July 2007

National evaluation report

Family and Parenting Support in

Sure Start Local Programmes

SureStart

Report 023

Evidence
& research

Family and Parenting Support in Sure Start Local Programmes

Acknowledgements

We would like to extend our thanks to all the managers, staff, volunteers and family members in Sure Start Local Programmes and their neighbourhoods, who willingly shared their time and knowledge with us for this study.

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Executive Summary

Aim of the Study

The themed study on Family and Parenting Support in Sure Start Local Programmes (SSLPs) aimed to identify the exact nature of the help offered to families under this heading. It also investigated whether there were any links between these services and different kinds of parenting behaviour in families where such differences had been identified by the Impact Module of the National Evaluation of Sure Start (NESS).

Methodology
The study had three parts:
   a. a review of the available evidence on what works in family and parenting support;
   b. a telephone survey of a sub-sample (59) of Sure Start Local Programmes (SSLPs) to establish the nature and extent of family and parenting support offered by them;
   c. case studies of good practice in 6 SSLPs

Definitions
Providing support for families was a core requirement of SSLPs (alongside health services, good quality play and early learning services, outreach and home visiting services and services for families with special needs). These core services overlapped to some degree. For the purpose of understanding what services could be grouped under the heading 'support for families and parenting' this study made the following distinction:

• Support for Parenting: services which aimed to enable parents to enhance their parenting. These included formal and informal interventions to increase parenting skills, improve parent/child relationships, parenting insight, attitudes and behaviours, confidence in parenting and so on.

• Family/Parent Support: services that aimed to reduce the stresses associated with parenting. These typically included informal activities which provided social contact and support, relaxation and fun, as well as programmes to develop confidence and self-esteem in parents – adult-learning programmes, for example.

Findings

1.   From the Review of Available Evidence
International systematic reviews of evidence support the use of a range of parenting interventions which start during the antenatal period and continue through infancy and early childhood. In the UK, evidence-based programmes are widely used to support parenting, alongside a multiplicity of methods to provide family support, by offering respite, social and practical help. These parenting interventions:

- are provided by a range of early years practitioners (or volunteers) who have received additional training and get ongoing support during their delivery;
- are aimed at encouraging new ways of parenting or helping to change established ways of parenting;
- involve the use of specific methods of intervention with parents, and may use specific techniques to enable parents to parent differently
- are goal-driven, with specified objectives to be achieved during the intervention and specific tasks to be undertaken;
- have a basis in theory and are often guided by the use of a manual.

2.   From the Telephone Survey of a sample of SSLPs

The survey showed that there was considerable diversity in the nature and extent of what was being provided as family support in this sub-sample of SSLPs taken from the sample of 150 SSLPs included in the studies of the Impact Module of NESS. A total of 649 parenting/parent and family support programmes were identified, an average of 11 per SSLP.

The majority of the programmes described were of the Parenting Support Variety (about two-thirds of those reported). Family Support programmes constituted the remaining one third of reported programmes.

a.   Support for Parenting

Programmes of this type included:

Parenting programmes that were intended to improve parent/child relationships and change parent attitudes and practices. While a small proportion of these were nationally recognised, standardised design, usually based on a manual and with staff trained to develop them, a majority were designed locally by SSLP workers and others. The latter sometimes included components taken from standardised programmes, but had no explicit format or training associated with them. The proportion of the SSLP population which had taken part in parenting programmes was overall quite low, though some SSLPs (particularly those using standardised programmes) reported achieving good attendance (often in the region of 90%) and were providing such programmes on a rolling basis.

Home visiting programmes, were usually directed at families with the most complex problems. but were not being used to provide intensive, one-to-one interventions to families or to deliver evidence-based parenting programmes, and home-visiting staff had not received the kind of training which would enable them to do so. They were also often being used to address common behaviour problems.

Perinatal programmes, were usually delivered by health staff and focused predominantly on traditional parentcraft classes, antenatal preparation, breastfeeding advice, postnatal depression support, and baby massage. Some innovative programmes addressed the emotional preparation of parents, but there is considerable scope to improve the training of staff for the delivery of programmes aimed at improving parental bonding and secure infant attachment.

Early Learning, some based on recognised methods of intervening, but most developed locally, covering group based activities and with no agreed structure or specific format.

b.   Family/Parent Support

Programmes of this type included:

Therapeutic Services, which included a diverse range of counselling provision, most of it based on widely tested ways of intervening with parents.

Adult Learning programmes, which were most likely to meet recognised criteria for content and delivery. Most were adult education courses but this category also included community-based courses such as NVQ training, ESOL courses, volunteer training and back-to-work guidance.

General Support programmes, the most informal group, the object of most being to improve family well-being by providing direct support to parents in the form of activities or respite from caring for children. While such programmes were an important aspect of SSLP provision, on their own they were unlikely to improve parenting. However, they could be used by SSLPs as a way of supporting parents to engage with parenting programmes – by providing childcare, or a forum for peer group encouragement, for example.

Survey results were used to determine whether there was an association between the level of provision of parenting support and SSLP performance as measured by the Impact Module of NESS. Overall differences between the high and low performing programmes were small, but where they were observable they were consistent with the belief that areas providing good parenting support (comprising the parenting programmes, home visiting, perinatal and early learning outlined above) were achieving better parenting outcomes. These successful programmes were also more likely to use nationally recognised, standardised programmes, to use the manual, to give specific training to staff, to target the programmes, to focus on parenting and discipline and to give written information to parents. All of this is in line with the national and international literature on 'what works' in parenting and family support.

3.   Case Studies

• Good Practice in Parenting Support
The case study programmes were selected because they were offering innovative support and examples of good practice in this area. Good practice included:

   i.   *Focusing on the relationship between parent and child.* This focus suffused all the activities offered to families by some SSLPs. *"Everything we do is ultimately aimed at influencing the way in which parents parent, every single thing from the minute they* [parents] *walk through the door hopefully, in the way that we are, the way that we talk*

with parents, and the way that we talk with their children…" (SSLP Manager). This philosophy is evident in the respect with which parents are treated, and the emphasis on a relationship between parent and child beginning before birth.

ii. *Modelling of good relationships by staff*. Staff model good relationships, between themselves as well as with parents. Ideally this included everyone working in the SSLP – caretaker, receptionist, administrator – and specialist workers in partnership with the SSLP. Team members are appointed on the basis of their willingness to contribute to a common vision as well as for their skills and experience.

iii. *Using a theoretical model* to underpin the way staff work with parents to achieve change. For example, in one programme the model used the Solihull approach comprising three theories about relating and change: psycho-analytic, child development and behaviourism. *"What we do is grounded in really good theoretical understanding, so none of us is tying to re-invent the wheel. We're actually trying to do things that we know are effective…how we think about children playing, adults learning…people's emotional lives and relationships. It's grounded in a really good theoretical understanding, and that's what makes it work."*

iv. *Providing at least one evidence-based, standardised parenting programme* ideally on a rolling basis so that a place on a programme was available for parents quickly, when they wanted one.

v. *Supporting parenting actively from pregnancy* to encourage parents to think about their relationship with the developing baby. SSLPs had developed a range of innovative methods here, usually in the form of group activities – antenatal groups that focus on the relationship between parent and baby; structured groups to help parents communicate with babies and think about them as social beings, and groups for parents and young children based on creative activities or early learning.

• Good Practice in Recruitment

Case study SSLPs recruited parents to parenting programmes and other family support activities by taking an active role and using local advertising, leaflets, flyers, newsletters, word of mouth, home visiting and outreach, professional referral and self-referral routes. Successful programmes had been publicised by the parents who had attended them. Where parents were wary about attending parenting courses, family support workers were active in offering encouragement or practical support. Parenting programmes were being offered universally to all who were interested. Having a mixture of parents in a group was seen as an important way to stimulate the group – where parents will share their experience as part of the process.

• Good Practice in Referral

Good practice in referral often amounted to a suggestion or encouragement to attend, rather than anything more formal. They arose out of encounters with SSLP staff – through home visits or other meetings with health visitors, midwives, creche workers and family support workers. Case study SSLPs emphasised that it is important that parents feel they have choice and are not being coerced into participation, and that this was particularly important when Social Services were involved with a family. They also emphasised that being non-judgmental was important in establishing trust between workers and families and in overcoming stigma. Workers described an ongoing dialogue with other workers in statutory services to develop understanding of this approach.

• Good Practice in Retention

A key aspect of successful retention of parents on courses was the development and maintenance of a trusting relationship between everyone involved, an emphasis on respect and not judging, and on not telling parents what to do. Case study SSLPs used active strategies to promote retention – contacting parents when they missed a session, actively helping them to catch up on any material missed.

• Good Practice in Making Programmes Accessible

Good practice in making programmes accessible included ensuring that programmes were delivered in an informal and friendly manner, including the structured and standardised programmes. Good practice also included making minor adaptations to programmes, in order to accommodate local needs, in particular for minority ethnic parents. These included translating materials, adapting them to cultural sensitivities and widening discussions to meet the diverse needs of a group.

• Good Practice in Training

In the case study SSLPs all practitioners delivering recognised, standardised programmes had received specific training to do so. Trainers were often available in the SSLP, and the wider staff had benefited from this by being able to gain a very thorough understanding of the materials and the approach of the programme, and to provide accurate information about it to parents. Training included ongoing support and supervision directly related to the programme and its delivery.

4.   Conclusions

The survey and case studies present a picture of a wide spectrum of Parenting and Family/Parent Support in SSLPs. The two approaches are linked, the latter services often enabling parents to participate in the former. There was, however, clearly prejudice against more formal parenting programmes in many SSLPs, and locally grown parenting programmes predominated, but cannot be relied upon to deliver the outcomes that should result from the evidence-based interventions. Where staff had been trained to deliver these programmes many expressed surprise and pleasure to see that they could be successful and that parents wanted to come to them. However, while many SSLPs were providing rolling programmes, and some were experiencing high rates of retention,

penetration was on the whole low, and unlikely to affect changes in parenting at a population level.

There was a surprisingly high incidence of behaviour management advice being given on home visits, but little evidence of the provision of the type of intensive home visiting that the evidence supports. There is as such scope for further training to prepare staff to work in this way.

Although perinatal services were provided in all SSLPs, there was little evidence of innovative programmes to support attachment and prepare parents for the emotional aspects of parenting. There were few programmes aimed at fathers and more were needed.

In case study SSLPs there was evidence of a range of good practice. Case study SSLPs were distinguished by their culture in which the whole emphasis of the SSLP was on working with parents to improve parenting, and a focus on the relationship between parents and their children from pregnancy through toddlerhood and beyond. They were also distinguished by the skills and insight of their staff, who were trained, confident and had access to good supervision. They also recognised the need to develop trusting, non-judgmental, empowering relationships with parents, and were able to balance the requirement to meet parents' needs at the same time as guiding them through a set programme. Parents corroborated staff views that the programmes worked well for them and they felt safe in participating in them. They also reported that they liked the structured nature of the courses.

The most difficult task more generally was to balance the provision of Support for Parenting and Family/Parent Support. While both have a role in delivering improved outcomes for children, only evidence-based programmes have been shown to change parenting, and the balance with many SSLPs was toward the use of family/parent support, much of which had been developed locally.

All Children's Centres will offer support for parenting. The National Academy for Parenting Practitioners will enable quality programmes to be delivered in them and elsewhere. This research points to a need to bolster the skills of the workforce to deliver appropriate, evidence-based programmes. In future the best indicator of successful support for parenting at local level will be the number of parents who have attended recognised programmes.

CHAPTER 1 - BACKGROUND

1.1   Introduction

Sure Start was developed with the aim of promoting the physical, social, psychological and intellectual well-being of children aged 0-3 years living in disadvantaged areas, in order to improve their chances of later success (DfES, 1997). It was a key initiative in the government's strategy for tackling social exclusion (DfES, 1997).

Funding was provided to enable agencies in disadvantaged areas to work together to develop innovative services and local resources for these communities. 524 Sure Start Local Programmes (SSLPs) had been established by 2004. SSLPs were required to provide a number of core services including family support, outreach, and home visiting. Programme guidelines emphasised the need for a 'bottom up' approach with a view to empowering the local community. This approach, together with reluctance to specify models or protocols at national level, offered SSLPs a high degree of autonomy and ensured a wide variety of provision.

The requirement for SSLPs to provide 'family support' reflected government views expressed in the White Paper *Supporting Families* (in addition to other documents published since then including *Every Child Matters*, (DfES 2003); *The National Service Framework for Children Young People and Maternity Services*, DH 2004; and the public health white paper *Choosing Health*, (DH 2004) about the importance of the family environment and parenting in particular, in determining key outcomes for children. This policy was consistent with research showing links between parenting and educational achievement/school drop-out (Desforges, 2003); behaviour problems, delinquency, criminality and violence (Patterson et al., 1989; Farrington, 2003); teenage pregnancy (Scaramella, 1998); drug and alcohol misuse (Egeland et al., 1993); and mental and physical health (Stewart-Brown & Shaw, 2004). It was also consistent with accumulating evidence suggesting that parenting is a mediator of the effect of socio-economic deprivation in childhood on outcomes in later life (e.g. Belsky et al., 2006; Conger et al., 1992; Zaslow et al., 1985), and the need to support parenting as an essential companion to initiatives which aim to reduce childhood poverty.

Early findings from the National Evaluation of Sure Start (NESS), based on data collected in 2004, suggest that overall SSLPs had had limited impact on outcomes though there does seem to be a slight effect on improving parenting (NESS 2005a; Belsky et al., 2006). The results also suggested that there was variation in the performance of SSLPs, with programmes that were better led, with clearer objectives, and which had used effective methods of identifying families, producing better outcomes (NESS, 2005b; Melhuish et al., 2007).

1.2   Family and parenting support

Over the past two decades there has been increasing evidence about the effectiveness of family and parent support and, in general, studies have concluded that parenting support benefits families in a variety of ways, especially when combined with local and national policies that address the broader social and economic factors that affect parents' and children's lives. Alongside this developing evidence base has been an improved ability to identify the factors that are associated with greater effectiveness.

The aim of this themed evaluation was to document the types of family and parenting support provided by SSLPs across the country, to identify good practice and to assess whether there was a difference in the types of support being provided by the programmes in which parenting outcomes were better compared with the programmes where they were less good (as measured by the Impact module of the National Evaluation of Sure Start). To this end, we have gathered data on the family and parenting support programmes, both formal and informal, provided by a subsample of SSLPs in order to explore the nature of these programmes, including the extent to which they adhered to factors associated with greater effectiveness and to explore whether these were associated with better outcomes for children, using the outcome data in NESS.

1.3   What is Already Known about Family and Parenting Support in Sure Start

A number of studies have already provided a picture of some aspects of family and parenting support in Sure Start. For example, a recent study entitled 'Implementing Sure Start local programmes: An in-depth study (Part Two – A Close up on Services) (Allnock, et al., 2005) provided a detailed account of provision across four service areas– Outreach and Home Visiting; Support to Families; Community services; Play, learning and childcare. Six aspects of service provision were examined - management and governance, staffing trends; access to services; parent involvement; quantity of services; SSLP 'added value' to services or 'quality. The following conclusions were reached.

Family services:
- The most commonly initiated 'new services' within SSLPs included leisure activities; home visiting; parenting programmes and drop-in centres with crèche facilities.
- The key family support activities were: leisure activities; drop-in facilities; fathers groups; support for grandparents; parenting groups; equipment loan schemes; swap shops; support for teenage parents.
- Parenting groups were the most commonly enhanced service across the case study SSLPs with evidence of a range of standardised and locally developed programmes being used;
- Fathers' groups continued to be 'gendered' in that they were 'less centred on parenting issues than on networking; fun activities; DIY etc.

- Family support services were the least prevalent in SSLPs and where such services were being enhanced in SSLPs it was in areas where their availability was high prior to Sure Start;

Outreach/home visiting:
- Home visiting was being undertaken: to increase awareness of the SSLP; to provide befriending services; as a means of delivering health/development services'; as a gateway to other substantive services; as a way of providing specialist services through outreach.

Community health
- The services most likely to be enhanced comprised post-natal depression services; other pregnancy services.
- Most SSLPs were expending most of their resources and effort on boosting the activities that existing statutory services were providing.

Good Quality Play, Learning and Childcare
- Received a high level of priority within most SSLPs
- There was enhancement of existing services rather than development of new early years services.

Overall, this report provides a picture of enhanced service provision across a number of areas, but of limited development of new services. Family support, and parenting programmes in particular, was an area in which new services had been developed, but there was little detail available about the nature and extent of these programmes.

Two further reports provided evidence about perinatal support in SSLPs (Kurtz et al., 2005) and the provision of home visiting (Ball et al., 2006). The first of these concluded with regard to the provision of family and parenting support during the perinatal period that:

- Sure Start resources had funded additional midwifery and health visitor time for work on a one-to-one basis with very vulnerable women;
- SSLPs had improved access to services and provided a setting for experimentation and innovation in maternity service;
- Sure Start had changed the way practitioners were working;
- While some SSLPs had created new evidence-based services this was not universal and in some places activities went against the evidence of successful practice.

Overall, this report suggests that Sure Start has contributed to the development of a range of services to support women during the perinatal period.   This support is diverse and includes innovative forms of provision for pregnant and newly delivered women including holistic antenatal groups such as free classes at local swimming pools; intensive one-to-one postnatal support; smoking cessation; healthy eating; support for breastfeeding; identification and treatment of mental health problems and the targeting of women with particular needs.

There also appears to be some emphasis on the promotion of attachment using

methods such as baby massage.

The second report (Ball et al., 2006) examined the provision of home visiting programmes in Sure Start and concluded that:

- the main goal of home visiting in most SSLPs was to get parents to leave their homes and join groups and services run by Sure Start or other providers;
- there was considerable variation in the way that home visiting was being delivered with some programmes preferring the use of non-professional delivered programmes and others preferring the opposite;
- there was considerable variation in the preparation of outreach workers ranging from none in the case of professionals such as health visitors to the provision of specialist training for staff regarded as not having the requisite skills as part of their core training;
- essential training for staff focused on the avoidance of risk and confidentiality procedures;
- parents expressed high levels of satisfaction with outreach and home visiting services;
- few outreach services delivered specifically to children in the home over a significant length of time to a structured curriculum delivered by a trained professional.

Overall, this report suggests considerable variation in the provision of home visiting with little use of the sort of intensive home visiting programmes that the evidence supports, and an emphasis on its use as a mechanism for reaching parents with a view to moving them onto other services.

The current study is intended to add to this research by examining in more detail the nature and extent of parenting and family support provided by SSLPs.

1.4   The Study

The aim of this themed study was to inform future decision-making about the provision of family and parenting support in Children's Centres by establishing what can be learnt from the experience of SSLPs to date.

The specific objectives of the study were:

- to identify the nature and extent of family and parenting support within a subsample of SSLPs;
- to examine the extent to which different types of provision might be associated with better parenting.

Unlike earlier reports which refer to family support in Sure Start Local Programmes, we have made the following distinction with regard to family/parent and parenting support (see section 3.1 for further details):

i) Parenting support - aims at enabling parents to enhance their parenting. This includes formal or informal interventions aimed at increasing parenting skills; improving parent child relationships, improving parenting insight, attitudes and behaviour; increasing parenting confidence etc.

ii) Family/Parent Support - aims at reducing the stresses associated with parenting. This typically includes informal activities that are aimed at reducing parental stress, increasing social support, providing activities and fun, as well as programmes which develop parents' confidence and self esteem – for example adult learning programmes.

We have used the term Sure Start Local Programmes (SSLPs) throughout despite the fact that during the course of the study most were in the process of becoming Children's Centres. This reflects the fact that this is a retrospective study charting the provision of family and parenting support during their period as SSLPs.

We have used the term 'programme' throughout to refer to the many family and parenting services provided by SSLPs.

CHAPTER 2 – METHODS

2.1 Study Components

This themed evaluation comprised three components:

I) A summary of what is currently known about 'what works' in parenting support;
II) A telephone survey;
III) A series of detailed case studies to identify areas of 'best practice'.

See appendix A for a full description of the methodology.

2.2 Description of the evidence base

The aim of this part of the study was to provide a summary of existing evidence about what works specifically as regards *parenting support*. The first part of this description of the evidence provides a review of the international evidence. It draws on recent systematic reviews of the literature undertaken by the authors and summarises the findings of reviews of reviews. The second part aims to provide an overview of some of the innovative and evidence-based parenting support in the UK, again drawing on recent work by the authors.

2.3 Telephone survey

A telephone survey was undertaken of a sub-sample of SSLPs taken from the random sample of 150 SSLPs studied in the Impact Module of NESS. The sampling strategy was to survey programmes from the top and bottom 25% of SSLPs on the basis of apparent improvements in parenting documented in the NESS Impact Study. This produced a total of 76 SSLPs, half of which were at the bottom of the distribution of parenting outcomes, and half in the top of the distribution.

The aim of the study was to examine the nature and extent of two types of support, i.e. family/parent support and parenting support. We also aimed to explore whether there were differences in the provision in the two groups of SSLPs. The interview sought information regarding: i) What informal and formal family and parenting support programmes had been delivered; ii) How they were delivered (i.e. frequency; duration; who provided etc); iii) What training was provided to staff (which staff received this; who provided it; duration); iv) What support was provided to programme providers (which staff received this; who provided it; frequency) etc.

A total of 76 SSLPs were invited to take part and 59 SSLPs responded positively: a response rate of 78%.

Telephone interviews were conducted with one member of staff from each SSLP, a majority of whom were programme managers or their deputies.

2.4　Detailed Case Studies

A purposive sample of local programmes, six in total, that were identified in the survey as providing effective, innovative and varied forms of family and parenting support, were used as case studies in order to identify examples of good practice in terms of the provision of family and parenting support.

The following criteria were used for the selection of case study SSLPs:

i) The extent to which the projects provided particularly innovative or successful
　　ways of supporting parents, as identified through the telephone survey
ii)　Geographical spread
iii) The inclusion of programmes serving large ethnic minority populations

A total of 24 staff members involved in provision of parenting support services and twenty-three regular users with first-hand knowledge of Sure Start services (almost half of whom were from minority ethnic groups) took part in group interviews (average 4 per group) (see Appendix E for further detail). Staff and parents were interviewed separately, and the groups were facilitated in the local Sure Start/Children's centre. Crèche facilities were made available for participating parents. The discussions aimed to examine provider and recipient perspectives concerning the support being provided.

2.5　Description of the Findings

Section three of this report provides a detailed summary of the international research evidence relating to parenting support. Sections four and five describe the results of the telephone survey: section four describes the nature and amount of family and parenting support, and section five describes the variation in provision across SSLPs. Section six describes the results of the in-depth case studies.

CHAPTER 3 – SUPPORTING PARENTING: THE EVIDENCE

3.1   Introduction

Interventions *to support parents in their role as parents* are diverse and range from providing respite (for example, by providing parents with access to outings, meeting places, and alternative therapies) to helping parents do a better job of parenting (for example, by providing access to therapies such as counselling). Interventions of this nature have an **indirect impact** on the well-being of children by relieving parents of some of the associated stresses of parenting.

During the past decade, there has been an increase in the development and use of interventions and services that are aimed at *changing parenting insight and practices* in *improving parent child relationships.* Interventions of this nature have a **direct impact** on the wellbeing of children, by helping parents to parent in ways that are recognised to promote optimal child outcomes. These programmes fall into four main categories.

a) **Perinatal programmes** that are mostly provided on a one-to-one basis during the perinatal period with parents-to-be and new parents, and focus explicitly on improving outcomes for infants by promoting sensitive parenting in the mother and secure attachment in the infant.

b) **Home visiting programmes** that are also provided on a one-to-one basis and may be of varying length. Some begin during the antenatal period and continue over an extended period of time, until the baby is two or three years of age. Home visiting programmes vary in their aims. Some have a broad set of goals and aim to improve a wide range of risk factors associated with poor outcomes in vulnerable pregnant women including health related behaviours during pregnancy, parenting during the early postnatal period, and factors that influence the maternal life course. Others have more limited goals – for example befriending and social support.

c) **Parenting programmes** which, are on the whole group-based and focus on helping parents to address the emerging behavioural and relationship issues of toddlers and older children. In addition to the more formal parenting programmes there are a range of **promotional materials** (e.g. leaflets; videos; books etc) to help parents to change their parenting practices.

d) **Early learning programmes** are sometimes provided directly to the child but the type that is of interest here are early learning programmes that involve working with parents often together with the child, to enable parents to improve their children's educational outcomes and related outcomes such as self-esteem.

These categories are not exclusive and there are examples of group-based attachment programmes for both high risk (Mellow Baby) and general population

groups that are provided around infancy and aimed at improving maternal sensitivity and attunement (e.g. PIPPIN). Behaviourally orientated parenting programmes which are typically delivered in a group setting may be provided on a one to one basis.

3.2 What Works: the International Evidence

A recent review of reviews (Tennant et al., 2006) identified more than five recent systematic reviews that had examined the effectiveness of interventions aimed primarily at supporting parenting using one of the groups of interventions referred to above (Bakermans-Kranenburg et al., 1998; Barnes & Freude-Lagevardi, 2003; Moran et al., 2004; Dretzke et al., 2004, and Barlow et al., 2005).

The first of these reviewed early preventive interventions aimed at promoting secure infant attachment (Bakermans-Kranenburg et al., 1998), and included 70 studies of interventions aimed at enhancing parenting in four categories:
• Sensitivity
• Support
• Representation
• Combination of these

The review found that a range of interventions could be effective in improving insensitive parenting and insecure infant attachment, and that interventions focusing on sensitivity alone tended to be more effective than other types of interventions. So, for example, one study showed that providing adolescent mothers with a videotape of themselves feeding their infant, increased sensitivity during mealtime. Interventions that included the use of video feedback were one of the most effective ways of intervening with parents. This review suggested that interventions conducted at home were not significantly better than interventions conducted elsewhere, that those with fewer than 5 sessions were often as effective as those with more sessions, and that interventions starting after six months were marginally more effective than those that started prior to this. Some of these findings conflict with those of other studies (see below).

The second review examined interventions aimed at improving parenting, family functioning and young children's mental health (Barnes, 2003; Barnes & Freude-Lagevardi, 2003). This review included all forms of therapy or support services for families with infants or pre-school aged children. The main type of interventions were home visiting, educational pre-school programmes, pre-natal & theoretically-driven programmes. The review aimed to address the influence on outcomes of the programme model, programme target, intervener, programme duration, timing and intensity.

The review reached the following conclusions in terms of successful programmes;
• ecological & developmental models that address both the context within which a child lives and the child's developmental stage are most likely to be effective;
• multi-method interventions that combine multiple delivery formats, offer

multiple therapeutic approaches and have added services may have greater effect than single-method strategies;
- group-based interventions appear to be a cost-effective alternative to individual therapy either in place of or complementing individual therapy;
- approaches that target both children and parents appear to be more effective than those that target children or parents on their own, although some important effects can be seen in programmes targeting parents only;
- brief, hospital-based interventions such as the BNBAS-exam and minimal parent coaching may be (cost)-effective in enhancing low-risk parents' knowledge, sensitivity and behaviour towards their infant in the short-term.

These reviewers also concluded that there is little evidence about which population groups benefit most from which interventions and that while the accumulation of risk factors may increase need, it does not necessarily increase a parent's capacity to benefit. However, first-time mothers (including teenage mothers & their infants) appear to benefit to a greater extent from early intervention.

Moran et al., (2004) reviewed the international literature on parent support focusing in particular on support that can be described as a formal 'intervention' or '*things done to or with parents*'. The following highlights the main conclusions:

- manualised programmes with centrally-monitored, systematised delivery tend to deliver better outcomes;
- programme integrity matters;
- quality and training of staff is vital to programme success;
- programmes that do not pay close attention to implementation factors are unlikely to be successful;
- successful programmes address more than one area of need, without losing sight of their core objectives;
- interventions that work with children **and** parents show better outcomes;
- intensive interventions are expensive to run and require great effort, but may have longer term pay-offs;
- low-level, low cost interventions may be under-rated as a means of getting information about child care out to parents in the community.

These authors also note that 'the best designed services typically experience high drop-out rates and show substantial proportions of the sample who do not benefit' (p. 88).

In terms of interventions that are aimed at improving child emotional and behaviour development this review concludes that successful interventions typically involve:

- behavioural parent training on an individual or group basis, though group-based programmes are more cost-effective;
- age-appropriate methods taking account of children's developmental stage.

Successful programmes aimed at improving child educational, cognitive and

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social outcomes typically involve:
- intensive two-generation programmes with multiple components;
- training parents in specific techniques and skills to help their children read.

Programmes that are successful in improving parenting skills typically involve:
- high attention to implementation issues to promote attendance and lasting engagement;
- interactive methods of teaching;
- practically focused tips for modifying parents behaviour;
- focus on younger children;
- group-based rather than one-to-one.

Successful programmes aimed at improving parental, emotional and mental health typically involve:
- medium length group work lasting eight to twelve weeks;
- parents of pre-school age children;
- staff whose level of training matches the type of intervention being delivered the severity of the outcome being targeted.

Standardised and nationally available parenting programmes have been the subject of a number of reviews, the most recent of which was commissioned by the National Institute of Health and Clinical Excellence (NICE), and supports their use to improve the behaviour of children aged 3-14 years (Dretzke et al., 2006), by changing parenting practices. There is, in addition, a range of reviews showing that such programmes can be effective with teenage parents (Coren and Barlow, ethnic minority parents (Barlow et al., 2004), and in parents of young children (Barlow et al., 2003). The latter found that parenting programmes including a toddler version of the Incredible Years Programme by Webster-Stratton, and other behavioural programmes (Nicholson et al., 2002; Sutton, 1992) were effective in improving parenting practices and the behavioural adjustment of children under the age of 3 years.

3.3   What Works in the UK

The above reviews suggest that there are a variety of effective ways of intervening to *support parenting*. Such interventions have not necessarily been developed or used in a UK context, and we therefore sought to identify methods of supporting parenting that are currently being used in the UK and for which there is at least preliminary evidence of effectiveness.

3.3.1 Promotional Materials

There are now a wide range of promotional materials being used to support parenting in the UK. Some of these comprise leaflets and booklets, while others comprise videotaped material. Such materials may be helpful to parents either as an adjunct to some of the more structured interventions referred to below, or as stand alone interventions. For example, the Triple P parenting programme provides a videotape - 12-episode television series "Families" about disruptive child behaviour and family adjustment for parents to use on their own in the

home. An RCT of 56 parents of children between 2 and 8 years in which parents in a media group watched the above videotape, showed significantly lower levels of disruptive child behaviour in the media group and higher levels of perceived parenting competence (i.e. an overall reduction from 43% to 14% of children with disruptive behaviour above the clinical level). These effects were maintained at 6-month follow-up (Sanders et al., 2000).

3.3.2 Perinatal Programmes

Perinatal programmes refer to services that are provided during the antenatal or perinatal periods to enhance the parenting of pregnant and newly delivered women. They are typically provided by midwives and health visitors, but may also be provided by other professionals including psychotherapists. They focus primarily on the emotional preparation of parents for parenthood, and promoting sensitive attuned parenting that is associated with secure attachment in the infant. Evidence-based methods of supporting parenting during the perinatal period currently being used in the UK include promotional interviewing (Puura et al., 2002), Brazelton (Rauh, 1988), infant massage (Onazawa et al., 2001), interaction guidance and videotape feedback (Svanberg, personal communication), the Solihull approach (Douglas and Brennan, 2004), parent-infant psychotherapy (Cohen et al., 2000; 1999).

Promotional interviewing involves specially trained primary health care workers (only health visitors have undertaken this role to date) conducting 'promotional' interviews immediately before and after all new births. The aim of the promotional interview is to promote positive interaction between parent and child as a key element of healthy psychosocial development during infancy and childhood, and to facilitate the transition to parenthood of first-time parents and also to identify parents in need of further input. Two promotional interviews were conducted as part of the European Early Promotion Project, one during the antenatal period and one post-natally. For example, the heath visitor might ask as part of an antenatal promotional interview, how the mother felt when she learned that she was pregnant. Positive feelings would then be endorsed and negative feelings explored further and talked about. The health visitor then works intensively using parent counselling techniques with those families that are identified at the postnatal interview as requiring further input. Early findings have shown that the training improved the capacity of the primary health care worker to identify families in need, and to make accurate judgements about need. The results also indicate that in the UK and Greece trained health visitors were seen as being significantly more helpful than untrained health visitors (Puura et al., 2002).

Videotape feedback and interaction guidance have been identified as being one of the most powerful methods of intervening to promote more sensitive and optimal parenting (Bakermans-Kranenberg et al., 1998). The Sunderland Infant programme pioneered in one SSLP was aimed at the early identification of attachment problems and the promotion of sensitive parenting, using a videotaped recording by the health visitor of a 3-minute period of mother-child interaction. Mothers of dyads who were identified as having minor problems in sensitive co-operative interaction were provided with developmental guidance

and/or interaction guidance by the health visitor, through feed-back of the previously videotaped interaction. Prior to the interaction guidance feed-back the interaction was discussed and analysed using Crittenden's CARE Index in consultation with clinical psychologists. Parents who were identified as having more significant problems were offered Parent-Infant psychotherapy, which involved helping the mother to resolve issues surrounding trauma, loss and attachment, developing mindfulness or 'reflective function', and discussing the mother's own experiences of being parented i.e. "hearing the mother's cry in order that she can hear her baby's cry." Other therapeutic modalities such as family therapy or couple therapy were also offered if appropriate. A recent evaluation of this programme showed that it was highly effective in promoting sensitive parenting and in reducing infant attachment problems (Svanberg, personal communication).

Parent-infant psychotherapy is being used in the UK to treat parent-infant dyads in which there are wide-ranging and sometimes serious clinical problems including unresolved loss in the mother; non-organic failure to thrive in the infant; concerns about abuse etc. The earliest approaches to parent-infant psychotherapy focused primarily on the mother's 'representational' world ('representation-focused' approach) or the way in which the mother's current view of her infant is affected by interfering representations from her own history. This approach was developed by Fraiberg (1980) who referred to this phenomenon as 'the Ghosts in the Nursery'. It is underpinned by the belief that once the mother has been helped to recognise the ghosts and to link them to her own past and current history, changes to the mother's representational world can take place, facilitating new paths for growth and development for both mother and infant. Much more recently this representational type approach has been combined with a more behavioural approach. 'Watch, Wait and Wonder' (WWW) is an 'infant-led' parent-infant psychotherapy which involves the mother spending time observing her infant's self-initiated activity, accepting the infant's spontaneous and undirected behaviour, and being physically accessible to the infant. The mother then discusses her experiences of the infant-led play with the therapist with a view to examining the mother's internal working models of herself in relation to her infant.

The two approaches were compared using an RCT with 67 anxiously attached dyads aged less than 30 months (Cohen et al., 2000; 1999). The results show that post intervention both WWW and the representational approach were successful in reducing infant presenting problems, decreasing parenting stress, reducing maternal intrusiveness and mother-infant conflict. The WWW group showed greater shift toward more organised or secure attachment and greater improvement in cognitive development and emotion regulation than PPT group, and WWW mothers reported greater increase in parenting satisfaction and competence and greater decrease in depression. However, these differences had disappeared at six months follow-up by which time the PPT group had caught up. At 6 months there were still advantages for the WWW group in terms of the mothers comfort in dealing with infant behaviours and parenting stress.

Infant massage is also being used to promote parent-infant interaction with a group of depressed mothers. Infant massage can be provided by specially trained health visitors in groups/classes which are made available to mother of infants from 0 – 24 months of age. The massage technique is demonstrated on a life-size doll and the parent practices on the baby. The potential benefits of this technique include improved bonding, communication, parental competence, fun, awareness through loving touch for the parent, and an improved sense of well-being, relaxation, love, acceptance, and security for the infant. Recent evidence from a systematic review showed that infant massage can be effective in improving sleep, and reducing crying and infant stress. There was also some evidence to suggest improved mother-infant interaction (Underdown et al., 2006).

Solihull Approach is a practical way of working with families based on three theoretical concepts – containment; reciprocity and behaviour management – which help parents to address emotions and anxieties that feel overwhelming; help practitioners and parents to explore how the child and parent interact as a basis for feedback and change; and help the parents to manage their child's behaviour (Douglas and Brennan, 2004).   This approach involves the practitioner in active listening and allowing the client to tell their own story, resulting in a change in the emphasis of practitioners work with all clients. It is being used to work with parents in a range of contexts including perinatal groups; breast-feeding training; healthy eating programmes and positive parenting groups (ibid). Preliminary research suggests that this approach impacted on the practice of Health visitors trained to use it (Douglas and Ginty, 2001), and preliminary evidence of improved symptoms including parental anxiety about the symptoms (Douglas and Brennan, 2004).

3.3.3 Parenting Programmes

Parenting programmes consist of brief (4 –12 weeks) group-based support for parents of children of all ages, and these are now being used quite extensively in the UK (Smith, 1996). They include programmes for which there is a robust evidence base such as the Webster-Stratton ***Incredible Years*** programme (Webster-Stratton et al., 2004) and ***Triple P*** (Ireland et al., 2003; Bor et al., 2002) as well as others which, although lacking RCT evidence, are underpinned by a sound theoretical base, are manualised and structured and conform to many of the principles of effective programmes. Both Incredible Years and Triple P are based on social learning theory and teach parents behaviour management strategies including consistency and clear rules, encouraging positive behaviour using rewards, and discouraging negative. Both also offer strategies for building parental confidence and enhancing the parent child relationship. ***Strengthening Families; Strengthening Communities*** is a culturally sensitive parenting programme originating in the US that has been adapted for use in the UK particularly with black and minority ethnic parents. It offers families behaviour management and relationship building strategies as well as developing parents' pride in their own cultures and has been shown in the US to improve children's social competence, and help parents and children to manage conflict (Steele et al., 2002).

Other programmes for which there is less robust evidence, but which are being widely used very successfully include, the **Family Links** parenting programme which was developed in the UK from a programme which was designed to enhance parenting in abusive families (the Nurturing Programme). The UK programme is offered universally. It covers positive discipline and strategies for managing problem behaviour, but with a focus on boosting parents and children's self esteem, and improving parent child relationships by increasing parental empathy and communication skills (Hunt, 2004). Preliminary evidence shows that parents valued this programme highly (Barlow and Stewart-Brown, 2005). **Mellow Parenting** and its infant version **Mellow Baby** are programmes developed for high risk and abusing families which aim to promote sensitive parenting. Both children and parents attend the programme for up to a day at a time, children spending some time in a crèche and some time with parents. Early evidence shows that this programme can make a difference to families (Puckering, 1994).   **Handling Children's Behaviour'** is a behavioural programme designed specifically for the parents of preschool children.   The content of the programme focuses on helping parents to understand why children behave the way that they do, and the ways in which behaviour patterns develop, and preliminary evidence about its benefits has been produced (Lawes, 1992).

While the majority of parenting programmes are provided following the birth of the infant, the **Parents in Partnership Parent Infant Programme (PIPPIN)** is an example of a parenting programme that begins antenatally and aims to promote healthy early mother-infant relationships. It provides a total of 35 hours of support through a series of weekly two-hour group-based sessions that are facilitated by two parent-infant group leaders (usually midwives and health visitors) and is often delivered as part of antenatal and postnatal classes within the NHS (Parr,1997).

3.3.4 Home Visiting Programmes

Home visiting programmes may be provided by professionals or volunteers. Those provided by volunteers usually aim to provide parent support rather than parenting support, but there are exceptions (see below). Professionally delivered home visiting may have a variety of goals, most aiming to support parenting in the broad sense of the term (including support for weaning, encouraging immunisation), but by no means all focusing on parenting support as the term is used in this report. Health visitors currently provide generic, non-specific home visiting services to large numbers of families in the UK. Specific professionally delivered home visiting programmes that are currently being used in the UK include the **Child Development Programme** (Percy and Barker, 1986), **First Parent Visitor Programme** (Emond et al., 2002) and the **Family Partnership Programme** (Davis et al., 2002). These all have a clear focus on improving parenting. The evidence suggests that volunteer and professionally delivered programmes they have a role to play alongside one another in supporting vulnerable parents (Barnes, 2003; Barnes & Freude-Lagevardi, 2003).

The Child Development Programme (CDP) (Percy and Barker, 1986) is delivered by specially trained health visitors, and the fundamental premise of the programme is that of 'empowerment' in which the parent is recognised as an

equal in the partnership with the home visitor and an expert on their own child. The approach of the programme is behavioural and visits are semi-structured, the content of each visit being left to the discretion of the parent and home-visitor. Visits are made every 4-5 weeks and are of 40-60 minutes duration. The programme focuses on six areas – health, language, cognition, socialisation, nutrition and early education, and the home visitor aims to encourage behavioural change in one or more of these areas by supporting and reinforcing the strategies decided upon by the parent. A Child Progress form is completed jointly each month prior to decisions being made about what the mother would like to do during the coming month to help her child's progress. During the following visit, the home visitor and parents discuss the progress that has been made in meeting these goals. Humorous illustrated materials are used covering the six areas mentioned above in order to present sensitive parenting issues in an informal way, and to illustrate different methods of handling problems and promoting development (ibid).

The limited evaluation of this programme showed higher immunisation rates, and less time spent in hospital in the intervention children (Percy and Barker, 1986). In addition, intervention children showed greater concentration, better social behaviour, and better language development and communication skills than comparable control children. Evidence from interviews suggest that the programme was also beneficial for parents (ibid).

This First Parent Visitor Programme (FPVP), evolved from the CDP and comprised a programme of regular home visits by a specially trained health visitor to first-time parents from deprived areas. The FPVP aims to support and advise the mother, who is visited at home antenatally (during the third trimester), at the statutory primary birth visit, 3-weeks postnatally, and then every five weeks up until the 8th postnatal month. Approximately 20% of families experiencing ongoing difficulties continue to receive the service until the child is 2 years of age (ibid). As with the CDP, the emphasis of the FPVP is on empowerment, and the programme is delivered using written materials including cartoons (ibid).

An evaluation of the effectiveness of this programme was undertaken using both prospective and retrospective data, in which four comparison areas were matched (i.e. on social, economic and demographic profiles) with three areas receiving the FPVP (Emond et al., 2002). Retrospective data was collected from a total of 2113 families, and prospective data from a total of 459 families. Overall, the evaluation did not show any clear advantage for the FPVP over conventional health visiting and with regard to child health, there were no differences in children's developmental outcomes at 1 and 2 years, and both height and weight scores were lower in the FPVP children at 2 years of age, than comparison children. Also there were no differences in immunisation rates, uptake of child health surveillance, or use of hospital services, and a higher proportion of families who received the FPVP were registered on the local child protection register compared with comparison families. There were, however, lower accident rates in the FPVP group in the second year of life and an increased use of electric socket covers. As regards maternal outcomes, women who received the FPVP were more likely to have changed partners, but also had a wider support network than comparison women. The FPVP group also

consulted with their GPs less often, and was more likely to have breast-fed their infant, and to have given their infant fruit-juice drinks. There were, however, no differences between the groups as regards self-esteem, locus of control or rates of depression (ibid).

The **Family Partnership Programme** is a parent counselling programme that is delivered by tier one staff including health visitors and paediatric medical officers who have received training in the use of counselling techniques, parenting, and child behavioural management. A recent evaluation of this programme was conducted in which an average of 8 hourly sessions (range 2 – 25) were delivered on a one-to-one basis in the home by health visitors and clinical medical officers. Referrals to the programme were made by health, education and social service personnel, in addition to self-referral. Referral criteria included that the child be preschool age with emotional and behavioural problems or that the parents be experiencing psychological/psychiatric or parenting problems. The results showed that the Parent Advisor Programme was effective in bringing about improvements in parental self-esteem, stress and emotional difficulties, parental constructions of their children, the home environment, and child behaviour problems (Davis and Spurr, 1998).

There are currently two types of volunteer home visiting programmes being used in the UK – Community Mothers and Home Start. **Community Mothers** is delivered by a non-professional, volunteer once a month to disadvantaged first-time mothers of children aged up to one year. This intervention has been shown to improve a range of outcomes including primary immunisations, being read to, more cognitive games, better diet, and less negative and more positive feelings (Johnson et al., 1993). A recently published follow-up study showed sustained beneficial effects on parenting skills and maternal self-esteem 7 years later with benefit extending to subsequent children (ibid).

Home-Start is another example of a UK-based volunteer home visiting programme in which trained volunteers offer regular support, friendship and practical help to young families under stress in their own homes. The goal is therefore parent support rather than parenting support. Referrals to Home Start are made primarily by GPs, health visitors, and social workers. Volunteers are of all ages and backgrounds, the only criterion for inclusion being that the volunteer has had experience of being a parent.

While a recent controlled study failed to show objective benefits of Home-Start, (McAuley 2004) and a cluster randomised study found minimal benefits in terms of reducing parental stress, but no improvement in parenting behaviour (Barnes et al., 2006). In-depth interviews with programme recipients indicated that the Home-Start programme made a positive difference to families in terms of meeting the physical, emotional, social, and educational needs of children, and in encouraging confidence in and respite from, parenting (van der Eyken, 1990).

3.3.5 Early Learning Programmes

Peers Early Education Programme (PEEP) is a UK based Early Years Education that is based on the growing body of evidence linking the early development of language, literacy, and personal and social development with outcomes relating to higher educational attainment, improved behaviour and crime prevention. The aim of PEEP is to promote learning and cognitive development during the first few years of a child's life. PEEP provide a home visit to all families with new babies living in deprived areas, and parents are invited to attend weekly group sessions where they are offered mutual support and group-based interactive activities with infants including sharing a book every day, songs and rhymes, listening games, playing with shapes, and belonging to the library. PEEP also link up with families who are not able to attend groups, and provide resources for use at home.

A longitudinal comparative study is currently being conducted by the National Federation for Educational Research (NFER) comparing a cohort of 300 babies from a PEEP area with a sample from a matched area without PEEP. The early findings showed improved verbal comprehension, vocabulary, concepts about print, phonological awareness, writing, early number concepts, and perhaps most importantly in terms of the prevention of preschool behaviour problems, improved self-esteem (Evangelou et al., 2005).

CHAPTER 4 - PARENTING AND FAMILY SUPPORT IN SURE START

4.1 Extent of Provision

A total of 649 parenting and family support programmes were identified among the 59 SSLPs which took part in the telephone survey, an average of 11 per SSLP, with a minimum of 4 and a maximum of 17. Appendix B lists these programmes and the number of times SSLP interviewees mentioned their provision.

While this covers the bulk of the more formal parenting support programmes, it very likely to under-represent the provision of informal family support services and programmes such as benefits advice; drop-in coffee shops; support for caregivers; children's groups/crèches etc, The main aim of the telephone interviews was to identify formal parenting support and it was not possible to chart fully the services and programmes for which this was not the main focus.

Overall, there was considerable diversity in the nature and extent of the family and parenting support being provided across the sub-sample of SSLPs that took part in the study.

The programmes and services are described under the two headings already discussed: Support for Parenting and Family/Parent Support .
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4.2 Support for Parenting

A majority (i.e. two-thirds) of the programmes being provided were classified as *'Parenting support'*, the remainder as '*Family/Parent support'*. Within the first group there were four main types of programme: parenting; home visiting/outreach; perinatal; and early learning.

4.2.1 Parenting Programmes
The research evidence suggests that parenting programmes are the ones most likely to have a direct impact on parenting, particularly those that meet the criteria highlighted in chapter two above, and they were the largest group of interventions described in the current survey, comprising nearly a quarter of all parenting support. A wide variety of programmes were being offered (see Appendix B). While two-thirds of these were described as 'formal', only a third comprised standardised or nationally recognised programmes (see below for further detail), the remainder being locally developed programmes. The primary objective of over half of these programmes was to improve parenting and child behaviour, the aims of some of the other programmes being described in more general terms as supporting the varying needs of local parents. Most were for parents only, with a small number being for both parents and children. Very few (less then one percent) were provided to fathers on their own.

The majority of these programmes were group-based, and two-thirds were described as being provided on a regular basis, although this could mean just two or three times a year to small numbers. Where SSLPs were providing nationally recognised programmes, attendance by parents was reported to be regular and high (nearly ninety per cent). The parenting programmes were most likely to be provided by health service or Sure Start staff, with less than half described as provided by specially trained members of staff.

Less then half of the parenting programmes were described as being based on the use of a manual. Where there was a manual, only a third of SSLPs said that they adhered to it strictly. There was evidence to suggest that some parenting programmes were being used in a highly modified way (see section 4).

Overall, among the SSLPs surveyed, 20 different nationally recognised or evidence based programmes were being provided. Some SSLPs were providing several programmes and some none. A large number of parenting programmes were described which were not based on a manual, lacked a specific format and were delivered by staff who had not received any training. In reality, there may not be a great deal of difference between such programmes and some of the family/parent support programmes described below.

4.2.1.2 Nationally Recognised, Standardised, Parenting Programmes

The most common of the standardised or nationally recognised programmes being delivered was the Incredible Years programme (Webster Stratton) which was offered by 20 of the 59 SSLPs.

Other standardised programmes offered included , Mellow Parenting; Positive Parenting: Family Caring Trust; Strengthening Families Strengthening Communities; Family Links; Triple P; One Step Ahead (NCH); and Parent Power (NCH) (see Appendix B). One SSLP described offering parents a range of programmes: *"We actually have a range of programmes. We use [ ] Coping with Kids programme which is a four week course. And then we use the Pressure off Parents which is a seven week course. And then finally we used Webster Stratton [ ]."*

Most programmes were described as aimed at improving parenting and in particular discipline and children's behaviour. Some programmes were also aimed at improving parent-child relationships or bonding, the aims of the remainder being described as the promotion of early education or health and general support. Two-thirds were providing written guidance and nearly all were being provided on a group basis.

A majority of the nationally recognised programmes were based on the use of a manual, although many SSLPs reported the need for some flexibility: *"We found the first time we ran it a few years ago that because it is [about] assertive discipline your parenting interpretation of assertive can sometimes be the wrong side of aggressive [ ]. So what we did was we put more in about praise and positives which is in there but we felt that for the parents in our area who might depend perhaps on more harsh methods of discipline and might be you know*

more verbally harsh and less inclined to praise that we actually needed to bring that in and that has worked quite well for them [ ]." [p5]

In SSLPs where these nationally recognised programmes were being provided, most Sure Start staff had received specific training in programme delivery, a small minority relying on their general training. Maintaining a pool of trained staff was, however, sometimes problematic: *"Over the last five years, several members of the team undertook that particular training and have delivered particular courses. Unfortunately we have lost quite a number of trained staff. So how we might run that in the future is problematic…."* [p3] A third were being provided by health professionals, around five percent by education or social services staff, and the remainder by Sure Start workers including community workers; family support workers; the portage team; training co-ordinators; parent forum facilitator; and inclusion workers. A small proportion was provided by outside facilitators or local organisations

Most of the standardised programmes that were not based on the use of a manual were nevertheless underpinned by recognised programmes. For example, 'Growing Together' is a modified version of Mellow Parenting and 'PIPPA' (Promoting Infant/Parent Attunement) is based on the Solihull Approach.

Nationally recognised programmes could be provided on a universal basis, both on a universal and targeted basis, or to specific groups: parents with complex needs, fathers, parents of teenagers or special needs children. One interviewee explained: *"Part of the Webster Stratton guidance is that you phone them each week and check how they are getting on with the homework that has been set and see if they are experiencing any problems and if they miss a session through child illness or whatever you do the catch up session so then they come to the next session they are not behind…" [p2]*

The majority of these programmes were described as recruiting through both professional referral or outreach and self referral, though a small proportion a were described as professional referral only or outreach only or self referral only. Parents telling other parents appeared to be one of the main ways in which recruitment to these programmes was sustained. One interviewee said: *"I am really surprised because the first session of training especially with the Pressure off Parents group we had eight or nine families that engaged and all of them finished the course, but because they then went out and told people in the community since then we have never had a problem filling that course."*

While many programmes were available to everyone, it was also clear that not everyone wanting to attend a programme would receive it, with some Sure Start programmes actively dissuading parents who wanted to attend from doing so,

and providing them one-to-one sessions in the home instead: *"And that is with people being referred and not necessarily taken in, you know sometimes people self-refer and say they really want it, we do the assessment and say honestly you really do not need anything, instead we will do one to one behaviour management within the home you know and do it in a different way. So not everyone who wants to go on the group necessarily gets on the group. They do*

have an assessment to see whether they are suitable first and we do still have about 50% drop out rate." [p2]

4.2.1.3   Adapting Nationally Recognised Standardised Parenting Programmes

Where SSLPs were not offering standardised programmes, staff expressed the view that parents did not want to attend formal parenting courses and that there was no demand for them.

*"I think we have taken a different approach to it really and rather than put courses and things on – **because that hasn't been the demand,** the demand and the need has been sort of very different in terms of the approach. And our philosophy in terms of supporting parents is also integrated into our other services …." [p3]*

*"I think one of the key things I would have to say in terms of parenting and any with that sort of provision I do think you need a menu of things available to meet different needs. **Because the courses don't do it for the vast majority – courses don't you know.** People are either not going to turn up or that message doesn't work or it might work in a way but it needs supporting by other things." [p6]*

Some staff perceived the material that was used as part of standardised programmes as unsuited to the needs of Sure Start families.

*"Briefly quite a long time ago we looked at that material but what was felt was that it was quite jargonistic and **there was a lot of material that we weren't sure that the parents that we were going to invite to come on a course would understand.** It was quite you know – it was more appropriate to professionals than the parents in a Sure Start area." [p8]*

Other staff felt that Sure Start parents would not 'stay the course':

*"Well twelve weeks is quite a long time for families to keep a programme and the programme is quite lengthy – each session is quite lengthy as well. And you know to that extent we find it very **difficult to commit** – to get parents to commit with that kind of intensity really." [p4]*

Some SSLPs had staff trained in the delivery of specific programmes (e.g. Webster Stratton), but were not actually offering the programme. One interviewee explained: '*Well yes actually quite a few of our staff are trained in Webster Stratton but we have just never managed to set up the groups really. I mean we haven't for the last three years anyway'*. Some staff had not heard of programmes such as Incredible Years (Webster-Stratton).

Views like these appeared to be based on assumptions about programmes rather than experience derived from attempts to provide such programmes. There were staff, however, who felt nationally recognised programmes did not meet the needs of Sure Start families and who *were* speaking from experience:

*"We have – they have trained and tried to do the Strengthening Families Strengthening Communities one but we found that that was actually in some ways **not relevant to our parents** because it covers a span of ages so there were chunks that weren't relevant. There were chunks that weren't and also it is very long with a big commitment, **it is a bit too much for our families**."* [p3]

As a result of these views and experiences, some SSLPs developed programmes described as being to meet specific local need. These were generally based on workers' knowledge and past training or experience rather than the evidence base: *"Basically, I mean I have lots of years working in nurseries and children's family centres and we have developed a package within there which strategies we give really work so I just tell them to use the same strategies and sort of **fine tune the package** to sort of make it more suitable for families who perhaps haven't got English as a first language"* (Sure Start manager)

Some of these local programmes were developed from a variety of sources: *"The programme that we came across in America years and years ago was brought over [ ] by a head teacher that went on a study tour and we sort of looked at it and we thought it has got some potential but it was a long way off what we wanted at the time. So we **developed it from there**"* (Family support worker, SSLP).

Many of the locally developed programmes were delivered to groups and comprised a mixture of components ranging from weaning through to the management of behaviour problems and language support: *"The material is put together by different members of staff who work within the programme. So there might be something that looks at play with babies and that might be delivered by one of the early learning staff. There might be a session with language support and that might be delivered by our speech and language therapist. There might be a session on dieting, weaning with particular aged children and that might be delivered by the dietician. But they are delivered by different members of you know the multi disciplinary team and there may be specialist input. But it is not a package off the shelf. I think the view is that it is informal, it can be a drop in, but there is a programme of events. The parents will be given the programme and they may choose to attend some of those that might be what they are interested in or more appropriate to their needs. They might have those that they don't necessarily have to attend every single one."* (Manager, SSLP)

Occasionally a locally developed programme was underpinned by a theoretical model. 'PIPPA' - 'Promoting Infant/Parent Attunement' is a 'slow, open group' lasting a year, modelling family dynamics with group members leaving or joining at the end of each term. The group develops its own themes for the term and the role of the group leader(s) is to support the framework of the group to work together to discuss these themes and to find their own way forward with them. The children are an integral part of the group, although they are eventually separated from their parents in an adjoining or nearby room. The staff model with the children the approach and themes being discussed in the parents' group and the function of PIPPA is to help parents learn how to contribute to the group

(family) with a way of thinking about parent/child issues which can become a life-long skill (see chapter five for a parent's views about this programme).

4.2.2 Home Visiting Programmes

Health professionals such as midwives and health visitors have been using home visiting as a mechanism for service delivery for over a century. Statutory (e.g. social services) and voluntary services (e.g. Home-Start) also have an established history of providing flexible services within the home. Home visiting programmes that comprise a structured and intensive programme of visits to multi-risk and deprived families with the aim of improving parenting are a more recent development, for which there is an established evidence-base (e.g. Bull et al., 2004).

The inclusion of Outreach and Home visiting as core services in all SSLPs represented 'an acknowledgement of the difficulties of reaching families' (Ball et al., 2006). SSLPs have used home visiting as a mechanism to engage families and link them to wider services, rather than as a specific intervention delivered in the home.

Around ten percent of the parenting programmes were described as being home visiting or outreach. Some of these were volunteer befriending programmes such as Home-Start or Community Mothers, some involved the delivery of regular development support from professional staff (like Portage, speech or occupational therapy), others were provided by family support workers and could include helping families with practical tasks after illness. Although much of home visiting was described as being 'formal' and therefore likely to be offering parenting support, it was not based on a manual, and less than a half of SSLPs said their programme had an agreed structure.

Of the professionally delivered home visiting, most was provided to families with 'complex problems', including families specifically experiencing child behaviour problems (see below for further discussion). Most were described as being 'needs led', and continuing for as long as necessary. This process was described as follows: *"Well [ ] most of our informal parenting support comes from those home visits and drawing up an action plan and teasing out with the parents what are the issues that you are sort of struggling with, need support with and more often than not, I mean it can be anything. It can be support getting to the town centre to see Women's Aid. It can be 'I need to get in touch with Connexions because I want to go back to college.' So it can be anything from that really to those sort of parenting issues. Parenting skills, behaviour management and then depending on what those issues are the key worker, family support worker would then put together a plan of action with that family which would be around visiting once a week, visiting once a fortnight to address some of the issues that they have raised"* (Worker, SSLP)

Another interviewee described it as follows:*"It depends what the needs are, what have been the flagged up needs. It is supposed to be a valued added service. So that means sometimes it could be anything – weaning is a favourite one, problems with eating, sleeping, weaning, speech and language and quite often*

you find when you when you go in for something and at that reason to go in you find that there are other issues that usually with women want to deal with. And it may be domestic violence, there are a lot of domestic violence issues in the area –and I think it is getting worse." (Worker, SSLP)

There were also indications that some staff were adapting training (Webster Stratton, for example) from other programmes to help them within this context, particularly in terms of managing behaviour problems.

A range of staff were involved in the delivery of home visiting: One member of staff described it as follows: *"Depending on the nature of it. I mean obviously health visitors go out and do home visiting, weighing babies, checking families are okay, if there is any concern. We have a nursery nurse that goes out supporting the health visitors with their work. We have got a midwife that does home visits. And a midwifery assistant who goes out doing home visits. And then I go out doing home visits and that is mainly – if it is one to one behaviour or some parenting advice or sometimes it is just even to pop in and say to a parent how are you feeling, how are you coping, and just sit and have a chat just to try and help them work through their problems and come up with solutions to help them you know, sometimes you are talking it through and they can come up with their own solutions to the problem".*

There was also some evidence of home visiting programmes being used to support behaviour management where families did not wish to take part in a group. *"I mean formally we do do home visiting. Behaviour management on a one-to-one. Because a lot of families we have found here don't want to come and join a group and don't respond well to such a structure so then it becomes a weekly home visiting or a fortnightly home visiting and we go and we might deal with an issue around temper tantrums or you know issues at meal times so we will actually go and physically go to the family's home at mealtime and sit through a meal time with them, you know it is very much the nanny style off the telly isn't it, you know you go and you see how things are going and then you make comments and ask them to act on that next time. So that is very much how we work. And that is very – well quite popular you know we are not full to capacity but we work at quite a busy level with the one to one stuff."* (Worker, SSLP)

Some respondents talked about assessing family needs prior to recommending a course of action: *"So basically they will go out, meet the family and we have – they do a brief assessment which is shared with the family and we look at the areas that the family need to be supported. So those say three of them are written down. So again that is also reviewed in the monthly supervision. So for example I have had – I can give you two examples that have happened this week. One I had a referral through from family support. When the family support went out and actually discussed it, had the discussion with the family, they realised that they didn't want family support, what she did want is that she wanted some group activities so she could engage with other parents, especially mothers who had children of a similar age. So in the end that case didn't become a family support case. That parent was advised and given options of different groups that she could join."* (Manager, SSLP)

Where staff had been trained for home visiting, the most common element of the training was focused on the safety of the worker. The following respondent was asked whether she had received training for delivering family support in the home: *"Parenting support and that no, I mean obviously I have had lots of time of working with parents so it is just a different way. Instead of seeing them in a little room in a nursery you are actually going into their home where they feel safer anyway. And you are just really supporting them. The only thing I have had extra training for is like lone workers training obviously because it is different going out on your own to do a visit and having someone coming in and seeing you where you have got extra support within the building. So just some training around that really so that you can learn to recognize if something does feel right or pick up the signs early that something may be wrong and really you are better off out".*

Overall, these findings are very similar to those that were obtained in relation to the NESS Themed Evaluation of Outreach and Home Visiting in Sure Start (Ball et al., 2006) in which it was concluded that few home visiting services were being *delivered to children in the home*; *over a significant length of time*; *to a structured curriculum*; *by a trained professional.*

The findings of the current study showed that while the provision of behaviour management advice was an important part of SSLP home visiting services, home visits were not being used to provide intensive proactive one-to-one interventions to families which were 'unable' to engage with other Sure Start services. Where families were receiving sustained home visiting support this was often indicative of complex family needs and support workers might well be dealing with a variety of demands when visiting.

4.2.3   Perinatal Programmes

Perinatal programmes are provided during the antenatal or postnatal periods to support pregnant and newly delivered women and their babies. While the focus of perinatal services to date has tended to be on the physical aspects of childbirth (e.g. labour, pain control, breastfeeding etc), some of the most innovative perinatal programmes are directed at the emotional preparation of parents for parenthood, and promoting parental bonding and secure infant attachment.

A recent NESS themed evaluation of Maternity Services in Sure Start concluded that *'one of the most significant contributions Sure Start has made to the maternity services is providing the scope for innovation'* (Kurtz et al., 2005). It also showed improved provision included the delivery of maternity services on a neighbourhood basis with more focus on the building of relationships and better support, clear and efficient referral links, and the targeting of marginalised groups (ibid).

The aim of the current themed study therefore was to examine the type of support being provided during the perinatal period, and in particular to examine interventions that were aimed at supporting parents and parenting.

The results of our survey showed that a significant proportion of the parenting support described by the participating SSLPs comprised programmes was delivered during the antenatal or postnatal periods (See appendix B for further detail). Most of this support was described as being informal and as having no specific format, and some had been developed locally. About a third of the reported programmes were described as being based on standardised or nationally available programmes (see below for further detail). The majority of these were provided on a group basis, only a small proportion being on a one-to-one basis or part of a workshop - although in some SSLPs both methods were used. Most were provided by health professionals.

Just over a half of staff providing perinatal programmes were described as having general training for the role, around a third having had specific training, most of which was training to provide infant massage. Most of these programmes were directed at parent and baby, with a few being for parents alone, and the occasional group for fathers only. Specific targeting during the perinatal period includes teenage parents, families with complex needs, and parents with special needs. None of these perinatal programmes were specifically targeted at minority ethnic groups.

4.2.3.1   Standardised or Nationally Available Perinatal Programmes

Of the perinatal programmes-based on standardised or nationally available programmes (less than half), the majority were infant massage, the remainder breastfeeding peer support training programmes and an unnamed ante-natal group.   One interviewee described provision during this period as follows: *"We run baby massage groups. So if they want to come on, obviously to help with bonding. And we do have sort of regular attendances for those. And then there is the baby clinic where they get weighed on a Monday, that is every Monday afternoon so if you know if a new parent is not quite sure what to do with baby at least they know if they don't want to phone up any other time they can come in on a Monday and chat to the health visitor then because they will definitely find her there."*

Half of these programmes were provided by health professionals, the remainder by a range of Sure Start staff, outside organisations, education and social services, in addition to a small number of unspecified others. Most staff were described as having received specific training to deliver these programmes, and over half as being based on the use of a manual or as having an agreed structure and content. The objectives for most programmes were bonding and attachment, or support and health.

4.2.3.2   Locally Developed Perinatal Programmes

Mainstream maternity services offer most first time mothers classes in late pregnancy that include advice on baby care. A major unmet need identified by many SSLPs was for groups which were local, accessible and took a more holistic approach to preparing for parenthood. Many SSLPS therefore established groups that began earlier in pregnancy but many of these focused mostly on standard topics associated with improved outcomes, such as nutrition

advice and breastfeeding. Complementary therapies were sometimes used for relaxation, with baby massage used to promote bonding, but little overall emphasis on the emotional preparation for parenthood, or parents relationship with the newborn infant.

In summary, the quantitative data obtained as part of this survey suggested that perinatal programmes comprised nearly one-fifth of the parenting programmes described and were being provided by a majority of programmes. The commonest parenting support during the postnatal period was for breast feeding and infant massage. The NESS themed study that examined maternity services and perinatal support in Sure Start using qualitative methods also noted that these services focused on the physical aspects of pregnancy and early motherhood with less attention being paid to the emotional preparation of parents for parenthood or the mother-baby relationship (Kurtz et al., 2005).

4.2.4 Early Learning

There is an established evidence-base supporting the provision of early learning, particularly centre-based early learning, to children living in disadvantaged areas. One of the aims of SSLPs was to support such early learning either by encouraging parents to provide early learning activities or through the direct provision of early learning services to children.

Early Learning services comprised one-fifth of the programmes described as part of the current survey. Some were based on standardised or nationally recognised methods of intervening to support learning during the early years. Examples of such programmes included PEEP, Early Start, Share, High Scope, and Story Sacks.

A smaller proportion of these programmes had been developed locally, and while most of these activities were group-based, around half of them were described as having no specific format. Some were provided on a regular or near regular basis, but only a few were described as having a firm or agreed structure to which they adhered.

The majority of these programmes were being provided by educational, health and Sure Start staff. Other providers included outside organisations, and other non-specified professionals. Two-thirds of staff were described as being reliant on their general training to provide these programmes, only a third having received specific training. The programmes for which specific training had been required included most of the nationally available programmes - PEEP, Early Start, Share, Highscope, Family Literacy, Developing thinking in the 0-3's, and Home learning.

4.3   Family/Parent Support

Within the group defined as '*Family support*' three main types of programme were identified: therapeutic (mental health) services; adult learning; and general support.

4.3.1 Therapeutic services

The therapeutic services offered to families included a range of programmes most of which were directed at improving parental mental health. While less than five percent of these were described as being provided by nationally recognised organisations (Relate; Freedom Programme) many were clearly underpinned by recognised approaches including cognitive behaviour therapy, general counselling, play therapy, art therapy and family therapy. Acupuncture and yoga were also mentioned.

The remaining programmes were either developed locally, or described as having no specific format or structure.   Just under a half of these services were described as being 'needs led', the remainder being aimed at providing support or improving health. Most were being provided on a regular basis (four-fifths) and the bulk was directed at parents only.   They included anger management and smoking cessation courses, Freedom Programme (to counter domestic violence), and pampering sessions.

Two-thirds of the therapeutic programmes were described as being provided by health professionals, a few were being provided by social services staff and Sure Start practitioners. Other providers included complementary practitioners/beauty therapists, outside organisations, and in one case, a life coach. Around a third of these practitioners were described as having undertaken specialist training to provide the service.

Approximately, half of these programmes were being provided on a group basis, the remainder being one-to-one or utilising both formats. Nearly two-thirds were provided on a regular basis.

In terms of the target group, just under half of these services were described as being provided to families with complex needs, a quarter during the perinatal period, the remainder being provided on a universal basis.

In summary, many of these services were underpinned by recognised methods of working with individuals to achieve change (e.g. cognitive behaviour therapy; family therapy; art therapy etc). But it was not clear that these programmes were always being provided alongside parenting programmes, and there was some evidence (see below) that SSLPs tended to major in one or the other area, but not in both.

4.3.2 Adult Learning

Adult Learning comprised only a small proportion of the programmes described. These were the group of programmes that were most likely to meet nationally agreed or recognised criteria in terms of content and delivery, just under half being adult education courses, the remainder comprising a range of community-based courses such as NVQ training, ESOL courses, volunteer training, and back-to-work guidance.

Adult learning programmes may be under-represented because interviewees did not perceive such programmes to be part of family or parenting support. Three-quarters were described as being standardised or nationally recognised, the remainder having been developed locally or having no specific format. Most were open to everyone, and were provided on a group basis, only a few having been provided on a one-to-one basis, or as part of workshops. The majority were described as being provided regularly, and two thirds as providing written guidance.

Most of this support was provided by educational staff, ten percent by the Sure Start team and three percent by health staff. Other providers included outside organisations and various other unspecified professionals. Nearly four-fifths of the staff providing these programmes had received specialist training to do so.

4.3.3 General Support

General support comprised around a fifth of the parent support programmes described, although it seems likely that this is an underestimate of the actual number because this type of programme was described late in the interview and there was often insufficient time to chart their full extent. These were the most informal group of programmes, and probably the least likely to have a direct impact on parenting. The objective of most was to improve parental or family well-being by providing direct support to parents in the form of activities, e.g. practical support or confidence building; or respite from caring for children.

Three-quarters of these programmes were provided universally, the remainder being spread fairly evenly across targeted groups (i.e. complex needs; age-related; perinatal; special needs; fathers; teenage parents etc). Most were described as having a flexible structure, and most were provided on a group basis. None utilised a manual. Most general support was provided by health or Sure Start staff, a much smaller proportion by education or social services, and some by volunteers. A small amount was provided by various other practitioners including a benefits advisor and community police officers.

4.4 Penetration by Parenting Programmes: How Many families do they Reach?

In addition to our interest in the type and spread of family/parent and parenting support, we were also interested in the issue of penetration i.e. the number of families that were reached by the programmes that were available. We were particularly interested in how many parents were being reached by the 'parenting' support programmes, and interviewees were asked how many programmes they had provided and how many parents had come on these programmes. Many were not able to answer these questions with any precision, but some gave rough figures for the total number of parents likely to have been reached during the lifetime of the SSLP and some gave a figure for the number of parents reached each year. Among the former reporting lifetime figures, the maximum was 40 parents; most reported less than 10. It was difficult to distinguish the number of families from the number of parents, but it is reasonable to assume that most parents were mothers and that both parents would have attended in a

minority of cases.

Among SSLPS reporting yearly figures, the majority reported reaching less than 20 parents annually. One such SSLP offering *Strengthening Families Strengthening Communities* commented: *'We have run those for sort of once or once or twice a year and in the last year we ran that in partnership with another agency – another local agency and in partnership they had referred a number of parents into that programme, but we have never formally referred people into it.'*

And how many parents do you think came on those courses?

'There might be five. I think that really you need about 12, you know 12-15 people on the course really but we might have run a course and continued to run even though [……..] there might be five people left on it you know that are coming regularly to sort of continue it throughout.

Two SSLPs, one providing *Baby Massage* and one providing *Pressure off Parents,* reported reaching 50-60 parents a year and two further SSLPs, one providing *PEEP* and one providing *Incredible Years* reported reaching a possible maximum of 140 and 80 parents per year respectively. The latter SSLP was clearly very successful in reaching parents with this evidence-based programme:*'Oh, I think that they have quite a lot of families, I mean we have 100 on the waiting list this time'…'I would say that we run probably about 4 or 6 [groups] per year and there's about 13 or 15 families but again, all these figures are very rough. I wouldn't like to comment on how many have gone through but I would say that it's into the hundreds….*

These two SSLPs may have reached a significant proportion of parents in their areas, but such high levels of penetration were unusual and most SSLPs providing parenting support appeared to have reached much smaller numbers of parents.

While it was hard to gain an accurate picture of the numbers of parents being reached by SSLPs in terms of parenting support, the figures provided suggest that penetration was on the whole rather low. This is an important finding because it was highly unlikely that Sure Start would improve population levels of parenting given such low overall levels of penetration.

CHAPTER 5 – VARIATION IN SERVICE PROVISION

5.1 Variation in provision

Were there differences in provision between the 25% of SSLPs with the best parenting outcomes and the 25% with the worst as measured in the Impact Study of National Evaluation of Sure Start? (NESS, 2005a: NESS, 2005b; Belsky et al., 2006; Melhuish et al., 2007)

In order to answer this question we grouped the programmes according distribution of parenting outcomes: group A was in the top 25% and group B was in the bottom 25%. We grouped the analyses according to the type of programmes that were provided (parenting or family support) using the following headings: formal/informal; objectives; method of recruitment; who targeted/attended; scope; mode of delivery; regularity of attendance; facilitation; use of a manual; structure; written guidance; evaluation. The data are all categorical, and chi-square was used to identify any associations

5.1.1 Parenting Support

Overall differences between the two groups were very small and very few reached statistical significance (see Appendix D). Where differences were observable however, these were consistent with the belief that areas with better parenting outcomes were providing better parenting support (comprising parenting programmes, home visiting/outreach, perinatal and early learning). A slightly larger proportion of group A programmes were described as being formal, involving perinatal or early learning, comprising standardised or nationally recognised programmes, being based on the use of a manual, and involving specific training or preparation of staff for their delivery. More of the group A programmes were being provided by Sure Start staff, and more had parenting/discipline or support/health as their primary objectives as opposed to being 'needs led'. More group A programmes were providing written information and slightly more were targeted.

5.1.2 Family Support

In terms of family support (comprising therapeutic; adult learning; and general support), a slightly smaller proportion of group A programmes were described as being standardised or nationally available, and fewer group A programmes were described as being therapeutic compared with adult learning or general support. Fewer group A programmes were described as being explicitly targeted, with more being provided on a universal basis. Group A offered more programmes with support or health as primary objectives compared with Group B where 'needs led' programmes predominated. Again, few of these differences were of statistical significance.

5.1.3 What Has Worked

While these differences are too small to draw very firm conclusions, their overall trend is consistent with national and international literature concerning 'what works' in parenting and family support. Assuming, that the documented change in parenting in NESS is valid, group A programmes (those which achieved more change in parenting) were characterised by an emphasis on parenting support programmes (i.e. parenting, home visiting/outreach, perinatal and early learning) as opposed to family support programmes (i.e. therapeutic, adult learning or general support), greater use of nationally recognised or standardised programmes, more use of a manual, more specific training or preparation of staff for their delivery, more targeting, more focus on parenting/discipline or support/health as opposed to being needs led, more written information, and more targeting.

CHAPTER 6 - GOOD PRACTICE IN SURE START

6.1 Introduction

"For me Sure Start has really been a lifeline, I don't know where I'd have been without coming here. I was hardly ever leaving the house, I would think, what's the use of getting dressed and going out…..for me it was really…. I wouldn't have done half the things I've done if it wasn't for Sure Start." (case study 2)

In order to investigate best practice in terms of parenting and parent support programmes in Sure Start six SSLPs were selected on the basis of innovative practice. The selection process also ensured good representation of SSLPs serving large minority ethnic communities and included one SSLP with a rural population. These six SSLPs enabled us to investigate parenting support in greater depth than had been possible in the telephone interviews.

6.2 Elements of Good Practice

Good practice in family and parenting support, whatever the nature of the support, contained the following ingredients:

i)   An emphasis on the relationship between parents and children, and helping parents to develop new ways of parenting;
ii)   A model of change: most of the case study projects were working with specific models in terms of the way in which staff within the centre worked with parents to achieve change;
iii)   The regular provision of at least one standardised parenting programme: SSLPS provided a range of examples of good practice with regard to way in which standardised programmes were being used particularly in terms of the recruitment and retention of parents;
iv)   The active provision of parenting support from pregnancy through to toddlerhood and beyond.
v)   Using parent support to support parenting.

6.3 A focus on the relationship between parents and children

One of the key features of the six SSLPs studied was their emphasis on the relationship between parents and children, and thereby on helping parents to parent better. One member of staff described this as follows: *"Everything we do is ultimately aimed at influencing the way in which parents parent, every single thing from the minute they [parents] walk through the door hopefully, in the way that we are, the way that we talk with parents, and the way that we talk with their children…"*

A fundamental aspect of achieving this was treating parents with respect: *"…hopefully what we do more than anything else is treat people with the respect which we think they deserve […] so many parents feel disrespected by so many agencies and services that they go to for help, and feel that they are patronised*

and spoken down to….so from the outset we said that the thing we most want to do, and we knew would have a knock on effect on their parenting was to actually help people feel a strong sense of self respect and self esteem, and for us always without qualification to support people in all the great things they are doing, recognising and supporting all the things that were going really well for people and making sure that we never missed commenting on that."(case study 2).

The focus on parenting and the relationship between the parent and baby was paramount even before parents had given birth. A member of staff described this as follows: *"From the outset [we are] trying to develop the relationship between the baby and family. The emphasis is all the time on the growing relationship between the parent to be and their baby, and how it changes the dynamics of the family"………"Our belief is that the way we support parents and children emotionally, helps them to enhance their own relationships thereby affecting the behaviour of both the parents and the children".*

6.4   Models of Change

The case study projects were using 'active models' in terms of the ways in which staff worked with parents in order to help them not only to develop and grow but to parent their children differently. For example, one case study was underpinned by the use of the Solihull Approach – a model that was already being used more widely within the Borough the aim being that this model of practice, (in essence a relationship-based service), would imbue every aspect of the way in which all staff interacted with parents and children.

The Solihull approach is an integrated model based on three theories about relating and change - psychoanalytic theory, child developmental theory and behaviourism. The central tenet of this model is that through the development of a reciprocal relationship an individual can experience emotional containment that supports their capacity to think or manage their own and their children's behaviour. This can be true for one adult in relation to another adult, or an adult in relation to a child. Another key feature of the Solihull Approach is the concept of 'parallel process' in which staff 'model' the quality of relationship which can promote emotional containment, and parents can begin to internalise this relationship dynamic, and demonstrate it with their children. The Childcare Team also use the Solihull Approach in all their interactions with children either in the Centre or in any of our outreach settings. The Early Years Co-ordinator also has a brief to try to introduce this approach into other childcare and nursery settings.

The same approach has been exemplified throughout the programme involving Groups run by the Midwife, Health Visitor, Speech & Language Therapist, Further Education Tutor, Early Years Co-ordinator, Community Development Officer etc.

One member of staff described this as follows: *"What we do is grounded in really good theoretical understanding, so none of us is trying to reinvent the wheel. We're actually trying to do things that we know are effective……how we think about children playing, adults learning…people's emotional lives and relationships. It's grounded in a really good theoretical understanding, and that's what makes it work […]*

Team members were appointed on the basis of their experience and expertise and also on their willingness to contribute to a common vision for the whole team. Promoting positive relationships between parents and the whole staff team, as well as between staff members themselves was fundamental to the approach. All staff, from caretaker, receptionist, administrator, as well as specialist workers, were trained in the approach.

6.5   Using evidence-based standardised programmes to support parents

While all of the case study projects indicated a commitment to be responsive to parental needs, and to be flexible in provision, most were providing at least one formal, nationally available, structured parenting programmes on a regular basis.

6.5.1 Choice of programme

A number of the most well-known evidence-based parenting programmes were being used including Webster Stratton, Triple P, and Strengthening Families Strengthening Communities. Factors influencing choice of programme included the following;

- being responsive to parents needs and local issues
- staff training, availability and background
- financial considerations (including costs of training and materials)
- programme content
- evidence of effectiveness.
- timing - important consideration in order to co-ordinate parallel crèche sessions/places.

Some centres were in the process of reviewing their parenting programme provision in the light of the change to Children's Centre status, and in order to streamline provision and provide continuity across the area.

6.5.2 Penetration

In some of the SSLPs parenting programmes were being provided on a rolling basis so that as soon as one programme finished another started. Most SSLPs were offering programmes on a regular basis through the year, (i.e. not intermittently).

6.5.3 Recruitment

Recruitment of parents to parenting programmes and courses **was active** and was achieved in a number of ways:

- Local advertising
- Leaflets and flyers
- Newsletters
- Word of mouth
- Through home visiting and outreach
- Professional referral
- Self referral

It was acknowledged that many parents had preconceived ideas about attending a 'parenting course' that could act as a barrier to recruitment: "*… it is a really difficult area isn't it parenting because if you go on a parenting course you have got to kind of admit that you need to go on … I mean it is not quite so difficult to admit that you need to brush up your language or humanities. It might be still scary but it is not like saying well I think I am a crap parent […] (case study 2).*

Recruitment to courses used **forward planning and the necessary time and commitment.** Where parents were wary or had misgivings about attending a course, support workers were **active in offering encouragement or more practical support** such as help with transport or attending the group with the parent until they felt comfortable to attend alone. This type of support was regarded as being a continuity of outreach and home support, as a means of encouraging and helping parents to venture out and attend a Sure Start programme: *"We make a real effort by doing things like going to collect them and attend with them if confidence is an issue, walk with them to the venue…" (case study 6).*

While there was acknowledgement that parents might be reluctant to commit to the required number of sessions (generally between 8 and 12 weekly sessions), many staff noted that once programmes had become established, parents were more willing to attend as a result of **word-of-mouth recommendations** from other parents who had attended a course. One centre that was delivering Strengthening Families Strengthening Communities, which requires a commitment of 14 weeks, had achieved a good success rate despite predictions from workers from outside agencies that certain parents would be unlikely to 'stay the course': *"Some that have been 'labelled' by other agencies as 'no chance they'll stay the course' have not only stayed but very much benefited from it, some families have even done it twice! We've had really good feedback." (case study* 6).

Parenting programmes were being **offered universally** to anyone who was interested. This was seen as important in ensuring that the composition of groups was not skewed towards parents who had been identified as having problems, and therefore less likely to be stigmatising. The effect of having a **mix of parents in the group** was seen as an important way to stimulate the group process: *"Even if they haven't got problems with their children it can be very good*

to go on [Webster Stratton] it because the skills you learn to use are useful in everyday life' (case study 3).

Another member of staff said: *"One of the positive things to come out of the groups is parents sharing their experiences so it's important to have a mixed group of targeted and universal [not having specific problems] so that there is some good role modelling going on in the group as well as the structured learning. We would be very wary about having a group just for targeted families, most families at some time or other has issues around parenting, that's what's so reassuring to people…..it has to be acknowledged that nobody finds it [parenting] an easy job."* (case study 6).

6.5.4 Referrals

While it was clear that SSLPs were aiming to provide services on a universal basis, parents were also 'referred' to the programme. 'Referral', however, was seen as 'a suggestion' or 'encouragement to attend'. Referrals could arise from numerous encounters or situations between parents and workers. Most were informal referrals in the sense that courses and programmes would be highlighted to parents as potentially helpful with particular issues or situations.

"[…] we try to build up relationships with people, which I think, […] you just get chatting. So a family could be chatting to the caretaker or me (psychologist) or any… admin anything and because we have all got in the back of our heads what is on offer and what we could offer people it is then through that kind of relationship that you are saying oh what I am hearing is this. We have got somebody here who can help with that." (case study 2).

Referrals would also often arise out of encounters with workers at all levels e.g. home visits, encounters with health visitors, midwives, crèche workers, family support workers.

These SSLPs all emphasised the importance of retaining an element of 'choice' for parents. The issue of choice was seen as particularly important in the case of more formal social services referrals. Practitioners were clear that in order to retain the trust and respect of parents it was not helpful for them to be seen as 'enforcers' or to be coercing anyone into doing something they were not happy to be involved with. On the whole, centre staff were clear that their remit was to work collaboratively and cooperatively with Social Services staff who might recommend clients to use services and courses, but that it could be counterproductive to act in a coercive way that might potentially damage the relationships and trust that are integral to the success of the implementation of services.

"We make it clear to Social Services that we can be part of a care plan and package, and we will offer support and help, but if they don't come we don't coerce them […] we don't work in that way." (case study 6).

Being seen as **non-judgemental** was described as being key to establishing trust and respect between workers and families, and in overcoming stigma. Staff

described how 'word of mouth' could work negatively as well as positively and how it was felt to be extremely important to encourage parents who were involved with Social Services that they would not be *'told what to do'* by Sure Start.

"Families who come here may be involved with social services and children may be on child protection register but they don't come here by order. They come because our services are as available to them as they are to anybody else. We wouldn't necessarily know anyway, and we certainly won't take part in assessing them while they are here. So social services may say so and so is coming along to your group, will you carry out an assessment, and we say absolutely not. That's not our role, and if we start that we will lose families." (case study 2).

Workers described a process of ongoing dialogue with statutory service providers in order to establish an understanding of this different way of working.

6.5.5 Retention

One of the key aspects of successful retention to courses that was highlighted by the case study projects was the **development and maintenance of a trusting relationship** with everyone involved, an emphasis on **respect and non-judgmentalism**, and the avoidance of telling parents what to do.

A number of staff within the case study projects also emphasised that it was important for parents to feel positive about the materials being presented, the need for discussion of materials within the context of the particular needs of individual group members, enjoyment of the group setting, and the chance to meet other parents experiencing similar issues, and the opportunity for socialising with other parents. Staff said: *"Most participants attend from start to finish. We have to keep starting new groups because mums don't want to stop coming to our groups" (case study 3)*; *Once they've started coming and they've built their confidence they are empowered to keep attending, and they do generally.' (case study 6).*

Other examples of good practice included the use of **active strategies to promote retention**. So, for example, where parents missed sessions or appeared to have dropped out, a common strategy was to continue to encourage and support them through personal contact (either visits or telephone calls), and to actively provide help to 'catch up' on material missed (using home visits, personal contact or telephone support). Home visiting staff working with parents who had expressed a reluctance to attend groups, perhaps through shyness, lack of self esteem or mistrust, might also offer to attend group sessions with the parent as a stepping stone to them attending independently - *"we can go with mums to support them until they've got used to a class, so we can sit with them, help them, until they feel confident enough to go on their own".*

Parents who had attended courses lasting a number of weeks felt that once they had begun a course there were a number of things that encouraged them to continue attending including the opportunity to get to know more people, the opportunity to learn more skills, and a chance to get out of the house and have a

break from the children. Family support was often significant here, providing childcare, informing people about groups, and even accompanying them in some instances.

6.5.6 Making parenting programmes accessible – the issue of formality

Staff within the case study SSLPs described how the use of standardised programmes could be perceived negatively by parents who had had previous negative experiences of educational settings, and that formality could be a barrier to participation. Staff who were successfully delivering this type of programme therefore emphasised the need for a **relaxed and informal manner of delivery and an informal setting** irrespective of the actual formality of the programme (i.e. the use of a structured programme and manual).

"…These groups need a structure and you need to follow the plan that's laid down to deliver them in the way they are intended, but on the other hand you need to be flexible as well and respond to parents […] The actual group feels very informal, so although it's structured in content, the way it's delivered and it feels, it's chatty, very informal in that way, and encourages people to keep it up" *(case study 5).*

This was one of the reasons why word of mouth recommendation was felt to be a key aspect of recruitment of parents to these kinds of courses.

6.5.7 Adapting programmes

Most structured and manualised programmes are designed to be delivered according to the training and manual, and this is important in terms of ensuring that the integrity of the course is not compromised. In SSLPs there was also a need to respond flexibly to the parents taking part in the group, and in some circumstances **minor adaptations to the programme were made in order to accommodate local needs**, in particular for minority ethnic parents, whilst retaining the overall structure of the programme.

I. Translating or adapting the course into other languages

In SSLPs with a high minority ethnic population it was sometimes found to be necessary to tailor the course to make it more accessible to parents in that locality. This could involve translating the programme into a number of different languages. One of the benefits of having workers who were part of the local culture was that they were able to translate and deliver course materials in a culturally sensitive way.

"[…] we have to adapt it because in terms of English – isn't predominantly people's first language [here] so in terms of like, translators, and the information we give to parents we try to put it in pictorial ways, in different languages and do the translation" *(case study 1).*

II. Adapting material to make it culturally sensitive

Delivery of parenting programmes to BME parents involved staff being aware of diverse cultural practices in relation to parenting, and often in providing parents with additional contextual information to enable them to better understand some of the issues and strategies being promoted by course materials. This was often perceived to be necessary, for example, in relation to the use of new methods of discipline: *"In India smacking children is acceptable, whereas here it is not – so when you deliver this service you have to know about their culture and their background…" (case study 3).*

One of the case study programmes was also actively using a **culturally sensitive parenting programme** that has been developed specifically to meet the needs of BME parents, and adapted for use in the UK - "Strengthening Families Strengthening Communities". One member of staff stated: *"It's a very heavy commitment in terms of time, 14 sessions but we felt it reflected the needs of the community and it has been well received and some of the parents have gone on to be able to deliver that themselves." (case study 6).*

III. Adapting material to meet the diverse needs of the group

Other examples of good practice in relation to the use of standardised parenting programmes included balancing the integrity with which the programme was delivered with the need for flexibility in terms of the particular experiences or issues of parents. This involved widening discussion to include the specific experiences of individual parents, rather than changing course material per se. One member of staff described this as follows:

"Where domestic violence had been part of the group's experience] we had to tailor discussions around that because to not do that would be saying it's our agenda that's important and not yours […] You have to be able to cover the materials that you hoped to cover but you also have to prioritise the needs of people attending that particular group. It takes a degree of confidence for staff to do this…." (case study 2).

6.6 From pregnancy to toddlerhood and beyond - the active provision of parenting support

The case study SSLPs were offering a wide range of support which aimed either directly or indirectly to improve parenting. These were viewed as being part of a continuum of support from the antenatal period up until four years of age and one of their key features was a focus **on the mother-baby/child relationship.** Thus, they were often provided at key stages in the child's development, in addition to being available irrespective of the child's age e.g. counselling services. They could in addition fulfil a number of other functions (a gateway into other Sure Start services; provision of information around specific aspects of parenting; provision of social support and opportunities for friendship and to share experiences and expertise) in addition to supporting the mother-baby/child relationship,

6.6.1 Antenatal stage

A variety of antenatal groups were being provided, and while these were facilitated by a midwife or health visitor many were also being provided in conjunction with a member of staff with a focus on parenting and mental health thereby encouraging parents to begin to think about their **relationship with the developing baby.**

Good Practice - Antenatal Group

*'The midwife runs a group for parents-to-be……although she does talk about labour and all the things that parents are interested in**, the emphasis all the time is on the growing relationship between the parent to be and their baby, and how it changes, the dynamics of the household, and all of that***. And it is delivered by the midwife but we always have a child psychotherapist or our CPN in that group. So what we are trying to do is all the time from the outset get away from the idea that the baby is a package that they do something unto….but trying to develop the idea that that it is the relationships that will decide how that baby is….."*

6.6.2 Postnatal support

While all of the case study SSLPs utilised standard procedures for the identification of postnatal depression (e.g. screening by midwives and health visitors using the EPDI) a number of other examples of good practice were in evidence.

For example, in one area, in addition to formal screening procedures, all staff were trained to recognize signs of parental stress and depression, and many of the key staff were trained in basic counselling skills, which they could utilize in helping parents to talk about difficult feelings. This was seen as being the first step in the provision of further support. In another SSLP, the counselling was provided by a child psychologist who had been part of the antenatal group parents had attended before the birth of their child. The programme managers viewed this as being an important means of developing continuity in relationships with parents, and enabling parents to access additional support as needed, during the postnatal period. One parent talked about the importance of trusting relationships during this time: *"You don't want to have them [health visitor or midwife] knocking on your door checking up on you just because I've said so and so isn't behaving or they think I'm doing things wrong….even though you have a relationship with your midwife and health visitor when you have a baby….here, it's very approachable and you know it's confidential, you build relationships with people and for some reason I seem to feel that workers here seem to know what they are talking about more than health professionals sometimes!" (case study 1)*

There were, in addition to the one-to-one counselling sessions, a number of groups provided specifically to help parents with post natal depression. While the programme of activities provided by such groups was often diverse, a common example of good practice was an **ongoing emphasis on parenting, and relationships**, not only between group facilitators and parents, but between

parents themselves and between parents and their children. One interviewee expressed this as follows: *"It's the overall ethos, in terms of modelling relationships that's important. You know, you could be talking about how to clean a baby's bottom, it's simple, but it's the way that you do it that's important isn't it?"*

Good Practice - Baby Start Group

Baby Start meets once a week with a rolling programme of activities. Parents are encouraged to collaborate in order to discuss the needs of the group, which are then built into the programme for the forthcoming weeks. Advice and information sessions are set up to cover **aspects of parenting** that the members of the group have expressed an interest in exploring in more detail. Practitioners from a variety of specialisms are invited in to the group for some sessions, whilst other sessions may focus entirely on group discussion between parents, sharing experiences and ideas. The group thus provides structured information sharing sessions as well as opportunities for parents to socialize and network. **Emphasis on relationships** is the focus throughout the group, whether that is modelling behaviour within the group between participants, or thinking about the parent/baby relationship.

'They start to trust you that you are not going to be telling them what to do. And it is really social for parents as well. They get to know other parents [...] they trust each other as well [...] and that is enormously helpful because they learn a huge amount from each other [...] what so and so tried, what somebody else tried..." (case study 2).

6.6.3 Early mothering/young babies groups

A range of early mothering and young babies groups were being provided. Examples of good practice included a recognition of the importance of using these sessions as a means of **promoting good parenting** (e.g. using a 'stay and play' model). For example, in one Sure Start centre a parent and child attend a group facilitated by Sure Start workers (typically play development, family support, and early years workers), which has an element of structured learning or practical play. An integral aspect of these play and stay groups is **workers modelling positive interactions with the baby/toddler**, as well as with the parents; and **utilising the group as a means of working with both the parent and baby/toddler** particularly in relation to helping parents understand about their baby's development not only to help them to develop realistic expectations, but also to enable them to understand about the importance of communication; their child's social and emotional needs; and the value of engaging in play activities with the child. One parent said: *"[Child] went to nursery last year, and when she got her end of year report it said she was such a confident little girl and she was standing up in the class singing nursery rhymes and I think it had really helped that she'd been to Sure Start since she was little, I think she was about 10 weeks old and after that we regularly came and I think she got to know the other children and staff here - she came here the other day and she gave one of the workers a massive hug"* (case study 2).

Play and stay sessions also provided workers with opportunities to observe parents and children and to identify where parents were experiencing difficulties with aspects of parenting that might need more specialist input:

Good Practice: Tuning into Babies

Parents attend the group for a two-hour session in which structured activities are facilitated to help parents learn more about **communication with babies**. Parents are encouraged to think about the **baby as a social being**, and to gain an awareness and understanding of the babies capabilities. One parent described it as follows:

"It is all about talking to your baby and recognizing that when they are gurgling or smiling or making faces…..they are indicators of your child communicating with you." (case study 1).

Good Practice: Little Star Group

Run by workers experienced in child development, working closely with parents on small activities such as Rhythm and Rhyme, that are enjoyable and that contribute towards enhancing the **bond between parent and child**.

"It's about getting the parents to know that they can get down on the child's level and play and enjoy being with them." (case study 3).

Groups and courses like these were felt to be of particular importance in areas where there was a high BME population, where there may be cultural differences in attitudes and practices particularly around parents' playing together with children: *"In the Muslim community it [play] isn't something that they would necessarily see as important in their culture." (case study 3).*

Other examples of good practice included promoting secure infant attachment and the identification of parents having specific difficulties in terms of bonding or the identification of parent-child dyads in which the child was showing evidence of early attachment problems. The identification of such problems was often made within existing groups (e.g. stay and play) and further support was then provided.

Good Practice: Growing together

 'Growing Together' is a group which meets a specific need for parents who wish to **enhance the quality of their relationship** with their child. It is a ten week course lasting most of a whole day each week. The facilitator provides are specific themes for parents to discuss, directed interactive time with their children, and a lunch prepared by the parents and shared together with all the children. Each parent and child are videoed together at home and the parent is able to choose which part of the video they wish to show the other parents for discussion. (case study 2).

Parents said:

"If they are angry or they're sad the staff here explain their feelings to them and help them to recognise their feelings. My daughter will say "I'm cross so I'm sitting on my bed for a while" We wouldn't have had that when we were little. Instead of thinking – what's this feeling? They learn to recognise their feelings and put a name to it." (case study 2).

Another area of growing importance within SSLPs has been the introduction of **baby massage** groups and sessions. Examples of good practices included the use of infant massage not only to focus on parents bonding and enjoyment of their baby, but to address other difficulties that might arise or be identified by observing parent and baby together.

"I mean it is really good in terms of bonding for the parent and the child, but it is also engaging new parents to come together and discuss issues that they might not necessarily think they could bring up. I mean, once you have got a group….you know, it just gives you a brilliant forum for any kind of issues …fears around development and needs and things with children….." (case study 3).

While many of these age-related groups had been locally developed, they were on the whole underpinned by well-established models of working with parents.

Good Practice: PIPPA Group

Based on the Solihull approach, this group is open to everybody . 'PIPPA' stands for 'Promoting Infant/Parent Attunement'. It is a 'slow, open' group lasting a year, modelling family dynamics with group members leaving or joining at the end of each team. The group develops its own themes for the term and the role of the group leader(s) is to support the framework of the group to work together to discuss these themes and to find their own way forward with them. The children are an integral part of the group, though are eventually separate from their parents and in an adjoining or nearby room. The childcare staff model with the children the approach and themes being discussed in the parents' group. The function of PIPPA is to help parents learn how to contribute to the group (family) with a way of thinking about parent/child issues which can become a life-long skill.
Parents said: *"Because a lot of the time you can see that, you can actually see that the way a person is treating their child is the way they have been treated. Not always. But you know from their childhood. And part of the PIPPA group is about changing that I think. Breaking it. You know and being able to do it a different way. And I think that is where it can get kind of emotional." (parent, case study 2).*

"It is a lot to do with how you [yourself] are behaving[…] how you can change your behaviour to try and change theirs[child's] as well." (parent case study 2).

6.6.4 Early Learning

A number of groups that were orientated towards early learning and literacy were again focused on the relationship between the mother and baby/toddler, and a key area of focus for these groups was **the inclusion of both parent and child.**

Good Practice: Early Start

Early start courses focus on the **interactions and communication between parents and children**. There are separate and joint sessions for parents and children, and parents are shown activities that they can do with their children at home. The three separate stages of Early Start are Baby Talk - the first year; Small Talk - the second year; and Talk Together - the third year.

In one case study SSLP early start groups were implemented and the course materials were successfully combined with the Solihull approach to respectful and meaningful relationships.

Good Practice: PEEP Groups

The PEEP programme offers developmentally appropriate support for parents and carers. It covers the period from the child's birth to starting school. It aims to promote parents' and carers' awareness of children's very early learning and development through making the most of everyday activities and interactions, and to support parents/carers in their relationships with their children, and enhance the children's self-esteem. During the weekly group sessions the leaders model different ways of sharing books with children, songs and rhymes are taught, and the contribution of everyday talk to children's development is emphasised. The programme can be offered in groups and one-to-one sessions thus providing flexibility for SSLPs to accommodate the needs of local parents. The materials can also be used in a variety of settings.

"When you have got a baby it will tell you like scenarios that might happen and how to deal with it, how the baby might be feeling, how you might feel as a parent. And it is things you can relate to, you can understand and you can apply. You get a file, and every week you learn something new […] and you can take it home and it gives you ideas on play. Information on what your child will know at that age and how it will respond to things at that age. The nursery rhymes they will appreciate at that age…." (parent, case study 5).

Parents also valued opportunities to watch the way workers interacted and communicated with children.

``When you read a story to the child you don't know how to read it – but they do it so you can see what will actually get the child's attention" (parent, case study 6).

6.7   Using parent support to support parenting

The case study SSLPs were also providing a range of parent support programmes with a view to enhancing or supporting parenting as well. For example, one centre was providing formal courses in confidence building and personal development training: "*We look at you know values, attitudes, beliefs, you know where you get those values from, why you act in a particular way, touching on people's comfort zones, looking at non gender specific roles and looking at their aspirations and that is a six week programme that is very well attended, people don't want the course to finish at all. […] A lot of the parents have said that they have seen a huge difference in the way that they talk to their children in the way that they participate and sort of actually just have their own relationships with their partners…"(case study 1).*

These courses aimed at helping parents to become more emotionally literate and self-aware by focusing on parents' own experiences of being parented, helping parents to become aware of the way in which this has impacted both on their own confidence and self-esteem and the way in which they parent their own children. One parent described this as follows: "*For me it was a case of seeing things that my mum used to say to me that really kind of brought you down, down, down. It relates back to the positive parenting course I attended – having the positiveness in your children, praising your children" (parent, case study 1).*

Another parent said: *"Every day you had to write down things that had happened that day or that week. And you think – nothing has, but then when you thought about it positive things had happened but you were focusing on all the bad things. I now sometimes think about all the positive and all the good things and things I feel good about [.] if I hadn't done that course I would probably still be in that relationship [destructive relationship] and still be depressed" (case study 5).*

A wide variety of adult literacy courses were also being offered, both vocational and non vocational, including English language courses, numeracy and literacy, information technology, childcare and social care, confidence building and assertiveness. Many of the courses enabled parents to gain experience and

qualifications in peer support and mentoring, often in family related areas such as breastfeeding, peer support training and volunteer training.

As with many of the other programmes being provided within these case study programmes, adult learning was regarded as a means of improving parenting by improving parents' ability to be more in tune with their children's learning needs.

The parents we interviewed had been actively encouraged to attend a range of adult education classes and courses. All of them appeared to feel a sense of achievement, and increased confidence, and in some cases the training had led to further vocational development, a degree course, volunteer and work experience, and employment opportunities either within Sure Start itself, or beyond: *"It gave me the confidence to go to college last year and complete a classroom assistant course and I think without having Sure Start and being on the board, and doing the voluntary stuff, I wouldn't have had the courage to walk into the college, not even to enrol, let alone walking in to a classroom full of people you don't know, but it gave me the confidence. And I think it has done for other people as well." (Parent, case study).*

6.8 Training and supervision for delivery of parenting support

The training and supervision of staff working in Sure Start Centres, was of central importance irrespective of the type of support being delivered. The case study SSLPs were distinguished by their particular approaches to training and supervision. Thus, while there was wide variation in the range of staff trained to provide support to parents, all practitioners and particularly those delivering recognised standardised parenting programmes, had received additional training either by authorised trainers or through the originating organisation: *"No one is actually delivering courses here that actually haven't been trained in that […] we have specific people within our team that have trained to a high level and they are now able to deliver the programme but also train and give an overview [of the course] and understanding to other staff". (case study 1).*

Within the case study SSLPs staff were not relying on previous experience even though many of them were highly trained and experienced workers. Many of the case study centres had trainers that were available within the centre, thereby enabling all staff to gain a thorough understanding of the course and the material being covered, and better enabling the accurate provision of information to parents. It also enabled Sure Start programmes to maintain a pool of trained staff irrespective of staff movements.

The case study SSLPs were also distinguished by the availability of ongoing training and support (in the form of supervision), that was being provided to staff working in a supportive role with parents. Thus training included ongoing support and supervision specifically related to the delivery and presentation of course materials as well as advice and supervision relating to specific circumstances that might have arisen during the delivery of a programme or during work with parents. This ongoing training and support was highly valued by staff and appeared to have enabled staff to work more effectively with parents. Thus, in addition to line-management and peer support, more regular supervision

sessions by specially trained supervisors were also often available: *"… I work for the PCT so we get monthly supervision here but all of us have our own clinical supervision and external supervision if you need it. So supervision is taken so seriously here thankfully."* (Health Visitor, SSLP).

6.9   Parents' views

Parents' views are particularly important in ensuring that support provided within SSLPs is appropriate and acceptable. The parents who were interviewed in the case study programmes appeared to value many different aspects of the support (see section 6.6.3 and 6.6.4 above), and were most vocal about some of the more structured parenting programmes that had been provided. For examples, some parents appeared to feel that parenting groups had provided a safe space to discuss parenting issues without feeling an overwhelming sense of discomfort. Sharing experiences and gaining insights from other parents was greatly valued: *"When we do come to this group you can say your child's worst behaviour and also feel comfortable talking about it because you want help for it. And everybody will say you could do this, you could do that and you have got all these ideas in front of you. So it is really good."* (Mother, case study 6).

In addition to the group process, parents also described learning new strategies and techniques that they felt enabled them to enhance their parenting and gain a greater sense of control. One parent described how she had found it impossible to manage her young daughter's constant 'nagging' at her and would often end up screaming and shouting. She learned through attending a parenting course that it might be helpful to talk to her daughter more, even if she was out of the room in order to keep some communication going.

"It's something I will always remember, I don't want to be the mum that's screaming constantly. I found I was a lot calmer with her and more patient because I know how to handle her" (Mother, case study 1).

Most parents who had attended parenting courses had gained new confidence to parent their children differently.   Having attended Webster Stratton Incredible Years course, one parent commented; *"[I learned] to play with my daughter, listen to her, praise her [….] you learn different ways of coping"* (case study 3).

Structured courses were valued by parents because they provided clear guidelines and some predictability: *"…this week we are going to do this, this week we will do that. And you know what to expect and it is a very comfortable atmosphere and you get to know a lot of other parents as well, just knowing so many other parents makes it more comfortable to live in the area"* (case study 6).

These data from parents in some case study SSLPs provides some very moving testimonies to the ways in which parents and children are able to change and grow. They suggest that the support being provided within these centres, was highly valued by parents, not only in terms of them liking the support, but also in terms of the ways in which they felt their children had benefited.

CHAPTER 7 - LESSONS FROM SSLP EXPERIENCE IN PROVIDING PARENTING AND FAMILY SUPPORT

7.1   Parenting and Family Support in Sure Start

Together, the results of the survey and the case studies present a picture of a wide spectrum of parenting and parent support in SSLPs. Overall, however, they suggest that, while parenting support was on the agenda of most SSLPs, the level and quality of provision was not sufficient to deliver major impact on parenting at a population level.

7.2   Parenting programmes

The survey data suggested that while SSLPs were providing support for parenting through evidence based programmes, staff in some SSLPs believed that such programmes were not suitable for their families. As a result, some preferred to develop parenting programmes 'in house' for local populations. The data also suggest that many of those developing and running such 'in house' programmes had not received training in this area or availed themselves of training. There was also evidence of staff putting off parents who wanted to go on parenting programmes, saying they really didn't need it, and examples of SSLPs where staff were unaware of popular and thoroughly evidence-based programmes like Incredible Years (Webster Stratton). There were also instances where staff with proper training were pleasantly surprised to find that when they offered nationally recognised programmes, courses were successful and parents wanted to attend.

At the most encouraging end of the spectrum there were examples of SSLPs providing back-to-back, evidence-based programmes, sometimes with more than one group running at one time, reaching what was likely to have been a significant proportion of local parents. Some SSLPs provided a range of different nationally recognised programmes to suit the needs of different groups of parents. In the majority of SSLPs, parenting programmes were offered universally, and those parents that used them may not have been from the neediest families. However, the level of attendance suggests that these SSLPs had made good progress towards ensuring that participation in such programmes was not stigmatised.

This is most clearly evidenced in the data we collected from the case study SSLPs all of which were providing evidence-based parenting programmes and had clearly run them often. While, like staff in the survey SSLPs, case study staff were aware of the potentially stigmatising nature of parenting programmes, they were also quite clear that they were likely to be helpful to families. Case study staff were trained, confident and had access to good supervision. They recognised the need to develop trusting, non-judgemental, empowering relationships with parents. They paid attention to the 'how' of provision - informal setting and relaxed atmosphere- at the same time as providing clarity and structure in the sessions. While we were told of examples of case study staff developing (age-specific) programmes locally, these were on the whole

underpinned by well-established models of working with parents. Staff in these SSLPs seemed able to walk the tightrope required of successful provision of parenting programmes, balancing the requirement to meet parents' expressed needs at the same time as guiding the group of parents through a set 'syllabus'. Parents in these programmes corroborated staff views that they worked well if the parents felt safe. They also reported that they liked the structured nature of the courses.

Together these data suggest that high volume delivery of effective parenting programmes is possible. Some SSLPs were able to achieve this and some were not. Case study SSLPs were distinguished by a culture that focused explicitly on parenting, and by the skills and insight of their staff. Delivering parenting programmes effectively required some natural facility combined with effective training, supervision and experience and it is perhaps not surprising that this was not possible for all SSLPs.

7.3   Other approaches to parenting support

The findings relating to home visiting programmes largely confirm the findings of the recent themed evaluation of home visiting, suggesting that they were offered primarily as an extension of routine midwifery and health visiting practice, and a way of other practitioners making contact with people who might not otherwise make use of SSLP services to encourage them to participate in centre-based and group services. There was limited evidence of the sort of long-term, theoretically driven home visiting programmes described in section three, which aim to support parenting among high-risk families. One unexpected finding relating to home visiting programmes was the strong focus respondents reported on behaviour management advice. Practitioners doing home visiting appeared to be using adaptations of individual sessions of group-based parenting programmes as well as offering general behaviour management advice, though few had had specific training for this or other home visiting activity (except personal safety) (NESS 2006). It is possible that because our survey focused on parenting support, respondents emphasised this aspect of their home visiting services giving us a disproportionate view of its frequency.

There is evidence to show that it is possible to deliver effective behaviour management through home visiting programmes (e.g. Davis and Spurr, 1998), but the practitioners involved in the delivery of such programmes have typically undergone specialist or additional training. It remains uncertain whether the approach adopted by practitioners doing home visiting in SSLPs was effective.

Volunteer home visiting seemed to be a minority approach among the SSLPs included in the survey, and the content was much more likely to focus on parent support than parenting support.

As suggested in the themed evaluation of perinatal services in SSLPs, the focus of these services remained on parentcraft classes and breast feeding support. There was little evidence of the development of innovative programmes to support attachment and prepare parents for the emotional aspects of parenting. The only common postnatal parenting programmes we were told about were

baby massage programmes. Early learning programmes were relatively uncommon and evidence-based programmes such as PEEP were in the minority. The number of programmes of any sort being offered to fathers was small. A variety of family and parent support programmes were described, many delivered with the intention of attracting parents who might not otherwise have accessed any of the services. Counselling services were common and based on a mixture of approaches, most of which were well recognised. We got the impression that many participating SSLPs tended to focus primarily on family/parent support.

7.4   Excellence within Sure Start: Innovative approaches to supporting parents and parenting

The 'bottom-up' approach underpinning Sure Start provided ample opportunity for individual SSLPs to provide innovative methods of both supporting parents and parenting. This was as such an important opportunity not only to build on existing services, but to extend and change them.

The case study SSLPs had been selected from the SSLPs surveyed because they appeared to be offering innovative approaches to parenting support, and this impression was confirmed during case study interviews. What distinguished these SSLPs was not so much the provision of evidence-based programmes, although all were providing these, but the way in which parenting support suffused everything they did. Perhaps most importantly, was the evolution of a very clear culture that had been strongly informed by the application of a theoretical approach explaining how to work with parents to produce change. Such an approach was used to define all of the activities undertaken within some of these centres, and also to strengthen the training and support being provided. Just as importantly, these centres had a very distinctive culture in terms of an almost complete focus on promoting good parenting and an emphasis of the mother (i.e. parent) baby/child relationship. Within such centres, all staff had received additional training within the model being used (e.g. Solihull Approach), and a wide range of innovative parenting support was being provided from the antenatal period through infancy, toddlerhood and beyond. Such centres were strongly goal-directed, and frequently had quite strong input from psychologists or psycho-dynamically trained staff.

In addition to being aware of the need to model with parents the sort of respectful, empathetic, trustworthy relationships they were trying to help parents develop with their children, the focus on parenting very frequently suffused other family/parent support such as for example, adult education courses, assertiveness courses and groups for postnatal depression. Thus, these groups were being used to help parents develop insight into, for example, the origins of their low self-esteem, enabling them to track this back to the way they were treated by their own parents. In this way parents were enabled to develop insight into the negative effects on their children of being treated in the way that many of them had been treated as children. Adult learning courses were being used to help parents understand the learning process and become better able both to learn themselves, and to support their children's learning. Parents spoke warmly of the impact of these courses and many reported developing the confidence to

go on and get formal qualifications and jobs as, for example, teaching assistants or crèche workers.

The data from these centres of excellence suggest that activities that we have classified as family/parent support can be delivered in such a way that they also offer support for parenting. Perhaps most importantly, these centres of excellence within Sure Start offer alternative models of working that maybe important in informing future Children's Centres.

7.5 Parenting and Family Support in Sure Start Children's Centres

The need for parenting support is widely recognised in government policy and it is intended that all Children's Centres will offer such support. A National Academy for Parenting Practitioners is being established to enable the delivery of quality parenting support in these Children's Centres and in schools. These findings emphasise the importance of this Academy, since there is clearly a need to bolster the knowledge and skills of the workforce to offer evidence-based programmes.

Although, training for the provision of recognised parenting programmes is relatively straightforward, given the large numbers of staff, this may take some time to implement,. There are good quality programmes to train trainers and the number of accredited trainers is increasing. Our findings, however, also suggest the need for the development of a new culture amongst early years practitioners and others who are in a position to support parenting, one in which practitioners have the skills, including attachment and psychotherapeutic insights and skills, to help parents develop behaviour management techniques. Practitioners with the latter skills are relatively rare at present and the necessary workforce development is therefore likely to take some time. Practitioners working in Children's Centres like those in our case study SSLPs who have developed such approaches, may be much in demand to show others how it can be done, and may be able to offer training as well as providing services.

While changes in culture are important, they are difficult to monitor with easily gathered quantitative data. In the absence of the latter the best indicator of successful parenting support at the local level is likely to be the number of parents who have attended recognised parenting programmes. Recruitment and retention of a significant proportion of parents to such programmes is likely to require the sort of skills, attitudes and beliefs that we observed in the best performing case study SSLPs.

8. References

Allnock, D., Tunstill, J., Meadows, P., Akhurst, S., Chrysanthou, J., Garbers, C., & Morley, A. (2005). *Implementing sure Start local programmes: An in-depth study: Part Two – A close up on services.* Nottingham, DfES.

Bakermans-Kranenburg, M. J., Juffer, F., & van IJzendoorn, M.H., (1998). Intervention with video feedback and attachment discussions: does type of maternal insecurity make a difference? *Infant Mental Health Journal,* 19, 202-219.

Ball, M., Chrysanthou,J., Garbers, C., Goldthorpe, J., Morley, A., & Niven, L. (2006). *Outreach and Home Visiting Services in Sure Start Local Programmes.* Nottingham, DfES.

Barlow, J., & Stewart-Brown, S. (2000). Review article: behavior problems and parent-training programs. *Journal of Developmental and Behavioral Pediatrics,* 21, 356-370.

Barlow, J., Parsons, J., & Stewart-Brown, S. (2005). Systematic review of the effectiveness of group based parenting programmes for infants and toddlers. *Child: Care, Health and Development,* 31, 33-42.

Barlow, J., Shaw, R., & Stewart-Brown, S. (2004). *The effectiveness of parenting programmes for ethnic minority parents.* York: Joseph Rowntree Foundation, pp. 1-115.

Barnes, J. (2003) Interventions addressing infant mental health problems. *Children & Society.* 17, 386-395.

Barnes,J. & Freude-Lagevardi, A. (2003). *From pregnancy to early childhood: early interventions to enhance the mental health of children and families.* London: Mental Health Foundation.

Barnes, J., MacPherson, K. & Senior, R. (2006). The impact on parenting and the home environment of early support to mothers with new babies. *Journal of Children's Services*, 1, 4-20.

Belsky, J., Melhuish, E., Barnes, J., Leyland, A., Romaniuk, H. & the NESS Research Team. (2006) Effects of Sure Start Local Programmes on Children and Families: Early Findings From a Quasi-experimental, Cross-sectional Study. *British Medical Journal*, 332, 1476-1478.

Bor, W., Sanders, M.R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occuring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology,* 30*, 571-587.*

Bull, J., McCormick, G., Swann, C., Mulvihill, C. (2004). *Ante- and post-natal*

home-visiting programmes: a review of reviews. London: HAD.

Cohen, N., Muir, E., Lojkasek, M., Muir, R., Parker, C.J., Barwick, M., & Brown, M. (1999). Watch, Wait, and Wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal,* 20, 429-451.

Cohen, N., Lojkasek, M., Muir, E., Muir, R., & Parker, C.J. (2000). Six-month follow-up of two mother-infant psychotherapies. *Infant Mental Health Journal*, 4, 361-380.

Conger, R.D., Conger, K., Elder, G., Lorenz, F., Simmons, R., & Whitbeck, L. (1992). A family process model of economic hardship and adjustment of early adolescent boys. *Child Development*, 63, 526-41.

Davis, H., Day, C., & Bidmead, C. (2002). *Working in Partnership with Parents: The Parent Adviser Approach.* London: The Psychological Corporation.

Davis, H., and Spurr, P. (1998). Parent counselling: An evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 39, 365-376.

Department for Education and Skills (2003). *Every child matters: change for children.* London: Stationery Office.

Department for Education and Science (1999). *Making a Difference for Children and Families: Sure Start.* London: Stationery Office.

Department of Health (2004). *Choosing Health: Making healthier choices easier.* London: HMSO.

Department of Health and Department for Education and Skills (2004). *National Service Framework for Children, Young People and Maternity Services.* London: HMSO.

Desforges, C. (2003). The Impact of Parental Involvement, Parental Support and Family Education on Pupil Achievement and Adjustment. London: DfES.

Douglas, H., and Brennan, A. (2004). Containment, reciprocity and behaviour management: preliminary evaluation of a brief early intervention (The Solihull Approach) for families with infant sand young children. *International Journal of Infant Observation,* 7, 89-107.

Douglas, H. and Ginty, M. (2001). The Solihull Approach: changes in health visiting practice. *Community Practitioner,* 74, 222-224.

Dretzke,J., Frew, E., Davenport, C., Barlow, J., Stewart-Brown, S., Sandercock, J., Bayliss, S., Raftery, J., Hyde, C., & Taylor, R. (2004). *The effectiveness and cost-effectiveness of parent training/education programmes for the treatment of conduct disorders, including oppositional defiant disorders, in*

children. Birmingham: West Midlands Health Technology Assessment Collaboration, University of Birmingham, March, 9(50), 1-250.

Egeland, B.E., Carlson, E., & Sroufe, A. (1993). Resilience as Process. *Development and Psychopathology*, 5, 517-528.

Emond, A., Pollock, J., Deave, T., Bonnell, S., Peter, T.J., & Harvey, I. (2002). An evaluation of the First Parent health Visitor Scheme. *Archives of Disease in Childhood,* 86, 150-157.

Evangelou, M., Brooks, G., Smith, S., & Jennings, D. (2005). *The Birth to School Study: A longitudinal evaluation of the Peers Early Education Partnership (PEEP)*. London: DfES.

Farrington, D. (2003). Early Prevention of Adult Antisocial Behaviour. Cambridge: CUP.

Fraiberg, S. (1980). *Clinical Studies in Infant Mental Health: The First Year of Life.* London: Tavistock.

Hunt, C. (2004). *The Parenting Puzzle: How to get the best out of family life*. Oxford: Family Links.

Ireland, J.L., Sanders M.R., & Markie-Dadds, C. (2003). The impact of parent training on marital functioning: A comparison of two group versions of the Triple P- Positive Parenting Program for parents of children with early-onset conduct problems. *Behavioural and Cognitive Psychotherapy,* 31, 127-142.

Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T., & Byrne, P. (2000). Community Mothers Programme – seven year follow-up of a randomised controlled trial of non-professional intervention in parenting. *Journal of Public Health Medicine,* 22, 337-342.

Kurtz, Z., McLeish, J., Arora, A., Ball, M., & NESS (2005). Maternity services in the first four rounds of Sure Start Local Programmes. Sure Start report 12. London:DfES.

Lawes, G. (1992). Individual parent-training implemented by nursery nurses: Evaluation of a programme for mothers of pre-school children. *Behavioural Psychotherapy,* 20, 239-256.

McAuley, C., Knapp, M., Beecham, J., McCurry, N., & Steed, M. (2004) *Young families under stress. Outcomes and costs of Home-Start support.* York: Joseph Rowntree Foundation

Melhuish, E.C., Belsky, J., Anning, A., Ball, M., Barnes, J., Romaniuk, H., Leyland, A., & NESS Research Team (2007). Variation in Sure Start Local Programme implementation and its consequences for children and families. *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 48, *543-551.*

Moran, P., Ghate, D., & van der Merwe, A. (2004). *What Works in Parenting Support? A Review of the International Evidence.* London: HMSO.

NESS Research Team (2005a). *Early Findings on the Impact of Sure Start Local Programmes on child development and family functioning: Final report of the cross-sectional study of 9-and 36-month old children and their families, Surestart Report 13.* London: DfES. Available at http://www.ness.bbk.ac.uk/documents/activities/impact/1183.pdf

NESS Research Team (2005b). *Variation in Sure Start Local Programmes Effectiveness: Early Preliminary Findings. Surestart Report 14 .* London: DfES. Available at http://www.ness.bbk.ac.uk/documents/activities/impact/1184.pdf

Nicholson, B., Anderson, M., Fox, R., & Brenner V. (2002). One family at a time: A prevention program for at-risk parents. *Journal of Counselling and Development* 80 (3), 362-371.

Onzawa, K., Glover, V., Adams, D., Modi, N., & Kumar, R. (2001). Infant massage improves mother-infant interaction for mothers with postnatal depression. *Journal of Affective Disorders,* 63, 201-207.

Parr, M. A New Approach to Parent Education (1997). *British Journal of Midwifery,* 6, 160-165.

Patterson, G.R., DeBaryshe, D., & Ramsey, E. (1989). A Developmental Perspective on Antisocial Behavior. *American Psychologist,* 44, 329-335.

Percy, P., & Barker, W. (1986). The child development programme. *Midwife, Health Visitor and Community Nurse,* 22, 235-240.

Popay, J.A., Rogers et al (1998). Rationale and standards in the systematic review of qualitative literature in health. *Qualitative Health Research* 8, 341-51.

Puckering, C., Roger, J., Mill, M., Cox, A.D., & Mattsson-Graff, M. (1994). Process and evaluation of a group intervention for mothers with parenting difficulties. *Child Abuse Review,* 3, 299-310.

Puura, K., Davis, H., Papadopoulou, K., Tsiantis, J., et al (2002). The European Early Promotion Project: A new Primary Health Care Service to Promote Children's Mental Health. *Journal of Infant Mental Health,* 23, 606-624.

Rauh, V., Achenbach, T., Nurcombe, B., Howell, C., & Teti, D. (1988). Minimizing adverse effects of low birthweight: Four-year results of an early intervention program. *Child Development,* 59, 544-553.

Sanders, M.R et al. (2000). The mass media and the prevention of child behavior problems: the evaluation of a television series to promote positive outcomes

for parents and their children. *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 41, 939-48.

Scaramella, L.V., Conger, R.D., Simons, R.L., & Whitbeck, L.B. (1998). Predicting a risk for pregnancy by late adolescence: a social contextual perspective. *Developmental Psychology,* 34, 1233-45.

Smith, C. (1996). *Developing Parenting Programmes*. London: NCB.

Steele. M., Marigna, M., Tello, J., & Johnson, R. (2002). *Monograph Parenting styles and program Impact (Strengthening Multi-Ethnic Families and Communities: a violence prevention and parent training program).* Los Angeles, CA: Consulting and Clinical Services.

Stewart-Brown, & Shaw, R. (2004). The roots of social capital: relationships in the home during childhood and healthin later life. In A Morgan and C Swann (Eds) Social capital for health: issues of definition, measurement and links to health. HDA.

Sutton, C. (1992). Training parents to manage difficult children – a comparison of methods. *Behavioural Psychotherapy,* 20, 115-139.

Tennant, R., Barlow, J., Goens, C., & Stewart-Brown, S. (2007) A systematic review of interventions to promote mental health and prevent mental illness in children and young people. *Journal of Public Mental Health* 6(1), 25-32.

Underdown, A., Barlow, J., & Stewart-Brown, S.(in press - 2006). *Systematic review of the effectiveness of infant massage.* Cochrane Library, Issue 4.

Van der Eyken, W. (1990) *Home-start: A four-year evaluation.* Leicester, UK: Home-start Consultancy.

Webster-Stratton, C., Jamila, R., Reid, M., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child and teacher training. *Journal of Clinical Child and Adolescent Psychology,* 33, 105-124.

Zaslow, M.J., Pedersen, F.A., Suwalsky, J.T.D et al (1985). The early resumption of employment by mothers: Implications for parent-infant Interaction. *Journal of Applied Developmental Psychology,* 6, 1-16.

APPENDIX A – METHODS

Study design

This themed evaluation comprised two stages:

Stage one used quantitative methods and comprised a telephone survey of a subsample of SSLPs. The subsample was taken from the random sample of 150 SSLPs used by the Impact Module of NESS and selected from the first four rounds of SSLPs. The aim of the survey was to examine the forms of support i.e. family support (formal or informal); parenting support (formal or informal).

Stage two used qualitative methods and explored in more detail, using a case study methodology, a purposive sample of local programmes that were identified in the survey as providing effective, innovative and varied forms of family and parenting support.

Stage One – Telephone Survey

Sampling Strategy

Our sampling strategy was to survey programmes from the top and bottom 25% of SSLPs on the basis of apparent improvements in parenting documented in the NESS Impact Study. This produced a total of 76 SSLPs, half of which were at the bottom of the distribution in terms of documented improvements in parenting, and half in the top of the distribution.

The aim of this strategy was to explore whether there were differences in the provision provided by the two groups of SSLPs, in addition to documenting the range of provision among SSLPs in general.

Data Collection

Telephone interviews were conducted with the above subsample of SSLPs.

Individuals from NESS local evaluation support team were asked to identify key personnel at each of the involved SSLPs. A researcher who was blind to which programmes were in the top and bottom 25% contacted key members of personnel by telephone and administered a brief semi-structured set of questions. The interviews were all recorded. The interview schedule aimed to explore the following:

i) What informal and formal family and parenting support programmes have been delivered; ii) How were they delivered (i.e. frequency; duration; who provided etc); iii) What training has been provided to staff (which staff received this; who provided it; duration); iv) What support has been provided to programme providers (which staff received this; who provided it; frequency) etc.

Transcription and data analysis

The data were fully transcribed. The transcriptions were used in the following ways:
- Full coding of each interview transcription was undertaken,using the interview schedule as the basis of the coding schema, and entered into SpSS for data analysis.
- Quotations were selectively identified to illustrate the quantitative data.

Following data entry, the responses to the questions from all Sure Start areas surveyed were analysed using a) descriptive statistics (e.g. percentage distributions and chi-square) to explore the nature and extent of the programmes being used across the programmes surveyed; b) analytic statistics (e.g. Correlations and T-tests) to examine which types of parenting support were associated with greater success in the parenting outcomes being assessed in NESS (i.e. by grouping the programmes according to whether they were located in the top or bottom of the distribution of documented changes in parenting).

Response Rate

A total of 76 SSLPs were invited to take part in a telephone interview. Fifty-nine SSLPs responded positively, a response rate of 78%.

Telephone interviews were conducted with one member of staff from a total of 59 SSLPs, a majority of whom were programme managers or their deputies.

Stage Two – Case Studies

Project Selection
The initial criteria that were proposed for the selection of projects for inclusion in stage two included the following:

i) The extent to which the projects provided particularly innovative or successful ways of supporting parents
ii) Good geographical spread
iii)The inclusion of programmes serving large ethnic minority populations

Recruitment of Interviewees

A letter was sent to the programme co-ordinator of the 6 selected SSLPs explaining that their centre had been selected as a result of the success they had achieved in working in innovative ways with parents and inviting them to act as a case study for the benefit of other SSLPs. A follow-up telephone call was made to establish if the selected project programme co-ordinators were willing to take part. Only six of the eight programmes were able to participate.

Consenting programme co-ordinators were asked to invite key staff members (i.e. those who have been involved in managing or providing family and parenting support) to take part in a group discussion. They were also asked to send a written invitation to a sample of parents who had received some of these support

programmes. An introductory letter from the programme co-ordinator, an information sheet, a consent form and a pre-paid envelope were provided and sent to those parents selected by the programme co-ordinator. Parents who provided written consent for the project to pass their details to the research team were contacted by telephone and invited to take part in a group discussion.

Procedure for Collecting Data

Group discussions were held with a) SSLP staff; and b) parents separately (See Appendix B). The groups were facilitated in the local Sure Start/Children's centre, and crèche facilities were made available for participating parents.

Sample

A final sample of 4 providers and 4 programme recipients, from each of the 7 case study projects, were involved in a group discussion.

Data Analysis

The data from the interviews were analysed thematically. The analysis revealed key themes and these will facilitate the transcription of the interviews, which will be carried out selectively. While key themes have been identified within each individual project, others have been identified across the 8 case study projects as a whole.

Ethics Approval

Ethics committee approval to conduct stage two of the research was obtained from Warwick Medical School Ethics Committee at the July 2005 meeting.

Appendix B –Family and Parenting Support Programmes

Parenting programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Fathers parenting programme	1	.7	.7	.7
	Webster-Stratton	20	13.4	13.4	14.1
	Living with Children	3	2.0	2.0	16.1
	Young parents group	13	8.7	8.7	24.8
	Dad's group	12	8.1	8.1	32.9
	Terrific Two's	1	.7	.7	33.6
	Challenging children	1	.7	.7	34.2
	Video inter-active guidance	1	.7	.7	34.9
	"The Special Interest Group"	1	.7	.7	35.6
	Positive Parenting	6	4.0	4.0	39.6
	Happier Parenting	1	.7	.7	40.3
	parent forum	6	4.0	4.0	44.3
	Lets Talk	2	1.3	1.3	45.6
	parenting course	10	6.7	6.7	52.3
	One Step Ahead (NCH)	1	.7	.7	53.0
	Little explorers/little waddlers	2	1.3	1.3	54.4
	Sleep clinic	5	3.4	3.4	57.7
	Parent Power (NCH)	2	1.3	1.3	59.1
	Parent and Problem Challenge (PATCH)	1	.7	.7	59.7
	Mencap Parent Group	1	.7	.7	60.4
	Parenting advice/skills	4	2.7	2.7	63.1
	Hanen (various course names)	6	4.0	4.0	67.1
	Managing Children's Behaviour	1	.7	.7	67.8
	Me and My Child	1	.7	.7	68.5
	Bengali group/or Bangladeshi mothers group	3	2.0	2.0	70.5
	"Plan Group"	1	.7	.7	71.1
	Mellow Parenting	5	3.4	3.4	74.5
	School holiday Supernanny	1	.7	.7	75.2
	Coping with kids	1	.7	.7	75.8
	Talking Together	2	1.3	1.3	77.2
	Playing Together	1	.7	.7	77.9
	Growing Together	1	.7	.7	78.5
	Our Family Matters	1	.7	.7	79.2
	Boys will be boys	1	.7	.7	79.9

Strengthening Families Strengthening Communities	2	1.3	1.3	81.2
Fun and Families parenting course	1	.7	.7	81.9
In betweenies	1	.7	.7	82.6
Family Caring Trust - parenting course	2	1.3	1.3	83.9
Family Links	2	1.3	1.3	85.2
Parenting Matters	2	1.3	1.3	86.6
play skills support	2	1.3	1.3	87.9
Growing Together (from mellow parenting)	1	.7	.7	88.6
Childhood Matters	1	.7	.7	89.3
PIPPA	1	.7	.7	89.9
Ages and Stages	1	.7	.7	90.6
Confident Parents Confident Children	1	.7	.7	91.3
Behaviour clinic	1	.7	.7	91.9
Triple P	2	1.3	1.3	93.3
Parenting issues - key units on various topics	1	.7	.7	94.0
Understanding Children's behaviour (futures)	1	.7	.7	94.6
Cooperative Kids	1	.7	.7	95.3
Enjoying your Children (using Solihull)	1	.7	.7	96.0
Early Bird (Nat.Autistic Society)	1	.7	.7	96.6
Parenting courses - age related	1	.7	.7	97.3
Parent and child empowerment	1	.7	.7	98.0
Tackling Troubles	1	.7	.7	98.7
Tackling Tantrums	1	.7	.7	99.3
Tackling Sleep Problems	1	.7	.7	100.0
Total	149	100.0	100.0	

Standardised parenting programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Webster-Stratton	20	38.5	38.5	38.5
	Positive Parenting	4	7.7	7.7	46.2
	Happier Parenting	1	1.9	1.9	48.1
	Parenting course	1	1.9	1.9	50.0
	One Step Ahead (NCH)	1	1.9	1.9	51.9
	Parent Power (NCH)	2	3.8	3.8	55.8
	Hanen (various course names)	3	5.8	5.8	61.5
	Managing Children's Behaviour	1	1.9	1.9	63.5
	Me and My Child	1	1.9	1.9	65.4
	Mellow Parenting	5	9.6	9.6	75.0
	Strengthening Families Strengthening Communities	2	3.8	3.8	78.8
	Family Caring Trust - parenting course	2	3.8	3.8	82.7
	Family Links	1	1.9	1.9	84.6
	Growing Together (from mellow parenting)	1	1.9	1.9	86.5
	PIPPA	1	1.9	1.9	88.5
	Confident Parents Confident Children	1	1.9	1.9	90.4
	Triple P	2	3.8	3.8	94.2
	Understanding Children's behaviour (futures)	1	1.9	1.9	96.2
	Cooperative Kids	1	1.9	1.9	98.1
	Early Bird (Nat.Autistic Society)	1	1.9	1.9	100.0
	Total	52	100.0	100.0	

Home visiting/outreach reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Home Visiting and Outreach	49	89.1	89.1	89.1
	Home start	3	5.4	5.4	94.5
	Community mothers training programme	1	1.8	1.8	96.3
	Contact a Family/Befriending schemes	2	3.6	3.6	100.0
	Total	55	100.0	100.0	

Perinatal programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Infant massage	43	25.9	25.9	25.9
	Post natal group	12	7.2	7.2	33.1
	Ante natal group	11	6.6	6.6	39.8
	Breastfeeding support	29	17.5	17.5	57.2
	Weaning group	10	6.0	6.0	63.3
	Pregnancy Matters	1	.6	.6	63.9
	Baby Matters	3	1.8	1.8	65.7
	Baby talk	2	1.2	1.2	66.9
	Mini Movers	2	1.2	1.2	68.1
	Breastfeeding peer support training	9	5.4	5.4	73.5
	"Something More"	1	.6	.6	74.1
	Baby cafe/Baby club	5	3.0	3.0	77.1
	Baby groups (age related)	7	4.2	4.2	81.3
	Baby Fun	1	.6	.6	81.9
	Play and language workshops	1	.6	.6	82.5
	Screening tea party/develp check	1	.6	.6	83.1
	Baby Gym	6	3.6	3.6	86.7
	Music and movement	6	3.6	3.6	90.4
	16 & 18	5	3.0	3.0	93.4
	aqua natal group	3	1.8	1.8	95.2
	1 & 19	2	1.2	1.2	96.4
	Basildon Neonate Assessment	1	.6	.6	97.0
	Baby yoga	3	1.8	1.8	98.8
	Health visitor support group	1	.6	.6	99.4
	Bumps and Babes	1	.6	.6	100.0
	Total	166	100.0	100.0	

Early learning programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	PEEP	9	15.5	15.5	15.5
	Library open sessions	3	5.2	5.2	20.7
	Best Start Group	1	1.7	1.7	22.4
	Book start	2	3.4	3.4	25.9
	Play and learn group	3	5.2	5.2	31.0
	Speech and Language	7	12.1	12.1	43.1
	Reach out and read	1	1.7	1.7	44.8
	Busy Babies	1	1.7	1.7	46.6
	Early Start	5	8.6	8.6	55.2
	Fun Tots/Musical Tots	3	5.2	5.2	60.3
	Kiddy Talk/Wilstar Screening	1	1.7	1.7	62.1
	Story time/rhyme time	10	17.2	17.2	79.3
	Sing and sign	1	1.7	1.7	81.0
	Share Programme	2	3.4	3.4	84.5
	Share plus	1	1.7	1.7	86.2
	Highscope	2	3.4	3.4	89.7
	Family Literacy	1	1.7	1.7	91.4
	Babies love books	1	1.7	1.7	93.1
	Developing thinking in the 0-3's	1	1.7	1.7	94.8
	story sacks	2	3.4	3.4	98.3
	Home Learning	1	1.7	1.7	100.0
	Total	58	100.0	100.0	

Therapeutic programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Confidence building and assertive	3	4.7	4.7	4.7
	Counselling - relate	3	4.7	4.7	9.4
	pampering group/sessions	5	7.8	7.8	17.2
	Time for Me	4	6.3	6.3	23.4
	Getting Started	1	1.6	1.6	25.0
	EPDS	3	4.7	4.7	29.7
	Postnatal depression group	4	6.3	6.3	35.9
	Counselling - general	15	23.4	23.4	59.4
	Wellbeing workshops	2	3.1	3.1	62.5
	Women feeling fine	1	1.6	1.6	64.1
	health workshops various	4	6.3	6.3	70.3
	Smoking cessation	2	3.1	3.1	73.4
	Anger management	1	1.6	1.6	75.0
	Domestic violence drop in and share	1	1.6	1.6	76.6
	Shade Programme (mental health)	1	1.6	1.6	78.1
	Freedom Programme(domestic violence)	1	1.6	1.6	79.7
	Family therapy	1	1.6	1.6	81.3
	Healthy Minds Healthy Bodies	1	1.6	1.6	82.8
	Defeating depression	1	1.6	1.6	84.4
	Counselling - play therapy	1	1.6	1.6	85.9
	Counselling - CBT	1	1.6	1.6	87.5
	Adult yoga	2	3.1	3.1	90.6
	Mental health link	1	1.6	1.6	92.2
	Art Therapy	1	1.6	1.6	93.8
	Relate course - separation issues	1	1.6	1.6	95.3
	Life Story Group	1	1.6	1.6	96.9
	Counselling - art therapy	1	1.6	1.6	98.4
	Acupuncture group	1	1.6	1.6	100.0
	Total	64	100.0	100.0	

Adult learning programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adult Education courses	13	41.9	41.9	41.9
	Community courses	5	16.1	16.1	58.1
	Back to work guidance	1	3.2	3.2	61.3
	Community course - childcare	1	3.2	3.2	64.5
	Move on Up	1	3.2	3.2	67.7
	Speak Easy	4	12.9	12.9	80.6
	Volunteer training	1	3.2	3.2	83.9
	ESOL courses	1	3.2	3.2	87.1
	NVQ Childcare	2	6.4	6.4	93.5
	Personal development training	1	3.2	3.2	96.9
	keep your language alive	1	3.2	3.2	100.0
	Total	31	100.0	100.0	

General support programmes reported across 59 SSLPs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Stay and play	37	29.4	29.4	29.4
	Dance group	1	.8	.8	30.2
	Taster sessions	1	.8	.8	31.0
	Safeguarding Group	1	.8	.8	31.7
	Breakfast club	2	1.6	1.6	33.3
	Playgroup	1	.8	.8	34.1
	Outings and trips	7	5.6	5.6	39.7
	Child health clinic/drop in	10	7.9	7.9	47.6
	Young Mum's Group	1	.8	.8	48.4
	Women's group	6	4.8	4.8	53.2
	Welfare and benefits surgery	1	.8	.8	54.0
	Healthy Eating/Meet and Eat	5	4.0	4.0	57.9
	Allotment project	1	.8	.8	58.7
	Community police surgery	1	.8	.8	59.5
	Toy library	7	5.6	5.6	65.1
	Jump Start	1	.8	.8	65.9
	Community drop in	4	3.2	3.2	69.0
	Way to Say	1	.8	.8	69.8
	Cooking [group]	8	6.3	6.3	76.2
	Community cafe	5	4.0	4.0	80.2
	Mums in Mind	1	.8	.8	81.0
	Lunch club	2	1.6	1.6	82.5
	Toddler Time	2	1.6	1.6	84.1
	Family support drop in	1	.8	.8	84.9
	Common childhood illnesses	1	.8	.8	85.7
	Forrest School outdoor activities	1	.8	.8	86.5
	Keep me Safe	1	.8	.8	87.3
	Children's group	1	.8	.8	88.1
	Grandparents drop in	1	.8	.8	88.9
	Twins club	1	.8	.8	89.7
	Little Chef	1	.8	.8	90.5
	Craft group	4	3.2	3.2	93.7
	Childminder support group	1	.8	.8	94.4
	Lets Play/Messy Play	3	2.4	2.4	96.8
	Fun with Food	1	.8	.8	97.6
	Benefits advice drop in	1	.8	.8	98.4
	Minor Illness Service	1	.8	.8	99.2
	MISC (Maximising & Intensifying Support for caregivers)	1	.8	.8	100.0
	Total	126	100.0	100.0	

Appendix C - Interview Schedules for Stage Two

Interview schedule for programme providers

I'd like to ask you some questions about the family and parenting support that you have been providing over the past few years (i.e. when you were a Sure Start Centre)

We are particularly interested in the sort of things that you do to support both parents and also parenting.

- Could I start by asking if your centre has an overall strategy for supporting parents and parenting? If so, is it a written strategy (get a copy if yes) what does it say and why do you have this? How does it affect the way in which you provide services to children and parents?

- Would you say that your Sure Start has any sort of overall view about staff need to do to help parents change?

- Does it matter whether you have a strategy that underpins the provision of all services…?

- What are/have been the aims your SSLP in relation to supporting parents?

- What are/have been the aims of your SSLP in relation to supporting parenting?

- How do you go about identifying parents that might be having problems?

- What sort of support do you think parents value the most?

Parenting support services

- What services do you provide that are aimed specifically at influencing the way in which a parent parents his or her child?

- Does it matter how these services are provided? Are they formal/informal; structure/unstructured; do staff have specialist training or support.

- Have you ever uses any nationally available or standardised programmes that have a set structure and a manual?

    - How do you decide which of those that are available to use?
    - Have any of them been shown to be effective, and does this matter?

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- Do you ever think about modifying programmes of this sort in any way? For example, only delivering half of the number of sessions normally provided; or by mixing parts of this programme with parts of another programme?
  - What are the advantages or disadvantages of such programmes?

- Do you ever develop your own parenting programmes?

- Does it matter whether they are locally developed or nationally available?

- Do you provide parenting support to parents that are experiencing problems or do you also provide it to groups of parents that don't have apparent problems?

- How do you get parents to attend these programmes?

- How do you get parents to keep coming to them?

- What perinatal programmes do you provide and why?

- Do you do any home visiting? What is the content of these visits; How are staff trained and supported?

Family support services

- What sort of services do you provide that are aimed specifically at supporting parents (as distinct from specifically supporting parenting)

- In what ways (if at all) do you feel that these programmes influence the ways in which parents parent their children?

- In what ways are these services different from the services that you provide specifically to support the way in which a parent parents her child?

Decisions about the type of support that is provided

- How do you decide what type of parent and parenting support that you provide?

- What other factors influence decisions about what sort of support you provide? E.g. amount of funding available; what you know is available locally; whether something has been shown to be effective etc.

Decisions about how to use programmes locally

- If you decided to provide a particular service such as the Webster-Stratton parenting programme, how would you go about developing it so that it would work locally? Do you think it matters if you adapt programmes like this at all? If not, what sort of adaptations might you make?

- Do you have an overall model or objective that you use to make decisions about the type of family and parenting support you provide?

- If you have a particular group of parents that you want to reach (e.g. fathers; teenagers) how would you decide how to go about doing this?
  - How would you decide what programmes to offer them?

Use of evidence-based programmes

- Do you think about whether there is research available to show that something is effective before you provide it? Probe.

- Is evidence about effectiveness important?

Informal programmes

- What would you say is the role of informal programmes in Sure Start Centres?
- What are the benefits of informal programmes
- What are the disadvantages of informal programmes

Formal (structured) programmes

- What would you say is the role of formal programmes in Sure Start?

- How do you get people to attend formal programmes and to keep coming?

- What is the ratio of formal to informal programmes?

Interview schedule for parents

We're interested in finding about a bit more about what it is that parents of young children have found helpful or they liked at their Sure Start centre. We are particularly keen to know more about the things that they do at Sure Start, that support you as a parent.

<u>Types of provision</u>

- So, to start, could you tell me a bit about the sorts of things that you do when you come to this Sure Start Children's Centre. Perhaps think back to the last time that you came…what sort of things did you do?

- Have you ever attended some of the more formal courses that Sure Start provide… *If yes, Why. How was it? If no, why not?*

- Have you ever attended anything that you found hard but that was also helpful*. If yes, why do you attend…why was it hard…how was it helpful*.

- If you had a friend that was experiencing problems with one of their children…in what way do you think Sure Start would be able to help them?

<u>Feeling supported</u>

- Would you say that any of the things that you have ever done at the Children's Centre have ever helped you look after your children better?
    - o   What did they do to help?
    - o   In what way did they help?
    - o   Was anything that they did unhelpful or you didn't like?

- Would you say that any of the things that you have ever done at SS have ever helped you yourself or your family more generally?
    - o   What did they do to help?
    - o   In what way did they help?
    - o   Was anything that they did unhelpful or you didn't like?

<u>Likes and dislikes</u>

- What things do you like best about your Sure Start Centre?

- What things do you like least?

Recruitment and retention

- In what ways have people encouraged you to take part in different things that were being provided here? How did that feel?

- Thinking back to the times that you attended something regularly, what made you want to come back? Were there things that made you not want to come back?

Appendix D - Results for Section 4

Parenting support programmes

Parenting support programmes comprised four types of services – parenting; home visiting/outreach; perinatal; and early learning. Group A was providing slightly more formal programmes compared with group B (54% cf. 51%), and also more standardised or nationally recognised programmes (24% cf. 18%).

In terms of the type of programme, similar levels of perinatal (40% cf 37%), early learning (14% cf 12%), parenting (37% cf 34%) and home visiting/outreach (14% cf 12%) were being provided. More of the Group A parenting support programmes were described as being standardised or nationally recognised programmes (24% cf 18%), group B having slightly more locally developed programmes (35% cf 32%) and more programmes described as having no specific format (43% cf 40%).

Slightly more of the group A programmes were described as involving the use of a manual (24% cf 20%), and **significantly more group A programmes were described as involving specific training or preparation of staff for their delivery (42% cf 30%) (p<0.05).**

Slightly more group A programmes utilised both professional and self referral (36% cf 32%).

There were similar distributions across the two groups in terms of programmes described as involving regularity of attendance (around 60%). In terms of the targeting strategies slightly more of the group A programmes were described as being targeted-only compared with group B (68% cf 65%), the latter having slightly more programmes that were described as being both universal and targeted (11% cf 7%).

The two groups were similar in terms of the proportion of programmes provided to parents alone (30% cf 27%), compared with parents and children, or children alone.

Similar proportions of programmes were described as being provided on a group basis (78% cf 75%). **Significantly more group A programmes were utilising written information (26% cf 19%) (p<0.05).**

The aims and objectives were similar across the five broad groupings (parenting/discipline; relationships/bonding; early education; needs led; support/health).

In terms of the staff providing these programmes group B were utilising more health staff to deliver the programmes (43% cf 37%), while Group A were relying more heavily on staff described as being part of the Sure Start team (26% cf

21%).

Family Support Programmes

Family support comprised three types of programme – therapeutic; adult learning; and general support. Similar proportions of the programmes of both groups were described as formal (34%), standardised or nationally available (13% cf 11%), as having no specific format (60% cf 58%), and as having been developed locally (30% cf 28%).

In terms of the type of programme, group B were providing slightly more therapeutic services (34% cf 26%) with group A providing slightly more general support programmes (60% cf 53%) but similar levels of adult learning (15% cf 13%). Slightly more group B family support programmes were described as being based on the use of a manual (6% cf 2%), although similar proportions of both group's programmes were described as involving specific training or preparation of staff for their delivery (around 20%).

Similar proportions of both groups of programmes were described as utilising both professional/outreach (9% cf 7%), and self-referral (7% cf 4%). Group A had slightly more programmes described as open to everyone (65% cf 59%).

There were similar distributions across the two groups in terms of programmes described as involving regular or some regularity of attendance (around 60%) and similar proportions in terms of programme users (i.e. parents or parents and child). In terms of the use of targeting strategies slightly more of the group A programmes were described as being universal only (63% cf 57%) group B having slightly more programmes that were described as being explicitly targeted (6% cf 3%).

There were no differences between the two groups in terms of the mode of delivery of family support programmes (group-based or one-to-one), but more group B family support programmes were described as providing written information (18% cf 15%).

The aims and objectives of the family support programmes were similar for group A and group B across the five broad sets of objectives (parenting/discipline; relationships/bonding; early education; needs led; support/health).

Group B were utilising slightly more health staff to deliver the programmes (38% cf 31%), while Group A were relying more heavily on staff described as being part of the Sure Start team (23% cf 14%).

Appendix E

Staff interviews for Case Studies

- Community development worker
- Inclusion training mentor
- Training and employment
- Training mentor support worker - special needs and disability
- Family Support worker
- Senior Family Support worker
- Under 4 specialist
- Adult Tutor
- Operational centre manager
- Family Support Manager - social work background
- Family support worker - ethnic minority
- Health promotion and family support worker
- Community development coordinator
- Early years support worker
- Independent service provider
- Operations manager
- Senior Family worker
- Childcare development worker
- Community Involvement worker
- Home Visiting Coordinator
- Family Centre Deputy
- Parenting development worker
- Project manager/early years