NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

Social and emotional wellbeing: early years

Introduction: scope and purpose of this draft guidance

What is this guidance about?

This guidance aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be effectively supported through home visiting, childcare and early education. The recommendations cover:

- strategy, commissioning and review
- identifying vulnerable children and assessing their needs
- pre- and postnatal home visiting for vulnerable children and their families
- early education and childcare
- managing services
- delivering services.

This guidance does not cover the clinical treatment of emotional and behavioural difficulties or mental health conditions, or the role of child protection services. (For related NICE guidance, see section 7.)

Who is this guidance for?

The guidance is for all those responsible for ensuring the social and emotional wellbeing of children aged under 5 years. This includes those planning and commissioning children's services in local authorities (including education), the NHS, and the community, voluntary and private sectors. It also includes: midwives, health visitors, GPs, paediatricians, practitioners working in child and adolescent mental health services, social workers, teachers, staff in children’s centres, nursery nurses and child minders.

The guidance may also be of interest to parents, other family members and the general public.

Why is this guidance being produced?

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce this guidance.

The guidance should be implemented alongside other guidance and regulations (for more details see sections 4 and 7 on implementation and related NICE guidance respectively).

How was this guidance developed?

The recommendations are based on the best available evidence. They were developed by the Public Health Interventions Advisory Committee (PHIAC). Members of PHIAC are listed in appendix A.

The guidance was developed using the NICE public health intervention process. See appendix B for details.

Supporting documents used to prepare this document are listed in appendix E.

What evidence is the guidance based on?

The evidence that PHIAC considered included: two reviews of the evidence on effectiveness, a review of risk factors, economic modelling, the testimony of expert witnesses and commissioned reports. Further detail on the evidence is given in the considerations section (section 3) and appendices B and C.

In some cases, the evidence was insufficient and PHIAC has made recommendations for future research.

More details of the evidence on which the guidance is based, and NICE's process for developing public health guidance, are on the NICE website.

Status of this guidance

This is **draft** guidance.

This document does not include all sections that will appear in the final guidance. NICE is now inviting comments from stakeholders (listed on our website).

Note that this document is not NICE's formal guidance on social and emotional wellbeing in early years. The recommendations made in section 1 are provisional and may change after consultation with stakeholders and fieldwork.

The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Committee will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Committee will produce a second draft of the guidance.
- The draft guidance will be signed off by the NICE Guidance Executive.

For further details, see 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)'.

The key dates are:

Closing date for comments: 15 June 2012.

Next PHIAC meeting: 20 July 2012.

Contents

1 Draft recommendations

The Public Health Interventions Advisory Committee (PHIAC) considers that the recommended interventions are cost effective.

The evidence statements underpinning the recommendations are listed in appendix C. For the gaps in research, see appendix D.

The evidence reviews, supporting evidence statements and economic modelling report are available at the NICE website.

Background

The recommendations cover home visiting, early education and childcare and They:

- Adopt a 'life course perspective', recognising that disadvantage in a child's early years can have a life-long, negative effect on their health and wellbeing.
- Focus on supporting the social and emotional wellbeing of vulnerable children as the foundation for their healthy development and to offset the risks relating to disadvantage.
- Are based on the principle of 'progressive universalism'[1]. The aim is to ensure universal services (including maternity, child health, social care, education and family welfare services) support all vulnerable children and that they receive more intensive help to meet their additional needs
- Aim to meet the broader goal of children's services, that is, to ensure all children have the best start in life.
- Support a broad range of universal and targeted services designed to ensure children's physical, as well as their mental health and wellbeing.

[1] Marmot Review Team (2010) Fair society, healthy lives. London: The Marmot Review

The recommendations should be used in conjunction with local child protection and other procedures to safeguard children.

Definitions

Social and emotional wellbeing

Social and emotional wellbeing provides the building block for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental illness. For the purposes of this guidance, the following definitions are used:

- emotional wellbeing – this includes being happy and confident and not being anxious or depressed
- psychological wellbeing – this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive
- social wellbeing – has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully.

Vulnerable children

The term vulnerable is used to describe children who are at risk of, or who are already experiencing, social and emotional problems. Vulnerability may be linked to disadvantage and poverty.

Vulnerable children include those who are exposed to:

- parental drug and alcohol problems
- parental mental health problems
- family relationship problems, including domestic violence
- criminality.

Vulnerable children may also include those who are in a single parent family or who were born to mothers:

- aged under 18

- with a low educational attainment
- who are (or were as children) looked after (that is, they have been in the care system).

Mother (or primary carer)

The family unit can take many different forms. In this guidance, most references made to the mother could be applied to anyone who is the child's primary carer. This includes the father, other family members or a non-family member who is the primary carer (including a foster parent).

Whose health will benefit?

Vulnerable children aged under 5 years and their parents.

Recommendation 1 Strategy, commissioning and review

Who should take action?

All those responsible for planning and commissioning (including joint commissioning) services for children aged under 5 in local authorities and the NHS. This includes:

- Health and wellbeing boards.
- Public health, education and social services within local authorities.
- Those working in the voluntary, independent and private sectors.

What action should they take?

- Health and wellbeing boards should ensure the social and emotional wellbeing of vulnerable children features in the 'Health and wellbeing strategy', as one of the most effective ways of addressing health inequalities. The resulting plan should include outcomes for ensuring healthy child development and 'readiness for school' and for preventing mental health and behavioural problems[2].

[2] See the 'Public health outcomes framework' indicators for early years.

- Directors of public health and directors of children's services should assess the social and emotional needs of children under 5, including vulnerable children (and their families), as part of the strategic needs assessment. Population-based models (such as PREview[3]) should be considered as a way of determining need and ensuring resources and services are effectively distributed.

- Health and wellbeing boards should ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. The aim is to ensure:
    - Vulnerable children at risk of developing (or who are already showing signs of) social and emotional difficulties and behavioural problems are identified as early as possible by children and family services. These include general practice, maternity services, health visiting, the Healthy Child Programme, children's centres and related networks, nurseries and child minders.
    - Targeted, evidence-based (and structured) interventions are available to help vulnerable children and their families. These should be monitored against outcomes.
    - Children and families with multiple needs have access to specialist services, including child protection and mental health services. Also see NICE guidance on when to suspect child maltreatment; antenatal and postnatal mental health; conduct disorder in children – parent-training/education programmes; depression in children and young people; attention deficit hyperactivity disorder (ADHD) and looked-after children and young people.

- Local authority scrutiny committees for health and wellbeing should review delivery of plans and programmes designed to improve the social and emotional wellbeing of vulnerable children aged under 5.

[3] PREview is a set of planning resources to help ensure resources, particularly those provided by the Healthy Child Programme, are targeted at those most in need.

Recommendation 2 Identifying vulnerable children and assessing their needs

Who should take action?

All those involved in providing services for children and families including those working in:

- Maternity services.
- Health visiting.
- The Healthy Child Programme.
- Early years organisations, including children's centres, nurseries and primary schools (independent, maintained, private, and voluntary).
- Voluntary sector organisations.
- General practice.
- Paediatrics.
- Child protection services.
- Local authority housing departments.
- Police.
- Child and adolescent mental health services.

What action should they take?

- All health and early years professionals should develop trusting relationships with vulnerable families and adopt a non-judgmental approach. They should do this by:
    - identifying the strengths and capabilities of the family, as well as factors that pose a risk to the social and emotional wellbeing of the child

  - talking about the aspirations and expectations for the child
  - seeking to understand and respond to perceived needs and concerns
  - discussing any risk factors in a sensitive manner to ensure families do not feel criticised, judged or stigmatised.

- Health professionals in antenatal and postnatal services should identify factors that may pose a risk to the child's social and emotional wellbeing. This includes any risks to the mother's social and emotional wellbeing which could impact on her capacity to provide a loving and nurturing environment. For example, discuss any problems she may have in relation to:
  - her mental health
  - substance or alcohol misuse
  - family relationships, circumstances and networks of support.

- Health visitors, nursery staff and other early years professionals should identify any risk factors that were not evident at the antenatal stage, as part of an ongoing assessment of the child's development. For an infant or child, factors could include being withdrawn, unresponsive or showing signs of behavioural problems. For parents, this could include indifference to the child or insensitive or harsh behaviour towards them.

- Others who are in contact with a vulnerable child and their family (such as family welfare, housing, voluntary services or the police) should be aware of factors that pose a risk to the child's social and emotional wellbeing. They should raise any concerns with the local GP or health visitor (working in the context of local safeguarding policies).

- Health and early years professionals should ensure procedures are in place:
  - to collect, consistently record and share information as part of the common assessment framework (relevant child and adult datasets should be linked)

- for integrated team working
- for continuity of care
- to avoid multiple assessments.

Recommendation 3 Pre- and postnatal home visiting for vulnerable children and their families

Who should take action?

- Maternity services.
- Health visiting.
- The Healthy Child Programme.
- Children's centres and related early years services.

What action should they take?

- Health visitors or midwives should offer a programme of home visits by specially trained professionals to women assessed to be in need of additional support (see recommendation 2). For example, they could refer first-time teenage mothers to the Family Nurse Partnership from early pregnancy onwards. They should also offer to provide similar intensive support themselves to other vulnerable women, such as young mothers-to-be presenting late in pregnancy and postnataly to those experiencing domestic violence and abuse.
- Health visitors or midwives should provide information about the programme of home visits, including its purpose and benefits. The information should take into account the mother's first language and differing attitudes, expectations and approaches to parenting (for example, according to their ethnic or religious background).
- Health visitors or midwives should ensure the programme is agreed with the mother or mother-to-be. They should encourage them to participate, taking into account their priorities and commitments. They should also try to

involve fathers and other family members, if appropriate and acceptable to the mother.

- Health visitors or midwives should ensure the programme comprises a defined number of visits over a sustained period of time. It should be based on a set curriculum of activities which aim to achieve specified goals in relation to:
    - maternal sensitivity (how sensitive the mother is to her child's needs)
    - the parent-child relationship
    - home learning
    - parenting skills and practice.

- Health visitors or midwives should consider using interactive video guidance to improve maternal sensitivity, mother-infant attachment and the child's behaviour. (For example, this might be necessary when the mother has depression or the infant shows signs of behaviourial difficulties.)

- Health visitors or midwives should regularly check the mother's level of involvement and offer her a break from the programme, if necessary. In such cases, they should continue to communicate regularly with her. Encourage parents participation in other services provided by the Healthy Child Programme and children's centres.

- Health visitors or midwives should involve other professionals such as therapists and family support workers from the Healthy Child Programme and children's centres.

- Those managing and providing the intensive home visiting programme should conduct regular audits to ensure consistency and quality of delivery.

- Volunteers should only provide help with home visits in conjunction with a health or early years professional. Volunteers should be trained for this role, which should be for a specific purpose and carried out according to an

agreed plan. Volunteers should be given support sessions on a regular basis.

Recommendation 4 Early education and childcare

Who should take action?

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

What action should they take?

- Ensure all children have the opportunity to attend high quality childcare[4] and early education services outside the home on a part- or full-time basis. Attendance times should be flexible so that parents or carers (including those from vulnerable families) have the opportunity to take on paid employment.
- All those involved in providing early education and childcare services should encourage a broad social mix of children to attend high quality childcare services. They should address any barriers that may hinder participation by vulnerable children, such as geographical access, the cost of transport or a sense of discrimination and stigma.
- Those involved in early education services should ensure vulnerable children have the opportunity to attend high quality preschool education (from the age of 2 years) to enhance their social and emotional wellbeing and build their capacity to learn.

[4] As indicated by Ofsted inspection criteria. See consultation document Proposals for a revised framework for the registration, inspection and enforcement of registered early years provision [online].

- Ensure childcare and early education services are run by well-trained qualified staff, including graduate staff and qualified teachers. Services should be based on an ethos of openness and inclusion. They should promote the development of positive, interactive relationships between staff and children, whereby individual staff get to know, and develop an understanding of, a particular child's needs (that is, they provide continuity of care, particularly for younger children).

- Ensure staff in childcare and early education services focus on social and emotional, as well as educational development. They should provide a structured daily schedule offering a range of opportunities for independent group and adult-led learning.

- Ensure parents and other family members are fully involved in early education and childcare services. For example, parents should be encouraged to get involved in making decisions about how the services are provided, or to participate in learning or other activities, as appropriate.

- Ensure the environment is spacious, well maintained and pleasant, offering appropriate facilities for educational and other activities.

Recommendation 5 Managing services

Who should take action?

- Maternity services.

- Health visiting.

- The Healthy Child Programme.

- Early years services, including children's centres, nurseries and primary schools (maintained, private, independent and voluntary).

- General practice.

- Paediatrics.

- Child protection services.
- Child and adolescent mental health services.
- Training organisations involved with professionals who work with young children.

What action should they take?

- Managers of early years services should ensure local systems are in place to secure the social and emotional wellbeing of vulnerable children aged under 5. This involves developing and agreeing pathways and referral routes that define how professionals will work together as a multidisciplinary team across different services to:
  - identify children at risk of developing (or already showing signs of) social and emotional difficulties and behavioural problems as early as possible
  - involve parents in determining the additional help and support they need to promote a child's social and emotional wellbeing
  - provide an integrated set of universal and targeted services and programmes.
- Managers of early years services (including children's centres) should ensure improving the social and emotional wellbeing of vulnerable children is an explicit aim stated in the operational policy and plans. Relevant outcome measure should be in place to manage, monitor and evaluate performance.
- Managers of early years services should ensure processes are in place to systematically involve parents and families in the planning and development of services. As part of this process, vulnerable parents and families should be asked about their needs and concerns – and their experiences of the services on offer.
- Managers and trainers should ensure early years professionals are trained to deliver evidence-based programmes and services to support and

develop the social and emotional wellbeing of vulnerable children aged under 5.

Recommendation 6 Delivering services

Who should take action?

- Maternity services.
- Health visiting.
- The Healthy Child Programme.
- Early years services, including children's centres, nurseries and primary schools (maintained, private, independent and voluntary).
- General practice.
- Paediatrics.
- Child protection services.
- Child and adolescent mental health services.
- Training organisations involved with professionals who work with young children.

What action should they take?

- Health and early years organisations should have integrated administrative systems and datasets to support the planning, management, review and evaluation of both universal and targeted services to support vulnerable children's social and emotional wellbeing.
- Health and early years professionals should be clear about their roles and responsibilities for improving the social and emotional wellbeing of vulnerable children and their families in any particular locality.

- Health and early years professionals should be systematic and persistent in their efforts to encourage hard-to-reach vulnerable parents to use early years services. (This includes parents who do not use universal services, such as primary care.) Activities should include:
    - targeted publicity campaigns
    - using key workers and referral partners to make contact
    - sending out repeat invitations
    - knocking on doors
    - using local community venues, such as places of worship and play centres to encourage them to participate and to address any concerns about discrimination and stigma
    - using home visits by family support workers.

- Health and early years professionals should use outreach methods to maintain or improve the participation of vulnerable parents and children in programmes and activities. Parents who may lack confidence or are isolated will require particular encouragement. (This includes those with drug or alcohol problems and families experiencing domestic violence.)

2 Public health need and practice

Government policy puts a significant emphasis on early intervention services to ensure all children have the best possible start in life. The aim is to address the inequalities in health and life chances that exist between children living in disadvantaged circumstances and those in better-off families.

The importance of social and emotional wellbeing in relation to healthy child development is set out in a joint Department for Education and Department of Health publication, ‘Supporting families in the foundation years’ (2011). The primary aim of the foundation years (years 0–5) is defined as: ‘promoting a child’s physical, emotional, cognitive and social development so that all children have a fair chance to succeed at school and in later life’.

Other relevant policy documents and related reviews include:

- ‘Fair society, healthy lives’ (Marmot Review Team 2010).
- ‘Healthy child programme: pregnancy and the first five years of life’ (DH 2009).
- ‘Healthy lives, healthy people: our strategy for public health in England’ (DH 2010a).
- ‘Healthy lives, healthy people: update and way forward’ (DH 2011).
- ‘No health without mental health: a cross-government mental health outcomes strategy for people of all ages’ (HM Government 2011).
- ‘Support and aspiration: a new approach to special educational needs’ (Department for Education 2011a).
- ‘The early years: foundations for life, health and learning’ (Tickell 2011).
- ‘The importance of teaching’ (Department for Education 2010).

Benefits of social and emotional wellbeing

Social and emotional wellbeing is important in its own right, but it also provides the basis for future health and life chances.

Poor social and emotional capabilities increase the likelihood of antisocial behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity. For example, aggressive behaviour at the age of 8 is a predictor of criminal behaviour, arrests, convictions, traffic offences, spouse abuse and punitive treatment of their own children (Farrington et al. 2006).

Factors that impact on social and emotional wellbeing

The child’s relationship with their mother (or main carer) has a major impact on social and emotional development. In turn, the mother’s ability to provide a nurturing relationship is dependent on their own emotional and social wellbeing and intellectual development – and on their living circumstances.

The latter includes family environment, social networks and employment status (Shonkoff and Phillips 2000).

Most parents living in poor social circumstances provide a loving and nurturing environment, despite many difficulties. However, children living in a disadvantaged family are more likely to be exposed to adverse factors such as parental substance misuse and mental illness, or neglect, abuse and domestic violence. Consequently, they are more likely to experience emotional and behavioural problems that can impact on their development and opportunities in life (Farrington et al. 2006; Shonkoff and Phillips 2000). For example, measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5, compared to children from more affluent backgrounds (Waldfogel and Washbrook 2008).

There are less opportunities after the preschool period to close the gap in behavioural, social and educational outcomes (Allen 2011; Field 2010).

Current services

Services that support families and children during their early years are generally not well coordinated and integrated either at the strategic or local level (Allen 2011a; Field 2010; Munro 2011; Tickell 2010).

The level and quality of early childcare and education services varies, with the most disadvantaged children likely to get the worse provision (Ofsted 2010). In addition, only an estimated 50% of children aged 2 and 2 ½ years in England are being assessed by the Healthy Child Programme – and not all women are being offered antenatal and parenting support services (Care Quality Commission 2010; DH 2010b).

The approaches and interventions used to address specific problems (such as abuse, maternal mental health problems and poor parenting) also vary widely and, while some interventions have been proven to be effective and cost effective, others have not. Where evidence-based interventions are used, they are not always being implemented effectively (Allen 2011a; Field 2010).

There is limited UK data on the indicators that provide an overall measure of the social and emotional wellbeing of children aged under 5 years. Independent reviews recommend that measures should be developed to assess children's cognitive, physical and emotional development at ages 3 and 5 years (Allen 2011b; Field 2010; Tickell 2011).

Costs

Early intervention can provide a good return on investment (Knapp et al. 2011). For example, an evaluation of the US-based 'Nurse family partnership' estimated that the programme made savings by the time the children of high-risk families had reached the age of 15. These savings, which were over five times the cost of the programme itself, resulted from reduced welfare and criminal expenditure, higher tax revenues and improved physical and mental health (Karoly et al. 2005).

The cost of not intervening to ensure (or improve) the social and emotional wellbeing of children and their families are significant, for both them and wider society (Aked et al. 2009). For example, by the age of 28, the cumulative costs for public services are much higher when dealing with someone with a conduct disorder, compared to providing services for someone with no such problems (Scott et al. 2001).

3 Considerations

The Public Health Interventions Advisory Committee (PHIAC) took account of a number of factors and issues when developing the recommendations.

3.1 PHIAC focused on local interventions to improve children's social and emotional wellbeing – either directly, or by improving the ability of parents to provide a nurturing and loving family environment. However, such family-based services can only form one component of a broader, multi-agency local strategy within a supportive national policy framework. Other elements may include, for example, policies to improve the social and economic circumstances of disadvantaged children.

3.2 Traditionally, child development policy and practice has focused on physical health and cognitive development. However, the recent series of independent reviews on early intervention, early education and child protection have underlined the importance of social and emotional wellbeing. (The reviews include Allen [2011a; 2011b]; and Department for Education and DH [2011].) Social and emotional wellbeing forms the basis for healthy child development and 'readiness for school'. It can also help prevent poor health and improve education and employment outcomes in adolescence and throughout adulthood.

3.3 There is a lack of consensus on how to define and measure young children's social and emotional wellbeing. Much of the evaluation literature concentrates on the consequences of someone lacking mental or social and emotional wellbeing. Evidence on interventions aiming to improve or sustain social and emotional wellbeing is comparatively limited – and the quality varies significantly. There are a small number of high-quality, long-term UK studies. However, the main body of evidence is from the US

and it was difficult to determine how relevant this was for early years services in the UK.

3.4 The recommendations build on important national developments to promote and protect the social and emotional wellbeing of children, especially vulnerable children. These developments include:

- Expansion of the health visitor workforce.
- The new core purpose of children's centres: 'to improve outcomes for young children and their families with a particular focus on the most disadvantaged, so that children are equipped for life and ready for school, no matter what their background or family circumstances' (Department for Education 2011b).
- Free early education extended to infants aged 2 years who are disadvantaged.
- The designation of social and emotional wellbeing as one of the key themes in the early years foundation stage (the statutory framework that sets standards for learning, development and care for children from birth to 5).
- Stronger links between the Healthy Child Programme and early education assessment and review processes to help identify and respond to children with particular needs.

3.5 Evidence relating to the Family Nurse Partnership programme (derived originally from long-term randomised control trials [RCTs] in the US) showed that this model can have a positive effect on children's emotional and behavioural development. PHIAC noted that the current UK randomised control trial based on this programme will provide valuable evidence on its effectiveness in this country. It also acknowledged that long-term follow-up and an analysis of the costs and benefits will be crucial.

3.6 Independent reviews (Allen 2011; Field 2010) stressed the critical role of the whole family, including fathers and grandparents, in influencing a child's social and emotional wellbeing and subsequent life chances. There is limited evidence on the most effective ways that fathers and grandparents who provide childcare support can promote social and emotional wellbeing. However, PHIAC recognised that a 'whole-family' approach should be adopted to promote and protect the social and emotional wellbeing of children.

3.7 PHIAC was aware of the financial constraints on public sector services, and the need to ensure value for money. Members noted that the Allen reviews (2011a; 2011b) set out a strong economic case for early years 'preventive' services. The reviews showed that the greatest cost savings could be achieved by intervening during the early years of life.

3.8 PHIAC judged that if effective, evidence-based interventions are systematically implemented, then cost savings are likely to be achieved over 3 to 4 years – and in the longer term.

3.9 While prevention of child abuse is not the primary focus of this guidance, neglect and abuse are major risks to a child's social and emotional development (as well as to their overall health and wellbeing). PHIAC believes the recommendations should help prevent child abuse.

3.10 Evidence showed that effective interventions had 'high fidelity', that is, they were structured, replicable and auditable.

3.11 PHIAC put an emphasis on arrangements that could be used to 'scale up' and systematically deliver evidence-based interventions. This includes having clear pathways, protocols, monitoring, audit and evaluation processes in place.

4 Implementation

NICE guidance can help:

- National and local organisations improve quality and health outcomes and reduce health inequalities.
- Local authorities improve the health and wellbeing of people in their area.
- Local NHS organisations, local authorities and other local partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for integration and partnership working across social care, the NHS and public health organisations.

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued.

5 Recommendations for research

The Public Health Interventions Advisory Committee (PHIAC) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful/negative side effects.

5.1 How effective are interventions to promote social and emotional wellbeing among, and reduce the vulnerability of, different groups of vulnerable children aged under 5 years?

5.2 How can the factors that pose a risk to, or protect, the social and emotional wellbeing of children aged under 5 years be identified and assessed to determine how they can benefit from different interventions?

5.3 What approaches can be used to ensure fathers and grandparents help protect or improve the social and emotional wellbeing of vulnerable children aged under 5 years?

5.4 What types of home-based intervention are effective in promoting the social and emotional wellbeing of vulnerable children aged under 5 years without involving the parents? (This could include childcare provided by other family members.)

5.5 How can interventions which have been proven effective in other countries be assessed for their cultural relevance to the UK? What measures should be used to assess how transferrable they are?

5.6 What organisational mechanisms can be used to ensure interventions to improve the social and emotional wellbeing and 'readiness for school' of vulnerable children aged under 5 are effectively implemented? How does this differ by local context?

5.7 What are the short, medium and long-term economic benefits of interventions aimed at developing the emotional and social skills of vulnerable, preschool children – for the individual, family and wider society? How should these be assessed?

5.8 What indicators and datasets should be used to measure and predict social and emotional wellbeing over time? Which indicators and datasets can be used to assess the long-term benefits of interventions aimed at improving the social and emotional wellbeing of vulnerable children aged under 5 years?

More detail on the gaps in the evidence identified during development of this guidance is provided in appendix D.

6 Updating the recommendations

This section will be completed in the final document.

7 Related NICE guidance

Published

Looked-after children and young people. NICE public health guidance 28 (2010).

Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009).

When to suspect child maltreatment. NICE clinical guideline 89 (2009).

Attention deficit hyperactivity disorder (ADHD). NICE clinical guideline 72 (2008).

Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).

School-based interventions on alcohol. NICE public health guidance 7 (2007).

Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007).

Conduct disorder in children – parent-training/education programmes. NICE technology appraisal 102 (2006).

Bipolar disorder. NICE clinical guideline 38 (2006).

Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD). NICE clinical guideline 31 (2005).

Depression in children and young people. NICE clinical guideline 28 (2005).

Under development

Preventing and reducing domestic violence. NICE public health guidance (publication expected February 2014)

8 References

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Appendix A Membership of the Public Health Interventions Advisory Committee (PHIAC), the NICE project team and external contractors

Public Health Interventions Advisory Committee

NICE has set up a standing committee, the Public Health Interventions Advisory Committee (PHIAC), which reviews the evidence and develops recommendations on public health interventions. Membership of PHIAC is multidisciplinary, comprising public health practitioners, clinicians, local authority officers, teachers, social care professionals, representatives of the public, academics and technical experts as follows.

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External contractors

Evidence reviews

Review 1 was carried out by the School of Health and Related Research (ScHARR), University of Sheffield. The principal authors were: Susan Baxter, Lindsay Blank, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

Review 2 was carried out by ScHARR, University of Sheffield. The principal authors were: Lindsay Blank, Susan Baxter, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

Review 3 was carried out by ScHARR, University of Sheffield. The principal authors were: Lindsay Blank, Susan Baxter, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

Cost effectiveness

The economic modelling was carried out by ScHARR, University of Sheffield. It was split into two parts – part one is the econometric analysis and part two is the economic model. The principal authors for part one were: Mónica Hernández Alava, Gurleen Popli, Silvia Hummel and Jim Chilcott. The principal authors for part two (which included the review of economic evaluations) were: Silvia Hummel, Jim Chilcott, Andrew Rawdin and Mark Strong.

Commissioned expert reports

Expert report 1 was carried out by Warwick Medical School, University of Warwick and Institute for the Study of Children, University of London. The principal authors were: Anita Schrader-McMillan, Jacqueline Barnes and Jane Barlow.

Expert report 2 was carried out by The Social Research Unit, Dartington. The principal authors were Nick Axford and Michael Little.

Expert report 3 was carried out by the Personal Social Services Research Unit (PSSRU) London School of Economics and Political Science. The principal author was Madeleine Stevens.

Appendix B Summary of the methods used to develop this guidance

Introduction

The reviews, primary research, commissioned reports and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Interventions Advisory Committee (PHIAC) meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available at the NICE website.

Guidance development

The stages involved in developing public health guidance are outlined in the box below.

1. Draft scope released for consultation

2. Stakeholder meeting about the draft scope

3. Stakeholder comments used to revise the scope

4. Final scope and responses to comments published on website

5. Evidence reviews and economic modelling undertaken and submitted to PHIAC

6. PHIAC produces draft recommendations

7. Draft guidance (and evidence) released for consultation and for field testing

8. PHIAC amends recommendations

9. Final guidance published on website

10. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by PHIAC to help develop the recommendations. The overarching questions were:

1. What are the most effective and cost-effective early education, childcare and home-based interventions for helping improve and maintain the cognitive, social and emotional wellbeing of vulnerable children and their families?

2. Which progressive early education, childcare and home-based interventions are effective and cost effective in terms of promoting the cognitive, social and emotional wellbeing of vulnerable children and their

families at: 0–3 months, 3 months to 1 year, 1–2 years, and other early-life stages?

3. How can vulnerable children and families who might benefit from early education, childcare and home-based interventions be identified? What factors increase the risk of children experiencing cognitive, social and emotional difficulties? What is the absolute risk posed by these different factors – and in different combinations?

4. How can home-based interventions reduce a child's vulnerability and build resilience to help achieve positive outcomes? In particular, how can interventions help develop a strong and positive child-parent attachment?

5. How can early education and childcare interventions reduce vulnerability and build resilience to help achieve positive outcomes and generally prepare children for school?

5. Which characteristics of an intervention are critical to achieving positive outcomes for vulnerable children and families?

6. What lessons can be learnt from current UK-based programmes aimed at promoting the social and emotional wellbeing of children under 5?

These questions were made more specific for each review (see reviews for further details).

Reviewing the evidence

Effectiveness reviews

Two reviews of effectiveness were conducted. One looked at review-level evidence (review 1), the other focused on primary evaluation studies of UK programmes (review 2). The latter included related qualitative evidence on factors influencing uptake and implementation.

Identifying the evidence

A number of databases and websites were searched for review level and evaluation studies from January 2000. See each review for details of the databases searched.

Additional methods used to identify evidence were as follows:

- reference list search of included papers (for reviews 1 and 2)
- cited reference searches of included studies in the Web of Knowledge, Scopus and Google Scholar
- additional searches in Medline and the Web of Knowledge for key UK programmes
- consultation with an expert advisory group.

Selection criteria

Studies were included in the effectiveness reviews (reviews 1 and 2) if the:

- populations included vulnerable children aged 0–5 and their families
- interventions were 'progressive' **and**
- were provided at home, within early education or childcare settings **and**
- aimed to improve the social and emotional health and cognitive ability of vulnerable under-5s and their families.

Studies were excluded if they focused on:

- tools and methods used to assess the risk and diagnose social and emotional problems or a mental health disorder
- clinical or pharmacological treatments
- support provided by specialist child mental health services.

See each review for details of the inclusion and exclusion criteria.

Other reviews

Review 3 focused on the risk factors associated with children experiencing social, emotional and cognitive difficulties.

Identifying the evidence

The Millennium Cohort database (maintained by the Centre for Longitudinal Studies) was searched for review 3. All records were hand-searched at the title/abstract level to identify relevant publications. See the review for details.

Selection criteria

Studies were included in review 3 if any aspect of a child's social and emotional wellbeing were reported (including behaviour, development and mental health).

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for the development of NICE public health guidance' (see appendix E). Each study was graded (++, +, –) to reflect the risk of potential bias arising from its design and execution.

Study quality

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

– Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see appendix A). The statements reflect their judgement of the strength (quality, quantity and

consistency) of evidence and its applicability to the populations and settings in the scope.

Commissioned reports

Three expert reports were commissioned.

- Expert report 1 summarised the evidence from primary evaluation studies on progressive interventions to promote the social and emotional wellbeing of vulnerable children aged under 5 years. The evidence came from the UK, US, the Netherlands and elsewhere.
- Expert report 2 looked at programmes to promote the social and emotional wellbeing of vulnerable children aged under 5 years. It included the results of applying the 'Evidence2Success' standards of evidence.
- Expert report 3 looked at the costs and benefits of intervening early with vulnerable children and families to promote their social and emotional wellbeing.

Cost effectiveness

There was a review of economic evaluations and an economic modelling exercise.

Review of economic evaluations

A systematic search of key health and medical databases was undertaken for relevant economic evaluation studies. The inclusion and exclusion criteria were the same as for the systematic review of UK interventions (review 1). Included studies were then quality-assessed.

Economic modelling

The economic modelling comprised two parts: an econometric analysis and the development of an economic model.

An econometric analysis of longitudinal data was undertaken to:

- understand the factors determining aspects of social, psychological and cognitive development in early childhood
- establish a link between early childhood development and adult outcomes
- predict the effects of childhood interventions on long-term outcomes.

An economic model was developed to determine the long-term outcomes of the intervention (home visiting, early education and childcare). It incorporated data from the reviews of effectiveness and the economic evaluation and outputs from the econometric analysis.

The results are reported in the economic modelling reports – see appendix E.

Fieldwork

This section will be completed in the final document.

How PHIAC formulated the recommendations

At its meetings in January 2012, the Public Health Interventions Advisory Committee (PHIAC) considered the evidence, expert reports and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

PHIAC developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.

- The applicability of the evidence to the populations/settings referred to in the scope.

- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

Appendix C The evidence

This appendix lists the evidence statements from three reviews provided by external contractors (see appendix A and appendix E) and links them to the relevant recommendations. See appendix B for the meaning of the (++), (+) and (-) quality assessments referred to in the evidence statements.

Appendix C also lists three expert reports and their links to the recommendations and sets out a brief summary of findings from the economic analysis.

The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from. The letter(s) in the code refers to the type of document the statement is from, and the numbers refer to the document number, and the number of the evidence statement in the document.

Evidence statement 1.1 indicates that the linked statement is numbered 1 in review 1. **Evidence statement 2.ES1** indicates that the linked statement is numbered 1 under the heading ‘Effectiveness studies’ in review 2. **Evidence statement 2.PS1** indicates that the linked statement is numbered 1 under the heading ‘Process studies’ in review 2. **Evidence statement 3.1** indicates that the linked statement is numbered 1 in review 3.

The three reviews are:

- Review 1: ‘Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): Systematic review level evidence’
- Review 2: ‘Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): UK evidence review’
- Review 3: ‘ Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties’

The reviews, expert reports, economic analysis are available at the NICE website. Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Where the Public Health Interventions Advisory Committee (PHIAC) has considered other evidence, it is linked to the appropriate recommendation below. It is also listed in the additional evidence section of this appendix.

Recommendation 1: evidence statements 1.1, 1.2, 1.4, 2.ES1, 2.ES3; Additional evidence expert report 1, expert report 2; expert testimony: PREview project

Recommendation 2: evidence statement 3.1; Additional evidence expert report 1; expert testimony: PREview project

Recommendation 3: evidence statements 1.1, 1.2, 1.4, 2.ES1, 2.ES3, 2.PS1, 2.PS2, 2.PS3; Additional evidence expert report 1, expert report 2; expert testimony: Family Nurse Partnership

Recommendation 4: evidence statements 1.3, 2.PS1, 2.PS2; Additional evidence expert report 1, expert report 2

Recommendation 5: evidence statements 2.ES3, 2.PS4; Additional evidence expert report 1

Recommendation 6: evidence statements 2.ES3, 2.PS1, 2.PS2, 2.PS4; Additional evidence expert report 1

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the evidence reviews to make them more consistent with each other and NICE's standard house style. The superscript numbers refer to the studies cited beneath each statement. The full references for those studies can be found in the reviews.

Evidence statement 1.1: Home visits during pregnancy and the post-partum period (0–1 years)

There is moderate evidence from six review papers[1,3,4,5,6,7] (four [-], one [+] and one [++]) suggesting that postpartum home visits interventions may be effective for improving parental outcomes in at-risk families, with one suggesting that nurse-delivered interventions may be more effective than those delivered by para-professionals or lay visitors. One additional (++) review paper[2] suggests that there is insufficient evidence regarding the effectiveness of postpartum visits to women with an alcohol or drug problem.

These studies were carried out in populations described as: families at risk of dysfunction or child abuse; mothers at risk for postnatal depression; mothers identified as having additional needs; families living in a deprived area; teenage mothers; African-American women; drug users; economically deprived women; socially at-risk women; preterm infants and mothers with maternal risk.

In regard to specific outcomes: one of these reviews (-)[6] provides evidence for the effectiveness of programmes delivered by nurses on intimate partner violence and reducing child abuse potential in low-income families, ethnic minority families, substance abusing mothers, and families at risk for child abuse.

Three reviews (one [+][7] and two [-][5,3]) provide evidence that interventions may impact on maternal outcomes (such as psychological status, postnatal depression, maternal self-esteem, quality-of-life and contraceptive knowledge and use, interaction with the child and parenting). One (-) study[3] suggests that child development outcomes may be improved in preterm infants.

Two further reviews provide evidence that postpartum interventions may be effective for parental outcomes in adolescent mothers. One (-) review[4] describes positive outcomes such as improved self-confidence and self-esteem following support-education interventions for postpartum adolescent mothers. A second (++) review[1] suggests that interventions may have a

positive impact on parent outcomes such as improving maternal-child interaction and maternal identity.

[1] Coren and Barlow (2009)
[2] Doggett et al. (2005)
[3] Kearney et al. (2000)
[4] Letourneau et al. (2004)
[5] McNaughton (2004)
[6] Sharps et al. (2008)
[7] Shaw et al. (2006)

Evidence statement 1.2: Home interventions for wider populations (in addition to or not including pregnancy/postpartum)

Seven reviews provide evidence [1,2,3,4,5,6,7] (two [++], four [+] and one [-]) regarding the effectiveness of home visiting on interventions for at-risk families. Small to medium effects are reported on maternal sensitivity and the home environment, a moderate effect size on parent-child interaction and measures of family wellness, and a small effect size on: attachment security; cognitive development; socio-emotional development; potential abuse; parenting behaviour; parenting attitudes; and maternal lifecourse education. One (+) review[3] provides mixed evidence regarding the impact of parenting interventions on childhood behaviour problems.

The study populations in the primary papers were described as including: ethnic minority teenage mothers; pregnant and postpartum women who were socially disadvantaged or substance abusers; low birthweight newborns; children with failure to thrive; low socioeconomic status families; low income families; families at risk of abuse or neglect and families considered to be at risk. One (++) review[7] concluded that interventions delivered in the home for participants with low SES had lower effect sizes than those with mixed SES levels. A second (++) review[2] similarly concluded that interventions with low SES or adolescent populations had lower effect sizes than middle class non-adolescent parents. One review noted that lower effects were found for studies using HOME (Home Observation and Measurement of the

Environment) or NCATS (Nursing Child Assessment Teaching Scale) as outcome measures compared with other rating scales or measures.

It is unclear how the timing, intensity and other characteristics of inventions influence effectiveness, particularly with respect to levels of risk and needs. One (+) meta-analysis[5] reported that characteristics of more successful interventions across all the studies were that: video feedback was included; interventions had less than 16 sessions; interventions did not include personal contact (but provided equipment); interventions started after the age of 6 months. Another (-) review[6] concluded that interventions were more successful when of a moderate number of sessions (5–16 versus more than 16) in a limited time period, and were carried out at home either prenatally or after the age of 6 months. Another (++) review[7] in contrast concluded that effect sizes were higher for interventions of 13 to 32 visits and lower for interventions of 1 to 12 visits and 33 to 50 visits. Also, that effect sizes were lower for interventions without a component of social support than for those that included social support. One (++) review[2] suggested that there may be some reduction in intervention effect over time, and highlighted that the multifaceted nature of interventions provides challenges in ascertaining which element or elements of an intervention are most effective.

[1] Bayer et al. (2009)
[2] Kendrick et al. (2000)
[3] Bernazzani et al. (2001)
[4] Sweet and Appelbaum (2004)
[5] Bakermans-Kraneburg et al. (2005)
[6] Bakermans-Kraneburg et al. (2003)
[7] MacLeod and Nelson (2000)

Evidence statement 1.3: Programmes delivered in educational or centre settings

Four reviews provide moderate evidence[1,2,3,4] (three [+] and one [-]) regarding the effectiveness of interventions delivered in an educational or daycare

setting. The detail of interventions and distinctions between daycare and childcare were not well defined.

Most evidence related to cognitive outcomes. Other outcomes included social competence and child mental health. One (+) review[1] found that more than 70% of positive effects reported were regarding cognitive outcomes. Most of the programmes were described as being conducted with economically disadvantaged populations. However, some reviews included both universal and progressive interventions with little detail provided regarding the precise content of the programmes or the population.

Most of the programmes had multiple strands –and varied in intensity. Few reviews examined daycare and preschool education without the addition of centre or home-based parenting support. Most of the programmes were for children aged 3 years and above.

Positive cognitive effects were reported for some programmes for: vocabulary; letter and word identification; letter knowledge; book knowledge; colour-naming; reduction in number of children kept back a year; increased IQ scores; verbal and 'fluid intelligence' gains; school readiness; improved classroom and personal behaviour (as rated by the teachers); reduced need for special needs education; a reduction in delinquent behaviour; fewer arrests at aged 27. Reported effectiveness however varied across programmes with one review reporting that 53% of the studies demonstrated no effect.

Beneficial effects reported on child mental health included reduced anxiety and the ability to externalise behaviour problems. However one (+) review[3] highlighted the potential for making difficult behaviours worse. Improvements in social competencies were reported across a number of programmes, including improvements in mother-child interaction and communications. A study of the effective provision of preschool education project found improved self-regulation and positive behaviour if children attended a centre rated as high quality. One (+) review[4] of eight daycare interventions in the US concluded that out of home daycare can have beneficial effects in relation to enhancing cognitive development, preventing school failure, improving

children's behaviour, and improving maternal education and employment. The authors suggested that the chance of success is higher for interventions if the intervention starts at age 3 three rather than age 4 years.

[1] Anderson et al. (2003)

[2] Burgher (2010)

[3] D'Onise et al. (2010)

[4] Zoritch et al. (2009)

Evidence statement 1.4: Longer-term outcomes of early interventions in adolescence

Two good quality (both [+]) meta-analyses[1,2] of outcomes following early developmental prevention programmes provide good evidence of lasting impact in adolescence, particularly as measured by cognitive outcomes. Overall, effect sizes are small to medium. Study populations were described as at risk or disadvantaged with many including a high proportion of participants from African-American backgrounds. Interventions included structured preschool programmes, centre-based developmental daycare, home visitation, family support services and parental education.

One (+) review[1] reported that the largest effects were seen for educational success during adolescence, reduced social deviance, increased social participation, and cognitive development, with smaller effects for family wellbeing and social-emotional development. It was highlighted that programmes with more than 500 sessions per participant were significantly more effective than those with fewer. The second (+) review[2] reported a similar pattern of outcomes. It was noted that programmes with direct teaching components in preschool and those that followed through from preschool to school tended to have the greatest cognitive impacts. Longer programmes tended to produce greater impacts on preschool cognitive outcomes and on social and emotional outcomes at school age. More intense programmes tended to produce greater impact on preschool cognitive outcomes and grade 8 parent-family outcomes.

[1] Manning et al. (2010)

[2] Nelson and Westhues (2003)

Evidence statement 2.ES1: Home visiting programmes

Evidence from seven studies (eight papers – four [++] and four [+])[1,2,3,4,5,6,7,8] suggests that some home visiting programmes may be effective in directly improving social and emotional wellbeing of vulnerable children. The extent of effect depends partly on the type and nature of intervention being delivered, and the particular outcomes measures. Some outcome measures were indirectly linked to the social and emotional development and cognitive development of the child, concerned with parental support and home environment. Many of the outcomes were self-reported introducing potential biases into the studies.

The heterogeneity of interventions across the small number of studies made it difficult to identify clear categories; and difficult to discern clear relationships between particular types of interventions and outcomes. However some distinction was evident. The more structured intensive interventions (with a focus on child-mother interaction) delivered by specifically trained nurses during the first 18 months appears more likely to have positive effects (the 'Family partnership model'). The lower intensity, less structured interventions involving lay providers (Home Start, peer mentoring) are less likely to have positive effect on the social and emotional wellbeing of vulnerable children.

Two studies [6,7] (both +) evaluated 'Starting well', an 'intensive home visiting' programme delivered by health professionals and health support workers to socioeconomically deprived parents of newborn children aged up to 24 months (Glasgow). Positive effect on home environment were reported; but methodological limitations meant the studies provided little robust evidence of effectiveness on social and emotional wellbeing.

An (++) evaluation[2] of Home Start, a volunteer home visitor programme, showed a positive effect on parent-child relationships; but no effect on maternal depression. This programme offered 'unstructured' mainly social

support to vulnerable families with newborns consisting of two or more visits over 12 months provided by lay, local volunteer mothers.

The (+) study[4] of a small scale home visiting (intensive compensatory education) programme showed a positive effect on academic readiness and inhibitory control. This intervention consisted of weekly visits for 12 months delivered to infants aged 3 years by project workers (in an economically disadvantaged area of Wales). The intervention was a parent-delivered education programme aimed at improving school readiness.

The (++) evaluation[2] of the 'Family partnership model', a home visiting programme consisting of 18 months of weekly visits from a specifically trained health visitor in two UK counties, showed a positive effect on a small number of outcomes, including maternal sensitivity and infant cooperation.

The 'Avon premature infant project' was a home visiting programme with parental child developmental education and support (using a counselling model) delivered over 2 years by nurses. The (+) evaluation[5] showed that at 5-year follow-up a development advantage was identified, but at 2 years this was not evident.

'Social support and family health' was a home visiting programme delivered by a health visitor providing 'supportive listening', weekly and then monthly over 2 years (in London: Camden and Islington). The (++) evaluation[8] reported a possible effect on maternal health.

The (++) study[3] of a peer mentoring home visiting programme reported negligible effects on social and emotional wellbeing. This programme was delivered by recruited existing mothers twice-monthly during pregnancy and monthly for the following year (in deprived areas in Northern Ireland).

[1] Barlow et al. (2007)

[2] Barnes et al. (2006; 2009)

[3] Cupples et al. (2010)

[4] Ford et al. (2009)

[5] Johnson et al. (2005)

[6] Mackenzie et al. (2004)

[7] Shute and Judge (2005)

[8] Wiggins et al. (2004)

Evidence statement 2.ES3: National evaluation of Sure Start

Moderate evidence from two studies (reported in four papers: two [++][1,2] and two [+] [3,4]) shows that the Sure Start programmes are effective in improving some outcomes among infants aged 9 months and 3 years relating directly and indirectly to the social and emotional development and cognitive development of preschool children (including child positive social behaviour, child independence, better parenting, home learning environment).

There was variation in effects between subgroups and over time (evaluation periods). The earlier evaluation findings showed the small and limited effects varied with degree of social deprivation. Children from relatively more socially deprived families (teenage mothers, lone parents, workless households) were adversely affected by living in Sure Start local programme areas. Later evaluation results differed from the earlier findings in that beneficial effects could be generalised to all subgroups, including teenage mothers and workless households. The findings of the impact evaluation study reported the link between implementation (fidelity) and outcomes, and attributed improved outcomes to children being exposed longer to more mature local programmes *(*see UK process studies: evidence statement 5 below).

It is important to note that this evidence relates to the effect of Sure Start local programmes as a whole. Although Sure Start local programmes had common aims set by central government, the types and mix of interventions were not necessarily common between delivery sites. It is likely that interventions included home visiting, early education and daycare, and the education/daycare components were strengthened after the initial phase (although the evaluation was not depended on these being present). There are a broad spectrum of outcome measures but not all of these relate directly to emotional and social wellbeing.

[1] Belsky et al. (2006)

[2] Melhuish et al. (2008)

[3] Melhuish et al. (2008)

[4] Melhuish et al. (2005)

Evidence statement 2.PS1: Engaging families and the take up of early interventions services

Moderate evidence from eleven papers[1,2,3,4,5,6,7,8,9,10,11] suggests that the uptake of early interventions among vulnerable families is influenced by mothers' perception of benefits, timely provision of information about the interventions, personal circumstances and views, the reputation of the services, recruitment procedures, perceptions about quality of interventions and their physical accessibility.

Three papers (two [+][1,10] and one [-][11]) reported that the perceived benefits for parents in their child attending childcare/early education were described in terms of building networks, providing an opportunity to take a break from parenting and a facilitator for employment

Five papers (four [+][2,3,4,7] and one [-][9]) reported that a perceived lack of need influenced parents' decision not to take up home visiting. In some cases their needs were seen as being fulfilled by support from friends, family, or other services. The 'wrong type of support' was described by one (+) paper[3] with parents needing practical support rather than other support.

Parental lack of knowledge regarding the content and potential benefits of available services was reported in four papers (three [+][1,5,8] and one [-][6]). One good quality (+) paper[4] described how mothers were unclear regarding what a programme offered, with women not understanding or not remembering information. Some women reported that the offer of the programme might have been preferred after the birth of their baby.

Two (+) papers[3,4] described the influence of personal choice with some women changing their minds or not being interested in a programme, and one (+) paper[7] highlighted that needs changed over time. Waiting lists for

interventions meant that some women no longer needed the service when it was offered to them.

Three papers of mixed quality (one [-][6] and two [+][8,5]) described the influence of personal circumstances and views in influencing uptake. These included personal and family reasons and perceived cultural and language differences.

Personal choice may also be influenced by the confidence levels of parents. Two papers (both [+])[1,5] described how personal time factors could present barriers to uptake; with difficulty fitting the intervention into a personal routine or multiple demands.

Four mixed quality papers (two [+][1,10] and two [-][6,12]) highlighted the importance of marketing, outreach, and recruitment processes for programmes. Studies suggested the use of key workers and targeted publicity, door-knocking, making use of referral partners and ongoing invitations. Two good quality papers (both [+])[1],[5] suggested the influence of the reputation of early education programmes in uptake. The reputation and feedback from other parents could be influential, and also a perceived stigma that services were ‘for certain groups’.

Two good quality papers (both [+])[1,10] described parental worries regarding the cleanliness of venues, staff prying into their personal lives and concerns for their child.

The importance of the location of a service was discussed in three papers (two [+][5,8] and one [-][6]). The papers highlight that the accessibility of a site is important, with settings being visible and accessible to the public through adequate positioning on a busy street and clearly signposted. There was the suggestion that associating the nursery service with nearby schools made the programme appear more ‘official’ to parents and provided continuity of services.

[1] Avis et al. (2007)

[2] Barlow et al. (2005)

[3] Barnes et al. (2006)

[4] Barnes et al. (2009)

[5] Coe et al. (2008)

[6] Kazimirski et al. (2008)

[7] MacPherson et al. (2009)

[8] Mori (2009)

[9] Murphy et al. (2008)

[10] Smith et al. (2009)

[11] Toroyan et al. (2004)

[12] Tunstill (2005)

Evidence statement 2.PS2: Parents experience of services and ongoing engagement in early interventions

Moderate evidence from thirteen papers [1,2,3,4,5,6,7,8,9,10,11,12,13] suggests that ongoing engagement with early interventions among vulnerable families is influenced by perceived benefits to children, perception of a quality service, timing of the programme, the involvement of parents and personal reasons.

Three good quality (all [+]) papers[1,10,12] described that parents who took up the childcare/early education interventions valued the approach, and believed that it was beneficial to their children. Parents continued to use services as they valued how the programme was delivered, structured, and the way information and advice was given in a non-intrusive manner. Perceived benefits for children were the ability of children to mix, play, and learn with other children.

Three papers (two [+][10,12] and one [-][7]) suggested that parental perception of quality of provision influenced ongoing engagement. It was reported that smaller groups are preferable to parents, but if the staff and venue were perceived to be of high quality, maintaining smaller group sizes was of less importance.

Three papers (two [+][10,12] and one [-][7]) suggested that feedback to parents is an important factor in the success of an early education intervention. One (-)

paper[8] highlighted a need to make parents feel more comfortable with taking part in activities that were designed for parent and child.

Three papers (all [+])[1,6,10] suggested that a lack of programme flexibility precluded some parents from engaging with programmes. Some parents indicated that they would value events outside of typical centre hours, with a desire for increased programme flexibility particularly among students and part-time workers.

Three papers (all [+])[2,8,13] highlighted that making a large time commitment to in-home support programmes could be a barrier to engagement. One (+) paper[5] reported that parents did not like the frequency of visits or fragmented visits. The timing of visits was noted as a problem in one (+) study[9] with mothers feeling disrupted by the timing and scheduling of visits. Two studies (one [+][4] and one [-][11]) reported that flexibility on the part of the visitor to the needs of the client to ensure the service was delivered at a suitable time, was key.

One (+) paper[5] suggested that a home visitor should be proactive in recognising warning signs of losing a client, offering the family a break from the programme, changing the content delivered, and working with families to meet their needs and achieve goals. Another (+) paper[8] highlighted that it made it easier for families to engage in other services once they were taking part in one programme.

Four (all [+]) papers[3,4,5,13] described personal reasons for not engaging with a service such as losing interest in the programme, missing too many appointments, moving out of the area, infant illness and other commitments.

[1] Avis et al. (2007)
[2] Barlow et al. (2005)
[3] Barnes et al. (2006)
[4] Barnes et al. (2008)
[5] Barnes et al. (2009)
[6] Coe et al. (2008)

[7] Kazimirski et al. (2008)

[8] Kirkpatrick et al. (2007)

[9] MacPherson et al. (2009)

[10] Mori (2009)

[11] Murphy et al. (2008)

[12] Smith et al. (2009)

[13] Wiggins et al. (2004)

Evidence statement 2.PS3: Home-based interventions and staff-parent relationships

Moderate evidence from eight papers[1,2,3,4,5,6,7,8] suggests that the nature of the relationship between staff and parents is an important factor influencing the ongoing engagement of vulnerable families in home-based interventions.

The importance of building relationships was highlighted in six papers (five [+][1,3,4,5,6] and one [-][8]) with regular interaction resulting in parents feeling at ease and being able to 'open up', and with home visitors acting as a mentor, friend, and teacher. Women reported that they liked that home visitors did not impose their views, and took an honest, open, humane and egalitarian approach. Some younger women however reportedly viewed a health visitor intervention as somewhat authoritarian, almost like advice from parents and some women were worried about how they may be perceived by home visitors, believing that they were being checked up on, and were concerned about visitors passing judgment on their lifestyle and parenting skills. One (+) paper[3] found fathers were pleased with the programme but took a few sessions to become engaged.

Support was a theme described in all six papers. Parents reported that having someone there to listen and provide additional support was beneficial, visitors offered assistance in difficult times, allowed parents to vent frustrations, and encouraged parents to develop life skills and confidence.

Parents valued the support of a peer home visitor, especially if they had little existing social support, with some women describing how they were reluctant to seek emotional support from family or friends.

[1] Barlow et al. (2005)
[2] Barnes et al. (2006)
[3] Barnes et al. (2008)
[4] Barnes et al. (2009)
[5] Kirkpatrick et al. (2007)
[6] McIntosh et al. (2006)
[7] MacPherson et al. (2009)
[8] Murphy et al. (2008)

Evidence statement 2.PS4: Professional roles and practices

Evidence from eleven papers[1,2,3,4,5,6,7,8,9,10,11] suggests that issues relating to professional roles and working practices impact on service delivery and performance. Staff perceptions of the work being rewarding, the need for skilled staff, clarity about professional roles and inter-agency team working are seen as linked to the success of a programme. Concerns relating to high stress and complex workloads were highlighted, and the need for training and support.

Two papers (one [-][3] and one [+][6]) indicate staff's belief in the programme was related to perceptions that the nature of the work was particularly rewarding. This was noted as a key factor for success.

The level of skills among staff was noted as important to the success of programmes in four papers (three rated [-][3,9,10] one no rating [4]). Particular elements were: empowering users and staff; ongoing monitoring; staff keeping families notified of services and the results of any outreach and a supportive and flexible centre manager. Also one (-) paper[10] highlighted that clear roles and responsibilities for staff must be in place to avoid the potential for staff to face conflicting management and loyalty pressures between their original home organisation and their new roles.

Five papers (three [+][1,2,8] and two [-][7,11]) described concerns from staff regarding home-based programmes. Stress due to a larger caseload, stress related to the job, fatigue from extended hours of working and the complex nature of issues presented during home visits was described.

Three (+) papers[5,8,11] described how home visitors harboured frustrations with not being able to reach clients. They, struggled with losing clients they wished they could help, and had to balance the needs of varying clients and had concerns that interventions were too short. One (+) paper[1] highlighted the potential for professional roles to be undermined, with concerns apparent regarding role clarity especially when working in mixed teams. While mixed team working was perceived as advantageous in helping at-risk families, there was a blurring of roles and boundaries which created confusion, and in some instances tension within teams.

There were mixed views of supervision found in three further studies (two [+][1,8] and one [-][7]). One reported satisfaction with management, while another described a need for safer working conditions and better management. In one study[7] peer mentors reported that at times, they felt unprepared for some of the cultural and ethnic differences that they encountered in the home while visiting mothers, and felt they could not provide adequate support. The need for visitors to be well supported by peers and supervisors was highlighted in one (+) study[2].

[1] Barnes et al. (2008)
[2] Barnes et al. (2009)
[3] Kazimirski et al. (2008)
[4] Mathers and Sylva (2007)
[5] McIntosh et al. (2006)
[6] Mori (2009)
[7] Murphy et al. (2008)
[8] Smith et al. (2009)
[9] Toroyan et al. (2004)
[10] Tunstill et al. (2005)

[11] Wiggins et al. (2004)

Evidence statement 3.1: How can those vulnerable children and families who might benefit from early education and childcare interventions be identified?

It may be possible to identify children and families who might benefit most from early education and childcare interventions by considering the factors which research suggests are likely to increase their risk.

The models for predicting future likely child health outcomes could be used at a population level to direct early intervention investment towards those children and families that are most likely to experience the poorest outcomes. However, the model is dependent on the robustness of the longitudinal data sets in identifying all the key risk factors and the availability of local data to map these factors. Certain factors are not well represented, including those relating to parenting and parental mental health problems. The relationship between cultural factors and child outcomes is not well understood.

Also, such models cannot be used to predict outcomes at an individual level. The models may inform practitioners about risk factors, however, practitioner knowledge will also be vital in validating the model for use for individual risk-assessment purposes.

Additional evidence

Expert report 1: 'Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5'

Expert report 2: 'Programmes to promote the social and emotional wellbeing of vulnerable children under 5: messages from application of the Evidence2Success standards of evidence'

Expert report 3: 'The costs and benefits of early interventions for vulnerable children and families to promote social and emotional wellbeing: economics briefing'.

Expert testimony on the Family Nurse Partnership: Kate Billingham, Department of Health

Expert testimony on the PREview project: Helen Duncan, Child and Maternal Health Observatory (CHiMAT) and Kate Billingham, Department of Health

Economic modelling

The review of cost-effectiveness interventions found little UK evidence. By contrast, the US literature indicates that preschool education and/or home visiting programmes for at-risk populations may be cost effective.

Two econometric models were developed to understand what determines aspects of social, psychological and cognitive development (or 'ability') in early childhood. They also aimed to establish a link between early childhood development and adult outcomes.

Measures of cognitive and behavioural development were found to have a very important effect on long-term outcomes, as was parental 'investment' in the early years – through its effect on cognitive and behavioural development.

The authors noted a number of limitations in the econometric models, however, including reliance on self-report data, limited common variables in the datasets, use of observational data and associated problems with direction of causality.

An economic model was used to conduct an economic analysis of interventions to improve the social and emotional wellbeing of infants from a public sector perspective. Seventeen scenarios were modelled, drawing on evidence from the UK and US and reported in review 2.

The results were not conclusive. Interventions which improved child cognition could be cost-saving to the public sector, through improved educational outcomes, higher wages and tax revenues.

Modelling of the long-term effects of behavioural changes in childhood yielded more modest financial benefits. Improvements in behaviour in childhood

improves adult educational outcomes, reduces the probability of being on benefits, being economically inactive or being involved in crime. All these factors yield cost savings for the public sector, but the sums are relatively small compared to the effects of improved cognition.

The authors concluded that there is potential for interventions with vulnerable preschool children to be cost effective or cost saving, even without taking into account other potential benefits. (Other benefits might include avoiding child neglect and improving the socioeconomic outcomes for the children's descendants.)

A number of limitations were noted including:

- The limited number of outcomes that can be used to generate financial benefits.
- Uncertainty introduced by mapping variables across different ages and data sets.
- The limited nature of the evidence base.
- The need to estimate the effects of social and emotional wellbeing on long-term outcomes (such as the probability of a criminal conviction, economic activity and unemployment).

Appendix D Gaps in the evidence

The Public Health Interventions Advisory Committee (PHIAC) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There is limited UK evidence on the effectiveness of interventions (home visiting, childcare and early education) to improve the social and emotional wellbeing of vulnerable children aged under 5 years.

2. There is limited UK evidence on the cost effectiveness of early interventions to improve the social and emotional wellbeing of vulnerable children aged under 5 years. This includes evidence on the distribution of costs and benefits across all relevant sectors including health, education, social care, welfare and criminal justice.

3. There is a lack of nationally agreed definitions and measures of vulnerability and risk relating to the social and emotional wellbeing of children aged under 5 years. This makes surveillance, planning and evaluation difficult.

4. There is limited evidence on the effectiveness of different methods of delivering early interventions.

5. There is limited evidence on the differential impact of early interventions on the social and emotional wellbeing of particular groups of vulnerable children aged under 5 years and their families. (This includes, for example, the impact on particular minority ethnic groups and on children whose parents have mental health problems.)

Appendix E Supporting documents

Supporting documents include the following.

- Evidence reviews:
    - Review 1: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): Systematic review level evidence'
    - Review 2: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): UK evidence review'
    - Review 3: 'Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties'

- Economic modelling:
    - 'Economic outcomes of early years programmes and interventions designed to promote cognitive, social and emotional development among vulnerable children and families. Part 1 – econometric analysis of UK longitudinal data sets'
    - 'Economic outcomes of early years programmes and interventions designed to promote cognitive, social and emotional development among vulnerable children and families. Part 2 – economic model'.

- Commissioned expert reports:
    - Expert report 1: 'Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5'
    - Expert report 2: 'Programmes to promote the social and emotional wellbeing of vulnerable children under 5: messages from application of the Evidence2Success standards of evidence'

  - Expert report 3: ‘The costs and benefits of early interventions for vulnerable children and families to promote social and emotional wellbeing: economics briefing’.

For information on how NICE public health guidance is developed, see:

- ‘Methods for development of NICE public health guidance (second edition, 2009)’
- ‘The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)’.