

The Best for Every Child

A report on the potential to transform disadvantaged communities in Lisburn through early intervention

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The title of this report, “The best for every child” is a quote from one of the parents who participated in the consultations during the research phase in developing this report

Executive Summary

1. Introduction

This feasibility study and consultation was commissioned from Barnardo's with funding from the Public Health Agency, by Resurgam Development Trust representing community and youth organisations in disadvantaged communities in the City of Lisburn, including Old Warren, Hilden, Hillhall, Tonagh, Knockmore and Lagan Valley. It involved consultations with a very wide range of community organisations, schools and professional agencies working in Lisburn. It also included research into: the needs of the target areas; the desired outcomes for children and young people; the evidence and arguments for taking an early intervention approach to the issues; the public policy context and the extent that it might support an early intervention approach; and the evidence of the potential impact of delivering particular proven programmes in the target areas of Lisburn.

2. The needs of disadvantaged communities in Lisburn

Research into the needs of disadvantaged areas of Lisburn complemented by consultations with local community groups and professionals working in the target areas identified very significant issues concerning the health, wellbeing, safety and security of the population in these areas, which have a very detrimental effect on the lives of many families. Concerns about parenting were also very prominent in most of the consultations. These findings are consistent with the international literature on inequality and deprivation on a range of wellbeing indicators.

What was more shocking was the very poor educational outcomes of the children and young people, right from primary school. Of those attending the three post-primary controlled and integrated secondary schools in Lisburn, three-quarters leave school without 5+ GCSEs with English and Maths and very few go on to university or college. There was significant evidence of educational under-achievement being replicated down the generations. The nature of employment in the 21st Century would suggest that, as a result of poor educational achievement, the level of deprivation, and the extent of poor health and wellbeing, in these areas will, if not arrested by a major intervention, increase further in future years. It was clear from the research that tinkering at the edges of the problem will not be enough to tackle this chronic problem: a substantial and comprehensive initiative is urgently required if the next generation of lives of children and young people is not to be blighted.

3. Why Early Intervention?

A consensus has developed amongst neuro-scientists, psychologists, economists and others concerned with the development of children and young people that:

- 80% of brain development happens before a child is three years old and so these are the most critical years to invest in the development of the child;

- investing in these early years and in the early stages when challenges in a child's life are becoming evident are both more effective than investing in dealing with the chronic later phases of these problems;
- investing in the early years of a child's life and the early stages of social problems before they become chronic can produce very substantial savings to the public purse in later years;
- prevention science is critically important in demonstrating, through robust research, usually involving random control trials, what interventions actually work; and
- being clear about the specific outcomes that any intervention is designed to impact on is vitally important.

4. Public Policy Context

Although the concepts around an early intervention approach have only become commonly discussed internationally in the last decade, they have now had a significant impact on the strategic thinking of a range of government departments and agencies in Northern Ireland, which now emphasise prevention, early intervention and evidence-based practice, although actual implementation of the approach is still at a very early stage. It requires a longer-term perspective in realising the savings to the public purse of such an approach and the breaking down of departmental silos, as the positive outcomes of an investment from one department may accrue to another department.

5. Theory of Change

The report outlines a logic model which demonstrates the links between the investment of resources; the programmes to be delivered; the outputs from these programmes; the outcomes in terms of changed lives; and how each of these can be measured. The logic model suggests that the following outcomes should be addressed:

- Reduced number of teenage pregnancies
- Reduced level of smoking during pregnancy
- Improved parenting skills and confidence
- Improved parent-child attachment for 0-2 year olds
- Improved school readiness amongst 3 & 4 year olds
- Improved literacy and numeracy in children aged 4-11
- Improved social and emotional skills and resilience of 4-11 year olds
- Improved school attendance
- Improved educational aspirations and attainment on leaving school
- Reduced behavioural/conduct problems
- Reduced smoking, alcohol and drug consumption amongst young people
- Reduced crime and anti-social behaviour amongst young people

Executive Summary

Effective interventions need to commence with a family before a child is born and continue at least through primary school age. They need to include universal programmes as well as targeted services.

In order to address this, the approach proposed has two key elements:

- 1) Although Lisburn is under-served in relation to support for children and families, as it does not receive regeneration funding such as Neighbourhood Renewal, despite having areas within the 10% most deprived in the 2010 MDM figures and has much worse educational outcomes than areas within the worst 10%, there is still a need improve the co-ordination, effectiveness and integration of existing services for children, young people and families in the Lisburn area by developing a common outcomes framework (which will enable impact to be measured), creating a shared focus on quality achieved through joint reflective practice, training and peer learning, whereby different organisations can learn from one another. In addition, all existing organisations will need to work together to transform the culture within the City of Lisburn, especially within areas of deprivation, to emphasise aspiration and achievement (particularly in relation to education).
- 2) The scale of the problem in Lisburn, whereby 75% of pupils from all of the three controlled / integrated schools leave without the minimum 5 GCSE with Maths and English, is such that significant new sustainable investment is needed in new interventions to break the cycle of poor outcomes, which is likely to only get worse. These new or enhanced interventions must compliment and work alongside existing community services within Lisburn so that all services are working together under a common outcomes framework. The new or enhanced interventions should also have clearly demonstrated effectiveness so that confidence can be gained that they will deliver the level of improvement required.

Specific interventions will be identified by the multi-agency Early Intervention Lisburn Consortium once funding is in place, but are likely to include interventions based on:

- intensive home visiting;
- parenting training;
- pre-school early years child development;
- additional literacy support in the primary years;
- social and emotional development; and
- mentoring support.

6. Operating Model

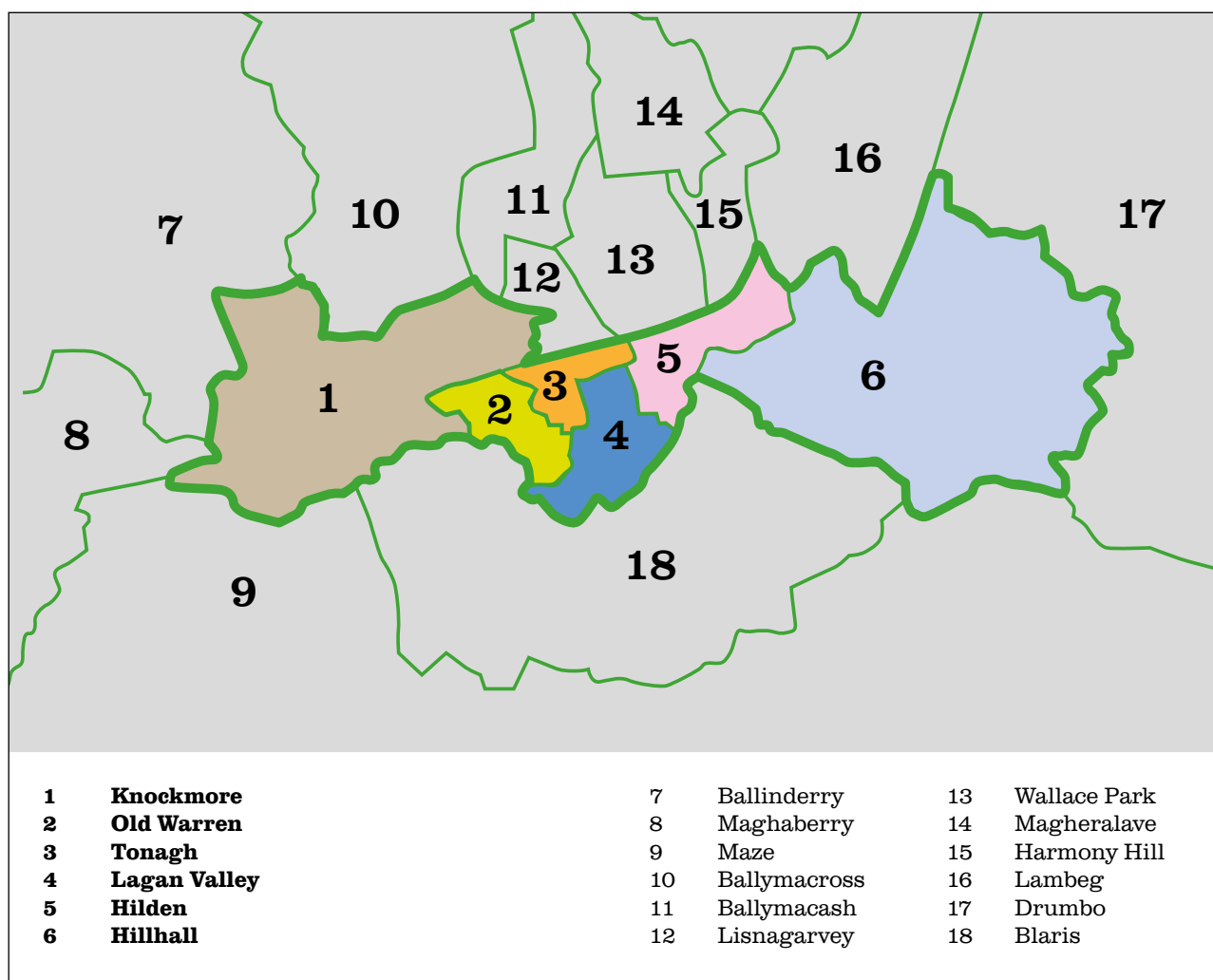
The report outlines an operating model for delivering the recommended programmes in Lisburn which will be both owned by the local community; fully engage all the key stakeholders who have an interest in outcomes for children and young people in the target areas in a collaborative approach; and be delivered by an agency with strong experience in delivering early intervention programmes for children and families.

There are also considerable advantages in developing a close relationship with other areas that have developed an Early Intervention approach. A partnership with the Early Intervention initiative in Derry-Londonderry, which is at a similar stage would have particular advantages.

7. Implementation Plan

The report outlines a medium-term implementation plan in phases for taking forward the recommendations in the report. The phased approach allows for the potential findings from the large number of RCT evaluations that will report over the next four years in future phases to be taken on board.

Introduction



This report has been commissioned by Resurgam Development Trust and funded by the Public Health Agency to explore the feasibility of an early intervention initiative to break the cycle of under-achievement amongst children and young people in disadvantaged communities in Lisburn. The concept of Early Intervention Lisburn has been pioneered by the recently created Resurgam Development Trust representing a wide range of community and youth organisations in disadvantaged areas in Lisburn.

Lisburn is a recently designated city to the south-west of Belfast on the River Lagan. It has a growing population of 117,836. It is an area of sharp contrasts. It contains some of the most prosperous areas in Northern Ireland (including Wallace Park – the most prosperous), as well as a series of disadvantaged housing estates built in phases between the end of WWII and the 1970s to encourage population growth away from Belfast. These estates include the predominately Protestant/Unionist/Loyalist Old Warren, Hillhall, Hilden and the more mixed Knockmore and

Tonagh estates. There are also significant smaller pockets of deprivation around Lisburn, including in Ballymacash and Milltown/Derriaghy.

Twinbrook, Poleglass, Kilwee and Colin Glen, while currently within the Lisburn Local Government Area, identify more with West Belfast; will become part of Belfast Council area following the implementation of the Review of Public Administration; and are already part of the successful Colin Early Intervention Community and so have not been included in this study.

The process of developing this report has involved, in addition to extensive desk research, a series of consultation meetings and workshops with communities, school principals, voluntary organisations and statutory agencies working within disadvantaged areas in Lisburn. Participants in consultation workshops and interviews have included the following who have made a valuable contribution to the development of the strategy:

Adrian Arbuthnot – Department of Education NI
Annie Armstrong - Colin Neighbourhood Partnership
Adie Bird – Chair of the Early Intervention Lisburn Steering Group/Resurgam
Owen Brady – Northern Ireland Housing Executive
Sonia Brown – Hilden Community Association
Caitlin Burns - Hillhall Regeneration Group
Tony Canavan – Department of Justice NI
Louise Clarke – Hilden Community Association
Rosie Colquhoun – Knockmore Community Association
Patricia Connelly – Tonagh Women’s Group
Jonathon Craig MLA – Member of the NI Assembly Education Committee
Evelyn Curran - Eastern Childcare Partnership
Michael Devine – South Eastern Education and Library Board
Martin Devlin – South Eastern Health & Social Care Trust
Sharon Dickson – Lisburn YMCA
Kieran Drayne - Colin Early Intervention Community
Francis Ferris – Training For Women Network and Hillhall Community Association
Sharon Gibson – Resurgam/Lisburn PSP
Paul Givan MLA – Chair of Assembly Justice Committee
Sam Hamilton - Old Warren Community Association
Ann Hardy – Children & Young Person’s Strategic Partnership
Julie Healy – Barnardo’s
Sharon Heazley – Northern Ireland Housing Executive
Hilden Women’s Group
Fiona Irvine – Tonagh Women’s Group
Ingrid Irvine – Tonagh Women’s Group

Introduction

Pamela James - Knockmore Primary School
Maureen Jamison – South Eastern Health & Social Care Trust
Maura John - Old Warren Community Association
Sheena Kerr – Tonagh Women’s Group
Tommy Kynes - Old Warren Community Association
Alice Lennon - South Eastern Education and Library Board
Julie Lenaghan – Tonagh Women’s Group
Helen Lewis - Brownlee Primary School
Monica McCann – Barnardo’s
Eamon McCarthy – Derry Healthy Cities
Patricia McCormick – Hilden Community Association
Jim McLaughlin – Derriaghy Community Association
Margaret McCormick - Fort Hill College
Neil McGivern – SEELB
Pauline McMillan - Lisburn YMCA
James Martin - Laurelhill Community College
Monica Meehan – South Eastern Education and Library Board Youth Service
Edward Milliken – Hillhall Regeneration Group
Lawrence Milliken – Hillhall Regeneration Group
Jason Milliken – Hillhall Regeneration Group
Tony Morgan – University of Ulster
Gail Mullan - Hillhall Regeneration Group
Ashley Mulligan - Killowen Primary School
Old Warren Women’s Group
Denis Paisley – Old Warren Youth Initiatives
Sarah Jane Patterson – Community worker Knockmore/Tonagh
Heather Phillips – Hilden Community Association
Paul Porter – Lisburn City Councilor
Tanya Porter – Hilden Community Association
Marian Quinn and other staff – Tallaght West Childhood Development Initiative
Seamus Quinn - St Patrick’s Academy
Gordon Rea – Hilden Community Association
Jim Rose – Lisburn City Council
Mabel Scullion – Public Health Agency
Jim Sheerin - Lisnagarvey High School
David Smith - South Eastern Regional College
Claire Spiers - Tonagh Primary School
Julie Stephenson – Department of Education NI
Harry Stewart - Largymore Primary School
Ian Sutherland - South Eastern Health & Social Care Trust
Fiona Teague – Derry Health Cities
John Todd – Department of Justice NI

Chris Totten – Public Health Agency
Lisa Tucker – Raggedy Bap
Laura Turner – Ballymacoss/North Lisburn
Anne Watson Knockmore Community Association
Jason White – South Eastern Health & Social Care Trust
Andrew Williamson - Old Warren Primary School

The research and consultations were guided by the Early Intervention Lisburn Steering Group (list of members of the steering group are shown in Appendix 1).

The report is in six main sections:

Section 2 looks at the needs of disadvantaged communities in Lisburn in relation to health, wellbeing, parenting, safety, security and education.

Section 3 explores the concept of Early Intervention and why it has become critical in the development of thinking about social programmes internationally as well as in the UK and Ireland.

Section 4 explores the relevant Northern Ireland public policy context and its relevance to the Early Intervention evidence-based approach

Section 5 outlines a Theory of Change and Logic Model and assesses and highlights the evidence-based programmes that have been shown to make a significant impact on the outcomes which are appropriate for Early Intervention Lisburn

Section 6 explores the most appropriate operating model for engaging all the key stakeholders in delivering the Early Intervention Lisburn vision

Section 7 provides a suggested implementation plan for taking forward the early Intervention initiative.

The needs of disadvantaged communities in Lisburn

2.1 Introduction

The following section outlines the issues of concern that were highlighted in community consultations, along with an analysis and summary of the available data on various forms of disadvantage in the target areas in Lisburn which prevent children and young people achieving their potential.

The Northern Ireland Statistics and Research Agency (NISRA) gathers data on all wards and Super Output Areas (SOAs) in Northern Ireland from a variety of sources, which it disseminates through its NINIS database. This data provides a range of important information about the target disadvantaged communities in Lisburn.

Some of the analysis below refers to electoral wards and others to Super Output Areas (SOA), where the information is available. Some SOAs are co-terminus with the electoral wards (e.g. Old Warren and Tonagh). In Hillhall, Hilden and Knockmore wards, however, there are two SOAs in each ward. The boundaries of wards or SOAs may not be the same as the boundaries of a community as perceived by the residents within those boundaries. The Knockmore estate, for example, is in Old Warren rather than the Knockmore ward. Part of the Old Warren estate is in Lagan Valley ward.

Significant pockets of deprivation can also be contained within a ward or SOA that also contains comparative affluence, so that the scores/rankings for the ward/SOA may mask the existence of these smaller pockets of deprivation around Lisburn, including in Ballymacosh and Milltown/Derriaghy.

Population (by ward and SOAs)*

The estimated populations (and religious breakdown) of each of the target wards and SOAs in 2011 are as follows:

Old Warren (70.4% Protestant and 24.9% Catholic)	2,401
Tonagh (62% Protestant and 35.4% Catholic)	2,537
Hillhall (90.2% Protestant and 5% Catholic)	2,815
Hillhall 1 (88.7% Protestant and 5.9% Catholic)	1,412
Hillhall 2 (76.1% Protestant and 18.4% Catholic)	1,403
Knockmore (76.1% Protestant and 18.4% Catholic)	3,537
Knockmore 1 (73.4% Protestant and 22.8% Catholic)	1,862
Knockmore 2 (79.2% Protestant and 13.6% Catholic)	1,675
Hilden (89.5% Protestant and 5.4% Catholic)	2,826
Hilden 1 (84.2% Protestant and 8.7% Catholic)	1,351
Hilden 2 (94.4% Protestant and 2.4% Catholic)	1,475
Lagan Valley	2,967
Lagan Valley 1 SOA (84.6% Protestant; 8.9% Catholic)	1,379
Total population	17,083

Number of Children (under 16)*

The estimated total number of children in the target areas in 2010 are as follows:

Ward	SOA	Total no. of children	0-2 year olds	3-5 year olds
Old Warren	Old Warren	600	116	128
Tonagh	Tonagh	512	79	97
Hillhall		611	122	115
	Hillhall 1	296		
	Hillhall 2	316		
Knockmore		757	157	242
	Knockmore 1	329		
	Knockmore 2	427		
Hilden		588	110	112
	Hilden 1	293		
	Hilden 2	294		
Lagan Valley		573	98	119
All target areas		3,641	682	717

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

The needs of disadvantaged communities in Lisburn

Births*

There were the following number of births in the target areas during 2009/10:

Derryaghy 1	119 (2010/11)
Knockmore	73
Hilden	57
Tonagh	44
Old Warren	41 (46 in 2010/11)
Hillhall	37 (23 in Hillhall 1 SOA in 2010/11)
Lagan Valley	36
Total number of births:	288

2.2 Multiple Deprivation

This section looks at the NINIS composite measure of deprivation* and some of the views that emerged from the community consultations.

Multi-deprivation 2010 rankings*

The following are the MDM rankings for the target areas of Lisburn out of 582 wards and 890 SOAs:

Ward	MDM ranking	Comments
Old Warren	32nd	Within the 10% most deprived wards
Tonagh	103rd	Within the 20% most deprived wards
Hilden	154th	Within the 30% most deprived wards. Hilden 1 SOA is ranked 299th out of 890 SOAs; Hilden 2 is ranked 227th
Lagan Valley	156th	Within the 30% most deprived wards; SOA Lagan Valley 1 is ranked 231st out of 890, just outside the worst 25% most deprived SOAs
Hillhall	203rd	Super Output Area Hillhall 1 is one of the 20% most deprived SOAs in NI – ranked 145th
Knockmore	285th	SOA Knockmore 1 is ranked 550th out of 890; Knockmore 2 SOA is ranked 310th

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

Economic wellbeing – income support(2011)*

Old Warren	Consistently much worse than the NI average on all income support indicators. It is more than twice the NI average for the number of children living in income support households. It is two and three-quarters times the NI average for lone parents claiming income support
Tonagh	Worse than the NI average for number of children in income support households and number of lone parents claiming income support
Hilden	Consistently worse than the NI average on all income support indicators
Hillhall	Worse than the NI average on the number of children in income support households and lone parents claiming income support
Knockmore	18% above the NI average of number of income support claimants and income support claimants with a disability premium
Lagan Valley	20% above the NI average for income support claimants; a third above the NI average for number of children in income support households; and 57% above the NI average for lone parents claiming income support

Community Consultations

Consultations with communities and professionals working in the target areas (see the list of consultees in the Introduction) highlighted the serious impact of socio-economic disadvantage on families in the target communities.

One community representative described the sense of economic exclusion from local facilities, such as the nearby leisure centre and activity centre, which are unaffordable to many families on low incomes. The same representative also described the challenges for low income families who have a child who gains a place in a grammar school which expects parents to pay a “voluntary” fee, plus the cost of the uniform, school trips, tuition, etc. Middle class families can afford to pay for special tutors to help ensure the child passes the 11+ tests, and gains extra help with key subjects if they require it, as well the other additional contributions expected by grammar schools.

The community consultations highlighted concerns about increasing levels of unemployment (although lower than many other areas of significant deprivation); the increasing number of jobs which are temporary, part-time and/or low paid; and problems of unemployability due to the low levels of educational achievement, discussed below.

The consultations also highlighted the impact of a “benefits culture” particularly for families where no-one is working, where, to enhance their meagre incomes, their efforts are often focused on maximizing benefits claims for medical

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

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conditions or disabilities amongst the parents and children. The benefits trap which makes it disadvantageous for parents to take up low paid employment because they will be worse off was also highlighted.

The lack of affordable childcare was also cited as another barrier in parents gaining paid employment during various of the consultations with community and women's groups in the target areas. It is supported by the lack of identifiable all-day childcare provision in the areas.

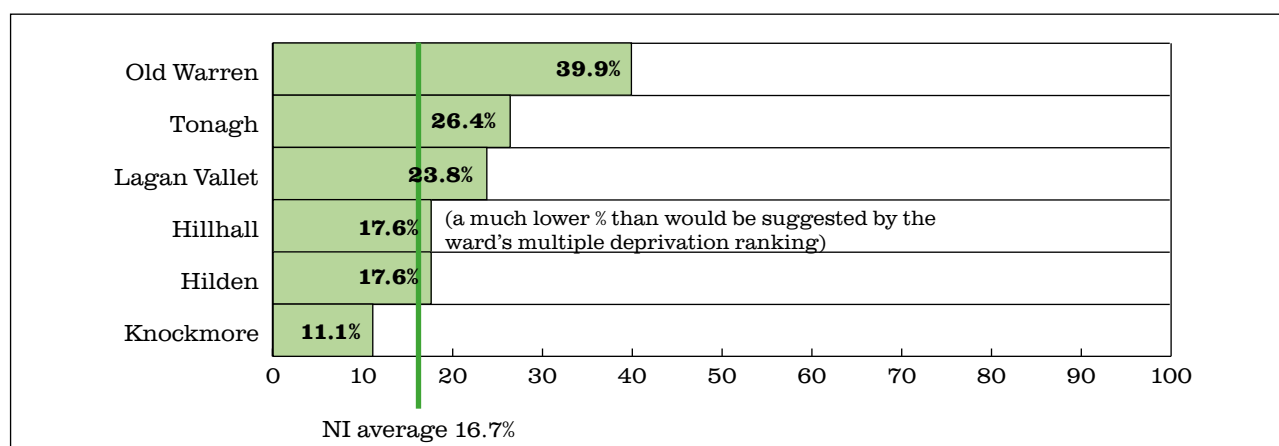
2.3 Education

This section explores the relevant data on educational performance (based on 2009/10 statistics from DENI). It highlights the inadequate educational outcomes for many children in disadvantaged communities in Lisburn, much of it reflecting the environmental factors in the lives of the children.

Please note that statistical information by ward provided by NINIS is from the year 2009/10. Statistical information from the Department of Education on school performance is for the year 2010/11

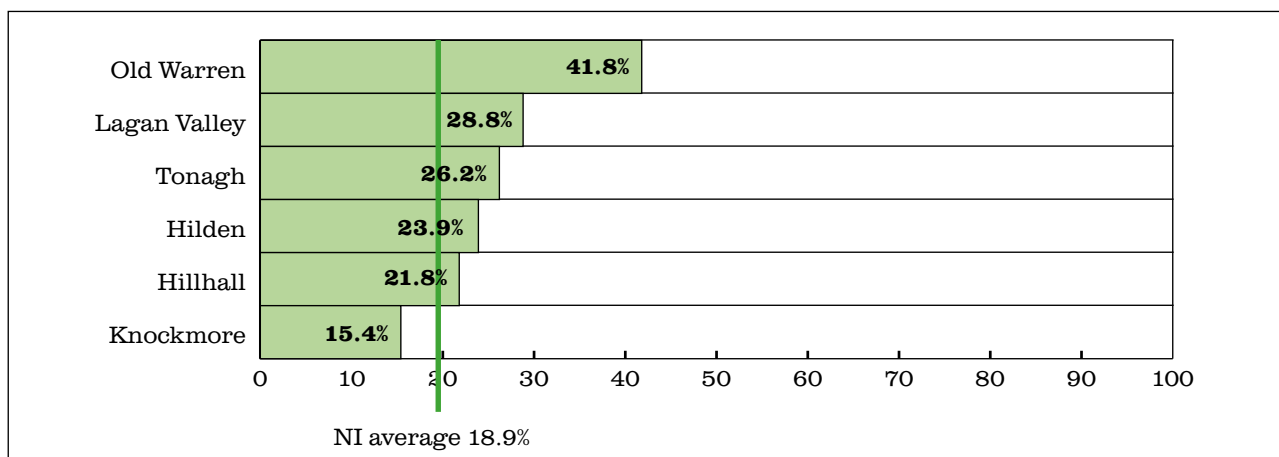
Percentage of post-primary pupils entitled to free school meals

Mostly consistent with the Multiple Deprivation Measures for each ward, highlighted above, the following are the percentage of children entitled to free school meals in each ward:



Percentage of pupils statemented/SEN years 1-7

All the target wards are above the NI average of 18.9%, in terms of the percentage of pupils in school years 1 to 7, who have been statemented as a result of learning difficulties or designated as having special educational needs, except for Knockmore which is below average (15.4%):



At post-primary level, more than one quarter (27.7%) of students at Laurelhill Community College have special educational needs; 20.9% at Fort Hill College. and 13.3% at Lisnagarvey Secondary School.

Speech and language difficulties

The number of speech and language referrals for children aged under 16 at the time of referral in the target areas are shown in the table below:

LISBURN WARD	New	Review	Group Contact	Can C	Did not respond /attend	Grand Total	Multiple Deprivation Ranking
BALLYMACOSS	45	705	353	112	46	1261	395
DERRYAGHY	64	667	289	89	68	1177	198
HILDEN	17	315	254	36	30	652	154
LAGAN VALLEY	16	375	194	35	19	639	156
TONAGH	15	318	230	31	15	609	103
BALLYMACASH	20	371	146	28	25	590	575
BLARIS	12	376	156	25	15	584	470
OLD WARREN	17	243	261	31	19	571	32
HILLHALL	17	282	220	22	25	566	203
KNOCKMORE	27	239	92	47	35	440	285
TWINBROOK	12	243	116	19	34	424	10
POLEGLASS	30	213	90	39	42	414	80
WALLACE PARK	11	174	54	15	14	268	582
LISBURN (all wards) Total	619	9230	4736	1191	753	16529	

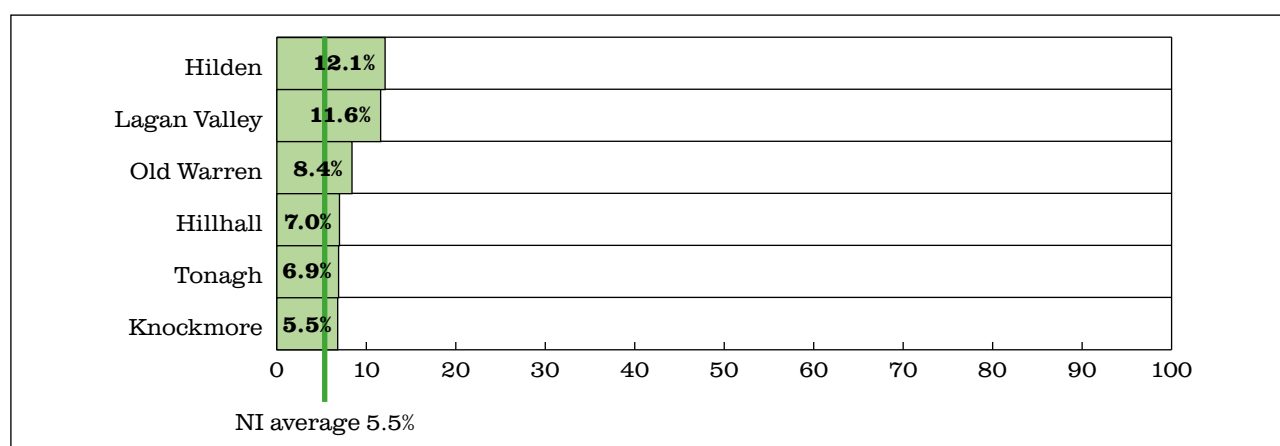
Twinbrook, Poleglass and Wallace Park wards have been included by way of contrast.

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It might have been expected that children from more deprived wards are likely to experience greater problems with their speech/language. This table, however, does not confirm any relationship between the level of deprivation of a ward and the number of referrals of children with speech and language difficulties. The lack of any expected relationship may be to do with the confidence of more middle-class parents to access the services they feel their child, who is experiencing speech or language delays, requires, counterbalancing any relationship with deprivation.

Percentage of poor attendance (less than 85%) at primary school

All the target wards are worse than the NI average of 5.5% in terms of children not achieving 85% attendance at primary school:



Sub-domain for primary school ranking

NINIS calculates a sub-domain score and ranking, based in data from 2006/7-2007/8. It is calculated using three sets of indicators:

- The % of children achieving level 4 or higher at key stage 2
- The % of children with special educational needs
- The level of absenteeism

The general relationship between the SOA NINAS primary school sub-domain rankings and the Multiple Deprivation rankings is highlighted in the table below. However, the Hilden SOAs (with a multiple deprivation rankings of 227 and 299) have primary school sub-domain rankings of 117th and 119th, which are much worse than would be expected. Tonagh, Lagan Valley 1, Knockmore 1 and Hillhall 2 are also worse than would be expected from the Multiple Deprivation Rankings. Old Warren and Hillhall 1 are better than would be expected.

SOA	Primary School Ranking	MDM Ranking	Comments
Hilden 2	117th	227	Within the worst 15% of SOAs
Hilden 1	119th	299	Within the worst 15% of SOAs
Old Warren	129th	85	Within the worst 15% of SOAs
Tonagh	138th	192	Within the worst 15% of SOAs
Lagan Valley 1	187th	231	Within the worst 25% of SOAs
Knockmore2	312th	310	
Knockmore1	383rd	550	
Hillhall1	397th	145	
Hillhall2	430th	612	

Primary School Performance at Key stage 1 and 2 (English and Maths)¹

The expectation is that all primary school pupils will achieve at least level 2

English and Maths at key stage 1 and level 4 in English and Maths at Key Stage 2.

The table below shows the number of primary schools in Lisburn that do not enable 90% of their pupils to achieve these standards, out of a possible maximum of 14 schools. They are partly based on subjective teacher assessments so they need to be treated with some caution.

Stage and Level	The number of primary schools not achieving 90% of the target	The number of primary schools in Lisburn achieving below the NI average for that band of free school meal entitlement	Comments
Key Stage 1 Level 2 English	5	6	3 of the schools not achieving 90% have a free school entitlement of 30%+. Three are currently Extended Schools ² , two of which have nursery classes. Two are below their target intake
Key Stage 1 Level 2 Maths	3	8	Only 1 of the schools not achieving 90% has a free school entitlement of 30%+. It is currently an Extended School with a nursery class. It below its intake target
Key Stage 2 Level 2 English	8	6	4 of the schools not achieving 90% have a free school entitlement of 30%+, all of which are currently Extended Schools, two of which have a nursery class and one a reception class. Two are below their target intake.
Key Stage 2 Level 2 Maths	8	7	4 of the schools not achieving 90% have a free school entitlement of 30%+, all of which are currently Extended Schools, two of which have a nursery class and one a reception class. Two are below their target intake.

¹ From Key Stage One & Two Assessments for schools in the Lisburn Area in 2010/11 – Department of Education

² The 2012/13 Extended School entitlement will be determined prior to September 2012.

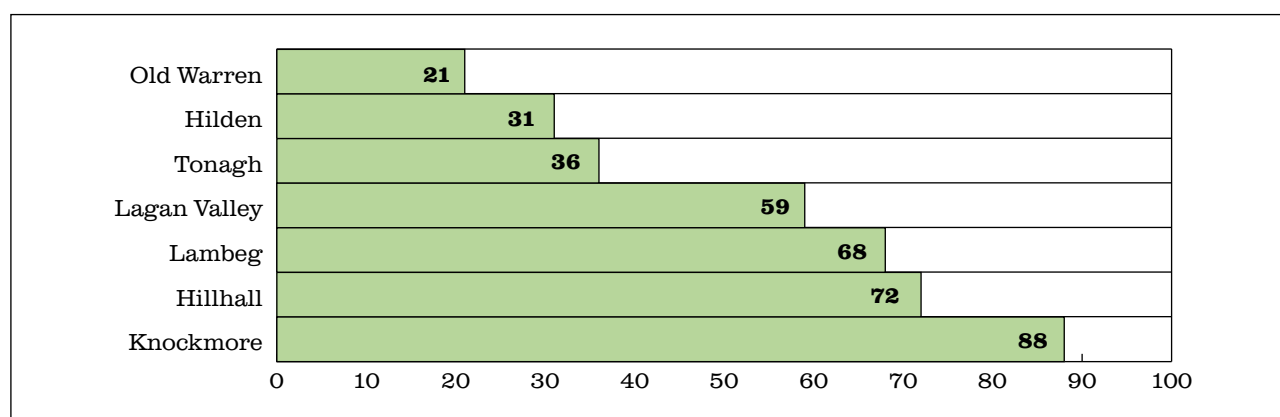
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These primary school Key Stage 1 & 2 findings would suggest serious concerns about the Stage 1 results in five of the primary schools (five in English and three in Maths) and Key Stage 2 results in seven primary schools in both English and Maths. Surprisingly, four of these schools have less than 20% of pupils entitled to free school meals.

Two of the primary schools listed send 70%+ of their pupils to a grammar school. Five primary schools (including the above two) send more than half of their pupils to a grammar school. Six of the schools sent 20% or less of their pupils to a grammar school. The findings also show that good results at Key Stage 1 do not necessarily mean good results at Key Stage 2 and visa-versa.

These statistics on primary school performance are very interesting, because there is a weaker link between the assessment scores and the percentage of pupils entitled to free school meals (a measure of deprivation) than the literature would suggest. This implies that, in addition to the role of parents, the role of the school is very important in increasing the aspirations and achievement of children.

By ward, the numbers (not percentage) of pupils who are resident in the target areas and attend a grammar school are as follows:



By way of contrast, the figure for Wallace Park is 175 and the figure for Poleglass is 125.

The results suggest that, on average, at Key Stage 2, about one quarter of pupils in Lisburn Extended Schools are not achieving the minimum acceptable standard at Key Stage 2 English or Maths. However, the actual percentage varies between schools and subjects: from 19.45% to 53.55%. These 25% of primary school pupils (and the worst performing schools) should be an important focus of any Early Intervention initiative and the generations which are likely to follow in their footsteps, unless decisive action is taken.

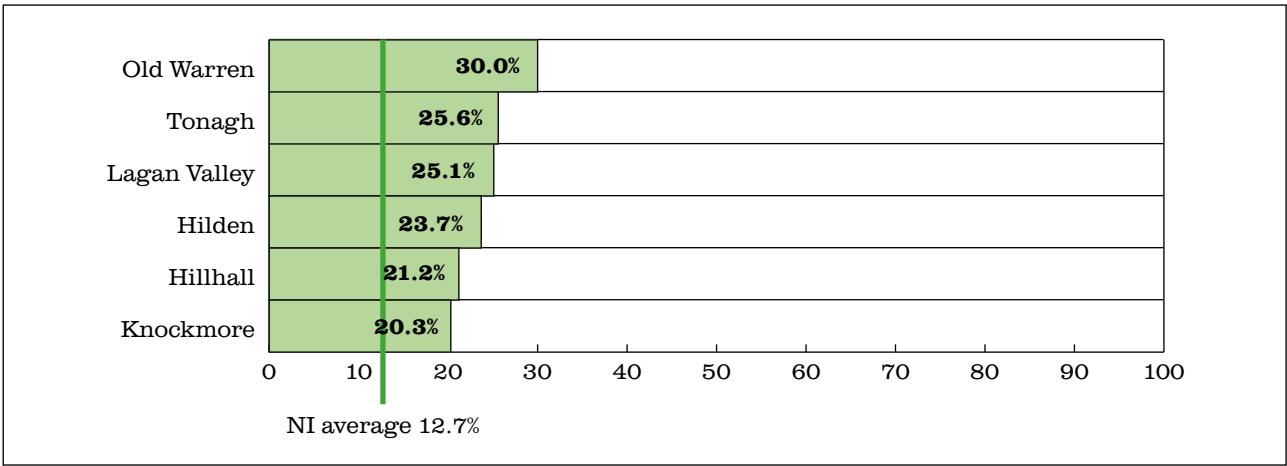
These primary school results would suggest, subject to the outcome of the audit of schools that is currently taking place, which may result in further school closures, any primary schools initiative should, perhaps, be concentrated on the schools designated as Extended Schools (3 of which have nursery classes and 1 which has a reception class), or on the four of the Extended Schools with the lowest key stage results (two of the Extended Schools have impressive Key Stage 1 & 2 results).

The evaluation of the Extended School programme did not demonstrate a relationship between Extended School funding and Primary School performance, but re commended a closer relationship between the activities funded under the Extended School programme and the educational aims of the school.

Post-Primary Performance

Percentage of poor attendance (less than 85%) at post-primary school

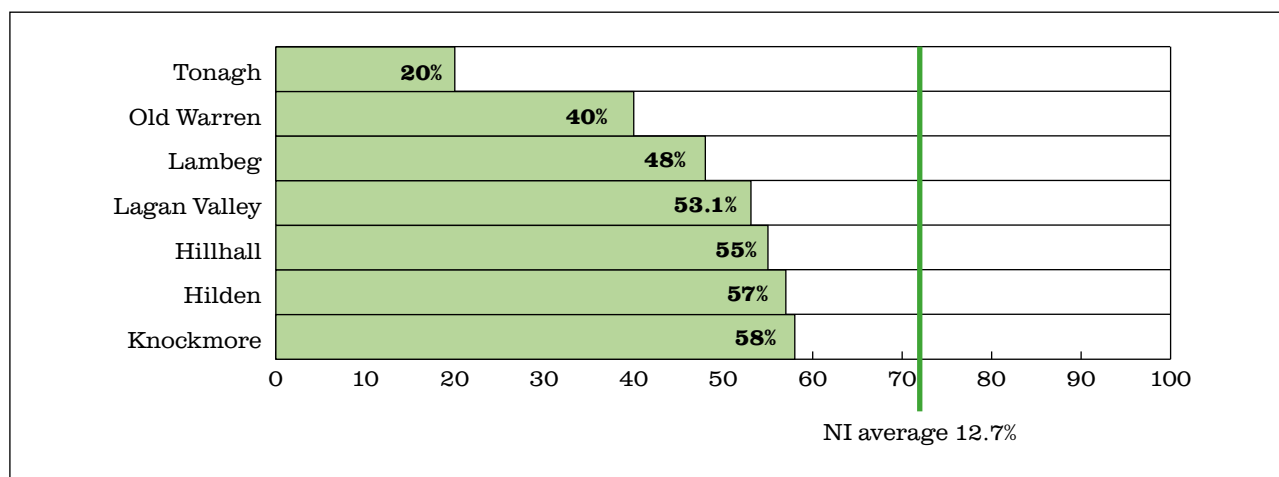
All the target wards in Lisburn are worse than the NI average of 12.7% for not achieving 85% attendance at post-primary schools:



The needs of disadvantaged communities in Lisburn

Leaving school with 5+ GCSEs at grade A*-C (2009/10)*

All the target wards are consistently well below the NI average of 72% for young people leaving school with at least 5 GCSEs at grade A* to C, including the more affluent Lambeg ward:



Average number of pupils leaving controlled and integrated schools in Lisburn in 2010/11 with 5+ GCSEs (Dept of Education)

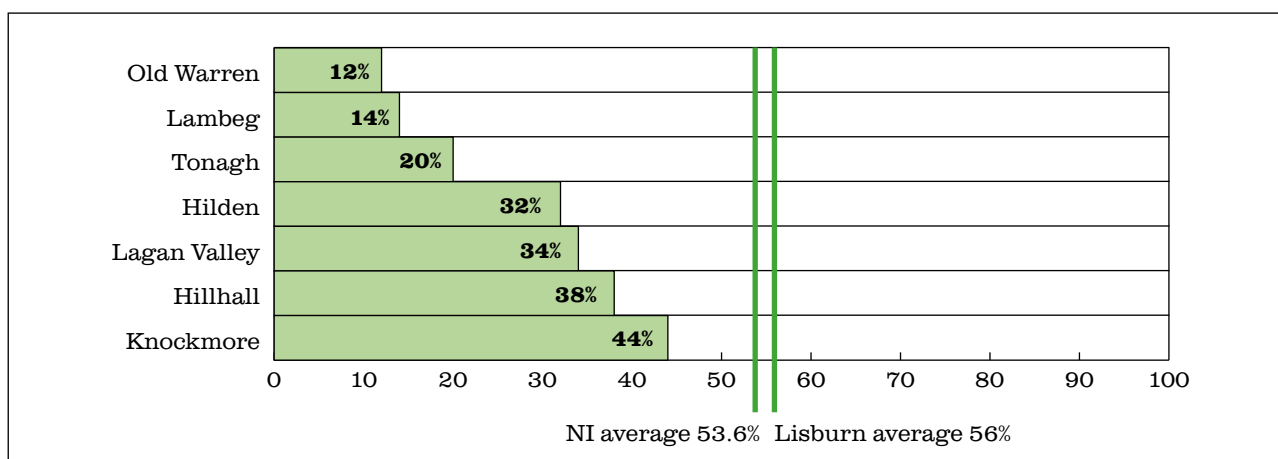
	Average and Range 2010/11	Comment
% of controlled and integrated secondary school pupils in Lisburn achieving 5+ GCSEs A*-C with English and Maths (2010/11)	Average: 24.27% Range: 19.6 – 26.7%	The average for all NI schools is 60%. (and 36% for all NI non-grammar schools). The NI government's PfG target is an average of 66% for all pupils and 49% for disadvantaged pupils by 2014/15
% of controlled and integrated secondary school pupils in Lisburn achieving 5+ GCSEs A*-C (2010/11)	Average: 44.57% Range: 43.5 – 46.4%	The average for all Lisburn schools is 75.1%. (96.8% for Lisburn grammar schools) The average for non-grammar schools in Northern Ireland is 57.3%.

One of the Lisburn secondary schools currently has Extended Schools funding. Another had the funding under a previous round. Two of the secondary schools are current subject to Formal Intervention.

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

Leaving school with 2 or more A levels

All the target wards are consistently lower than the NI average of 53.6% for young people leaving school with 2 or more A levels (56% in Lisburn). Even the more affluent Lambeg Ward has a poor record in terms of A level results:

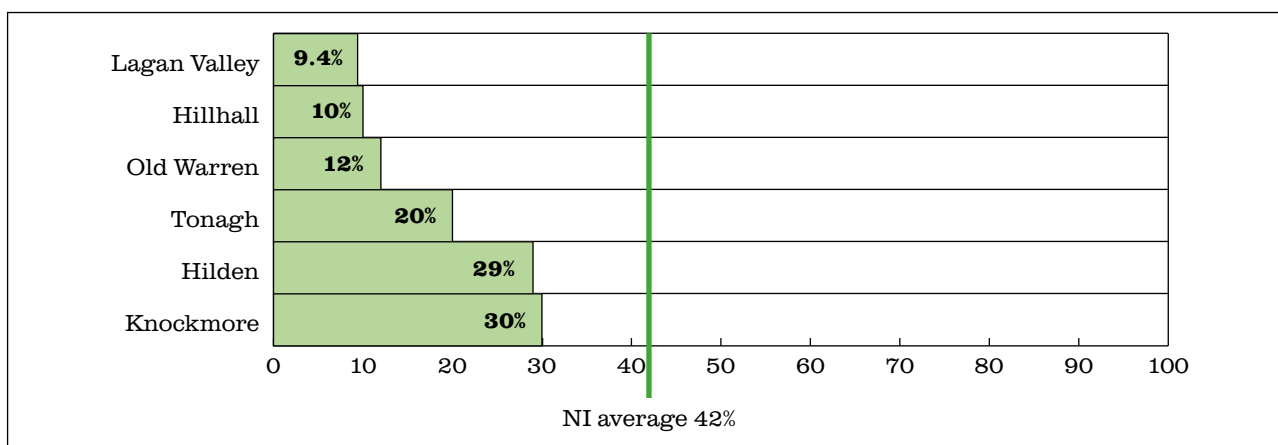


A level results of post-primary schools

The NI average for all post-primary schools A level results in 2010/11 is 51.5% leaving school with 3+ A levels A*-C (Department of Education). The average for the secondary schools in Lisburn is 35.1% (48.4% achieved 5+ GCSEs).

Percentage of school leavers in higher education*

All the target wards are worse than the NI average of 42% for young people going on to higher education i.e. university:



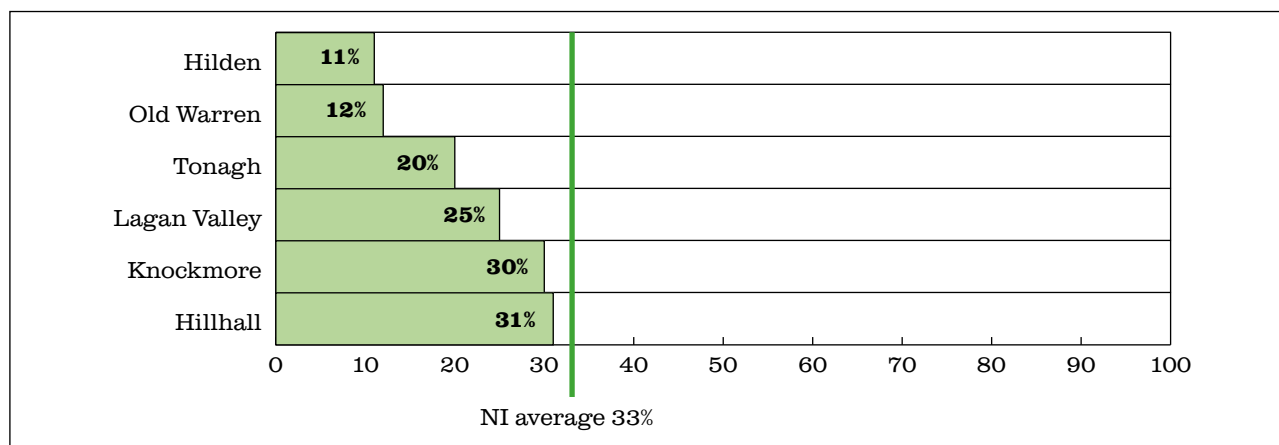
The NI average for young people leaving non-grammar schools and going on to university or equivalent is 19.2%. The NI average for young people entitled to free school meals going on to university or equivalent is 18.3%. Again boys tend to do much worse than girls.

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

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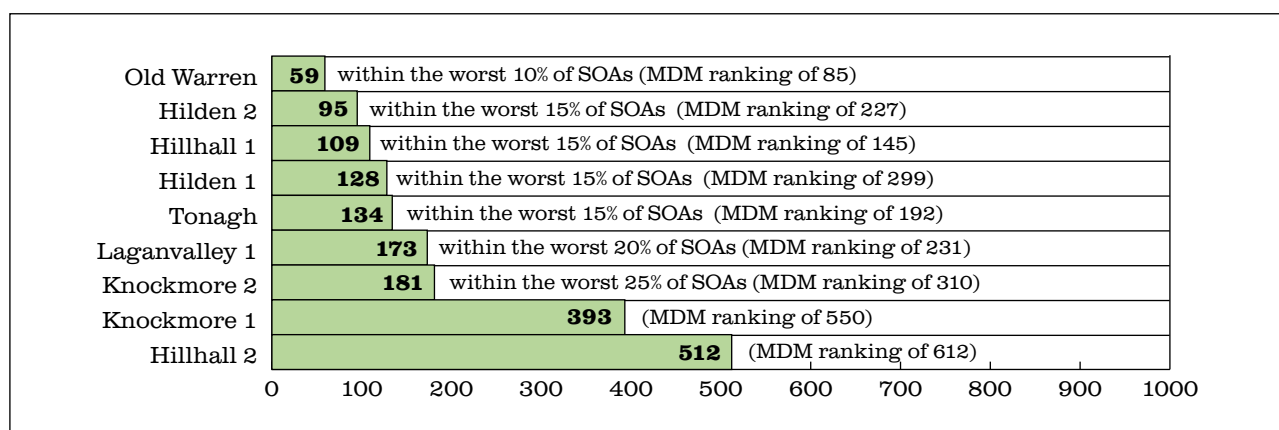
Percentage of school leavers in further education*

All the target wards are worse than the NI average of 33% (and the NI non-grammar average of 43.7%) for young people going on to further education (i.e. college):



Education, skills & training deprivation domain ranking for SOAs*

The overall NINIS 2010 education, skills & training rankings for all the target SOAs areas are much worse than their overall multiple deprivation ranking. Some of the differences are striking.



Community Consultations

The findings, above, from the statistics on educational achievement, were echoed by the findings from the community consultations. Much of the discussion around educational underachievement highlighted a vicious circle involving:

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

- parents who often themselves had poor experiences in the education system and therefore do not value education;
- poverty restricting the ability of many families to encourage their children to go to a grammar school, get extra tuition when they need it, and/or go on to university instead of getting a job;
- parents facing overwhelming personal difficulties (mental health, physical health, carer responsibilities, addiction, domestic violence, etc) themselves;
- parents having low ambitions for themselves and their children;
- parents with poor literacy and numeracy;
- parents not reading to their children;
- the tendency of children to follow in the footsteps of their parents, older siblings and/or friends, including those who have less potential;
- lack of consistent boundaries set for children e.g. letting children stay up late and are late or tired the next day in school, or not ensuring the children attend school;
- lack of consistent positive discipline, or very harsh discipline, leading to poor behaviour/conduct;
- lack of focused support for children with learning difficulties/development delay, but not stated;
- the lack of community role models championing the importance of education;
- the lack of available jobs which could create a motivator to obtain qualifications;
- lack of parental engagement with schools particularly after P1 & P2; and
- parents and teachers viewing many children as “not academic” and treating them accordingly (in contrast to middle-class parents who will tend to seek out and pay for appropriate private tuition or support service, to ensure their child will fulfill their ambitions/potential.

Parents consulted who are working tended to resent the priority given to parents on income support or jobseekers allowance in obtaining places in nursery schools; as well as nursery places being allocated to middle-class children from outside of the area.

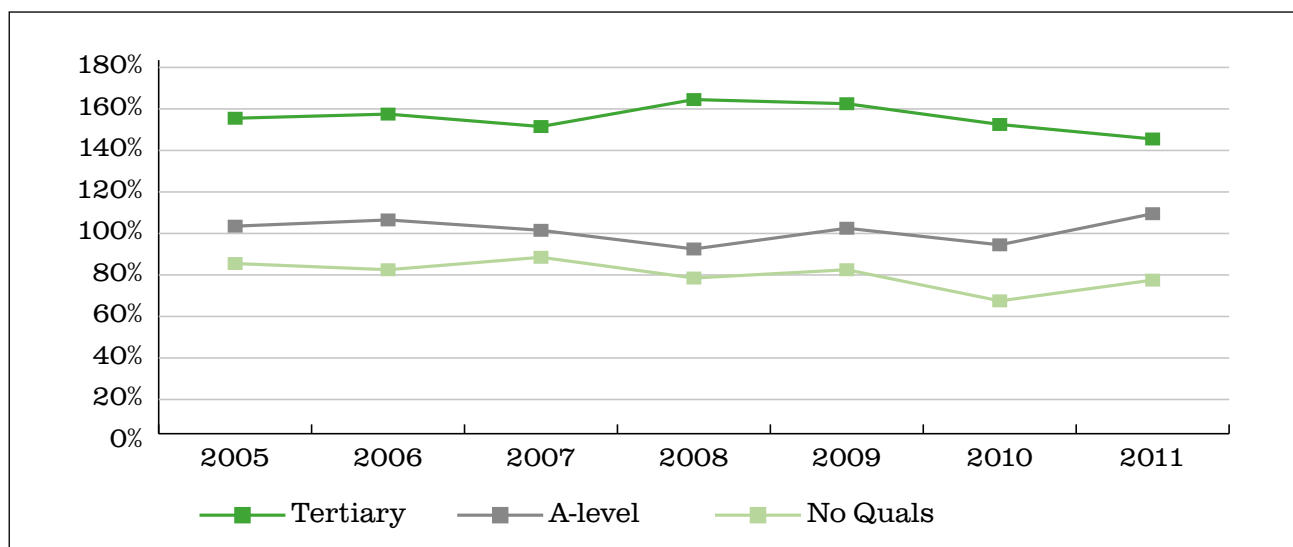
The consultations also highlighted the particular challenges faced by the increasing number of lone parents. One teacher highlighted a particular class in their school which had no fathers living with their children. The vast majority of primary school teachers are also women, raising concerns about the lack of positive male role models in the lives of boys.

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Consequences of poor educational outcomes

Leaving school with few or no qualifications has very significant implications for the outcomes for that child in later life. Of those who left school with no qualifications in Northern Ireland, only 45% are currently in any form of employment. The qualifications gained also have a major impact on the income of the individual, as shown by the graph below.

Wage Rates by Qualification Level



Those with a third/tertiary (degree) level qualification earned more than 40% above the average. Those with no qualifications earned only c.75% of the average and therefore are at high risk of poverty.

Comment on educational disadvantage

These findings show clearly that on all educational indicators the majority of children and young people in the target areas are failing to achieve their potential in terms of educational outcomes. Even attendance at school is a significant problem, right from primary school (and much worse at post-primary). Outcomes in terms of going on to a grammar school, achieving GCSEs, A levels and going on to college or university are very significantly lower than the NI average.

The extent of educational disadvantage is much worse than would be anticipated from the data on economic disadvantage (see above) alone and compares poorly with other more economically disadvantaged predominantly Catholic/Republican areas.

If the evidence in relation to gender for Northern Ireland as a whole is the same in Lisburn, it is also likely that boys in Lisburn are performing more poorly than girls.

These findings are consistent with the findings of the PWC NI-wide study commissioned by the Department of Education in 2008, which showed that at Key Stage 2 English and Mathematics, proportionately four times as many controlled schools were underperforming in NI compared to maintained schools. At GCSE English and Mathematics, 14% of controlled schools in NI were underperforming, compared with 4% of maintained schools. They also support the conclusions of the Purvis Review in relation to under-achievement of Protestant working-class children.

It is common for schools to be blamed for this under-achievement. However, the research evidence shows that 75-90% of the difference between children who achieve and under-achieve is due to factors outside of the control of schools, particularly in relation to parents who themselves have under-achieved educationally and, as a result, do not value education.

2.4 Health & Wellbeing

This section looks at some of the measurable indicators of health within the target disadvantaged communities in Lisburn and the views of those involved in the community consultations.

Dental registrations of young children¹

The levels of dental registrations of 0-2 and 3-5 year olds in 2011 are consistently lower than the NI average (27.8% for 0-2 year olds and 63.6% for 3-5 year olds) in all the target areas, except for 0-2 year olds in Hillhall.

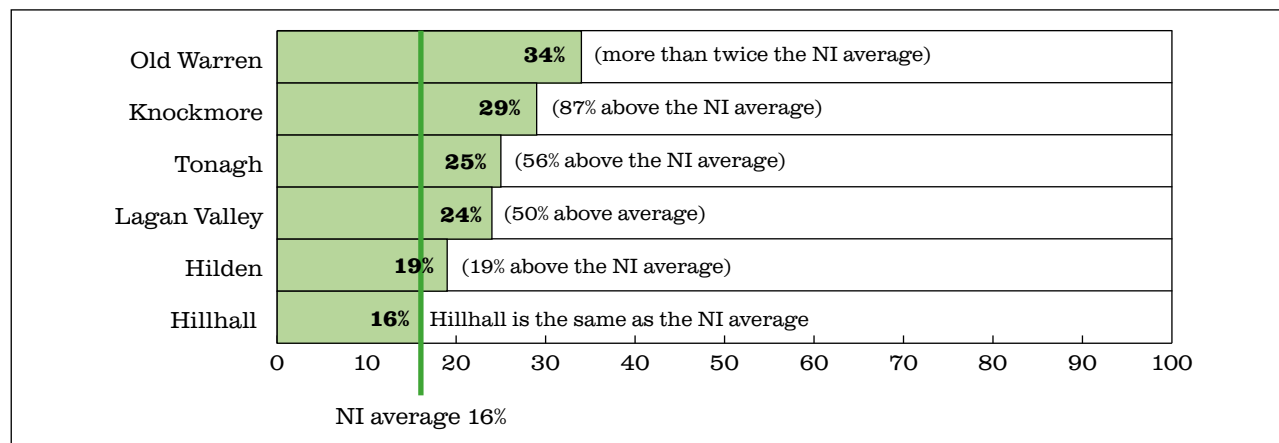
Ward	Dental registrations of 0-2 year olds	Dental registrations of 3-5 year olds	Comment
Old Warren	19.6%	43.2%	68% and 70% respectively of the average
Lagan Valley	17.9%	46.7%	64% and 73% respectively of the average
Tonagh	21.6%	40.2%	78% and 63% respectively of the average
Hilden	24.8%	49.5%	89% and 78% respectively of the average
Knockmore	24.4%	54.3%	88% and 85% respectively of the average
Hillhall	27.9%	51.8%	The same as the NI average for 0-2 year olds but only 81% of the average for 3-5 year olds
NI Average	27.8%	63.6%	

¹ Dental Registrations 2011 CSA

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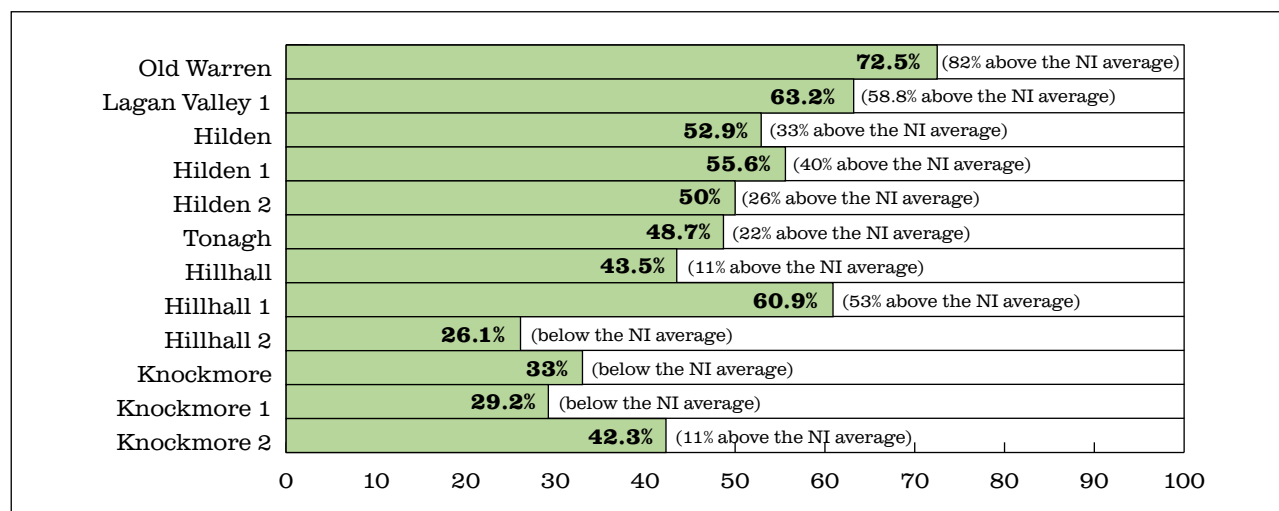
Smoking during pregnancy

Mothers in most of the target areas are much more likely to smoke during pregnancy than the NI average of 16%:



Percentage of births to unmarried mothers²

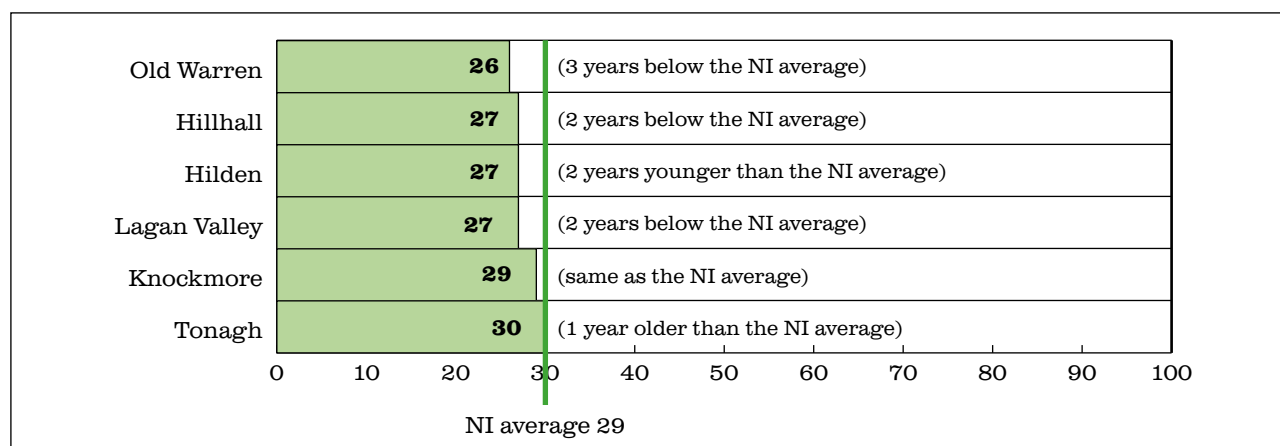
Most of the target areas are substantially above the NI average of 39.8% for the percentage of births to unmarried mothers in 2009, except for Knockmore 1. The SOAs with the highest % of births to unmarried mothers are Old Warren, Lagan Valley 1 and Hillhall 1.



² NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

Median age of mothers of new-born babies (not available by SOA)

The NI average age for mothers of new-born babies is 29. The average in Old Warren, Hillhall and Hilden is younger than the NI average.

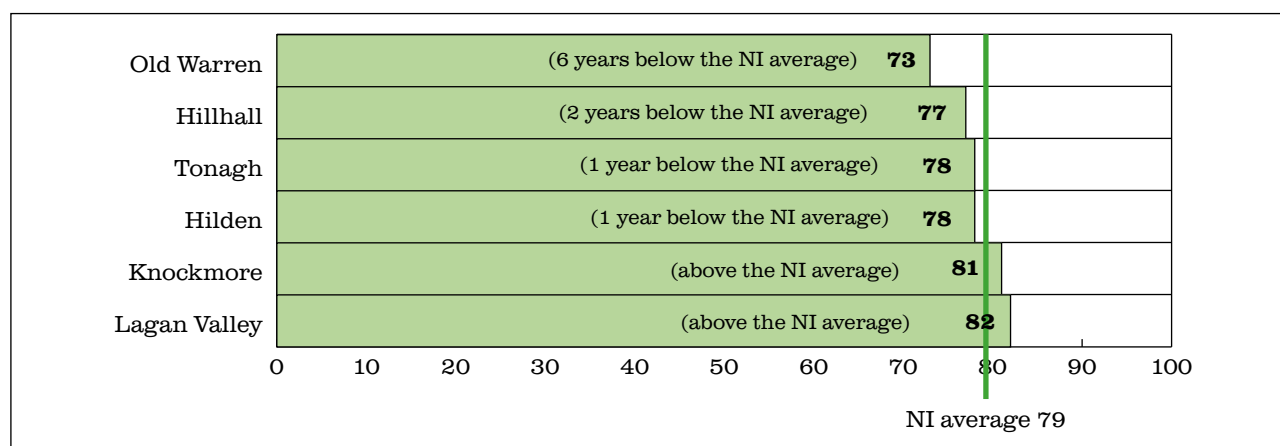


Life Expectancy

Life expectancy (see median age at death, below) is below the NI average for both men and women in Old Warren and Tonagh. It is also below the NI average for men in Hillhall and for women in Knockmore.

Median age at death (not available by SOA)

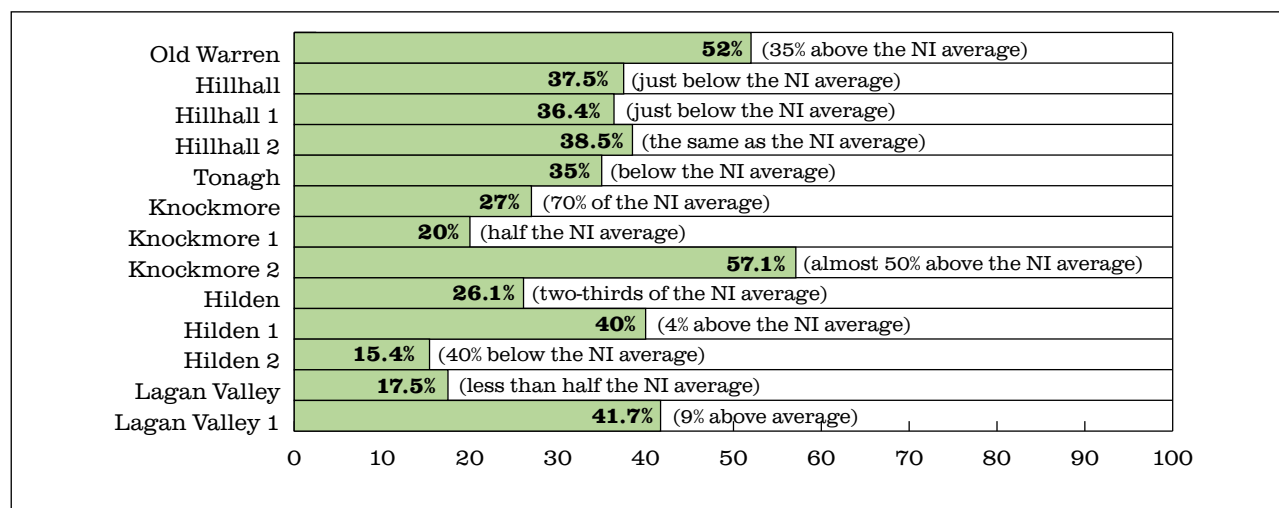
Most of the target wards have an average lifespan below the NI average of 79. Of particular concern is Old Warren where the difference is 6 years.



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Percentage deaths under age 75*

Old Warren and Knockmore 2 are well above the NI average of 38.4% for the percentage of deaths in 2009 for people under the age of 75.



Community Consultations

The community consultations also highlighted a range of physical, mental and sexual health related issues of concern, which, in the research literature, are often associated with geographical areas of significant disadvantage. These inter-related issues include the following:

- Smoking (including smoking during pregnancy)
- Heavy drinking (including drinking during pregnancy)
- Drug use, especially prescription drugs
- Depression and other mental health difficulties
- Self-harm and suicide
- Unhealthy eating
- Obesity
- Lack of exercise

Comments on health and wellbeing issues

The statistics and community consultations raise significant concerns about health and wellbeing issues in the target areas. The level of early death in Old Warren and Knockmore 2 is particularly disturbing. The fact that the majority of births are to unmarried mothers reflects changes in society, but is much higher than other parts of Northern Ireland (and Lisburn). It reinforces the evidence from schools of the high level of lone parents, which can have significant implications for parenting. The high level of smoking during pregnancy is one contributing

* NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

factor to passing on disadvantage to the next generation. The level of dental registrations is a further indication of some parents' knowledge or lack of concern for the health and wellbeing of their children.

2.5 Safety and Stability

This section explores issues of safety and stability in disadvantaged communities in Lisburn, including protection of children, anti-social behaviour and crime.

Child Protection

The following table shows the number of children who were referred to social services in relation to child protection issues last year and, as children move in and out of the Child Protection Register over time, the number of children who are currently on the child protection register in each of the target SOAs:

SOA	Number of children referred (2011)	Number of children currently on the child protection register (a particular point in time in 2012)
Derryaghy 1	113 (the 2nd highest SOA in the SEHSCT area)	10
Old Warren	78	15
Tonagh	53	18 (the highest of any SOA in the SEHSCT area)
Hilden 1	34	*
Hillhall 1	33	10
Lagan Valley 1	30	7
Lagan Valley 2	27	*
Hilden 2	5	*

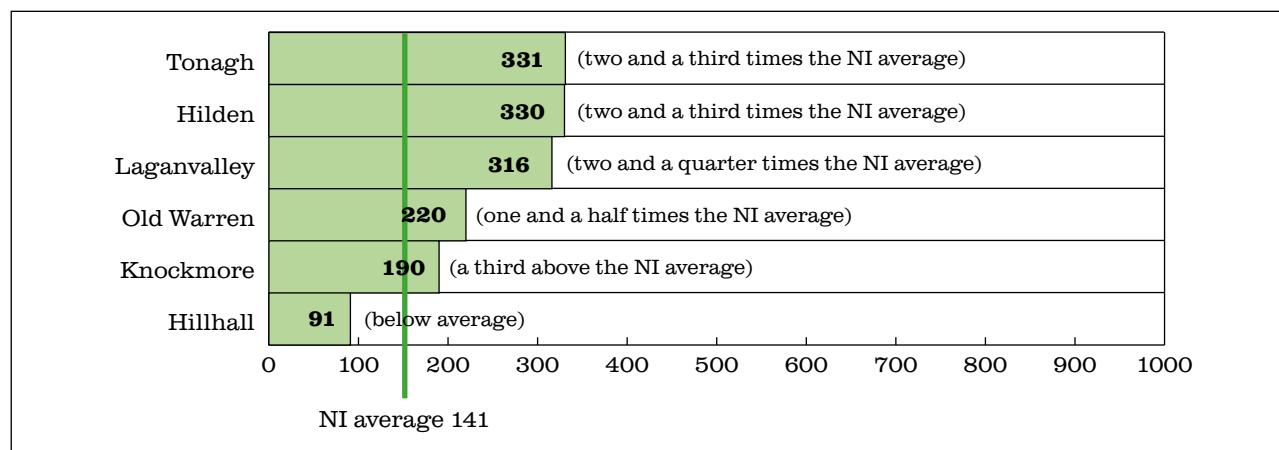
* Less than 5

These statistics suggest particular child protection concerns in Derryaghy 1, Old Warren, Tonagh and Hillhall 1.

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Number of anti-social behaviour incidents

All the target wards are well above the NI average of 141 for the number of anti-social behaviour incidents reported, except for Hillhall (91):



Number of criminal offences per 10,000 of the population (2010/11)¹

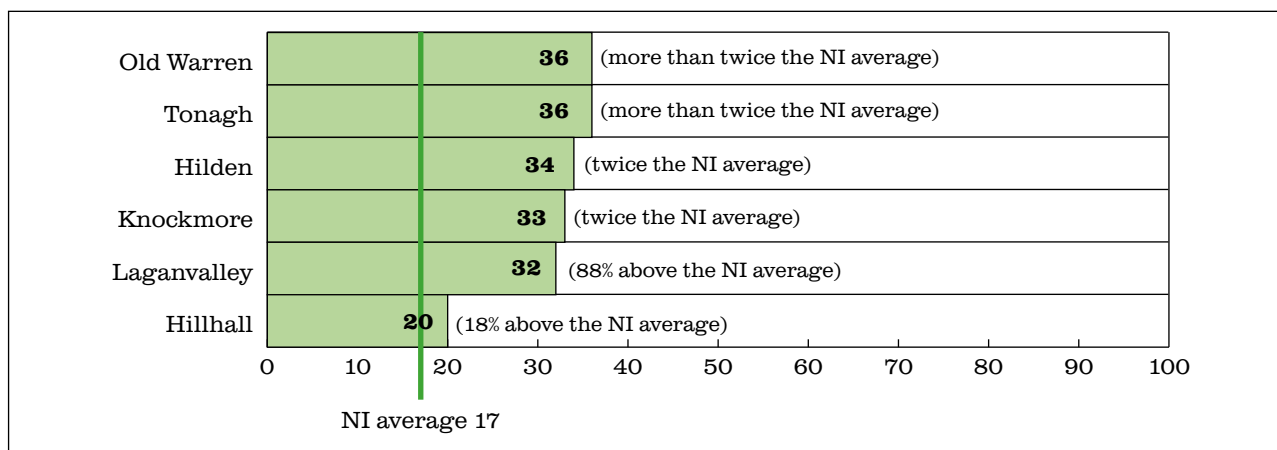
All the target wards are well above the NI average for crime, except for Hillhall and Knockmore. Violent crimes are more than twice the NI average in Hilden and Tonagh.

	Violent crimes	Criminal damage	Burglary	Other theft offences	Vehicle offences	Totals
Hilden	502.4	303.6	150	376.8	41.9	1573.6
Tonagh	477	278.9	32.3	319.3	68.7	1321.7
Laganvalley	310	330	73.3	190	40	1126.7
Old Warren	252.5	332.7	80.2	64.1	36.1	853.7
Hillhall	126.6	94	32.5	94	36.2	470.2
Knockmore	110	107.7	60.9	67.9	70.2	461.1
NI average	165.6	138.9	65.9	102.8	38.5	583.8

¹ NINIS ward and SOA profiles (www.ninis.nisra.gov.uk – last updated October 2011)

Number of domestic abuse offences

All the target wards are above the NI average of 17 for the number of domestic abuse cases reported in 2010:



Community Consultations

The consultations with local communities, schools and professionals working in the area, also highlighted concerns in relation to safety and stability, in particular:

- young people engaging in anti-social behaviour and criminal activity, including violence
- domestic violence

However, in some areas there also seems to have been important improvements in relationships with the police in starting to try to tackle some of these issues.

Comments on safety and stability

The statistics from the target areas reflect very significant concerns about child protection issues, anti-social behaviour and crime, including domestic violence, in many of the target areas, which were reinforced during the community consultations.

2.6 Parenting

A key underlying issue in all the community consultations was a major concern about parenting, which, in itself, has an impact on the other issues highlighted above of: educational under-achievement; lack of ambition; unhealthy lifestyles, etc. ensuring that the cycle of disadvantage and under-achievement is passed on generation to generation.

Parenting issues are harder to quantify in statistical information and can often only be quantified indirectly e.g. through issues like the level of dental

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registrations (highlighted under “health” above), child accidents or hospital admissions, or children on the risk register, or in care.

However, parenting came up as the major theme in nearly all the community consultations. Some of the key issues highlighted in the consultations were as follows:

- Having children when the parents were too young
- Parenting skills no longer passed down through the generations
- Lack of parenting knowledge
- Lack of a parenting culture
- Lack of ownership of the education and development of their children (they are perceived as other people’s responsibilities)
- Lack of ambition for their children
- Want to be their children’s friends – lack of discipline
- Lack of engagement of fathers
- Lack of male role models

Other issues particularly concerned with parenting and health, already highlighted above, were as follows:

- Feeding their children unhealthy food
- Obesity
- Smoking and drinking
- Exercise
- Mental health issues for parents affecting the children
- Medical problems for parents affecting the children

Other issues concerned primarily with parenting and education, already highlighted above, were as follows:

- Bad experience of education themselves
- Not reading to their children
- Parents not stakeholders in our education system
- Not engaging enough with school
- Parents only interested in being involved in P1 & P2 and lose interest after that
- Not helping children with their homework
- Lack of ambition or expectation for their children
- Children being allowed to stay up late – children tired and late the next morning
- There are parents who in other ways are good parents but don’t value education
- Poor discipline at home leading to conduct problems at school

2.7 Provision for Children and Young People

Old Warren

There is one playgroup (a satellite of the Colin Surestart) in Old Warren, with a morning crèche for 10 children, while their parents participate in a programme and an afternoon programme for 2 year olds.

Raggedy Bap playgroup for children aged 2 years and 10 months, in a former NIHE house in Avonmore Park Old Warren, is managed by Old Warren Community Association. There are morning and afternoon sessions. Raggedy Bap is a member of Early Years.

Old Warren Primary School has a Nursery Class.

Knockmore

There is a playgroup each morning in Grove Activity Centre for children between 2 years and 10 months to 4 years old. St Aloysius Primary School in Knockmore estate (Old Warren ward) has a nursery class.

Tonagh

Tonagh Primary School has a reception class. There is a mother and toddlers group in a church hall in Tonagh. There is a crèche in St Columbas Presbyterian-Methodist Church.

Hilhall

The Colin SureStart has an outreach programme based in an old shop unit in Hilhall, but will be moving into a new community facility. There is a nursery (Barbour Nursery) in Hilhall Estate. Local residents have concerns about the criteria for prioritizing admission to the nursery which, in their view, favours the children of middle-class families from outside the area, and the unemployed from within the area. There is also a statutory nursery in Largymore Primary School.

Hilden

Barnardos run a Parent Infant Programme in Hilden. There is a mothers and toddlers group in the Gospel Hall. After-schools programmes are run in the community house for 5-11, 12-18 and 14/15 year olds. Some young people tend the Fusion Youth Programme in Lisburn Cathedral.

Lagan Valley

In Lagan Valley there is one playgroup, 1 day nursery (in the Hospital) and 1 After-school club.

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Ballymacash

There is a playgroup in Ballymacash Primary School (member of Early Years) and a nursery class in Killowen Primary School.

In contrast to the above provision, there are 3 playgroups, 1 after-schools club and 1 creche in Wallace Park; 3 playgroups in Twinbrook; and 3 creches, 2 day nurseries and 1 after-schools club in Poleglass.

Youth Work

SEELB is funding a qualified youth worker to provide 6 contact sessions with young people in Old Warren, through Old Warren Youth Initiatives and Streets Ahead (in Old Warren, Hillhall and Hilden). The Streets Ahead funding ends in 18 months.

A qualified youth worker is also funded by the Board to provide 6 hours youth work in Old Warren and 6 hours in Hillhall. The Board also funds a second 6 hour youth outreach post in Hillhall and one in Hilden.

SEELB is also funding full and part-time youth workers in the YMCA in central Lisburn. The Board Youth Service has asked them to focus on Knockmore.

There is a full-time youth centre as part of Laurelhill Community College, with a main catchment area of Knockmore and Ballymacash, plus Laurelhill school students from other areas.

Following the closure of Derriaghy Primary School, the site is being turned into a youth and community facility, with a full-time youth worker.

SEELB youth workers deliver the school-based “New Beginnings” programme for new year 1 pupils.

Many churches are involved in youth work in Lisburn. Six Lisburn churches have full-time youth workers. Lisburn YMCA, in addition to 1.1 family work and wrap-around support, provides youth provision in central Lisburn four nights and one afternoon a week, in addition to work with young people at risk of school exclusion, in post-primary schools; an alcohol programme in post-primary schools; advice on sexual and mental health; and training and employment for NEETS.

The Department of Education plan to issue the long-awaited “Priorities for Youth” draft youth work strategy for Northern Ireland before the summer 2012.

2.8 Conclusions in relation to indicators of need in the target communities in Lisburn

The statistics in relation to needs in the target communities, in some respects, show a pattern that is common to many working class communities and confirmed by many research studies, with low incomes; dependence on benefits; young unmarried mothers; smoking during pregnancy; emotional and mental health difficulties; and difficulties with anti-social behaviour and crime, including domestic violence.

The findings that are both shocking and unexpected from an academic perspective, are the very poor educational outcomes of a very significant number of children and young people, the vast majority of whom do not even achieve 5 GCSEs with English and Maths, and therefore do not achieve A levels or go on the university or college. Concerns about attendance at school and under-achievement are evident from primary school onwards.

Cycle of deprivation and under-achievement

These findings, in addition to the views expressed during the consultations with communities and professionals in the target areas, suggest a vicious cycle of deprivation and under-achievement, that, as the literature would suggest, is passed down through the generations and which is not broken by the current set of agencies, services and programmes working in the areas. This cycle presents major challenges in trying to bring about change. In terms of interventions, discussed later, it is possible to attempt to intervene at any point in the cycle.

The needs of disadvantaged communities in Lisburn

Cycle of Deprivation and Under-Achievement



Why early intervention

3.1 Introduction

The Centre for Excellence and Outcomes for Children and Young People (CE04) defines Early Intervention as “intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population at risk of developing problems. Early intervention may occur at any point in a child’s life” (Grasping the Nettle’ Report 2009). An early intervention approach suggests interventions:

- in the early years of a child’s life, where, the evidence suggests, many problems in later life are created and at which stage brain development is moulded;
- at the early stage of difficulty, when a child may be vulnerable to poor developmental outcomes;
- based on whole society approach to early intervention through a network of supports and services and multi-agency working;
- which are evidence-based through rigorous evaluation (either adopting evidence-based programmes which have previously been rigorously evaluated, or innovating evidence-informed programmes which are then robustly evaluated;
- are focused on clearly measurable outcomes;
- supporting and empowering parents, families and informal support networks;
- which are long-term/sustainable (not short-term funded projects which end when the funding ends);
- which combine universal (all children) prevention programmes and non-stigmatising targeted early intervention on those most at risk;
- are accessible and flexible; and
- promote participation and inclusion.

3.2 Why is Early Intervention Important?

The international evidence from a very wide range of sources and disciplines is all pointing towards the crucial importance of early intervention in tackling disadvantage and under-achievement. The main reasons are as follows:

- A series of national and international studies have shown that problems in children as young as three can predict more serious problems in the teenage years and twenties.
- A gap in capabilities of a child aged three years old from a low socio-economic group, compared with one from a high socio-economic group, will tend to increase continually throughout the child’s school years.

Why early intervention

- Brain studies have shown that the majority of the development of the human brain takes place in the first three years. How the brain develops has huge implications for the development of the child.
- It is more cost-effective to intervene at a young age. Nobel economist Jim Heckman has shown that resources invested in the early years (0-4) is likely on average to result in seven times that amount in the later life of the child in terms of reduced mental health costs, justice system costs, etc.

3.3 The Link between Poverty and Educational Disadvantage in the UK

In 2010 the Joseph Rowntree Foundation published a study of children's educational attainment (Alisa Goodman and Paul Gregg 26 March 2010), based on four large-scale longitudinal sources of data on children growing up in the UK today. These were the Millennium Cohort Study (UK-wide), the Avon Longitudinal study of Parents and Children, the Longitudinal Study of Young People in England and the Children of the British Cohort Study. The children in these studies ranged from early childhood through to late adolescence.

The research showed that educational deficits emerge early in children's lives, even before entry into school, and widen throughout childhood. Even by the age of three there is a considerable gap in cognitive test scores between children in the poorest fifth of the population compared with those from better-off backgrounds. This gap widens as children enter and move through the schooling system, especially during primary school years.

Analysis of the Millennium Cohort Study showed big differences in cognitive development between children from rich and poor backgrounds at the age of three, and this gap widened by age five. There were similarly large gaps in young children's social and emotional well-being at these ages. Children from poorer backgrounds also faced much less advantageous 'early childhood caring environments' than children from better-off families. For example, compared with children from better-off backgrounds, there were significant differences in poorer children's and their mothers':

- health and well-being (e.g. birth-weight, breastfeeding, and maternal depression);
- family interactions (e.g. mother-child closeness);
- the home learning environment (e.g. reading regularly to the child); and
- parenting styles and rules (e.g. regular bed-times and meal-times).

Differences in the home learning environment, particularly at the age of three, have an important role to play in explaining why children from poorer backgrounds have

lower test scores than children from better-off families. However, a large proportion of the gap remains unexplained, or appears directly related to other aspects of family background (such as mother's age, and family size).

This suggests that policies to improve parenting skills and home learning environments cannot, on their own, eliminate the cognitive skills gap between rich and poor young children. On the other hand, many aspects of the early childhood caring environment do have a positive effect on children's social and emotional development and resilience, meaning that policies aimed at improving health, parenting skills and the home learning environment could still be very important.

Analysis of the Avon Longitudinal Study of Parents and Children suggested that the gap in attainment between children from the poorest and richest backgrounds, already large at age five, grew particularly fast during the primary school years. By age eleven, only around three-quarters of children from the poorest fifth of families reached the expected level at Key Stage 2, compared with 97 per cent of children from the richest fifth. Poorer children who performed well in Key Stage tests at age seven were more likely than better-off children to fall behind by age eleven, and poorer children who performed badly at seven were less likely to improve their ranking compared with children from better-off backgrounds – an important factor behind the widening gap.

Some of the factors that appear to explain the widening gap during primary school are:

- parental aspirations for higher education;
- how far parents and children believe their own actions can affect their lives (self-efficacy); and
- children's behavioural problems, including levels of hyperactivity, conduct issues and problems relating to their peers.

Parental aspirations and attitudes to education vary strongly by socio-economic position, with 81 per cent of the richest mothers saying they hoped their nine-year-old would go to university, compared with only 37 per cent of the poorest mothers. Such adverse attitudes to education of disadvantaged mothers are one of the single most important factors associated with lower educational attainment at age eleven. The findings suggest that government policies aiming to change mothers' and children's attitudes and behaviour during primary schooling could be effective in reducing the growth in the rich-poor gap that takes place during this time.

Analysis of the Longitudinal Study of Young People in England found that attainment gaps at age eleven were already large and further widening was relatively small in the teen years compared with earlier in childhood. By the time

Why early intervention

young people take their GCSEs, the gap between rich and poor is very large. For example, only 21 per cent of the poorest fifth managed to gain five good GCSEs (grades A*-C, including English and Maths), compared with 75 per cent of the richest fifth (see the previous chapter for similar findings in Northern Ireland).

It becomes harder to reverse patterns of under-achievement by the teenage years but there are some ways that disadvantage and poor school results continue to be linked. Even after controlling for long-run family background factors and prior attainment, young people are more likely to do well at GCSE if their parents:

- think it likely that the young person will go on to higher education;
- devote material resources towards education including private tuition, computer and internet access;
- spend time sharing family meals and outings; and
- quarrel with their child relatively infrequently.

The study also found that young people are more likely to do well at GCSE if the young person him/herself:

- has a greater belief in his/her own ability at school;
- believes that events result primarily from his/her own behaviour and actions;
- finds school worthwhile;
- thinks it is likely that he/she will apply to, and get into, higher education;
- avoids risky behaviour such as frequent smoking, cannabis use, anti-social behaviour, truancy, suspension and exclusion; and
- does not experience bullying.

Since young people growing up in poor families do less well in all these respects compared with those in better-off families, this provides some explanation for their poorer educational attainment by the end of compulsory schooling. While intervening earlier in childhood is likely to be most effective, policies aimed at improving attitudes and behaviour among teenagers could also have some beneficial effects in preventing children from poor backgrounds falling yet further behind during the secondary school years.

The analysis of children of the British Cohort Study found that children's test scores were lowest when poverty had persisted across the generations, and, at the other end of the spectrum, highest when material advantage was long-lasting.

Parents' cognitive abilities and other childhood circumstances play a very important role in explaining the gap between the test scores of richer and poorer children today. Nearly one-fifth of the gap in test scores between the richest and poorest children could be explained by an apparent 'direct' link between the childhood cognitive ability of parents and that of their children. This was found

even after controlling for a wide range of environmental factors, and after taking into account many of the channels through which cognitive ability might operate, such as parents' subsequent educational attainment, adult socio-economic position and attitudes to education. Over four-fifths of the gap in the test scores of richer and poorer children, however, is not explained by the direct link between the cognitive ability of parents and that of their children.

On the other hand, while good social skills also appeared to be linked across generations i.e. parent to child, these do not make a significant direct contribution to the current gap in cognitive test scores between rich and poor children.

There was also a strong intergenerational correlation between a wide variety of other attitudes and behaviours, such as whether a parent reads to their child every day, and parental expectations for advanced education. The passing of such traits across generations also helps to explain the persistent disadvantage that children from poor backgrounds face in their educational attainment.

These findings suggest that attitudes and behaviour are potentially important links between socio-economic disadvantage and children's educational attainment and have shown two major areas where policy might help to reduce educational inequalities.

Parents and the family home:

- Improving the home learning environment in poorer families (e.g. books and reading pre-school, computers in teen years).
- Helping parents from poorer families to believe that their own actions and efforts can lead to higher education.
- Raising families' aspirations and desire for advanced education, from primary school onwards.

The child's own attitudes and behaviours:

- Reducing children's behavioural problems, and engagement in risky behaviours.
- Helping children from poorer families to believe that their own actions and efforts can lead to higher education.
- Raising children's aspirations and expectations for advanced education, from primary school onwards.

There has been a marked shift in government policy emphasis in recent years away from a narrower focus on educational outcomes, and towards the wider emotional and social well-being of children (at least in England, Wales and Scotland).

Why early intervention

However, some of the areas highlighted by the JRF study above (Goodman and Gregg 2010) are better covered by existing policy and evidence than others. For example:

- There has been increasing emphasis on parenting programmes and improving child behaviour in the early years before schooling starts, but much less so in the primary school years (and even less in secondary). The JRF research (Goodman and Gregg 2010) suggests that reaching families while children are of school age might continue to be useful.
- Intensive programmes that focus on helping small numbers of children most in need tend to have the strongest evidence behind them. However, educational disadvantage affects a very large number of children from low-income families, but with lower intensity than those at the extreme, and it may be that policy needs to focus more on these.
- Programmes to raise educational aspirations (such as Aim Higher in England and Wales) typically start in the secondary school years, while this research suggests that such interventions could be worthwhile at a younger age – for example in primary schools.
- The evidence on school and local-based interventions to improve young people's social and emotional skills, behaviour, and participation in positive activities needs to be strengthened through robust evaluation.
- Educational bodies and schools have a significant role to play in tackling many of the issues raised here. Relevant policies are likely to include how funds are allocated towards pupils from the poorest backgrounds, and the direct teaching support provided to children when they start to fall behind. If successful, these suggested changes might at least help to prevent children from poor backgrounds from slipping further behind their better-off peers throughout their schooling, and indeed could go some way towards closing the rich-poor gap.

The findings of the JRF study (Goodman and Gregg 2010) may be particularly important in trying to understand why the data for working class Protestant/Loyalist communities in Lisburn (and Northern Ireland more generally) shows such poor educational outcomes, compared to even more deprived Catholic/Republican areas. A key issue may be parental attitudes and aspirations.

The independent report from Dawn Purvis MLA (Purvis 2011) suggests that it may be a result of different attitudes to education within working class Protestant/

Loyalist communities that historically relied on children following their parents footsteps into large-scale industrial employment (e.g. linen mills, thread mills, ropeworks, shipyard, aircraft manufacture, etc), a trade, or the security services, for which educational requirements were low. While much of these kinds of jobs have gone and the routes into employment are now based on public advertisements with clear selection criteria increasingly based on qualifications and experience obtained. However, the culture and attitudes that existed in previous generations may be still influencing attitudes towards education and aspirations in Protestant/Loyalist working class communities.

3.4 Allen Reports

Work in England by Graham Allen MP and Ian Duncan Smith MP in 2008 (Early Intervention: Good Parents, Great Kids, Better Citizens Allen & Duncan Smith 2008) and Graham Allen in 2011 (Early Intervention – the Next Steps Allen 2011) has highlighted the need for an emphasis on early intervention to make sure children get the best start in life. For example, their review of the international literature found that:

- A child's development score at just 22 months of age can serve as an accurate predictor of educational outcomes at age 26
- Boys assessed as being "at risk" by nurses at the age of 3 were 2.5 times as likely to have criminal convictions (55% for violent offences) at the age of 21 as those deemed not at risk

The Allen reports highlight the international evidence which shows that brain development in the early years is a critical factor in the development of children. Babies are born with one-quarter of their brain developed. There is then very rapid development of the brain, so that by the age of three, 80% of their brains have been developed. During this critical period, neglect, the wrong type of parenting or other adverse experiences can have a profound effect on how children are emotionally "wired", which will deeply influence future responses to events and their ability to empathise with other people.

The Allen reports demonstrate, from the literature, that early intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities and that it can also help prevent criminal behaviour (especially violent behaviour), drug and alcohol misuse and teenage pregnancy.

Why early intervention

Allen concludes that the right kind of parenting is a bigger influence on children's future than wealth, social class, education or any other social factor and so parents need to be given the information and support that they need to help their children.

The reports also recommend the introduction of early intervention programmes which have been shown to work in improving outcomes for children. He lists 72 of the most promising early intervention programmes, 19 of which already have very significant evidence for their effectiveness.

His review of the literature also demonstrates the cost effectiveness of intervening early in a child's life to tackle a social problem as opposed to intervening later on. Economic evaluations of some of the most effective early intervention programmes have shown that investing in the first few years (from pregnancy) of a child's life can save multiples of that investment in later costs of prison, welfare benefits, justice services, treatment programmes, mental health services, etc. It has been shown, for example, that Life Skills Training programmes can produce savings of 25 times the cost of the programme.

Research on the Consequences of Childhood Disadvantage in Northern Ireland Sullivan et al (2010) published a research report* on the Consequences of Childhood Disadvantage in Northern Ireland at age 5, based on the NI part of the UK Millennium Cohort Study, in 2010. The research found that:

- Health-related indicators among parents, such as smoking, breastfeeding and BMI were less favourable in NI than in GB
- Parents' Body Mass Index (BMI) is linked to the child's BMI and also to the child's educational and behavioural scores
- Poverty is linked to all the outcomes. However, cognitive and educational outcomes are more strongly structured by poverty than the health and behavioural outcomes. Parental education and social class are particularly powerful predictors of educational and cognitive outcomes. Their impact however can only partially account for despite the large number of potential mediators including rich information on parenting practices
- Variables reflecting good parenting practices, regularity and a strong home learning environment predict positive cognitive, educational and behavioural outcomes. Father's involvement has explanatory power for cognitive and educational outcomes

* Sullivan, A., Cara, O., Joshi, H. Ketende, S. and Obelenskaya, P. (2010) *The Consequences of Childhood Disadvantage in Northern Ireland at Age 5* OFMDFM

- Parents' longstanding illnesses and mental distress are linked to poorer cognitive, educational and behavioural assessments and general health in the child

3.5 Conclusions in relation to Early Intervention

All the evidence from the UK and international sources points to the impact of parents' education and social class on the outcomes for their children. The gap between children of different backgrounds is evident even in the first two years of life and widens continuously throughout their childhood.

The evidence demonstrates both the effectiveness and cost-effectiveness of intervening in the first couple of years of a child's life. There are considerable savings for the state in investing in early children rather than trying to tackle the social problems that emerge later in life.

The literature also highlights the importance of basing interventions on real evidence of what works, especially evidence gathered from well run large scale Random Control Trials.

The research on early intervention also highlights various other issues, including the following:

- Parents' obesity, physical illness and mental health problems can have a significant impact on the outcomes for their children.
- Parenting is critical to the development of children and young people. Efforts to improve parenting need to start from before birth and continue in primary school.
- Interventions need to be prioritized on the 0-12 age group, especially the 0-2 year olds and their parents
- Increasing educational aspirations, so that education is valued, is critical to improving educational achievement.
- Programmes that target a very small number of vulnerable families e.g. those focused on child protection, miss the large number of children in disadvantaged communities who are likely to underachieve and in turn face a range of economic, personal and social problems

The Northern Ireland public policy context that supports the need for change

4.1 Introduction

The following section highlights some of the key public policy documents that are helping to drive the change in emphasis towards prevention and early intervention. These public policy documents come under the broad heading of public health; children, young people and families; education; area-based initiatives; and the Programme for Government. However, it is important not to reinforce the fragmentation of policy and services that has developed from silo thinking in policy development.

Relevant quotes that specifically support an early intervention approach are underlined below.

4.2 Public Health

Investing for Health

In 2002 the DHSSPS published its Investing for Health strategy which recognises that health and wellbeing are crucially determined by the social, economic, physical and cultural environment and seeks to shift the emphasis from a concentration on the medical treatment of ill-health towards tackling the factors which adversely affect health and perpetuate health inequalities. The strategy highlights the consistent international evidence that the lower the socio-economic circumstances of families, the worse the health and wellbeing of members of the family are likely to be. It states that “investing in the crucial early years and education can break the cycle of deprivation”.

The strategy set out two overarching goals:

- To improve the health of our people by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability
- To reduce inequalities in health between geographic areas, socio-economic and minority groups

It also established a number of objectives including:

- To reduce poverty in families with children
- To enable all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices.

The strategy recognises that

- responsibilities for achieving these goals rests with a range of different government departments
- Actions need to be carried in partnerships between all the relevant bodies

- That communities need to be engaged through a community development approach

A Healthier Future

In 2005 the DHSSPS published a 20 year vision for health and wellbeing in Northern Ireland 2005 – 2015 entitled, A Healthier Future, to “improve the physical and mental health and social wellbeing of the people of Northern Ireland”.

The vision explicitly recognises that “the most important factors in determining the health and social wellbeing of the population are determined by the circumstances in which we live and work, such as:

- disadvantage and social exclusion
- poverty
- unemployment
- low educational achievement
- social and community environment
- housing and living conditions
- working conditions
- the wider environment.

It highlights that poorer socio-economic groups are likely to have higher incidence of cancer, diabetes and other long-standing illnesses.

The Vision recognises that there needs to be “a new emphasis on reducing smoking (esp. amongst children), reducing alcohol-related harm, tackling levels of obesity, increasing levels of physical activity and promoting good mental health.

It sets an outcome to “reduce by two thirds the gap in life expectancy between those living in the most deprived 20% of electoral wards and the average life expectancy here for both men and women between 2000 and 2015.

Marmot Review

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, ‘Fair Society Healthy Lives’, was published in February 2010, and concluded that

- Reducing health inequalities is a matter of fairness and social justice. The many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

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- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. (proportionate universalism).
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
- Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

The report recommends that reducing health inequalities will require action on six policy objectives:

- 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.

It argues that: delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups; national policies will not work without effective local delivery systems focused on health equity in all policies; and effective local delivery requires effective participatory decision-making at local level, by empowering individuals and local communities.

PHA Corporate Strategy

This report has had a significant impact on the corporate strategy of the Public Health Agency (PHA) in Northern Ireland, *Realising the health and wellbeing potential of people*, which has four priorities for improving health and wellbeing:

- Give every child the best start in life
- Work with others to ensure a decent standard of living
- Build sustainable Communities
- Make healthier choices easier

Actions to promote these priorities include

- Commissioning Family Nurse Partnerships and other evidence-based family support for families who do not qualify for FNP
- Reviewing antenatal education to promote parent child interaction and infant brain and emotional development
- Breast feeding peer support programmes
- Roots of Empathy programmes in schools
- Supporting social economy businesses and community skills development
- Support incremental expansion of programmes to develop the top 20% most disadvantaged communities
- Implement the Fitter Futures for All framework to address obesity
- Stop Smoking Support services especially for pregnant women
- Put in place integrated plans to prevent suicide and promote emotional health

PHA Community Development Thematic Action Plan

The Public Health Agency recognizes the crucial importance of using an asset-based community development approach, which looks beyond the medical model in improving health and wellbeing and closing health inequalities. There are four main streams:

- Direct community development support to organizations and communities
- Commissioning of services which promote sustainable communities
- Commissioning of health and wellbeing improvement services from community-based organisations
- Innovation and testing out new ways of working.

Mental Health Review

In 2006 a comprehensive Review of Mental Health and Learning Disability was carried out by Bamford making a wide Range of recommendations for how services in this area could be improved. In 2009 the NI Executive published a 2009-2011 Action Plan in response to the Review, including an aim to promote “positive health, well-being and early intervention”. These planned actions included:

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- Publish a revised cross-sectoral Promoting Mental Health and Wellbeing Strategy
- Develop, consult on and implement an Early Years Strategy
- Introduce a revised curriculum which provides opportunities through personal development and other areas for young people to develop the skills they need to cope with challenging personal situations such as violence against women and children; self-harm etc.
- Sustain independent counseling support service in post-primary schools
- Produce guidance for post-primary schools on proactively promoting positive emotional health and wellbeing among staff and pupils

Sexual Health Promotion

In November 2008 DHSSPS published a Sexual Health Promotion Strategy and Action Plan, in order to improve, protect and promote the sexual health and wellbeing of the population in Northern Ireland". Its objectives include:

- To reduce the number of unplanned births to teenage mothers
- To promote opportunities to enable young people to make informed choices before engaging in sexual activity, especially, empowering them to delay first intercourse until an appropriate time of their choosing.

The approach of the strategy includes ensuring that services are accessible and responsive to need, include the needs of disadvantaged groups and those at highest risk; and action to tackle the determinants of sexual health based on an evidenced based approach.

The Strategy acknowledges that there is a "strong link between social deprivation and STIs, abortions and teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation and poverty". Research in Northern Ireland has shown that "respondents from a partly skilled socio-economic background were twice as likely as those from a professional/managerial background to have had sexual intercourse before the age of sixteen".

A crucial aspect of the Sexual Health Promotion Strategy is Prevention, including "everyone having the life skills and access to services to enable them to make informed choices and to deter the development of health compromising behaviours. This is particularly important for young people as the majority of parents, health and educational professionals agree that sexual relations are best delayed until a young person is sufficiently mature to participate in a mutually respectful relationship".

It also stresses the importance of parents and carers having the “skills and knowledge to talk to their children, as good parent/child communication and sexual health issues can help delay first sexual experience and limit poor sexual health outcomes” It highlights the potential role of SureStart, Healthy Schools, Health Action Zones and Healthy Living Centres in promoting partnerships.

The strategy also acknowledges that “schools have an important contribution to make in influencing and developing young people’s sexual health and wellbeing through the delivery of effective Personal development, including Relationship and Sexual Education”.

The strategy sets specific targets including the following:

- 92% of 11-16 year olds should not have experienced sexual intercourse by 2013
- A reduction of 25% in the rate of births to teenage mothers under 17 years of age by 2013.

Specific activities in the Action Plan include the following:

- To continue to implement guidelines on Relationships and Sexual Education
- To provide opportunities to young people in school and youth settings to develop the skills they need for life to support them in appropriately managing their relationships, including sexual lifestyles
- To further develop, particularly in areas of socio-economic deprivation and rural areas, community based teenage personal development programmes that will incorporate sexual health issues and risk talking behaviour

Suicide Prevention

In 2006 the DHSSPS issued its 5-year Suicide Prevention Strategy and Action Plan, *Protect Life*, following very significant concern about the number of suicides in Northern Ireland, particularly amongst young people. Actions to be delivered by various partners included were:

- To provide families with the opportunity to avail of non-stigmatising practical interventions to help consolidate parenting, coping and life skills
- To promote the inclusion of promoting positive mental health as a key element of the “Healthy Scvhools” programme and ensure that children and young people are protected from all forms of bullying
- To raise awareness of and ensure availability and timely access to appropriate intervention services (e.g. Child and Adolscent Mental Health Services, mentoring schemes and other appropriate statutory and voluntary services).
- Encourage the inclusion of coping and life skills, emotional literacy, and programmes that promote positive mental health in the school curriculum
- To develop enhanced linkages between the Health and Socal Services and the

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community/voluntary counseling and support network, particularly in relation to transition services and to bridge any gaps in service provision

- To enhance the role of the community/voluntary sector concerning the provision of mentoring support for young people at risk of suicide and self-harm
- To ensure that appropriate support services reach out to all marginalized and disadvantaged groups, in particular lesbian, gay, bi-sexual, and trans-gender groups, rural communities, ethnic minorities, and those people who are economically deprived.

Alcohol and Drugs

In 2006 the DHSSPS published a 5-year cross-sectoral strategy, *New Strategic Direction for Alcohol and Drugs*, that sought to reduce the harm related to both alcohol and drug misuse in Northern Ireland (see outline of draft Phase 2 below).

In 2008 the DHSSPS published a *Regional Hidden Harm Action Plan* to respond to the needs of children born to and living with parental alcohol and drug misuse in Northern Ireland. The Plan highlights some of the potential impacts for a child of living with parental alcohol or drug abuse, including:

- Harmful physical effects on unborn and new born babies
- Impaired patterns of parental care and routines which may lead to early behavioural and emotional problems in children
- Higher risk of emotional and physical neglect or abuse
- Lack of adequate supervision
- Poverty and material deprivation
- Repeated separation from parents...
- Children taking on inappropriate substitute caring roles and responsibilities for siblings and parents
- Social isolation
- Disruption to schooling and school life
- Early exposure to alcohol and drug misusing culture and associated illegal activities and lifestyles
- Poor physical and mental health in adulthood

The principles underpinning the action plan include “A focus on prevention and early identification” and that services need to be based on “evaluation of effectiveness”, as well as what children and parents/carers say they need.

The Action Plan outlines what should be included in a continuum of specialist services, including:

- Family planning services
- Maternity services

- Post-natal and early Years
- Specialist services and support for children (and provides some UK examples)
- Confidential help and advice
- Parenting interventions, including “well-evaluated parenting programmes, such as Webster-Stratton, and specific programmes targeted to substance misusing parents (and gives 3 UK examples of services)
- Family focused services, including family therapies, parenting work, 1:1 work including counseling with children and with parents
- practical support
- Art, drama and play therapy

In 2009 the Department issued an Action Plan, *Addressing Young People’s Drinking in Northern Ireland*, to support the *New Direction for Alcohol and Drugs*. The Plan aims to reduce both the supply of, and demand for, alcohol amongst young people; prevent and reduce the harms from alcohol use; and identify and provide the appropriate support for those most vulnerable or at risk. The principles which underpin the Plan include the role of families, the need for evidence-based information, the identification of local needs, and a focus on the most disadvantaged areas through the Neighbourhood Renewal Areas. Actions include:

- Delivery, in a consistent manner, alcohol education to all young people in schools; develop, and/or enhance local peer learning/information projects and initiatives
- Local communities to identify and develop support/diversionary activities where young people’s drinking is identified as an issue
- Continue to provide information, interventions and programmes on safe sexual practices, promoting mental health, suicide and self-harm, home accidents, traffic accidents – particularly targeting young drinkers and those young people living in Neighbourhood Renewal Areas
- Develop a research programme on young people and alcohol, and ensure all initiatives are robustly evaluated
- Commission and publish a range of research and evaluations to uncover which interventions most effectively address this issue...
- Local Hidden Harm Action plans developed and effectively implemented and that take full account of issues relating to alcohol misuse...from conception to 18

In January 2011 the Department issued a consultation document to revise and extend the original strategy (*New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016*) rather than produce a new strategy. Objectives in the revised strategy include to “promote opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or misuse drugs.

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Some of the emerging issues highlighted by the Draft New Strategic Direction include:

- Families and hidden harm
- Mental health, suicide and drugs and alcohol misuse
- Alcohol
- Links with sexual violence and abuse, and domestic violence.

The principles set out in taking the strategy forward include:

- Evaluation, Evidence and Good Practice Based e.g. informed by evidence of the problems and “what works” and improving the evidence base through evaluation
- Partnership and working together
- Addressing local need
- Community Based
- Long-term focus

The draft *New Strategic Direction* highlights Prevention and Early Intervention as one of the critical support pillars. It states that “Prevention and early Intervention is largely concerned with encouraging and developing ways to support and empower individuals, families and communities in the acquisition of knowledge, attitudes and skills”. It recommends that “a particular focus should be put on the importance of early intervention (especially young children and families) and the adoption of targeted, as well as universal types of prevention which will lead to the reduction of risk factors and the development of protective factors associated with the prevention of alcohol and drug-related harm”. It also argues that “interventions must be tailored to particular settings such as the school, community and workplace...The importance of formal and informal education and community-based approaches is acknowledged.”

It recommends that resources to deliver the *New Strategic Direction* should be “properly targeted at activities and programmes that have been shown by previous research and evaluation to be effective”.

The suggested Key Priorities include:

- Targeting those at risk and vulnerable, including vulnerable young people (e.g. children and alcohol/drug using parents; and school excludees)
- Promoting good practice in respect of alcohol and drug-related education and prevention, based on “sound conceptual principles and ...evidenced good practice”

The Draft Strategy outlines short to long term outcomes, including reducing the proportion of young people who drink on a regular basis; who get drunk; who take drugs.

Maternity Strategy

In 2011 DHSSPS issued a draft Maternity Strategy for consultation, which recognises that “disadvantage starts before birth and accumulates throughout life”. It highlights the fact that those in deprived communities, younger mothers, mothers who do not breastfeed, mothers who smoke, drink heavily, use drugs, or are obese are more likely to have poorer pregnancy outcomes. It acknowledges that if health inequalities can be reduced before, during and after pregnancy this will impact on the future health of the population.

Tackling Health inequality at a sub-regional level

The South Eastern Health & Social Care Trust (SEHSCT) has its own Health Inequality Action Plan 2011/12, which focuses on the most deprived 20% of areas within the Trust (which includes Old Warren and Tonagh) including the following objectives:

- Support the Emotional Development of young children in the 20% most deprived (Neighbourhood Renewal/SureStart) areas –
 - through the delivery of Roots of Empathy programme “with a strong evidence for effectiveness”
 - Supporting parents in developing their children’s emotional foundations through the New Parent Programme, Incredible Years Parenting Programme and Mellow Parents/ Mellow Babies programmes
- Reduce smoking in the 20% most deprived areas including an anti-natal incentive and support scheme
- Reduce childhood obesity in the 20% most deprived areas, through Mini-Mend for 2-4 year olds in Sure start
- Mental health, Suicide prevention and self harm by
 - Delivering a mental health programme in secondary schools in the 20% most deprived areas
 - A communication and training programme in the 20% most deprived communities
- Drugs and alcohol by developing and delivering a new programme aimed at the families of teenage drinkers
- Support social enterprise/employment schemes in neighbourhood renewal areas e.g. Kilkooley, Colin Bridge and Ballymote
- Improve outcomes for looked after children

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4.3 Children, Young People & Families

The Government's 10-year Strategy for Children and Young People

In 2006, OFMDFM published its inter-departmental 10-year strategy for children and young people - *Our Children and Young People – Our Pledge* (OFMDFM 2006) setting out 6 high level outcomes for children and young people that all agencies in Northern Ireland should be working towards: Children and young people should be:

- Healthy
- Enjoying, learning and achieving
- Living in safety and with stability
- Experiencing economic and environmental wellbeing
- Contributing positively to community and society
- Living in a society which respects their rights

The supporting themes of the 10 year strategy include the following:

- The need to adopt a “whole-child” approach, which gives recognition to the complex nature of our children’s and young people’s lives
- Working in partnership with those who provide and commission children’s services...
- Securing and harnessing the support of parents, carers and the communities in which our children and young people live
- Making a gradual shift to preventative and early intervention approaches without compromising those children and young people who currently need our services most

The Strategy contains a specific pledge “we will promote a move to preventative and early intervention practice without taking attention away from our children and young people currently most in need of more targeted services.

It also contains a pledge to “deliver improved outcomes for all children and young people, we will ensure that all future policies developed and services offered to, and accessed by, children and young people, are based on identified need and on evidence about what works”.

Implementation and resourcing of the 10-year strategy has been disappointing to many of the organisations concerned with child outcomes. The OFMdfM Children’s Unit has been incorporated into a wider department.

Children and Young People's Strategic Partnership

In 2011 a Children and Young People's Strategic Partnership (CYPSP) was established to improve outcomes for children and young people through integrated planning.

The CYPSP is the first Chief Executive led cross agency, cross sectoral integrated planning and commissioning process for Northern Ireland. This includes ALL statutory sector organisations with responsibility for children and young people and representatives from Voluntary and Community and BME sectors. With a focus on early intervention the Children and Young People's Plan is the key driver for this work.

The Partnership has developed a "Northern Ireland Children and Young People's Plan 2011-2014, which sets out how integrated planning and commissioning arrangements will be put in place to secure improvements in the 6 high level outcomes for children and young people (highlighted above). One of the four themes of the strategy is Early Intervention – in particular, seeking designation of Northern Ireland as a site for early intervention and supporting all agencies to work together in relation to the integrated planning and commissioning of early intervention. The other themes are "Communicating with Government", "Integration of Planning" and "Optimisation of Resources".

Apart from the definition of early intervention and how the CYPSP has agreed to take forward early intervention. One of the actions within the Children and Young People's Plan includes the development of a standardised resilience framework for the evaluation of early intervention programmes across Northern Ireland.

Outcome groups have been established in each sub-region. The South Eastern Outcomes Group, which a wide membership from the statutory, voluntary and community sectors, has been mandated by the Partnership to implement outcomes based planning for Lisburn & Down and North Down & Ards. The purpose of the South Eastern Outcomes Group is to "carry out integrated planning and commissioning for children and young people in the area, with specific emphasis on sharing resources across agencies to improve outcomes for children and young people". The Outcomes Group is currently looking at the establishment or designation of more local Locality Groups (such as Colin Early Intervention Community and Early Intervention Lisburn) to carry out outcomes based planning at the level of geography which makes sense locally.

The South Eastern Outcomes Group has also set in place the foundations for a geographically based Family Support Hub to engage with families who do not meet the threshold for statutory social work support and improve co-ordination of

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service delivery to individual families. Barnardo's has been contracted to deliver the family support service through three family support workers in Lisburn. It is currently dealing with c.50 referrals per month.

DHPSSPS Families Matter (2009)

The DHSSPS Family support strategy, *Families Matter* is based on the six outcomes in the 10 year strategy for children and young people and a family support (Hardiker) model with four levels:

Level 1: All children

Level 2: Children who are vulnerable

Level 3: Children in need in the community

Level 4: Children in need of rehabilitation

The strategy acknowledges that “early intervention produces positive dividends in terms of children and families not needing more specialist services at a later date” and the “current inequity in resourcing early intervention services compared to those of higher needs and this must be addressed”.

The strategy highlights four priority themes for DHSSPS:

- Information for parents and service planners
- Access, including avoiding stigma, language, etc
- Supporting Families and Parents, including Parenting Education, Positive Parenting, locality based services e.g. extended schools, children's centres, relationship support/mediation and Surestart
- Working Together for families and Communities, including multi-agency working and common assessment

Health Child, Healthy Future

The DHSSPS published a Framework for the Universal Child Health Promotion Programme in Northern Ireland from pregnancy to 19 years, in 2010. It is based on the concept of progressive universalism i.e. every child/family receives a standard universal service i.e. set contacts by the midwife, health visitor and school nurse, etc. to the standards in the framework. However, a comprehensive assessment of need (UNOCINI) should identify where additional early intervention support and interventions are to be offered to ameliorate the potential early negative impact of any physical, social or emotional factor, such as Surestart, breastfeeding support, counseling, evidence-based parenting, thus reducing inequalities. Where this early intervention is unable to address the need, children/families are escalated to a more progressive level of intervention to safeguard the welfare of the child.

The strategy recognises the particular importance of providing additional support to pregnant teenagers due to the higher risk of low breast feeding, low birth weight, high infant mortality, high child accidents, high postnatal depression.

The Framework recognises the developed understanding of the neurological development of a child's brain, the importance of parent-child attachment in the first few years of life, and the negative impact of maternal stress in pregnancy. A major emphasis in the Framework is on the provision of parenting support and positive parenting e.g. using agreed evidence-based programmes to support specific work e.g. Solihull approach, Incredible Years, Mellow Parenting, the Social Baby Book/Video, and Baby Express Newsletters.

The Framework aims to achieve 10 specific outcomes:

- Strong parent-child attachment and positive parenting, leading to better social and emotional wellbeing among children
- Care that helps keep children healthy and safe
- Healthy eating and increased activity
- Prevention and reduction of some serious diseases and communicable diseases
- Increased rates of initiation and continuation of breastfeeding
- Readiness for school and improved learning
- Early recognition of growth disorders and risk factors for obesity
- Early detection and actions (including early intervention/referral) to address developmental delay 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 includes the following core elements:

- Health improvement
 - Support for parenting: Early Intervention and prevention programmes for children and families
 - Engaging fathers/partners
 - Health promotion including “strong links and closer communication with community development programmes and other initiatives aimed at reducing inequalities, social exclusion, eliminating poverty and improving educational outcomes”
 - Promotion of Social and Emotional Development
 - Safeguarding

¹ The evidence base for some of these interventions is weaker than others

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- School health profiling, in order to “develop prevention and early intervention programmes to address the needs of this population with the school setting and within local communities” (Note: PHA to lead to develop one tool supported by ICT)

■ Health protection

- Surveillance
- Screening
- Immunisation

Discussions with community groups and those involved in health visiting has highlighted the lack of resources available in Northern Ireland to effectively delivery the *Healthy Child, Healthy Future* framework. Although, perhaps better in the SE Trust area than other Trust areas, a health visitor in the SE Trust area is likely to have a caseload of 300-400+ families. To be able to provide more intensive support for the most vulnerable new mothers (from the 20th week of the pregnancy to two years old) the Trust has introduced the evidence-informed *New Parenting Programme*. An additional health visitor is employed in both Old Warren and Hilhall, with a caseload of 25 families each. The delivery of the service is being evaluated by QUB (not with a control group). A similar model is being delivered in the Colin area, with a health visitor plus two support workers. The evidence-informed (but not a proven programme) 10-14 week parenting skills programme, *Mellow Parents*, developed in Scotland, is also being delivered in Old Warren by the Trust.

Child Poverty Strategy

The Child Poverty Act 2010 places a statutory obligation on the NI Executive to develop a child poverty strategy. The Executive’s strategy is designed to try and break the cycle of poverty and underachievement by “raising aspirations, increasing access to opportunities through education, supporting parents into work, and, providing the necessary support to those most in need such as children with disabilities, lone parents and others”.

The cross-departmental Strategy sets out the key areas that the Executive believes are crucial in addressing the causes and consequences of child poverty and in meeting the Government’s obligations in The Act. The Strategy has two key strands of work relevant to the causes and the consequences of child poverty:

1. reducing worklessness amongst adults with children
2. promote longer term outcomes through child based interventions which are designed to tackle the cyclical nature of child poverty

The Strategy highlights a number of principles that underpin and should support the delivery of the strategy:

- A shift towards tackling the root causes of poverty and not just treating its symptoms.
- Putting children at the centre of the Strategy and taking into account their views when developing policies and programmes to tackle child poverty.
- Adopting a Life Cycle approach, breaking the cycle that results in children born into poverty becoming working age adults in low income.
- Promoting excellence in support across a range of key policy areas including employment and skills, education, childcare, health and family support, housing and neighbourhoods, and financial support.
- A gradual shift towards the use of preventative measures to tackle child poverty and, when families face difficulties, intervention at an early stage, reducing the likelihood of more serious problems developing in the future
- Applying an evidence based approach.
- Adopting a whole family approach which concentrates on all members of the family - children, young people, and their parents and supporting family life.
- Empowering and enabling parents on low income into work and make work pay for those on low pay.
- Promoting partnership working across all sectors including public, private, voluntary, and community sectors.
- Recognising the current economic climate and the need for the Strategy to be balanced against existing financial limits.

The Key Strategic Priorities in the Strategy are as follows:

- Ensure, as far as possible, that poverty and disadvantage in childhood does not translate into poorer outcomes for children as they move into adulthood.
- Support more parents to be in work that pays.
- Ensure the child's environment supports them to thrive.
- Target financial support to be responsive to family situations.

Some of the relevant Action Areas under two of these priorities, which are relevant to an early intervention approach are as follows:

Ensure, as far as possible, that poverty in childhood does not translate into poor outcomes for children as they move into adult life

- Provide all children and young people with opportunities to reach their educational attainment regardless of background and address barriers to pupils achieving their full potential.
- Support disadvantaged families to promote the physical, social, intellectual and emotional development of their children so that they flourish at home and when they get to school.

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- Support the delivery of an accessible, flexible and quality childcare sector, so that it is effective in reducing barriers to employment, particularly those experienced by disadvantaged groups, and supports child development and well being”.
- Improve health outcomes and target those groups who are particularly at risk or vulnerable, in order to tackle health inequalities of children and young people.
- Strengthen and improve prevention and early intervention for all children and their families, particularly in the first three years of life to maximise future outcomes in health and wellbeing.
- Provide family support and intervention services to children in vulnerable families.
- Improve school readiness and increase participation in formal and non-formal education, youth services and sports through accessible and affordable culture, arts and leisure services.
- Address socio-economic disadvantage in children and maximise access to key services for children and young people.

Ensure the child's environment supports them to thrive:

- Promote affordable, accessible play and leisure provision for all children and young people.
- Provide different learning environments through youth services which complement formal learning and are focused on the personal and social development of children and young people.
- To improve opportunities for low income families to participate in arts, cultural, sporting and leisure activities.
- Ensure that parents can access information and services, including the Regional Family Support Database in their local areas to support them in carrying out their parental responsibilities.
- Make public transport more accessible and affordable to all children including those with a disability in both urban and rural areas.
- Continue to take action to address fuel poverty in vulnerable households.
- Ensure children and young people are living in homes which achieve the Decent Homes Standard.
- Support statutory and voluntary agencies, including local councils, to provide services and programmes which meet the needs of local communities, particularly disadvantaged communities.
- Continue to address the underlying causes of disadvantage and improve the physical environment of the most deprived neighbourhoods.

An action plan to implement the Child Poverty strategy is expected to be published by the Summer 2012.

4.4 Education

Every school a good school – a policy for school improvement

The Department of Education undertook a review of the previous school improvement policy and issued the findings of this review and proposals for the way forward for public consultation in January 2008. Following consultation, the finalised policy document, Every School A Good School - A Policy for School Improvement was launched by the then Education Minister, Caitriona Ruane in April 2009.

The Department's vision is "to ensure that every learner fulfills his or her potential at each stage of her or his development".

The policy recognises that "there are still too many young people finishing their 12 years of compulsory schooling without reaching" 5+ GCSEs grade A*-C, especially those who are economically and socially disadvantaged, so that "schools serving disadvantaged communities, and communities where the value placed on education may not be as high as it might be, will need much greater levels of support". Inspectors have reported that in one-third of primary schools inspected the quality of provision was not good enough (Chief Inspector's Report 2006-2008).

The policy highlights the characteristics and indicators of a good school with effective performance, in relation to:

- Child-Centred provision
- High quality teaching and learning
- Effective leadership
- A school connected to the local community

The Department commits, amongst a range of things, to "maintaining a particular focus on tackling the barriers to learning that many young people face" and in particular to "continue to support work through the developing pupil's emotional health and wellbeing programme and the counselling provision in schools in order to build pupil's resilience to deal with challenges in their lives and improve their readiness to learn"; and to plan and track literacy and numeracy better through clearer outcomes.

The Policy also recognises the importance of "increasing engagement between school and parents, families and communities they serve", through

- The Extended Schools Programme which supports over 400 schools in disadvantaged communities, will "continue to ensure that those schools serving the most disadvantaged communities receive additional support to

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provide activities outside of normal school hours that reflect and respond to the needs of their pupils and the local community”

- Full service extended schools (already being piloted in 3 Belfast school) – the Department will “publish a strategy for the further development of this concept”
- Health promoting schools (200 schools already engaged)
- Identifying and disseminating “good practice with a particular focus on community use of schools to help schools in building stronger links with their parents and local communities”

Extended Schools

The Extended Schools concept was originally introduced in Northern Ireland in 2006, based on *Extended Schools: schools, families, communities – working together* document published by the Department of Education. Extended Schools were to be schools which:

- views working with its pupils, families and community as an essential element in raising the standard of pupils achievement;
- builds partnerships with neighbouring schools, the further education sector and other statutory, voluntary, business and community organizations to develop and deliver better services for the community as a whole and for children and young people and their families in particular;
- helps to strengthen families and communities through providing opportunities for lifelong learning and personal development; and
- uses its accommodation flexibly and outside of school hours for the good of learners and the community.

The document highlights a large number of potential benefits for pupils, schools, families and communities from engagement with Extended Schools.

The criteria for receiving Extended Schools funding for primary and nursery schools was inclusion in a neighbourhood renewal area; be in the 30% lowest ranking wards or SOAs in relation to the Education domain; or Free School meals entitlement of 37% or higher. In terms of funding schools were to receive a block allocation, plus an amount per pupil, based on a sliding scale, plus an extra allowance for being part of a cluster. Schools were required to submit a proposed Extended School action plan.

Following ETI evaluations of the Extended Schools Programme in 2009 and 2010, which showed progress but required better integration with whole-school improvement planning and more attention to raising standards and the achievement of specific high level outcomes, in November 2010 the Department

issued a revised Circular on *Extended Schools – Building on Good Practice*. It states that “the primary function of an Extended School must be to raise standards through the provision of targeted support services which have a focus on learning, development and progress” and “to promote, support and sustain the drive to maximize learning and achievement for those children and young people most in need or who are at risk of low educational attainment”. It states that “Above everything else, it must be remembered that the activities and services provided by Extended Schools must be focused on the core purpose of improving children’s learning and levels of educational attainment”.

The Circular states that effective Extended Schools programmes have:

- Mapped provision in relation to data and analysis of need;
- Joined up plans with other provision such as the youth service, health, neighbourhood renewal, and community relations;
- Actively participated in a cluster working to promote the sharing of provision and expertise between schools and promoted cross community collaboration where possible; and
- Engaged with the voluntary and community sector in the delivery of services and activities allowing schools to build their capacity.

Putting Pupils First: Shaping Our Future

In his first public policy statement, in September 2011, which was published as *Putting Pupils First: Shaping Our Future* John O’Dowd set out his vision for education. This included the following statement:

“In focusing on the needs of all children, we must start by laying the right foundations for learning in those all-important early years”

It also included a commitment to finalising the Early Years Strategy. The draft strategy set out to, amongst other objectives, “promoting better learning outcomes for children by the end of the Foundation stage, especially in language and number; and in the children’s personal and social development, emotional well-being and readiness to learn”. The draft strategy also identifies the following issues:

- identifying best practice
- early intervention where necessary
- tackling barriers to learning
- developing strong links with families and communities

The draft strategy also proposes reviewing the pre-school curriculum, reflecting the centrality of the curriculum to literacy and numeracy. It also proposes setting out the milestones to be expected in a child’s development.

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In 2012 the Department asked the Education and Library Boards, in partnership with the other educational management bodies to produce an audit of all schools and produce plans for the future of the post-primary (end of March 2012) and primary (end of June 2012) sectors. This is likely to result in the closure of both primary and post-primary schools in Lisburn, and elsewhere.

Literacy and Numeracy

In 2011 the Government published its strategy to improve outcomes in literacy and numeracy, Count, read: succeed. Amongst other measures to support pupils, teachers, school leaders and governors, including the development of guidance for parents re pre-school children the strategy highlights the importance of “early intervention where necessary for pupils of any age, informed by the effective use of data, to address the needs of those who are struggling”, especially in the early years and “ensuring early intervention to address actual or potential underachievement”. The Action Plan states that “Extended schools will ensure their extended schools activities or services are integrated into their planning for raising standards.

The strategy says that a Directorate will be created in DE linking with parents, families and communities to help them support their children, particularly in numeracy and literacy.

Childcare

The Department of Education has also committed to producing a Childcare Strategy for 0-6 years olds and has carried out a consultation process.

4.5 Area-based Initiatives

Neighbourhood Renewal

In June 2003, Government launched People and Place – A strategy for Neighbourhood Renewal. This long term (7 – 10 year) strategy targets those communities throughout Northern Ireland suffering the highest levels of deprivation. Neighbourhood Renewal is a cross government strategy and aims to bring together the work of all Government Departments in partnership with local people to tackle disadvantage and deprivation in all aspects of everyday life. Neighbourhoods in the most deprived 10% of wards across Northern Ireland were identified using the Noble Multiple Deprivation Measure. Following extensive consultation, this resulted in a total of 36 areas, and a population of approximately 280,000 (one person in 6 in Northern Ireland), being targeted for intervention. The areas include:

- 15 in Belfast,
- 6 in Londonderry and

- 15 in other towns and cities across Northern Ireland (including Colin incorporating Poleglass and Twinbrook).

Neighbourhood Partnerships have been established in each Neighbourhood Renewal Area as a vehicle for local planning and implementation. Each Neighbourhood Partnership includes representatives of key political, statutory, voluntary, community and private sector stakeholders. Together, they have developed long term visions and action plans designed to improve the quality of life for those living in the area.

The key strategic objective of Neighbourhood Renewal is: To tackle the complex, multi-dimensional nature of deprivation in an integrated way, through the following:

- Community Renewal - to develop confident communities that are able and committed to improving the quality of life in their areas
- Economic Renewal - to develop economic activity in the most deprived neighbourhoods and connect them to the wider urban economy
- Social Renewal - to improve social conditions for the people who live in the most deprived neighbourhoods through better co-ordinated public services and the creation of safer environments
- Physical Renewal - to help create attractive, safe, sustainable environments in the most deprived neighbourhoods.

None of the target areas in Early Intervention Lisburn are considered to be Neighbourhood Renewal areas, based on the 2001 multiple deprivation data.

Areas At Risk

The *Areas at Risk* Pilot Programme was established in 2006 to identify and intervene in areas considered at risk of slipping into a spiral of decline. The Department, through the Voluntary and Community Unit, in conjunction with a range of other partners, will help to support these communities, which perhaps feel neglected or isolated in order to help build confidence and a sense of belonging. The types of areas that the programme operates within include for example:

- 'Interface' areas that lie outside of Neighbourhood Renewal areas
- Areas in economic decline
- Areas at 'risk of decline' for example, those areas that without targeted support may move into the top 10% as defined by Noble
- Areas at risk of 'descending into instability and crisis' or areas in which there is a decline in community cohesion which threatens peace and stability
- Areas where the loss of the service provided by organisations would have a significant negative impact on the local community.

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Programme Objectives - The key objectives of the Programme are to:

- reduce the level, frequency and impact of interface violence within the community;
- increase levels of economic activity within the targeted areas;
- stabilise targeted areas to the point that the area is either no longer considered as an 'area at risk', or that the risk of the area slipping into decline is prevented;
- increase community cohesion and capacity;
- strengthen community infrastructure in those areas where it is weak; and
- achieve a more sustainable approach to community participation and development.

In order to ensure that the communities participating in this programme meet the criteria a strategic partnership was established, chaired by the Voluntary and Community Unit. Permanent partners are the Development Offices (BRO; RDO; NWDO) and the Northern Ireland Housing Executive, in both cases involvement is devolved to local offices. Other statutory bodies are invited to join on an ad hoc basis as and when their expertise would lend significance to the programme.

Potential areas for inclusion in the programme were sought from the permanent partners, who also have to provide an evidential basis for inclusion. Other sources of reference included local politicians including Councillors and MLA's. Each nominated area was considered against criteria before being sent to Minister for consideration and approval.

Once an area was included a local voluntary organisation was nominated (by the permanent partners) to act as the lead organization, charged with assisting to carry out a community audit. The Department takes the lead in appointing a consultant to carry out the audit which can be supported through programme funds, before submitting a project proposal. The project proposal was considered by all partner organisations and subject to unanimous agreement.

The pilot programme is currently operating in the following areas:

Phase One: Sydenham (East Belfast); Taughmonagh (South Belfast; Seacourt (Larne); West Portadown; Rathenraw (Antrim); Dunclug (Ballymena; Limavady; Dhu Varren (Portrush); Ballynashallog (Londonderry)

Phase Two: (Announced 13 November 2007 by Minister Margaret Ritchie): Lower Whitewell (North Belfast); Ballybeen (Dundonald); Gilford (Banbridge); Annadale (South Belfast); Scrabo (Newtownards); Killicomaine (Portadown); Alexander/Lisanally (Armagh); Ashfield Gardens (Fintona); Seymour Hill (Dunmurry);

Craigyhill and Antiville (Larne); Harryville (Ballymena); Caw/ Nelson Drive/ Lincoln Courts (Derry/Londonderry)

Phase Three: (Announced 28 January 2009 by Minister Margaret Ritchie): Beechfield (Donaghadee); Lettershandoney (Derry/Londonderry); Strathfoyle (Derry/Londonderry); Ferris Park (Larne Town); Doury Road (Ballymena).

None of the Early Intervention Lisburn target areas have been designated as Areas At Risk.

Community Safety Strategy

In January 2011 the new Department of Justice issued for consultation “Building safer, Shared and Confident Communities – a consultation on a new community safety strategy for Northern Ireland” designed to help build:

- Safer communities: with lower levels of crime and anti-social behaviour, including supporting early intervention for long-term crime reduction
- Shared communities: where everyone’s rights are respected in a shared, and cohesive community
- Confident communities: in which people feel safe and have confidence in the justice agencies that serve them

The draft principles for delivering the strategy include both

- **early intervention**, “recognizing the importance of early interventions to help address the underlying risk factors that can lead to crime and anti-social behaviour”; and
- **Evidence-based solutions**, “focusing on solutions that prevent and reduce crime which are evidence-based, innovative and responsive to local needs.

In order to build safer Communities the strategy would “build on what works in reducing and preventing crime, and work in greater partnership with other Executive Departments to create safer communities over the long term particularly in the areas of health, education and addressing inequality and social disadvantage”.

Section 5.4 outlines the relationship between crime and the underlying causes and risk factors and the rationale for an early intervention approach. It provides two evidence-based early intervention approaches including the Perry Preschool Project.

The draft strategy commits the Department of Justice to “work with other Executive Departments to consider how we can support early intervention and promote it at local partnership level where appropriate. We will continue to

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support and develop early stage intervention projects, and review what works in early stage provision.

The Department of Justice has developed a Strategic Framework for Reducing Offending which will be going out for consultation before the Summer 2012 for approval by the end of the year. This framework, amongst other things, highlights the importance of tackling social determinants of crime such as improving educational attainment and reducing poverty, as well as prevention and diversion activities including Early Interventions, tackling drugs and alcohol misuse and responding to mental health issues

4.6 Programme for Government 2011 – 2016

In March 2012 the Government launched its Programme for Government (PfG), following a period of consultation. The Programme has five aims:

- Growing a sustainable economy and investing in the future
- Creating opportunities, tackling disadvantage and improving health and wellbeing
- Protecting our people, the environment and creating safer communities
- Building a strong and shared community
- Delivering high quality and efficient public services

The Programme contains the following relevant commitments:

- Introduce and support a range of initiatives aimed at reducing fuel poverty across NI including preventive interventions
- Provide £40million to improve pathways to employment, tackle systemic issues linked to deprivation and increase community services through the Social Investment Fund (in 8 regions of disadvantage and poverty)
- Publish and implement a strategy for integrated and affordable childcare
- Deliver a range of measures to tackle poverty and social exclusion, through the Delivering Social Change delivery framework
- Use the Social Protection Fund to help individuals and families facing hardship due to the current economic downturn
- Fulfill our commitments under the Child Poverty Act to reduce child poverty
- Improve community safety by tackling anti-social behaviour
- Increase the proportion of young people who achieve at least 5 GCSEs at A*-C or equivalent including GCSEs in Maths and English by the time they leave school
- Improve literacy and numeracy levels among school leavers, with additional support targeted at underachieving pupils
- Ensure that at least one year of pre-school education is available to every family that wants it
- Allocate an increasing percentage of the overall health budget to public health

- Invest £7.8 million in programmes to tackle obesity
- Provide £40 million to address dereliction and promote investment in the physical regeneration of deprived areas through the Social Investment Fund.

The Programme does not specifically include a commitment to early intervention or to evidence-based approaches. In February 2012 the Children's Commissioner's (NICCY) response to the Draft Programme for Government recommended including a specific commitment in the PfG "to early intervention and prevention for children and young people, linking funding and joint working across departments".

Social Investment Fund

The Executive agreed on 22 March 2011 to the establishment of the Social Investment Fund (SIF) and monies totaling £80million over a four year period were subsequently allocated in the Budget. the PfG, highlighted above, includes a renewed commitment to the Fund.

The high level aim of the Social Investment Fund is to reduce poverty, unemployment and physical deterioration in areas through area based interventions of significant scale which will be delivered in partnership with communities. The Fund will to encourage communities, statutory agencies, business and departments to work together in a co-ordinated way, reducing duplication, sharing best practice and enhancing existing provision for the benefits of those communities most in need.

The SIF's strategic objectives are to support communities to:

- build Pathways to Employment;
- tackle the systemic issues linked to deprivation;
- increase community services; and
- address dereliction.

A "pre discussion" paper was published in March 2011 and outlines the high level strategic concept, objectives and overall methodology of the Fund. A consultation document was published to seek views on the proposed operation of the Social Investment Fund (SIF), including options for applying to the Fund, application/assessment criteria, how the Fund should be managed and the structures to support its delivery. The Consultation on the proposed operation of the Social Investment Fund (SIF) closed on the 23 December 2011.

Social Protection Fund

The NI Executive has also established a Social Protection Fund (SPF) to "assist those most in need in the wider community". This year (2011/12) they agreed

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to prioritise fuel poverty through the fund, and committed the full £20 million budget to a winter fuel poverty payment scheme through the Department for Social Development and the Department of Health, Social Services and Public Safety (DHSSPS) under the Financial Assistance Act (Northern Ireland) 2009. Through the scheme, a one-off payment of £75 has been made to persons in receipt of income-based means-tested benefits, including income support, income-related employment and support allowance and income-based jobseeker's allowance. Pension credit recipients and people in receipt of cancer treatment in line with criteria determined by DHSSPS are receiving one-off payments of £100. Although funding for the programme was secured for only one financial year, the Executive are committed to securing moneys for future SPF programmes during the remainder of the current Budget period.

4.7 Conclusions in relation to the Public Policy Context

The public policy context presents a consistent sense of transition towards an early intervention and evidence-based approach to addressing many of the difficulties facing children, young people and families in Northern Ireland. There is a clear understanding of the implications of deprivation and wider inequalities for the outcomes for children and young people and a stated commitment to tackling these inequalities. The policy context suggests the principles that should drive this early intervention approach are as follows:

Interventions should:

- focus on tackling root causes and not just treating symptoms;
- take place in the early years of a child's life, where, the evidence suggests, many problems in later life are created and at which stage brain development is moulded, and/or at the earliest stage of difficulty, when a child may be vulnerable to poor developmental outcomes;
- adopt a whole child approach, which gives recognition to the complex nature of our children's and young people's lives;
- adopt a whole family approach which concentrates on all members of the family - children, young people, and their parents and supporting family life;
- adopt a whole society approach to early intervention through a network of integrated supports and services and multi-agency working;
- build on the strengths and resilience of children, young people and families and not only respond to their needs;
- be evidence-based through implementing programmes which have been subject to rigorous evaluation (esp. RCTs). Innovations that have not been robustly evaluated before should be rigorously evaluated;
- be focused on achieving clear measurable outcomes;
- Be implemented with fidelity by skilled and trained staff;
- be "owned" by the community through a community development approach;

- be accessible and promote participation and inclusion;
- be sustained and long-term;
- combine
 - Level 1 support: universal (all children);
 - Level 2 support: target communities and groups/categories of families which are most vulnerable due to deprivation, etc.; and
 - Level 3 support: non-stigmatising targeted early intervention on particular families assessed to be most at risk.

The policy context raises other important issues to be considered:

Identification of areas of deprivation

The recognition of the importance of deprivation in determining outcomes for children and young people has resulted in the development of the valuable Multiple Deprivation Measure (MDM) to rank wards and Super Output Areas. This has been used by a range of initiatives to target those “most in need”. Neighbourhood Renewal has focused a wide range of services and resources in the 10% of most deprived communities (based on the 2001 MDM). This approach has significant shortcomings, including:

- The majority of poor families live outside Neighbourhood Renewal areas
- Many better off families live in the most disadvantaged SOAs
- Resources available to communities which rank just outside the 2001 10% ranking have been diverted towards Neighbourhood Renewal Areas
- Deprivation changes over time. If calculated now, Old Warren would be a Neighbourhood Renewal Area
- MDM includes proximity to a hospital, in this case, Lagan Valley Hospital which is very close to Tonagh/Old Warren/Knockmore, but is no longer a full acute hospital
- Averaging Deprivation through an aggregate measure such as MDM ignores the importance of indicators which may show a very different picture. For example, the very low level of educational attainment in Protestant working class areas in Lisburn (and other parts of Northern Ireland) is very disturbing, requiring urgent action, but is masked by a focused on MDM.

Resourcing and Implementation

Many of the strategies above express a good understanding of the issues to be addressed very positive aims and principles. However, the long-term resourcing and implementation has been poor. Despite these positive sounding strategy documents, little has changed for disadvantaged families in the target areas of Lisburn characterised by poverty and, even more so, by educational underachievement. Many evidence-based initiatives have been introduced in a

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half-hearted way with inadequate and/or short-term resources. There needs to be a clear commitment to effective long-term resourcing of robustly evidence-based programmes, otherwise the inequalities will continue to widen.

The economic evidence that early intervention programmes can, rather than cost money, over the longer-term, save considerable amounts of money for the state, but the nature of short-term funding decisions means that the criteria used to make these decisions do not take into account these long-term savings.

Partnership working

The mantra of cross-sectoral and integrated partnership working, based on a whole child model, cannot be delivered through traditional silo models and structures. Early Intervention often means investments by one Department or agency in order to produce desired outcomes for a different Department or agency.

Hopefully, the new Children and Young People's Strategic Partnership and the sub-regional Outcome and Locality Groups present the opportunity to make a serious commitment to partnership working and developing truly integrated services.

There is still a big gap between the work of public health and social care agencies and work in schools. The Extended Schools initiative has made a small contribution towards more integration, but this is only at the early stages. For early intervention to be successful there needs to be seamless working between schools (which nearly all children attend), community-based initiatives, and the health and social care sector.

Theory of change

5.1 Outcomes

The previous sections have:

- analysed the needs of the target communities in Lisburn, as identified both by desk research and through the consultations with community representatives, schools and those from the relevant professional agencies working in the areas;
- examined the concepts, and rationale, around early intervention; and
- summarised the relevant public policy context.

These, together, suggest that the specific outcomes which the Early Intervention Lisburn Initiative should target, to have an impact on the Government's high level outcomes for children of being: Healthy; Enjoying, learning and achieving; Living in safety and with stability; Experiencing economic and environmental wellbeing; Contributing positively to community and society; and Living in a society which respects their rights, should be as follows:

- Reduced number of teenage pregnancies
- Reduced level of smoking during pregnancy
- Improved parenting skills and confidence
- Improved parent-child attachment for 0-2 year olds
- Improved school readiness amongst 3 & 4 year olds
- Improved literacy and numeracy in children aged 4-11
- Improved social and emotional skills and resilience of 4-11 year olds
- Improved school attendance
- Improved educational aspirations and attainment on leaving school
- Reduced behavioural/conduct problems
- Reduced smoking, alcohol and drug consumption amongst young people
- Reduced crime and anti-social behaviour amongst young people
- Reduced childhood and teenage obesity
- Increased engagement of fathers in their children's learning

There is broad agreement that these are important outcomes to be addressed to improve the lives of the people of the target areas. However, the key question is how best to achieve these outcomes. This in turn suggests a number of other questions, which need to be addressed, as follows:

- What impact do current programmes and services make on these outcomes and how could they make a greater impact?
- What are the most effective interventions to achieve these outcomes? and how robust is the evidence for the potential impact of the interventions?

Theory of change

- What are the most cost-effective interventions i.e. which interventions will create the greatest long-term savings to the public purse?
- Which interventions should be universal, targeted on particular communities/populations, or targeted on particular families?
- Where should interventions take place: in the home, community venues and/or schools?
- How can progress against the agreed outcomes be measured?
- What resources are required to implement the evidence-based programmes that will have a significant impact on the agreed outcomes?

5.2 Aligning existing programmes and services

Although Lisburn is underserved in terms of support for children and families, as it does not receive regeneration funding such as Neighbourhood Renewal, despite having areas within the 10% most deprived in the 2010 MDM figures and considerably worse educational outcomes than many other areas within the worst 10%, there are some existing services and programmes that operate in one or more of the target areas, delivered by different statutory and voluntary agencies. As a first step it will be important to:

- increase the awareness of, and focus on, prevention and early intervention;
- map and improve the co-ordination and integration of existing services for children and families, towards achieving the agreed outcomes;
- support existing community services for children, young people and families in the Lisburn area by developing a common outcomes framework (which will enable impact to be measured);
- help programmes/services to set and measure specific outcomes; learn from the international literature; and manualise programmes/services;
- develop a shared focus on quality achieved through joint reflective practice, training and peer learning, whereby different organisations can learn from one another; and
- encourage and support existing organisations to work together to transform the culture within the City of Lisburn, especially within areas of deprivation, to emphasise aspiration and achievement (particularly in relation to education). This can be done through local media, door to door consultations, celebrating local champions etc.

5.3 What Works?

There has been extensive work carried out around the world to evaluate which of the many early intervention social programmes actually work i.e. have a

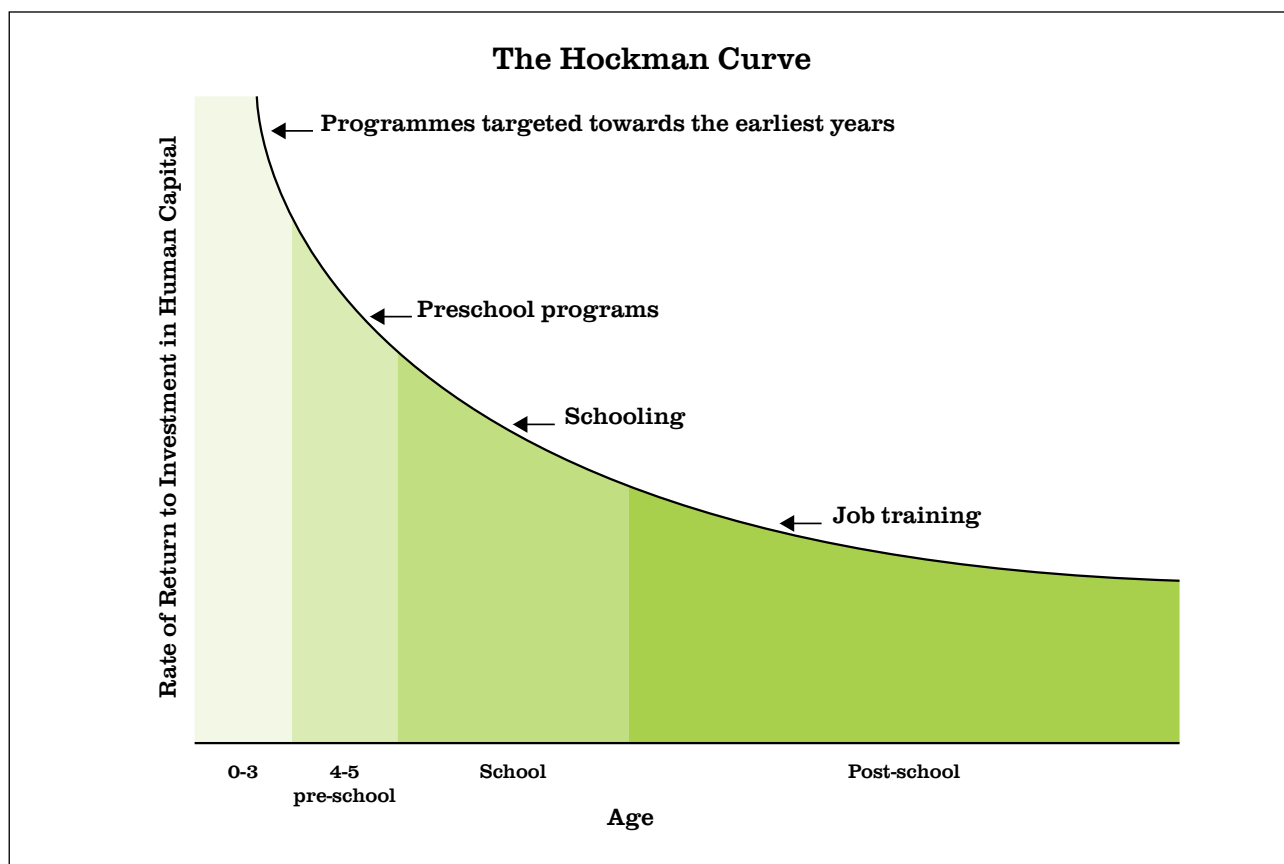
significant positive impact on the desired outcomes. The strongest evidence is from evaluations, carried out by experienced independent evaluators, which involve large numbers of children, families and/or young people receiving a manualised (standardised) programme; where there is a Random Control Trial (RCT) with a randomised control group not receiving the programme which is therefore very similar to the group receiving the programme; and testing is carried out both before and after the intervention, using well-established measurement instruments.

There are various organisations internationally which specialise in analysing the quality and robustness of evaluation information from social programmes around the world in order to highlight programmes which are “proven” or “promising”, including *Blueprints* and the *What Works Clearing House*. Work is now underway to develop an equivalent of the Blueprints database for Europe. Dartington Social Research Unit in England have worked with Steve Aos from Washington State USA to create a cost benefit model for England which will form part of a soon to be launched “Blueprints for Europe” (see <http://www.dartington.org.uk/investinginchildren>). Graham Allen MP, in his reports, has highlighted the programmes which he has been advised by UK experts have the strongest evidence base.

The impact of some of the best programmes has also been evaluated in terms of the long-term costs and benefits. These have shown that investment in the right evidence-based early intervention programmes can produce very substantial longer-term savings in issues like: welfare benefits, medical and mental health services, prison and other justice services, etc. This means that for the Government in Northern Ireland to invest in the recommended programmes in Lisburn is likely to result in long-term savings many times the amount of the investment that is required now.

Nobel laureate economist Jim Heckman has analysed a large number of cost-effectiveness studies and shown that the younger the age of children engaged in the programmes the more effective they are in reducing inequalities and more cost-effective the programmes are in generating long-term savings. This suggests that the bedrock of the Early Intervention Lisburn programme should be family interventions from pregnancy to age 3. His subsequent work, however, also shows that these interventions need to be sustained as the children get older, particularly during their primary school years, to prevent inequalities being strengthened again. This indicates the importance of programmes that address the needs of 3-11 year olds and those who make the difficult transition to post-primary school, as well as the crucial programmes for children aged 0-3 and their parents.

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5.3 Proven Early Intervention Programmes

What works in meeting the complex needs of families is a range of approaches. In order to give an indicative list of potential programmes, the following are some of the most robustly evaluated “proven” programmes (i.e. have been subject to at least two robust RCT evaluations which produced statistically significant results) most of which have been shown to result in substantial later savings, in relation to each of the important outcomes for Early Intervention Lisburn, highlighted above:

Reduced number of teenage pregnancies

- Family Nurse Partnership* (pregnancy – age 2) – delivered by a trained health visitor or other nurse to targeted parents in the home – which has been shown to reduce and delay subsequent births – It is currently being delivered in Northern Ireland by the Western Health & Social Care Trust in Derry/Londonderry and, although PHA identified Lisburn as a priority area in the South East, Belfast and the Southern Trust areas have been chosen for new Family Nurse Partnership programmes, rather than Lisburn. It is also being delivered in Scotland in Edinburgh and Tayside and in England by Nottingham local authority. There is currently a major RCT trial being carried out on Family

* Known as Nurse Family Partnerships in the USA where the programme originated

Nurse Partnerships in GB. Previous evaluations show that the parent and child programmes combined are more effective than either delivered on their own.

Reduced level of smoking, drinking and drug use during pregnancy

- Family Nurse Partnership (pregnancy – age 2) – see above

Improved parenting skills and confidence

- Incredible Years (aged 0-9) Parents Programme: Basic (12-14 weeks); Advanced (10-12 weeks); and SCHOOL and Dina Dinosaurs (an hour twice a week (or two hours once a week for 20-22 weeks) for children with conduct problems) – Targeted on identified families – It is currently being delivered in the Republic of Ireland (Youngballymun/Archways) and various aspects of Incredible Years is being delivered in various places in Northern Ireland (IFI are funding a cross-community initiative in the SEELB area to deliver Incredible Years in 16 schools, including in Old Warren Primary School)
- Parent-Child Interaction Therapy (age 2-7 year olds) – Targeted on pre-school children with evidence of a conduct disorder and their parents

Improved parent-child attachment for 0-2 year olds

- Family Nurse Partnership (pregnancy – age 2) – see above
- Incredible Years (aged 0-12) – see above

Improved literacy and numeracy in children aged 4-11

- Doodle Den – a literacy programme for 5/6 year olds, with additional parent and family sessions. It is delivered for 90 minutes three times a week after school (in school and community venues) by a specially trained teacher and youth worker to a group of 15 children. The RCT of the pilot in West Tallaght Dublin has demonstrated its impact.
- Success for All, including Curiosity Corner (age 3-11 year olds) – Universal - school-based - Institute of Effective Education University of York. There are modules for each key stage from foundation to key stage 3
- Time to Read (age 8 – 10 year olds) – developed in NI by Business in the Community, using volunteers from companies to read for 30 minutes each week with children in a primary school setting. A random control trial evaluation has indicated its effectiveness, esp. for those children whose reading development is only slightly delayed. Reading Recovery is likely to be more effective for the lowest 20% of readers. Time to Read is free to the schools. The key issue is BITC being able to identify appropriate volunteers to deliver the

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programme. It is already being delivered in Old Warren and Killowen Primary Schools

Improved social and emotional skills, conduct and resilience of 4-11 year olds

- PATHS (4/5 -11 year olds) – Universal - school-based – Barnardo’s in Northern Ireland (around Craigavon) and local authorities in Birmingham, Norfolk and Manchester
- Incredible Years for children, parents (see above) and teachers (6 day training workshop on classroom behaviour management) – see above and Appendix for details

Reduced behavioural/conduct problems

- Incredible Years (aged 0-12) – child programme (inc Dina Dinosaur) – universal prevention programme and treatment programme for small groups of particularly at risk children – see above and Appendix for details
- Triple P (aged 0-16) – Both universal and targeted (4 levels) – only proven if the whole programme at the 4 levels is delivered (only a “promising” Blueprints Programme). Is being piloted in Longford West Meath Parenting Partnership in the Republic of Ireland and England

Improved school attendance

- Big Brothers/Big Sisters (6-18 year olds) – Targeted - mentoring delivered by carefully selected and trained volunteers – being delivered in various parts of the Republic of Ireland through Foroige.

Reduced smoking, alcohol and drug consumption amongst young people

- Big Brothers/Big Sisters (6-18 year olds) – see above
- Life Skills Training (9-15 year olds) – Universal – 3-year school-based programme (15 sessions in year 1; 10 in year 2; and 5 in year 3) – currently being delivered in Nottingham. Barnardo’s have Big Lottery funding to deliver LST in the UK, including Northern Ireland
- Functional Family Therapy (10-18 year olds) – Targeted - family-based – delivered by a specially trained qualified social worker - currently being delivered by Archways in Dublin and being trialed in Brighton. Action for Children are planning to deliver it in Northern Ireland with Big Lottery funding
- Nurse-Family Partnerships – see above

Reduced crime and anti-social behaviour amongst young people

- Nurse-Family Partnerships – see above
- Functional Family Therapy (10-18 year olds) – see above
- Multisystemic Therapy– Targeted on at risk young people (aged 12-17) - family and community-based. Extern have been piloting MST in Northern Ireland and are planning to expand the programme with funding from the Big Lottery

Increased engagement of fathers with their child's learning

No “proven” programmes. The US programme Father's Reading Every Day (FRED) looks as if it has potential and engages Libraries in early intervention. All agreed programmes should follow the Fatherhood Institute guidelines on engaging fathers.

Improved educational attainment on leaving school

- Big Brothers/Big Sisters (6-18 year olds) – see above

Reduced childhood and teenage obesity

- There have been few studies that have demonstrated effectiveness in preventing obesity. Efforts to tackle obesity in school have had poor results. The focus of current research is on the ante-natal, post-natal and pre-school periods. SureStart seems to have an impact on children's BMI but not on the level of obesity. PHA are involved in a range of programmes to try and improve physical fitness and reduce obesity

Other Programmes

There are other programmes which address the outcomes highlighted above, but they lack the robust evidence-base to be confident that implementing these other programmes in Lisburn would have a significant impact on the agreed outcomes.

Other popular programmes are already being delivered in Lisburn, including the New Parenting Programme, Parent Infant Programme (PIP) and Mellow Parents/Fathers/ Bumps. There are also a number of youth work programmes in the target areas of Lisburn. The Early Intervention approach does not mean that these “unproven” programmes should immediately be abandoned, unless there are alternative “proven” programmes that can replace them, but that, where they are already manualised, delivered to a significant number of children/families and focused on specific outcomes, they should be robustly evaluated using an RCT methodology as soon as possible. Other current programmes which are not yet at this stage of development, such as youth work, should be further developed, using the robust international research evidence, to create more clearly desired

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outcomes, and be manualised and evaluated. The current partnership with the University of Ulster should assist in this process.

SureStart

SureStart, which is a key Government early intervention in disadvantaged communities and which currently operates in Old Warren and Hillhall, has not yet been discussed in any detail in this report.

SureStart is a government led initiative aimed at giving every child the best possible start in life and which offers a broad range of services focusing on Family Health, Early Years Care and Education and Improved Well Being Programmes to children aged 4 and under. The SureStart Programme is supported by a number of key principles:

- To co-ordinate, streamline and add value to existing services for young children and their families in local communities
- To involve parents
- To avoid stigma
- To ensure lasting support
- To be sensitive to local families needs
- To promote the participation of all local families

Services provided by projects must:

- Add value to existing/planned services
- Be based upon evidence of what interventions are successful
- Imaginatively respond to local need
- Be informed by strategic direction

SureStart work is focused on 6 high level outcomes to ensure children are:

- Being Healthy
- Enjoying Learning and Achieving
- Living in Safety and with Stability
- Living in a Society which Respects their Rights
- Experiencing Economic and Environmental Well-being
- Contributing Positively to Community and Society

The core services of SureStart are:

- Outreach and Home Visiting Services - to make contact as early as possible in the child's life and draw families into using other services
- Family Support and Parenting Information - both group and home based
- Good Quality Play, Learning and Child Care Experiences - for children, both group and home based
- Primary and Community Healthcare and Advice

- Support for Children with Special Needs - through signposting to more specialised services where necessary

Examples of specific services offered through projects include:

- Home based ante natal care
- Breastfeeding Support Groups
- Advice, support and information on health related topics
- Early Language Development Programmes
- Play development for all ages and stages
- Age appropriate physical development opportunities
- High quality crèche sessions
- Promotion of the creative arts
- Support for smooth transitions between pre school and school

SureStart services are currently available in at least the top 20 per cent ward areas of disadvantage in Northern Ireland, and the top 20 per cent Super Output areas, as defined by the Northern Ireland Multiple Deprivation Measure 2010. There are now 34 SureStart programmes across Northern Ireland which cover a wide geographic spread and have a good urban and rural mix. Over 30,000 children aged under four years and their families have access to the services provided through the programme. Out of the 32 programmes operating here, approximately one-third are based in rural settings.

SureStart programmes have been designed specifically to reflect and respond to local needs. For that reason, each SureStart programme is unique in terms of the services it provides and the manner in which it provides them. However, all SureStart projects now provide a Developmental Programme for two to three year olds which aims to enhance social and emotional development, build on communication and language skills and encourage imagination through play. This can help some children to be prepared for starting pre-school education. The Programme is not intended to be a universal service for all children in the year before starting pre-school education but is aimed primarily at those children who are likely to benefit most from this support.

There is a major national evaluation of the SureStart programme in England, which should produce a clearer understanding of the impact of the programme by the end of 2012. Interim evaluations have shown that children in Surestart areas are likely to have better physical health than the equivalent non-SureStart areas. Mothers also reported providing a more cognitively stimulating and less chaotic home learning environment for their children; experiencing greater life satisfaction; and engaging in less harsh discipline. However the mothers also

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reported more depressive symptoms and less engagement with their child's school (although it was low overall already).

The SureStart evaluator, on the basis of the initial evidence has recommended, in the Graham Allen 2011 Early Intervention report (Allen 2011), that SureStart, delivered to a high standard, should be a key component in any early intervention initiative, although not sufficient in itself.

There is also an important question as to the number of families that any particular SureStart scheme will be able to support in light of the funding made available. The evidence, highlighted above, is that the majority of children in the target areas of Lisburn are likely to significantly underachieve educationally, with very important implications for other aspects of their lives. Current schemes in Old Warren and Hillhall (currently part of the Colin Neighbourhood initiative) can only support a very small number of families. If SureStart is to make a significant impact in the target areas, it needs to reach a much larger number of families with high quality services delivered by well trained staff. On the current DENI criteria, Tonagh should also have a SureStart scheme. From the statistical evidence, on educational grounds, there is a strong case for also having a SureStart scheme in Hilden and Lagan Valley.

5.4 Criteria to use in selecting early intervention programmes to deliver

Having suggested a long-list of evidence-based programmes which would have an impact on the desired outcomes, it is important to be clear about the criteria that will be used to select a smaller number of programmes from this list. It is recommended that these short-listing criteria are as follows:

Number of outcomes each of the programmes is likely to have an impact on

Each of the evidence-based interventions highlighted above have an impact on a different number of the desired outcomes. All things being equal, priority should therefore be given to programmes that have a positive impact on the largest number of desired outcomes. The number of outcomes that would be affected by the long-listed programmes are as follows:

There is evidence that a Family Nurse Partnership programme could have a positive impact on at least five of the desired outcomes.

Incredible Years programme for parents, children and teachers is likely to have an impact on at least four of the desired outcomes.

Big Brothers/Big Sisters is likely to have an impact on at least three of the desired outcomes, including school attendance and educational attainment which are clearly critical outcomes in Lisburn.

Functional Family Therapy is likely to have an impact on at least two of the desired outcomes

The following programmes are likely to have an impact on at least one of the outcomes above:

- PATHS
- Parent-Child Interaction Therapy
- Success for All including curiosity corner
- Triple P
- Life Skills Training
- Multisystemic Therapy
- Doodle Den
- Time to Read

Age group to be addressed

The evidence is that the earlier the age of the recipients of a programme the more effective and cost-effective it is likely to be. However, it is also important that programmes to enhance the life chances of disadvantaged children and young people continue after the early years programmes through primary school and the transition to secondary school. The target age groups of each of the programmes are as follows:

From birth:

- Family Nurse Partnership - pregnancy – age 2 (targeted – home-based)
- Incredible Years - age 0-12 (community-based inc. schools)
- Triple P - age 0-16

From age 2/3:

- Success for All, including Curiosity Corner - age 3-11 (universal in primary)
- Parent-Child Interaction Therapy - age 2-7 (targeted home-based)

From age 4-6

- PATHS – age 4/5 - 11 (universal in primary schools)
- Big Brothers/Big Sisters – age 6-18 (targeted – community-based)
- Doodle Den – age 5/6 (targeted in primary schools)

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From age 8-12

- Time to Read – aged 8-10
- Life Skills Training age 9-15 (universal in primary and post-primary schools)
- Strengthening Families age 10-14 (targeted home-based)
- Functional Family Therapy – age 10-18 (targeted home-based)
- Multisystemic Therapy - age 12-17 (targeted home-based)

The appropriate location of programmes

Each of the programmes are designed to be delivered in different types of locations. The ability of one type of venue to take on more than one new programme at a time would suggest that programmes should cover a range of different venues. These potential types of venues are highlighted below:

Universal in primary schools

- PATHS (4/5 - 11 year olds)
- Success for All, including curiosity corner (3-11 year olds)
- Life Skills Training (9-15 year olds)

Targeted in primary school

- Time to Read (6-8 year olds)
- Doodle Den (5/6 year olds)

Universal in post-primary Schools

- Life Skills Training (9-15 year olds)

Targeted – based in a community venue (including schools and libraries)

- Incredible Years (0-12)
- Big Brothers/Big Sisters (6-18 year olds)

Targeted – home-based

- Family Nurse Partnership (pregnancy – 2 year olds)
- Parent-Child Interaction Therapy (2-7 year olds)
- Functional Family Therapy (10-18 year olds)
- Multisystemic Therapy (12-17 year olds)

Capacity to deliver

The choice of the most appropriate interventions and the timing of their introduction will also depend on the local capacity to introduce and deliver the programme with fidelity. A programme developed in the USA, for example, that has never been used in the UK or Ireland is likely to need to be adapted in a way that is appropriate for the local language and culture and the adaptation will need to be approved by the programme license-holder(s) of the programme. On the positive

side there is a rapidly increasing skill and experience in delivering a range of evidence-based programmes in the UK and Ireland, including Northern Ireland.

Programmes already being delivered in Northern Ireland

- Incredible Years
- Family Nurse Partnerships
- PATHS
- Multi-systemic Therapy

Programmes already planned for Northern Ireland

- Life Skills Training

Programmes already being delivered in the UK or Ireland (in addition to those delivered in Northern Ireland, which are all also being delivered in UK and/or Ireland)

- Big Brothers/Big Sisters
- Success for All
- Functional Family Therapy
- Triple P

Other programmes

- Parent-Child Interaction Therapy
- Multisystemic Therapy

Short-listed evidence-based programmes

The above selection criteria would suggest that the most effective and practically deliverable interventions to impact on the desired outcomes above would be as follows:

- Incredible Years (parent and child programmes - through the primary schools with the poorest test results at stages 1 & 2 and through Surestart)
- Family Nurse Partnerships
- Big Brothers/Big Sisters mentoring programme
- PATHS
- Life Skills Training
- Multisystemic Therapy
- Success for All
- Doodle Den
- Time to Read

Note: Functional Family Therapy and Multisystemic Therapy are effectively alternatives to each other. On cost grounds Multisystemic Therapy is being recommended here.

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It is important to say that the amount of robust evaluation evidence, both positive and negative, on programmes for children, young people and families is increasing rapidly. Within two years there will be over twenty RCT evaluations of such programmes in the UK and Ireland, which will further enhance the ability of EIL to identify the most appropriate initiatives to achieve the agreed outcomes. The shortlisted “proven” programmes recommended in this report are based on the current best evidence. Resurgam and Early Intervention Lisburn Steering Group/ Consortium, in consultation with the main stakeholders/funders, will need to make final decisions as to the programmes to prioritise in phase 1, as well as continuing to examine the emerging national and international efficacy evidence (the CYPSP particularly recommends* tracking the outcomes of RCT evaluations in Northern Ireland); building local capacity, so that there is an ongoing sustained effort to change outcomes for children, young people and families.; promoting innovation and the inclusion of local communities, children and young people in building on their assets, promoting their rights and responding to their needs.

5.5 Costs of the Early Intervention Programmes

The evidence on the costs of delivering the long-listed evidence-based programmes is as follows:

Programme	Target group		Total cost** to deliver
Incredible Years	Parents and 3-8 year olds	Parent programme: £4,833 per school each year; School Readiness (enhanced parenting programme): £1,500 per school; Dina Children's Programme: £6,253 per school	£12,586 per school/venue (inc. all 3 IYS programmes)
PATHS	4-6 year olds	Cost of £10,000 per year per school (total costs)	£10,000 per school
Family Nurse Partnership	Pregnancy – age 2	Cost of £3,000 per client family per year, inc. nurse training	£669,000 for 10% of families in target areas
Big Brothers/ Big Sisters	6-18 year olds	Cost per young person per year c.£627	£140,000 for 10% of all children aged 6+ in the target areas
Life Skills Training	9-15 year olds	Cost of c.£4.40 per student plus the cost of training: £2,508	£7,000.00 for all young people aged 9-15
Multisystemic Therapy	12-17 year olds	c.£2,821 per young person	£282,100 for 10% of young people age 12-17
Success for All, including curiosity corner	3-11 year olds	£3,467 for Key Stage 1 and £7,280 for Key Stage 2, per school (all costs) £3,526 for the nursery/reception programme	£10,747 per school (£14,273 for a school with a nursery or reception)

* CYPSP 2012 Recommendations “How to make Northern Ireland an Early Intervention Region”

** Will need to be adjusted each year for inflation

Doodle Den	5/6 year olds	£18,000 site costs plus £4,200 per group of 15 children	£35,000 to deliver in four primary schools (15 pupils each)
Time to Read	6-8 year olds	Free. The critical resource are the volunteers to deliver the programme	Free
Total Costs (assuming school-based programmes are delivered in four schools/venues): £1,312,777			

5.6 Costs of the Co-ordination Infrastructure

In addition to programme related costs, Early Intervention Lisburn would require funding for its infrastructure, in order to develop and implement programmes; ensure programme fidelity/quality; co-ordinate relationships with the various stakeholders; manage finance; ensure effective community engagement, etc..

Cost Headings	Annual Cost (need to adjust for inflation)
Early Intervention Community Co-ordinator (salary & related costs) - Resurgam	£35,000
Early Intervention Delivery Manager (salary & related costs) – Delivery Partner	£45,000
Early Intervention Quality & Monitoring Officer (salary & related costs) – Delivery Partner	£35,000
Administration and servicing of the Early Intervention Consortium - Resurgam	£3,000
Programme-related Finance/Administration	£15,000
Travel (local, national and international), phone costs	£8,000
Office and energy costs - Resurgam	£7,500
Office and energy costs – Delivery partner	£7,500
Stationary, PR and marketing costs (inc Newsletter)	£6,000
Governance costs - Resurgam	£3,000
Evaluation (see below)	£50,000
Community Consultations - Resurgam	£2,000
One Project-Two Cities with Early Intervention Derry-Londonderry and effective partnership working with other Early Intervention sites	£10,000
The cost of parent-friendly events and activities to help build the relationships with parents and attract them to participate in more rigorous programmes	£3,000
Total Annual Costs	£230,000

The total annual cost of implementing the recommended programmes and the related infrastructure costs would therefore be c. £1,540,000. However, it is likely to be several years before the investment can be put in place to deliver all the recommended programmes, so the funding required in year 1 is likely to be considerably lower.

The costs of SureStart have not been included in these calculations, as they are subject to separate negotiations with the Eastern Childcare Partnership.

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There are also potential issues concerning community premises where programmes are going to be delivered, which are hard to calculate at this stage. In some of the target areas there are good community buildings; other areas are likely to be able to access greatly improved community premises in the near future. There are also some areas with very poor facilities, which currently provide little scope for additional early intervention services.

5.7 Evaluation

There is an important issue concerning the evaluation(s) of any agreed programmes implemented. If the programmes have already been robustly evaluated at least twice (as “proven” Blueprints programmes are, or if they are already subject to a major RCT trial elsewhere in the UK or Ireland, it may not be necessary to commission an RCT evaluation. However, programmes that have some promising evidence, such as Mellow Parents, the Parent Infant Programme (PIP) and the New Parenting Programme, but have not yet been subject to a large-scale RCT should be subject to a RCT trial. In addition it is still important to commission an objective formative and summative assessment of how well the programmes have been implemented, what progress is being made in achieving the agreed outcomes, and identify any lessons that can be learnt.

It would also be incredibly valuable to commission a long-term assessment, against data from comparable areas, as to the extent that the agreed set of Early Intervention Lisburn programmes overall have been able to impact on the measurable outcome indicators. Ideally this should be over at least 15 years.

There are also various existing programmes and services for children, young people and families currently being delivered in some of the target areas. The evidence from this report would suggest that collectively these programmes and services are not enabling the children and young people from the target areas to achieve their potential. However, perhaps these outcomes would be even worse if these programmes and services, or some of them, did not exist. These programmes and services need to be effectively mapped and assessed against the evidence for the impact they are making on the desired outcomes, highlighted above. It would then be possible to make informed decisions on ways of:

- clarifying outcomes of existing programmes and services and evaluating their impact on these outcomes;
- focusing existing programmes and services to improve the desired services;
- expanding existing programmes and services;
- co-ordinating the various programmes and services better;
- reducing or closing existing services; and/or
- filling the gaps identified.

5.8 Performance Management

In addition to external evaluation there needs to be an effective performance management and quality assurance system that ensures that all programmes are delivered with fidelity (as set down by the owners of the license) and in accordance with the objectives and commitments agreed with funders. Some licensed programmes have very tight fidelity and quality assurance requirements e.g. PATHS, others are less tightly specified e.g. Incredible Years. The danger in the latter is that programmes may be implemented in a way that fails to achieve the outcomes which RCT evaluations have shown they can achieve. Any programmes implemented through EIL need to demonstrate a very high standard of fidelity.

There also needs to be an effective process for gathering, measuring, analyzing and reporting on relevant data from each programme.

This issue is discussed more under the Operating Model below.

5.9 Potential Sources of Funding:

From the scan of public policy documents, the following are Government Departments and agencies which have relevant public policy objectives in relation to the agreed outcomes and should therefore be potential sources of funding for the Early Intervention Lisburn programmes:

- OFMdfM – Social Investment Fund
- DHSSPS
- Health & Social Care Board
- Public Health Agency
- South Eastern Health & Social Care Trust
- Children & Young Persons Strategic Partnership
- Department of Education
- South Eastern Education & Library Board – schools budget
- South Eastern Education & Library Board – youth service budget
- Schools' Extended Schools budget
- Department of Justice
- Youth Justice Agency
- Probation Board
- PSNI
- Department of Social Development
- Departmental research budgets re evaluations
- Lisburn City Council
- NI Housing Executive
- Big Lottery – e.g. Supporting Families
- Charitable trusts/foundations

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5.10 Theory of Change Linkages

A theory of change highlights the logic of the approach to be adopted i.e. between inputs, activities, outputs and outcomes. The following highlights the overall logic of the suggested Early Intervention Lisburn approach:

The overarching objective of Early Intervention Lisburn is:

To improve the outcomes for children and young people in disadvantaged areas of Lisburn

This is to be achieved by:

Putting in place and effectively implementing proven universal and targeted programmes which have been shown to improve outcomes for children and young people over a sustained period.

This is to be achieved by:

Being clear about the outcomes where children and young people in disadvantaged communities in Lisburn fall significantly short of the Northern Ireland average.
AND

Identifying those proven universal and targeted programmes which have been shown to improve the specific agreed outcomes for children and young people in disadvantaged communities AND

Either robustly evaluating, and/or stop delivering, existing programmes that do not demonstrate clearly their positive impact on the agreed outcomes AND

Gaining effective community, political and statutory commitment to and support for the implementation of a comprehensive sustained early intervention programme and to working effectively together AND

Gaining sufficient long-term funding to support a sustained early intervention programme AND

Implementing agreed evidence-based programmes with fidelity AND

Attracting and retaining the participation of the target parents and children in the programmes implemented AND

Effectively evaluating the programmes against agreed outcomes

5.11 Logic Model

The following logic model articulates in more detail the potential relationship between inputs, activities, outputs, intermediate and final outcomes and how they can be measured.

Inputs	Activities	Outputs	Intermediate outcomes	Final outcomes
==>	==>	==>	==>	
<p>Annual Financial support of £1.5M from stat. sources:</p> <ul style="list-style-type: none"> • Co-ordinator & programme staff • Programme costs • Governance & m'tment costs • Evaluation • A commitment from agencies to work together to achieve the outcomes • Engagement of target local communities • Support from political reps • Contribution from schools to promote effective delivery & liaison • Contribution from each partner to participate in the Consortium & deliver agreed programmes • Contribution from parents & children to participate • Quality assurance re. programme fidelity • Evaluation expertise 	<p>Universal in Primary Schools</p> <ul style="list-style-type: none"> • PATHS (4-6 year olds) • Success for All inc. curiosity corner (age 3-11) • Time to Read (8-10 yr olds) • Life Skills Training (9-15 year olds) <p>Universal in Post-Primary Schools</p> <ul style="list-style-type: none"> • Life Skills Training (9-15 year olds) <p>Targeted in community venues</p> <ul style="list-style-type: none"> • Incredible Years (age 0-12) • Big Brothers/ Big Sisters (BB/BS) (6-18 year olds) <p>Targeted home-based</p> <ul style="list-style-type: none"> • Family Nurse P'ship (NFP) (pregnancy - 2) • Multisystemic Therapy (12-17 year olds) 	<ul style="list-style-type: none"> • PATHS (x sessions for y children over z months) • Success for All (x sessions for y children over z months) • Life Skills Training (x sessions for y children over z months) • Incredible Years (x sessions for y children over z months) in • BB/BS (x sessions for y children over z months) • FNP (x sessions for y children over z months) • Multisystemic Therapy (x sessions for y children over z months) 	<ul style="list-style-type: none"> • Reduced number of teenage pregnancies • Reduced level of smoking during pregnancy • Improved parenting skills and confidence • Improved parent-child attachment for 0-2 year olds • Improved school attendance • Improved school readiness amongst 3 & 4 year olds • Improved the social and emotional skills and resilience of 4-11 year olds • Improved literacy & numeracy in children aged 4-11 	<ul style="list-style-type: none"> • Improved educational attainment • Reduced behavioural/ conduct problems • Reduced smoking, alcohol & drug consumption amongst young people • Reduced crime and anti-social behaviour amongst young people • Improved physical and mental health of children

Theory of change

How inputs will be measured	How activities will be measured	How outputs will be measured	How intermediate outcomes will be measured	How final outcomes will be measured
==>	==>	==>	==>	
<p>Financial budget and quarterly management accounts</p> <p>Outputs in relation to parent and child participation</p> <p>Participation in the early Years Lisburn Steering Group and sub-groups</p>	<p>Outputs (see column to the right)</p> <p>Fidelity to the programme manual</p> <p>Parent satisfaction</p> <p>Young participant satisfaction</p>	<p>Number of programme sessions delivered</p> <p>Number of children and young people involved in the programmes</p> <p>Number of parents involved in the programmes</p> <p>% attendance at programmes</p> <p>% of participants completing the programmes</p>	<ul style="list-style-type: none"> • % of mothers smoking during pregnancy • Increased parenting confidence (Parents Sense of Competence Scale) • Increased parental engagement with their child's education • Improved child behaviour (The Eyberg Child Behaviour Inventory for Parents and the Sutter-Eyberg Behaviour Inventory for teachers) • Improved child social & emotional skills (SDQ for parents and teachers) • Literacy & numeracy at Key stages 1 & 2 • Number of teenage pregnancies • Improved parent-child attachment for 0-2 year olds • increased % of children with 85% school attendance 	<p>% deaths under the age of 75</p> <p>Average age at death</p> <p>% young people going on to higher or further education</p> <p>% of young people achieving 5+ GCSEs A*-C</p> <p>% of young people achieving 2+ A levels A*-C</p> <p>Number of crimes and anti-social behaviour incidents</p> <p>Level of smoking, alcohol and drug consumption amongst teenagers</p>

Operating model

6.1 Introduction

It is vital to have an effective and accepted operating model to plan and implement a comprehensive programme of universal and targeted early intervention programmes in Lisburn. The structures need to engage all the key agencies if it is to ensure effective co-ordination and seamless delivery of services. It is also vitally important that the local communities which Early Intervention Lisburn would serve feel a sense of ownership of the programmes that are delivered, otherwise, if they are perceived to be parachuted in by external agencies, the programmes are unlikely to get the participation of those who most need the services in order to be successful.

6.2 Resurgam Trust

The Resurgam Development Trust has been established to create a community-owned organisation designed to promote the interests of those in disadvantaged communities in Lisburn. It was formally constituted as a company limited by guarantee in January 2011. It has been accepted as charitable for tax purposes by the Inland Revenue. The membership of Resurgam is made up of c.1,000 individual members (adults and young people). The Board is made up of representatives from local community and youth organisations.

It is Resurgam that initiated the current exploration of an early intervention approach to addressing many of the problems faced by disadvantaged communities in Lisburn and currently co-chairs and services the Early Intervention Lisburn Steering Group made up of a wide range of relevant agencies.

Currently, at the time of writing this report, however, Resurgam is a very new player and does not receive any core funding. This is an issue that would need to be resolved if it is to have the capacity to play a leading role in the development and management of Early Intervention Lisburn. Discussions are currently taking place with DSD in relation to Resurgam as a flagship social enterprise initiative.

It is also important that Resurgam has the organisational and financial policies and procedures, and assured governance development processes that reflect its potential as the central co-ordinating and servicing body of Early Intervention Lisburn.

6.3 Children and Young People's Outcomes Group

A second key player is the inter-agency inter-sectoral South Eastern Outcomes Group of the Children and Young People's Strategic Partnership, which is playing a vital role in driving the early intervention agenda. All the main statutory and voluntary bodies concerned with meeting the needs of children and young people within the South-Eastern area are represented on the group.

Operating model

The Early Intervention Lisburn Steering Group, which has representatives from various community groups and all the key statutory agencies, should be refreshed as the Early Intervention Lisburn Consortium and be recognised as a Locality subgroup of the South-Eastern Young People's Strategic Partnership Outcomes Group and should become the key co-ordinating inter-agency body, similar to the role fulfilled by Health Improvement or Health Cities Partnerships.

6.4 Other Important Partners

The following are some of the other key players which need to be engaged and committed to the Early Intervention Lisburn Consortium if it is to be a success:

- Public Health Agency
- South Eastern Health & Social Care Trust
- South Eastern Childcare Partnership
- Department of Education
- South Eastern Education & Library Board/ESA
- Statutory Youth Service - South Eastern Education & Library Board/ESA
- Department of Justice/Youth Justice Agency
- PSNI
- Department of Social Development
- Lisburn City Council
- NI Housing Executive
- Elected representatives

6.5 Delivery Partner(s)

Delivering the portfolio of early intervention programmes recommended in this report will require extensive experience of delivering and quality assuring programmes for children and families. It is therefore vital that one of more experienced delivery partner are appointed by Early Intervention Consortium Lisburn Consortium.

There is an important question as to how many delivery partners there should be. It is possible to make an argument for several different arrangements:

Option 1: Separate delivery partners for every programme (potentially large number of different delivery partners)

- Pros: able to bring in experience of delivering all the target programmes; bodies currently delivering the target programmes elsewhere can be included in EIL
- Cons: complex structure; various different organisational cultures and systems; complex, diffuse accountability; more difficult to build effective relationships and cross-programme working; time and energy required to effectively co-ordinate the various bodies

Option 2: One experienced delivery partner which takes responsibility for the implementation of all programmes

- Pros: simple structure; single organisational culture and systems; clear accountability; easier to build effective relationships and cross-programme working
- Cons: one body is unlikely to have previous experience of delivering all the target programmes.

Option 3: One delivery partner, which can sub-contract delivery of programmes, if necessary

- Pros: Simple structure; single organisational culture and system; clear accountability and reporting lines; easy to build effective relationships; can engage other agencies in delivery (e.g. SEHSCT in delivering FNP); sub-contracting can be quality assured by the delivery partner; strong effective co-ordination between the programmes
- Cons: Success of the EIL initiative depends on the appointment of the right delivery partner which can deliver complex programmes with fidelity and work well with the community

Option 3 is recommended.

6.6 Potential role of Resurgam

Community engagement is critical to the success of Early Intervention Lisburn. Resurgam, as an representative umbrella community body for the target areas, has, therefore, a crucial role in the success of the initiative. The South-Eastern Young People's Strategic Partnership Outcomes Group, on behalf of the relevant agencies, should contract with Resurgam to fulfill the following roles for the Early Intervention Lisburn Consortium/Locality Group:

Consortium

- Organise and co-ordinate meetings of the Early Intervention Lisburn Consortium (not less than 4/5 times a year)
- Ensure all Consortium meetings are well planned and effectively serviced
- Provide a co-chair for the Consortium
- Ensure the Early Intervention Lisburn Consortium has the appropriate structure and officers
- Ensure the Consortium operates to the highest governance standards and regularly reviews its performance

Delivery Partner

- Draw up the brief (with expert assistance if required) for the appointment of a delivery partner, for approval by the Consortium

Operating model

- Service the recruitment and selection of a delivery partner by a panel appointed by the EIL Consortium
- Maintain effective liaison with the delivery partner
- Facilitate and support the relationship between the delivery partner and relevant community groups/organisations
- Liaise with the Delivery Partner in relation to the development of the portfolio of new evidence-based early intervention programmes, as agreed with the Consortium

Risk Management

- Develop, and keep up-to-date, a risk register
- Highlight to the Consortium and Delivery Partner any potential barriers or challenges to achieving the agreed plans
- Ensure Resurgam and Early Intervention Initiative Lisburn Consortium comply with the highest standards in relation to governance and potential conflicts of interest

Marketing and PR

- Actively promote and publicise the Early Years Lisburn Initiative, locally in the target communities and wider community networks
- Actively support the marketing of relevant programmes in the target areas
- Produce a regular Early Intervention Lisburn Newsletter, in partnership with the Delivery Partner, and disseminate widely within the target communities

Employment

- Employ and manage an Early Intervention Community Engagement Officer
- Ensure good practice in the recruitment, selection, induction and management of staff in all aspects of Early Intervention Lisburn
- Contribute as a panel member to the selection of staff for agreed programmes

Programme Development

- Negotiate, with the Consortium, funding for the initial agreed evidence-based programmes and infrastructure costs
- Facilitate (with expert assistance if necessary) the development, implementation and monitoring of overall Early Intervention Lisburn strategic and annual operational plans

Quality Assurance & Performance Management

- Consider Quality assurance reports from the Delivery Partner in relation to ensuring the effective delivery of the overall programme and ensuring the fidelity of evidence-based programmes

- Ensure the Delivery Partner has appropriate systems in place to monitor and evaluate the performance of agreed programmes; and against specific indicators for the overall programme in relation to each Outcome

Finance

- Ensure the highest standards of financial planning, accounting and reporting
- Ensure appropriate financial reporting mechanisms to funders/contractors which are providing funding directly to Resurgam and/or the Early Intervention Lisburn Consortium

Collaboration

- Collaborate effectively with other community organisations engaged in early intervention initiatives in Northern Ireland, GB and Ireland
- Build effective relationships and work positively to resolve any disputes or difficulties

Consultation

- Actively promote the active participation of all the local target communities in the agreed programmes
- Consult local target communities on perceptions of the programmes and emerging needs and issues
- Ensure there is an effective community voice on the Early Intervention Lisburn Consortium
- Ensure all relevant local community groups are effectively represented on Resurgam

Research and Evaluation

- Facilitate the appointment and servicing of an Expert Advisory Committee (of early intervention and evaluation experts) to advise the Consortium
- Draw up a brief (with expert assistance, if required) for the appointment of evaluators
- Source experienced evaluators through administering a thorough tender recruitment process and sit on the panel (the panel to be appointed by EIL Consortium)
- Ensure the evaluation contract is effectively managed
- Ensure effective liaison with evaluators

Operating model

6.7 Role of the Delivery Partner

The following is suggested as appropriate responsibilities of the Delivery Partner:

Quality Assurance & Performance Management

- Ensure the agreed programmes are delivered with fidelity, through effective quality assurance
- Ensure good practice in identifying and sourcing any sub-contracted delivery bodies
- Ensure there are appropriate systems in place to internally monitor and evaluate the performance of agreed programmes

Programme Development

- Contribute to the negotiations for funding of agreed evidence-based programmes and infrastructure costs
- Develop tender briefs for agreed programmes to be delivered by sub-contractors, for Consortium approval
- Contribute to the development, implementation and monitoring of overall Early Intervention Lisburn strategic and annual operational plans
- Liaise with the Early Intervention Lisburn Consortium and Resurgam in relation to the development of the portfolio of new evidence-based early intervention programmes

Risk Management

- Develop, and keep up-to-date, a risk register in relation to the agreed programmes
- Highlight to the Consortium and Resurgam, as soon as possible, any barriers or challenges to achieving the agreed plans
- Comply with the highest standards in relation to governance and potential conflicts of interest

Marketing and PR

- Actively promote and publicise the Early Years Lisburn Initiative, locally in the target communities, NI-wide and in the UK and Ireland
- Actively market the relevant programmes in the target areas
- Produce a regular Early Intervention Lisburn Newsletter, in partnership with Resurgam

Employment

- Employ and manage an Early Intervention Manager (not necessarily the final job title) to lead and co-ordinate the various programmes and liaise with the Consortium and Resurgam

- Ensure good practice in the recruitment, selection, induction and management of staff in all aspects of Early Intervention Lisburn
- Contribute to the selection of staff for any agreed sub-contracted programmes
- Ensure all staff are trained to the appropriate standard

Finance

- Ensure the highest standards of financial planning, accounting and reporting
- Ensure appropriate financial reporting mechanisms to funders/contractors

Collaboration

- Ensure effective collaboration with SureStart, relevant schools, and other relevant programmes, organisations and venues
- Collaborate effectively with other early intervention delivery bodies in Northern Ireland and build relationships with other early intervention initiatives in GB and Ireland
- Liaise closely with any sub-contracted delivery agencies and work positively to resolve any disputes or difficulties

Consultation

- Actively promote the active participation of the local target communities
- Consult local target communities on perceptions of the programmes and emerging needs and issues

Research and Evaluation

- Keep up to date with emerging evidence in the UK, Ireland and internationally of the efficacy of relevant early intervention programmes
- Ensure there is an appropriate performance management information system which is effectively implemented
- Ensure the evaluation contract is effectively managed
- Ensure effective liaison with evaluators

Reporting

- Produce a report for the Early Intervention Lisburn Consortium and Resurgam (not less than 4 times a year) in a format agreed with the Consortium
- Produce financial and monitoring reports as agreed with the relevant funders

Implementation plan

7.1 Introduction

This short section will outline the next steps in terms of moving towards implementing the recommendations above. It is not possible to implement a range of new programmes at once, so it is important to phase their introduction. Which programmes would be implemented before other programmes would be partly determined by funding, the availability of a Delivery Partner with relevant experience, and the readiness of the environment e.g. the communities and schools to support the implementation of a programme.

7.2 Timetable

The following outlines a suggested implementation plan between June 2012 and December 2018:

June – September 2012

- Early Intervention Lisburn Steering Group to discuss the report and agree which recommendations (if any) it wishes to endorse
- Agree the process for printing and disseminating the report
- Meet with the South East Outcomes Group of the Children & Young Person's Strategic Partnership to discuss the report
- Agree a programme of face-to-face presentations of a summary of the report to a range of key stakeholders, including community organisations and statutory agencies
- Agree the process for developing a common outcomes framework (which will enable impact to be measured) and a shared focus on quality achieved through joint reflective practice, training and peer learning, whereby different organisations can learn from one another.
- Bring existing organisations together to identify how best to transform the culture within the City of Lisburn, especially within areas of deprivation, to emphasise aspiration and achievement (particularly in relation to education) through local media, door to door consultations, celebrating local champions etc.
- Agree a process for mapping existing services/programmes serving disadvantaged communities in Lisburn and the evidence for the contribution they make towards the agreed outcomes

- Meet with the primary schools in the Extended Schools programme in Lisburn to discuss with them the kinds of support and assistance they require to help them achieve their objectives and the potential to host appropriate proven models in the schools
- Draw up a brief and process for the appointment of a Delivery Partner.
- Appoint an appropriate Delivery Partner
- Agree a Service-Level Agreement with the Delivery Partner
- Consider the potential for any of the programmes to be delivered in partnership over a wider geographical area (e.g. the One Project:Two Cities initiative; SEHSCT area)
- Identify the most appropriate source(s) of infrastructure finance, and apply, for funding in accordance with appropriate objectives and procedures.
- Identify the potential funders of recommended programmes and arrange meetings with each to discuss the report and potential funding
- Negotiate an initial contract between the Children & Young Person's Strategic Partnership and Resurgam to take forward the recommendations in the report
- Draw up and approve job descriptions and specifications for infrastructure posts in Resurgam and the Delivery Partner
- Arrange study visits to see the recommended programmes in the UK and Ireland in operation
- Ensure Resurgam has all the organisational policies and procedures, financial policies and procedures, and externally supported governance development processes that reflect its potential as the co-ordinating and servicing body of the Early Intervention Lisburn Consortium
- Consider the most appropriate membership of the Early Intervention Consortium
- Appoint the co-chairs of the early Intervention Lisburn Consortium

Implementation plan

October – December 2012

- Recruit and select a Resurgam Early Intervention Community Co-ordinator (subject to funding having been negotiated) through open recruitment (in accordance with agreed policies and procedures)
- The Delivery Partner to recruit and select an appropriate Early Intervention Lisburn Delivery Manager
- Draw up (Delivery Partner) service design briefs for each of the agreed phase 1 programmes e.g. from Incredible Years, Family Nurse Partnerships, Big Brother/Big Sisters, PATHS, Success for All and Life Skills Training
- Put detailed proposals/applications to funders/contractors, in relation to phase 1 programmes and infrastructure, as agreed
- Meet with the target schools concerning their potential to host appropriate programmes e.g. Incredible years full parent and child programmes, PATHS and Success for All
- Draw up an evaluation brief for the overall Early Intervention Lisburn Programme and seek funding for the evaluation

January – March 2013

- Induct and train the Resurgam Early Intervention Community Co-ordinator and Delivery Partner Early Intervention Delivery Manager
- Recruit and select a Delivery Partner Early Intervention Quality & Monitoring Officer (subject to funding having been negotiated) through open recruitment (in accordance with agreed policies and procedures)
- Go out to tender on the phase 1 agreed programmes e.g. from Incredible Years, Family Nurse Partnerships and Big Brothers/Big Sisters, PATHS, Success for All, Life Skills Training, when appropriate funding has been approved
- Meet with BITC about the potential to deliver Time to Read in the additional target primary schools
- Put more detailed proposals/application to funders/contractors, in relation to phase 1 as agreed
- Agree which programmes to include in phase 2 e.g. from the priority programmes not implemented in phase 1

- Go out to tender for an appropriate evaluation team
- Draw up and agree a strategic plan for 2013-2018 and an operational plan for 2013/14.

April 2013 – August 2013

- Delivery Partner to carry out the start up (planning, training and recruitment) phase of the first early intervention programmes
- Market the phase 1 programmes effectively to the target local audiences
- Draw up service design briefs and tender specifications for each of the agreed phase 2 programmes
- Evaluators to agree measures and instruments and carry out baseline measurement
- Put detailed proposals/application to funders/contractors, in relation to phase 2 as agreed
- Early Intervention Lisburn Consortium and Resurgam to discuss annual early intervention report from the Delivery Partner

September – December 2013

- Start delivering agreed phase 1 early intervention programmes
- Evaluators to produce baseline report
- Put more detailed proposals/application to funders/contractors, in relation to phase 2 programmes, as agreed
- Go out to tender on the phase 2 agreed programmes, when appropriate funding has been approved

January - June 2014

- Delivery Partner to carry out start up phase (planning, negotiating licenses, training, baseline evaluation and recruitment) of phase 2 early intervention programmes
- Agree which programmes should be part of phase 3

Implementation plan

- Put detailed proposals/application to funders/contractors, in relation to phase 3 programmes, as agreed
- Early Intervention Consortium and Resurgam to discuss annual early intervention report from the Delivery Partner

July – December 2014

- Start delivering agreed phase 2 early intervention programmes (community, home and school based)
- Draw up service design briefs and tender specifications for each of the agreed phase 3 programmes
- Go out to tender on the phase 3 agreed programmes
- Review the governance of the Early Intervention Lisburn initiative and agree actions to further improve it
- Put more detailed proposals/application to funders/contractors, in relation to phase 3 programmes, as agreed
- Consider 1st year formative evaluation report(s) and adjustments required in the delivery of the programmes

January – June 2015

- Start up (planning, negotiating licenses, training, baseline evaluation and recruitment) phase of phase 3 early intervention programmes
- Agree which programmes should be part of phase 4 (considerable additional evidence on what works in terms of early intervention should be available at this point, inc a range of RCTs in Ireland and GB)
- Put detailed proposals/application to funders/contractors, in relation to phase 4 programmes, as agreed
- Early Intervention steering group to discuss annual early intervention report from Resurgam

July – December 2015

- Start delivering agreed phase 3 early intervention programmes
- Consider the formative 2 year evaluation report (2 years of phase 1 and 2 years of phase 2)
- Draw up service design briefs for each of the agreed phase 4 programmes (where funding is agreed and there is a viable delivery agency), which have not been developed in the previous 3 phases of the programme.

January – June 2016

- Start up (planning, negotiating licenses, training, baseline evaluation and recruitment) phase of phase 4 early intervention programmes
- Early Intervention steering group to discuss annual early intervention report from Resurgam

July – December 2016

- Start delivering agreed phase 4 early intervention programmes
- Consider the 3 year evaluation report (3 years of phase 1 ; 2 years of phase 2 ; and 1 year of phase 3)
- Review the governance of the Early Intervention Lisburn initiative and agree actions to further improve them

January – June 2018

- Early Intervention Consortium and Resurgam to discuss annual early intervention report from the Delivery Partner

July – December 2017

- Consider the 4 year evaluation report (4 years of phase 1 ; 3 years of phase 2 ; 2 years of phase 3 ; and 1 year of phase 4)

January – June 2018

- Early Intervention Consortium and Resurgam to discuss annual early intervention report from the Delivery Partner

July – December 2018

- Consider the 5 year evaluation report (5 years of phase 1 ; 4 years of phase 2 ; 3 years of phase 3 ; and 2 years of phase 4)

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Terms of Reference for the development of a detailed model of delivery for Early Intervention Lisburn

Background

Resurgum Development Trust has developed the concept of an Early Intervention Locality within Lisburn in order to meet a range of disproportionately poor outcomes for children and families in the Lisburn area. To develop this concept further, Resurgum and the Public Health Agency have commissioned Barnados to deliver specific deliverables which will help take this initiative forward. Barnados are also contributing funding to this project in a spirit of collaboration and have allocated an experienced consultant to operationally lead this work on their behalf.

Timescale

All deliverables should be completed by 31st May, 2012

Deliverables

The main deliverable from this piece of work will be a single report titled 'The Development of an Early Intervention Locality within Lisburn'. Within this report, several distinct elements will be covered, as detailed below:

1. **The Case for Change:** this section will articulate why an early intervention initiative is required in Lisburn. It would detail outcomes for children living within the most deprived estates within Lisburn, especially Old Warren, Hillhall and Tonagh (although it will also cover other estates) and how these compare with other areas in Northern Ireland. This section will also detail the specific needs within Lisburn, the current services in place, the gaps and the potential overlaps between current services.
2. **Shared Outcomes and Principles:** This key section will articulate the shared OUTCOMES and PRINCIPLES that all stakeholders in Early Intervention Lisburn have signed up to. Obviously, to get to this point, engagement with community, statutory (including schools) and voluntary partners will need to take place. This engagement should include all key stakeholders and should be fully inclusive from an early stage. The engagement process will need to be designed and implemented to ensure the views of all key stakeholders are included and that agreement is reached between all partners as to which shared outcomes and principles should underpin the development of Early Intervention Lisburn.
3. **What works – a global review of evidence:** Using the Outcomes agreed in section 2, this section will detail the types of programmes and practices which have been proven to deliver the expected Outcomes e.g. improved adolescent mental health, reduced teenage drinking, kids more ready for school in P.1, improved school attendance or better academic achievement etc etc.

4. Design of an integrated model of delivery for Early Intervention Lisburn (EIL): This element will take all the learning from the previous sections and will design a suite of interventions which collectively will enable EIL to achieve the Outcomes identified in section 2. Thus, each intervention will be clearly linked to specific Outcomes. In addition, clear performance indicators will be identified to ensure that progress towards specific outcomes can be measured e.g. GCSE results for an outcome of better academic achievement. This section will also provide an estimate for the overall projected cost of the programme. This cost should include the recruitment by Resurgum of an overall EIL Programme Manager to oversee the implementation of the EIL initiative. This section will not detail potential providers but may provide examples of where specific programmes have been proven to make a measurable difference in other areas.
5. Role of Resurgum as programme owners: This section will provide background information about Resurgum and will lay out the rationale for Resurgum taking responsibility, as a leading community organisation in Lisburn, for the delivery of the Early Intervention Lisburn initiative. Specific elements of the role of Resurgum may include:
 - a. Responsibility for financial management
 - b. Responsibility for identifying and sourcing, via tendering, the best providers for each intervention
 - c. Monitoring the performance against specific indicators for the overall programme in relation to each Outcome
 - d. Reporting progress to funders
 - e. Quality assurance of the delivery of the overall programme
6. Implementation Plan: This short section will outline the next steps in terms of moving towards implementation such as designing a detailed specification for each intervention, leading to tender documentation and the recruitment by Resurgum of an overall EIL Programme Manager.

APPENDIX TWO

Membership of the Early Intervention Lisburn Steering Group:

Adie Bird (Chair)
Denis Paisley
Jason White
Anne Hardy
Mabel Scullion
Caroline McGrath
Ian Sutherland
Jonathon Craig
Martin Devlin
Neil McGivern
Monica McCann
Paul Porter
Una Geelan
Paul Givan
Francis Ferris

Descriptions of Recommended Early Intervention Programmes

Multisystemic Therapy

Big Brothers Big Sisters

Functional Family Therapy

Life Skills Training

Family Nurse Partnerships

PATHS (Promoting Alternative Thinking Strategies)

Incredible Years

Triple P – Positive Parenting

Parent-Child Home

Reading Recovery

Parent-Child Interaction Therapy

Fathers Reading Every Day (FRED)

Time to Read

Descriptions of Recommended Early Intervention Programmes

MULTISYSTEMIC THERAPY (MST)

Program Summary

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

Program Targets

MST targets chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement, and the offenders' families.

Program Content

MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded. MST strives to promote behavior change in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.

The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model of services delivery. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains. The usual duration of MST treatment is approximately 60 hours of contact over four months, but frequency and duration of sessions are determined by family need.

Program Outcomes

Evaluations of MST have demonstrated for serious juvenile offenders:

- reductions of 25-70% in long-term rates of rearrest,

- reductions of 47-64% in out-of-home placements,
- extensive improvements in family functioning, and
- decreased mental health problems for serious juvenile offenders.

Program Costs

MST has achieved favorable outcomes at cost saving in comparison with usual mental health and juvenile justice services, such as incarceration and residential treatment. At a cost of \$4,500 per youth, a recent policy report concluded that MST was the most cost-effective of a wide range of intervention programs aimed at serious juvenile offenders.

Program Background

Multisystemic Therapy (MST) was developed in the late 1970s. It addresses several limitations of existing mental health services for serious juvenile offenders which include minimal effectiveness, low accountability of service providers for outcomes, and high cost.

Treatment efforts, in general, have failed to address the complexity of youth needs, being individually-oriented, narrowly focused, and delivered in settings that bear little relation to the problems being addressed (e.g., residential treatment centers, outpatient clinics). Given overwhelming empirical evidence that serious antisocial behavior is determined by the interplay of individual, family, peer, school, and neighborhood factors, it is not surprising that treatments of serious antisocial behavior have been largely ineffective. Restrictive out-of-home placements, such as residential treatment, psychiatric hospitalization, and incarceration, fail to address the known determinants of serious antisocial behavior and fail to alter the natural ecology to which the youth will eventually return. Furthermore, mental health and juvenile justice authorities have had virtually no accountability for outcome, a situation that does not enhance performance. The ineffectiveness of out-of-home placement, coupled with extremely high costs, have led many youth advocates to search for viable alternatives. MST is one treatment model that has a well-documented capacity to address the aforementioned difficulties in providing effective services for juvenile offenders.

Theoretical Rationale/Conceptual Framework

Consistent with social-ecological models of behavior and findings from causal modeling studies of delinquency and drug use, MST posits that youth antisocial behavior is multidetermined and linked with characteristics of the individual youth and his or her family, peer group, school, and community contexts. As such, MST interventions aim to attenuate risk factors by building youth and family strengths (protective factors) on a highly individualized and comprehensive basis. The provision of home-based services circumvents barriers to service access that

Descriptions of Recommended Early Intervention Programmes

often characterize families of serious juvenile offenders. An emphasis on parental empowerment to modify the natural social network of their children facilitates the maintenance and generalization of treatment gains.

Brief Description of Intervention

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to:

- improve caregiver discipline practices;
- enhance family affective relations;
- decrease youth association with deviant peers;
- increase youth association with prosocial peers;
- improve youth school or vocational performance;
- engage youth in prosocial recreational outlets; and
- develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes.

Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, and community). The treatment plan is designed in collaboration with family members and is, therefore, family driven rather than therapist driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, that promotes health. The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring each week, determined by family need.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident:

1. MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains. MST programs have an extremely strong commitment to removing barriers to service access (e.g., the home-based model of service delivery).
2. MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes).
3. Most importantly, MST has well-documented long-term outcomes with

adolescents presenting serious antisocial behavior and the adolescents' families.

The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders. Importantly, results from these studies showed that MST outcomes were similar for youth across the adolescent age range (i.e., 12-17 years), for males and females, and for African American as well as White youth and families.

Evidence of Program Effectiveness

The first controlled study of MST with juvenile offenders was published in 1986, and three randomized clinical trials with violent and chronic juvenile offenders have been conducted since then. In these trials, MST has demonstrated long-term reductions in criminal activity, drug-related arrests, violent offenses, and incarceration. This success has led to several randomized trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youth presenting serious clinical problems and their families.

The information for this fact sheet was excerpted from:

Henggeler, S.W., Mihalic, S.F., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). Blueprints for Violence Prevention, Book Six: Multisystemic Therapy. Boulder, CO: Center for the Study and Prevention of Violence.

Descriptions of Recommended Early Intervention Programmes

BIG BROTHERS BIG SISTERS OF AMERICA (BBBSA)

Program Summary

Big Brothers Big Sisters of America (BBBSA) has been providing adult support and friendship to youth for nearly a century. A report in 1991 demonstrates that through BBBSA's network of nearly 500 agencies across the country, more than 70,000 youth and adults were supervised in one-to-one relationships.

Program Targets

BBBSA typically targets youth (aged 6 to 18) from single parent homes.

Program Content

Service delivery is by volunteers who interact regularly with a youth in a one-to-one relationship. Agencies use a case management approach, following through on each case from initial inquiry through closure. The case manager screens applicants, makes and supervises the matches, and closes the matches when eligibility requirements are no longer met or either party decides they can no longer participate fully in the relationship.

BBBSA distinguishes itself from other mentoring programs via rigorous published standards and required procedures:

- Orientation is required for all volunteers.
- Volunteer Screening includes a written application, a background check, an extensive interview, and a home assessment; it is designed to screen out those who may inflict psychological or physical harm, lack the capacity to form a caring bond with the child, or are unlikely to honor their time commitments.
- Youth Assessment involves a written application, interviews with the child and the parent, and a home assessment; it is designed to help the caseworker learn about the child in order to make the best possible match, and also to secure parental permission.
- Matches are carefully considered and based upon the needs of the youth, abilities of volunteers, preferences of the parent, and the capacity of program staff.
- Supervision is accomplished via an initial contact with the parent, youth, and volunteer within two weeks of the match; monthly telephone contact with the volunteer, parent and/or youth during the first year; and quarterly contact with all parties during the duration of the match.

Program Outcomes

An evaluation of the BBBSA program has been conducted to assess children who participated in BBBSA compared to their non-participating peers. After an eighteen month period, BBBSA youth:

- were 46% less likely than control youth to initiate drug use during the study period.
- were 27% less likely to initiate alcohol use than control youth.
- were almost one-third less likely than control youth to hit someone.
- were better than control youth in academic behavior, attitudes, and performance.
- were more likely to have higher quality relationships with their parents or guardians than control youth.
- were more likely to have higher quality relationships with their peers at the end of the study period than did control youth.

Program Costs

The national average cost of making and supporting a match relationship is \$1,000 (£627) per year.

Program Background

Big Sisters activity was initiated in 1902, when a group of women in New York City began befriending girls who came before the New York Children's Court. Known then as the Ladies of Charity, the group later became Catholic Big Sisters of New York. A story in the New York Times in 1902 reported that a judge of the New York Children's Court secured promises from a group of influential men that each one would befriend one boy who had been before his court. His activity could have influenced a member of his court, Clerk Ernest K. Coulter, who is credited with founding the organized Big Brothers Movement in 1904. A Cincinnati businessman, Irvin F. Westheimer, and a member of a closely knit, charity-minded Jewish community, urged his friends and business associates to befriend troubled and disadvantaged youths, which eventually led to the organization of a Big Brothers agency in Cincinnati in 1910.

Before World War I, the Big Brothers and Big Sisters Movement was characterized by many forms of organization, under a variety of sponsors, utilizing a number of approaches. But all of the efforts were united by a single spirit—a desire to help children, generally from one-parent homes, whose moral, mental, and physical development was endangered by their environments and backgrounds.

By 1922, “standards” (i.e., basic requirements) were created and adopted. These early standards addressed the one-to-one relationship as a volunteer's individual and personal effort in behalf of children, and asserted the need for an agency to manage its affairs in a professional manner. By the early 1930s, the standards had become more stringent in setting forth minimum requirements for operation at the local level.

In the mid-1930s, the Great Depression affected the Big Brothers and Big Sisters Federation, and by 1937 the national office closed its doors, while local agencies

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continued to operate. Following World War II, a new federation was established only for Big Brothers agencies. Out of a conviction that women could help meet the needs of girls, Big Sisters International was created by the Big Sisters agencies then operating in 1970. In 1977, Big Sisters International and Big Brothers of America merged to become Big Brothers Big Sisters of America (BBBSA).

Efforts focused on the development and piloting of a set of Standards and Required Procedures for One-To-One Service (Big Brothers Big Sisters of America, 1986; as amended, 1996), which were adopted in 1986. This consists of corporate management and program management standards, with each standard having a set of required procedures that were deemed necessary to fulfill each standard. Compliance with these standards and required procedures became the hallmark of an effective Big Brothers Big Sisters (BBBS) agency and the basis for building a consistent one-to-one service of over 500 BBBS agencies across all 50 states. A description of manuals published by BBBSA can be found in Appendix B.

During more than 85 years of national organizational development and localized service delivery, the word “mentoring” was not a part of the movement’s nomenclature. In fact, it was not until the late 1980s, when funders and researchers determined that mentoring may be a promising approach for children at-risk, that the word mentoring found its way into the BBBSA’s rhetoric for describing their service. There was a strong inclination on the part of local BBBS agencies, however, to not confuse BBBSA’s systematic and structured volunteer approach with the more loosely fashioned mentoring programs that were being developed. Mentoring has various definitions, depending on the emphasis that a particular community youth program has as its goal. “Mentoring” is often used interchangeably with “tutoring,” and sometimes, with the goal of apprenticeship. Mentoring tends to be an add-on to programs that have very specific goals and objectives, with mentoring being seen as only one of many ingredients. Historically, mentoring has had a helping-to-learn aspect to it; for example, an older person guiding a younger person, usually around some prescribed activity or aspect of life. Big Brothers Big Sisters work, however, focuses on friendship as the primary aspect of the relationship, which should lead to a feeling of trust over time, and which then may lead to some aspects of learning, regardless of the subject or behavior. But the relationship—the trust, the mutually shared experiences of everyday life—is the essence of the service. While the word mentoring is now used, for the most part, interchangeably with Big Brothers Big Sisters, BBBSA’s emphasis continues to be on the quality of the relationship between the volunteer and the child, and not on a set of prescribed activities.

Theoretical Rationale/Conceptual Framework

Although BBBSA was not developed with academic theories of delinquency in mind, the project's rationale most closely resembles social control theory. According to this perspective, attachments to prosocial others, commitment to socially appropriate goals, and involvement in conventional activities restrain youth from engaging in delinquent activities or other problem behaviors, because more socially bonded youth have more to lose by misbehavior.

The rationale that has guided BBBSA service for nearly a century has been that the consistent presence of a non-familial caring adult can make a difference in the social/emotional development of a child or young person, particularly one growing up in a single parent family or in an adverse situation. Over the years the development of the BBBS service has been based on the overriding belief that a consistent and frequent volunteer contact is a powerful influence. This belief has been based, predominantly, on anecdotal reports from parents, teachers, case managers, and children themselves.

The most relevant research to date has come from the resiliency studies carried out by researchers such as Emmy Werner, and others, under the rubric of "caring adults." Werner, in a 30 year longitudinal study on the island of Kauai, has found that the number of caring adults outside the family with whom the child liked to associate was a significant protective factor for both high risk boys and girls who made a successful transition into adulthood. Based on such research, BBBSA continues its generalized approach and concentrates on enhancing the infrastructure to support the development and maintenance of the relationship between the volunteer and child.

Brief Description of Intervention

BBBS is a community mentoring program which matches an adult volunteer, known as a Big Brother or Big Sister, to a child, known as a Little Brother or Little Sister, with the expectation that a caring and supportive relationship will develop. Hence, the match between volunteer and child is the most important component of the intervention. Equally important, however, is the support of that match by the ongoing supervision and monitoring of the match relationship by a professional staff member. The professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship.

In practice, the volunteer intervention in the traditional one-to-one relationship with a child is three to five hours per week, on a weekly basis, over the course of a year or longer. The generalized activity of that relationship is related to the goals that were set initially when the match was established. These goals are identified

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from the extensive case manager interview held with the parent/guardian and with the child. The foremost goal usually set is to develop a relationship—one that is mutually satisfying, where both parties come together freely on a regular basis. More specific goals might relate to school attendance, academic performance, relationships with other children and siblings, general hygiene, learning new skills or developing a hobby. The goals established for a specific match are developed into an individualized case plan, which is updated by the case manager as progress is made and circumstances change over time.

Generally speaking, BBBS agency staff do not tell a volunteer specifically what activities to engage in with the child during their time together, but they guide the volunteer and make suggestions of possible activities and approaches, based on the child's and volunteer's interests and needs. Consistency in the relationship over time is a higher priority than the types of activities in which they participate. Once the match has been initially agreed upon, in the presence of the child, volunteer, and the child's parent/guardian, it is then the responsibility of the professional staff member, known as the case manager, to maintain on-going contact with all parties in the match relationship.

The Standards and Required Procedures for One-To-One Service outlines the schedule of contacts the case manager is to have with the volunteer, as well as with the parent and/or child. There is to be more frequent contact during the early stages of the match with an initial contact within two weeks of making the match, then monthly contact throughout the rest of the year, and then contact every three months after the first year and throughout the duration of the match. The case manager calls the volunteer and the parent after the first and second week of the relationship to determine how the relationship is developing, and may continue on a weekly basis through the first six weeks, depending on the situation. However, it eventually develops into a monthly contact with the volunteer and the parent.

At least quarterly, the case manager is in touch with the child to learn of the youth's experiences. These supervisory contacts inform the case manager how the relationship is developing and provide an opportunity to give advice and guidance around any issues the volunteer might have, as well as to encourage and support various activities. For most agencies, the on-going case manager supervision with the volunteer takes place over the phone. The case manager is to assess the match goals on an annual basis and make appropriate adjustments to the case plan.

Evidence of Program Effectiveness

In contrast to prior research on mentoring programs which has failed to demonstrate the effectiveness of those programs, research conducted by Public/Private Ventures (P/PV) on the BBBS model provides clear evidence that a caring

relationship between an adult volunteer and a young person can provide a wide range of tangible benefits.

P/PV conducted a comparative study of nearly 1,000 ten- to sixteen-year olds from eight BBBS agencies during the years 1992-1993. Half of these young people were randomly assigned to a treatment group, for which BBBS matches were made; the other half were randomly assigned to a control group and were not matched (the control group members were put on a waiting list for 18 months). The P/PV study compared these two groups after an 18 month period of time.

At the conclusion of the 18-month study period, it was found that Little Brothers and Little Sisters (youth participants in the program) were less likely to have started using drugs or alcohol, were less likely to have hit someone, felt more competent about doing schoolwork, attended school more, got better grades, and had better relationships with their parents and peers than those who did not participate in the program.

The information for this fact sheet was excerpted from:

McGill, D.E., Mihalic, S.F., & Grotpeter, J. K. (1998). Blueprints for Violence Prevention, Book Two: Big Brothers Big Sisters of America. Boulder, CO: Center for the Study and Prevention of Violence.

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FUNCTIONAL FAMILY THERAPY (FFT)

Program Summary

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes.

Program Targets

Youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder. Often these youth present with additional comorbid challenges such as depression.

Program Content

FFT requires as few as 8-15 sessions of direct service time for commonly referred youth and their families, and generally no more than 26 total sessions of direct service for the most severe problem situations.

Delivery modes

Flexible delivery of service by one and (rarely) two person teams to clients in-home, clinic, school, juvenile court, community based programs, and at time of re-entry from institutional placement.

Implementation

Wide range of interventionists, including trained probation officers, mental health technicians, degreed mental health professionals (e.g., M.S.W., Ph.D., M.D., R.N., M.F.T., L.C.P.).

FFT effectiveness derives from emphasizing factors which enhance protective factors and reduce risk, including the risk of treatment termination. In order to accomplish these changes in the most effective manner, FFT is a phasic program with steps which build upon each other. These phases consist of:

- Engagement, designed to emphasize within youth and family factors that protect youth and families from early program dropout;
- Motivation, designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for lasting change;
- Assessment, designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they related to change techniques;
- Behavior Change, which consists of communication training, specific tasks and technical aids, basic parenting skills, problem solving and conflict management skills, contracting and response-cost techniques; and

- Generalization, during which family case management is guided by individualized family functional needs, their interface with community based environmental constraints and resources, and the alliance with the FFT therapist/Family Case Manager.

Program Outcomes

Clinical trials have demonstrated that FFT is capable of:

- Effectively treating adolescents with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorders, and who are delinquent and/or violent;
- Interrupting the matriculation of these adolescents into more restrictive, higher cost services;
- Reducing the access and penetration of other social services by these adolescents;
- Generating positive outcomes with the entire spectrum of intervention personnel;
- Preventing further incidence of the presenting problem;
- Preventing younger children in the family from penetrating the system of care;
- Preventing adolescents from penetrating the adult criminal system; and
- Effectively transferring treatment effects across treatment systems.

Program Costs

The 90-day costs range between \$1,600 and \$5,000 for an average of 12 home visits per family. Current costs vary and are highly dependent on cost of labor.

Program Background

Many therapies are named to reflect a theoretical perspective (e.g., behavioral, object relations) or a primary focus (e.g., multiple systems, cognitive). Functional Family Therapy (FFT) is named to reflect a set of core theoretical principles which represents the primary focus (family), and an overriding allegiance to positive outcome in a model that understands both positive and negative behavior as representations of family relational systems (functional). Thus, Functional Family Therapy has adopted an integrative stance that stresses functionality of the family, the therapy, and the clinical model.

The developers and replicators of Functional Family Therapy have recognized that solutions require an integration of high quality science, tested theoretical principles, and extensive clinical experience in pursuit of specific functional goals of:

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1. Effectively changing the maladaptive behaviors of youth and families, especially those who at the outset may not be motivated or may not believe they can change
2. Reducing the personal, societal, and economic devastation that results from the continuation or exacerbation of the various disruptive behavior disorders of youth
3. Doing so with less cost, in terms of time and money, than so many of the more expensive (but not necessarily effective) treatments currently available.

Unlike other therapies, FFT was not developed on college students, neurotic individuals, or inpatient adults. Instead, FFT grew out of a need to serve a population of at-risk adolescents and families that were under served, had few resources, were difficult to treat, and were often perceived by helping professions to be treatment resistant. In many cases these families entered the “system” angry, resistant, and unmotivated to change. Essentially the “helping professions” did not know how to treat this population. FFT developed out of the awareness that to be successful in treatment of this population we needed to be culturally competent, and understand why this group was so treatment resistant. Thus, FFT attempted to develop ways to engage these families in order to help them achieve obtainable change and become more adaptable and productive. Over the last 30 years, FFT has learned that it is important to do more than simply stopping bad behaviors. We know that it is important to motivate families to change in a positive way by uncovering and developing the unique strengths of the family in ways that enhance the families’ self-respect while providing specific ways to improve.

Since its inception in 1969, FFT has accomplished its primary goals by integrating the most promising theoretical perspectives, the empirical data available, and hours and hours of direct clinical experience with the troubled youth we wanted to help. FFT is designed to increase efficiency, decrease costs, and enhance our ability to provide service to more youth by:

1. Targeting risk and protective factors that we can, in fact, change and then programmatically changing them;
2. Engaging and motivating the families and youth so they participate more in the change process;
3. Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation;
4. Constantly monitoring process and outcome so we don’t fool ourselves or make excuses for failure; and
5. Believing in the families we see and then believing in ourselves.

At the time of the inception of Functional Family Therapy, the major theoretical perspectives and services available for treating troubled youth in a family context were rudimentary, though promising. Early on, FFT represented an integration of systems perspectives and behavioral techniques. The systemic background of FFT emphasized dynamic and reciprocal processes which needed to be identified in referred families. This led to early observational research on the interactions of delinquent and non-delinquent families using a systemic framework. The behavioral background of FFT provided not only specific, manualizeable interventions such as contracting, but it also featured an urgent awareness of the need for rigorous treatment development—a scientific imperative to systematically examine the effects of intervention and develop strategies for identifying positive change processes. These origins led to a continuing series of studies involving controlled outcome evaluations and additional replications. During the mid-1970's, FFT also began addressing issues of therapist characteristics and in-session processes from an integrated clinical/research perspective, both reflecting and contributing to the training of therapists for subsequent interventions. In the late 1990's FFT further articulated the clinical change model adding a comprehensive system of client, process, and outcome assessment implemented through a computer-based client tracking and monitoring system (FFT-CSS).

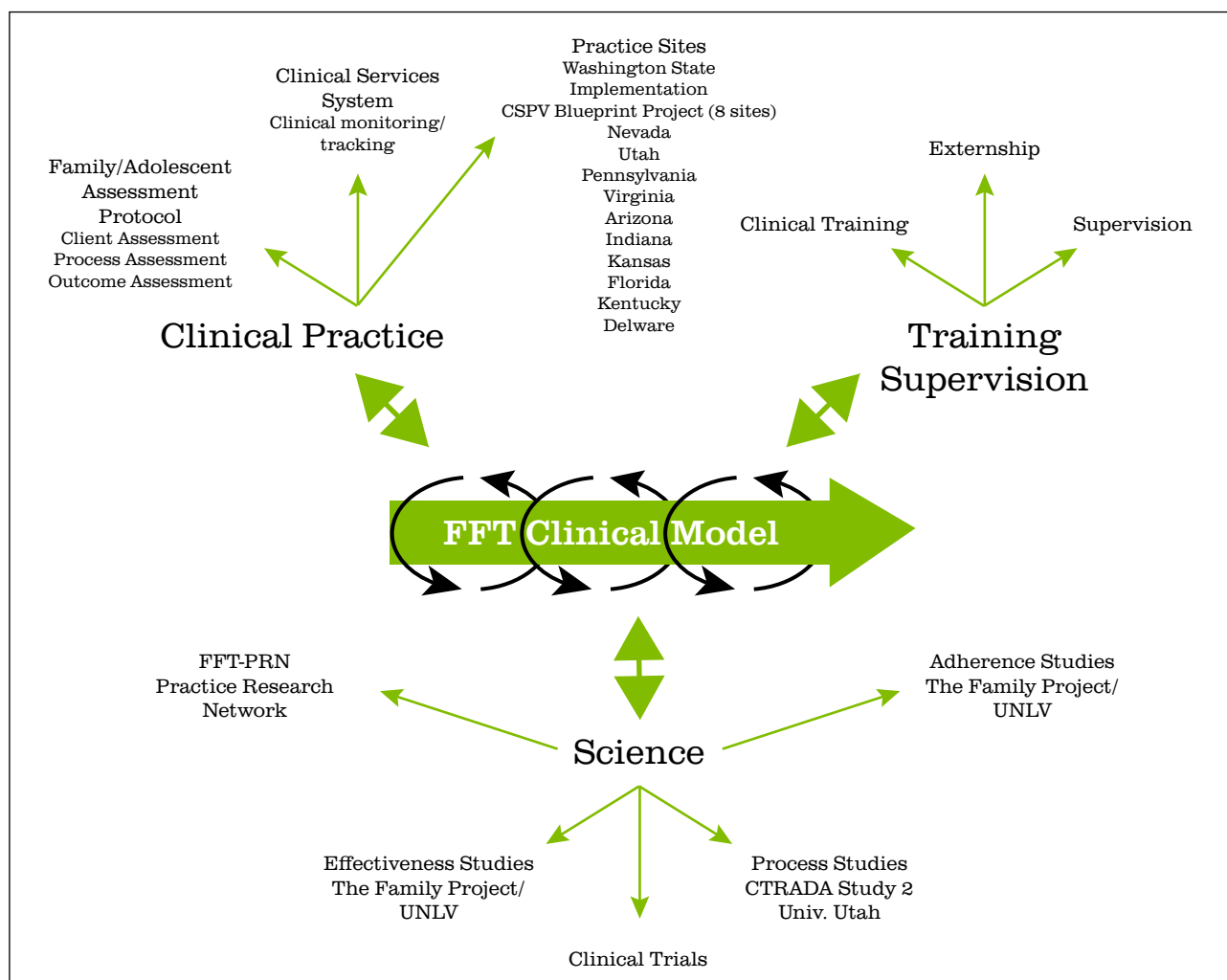
Throughout its development FFT has insisted on step by step descriptions of the clinical change process as well as rigorous evaluation of both the process and outcomes of this work. FFT has also insisted on integrating high quality science (in regard to evaluation and research) with sound clinical judgement and experience and comprehensive theoretical principles. Thus, over the last 30 years FFT has been a dynamic and evolving clinical system that retains its core principles while adding clinical features that further enhance successful outcomes. In its most recent iteration, FFT has developed a functional family assessment system to aid FFT therapists in targeting and implementing therapeutic change goals in a way that leads to accountability through process and outcome evaluation. Thus, FFT has matured into a clinical intervention model with systematic training, supervision, and process and outcome assessment components all directed at enhancing the delivery of FFT in local communities (see Figure 1).

Brief Description of Intervention

Functional Family Therapy (FFT) is a well documented family prevention and intervention program which has been applied successfully to a wide range of problem youth and their families in various contexts. While commonly employed as an intervention program, FFT has demonstrated its effectiveness as a method for the prevention of many of the problems of at-risk adolescents and their families. Functional Family Therapy (FFT) is an empirically grounded intervention program

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Figure 1: Mature Clinical Model



that targets youth between the ages of 11 and 18, although younger siblings of referred adolescents are also treated. FFT is a short-term intervention with, on average, 8 to 12 one-hour sessions for mild cases and up to 26 to 30 hours of direct service for more difficult situations. In most programs sessions are spread over a three-month period of time. Target populations range from at-risk preadolescents to youth with very serious problems such as conduct disorder. The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost-effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions.

As it developed, FFT has been readily adopted in many contexts due to its clear identification of specific phases, each of which includes descriptions of goals, requisite therapist characteristics, and techniques. The phases of intervention, and their component activities, have developed in the context of many clinical hours with many families of various characteristics, coupled with intensive supervision and clinical case discussion. As a result, each phase involves clinically rich and successful interventions that are organized in a coherent manner and allow clinicians to maintain focus in the context of considerable family and individual disruption. The phases consist of:

1. **Phase 1: Engagement and Motivation.** During these initial phases, FFT applies reattribution (e.g., reframing) and related techniques to impact maladaptive perceptions, beliefs, and emotions. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reducing the oppressive negativity within family and between family and community, and increasing respect for individual differences and values.
2. **Phase 2: Behavior Change.** This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.
3. **Phase 3: Generalization.** In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multisystemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

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As a clinical model, FFT has been conducted in varied clinical settings and as a home-based model. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability (FFT-CSS). The FFT Practice Research Network (FFT-PRN) allows clinical sites to participate in the development and dissemination of FFT model information.

Evidence of Program Effectiveness

To date, thirteen studies in referenced journals (plus one in preparation) demonstrate dramatic and significant positive treatment effects, including follow-up periods of up to five years. Rates of offending and foster care or institutional placement have been reduced at least 25 percent and as much as 60 percent in comparison to the randomly assigned or matched alternative treatments, or base rates. One study also demonstrated a positive three year follow-up effect on siblings. Additional formal program reports (e.g., county and federal funded projects) from completed and ongoing replications reflect similar positive outcomes, and five currently funded trials (National Institute of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Government of Sweden) promise additional data regarding generalization of effects for FFT across more contexts and populations. Studies have also identified specific FFT based interventions and direct changes in family functioning which relate to the outcome findings.

One major factor in the successful evolution of FFT has been the continuous (29 year) involvement of its progenitors and many of its co-contributors in various university settings. This context has not only maintained a standard of scientific scrutiny, but has also contributed to the conceptual integrity of the major constructs and techniques. The prime example of this impact is the extensive work on reframing in FFT, informed by other well-developed theoretical perspectives such as information processing theory, social cognition, and the psychology of emotion. Laboratory based research has identified specific components of this critical technique, which in turn has led to applied research on cognitive set and attributional processes in referred adolescent families. Further, investigations have identified in-session therapist characteristics and family interaction processes relevant to the phases of FFT which are predictive of positive change. Most notable process changes appear to be in family communication patterns, and especially negative/blaming communications and “withholding” types of silence. With respect to therapist characteristics, process and outcome data demonstrate that FFT therapists must be first relationally sensitive and focused, then capable of clear structuring and teaching, in order to produce significantly fewer dropouts during treatment and lower recidivism.

More recently, FFT has been widely adopted because it has evolved an increasingly multicultural perspective, and has added effective home-based intervention. In the home-based Clark County, Nevada, Youth and Family Services program, for example, referred adolescents are roughly 30 percent African American, 20 percent Hispanic/Latino (mostly Mexican American), and just under 50 percent European American with a few American Indian and Asian American youth. Preliminary data on the first year of FFT involvement indicate no difference in reoffending rate among the different ethnic/racial groups, supporting the generalizability of FFT effects across cultural/racial groups. The Fayetteville, North Carolina, program has involved primarily White and African American families and therapists, including a significant number of mixed race relationships and offspring. The two clinical trials being conducted in New Mexico involve Hispanic/Latino and White youth, and the home-based program in urban Willow Run, Michigan, involves a large proportion of African American and mixed families. (See replication information in later sections for more details.) As the model has been increasingly adopted in multicultural contexts, focus is being placed on issues of culture and ethnicity, with much of this recent work undertaken in the context of the multi-site National Institute of Drug Abuse (NIDA) funded Center for Research on Adolescent Drug Abuse (CRADA, Howard Liddle, P.I.).

Taken together, 28 years of data and clinical experience with FFT involving hundreds of therapists and thousands of families have provided strong empirical support for this family-based intervention with adolescents. In addition, the research has demonstrated that intervention must include a major focus on changing emotional and attributional, especially blaming, components of family interaction, then provide a program of specific behavior change techniques that are culturally appropriate, family appropriate, and consistent with the capabilities of each family member.

The information for this fact sheet was excerpted from:

Alexander, J., Barton, C., Gordon, D., Grotmeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H., & Sexton, T. (1998). *Blueprints for Violence Prevention, Book Three: Functional Family Therapy*. Boulder, CO: Center for the Study and Prevention of Violence.

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LIFE SKILLS TRAINING (LST)

Program Summary

The results of over a dozen studies consistently show that the Life Skills Training (LST) program dramatically reduces tobacco, alcohol, and marijuana use. These studies further show that the program works with a diverse range of adolescents, produces results that are long-lasting, and is effective when taught by teachers, peer leaders, or health professionals.

Program Targets

LST is a primary intervention that targets all middle/junior high school students (initial intervention in grades 6 or 7, depending on the school structure, with booster sessions in the two subsequent years).

Program Content

LST is a three-year intervention designed to prevent or reduce gateway drug use (i.e., tobacco, alcohol, and marijuana), primarily implemented in school classrooms by school teachers. The program is delivered in 15 sessions in year one, 10 sessions in year two, and 5 sessions in year three. Sessions, which last an average of 45 minutes, can be delivered once a week or as an intensive mini-course. The program consists of three major components which teach students (1) general self-management skills, (2) social skills, and (3) information and skills specifically related to drug use. Skills are taught using training techniques such as instruction, demonstration, feedback, reinforcement, and practice.

Program Outcomes

Using outcomes averaged across more than a dozen studies conducted with LST, it has been found to:

- Cut tobacco, alcohol, and marijuana use 50% - 75%.

Long-term follow-up results observed six years following the intervention show that LST:

- Cuts polydrug use up to 66%;
- Reduces pack-a-day smoking by 25%; and
- Decreases use of inhalants, narcotics, and hallucinogens.

Program Costs

LST can be implemented at a cost of approximately \$7 per student per year (curriculum materials averaged over the three-year period). This does not include the cost of training which is a minimum of \$2,000 per day for one or two days.

Program Background

The Life Skills Training (LST) program was developed to address the monumental problem of substance abuse in this country. The adverse health, social, and legal consequences of this problem have been well documented. Cigarette smoking is a risk-factor for heart disease, various cancers, and chronic obstructive lung disease and accounts for over 430,000 deaths per year. Alcohol is not only related to chronic diseases such as cirrhosis of the liver, but is also a major factor in auto fatalities and homicides. Beyond this, adolescent drug use predicts a number of other undesirable outcomes such as reducing traditional educational accomplishments and job stability, increasing the likelihood of marrying and having children at younger ages, and increasing the likelihood of engaging in criminal behavior.

Despite considerable public attention and the expenditure of well over a billion dollars in the past few years alone, little if any progress has been made toward reducing drug abuse. At present, drug use among American youth is a problem of enormous proportions and it is getting worse. Since 1991, according to national surveys, drug use has increased by more than 30 percent leading some experts to believe that we are on the verge of a new drug epidemic. Figure 1 illustrates this trend in annual prevalence (proportion of users) of illicit drug use for twelfth grade students since 1975. According to the most recent national survey data, the following proportions of high school students have used alcohol, cigarettes, and illicit drugs at least once (Johnston, O'Malley & Bachman, 1995):

	Alcohol	Cigarettes	Illicit Drugs
8th Graders	56%	46%	26%
10th Graders	71%	57%	37%
12th Graders	80%	62%	46%

Results from the same survey indicated that during the past 30 days, the following proportions of high school students used the following substances one or more times:

	Alcohol	Cigarettes	Illicit Drugs
8th Graders	26%	19%	11%
10th Graders	39%	25%	19%
12th Graders	50%	31%	22%

For some of these teens, use may be discontinued after a brief period of experimentation. However, for many, initiation of cigarette smoking, drinking, or drug-taking may lead to patterns of use which result in both psychological and physical dependence. In general, programs designed to help individuals quit

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smoking, drinking, or using drugs have only been moderately effective. Quite simply, once any type of substance use habit is acquired it is extremely difficult to break. Scientific evidence now suggests that the development of effective prevention programs may offer the greatest potential for impacting this important health problem.

Unfortunately, reviews of the prevention research literature and meta-analytic studies show that many widely used drug abuse prevention approaches are ineffective. The most common approaches to substance abuse prevention over the past two decades have involved either the presentation of factual information concerning the dangers of substance use or what has been referred to as “affective” education.

Approaches relying on the provision of factual information are based largely on the assumption that increased knowledge about psychoactive substances and their adverse consequences would be an effective deterrent. Affective education approaches are designed to enrich the personal and social development of students through class discussion and experimental classroom activities. Both of these approaches have proven to be largely ineffective because they do not address the factors promoting the initiation and early stages of substance use/abuse.

The LST program is a drug abuse prevention program that is based on an understanding of the causes of smoking, alcohol, and drug use/abuse. The LST intervention has been designed so that it targets the psychosocial factors associated with the onset of drug involvement. With this in mind, the program impacts on drug-related expectancies (knowledge, attitudes, and norms), drug-related resistance skills, and general competence (personal self-management skills and social skills). Increasing prevention-related drug knowledge and resistance skills can provide adolescents with the information and skills needed to develop anti-drug attitudes and norms, as well as to resist peer and media pressure to use drugs. Teaching effective self-management skills and social skills (improving personal and social competence) offers the potential of producing an impact on a set of psychological factors associated with decreased drug abuse risk (by reducing intrapersonal motivations to use drugs and by reducing vulnerability to pro-drug social influences).

Theoretical Rationale/Conceptual Framework

Many theories have been advanced to explain drug abuse. The most prominent among these focus on social learning, problem behaviors, self-derogation, persuasive communications, peer clusters, and sensation-seeking. However, the etiology of drug abuse involves a dynamic process which unfolds over many years.

A common limitation of most theoretical models is that they are essentially snapshots of the etiology of drug abuse and do not adequately capture the complexity of the problem.

We now know that the initiation of drug use is the result of the complex combination of many diverse factors. There is no single pathway or single variable which serves as a necessary and sufficient condition for the development of either drug use or drug abuse. With this in mind, the LST approach to drug abuse prevention is based on a person-environment interactionist model of drug abuse. Like other types of human behavior, drug abuse is conceptualized as being the result of a dynamic interaction of an individual and his/her environment. Social influences to use drugs (along with the availability of drugs) interact with individual vulnerability. Some individuals may be influenced to use drugs by the media (TV shows and movies glamorizing drug use or suggesting that drug use is normal or socially acceptable as well as advertising efforts to promote the sale of alcohol and tobacco products), by family members who use drugs or convey pro-drug attitudes, and/or by friends and acquaintances who use drugs or hold attitudes and beliefs supportive of drug use. Others may be propelled toward drug use or a drug-using peer group because of intrapersonal factors such as low self-esteem, high anxiety or other dysphoric feelings, or the need for excitement.

Since there are multiple pathways leading initially to drug use and later to drug abuse, a more useful way of conceptualizing drug abuse is from a risk-factor perspective similar to that used in the epidemiology of chronic diseases such as cancer and heart disease. From this perspective, the presence of specific risk factors is less important than their accumulation. As more risk factors accumulate so does the likelihood that an individual will become a drug user and eventually a drug abuser. Thus, the presence of multiple risk factors is associated with both initial drug use and the severity of drug involvement.

It has also been well established that the prevalence of drug use generally increases with age and progresses in a well-defined sequence. Drug use typically begins with the use of alcohol and tobacco first, progressing later to the use of marijuana, and, for some, to the use of stimulants, opiates, hallucinogens, and other illicit substances. Not surprisingly, this progression corresponds exactly to the prevalence and availability of these substances with alcohol being the most prevalent form of drug use and the most widely available, followed by tobacco (cigarettes) and marijuana. Because alcohol, tobacco, and marijuana are among the first substances used, they have been referred to as “gateway” substances. The use of these “gateway” substances significantly increases the risk of using illicit drugs other than marijuana.

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Taking this into account, the LST prevention program targets those “gateway” substances (tobacco, alcohol, and marijuana) that occur at the beginning of the developmental progression. Thus, LST offers the potential for interrupting the normal developmental progression from use of these substances to other forms of drug use/abuse. A second reason for targeting this type of drug use is that the use of these substances accounts for the largest portion of drug-related annual mortality and morbidity.

Brief Description of Intervention

Overview

The LST prevention program is a three-year intervention designed to be conducted in school classrooms. Based on the theoretical framework discussed earlier, the LST program was developed to impact on drug-related knowledge, attitudes and norms; teach skills for resisting social influences to use drugs; and promote the development of general personal self-management skills and social skills. Consistent with this, the LST prevention program can best be conceptualized as consisting of three major components. The first component is designed to teach students a set of general self-management skills. The second component focuses on teaching general social skills. The third component includes information and skills that are specifically related to the problem of drug abuse. The first two components are designed to enhance overall personal competence and decrease both the motivations to use drugs and vulnerability to drug use social influences. The problem-specific component is designed to provide students with material relating directly to drug abuse (drug resistance skills, anti-drug attitudes, and anti-drug norms). A complete description of each LST component may be found in the section labeled “Program as Designed and Implemented.”

Program Structure

The LST program consists of fifteen class periods (roughly 45 minutes each) and is intended for middle or junior high school students, depending upon the structure of the school. A booster intervention has also been developed which consists of ten class periods in the second year and five class periods in the third year. This means for school districts with a middle school structure, the LST program can be implemented with students in the sixth grade, followed by booster sessions in the seventh and eighth grades. If the LST program is implemented in a junior high school setting, students receive the program in the seventh grade, and the booster sessions in the eighth and ninth grade, respectively. The rationale for implementing the LST program at this point concerns a variety of factors concerning the developmental progression of drug use, normal cognitive and psychosocial changes occurring at this time, the increasing prominence of the peer group, and issues related to the transition from primary to secondary school.

Drug experts have established that early adolescence is a time of increased risk for experimenting with one or more psychoactive substances. Children first typically experiment with alcohol during the sixth and seventh grades. The greatest proportional change in cigarette smoking occurs between the seventh and eighth grades. Correspondingly, the greatest change in marijuana use takes place between the eighth and ninth grades. Adolescence is also a time of increased reliance on the peer group, separation from parents as they develop a sense of independence and autonomy, and changes in the way individuals think. For example, during this time, individuals begin to shift from a concrete style of thinking that includes a clear sense of right and wrong or absolute rules of behavior to one that is more relative and hypothetical. This enables the adolescent to accept deviation from established rules and to recognize the frequently irrational and inconsistent nature of adult behavior. In addition, it has been noted that the transition from primary to secondary school can be a source of stress that increases risk from problem behaviors such as tobacco, alcohol, and illicit drug use. Finally, the strongest evidence concerning the effectiveness of drug abuse prevention programs is based on evaluation research with programs implemented with individuals during this period.

While the program is effective with just the one year of primary intervention, research also has shown that prevention effects are greatly enhanced when booster sessions are included. For example, two studies have shown that one year of the primary intervention of LST produced reductions of 56-67 percent in smoking without any additional booster sessions; but for those students receiving booster sessions, these reductions were as high as 87 percent. In addition, the booster sessions enhance the durability of prevention effects, so that they do not decay as much over time. LST has been shown to be effective using a variety of service providers including outside health professionals, regular classroom teachers, and peer leaders. Peer counselors are often slightly older (high school) and almost always work in conjunction with a trained adult provider.

Evidence of Program Effectiveness

Overview

Considerable prevention research has been conducted over the past twenty years. Despite the best efforts of educators, health professionals, and drug abuse prevention specialists, a large number of evaluation studies have failed to demonstrate that the prevention approach being utilized was able to produce a measurable impact on drug use behavior. Some studies have demonstrated reductions in attitudes toward drugs and drug use. Others have demonstrated increases in knowledge about drugs or the consequences of using drugs. But, efforts to demonstrate that prevention programs could impact on actual drug use have been disappointing.

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Research with the Life Skills Training Program

More than one and a half decades of research with the LST program have consistently shown that participation in the program can cut drug use in half. These reductions (relative to controls) in both the prevalence (i.e., proportion of persons in a population who have reported some involvement in a particular offense) and incidence (i.e., the number of offenses which occur in a given population during a specified time interval) of drug use have primarily been with respect to tobacco, alcohol, and marijuana use. These studies have demonstrated that this prevention approach can produce reductions in drug use that are long-lasting and clinically meaningful. For example, long-term follow-up data indicate that reductions in drug use produced with seventh graders can last up to the end of high school. Evaluation research has demonstrated that this prevention approach is effective with a broad range of students including White, middle-class youth and poor inner-city minority (African American and Hispanic/Latino) youth. It has not only demonstrated reductions in the use of tobacco, alcohol, or marijuana use of up to 80 percent, but evaluation studies show that it also can reduce more serious forms of drug involvement such as the weekly use of multiple drugs or reductions in the prevalence of pack-a-day smoking, heavy drinking, or episodes of drunkenness.

Results from four published studies testing the LST program show that drug use among the LST students was at least half that of the control group.

The information for this fact sheet was excerpted from Botvin, G.J., Mihalic, S.F., & Grotmeter, J.K. (1998). *Blueprints for Violence Prevention, Book Five: Life Skills Training*. Boulder, CO: Center for the Study and Prevention of Violence.

FAMILY NURSE PARTNERSHIPS (NURSE-FAMILY PARTNERSHIPS IN THE USA)

Program Summary

Family Nurse Partnerships or Nurse-Family Partnerships in the USA (Formerly Prenatal and Infancy Home Visitation by Nurses), guided by a strong theoretical orientation, consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child. While the primary mode of service delivery is home visitation, the program depends upon a variety of other health and human services in order to achieve its positive effects. The program is designed to serve low-income, at-risk pregnant women bearing their first child.

Program Content

Nurse home visitors work with families in their homes during pregnancy and the first two years of the child's life. The program is designed to help women improve their prenatal health and the outcomes of pregnancy; improve the care provided to infants and toddlers in an effort to improve the children's health and development; and improve women's own personal development, giving particular attention to the planning of future pregnancies, women's educational achievement, and parents' participation in the work force. Typically, a nurse visitor is assigned to a family and works with that family through the duration of the program.

Program Outcomes

This program has been tested with both White and African American families in rural and urban settings. Nurse-visited women and children fared better than those assigned to control groups in each of the outcome domains established as goals for the program. In a 15-year follow-up study of primarily White families in Elmira, New York, findings showed that low-income and unmarried women and their children provided a nurse home visitor had, in contrast to those in a comparison group:

- 79% fewer verified reports of child abuse or neglect;
- 31% fewer subsequent births;
- an average of over two years' greater interval between the birth of their first and second child;
- 30 months less receipt of Aid to Families with Dependent Children;
- 44% fewer maternal behavioral problems due to alcohol and drug abuse;
- 69% fewer maternal arrests;
- 60% fewer instances of running away on the part of the 15-year-old children;
- 56% fewer arrests on the part of the 15-year-old children; and
- 56% fewer days of alcohol consumption on the part of the 15-year-old children.

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Program Costs

The cost of the program was recovered by the first child's fourth birthday. Substantial savings to government and society were calculated over the children's lifetimes. In 1997, the two-and-a-half-year program was estimated to cost \$3,200 per year per family during the start-up phase (the first three years of program operation) and \$2,800 per family per year once the nurses are completely trained and working at full capacity. Actual cost of the program will vary depending primarily upon the salaries of local community-health nurses. Communities have used a variety of local, state, and federal funding sources to support the program, including Medicaid, welfare-reform, maternal and child health, and child abuse prevention dollars.

Program Background

Many of the most pervasive, intractable, and costly problems faced by young children and parents in our society today are a consequence of adverse maternal health-related behaviors (such as cigarette smoking, drinking, and drug use) during pregnancy, dysfunctional infant caregiving, and stressful environmental conditions that interfere with parental and family functioning. These problems include infant mortality, preterm delivery and low birthweight, child abuse and neglect, childhood injuries, youth violence, closely spaced pregnancy, and thwarted economic self-sufficiency on the part of parents. Standard indices of child health and well-being indicate that many children in our society are suffering.

- Nine infants out of every thousand in the United States die before their first birthday. As a result of high rates of low birthweight (less than 2500 grams or 5 pounds 8 ounces), our infant mortality rate is worse than 19 other nations, in spite of dramatic reductions in infant mortality in the last two decades due to improvements in newborn intensive care. Low birthweight babies who survive are 50 percent more likely to use special education services once they enter school than are normal birthweight controls.
- Over 2.5 million children were reported as being abused or neglected in 1990, and one in three of the victims of physical abuse were infants less than one year of age. Between 1,200 and 1,500 children die each year as a result of parent or caregiver maltreatment. Not only is maltreatment morally unacceptable, but the social consequences are so devastating that the U.S. Advisory Panel on Child Abuse and Neglect has called child maltreatment a national emergency.
- Childhood injuries are the leading cause of death among children aged one to fourteen.
- High rates of violence among adolescents, both as victims and perpetrators, threaten the safety and well-being of our neighborhoods. Among young people aged 15-24, homicide is a leading cause of death, and for African Americans it is the number one cause.

- In 1992, 52 percent of the mothers on AFDC had their first birth as teens, costing the government approximately \$12.8 billion. Rapid successive pregnancy increases the likelihood of continued welfare dependence and a host of associated problems.

Evidence indicates that a significant portion of these problems can be traced to parental behavior—in particular, to women’s health-related behaviors during pregnancy, to the quality of care that parents provide to their children, and to women’s life choices with respect to family planning, educational achievement, and workforce participation. While these problems cut across all segments of U.S. society, they are more common among women who begin childbearing as poor, unmarried adolescents. Low-income, single, adolescent mothers can have good pregnancy outcomes and children who do well, but their capacity to care for themselves and for their children is often compromised by histories of maltreatment in their own childhood, psychological immaturity or depression, stressful living conditions, and inadequate social support. These conditions contribute to the greater likelihood that socially disadvantaged parents will abuse cigarettes and other drugs during pregnancy and will fail to provide adequate care for their children, often with devastating results.

Women who smoke cigarettes and use other substances during pregnancy, for example, are at considerable risk for bearing low birthweight newborns, and their children are at heightened risk for neurodevelopmental impairment. Even subtle damage to the fetal brain can undermine children’s intellectual functioning and capacity for emotional and behavioral regulation. Parents’ capacities to read and respond to their infants’ communicative signals form the basis for children’s sense of security and trust in the world and their belief in their capacity to influence that world. Breaches of that trust have long-term consequences, especially when caregiving dysfunction is combined with neurodevelopmental impairment on the part of the child.

A longitudinal study of a large Danish sample of children and their families found that children who experienced the combination of birth complications and parental rejection in the first year of life were at substantially increased risk for violent criminality at age 18 in comparison to children who experienced only birth complications or parental rejection alone. While only 4.5 percent of the sample experienced both birth complications and parental rejection, that group accounted for 18 percent of all violent crimes among those 18 years of age. Parental rejection or birth trauma by itself did not increase the risk for violence. When risk factors accumulate, the risk for adverse outcomes increases, often in synergistically vicious ways.

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The problems listed have been resistive to government intervention over the past thirty years. However, scientific evidence is accumulating that it is possible to improve the outcomes of pregnancy, to improve parents' abilities to care for their children, and to reduce welfare dependence with programs of prenatal and early childhood home visitation, but it is not easy. Our optimism stands in contrast to earlier research on home visitation. The earlier research was difficult to interpret because the programs studied were often not designed to address the needs of parents in sensible and powerful ways, and the research itself frequently lacked scientific rigor.

The program of prenatal and infancy home visitation by nurses described here is distinguished from other programs by its firm foundation in epidemiology and theory. The program is based upon an analysis of proximal risks for the particular outcomes that it is designed to affect (usually parental behaviors or conditions in the home that increase the likelihood of adverse outcomes on the part of the mother or child). It also is founded upon three interrelated theoretical foundations—self-efficacy, attachment, and human ecology theories. Each of these theories addresses different aspects of the developmental system that contributes to adverse maternal and child outcomes in vulnerable families.

Theoretical Rationale/Conceptual Framework

The program has been grounded in theories of human ecology (Bronfenbrenner, 1979, 1992), self-efficacy (Bandura, 1977, 1982), and human attachment (Bowlby, 1969). The earliest formulations of the program gave greatest emphasis to human ecology, but as the program has evolved, it has been grounded more explicitly in theories of self-efficacy and human attachment.

The original formulation of this program was based in large part on Bronfenbrenner's theory of human ecology. Human ecology theory emphasizes the importance of social contexts as influences on human development. Parents' care of their infants, from this perspective, is influenced by characteristics of their families, social networks, neighborhoods, communities, and cultures, and interrelations among these structures. Bronfenbrenner's original theoretical framework has been elaborated more recently (with greater attention to individual influences) in his person-process-context model of research on human development.

The person elements of the model are reflected in the program components that have to do with behavioral and psychological characteristics of the parent and child. In the formulation of the theoretical foundations of the program, parents, and especially mothers, are considered both developing persons and the primary focus of the preventive intervention. Particular attention is focused on parents' progressive mastery of their roles as parents and as adults responsible for their own health and

economic self-sufficiency. This program emphasizes parent development because parents' behavior constitutes the most powerful and potentially alterable influence on the developing child, particularly given parents' control over their children's prenatal environment, their face-to-face interaction with their children postnatally, and their influence on the family's home environment.

The concept of process encompasses parents' interaction with their environment as well as the intrapsychic changes that characterize their mastery of their roles as parents and providers. Three aspects of process emphasized here relate to individuals' functioning: (1) program processes (e.g., the ways in which the visitors work with parents to strengthen parents' competencies); (2) processes that take place within parents (i.e., the influence of their psychological resources—developmental histories, mental health, and coping styles—on behavioral adaptation); and (3) parents' interaction with their children, other family members, friends, and health and human service providers. For the sake of simplicity, the discussion of these processes has been integrated below into the person (parent) part of the model.

The focus on parents elaborated here is not intended to minimize the role that contextual factors such as economic conditions, cultural patterns, racism, and sexism play in shaping the opportunities that parents are afforded. Most of those features of the environment, however, are outside of the influence of preventive interventions provided through health and human service systems. Certain contexts, nevertheless, are affected by parents' adaptive competencies. It is these features of the environment that the current program attempts to affect, primarily by enhancing parents' social skills. The aspects of context that we are most concerned about have to do with informal and formal sources of support for the family, characteristics of communities that can support or undermine the functioning of the program and families, the impact of going to school or working on family life, as well as cultural conditions that need to be taken into consideration in the design and conduct of the program.

One of the central hypotheses of ecological theory is that the capacity of the parent-child relationship to function effectively as a context for development depends on the existence and nature of other relationships that the parent may have. The parent-child relationship is enhanced as a context for development to the extent that each of these other relationships involves mutual positive feelings and that the other parties are supportive of the developmental activities carried on in the parent-child relationship. Conversely, the developmental potential of the parent-child relationship is impaired to the extent that each of the other relationships in which the parent is involved consists of mutual antagonism or interference with the developmental activities carried on in the parent-child relationship.

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Limitations of Human Ecology Theory.

Compared to other developmental theories, Bronfenbrenner's framework provides a more extended and elaborated conception of the environment. The original formulation of the theory, however, tended to treat the immediate settings in which children and families find themselves as shaped by cultural and structural characteristics of the society. Little consideration was given to the role that adults (in particular parents) play in selecting and shaping the settings in which they find themselves. While many investigators today reason that the personal characteristics that influence individuals' selection and shaping of their contexts have genetic origins, we have chosen to determine the extent to which and the means by which healthy choices and adaptive behaviors can be promoted.

Consequently, self-efficacy and attachment theories were integrated into the model to provide a broader conception of the parentsetting relationship. The integration of these theories allows for a conceptualization of development that encompasses truly reciprocal relationships in which settings, children, and other adults influence parental behavior, and in which parents simultaneously select and shape their settings and interpersonal relationships.

Self-Efficacy Theory

Self-efficacy theory provides a useful framework for promoting women's health-related behavior during pregnancy, care of their children, and personal development. According to Bandura, differences in motivation, behavior, and persistence in efforts to change a wide range of social behaviors are a function of individuals' beliefs about the connection between their efforts and their desired results. According to this view, cognitive processes play a central role in the acquisition and retention of new behavior patterns. In selfefficacy theory, Bandura distinguishes outcome expectations from efficacy expectations. Outcome expectations are individuals' estimates that a given behavior will lead to a given outcome. Efficacy expectations are individuals' beliefs that they can successfully carry out the behavior required to produce the outcome. It is efficacy expectations that affect both the initiation and persistence of coping behavior. Individuals' perceptions of self-efficacy can influence their choice of activities and settings, and can determine how much effort they will put forth in the face of obstacles.

Limitations of Self-Efficacy Theory. While self-efficacy theory provides powerful insights into human motivation and behavior, it is limited in several respects. The first limitation is that it is primarily a cognitive-behavioral theory. It attends to the emotional life of the mother and other family members only through the impact of behavior on women's beliefs or expectations, which in turn affect emotions. Many people have experienced multiple adversities in the form of overly harsh parenting, rejection, or neglect that often contribute to a sense of worthlessness, depression,

and cynicism about relationships. Self-efficacy gives inadequate attention to methods of helping parents cope with these features of their personal history or the impact of those early experiences on their care of their children. We have augmented the theoretical underpinnings of the program regarding these social and emotional issues with attachment theory (discussed below).

The second limitation is that self-efficacy attends to environmental influences in a cursory way. People can give up because they do not believe that they can do what is required, but they also can give up because they expect that their efforts will meet with punitiveness, resistance, or unresponsiveness. While Bandura acknowledges that adversity and intractable environmental conditions are important factors in the development of individuals' sense of futility, the structure of those environmental forces is not the subject of Bandura's theory. In other words, individuals' feelings of helplessness and futility are not simply intrapsychic phenomena, but are connected to environmental contexts that provide limited opportunities and that fail to nurture individuals' growth and well-being. The structure of those environmental influences is the primary subject of human ecology theory, discussed above.

Attachment Theory

Historically, this program owes much to Bowlby's theory of attachment. Attachment theory posits that human beings (and other primates) have evolved a repertoire of behaviors that promote interaction between caregivers and their infants (such as crying, clinging, smiling, signaling), and that these behaviors tend to keep specific caregivers in proximity to defenseless youngsters, thus promoting their survival, especially in emergencies. Humans (as well as many other species) are biologically predisposed to seek proximity to specific caregivers under times of stress, illness, or fatigue in order to promote survival. This organisation of behavior directed toward the caregiver is attachment.

In recent years, a growing body of evidence indicates that caregivers' levels of responsiveness to their children can be traced to caregivers' own childrearing histories and attachment-related experiences. Caregivers' attachment-related experiences are thought to be encoded in "internal working models" of self and others that create styles of emotional communication and relationships that either buffer the individual in times of stress or that lead to maladaptive patterns of affect regulation and create feelings of worthlessness. Differences in internal working models, according to attachment theorists, have enormous implications for mothers' capacities for developing sensitive and responsive relationships, especially with their own children.

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Limitations of Attachment Theory

Attachment theory provides a rich set of insights into the origins of dysfunctional care-giving and possible preventive interventions focused on parent-visitor and parent-child relationships. It gives scant attention to the role that individual differences in infants may play as independent influences on parental behavior, and it provides inadequate attention to issues of parental motivation for change in care-giving. Moreover, it minimizes the importance of the current social and material environment in which the family is functioning as influences on parents' capacities to care for their children. For more systematic treatments of these issues, we turned to self-efficacy and human ecology theories (discussed above).

Summary of the Role of Theory and Epidemiology in Program Design

The program and its specific intervention strategies have been built upon:

- theories about human development and change, and
- a solid understanding of the risk factors for particular negative outcomes and how to reduce those risks by promoting adaptive behavior.

Brief Description of Intervention

The program of home visitation begins during pregnancy and continues through the child's second birthday. Each family is assigned a nurse who visits families about once every other week during pregnancy and the first two years of the child's life. To the extent possible, programs should keep the same nurse assigned to a family for the entire time they participate in the program. Program process studies have shown that program effectiveness tends to decline when families are served by more than one nurse over the course of their participation.

The nurses use program protocols that are designed to accomplish three overriding goals: (1) the improvement of pregnancy outcomes; (2) the improvement of the child's health and development; and (3) the improvement of the mothers' own personal development. In the home visits, the nurses promote three aspects of maternal functioning: (a) health-related behaviors during pregnancy and the early years of the child's life; (b) the care parents provide to their children; and (c) parents' family planning, educational achievement, and participation in the work force. In the service of these three goals, the nurses link families with needed health and human services and involve other family members and friends in the pregnancy, birth, and early care of the child.

The nurses use detailed assessments, record-keeping forms, and protocols to guide their work with families but adapt the content of their home visits to the individual needs of each family. They provide a comprehensive educational program designed to promote parents' and other family members' effective physical and emotional

care of their children. The nurses also help women clarify their goals and develop problem-solving skills to enable them to cope with the challenges of completing their education, finding work, and planning future pregnancies. Developing a close working relationship with the mother and her family, the nurses help mothers identify small achievable objectives that can be accomplished between visits that, if met, will build mothers' confidence and motivation to manage the demands of caregiving and become economically self-sufficient.

The program focuses on specific parental behaviors and modifiable environmental conditions that are associated with adverse outcomes in each of the domains identified as program goals. The protocols and record keeping system are designed to reinforce home visitors' focus on program goals and theoretical foundations of the program.

The nurses are scheduled to visit families once a week for the first month after registration and then every other week through delivery. After delivery the nurses are scheduled to visit once a week for the first six weeks of the baby's life and then every other week until the 21st month postpartum. From 21 to 24 months postpartum, the nurses visit once a month. In these visits, which typically last from 60-90 minutes, the nurses work to achieve the goals and objectives outlined above, employing clinical interventions that are grounded in theories of human ecology, attachment, and self-efficacy. It should be noted, however, that some mothers are in crises that interfere with their consistently keeping scheduled appointments. Although the nurses make every effort to follow the specified schedule of visits, they are allowed to visit more frequently when families exhibit crises that would warrant more intensive support. In addition, although there are specified domains of program content that are developmentally organized and expected to be covered during particular periods, families exhibit considerable variation in their expressed needs. This leads to substantial individual variation in the amount of time that may be spent on particular program content areas. All of this leads to variation in the amount and content of the program experienced by any one family. The program nevertheless adheres to a core set of program goals, content, and methods.

Evidence of Program Effectiveness

For low-income women and their children, the program has been successful in:

- improving women's prenatal health-related behaviors (especially reducing cigarette smoking and improving diet);
- reducing pregnancy complications, such as hypertensive disorders and kidney infections;

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- reducing harm to children, as reflected in fewer cases of child abuse and neglect and injuries to children revealed in their medical records;
- improving women's own personal development, indicated by reductions in the rates of subsequent pregnancy, an increase in spacing between first and second born children, a reduction in welfare dependence, and reductions in behavioral problems due to substance abuse and in criminal behavior on the part of mothers who were unmarried and from low-income households at registration during pregnancy; and
- reducing criminal and antisocial behavior on the part of the 15-year old children as indicated by fewer arrests, convictions/violations of probation, and days of consuming alcohol.

The cost of the program, from the standpoint of government spending, is recovered by the time the children reach four years of age, and the cost savings to government and society exceed the cost of the program by a factor of at least 4:1 over the child's lifetime.

In the UK Family Nurse Partnerships tends to be delivered to young parents e.g. up to age 20 or up to age 24.

The information for this fact sheet was excerpted from:

Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses. Boulder, CO: Center for the Study and Prevention of Violence.

PROMOTING ALTERNATIVE THINKING STRATEGIES (PATHS)

Program Summary

The PATHS (Promoting Alternative THinking Strategies) Curriculum is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children while simultaneously enhancing the educational process in the classroom. This innovative curriculum is designed to be used by educators and counselors in a multi-year, universal prevention model. Although primarily focused on the school and classroom settings, information and activities are also included for use with parents.

Program Targets

The PATHS Curriculum was developed for use in the classroom setting with all elementary school aged-children. PATHS has been field-tested and researched with children in regular education classroom settings, as well as with a variety of special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted). Ideally it should be initiated at the entrance to schooling and continue through Grade 5.

Program Content

The PATHS Curriculum, taught three times per week for a minimum of 20-30 minutes per day, provides teachers with systematic, developmentally-based lessons, materials, and instructions for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. A key objective of promoting these developmental skills is to prevent or reduce behavioral and emotional problems. PATHS lessons include instruction in identifying and labeling feelings, expressing feelings, assessing the intensity of feelings, managing feelings, understanding the difference between feelings and behaviors, delaying gratification, controlling impulses, reducing stress, self-talk, reading and interpreting social cues, understanding the perspectives of others, using steps for problem-solving and decision-making, having a positive attitude toward life, self-awareness, nonverbal communication skills, and verbal communication skills. Teachers receive training in a two- to three-day workshop and in bi-weekly meetings with the curriculum consultant.

Program Outcomes

The PATHS Curriculum has been shown to improve protective factors and reduce behavioral risk factors. Evaluations have demonstrated significant improvements for program youth (regular education, special needs, and deaf) compared to control youth in the following areas:

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- Improved self-control,
- Improved understanding and recognition of emotions,
- Increased ability to tolerate frustration,
- Use of more effective conflict-resolution strategies,
- Improved thinking and planning skills,
- Decreased anxiety/depressive symptoms (teacher report of special needs students),
- Decreased conduct problems (teacher report of special needs students),
- Decreased symptoms of sadness and depression (child report – special needs), and
- Decreased report of conduct problems, including aggression (child report).

Program Costs

Program costs over a three-year period would range from \$15/student/year to \$45/student/year. The higher cost would include hiring an on-site coordinator, the lower cost would include redeploying current staff.

Program Background

The PATHS (Promoting Alternative THinking Strategies) Curriculum was developed to fill the need for a comprehensive, developmentally-based curriculum intended to promote social and emotional competence and prevent or reduce behavior and emotional problems. From its inception, the goal of PATHS was focused on prevention through the development of essential developmental skills in emotional literacy, positive peer relations, and problem-solving. The Curriculum (Kusché & Greenberg, 1994) is designed to be taught by elementary school teachers from grade K through grade 5.

Two decades of prior research had indicated an increasing emphasis on the need for universal, school-based curricula for the purposes of both promoting emotional competence and decreasing risk factors related to later maladjustment. However, although previous research has suggested that such approaches might be especially effective during the elementary school years, most evaluations had been restricted in scope and/or had involved programs with considerable limitations (e.g., narrow developmental focus, short duration, and unreliable and invalid outcome measures). Extensive focus on teaching emotional competency, understanding, and awareness was notably lacking, and comprehensive evaluations and inclusive programs were rare. These shortcomings were surprising, given the wide range of curricula utilized in elementary education that were intended to promote social competence and prevent disorder. Nevertheless, research strongly suggested that a comprehensive prevention program in the classroom setting had the potential to provide much needed assistance for both normally-adjusted and behaviorally at-risk students.

In addition, we believed that the rapid and complex cultural changes of the past few decades, as well as those predicted for the foreseeable future, made emotional and social competency crucial requirements for adaptive and successful functioning of children and for their continuing adaptation as adolescents and adults.

Although social and emotional competence had never been considered a necessary component of education in the past, we felt that it had become as critical for the basic knowledge repertoire of all children as reading, writing, and arithmetic. Teachers acknowledged that they had little background or established strategies to deal with emotional and social competency, so we felt that it was necessary to provide detailed lessons, as well as materials and instruction.

As with many of the more recent school-based preventive interventions, PATHS was designed to be taught by regular classroom teachers (initially with support from project staff) as an integrated component of the regular year-long curriculum. However, it is important to ensure that children generalize (i.e., apply the skills to new contexts) the use of PATHS skills to the remainder of the day and to other contexts. Thus, generalization activities and strategies were incorporated to be used in (and outside of) the classroom throughout each school day, and materials were included for use with parents.

More recent literature reviews have indicated that successful programs have the following characteristics: (a) utilizing a program of longer duration, (b) synthesizing a number of successful approaches, (c) incorporating a developmental model, (d) providing greater focus on the role of emotions and emotional development, (e) providing increased emphasis on generalization techniques, (f) providing ongoing training and support for implementation, and (g) utilizing multiple measures and follow-ups for assessing program effectiveness.

All seven of these under-emphasized but critical factors have been incorporated into the PATHS curriculum. Furthermore, as PATHS has been utilized with different cohorts and populations over the past 15 years, multiple field-tests with extensive feedback from teachers has led to expansion and improvement in PATHS over time.

Theoretical Rationale/Conceptual Framework

The PATHS prevention-intervention program is based on five conceptual models. The first, the ABCD (Affective-Behavioral-Cognitive-Dynamic) Model of Development focuses on the promotion of optimal developmental growth for each individual. The second model incorporates an eco-behavioral systems orientation and emphasizes the manner in which the teacher uses the curriculum model and generalizes the skills to build a healthy classroom atmosphere (i.e., one that supports the children's use and internalization of the material they have been taught). The third model involves the domains of neurobiology and brain

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structuralization/organization, while the fourth paradigm involves psychodynamic education (derived from Developmental Psychodynamic Theory). Finally, the fifth model includes psychological issues related to emotional awareness, or as it is more popularly labeled, emotional intelligence.

The ABCD Model

The ABCD model incorporates aspects of diverse theories of human development including psychodynamic developmental theory, developmental social cognition, cognitive developmental theory, cognitive social-learning theory, and attachment theory. The ABCD model places primary importance on the developmental integration of affect (i.e., emotion, feeling, mood) and emotion language, behavior, and cognitive understanding to promote social and emotional competence. A basic premise is that a child's coping, as reflected in his or her behavior and internal regulation, is a function of emotional awareness, affective-cognitive control, and social-cognitive understanding. Implicit in the ABCD model is the idea that during the maturational process, emotional development precedes most forms of cognition. That is, young children experience emotions and react on an emotional level long before they can verbalize their experiences. In early life, affective development is an important precursor of other ways of thinking and later needs to be integrated with cognitive and linguistic abilities, which are slower to develop. Table 1 presents a summary of stages in the ABCD Model (See Greenberg & Kusché, 1993 for elaboration).

During the first three years of life, the entire repertoire of emotional signals develops, and these signals/displays are subsequently used throughout the rest of an individual's lifetime. Thus, by the time children are beginning to utilize language fluently to express internal states of being (e.g., feeling sad, happy, jealous), most of their emotional responses have already become habitual.

By the end of the preschool years, most children have become skilled in both showing and interpreting emotional displays, although there are considerable individual differences in children's emotional profiles. The child also begins to demonstrate affective perspective-taking skills (i.e., the ability to differentiate the emotions, needs, and desires of different people in a particular context). The preschooler gradually finds new ways to cope with unpleasant emotions and discovers that internally experienced affects can be directly shared with others through verbal means. Furthermore, the child begins to regulate internal affective states through verbal self-regulation, a critical developmental achievement. An example of this ability is when a preschooler is able to tell someone he is angry instead of showing aggression towards a peer or object.

Between the ages of 5 and 7, children undergo a major developmental

transformation that generally includes increases in cognitive processing skills, as well as changes in brain size and function. This transition and the accompanying alterations allow children to undertake major changes in responsibilities, independence, and social roles.

During the elementary school years, further developmental integrations occur between affect, behavior, and cognition/language. This integration is of crucial importance in achieving socially competent action and healthy peer relations. For example, in the early elementary years when a child has been rebuffed when attempting to enter a game with peers, she might walk away, calm down, assess how both she and the other kids feel, and think of another strategy to enter the game, or think of something else to do or someone else with whom she can play.

Although research has demonstrated the linkage between deficits in emotional development and psychopathology, surprisingly little attention has been paid to the crucial role of emotional development in models of preventive intervention. Taking this factor into account, the PATHS Curriculum model synthesizes the domains of self-control, emotional awareness and understanding, and social problem-solving to increase social and emotional competence.

Table 1
ABCD Model (Affective-Behavioral-Cognitive-Developmental)

Stages of Developmental Integration	
1. Infancy (Birth to 18 months)	Emotion = Communication Arousal and Desire = Behavior
2. Toddlerhood (18 months to 36 months)	Language Supplements Emotion = Communication Very Initial Development of Emotional Labeling Arousal and Desire = Behavior
3. Preschool Years (3 to 6 years)	Language Develops Powerful Role in Communication Child can Recognize/Label Basic Emotions Arousal and Desire > Symbolic Mediation > Behavior Development of Role-taking Abilities Beginning of Reflective Social Planning Problem-Solving (Generation of Alternative Plans for Behavior)
4. School Years (6 to 12-13 years)	Thinking in Language has become Habitual Increasing Ability to Reflect on and Plan Sequences of Action Developing Ability to Consider Multiple Consequences of Action Increasing Ability to Take Multiple Perspectives on a Situation
5. Adolescence	Utilize Language in the Service of Hypothetical Thought Ability to Simultaneously Consider Multiple Perspectives

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The Eco-Behavioral Systems Model

The second conceptual model incorporates an eco-behavioral systems orientation and examines learning primarily at the level of systems change. School-based programs that focus independently on the child or environment are not as effective as those that simultaneously educate the child and instill positive changes in the environment. Training programs may appropriately be considered person-centered when skills are taught in the absence of creating environmental supports for continued skill application in daily interactions. In contrast, ecologically oriented programs emphasize not only the teaching of skills, but also the creation of meaningful real-life opportunities to use skills and the establishment of structures to provide reinforcement for effective skill application. Thus, although a central goal of PATHS is to promote the developmental skills of each child by providing learning that integrates affect, cognition, and behavior, a critical ingredient for success is the development of a healthy classroom and school environment.

From this perspective, the success of skills training programs may depend largely on their attention to encouraging and supporting socialization patterns and supports in the intervention setting. For example, ecologically oriented problem-solving programs try to introduce a common social information processing framework that children and teachers can use to communicate more effectively about problem situations. In other words, they try to change not only the child's behavior, but also the teacher's behavior, the relationship between the teacher and child, and classroom and school-level resources and procedures to support adaptive problem-solving efforts, assuming that the interactions are dysfunctional or ineffective.

The generalization procedures, extensive teacher training, and focus on some level of parent participation used in PATHS have the goal of combining classroom instruction with efforts to create environmental support and reinforcement from peers, family members, school personnel health professionals, and other concerned community members. Further, training emphasizes the manner in which the teacher uses the curriculum model and generalizes the skills to build a healthy classroom atmosphere (i.e., one that supports the children's use and internalization of the material they have been taught).

Neurobiology and Brain Structuralization/Organization

When designing PATHS, we paid special attention to developmental models of brain organization. Two of the most relevant concepts we incorporated involve "vertical" control and "horizontal" communication (Kusché, 1984).

"Vertical" control refers to higher-order processing and regulation of emotion and actions by the frontal lobes over the limbic system and sensory-motor areas. When adults first experience emotional information, it is rapidly perceived and processed

in the limbic system in the middle part of the brain. This initial information is then transmitted to the frontal lobes in the neocortex for further processing and interpretation, and, subsequently, the frontal lobes can transmit messages back to the limbic system to modify emotion signals and to the sensory-motor cortex to influence potential actions.

For example, if you saw a car coming towards you and you startled and jumped to the side of the road, all of this rapid processing would have occurred primarily in the limbic system without any true conscious awareness on your part. Afterwards, however, you would take in and process further information at a cortical level (e.g., the thought, “That car almost hit me!”; the color of the car; the license plate number, etc.). In addition to the initial fear, you would probably start to feel angry, as well as relieved, and you might decide to report the incident to the police.

Rapid primary processing is sometimes crucial for survival, as in this case, but secondary processing in the frontal cortex is important because it allows us to integrate data involving emotions with knowledge-based information, which, in turn, assists with making appropriate plans for further action.

Early in development (i.e., by the time of toddlerhood), there are few interconnections between the limbic system and the frontal lobes; thus, during the “terrible-twos,” children frequently hit, bite, or kick “automatically” when they feel angry. As children mature, however, increasing neuronal interconnections evolve between the frontal lobes and the limbic system. This is especially important with regard to the development of self control, because the frontal cortex becomes increasingly able to regulate impulses from the limbic areas and modify potential actions. Between the ages of 5 and 7, a major shift occurs in which networks in the frontal areas achieve significant dominance with regard to exerting emotional self-regulation and behavioral self-control.

However, these developmental milestones do not automatically unfold, but rather are heavily influenced by environmental input throughout early childhood. Moreover, if these networks do not develop in an optimal manner, children will not have the neuronal structure necessary to control their actions in response to strong emotional signals.

Thus, in order to promote the development of executive or vertical control with PATHS, we teach children to practice conscious strategies for self-control, including self-talk (i.e., verbal mediation and the Control Signals Poster). For younger children and those with either delayed language or difficulties in behavioral and emotional control, we utilize the “Turtle Technique,” which includes a motor-inhibiting response in addition to self-talk.

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“Horizontal” communication refers to a phenomenon that results from the asymmetry of information processing in the two halves of the neocortex (the outermost and evolutionarily newer part of the brain).

The left hemisphere is responsible for processing receptive and expressive language as well as expressing positive affect. The right hemisphere is specialized for processing both comfortable and uncomfortable receptive affect and uncomfortable expressive affect in the majority of English-speaking adults, the only cultural group on which research is available (Bryden & Ley, 1983).

Nonlinguistic information (such as emotional signals) is often processed without awareness (preconscious processing) unless we verbally “think” about it. To verbally label our emotional experiences, and thus become consciously aware of them, this information must be transmitted to the left hemisphere. However, the left and right hemispheres can communicate with one another only via the corpus callosum, a “bridge” that horizontally connects the two sides of the brain. Therefore, in order to be truly aware of our emotional experiences, we must utilize both the right and left hemispheres. The language areas on the left side of the brain can also modify and influence affective processing in the right (Davidson, 1998; Sutton & Davidson, 1997).

An interesting situation occurs if, for some reason, emotion information does not reach the left hemisphere (e.g., an adequate neural network has never developed or interconnections are blocked from intercommunication). When this occurs, an individual will experience emotion, but will not be aware of having done so. Thus, other people can be aware of how the person feels (i.e., by observing facial cues), but the individual will not be aware of having experienced the feelings. A frequent illustration of this phenomenon occurs when a teacher observes a child who is clearly feeling angry, but that child truly has no conscious awareness of such an emotion (“I am not angry; I feel fine”).

Development of the corpus callosum is relatively slow, so that it is only with maturation that optimum hemispheric communication is possible. As with vertical neural networks, the way in which interhemispheric communication occurs depends heavily on environmental input during development.

Based on this theory of “horizontal” communication and control, we hypothesized that verbal identification and labeling, especially of uncomfortable feelings, would powerfully assist with managing these feelings, controlling behavior, and improving hemispheric integration. Thus, we stress the use of Feeling Face cards that include both the facial drawing of each affect (recognition of which is mediated by the right hemisphere) and its printed label (which is mediated by the left). In

addition, we also utilize a color-coded differentiation of comfortable (yellow) versus uncomfortable (blue) feelings. In addition, encouraging children to talk about emotional experiences (both at the time they are occurring and in recollection) further strengthens neural integration.

In summary, our knowledge of the neurobiological development of the brain was heavily influential in the development of PATHS. Research strongly suggests that learning experiences in the context of meaningful relationships during childhood influence the development of neural networks between different areas of the brain, which in turn affect self-control and emotional awareness. Thus, we incorporated strategies in PATHS to optimize the nature and quality of teacher-child and peer-peer interactions that are likely to impact brain development as well as learning (Greenberg & Snell, 1997). Optimum development of both “vertical” and “horizontal” communication and control during childhood should promote better adaptation in both current and later life.

Psychodynamic Education

The application of psychoanalytic theory to the education of children has only recently received significant attention. Psychodynamic education is intended to enhance developmental growth, promote mental health, and prevent emotional distress, but it is not treatment. In this regard, teachers are not therapists and are not expected to act as such. However, teachers are powerful role models (individuals with whom children can identify in a positive manner), and the information they impart is often given the status of absolute truth (i.e., omniscience), especially during the elementary school-age years. When teachers express an interest in children’s feelings and emotional experiences or show respect for children’s opinions, their students are impacted in a profound manner. As the teacher-student relationships grow increasingly more positive and enriched, learning is enhanced.

Psychodynamic education is derived from a developmental theory and aims to coordinate social, emotional, and cognitive growth. Teachers are encouraged to utilize actual classroom experiences and use children’s creative, imaginal processes. Students can then develop a healthy sense of self-esteem from observing the positive reactions of others towards them, not because they have been encouraged to parrot simplistic affirmations. Further, teachers play a crucial role by providing clarifications and explanations of emotions and situations. An important way in which psychodynamic education differs from other models is its emphasis on internalization, the process of healthy development of conscience, or “taking ownership” and self-responsibility for one’s actions.

By promoting the development of internal self-control and self-motivation along with healthy standards for behavior, children develop an optimal sense of autonomy

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and decision-making while also considering the needs and feelings of others. For example, students contemplate and discuss the consequences of having good vs. bad manners and evaluate why good manners are important (e.g., the way we act affects how other people feel), rather than simply being taught a list of good manners that they are supposed to use. In this way, the children come to “own” the concepts as belonging to themselves (i.e., they internalize them); as a result, they voluntarily choose to use good manners because they believe it is the right thing to do.

In summary, some of the long-range goals of psychodynamic education are for each child to develop a kind but fair sense of prosocial behavioral control, positive sense of self, respect for self and others, healthy internal motivation, curiosity and love for learning, and so on that operate independently of the external environment. These factors enhance developmental growth, improve school functioning, and optimize mental health, while preventing antisocial tendencies, violent behavior, and substance abuse.

Psychological Issues Related to the Crucial Role of Emotional Awareness

Research suggests that as children develop more complex and accurate plans and strategies regarding emotions, these plans have a major influence on their social behavior. For example, the ability to think through problem situations and to anticipate their occurrence is critical for socially competent behavior. However, these “cold” cognitive processes are unlikely to be effectively utilized in real world conditions (e.g., when being teased) unless the child can both accurately process the emotional content of the situation and effectively regulate his or her emotional arousal so that he and she can think through the problem.

Similarly, if children misidentify their own feelings or those of others, they are likely to generate maladaptive solutions to a problem, regardless of their intellectual capacities. In addition to these types of challenges, the child’s motivation to discuss these feelings and problem-solve in interpersonal contexts will also be greatly impacted by the modeling and reinforcement of adults and peers.

Emotional awareness and understanding are implicit in many models that have been developed to promote social competence, but have rarely been a central focus, even though numerous studies have assessed social problem-solving ability as both a mediator and outcome of intervention.

Recently, emotional competence has been subsumed under a new, more popular term, emotional intelligence (Goleman, 1995; Mayer & Salovey, 1997), defined as the ability to recognize emotional responses in oneself, other people, and situations, and use this knowledge in effective ways (e.g., in managing one’s own emotional responses, motivating oneself, and handling relationships effectively). “Self-awareness—recognizing a feeling as it happens—is the keystone of emotional

intelligence....[T]he ability to monitor feelings from moment to moment is [also] crucial to psychological insight and self-understanding. An inability to notice our true feelings leaves us at their mercy. People with greater certainty about their feelings are better pilots of their lives” (Goleman, 1995, p. 43). Thus, it has been proposed that emotional intelligence may be more important than cognitive intelligence in achieving success and happiness in life.

As such, a central focus of PATHS is encouraging children to discuss feelings, experiences, opinions, and needs that are personally meaningful, and making them feel listened to, supported, and respected by both teachers and peers. As a result, the internalization of feeling valued, cared for, appreciated, and part of a social group is facilitated, which, in turn, motivates children to value, care for, and appreciate themselves, their environment, their social groups, other people, and their world.

This focus cannot be emphasized enough. Although all children need to feel listened to or respected by others, especially adults, many children do not have an adult role model who will support them in this manner; hence, they do not learn to respect themselves or others. These aspects of socialization must be taught to children, and to become truly socialized, children must internalize and embrace them as their own, hopefully prior to reaching adolescence. It is important to recognize, however, that this cannot be forced upon children, but rather is best achieved through nurturance and respect.

Brief Description of Intervention

The PATHS Curriculum consists of an Instructional Manual, six volumes of lessons, pictures, photographs, posters, Feeling Faces, and additional materials. PATHS is divided into three major units: (1) the Readiness and Self-Control Unit, 12 lessons that focus on readiness skills and development of basic self-control; (2) the Feelings and Relationships Unit, 56 lessons that focus on teaching emotional and interpersonal understanding (i.e., Emotional Intelligence); and (3) the Interpersonal Cognitive Problem-Solving Unit, 33 lessons that cover eleven steps for formal interpersonal problem-solving. Two further areas of focus in PATHS involve building positive self-esteem and improving peer communications/relations. Rather than having separate units on these topics, relevant lessons are interspersed throughout the other three units. There is also a Supplementary Unit containing 30 lessons which review and extend PATHS concepts that are covered in the major three units. The PATHS units cover five conceptual domains:

1. self-control,
2. emotional understanding,
3. positive self esteem,

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4. relationships, and
5. interpersonal problem solving skills.

Each of these domains has a variety of sub-goals, depending on the particular developmental level and needs of the children receiving instruction.

PATHS is an expansive and flexible program that allows implementation of the 131 lessons over a 5 year period, but it should be noted that any particular lesson is not necessarily equivalent to one session; indeed, depending on the needs of any specific classroom, one PATHS lesson can run from one to five or more PATHS sessions. Pictures and photographs are included for all of the lessons, with smaller graphics provided in the margins of the scripts to make the curriculum more user-friendly. Most of the materials that are needed are included in The PATHS Curriculum kit, but supplementary materials can certainly be added as desired.

A separate volume is also included with PATHS to serve as an Instructional Manual for teachers. To encourage generalization to the home environment, parent letters and information are provided periodically in the curricular lessons and can be sent home by the teachers as desired. “Home activity assignments” (separate versions for younger and older students) are also included for children to do at home (e.g., Ask your mom or dad or other adult about a time when they felt proud) to further involve parents (please see Appendices E and F).

Evidence of Program Effectiveness

Three controlled studies with randomized control vs. experimental groups (using one year of PATHS implementation with pre, post, and follow-up data) have been conducted by the present authors. These have included three different populations including deaf/hearing impaired, regular education, and special education-classified children.

The robust RCT evaluation of the PATHS programme in Craigavon/Lurgan should report in 2012.

Increasing Protective Factors

In all three clinical trials, compared to matched control children, the use of the PATHS Curriculum has significantly increased the children’s ability to:

- Recognize and understand emotions
- Understand social problems
- Develop effective alternative solutions
- Decrease the percentage of aggressive/violent solutions

In all three groups of children, teachers report significant improvements in children's prosocial behavior in the following domains:

- Self-control
- Emotional understanding
- Ability to tolerate frustration
- Use of effective conflict-resolution strategies

Cognitive testing indicates that PATHS leads to improvements in the following skills:

- Ability to plan ahead to solve complex tasks with normal and special needs children (WISC-R Block Design and Analogies of the Test of Cognitive Abilities; not tested in the Deaf/Hearing-Impaired group)
- Cognitive flexibility and low impulsivity with non-verbal tasks (Coding from the WISC-R)
- Improved reading achievement for young deaf children

Reducing Maladaptive Outcomes

Teachers report the following reductions in behavioral difficulties at one-year post intervention:

- Decreased internalizing symptoms (sadness, anxiety, and withdrawal) in special needs classrooms
- Decreased externalizing symptoms (aggressive and disruptive behavior) in special education classrooms

Students (in regular and special needs classes) self-report the following reductions in behavioral difficulties at one-year post intervention:

- Decreased symptoms of sadness and depression (Child Depression Inventory)
- Decreased report of conduct problems

Initial Finding from the National Fast Track Demonstration Program

The FT/PATHS Curriculum (a revised version of PATHS which maintains the critical components of the original curriculum) is the central universal prevention component of the Fast Track Program. Fast Track is a comprehensive program whose goals include the prevention of aggression and delinquency and the promotion of social and academic competence. The Fast Track Program involves a longitudinal design and is conducted in four American locations (Seattle, Nashville, Durham, and rural Pennsylvania). Findings at the end of first grade (after one year of implementation) indicate that in schools in which PATHS is

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operating, there is improved social adaptation (as compared to matched control schools) as indexed by more positive reports of the following dimensions:

- Lower peer aggression scores based on peer ratings (Sociometrics)
- Lower teacher ratings of disruptive behavior (Teacher report)
- Improved classroom atmosphere (assessed by Independent Observers)

The information for this fact sheet was excerpted from:

Greenberg, M.T., Kusché, C. & Mihalic, S.F. (1998). Blueprints for Violence Prevention, Book Ten: Promoting Alternative Thinking Strategies (PATHS). Boulder, CO: Center for the Study and Prevention of Violence.

INCREDIBLE YEARS SERIES (IYS)

Program Summary

The Incredible Years Series is a set of three comprehensive, multi-faceted, and developmentally-based curriculums for parents, teachers and children designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotion problems in young children.

Program Targets

Children, ages two to ten, at risk for and/or presenting with conduct problems (defined as high rates of aggression, defiance, oppositional and impulsive behaviors). The programs have been evaluated as “selected” prevention programs for promoting the social adjustment of high risk children in preschool (Head Start) and elementary grades (up to grade three) and as “indicated” interventions for children exhibiting the early onset of conduct problems.

Program Content

This series of programs addresses multiple risk factors across settings known to be related to the development of Conduct Disorders in children. In all three training programs, trained facilitators use videotape scenes to encourage group discussion, problem-solving, and sharing of ideas. The BASIC parent series is “core” and a necessary component of the prevention program delivery. The other parent training, teacher, and child components are strongly recommended with particular populations that are detailed in this document.

Incredible Years Training for Parents

The Incredible Years parenting series includes three programs targeting parents of high-risk children and/or those displaying behavior problems. The BASIC program emphasizes parenting skills known to promote children’s social competence and reduce behavior problems such as: how to play with children, helping children learn, effective praise and use of incentives, effective limit-setting and strategies to handle misbehavior. The ADVANCE program emphasizes parent interpersonal skills such as: effective communication skills, anger management, problem-solving between adults, and ways to give and get support. The SUPPORTING YOUR CHILD’S EDUCATION program (known as SCHOOL) emphasizes parenting approaches designed to promote children’s academic skills such as: reading skills, parental involvement in setting up predictable homework routines, and building collaborative relationships with teachers.

Incredible Years Training for Teachers

This series emphasizes effective classroom management skills such as: the effective use of teacher attention, praise and encouragement, use of incentives for difficult

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behavior problems, proactive teaching strategies, how to manage inappropriate classroom behaviors, the importance of building positive relationships with students, and how to teach empathy, social skills and problem-solving in the classroom.

Incredible Years Training for Children

The Dinosaur Curriculum emphasizes training children in skills such as emotional literacy, empathy or perspective taking, friendship skills, anger management, interpersonal problem-solving, school rules and how to be successful at school. The treatment version is designed for use as a “pull out” treatment program for small groups of children exhibiting conduct problems. The prevention version is delivered to the entire classroom by regular teachers, two to three times a week.

Program Outcomes

Multiple randomized control group evaluations of the parenting series indicate significant:

- Increases in parent positive affect such as praise and reduced use of criticism and negative commands.
- Increases in parent use of effective limit-setting by replacing spanking and harsh discipline with non-violent discipline techniques and increased monitoring of children.
- Reductions in parental depression and increases in parental self-confidence.
- Increases in positive family communication and problem-solving.
- Reduced conduct problems in children’s interactions with parents and increases in their positive affect and compliance to parental commands.

Multiple randomized control group evaluations of the teacher training series indicate significant:

- Increases in teacher use of praise and encouragement and reduced use of criticism and harsh discipline.
- Increases in children’s positive affect and cooperation with teachers, positive interactions with peers, school readiness and engagement with school activities.
- Reductions in peer aggression in the classroom.

Multiple randomized control group evaluations of the child training series indicate significant:

- Increases in children’s appropriate cognitive problem-solving strategies and more prosocial conflict management strategies with peers.

- Reductions in conduct problems at home and school.

Independent replications in England, Wales, Norway, Canada, and the US confirm these findings.

Program Costs

The costs of curriculum materials, including video or DVDs, comprehensive manuals, books and other teaching aids for the Parent Training Program are \$1,300 for the BASIC program, \$775 for the ADVANCE program, \$1250 for the SCHOOL program; \$1,250 for the Teacher Training Program; and \$1250 for the Child Training Program. Discounts are available for purchases of more than one set of any program. Training and technical assistance costs are charged based on a daily fee.

Program Background

The mission of the Incredible Years Training Series is to promote positive, effective, and research-based parenting and teaching practices and strategies which strengthen young children's social competence and problem-solving strategies and reduce aggression at home and at school. There are three types of interlocking training curriculums, which are targeted at parents, teachers and children (ages two to eight years). Initially, in the 1980's, the BASIC parent program was evaluated and found to be very successful in promoting positive and lasting improvements in parent-child interactions and in reducing children's behavior problems at home for at least two-thirds of children. However, a follow-up evaluation three years later indicated that approximately one-third of the children were still having considerable difficulties at school and with peer groups. Improvements at home did not necessarily generalize to school settings or to peer interactions for some children. In particular, stressful family situations (e. g., marital distress and poverty) were related to poorer outcomes. As a result of these findings, two new components were developed: (1) the ADVANCE parent program focusing on communication, anger management and problem-solving skills and, (2) the child program (Dina Dinosaur Curriculum) designed to train children in social skills, problem-solving strategies and emotional language. Evaluation of these components indicated that the programs enhanced effects in terms of peer relationships, social problem-solving and marital collaboration. However, it was still evident that a portion of the children and their families were having difficulties managing the school experience and working successfully with teachers. In particular, about 40 percent of the children were found to be co-morbid for other problems such as Attention Deficit Hyperactivity Disorder, as well as language and learning delays. These problems created particular difficulties for the children in the classroom, with teachers and with peers. Moreover, parents of these children were having difficulty knowing how to successfully collaborate with teachers in

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planning for their academic and social needs. Consequently, for the past six years, a teacher training curriculum has been developed and evaluated for use in teaching positive classroom management skills and promoting social, emotional and academic competencies in the classroom. In conjunction with this program, the Supporting Youth Child's Education (SCHOOL) program for parents was developed to help parents learn how to foster academic competence at home (e. g., reading skills and study habits) and have successful conferences with teachers at school. Recent evaluations of these programs indicated significant effects in decreasing classroom aggression and increasing academic competence.

These curriculums may be used in schools (e. g., Head Start, daycare, and kindergarten through grade three) as early prevention programs for high-risk children and their families and are designed to build protective factors (e. g., anger management, empathy skills, positive discipline and home-school collaboration) and reduce risk factors (e. g., early signs of aggression and peer rejection) that research has shown to be related to later violence. Additionally, these curriculums may be used in mental health centers as treatment programs for children diagnosed with early-onset Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and Attention Deficit Hyperactivity Disorder (ADHD). The long range goal of these prevention programs is to enhance young children's social, emotional, and academic development, as well as prevent and reduce conduct problems in order to decrease violence, drug abuse, and delinquency in later years.

Conduct Problems in Young Children

The incidence of aggression in children is escalating— and at younger ages. Studies indicate that anywhere from 7 to 20 percent of pre-school and early school age children meet the diagnostic criteria for Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). These rates are even higher for low-income families. Research on the treatment and prevention of Conduct Disorders has been identified as one of the nation's highest priorities. This agenda is vitally important because the widespread occurrence of delinquency and escalating violence in adolescence result in a high cost to society. "Early onset" ODD/ CD (in the form of high rates of oppositional defiance, aggressive and noncompliant behaviors) is a stable trait over time for many preschool children and appears to be the most important behavioral risk factor for antisocial behavior for boys and girls in adolescence. Such behavior has repeatedly been found to predict the development of drug abuse in adolescence, as well as other problems, including juvenile delinquency, depression, violent behavior, and school dropout.

Theories regarding the causes of child conduct problems include child biological and developmental risk factors (e. g., attention deficit disorders, learning disabilities, and language delays); family factors (e. g., marital conflict, depression,

drug abuse, and criminal behavior); ineffective parenting (e. g., harsh discipline and low parental involvement in school activities); school risk factors (e. g., teachers' use of poor classroom management strategies, classroom level of aggression, large class sizes and low teacher involvement with parents); and peer and community risk factors (e. g., poverty and gangs).

Since Conduct Disorder becomes increasingly resistant to change over time, intervention that begins in the early school years is clearly a strategic way to prevent or reduce aggressive behavior problems before they “ripple” to result in well-established negative reputations, academic failure, and escalating violence in adolescence. Recent projections suggest that approximately 70 percent of the children who need services for conduct problems— in particular, young children— do not receive them. And very few of those who do receive intervention ever receive an intervention which has been “empirically validated.”

Highlights of the Incredible Years Parent, Teacher and Child Training Series

- Comprehensive (includes integrated training for parents, teachers and children)
- Proactive, collaborative approach built on the “strength model”
- Flexible in delivery using sequenced modules (26 topics in total)
- Culturally sensitive (available in Spanish, British dialect, and Norwegian, as well as multi-ethnic videotape actors and puppets)
- Appropriate for prevention programs for high-risk children, as well as for treatment of children with conduct problems
- User friendly— uses a combination of books, videotapes, extensive facilitator manuals, and home and school activities
- Developmentally appropriate for young children—includes puppets, games and activities
- Provides extensive program support for training facilitators, school personnel, and organizations, including group facilitator training
- Provides certification for facilitators to assure quality implementation
- Evidence-based and replicated by independent researchers

Theoretical Rationale/Conceptual Framework

The theoretical rationale for the three curriculums for parents, teachers, and children is described below.

Theoretical Rationale/ Conceptual Framework for the Incredible Years Parent Training Series

Parenting interactions are clearly the most well researched and most important proximal cause of the development of conduct problems in young children.

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Parenting practices associated with the development of conduct problems include permissive, inconsistent, irritable, and harsh discipline and low monitoring. Dishion and Loeber (1985) and others have found that parental monitoring and discipline are low for adolescent substance abusers; moreover, these parental constructs at age ten predicted later antisocial behavior and drug abuse. The most influential developmental model for describing the family dynamics that underlie early antisocial behavior is Patterson's social learning theory regarding the "coercive process" (Patterson et al., 1992), a pattern whereby children learn to escape or avoid parental criticism by escalating their negative behaviors. This, in turn, leads to increasingly aversive parent interactions and escalating dysregulation on the part of the child. These negative parent responses directly model and reinforce the child's deviant behaviors.

In addition to social learning theory, attachment theory (Bowlby, 1980) and new methods of measuring attachment beyond the toddlerhood period have emphasized the importance of the affective nature of the parent-child relationship. Considerable evidence indicates that a warm, positive bond between parent and child leads to more positive communication and positive parenting strategies and a more socially competent child, whereas high levels of parental negative affect and hostility is disruptive to children's ability to regulate their emotional responses and manage conflict appropriately. For example, research has shown that the relationship between harsh discipline and externalizing problems occurs only among children in homes in which a warm child-parent relationship is lacking (Deater-Deckard, Dodge, Bates, & Pettit, 1996). Likewise, in a recent review of research on risk and resilience, Doll and Lyon (1998) conclude that a warm relationship with at least one caregiver is a strong protective factor against the negative influences of family dysfunction. This finding is supported by results of a large national study of adolescent development that showed that youth who report positive relationships and bonding with their families and schools engage in less risky and fewer antisocial behaviors (Resnick et al., 1997).

Other family factors, such as depression, marital conflict, and high negative life stress, have been shown to disrupt parenting skills and contribute to parental high negative affect, inconsistent parenting, low monitoring, emotional unavailability and insecure attachment status. Family and parenting risk factor research suggests the need to train parents in effective child management skills and assist them in coping with other family stressors.

Theoretical Rationale/Conceptual Framework for the Incredible Years Teacher Training Series

Once children with behavior problems enter school, negative academic and social experiences make key contributions to the further development of conduct

problems. Aggressive, disruptive children quickly become socially excluded, leading to fewer opportunities to interact socially and learn appropriate friendship skills. Over time, peers become mistrustful and respond to aggressive children in ways that increase the likelihood of reactive aggression. Evidence suggests that peer rejection eventually leads to these children's association with deviant peers. Once children have formed deviant peer groups, the risk for drug abuse and antisocial behavior is even higher.

Furthermore, Rutter and colleagues (1976) find that teacher behaviors and school characteristics such as low emphasis of teachers on academic work, low rates of praise, little emphasis on individual responsibility, and high student-teacher ratio are related to classroom aggressive behaviors, delinquency, and poor academic performance. High-risk children are often clustered in classrooms with a high density of other high-risk students, thus presenting the teacher with additional management challenges. Rejecting and non-supportive responses from teachers further exacerbate the problems of aggressive children. Such children often develop poor relationships with teachers and receive less support, nurturing, and instruction and more criticism in the classroom. Some evidence suggests that teachers retaliate in a manner similar to parents and peers. Walker and Buckley (Walker, 1995; Walker & Buckley, 1973) report that antisocial children are less likely to receive encouragement from teachers for appropriate behavior and more likely to be punished for negative behavior than well-behaved children. Aggressive children are also frequently expelled from classrooms. In our own clinic studies with conduct problem children aged three to seven years, over 50 percent had been asked to leave three or more schools by second grade. The lack of teacher support and exclusion from the classroom exacerbates not only these children's social problems, but also their academic difficulties, and also contributes to the likelihood of school dropout. Finally, recent research has shown that poorly managed classrooms have higher levels of classroom aggression and rejection that, in turn, influence the continuing escalation of individual child behavior problems. A spiraling pattern of child negative behavior and teacher reactivity can ultimately lead to parent demoralization, withdrawal and a lack of connection and consistency between the socialization activities of the school and home. While most teachers want to be active partners in facilitating the bonding process with parents, many lack the confidence, skills, or training to work collaboratively with families. Teacher education programs also devote scant attention to building relationships and partnerships with parents or implementing social and emotional literacy curriculums.

This literature suggests that a preventive model needs to promote healthy bonds or "supportive networks" between teachers and parents and children and teachers. Strong family-school networks benefit children due to parents'

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increased expectations, interest in, and support for their child's social and academic performance, and create a consistent socialization process across home and school settings. The negative cycle described above can be prevented when teachers develop nurturing relationships with students, establish clear classroom rules about bullying, prevent social isolation by peers, and offer a curriculum which includes training students in emotional literacy, social skills, and conflict management. Considerable research has demonstrated that effective classroom management can reduce disruptive behavior and enhance social and academic achievement. Well-trained teachers can help aggressive, disruptive, and uncooperative children develop the appropriate social behavior that is a prerequisite for their success in school. Teacher behaviors associated with improved classroom behavior include the following: high levels of praise and social reinforcement; proactive strategies such as preparing children for transitions and setting clear, predictable classroom rules; effective use of short, clear commands, warnings, reminders, and distractions; tangible reinforcement systems for appropriate social behavior; team-based rewards; mild but consistent response costs for aggressive or disruptive behavior including Time Out and loss of privileges; and direct instruction in appropriate social and classroom behavior, problem-solving and self-management skills.

Theoretical Rationale/Conceptual Framework for the Incredible Years Child Training Series

Moffitt (Moffitt, 1993; Moffitt & Lynam, 1994) and others have argued that some abnormal aspect of the child's internal organization at the physiological, neurological, and/ or neuropsychological level (which may be genetically transmitted) is linked to the development of Conduct Disorders, particularly for "life course persisters" (i. e., those with a chronic history of early behavioral problems).

Children with conduct problems have been reported to have certain temperamental characteristics such as inattentiveness, impulsivity, and Hyperactivity Attention Deficit Disorder. Researchers concerned with the biological aspects of the development of conduct problems have investigated variables such as neurotransmitters, autonomic arousal system, skin conductance and hormonal influences, and some findings suggest that such children may have low autonomic reactivity (i. e., low physiological response to stimuli). Other child factors have also been implicated in child Conduct Disorder. For example, deficits in social-cognitive skills contribute to poor emotional regulation and aggressive peer interactions. Research has shown that children with ODD/ CD may define problems in hostile ways, search for fewer cues when determining another's intentions and focus more on aggressive cues. Children with ODD/ CD may also distort social cues during peer interactions, generate fewer alternative solutions to social problems, and

anticipate fewer consequences for aggression. The child's perception of hostile intent in others may encourage the child to react aggressively. Research reveals that aggressive behavior in children is correlated with low empathy across a wide age range which may contribute to a lack of social competency and antisocial behavior. Additionally, studies indicate that children with conduct problems have significant delays in their peer play skills; in particular, difficulty with reciprocal play, cooperative skills, turn taking, waiting, and giving suggestions.

Finally, reading, learning and language delays are also implicated in children with conduct problems, particularly for "early life course persisters" (Moffitt & Lynam, 1994). For these children, low academic achievement often manifests itself during the elementary grades and continues through high school. Poor academic achievement also predicts adolescent drug abuse in both cross-sectional (Jessor, 1987; Newcomer, Maddahian, & Bentler, 1986) and longitudinal samples (Smith & Fogg, 1978). The relationship between academic performance and CD is bi-directional. Academic difficulties may cause disengagement, increased frustration, and lower self-esteem, which contribute to the child's behavior problems. At the same time, noncompliance, aggression, elevated activity levels, and poor attention limit a child's ability to be engaged in learning and achieve academically. Thus, a cycle is created in which one problem exacerbates the other. This combination of academic delays and conduct problems appears to contribute to the development of more severe CD and school failure.

The data concerning the possible biological, socio-cognitive and academic or developmental deficits in children with conduct problems suggest the need for parent and teacher training programs which help them understand children's biological deficits (their unresponsiveness to aversive stimuli and heightened interest in novelty) and support their use of effective parenting and teaching approaches so that they can continue to be positive and provide consistent responses. The data regarding autonomic underarousal theory suggests that these children may require overteaching (i. e., repeated learning trials) in order to learn to inhibit undesirable behaviors and manage emotion. Parents and teachers will need to use consistent, clear, specific limit-setting that utilizes simple language and concrete cues and reminders. Additionally, this information suggests the need to directly intervene with children and focus on social learning needs such as problem-solving, perspective taking, and play skills as well as literacy and special academic needs.

Brief Description of Intervention

The Incredible Years Series is a comprehensive program for parents, teachers, and children with the goal of preventing, reducing, and treating behavioral and emotional problems in children ages two to eight. The core of the program

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is the BASIC parent training component which emphasizes parenting skills such as playing with children; helping children learn; using effective praise, incentives, and limit-setting; and handling misbehavior. Additional parent training components include an ADVANCE series which emphasizes parent interpersonal skills such as effective communication, anger management, problem-solving between adults, and ways to give and get support, and a SCHOOL series which focuses on parenting approaches designed to promote children's academic skills.

To facilitate generalization from home to the school environment, a training series for teachers providing effective classroom management skills was added to the Incredible Years Series. The last addition was the training series for children (Dina Dinosaur Curriculum), a “pull out” treatment program for small groups of children exhibiting conduct problems. This curriculum emphasizes emotional literacy, empathy and perspective taking, friendship development, anger management, interpersonal problem-solving, following school rules, and school success.

The BASIC component, which is the core program, **MUST** be implemented, and other components may be added according to the particular family and child risk factors. A brief description of the parent, teacher, and child programs is provided below.

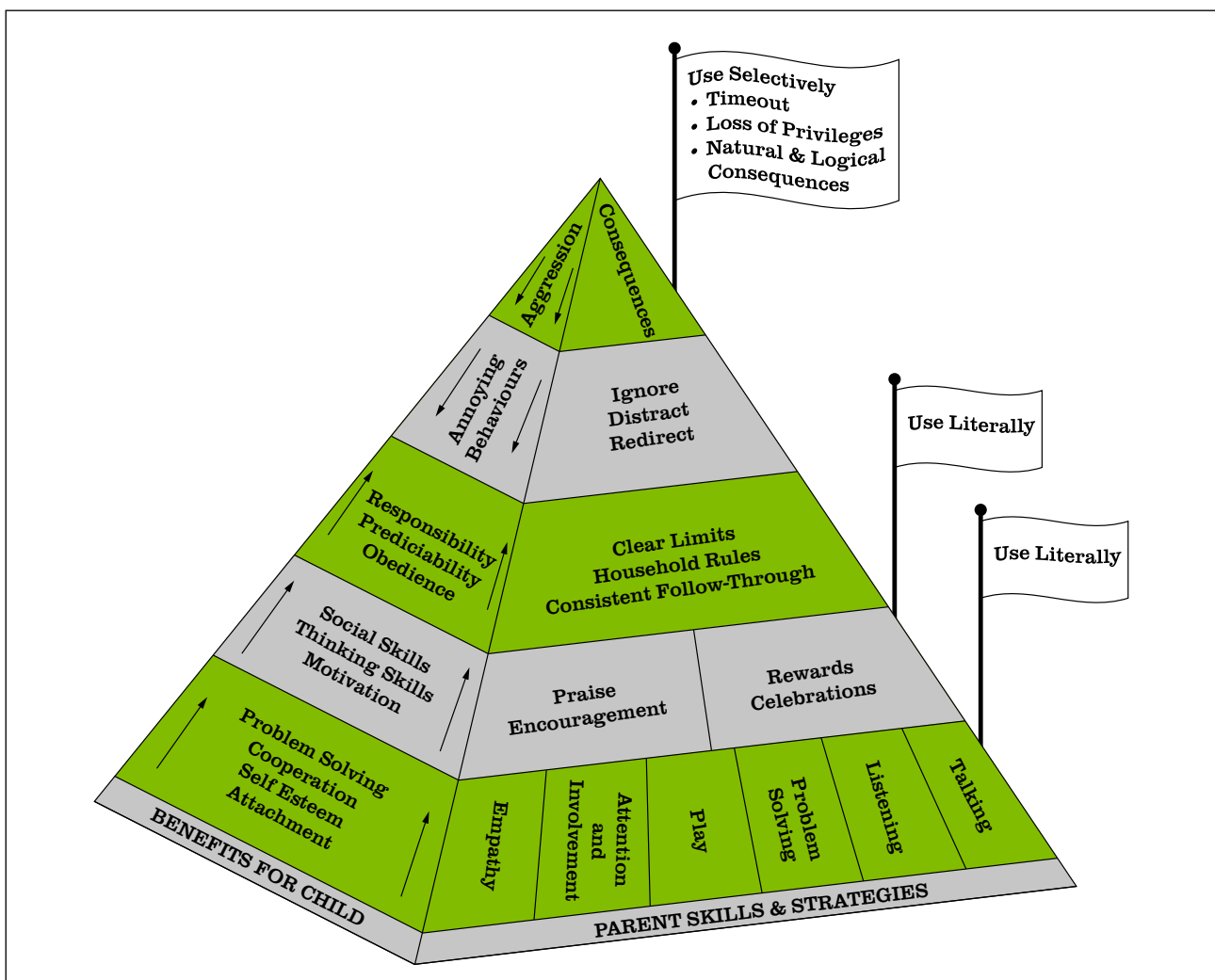
Parent Training Programs

BASIC. The BASIC parent training program is guided by the cognitive social learning and attachment relationship theories described above. It is a 12 to 14 week program for parents involving facilitator-led group discussions of 250 video vignettes. The program teaches parents child-directed interactive play, empathy, and reinforcement skills, which help parents achieve a realistic, developmentally appropriate understanding of their children and their temperaments in order to foster attachment and nurturing relationships. The latter half of the program focuses on nonviolent discipline techniques, including “Time Out” and “Ignore,” logical and natural consequences, and problem-solving strategies. Finally, the program teaches parents appropriate monitoring strategies and how to respond to children in clear, predictable ways. The school-age version of the BASIC parent training series (developed with a more culturally diverse population) is designed for use with parents of children up to age eight (grade three).

SCHOOL. The Supporting Your Child's Education (SCHOOL) program was designed to teach parents to strengthen their child's reading and academic readiness and promote strong connections between home and school by developing partnerships with teachers.

ADVANCE. The ADVANCE parent training program is also guided by cognitive social learning theory and utilizes effective aspects of marital and depression therapy (Jacobson, Schmalings, & Holtzworth-Monroe, 1987). This program is a 10 to 12 week supplement to the BASIC program and addresses other family risk factors such as depression, marital discord, poor coping skills, and lack of support. The program content includes teaching cognitive self-control strategies, problem-solving, communication skills and ways to give and get support.

Figure 1. Parenting Pyramid



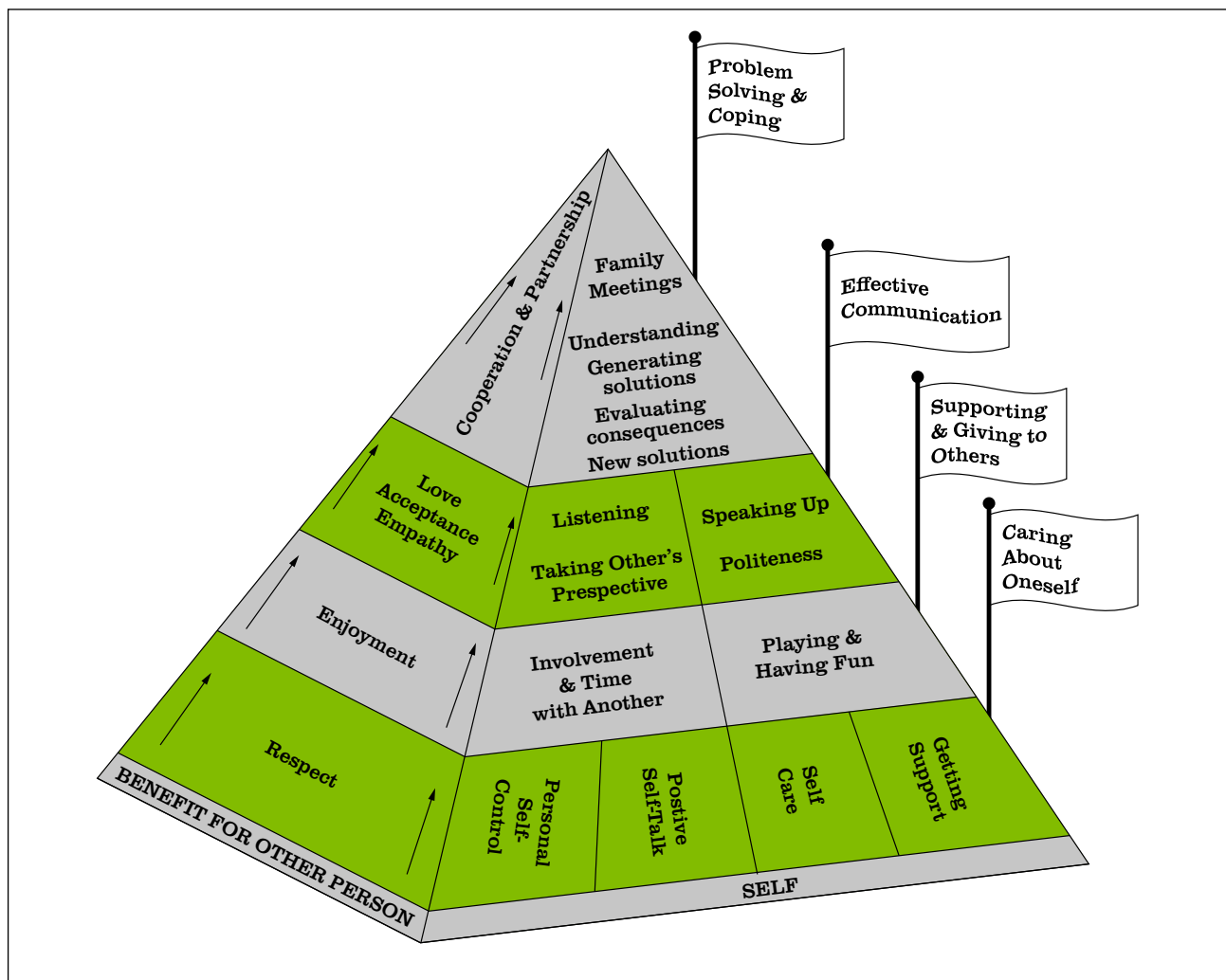
All of the training programs utilize a collaborative training process of group discussion guided by trained facilitators, and program materials include videotapes, detailed manuals for facilitators, parent books and audiotapes, and home activities and refrigerator notes.

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Teacher Training Program

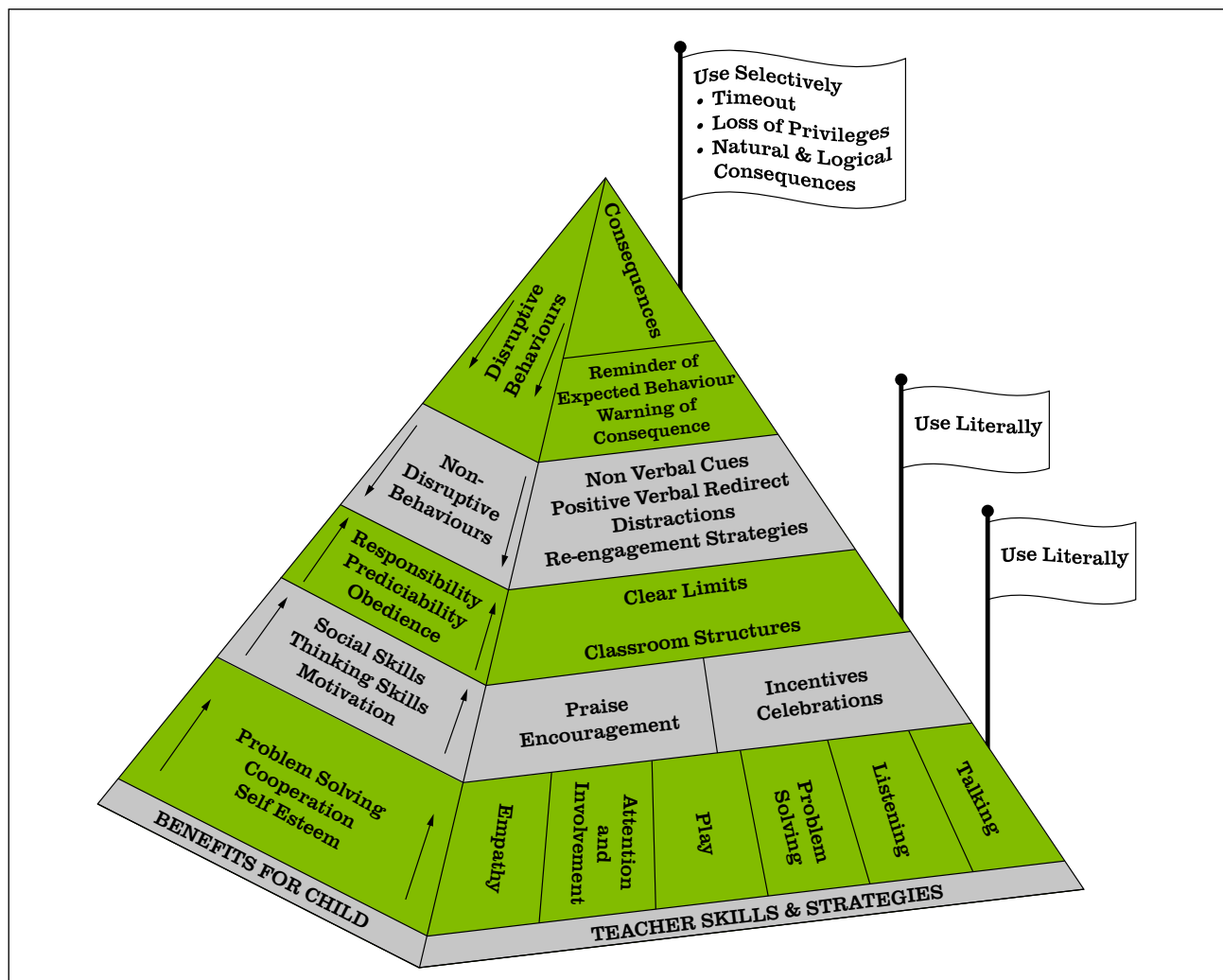
The teacher training program includes a six-day (or 42-hour) workshop for teachers, school counselors, and psychologists that involves group-based training to target effective classroom management strategies for dealing with misbehavior; promoting positive relationships with difficult students; strengthening social skills in the classroom, playground, bus, and lunchroom; and teachers' collaborative process and positive communication with parents (e. g., the importance of positive home phone calls, regular meetings with parents, home visits, and successful parent conferences). For indicated children (i. e., children with Conduct Disorder), teachers, parents, and group facilitators will jointly develop "transition plans" that detail classroom strategies that are successful with each individual child; goals achieved and remaining; characteristics, interests, and motivators for the child; and preferred methods of contacting parents. This information is passed on to the following year's teachers.

Figure 2. Pyramid for Building Relationships



Additionally, teachers learn how to prevent peer rejection by teaching the aggressive child appropriate problem-solving strategies and helping his/ her peers respond appropriately to aggression. Teachers are encouraged to be sensitive to individual developmental differences (i. e., variation in attention span and activity level) and biological deficits in children (e. g., unresponsiveness to aversive stimuli, heightened interest in novelty), as well as how to respond to these differences in positive, accepting and consistent ways. Physical aggression in unstructured settings (e. g., playground) is targeted for close monitoring, instruction and incentive programs.

Figure 3. Teaching Pyramid



Child Training Program (Dinosaur Curriculum)

Dina Dinosaur's Social Skills and Problem-Solving Curriculum was guided by child risk factor research and aims to enhance children's appropriate classroom behaviors (e. g., quiet hand up and listening to teacher), promote social skills and

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positive peer interactions (e. g., waiting, taking turns, asking to enter a group and complimenting, etc.), help children develop appropriate conflict management strategies, and reduce conduct problems. In addition, the program teaches children ways to integrate into the classroom and develop positive friendships. The curriculum is used as a “pull out” program for treating small groups of five to six children with conduct problems. These small group sessions can be offered twice a week for an hour or once a week for two hours (see “Future Directions” for how program is used as a classroom-based curriculum). Finally, the child program is organized to dovetail the parent and teacher training programs.

Summary

Each of the three types of training programs described above targets different antecedents of Conduct Disorder in the home, classroom, and school setting, as well as in the individual child and his/ her peer group. Each of the three sets of curriculums has been designed to be practical, “user friendly,” and implemented by trained facilitators including school personnel. Initially, these facilitators will receive extensive, group-based training to conduct the classroom and parent interventions. Additionally, self-administered manuals have been developed for the teacher and parent training programs so that participants can make-up missed sessions in a cost-effective manner.

Each of the three interventions includes a 500 page manual outlining content; group facilitator scripts (including questions for group discussions); homework or classroom activities; refrigerator and blackboard notes outlining key points; videos; and books for children, parents, and teachers.

Trained group facilitators use the videotaped vignettes to facilitate discussion, problem-solving, and sharing of ideas among teachers. Group facilitators help participants discuss important principles and practice new skills through role-playing and classroom assignments.

Evidence of Program Effectiveness

Incredible Years Parent Training Studies with Children Diagnosed with Oppositional Defiant Disorder and/or Conduct Disorder

Over the past 20 years, the BASIC program has been evaluated extensively as a treatment program in a series of six randomized studies with more than 800 children referred to the program for conduct problems. These studies have shown that the BASIC program results in significantly improved parental attitudes and parent-child interaction, a reduction in parents’ use of violent forms of discipline, and reduced child conduct problems. Effects have been sustained up to three years after intervention (Webster-Stratton, 1990b).

The ADVANCE program has been shown in a randomized study to be a highly effective treatment for promoting parents' use of effective problem-solving and communication skills, reducing maternal depression, and increasing children's social and problem-solving skills. These effects were obtained over and above the significant changes obtained in the BASIC program (Webster-Stratton, 1994). Later studies combining BASIC and ADVANCE replicated these findings and have shown effects lasting up to one 4year (Webster-Stratton & Hammond, 1997). Users have been highly satisfied with both programs, and the drop-out rates have been low regardless of socioeconomic status.

Incredible Years Parent Training Studies with High-risk Families

The BASIC program was also evaluated as a selective prevention program in two randomized trials with over 500 Head Start families representing a multi-ethnic (50 percent minority) population living in poverty situations. In the first study, results indicated that the parenting skills of Head Start parents who received training and the social competence of their children significantly improved compared with the control group families. This data supported the hypothesis that strengthening parenting competence and increasing the parental involvement of high-risk welfare mothers in children's school-related activities helps to prevent children's conduct problems and promote social competence (Webster-Stratton, 1998b; Webster-Stratton & Reid, 1999a). Most of these improvements were maintained one year later. The second study replicated the findings of the first study with Head Start parents and also evaluated adding a second year booster parent intervention utilizing abbreviated components of the ADVANCE and SCHOOL programs (Webster-Stratton, Reid & Hammond, in press). Two-year follow-up results of this study are currently being conducted.

These findings have been independently replicated in three other studies with families of children with conduct problems (Scott, 1999; Taylor, Schmidt, Pepler, & Hodgins, 1998; Miller, Kamboukos, Klein, & Coard, 1999) and in three prevention trials in low income child care centers with primarily African American families in Chicago (Gross, Fogg, & Tucker, 1995; Gross, Fogg, Webster-Stratton, & Grady, 1999), with Spanish-speaking Head Start families in New York (Miller & Rojas-Flores, 1999), and with a multi-ethnic group of Head Start parents in Massachusetts (Arnold et al., in progress).

Incredible Years Teacher Training Studies

The teacher training program was first evaluated in a randomized trial with 133 children diagnosed with conduct problems, and analyses compared child training and parent training with and without teacher training. Post-treatment classroom observations of teacher behavior consistently favored conditions in which teachers received training. Trained teachers were less critical and less harsh than control

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teachers. Trained teachers used more praise and were more nurturing, less inconsistent, and reported more confidence in teaching than control teachers. Results also indicated that in classrooms where teachers were trained, children were observed to be significantly less aggressive with peers and were more cooperative with teachers than children in untrained teacher classrooms. Trained teachers also reported that children had increased academic competence compared to children in control classrooms (Webster-Stratton & Reid, 1999).

Nearly identical findings emerged in a randomized trial with 272 Head Start children wherein teachers and parents received the training programs and were compared with those receiving regular Head Start services. Additionally, in classrooms where teachers received training, children were observed to have higher school readiness scores (engagement and on-task behavior) and increased pro-social behaviors, as well as significantly reduced peer aggression. Teachers' reports of parent bonding and involvement in school, as well as children's social competence, were also significantly higher for trained teachers than for untrained teachers.

These findings have been independently replicated by Arnold (in progress) in a randomized study involving eight daycare centers (12 intervention and 8 control classrooms). Results indicated that teachers in the intervention classrooms reported using more effective teaching strategies and less lax discipline than teachers in control classrooms. Moreover, intervention teachers reported fewer aggressive behaviors than did teachers in control classrooms.

Incredible Years Child Training Studies— Dina Dinosaur Curriculum

The Dina Dinosaur Curriculum for children was evaluated in two randomized trials with conduct-disordered children ages four to eight. The first of these studies showed that the 20 to 22 week child training program resulted in significant improvements in observations of peer interactions. Children who had received the Dinosaur Curriculum were significantly more positive in their social skills and conflict management strategies than children whose parents received parent training only or served as untreated controls. Results showed that the combined parent and child training was more effective than parent training alone and that both were superior to the control group. One year later, the combined parent and child intervention showed the most sustained effects.

In the second study, the effects of the 20 to 22 week child training program were replicated in terms of improved peer conflict management skills in comparison to children who only received parent training (Webster-Stratton & Reid, 1999). When child training was combined with teacher training, there were improved reductions in aggressive behavior in the classroom.

Summary of Results

The Incredible Years training programs have been shown to affect the following risk and protective factors:

Parents

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

Teachers

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

Child

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

These findings have been reflected in teacher and parent ratings, child testing and interviewing, independent observations in the home and at school, and laboratory observations of peer interactions and interactions with parents.

This information was excerpted from:

Webster-Stratton, C., Mihalic, S., Fagan, A., Arnold, D., Taylor, T., & Tingley, C. (2001). Blueprints for Violence Prevention, Book Eleven: The Incredible Years: Parent, Teacher And Child Training Series. Boulder, CO: Center for the Study and Prevention of Violence.

Descriptions of Recommended Early Intervention Programmes

TRIPLE P - POSITIVE PARENTING PROGRAM

Program Overview

The Triple P (Positive Parenting Program) is a comprehensive, community-wide system of parenting and family support. The five intervention levels were designed to enhance parental competence and prevent or alter dysfunctional parenting practices, thereby reducing an important set of family risk factors both for child maltreatment and for children's behavioral and emotional problems. At the population level, the existing workforce crossing several disciplines and settings (such as family and social support services, preschool and childcare settings, elementary schools and other community entities with direct contact with families) is trained to deliver the Triple P system of interventions. This workforce is then responsible for delivering the program to parents.

Program Targets

The community-wide version of Triple P targets parents with children younger than eight years of age, and the intervention is delivered community-wide through multiple providers.

Program Content

The multilevel system includes five intervention levels of increasing intensity and narrowing population reach:

Universal Triple P (Level 1) uses media and informational strategies that:

- destigmatize parenting and family support
- make effective parenting strategies available to all parents
- facilitate help seeking and self-regulation

Selected Triple P (Level 2) normalizes parenting interventions through:

- brief and flexible consultation with individual parents
- parenting seminars with large groups of parents

Primary Care Triple P (Level 3) manages discrete child behavior problems through:

- four brief consultations that incorporate active skills training
- selective use of parenting tip sheets on common problems of young children
- generalization enhancement strategies to apply skills to other areas

Standard and Group Triple P (Level 4) benefits indicated populations of children with detectable problems by:

- teaching parents a variety of child management skills
- combining provision of information with active skills training and support

- teaching parents to apply skills to a broad range of target behaviors in numerous settings

Enhanced Triple P (Level 5) is directed at families with additional risk factors and includes:

- optional modules on partner communication, mood management and parent coping skills
- additional practice sessions addressing parent-child issues

Program Outcomes

Compared to control counties, positive effects in the Triple P System counties were seen for rates of:

- substantiated child maltreatment
- child out-of-home placements
- hospitalizations or emergency-room visits for child maltreatment injuries

Note

Only Triple P, when implemented as a total system in a community, is being certified by Blueprints. Evaluations of individual levels of Triple P implemented alone, such as the Level 4 Standard, Group, or Self-Directed formats, have not met Blueprints criteria.

References

Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., and Lutzker, J.R. (2009). Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*, 10, 1-12.

Descriptions of Recommended Early Intervention Programmes

Parent-Child Home

The Program Model

The importance of Parent-Child interaction

All children's first years should be filled with verbal stimulation to build language and literacy skills. Each day should be full of discovery and offer opportunities to gain new skills and learn new concepts. Fostering verbal interaction between parents and their young children is a critical component of healthy and successful development (Bruner, 1964 and 1966; Vygotsky 1962). The importance of this interaction has been further validated by the brain and language development research (Hart & Risley). Formative research on The Parent-Child Home Program's 1965 pilot project (then The Mother-Child Home Program) affirmed that this critical parent-child interaction could be strengthened by modeling reading, play, and conversation for parents and children in their own homes (Levenstein and Sunley 1968).

School readiness: Bridging the preparation gap

Across the country, millions of children begin kindergarten unprepared. They are "left behind" as early as the first day of school. These children have not adequately experienced quality verbal interaction or books. They have not been exposed to play and interactive experiences that encourage problem-solving and appropriate social-emotional development. They do not have the language skills they need to successfully interact with their teachers and their classmates. They may not be able to control their behaviors or emotions as well as other students. They may have heard more discouragements than encouragements. Without the skills they need to successfully adjust to the classroom, they begin their academic careers behind their peers. Many of these children will never catch up.

The Parent-Child Home Program bridges this "preparation gap" by helping families challenged by poverty, limited education, language and literacy barriers, and other obstacles to school success prepare their children to enter school ready to be in the classroom.

The approach: Modeling vs. teaching

The Parent-Child Home Program utilizes a non-directive, non-didactic approach, modeling behaviors for parents that enhance children's development rather than teaching behaviors. Home Visitors help parents realize their role as their children's first and most important teacher, generating enthusiasm for learning and verbal interaction through the use of engaging books and stimulating toys. Parents are never given homework or assignments to complete but are encouraged to continue quality play and reading between visits with the books and toys they receive

each week. The “light touch” employed by Parent-Child Home Program Home Visitors is non-intimidating and empowers parents, allowing them to prepare their children for school success, and take pride in their commitment to, and impact on, their child’s education. Every Parent-Child Home Program local site adheres to a carefully developed and well-tested model to ensure high quality services and consistent results:

Site Structure:

- Each site is run by a Site Coordinator hired by the local partner agency and trained by The Parent-Child Home Program’s National Center.
- The Site Coordinators are then prepared to recruit and train their local Home Visitors.
- Training in multicultural awareness and the ethics of home visiting are important components of the Parent-Child Home Program’s training curriculum for Site Coordinators and Home Visitors. Respect and understanding are critical for successful home visiting relationships.
- Families participate in the two-year program when their children are two- and three-years-old, completing the Program as they turn four and transition into pre-kindergarten or Head Start. A child can, however, enter the Program as young as 16 months and some sites serve families with children up through four-years-old if there are no other pre-school services available in the community.

Home Visit Structure:

- A Home Visitor is matched with the family and visits them for half-an-hour, twice-a-week on a schedule that is convenient for the family.
- On the first visit of each week, the Home Visitor brings a carefully-selected book or educational toy, the curricular material for the week, which is a gift to the family.
- In the twice-weekly home sessions with the parent (or other primary caregiver) and the child, the Home Visitor models verbal interaction, reading, and play activities, demonstrating how to use the books and toys to build language and emergent literacy skills and promote school readiness.
- Over the course of the two years in the Program, families acquire a library of children’s books and a large collection of educational and stimulating toys.
- Each Program Year or Cycle consists of a minimum of 23 weeks of home visits or 46 home visits.

The Parent-Child Home Program model does allow for some modifications, if they do not affect the validity of the model and are approved in advance by the National Center, in order to appropriately serve families in diverse communities and a wide range of circumstances.

Descriptions of Recommended Early Intervention Programmes

Reading Recovery

Reading Recovery is a school-based, short-term intervention designed for children aged between five and six, who are the lowest literacy achievers after their first year of school. These children are often not able to read the simplest of books or even write their own name before the intervention.

The intervention involves intensive one-to-one lessons for 30 minutes a day with a trained Reading Recovery teacher, for an average of 20 weeks (about two terms). The programme is different for every child, assessing what the child knows and what he/she needs to learn next. The focus of each lesson is to comprehend messages in reading and construct messages in writing; learning how to attend to detail without losing focus on meaning.

Children complete the intervention when an independent observer judges them as able to read and write without help, within the appropriate band for their age. On average, children who have completed have gone from text level 0 to a level 17; these are books with elaborated episodes and events, extended descriptions, some literary language, full pages of print, more unusual and challenging vocabulary and less support from illustrations. Progress continues after the intervention, with children making on average one month's gain with each month that passes.

Children who do not make these gains are referred back to the school for long-term support (one in five). However they too make considerable improvements, making one year's gain in six months, and on average going from a text level 0 to a level 9; these are simple story books with some repetition of phrase patterns, ideas and vocabulary, several lines of text and around 20-40 words per page.

Reading Recovery is the foundation intervention for Every Child a Reader (ECaR).

History

Reading Recovery was founded in New Zealand by Marie Clay, based on her extensive research into early literacy difficulties

- In 1987 Marie visited Cambridge University, where she spoke of the development of Reading Recovery in New Zealand. Inspired by Marie's visit Jean Prance, an experienced primary headteacher and teacher educator, went to the University of Auckland to train as the first UK Reading Recovery tutor (now known as teacher leader)
- In 1990 the first Reading Recovery teachers were trained in Surrey, by Jean Prance and an experienced New Zealand tutor, for Surrey Education Authority

- In 1991 the Institute of Education (IOE) invited Marie to return to the UK with a small group of New Zealand colleagues to set up a tutor professional development programme. Seven tutors completed the training for local authorities in London and the South East
- In 1992 the government carried out a three year pilot funded by Grants for Education Support and Training. Marie returned to the UK for the first year to set up two parallel tutor training courses, one based at the IOE and a second in Sheffield, and 24 tutors were trained in the first year for local authorities across England. Jean Prance and Julia Douetil were trained as the first trainers for the UK
- By the mid 1990s Reading Recovery had spread across England and extended to schools in Jersey, Scotland, Wales, Northern Ireland and the Republic of Ireland
- In 1995, after the three year pilot was complete, Reading Recovery became locally funded with government support for national coordination in England
- The first tutors for Northern Ireland were trained in 1993, for Scotland in 1998, and for Ireland and Wales in 1999
- In 2003 a university professor from Copenhagen trained as a Reading Recovery trainer at the Institute of Education and began a redevelopment of Reading Recovery into Danish for implementation in Denmark
- In May 2005 Reading Recovery was included in the DEIS (Delivering Equality of Opportunity in Schools) Action Plan for the Republic of Ireland, with funding targeted to children in disadvantaged schools
- In early 2005 the European Centre for Reading Recovery worked with colleagues from KPMG Foundation to develop Every Child a Reader (ECaR) as an extension of Reading Recovery
- In September 2005 a three-year ECaR pilot, with Reading Recovery at its core, was funded by a collective of charitable organisations led by KPMG Foundation and the Department for Children, Schools and Families (DCSF)
- In 2008-11 the success of the ECaR pilot led to the programme being government funded in a three-year rollout across England

In 2011 government funding for ECaR was placed into Dedicated Schools Grant for the full three years of the 2011-14 Comprehensive Spending Review, with the intention to shift the ECaR strategy to a market-led model

Program Description

Reading Recovery® is a short-term tutoring intervention intended to serve the lowest-achieving (bottom 20%) first-grade students. The goals of Reading Recovery® are to promote literacy skills, reduce the number of first-grade students who are struggling to read, and prevent long-term reading difficulties. Reading Recovery® supplements classroom teaching with one-to-one tutoring sessions,

Descriptions of Recommended Early Intervention Programmes

generally conducted as pull-out sessions during the school day. Tutoring, which is conducted by trained Reading Recovery® teachers, takes place daily for 30 minutes over 12–20 weeks.

Research

Four studies of Reading Recovery® meet What Works Clearinghouse (WWC) evidence standards, and one study meets WWC evidence standards with reservations. The five studies included approximately 700 first-grade students in more than 46 schools across the United States.³

Based on these five studies, the WWC considers the extent of evidence for Reading Recovery® to be medium to large for alphabetics, small for fluency and comprehension, and medium to large for general reading achievement.

Effectiveness

Reading Recovery® was found to have positive effects on alphabetics and general reading achievement and potentially positive effects on fluency and comprehension.

Parent–Child Interaction Therapy (PCIT)

What is PCIT?

Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.

Parent–child interaction therapy (PCIT) is a form of psychotherapy developed by Sheila Eyberg for children ages 2–7 and their caregivers. It uses a unique combination of behavioral therapy, play therapy, and parent training to teach more effective discipline techniques and improve the parent–child relationship. PCIT evolved from Connie Hanf's two-stage operant model of parenting.

Stages of PCIT

Although PCIT is divided into two stages, relationship development (child-directed interaction) and discipline training (parent-directed interaction), there are also three distinct assessment periods (pre-treatment, mid-treatment, post-treatment).

Child-directed interaction

The child-directed interaction portion of PCIT aims to develop a loving and nurturing bond between the parent and child through a form of play therapy. Parents are taught a list of “dos” and “don'ts” to use while interacting with their child. They will use these skills during a daily play period called Special Time.

DRIP/PRIDE skills

Parents are taught an acronym of skills to use during Special Time with their children. Although the acronym varies from therapist to therapist, it is generally either “DRIP” or “PRIDE.” DRIP stands for the following:

- D – Describe
- R – Reflect
- I – Imitate
- P – Praise

Descriptions of Recommended Early Intervention Programmes

Likewise, PRIDE stands for the following:

P – Praise
R – Reflect
I – Imitate
D – Describe
E – Enthusiasm

Most PCIT therapists currently use PRIDE because DRIP is awkward and the “E” supports the value and importance of parental positive affective engagement in parent–child interactions.

These acronyms are reminders that parents should describe the actions of their child, reflect upon what their child says, imitate the play of their child, praise their child’s positive actions, and remain enthusiastic throughout Special Time.

Parent-directed interaction

The parent-directed interaction portion of PCIT aims to teach the parent more effective means of disciplining their child through a form of play therapy and behavioral therapy. It can be used with maltreated children.

Used

PCIT has been used with abusive families. PCIT has been used with oppositional children. Parent–child interaction therapy is a model that has demonstrated success with children with oppositional defiant disorder that has recently been applied to children with autism. Currently, a lot of research has been done on how PCIT can be used to keep difficult parenting populations in treatment. Research shows that skills learned in PCIT training sessions generalize to the home.

Efficacy

PCIT outcome research has demonstrated statistically and clinically significant improvements in the conduct-disordered behavior of preschool age children: After treatment, children’s behavior is within the normal range. Studies have documented the superiority of PCIT to waitlist controls and to parent group didactic training. In addition to significant changes on parent ratings and observational measures of children’s behavior problems, outcome studies have demonstrated important changes in the interactional style of the fathers and mothers in play situations with the child. Parents show increases in reflective listening, physical proximity, and prosocial verbalization, and decreases in sarcasm and criticism of the child after completion of PCIT. Outcome studies have also demonstrated significant changes on parents’ self-report measures of psychopathology, personal distress, and parenting locus of control. Measures of

consumer satisfaction in all studies have shown that parents are highly satisfied with the process and outcome of treatment at its completion.

Cost effectiveness

Parent–child interaction therapy has been found to be a cost effective approach. The way that cost effectiveness was measured was by comparing ratio of treatment costs to behavior gains, as measured by clinically significant improvement on the CBCL (reduction ranging from 17–61%).

For a summary of PCIT and information about the future research directions of PCIT see:

Zisser, A., & Eyberg, S.M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In A.E. Kazdin & J.R. Weisz (Eds.) *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 179-193). New York: Guilford.

Descriptions of Recommended Early Intervention Programmes

Fathers Reading Every Day (FRED)

Fathers Reading Every Day (FRED) is an award-winning US family literacy programme held at libraries, early years centres, nurseries, primary schools, churches etc.

Fathers receive a pack containing a reading log, tips for reading aloud and recommended book lists. During four weeks the dads document time spent reading to their children and the number of books read. Collaborating with a public library encourages fathers to sign up, familiarizes them with the library, and provides access to free books to use in the programme, as well as books in languages other than English.

More than 7,000 fathers have participated so far and statistically significant increases pre/post intervention include time spent reading to children, number of books read, level of involvement in children's education, amount and quality of time spent with children, and level of satisfaction with the father-child relationship. The percentage of fathers reading to their children three or more times per week increased from 53% to 80%.

Over 6,000 fathers and children from 77 Texas Counties have participated in the FRED program since 2002. Outcomes from the program are very positive. Participants who completed the program averaged approximately 9 hours of reading time with their children and read nearly 40 books over the course of the four-week program.

Results from a recent evaluation study of 300 participants demonstrated significant improvements in many areas, including the amount of time fathers spent reading to their children, number of books read during a typical week, level of involvement in their children's education, amount and quality of time spent with their children, and level of satisfaction with the father-child relationship. There was also a significant increase from pre to post in the number of fathers obtaining a library card. Other significant findings from FRED participants include:

- 61.4% reported that FRED "Increased the time I spent with my child."
- 58.7% reported that FRED "Improved the quality of the time I spend with my child."
- 57.2% reported that FRED "Helped me become more involved in my child's education."
- 66.2% reported that FRED "Increased my satisfaction level as a parent."
- 70.3% reported that FRED "Improved my relationship with my child."

In open-ended responses, many fathers indicated that they noted improvements in their child's vocabulary, reading ability, and interest in books as a result of participating in FRED. Some fathers even noticed improvements in their own literacy skills.

Descriptions of Recommended Early Intervention Programmes

Time to Read

Time to Read is a paired reading programme engaging business volunteers on a one-to-one basis with Key Stage two children to develop them socially and emotionally as well as enhancing their literacy skills. The programme was established in 1999 and was initially championed by Northern Ireland Electricity. the programme was evaluated by Queens University using a random control group demonstrating its effectiveness.

Time to Read is one of three Time to...programmes developed by Business in the Community, in partnership with the local Education and Library Boards, to help improve literacy, numeracy and computing skills in local primary schools. The other programmes are: Time 2 Count and Time to Compute, the 'Time to' Companies support their staff to volunteer an hour per week to work alongside Key Stage Two children (eight – ten year olds).

Currently 48 of Northern Ireland's leading companies participate on the 'Time to' programmes working in 63 schools across Northern Ireland, including Old Warren and Killowen Primary Schools.

Suggested benefits to the company include:

- develops staff confidence
- self-esteem and communication skills
- motivates staff and enhances teamwork
- raises profile in the local community
- builds partnerships with local schools

Suggested benefits to the schools include:

- provides an insight into the business world
- motivates and develops children academically and socially
- introduces children to a positive role model from the world of work
- enables children to work on a one-to-one basis improving communication skills

Time 2 Count (not yet robustly evaluated) also focuses on children in Primary 5 – Primary 7. The aim of this programme is to motivate children to enjoy maths and to recognise it as an everyday activity. Volunteers play math based games with the children to consolidate maths learning in the classroom. Northern Bank lead this numeracy programme.

Time to Compute (not yet robustly evaluated) has been developed to help bridge the digital divide in local primary schools. Business volunteers work on a one-to-one programme with children aged 8-10 helping them to become literate in Information

and Communications Technology (ICT). HP have supported the Time to Compute programme from its launch.

The Commitment

Companies involved agree to release staff for one hour a week to volunteer in a local school. Initial commitment is for one year with the option of extending and many of our volunteers are now in their fifth and sixth year. Companies involved in Time to Read and Time to Count also agree to contribute financially to help provide resources for the school (either books or maths materials).

Early Intervention Sites in the UK and Ireland

Nottingham

youngballymun

West Tallaght CDI

Nottingham Early Intervention

The Early Intervention Projects

A number of innovative delivery projects have been trialled as part of the broader Early Intervention Programme. The projects included new work and learning from existing work, and have focused on tackling intergenerational cycles of deprivation and complex problems within Nottingham, driving the Programme's vision.

The projects were developed by the six Theme Partnerships of One Nottingham, requiring joined-up working to tackle cross-cutting issues.

- Crime and Drugs Partnership
 - DrugAware Award
 - Stronger Families Project
 - Adult Offending Team Family Intervention Project
- Children's Partnership
 - Developing Natural Learning
 - Raising Aspirations
 - Using Customer Insight to Enable Effective Engagement
 - Putting Families at the Centre
 - 11-16 Life Skills
 - iRise
 - Family Welfare - Reducing Persistent Absence
- Health and Wellbeing Partnership
 - Family Nurse Partnership
 - Active Families
- Neighbourhood Partnership
 - Sanctuary Initiative

These projects concluded in March 2011, with learning from the most successful elements either being sustained through mainstream systems or being further developed and tested. This will enable the development of more robust evidence of the impact of these models.

Elements of the following projects are continuing:

- Stronger Families Project
- Raising Aspirations
- 11-16 Life Skills

Early Intervention Sites in the UK and Ireland

- DrugAware Award
- Family Nurse Partnership
- The broader Family Intervention Project
- Active Families
- Sanctuary Initiative

More information will be available soon on these approaches going forward.

CRIME AND DRUGS PARTNERSHIP

DRUGAWARE AWARD

Setting a robust standard of excellence in drugs education and policy within schools and the community. Providing an identifiable brand that can be used to drive forward the standard of drugs and alcohol education in Nottingham City to:

- Encourage schools to reach above and beyond the Healthy Schools standard
- Raise the profile of drugs education for pupils, parents and the community
- Ensure effective screening of drug use and risks of drug use
- Ensure effective targeted interventions for those pupils assessed as 'at risk' through improved referral pathways to specialist services and through embedding targeted interventions within a school setting with appropriately trained staff
- Help parents to be more fully engaged (in both policy setting and drugs education)
- Increase partnership working with the school community, Neighbourhood Beat Team and Trading Standards
- Involve pupils in the City-wide drugs education policy setting
- Increase the skill base of key staff within schools

STRONGER FAMILIES PROJECT

Stronger Families, delivered by Women's Aid, offers a 12-week programme of focused group therapeutic sessions for mothers and children (aged 4-16) who have been affected by domestic abuse, once the perpetrator has now left the family home.

Mothers and children partake in separate group sessions which run concurrently. The sessions provide both mother and child with a safe space and the opportunity to disclose, process and understand the abuse that they have experienced or witnessed. Mothers are supported to better understand their child's behaviour, relating to the abuse.

The project aims to stop the intergenerational impact of domestic abuse by supporting families to recover from the abuse and decrease the likelihood of repeat incidents.

From August 2009 to December 2010, there have been two domestic violence related repeat incidents within the first 26 families (7.7%) who have completed the programme; significantly lower than the national domestic violence repeat incident rate of 44%.

Schools have reported improvements in the behaviour, confidence and interactions of young people in the programme. There has been increased school attendance of children where this had previously been a problem.

ADULT OFFENDING TEAM FAMILY INTERVENTION PROJECT

Reducing the risk of offending and entry into the criminal justice system by children in the families of adult offenders, particularly persistent and prolific offenders. The project provides stability of accommodation, support to reduce substance misuse, help to obtain training and employment for relevant family members and to increase the academic success of children in the family.

The project works holistically and intensively with the families of adult offenders who are either themselves parents or are older siblings living within or impacting upon an existing family unit in order to break the cycle of intergenerational offending and reduce the criminal influence that adult offenders have upon the children with whom they have contact. Intensive support of at least six months is provided to the families using, where appropriate, a 'coercive' model of engagement.

Children's Partnership

DEVELOPING NATURAL LEARNING

Trialling the Forest Schools approach with six schools in the City, encouraging children to explore their local environment and develop reasoning skills, analyse risks and predict the consequences of their actions. The seven-week outdoor learning programme promotes team work, listening skills, risk taking, tool use, safety awareness, cooperation and independence.

The activities create opportunities for emotional, social and behavioural development, improving outcomes through improving behaviour and higher level thinking skills. The project aims to embed the learning in schools and provide opportunities for staff within the school to share learning and best practice with other schools and colleagues.

Early Intervention Sites in the UK and Ireland

Children have reported that the project increased their confidence, social skills and their ability to make better decisions and has helped them to learn which risks are wise to take. Parents and teachers have also given positive feedback and there have been no exclusions in these groups since the project started.

RAISING ASPIRATIONS

Developing and trialling an aspirations-raising toolkit, which includes a unique aspirations assessment tool, a package of interventions designed to raise aspiration and a process for developing an aspirations focus. Aspiration Development Officers are delivering interventions in schools and researching and planning future interventions.

The assessment tool is the first primary-age appropriate, aspiration assessment tool nationally. It allows schools to take an early intervention approach to underachievement and negative behaviours. Children can now be identified as being 'at risk' of making negative decisions as a result of low levels of aspiration. Previously there has been no assessment mechanism.

Early indicators of impact from the interventions being trialled are already being reported by teachers, including significant improvements in the confidence, attitude, behaviour and engagement of pupils in the cohort who had been identified as having very low levels of confidence and aspiration at the start of the project.

The project is also showing positive impact on attendance and attainment of those pupils involved in the project. Two schools have already reported that the cohort receiving aspiration-raising support, performed well above expectation in their SATs, with two other schools reporting results 10% higher than predictions and in one school a number of individual pupils have made up 13 sub-levels of progress, compared to the predicted six.

It is planned that the toolkit will be used across the wider Children's Workforce.

USING CUSTOMER INSIGHT TO ENABLE EFFECTIVE ENGAGEMENT WITH CHILDREN AND THEIR PARENTS

Research has been undertaken using Experian's Customer Insight database, which provides the understanding of need within Nottingham City that is required to deliver the right services to the right children, young people and families, through the right facility at the right time. The information is being used to reengineer services so that service provision meets need through:

- Understanding levels of need for services within each locality

- Understanding the children and families who use and need services, with services being delivered in the most appropriate, accessible and effective way
- Communication with the target groups being undertaken in the most effective way

Effectively understanding need within localities will enable comparison of service provision, service uptake and need and therefore identification of efficiency of services. This will enable the targeting of work at individuals or families who are very likely to have difficulties or impaired outcomes without effective support or intervention.

Further detail on customer insight can be found at <http://www.nottinghaminsight.org.uk/>

PUTTING FAMILIES AT THE CENTRE (PART OF THE COLLABORATION FOR LEADERSHIP IN APPLIED HEALTH RESEARCH AND CARE, NOTTINGHAMSHIRE, DERBYSHIRE AND LINCOLNSHIRE STRAND [CLAHRC NDL])

A national NHS and University of Nottingham collaboration. Nottingham is a partner in the NDL strand of the CLAHRC. The focus of the project is translating current academic research around mental health services and children and young people into working practice through two 'Diffusion Fellows', acting as change agents across the City. The work is exploring the impact of uncovering parental mental health needs in order to better meet the needs of the child and is looking into the organisational barriers to a joined-up model of adult and child mental health provision in the City. Proposals to trial a joined-up, family focused model are being developed.

11-16 LIFE SKILLS

The 11-16 Life Skills curriculum programme is designed to support the development of the skills and knowledge needed for young people to make the best life decisions, increase confidence levels and raise aspirations.

There are currently just under 3000 young people accessing the programme within six settings. A training programme and toolkit for schools to deliver the programme is being developed, with the aim of rolling it out to all secondary settings in the City early in 2011.

The toolkit will include a number of Planning Framework models and the new SEAC (Social Emotional Aspects of Change) resource materials, which is based on SEAL (Social Emotional aspects of Learning, used in all primary schools) focusing on changing negative behaviours.

Early Intervention Sites in the UK and Ireland

The National Foundation for Educational Research (NFER) have conducted an independent evaluation of the project; the initial consultation and design process, which involved 550 students and 218 staff, was cited as excellent practice. The consultation found that students feel that there is a need for more coverage of mental health issues, financial capability, sexual relationships, parenting and democracy.

So far, the following improved outcomes for children and young people have been demonstrated;

- Improved confidence to discuss sensitive topics with teachers and formulate and express opinions
- Improved skill development, knowledge and understanding of topic areas
- Students reported that they felt better informed and equipped to make decisions about sex and relationships and risk awareness
- Students have improved awareness of how to seek help, for example, how to access support from the school nurse about contraception and STIs.

Staff have also reported an increased confidence in teaching sensitive topics.

IRISE

iRise works with a group of children and young people in Key Stages 2-4 (ages 8-16) in Nottingham City schools, who are in the care of the Local Authority. The project aims is to increase the young people's attainment and aspiration and develop their social and emotional resilience. This will be achieved through individual learning support, motivational personal development programmes focusing on goal setting and self esteem and aspiration-raising events to inform young people about post-16 educational opportunities.

A positive psychology development programme has been delivered to a number of young people in the care of the Local Authority. Participants have reported that the course is useful for a number of areas of their life; mostly 'taking care of myself', 'taking an active part in Further Education (FE)' and personal goal setting - 94% say that they would recommend it.

Partnerships have been developed with Aiming Higher, New College Nottingham and Nottingham City Council Sport and Leisure Services to deliver aspiration-raising educational opportunities awareness events. All young people involved in the project have reported that these events have made them aware of the opportunities available to them and that they are now planning to access post-16 education.

FAMILY WELFARE - REDUCING PERSISTENT ABSENCE

Improving the use of resources to tackle the causes of absence in schools. The project focuses on the early stage in the cycle of absence, particularly in primary schools and Years Seven and Eight of secondary schools, as well as focusing on families with young children who have poor attending older siblings, in order to break the intergenerational cycle of non-attendance.

A significant decrease in persistent absence has been demonstrated. Across the six schools specifically targeted by the Department for Education, between September 2009 and March 2010, there was a decrease of 133 cases of persistent absence; a reduction of 26%. Summer term 2009 statistics show a reduction of 23.5% across all Secondary schools and Academies, and 44.9% across Primary schools.

Indicators also show that persistent absence is tackled and resolved more quickly with the use of the Lead Professional budget, as the amount of children or young people who are persistently absent for more than one term has shown a decreasing trend since the start of the project, from 46% in Autumn 2008/09 to 23% in Autumn 2009/10.

HEALTH AND WELLBEING PARTNERSHIP FAMILY NURSE PARTNERSHIP

Providing support to first-time pregnant teenagers and their partner, in order to positively impact on their parenting skills and outcomes for them and their child.

The programme has demonstrated improved mental health and parenting skills, increased breast feeding and immunisation take-up rates and reduced smoking rates.

Anecdotal evidence indicates that issues are identified at an earlier stage and therefore Social Care support is more effective.

Nottingham is part of an international trial of a model for delivery to groups (currently one-to-one) and is looking into the cost and impact of this.

The project received additional funding to explore engagement of fathers in their child's life. Findings are now ready for dissemination, with key messages including that some men do not engage with the service because they believe it to be just for mothers; however the depth of the relationship the nurse develops with the father is crucial in achieving successful outcomes for the child.

Early Intervention Sites in the UK and Ireland

ACTIVE FAMILIES

Increasing opportunities for families to engage in physical activity, regularly together. Aiming to halt the rise in obesity and reduce health inequalities and cardiovascular disease. A variety of physical activity and sport sessions are provided each week at a selection of leisure centres across the City.

310 families (1073 individuals) have engaged in the project since the launch in May 2009. 12% of these families have already started to show continued engagement (5 sessions or more attended). 63% of those engaged are from areas with low levels of physical activity and high levels of child obesity and deprivation.

The project also acts as a unique referral pathway for childhood obesity between the ages of two and four, and also a pathway from the Go4It! project.

NEIGHBOURHOOD PARTNERSHIP THE SANCTUARY INITIATIVE

Providing additional security to the homes of survivors of domestic abuse, once the perpetrator has been removed, and a package of floating support, including home visits, for up to six months. The project enables families to stay in their own home and social network and the children to stay in their current school.

Evidence of impact is demonstrated by the reduced rate of repeat domestic violence incidents within the cohort (30%), much lower than the national repeat incident rate of domestic violence (44%). There has also been a reduced prevalence of homelessness applications due to domestic violence (Nottingham City Housing Aid) - this has gone from being the third most prevalent reason in 2006/07 to the fifth in 2008/09.

youngballymun

youngballymun is one of three projects established through the Prevention and Early Intervention Programme, jointly supported and resourced by the Office of the Minister for Children and Youth Affairs in the Republic of Ireland and the Atlantic Philanthropies.

The Prevention and Early Intervention Programme for Children was established by Government in February 2006 to support and promote better outcomes for children in areas designated as disadvantaged, through more innovation, effective planning, integration and delivery of services.

The Programme targets three geographic areas in which there is evidence of the need for early intervention - Ballymun, Tallaght West and Darndale. The purpose of the programme is to support the development, implementation and evaluation of strategies for children at local level drawn up by the statutory, voluntary and community agencies operating in the areas concerned. The Programme provides for the introduction and evaluation of a range of integrated interventions for children and their families and test if they make a positive difference to children.

The focus of the programme is on supporting interventions which fit with national policy objectives and have been developed in conjunction with the local community. Learning and evaluation are important components of the programme and individual services, area projects and the overall programme will be subject to ongoing and robust review and evaluation.

The OMCYA has partnered with the Atlantic Philanthropies in funding this programme and a total fund of up to €36,000,000 is available across the three projects. Government and the Atlantic Philanthropies will provide €18 million each in funding.

youngballymun, the Childhood Development Initiative, Tallaght and Preparing for Life Northside Partnership together are the projects that make up the Prevention and Early Intervention Programme. Research and planning on prevention and early intervention measures sponsored by Atlantic Philanthropies, had been undertaken in these areas and they were considered to be in an excellent position to test new models of service delivery. If these models prove successful, the results of these projects may provide the basis for enhanced resource allocation processes and policy changes.

Early Intervention Sites in the UK and Ireland

The overall programme is being managed by the Office of the Minister for Children and Youth Affairs on behalf of the Government. Approval has been given to fund all three projects 2007-2011/12.

West Tallaght Child Development Initiative

Introduction

The Childhood Development Initiative (CDI) began as a planning initiative in 2003 to support better outcomes for children in Tallaght West. A consortium of 23 members representing community leaders, residents and professionals living and working in Tallaght West developed the outcomes-focused 10-year strategy 'A Place for Children'. Based on this long-term strategy, a detailed implementation was agreed for 2007-2011, against which a major investment of €15 million euro was made, co-funded by the Department of Children and Youth Affairs, through the Prevention and Early Intervention Fund, and The Atlantic Philanthropies.

Mission

The mission of West Tallaght CDI is "We who live and work in Tallaght West have high expectations for all children living in our communities. We want our children to love who they are and to be cherished irrespective of social background, cultural differences and country of origin. We see every child and every family being provided with support, opportunities and choices to meet these expectations. We see the whole community owning responsibility for the quality, beauty and safety of the local environment. We see children encouraged and cherished by the whole community."

Quality Services, Better Outcomes Workbook

The CDI have recently published 'Quality Services, Better Outcomes' which provides a practical resource for frontline staff, service managers and organisations that are currently implementing or intend to implement, evidence-based programmes and services for children and/or their families, drawing on research examples of best practice.

The CDI Programmes

- Early Years Service
- Doodle Den Programme
- Mate -Tricks Programme (has now been stopped following poor evaluation results)
- Healthy Schools Programme
- Community Safety Initiative
- Quality Enhancement Programme
- Safe and Healthy Place

- Restorative Practice
- Restorative Practice Schedule 2011
- Community Coaching Programme

Their five main programmes are subject to RCT evaluations and should be available shortly.

Governance

The West Tallaght CDI governance structures include the following:

- CDI Board
- CDI Implementation Support Group
- Expert Advisory Committee
- Finance and Risk Sub Committee
- Executive Sub Committee
- Community Safety Initiative Steering Committee
- Healthy Schools Steering Committee
- Safe and Healthy Place Steering Committee
- Restorative Practice Management Committee









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