Improving Health and Wellbeing Outcomes in the Early Years

Research and Practice

IPH

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Improving Health and Wellbeing Outcomes in the Early Years:

Research and Practice

Institute of Public Health in Ireland and
the Centre for Effective Services

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Contents

Institute of Public Health in Ireland

The remit of the Institute of Public Health in Ireland (IPH) is to promote cooperation for public health between Northern Ireland and the Republic of Ireland in the areas of research and information, capacity-building and policy advice. Our approach is to support Departments of Health and their agencies in both jurisdictions, and maximise the benefits of all-island cooperation to achieve practical benefits for people in Northern Ireland and the Republic of Ireland. Since its establishment, IPH has placed a specific focus on health inequalities.

IPH wants to work to improve everyone's health and reduce inequalities and placing an emphasis on early years can support a trajectory that aligns with better chances of health throughout life. We believe and concur with Professor Sir Michael Marmot when he states in his review of health inequalities that it is imperative that every child has the best start in life and that all children and young people are enabled to maximise their capabilities and have control over their lives.

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Centre for Effective Services

The Centre for Effective Services (CES) connects research, policy and practice to ensure the implementation of effective services to improve the lives of people across the island of Ireland. CES works to influence policy and systems change; champion innovative service design and implementation; and build knowledge, skills and capacity for government departments, organisations, researchers and practitioners.

CES is a not for profit, intermediary organisation with offices in Dublin and Belfast.

www.effectiveservices.org

Acknowledgements

ABC	Area Based Childhood
AP	The Atlantic Philanthropies
CDI	Childhood Development Initiative
CES	Centre for Effective Services
CORU	The Health and Social Care Professionals Council
CYPSC	Children and Young People's Services Committees
DCYA	Department of Children and Youth Affairs
DEIS	Delivering Equality of Opportunity in Schools
DHSSPS	Department of Health, Social Services and Public Safety
EDI	Early Development Instrument
ECCE	Early Childhood Care and Education
EITP	Early Intervention Transformation Programme
EPPE	Effective Provision of Pre-School Education
EU	European Union
EU-SILC	EU Survey on Income and Living Conditions
FAST	Families and Schools Together
FDP	Food Dudes Programme
FFM	Family File Meeting
FLNP	Family Links Nurturing Programme
FPI	Fingal Parenting Initiative
GP	General Practitioner
HSE	Health Service Executive
IPH	Institute of Public Health in Ireland
IY	Incredible Years

MoU	Memorandum of Understanding
NEYAI	National Early Years Access Initiative
NICE	National Institute for Health and Care Excellence
NSP	Northside Partnership
OECD	Organisation for Economic Cooperation and Development
OFMDFM	Office of the First Minister and Deputy First Minister
PCF	Parent/carer facilitators
PCPS™	Parent-Child Psychological Support Programme
PEIP	Prevention and Early Intervention Programme
PFL	Preparing for Life
PPEY	Parents Plus Early Years Programme
PSLT	Principal Speech and Language Therapist
RCT	Randomised Controlled Trial
SLAs	Service Level Agreements
SEBD	Social, emotional and behavioural difficulties
SLT	Speech and Language Therapy
SSP	School Support Programme
TPS	Triple P – Positive Parenting Programme
UCD	University College Dublin
UK	United Kingdom
UNCRC	United Nations Convention on the Rights of the Child
UNOCINI	Understanding the Needs of Children in Northern Ireland
WHO	World Health Organization

Foreword

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The early years period is a critical time for child health and wellbeing. Where children grow up with secure relationships, safe home-learning environments, adequate housing, and have good nutrition, the probability of lasting positive health and wellbeing is strong. On the other hand, adverse childhood experiences in the early years such as poverty, child abuse and neglect, or parental substance misuse, not only impact negatively on children's health and wellbeing, but can effect a wide range of future outcomes including learning, anti-social behaviour, and premature ill-health and death. With respect to health, people in lower socio-economic groups are more likely to experience ill health and die earlier than those who are more advantaged. These differences in health status, widely referred to as health inequalities, arise from the socially determining factors that impact on the conditions in which people are born, grow, live, work and age. This publication explores how these conditions can in part be addressed through prevention and early intervention approaches with children, parents and professionals. In the context of this work, early intervention means intervening at a young age or early on in the life course, while prevention refers to avoiding the negative impacts of the social determinants of health.

Prevention and early intervention has become a distinctive feature of child policy developments across the island of Ireland. In Northern Ireland, policies and frameworks including *A Ten Year Strategy for Children and Young People in Northern Ireland 2006-2016,* the *Child Poverty Strategy 2014-2017,* and the *Delivering Social Change Framework* all emphasise the importance of prevention and early intervention for improving health and wellbeing outcomes and reducing inequalities. In Ireland, *Better Outcomes, Brighter Futures: The national policy framework for children and young people 2014-2020* identifies prevention and early intervention as a key transformational goal for achieving better outcomes for children. *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-202*5 similarly recognises the importance of early intervention. A significant body of evidence on prevention and early intervention approaches with children and families in Ireland and Northern Ireland has also emerged in recent years. For example, the *Prevention and Early Intervention Initiative,* made possible through an investment in agencies and community groups of over €127 million by The Atlantic Philanthropies, funded 52 prevention and early intervention programmes on the island of Ireland, which were rigorously evaluated. A Centre for Effective Services report, *Ten Years of Learning,* presents the distilled learning from these initiatives and highlights evidence on the positive impacts of interventions adopting prevention and early intervention approaches with children and parents in the first three years of life. It also emphasises how upskilling professionals working with children, young people and families in prevention and early intervention can promote child health development and the identification of needs requiring additional support.

It is widely recognised that

policies and actions formulated in non-healthcare sectors have a significant impact on people's health and wellbeing.

For example, a housing sector scheme on damp proofing is likely to significantly improve respiratory health, particularly for vulnerable residents such as older people and young children. Similarly, a transport sector policy to promote active forms of travel is likely to improve levels of physical activity with subsequent health benefits. In addition, many of the problems which adults experience have their origins in early childhood, which has implications for a wide range of social policies. Prevention and early intervention initiatives in the early years support today's children to become healthy, socially and economically engaged adults in the future. Research demonstrates that the costs of unresolved childhood problems are borne by a range of government departments and agencies. Whilst examining the wide range of policies and initiatives required to improve health and wellbeing outcomes is beyond the scope of this book, insights are provided into how

prevention and early intervention approaches can contribute to tackling issues in the early years, before they become embedded and costly.

The academic authors outline the rationale and evidence for prevention and early intervention, including some of the learning that has emerged across the island of Ireland, and a series of vignettes demonstrate how this evidence can be applied in practice settings. Dr Sinéad Hanafin focuses on evidence for working with children, Dr Sinéad McGilloway focuses on working with parents, and Dr Gavin

Davidson explores effective approaches for professionals. There are supporting examples for each of these chapters from practitioners, demonstrating the practical application of interventions and providing key insights into how to translate prevention and early intervention evidence into practice.

Dr Davidson outlines how professionals can work to improve health outcomes for children and promote health equity. He provides a broad definition of 'professionals' to

> encompass anyone, across statutory, community, voluntary and private sectors, whose job involves … this area of work. This therefore includes people working across health and social care but also those working in housing, education, criminal justice, social security, culture, transport, economic development, policy, research and politics.

Support for the work of these groups of professionals is a key ingredient in successful interventions. Their work is often difficult and highly complex as effective interventions require multidimensional approaches. As Dr Hanafin states, this complexity is acknowledged in Northern Ireland and the Republic of Ireland, where policies are underpinned by the Bronfenbrenner model of childhood, which identifies strategic approaches at the level of the family, the school environment and the broader neighbourhood context. Dr McGilloway's chapter discusses how parenting programmes, in particular, together with other forms of parent support have grown in popularity as a means of assisting and empowering parents to positively influence their children's lives. As Dr McGilloway explains, parenting interventions may be provided on a continuum from universal service provision to more intensive and targeted forms of support for more vulnerable children and their families. As all three academic authors attest, however, all such prevention and early intervention strategies have to address a number of key issues. A key task is to harness community

resources enabling statutory, voluntary and community agencies and groups to work together in collaboration, while recognising that individuals and families may have particular issues and problems inextricably linked to poverty and its attendant determinants of health and wellbeing.

The vignettes included in this publication make a welcome contribution to enhancing our understanding of how evidence on effective prevention and early intervention approaches in the early years can be applied in practice and how best to utilise strengths at a local level. These vignettes are some examples of the many approaches being taken. They are not being endorsed, and are instead selected as illustrations of what can be achieved. Michael Neary focuses on the development of healthy eating behaviours, which have been linked to improvements in a variety of health outcomes including obesity. Alan Herron and Laura McQuade show how play can have a significant impact on the development of social and emotional competence in children. John Sharry, Sarah Jane Gerber and Noel Kelly illustrate how addressing parental depression, stress and negative parenting can support children's development, and how effective approaches can be aimed at whole populations or targeted at individuals or specific groups. Conor McArdle and Mary Magee, Grainne Smith and Hazel O'Byrne in different ways show how improved health outcomes in the early years can be achieved by supporting professionals to improve the quality of their work with children and families. This support can take various forms including training, quality assurance, and reflective practice. There is also an emphasis on partnership working with other services in order to achieve more integrated service delivery and influence systems change. Each of the vignettes featured in the book provide an insight into professional practice, and each is followed by a summary of lessons learned that can guide and inform practice.

In speaking to the dialogue between research and practice, this publication should be of interest to a wide range of people including researchers and practitioners working with children, parents and other professionals, to improve health and wellbeing outcomes in the early years.
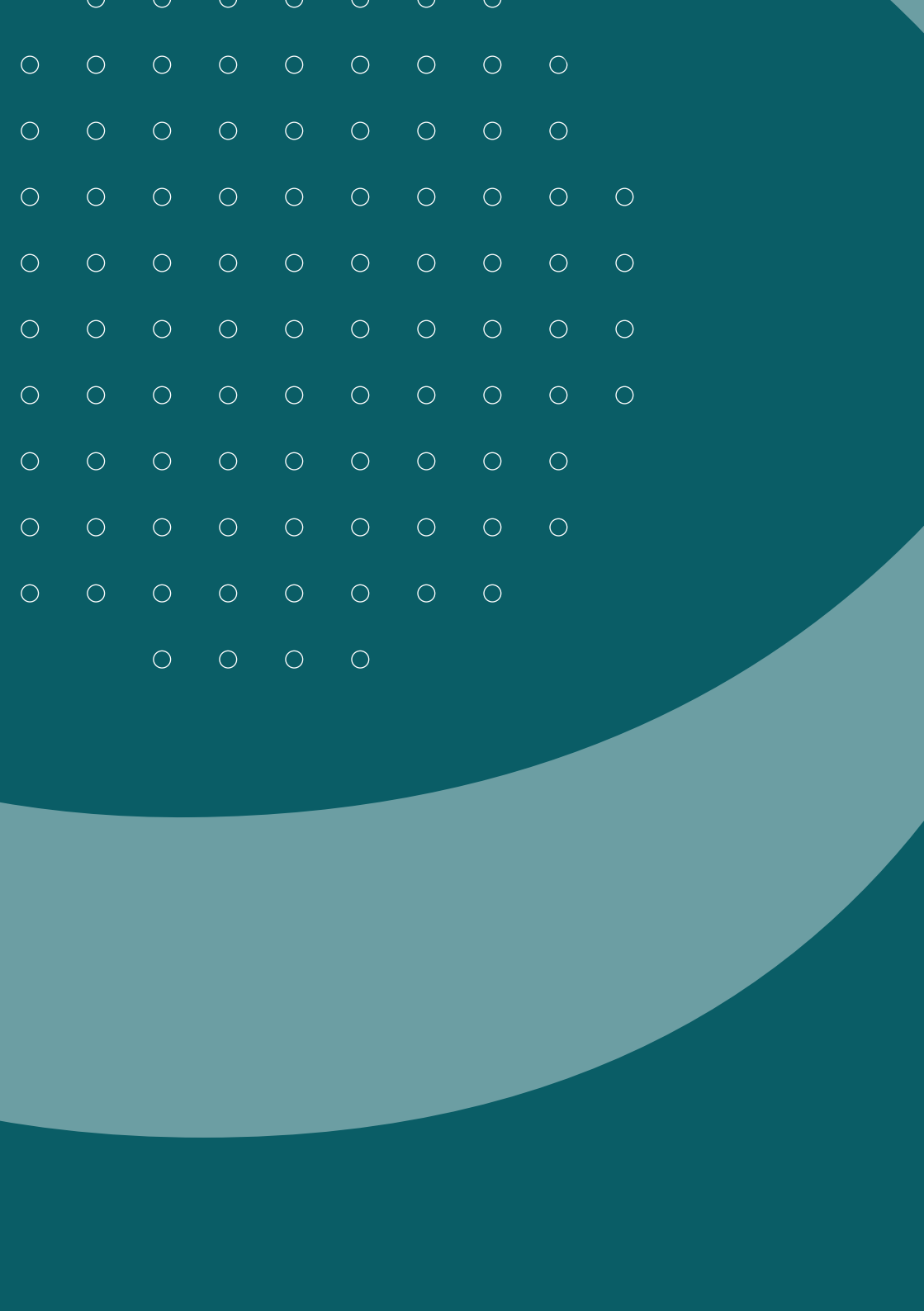
We are delighted our organisations have joined forces to produce this volume and we wholeheartedly thank all the contributors for giving so freely of their time, insight and understanding.

Chief Executive of IPH   Director of CES

Introduction

# All-Island Policy Overview Noëlle Cotter

Introduction

This publication focuses on the research and practice of improving health and wellbeing outcomes in the early years. The term early years refers to the period from prenatal development to eight years of age. The discussions that follow in some cases extend to include prevention and early intervention beyond age eight. This chapter sets the context for a focus on early years and summarises the most important recent policy developments in this area across the island of Ireland. At the outset it is important to state that while the terms health inequality and health inequity are often used interchangeably, there is a distinction between these terms. Health inequalities may be unavoidable due to factors such as age or genetic disposition, whereas health inequities refer to health differences that are avoidable, unjust or unfair. In gaining a greater understanding as to why and where these differences occur it is important to consider how health is determined. In summarising how health is determined, Figure 1. (Department of Health, 2013) illustrates why there is a need for buy-in across sectors rather than a silo view of policy-making, to ensure mutual benefits for policy impacts across sectors.

The World Health Organization (WHO) (Irwin et al, 2007) notes that early childhood is one of the most important developmental phases across the lifespan. Healthy early child development – including physical, social-emotional and language-cognitive development – is fundamental not only for childhood, but throughout the life course. The Marmot Review (2010) states that the foundations for virtually every aspect of human development (physical, intellectual, emotional) are laid down in early childhood. In echoing the WHO, the Marmot Review describes how the early years have a lifelong effect on many aspects of health and wellbeing; from obesity, heart disease and mental health to educational achievement and economic status.

Figure 1.
Determinants of Health
(Department of Health,
2013:43)
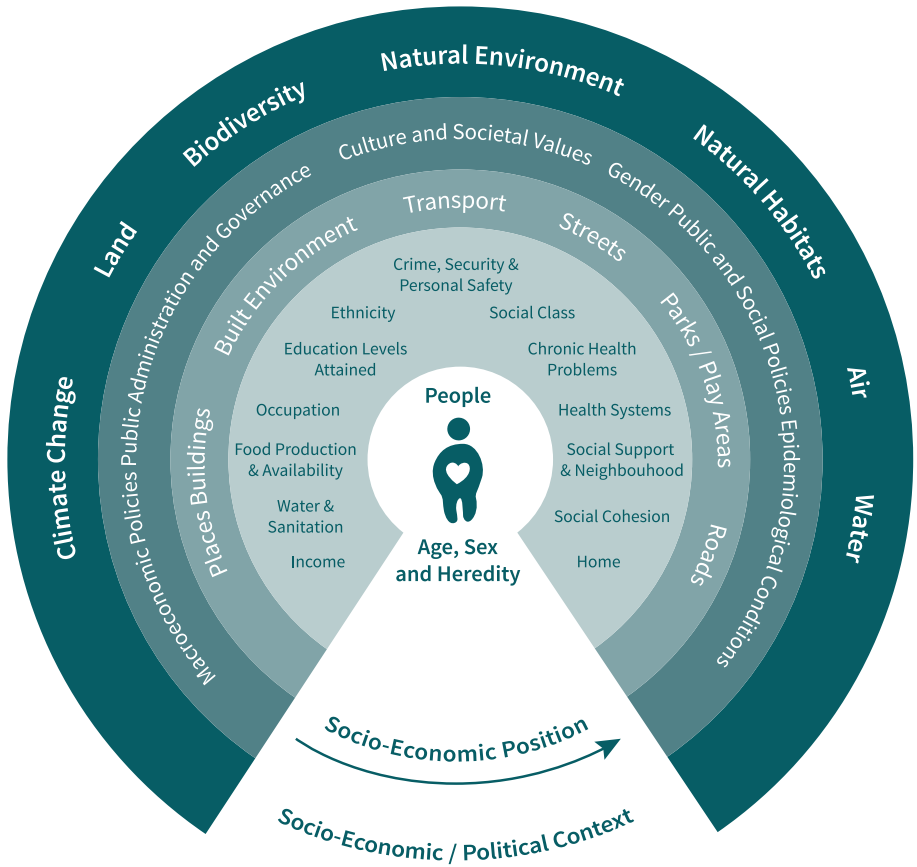
The Marmot Review also advocates giving every child the best start in life through applying a system of 'progressive universalism', i.e. universal services for all with additional support provided for cohorts who require more assistance. The Marmot Review (2010) and Heckman (2008) state that intervening at an early age confers benefits across the life course impacting on health equity, and that this is the most cost effective (albeit, not inexpensive) point of intervention. The potential of the early years to influence outcomes across the life course is why this publication focuses on this important period. However, Geddes et al (2011:25–6) caution with regard to the impact of the broader context as *even the most impressive early child development programmes will struggle to shift the social distribution of human development outcomes unless these enabling social and economic policies are also in place.*

Policy Context

In Northern Ireland and the Republic of Ireland a number of key policies support early intervention to improve health and wellbeing outcomes. In recent years, there has been significant investment and capacity building to implement policy actions, and the results of this are evident in many of the vignettes that follow. For example, through a partnership with The Atlantic Philanthropies (AP), the Republic of Ireland and Northern Ireland have invested in rigorously evaluated early intervention projects in disadvantaged communities. This chapter provides the high-level policy context within which this shift has taken place and continues to evolve.

Northern Ireland

Northern Ireland, as a society emerging from conflict, has been working to alleviate poverty and to improve health and wellbeing for its population. With regards to the early years, the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Education have taken the lead for policy in this area. The Office of the First Minister and Deputy First Minister (OFMDFM) has provided vision. Across the Northern Ireland Executive, commitments to interdepartmental and collaborative working are advancing improved health and wellbeing in the early years.

A ten year strategy for children and young people in Northern Ireland, covering the period 2006 – 2016, launched by OFMDFM, pledged a shared vision. The vision is that all children and young people living in Northern Ireland thrive and look forward with confidence to the future. The intention was to take a 'whole child' approach; providing high quality evidence-based universal services, with targeted interventions to remove or narrow gaps for particular groups of children and young people. A more holistic approach, such as this intention to take a 'whole child' approach, requires cooperative working practices. The *Delivering Social Change* framework was established by the Northern Ireland Executive to address poverty and social exclusion. The intent is for more joined-up working, and chief among its aims is to ensure a sustained reduction in poverty and improvements in children and young people's health. Key areas that have been identified include the need for parenting support and early intervention for children. A *Delivering Social Change* consultation in 2014 was held to ensure an integrated policy framework encompassing policy on children and young people, including child poverty and children's rights. *Delivering Social Change* does not replace existing work, but rather adds to existing government work incorporating existing strategies.

Promotion Programme in 2008. This stimulated DHSSPS in Northern Ireland to review the current children and young people's health promotion programme. In 2010 *Healthy Child, Healthy Future: A Framework for Universal Child Health Promotion Programme in Northern Ireland* was released (DHSSPS, 2010). The intention was that effective implementation would lead to:

- Strong parent-child attachments, positive parenting resulting in better social and emotional wellbeing

- Care that helps keep children healthy and safe

- Healthy eating and increased activity leading to a reduction in obesity

- Prevention of serious and communicable diseases

- Increased rates of initiation and maintenance of breastfeeding

- Readiness for school and increased learning

- Early recognition of growth disorders and risk factors for obesity

- Early detection of and actions to address developmental delay, abnormalities and ill health, and concerns about safety

- Identification of factors that could influence health and wellbeing in families

- Better short and long term outcomes for children who are at risk of social exclusion.

The framework also places emphasis on integrated services, which are outcomes-focused and evidence-based, which build on the 'whole child' approach by looking beyond the child to include the family and environment.

Northern Ireland's public health policy, *Making Life Better: A whole system strategic framework for public health 2013-2023* (DHSSPS, 2014) follows *Investing for Health* and similarly takes a broad perspective.

As with *Delivering Social Change and Healthy Child, Healthy Future* it recognises the inter-relationship between health, disadvantage, inequality, childhood development and education, employment, the social and physical environment, and economic growth. *Making Life Better* (DHSSPS, 2014) has six principal themes, one of which is 'giving every child the best start'. The key long term outcomes under this theme are to ensure:

- Good quality parenting and family support

- Healthy and confident children and young people

- Children and young people skilled for life.

Intentions to coordinate action early in children's lives, consistent with obligations under the *Child Poverty Act 2010*, are supported by a shift in investment towards early intervention services and programmes for children and families. Since 2014, DHSSPS is leading on the implementation of the *Early Intervention Transformation Programme* (EITP) which is funded by various government departments and AP. This Programme aims to shift mainstream services towards evidence-based early intervention with a focus on outcomes. It includes pre-birth to pre-school support, including a health visitor aligned to each Department of Education funded pre-school education setting. A *Making Life Better* progress report notes development under the *Delivering Social Change* programme in:

- Cross-departmental and multisectoral collaboration for work to support positive parenting

- Notable progress made on increasing the number of family support hubs

- Parenting support programmes now serve up to 1,200 families.

In addition, this progress report notes that since 2014 the school age childcare grant scheme has principally served disadvantaged

communities through the 2,300 places available.

The *Programme for Government 2011-2015* committed the Northern Ireland Executive to publish and implement a childcare strategy with key actions to provide integrated and affordable childcare. This childcare strategy forms an important part of the *Delivering Social Change* framework, providing subsidised childcare based on the percentage intake of parents receiving the working tax credit covering the shortfall between income and running costs. The Northern Ireland Executive launched a consultation for *Delivering Social Change through Childcare. A Ten Year Strategy for Affordable and Integrated Childcare 2015-2025* has a dual focus on children's development, through affordable and integrated quality childcare, and on ensuring that childcare costs are not a barrier to parents working outside the home. This forthcoming strategy will follow on from the work of *Bright Start*. In addition, Northern Ireland's paternity and maternity statutory leave entitlements have now been extended to 'shared parental leave' which is a progressive policy encouraging the caring role of the father. Northern Ireland's maternity strategy (DHSSPS, 2012) seeks to give every baby and family the best start in life with a particular focus on families from disadvantaged backgrounds. There have been notable successes in this area; the number of stillbirths in 2014 was at its lowest ever recorded in Northern Ireland, however, the figure is still higher than other European countries and the Republic of Ireland. In addition, the number of live births to teenagers has also recorded a new low at 839 in 2014, down from 1,486 a decade ago (NIRSA, 2015).

The Department of Education in Northern Ireland leads on a range of early years education and learning provisions for children under age of six and their families, investing over £210 million in early years education and learning services. Northern Ireland provides both part-time and full-time funded places for children in statutory nursery schools and nursery units within primary schools, as well as part-time

funded places in the voluntary sector under the Pre-School Education Programme. In 2013, following an extensive consultation process, the Department of Education launched *Learning to Learn: Framework for Early Years Education and Learning*. This framework recognises the importance of the early years' experience for the child, the central role of the parent and the need for a high quality professional experience from services. Again, this framework recognised that children and their families' needs require support across a range of services. Against the backdrop of wider Northern Ireland Executive policies such as *Delivering Social Change*, this framework sought to achieve enhanced collaboration and integration in the area of early years.

In broader policy terms, Northern Ireland has been ahead of the curve in producing a 'children's budget' (Kemp et al, 2015). This was a response to the recommendation of the United Nations Convention on the Rights of the Child (UNCRC). The intention was to map total expenditure on children's services including expenditure on evidence-based programmes and practices, while also assessing the extent to which services are seeking to prevent/intervene. Barriers to this process were honestly conveyed as including Organizational barriers and a lack of communication around funded initiatives. Attempts are already being made to overcome Organizational barriers, however greater information is needed on the breakdown of spending within funded initiatives and more emphasis is needed on the evidence-base for schemes.

Northern Ireland has also produced public health policies to benefit the wider population that may have particularly positive impacts on children. Important developments in public health policy are addressing key behavioural issues; these include tobacco and alcohol policies, nutrition and physical activity strategies.

Northern Ireland has been particularly focused on the 'hidden harm' of alcohol; how alcohol can have a negative impact on children from

the antenatal period throughout childhood with impacts experienced into adulthood. In the area of tobacco control, tobacco product display is banned in all retail outlets and in line with UK-wide regulations standardised packaging for all cigarette and hand-rolled tobacco products has been agreed. Forthcoming legislation will potentially ban smoking in cars with children and e-cigarettes will be more closely regulated. This same legislation contains an amendment for consultation on a sugar-sweetened drinks tax. However, despite the best intentions of policy, positive impacts for children and young people may take many years to become evident.

Fitter Futures for All (DHSSPS, 2012a), Northern Ireland's obesity prevention framework set a 2022 target to reduce obesity by three per cent and overweight and obesity by two per cent. Under the 'Minimum Care Standards' early years settings should be meeting nutrition and physical activity guidelines, and are supported in this through training and guides such as the UK Physical Activity guidelines, the Chief Medical Officer's physical activity guidelines for the early years, and the Department of Education's curricular guidance on physical development and movement (DHSSPS, 2012b). Northern Ireland has been working hard to improve breastfeeding rates. Initiation has doubled over the twenty year period to 2010, however Northern Ireland still has the overall lowest rate of breastfeeding in the UK (DHSSPS, 2013). In addition, the obesity trends are not yet reflecting these policy measures. In 2008/09, 4.9 per cent of Primary One pupils were obese, and in 2013/14 this figure was five per cent (OFMDFM Statistics and Research Branch, 2015). In this case there is insufficient time-lag to see a change, but other influences on obesity levels external to the health sector cannot be discounted.

Despite public health policy development, poverty still impacts negatively on too many children in Northern Ireland. There has been an increase in the number of families presenting as homeless, with

the figure standing at 6,194 in 2014/15, up 324 from the previous year. However, the number of families in temporary accommodation was at its lowest in 2014/15 in nine years of data (OFMDFM Statistics and Research Branch, 2015). The anti-poverty and social inclusion strategy *Lifetime Opportunities* published indicators showing that many targets have not been achieved (OFMDFM Statistics and Research Branch, 2015). Child relative income poverty was supposed to be halved to a rate of 15 per cent but this was not achieved, while child absolute income poverty increased slightly over time from 25 per cent in 2002/03 to 26 per cent in 2013/14. In 2013/14 the number of children living in absolute poverty was twice the target figure. The combined child low income and material deprivation poverty rate has remained stable rather than experiencing a decrease, which was hoped to drop to five per cent or less by 2020/21.

An area of ongoing concern is the data for infant mortality in Northern Ireland. The infant mortality rate for males has increased over the last two years of recorded data, however for females there has been a decrease despite fluctuations between 1997 and 2014. Overall Northern Ireland has the highest infant mortality rate in nine of the last ten years of recorded data compared to the UK, Ireland and the EU.

Northern Ireland has made significant advances in recognising the benefits of improving health and wellbeing in the early years, and the steps required to achieve these improvements. These steps include greater collaborative working, using an evidence-based approach while being transparent in reporting progress. The wider policy space has also witnessed considerable changes that will have positive repercussions for child health, however persistent child poverty remains a significant negative force with the potential to impact on the strides that have been achieved.

Republic of Ireland

In the Republic of Ireland there has been a similar emphasis on the early years, focusing on providing enhanced integrated services that are evidence-based and outcomes focused. The *Programme for Government*, published in 2011, made a number of commitments that impact on the early years. These included holding a referendum on children's rights (held in 2012), establishing the Child and Family Agency, Tusla in 2014, maintaining and improving the universal free pre-school year (extended in Budget 2015), and taking an area-based approach to ending child poverty (the Prevention and Early Intervention Initiative and the Area Based Childhood Programme). In addition, there have been structural developments, for example the establishment of the Department of Children and Youth Affairs (DCYA) separate to the Department of Health in 2011 with a senior ministerial post of Minister for Children and Youth Affairs.

The Republic of Ireland's latest public health policy framework, *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025* (Department of Health, 2013:5) states that its vision is for:

> *A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility.*

Its goals include reducing health inequalities and increasing the proportion of people who are healthy at all stages of life from prenatal through older age. *Healthy Ireland* recognises the importance of early intervention (versus later intervention) in terms of rate of return, reducing inequalities and improving health and wellbeing outcomes.

Against the backdrop of *Healthy Ireland*, in 2014 DCYA published *Better Outcomes, Brighter Futures. The national policy framework for children and young people 2014-2020*. This states the key commitments to children and young people up to 24 years of age. Similar to policies in Northern Ireland, this framework seeks to promote a shift in policy toward earlier intervention; not only through early years education but in health promotion, and through lifting over 70,000 children out of consistent poverty by 2020. Six goals were identified for the period of the policy framework with the intended potential to transform the effectiveness of existing policies, services and resources. These include:

• Supporting parents

• Cross-government and interagency collaboration and coordination

• Ensuring quality in services

• Earlier intervention and prevention with a gradual transfer of resources from crisis to earlier points of intervention

• Listening to and involving children and young people

• Providing support around times of transition in children and young people's lives

The seven year period of *Better Outcomes, Brighter Futures* has a focus on implementation as a central theme, transferring policy into practice and informing practice with evidence of what works. *Better Outcomes, Brighter Futures* (2014:113) will be followed by several key strategic documents that intend to provide greater detail for the programme of work in particular areas. These include a policy on parenting and family support and the Republic of Ireland's first national early years strategy.

In 2015, DCYA produced an annual report for the first year of implementation of *Better Outcomes, Brighter Futures*. This document outlines the robust framework and roadmap for implementing commitments that have been put in place over the course of this first year. This includes an implementation plan detailing specific actions for the 163 commitments made in *Better Outcomes, Brighter Futures*. Government departments and agencies have provided actions for each year 2014, 2015 and 2016 under each commitment, as well as stating intended outcomes for 2017. While this annual report acknowledges the time delays in establishing the infrastructure it also states its intent to advance structures and processes above and beyond those outlined in *Better Outcomes, Brighter Futures*. This ambition is somewhat tempered in comments by the Chair of the Advisory Council who notes that the target to lift over 70,000 children out of consistent poverty by 2020 is a two-thirds reduction on the 2011 level. However the position worsened in 2012 and again in 2013. To meet the original target by 2020, 101,000 children will need to be lifted out of consistent poverty. The Chair comments (DCYA, 2015:7) that

> *efforts to tackle child poverty here and now will ultimately be thwarted unless the longer term root causes are tackled through timely evidence-based programmes and services from the early years onwards.*

In 2013, the Department of Children and Youth Affairs published *Right from the Start: Report of the Expert Advisory Group on the Early Years Strategy* focusing on children up to six years old. This group undertook to develop a report on the key challenges, opportunities and recommendations for the anticipated strategy. The values that underpinned this work were progressive universalism, children's rights, and the need to place young children as a central consideration for wider society.

The group identified five key 'peaks' that need to be scaled to transform the landscape for children. These are to:

- Increase investment in early care and education services

- Extend paid parental leave

- Strengthen child and family support led by 'child and family' public health nurses

- Insist on good governance, accountability and quality in all services

- Enhance and extend quality early childhood care and education services.

To 'scale these peaks' the group identified ten themes with recommendations developed under each of these. In sum, the expert advisory group recommended investing in the early years, proportional to population growth, providing support to families through inclusive, quality, affordable services that are monitored and regulated with outcomes evident through ongoing research and data collection. Some of the recommendations have been achieved in the intervening time, such as free General Practitioner (GP) care to children age six and under, and the extension of the Early Childhood Care and Education (ECCE) scheme. However, the early years strategy is still being formulated.

Alongside recent direct progress for children and parents, the wider policy sphere has also provided the context for improved health and wellbeing for the general population, including young children. Similarly to Northern Ireland, the Republic of Ireland has experienced important developments in public health policies addressing key behavioural issues; for example, tobacco and alcohol policies. However, problems persist, particularly in the area of childhood obesity and the overarching nature of poverty continues to cast a shadow over public health advances.

The Republic of Ireland has been to the forefront of tobacco control policies for several years, and more recently the intention to make Ireland 'tobacco-free' by 2025 has been stated (Department of Health, 2013a). Among other strategies, to deliver on this target the Republic of Ireland intends to introduce plain packaging for tobacco products *(The Public Health (Standardised Packaging of Tobacco) Bill 2014)* and to ban smoking in cars with children (*Protection of Children's Health (Tobacco Smoke in Mechanically Propelled Vehicles) Act 2014)*. The Republic of Ireland also intends to introduce minimum unit pricing to address the problems alcohol misuse has contributed to/caused in Irish society while regulating alcohol advertising near schools and playgrounds. Data from 2010 shows that the percentage of children (age 10-17) who report never smoking has increased from 50.8 per cent in 1998 to 73.5 per cent in 2010 while the same age group stating they had never had an alcoholic drink increased by 14 per cent in the same period (DCYA, 2014a). The Republic of Ireland has also published its first physical activity plan (Department of Health, 2016), and an obesity policy is anticipated in mid-2016. Among 40 WHO countries and regions, children in the Republic of Ireland have one of the highest physical activity levels (DCYA, 2014a). However, the Republic of Ireland, like Northern Ireland, has among the lowest breastfeeding rates in the EU and among the highest rates of overweight and obesity. *Growing Up in Ireland,* the Republic of Ireland's longitudinal study of children, states that one in four three-year olds are overweight or obese, and social class inequalities are evident in these prevalence statistics. While policies exist to address these problems, and will hopefully return significant positive outcomes in the future, the area of perinatal and infant mental health remains relatively ignored. This is also the case internationally, although there is a growing recognition of the importance of this period in terms of infant development (Menton, 2015).

Despite moving in a generally positive direction in the policy sphere, recent years have seen significant threats to child wellbeing and development emerge in the context of economic recession. In 2013, almost 18 per cent of children were considered to be at risk of poverty and 11.7 per cent of children experienced consistent poverty (DCYA, 2014a). In 2011 the triennial assessment of housing needs identified 43,578 households with children in need of social housing (DCYA, 2014a). At the end of September 2015, 1,571 children were homeless; an 81 per cent increase since January 2015. The child-age restriction on the receipt of lone parent's allowance is in force since 2015. It is estimated that the Republic of Ireland has amongst the highest childcare costs in OECD countries (DCYA, 2013).

Conclusion

The Republic of Ireland and Northern Ireland have both identified and responded to the evidence for early intervention in similar ways. Across government policies to institutionalise interdepartmental and interagency collaboration and cooperation provide the frameworks for improving health and wellbeing in the early years across the island. There have been considerable advances in addressing early intervention through policy; with intentions to move towards providing affordable, quality childcare to families and support through progressive universalism. The wider policy-making sphere also provides much optimism for the health and wellbeing of children, however, it is necessary to be mindful that policy gains could be hindered by the impacts of poverty on the population.

Across the island of Ireland, there is an increasing recognition at policy level that early intervention is an effective means to address health inequalities throughout the life course and this is the most cost effective period in which to intervene. There is also recognition that progressive universalism, providing universal services along a

continuum of need, is an effective way to address health inequalities across the population, rather than focusing only on the most disadvantaged. However, it should be noted that intervening in the early years should not be viewed as a one-off opportunity to resolve all potential issues. Rather it is the period within which the most intensive interventions may be most effective with points of re-entry potentially required throughout childhood. The island of Ireland is beginning to emerge from a period of significant economic crisis during which state and family resources have been curtailed, but there is recognition at policy level that investment in the early years could contribute to savings in years to come. IPH and CES welcome these policy commitments and will continue to support full implementation in the coming years.

Key opportunities and challenges to improving health and wellbeing outcomes in the early years across the island of Ireland

Assets and opportunities at policy level

- The public health frameworks across the island intend to advance intersectoral working and to give every child the best start in life.

- Across the island, there is concerted policy activity for action in the early years, with an opportunity to further enhance prevention and early intervention as strategy lifetimes draw to a close and new strategies are designed.

- Across the island, strategies that reference childcare settings have the potential to support working parents and enhance child health and development in the pre-school setting. Legislation, as in the case of paternity/maternity leave, is also supporting working parents.

- Free GP care is now available across the island for young children and child health promotion programmes are addressing screening, health behaviours and development.

- The reduction in teenage pregnancies has the potential to be of benefit to the next generation of children due to the association of young parenting and/or lone parenting with poverty.

- There has been considerable investment in early years and research in recent years. For example, the funding of EITP, and the longitudinal studies – *Growing Up in Ireland* and the *Millennium Cohort Study* – creating a legacy, and providing essential data.

- In the wider public health sphere, there has been significant progress that will positively impact on children, in particular, policy and legislation for tobacco and alcohol regulation.

- Comprehensive policies and actions to address the epidemic of childhood obesity through nutrition and physical activity plans are to be welcomed.

Barriers and threats at the policy level

- Although the direction is positive, it may need to move faster. There remain barriers to intersectoral and interdepartmental working.

- There are gaps in data and research, including the long term effects of interventions that may take many years to emerge.

- Sources of funding are expected to become scarce in the near future. Long term funding by central government may be required to ensure sustainability of the work that has been accomplished to date.

- Gaps remain in addressing the mental health needs of parents, infants and young children.

- Problems with nutrition are evident from an early age. The high levels of overweight and obesity among pre-school children require urgent action.

- Child poverty and deprivation continues to impact on children while the legacy of the recession, for example the housing crises and welfare reforms, has the potential to hinder progress made in other policy areas.

Working with Children

The Benefits of Working with Children for Health Equity Sinéad Hanafin

Background

The purpose of prevention and early intervention is to give the best start in life by providing services and supports to children and their families. Early understandings of childhood represented children as inactive and passive recipients of care but these have long been superseded by more reflective, comprehensive and deeper understandings of childhood. Authors such as Bronfenbrenner (1979), James and Prout (1990), and Bronfenbrenner and Morris (1998) draw attention to the capacity of children to actively shape their own lives as well as being shaped by the people and environments around them. Children are now seen as having agency in their own right and are not viewed simply in terms of the roles assigned to them by adults or in terms of how they are socially constructed within societies. This chapter discusses the difference working with children can make in improving health and wellbeing outcomes, and reducing health inequalities and inequities.

Effective interventions require multidimensional approaches. This is acknowledged in national policy in both Northern Ireland and the Republic of Ireland where policies are underpinned by the Bronfenbrenner model of childhood that identifies strategic approaches at the level of the family, the school environment and the broader neighbourhood context. In the Republic of Ireland, an area-based approach to child poverty is being implemented in cooperation with philanthropic partners. This programme draws upon best international practice and existing services to break the cycle of child poverty where it is most deeply entrenched. Similarly in Northern Ireland the child poverty strategy (Northern Ireland Executive, 2011) identifies many different strands to address the cycle of intergenerational poverty.

Universal and targeted approaches

A philosophy of giving all children an optimal start to ensure more equal outcomes is closely linked with a debate about whether limited and (almost always) scarce resources should be invested in universal or targeted approaches to service provision.

Universal programmes are predicated on an understanding that the early childhood period can be a vulnerable time for all children because of the rapid growth that takes place across the brain, nervous, endocrine and immune systems. This, in addition to children's experiences and the social, cultural and economic environments within which they live, exerts powerful influences on their development (Mistry et al, 2012). It has been argued, therefore, that programmes of intervention, aimed at improving children's outcomes, need to focus on all children rather than on those experiencing disadvantage, particularly socio-economic disadvantage. Examples of universal approaches include the public health nursing services and the free pre-school year in the Early Childhood Care and Education (ECCE) programme. The public health nursing service is available free at the point of delivery for all families with children up to the completion of primary school level. Internationally, there is growing evidence supporting the implementation of home-visiting programmes by nurses and there is extensive literature on this area which demonstrates short, medium and long positive outcomes (Karoly et al, 2005; Kahn and Moore, 2010; Olds et al, 2010; Family Nurse Partnership Unit, 2011; Cowley et al, 2013). This type of programme supports the importance of working in partnership with families and of focusing on the needs of children within families. The free Pre-School Year in the ECCE

programme was introduced in the Republic of Ireland in January 2010, and this was extended in the most recent Budget to two free years.

Targeted approaches are generally developed on the basis of children in economically deprived situations being more likely to have poorer outcomes and because their families are less likely to be able to afford interventions. Numerous poor health outcomes have been found for children living in areas of disadvantage, including low birth weight, lower levels of immunisation, higher levels of obesity, and higher levels of chronic illness. The provision of targeted approaches is evident in the Irish context. Since 2005, the Department of Education has provided for the Delivering Equality of Opportunity in Schools (DEIS) programme in schools in disadvantaged communities across the Republic of Ireland. In its most intensive form for example, the School Support Programme (SSP), participants are entitled to a range of supports including access to additional funding, literacy and numeracy, other programmes such as the Home/School/Community Liaison service and the School Completion Programme. Almost all these interventions are directly focused on improving services for children themselves, while the home-school liaison service provides a direct link between what happens in the school environment and in the home. Most interventions to improve the course of children's lives are mediated through family, particularly parents and even when these interventions take place in school settings, the primary role of parents is acknowledged and recognised. A recent evaluation of the SSP in primary school settings (Weir and Denner, 2013) shows encouraging outcomes including significant improvements in both reading and mathematics test scores, particularly in schools that had high levels of disadvantage, and a reduction in the percentage of pupils scoring at or below the tenth percentile in both. The findings also showed a reduction in school absenteeism. The authors highlight the absence of a control group as a limitation of these findings.

Centre and school-based programmes in areas of disadvantage provide the greatest opportunities to work directly with children, to strengthen them as individuals and their outcomes. Early education, according to Valentine et al (2009:196) notes that historically, early education and care has had at least three elements and these are:

- An educative element, focusing on the education of pre-school age children and on ensuring their readiness for school.

- A labour market element, improving the capacity of mothers to participate in the paid workforce.

- A welfare or compensatory element, ameliorating the effects of poverty for young children and their families.

The evidence for this type of intervention follows the identification of successful outcomes arising from studies such as High Scope/Perry Pre-school Programme (Reynolds et al, 2011); the Effective Provision of Pre-school Education (EPPE) and the Head Start programmes (Lee et al, 2014). Key benefits identified from these programmes, particularly in terms of better cognitive outcomes, included higher reading and maths scores (Lee et al, 2014), in addition to economic benefits with reports of an 18 per cent annual return on dollars invested (Reynolds et al, 2011; Heckman, 2007). The situation, in respect of social and behavioural benefits, appears to be more mixed with Sammons et al (2004) finding evidence of poorer outcomes on these domains for those who had little or no pre-school attendance, while Lee et al (2014) report evidence of higher levels of conduct problems than those in parental care.

Baker (2011) cautions about the extent to which these programmes, which were originally targeted, implemented and evaluated for children in at risk situations, are transferable to all children. Baker suggests that better understanding of the developmental trajectories of more advantaged children is required. Valentine et al (2009), on the other hand, report that their experience in the Australian situation suggests

specific resources are needed to ensure enhanced services to benefit vulnerable children are provided in early childhood care services. The findings raise questions about the conditions required to make these programmes successful, desirable and sustainable, and studies have shown that in order to have positive and beneficial effects, care and education provided must be of a high quality.

Much consideration has been given to health inequalities and their relationship with income and there are particular concerns about intergenerational poverty and its consequences for children's trajectories (Hertzman and Bertrand, 2007). Findings from a number of reports show high levels of child poverty in Ireland and also across the European Union (Watson et al, 2012), for example, an analysis of the 2014 EU-SILC survey data by the Central Statistics Office reported that households with one adult and one or more children under age 18 had a deprivation rate of 58.7 per cent – in 2012 the Central Statistics Office reported that 27 per cent of all children aged between two and 17 years are affected by some form of deprivation. The authors note, however, that many parents appear to divert resources or, are otherwise able to protect their children from experiencing deprivation. The findings also support those from other studies, which show that mother's employment and maternal educational attainment are both important factors in protecting children from child-specific deprivation (Williams et al, 2013). Melhuish (2010), however, notes that as inequality increases, parents' capacity to invest in their children becomes more unequal. Consequently, he suggests that as those who are well off and can afford to purchase better services for their children do so, poorer children move even further away and the inequity becomes greater. This difference is most pronounced for those at the top and bottom of the social structure.

Some concerns have been raised about targeting interventions solely on the basis of economic disadvantage. There are numerous other risk factors for poor child health outcomes such as neglect, parental mental illness, and migrant status. Hertzman and Bertrand (2007), reporting on the implementation of the Early Development Instrument (EDI) in British Columbia, noted that while vulnerabilities in children's developmental outcomes at school entry are more prevalent in poorer communities, they are present in all communities. As a consequence, Hertzman and Bertrand (2007) propose a decoupling of child development outcomes from family socioeconomic status as a mechanism for breaking the cycle of intergenerational poverty. Such an approach would be in keeping with a focus on children's outcomes rather than on family context and would provide benefits for children in terms of health equity. Others, however, argue that the use of public money, in the form of subsidies for all, benefits already privileged groups and this results in widening inequity. One mechanism for dealing with this is through 'Progressive Universalism'. The Report of the Expert Advisory Group on the Early Years Strategy sees progressive universalism as a mechanism for dealing with inequities noting that this approach extends help to all and extra help to those who need it most (DCYA, 2013:14).

Interventions

Two topics will now be explored in more depth, namely, obesity and play. These relate to the interventions targeting these issues as discussed in greater detail in this section. These interventions provide insight into the potential of intervening early in children's lives. Many of the chronic illnesses seen in later life are strongly influenced by behaviour and lifestyle in childhood.

Early years settings can provide a platform for intervening in children's lives to meet public health priorities, and a platform for the delivery of interventions to narrow inequities.

While there are a number of challenges arising at this time in terms of children's health, the issue of obesity and overweight is considered one of the most challenging.

Obesity

Obesity, defined as a condition described as *a pathologically increased fatty deposition in the human body, to such a degree that it constitutes a risk to human health* (Luciano et al, 2003:453) has been identified as a particular concern in children. The *Growing Up in Ireland* study found that about one in four nine year old children were overweight (19 per cent) or obese (seven per cent) (Williams et al, 2010) and similar proportions were identified in three year old children (Williams et al, 2013). Children from less advantaged backgrounds were more likely to be classified as overweight and obese with findings showing 22 per cent of children from semi-skilled/unskilled backgrounds being overweight compared with 18 per cent of children from professional/managerial backgrounds. Ireland is not unique in this regard and findings from many developed countries clearly show similar levels of children who are obese and overweight across the social class gradient. Obesity in childhood has implications for children's wellbeing, including their capacity to take part in physical activity, their emotional wellbeing and the development of self-esteem. There are also significant concerns in terms of their health, since being overweight in childhood predisposes children to the development of cardiovascular disease and hypertension, diabetes mellitus, orthopaedic and psychological problems in adulthood (Koukourikos et al, 2013).

There are also considerable economic costs associated with obesity (Hollingworth et al, 2012).

Childhood obesity is connected with unhealthy eating habits and reduced physical activity. Since children spend a large part of their time at school or in early childhood and care settings, there is agreement that these settings should encourage healthy eating habits, as well as encouraging physical activity. Challenges have been noted in adopting healthy eating practices in early years settings, with Reynolds et al (2013) identifying the following issues:

- Perceived and real higher costs of healthier food.

- Lack of knowledge and need for training and technical assistance on developing menus with variety, modifying recipes to meet better standards, and leading structured physical activity.

- Unhealthy food and beverages brought with children from home.

- Parent resistance and lack of engagement, particularly if changes are perceived to be driven by 'cost-cutting' considerations.

- Limited outdoor play space.

- Limited indoor play space, especially in areas where inclement weather is common.

- Resource scarcity.

- Engaging early childcare providers and parents, particularly those who are overweight/obese, to consistently model healthy behaviours.

- Fostering better collaboration between providers and parents.

Some interventions have focused on the provision of nutritious food as a mechanism for improving other outcomes of children's lives. The main objective of a Cochrane Review by Kristjansson et al (2007) was to determine the effectiveness of school feeding programmes on the improvement of physical and psychosocial health for disadvantaged school pupils. Their findings suggest that attendance at school, cognition, weight and height all improved, suggesting that the school can be an important point of intervention to improve healthy eating.

A recent review of the evidence on obesity interventions with children synthesised the findings from five trials published between 1995 and 2009 and which had included a total of 3,904 school children from different countries (Mahmood et al, 2013). The authors reported that the success and failure of interventions was dependent on the following factors:

- Duration of intervention.

- Quality of education or diet programmes.

- Adherence rate of schoolchildren to those interventions.

A 2011 Cochrane Review (Waters et al, 2011) of the literature on obesity found strong evidence to support beneficial effects of childhood obesity prevention programmes on body mass index, particularly for programmes targeting children aged six to 12 years. While many of the programmes were based on small numbers, and the authors caution about their generalisability, they nevertheless highlight the following areas which were identified as effective:

- A school curriculum that includes healthy eating, physical activity and body image.

- Increased sessions for physical activity and the development of fundamental movement skills throughout the school week.

- Improvements in nutritional quality of the food supply in schools.

- Environments and cultural practices that support children eating healthier foods and being active throughout each day.

- Support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development, capacity-building activities).

- Parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time on screen based activities.

Play

In parallel with increasing concerns about obesity, issues have been raised about low levels of engagement in physical activity by children and in that regard, play provides an important mechanism through which children can spontaneously engage in movement to improve their health and wellbeing. The Republic of Ireland's National Children's Office (2004), the Office of the Minister for Children and Department of Health and Children (2007), the Department of Health and the Department of Transport, Tourism and Sport (2016) as well as Northern Ireland's Office of the First Minister and Deputy First Minister (2010) have all acknowledged the importance of a strategic approach to ensuring children and young people are strategically supported to engage in play and recreation activities.

A position paper published by PlayBoard in Northern Ireland highlights the following impacts from play:

• Play assists in a child's intellectual development, as it is a learning process in itself.

• Play offers a holistic approach to learning, incorporating social, emotional, creative and physical development.

• Play provides the child with opportunities to freely express himself/herself and prepares the child for later life.

• Creative play provides children with opportunities to express themselves, develop creatively, experiment and learn how and why things work.

• By doing, risking and failing in play, children learn how to deal with their environment and to understand their abilities and limitations.

• The focus of play is about the child being at the centre of the process. Helping children make, establish, maintain and dissolve relationships are fundamental to emotional development.

• Play also has a therapeutic role in helping children to work through negative experiences, express themselves, build relationships and establish trust with peers and adults.

Support is growing for play-based interventions; strategies such as modelling, prompting, add-ons and reinforcement have all been reported to assist in the enhancement of children's play skills (Dempsey et al, 2013).

The vignettes presented later provide important insights into interventions that can improve health and wellbeing of children.

Future directions for research

The *National Strategy for Research and Data on Children's Lives 2011-2016* (DCYA, 2011) identified many gaps in our knowledge about children's lives across a broad range of areas. Children's health outcomes were a key focus, and topics for further investigation include:

- Reporting on health status, health promotion initiatives and health surveillance mechanisms for children and young people.

- Mental and emotional health status of children and young people, and the impact on their lives.

- Children's behaviours around nutrition and physical activity, the impact on their physical growth and development, and the services and structures to support them.

- Sexual health and related behaviours.

There is a clear overlap between the focus for the vignettes that follow from this chapter and these priorities. In the context of evaluations, there are many variables unaccounted for and future research and programme development may need to consider the following research areas in greater detail:

- What are the long-term effects of large-scale programmes following scale-up and what methods can to be developed to accurately predict these effects at an early stage in the development?

- How can benefits accrue for all participants that take part in interventions, irrespective of their individual or family characteristics?

- What are the pathways to effectiveness, and how can the individual impacts be stripped out so that the most parsimonious, but effective model, can be implemented?

Conclusion

In summary, there are a number of considerations to take into account when intervening for health equity to improve children's lives. First, almost all interventions with children are mediated through adults and this is particularly the case with very young children. The early childhood care and education setting provides a platform through which interventions can take place, but in general, the literature in this area does not differentiate between the specific elements that are based within the early years care and education setting and those that take place in the home setting. Indeed, as with the DEIS programme, it is clear that most programmes with children, even at school-going age, incorporate an element of parental involvement.

> **Current policies and small scale interventions and pilot programmes often focus on the most economically deprived children, however there are many factors influencing children's outcomes beyond poverty, albeit frequently interacting with poverty.**

Focussing only on children from lower socio-economic backgrounds may serve to ignore the health and wellbeing issues for children on the socio-economic continuum. However, providing children who are from more privileged backgrounds with equal access to beneficial interventions may serve to widen the inequity gaps as well as prove costly. Therefore, the policy of progressive universalism is frequently cited as a way to 'work with children' across the social gradient to the benefit of all.

Key public health concerns are amenable to intervention in early childhood and this is particularly the case with obesity and social, emotional and behavioural difficulties. These problems have a lifelong impact and it is both economically and socially in the best interests of society to intervene at an early stage. While working directly with children has been shown to be important, and there is wide-ranging literature on the importance of listening to children's voices in any programme of support, it is equally clear that interventions around children need to take account of the broader socio-ecological context within which they live. Interventions at the level of the family, school and neighbourhood environment are all necessary to support good outcomes in children's lives and single interventions, focusing only on the child, are uncommon. Indeed, it is well recognised in theory and practice that children live within a socio-ecological context where there are multiple influences and multiple stakeholders. Of central importance within this is the role played by the family and many programmes that aim to improve children's lives across multiple domains involve working with parents, both getting them involved and keeping them involved (Centre for Effective Services, 2013).

Irrespective of whether programmes are universal or targeted, or whether they are provided directly to children or mediated through adults, it is clear that establishing appropriate supports and interventions is critical to achieving good outcomes (Barlow et al, 2010). The life course perspective, which focuses on key developmental periods that can shift a person's trajectory over the life course, can play an important role in highlighting areas where supports can, and should be put in place so that children are well positioned for long-term success and health.

Vignettes — Working with Children
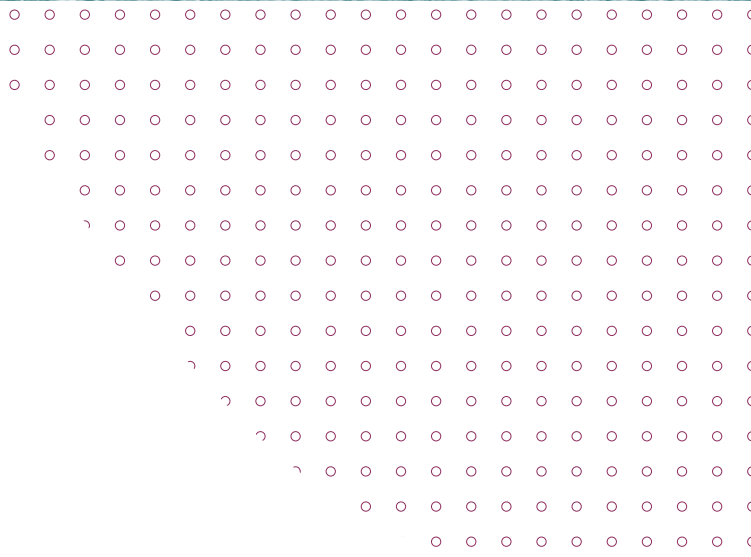
Introduction

Evidence suggests that interventions at the level of the family, school and neighbourhood environment are all necessary to support positive outcomes, as children live within a socio-ecological context where there are multiple influences and multiple stakeholders. The following vignettes illustrate approaches to improving health outcomes in schools and community settings. They target the development of healthy behaviours and social and emotional competence in children, which have been linked to improvements in a variety of health outcomes including obesity, cardiovascular disease and mental health difficulties. They illustrate some of the issues involved and the lessons that can be learned for practice with children in different contexts.

a. Food Dudes

Michael Neary, *Bord Bia*

Background to the Food Dudes Programme

The School of Psychology at Bangor University in Wales developed *The Food Dudes Programme* (FDP) to change the eating habits of children for the better. The programme focuses on three factors: taste exposure, modelling and rewards. Children watch peer models on film eating and enjoying fruit and vegetables. These peer models are the Food Dudes who are slightly older than the children and therefore tend to be admired. Food Dudes are in constant battle with General Junk and his evil associates who want to rid the world of healthy food, but in each encounter the Food Dudes triumph. The children see an episode of the adventures of the Food Dudes and then receive fruit and vegetables to taste (in the initial days) and eat (later in the programme). They are rewarded for tasting/eating fruit and vegetables and this influences them to do so repeatedly and to develop a liking for them. In a short time they come to see

themselves as part of the culture that strongly supports the eating of fruit and vegetables. The combination of these powerful biological and psychological factors maintains the behaviour change over time.

Levels of obesity are rapidly increasing globally particularly in children and younger age groups. Unhealthy and unbalanced diets, and a lack of exercise are key factors contributing to this epidemic. Fresh produce in the form of fruits and vegetables are considered important elements of a healthy and balanced diet. However, the daily intake worldwide is still below the recommended 400 grams of fruit and vegetables per day according to the WHO. Ireland is no different. The National Adult Nutrition Survey (Walton, 2011), reported that consumption nationally was lower than half the recommended level. The *Healthy Ireland* survey reports that 22 per cent of people in Ireland do not eat fruit and vegetables every day (Ipsos MRBI, 2015). Fruit and vegetables are essential for health and contain high levels of vitamins, minerals, fibre and antioxidants which are vital for normal growth and development. A diet high in fruit and vegetables can protect against illness and help reduce the risk of obesity.

The above factors influenced Ireland's decision to implement FDP. The FDP is divided into Phase One *Intervention* and Phase Two *Maintenance*. Prior to the commencement of Phase One, information was sent to all parents explaining the programme and inviting their cooperation.

Phase One — Intervention

Phase One introduces the children to the programme and encourages them to initially taste and then eat fruit and vegetables. This phase takes place in the school and lasts for 16 days. During this period each child receives a portion of fruit and a portion of prepared raw vegetables per day e.g. apple and baton carrots; banana and sliced pepper. Over the course of 16 days each child receives four different

fruits and four different vegetables repeated in a four day cycle – for example apple and baton carrots on days one, five, nine and 13; banana and pepper on days two, six, 10 and 14. Thus the opportunity for repeated tasting of each food is provided and the child develops a liking for them.

Each day during Phase One the teacher encourages the children to taste/eat the fruit and vegetables by showing an episode from the adventures of the Food Dudes or reading letters from them before the fruit and vegetables for that day are distributed for consumption. The children who taste/eat their daily allocation of fruit and vegetables are given a reward. The rewards are small educational/fun items such as colouring pencils, pedometers, water bottles, rulers and they all carry the Food Dudes logo.

During Phase One a home pack is sent to the parents to encourage eating of fruit and vegetables at home and to prepare for Phase Two. Two small containers are also included, to facilitate the children bringing fruit and vegetables to school.

Phase Two — Maintenance

On day 17 Phase Two commences and the focus changes to the home. The children are encouraged to bring a portion of fruit and a portion of vegetables to school each day. On a wall chart in the classroom the teacher records daily consumption for each individual child. The rewards are phased out and replaced by certificates of achievement which each child receives when particular milestones on the wall chart are reached. Each child can reach the milestones at his/her own pace. Ongoing monitoring and encouragement by teachers in the Maintenance Phase is vital in ensuring that the improved consumption patterns established in Phase One are maintained.

The national roll-out of the Food Dudes programme commenced in 2007 and by the end of 2014 over 3,100 national schools and in excess of 470,000 pupils had participated.

A boost programme is now underway for children between ages eight and twelve alongside the full FDP for junior classes. The FDP is funded by the Department of Agriculture, Food and the Marine and managed by Bord Bia. Since 2009, fifty per cent of the cost of the fruit and vegetable supplied to the schools has been funded under the EU School Fruit and Vegetable Scheme.

A controlled evaluation of the programme showed that the provision and actual consumption of fruit and vegetables more than doubled in a school that implemented FDP when compared with a control school that did not implement the programme

(Horne et al, 2009). A further unpublished evaluation by University College Dublin (UCD) for the Department of Agriculture, Food and the Marine has shown the long lasting effect of the programme with close to an additional two portions of fruit and vegetables being consumed 1.5 and 2.5 years after the programme was implemented. A survey of parents whose children had taken part in the FDP reported that their children were eating more fruit and vegetables at home (94 per cent), and 88 per cent of parents reported that they themselves were consuming more fruit and vegetables on a daily basis as a result of their child participating in the programme. The evaluation by UCD in 2010 reported that children who had participated in the programme were consuming on average an additional 4.5 portions of fruit and vegetables per day. Studies and experimental evaluations of the

programme in other countries have reported similar positive outcomes (see Horne et al, 2004, UK; Wengreen et al, 2013, USA).

Key lessons from *Food Dudes*

- Introducing children to fruit and vegetables at an early age in a fun way can encourage positive eating behaviours beyond exposure to the intervention.

- Including independent evaluations of the programme from inception has played an important role in providing a strong evidence-base for expansion of the FDP.

- FDP meets priorities for: the Department of Agriculture, Food and the Marine, the Department of Health, the Department of Children and Youth Affairs, and the Department of Education and Skills.

- Making the links between FDP and other areas of the curriculum helped to embed the programme in current teaching without disruption, and in fact, created opportunities for teachers.

- Linking with a source of EU funding has helped ensure the sustainability of FDP, while overall the programme does not require a particularly large investment.

- Relationships between staff across different sectors were very important in the early stages of FDP when trying to embed the programme.

b. Role of Play in Improving Health and Wellbeing

Laura McQuade and Alan Herron, *PlayBoard Northern Ireland*

PlayBoard Northern Ireland '*Can Play*' Programme

PlayBoard's *Can Play* Programme uses a playwork approach to promote free play in shared recreational spaces and promote positive intercommunity use of these spaces. The programme was delivered across the Carrickfergus, Antrim and Newtownabbey council areas between September 2012 and September 2013 and was focused on a broad age range from babies and toddlers up to teenagers. Outdoor play sessions took place in local council parks and open spaces in afternoons and evenings. These sessions were about encouraging and enabling children and young people to play as they want to, whether it's den building, outdoor arts and crafts or traditional games. Funding was obtained from the CAN Peace III Partnership, to promote the concept of positive play by supporting children, young people and local communities to 'reclaim' community spaces for the purpose of outdoor play.

As stated in the UNCRC (2013:58f),

> *In order to achieve the necessary child-friendly urban and rural environments, consideration should be given to...availability of inclusive parks, community centres, sports and playgrounds [and the] ...creation of a safe living environment for free play.*

Northern Ireland's often turbulent political history has diluted and reduced access to freely chosen play opportunities. There is a long standing concern about the impact of the so called 'troubles', as years of sustained conflict led to children and young people being restricted in how, where and with whom they played. For example, the ability of children from different backgrounds to play together in shared spaces has often been curtailed. This has resulted in play deprivation

whereby children are unable to access experiences that are regarded as developmentally essential. At the same time, the demographics of the population are changing, with a growing migrant and ethnic population and an influx of children with no spoken English or with English as their second language. All of these children (and families) need practical support mechanisms to help them adapt to living in society, and play is a fundamental tool in this process.

> **The benefits of unstructured outdoor play and in particular free-play to cognitive, physical, social and emotional wellbeing are widely acknowledged. Play also presents an ideal opportunity for parents to engage fully with their children.**

From the outset *Can Play* aimed to demonstrate how the lives of children and young people could be enhanced by providing them with the opportunity on a weekly basis to choose how they wanted to play. Observational and interactive evaluation approaches were used to engage with children and young people to get a feel for the impact of the programme. There was also an emphasis on reflective practice and learning built into delivery. Evaluation and reflection shows that the programme has led to children and young people engaging in play activities involving physical and mental challenge to stimulate use of the imagination. There was an increased level of participation from teenagers who initially tended to stay on the fringes. Children and young people made new friends and developed social relationships with those from the wider community, and return attendees welcomed newcomers into the play environment, providing support and encouragement.

One of the challenges of the programme at the start was low levels of engagement due to inclement weather. This however changed once the children experienced the variety of outdoor play opportunities

available. Throughout the cold wintry months of 2012/2013 more and more children braved the weather to play. Over time engagement levels grew, and during the summer of 2013 there were upwards of 40 participants at many of the sessions. Another early challenge was the perception of children and young people by some park staff and their understanding of play which often revolved around a fixed notion of play using play equipment only. As a result the project was initially challenging for some park staff as they struggled with the concept of free, child-led play and the sometimes 'chaotic' and 'messy' looking nature of free play. At a practical level this included amongst other things, adult unease at the 'mess' caused by children using chalk on pavements, building dens with cardboard boxes and natural materials on green space etc. Resolving this matter highlighted the importance of discussions and partnership working with PlayBoard staff explaining the free-play child-led approach and assuring park staff of an appropriate clean-up procedure. Over time park staff came to see the benefits of free, child-led play and the opportunities it presents for children, young people and the wider community.

Although there was no widespread media promotional strategy, word of mouth was sufficient to ensure good buy-in from parents, children and communities, who were supportive because they felt it was an effective way of reclaiming unused space in the area. The local schools championed the project by sending home flyers. Another enabling factor for the project was that the funders had a real commitment to its success.

The project demonstrates how community-based models of play provision can overcome some of the barriers faced by children and young people in their quest to realise their right to play within their communities. As the programme has developed, there has been an increase in attendance from both minority ethnic communities and from children with disabilities. The programme is low cost and demonstrates that value can be effectively added to the play

experience. '*Can Play*' is a step towards achieving a play-friendly society that offers a wide range of play and recreational opportunities to improve the lives of our children and young people.

Key lessons from *Can Play*

- Children had the opportunity to play during the winter months when outdoor play opportunities tend to be restricted. The programme opened up access to the parks for children and young people at a time when opportunities are limited due to dark nights and poor weather.

- Children initiated play activities providing physical and mental challenges, stimulating use of the imagination, and developed team working skills, for example through den building or rope bridge construction.

- Children had an opportunity to make new friends and to develop social relationships with those from the wider community and those returning welcomed newcomers into the play environment, providing support and encouragement.

- After a hesitant start, the children and young people soon began to embrace the natural environment even during inclement weather conditions and dark evenings.

- The presence of Play Development Officers provided reassurance for parents/carers, helped develop confidence and helped to promote the parks as a shared, safe space.

- Parents/carers had opportunities to engage with others from both their own community and other communities, with whom they would not ordinarily have had contact.

- The programme supported intergenerational relationships with parents/carers and grandparents becoming involved in play activities.

Working with Parents

Empowering parents as a means to promote health equity. What do we know? Sinéad McGilloway

Introduction

There are many factors that affect the overall health and wellbeing of children but it is now widely acknowledged that parenting and parenting practices in particular play a pivotal role in child health, development and behaviour. For example, we know from numerous studies that early exposure to harsh or inadequate parenting can impact significantly on a child's behaviour, their social and emotional competence, and their outcomes in later life (e.g. Collins et al, 2000; Hogan et al, 2002; Maccoby, 2002).

Although children from disadvantaged backgrounds are exposed to multiple risk factors, research has demonstrated the potential of positive parenting irrespective of socioeconomic status. Thus, parenting can determine the quality of a child's upbringing whilst positive parenting can also be an important protective factor in countering some of the negative outcomes associated with disadvantage. The important role of parents has been acknowledged in the *United Nations Convention on the Rights of the Child* which states that it is the right of the child to be supported by their parents as they grow and develop, and in turn, therefore, it is the responsibility of parents to ensure that this is the case.

Inadequate parenting and poor parent-child interactions at an early age are associated with an increased risk of negative or insecure attachment and a low level of social adjustment. It would seem that it is what parents do with their children rather than who they are that appears to be crucial. The parent-child relationship is more important for children's development than family income or structure. Factors that are known to be important to the parent-child relationship include the parent's personality, mental health status, their values, the nature and extent of social support that is available to them, cultural influences, as well as the characteristics of the child (Sneddon and Owens, 2012).

This chapter outlines the evidence for the importance of parenting in children's lives and identifies interventions and intervention characteristics that demonstrate positive outcomes for both children and the parents themselves and which, in so doing, help to mediate factors related to health equity.

Why parenting interventions and what is the evidence?

The challenges and complexities of parenting, in all its forms, as well as its potentially positive impact on children, have been increasingly recognised. As a result, parenting programmes and other forms of parent support have grown in popularity, both on the island of Ireland and elsewhere, as a means of assisting and empowering parents to positively influence their children's lives.

> **Importantly, parenting interventions can be used with families at varying levels of need and may be provided on a continuum from universal service provision to more intensive and targeted forms of support for more vulnerable children and their families.**

This notion of a continuum of services is encapsulated well in a framework developed by Hardiker et al (1991) which has been adopted and adapted by governments on the island of Ireland to guide and inform service planning and provision in all its forms including where appropriate, parent training support (see Figure 2.1). For example, stand-alone evidence-based parent training interventions are already being delivered by social care staff in a number of locations in Ireland.

Figure 2.1. Framework
of Intervention Need
(Hardiker et al, 1991)

Level 4

Intensive and Longterm Support and
Protection for Children & Families

Level 3

Therapeutic and Support Services for Children
& Families with Severe Difficulties

Level 2

Support and Therapeutic Intervention for
Chirldren & Families in Need

Level 1

Universal Preventative & Social
Development Services

Level of Intervention

Population Size
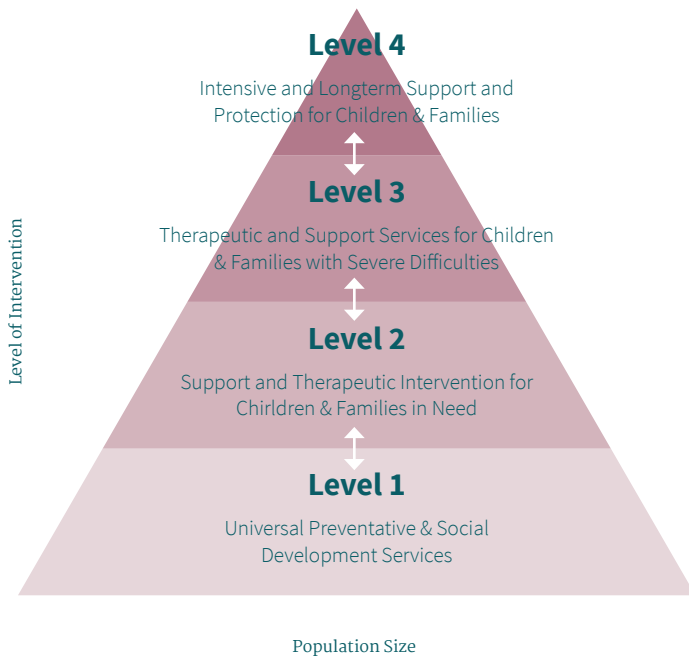
There are many forms of parent support and according to a recent parenting support strategy, parenting support is

both a style of work and a set of activities that provides information, advice and assistance to parents and carers in relation to the upbringing of their children, in order to maximise their child's potential (Child and Family Agency, 2013:1).

However, there is no 'one size fits all' approach to supporting parents during the various stages of their child's development and evidence suggests that the most successful method for supporting parents is to provide a tailored approach that takes into account factors such as the location and mode of delivery (Sneddon and Owens, 2012). Parent training interventions, are increasingly being incorporated into community-based health and education services throughout the world in order to promote positive family and community adjustment and to foster warm, healthy, supportive and nurturing environments for children (Cotter, 2013). Importantly, positive parenting can also mediate the effects of risk factors such as social disadvantage (Paulussen–Hoogeboom et al, 2008) and in that sense, they are also important in addressing issues around health equity.

Furthermore, poor quality parenting in early childhood – including harsh, neglectful or inconsistent discipline, inadequate supervision and low levels of parental warmth and involvement – is one of the most important precursors of early onset conduct problems, also known as social, emotional and behavioural difficulties (SEBD) (Shaw and Winslow, 1997). These include troublesome and disruptive externalising and aggressive behaviours, oppositional/defiant behaviour or non-compliance, and/or hyperactive-inattentive behaviours, all of which may be associated with low self-esteem, emotional volatility, poor social skills and peer rejection (Collishaw et al, 2004). The risk factors identified by the National Institute for Health and Care Excellence (NICE) for conduct and oppositional defiant disorders in children

aged between three and twelve years, are also associated with social exclusion and health inequality (Puckering, 2009). These kinds of problems are of particular interest to researchers, policy makers and practitioners alike because if left untreated, they can present significant short, medium, and longer-term challenges for parents, professionals and for society as a whole. Furthermore, it is predicted that by 2020, behavioural and mental health disorders are likely to surpass physical illness as a major cause of disability (Rosenberg, 2012).

Typically, SEBD occurs in approximately five to ten per cent of children aged between five and fifteen years (Meltzer et al, 2000), although recent work undertaken in disadvantaged areas in Ireland has shown prevalence rates of 25 per cent to 40 per cent (McCoy and Banks, 2012; Hyland et al, 2014). Bywater et al (2009) state that 10 per cent of children aged five to 15 years in the UK have a mental health disorder, half of which are clinically significant, while 20 per cent of children from disadvantaged areas have a conduct disorder. Bayer et al (2011) cite a WHO prediction that by 2030, internalising problems will be second only to HIV/AIDS in the international burden of disease, with an estimate of prevalence of one in seven school-age children, thereby impacting negatively on peer relations, school engagement, mental health, adult relationships and employment.

Childhood conduct problems often persist into adolescence and adulthood and numerous studies have highlighted links between early onset problem behaviour and negative outcomes in adulthood including: early school leaving and poor educational outcomes, mental health problems, social difficulties, substance abuse, low occupational status and an increased reliance on social care systems (Scott et al, 2001).

A wide and diverse range of parenting interventions and supports have been developed, piloted, implemented and evaluated in recent years on the island of Ireland and elsewhere. The vast majority of these have

focused on, or have incorporated, group-based parenting programmes. These typically involve an interactive and collaborative learning format in which programme facilitators build capacity in key behavioural principles and parenting skills such as play, praise, rewards, and discipline. Parents and caregivers then practise the skills that they have learned. Key elements of effective programmes (Webster–Stratton and Hammond, 1997; Mihalic and Irwin, 2003; Kling et al, 2010) tend to include:

- Learning how and when to use positive parenting skills

- Observation, modelling, behaviour rehearsal, discussion, homework assignments, using peer support, reframing unhelpful cognitive perceptions about a child's behaviour and child management in general

- Tackling barriers to attendance.

Group-based parenting programmes are often delivered in settings in the community (including schools). This is important in terms of lending them credibility and reducing potential stigma. Home-visiting programmes tend to be more labour-intensive, but are obviously more private and can be particularly useful for those parents who are least likely to take part in group programmes and who may be in greatest need. However, it should be noted that the attrition rate from all forms of parenting programmes can be high especially among more vulnerable parents who have other issues in their lives. For example, McGilloway et al (2012; 2012a) reported that 31 per cent of participants in their randomised controlled trial (RCT)-based study of a parenting programme, had attended three or fewer sessions, albeit due mainly to practical or circumstantial reasons (e.g. illness, change in employment status). This potentially high level of attrition should be borne in mind when planning and delivering such services.

Practitioners and service providers are increasingly recognising that additional structured supports for parents may be required and preferably from the earliest stage in a child's life. For this reason, an international research team led by Maynooth University (Mental Health and Social Research Unit) are working closely with Public Health Nurses, Child Welfare Teams, social care and voluntary services in Dublin and elsewhere, to help develop and evaluate new parent-focused wraparound interventions to meet the needs of children (aged 0-10 years) and their families. This work includes a focus on mothers and babies as well as children at risk of maltreatment or abuse who are deemed to have needs at Hardiker levels two and three. This research (ENRICH, EvaluatioN of wRaparound in Ireland for CHildren and families, www.enrichireland.com) is being undertaken as part of a large five-year research programme funded by the Health Research Board in Ireland.

Some studies of parenting programmes have shown positive outcomes with both clinical and non- or sub-clinical preventive populations. For example, the work of Larsson et al (2008) in Norway showed that children (aged four to eight years) with clinically significant conduct problems who were attending a psychiatric outpatient clinic, improved dramatically after their parents had taken part in *Incredible Years* parent training, to the extent that two-thirds of treated children were functioning within the normal range. Likewise, research undertaken in the Republic of Ireland in regular service settings has shown positive effects both in the short and longer term, with predominantly disadvantaged parents who took part in the *Incredible Years* parenting programme and whose children presented with clinically significant emotional and behavioural problems (McGilloway et al (2012; 2012a) (see below). Notably, another series of studies conducted in the Republic of Ireland by Fives et al (2014) included a large-scale population study (n≈3000) based on the *Triple P-Positive*

Parenting Program (TPS) (e.g. Sanders, 2008) and undertaken in two 'intervention' and two 'non-intervention' matched communities during an approximate two-year (pre-post) period. The results showed small, but statistically significant population effects (or positive changes over time) in overall emotional and behavioural problems and in emotional symptoms, amongst children (aged three to seven years) living in the TPS versus the matched communities. There was also a significant reduction in the TPS areas, in the proportion of children with 'abnormal/borderline' levels of emotional and behavioural problems. However, there were no significant differences with regard to conduct problems, peer relationships or hyperactivity. Parents in the TPS versus intervention areas reported significant (small to medium) improvements in psychological distress, positive parenting, likelihood of using appropriate discipline and in enjoying a good relationship with their child.

The evidence in favour of parenting programmes has emerged across many different cultural contexts (see Gardner et al, 2006; Kim et al, 2008) and in replications undertaken by independent investigators (Hutchings et al, 2007; McGilloway et al, 2012). Indeed, there is a very substantial literature on parenting interventions, reflecting its importance throughout the world. For example, a Cochrane Review of group-based (behavioural and cognitive/behavioural) parenting programmes for parents of children with conduct problems aged three to twelve years old, initially identified over 16,000 potentially relevant articles on parenting from the international literature (Furlong et al, 2012). Notably, this review, which was led by a team in Maynooth University Department of Psychology, provides the first definitive evidence to show that group-based parenting programmes aimed at preventing or ameliorating conduct problems in childhood, can provide an effective means of improving children's social and emotional wellbeing and behaviour, as well as positive parenting skills

and practices, whilst also reducing parental depression, stress and negative parenting.

A number of other systematic reviews of parenting programmes and supports which have been undertaken within the last two decades, have produced evidence to suggest that group-based parenting interventions in general, provide the most effective treatment for behavioural difficulties in children under the age of 12 (Brestan and Eyberg, 1998; Barlow and Stewart-Brown, 2000; Mihalic et al, 2002; NICE, 2007). This serves to illustrate further the growing and continuing importance of this field and the considerable potential of parent-based interventions in improving both child and parent outcomes, at least in the short to medium term. However, the evidence for effectiveness in the longer term is lacking due mainly to resource and design challenges which often preclude the possibility of following up parents over a longer period of time (Cotter, 2013).

What works?

A number of promising international and national evidence-based parenting interventions and programmes have been shown to be effective in improving child socio-emotional, behavioural and educational outcomes, as well as parent outcomes. Typically, these are based on robust programmes that have been evaluated by 'gold standard' RCTs, in both vulnerable and non-vulnerable parent populations. These include examples of:

- Multi-modal (or complex) programmes that comprise a number of different interacting components that tend to be delivered across several contexts, such as parent and teacher programmes in schools

- Universal interventions which are primarily focused on whole populations

- Targeted interventions which are aimed more at individual or smaller groups of parents who are vulnerable and in need of additional support.

(Bywater and Sharples, 2012)

Parenting interventions: International and national exemplars

There are several international exemplars of multi-modal parenting programmes that have been subjected to rigorous evaluation with positive results. These are particularly interesting because, in line with Bronfenbrenner's bioecological framework/theory (1998), they recognise the fact that children are located in, and interact within, a number of different settings or contexts. They also illustrate the importance of adopting a more holistic approach to promoting positive outcomes in both children and their parents. Those described briefly here are drawn from a number of different geographical and cultural contexts.

The *Families and Schools Together* (FAST) programme was developed in the UK for a number of age groups from 'baby' to 'teen'. The programme, which incorporates several different approaches, is designed to bring together families, schools and the local community. It offers parent training sessions in combination with kids' clubs and structured peer time to improve school readiness, to tackle anti-social behaviour and enhance overall family functioning. Several RCTs undertaken in the US indicate post-training improvements up to two years later – in samples of disadvantaged children (aged four to nine years) – in terms of classroom behaviour, social skills, academic performance and family adaptability (e.g. Kratochwill et al, 2004; 2009). This programme is currently being delivered in five local authority areas/sites across the UK and an RCT is also underway.

The *Work-Place Triple P* is a group-based parenting programme developed in Australia, based on behavioural and social learning

principles and, uniquely, designed for delivery in the workplace. Families receive four-weekly group sessions, each of two hours' duration and then four weekly individual telephone calls, each lasting 15-30 minutes. Parents are taught 17 core positive parenting and child management strategies, such as praise, engaging activities, setting rules and logical consequences. Parenting skills are then applied to a broad range of target behaviours in both home and community settings with both the target child and all relevant siblings. Active training methods include video modelling, practice, homework, feedback and goal setting. A small RCT by Martin and Sanders (2003) (n=43) showed post-training improvements at four months follow-up in disruptive child behaviour and dysfunctional parenting practices, as well as higher levels of parental self-efficacy in managing both home and work responsibilities. There were additional improvements in reported levels of work stress and parental distress at follow-up in the intervention group. Other versions of the Triple P programme (e.g. Primary Care Triple P – Level 3; Group Triple P – Level 4) have also been delivered with positive results, to parents in the general population (e.g. Fives et al, 2014).

The *Family Links Nurturing Programme* (FLNP) was developed in the US in the 1970s to promote emotional literacy in parents and children. One of its two programmes – the *Parent Nurturing Programme* – is a 10 week (universal and targeted) intervention for parents of children ideally aged between four and 11 years, and based on four underpinning principles or 'constructs' of:

- Building self-awareness and self-esteem

- Empathy

- Appropriate expectations

- Positive child behaviour.

Importantly, this programme encompasses a number of topics related to parenting such as negotiation, constructive praise and criticism and problem solving, as well as other broader parent support issues such as those around sex. The second companion programme – called the *Schools and Early Years Nurturing Programme* – is delivered in schools for an hour to an hour and a half per week per term. A recent evaluation in the UK of the Parent Nurturing Programme (Grant, 2011) showed that children's behaviour, on average, shifted from 'borderline risk to mental health' to 'normal' whilst parental wellbeing also improved significantly following participation in the programme and especially for parents who had children registered for 'Special Educational Needs', thereby indicating the suitability of the programme for the more vulnerable parents. Over 90 per cent of the parents also reported that the programme had helped them in other areas of family life.

Lastly, the *Incredible Years* (IY) *Parent, Teacher and Child Training Series* was developed in the US by Carolyn Webster-Stratton during a period spanning at least three decades. This comprises a suite of interlocking evidence-based programmes aimed at parents, teachers and children. The aim of the programme is to prevent or alleviate SEBD in young children, to promote positive child behaviour and to enhance parental and teacher management competencies and wellbeing. The effectiveness of the programme in improving child anti-social behaviour and reducing social inequalities has been demonstrated in a number of RCTs undertaken both in the US by the programme developer, and in several European countries by independent researchers including the Republic of Ireland, Wales, England, Norway, Sweden, the Netherlands and Portugal. A unique IY 'pooling study' of those RCTs undertaken in a European context is also currently being completed by a team led by Professor Frances Gardner at Oxford University in collaboration with the Principal Investigators of the trials in each of the relevant countries. This will provide, for the first time,

definitive evidence for whom the IY parenting programme is most (or least) effective, whilst also assessing its wider public health benefits (or harms) and its overall cost-effectiveness.

The Irish evaluation of the Incredible Years programme (Incredible Years Ireland Study) was conducted over a five-year period with funding from AP. This research programme involved a comprehensive and methodologically rigorous, community-based evaluation of different elements of the Incredible Years suite of programmes including the Incredible Years BASIC parenting programme (McGilloway et al, 2009; Furlong and McGilloway, 2011; McGilloway et al, 2012; 2012a; McGilloway et al, 2013; O'Neill et al, 2013; McGilloway et al, 2014; Furlong and McGilloway, 2015; 2015a). The parenting RCT met the stringent criteria for inclusion in a subsequent Cochrane Review of parenting programmes for children with conduct problems aged 3-12 years (Furlong et al, 2012).

Specifically, the findings from the Irish evaluation of the *Incredible Years BASIC* parenting programme (n=149), which was based on a multi-method approach, showed significant and large effects with respect to post-intervention improvements in the formerly clinically significant behaviour of children aged three to seven years. Parental mental health also improved significantly following participation in the programme. These effects were maintained over time at 12-month follow-up, while significant improvements in sibling behaviour and marital adjustment (where applicable) were also recorded at the 12-month follow-up. Almost two-thirds of the parents were socially disadvantaged. The parents were generally very positive about the programme although there were some challenges. For example, a series of one-to-one interviews with parents who had taken part in the programme – and conducted as part of the qualitative component of the work (or process evaluation) – showed that some parents experienced cultural, personal and environmental challenges in learning the new skills, including

discomfort with praise and positive attention, conflict with their partner and parenting within an anti-social environment. However, parents dropped out of the course for largely circumstantial reasons (Furlong and McGilloway, 2011). A separate cost-effectiveness analysis indicated that the costs of the programme were modest when compared to other similar programmes, with considerable potential long-term benefits to society (O'Neill et al, 2013).

The findings from the above evaluation, and a number of others conducted on the island of Ireland and supported by AP, have been collated and assessed by the Centre for Effective Services in terms of 'what works' for parents. Aside from the *Incredible* Years and *Triple P* programmes, these also included the following three programmes that have an early years parenting element: the Preparing for Life home-visiting programme in North Dublin; the *Childhood Development Initiative* (CDI) Tallaght West in Dublin; and the Early Years programme in Northern Ireland. Both the *Incredible Years* and *Triple P* (levels three and four) showed significant improvements in outcomes whilst the Early Years and Preparing for Life home-visiting programme as well as elements of the CDI programme, showed positive trends. Overall Sneddon and Owens (2012) conclude that across the programmes considered; parents reported increased confidence, were more positive about parenting, and used more positive techniques for interacting with their children, whilst overall levels of stress were also reduced in the home environment. Collectively, these findings suggest that there may be real benefits in adopting a public health approach to parenting that incorporates both targeted and universal supports, although as indicated below, there are areas where further evidence on effectiveness (and cost-effectiveness) is required.

Conclusion

To date, most studies of parenting and parent support programmes have examined the effectiveness of parent training programmes in relation to child emotional and behavioural difficulties, parental mental health and parenting competencies (e.g. Hutchings et al, 2007; McGilloway et al, 2012; 2012a). Whilst these have yielded generally positive results, very little is known about the effectiveness of such interventions, or indeed other parent support programmes, with regard to:

• Child and parent physical health

• Child cognitive/educational abilities

• Parental social support

• Potential adverse outcomes, such as conflict with a partner through the introduction of new parenting techniques into the home

• The longer-term measurement of outcomes

• Evidence of cost-effectiveness.

> **The cumulative evidence, to date, suggests that parenting programmes offer a promising approach to reducing health inequities in the early years, and it would appear that parents who are socially disadvantaged benefit the most.**

Furthermore, these programmes, when implemented with fidelity (i.e. in the way originally intended by the programme developers), can yield a number of therapeutic and other benefits that go considerably beyond improvements in child behaviour and wellbeing, or parent-child interactions, to positively impact the wellbeing and functioning of families, the community and wider society as a whole.

Vignettes – Working with Parents
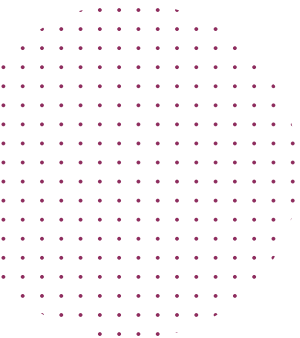
Introduction

The following vignettes demonstrate how parenting and parental practices can play a crucial role in child health development and behaviour. Many interventions to improve health outcomes in the early years are mediated through parents. Working with parents to support their children's development can help to avoid physical, social, emotional and behavioural difficulties in children, which can present long term challenges for parents, professionals and society. They can also reduce parental depression, stress and negative parenting. Effective approaches can be aimed at whole populations or targeted at individuals or specific groups. The following two vignettes illustrate interventions that involve working with parents to improve children's social and emotional wellbeing and behaviour, as well as develop positive parenting skills and practices.

a. Preparing for Life

NOEL KELLY, *Dublin Northside Partnership*

Background to Preparing for Life (PFL)

Preparing for Life (PFL) is a prevention and early intervention programme which aims to improve the life outcomes of children and families living in North Dublin by intervening during pregnancy and working with families until children start school. PFL is being evaluated using a longitudinal randomised control trial design (RCT) and an implementation analysis. The experimental component involved the random allocation of participants to a high treatment group (n=115) or a low treatment group (n=118). Both groups receive developmental toys, as well as access to pre-school, public health workshops, and a support worker. Participants in the high treatment group also receive regular home visits between pregnancy and school entry from a PFL mentor to support parenting and child

development. The high treatment group also receive parent training via the Triple P Positive Parenting Programme. The treatment groups are also being compared to a 'services as usual' comparison group, who do not receive the supports of PFL (n=99).

The need for this intervention emerged from concerns that children were starting school without the requisite skills. Research on the school readiness skills of children (Murphy et al, 2004) found that less than 50 per cent of the children starting school in September 2004 were school-ready. The areas where children scored lowest were language, communication, cognitive development and general knowledge. The research identified the need for an intervention before the children began school. Following a review of the available evidence it was decided to intervene by supporting parents as the primary educators of their children. Supporting and upskilling parents was expected to impact positively on child outcomes as well as leaving a knowledge and skills legacy in the community. Two interventions were identified to support parents in the areas of child development and parenting.

In designing a home visiting component it was decided not to follow a specific model but rather to use the learning from other home visiting models while designing the curriculum. This curriculum was informed by information already available through the Health Service Executive (HSE). Following a review, two evidence based parenting programmes were shortlisted for consideration; *The Incredible Years* and *Triple P*. *Triple P* was chosen as it could be delivered in one-to-one and group settings. This decision was informed by local knowledge indicating that a considerable percentage of families would not attend group parenting programmes. During implementation this proved accurate as approximately 40 per cent of parents chose not to attend group-based parenting training. PFL staff are trained in *Triple P* approaches and to deliver parenting modules during the home visits to families that are reluctant to attend group sessions.

Outcomes in the PFL Programme are analysed across the following domains: child development, child health, parenting, home environment, maternal health and wellbeing, social support, childcare, household factors and socioeconomic status. The results from the six, 12, 18, 24 and 36 month evaluations show that while the programme's impact was concentrated on parental behaviours and the home environment up to 18 months, from 24 months impacts were emerging on child development and child health. Specifically, the programme was effective at improving the quality of the home environment and improving parent-child interactions when children were very young, and more effective at improving child development and child health as children got older. The findings indicate that home visiting programmes can be effective at improving parenting skills and child outcomes within a relatively short timeframe, yet continued investment is required to observe longer-term effects on child development and child health.

During the planning phase all key partners, including the local communities and funders, participated in the planning process, which created significant buy-in and support for the programme that has strengthened throughout the implementation phase. External experts provided extensive guidance throughout the planning, implementation and research phases. Involving community representatives in programme development helped when recruitment commenced as there were strong supportive voices in the community. Having a highly committed staff team who fully believe in and are passionate about the programme also ensured that positive relationships were established when work commenced with families.

Despite rigorous planning there were significant challenges in recruiting families particularly in the early stages. The main challenges that hindered recruitment were fears about intrusion into families,

the length of the commitment being sought from families (five years), service fatigue among some families, reluctance to join a new un-tested programme, and apathy. There were no quick fixes to any of these challenges, but they were addressed in a number of ways including:

- Adopting a very respectful approach to engagement with families

- Providing a high quality service in order to develop a positive profile and reputation in the community

- Having visibility around the community to create acceptance

- Building positive relationships with families who joined

- Building alliances with organisations that could refer parents and persisting until a tipping point was reached when it became acceptable among families to join PFL.

Having systematically faced the challenges, and achieved community-wide acceptance and support the persistent challenge is to build a consistent working relationship with families most in need of the supports. The main challenge is to engage and reach parents who are unable to see the connection between their behaviour and their child's outcomes. The ongoing research shows that the PFL programme is effective in generating better outcomes for parents and children.

Key lessons from the PFL Programme

- Identify and undertake a needs analysis before planning an intervention.

- Invest time in planning and include every possible partner in the planning phase. This pays off in the long run as it leads to sustained support.

- There are lots of experts out there – connect with them and they are more than happy to share their expertise.

- Select staff carefully as they are the key to achieving the desired outcomes. The right team will bring passion, commitment and confidence to the work with families.

- All families deserve respect. Being able to work where the family is at – in a non-judgmental way – builds confidence. Families know immediately if staff members are interested in them.

- Invest time in building strong respectful relationships with families as without this it's not possible to implement a successful programme.

- Deliver the programme/intervention with fidelity – having an implementation manual/plan is essential.

- It is really important to persist. Staff will get knocked back but if they give up it will become just another service the family feel let down by.

b. Parents Plus Early Years

JOHN SHARRY AND SARAH JANE GERBER, *Parents Plus*

Background to the Parents Plus Early Years Programme (PPEY)

The PPEY is one of five evidence-based *Parents Plus* Programmes that were developed in Ireland in collaboration with families. Drawing on well-researched ideas on child development, attachment and behaviour management, the PPEY uses video feedback, small group discussion and role-play to support parents to:

- Tune into and connect with their children

- Expand children's learning, language and attention

- Teach children everyday tasks

- Manage tantrums and misbehaviour

- Help children be more cooperative and to keep rules.

The PPEY was originally developed in a child mental healthcare setting for parents of children, aged one to six years with identified emotional/behavioural and developmental difficulties. The programme was delivered over eight to twelve weeks using both group and individual parent coaching sessions. In recent years a shorter six to eight week preventative, group-only version has been developed for delivery within pre-school and community settings.

There is a growing body of evidence demonstrating positive outcomes for parents attending the Parents Plus Programmes and currently nineteen studies attest to their effectiveness in clinical and community settings, including six specifically relating to the PPEY (Carr et al, 2015).

Two examples are provided below.

Early Years Services, Childhood Development Initiative (CDI), Tallaght West

The PPEY was delivered in targeted pre-school services in CDI Tallaght West, Dublin as part of a suite of services offered to pre-school children in disadvantaged settings. Uniquely, the programmes were delivered by parent/carer facilitators (PCF) who were attached to the service and had special responsibility to engage and support parents as opposed to independent mental health care workers. These posts were specifically recruited as part of the CDI project, and each PCF received training and supervision from Parents Plus in the delivery of the PPEY. The programme was independently evaluated as part of a clustered randomised control trial. It demonstrated significant positive effects on parents' direct engagement with their children's academic development at home such as reading with children, promoting children's number skills and creating a rich literacy environment for the child.

Fingal Parenting Initiative (FPI)

As one of the ten national projects supported by the *National Early Years Access Initiative*, one-off preventative community parenting workshops and the seven week PPEY programme were delivered to parents in Fingal, North Dublin over a two year period. The Fingal Parenting Initiative roll-out adopted an inclusive community-based approach aiming to include targeted parents in disadvantaged areas as well as all parents of children starting the Early Childhood Care and Education (ECCE) free pre-school year. Overall, 800 parents participated in either a workshop or one of the 35 PPEY programmes delivered in local pre-school settings. The PPEY sessions were delivered by childcare practitioners and community link workers from existing community agencies in the Fingal area. Facilitators received training and supervision from Parents Plus under the coordination of the local Children and Young People's Services Committee (CYPSC), (a structure

for bringing diverse agencies together to jointly plan and coordinate local children and young people's services). The evaluation of over 350 parents completing the PPEY showed significant reductions in child behaviour problems and parental stress, and the courses successfully engaged disadvantaged families with clinically significant problems who benefited most.

These two examples describe different ways of delivering the PPEY in early years contexts. In the CDI model, a parent/carer facilitator was recruited to provide special support to parents which ensured high parental engagement. While this model might be hard to replicate in all services nationally given the cost implications for recruiting special staff, it could certainly be the model of choice for high need, disadvantaged settings when special support to engage parents is necessary. In the FPI, existing childcare staff in partnership with professionals from other community agencies, were supported to deliver the PPEY. In utilising existing staff, this model has the potential to be more sustainable nationally, though the success of the project did depend on having a funded area coordinator supported by the CYPSC. In addition, while childcare staff voluntarily delivered the courses in return for training, supervision and programme materials, support will be necessary for them to continue to provide these services to parents on an ongoing basis beyond the duration of the project. Through the research and experience, a number of useful insights have emerged.

Key lessons from the PPEY

- Providing structured support to parents in early years childcare settings is an accessible, non-stigmatised way to promote children's wellbeing and school readiness as well as reducing behaviour problems and parental stress.

- The point of enrolment of a child in a pre-school is an opportune time to engage parents; at this time they are often receptive to professional support. The PPEY programme has provided two examples of how this support could be provided.

- Such programmes have the potential to provide better outcomes for children as well as to strengthen parent/pre-school partnerships helping to prepare families for national school.

- There may be an opportunity to link with the existing Aistear (early childhood curriculum framework) national policy which emphasises the importance of working with parents to the provision of national training in providing structured parenting courses such as the PPEY.

- Some specific funding could be provided to pre-school services (perhaps linked to the funded pre-school year and under the coordination of the childcare committees) to provide these parenting supports. This would be a relatively minimal investment that could greatly increase access to parenting supports.

Working with Professionals

From Theory to Practice: Working with Professionals to Promote Health Equity in the Early Years

Gavin Davidson

Introduction

The previous two sections have highlighted the positive outcomes associated with working with children and working with parents to improve health outcomes in the early years. This chapter now focuses on work that is directly undertaken with professionals to improve health outcomes for children and to promote health equity. The previous two sections have comprehensively dealt with the many robust interventions and considerable evidence-base that now exists on the island of Ireland. This final section will take a wider lens to consider the role of professionals in influencing policy for health equity in the early years. A broad definition of 'professionals' is used to encompass anyone, across statutory, community, voluntary and private sectors, whose job involves, or perhaps at least has the potential to involve, this area of work. This therefore includes people working across health and social care but also those working in housing, education, criminal justice, social security, culture, transport, economic development, policy, research and politics. This reflects the understanding of health equity as being primarily influenced by sectors and environments external to health and health care.

Professionals work within specific legal, policy and professional duties, guidance and standards. In Northern Ireland, authorities have a statutory duty, under Article 18 of the Children (Northern Ireland) Order 1995:

a. *To safeguard and promote the welfare of children within its area who are in need.*

b. *So far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of personal social services appropriate to those children's needs.*

There is also a series of policies that emphasise the need for integrated services and early intervention to improve outcomes for all children and families (Office of the First Minister and Deputy First Minister, 2006; Department of Health, Social Services and Public Safety (DHSSPS), 2009; DHSSPS, 2010). *The Early Intervention Transformation Programme* is currently a major initiative to implement some of these key policy priorities. In the Republic of Ireland, Tusla, the Child and Family Agency, was established in January 2014 under the *Child and Family Agency Act 2013*. It is required by Section Eight of the Act to:

> *Support and promote the development, welfare and protection of children, and support and encourage the effective functioning of families.*

Tusla brings together professionals across a range of services including child protection, early intervention and family support. *The Children First Act 2015*, signed into law in November 2015, reinforces the need to better integrate planning and services.

In addition to these legal and policy requirements, professionals also work within codes of conduct that inform and influence their practice. For example, the first requirement of the Northern Ireland Social Care Council's (2015:5) *Standards of Conduct and Practice for Social Care Workers and Social Workers* is that all social care workers must

> *protect the rights and promote the interests and wellbeing of service users and carers*

and in Ireland, CORU's (2011:5) Code of Professional Conduct and Ethics for Social Workers requires social workers to promote social justice by

> *advocating for the fair distribution of resources based on identified levels of risk/need.*

So, for professionals, promoting health equity is a legal, policy and professional requirement that should be central to their work.

Professionals can improve child health outcomes in a range of different ways and across different levels. Farrell et al (2008) identified that the main ways include: focusing on the most disadvantaged groups narrowing health gaps, and reducing the social gradient. Professionals can engage with these approaches to promote health equity across different levels of practice.

At the individual level this could involve developing and integrating interventions that target and address the social determinants of health as part of ongoing practice. At the organisational and community levels this could involve developing services to focus more on early intervention, family support and the redistribution of resources within communities.

At the policy level, Scott et al (2013) have argued that addressing the wider societal issues of inequalities in resources, income and power, is central to promoting health equity and professionals also have an important role in informing and influencing change at this level.

This chapter will therefore outline the key messages from the literature about how professionals can promote health equity across these levels and how effective these different approaches may be. The chapter will also explore how change can be achieved across the policy, interagency, organisational, team and individual levels. In other words how the research and policy directions are translated into practice.

Individual level

Individual professionals, across all disciplines and sectors, have a central role in directly addressing health inequities and informing how services and policies can more effectively reduce inequities in society, service provision and practice. At times

individual professionals may feel relatively powerless to respond to inequities that are the result of societal level policies but there is a range of ways professionals may respond individually and by working with others to do so. Professionals working with the consequences of health inequities are uniquely placed to understand, record and communicate the impacts of these issues.

It is important to acknowledge that the stressful pressures of responding to the immediate needs of families may make protecting time and energy to respond to these wider issues very difficult. To neglect them though is, arguably, to collude in allowing their ongoing negative and preventable impact.

An initial consideration for professionals is their own level of awareness and understanding of the importance of health inequities. Allen et al (2013) have argued that education and training that enables professionals to understand the importance and impact of inequities is essential. Allen et al (2013) suggest this can be achieved by ensuring that teaching the social determinants of health as a compulsory part of health and social care professionals' training and, it could be argued, awareness of these issues and the impact of them should be a core component of training across sectors. Allen et al (2013) also highlight that professional training should provide the skills necessary

to identify and respond to inequities. Professionals will then be appropriately aware and skilled to respond to inequities as a routine part of practice. This has implications for all aspects of the process of intervening with people at the individual level. The assessment of need must include consideration of the current and past impact of inequities. It must also consider children and parents in their family, community and societal context, in other words, assessment must be systemic. The care planning process must identify any intentional or unintentional discrimination in the accessibility and availability of services. Intervention must include addressing these issues and avoid attributing blame to the people who are most negatively affected by them. In the evaluation of their individual practice, professionals should identify the relative effectiveness of the different strategies for addressing inequities at this level. Maynard (British Academy, 2014) has made the important point that professionals often have to choose between competing interventions to address inequities and, he argues, these decisions should always be based on the most up-to-date evidence of cost-effectiveness.

The inclusion of the social determinants of health in education, training and practice at the individual level is a necessary component of working towards greater equity, and can be effective for improving the outcomes for a relatively small number of families, but it is not enough on its own. Professionals are in an ideal position to raise the awareness of families and colleagues about the impact of the inequitable distribution of services, resources and power. They can advocate on behalf of families but also provide them with the information, encouragement and support to campaign on the issues directly affecting them and others. Professionals can also link with colleagues across teams, agencies and sectors to highlight and jointly respond to health inequities. This is important to provide more comprehensive,

joined-up and effective services but also for professionals to make strategic alliances within and across services to inform and influence change.

Professionals have unique access to experiences and data that can provide evidence to establish the nature, extent and impact of inequity. As Allen et al (2013:70) state,

> *health professionals, students and health organisations all have a responsibility to advocate for change across the health system, in education and training and to health workforce regulations, and also beyond it – directed at policies that effect health inequalities. Measurement, monitoring, research and evaluation are valuable tools in greater advocacy.*

However, even the best possible efforts by professionals at the individual level, if not reinforced, supported and combined with work at the community and societal levels, risk simply securing resources for one individual or family at the expense of another individual or family with a less effective advocate.

Organisational and community level

Organisations have a key role in ensuring professionals have the appropriate training, supervision and support to implement the most effective interventions but there is also an important role for both formal and informal peer coaching and mentoring. This role is illustrated in the case of youngballymun's 3, 4, 5 Learning Years Service, where one of the key aims is to

> *improve holistic developmental and learning outcomes for children in early childhood care and education* (ECCE) *settings in Ballymun by increasing the quality of service provision through staff professional development and the provision of mentoring and coaching support to enhance practice* (SQW, 2012:i).

In order for evidence-based policies and interventions to achieve their aims, they must be effectively implemented at the individual level, and professionals can support each other to do this (Sneddon et al, 2012).

Although health, social care and community organisations may be constrained to some extent by the wider policy, economic and societal context in which they operate, there are still many opportunities within these boundaries to address inequities. Organisations need to ensure their workers are encouraged and enabled to identify and respond to inequities. This can be done through supervision, ongoing training and policies and procedures that make identifying inequities a core component of routine service provision. Professionals, appropriately trained, skilled and supported to identify health inequities and unmet need, can provide the evidence needed for organisations and communities to respond in a more coordinated, effective way at this level.

To facilitate this, organisations and communities need to have systems in place to collect, analyse and respond to the issues that are identified by professionals and families in practice. Service development and the prioritisation of resources can then be informed by local data and the best international evidence on the most effective interventions. Organisations and communities also have an important role in promoting the involvement of families in the planning and delivery of services to ensure that the perspectives and priorities of professionals are complemented by the experiences of the families they are working with. Although single organisations can, and should, respond to health inequities their work will be more effective if it is a part of a coordinated approach across agencies and sectors (Quinn and Biggs, 2010).

A range of integrated approaches and area-based interventions have been developed to address health equity at the interagency and community level but it is perhaps more difficult to be conclusive about the effectiveness of these more complex, community level interventions. Statham (2011:4) reviewed the international evidence on interagency working and concluded that,

> *interagency working is becoming increasingly common in children's services internationally and is widely regarded as improving the quality of services and support offered to children, young people and their families. There is, as yet, limited evidence on improved outcomes for children and families from this way of working, but there is promising evidence from many countries on the benefits of a more joined-up approach in improving professional practice and providing better support at an earlier stage for children and families who need it.*

One approach that has recently been evaluated in Ireland is the *National Early Years Access Initiative* (NEYAI), a three-year programme (2011–2014) which targeted disadvantaged areas and aimed to improve quality of services and outcomes for children from birth to six years old. One aspect of the evaluation, which focused on the Free Pre-School Year concluded that the findings support *the case for earlier intervention, particularly where a child's family circumstances are not conducive to normal healthy development. It also underlines why improving child outcomes and reducing socially-generated gaps in child outcomes cannot be the sole responsibility of Ireland's early years system, even if it has a substantial and potentially more important role to play* (McKeown et al, 2014:133). In Northern Ireland, the Colin Early Intervention Community is another area-based intervention that brings organisations together to provide a more comprehensive, integrated range of services including family support, early intervention and support for fathers. An evaluation of that initiative did identify some

improvements in population outcomes but also reported ongoing challenges in coordinating services, providing evidence-based interventions and so effectively addressing the long-term health inequities in that area (National Children's Bureau, 2012).

Rochford et al (2014) have highlighted that the need for and benefits of interagency working have been repeatedly identified. There are now important structures and policies in place that may help facilitate a more integrated approach to promoting health equity in Northern Ireland through the Children and Young People's Strategic Partnership, the *Children Services Co-operation Act 2015*, and in Ireland through the Children and Young People's Service Committees.

Policy level

Professionals, from frontline practitioners to those who are directly advising civil servants and politicians, have a role in advocating at the policy level for those families who are experiencing the ongoing impact of inequities. The Marmot Review (2010:9) has provided clear direction on the action needed at the policy level to reduce health inequities:

- Give every child the best start in life

- Enable all children young people and adults to maximise their capabilities and have control over their lives

- Create fair employment and good work for all

- Ensure healthy standard of living for all

- Create and develop healthy and sustainable places and communities

- Strengthen the role and impact of ill health prevention.

> *A recent review of policy, research and practice in Northern Ireland for families experiencing multiple adversities identified three key policy and practice themes which could contribute to addressing health inequities: early intervention, integrated services and whole family approaches (Davidson et al, 2012).*

There is growing evidence that only focusing on health is not sufficient. Cooper and Stewart (2013) conducted a systematic review to consider whether money or income itself makes a difference to children's outcomes. They concluded that:

> *Poorer children have worse cognitive, social-behavioural and health outcomes in part because they are poorer, and not just because poverty is correlated with other household and parental characteristics. The evidence relating to cognitive development and school achievement is the clearest, followed by that on social and behavioural development. Evidence about the impact of income on children's physical health is more mixed, and there were no studies that looked at children's subjective wellbeing or social inclusion* (Cooper and Stewart, 2013:4).

This would suggest that redistribution, whether achieved through progressive taxation or greater equity in income, is a central component of the required response.

Recent research in Scotland focussing on mortality also suggests that the response needs to be across government departments and involve intervention at the community and societal levels. It concluded:

Evidence that all-cause socioeconomic inequalities in mortality persist despite reductions for some specific causes, and that inequalities are greater with increasing preventability, suggests that focussing on reducing individual risk and increasing individual assets will ultimately be fruitless in reducing inequalities and may even increase them. Elimination and prevention of inequalities in all-cause mortality will only be achieved if the underlying differences in income, wealth and power across society are reduced (Scott et al, 2013:6).

Quality standards and frameworks at the policy level can also provide support, guidance, direction and opportunities for professionals across all levels working to promote health equity. For example, equality is one of the principles on which Aistear, the Early Childhood Curriculum Framework in the Republic of Ireland, is based (National Council for Curriculum and Assessment and Early Childhood Ireland, 2013). This offers professionals the opportunity to explore what this means, or should mean, in practice. Northern Ireland's Department of Education's framework for Early Years Education and Learning also reinforces the need to work together across professions and agencies:

Children's needs cross organisational boundaries particularly between health, education and social services. The importance of multi-disciplinary and multi-agency working, together with good communication and information sharing are essential to the common goal of improving outcomes for all children and their families (Department of Education, 2013:26).

Similar to the concern about efforts at the individual level simply diverting resources to those with the most effective advocates,

a concern at the organisation level is that, without action at the societal level, efforts to prioritise the most disadvantaged and/or focus on early intervention risk neglecting other important areas of need. As Dyson et al (2010:iii) have stated:

> **'Children's policy' has to embrace not only measures directly targeted at children, but any measures which support and enhance families, communities and neighbourhoods. Single-strand policies, short-term programmes, and one-off interventions may have their place as part of a wide-ranging strategy of this kind. However, on their own they do not offer an adequate basis for an approach to reducing health inequalities.**

Conclusion

The growing evidence for the impact of inequities and the benefits of promoting health equity should help move this debate beyond party political, short term priorities to the point where there will be sufficient public support and political will to achieve the necessary redistribution of resources. The research on promoting health equity in the early years has tended to focus on the relative effectiveness of a range of targeted, area-based and limited universal interventions, and more recently the complexity of implementing these approaches into routine practice across different contexts. As earlier chapters demonstrated there is considerable value to these initiatives, while working within the status quo. However, professionals have the capacity to expand this learning into advocacy demonstrating how health equity can be achieved.

It may be useful to further explore how these extremely important messages can be better communicated to the public, politicians and policy makers who will decide what approaches are taken.

This may involve researchers who have traditionally focused on health and social care engaging with the research, literature and approaches of relatively unfamiliar areas such as political campaigning, advertising and marketing. In other words, the need for integrated, interdisciplinary approaches to promoting health equity may also be needed to develop more effective approaches to convincing society that these approaches should be prioritised. The examples in this publication demonstrate what can be achieved by working with children, parents and professionals and provide a positive glimpse of what could eventually be achieved for all.

Vignettes – Working with Professionals

Introduction

Research and evidence has demonstrated that improved health outcomes in the early years can be achieved by supporting professionals to improve the quality of their work with children and families. Professionals are supported through a variety of means including training, quality assurance, and reflective practice. There is also an emphasis on partnership working with other services in order to achieve more integrated service delivery and influence systems change. The following vignettes illustrate some of the issues involved and the lessons that can be learned for practice in different contexts.

a. Sure Start South Armagh

CONOR MCARDLE AND MARY MAGEE, *Sure Start*

Background to Sure Start South Armagh

Sure Start South Armagh is a local project for expectant parents or families with at least one pre-school child. Sure Start offer a range of services to deliver the best start in life for every child, and to optimise partnership working between statutory, voluntary and community sectors. The services aim to enhance the physical, intellectual and social development of babies and young children, so that they can flourish at home and when they get to school. Staff are trained in the 'Solihull Approach' which aims to improve emotional health and wellbeing in children and families.

Improving infant mental health and resilience is associated with positive long term outcomes for children. Sure Start has embraced evidence-based interventions at the point in a family's life when it can have greatest impact to enhance health equity in the early years. The Solihull Approach, which is based on psychodynamic and behavioural theory, is a practical way of working with families that fosters consistency and continuity for families. Its principles promote
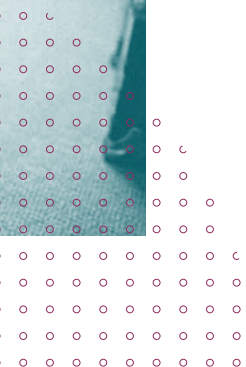
teamwork, collaboration and partnership working in the attempt to ensure a seamless transition for children and families from the antenatal period into early childhood.

Increasingly in times of austerity, organisations in receipt of government funding are expected to clearly demonstrate the impact of their service. Current monitoring arrangements within Sure Start South Armagh capture outputs and quantitative data; primarily service uptake. To address the challenge of measuring impact and monitoring 'soft' outcomes in terms of the progress made by families, a multidisciplinary team attends a monthly Family File Meeting (FFM) facilitated by the Sure Start Manager and Health Visiting Team.

The FFM seeks to ensure that Sure Start services are reaching the families that need them most. Pooling expertise from the Sure Start team helps to balance universal, prescriptive service delivery and bespoke evidence based interventions to vulnerable families. Referrals to the FFM come from within the Sure Start team and from other providers including: core Midwifery and Health Visitors, Social Services, Family Support Hub, Family Nurse Partnership, Homestart, Child Development Clinics, Community Paediatrics, local pre-schools and local voluntary and community groups. This multidisciplinary approach helps to identify and prioritise the families that are most in need, and allows for identification of a key worker with the most suitable professional and clinical skills to benefit the family at the point of referral.

Consent from the family is gained prior to discussion at the FFM and the principles of assessment adhere to the *Understanding the Needs of Children in Northern Ireland* (UNOCINI) framework. This means identifying, in partnership with the family, needs and risks, while also highlighting strengths, resilience and protective factors. Safeguarding is considered paramount during the process of the FFM. While the key worker is best placed to act as a constant in the family's journey

through Sure Start, other relevant staff may be involved depending on changes in the family's needs. The team discussions in the FFM are a valuable aid to Sure Start staff to prioritise what works best for particular families.

Families referred to the FFM vary from those needing minimal intervention and signposting, to those requiring intensive home support and outreach on a long-term basis to ensure the most positive outcomes for the family. The Solihull Approach assists staff to undertake a comprehensive assessment of needs and strengths with families, while introducing the key concepts underpinning the approach. Examples include:

- Promoting the emotional health of the mother in the antenatal and postnatal period

- Reinforcing the value of father involvement

- Contributing towards realistic expectations and preparation for parenthood

- Enhancing parental understanding of attuned sensitive parenting, and the impact of early relationships on positive infant mental health

- Encouraging parents to talk, sing, read, and play with their children highlighting their very valuable role in early childhood learning

- Promoting breastfeeding, healthy eating, physical activity, dental health and home safety in families

- Empowering families to recognise the importance of school readiness.

The FFM acts as a mechanism to track a family, and monitor effectiveness of interventions. Families that have been referred to the FFM are graded according to the initial level of input they require and family circumstances. Positive outcomes are evidenced by families progressing from a level of high input, to medium input and low input as a result of specific interventions, with eventual discharge back to universal Sure Start services. Regular feedback is provided to the initial referrer about the progress of a family and specific interventions offered. Staff report this mechanism of effective channels of communication enhances buy-in from key referral agents. While the primary function of the FFM is to ensure vulnerable families' access to tailored early intervention, an additional value is the contribution towards the governance and supervision framework within Sure Start.

The Solihull Approach promotes reflective practice, which enhances shared learning for multidisciplinary teams. The implementation of the monthly FFM coupled with the Solihull group supervision sessions for staff, facilitated by the Health Visitor, attempts to ensure clear lines of accountability, clarity of individual expertise, identification of training needs, and recognition of the need to refer to additional specialist services. These sessions enable staff to share experiences and maintain a professional perspective aimed at providing an intervention that promotes optimum outcomes for the family. In turn a strong sense of commitment, motivation and dedication to the families most in need is maintained at both an individual and organisational level.

Key lessons from Sure Start South Armagh

- Practice is strengthened when it is embedded within a robust theoretical structure.

- Mechanisms such as the Family File Meeting and Solihull supervision sessions enable a reflective evidence-informed approach.

- Promoting health equity is best served through purposeful partnerships between professionals to identify and prioritise the families that are most in need.

- Providing regular feedback to the initial referrer about the progress of a family and specific interventions offered enhances buy-in from key referral agents.

- Having data monitoring systems in place helps to demonstrate the impact of the delivery of services to funders and inform service delivery improvements.

- Multidisciplinary teams provide a range of professional and clinical skills from which the most appropriate key worker can be identified.

- Pooling expertise enables teams to find and provide a balance between a universal, prescriptive service delivery to families and bespoke evidence-based interventions.

b. 'Chit Chat' – Speech and Language Service

GRÁINNE SMITH, *Childhood Development Initiative (CDI) Tallaght, Dublin*

Background to CDI Tallaght 'Chit Chat' – Speech and Language Service

CDI was established to develop a suite of services to support children and families, and encourage better integration of education, social care and health provision. The CDI speech and language therapy model is a three pronged approach which involves:

- On-site delivery of a speech and language therapy service, whereby therapists attend early years services and primary schools, carrying out assessments and providing therapy to children referred to the service

- Providing support to parents in both early years services and primary schools

- Providing training and support to staff in these settings to promote speech and language development.

Chit Chat was developed in response to a need identified during CDI's consultation process and audit of services which led to the development of a ten year strategy. Speech and language difficulties can be of particular concern in disadvantaged areas such as Tallaght West, where children may be more at risk of suffering from multiple disadvantages.

At the outset of the service, discussions with the local Health Service Executive's (HSE) Principal Speech and Language Therapist (PSLT) were held to design and establish the model of service delivery. Dual Policies, a Memorandum of Understanding (MoU), and Service Level Agreements (SLAs) were drawn up for all stakeholders. The speech and language therapy service, which now operates in 11 early years'

services and three primary schools, with children varying in age from two and a half up to five years of age, was established as a response to need in the local area identified by primary school principals. The HSE reported 50 per cent attendance at initial assessment, so this 'on-site' delivery sought to maximise attendance, minimise attrition and support parental engagement.

An independent evaluation carried out by Hayes et al (2014), found that having a dedicated speech and language service would enable more children to receive the intervention earlier thereby helping to remove or reduce a significant disadvantage before starting school. While data was being collected on the number of children referred, attending the service and the number of discharges, the evaluation looked at other factors which demonstrated the wide-reaching impact on other services, for example the number of children who had been referred to other services such as Ear, Nose and Throat.

In the evaluation, parents spoke about the non-stigmatising effect of the on-site service, with minimal disruption for children attending the early years services or school. The on-site approach also offered informal opportunities for staff to discuss issues or seek support from the therapist, thereby creating a heightened awareness of the importance of enhancing children's speech and language development. According to the evaluation, training and support has also had a major impact on practice with staff feeling more competent about correctly identifying children with speech and language needs, and enabling parents to make a referral, as well as having a direct and positive impact on how staff interact with children. Early years services were shown to have an improved print-rich environment and to more skilfully respond to children with speech and language needs.

In line with the need to embed practice within mainstream delivery, it was critical to deliver the speech and language therapy service through established early years services and schools, which had themselves

identified the need for a specialist service. A lot of groundwork was needed in early years services and schools to get them on board and prepare them to fully engage, e.g. access to a quiet room, photocopier, commitment to training, etc. The MoU helped with clarifying roles and expectations of each other, and clarified the process of ongoing and supportive communication. Similarly, SLAs helped to ensure buy-in from early years services and schools by clearly outlining roles and expectations. A policy was developed which clarified the process of accepting referrals and transferring cases between the HSE, the CDI SLT service, and specialist agencies. The involvement of the HSE PSLT in providing ongoing clinical support and supervision, and linking the CDI SLTs into the local team for continuing professional development, was also central to the effectiveness of the model.

Key lessons from the CDI Speech and Language Service

- Time and effort taken in the early stages to consider and clarify roles and responsibilities, agree realistic expectations and document the same (through MOUs and SLAs), is time well spent.

- It is important to build in regular opportunities for open, transparent communication to agree on plans, and to address issues before they become too great.

- Challenging 'norms' is necessary but it should be understood that some structures and systems are deeply entrenched and therefore hard to shift.

- Finding the 'champions' for any initiative helps to drive and support new ways of working.

- It is important to have a robust consultation with all relevant stakeholders. People may have a different idea of what an initiative might look like, how it will be delivered, by whom and to whom.

- Show or remind people that services can be designed as a direct response to a locally identified need.

- Education and training of all professionals supporting children's speech and language development, is a key part of mainstreaming evidence based services in communities.

- Document qualitative and quantitative data to demonstrate change, outcomes and lessons.

c. Ready Steady Grow

HAZEL O'BYRNE, *youngballymun*

Background to Ready Steady Grow, youngballymun

Ready Steady Grow is a community-wide Infant Mental Health strategy for birth to three year olds and their families in the community of Ballymun, Dublin. It is one of a number of initiatives undertaken by youngballymun, an agency which brings together partners from across disciplines and sectors to jointly engage with research evidence, participate in collective capacity-building, develop shared children's services initiatives and problem-solve collaboratively. *Ready Steady Grow is* made up of six components:

- Antenatal Service

- Infant Massage

- Parent-Child Psychological Support Programme™ (PCPS™)

- Talk and Play Every Day

- Hanen You Make the Difference®

- Infant Mental Health Therapeutic Support.

The *Ready Steady Grow* strategy was developed through an in-depth service design process, which brought together stakeholders with a role in working with children from birth to three years and their parents from across the health and community sectors. Members of the service design team included partners from HSE Public Health Nursing, HSE Speech and Language Therapy, HSE Psychology, the local Family Resource Centre, the local authority, and local community organisations working with families. The development of the service was informed by a detailed local needs and resource assessment. A range of approaches were considered in the development of the strategy with the eventual model for implementation agreed in close consultation with partners, with the Parent-Child Psychological

Support Programme™, offered to all babies born in the area, at the centrepiece of the *Ready Steady Grow* strategy.

In PCPS™, and across the whole *Ready Steady Grow* strategy, practitioners are trained and coached in evidence-based practices to provide support and feedback to parents about healthy growth and development of infants, parent-child interactions, bonding, attachment and infant social and emotional development. The objectives across the *Ready Steady Grow* strategy are to increase parenting competency, foster good quality parent-baby attunement and support the development of secure attachment. Evidence consistently finds that a responsive and interactive relationship with a parent or caregiver plays a crucial role in the brain growth and holistic development of infants and young children by establishing secure attachment.

A range of professionals deliver the components of the *Ready Steady Grow* strategy, particularly from HSE Primary Care (Public Health Nursing, Speech and Language Therapy, Psychology) as well as community-based Family Support Workers. Mainstream HSE Public Health Nursing and speech and language therapy services have been reconfigured to support the implementation of *Ready Steady Grow*.

In addition to programme-specific training and coaching for practitioners in each of the specific components that they deliver, professionals involved in implementing the *Ready Steady Grow* strategy, along with a wide cohort of practitioners, participate in a monthly Infant Mental Health study group. This involves a multidisciplinary group of professionals from the range of agencies working with infants, toddlers and their parents in Ballymun. The group convenes monthly for two hours to engage in peer learning activities incorporating theoretical and practice issues. Readings and case studies provide opportunities for reflection and discussion of material presented as well as practical application to individual members' work practice and settings.

A body of evidence has informed this strategy from the outset and throughout its implementation. The local needs and resource assessment during the service design phase identified the parents' key needs as being psychological and practical antenatal support into toddlerhood and beyond. This work was undertaken by researchers at Dublin City University (Matthews et al, 2007). Other research undertaken in the development phase showed that mothers in Ballymun had weaker parent-child relationships than mothers in Ireland as a whole and were less satisfied with themselves as parents (McKeown and Haase, 2006).

Some components of the *Ready Steady Grow* strategy are universally available for all expectant and new parents and their infants in Ballymun (Antenatal Service, Infant Massage, PCPS™) and others are accessed via referral from local practitioners *(Talk and Play Every Day group, Hanen You Make the Difference programme, Infant Mental Health Therapeutic Support)*. In this way, *Ready Steady Grow* offers a continuum of support with high quality universal services available to all parents and infants and more intensive interventions where particular need is identified. PCPS™ has a participation rate of 72 per cent of all babies born in Ballymun.

Through the implementation of PCPS™, a range of measures are captured for participating infants and parents. PCPS™ has in-built mechanisms to monitor parental stress and sense of competence before and after the programme and the Ainsworth Strange Situation Test is administered when children are 15 months old. This test provides a measure of attachment security, a key determinant of social and emotional wellbeing.

Bringing together practitioners from a range of professions in health and community services in an inclusive forum which respected practice expertise, provided the service design phase for *Ready Steady Grow* with a strong foundation of successful practice. In addition to valuing the professional knowledge of participants, other key factors that supported this process included a strong focus on data and reviews of models of practice nationally and internationally. Close attention was given to the needs of the various professionals delivering the service and the alignment between their work and the new initiatives, supported by independent facilitation. This model of communication and collaboration has continued into the full implementation of the strategy. An independently facilitated cross-sectoral, multidisciplinary implementation team, including parent representatives, meets on a quarterly basis to review and oversee the ongoing development of the *Ready Steady Grow* strategy. Open and honest engagement and regular reflection on local data, has enabled continuous development of the strategy.

Key lessons from Ready, Steady, Grow

- Prepare and plan for change: Ring-fence the time needed to build support and commitment to the goals and processes of change. Achieving long-term change, particularly at community-level, is challenging and requires sustained dynamic collaborative processes. It begins with highlighting a need for change, creating and nurturing a readiness for change, uniting behind a shared vision for change, and fostering a commitment to change.

- Collaborative decision-making: Meaningful stakeholder participation in a collaborative decision-making process is crucial to identifying and prioritising needs, planning how best to address these needs and gaining collective ownership. Meaningful participation occurs when stakeholders see that their contributions to a collaborative decision-making process have helped shape the initiative. It requires structures and processes to promote and facilitate participation, and the development of skills and competencies where needed.

- Connect the dots: Building a solid understanding of the local context and the root causes of the problem to be addressed is the bedrock to developing comprehensive strategically integrated responses. Needs analysis must include the generation of in-depth understanding of the pathways by which a particular issue or problem is caused and sustained, and how these are amenable to change. The levels of the change initiative should reflect the multiple aspects that contribute to the problem.

- Fit, integrate, align and influence: Fit programmes and interventions with the needs of the community, integrate

them with existing services, align them with systems and structures and influence the broader policy context. While the evidence for a programme or intervention is important to consider, an area-based initiative must also make sure that the programme or intervention is viable in a real world context. The degree to which programmes/interventions are integrated into existing organisations, and are effectively aligned is crucial to ensuring sustainable change.

Conclusion and Key Lessons

Conclusion and Key Lessons
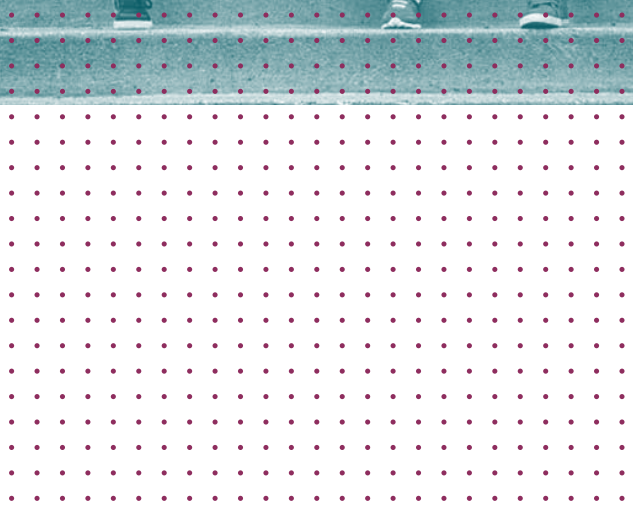
Institute of Public Health in Ireland and the Centre for Effective Services

A number of important lessons emerge from the contributions in this publication concerning how health and wellbeing outcomes can be achieved and health inequities can be addressed. In connecting evidence from research and practice on working with children, parents and professionals to achieve better outcomes, this publication offers a unique insight into prevention and early intervention in the early years. This work is reinforced at policy level where there is increasing recognition of the importance of prevention and early intervention approaches, as outlined in the Introduction. Yet prevention and early intervention approaches in the early years cannot resolve all potential issues and continued investment is required across the life course for longer-term measureable positive effects on outcomes. A partnership approach across services and government departments is also required.

There has been considerable policy activity across the island of Ireland to improve health and wellbeing outcomes in the early years, and this is to be commended. A series of strategies is working to provide every child on the island with a good start in life, using evidence-based, rigorously evaluated information and initiatives as a framework. This policy activity aims to ensure that good quality childcare is provided to support parents to have a genuine choice to work outside the home, help children to meet developmental goals and optimise outcomes across the life course. The wider policy space has frequently supported the advances in early years policy-making, however, challenges remain. Public health concerns, such as the worrying levels of obesity in pre-school children, persist in the most recent data available, and it is hoped that current policies will help to turn this tide in the future. In addition, the persistent problems of family poverty and deprivation continue to impact on children and may hinder some of the recent and intended progress.

In section one, Dr Hanafin outlines the evidence-base for addressing key public health concerns through prevention and early intervention approaches with children in early childhood.

International evidence has consistently shown that the early years is a period where focused investment and attention can reap major future rewards for children, their families and society at large.

Secure relationships, sensitive interactions and a safe home-learning environment during infancy all support development in this most rapid growth period and are positively associated with a wide range of future outcomes relating to health, education, behaviour and social and emotional wellbeing. Essentially, positive experiences in the early years are associated with rewards that may last a lifetime. Prevention and early intervention initiatives offer an opportunity to address children's immediate needs, as well as influencing longer term outcomes. Dr Hanafin highlights the importance of taking account of the broader socio-ecological context within which children live, including the school and neighbourhood environment. Dr McGilloway echoes this view, adding that negative outcomes often arise due to, or may be exacerbated by, socioeconomic disadvantage and/or educational under-achievement, as well as a number of other risk factors related to the family or home environment.

In Dr McGilloway's section, the association between parental mental health and parenting capacity and a child's health and development, is highlighted which can give rise to health inequities that may persist across the life course. Parents play a crucial role in influencing their children's physical, social and emotional development, before birth and throughout their lives. Sinéad McGilloway outlines the evidence

for how parenting programmes and supports have been shown to positively impact on parental stress, parents' confidence in their parenting role, parenting skills and child behaviour. Assisting parents in their parenting through programmes and supports not only helps parents directly, but offers an opportunity to promote one of the most important factors influencing child development. Offering parental support programmes and supports is not intended to tell parents how to care for their children; rather, they provide a mechanism through which parents are empowered in their parenting role if they so choose. Supporting mothers who are making the transition to becoming a parent for the first time represents a considerable opportunity to initiate and embed healthy behaviours during pregnancy as well as positive parenting practices that impact on children's health outcomes.

Effective prevention and early intervention approaches with children and parents can achieve positive effects however evidence clearly points to the importance of addressing the broader socio-ecological context in which children and their families live in order to achieve better health outcomes. Dr Davidson notes in section three that whilst there are numerous ethical, pragmatic and economic arguments for addressing these factors, a range of issues may prevent or restrict professionals from doing so. Professionals who work with children and families play an important role in promoting a child's health and wellbeing. In particular, public health nurses and health visitors have a significant role during the key period before and after birth especially in supporting the monitoring and achievement of key developmental milestones. High-quality education in early years services and schools, delivered by qualified trained staff, can also contribute significantly to identifying needs and supporting a young child's physical and emotional development. Professionals engaging with young children and their families can be supported in various ways such as locating Speech and Language Therapists in early years services and schools

and providing ease of access to parents, as well as by providing training to other colleagues, as shown in the work of CDI Tallaght.

Individually, professionals have to contend with the immediate and urgent demands of the families they are working with and addressing wider social issues may feel impossible. Systems of support are often lacking at organisational and community levels and there can also be resistance to professionals trying to inform and influence developments at the policy level to promote health equity. Learning from prevention and early intervention approaches in the Republic of Ireland and Northern Ireland, as well as from international research, shows the necessity for good interagency working to transcend a 'silo' approach and create a more supportive environment for better functioning of frontline services and staff. The costs of unresolved childhood problems are borne by a range of agencies, especially when these problems progress into adulthood, making the need for a partnership approach to planning and funding services crucial.

The vignettes provided in this publication offer learning on the implementation of evidence-informed prevention and early intervention approaches in the early years and demonstrate how practice can be tailored to meet the specific and individual needs of children, families and communities. Themes and key messages arising from these examples are outlined below and apply irrespective of specific contexts, although implementation always requires tailoring to the needs and requirements of particular situations and agencies. In no particular order, the lessons can be usefully elaborated under the following headings.

Understanding the needs of the community and service users

Understanding the needs of local communities and services users takes time but is a crucial investment. Starting from, and based on a local needs and resource assessment, there needs to be an appropriate balance between universal provision for children and families and more intensive interventions for children and families with additional needs. Involving community representatives in practice development can be extremely beneficial in terms of garnering support for the work, but also in terms of service design. Local knowledge might indicate, for example, that a considerable percentage of families would not attend group parenting programmes. In addition to the families themselves, key stakeholders come from across health and community sectors, and include statutory service providers, national government and local authorities, national agencies, and local community organisations. Sometimes independent facilitators are best placed to support stakeholder engagement. In other cases, engaging children in programmes can be an effective way of engaging parents who might otherwise be less inclined to participate. Prescriptive service delivery may not always be appropriate and interventions may need to be tailored to individual family needs. These needs are best identified in partnership with the family, taking into account specific needs and risks, while also highlighting strengths, resilience and protective factors.

Using theory and evidence to inform practice

Service delivery is strengthened when it is underpinned by relevant theory and appropriate evidence, which can be used to inform service development. This should include evidence of need and resources, and evidence on approaches and practices that effectively meet needs. Evidence shows, for example, that an interactive relationship between children and their parent/caregiver establishes a more secure

attachment, which in turn plays a crucial role in growth and holistic development (Rochford et al, 2014). The learning from theory and evidence, however, is optimal when balanced with the knowledge and expertise of practitioners. The establishment of effective monitoring arrangements are important for capturing and understanding outputs and outcomes data, which in turn provides a sound basis for reflection on data to inform practice and service improvement. This requires continuous collection of data, which can also be used by practitioners with parents and children for feedback purposes.

Multidisciplinary and partnership working

While multidisciplinary and partnership working can be challenging it offers many potential benefits for service development and delivery. Multidisciplinary approaches can optimise the skills available in the service of vulnerable families, for example identifying a key worker with the most suitable professional and clinical skills to benefit the family, and in selecting from an array of skills and expertise, what interventions will work best. Partnership working between statutory and voluntary organisations provides an integrated response to family needs. Good partnerships offer opportunities for timely and appropriate referrals between agencies so that families can access a wider range of supports, where needed. Practical mechanisms such as providing regular feedback to the initial referrer about the progress of a family and specific interventions enable effective channels of communication and enhance buy-in from key partners. Partnership work can be assisted and formalised by drawing up for example - joint policies, agreeing Memorandums of Understandings, Service Level Agreements; all of which can help those involved to make expectations explicit, clarify roles and responsibilities, and agree realistic targets. This kind of groundwork is valuable in enabling a range of professionals to work together, especially when this involves reconfiguring mainstream

services to support implementation of new initiatives and approaches. In turn, implementation is best assisted by a team which has been specifically set up to review and oversee ongoing service development on behalf of the partners.

Staff development and reflective practice

Staff is a crucial resource which has implications for recruitment and ongoing support. Giving staffing issues a high priority is essential in order to optimise the benefits of an evidence-informed approach. Selecting or nourishing a highly committed staff team who fully believe in and are passionate about the programme can ensure that positive relationships are established with families. Coaching and mentoring can enhance staff development and practice and improve job satisfaction. Group supervision sessions for staff with appropriate facilitation can help to ensure clear lines of accountability, clarify where individual expertise lies, identify general training needs, and enable better recognition of the need to refer to additional specialist services. Group sessions can also nurture a strong individual and organisational sense of commitment, motivation and dedication to the families most in need. Something as simple as a well-organised and regular monthly study group can facilitate interagency, multidisciplinary working. External experts can also be an excellent resource in providing guidance throughout all stages of an intervention including the planning, implementation and research phases.

Dissemination, scaling-up and mainstreaming

There is a growing body of evidence about programmes that have been shown to work, through rigorous evaluations, over time and in different contexts. This information needs to be made available to policy makers to inform investment decisions. Training can play an important and necessary part in upskilling and supporting professionals in existing

services, especially in relation to adopting new approaches and practices. It can also assist in the necessary task of embedding effective approaches into mainstream provision. An improvement in provision for families often requires reconfiguring mainstream services which can be assisted by:

- Open and transparent communication

- Identifying and supporting champions to drive the work

- Challenging norms so that deeply entrenched and hard to shift structures and systems are reconsidered

- Overcoming resistance by reminding people how a service responds to locally identified need, especially where good outcomes can be demonstrated

- Stakeholder engagement to design and establish the model of service delivery.

Conclusion

The evidence reviewed in this publication provides a strong rationale for the adoption of prevention and early intervention approaches to service provision in the early years for children and their families. Policy-making across the island of Ireland is increasingly recognising the advantages of early intervention – both as a means to improve health and wellbeing, but also as the most cost effective point of intervention. Evidence from international research has demonstrated the early years as the most influential point for effective intervention, supporting the policy-making process. The funding that has been made available across Ireland to support various initiatives in this regard has been vital. Not only has this funding meant the roll-out of initiatives, but it has also enabled rigorous evaluation to ensure that services are delivering the intended outcomes.

It is important to be realistic in terms of the reach and magnitude of the impact of locally-based prevention and early intervention programmes and services. Government policies and legislation must also seek to ensure that prevention and early intervention is integral to state-supported health, education, housing and family support services, so that the needs of all infants, young children and their families are met. Health and wellbeing is not solely determined in the healthcare arena, but rather in every sector. Cross-departmental, interagency and intersectoral working are therefore vital to ensure a holistic response to population needs. In addition, national policies relating to social protection, employment, housing and childcare must focus on ensuring parents are facilitated to make the best possible contribution to the earliest years of their child's development, as well as those policies directly related to health promotion and the health service. While prevention and early intervention approaches can be effective in improving outcomes, they must be accompanied by a range of policies and services that focus on reducing child poverty and creating more equal societies.

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DR JOHN BAMBER is a Project Specialist at CES and his main area of work is youth policy and practice. This includes support for the Youth Affairs Unit in the Department of Children and Youth Affairs. In particular John assists with the development of the National Quality Standards Framework in Youth Work. As part of this commitment, John works collaboratively with colleagues in the field to provide workshops and resources to support evidence-informed approaches to the work. Before joining CES he was Senior Lecturer in Community Education at the University of Edinburgh, where he gained his EdD in 2008.

DR NOËLLE COTTER graduated from Trinity College Dublin with a BA (Mod.) in History, a MSc in Applied Social Research and a PhD in Social Policy. Most recently Noëlle graduated from University College Dublin with a Diploma in Management. Noëlle joined the Institute of Public Health in Ireland in 2011 having previously worked in the area of housing research. She has also worked on a number of independent projects as a freelance consultant as well as with academic institutions. Noëlle is a Public Health Development Officer with the policy team and also the Chair of the Social Research Association of Ireland.

DR AISLING SHEEHAN is a Project Specialist with CES working across a range of areas including prevention and early intervention and research and evaluation. This includes projects such as the Area Based Childhood Programme, The Nurture Programme – Infant Health and Wellbeing, and working with the Department of Children and Youth Affairs to develop a national set of indicators for children and young people. Prior to joining CES, Aisling worked with children and young people with physical and intellectual disabilities and conducted post-doctoral research on children's healthcare transitions in Trinity College Dublin. Aisling holds a BA (Hons) in Applied Psychology from University College Cork, a PGD in Psychological Research Methods from the Open University, and a PhD in Health Services Research from the Royal College of Surgeons in Ireland.

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DR SINÉAD HANAFIN holds a Diploma in Research Methods (Royal College of Surgeons Ireland), MSc (Trinity College Dublin) and PhD (King's College London) and is also a qualified nurse, midwife and public health nurse. She has published nationally and internationally in several peer-reviewed journals in the areas of child protection, child wellbeing and service delivery. She worked as Head of Research in the Department of Health and Children where she developed and implemented a national children's research programme from 2003-2012. She has recently been appointed as a Visiting Research Fellow at Trinity College Dublin and now works as an independent research consultant.

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NOEL KELLY
Preparing for Life
Noel Kelly developed and manages Northside Partnership's (NSP) Preparing for Life Programme – an evidence-based prevention and early intervention programme. A former primary school teacher, Noel has extensive experience in the development and implementation of education and prevention and early intervention initiatives. Prior to his current role, Noel has worked as an Education Manager with NSP, developed and managed an Early School Leavers Initiative and taught in Darndale senior primary school as well as being one of the first Home School Community Liaison Coordinators in Ireland. Noel graduated from St. Patrick's Teacher Training College with a BEd in 1981 and a MEd in 2003.

Noel has extensive involvement at board level at both national and local levels. Currently he is a director of Tusla (The Child and Family Agency), a director of Start Strong as well as chairing the boards of a number of voluntary and community organisations in the North Dublin area.

www.preparingforlife.ie

CONOR MCARDLE & MARY MAGEE
Sure Start
Conor McArdle is a project coordinator with Sure Start, South Armagh. Mary Magee is a Health Visitor with Sure Start, South Armagh. Sure Start is a government programme which provides a range of support services for parents and children under the age of four, who live in disadvantaged areas across Northern Ireland. It aims to support parents from pregnancy and to give children the best start in life. Sure Start projects deliver a wide variety of programmes designed to support children's learning skills, health and wellbeing, and social and emotional development. The aims of Sure Start are to complement the work of existing local services and provide young families with advice on where to go and who to speak to, if they have more specialised needs or difficulties.

www.early-years.org/surestart

MICHAEL NEARY
Bord Bía
Bord Bia is the state agency in the Republic of Ireland with responsibility to promote and market Irish food, beverages and horticulture at home and abroad. Michael Neary is the Manager of the Horticulture Division of Bord Bia. Michael previously managed the Quality Assurance Department. Michael joined Bord Bia in 2004 when Bord Glas (The Horticultural Development Board) merged with Bord Bia. He worked with Bord Glas from 1991. Michael's role in Bord Bia includes the management of the Food Dudes Programme. This programme is funded by the Department of Agriculture, Food and the Marine and the EU School Fruit and Vegetable Scheme.

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LAURA MCQUADE & ALAN HERRON
PlayBoard Northern Ireland
Laura McQuade is the Senior Research Officer and Alan Herron is the Director of Service Delivery and Development with PlayBoard. PlayBoard is an independent charity and the lead organisation for the development and promotion of children and young people's play in Northern Ireland. Since its establishment in 1985, PlayBoard has been committed to supporting children and young people's play through a combination of: service delivery and development; campaigning and lobbying; research, evaluation and awareness raising; working in partnership with others to put play on the agenda of policy makers and resource providers; and promoting best practice in play and playwork. PlayBoard unites and provides support to over 100 member groups, all of whom are committed to helping us to achieve our goal of developing quality play opportunities that improve children and young people's lives across Northern Ireland.

www.playboard.org

HAZEL O'BYRNE
youngballymun
Hazel O'Byrne is a Projects Officer with
youngballymun. youngballymun is
a Collective Impact Implementation
Initiative. The model is a comprehensive
integrated strategy that drives, builds
capacity, coordinates and re-focuses
existing statutory and community services
to deliver evidence-based, prevention
and early intervention practice across a
whole community of children, parents
and practitioners. The objectives of
youngballymun are to measurably
improve learning and wellbeing outcomes
for children and families; and to inform
national policy and practice development
drawing from our data, implementation
resources and practice experience.
youngballymun implements a range of
frameworks, models and programmes, at
multiple levels, across children's services
systems. youngballymun, by investing in
capacity development of both practitioners
and systems, acts as a catalyst to unlock
value from existing investment in children's
services and improve outcomes for
children.

www.youngballymun.org

DR JOHN SHARRY & SARAH JANE GARBER
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with children and families.

The Parents Plus Charity was established
to develop and disseminate evidence-
based programmes for families in Ireland
and internationally. In order to ensure
long term sustainable benefit, the charity
adopts a 'train the trainer' approach to
empower professionals and community
leaders to deliver the programmes in their
agencies and local areas. Specifically, the
Parents Plus Charity provides programme
materials and facilitator training, post
training supervision and coaching, as well
as evaluation and implementation support
to local agencies and groups over time to
build long-term family support capacity in
targeted communities.

www.parentsplus.ie

GRÁINNE SMITH
Childhood Development Initiative Tallaght
Gráinne Smith is a Quality Specialist with the Childhood Development Initiative (CDI). Gráinne has worked with CDI since 2007, developing quality assurance mechanisms and supporting programme design and implementation. She holds a MEd in Education and has a background in nursing for adults and sick children, and has worked overseas with the Irish aid agency Goal. The Childhood Development Initiative (CDI) is funded under the Government's Area Based Childhood (ABC) Programme, an initiative to improve outcomes for children and families in areas of disadvantage, which builds on the learning to date from prevention and early intervention programmes. CDI was initially established through a partnership between the Department of Children and Youth Affairs (DCYA) and The Atlantic Philanthropies (AP), under the Prevention and Early Intervention Programme (PEIP). CDI designed, delivered and evaluated a suite of programmes across a spectrum of local needs on language, literacy, health, early years, conflict management and community safety. All CDI programmes are evidence-informed and manualised, and are delivered through existing structures and services.

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