Guidance about Effective Interventions to Support Parents, Their Infants and Children in the Early Years.

EXECUTIVE SUMMARY

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Introduction
This paper provides an overview of the evidence about effective support to improve health and wellbeing outcomes for parents, their infants and children in the early years. It covers the risk and protective factors and effective interventions from pregnancy to 5 years.

While there are many types of evidence, for consistency, in this paper we have drawn on the strongest evidence of the highest quality from reviews undertaken by organisations that have clear, quality assured processes such as the National Institute of Clinical Excellence, (NICE).

Details of the evidence reviews etc that have informed this paper are provided at the end of the document in Appendix 1.

This paper also provides guidance about how to use evidence and evaluate interventions.

Key messages

• Children’s life circumstances impact on their physical, psychological and wider development from pre-birth
• Health inequalities are the result of social factors and are not inevitable; they result in differences in health outcomes and exposure to risks to health
• There is a link between socio-economic disadvantage and health inequalities during the early years; in particular there is an increased risk of unintentional injuries, social emotional and cognitive difficulties
• Adverse and complex social factors experienced during pregnancy have the earliest impact on the health of the infant and their mother
• Effective communication between pregnant women and their carer(s), and in particular continuity of care and carers, improves the antenatal experience of women with complex social needs
A progressive universal model of care is the mechanism by which families with additional needs/risks may be identified and appropriately supported, (see definition below)

Interventions which enhance maternal mental health and wellbeing and those that promote positive parent infant relationships can have long term benefits

Effective interventions that may reduce unintentional injuries, linked to socio-economic status, combine the provision of home safety equipment and education

Effective interventions to promote social, emotional and cognitive development include:

- Pre and postnatal home visiting of vulnerable children and their families, led by suitably skilled health professionals, (e.g. FNP)
- High quality early years childcare and education, (e.g. children's centres – Sure Start1)
- Enhanced specialist group-based parenting programmes, that have been shown to be effective for secondary and tertiary prevention, (e.g. Triple P, Incredible Years)

Programme implementation fidelity is key

Environmental factors, parent’s perceptions of the benefits to families and children and their perception of staff skills influence family engagement and the maintenance of contact

Spacious, well maintained and pleasant facilities that are linked to good public transport are important to family (continued) engagement.

Progressive universalism

A progressive universal service offers a continuum of services that have been planned and are delivered in response to identified need. This includes services offered to all families, (such as primary health care) and the additional/enhanced services that are provided to families with specific needs and/or risks.

Universal services have a key role in identifying families with additional needs, providing enhanced services and making referral or signposting to additional services.

Local areas decide which enhanced services to offer over and above universal services. They also decide who delivers these enhanced services with reference to the local delivery context. Decisions about which services to offer should take account of the evidence of effectiveness for an intervention alongside the issues of identified need, cost, resources and workforce capacity.

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1 The evidence that informs this key message refers to Sure Start England.
THE EVIDENCE

The following sections provide evidence about the risk and protective factors and effective interventions to improve health and wellbeing outcomes for parents and their children in the early years. There is an explicit focus on these outcomes as they will impact on other future outcomes e.g. educational attainment.

Risk and Protective Factors
Children’s life circumstances impact on their physical, psychological and wider development and so can potentially increase or reduce the risk that children will experience adverse outcomes. However, it is important to bear in mind that their life circumstances are not deterministic / set in stone, but rather are interacting and so likely to change. Because of this the link between a child’s circumstances and their outcomes are influenced by multiple contributory factors rather than a single cause.

There is evidence across a range of health and developmental outcomes that a social gradient in health exists; with health inequalities apparent from the very start of life. The impact of these inequalities is enduring and the opportunity to reduce this impact declines as children age. The early years provide a vitally important opportunity to reduce the potential impact of risk factors and enhance the protective factors for children.

Health inequalities in the early years are the unfair differences that occur in health across social classes or population groups. They are the result of social factors and are not inevitable. They include differences in:

- Health outcomes, (e.g. low birth weight, unintentional injuries and developmental difficulties)
- Exposure to factors that increase the risk to health, (e.g. maternal smoking, the impact of long-term maternal physical and mental health difficulties, poor diet, poor housing quality and reduced community resources).

Pregnancy, birth and infancy
Health inequalities in the antenatal period arise from the experience of adverse and complex social factors. These can potentially:

- Increase the risk of illness, complications or death in the mother
- Increase the risk of illness, complications or death in the baby and result in
- Poorer long-term maternal and child health outcomes.

Women who experience complex social factors include those who:

- Misuse substances, (alcohol and/or drugs)
- Are recent immigrants and those who have difficulty reading or speaking English
- Experience domestic abuse
• Are young, (i.e. under the age of 20)
• Are known to social services / child protection services
• Are unemployed or experience socio-economic deprivation.
• Experience mental health problems.

Deprivation in pregnancy is associated with greater exposure to risks for poor outcomes such as smoking in pregnancy, unplanned pregnancy and planned bottle feeding. Infants who are born to women who experience complex social factors are at higher risk of death or morbidity / illness, pre-term labour, intrauterine growth restriction, low birth weight, low levels of or no breastfeeding and higher levels of neonatal complications.

Unintentional injuries
Unintentional injuries are often avoidable, yet serious injuries are one of the leading causes of death and disability in young children.

Unintentional injuries in children can occur in the home, at school, on the road and during play and recreation. Children under 5 years of age are most at risk from injuries in the home than in other areas.

As children grow and develop they are exposed to a range of hazards that may increase the risk that they will experience an unintentional injury. While the pattern of risk factors associated with unintentional injury in children is dependant upon the setting in which injury occurs and the type of injury, the risk of unintentional injuries increases with age, gender, (more likely in males) and low socio-economic status / socio-economic deprivation.

Social, emotional and cognitive development
Social, emotional wellbeing and cognitive development provide the foundation for a child’s future. A child’s experiences in utero and in the early years of life can have a life-long impact on their relationships, educational attainment and employability. While these are not absolutely deterministic recent analysis of the Millennium Cohort study data indicates that the following factors increase the risk that children of 5 years and under will experience difficulties with their social, emotional and cognitive development. These factors are:

• Being of low socio-economic status
• Living in a low income or workless household
• Living in rented or social housing or in an area of deprivation
• Living with mothers who have specific issues, including mental health problems, alcohol misuse, mothers who smoked during pregnancy and / or mothers who themselves were living away from home before the age of 17
• Living with a lone parent or an unemployed lone parent; co-habiting parents; living with a stepfather; disagreement between parents about parenting issues, high level of parental conflict
• Being from an ethnic minority background, (particularly Indian, Pakistani, Bangladeshi and Black African).
The most prevalent risk factors for children under the age of 5 in the UK are that of low income along with lone parent status and living in social housing. Less prevalent risk factors include ethnicity, child factors, (e.g. low birth weight) and maternal factors. Although these are less common, they are increased among families with low incomes or lower social and economic status. Consequently the link between these factors and the associated increased risk of poor outcomes among such disadvantaged children may be a result of socio-economic circumstances or other structural inequalities.

It is clear that the factors associated with the risk that children will experience difficulties are complex and interacting involving a dynamic relationship between them, the people who care for them and their wider environment. However, the factors associated with the highest levels of absolute risk of difficulties are maternal factors, (including age, education and health) and a family’s housing situation.

The factors that protect children against developing social, emotional and cognitive difficulties in the early years are almost a mirror image of those that put them at risk. These protective factors include the following:

- Being of high socio-economic status
- Being from a high income family
- Having early years education / childcare
- Their parents’ relationship: being married; having a positive relationship at birth
- Parenting factors: having a positive parenting style
- Child factors, including gender, (being a girl), being first born, having a higher birth weight, being older in the academic year, having higher British Ability Scale Scores, ethnicity, (having a white mother and English being the only language spoken)
- Maternal factors, including having a better education, being older at the time of pregnancy, having better self-rated health, ever having been in employment and feeling positive about their pregnancy.

The link between poverty and outcomes
The risk and protective factors outlined above highlight the link between poverty and health inequalities during the early years. The poorer children are and the longer they spend in poverty, the worse their health can become. This impact can last into adulthood. Growing Up in Scotland highlights that the longer children spend in poverty (compared to children who are either temporarily poor or who have never lived in poverty), the greater the likelihood that they will experience problems including obesity, unintentional injuries and social, emotional and behavioural difficulties.

The mechanism that influences the relationship between child poverty and outcomes is complex. The impact of poverty on children’s outcomes is linked to the accumulation and interaction of multiple risk factors. Such risks might include a family’s ability to pay for goods and services like food and electricity, their exposure to different types of physical environments, like dampness and the resources that parents have available.
A summary diagram that provides an overview of these influences and interactions is provided in Figure 1.

**Figure 1:** The relationship between family socio-economic status and outcomes (adapted from Gruenwald et al., 2012)

### EFFECTIVE INTERVENTIONS

**Reducing the impact of poverty**

Effective interventions to address the health impact associated with child poverty include:

- Interventions which maximise household income and resources
- Intensive support to families who are experiencing or who are most likely to experience poorer outcomes. This includes the provision of intensive home visiting and preschool education / child care.

Potentially effective interventions for tackling the underlying social causes of child poverty include addressing:

- Structural changes to the economic, tax and benefits systems and
- Legislative controls and enforcement.

In Scotland, universal services provide the earliest support to children and families. This provision begins in pregnancy.

**Pregnant women with socially complex needs**

Interventions that are aimed at reducing the impact of socially complex needs in pregnancy focus on the role of maternity care services and specifically on improving a woman’s access to and maintenance of contact with services. Women who have socially complex needs in pregnancy do not necessarily
attend for their first antenatal “booking” appointment later than women who do not have such needs. However, they may require greater support in order to be able to establish and maintain contact with antenatal services.

Enhancing access is two-fold: (1) physical access relates to the woman’s ability to engage physically with antenatal services while (2) cognitive access describes their ability to connect fully with services following uptake. This is largely dependent upon effective communication between the women and her care provider (s) that enables / encourages her to receive optimal care. This cognitive component of access is particularly important if women have socially complex needs.

An ongoing relationship that includes both continuity of care and of carer(s) facilitates effective communication and enhances the antenatal experience of specific groups of women with socially complex needs in the following ways:

- For women who misuse substances (alcohol / and or drugs), a named carer with specialist knowledge / experience improves their engagement
- For women who are recent immigrants / who do not speak or understand written English easily, continuity of care helps staff to understand religious, cultural and social differences and can help these women to navigate their way around the NHS systems
- For women under the age of 20, continuity of care may help to maintain their ongoing contact with antenatal services
- For women experiencing domestic abuse who may not disclose their situation during initial appointments, an on-going relationship can facilitate disclosure and referral to specialist support services.

However, the evidence that enhanced antenatal care provision, (i.e. services that are provided over and above routine universal care) improves specific outcomes for vulnerable pregnant women and their babies remains unclear.

**Maternal mental health and wellbeing**

In addition to the risk factors related to complex needs in pregnancy outlined above, maternal mental health and wellbeing is recognised as a key influence on a child’s development during their early years of life.

The high level evidence outlining the risk factors for developing postnatal depression is strong. In contrast, the evidence about the risk factors and treatments in relation to other mental health problems and the promotion and maintenance of mental wellbeing is relatively weak. Risk factors for postnatal depression include the following:

- Having a previous history of depression or other mental health problems
- Having poor social support and
- Having a poor relationship with their partner.
Providing treatment for women with risk factors for developing depression may have some benefit, particularly for those with existing symptoms. Social support and structured psychological short-term treatments are appropriate choices of treatment. Home visiting may be an acceptable way of providing psychological interventions, particularly in the late antenatal and postnatal phases.

While staff knowledge and skills for identifying and managing mental illness and promoting mental wellbeing is vital, their highly effective interpersonal skills are also essential. For example, the absence of a trusting relationship with their caregiver may inhibit disclosure by women at risk of poor outcomes and thus threaten their safety. Staff competence to accurately assess a mother’s social risk relies on building a strong relationship.

**Promoting positive relationships with infants and children**

A child’s attachment style develops from birth in response to their multiple experiences of their caregiver’s sensitivity to their need for safety and protection. Secure attachment is increasingly recognised as vital to the healthy development of infants and children. Providing information about attachment to parents can increase their knowledge about attachment and parenting. This may improve parent-child interaction and promote the development of secure infant attachment.

Interventions that focus exclusively on and effectively enhance maternal/caregiver sensitivity towards the child are universally effective. Information about parenting can be effectively provided through a variety of approaches, including group-based training, videos and one-to-one interventions. Encouraging close physical contact through interventions such as the use of soft baby carriers or kangaroo care, (i.e. holding the infant close to their parent’s chest) may enhance the development of secure attachment.

**Interventions to reduce domestic abuse**

Routine enquiry of abuse within universal services can increase rates of disclosure among those experiencing domestic abuse. The importance of effective counselling and management of care following disclosure and the need for universal services to liaise effectively with agencies providing support for those experiencing domestic abuse is emphasised. There is a clear need to support those experiencing domestic abuse to be able to make positive choices for themselves and their children. However, the high level evidence considered (which largely focuses on interventions for pregnant women), suggests that the impact of specific interventions in response to, or to prevent, domestic abuse is very limited.

Sometimes we do not have enough evidence to identify the most effective interventions, but absence of evidence does not mean that we should not take action. This is clearly an area in which further research and robust evaluations of new and existing programmes / interventions would be very helpful. Further guidance on using evidence and evaluation to support effective action is presented later in this paper.
The National Institute for Health and Clinical Excellence, (NICE) and the Social Care Institute for Excellence (SCIE) in England, are currently developing public health guidance to prevent and reduce domestic violence (currently due to be published in 2014). This guidance will be informed by reviews about the effectiveness of interventions and the systems that focus on preventing, identifying and responding to domestic violence. This will add to our understanding of this important issue.

Preventing unintentional injuries in the home

Children under five years are more likely to experience injuries in the home, (e.g. falls, burns and scalds) than in other locations compared to older children. Efforts to prevent unintentional injuries should balance the potential risks against the benefits that children experience, particularly in outdoor play and leisure activities.

Families may lack both the information to enable them to identify and manage risks in their home and the means by which to purchase and install home safety equipment.

Effective interventions that may reduce unintentional injuries, related to socio-economic inequalities, combine the provision of home safety equipment and education. These include:

- The provision of home safety advice and free or discounted appropriate safety equipment that is supplied and fitted, (e.g. smoke alarms, stair gates) to families at high risk of unintentional injury
- Education and information about general child development.

Factors that enable effective injury prevention programmes in the home include the following:

- Strong policy drivers / legislation, (e.g. around child resistant containers)
- Partnership and collaboration between service providers in low-income communities
- An understanding of the reasons behind a family’s failure to comply, (e.g. living in a home that they are not free to modify)
- Promoting / encouraging the safeguarding role of mothers.

Barriers to preventing injury in the home include the following:

- Faulty or poor equipment
- The cost of installing and maintaining equipment
- Living in accommodation that cannot be modified, (e.g. rented accommodation). Those delivering interventions should be mindful of situations where mothers lack the autonomy to make major household changes or decisions about household purchases
- A lack of professional knowledge about policy or home safety support services
- Policy and legal barriers, e.g. the poor enforcement of legislation.
Promoting child development and wellbeing

To ensure that all children have the best start in life, a life course approach to the early years has been recommended. This emphasises that focusing on the social and emotional wellbeing of vulnerable children under five years of age who are at risk of, or who are already experiencing problems, is the foundation for their healthy development. This can potentially reduce the negative impact of their family circumstances.

Providing support to parents, children and families who have different levels of need requires input from a range of services. The evidence suggests that home visiting interventions; early year’s education / child care and enhanced specialist early intervention programmes effectively promote child development and wellbeing in the early years. These can reduce the risk of poor outcomes for economically disadvantaged children in both the short and longer-term.

These interventions can be delivered as part of progressive universal provision. Universal services are those that are available to all families, e.g. health and education services. Enhanced services describe those that are provided in addition to, or involve the adaptation / increase of universal services, in response to the specific needs of families who have been identified as vulnerable.

Universal provision enables the identification and progression of vulnerable / at risk families (who are most likely to benefit from such interventions) to enhanced interventions, (e.g. intensive home visiting, Incredible Years). The skills and experience of practitioners, coupled with their relationship with a family is essential to assessing / addressing a family’s vulnerability.

Home visiting

Home visiting programmes can effectively improve a range of health and wellbeing outcomes for both children and their parents. Factors including the intensity and duration of home visiting and the skill of those providing it have been demonstrated to impact on its overall effectiveness.

There is good evidence that home-visiting during pregnancy and in the first year and beyond is effective for those identified as being at risk of poorer outcomes, e.g. deprived families or those with low birth weight babies. Home visiting has been linked to:

- Improvement in the home environment
- Improvement in family wellbeing, parent-child interactions and maternal sensitivity
- Improvement in maternal well-being, quality of life and contraception use
- Improvement in the social, emotional and cognitive development of children, including pre-term infants
- Increased infant attachment security.
Both parents and children may benefit most from intensive home visiting interventions. However, the effectiveness of home visiting in response to the support needs of families at risk of significant dysfunction or child abuse remains inconclusive.

**Teenage mothers**
Enhanced home visiting of teenage mothers, delivered by specialist nurses during pregnancy and the first 18 months of a child’s life can positively impact upon the social and emotional development of vulnerable children and their mothers, (e.g. Family Nurse Partnership). The best outcomes are seen in children of mothers with low emotional intelligence and/or poor mental health.

Home visiting interventions delivered to teenage mothers, with the specific aim of increasing maternal-infant attachment have not shown clear benefits. However, other targeted nurse–led home visiting programmes have been shown to be effective in helping young mothers to understand their infant’s behavior and cues.

**Substance misuse**
Although postnatal home visits may increase the engagement of substance misusing mothers with drug treatment services, there is no clear evidence that such engagement improves maternal or infant outcomes. While this would seem to be counter-intuitive, it may well be that the complexity of substance misuse is such that it cannot be ameliorated by a single intervention.

**Smoking cessation**
Smoking cessation during pregnancy can reduce the level of low birth-weight babies. The provision of home visits and social supports aimed at reducing the stress of pregnant women can effectively increase smoking cessation.

Interventions delivered postnatally in the home by nurses or other health practitioners that aim to increase parental self-efficacy may reduce maternal smoking and children’s exposure to tobacco.

Providing written information / details of cessation services alone is ineffective as an intervention to support smoking cessation.

**Delivery and implementation**
To ensure that programmes and interventions are effective it is important that they are delivered as designed, following any implementation guidance from developers.

Home visiting programmes are associated with:

- Higher levels of mother–infant interaction, breastfeeding initiation, parenting and medical knowledge, parenting satisfaction, and a sense of being supported
- A reduction in the symptoms of maternal depression and anxiety
- Improvement in some child cognitive outcomes
- Improvement in positive health behaviours and the prevention of injury.
Although the evidence is unclear about the \textit{optimal} duration, intensity and other characteristics of home visiting implementation, the benefits are maximised when home visiting:

- Lasts more than six months
- Involves more than 12 visits
- Begins antenatally or at birth rather than later
- Is delivered by professionals rather than paraprofessionals/lay providers
- Is structured and focuses on a broad range of outcomes for both the mother and child.

The recent Early Years Public Health Guidance 40 published by NICE, (2012) recommends that health visitors or midwives should offer a series of intensive home visits by appropriately trained nurses to those families assessed as being in need of additional support, (Recommendation 3, see Appendix 2).

\textbf{Early childhood education / children’s centres}

Preschool education and interventions delivered in day care or educational settings, (e.g. Sure Start) can help to reduce the poor outcomes of vulnerable children that are linked to their disadvantage. Such interventions can result in sustained improvements in their social, emotional and cognitive development.

Full-day programmes have been shown to be effective for improving the cognitive development of children who are particularly disadvantaged. These children gain more from \textit{intensive} preschool interventions and do not show any negative behavioural consequences associated with the additional hours spent in early education. However, half-day programmes may be sufficient for children of middle or higher socioeconomic status or income.

The home learning environment is also important to the child’s social and cognitive development. High quality early years education beginning in infancy, combined with home visits to improve the home-learning environment. that is targeted at high risk groups can result in improved cognitive and academic achievement that lasts into adulthood, (e.g. Abecedarian Project).

The quality of the preschool is important. Characteristics that lead to positive child outcomes include the following:

- Staff who have warm interactive relationships with children
- A trained teacher as a manager
- A good proportion of trained teachers on the staff
- Staff who regard educational and social development as complementary and equally important.

Once again the recent NICE Guidance recommends that local authorities ensure that all vulnerable children can benefit from high quality childcare / services outside the home, (on a part or full-time basis) and can take up their entitlement to early childhood education, where appropriate. Services should
be run by well trained, qualified staff, (including graduates and teachers) and
focus on social, emotional and educational development, delivered within well
maintained and pleasant environments, (Recommendation 4, see Appendix 2).

**Long term outcomes - home visiting and early year’s education**
There is evidence that early childhood interventions, including home visiting
and early education, result in lasting improvements in the outcomes of at risk
or disadvantaged children. The greatest positive effects include:

- Improved cognitive development
- Educational success during adolescence
- Reduced social deviance
- Increased social participation
- Smaller improvements in family wellbeing and social-emotional
development have also been reported.

**ENHANCED SPECIALIST PROGRAMMES**

**Group based parenting programmes**
The evidence provides support for the effectiveness of group based / media
based parenting programmes, (e.g. Incredible Years) in improving emotional
and behavioural problems in children aged 3 years and under. However, it is
still not clear whether group based parenting programmes are effective as
primary prevention interventions delivered to all parents, (i.e. preventing the
onset of problems) rather than secondary/tertiary prevention, (i.e. the
treatment of early mental health problems). Incredible Years and Triple P
have been shown to effectively reduce behavioral problems in children over
the age of 3.

**IMPLEMENTATION SUCCESS**

**Barriers and facilitators (of home-visiting and early childcare /
education)**
The time commitment required for delivering home-based interventions is
viewed as a potential barrier to parents’ ongoing engagement. Flexibility in
timing to accommodate parents’ needs is important. It has been suggested
that home visitors should be proactive in recognising signs of disengagement
by parents and offer possible solutions in trying to reengage them, e.g. by
offering a break from the programme, changing its content and/or working
differently with families to meet their needs. However, offering a break in
service may conflict with evidence that missing too many appointments is
associated with parents’ disengagement.

The relationship between parents and staff influences whether parents
continue to use services. Regular interaction (as part of an intensive home
visiting programme) enables parents to develop open, non-judgmental
collaborative relationships with health visitors. Home visiting interventions
improve parents’ skills and confidence and are particularly beneficial to parents who lack emotional support, especially those who are reluctant to seek support from family or friends. However, some parents, particularly young women report concern about how they might be perceived or judged as parents. Fathers may take longer to engage but find programmes to be beneficial.

**Professional roles and practices**

Staff enthusiasm and their belief both in a programme and working with vulnerable families are regarded as vital to the success of a programme. This may enable staff to cope with the demands and challenges of their role. The skills of staff are key to the success of programmes. Suitably skilled staff and supportive, flexible management are highlighted as contributing to programme success. There is a need for role clarity and responsibilities to enable staff to manage challenges around interagency / inter-professional team working and issues relating to previous organisation / current service.

Home visitors described issues around engaging with clients and service delivery as frustrating. In particular they noted the following as sources of frustration:

- Not being able to reach or maintain engagement with their clients
- Delivering interventions which they felt were too short or which they were unsure were effective and
- Balancing the competing needs of the families in their caseload.

The evaluation of the Sure Start interventions in England indicates that higher implementation proficiency is linked to better outcomes for families.

**Organisational and management issues**

Organisational and management issues were identified as being important, especially that of establishing good management links and inter-agency working.

Positive factors include:
- Balanced representation on partnership boards
- Established multi-agency team working
- Well functioning centres with low staff turnover
- Good pre-existing relationships with local agencies
- Clear and early establishment of purpose.

Negative factors include:
- Insecure funding
- Funding freezes
- Funding deficits.
The previous sections have been informed by the best quality published evidence about the effectiveness of interventions to support parents, their infants and children in the early years.

However we do not always have the "luxury" of such evidence to support effective action. In such instances we may need to draw on other types of evidence, (being transparent that we have done so) and then help to generate the evidence by evaluating innovative work.

The two boxes below provide brief guidance about how to use evidence and evaluate interventions.

### Understanding how to use evidence to support effective action

When deciding to use an intervention or programme it is important to assess the quality of the evidence supporting its use. Actions based on poor evidence may produce unexpected outcomes. At best, this can waste time and / or money but can also lead to outcomes that have a negative impact.

There are a various types of evidence, ranging from individual studies through to randomised controlled trials, systematic reviews (of a collection of individual studies) and reviews of reviews. Decisions about how effective a programme or intervention is are not normally based on the findings from a single study. These findings are important but may be unusual and potentially biased. Such bias may only become apparent when studies are repeated or interventions rolled out on a wider scale.

Decisions about which action to take are best made from combining and interpreting the body of available evidence and the quality of this. It is advisable to use the strongest, best quality evidence such as reviews that have been undertaken by organisations that have clear, quality assured processes.

However, there are inevitable gaps in our evidence base, and sometimes we do not have enough evidence to decide whether an intervention is effective or not. This is not the same as having evidence that indicates that an intervention is ineffective. Where there is little or no evidence but yet a need to take immediate action to inform future activities, it is useful to draw on approaches such as that used by NHS Health Scotland², whereby plausible theory and ethical principles are used to guide decision-making, in combination with the best available evidence.

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The 10 ethical principles are:
1. Do Good
2. Do not harm
3. Equity
4. Respect
5. Empowerment
6. Sustainability
7. Social Responsibility
8. Participation
9. Openness and
10. Accountability.

Contributing to the evidence base by evaluating interventions

Where there is a lack of evidence it is important to evaluate interventions to establish whether they are effective or potentially harmful or ineffective. It is also essential that evaluation is embedded within the planning and delivery of services to ensure that the local learning is captured on an ongoing basis.

This section outlines some of the key considerations and resources that will help practitioners evaluate the delivery and effectiveness of interventions in line with the underpinning ethical principles outlined above.

Planning an Evaluation
Planning an evaluation should start with a clear understanding of who is going to use the evaluation, for what purposes, with what potential consequences.

Different evaluation stakeholders may require different types of evaluation, for instance:

- Practitioners and Policy makers: effectiveness; what works, for whom, in what circumstances?
- Practitioners: improvement to strengthen implementation: How can we make it better?
- Funders: accountability; should we continue investing?
- Planning and Performance Managers: performance monitoring/targets; Developmental/formative evaluations
- Service users: Service quality – access, experience, relevance to needs.

It is crucial to understand what is being evaluated and to have a clear statement of the rationale and need for the evaluation, confirming the outcomes for the programme and the process by which these will be achieved. This will provide a sound basis for process and outcome evaluations. The resources identified below will help partners to do this.

The list below outlines a set of key principles that will guide practitioners in
planning and conducting evaluations of child and family services.

Key principles of evaluation:
• Be focused on the purpose, what you really need to know (prioritise), and what will be useful and used
• Be realistic about what you can and should evaluate; what is possible and what it is in your gift to influence, (e.g. your outputs, who you reach, your short-term outcomes)
• Be clear about how much evaluation is appropriate
• Be clear about your evaluation design before choosing the appropriate method of data collection
• Be appropriate about the indicators and sources of evidence you will use to measure progress towards your outcome(s)
• Be convincing to your evaluation audience: what will it take to convince a reasonable person?
• Be honest about why you are evaluating, what the evaluation will be used for, and what you can claim
• Be clear about the learning that emerges from the evaluation and how this can be used to inform service development.

The Evaluation Team, NHS Health Scotland

Useful resources
The following links provide some useful resources to plan and conduct locally relevant evaluations of peer support services.

Evaluation Support Scotland works with voluntary organisations and funders to enable them to measure and report on their impact and improve their services. Their website has a wealth of helpful resources, guides and tools to help organisations to plan, design and carry out evaluations.

The resources section on this website includes a helpful range of evaluation tools, toolkits, and support guides on all aspects of evaluation. For those new to evaluation that are unsure where to start there is an Evaluation Pathway in the Evaluation section of the website.

The ESS support guides lead readers through each step of the evaluation process including clarifying aims, outcomes and activities, developing a logic model, developing and using indicators, different approaches and methods to collect relevant data including qualitative evidence, analysing data, and using what is learned from the evaluation.

The Evaluation Support Scotland website can be accessed at http://www.evaluationsupportscotland.org.uk.

3The changes that are likely to be achieved or achieved in the short-term as a result of service delivery, (or a social intervention). A glossary of key terms used in outcomes-focussed planning and evaluation can be found on the NHS Health Scotland website at http://www.healthscotland.com/OFHI/Resources/Resources_glossary.html.
NHS Health Scotland provide a series of links and documents which give advice on how to monitor and evaluate interventions with a focus on public health that provides a starting point for those planning to undertake an evaluation.


The National Institute of General Medical Sciences provides a useful how-to guide in planning and conducting an evaluation that sets out different approaches to data collection and the benefits and challenges of each. The page can be accessed at http://www.nigms.nih.gov/Research/Evaluation/evaluation_steps.htm.

**Economic Evaluation**

Economic evidence helps us to understand measure and compare the benefit we get from the allocation of resources to specific interventions and services (NHS Health Scotland 2011). For those considering economic evaluation, NHS Health Scotland has produced a resource that introduces use of economic evidence to support the health improvement contribution of the third sector.


**CONCLUSION**

The life circumstances of children are strongly linked to the opportunities that they will experience and risks that they will encounter in their early years. While this paper has focused on interventions to improve health outcomes, equal consideration needs to be given to outcomes relating to education and social justice.

Cross-cutting interventions delivered by staff that value the physical, social and emotional well-being of young children and their parents can make a real difference to both the early and later life chances of our children and their families. To achieve this we need collaborative working between staff in the health service, education, social justice, local authorities alongside their partners in the third sector.

**Authors**

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Dr Kate Woodman, Public Health Adviser – Early Years, NHS Health Scotland.
Appendix 1.

References

Group-based parenting programmes to improve the emotional and behavioural adjustment of children from birth to three years old

Health-led parenting interventions in pregnancy and the early years

Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties

Promoting the social and emotional wellbeing of vulnerable pre-school children (0-5 yrs): systematic review level evidence

Promoting the social and emotional wellbeing of vulnerable pre-school children (0-5 yrs): UK evidence review

Growing Up in Scotland: Health inequalities in the early years.
Postnatal parental education for optimizing infant general health and parent–infant relationships

Saving Mothers’ Lives: reviewing maternal deaths to make motherhood safer:

Interventions for promoting early childhood development for health

The Circumstances of Persistently Poor Children

History of socioeconomic disadvantage and allostatic load in later life.

The Public Health Role of the Midwife. Systematic Review of Reviews:


Social and emotional wellbeing: early years

Evidence summary: Interventions to support parents, their infants and children in the early years (pregnancy to 5 years)
Antenatal Health Inequalities: a rapid review of the evidence

Cognitive behavioural therapy for men who physically abuse their female partner

Interventions for intimate partner violence: review and implications for evidence-based practice
Appendix 2. Recommendations from NICE public health guidance 40
‘Social and emotional wellbeing: early years’

About NICE public health guidance
NICE (the National Institute for Health and Clinical Excellence), produces public health guidance for England, aimed at promoting good health and preventing ill-health. The guidance is informed by the best available evidence on the effectiveness and cost-effectiveness of programmes or interventions, using a highly developed and rigorous process. Account is also taken of stakeholders’ views and fieldwork.

Although NICE Guidance has no formal status in Scotland, the evidence informed recommendations included may be relevant, subject to consideration of the Scottish policy and practice context. To ensure the accuracy of reporting, two relevant recommendations are presented below verbatim.

About NICE public health guidance 40
The “Social and emotional wellbeing: early years”, NICE public health guidance 40, (2012) aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The recommendations cover:

- Strategy
- Commissioning and review
- Identifying vulnerable children and assessing their needs
- Ante- and postnatal home visiting for vulnerable children and their families
- Early education and childcare delivering services.

This guidance does not cover the clinical treatment of emotional and behavioural difficulties or mental health conditions, or the role of child protection services.

The guidance is for all those responsible for ensuring the social and emotional wellbeing of children aged under 5 years. This includes those planning and commissioning children’s services in local authorities (including education), the NHS, and the community, voluntary and private sectors. It also includes: GPs, health visitors, midwives, psychologists and other health practitioners, social workers, teachers and those working in all early years settings (including child minders and those working in children’s centres and nurseries). The guidance may also be of interest to parents, other family members and the general public.
Recommendation 3 Antenatal and postnatal home visiting for vulnerable children and their families

Who should take action?4

- Maternity services.
- Health visiting services.
- Early years services.

What action should they take?

- Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support (see recommendation 2).

- The trained nurse should visit families in need of additional support a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes). Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:
  - maternal sensitivity (how sensitive the mother is to her child's needs)
  - the mother–child relationship
  - home learning (including speech, language and communication skills)
  - parenting skills and practice.

- The nurse should, where possible, focus on developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities.

- Health visitors or midwives should regularly check the parents' level of involvement in the intensive home visiting programme. If necessary, they should offer them a break, to reduce the risk that they will stop participating. If the parents do decide to have a break, the nurse should continue to communicate with them on a regular basis.

- Managers of intensive home-visiting programmes should conduct regular audits to ensure consistency and quality of delivery.

- Health visitors or midwives should explain to parents that home visits aim to ensure the healthy development of the child (see recommendation 2). They should take into account the parents' first language and make provision for those who do not speak English. They should also be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting.

4 While acknowledging that NICE guidance is only relevant in England, we note that in Nursing for Health (2001) within the model of practice there is no discernible difference between the role of a health visitor and that of a school nurse. Both have a public health focus, but work with different parts of the community. Thus the term currently used in Scottish policy is that of Public Health Nurse.
• Health visitors or midwives should try to ensure both parents can fully participate in home visits, by taking into account their domestic and working priorities and commitments. They should also try to involve other family members, if appropriate and acceptable to the parents.

• Health visitors and midwives should consider evidence-based interventions, such as baby massage and video interaction guidance, to improve maternal sensitivity and mother–infant attachment. For example, this approach might be effective when the mother has depression or the infant shows signs of behavioural difficulties.

• Health visitors and midwives should encourage parents to participate in other services delivered by children's centres and as part of the Healthy Child Programme 5.

• Health visitors and midwives should work in partnership with other early years practitioners to ensure families receive coordinated support. This includes psychologists, therapists, family support workers and other professionals who deliver services provided by children's centres and as part of the Healthy Child Programme.

Recommendation 4 Early education and childcare

Who should take action?

• All those involved in providing early education and childcare services. This includes child minders and those working in children's centres, nurseries and primary schools (maintained, private, independent and voluntary).

• Health visiting services.
• Local authority children's services.
• School nursing services.

What action should they take?
Local authority children's services should ensure all vulnerable children can benefit from high quality childcare outside the home on a part or full-time basis and can take up their entitlement to early childhood education, where appropriate. The aim is to give them the support they need to fulfill their potential. Childcare and education services should:

- offer flexible attendance times, so that parents or carers can take up education, training or employment opportunities

5 The Healthy Child Programme has no formal status in Scotland.
- address any barriers that may hinder participation by vulnerable children such as geographical access, the cost of transport or a sense of discrimination and stigma
- be run by well-trained qualified staff, including graduates and qualified teachers
- be based on an ethos of openness and inclusion.

- Managers and providers of early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn. Services should:
  - promote the development of positive, interactive relationships between staff and children
  - ensure individual staff get to know, and develop an understanding of, particular children’s needs (continuity of care is particularly important for younger children)
  - focus on social and emotional, as well as educational development.

- In line with the Department for Education’s statutory framework for the early years foundation stage, managers and providers of early education and childcare services should:
  - provide a structured, daily schedule comprising a balance of adult-led and child initiated activities
  - ensure parents and other family members are fully involved (for example, by contributing to decisions about service provision, or by participating in learning or other activities, as appropriate)
  - ensure the indoor and outdoor environment is spacious, well maintained and pleasant.
### Appendix 3: Early Year Task Force – Evidence Based Interventions
#### Subgroup Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
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<td>Anne Houston</td>
<td>CHILDREN 1st, Chief Executive</td>
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