

# 5. Early Years

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## 5.1 Breastfeeding

Breastfeeding has a major role to play in public health, promoting health and preventing illness in both baby and mother. The choice to breastfeed, particularly if sustained for six months or longer, can make a real contribution to the health and development of the infant and lessen health risks to the mother.

Breastfeeding contributes to the health of both mother and child, in the short and long-term. For example, babies who are not breastfed are many times more likely to acquire infections such as gastroenteritis in their first year (Ip et al, 2007; Horta et al, 2007). It is estimated that if all UK infants were exclusively breastfed, the number hospitalised each month with diarrhoea would be halved, and the number hospitalised with a respiratory infection would be cut by a quarter (Quigley et al, 2007). There is some evidence that exclusive breastfeeding is associated with the lowest rates of these illnesses in the first six months of life.

Exclusive breastfeeding in the early months may reduce the risk of atopic dermatitis (Department of Health, 2004). In addition, there is some evidence that babies who are not breastfed are more likely to become obese in later childhood (Department of Health, 2004; Li et al, 2003; Michels et al, 2007). Mothers who do not breastfeed have an increased risk of breast and ovarian cancers and may find it more difficult to return to their pre-pregnancy weight (World Cancer Research Fund, 2007; Department of Health, 2004).

In 2003, the World Health Organisation recommended that wherever possible, infants should be fed exclusively on breast milk until six months of age (World Health Organisation, 2003). The Government has adopted the World Health Organisation recommendations, and advocates that breastfeeding should continue after six months for as long as the mother and baby wish, while gradually introducing a more varied diet (Department of Health, 2003).

The Acheson independent inquiry (1998) recognised that breastfeeding is a strong indicator of social inequalities, that is, women who are most disadvantaged are least likely to breastfeed. Less privileged mothers are also more likely to introduce solid foods earlier than recommended and their children are at a greater risk of both 'growth faltering' (that is, they gain weight too slowly) in infancy and obesity in later childhood (Armstrong et al, 2003).

The most recent UK infant feeding survey 2005 (Bolling et al, 2007) showed that 78% of women in England breastfed their babies after birth, but by six weeks the number had dropped to 50%. Only 26% of babies were breastfed at six months. Exclusive breastfeeding was practised by only 45% of women one week after birth and 21% at six weeks (Bolling et al, 2007).

Three-quarters of British mothers who stopped breastfeeding at any point in the first six months (and 90% of those who stopped in the first two weeks) would have liked to have continued for longer. This suggests that much more could be done to support them. The British figures also contrast with data from Norway, where over 80% of mothers breastfeed for the first six months (Lande et al, 2003).

The most recent infant feeding survey 2005 (Bolling et al, 2007) confirmed that low maternal age, low educational attainment and low socio-economic position continue to have a strong impact on patterns of infant feeding. For example, 65% of UK women from managerial and professional occupations were breastfeeding at six weeks, compared to only 32% of those from routine and manual groups.

The breastfeeding initiation rate in 2005 in Devon was 78.7%, slightly above the national rate of 77% (Table 5.1). The latest available data shows the initiation rate for Devon for 2008 was slightly better at 80.4%.

Breastfeeding offers benefits to both mother and infant. In Devon, the breastfeeding initiation rate was just over 80% in 2008. However, there is a marked decline in breastfeeding within the first few weeks after initiation to 47.4% (Quarter 4, 2008-09). Initiation rates are lowest among families from lower socio-economic groups. A local strategy needs to be developed reflecting National Institute of Health and Clinical Excellence guidance (NICE, 2006) with particular emphasis on the reduction in inequalities.

**Table 5.1: Breastfeeding initiation rates in England and Wales compared to Devon Primary Care Trust, 2005**

| Age Group Years | England and Wales % | Devon Primary Care Trust % |
|---|---|---|
| <=19 | 53 | 54.8 |
| 20-24 | 66 | 67.6 |
| 25-29 | 77 | 79.6 |
| 30+ | 85 | 84.5 |
| Grand Total | 77 | 78.7 |

Source: Information Centre: Infant Feeding Survey 2005, Royal Devon and Exeter NHS Foundation Trust, South Devon, Derriford and North Devon Acute Trust Maternity Units (Note: England and Wales 2005 data is latest available for direct comparison)

Breastfeeding rates are strongly related to socio-economic factors, compounding the gap in health inequalities (Table 5.2). The highest incidence of breastfeeding was found among mothers from the least deprived areas.

**Table 5.2: Breastfeeding initiation rates in Devon by deprivation quintiles (Jan 2004–Dec 2008)**

| IMD Quintile (1 is most deprived) | | Initiation % |
|---|---|---|
| 1 | Most deprived | 60.5 |
| 2 | | 75.8 |
| 3 | | 81.7 |
| 4 | | 83.4 |
| 5 | Least deprived | 86.4 |
| **Total** | | **79.5** |

Source: Royal Devon and Exeter NHS Foundation Trust, South Devon, Derriford and North Devon Acute Trust Maternity Units (Note: Derriford data is only up until June 2008)

## References

Acheson, D. (1998). Independent inquiry into inequalities in health. London: The Stationery Office

Armstrong, J., Dorosty, A. R., Reilly, J. J. et al (2003). Coexistence of social inequalities in undernutrition and obesity in pre-school children. Archives of Disease in Childhood 88: 671–5.

Bolling, K., Grant, C., Hamlyn, B. et al (2007). Infant feeding 2005. A survey conducted on behalf of The Information Centre for Health and Social Care and the UK health departments by BMRB Social Research. London: The Information Centre.

Department of Health (2003). Infant feeding recommendation [online]. Available from: HYPERLINK 'http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097197' www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097197

Department of Health (2004). Choosing a better diet: a food and health action plan. London: Department of Health.

Horta, B. L., Bahl, R., Martines, J. C. et al (2007). Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses. Geneva: World Health Organization.

Ip, S., Chung, M., Raman, G. et al (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Evidence report/technology assessment 153. Rockville: Agency for Healthcare Research and Quality.

Lande, B., Andersen, L.F., Baerug, A. et al (2003). Infant feeding practices and associated factors in the first six months of life: the Norwegian infant nutrition survey. Acta Paediatrica 92: 152–161.

Li, L., Parsons, T. J. and Power, C. (2003). Breastfeeding and obesity in childhood: cross sectional study. British Medical Journal 327: 904–905.

Michels, K. B., Willett, W. C., and Graubard, B. I. et al (2007). A longitudinal study of infant feeding and obesity throughout life course. International Journal of Obesity 31: 1078–1085.

National Institute of Health and Clinical Excellence (2006). Postnatal care: Routine postnatal care of women and their babies (full guidance). [online]. Available from: http://www.nice.org.uk/Guidance/CG37/Guidance/pdf/English

Quigley, M. A., Kelly, Y. J. and Sacker, A. (2007). Breastfeeding and hospitalisation for diarrheal and respiratory infection in the UK millennium cohort study. Pediatrics 119: 837–842.

World Cancer Research Fund (2007). Food, nutrition, physical activity and the prevention of cancer: a global perspective. London: World Cancer Research Fund.

World Health Organisation (2003). Global strategy for infant and young child feeding. Geneva: World Health Organisation.

## 5.2 Family parenting support

Parenting support has been defined as “any intervention for parents aimed at reducing risks and promoting protective factors for their children in relation to their social, physical and emotional well-being” (Moran et al, 2004).

Evaluating community-based initiatives to support children and their families can be challenging. This includes difficulty in defining outcome measures for family support interventions. Although the policy framework is clear, there are relatively few research papers which review universal rather than specific interventions in particular groups.

Generic programmes in the United Kingdom include Home Start and Sure Start.

The Home Start scheme has been offering volunteer support to families under stress where there is at least one child under five years of age, generally referred by Health Visitors. An evaluation of Home Start carried out by the Joseph Rowntree Foundation (2004) found that although Home Start was well received by participating women, there was no hard evidence that it had made a significant difference to the mothers over the 11-month research period, compared with those in comparison groups.

Sure Start Local Programmes were set up between 1999 and 2003 with the goal of enhancing the life chances of young children and their families by improving services in areas of high deprivation. Programmes were area-based, with all children under four and their families living in a prescribed area serving as the ‘targets’ of intervention. This limited any potential stigma.

The most recent research available from the national Sure Start evaluation programme on three-year olds and their families (Department for Children, Schools and Families, 2008) found, that after controlling for pre-existing family and area characteristics, there were positive effects associated with Sure Start Local Programmes with respect to seven of the 14 outcomes assessed. Sure Start Local Programmes children showed better social development, exhibiting more positive social behaviour and greater independence/self-regulation than their non-Sure Start Local Programmes counterparts.

Parenting showed benefits associated with living in Sure Start Local Programmes areas, with families in Sure Start Local Programmes areas showing less negative parenting while providing their children with a better home-learning environment. The beneficial parenting effects appeared to be responsible for the higher level of positive social behaviour in children in Sure Start Local Programmes areas. Also, families in Sure Start Local Programmes areas reported using more services designed to support child and family development than did families not in Sure Start Local Programmes areas.

With regard to health, the report notes that it is difficult to determine clear-cut evidence of the effectiveness of Sure Start programmes. A 2005 national evaluation (DfES, 2005) found only a few small effects (a reduction, greater than in England, in emergency hospitalisations for zero to three-year olds for severe injury or respiratory infection, as well as increases in health screening and immunisations in a small proportion of programme areas). The most recent research available (Department for Children, Schools and Families, 2008) showed similar findings, that children living in Sure Start areas, compared with children in non-Sure Start areas seen two years earlier, were more likely to have received the recommended immunisations and were less likely to have had an accident-based injury in the preceding year, while in some programme areas the rate of breastfeeding has risen significantly (though tends to still remain below the rate in England overall).

In terms of international evidence of effectiveness of parenting support, a 2004 literature-based review provides some policy direction based on available evidence as listed below (Moran et al, 2004):

- Both early intervention and later intervention: early interventions report better and more durable outcomes for children, but late intervention is better than none and may help parents deal with parenting under stress.
- Interventions with a strong theory-base and clearly articulated model of the predicted mechanism of change: services need to know both where they want to go, and how they propose to get there.
- Interventions that have measurable, concrete objectives.

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- Universal interventions (aimed at primary prevention amongst whole communities) for parenting problems and needs at the less severe end of the spectrum of common parenting difficulties - though some types of universal services require more evaluation to determine their effectiveness.
- Targeted interventions (aimed at specific populations or individuals deemed to be 'at risk' for parenting difficulties) to tackle more complex types of parenting difficulties.
- Services that allow multiple referral routes for families.
- Interventions using more than one method of delivery.
- Group work, where the issues involved are suitable to be addressed in a 'public' format, and where parents can benefit from the social aspect of working in groups of peers.
- Individual work, where problems are severe or entrenched or parents are not ready/able to work in a group (often including an element of home visiting) as part of a multi-component service providing one-to-one, tailored support.
- Interventions delivered by appropriately trained and skilled staff, backed up by good management, support and supervision.
- Interventions of longer duration, with follow-up/booster sessions, for problems of greater severity or for higher risk groups of parents.
- Short, low-level interventions for delivering factual information and fact-based advice to parents, increasing knowledge of child development and encouraging change in 'simple' behaviours.
- Behavioural interventions that focus on specific parenting skills and practical 'take home tips' for changing more complex parenting behaviours and impacting on child behaviours.
- 'Cognitive' interventions for changing beliefs, attitudes and self-perceptions about parenting.
- Interventions that work in parallel (though not necessarily at the same time) with parents, families and children.

A 2003 Cochrane review (Barlow and Parsons, 2003) sought to establish whether group-based parenting programmes are effective in improving the emotional and behavioural adjustment of children less than three years of age, and to assess the role of parenting programmes in the primary prevention of emotional and behavioural problems. The reviewers concluded that the findings of this review provided some support for the use of group-based parenting programmes to improve the emotional and behavioural adjustment of children under the age of three years, but insufficient evidence to reach any firm conclusions regarding the role of such programmes in the primary prevention of such problems.

As well as social and health benefits, there is the potential of benefit to the criminal justice sector. A 2007 criminal justice report and literature review (McQueen et al, 2007) for the Scottish government on parenting support and services concentrated mainly on youth offending and antisocial behaviour, but one section considered effective approaches to family services, highlighting key characteristics for successful interventions with a number of examples of often-cited exemplar interventions. Its findings were as follows:

- Different types of intervention are required to meet the very different needs of families, with the most effective in reducing delinquency and antisocial child behaviour using early home visitation and pre-school education, parent training, and structured family work. Early intervention is likely to have the best outcomes for children.
- Universal interventions are successful in tackling common parenting needs at the lower end of the risk spectrum: simple and short interventions focusing on the provision of advice and information have been shown to boost parent knowledge and change behaviour. At the higher end of the spectrum, targeted services with longer cognitive and behavioural interventions teamed with follow-up and booster sessions, have shown documented effectiveness.
- Sufficient attention must be paid to engaging and sustaining families throughout, as drop-out is highlighted as a key factor in limiting the success of an intervention
- Key interventions for effective outcomes, in terms of consistent positive effects on crime and crime risk factors, have shown to be home visitation work provided by trained and committed volunteers or skilled professionals such as health visitors or social workers, aimed at helping, and sometimes training, parents of young children in adversity, using in home and direct social modelling techniques.

- The Perry Pre-school Programme (Whyte, 2003; Moran and Ghate, 2005; Department for Education and Skills, 2007) is often heralded as the exemplar of this approach to early intervention for parents of children aged three and above, targeting both high and low-risk parents and children combining early childhood instruction by teachers with weekly home visits providing parenting assistance and modelling. A longitudinal evaluation (Schweinhart and Weikart, 1997) compared long-term outcomes for the programmes cohort against a control group. The programme group was found to perform better in school and into employment, and to have markedly lower arrest rates (7% and 35% for the programme and control groups respectively by the age of 27), and another evaluation of a similar programme which adopted similar methods, found only 6% of the programme group had a conviction by age 15 compared with 22% of the control group, with a 73% reduction in statutory supervision (probation) by age 15.
- Two parent training interventions stand out: the "Webster-Stratton" programmes and "Parenting Wisely."

  The Webster-Stratton Incredible Years programmes (Gross et al, 1995; Gross et al, 2003) can be implemented as early intervention, or for parents of older children in order to teach parents positive parenting skills, such as anger management, and to teach children key social skills, such as empathy and conflict-management. Delivery is via group work modelling, including discussion and role play, and is bolstered by home-based activities and support for parents. Evaluation has found the Webster-Stratton programmes effective in addressing a number of parent and child outcomes. In particular, when the programme was used to address the antisocial behaviour of a UK-based sample of three to eight-year olds where at one-year follow up, parents were found to have successfully maintained a reduction in their child's antisocial behaviour, although children were still experiencing peer relationship difficulties (Scott, 2005).

  The "Parenting Wisely" programme also delivers parent and child training in key communication and management skills but via a self-administered CD-ROM series. A number of rigorous evaluations (Gordon, 2002), some utilising control group trials, have shown "Parenting Wisely" to increase the participation levels of high-risk families and contribute to the acquisition of parenting knowledge and skills and, as a result, improve family relations and child behaviour. The positive treatment effects have been attributed to the relevance of the content of the programme, the level of interaction demanded of the parent and child, and the 'privacy, self-paced, and non-judgemental format of the computer'.

## References

Barlow, J. and Parsons, J. (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year-old children. Cochrane Database of Systemic Reviews 2003, Issue 2. Art No.: CD003680. DOI: 10. 1002/14651858.CD003680. [online]. Available from: Department for Children, Schools and Families (2008). The impact of Sure Start Local Programmes on three-year-olds and their families, November 2005. National Evaluation of Sure Start [online]. www.dcsf.gov.uk/research

Department for Education and Skills (2007). Aiming high for children: Supporting Families. London: HM Treasury

DfES (2005). Early impacts of Sure Start Local Programmes on children and families. National Evaluation of Sure Start. NESS Research Report 13 [online]. Available from: www.surestart.gov.uk/_doc/P0001867.pdf

Gordon, D. (2002). Intervening with families of troubled youth: Functional family therapy and parenting wisely in McQuire, J. (ed) Offender Rehabilitation: Effective Programmes and Policies to Reduce Re-offending. Wiley Series in Forensic Clinical Psychology. London: Wiley

Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C. W. J. and Grady, J. (2003). Parent training with muliti-ethnic families of toddlers in day care in low-income urban communities. Journal of Consulting and Clinic Psychology 71: 261-278

Gross, D., Fogg, L. and Tucker, S. (1995). The efficacy of parent training for promoting positive parent-toddler relationships. Research in Nursing and Health 18: 489-499

Joseph Rowntree Foundation (2004). The outcomes and costs of Home Start support for young families under stress. York: Joseph Rowntree Foundation

MacQueen, S. et al (2007). Support and services for parents: a review of the literature in engaging and supporting parents. Scottish Government Social Research. Edinburgh: Scotland

Moran, P. and Ghate, D. (2005). The effectiveness of parenting support. Children and Society 19: 329-336

Moran, P., Ghate, D. and van der Merwe, A. What works in parenting support? A review of the international evidence, Policy Research Bureau. DfES Research Report 574 [online]. Available from: www.dfes.gov.uk/research

Schweinhart, L. J. and Weikart, D. P. (1997). Lasting Differences. The high/scope preschool curriculum comparison study through age 23, Ypsilanti. Michigan: High/Scope Educational Research Foundation

Scott, S. (2005). Do parenting programmes for severe child antisocial behaviour work over the longer term, and for whom? One year follow-up of a multi-centre controlled trial? Behavioural and Cognitive Psychotherapy 33: 403-421

Whyte, B. (2003). What Works with Children and Young People involved in Crime? Edinburgh: CJSWDC University of Edinburgh

## 5.3 Childhood immunisations

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health. Vaccination programmes play a vital role in protecting individuals and the community from serious diseases. Devon Primary Care Trust supports the immunisation programmes by ensuring individuals have access to all of the recommended immunisations.

The Department of Health recommends that as a community, an uptake of 90% for each individual immunisation is achieved. This provides protection both to the individuals who have been immunised and those who have not.

There has been much development of the Childhood Immunisation Programme in recent years, with vaccines against pneumococcal disease, meningitis C and haemophilus influenzae type b. Although the uptake of these vaccines in the Devon Primary Care Trust area is very good, improvement in the measles, mumps and rubella (MMR) vaccine uptake has been slow, particularly in certain parts of Devon.

The immunisation programme in the United Kingdom continues to change and evolve as we need to improve the control of the infectious diseases through immunisation. New immunisations are added to the programme and we aim to deliver these to the eligible individuals through our general practice partners and immunisation team. The immunisations are recommended by the Joint Committee on Vaccination and Immunisation (JCVI) and reflect the high standards of the World Health Organisation.

The National Childhood Immunisation Programme is detailed in Table 5.3.

### Measles, Mumps and Rubella (MMR)

The measles, mumps and rubella vaccine protects against three diseases which are the cause of potentially serious disease, either in children, adults or the unborn child. It is for this reason that the uptake of this vaccine is strongly supported. Confidence in the safety of the vaccine has grown since the publication of international research, coupled with refuting of the hypothesised link between the vaccine and autism. This link has now been proved to be false. As a consequence of the dip in MMR vaccination levels, there has been an increase in measles cases in England and Wales. Nationally, the number of cases has increased significantly. In 1998, there were 56 confirmed cases compared with 1370 cases in 2008 (Health Protection Agency, 2009).

There was an outbreak of measles in Cornwall between April and June 2008 and there was a cluster of cases in Buckfastleigh early in 2009. The concern is that there is a cohort of children who were not vaccinated between 5 and 10 years ago when the vaccine scare was at its height. As these young people are unprotected against measles, the virus can circulate and is extremely contagious.

It is interesting to compare the pattern of uptake of MMR vaccine geographically across Devon (Figure 5.1) with diphtheria, tetanus, pertussis and polio vaccination (Figures 5.2). Figure 5.3 shows the change in uptake for MMR and diptheria, tetanus, pertussis and polio vaccine uptake between 2007-08 and 2008-09 for each Devon town.

**Figure 5.1 Aged 5 Measles, Mumps and Rubella vaccination estimated uptake by lower super output area, 2007-08**

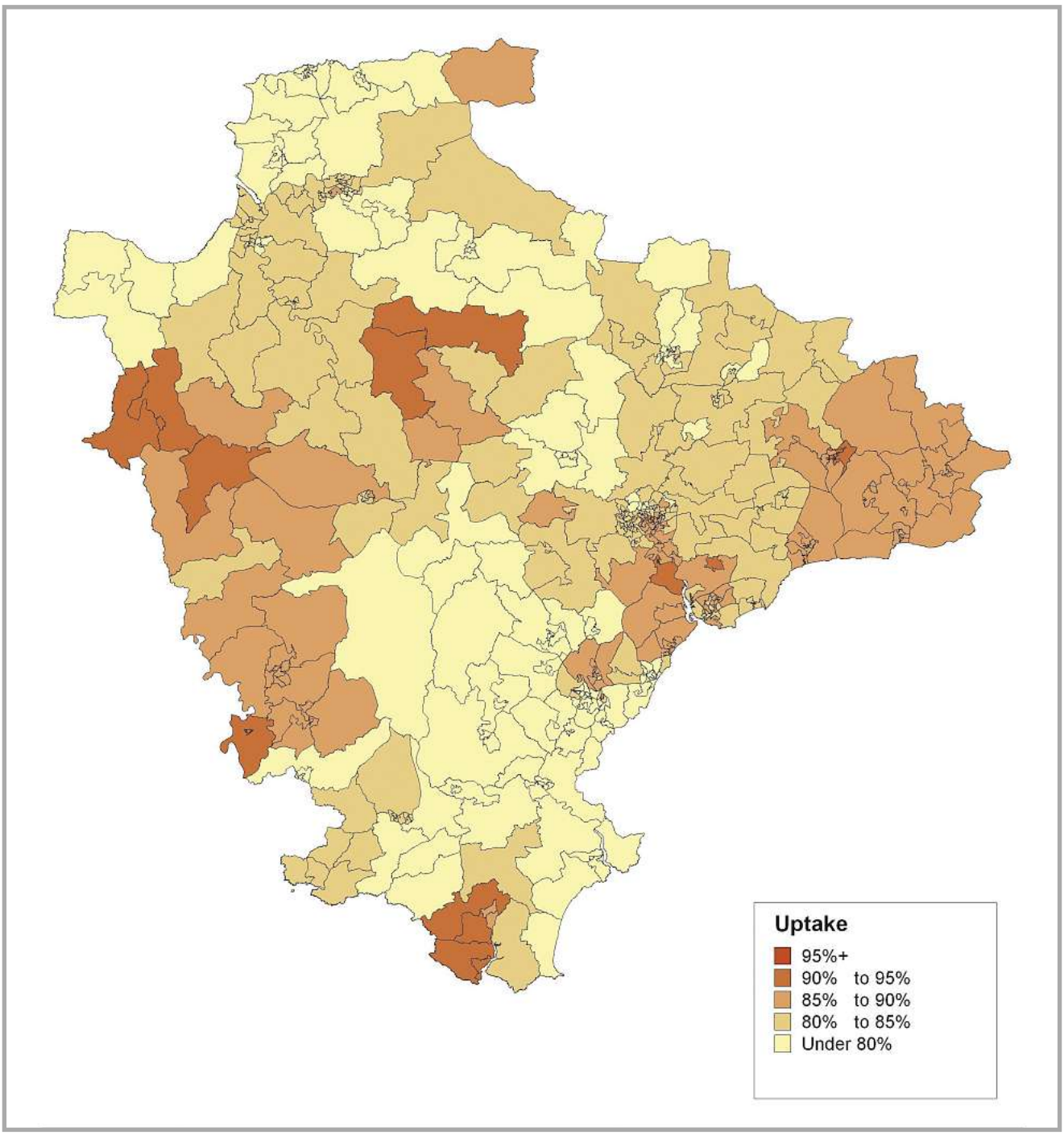
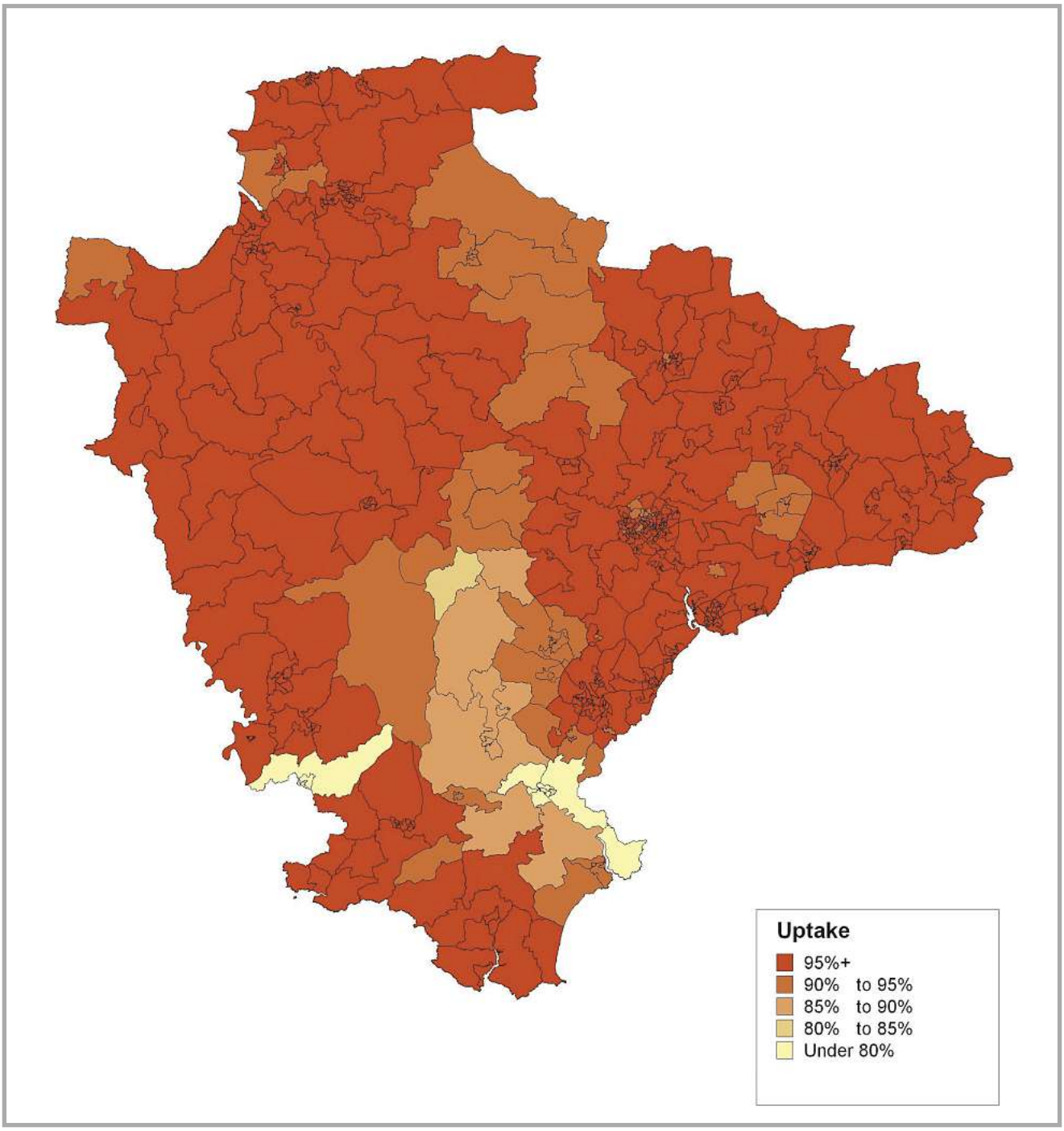


**Figure 5.2 Aged 5 Diphtheria, Tetanus and Polio vaccination estimated uptake by lower super output area, 2007-08**



## Meningitis C

Meningococcal C conjugate (MenC) vaccine has been available since November 1999. The MenC vaccine is offered at three and four months of age, with a third dose at one year in a combined vaccine with Haemophilus influenzae type b. The MenC conjugate vaccine protects selectively against Group C disease and does not protect against any other type of meningococcal infection.

This immunisation was introduced in 1999 for young people under the age of 18 and is now integrated into the childhood programme.

## Pneumococcal vaccine

The Pneumococcal vaccine has been licensed for use in the United Kingdom since 2001 and has been recommended for children at risk since 2002. Since 2006, the vaccine has been part of the childhood immunisation programme. The Pneumococcal vaccine protects against pneumococcal infection. This infection can cause diseases such as pneumonia, septicaemia and meningitis. Children are offered Pneumococcal Conjugate Vaccine (PCV) at two, four and 13 months, with people who are 65 and over being routinely offered Pneumococcal Polysaccharide Vaccine (PPV) to protect them against pneumococcal disease.

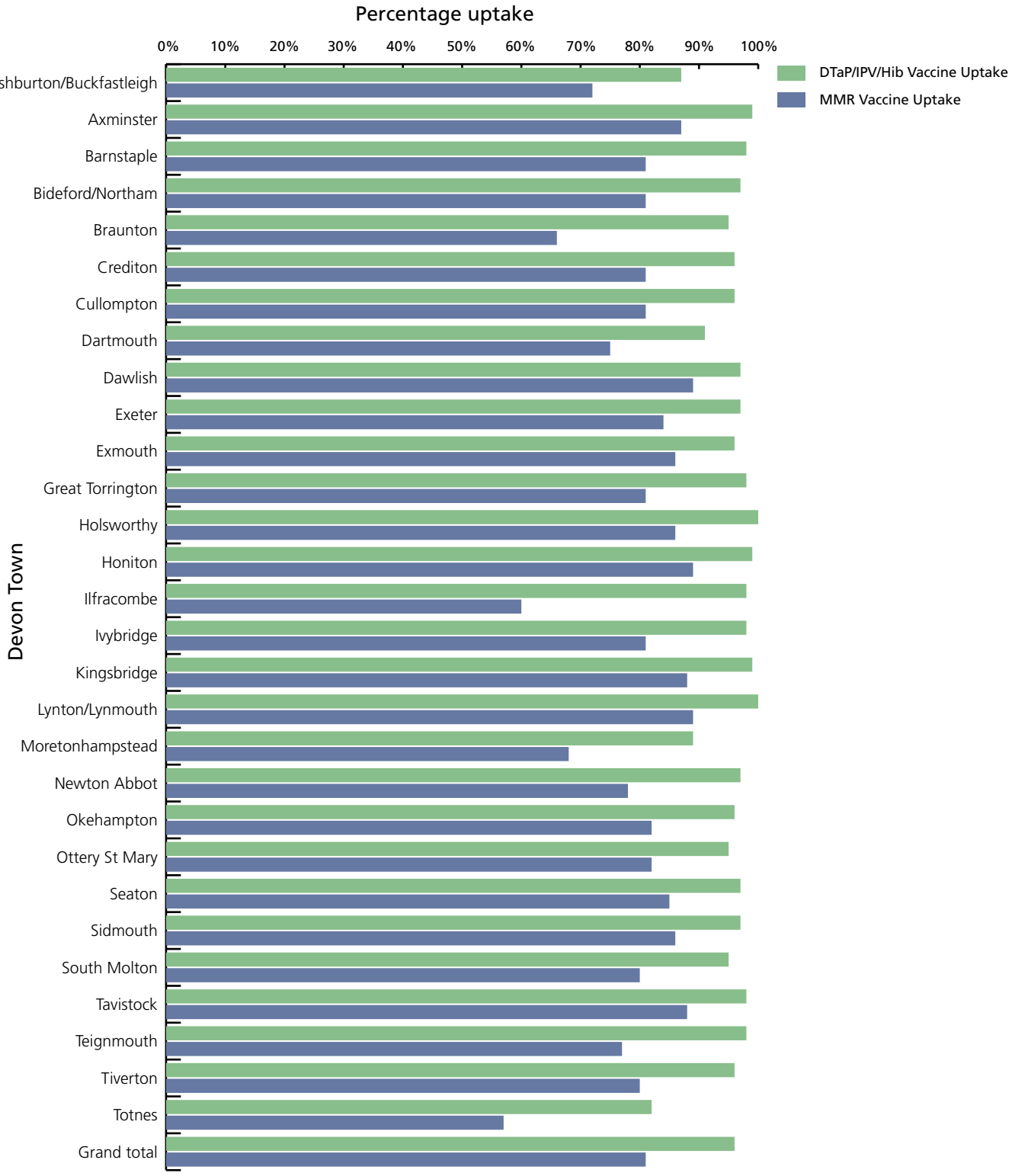
**Table 5.3 Routine Childhood Immunisation Programme, 2009**

| When to immunise | Diseases protected against | Vaccine given |
|---|---|---|
| Two months old | Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)<br>Pneumococcal infection | DTaP/IPV/Hib<br>+ Pneumococcal conjugate vaccine, (PCV) |
| Three months old | Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib)<br>Meningitis C | DTaP/IPV/Hib<br>+ MenC |
| Four months old | Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib)<br>Meningitis C<br>Pneumococcal infection | DTaP/IPV/Hib<br>+ MenC + PCV |
| Around 12 months | *Haemophilus influenza* type b (Hib)<br>Meningitis C | Hib/MenC |
| Around 13 months old | Measles, mumps and rubella<br>Pneumococcal infection | MMR<br>+ PCV |
| Three years and four months or soon after | Diphtheria, tetanus, pertussis and polio<br>Measles, mumps and rubella | DTaP/IPV or dTaP/IPV<br>+MMR |
| Girls aged 12 to 13 years | Cervical cancer caused by human papillomavirus types 16 and 18 | HPV |
| 13 to 18 years old | Diphtheria, tetanus, polio | Td/IPV |

Each vaccination is given as a single injection into the muscle of the thigh or upper arm.

Source: Department of Health, Crown Copyright, 2009

**Figure 5.3 Variation in vaccination uptake across Devon towns, 2007-08**




Source: COVER, NHS Immunisation Statistics, 2007-08

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## Recommendations

5.1 To develop a comprehensive breastfeeding strategy to increase rates of breastfeeding in Devon Primary Care Trust, to include local breastfeeding peer support programmes.

5.2 To implement a breastfeeding policy across Devon, which includes training for staff, as well as support for those staff who may themselves be breastfeeding.

5.3 To follow professional advice on feeding infants aged six months and above, promoting an increasingly varied diet using foods of different textures in appropriate amounts (in addition to milk) in response to the baby's needs.

5.4 To undertake a media campaign based on social marketing principles to improve the uptake of MMR vaccine.

5.5 To address the difference in uptake rates for the individual immunisations across the Devon Primary Care Trust area.

5.6 To commission parenting programmes that have evidence of effectiveness, and outcomes should be monitored. Evaluation of the Home Start programme found that it had not made a significant difference to mothers. However there is evidence of effectiveness of the Sure Start programme, in areas of high deprivation, for both parental and child outcomes. Effective outcomes for children's educational development have been shown with intensive two-generational programmes involving parents in skills to help their children read, and family literacy schemes.

5.7 To provide universal interventions, which appear to be successful in tackling common parenting needs at the lower end of the risk spectrum. Simple and short interventions focusing factual information and fact-based advice to parents, including child development and encouraging alteration of simple behaviours, have been shown to boost parental knowledge and change behaviour. Knowledge is enhanced by factual information given by authoritative professionals in a range of formats dealing with concrete issues, effective for all types of parents but gains are greatest for low-knowledge, high-risk groups.