' perception of antisocial behaviour and the nature of parent-child relationships, making it possible to assess the impact of intensive treatment on antisocial, disruptive behaviour.

Findings
By the end of primary school, the behaviour of the disruptive boys in the untreated group confirmed previous research findings that physical aggressiveness and academic problems, are predictors of delinquency that are identifiable early on in a child's development. The research also confirmed that social intervention can positively affect the social development of disruptive boys. Compared with the untreated boys, the boys who received the treatment exhibited less aggression in school, performed well academically more often, experienced fewer difficulties in adjusting to school, and reported committing fewer delinquent acts up to three years after the end of treatment. With respect to teacher-rated fighting, the boys in the control and observational groups had a significantly higher fighting score than those in the treated group. Untreated boys were twice as likely to be rated as having serious school behaviour and school performance problems as the boys in the treatment group (44% vs. 22%). A smaller proportion of the treated, than of the untreated, reported having committed delinquent acts involving trespassing (40% vs. 62%), stealing items worth less than $10 (19% vs. 45%), stealing items worth more than $10 (7% vs. 20%), and stealing bicycles (5% vs. 19%). No significant differences were found between the treated and untreated boys in terms of hyperactivity, prosociality and vandalism. There was also a brief positive update at age 15.

A follow up study when the boys were aged 24 found that, compared with the control group, the boys in the treatment group had significantly higher levels of high school graduation and with lower rates of acquiring criminal records. Boisjoli et al (2007) also compared the two groups with a normal or 'normative' group of young men of the same age, parental occupation mix etc. These comparisons are shown in the table below.

	Control group	Intervention group	Normative group
High school graduation	32.2%	45.6%	53.4%
Criminal record	32.6%	21.7%	16.1%
Ratio HSG to CR	1.0	2.1	3.3

Using the ratio of High School Graduations to numbers with criminal records at age 24, one could crudely deduce that an effective intervention at age 7 was able to remove two thirds of the disadvantage reflected in the behaviour of a group of disruptive kindergarten children. Richard Tremblay, one of the authors of this study, argues that the most effective time to intervene is when differences in aggression show (as he demonstrates that they do, with predictive validity) at ages 2 and 3. An effective intervention delivered at that age might be expected to achieve an even stronger result.

30. Preparing for the Drug Free Years (PDFY), USA

As communities and schools identify and prioritise risk and protective factors, it is important to consider effective parenting programmes as critical components of comprehensive prevention strategies. PDFY offers schools and communities a well-researched, universal parenting programme that increases protective factors, reduces risk factors, and ultimately decreases problem behaviours among teens.

Project design for PDFY
This universal, group parenting programme canvassed participants through TV promotions (29%) and communication from schools (72%). The target group was those with children in the 4th to 6th grades. While the general focus is on issues of parenting, part of the programme involves training community members to lead workshops, the prime method of delivery.

Findings
The following is from the publication on PDFY by Developmental Research and Programs in Seattle:

Evaluation Studies
Evaluation studies of PDFY have addressed two major issues. First, because the programme is designed for the general public, the success of dissemination efforts has been assessed. The questions addressed here are:

- Does the programme have a strategy for dissemination?
- Can a broad cross-section of parents be recruited for participation?
- Is the programme appropriate, or can it be made appropriate, for diverse groups?

The second issue is the efficacy of the programme. The questions here concern the immediate goals and the more long-term goals of the intervention:

- Does the programme reduce targeted risk factors and/or increase protective factors?
- Does the programme achieve the ultimate goal of reducing substance abuse?

Together, these studies provide promising evidence that the PDFY programme is appropriate for general and diverse populations and that it can be successfully disseminated. Most important, these studies show that PDFY improves parenting practices in ways that reduce risk factors and increase protective factors for adolescent problem behaviours. The initial pre- and post-test single-group evaluations described here demonstrate the acceptability and applicability of PDFY and the programme's effectiveness in teaching key parenting concepts to a very broad voluntary audience. These studies also suggest that participating families are likely to implement family meetings, a central objective of the curriculum. The experimental findings are promising in several respects. As before, these studies demonstrate the applicability of PDFY when looking at specific targeted outcomes. Data from the observations of workshop leaders show that training community members to lead workshops is effective. In addition, the studies show that most parents, once they agree to participate in the programme, will attend most of the PDFY sessions.

31. Project Alert and Project Alert Plus, USA

This intervention, administered by the BEST Foundation, sets out to:
keep low-risk *nonusers* from starting to use harmful substances;
keep moderate-risk *experimenters* from escalating substance use;
help high-risk *users* to reduce substance use.

BEST's claims include the following:
The project has achieved an Exemplary Program rating from the U.S. Department of Education and was designated a Model Program by the Substance Abuse and Mental Health Services Administration.

Project design for Project Alert
Based on the social influence model, the method uses videos and interactive teaching methods, such as guided classroom discussions, small group activities, and intensive role-playing.

For the validation study, students in 20 of the participating schools were assigned to receive Project ALERT's 11-lesson curriculum: eight lessons in seventh grade, followed by three booster lessons in eighth grade. Students in the remaining 10 schools served as the study's controls. They continued to receive whatever drug information programmes their schools offered.

To find out how well Project ALERT worked, the RAND researchers surveyed students about their drug use and drug-related attitudes before, during, and after the 2-year study. They then compared the results from Project ALERT students with those from the control students.

Findings
Project ALERT's Impact On Marijuana Use

- Although Project ALERT helped reduce marijuana use, it worked best at keeping kids from starting in the first place.
- Among the students who hadn't used marijuana or cigarettes at the start of the evaluation, Project ALERT reduced the proportion of new marijuana users by 38 percent compared to the control group.
- Among the moderate-risk students (those who had smoked cigarettes at baseline), Project ALERT reduced the proportion of new marijuana users by 26 percent compared to the control group.

Project ALERT's Impact on Cigarette Use

- Project ALERT kept students from starting to smoke and curbed smoking by students who had already started at the beginning of the evaluation.
- The proportion of new smokers in the Project ALERT group was 19 percent lower than that of the control group.

- The proportion of weekly smokers dropped by 23 percent among all students in the Project ALERT group.
- Project ALERT also kept about 40 percent of students who had experimented with cigarettes from becoming regular smokers.
- Instead of the more-committed smokers reacting negatively to Project ALERT, as they did in the pre-release study, they now responded by cutting back on their cigarette use.

Project ALERT's Impact on Alcohol Misuse

- Project ALERT reduced risky alcohol use, such as binge drinking, as well as drinking-related troubles, such as drinking that led to fights. These effects were measured by overall alcohol misuse scores.
- The alcohol misuse scores for all students were 24 percent lower in the Project ALERT group compared to the control group.
- Project ALERT was most successful for the highest-risk early drinkers, reducing their alcohol misuse scores by 20 percent.

On the face of it, the findings by RAND look very promising. However, another randomised control trial (by Stephen R. Shamblen, PhD for Pacific Institute for Research and Evaluation, Chapel Hill, North Carolina), delivering the programme to one year younger students (6^{th} and 7^{th} instead of 7^{th} and 8^{th} grades) did not find any significant improvement in their attitudes to the substances, but their Abstract does not clarify the actual findings of usage, which would need to be investigated.

32. Seattle Social Development Project (SSDP)

This was a multi-year, school-based intervention that used a risk-reduction and skill-development strategy to improve outcomes for participating children and youths. The programme was guided theoretically by the social development model, which hypothesises that youths who are provided with opportunities for greater involvement with their schools and families, who develop the competency or skills they need for fuller participation with their schools and families, and for whom skilful participation is constantly reinforced, ultimately develop strong bonds with their families and schools. Further, the model proposes that these strong bonds set children on a positive developmental trajectory, resulting in more positive outcomes and fewer health-risk behaviours later in life. The SSDP was first implemented in 1981. It combined teacher, child, and parent components with the goal of improving children's bonding with their families and schools. Teachers were trained in proactive classroom management, interactive teaching, and cooperative learning, while the students themselves were provided with direct instruction in interpersonal problem-solving skills and refusal skills to avoid problem behaviours. Parents were offered courses in child behaviour management skills, academic support skills, and skills to reduce their children's risk of drug use.

The age-21 follow-up by Hawkins et al. (2005) reported that full participation students were significantly more likely to have graduated from high school; reported significantly fewer thoughts of suicide; had fewer symptoms of depression; fewer symptoms of social phobia; were significantly less likely to have sold illegal drugs in the past year; were significantly less likely to have had a court charge; and were marginally less likely to have used alcohol, tobacco, or illicit drugs in the past month or year.

33. Second Step Programme

Significant Increases in Fifth- and Sixth-Graders' Social Competence

Two recent journal articles describe a study of the effects of the Norwegian version of the SECOND STEP programme, *Steg for Steg,* on fifth- and sixth-grade students. The first set of findings from the study showed that the programme resulted in significant increases in social competence for both boys and girls across the fifth and sixth grades. The second set of findings showed that low-socioeconomic-status (SES) students reported greater improvement in social competence, school performance, and satisfaction with life, compared to their middle- and upper-SES peers.

The impact of Second Step has also been evaluated in Germany and in the US. A University of Washington study examined the effectiveness of the SECOND STEP in helping children resolve conflicts, avoid disputes, and behave more prosocially. (Frey, K. S., Nolen, S. B., Edstrom, L. V., &

Hirschstein, M. K., 2005); a study by Edwards et al (2005) found significant gains by schoolchildren in knowledge about empathy, anger management, impulse control, and bully-proofing; Cooke et al (2007), in a city-wide implementation of the programme, found students showed significant improvements in positive approach/coping, caring/cooperative behaviour, suppression of aggression, and consideration of others. Nearly three-quarters of teachers reported that the SECOND STEP programme helped their students during the implementation year, and 91.7 percent said that the SECOND STEP programme would help their students in the future. The German study evaluated a curriculum to prevent violence in elementary schools (Schick, A., & Cierpka, M., 2005).

34. Reach for Health Community Youth Services, USA

The intervention was initially delivered to economically disadvantaged 7th and 8th grade students (12 and 13-year-olds) in 1994 in two large middle schools in Brooklyn, NY; one school was designated as the intervention school, the other as the control. A total of 68 classrooms participated in the initial implementation. In the control school, 33 classrooms (584 students) received the standard New York City health education programme, which includes some mandated lessons on drugs and AIDS. Within the intervention school, 22 classrooms (222 students) were randomly assigned to receive core *RFH* curriculum (classroom component only). The remaining 13 intervention classrooms (255 students) received the enhanced *RFH* plus Community Youth Services programme (*RFH-CYS*). Bi-lingual and special education classes were included from both school sites

Findings

Behaviours—

- **Delayed initiation of sexual intercourse**—Rates of sexual initiation increased by eight percentage points among comparison youth. Rates increased less among curriculum-only and CYS+ youth (three and four percentage points, respectively).
- **Reduced frequency of sex**—Rates of recent sex increased five percentage points among comparison youth and by three percentage points among curriculum-only youth. Rates decreased by nearly half a percentage point among CYS+ youth. The difference between comparison and CYS+ youth was statistically significant.
- **Increased condom use**—Comparison students reported an increase of three percentage points in recent sex without a condom. Rates among curriculum-only and CYS+ youth decreased by 13 and 16 percentage points, respectively.
- **Increased use of contraception**—Comparison students reported an increase of nine percentage points in recent sex without birth control pills. Rates decreased by five and eight percentage points, respectively, among curriculum-only and CYS+ youth.

Behavioural changes among special education students—Although the number of special education students in this study was small and findings must be used with caution, this group appeared to experience some of the greatest benefits of the curriculum alone.

- Among special education students, comparison youth reported a 26 percentage point increase in ever having had sex and CYS+ youth reported a four percentage point increase. The rate *decreased* by 13 percentage points among curriculum-only youth.
- Among special education students, comparison and CYS+ youth reported an increase of 31 and three percentage points, respectively, in recent sex. The rate *decreased* 11 percentage points among curriculum-only youth.
- Rates of recent sex without a condom decreased by eight, 100, and 27 percentage points, respectively, among comparison, CYS+, and curriculum-only groups of special education students.
- Special education comparison youth reported an increase of 22 percentage points in recent sex without birth control pills. Rates *decreased* by 50 and 22 percentage points, respectively, among CYS+ and curriculum-only youth.

46. Roots of Empathy, Canada

This Practice can be found at the end of this Appendix, Late Additions.

47. KIPP Schools (Knowledge is Power Program), USA

This Practice can be found at the end of this Appendix, Late Additions.

AFTER SCHOOL

35. The Carrera Project, USA

The Children's Aid Society-Carrera intensive programme is comprehensive, long-term and has multiple components including 5 main activities: 1) Daily academic assistance; 2) Job club - interviewing skills etc; 3) Family life and sex education; 4) Art activities such as drama, music, painting and dance; 5) Individual sports activities such as tennis, swimming and martial arts. Free mental health and medical care is provided through alliances with local health care providers. Reproductive health care is a key part of this, including physical examinations, testing for STDs and offering on site a range of contraceptive options.

However, in six other sites outside of New York City, not all of these favourable results for girls were obtained. Moreover, when communities in another state attempted to implement the programme without the benefit of training or programme materials, the programme did not curtail sexual risk-taking. Training of delivery staff and rigorous adherence to the programme model and materials are thought by the CAS to account for the failures to replicate success.

Project design for Carrera

Teens were recruited when they were aged about 13 to15 and encouraged to participate throughout high school. The programme operated 5 days a week and provided services in a wide range of areas: family life and sex education; general education, including individual academic assessment, tutoring, preparation for standardised exams, and assistance with college entrance; employment, including a job club, stipends, individual bank accounts, jobs, and career awareness; self-expression through the arts; individual sports; and comprehensive medical care, including mental health care, reproductive health services, and contraception when needed.

A total of approximately 1200 students in New York City, Maryland, Florida, Texas, Oregon and Washington. Forty-seven percent of the sample was black; the balance comprised a combination of other racial/ethnic backgrounds. About one-sixth of the families received public assistance or Medicaid and did not have a working adult in the house; another third lived in families with only one of those conditions. About half of the teens were from single-parent homes and homes that had reported family member unemployment.

Approximately 100 students at each site were randomly assigned to the CAS-Carerra programme or an alternative (control) programme.

Findings

As well as the headline findings reported on the Summary page, there were numerous significant differences between the CAS-Carerra group and the control group on health habits, sexual knowledge, and sexual behaviours. Compared to the control group, programme participants made significantly greater gains over two years on a sexuality knowledge exam (e.g., information on physiology, contraception, gender differences, pregnancy), and were significantly more likely to have 4 or 5 desirable health outcomes (e.g., medical check-up last year, teeth checked in the last year), to get their health care at a place other than the emergency room, to have had a social assessment at their last exam, to have the hepatitis B vaccine and to have made a reproductive health visit.

Certain other programme outcomes differed by participant gender. At the 3-year follow-up, female participants were significantly more likely to have used Depo-Provera and had significantly lower rates of pregnancies and births, compared to control females. Compared to control males, CAS-Carrera males were significantly less likely to have initiated marijuana use.

Within the category of life organisation and technical knowledge, CAS-Carrera participants were significantly more likely to have bank accounts, to have had work experience, to use word processing programmes and to use the Internet and e-mail. CAS-Carrera females, especially, were significantly more likely to use the computer and use it more often, use word processing programmes and e-mail. CAS-Carrera males were significantly more likely to use the Internet.

SECTION 1 (D) Social Care and Family Welfare Practice

SOCIAL CARE

36. Healthy Families America, USA

HFA services are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby) to support families at particular risk of abusing children.

The programme was launched in 1992 by Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse) in partnership with Ronald McDonald House Charities and was designed to promote positive parenting, enhance child health and development and prevent child abuse and neglect. The Freddie Mac Foundation has also been instrumental in supporting ongoing development of the programme.

Vision: All children will receive the nurturing care essential to becoming compassionate and contributing members of their communities.
Mission: To prevent the abuse and neglect of our nation's children through intensive home visiting.

Project design for Healthy Families America
The HFA model is based upon 12 Critical Elements derived from more than 30 years of research to ensure programmes are effective in working with families. These Critical Elements are operationalised through a series of best practice standards that provide a solid structure for quality yet offer programmes the flexibility to design services specifically to meet the unique needs of families and communities.

HFA Programme Goals:

- To systematically reach out to parents to offer resources and support
- To cultivate the growth of nurturing, responsive, parent-child relationships
- To promote healthy childhood growth and development
- To build the foundations for strong family functioning

Findings
HFA has a strong research base which includes randomised control trials and well designed quasi-experimental research. In 2006, HFA was named a 'proven program' by the RAND Corporation based on research conducted on the Healthy Families New York programmes. Additionally, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has rated HFA as Effective. Reviews of more than 15 evaluation studies of HFA programmes in 12 states produced the following outcomes:

- Reduced child maltreatment;
- Increased utilisation of prenatal care and decreased pre-term, low weight babies;
- Improved parent-child interaction and school readiness;
- Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services;
- Increased access to primary care medical services; and
- Increased immunisation rates.

37. Highland Region Streamlined Reaction - A proposed pioneering model for children's services in local authorities

The goal of this project was to get things right for children the first time they showed up on the radar as being at risk, so they did not appear again later. This was judged to be more cost effective than their previous, more typical local authority model where resource constraints were judged to prevent adequate intervention. (In Croydon in 2009 80% of referrals were not even investigated.).

A number of principles were adopted by Highland Region, to enable this shift to happen:

1) Management of Risk
2) Integrated Children's Services' and 'joined up working'

3) Streamlining processes of response and reaction to risk
4) Social Work set up differently

To improve management of risk, Highland Region re-examined its business processes, changed how agencies organised themselves to assess and manage risk, and introduced streamlined systems to improve reaction.

The introduction of Integrated Children's Services and joined-up working began with studying the typical pathway of a child through its life and its potential contact with outside agencies. They identified where in this pathway the earliest intervention could ensure the best long-term outcome and then developed practices to be more effective. This work was very outcome-focused. The streamlined processes were designed to make significant reductions in reports and meetings, take out bureaucracy and create a single point of management for each child. There is, for example, only one plan for any child and only one type of meeting for any child, whether there are issues affecting disability, schooling, risk, housing, domestic violence, family alcoholism or whatever.

Further information on the management of at-risk children is shown below under 'Child's Plan meeting'.

The core principle in all this work is that early intervention must be immediate to stop things escalating and no matter who triggers this (school, health services, police) they must work in an integrated manner with other agencies and ensure fast response to need.

Social work is set up quite differently and is, for example, much more integrated with schools and police. One category of social workers is located within schools (essentially one per school) and works closely with head teachers in providing support to children at risk. An interesting statistic is that social workers in Highland Region spend no more than 25% of their time on bureaucracy and paperwork. In 2009 the General Secretary of UNISON reported that the corresponding figure for England was 80%. Senior staff in Highland Region say the impact of the changed systems are reflected in much improved statistics for child protection, looked after children, offending and substance abuse.

Child's Plan meeting
All decision-making comes from this meeting, attended by all the people necessary for the decision. Generally, there are a core five – one each from Education, Social Work and Health, plus the child and the family. Children usually attend their own case meeting, and if they cannot, their views are gathered in advance. As appropriate, there may be representatives from Police, a Care Home or Foster care etc. The key figure in the system is the QARO (Quality Assessment and Review Officer).

The QARO's role is to (1) obtain information from the lead professional in advance of the meeting, (2) chair the meeting, (3) produce summary notes of the meeting.

QAROs are all registered Social Workers but their role is to be independent and be responsible for the Quality Assessment function; thus they also have a responsibility to gather aggregate data, give feedback from their meetings etc.

The QAROs report to an ISC (Integrated Service Co-ordinator), one for each of 3 geographic areas in this huge region of 10,000 square miles. The ISCs are described as 'the glue in the system'. The ISCs are part of a range of integrated services staff funded by a joint committee from different agencies. The ISCs link the agencies in their geographic areas, e.g. Education, Housing, Health, Police etc, and each of them leads 2 QAROs. The ISCs report to the Head of Children's Services.

Another, more junior set of integrated workers are the Integrated Service Officers, who operate across agency like the ISC but on the front line working with nurses, schools, local social workers etc. Most of their work is done with Universal Services.

Finally within Integrated Services come the Children's Services Workers, the hands-on social workers within the schools.

Results
Highland have not collected data systematically to show the impact of their new system. WAVE has discussed with them the possibility of collecting the relevant data, but this would require a special exercise. Highland is willing to do this if the necessary resource is supplied.
The data which do exist show numbers of persistent offenders in the 50s in 2003, in the 20s in 2009 and in the teens in 2010; rate per 1000 of children 0-15 on the Child Protection Register fell from 3.0 in 2004 to 1.6 in 2009; it has since risen again to 2.2 – Highland Region say this increase reflects an influx of migrants who had not benefited from the streamlined reaction system.

Croydon Total Place
Similarities between Croydon's planned new preventive system and the Highland Region approach include teamworking across agencies, single points of contact for difficult families, early identification of problems and a determination to ensure things are right at the beginning of a child's life rather than allowing problems to develop and then addressing them expensively (and ineffectively) at a later age.

Croydon has a number of additional ideas such as involvement of the community, proactively engaging parents and an Early Years Academy to train staff.

In theory the Croydon approach should produce better results because it intervenes before harm is done to children rather than (only) reacting rapidly afterwards. McLeod and Nelson (2000) identified that this was a more effective form of intervention. The Croydon model projects net savings of £25m in 6 years from an upfront investment of £2.5m.

An approach combining the best of both the Highland Region and Croydon models could deliver much improved outcomes for children plus significant cost savings. Neither approach contains a set of 'best practice' early interventions, such as the suite of effective early-years programmes captured in WAVE's proposed early prevention strategy for a local authority. The best possible outcomes could be produced by a combination of the best of all three approaches.

38. Parent Child Interaction Therapy (PCIT)
PCIT took shape mostly among families of single-parent mothers with disruptive children living in difficult, stressful circumstances. Thus, PCIT was developed within the context of 'real life' clinical experiences, guided by clinical and developmental theory and literature on parenting and behaviour change. It is a family-centred treatment approach for abused and at-risk children aged 2.5 to 12 and their biological or foster parents.

Project design for Parent Child Interaction Therapy (PCIT)
PCIT is delivered in 14-20 sessions, each lasting 1 hour. In the first stage key principles are discussed with the parents, and skills introduced to them. In the second stage parents interact with their children and try to implement the particular skills they have learnt - the skills of following the child while playing rather than leading them, and the skill of ensuring the child complies with instruction from the parent when required. The therapist observes them from behind an observation mirror and coaches the parent through a earpiece in 'real-time'. This kind of coaching continues until the parent-child relationship becomes consistently stable.

This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behaviour therapy in that parents learn to use specific behaviour management techniques as they play with their child.

As the parent develops the skills to interact positively with their child, the behaviour of the child improves – thus negative, coercive cycles are broken and replaced with positive ones.

Findings
At least 30 randomised tests have found PCIT to be useful in treating at-risk families and children with behavioural problems.

Conclusion: Changes in observed abusive parent-abused child interaction patterns can occur early in PCIT.

Practice implication: Prior to receiving behavioural parent training (PCIT), parents who have physically abused their children failed to match their parental response to their children's behaviour. This pattern of interaction improved rapidly and substantially during the first three sessions of PCIT. The changes in the patterns of interaction also remained relatively stable for the remainder of treatment while parents continued to practice positive parental responses as well as began practicing effective discipline techniques.

This suggests that use of immediate parent feedback through coaching, explicit directions to parents in how to respond to child behaviour, and customisation of the application of skills to the problems that arise in session are important components to effective parenting programmes with physically abusive parents. Targeting these behaviours with PCIT has been found to reduce rates of recidivism, further supporting clinical application of PCIT in these cases.

39. Holistic approach to looked-after children, Denmark and Germany

Social Pedagogy
The term social pedagogy is still relatively unfamiliar in English speaking countries, although it is popular and established on the continent. Basic training in social pedagogy is via a 3-year degree course. Combining education with upbringing delivers particularly successful results with children who are separated from the usual 'upbringing' focus of parenting, making an holistic approach particularly suitable for meeting children's needs in the residential care environment. The likely benefits of the type of approach were acknowledged in the 2009 Commons Committee report: *'The social pedagogy pilot programme is very welcome. We urge the Government to think broadly and creatively about the possible future applications of the social pedagogy approach in the care system….'* (Paragraph 108). This would imply raising staff qualification levels.

Staff qualification by country

Qualification	England (%)	Germany (%)	Denmark (%)
Low	8	0	0
Medium	36	45	3
High	20	51	94
Other childcare qualification	0	2	0
None/no relevant qualification	36	2	3
Total	100	100	100

Link between teenage pregnancy and qualification/quality of staff
Close analysis showed that the following 3 staff characteristics together accounted for **nearly 30%** of the variation in reported rates of pregnancies in under-19-year-olds:

- **higher rates of in-service training,**
- **offered more fact-seeking responses to hypothetical dilemmas involving young people, and**
- **intended to carry on in their current post for longer.**

(Petrie et all, 2006, p.107)

Education, employment, or training
Inter-country differences were very pronounced in the 15-18-year-old category (e.g. only one Danish respondent was not in education, compared with 1 in 6 German and almost a quarter of English respondents).

Only 3 of the 23 respondents who were working in Germany and 5 of the 16 who were working in Denmark were out of education, while in England, one third (16 out of 49) were neither in education

nor employment. Also, in Germany and Denmark most of those engaged in work, or work experience, were still in education too. A striking exception to this was one very successful establishment, run along pedagogic lines, where all residents usually went on to further education.

Criminal offending per resident
While striking, the levels of criminal offending per 1000 residents found by Petrie et al just missed statistical significance: Germany 92; Denmark 158; England 1,730.

40. The Bucharest Early Intervention Project

Sponsored by the Children's Hospital Boston, the purpose of the randomised intervention study was to determine the effect of early intervention (by placement into foster care) on physical, cognitive, social and brain development and psychiatric symptomatology in previously institutionalised children.

The intervention was designed for children abandoned at or around the time of birth and placed in one of six institutions for young children in Bucharest, Romania (Zeanah et al., 2003). The PI (Nelson) and Co-PIs (Zeanah and Fox) conducted this study from a feasibility phase in the fall of 2000, through baseline assessments and implementation of the intervention in the spring of 2001.

Project design for the Bucharest Early Intervention Project (BEIP)
The BEIP began with comprehensive assessments of 136 institutionalised children and their caregiving environments prior to randomisation. Half the children were randomly assigned to high-quality foster care and the other half to remain in institutional care. The average age at foster care placement was 22 months (range=6-31 months). All children were initially seen prior to randomisation and again for follow-up assessments at 30, 42 and 54 months og age. The development of children in foster care was compared to the development of children in institutions and to a group of never institutionalised children (community controls). These children are currently being assessed at age 8 years.

Primary Outcome Measures: Cognition, Physical Growth (weight, height and head circumference), Psychiatric Symptomatology, Language, Brain Function (EEG asymmetry, coherence and power), Attachment Disturbances and Disorders, Attachment Style (Strange Situation Procedure), Caregiving Environment, Indiscriminate Behaviour, Emotion Discrimination (ERP), Face Recognition, Brain Structure (MRI), Problem Behaviours, Social Communication and Interaction, Genetics.

Findings (Abstract from article in Science, Dec 2007)
In a randomised controlled trial, we compared abandoned children reared in institutions to abandoned children placed in institutions but then moved to foster care. Young children living in institutions were randomly assigned to continued institutional care or to placement in foster care, and their cognitive development was tracked through 54 months of age.

The cognitive outcome of children who remained in the institution was markedly below that of never-institutionalised children and children taken out of the institution and placed into foster care. The improved cognitive outcomes we observed at 42 and 54 months were most marked for the youngest children placed in foster care. These results point to the negative sequelae of early institutionalisation, suggest a possible sensitive period in cognitive development, and underscore the advantages of family placements for young abandoned children.

The findings resulted in a change in Romanian law to prohibit the institutionalisation of children under the age of 2 years.

41. Early Development of Delinquency within Divorced Families, Oregon

Divorce can be a trigger for greater delinquency by children, due to upset, anger or sense of loss. This intervention targets the mother, after divorce, and shows delinquency can be reduced by a well-designed intervention, targeted at specific at risk families, at this vulnerable time.

DeGarmo and Forgatch (2005) report on an experimental test of the Oregon Social Learning Center's coercion theory early onset model of delinquency.

There is a well-established link between marital transitions and increased likelihood of problem behaviours in children, especially young boys. Increased problem behaviours place boys at risk for peer rejection, deviant peer association, and subsequent delinquency. Although established developmental models exist, there remain few experimental trials addressing how preventive interventions operate to ameliorate problem behaviours associated with divorce. DeGarmo and Forgatch evaluate the roles of parenting and deviant peers in a clearly specified developmental theory of delinquency using a selective prevention sample.

Several studies conclude that early parenting has a direct impact on delinquency as well as an indirect impact on deviant peer affiliation. Still others conclude that early parenting has a weak or fully mediated association with delinquency upon entering deviant peer affiliation. There are few developmental models specifying how divorce is linked with delinquency. They attempt to expand this literature using an experimental design.

Project design
Results are from the Oregon Divorce Study-II, a randomised preventive intervention trial with a sample of 238 recently separated mothers and their sons in early elementary school. The objective was to experimentally manipulate parenting variables hypothesised to influence development of delinquent behaviours. Multiple-method assessment spanned 36 months. Because the intervention focused on parent training, it was expected that any intervention effects on changes in child outcomes would be mediated by hypothesised intervening mechanisms.

Participants were 238 recently separated single mothers and their sons residing in a medium-sized city in the Pacific Northwest. Mothers in eligible families (a) had been separated from their partner within the prior 3 to 24 months, (b) resided with a biological son in Grades 1 through 3, and (c) did not cohabit with a new partner. At baseline, mothers had been separated for an average of 9.2 months. Families had 2.1 children on the average. Mothers' mean age was 34.8 years, boys' mean age was 7.8 years (range 6.1 to 10.4). Most mothers were classified within the lower- and working-class ranges in terms of occupation.

Families were randomly assigned approximately two-thirds to the experimental group (n = 153) and one-third to the no-intervention control group (n = 85).

The intervention was built around five theoretically based parenting practices (appropriate discipline, skill encouragement, monitoring, problem solving, positive involvement) and specific issues relevant to divorcing women (e.g. regulating negative emotions, managing interpersonal conflict). The parenting topics taught mothers strategies for decreasing coercive exchanges with their children by responding early and appropriately to child misbehaviour with non-corporal discipline (e.g. time out, work chores, privilege removal). Simultaneously, the intervention focused on the use of contingent positive reinforcement (e.g. praise, incentive charts) to promote prosocial behaviour. The topics were presented in an integrated step-by-step approach. Each new topic was introduced to build upon a previously learned skill. Topics were usually introduced in one or more sessions and then reviewed and revisited throughout the remainder of the programme. The programme was flexible in that it allowed participants to discuss current relevant issues as part of the regular agenda for each session. Issues were often linked directly to a specific curriculum topic.

Findings
Delinquency exhibited a pattern of linear change with the experimental and control groups beginning to diverge at 24 months and becoming significantly different at 36 months, ($p < .05$). Overall, the fitted linear slopes indicated that the intervention significantly reduced delinquency over time and, further, the intervention operated through hypothesised mechanisms.

Linear growth models showed significantly greater reduction in boys' delinquency and deviant peer affiliation in the experimental group relative to the controls. Subsequent models using no method overlap in constructs demonstrated that the intervention effect on delinquency operated through growth in parenting and reduction in deviant peer affiliation.

In terms of direct beneficial impact to families as well as society, these data underscore the importance of prevention efforts with at-risk families during the developmental periods of early delinquent behaviours.

42. Cracow Instrument (NATO Science Series)

Researchers at the 2002 NATO Science Series conference in Cracow identified the following to be risk factors that differentiated multi-problem violent youth from the rest of the population. The risk factors identified represent findings from a combination of empirical study, theoretical understanding and clinical experience.

CRACOW INSTRUMENT - RISK FACTORS & BASIS OF INCLUSION		
Corrado *et al* (2002): A Preliminary Conceptual Framework for the Prevention and Management of Multi-Problem Youth. In "Multi Problem Violent Youth", R.R. Corrado (ed), IOS Press, NATO Science Series		
CONCEPTUAL FRAMEWORK	**EMPIRICAL**	**THEORETICAL / CLINICAL**
ENVIRONMENTAL		
Prenatal/Perinatal Complications		
Obstetrical Complications	X	
Maternal Substance Use During Pregnancy	X	
Living Conditions		
Exposure to Toxins	X	
Community Disorganisation	X	
Family socio-economic status	X	
Residential Mobility		X
Exposure to Violence	X	
Peers		
Peer Socialization	X	
School		
School Environment		X
INDIVIDUAL		
Biological		
Birth Deficincies	X	
Parental History of Mental Illness	X	
Executive Dysfunction	X	
Chronic Underarousal	X	
Abnormal Biochemical Activity	X	
Psychological		
Cognitive Delays/disorders	X	
Personality traints/disorders	X	
Other Mental Illnesses		X
Antisocial Attitudes		X
Poor Coping Ability		X
School Functioning	X	
FAMILY		
Parental Characteristics		
Teenage Pregnancy	X	
Maternal/Parental Coping Ability		X
Parental Antisocial Practices/Attitudes	X	
Parental Education and IQ	X	
Family Dynamics		
Familial Supports		X
Family Conflict/ Domestic Violence		X
Family Structure / Single-Parent Family	X	
Parent-Child Relationship		
Ineffective Parenting	X	
Early Caregiver Disruption	X	
Parent/Child Attachment		X
INTERVENTIONS		
Previous Interventions		X
Accessibility to Interventions		X
Familiar Responsivity to Intervention		X
Child/Youth Responsivity to Intervention		X
EXTERNALIZING BEHAVIOUR		
General Behavioural Problems	X	
Violence/Aggression	X	
General Offending	X	
Substance Use	X	

FAMILY WELFARE

43. Iowa's Family development and self-sufficiency program (FaDSS)

Project design for FaDSS
From the 2009 Annual Report:

The FaDSS programme basic design recognises that at-risk families face many issues and respond well to long term, intense personal interaction with trained staff to move to emotional and economic independence. FaDSS believes that families can become strong, self-sufficient community members through voluntary participation in the array of individualised services that FaDSS programmes offer.

FaDSS develops a comprehensive system of support services for each family. The services are provided in a manner that promotes, empowers, and nurtures the family to self-sufficiency and healthy reintegration into the community. FaDSS emphasises the strengths of families and builds upon those strengths, assisting families to set and attain goals, while recognising that families seek to address their multiple needs in a way that least threatens the integrity of the family unit.

This strong belief in the family unit is the foundation of the Certified Family Development Specialist's partnership with each family. This belief leads each grantee to tailor the design of programme services to best meet the needs expressed by each family in a manner most comfortable to the family. As such, each grantee's services are unique, but the following core components are consistent in all grantee programmes.

Method of delivery – core components
HOME VISITS are the foundation for all FaDSS services. During these regular monthly visits a trusting relationship is fostered between the FaDSS Specialist and each family member. The home visits continue until the family requests them to end or until 90 days after the family is no longer receiving cash assistance from the Family Investment Program (FIP).

ASSESSMENT is an intense self-reflection process that is completed with each family. The assessment tools that may be used are the genogram (family tree), ecomap (depicts family support system), time line (significant events), and a basic strengths assessment.

GOAL SETTING is directed by the family with guidance from the Family Development Specialist. The family develops long term goals in conjunction with their Family Investment Agreement (FIA) goals developed with PROMISE JOBS. FaDSS also helps the family set short-term goals that will lead to the achievement of their long-term goal of achieving economic self sufficiency.

SUPPORT by the Family Development Specialist is ongoing, strength-based and solution focused.

REFERRAL by the Family Development Specialist assists the families in accessing community resources to better meet their needs.

ADVOCACY is performed at first by the Family Development Specialist and later, as they become empowered, by the family to ensure that systems and services are equitable, inclusive and responsive.

SPECIAL NEEDS funds may be provided by the FaDSS programme (where available), when no other resources exist in the community.

GROUP ACTIVITIES (where available) are offered as a means of breaking isolation, encouraging networking, and reintegrating families into the community

44. Dundee Families Project, Scotland

With very few exceptions, referrals (126 referrals in its first 4 years) came predominantly from the housing and social work departments. 55% of referrals were accepted and actively worked with. 34% were deemed not to fit the Project's criteria, and 11% 'did not engage'. The referred families were all poor and almost always unemployed. Many households were headed by a lone parent, though in

some instances the other parent was still actively involved. The nature of the 'anti-social behaviour' was varied, but most prominent were conflict with neighbours and damage to property. In addition to housing difficulties, families usually had serious problems with child-care and control. There was also a high incidence of physical and mental health difficulties and a number of adults had drug or alcohol problems.

In its first year, the Project attracted considerable adverse attention from the media and local residents. However, the residents' survey showed that by 1999 the great majority of local people accepted the Project and few had experience of any negative incidents. In addition, the wider public perception of the project was transformed from a very negative to a very positive image as they came to see the Project as being very well managed. There was a comparatively stable staff group and staff praised the training provided by NCH. The Project maintained very thorough case records.

Project design for Dundee Families Project
A strong partnership approach was built in to the Project from the start, with the local authority's housing and social work departments providing funding and advisory input at regular meetings. Strong management commitment to the Project was expressed by all the key council departments. Relationships with front-line staff in other agencies were generally good, but there was scope for improvement with respect to social work, education and health.

Findings
An evaluation by Glasgow University (Dillane et al, 2001) of the 4 years' work found:

- Council information on closed cases showed the majority of families made good progress, particularly regarding housing issues; however, many still had serious childcare problems
- Lower percentage of outreach services were successful (56%) compared to dispersed (82%) and core (83%)
- The majority of respondents felt that a core small residential block was helpful in providing intensive support to families, although a few questioned the need for this
- Parents and children were very positive about the service. Adults identified major changes in their housing situation, facilities for children, positive changes in family relationships and behaviour. Children thought the staff were helpful and their housing situation improved. They identified improvements both in their own and in their parents' behaviour
- Evidence suggests that the project generates real cost savings, through stabilising families' housing situation, avoiding costs associated with eviction, homelessness administration and re-housing; and, in some cases, preventing the need for children to be placed in foster or residential care
- Crucial ingredients were: good management, stable staff, shared ownership by other agencies, and a holistic approach.

Costs and Savings
Evidence indicated the Project offers good value for money. Stakeholders were confident the Project helped stabilise families' housing situation, avoiding costs associated with eviction, homelessness administration and re-housing. In some of the successful cases, major long-term savings were achieved by preventing the need for children to be placed in foster or residential care. In addition, savings to other agencies are likely. The cost estimates suggested that the project was, at worst, no more expensive than the conventional way of dealing with these families. However, it is more likely that it actually generated real cost savings, particularly when long-term costs are taken into account.

Late additions

45. Kraamzorg

The system of maternity care, 'kraamzorg', in the Netherlands is totally 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 she will also be there after the birth to help clean up.

Kraamzorg is a postnatal service in the first eight to ten days (kraamperiode) after the birth of their baby. 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.

Every pregnant woman in the Netherlands has the right to kraamzorg but the hours she is entitled to 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.

The National Guidelines for Postnatal Care categorise kraamzorg in three levels:

1. Basic
If there are no complications with the birth or recovery and no exceptional circumstances within the household, the support consists of:

- care for mother and baby,
- regular health checks (e.g. that stitches are clean and healing, the uterus is shrinking),
- advice and instruction (hygiene, feeding etc),
- ensuring hygiene levels are high
- basic household chores which directly relate to the care of mother and baby (such as cleaning of the bathroom, the nursery and the mother's room and taking care of meals for the mother).
- support to integrate the newborn into the family

2. Minimum Care
The legal minimum kraamzorg that every woman is entitled to, regardless of her situation, allows for a maximum of three hours care a day spread over the first eight days after the birth, but excludes any time involved in the birth itself. The focus is on care and health checks of the mother and baby, advice and instruction, observation and signalling of any problems to the midwife.

3. Flexible Package
The number of hours may be increased to take account of special circumstances up to a maximum of eighty hours, distributed over the first ten days after the birth. Circumstances that warrant a higher level of kraamzorg include the number of children already in the family, existence of mental illness or communication barriers, an instable family situation, the birth of twins (or more) or problems with (breast)feeding.

In addition to the tasks included in the basic package, this package may include the care of other members of the household (e.g. other children) and additional household tasks not directly associated with the mother and newborn.

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, consultatieburo (health clinic) etc. 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 consultatiebureau 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.

46. 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 annum in 2,000 classrooms in Canada, USA, Australia and, for the last 2 years, in the Isle of Man. It will be introduced in Northern Ireland this year. Its fundamental goal is to break the intergenerational cycle of violence and poor parenting.

Within that focus the goals are to foster the development of empathy; to develop emotional literacy; to reduce levels of bullying, aggression and violence; to promote children's pro-social behaviours; and to prepare students for responsible and responsive parenting.

ROE prepares schoolchildren for parenthood. It emphasises, models, and provides literal hands-on experience of how to handle and interact with a real-life baby.

Given the number of children who now become parents by ages 12-15, this can be seen as a pre-pregnancy programme. This emphasis is captured in the programme's purpose: *'Roots of Empathy teaches the crucial role of parenting for optimal early childhood development leading to healthy human development. The children of today are the parents and citizens of tomorrow.'* There is a strong focus on abuse prevention, the view being children are never too young to learn about Shaken Baby Syndrome, Sudden Infant Death Syndrome, Fetal Alcohol Spectrum Disorder and the dangers of second-hand smoke.

As their name suggests, ROE fosters the development of empathy. They state *'the ability to see and feel things as others see and feel them is central to competent parenting and successful social relationships in all stages of life'*. Students learn emotional literacy, human development, infant safety and how to identify with another person's feelings. Children prone to developing violent behaviour patterns are connected with emotionally satisfying parenting, through interaction with visiting parents and their babies.

Roots of Empathy 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, pro-social behaviours rise and incidents of bullying and aggression fall.

In a classroom setting, children share in 9 monthly visits with a neighbourhood parent, infant, and trained ROE Instructor. The Instructors conduct 18 further visits without the family. Babies are aged 2-4 months at the beginning of the ROE 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, empathic parenting in their own lives have 9 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, shyness. School children on the programme learn to relate to their own feelings, as well as recognise these same emotions in others.

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

47. KIPP Schools

The Knowledge Is Power Program (KIPP) is a network of public charter schools designed to transform and improve the educational opportunities available to low-income families. Ultimately, the goal of KIPP is to prepare students to enrol and succeed in college. There are 82 KIPP schools operating in 20 different states: 16 elementary schools, 55 middle schools, and 11 high schools, with over 21,000 students.

Over 90 percent of KIPP students are African American or Hispanic/Latino, and more than 80 percent of KIPP students are eligible for the federal free and reduced-price meals programme. KIPP schools

enrol all interested students, space permitting, regardless of prior academic record, conduct, or socioeconomic background.

The KIPP Foundation selects and trains school leaders, seeks to identify ways schools can be improved, and provides supports and services to KIPP schools and regions, including legal support, real estate, technology, finance, corporate governance, operations.

The KIPP approach
KIPP schools are free, open-enrolment, college-preparatory public schools where underserved students develop the knowledge, skills, and character traits needed to succeed in top quality high schools, colleges, and the competitive world beyond.

By providing a safe and structured learning environment, more time in school, and passionate, committed teachers, KIPP schools have helped students make significant academic gains.

KIPP schools share a core set of operating principles known as the 'Five Pillars'. These are:

- **High expectations** for all students to reach high academic achievement, regardless of students' backgrounds
- **Choice and commitment** on the part of students, parents, and faculty to a public, college preparatory education as well as the time and effort required to reach success
- **More time on learning**, both in academics and extra-curricular activities, each day, week, and year
- **Power to lead** for school principals, who are accountable for their school's budget and personnel
- **Focus on results**, by regularly assessing student learning and sharing results to drive continuous improvement and accountability

Results
Achievement levels of KIPP students are often substantially higher than those of schools serving similar populations of low-income, minority students.

A review by Mathematica Policy Research, funded by Atlantic Philanthropies and other third parties, found that 'For the vast majority of KIPP schools studied, impacts on students' state assessment scores in mathematics and reading are positive, statistically significant, and educationally substantial.' They also found that:

1. KIPP does not attract more able students (as compared to neighbouring public schools).
2. KIPP schools typically have a statistically significant impact on student achievement.
3. Academic gains at many KIPP schools are large enough to substantially reduce race and income-based achievement gaps.
4. Most KIPP schools do not have higher levels of attrition than nearby district schools.,

Three years after entering KIPP schools, many students are experiencing achievement effects that are approximately equivalent to an additional year of instruction, substantially reducing race- and income-based achievement gaps.

International experience of early intervention for children, young people and their families

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