The Centre for Effective Services (CES) is a not-for-profit company limited by guarantee (Company Number 451580 and Charity Number 19438 in Ireland). The work of the Centre is supported by The Atlantic Philanthropies, the Department of Children and Youth Affairs and the Department of Environment, Community and Local Government.

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Published by the Centre for Effective Services, Dublin

The authors of this report are:
Dr. Helen McAvoy and Dr. Joanna Purdy, both of the Institute of Public Health (IPH) in Ireland, and Dr. Helga Sneddon and Claire Mac Evilly, both of the Centre for Effective Services (CES).

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The Centre for Effective Services
9 Harcourt Street
Dublin 2, Ireland
Tel: +353 (0) 1 4160500
Email: office@effectiveservices.org
www.effectiveservices.org

and
65-67 Chichester Street
Belfast BT1 4JD
Northern Ireland
Tel: +44 (0) 28 90 438 433
Email: nioffice@effectiveservices.org
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Acknowledgements

The Centre for Effective Services and the Institute of Public Health in Ireland would like to thank the following people who have made important contributions to this project: the other members of the ‘Capturing the Learning’ project team (Nuala Doherty, Stella Owens, Michelle Harris, Susan Kehoe, Sarah Rochford and Liza Clancy); Owen Metcalfe, Noelle Cotter and Teresa Keating in the Institute of Public Health in Ireland; the staff of the organisations who generously shared their insights and evaluation findings; the funders, The Atlantic Philanthropies, the Department of Children and Youth Affairs and Dr. Sean Denyer, whose considerable expertise helped to shape this publication.
Executive Summary

Background
The effectiveness of early intervention and prevention programmes in enhancing child health and development has been established through a number of large-scale international studies (Heckman, 2011). The World Health Organization Commission on Social Determinants of Health concluded that an emphasis on equity in child development is key to addressing health inequality in the short and long term (WHO, 2012). Recently developed public health strategies in the Republic of Ireland and Northern Ireland recognise the potential of such interventions in contributing to better population health and in tackling inequalities in health on the island of Ireland (Department of Health, 2013; DHSSPS, 2012a). However, while government policies now recognise the potential of early intervention and prevention programmes, evidence is needed in terms of what works in both jurisdictions.

The Prevention and Early Intervention Initiative
The Atlantic Philanthropies has invested over €96 million in 20 agencies and community groups running 52 prevention and early intervention programmes across the island of Ireland. These include a funding partnership between the Irish Government and The Atlantic Philanthropies to support three large-scale model prevention and early intervention projects in disadvantaged areas of Dublin (Childhood Development Initiative (CDI) in Tallaght West, youngballymun and Preparing for Life in North Dublin). The Prevention and Early Intervention Initiative (PEII) supports a diverse range of approaches addressing a wide range of areas relevant to child development, such as parenting, children’s learning, child health, child behaviour and social inclusion. In keeping with international evidence that these approaches can offer the most to children growing up in disadvantaged communities (Heckman, 2011), the programmes are principally focused in areas of socio-economic disadvantage. Services funded under the PEI were required to rigorously evaluate the effectiveness of their services in improving outcomes for children. These evaluations encompassed both outcome and process evaluations, and include randomised controlled trials, quasi-experimental studies and qualitative approaches.

For the purposes of this report, child health is considered according to the World Health Organization’s definition (WHO, 2006): ‘Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.’

The 10 programmes and services designated by the Centre for Effective Services as supporting child health are:

- **Preparing for Life** (PFL) (Northside Partnership) is a home-based early intervention/prevention programme designed to support families from pregnancy until their child starts school, with a focus on child development, parenting and school-readiness. The intervention involves regular home visits delivered by PFL trained mentors and facilitated by PFL Tip Sheets.

- **Growing Child Parenting Programme** (Lifestart) is a parent-directed child-centred learning programme focusing on child development delivered to parents of children aged from birth to 5 years of age. It is a structured month-by-month curriculum of information, knowledge and
practical learning activity for parents, delivered by trained family visitors in the parents’ own homes.

- **Ready, Steady Grow** (youngballymun) is an area-based infant mental health strategy supporting the developmental needs of infants and toddlers, with a particular focus on the parent–infant relationship and social and emotional development. It aims to improve health and well-being during pregnancy and infancy; to foster, promote and support the parent–infant relationship; and to improve child development outcomes.

- **Eager and Able to Learn** (Early Years) is a comprehensive centre-based and home-based early care and education programme for children aged 2-3 years. The outcomes relate to children’s learning, social and emotional development, and cognitive development. The programme places a particular emphasis on relationships – the practitioner/child relationship, the parent/child relationship and the partnership between the parent and the practitioner to support young children’s development.

- **Childhood Development Initiative Early Years** (CDI) is an early childhood care and education programme for children aged 2½-5 years. It aims to enhance children’s physical, psychological and social well-being, including their cognitive skills and language development, their social and emotional development, and their capacity for learning. It also features family support by focusing on parents’ psychological health, building on their parenting strategies and encouraging a positive parent–child relationship.

- **Speech and Language Therapy Service** (CDI) is a separately evaluated component of the CDI Early Years Programme and the Healthy Schools Programme. An alternative service delivery model was assessed which was linked to Early Years services and primary schools, and involved providing training and support to parents, Early Years practitioners and teachers.

- **Healthy Schools** (CDI) is a programme supporting schools to develop their capacity to address health through a Healthy Schools Coordinator based within the school. The aim is to improve children’s health and well-being, and enhance access to primary care services.

- **Brook Sexual Health Programme** (Brook NI) is a clinic-based service that provides young people with information, education and outreach, counselling, confidential clinical and medical services, professional advice and training. The aim is to improve young people’s sexual health and sexual relationships, and to increase their awareness of sexual health and positive relationships.

- **Big Brothers Big Sisters** (Foróige) is a youth mentoring programme in which children aged 10-18 were matched with a trained volunteer mentor. It aims to enhance the social, emotional, identity and life skills of young people at risk.

- **Protective Behaviours Programmes** (MCI Ireland) is a school-based education programme, operating at the pre-school, primary school and post-primary levels. It address relationship skills, including self-esteem, teenage relationships and support for children and young people experiencing domestic violence, dating abuse and negative family conflict.

**Aim of report**

This report synthesises the early learning drawn from evaluations of 10 interventions that were identified as addressing child health outcomes. Although reducing health inequalities was not a specific goal of the programmes, the location of many of the initiatives in areas of disadvantage and the scope for the programmes to address social determinants of health and foster equality in child development means that the findings are of particular relevance to health inequality concerns.
Executive Summary

This is the first in a series of reports on child health and subsequent reports will be issued as further evaluations are completed between 2013 and 2015. It is intended that the report will support and inform the interventions as they develop and the communities in which they operate. It is also intended that the report can inform policy-makers and those who design, deliver and fund services for children on the island of Ireland in working towards realising the potential of early intervention and prevention programmes.

Summary of key learning points

- The early findings from the evaluation of the Prevention and Early Intervention Initiative (PEII) show that such approaches have potential in contributing to child health and development outcomes.
- The evaluation evidence suggests that programmes have potential in addressing both immediate health outcomes as well as broader aspects of children’s capacity to thrive and develop. Interventions that support optimal child development can offer added value in terms of their influence on social determinants of health.
- The contribution of such approaches to child health in the longer term should be monitored. The selection and measurement of meaningful health outcomes should be continuously refined.
- Prevention and early intervention programmes demonstrated added value to existing public health programmes, as well as presenting some innovative solutions to inequalities in health service access.
- Integrated child development and health services in the community and linked to the family home present opportunities for multidisciplinary working and synergies in the delivery of child services.
- There is scope for making the links between child health outcomes addressed in the PEII and policy priorities within the public health, health promotion and health service sectors. In particular, findings show that programmes in the PEII offer potential in terms of evidence-based approaches to:
  - increasing childhood immunisation in disadvantaged communities;
  - establishing healthy eating in the early years;
  - protecting children from harm through addressing home safety and parental skills;
  - contributing to the mental and emotional well-being of ‘at risk’ youth;
  - enhancing parents’ ability to recognise if their child may be in need of early intervention;
  - enhancing parenting skills and abilities and contributing to maternal well-being;
  - helping children reach their developmental potential and be ready for school;
  - addressing direct health outcomes while also fostering a longer term social determinants of health approach.
- The PEII demonstrated some success in the establishment of partnerships for child health between a range of community-based prevention and early intervention programmes and health services.
- Support and skills development among both parents and workers in child health and education services in disadvantaged areas was an important aspect of the prevention and early intervention programmes.
- Further reflection is required in terms of supporting appropriate prevention and early intervention approaches in the school setting.
Section 1: Background to the report

Overview: Introduction to ‘Capturing the Learning’

For more than a decade, The Atlantic Philanthropies has funded an initiative to promote prevention and early intervention approaches for children and young people in the Republic of Ireland and in Northern Ireland. This has involved investing in a cluster of organisations delivering evidence-informed early intervention and prevention services in disadvantaged communities in both jurisdictions. The Atlantic Philanthropies has invested some €96 million in 20 agencies and community groups running 52 programmes delivered through the Prevention and Early Intervention Initiative in the Republic of Ireland and Northern Ireland. This initiative includes a funding partnership between the Irish Government and The Atlantic Philanthropies to support three large-scale model prevention and early intervention projects in disadvantaged areas of Dublin (Childhood Development Initiative in Tallaght West, youngballymun and Preparing for Life in North Dublin). The initiative supports services using a diverse range of approaches and working in a wide range of areas, such as parenting, children’s learning, child health, child behaviour and social inclusion. It was a condition of funding that the organisations rigorously evaluate the effectiveness of their services in improving outcomes for children. The goal was to help the communities in which they operate, but also to share their learning so that policy-makers and those who design, deliver and fund services for children can benefit from their experience and put it to work for other communities.

The ‘Capturing the Learning’ project, led by the Centre for Effective Services (CES), involves a process of synthesising the collective learning from many of the projects in the Prevention and Early Intervention Initiative (PEII): collating data and information from multiple sources and perspectives, and distilling out overarching messages about ‘what works’. This report is a best-evidence synthesis that places the learning from the PEII alongside what is known broadly about influences on children’s health and development. Further information on the PEII and each of the innovations, planning reports, implementation reports, evaluation reports and other relevant resources are available at www.effectiveservices.org/prevention/early-intervention.

This report is the first in a series synthesising what we have learned from the Prevention and Early Intervention Initiative so far in terms of children’s health and development. The Preparing for Life (PFL) evaluation is still ongoing and the results reported here represent the findings from participation in the first 24 months of a 5-year programme; further findings will be released approximately every 12 months between now and 2015. The Growing Child Parenting Programme evaluation is also still ongoing and the results reported here represent the findings from participation, on average, in the first 10 months of a 5-year programme; more findings will be released when the children involved are 3 and 5 years old. Further evaluations of programmatic activity are expected from the Mayo Children’s Initiative, youngballymun and the Child Development Initiative.

Other reports from the ‘Capturing the Learning’ project focus on what we have learnt from the PEII about influencing parenting (Sneddon and Owens, 2013); child behaviour and conduct (Statham, 2013); children’s learning (Sneddon and Harris, 2013); and promoting inclusion (McGurk and Kehoe, 2013). A report is also available examining what the organisations learned about choosing, developing and implementing innovations and evaluating their outcomes (Sneddon et al, 2012).
Structure of report
Following this Overview, the report is structured as follows:

Section 2: Improving children’s health from a prevention and early intervention perspective
This section presents an overview of the key influences of child health and development, as relevant to the health and development outcomes assessed in the 10 CES-selected programmes. Evidence on the role of early intervention and prevention in enhancing child health outcomes is presented, as well as evidence on what is known to be effective. This section also outlines the relevant policy landscape framing child health and prevention and early intervention services in the Republic of Ireland and Northern Ireland.

Section 3: The programmes in the Prevention and Early Intervention Initiative
This section outlines the 10 evaluated programmes and services, with identified health outcomes. Table 1 sets out the organisation, service, target group, duration/intensity and objectives of the interventions. Descriptions of the services are followed by an overview of findings. Table 2 presents a summary of the child health and development outcomes associated with each intervention.

Section 4: Discussion and key learning points
This section discusses the findings from the evaluations of the Prevention and Early Intervention programmes and draws out common learning. The discussion firstly presents learning on the processes involved in developing and evaluating prevention and early intervention programmes relevant to child health. This is followed by a discussion of the learning on impact and outcomes from the 10 CES-selected programmes. Section 4 concludes with key learning points.
Understanding child health, inequalities and development

‘Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.’

World Health Organization (2006)

‘Giving every child the best start is life’ has become a priority theme for governments seeking to reduce health inequalities (WHO CSDH, 2008; DHSSPS, 2012a; Department of Health, 2013). A child’s experiences in the early years lay the foundation for all aspects of development and the seeds for future health – physical and mental. Babies and infants thrive where there is good early nutrition, a warm loving family with secure attachment and frequent exposure to environments conducive to physical play, learning and social interaction. Throughout childhood, healthy growth and development is supported by regular physical activity, a varied nutritious diet within a supportive and stable family routine. Protection from harm is also an important aspect of child health, with immunisation, injury prevention and child protection processes of critical importance. It is during childhood and in the critical and sensitive period of early development in particular that the roots of health inequality are established (Marmot, 2010). On the island of Ireland, patterns of child health and development are socially determined (DCYA, 2012; Sullivan et al., 2010). For example, in the Republic of Ireland, achievement in reading and mathematics was related to social class, with children (aged 15) from the highest social class category achieving significantly higher reading scores compared with children in the lowest social class category (DCYA, 2012). Similar trends were observed among primary school pupils in Northern Ireland, with fewer children from the most disadvantaged primary schools achieving the expected level in literacy and numeracy at the end of primary school (OFMDFM, 2005).

Children living in disadvantaged circumstances and communities do not enjoy the same opportunities for health and development. Left unaddressed, inequalities in child health and development become embedded and may amplify as children grow, ultimately contributing to significant health inequalities across the life course (WHO CSDH, 2008).

The family is an important setting determining the health of most children (see Figure 1). Family circumstances, behaviours and culture directly influence the health of children, as well as mediating the effects of that child’s wider environment.
Determinants of health in the social environment, such as parental employment, income, social class and parents’ level of educational attainment, are highly significant in determining child health and development outcomes (WHO CSDH, 2012; OMCYA, 2009). Furthermore, the quality of the physical environment (including housing and the walkability and safety of the local area) can play a significant role in children’s opportunities for health, play and physical activity (De Róiste and Dinneen, 2005; O’Keefe, 2009).

**Role of early intervention and prevention approaches in child health**

Many social determinants of child health are rooted in Government policies. However, prevention and early intervention programmes and services can have an important role to play in securing better health outcomes for all children, and disadvantaged children in particular.

Prevention and early intervention programmes have the potential to improve child health in a number of ways. Firstly, such programmes can **directly support** behaviours that promote the health and development of children. For example, early intervention programmes can empower and support parents to adopt healthy behaviours, optimise their parenting skills and equip families to make healthy choices for their children. Such approaches are especially important to the
Section 2: Improving children’s health from a prevention and early intervention perspective

establishment of good self-esteem and the formation of relationships, as well as sowing the seeds for better mental health across the life course. Early intervention programmes can also support parents to create physical and social environments that are conducive to child health, play, safety and development. In later childhood and adolescence, early intervention programmes have the potential to support children to transition to adulthood in a way that protects and promotes their health. Secondly, early intervention programmes can act indirectly by affecting the social determinants of health – for example, by facilitating children to access the wider benefits associated with a better education, including opportunities for later employment and income. Early Years interventions can support equality of opportunity for children. For example, supporting disadvantaged children to be as ‘school-ready’ as more advantaged children, can create a more level playing field for educational outcomes, and indeed health outcomes, in the long term (Sneddon and Harris, 2013).

In the health sector, prevention and early intervention for child health is not a new approach. Many long-established child health programmes hold prevention and early intervention approaches at their core, including national child health immunisation programmes, and screening and assessment programmes. Core programmes of child health developmental assessment and screening operate in both jurisdictions of the Republic of Ireland and Northern Ireland (Programme for Action for Children/HSE, 2005; DHSSPS, 2010) and make a substantial contribution to supporting optimal child development. In addition, service-led and community-based health promotion initiatives have been developed with regard to many aspects of child health, including healthy eating, physical activity, injury prevention, mental health and tobacco/alcohol use (HSE, 2011).

Evidence arising from the evaluation of programmes in the Prevention and Early Intervention Initiative (PEII) can be important in enhancing practice in this area and supporting the ongoing development of evidence-based approaches. The reach and potential of early intervention and prevention approaches is undergoing intense research effort internationally. New approaches in early intervention and prevention are moving beyond the prevention of communicable disease and the early identification of disease, disability or developmental delay. Such approaches encompass aspects of the child’s experience in utero, parenting and early learning, as well as adolescent life skills. These approaches are particularly appropriate in the context of addressing the changing burden of childhood disease. This change is characterised by rising levels of non-communicable disorders, including obesity and mental health issues, occurring in the context of persistent inequalities in child and adolescent health (Wolfe et al., 2013). Addressing this pattern of childhood morbidity requires intervention where children live, grow and play, in addition to within the health service setting.

Investing in child health and development, particularly in the early years and including the antenatal period, may well be the most effective phase to impact on the future health and development of the child (Moore, 2006). Effective early intervention programmes have demonstrated substantial reductions in violent crime, higher educational attainment, better employment opportunities and enhanced parenting (Allen, 2011). A review of international evidence by the Centre for Excellence and Outcomes (C4EO) reported that early intervention works – when it is an appropriate intervention, applied well, following timely identification of a problem; and the earlier the better to
Section 2: Improving children’s health from a prevention and early intervention perspective

secure maximum impact and greatest long-term sustainability (Hosking and Walsh, 2010; C4EO, 2010).

This report attempts to capture the learning from evaluations of 10 prevention and early intervention projects with identified child health and development outcomes in the Republic of Ireland and Northern Ireland. It is hoped that the learning presented will further support evidence-informed decision-making in prevention and early intervention programmes relating to the well-being of young people, as well as wider public health and health inequality policy on the island of Ireland.

Child health – Policy landscape on the island of Ireland

Public health and health promotion policy
Public health policies on the island of Ireland clearly recognise the importance of prevention and early intervention approaches to improving population health. In the Republic of Ireland, the current public health strategy Healthy Ireland — A Framework for Improved Health and Well-being 2013-2025 acknowledges that ‘the most effective time to intervene in terms of reducing inequalities and improving health and well-being outcomes is before birth and in early childhood’. The strategy supports the implementation of evidence-based prevention and early intervention initiatives aimed at children and families, initially focusing on areas of disadvantage, drawing evidence emerging from the Prevention and Early Intervention Programme (Department of Health, 2013). In Northern Ireland, the consultation document for the forthcoming Public Health Strategy sets out its aim to improve the health and well-being status of all people and reduce inequalities in health (DHSSPS, 2012a). Early Years and early intervention approaches have been identified as a strategic priority in improving population health within the new framework. The final strategy is expected in late 2013.

Similarly, the HSE Health Promotion Framework 2011 emphasizes a social determinants approach to health in which the health promotion workforce works in partnership with the health and social care providers, as well as the statutory and voluntary sectors, to re-orient health services to become better at promoting health and tackling health inequalities (HSE, 2011).

Children’s policy
In the Republic of Ireland, early intervention and prevention programmes/services for children and young people are also clearly implicated in achieving the goals of Government policy. The National Children’s Strategy, Our Children, Their Lives (Department of Health and Children, 2000), sets out the broad policy context for children in the Republic of Ireland, including aspects of health and development. The National Children and Young People’s Policy Framework is currently being developed by the Department of Children and Youth Affairs (DCYA). The DCYA is also developing a new Early Years Strategy, which will cover a 10-year period. In 2005, the National Children’s Office developed a national set of child well-being indicators (NCO, 2005). The indicator set is based on the ‘whole child’ perspective as defined in the National Children’s Strategy, which allows for a broad and holistic understanding of children’s lives and assesses how well Irish children are doing across all aspects of their lives.
The Office of the Minister for Children published *The Agenda for Children’s Services: A Policy Handbook* in 2007. It sets out the strategic direction in relation to children’s health and social services in the Republic of Ireland. The 7 National Service Outcomes for Children in Ireland are:
- healthy, both physically and mentally; supported in active learning; safe from accidental and intentional harm; economically secure; secure in the immediate and wider physical environment;
- part of positive networks of family, friends, neighbours and the community; and included and participating in society. These have since been amalgamated to form 5 outcomes areas as outlined in the *National Strategy for Research and Data on Children’s Lives, 2011-2016* (DCYA, 2011).

*Best Health for Children* (2002) and *Best Health for Children Revisited* (2005) set out the core programme for child health surveillance in the Republic of Ireland by the Health Service Executive (HSE), including aspects of health promotion; vision and hearing, developmental assessment, nutrition, and child emotional and mental health. The *Best Health for Children* (2002) strategy *Investing in Parenthood to achieve best health for children* emphasizes the need for early intervention and prevention approaches in parenting support and skills if child health is to be enhanced and protected. The HSE is currently consulting on a parenting support strategy.

As part of the Republic of Ireland’s Programme for Government, 2011-2016, an *Area Based Response to Child Poverty Programme, 2013-2016* is being introduced by the Department of Children and Youth Affairs (2013). The aim of this new initiative is to build on the learning from prevention and early intervention programmes and to break the cycle of child poverty in areas where it is most deeply entrenched and improve the outcomes for children and young people where these are currently significantly poorer than they are for children and young people living elsewhere in the State.

In Northern Ireland, early intervention and prevention programmes/services addressing children and young people are also implicated in achieving the goals of Government policy for children. Early intervention and prevention approaches underpin the pledges of the current *Programme for Government, Child Poverty Strategy and Children and Young Person’s Early Action Document* to reduce inequalities in child educational achievement and tackle child poverty and its consequences (Northern Ireland Executive, 2011a and 2011b; OFMDFM, 2012). The *Ten Year Strategy for Children and Young People in Northern Ireland, 2006-2011: Our Children and Young People – Our Pledge* aims to ensure that by 2016 all children and young people are fulfilling their potential (OFMDFM, 2005). The strategy acknowledges the challenges in improving the lives of the most marginalised and disadvantaged children and young people, and seeks to address this through high-quality universal services and targeted interventions where required.

Early intervention is critical to the achievements of the outcomes set out in both the *Ten Year Strategy for Children and Young People*, as well as Northern Ireland’s family and parenting strategy, *Families Matter: Supporting Families in Northern Ireland* (OFMDFM, 2005; DHSSPS, 2009). Within these strategies, Government has recognised that improved outcomes for children and young people need to be underpinned by a gradual shift to effective preventative and early intervention practice.
Health outcomes addressed in the 10 prevention and early intervention programmes

The 10 programmes in the Prevention and Early Intervention Initiative evaluated in this report relate to a diverse group of direct and indirect child health outcomes, as well as a diverse range of approaches and settings. Programmes sought to improve child health by intervening in pregnancy, early years, school children and adolescence by capacity-building approaches for parents, as well as in the settings of Early Years childcare and education providers and schools. In addition, alternative health service delivery models were compared and explored.

The section below presents some background on some of the health outcomes addressed in the 10 programmes. Where possible, key data are presented on each issue from the Republic of Ireland and Northern Ireland. This is followed by a brief outline of what is known to be effective in prevention and early intervention on each issue. Finally, under each heading, the policy context in the Republic of Ireland and Northern Ireland is presented in an attempt to make the appropriate links between the aims of the programmes and broader policy objectives.

Pregnancy

The contribution of healthy pregnancy to child health and development outcomes

Birth outcomes strongly influence a child’s ability to enjoy a healthy childhood, as well as a child’s capacity to learn and develop. Maternal health, including nutrition, drug, alcohol and tobacco use and wider environmental exposures during pregnancy, can have significant influences on short- and long-term child health and development outcomes (EuroPeriStat/EUROCAT, 2013). A review of childhood outcomes in 5-year-olds in Northern Ireland, based on the Millennium Cohort Study, found that low birth weight was associated with a range of poor child development outcomes in pre-school children (Sullivan, 2010). Similarly, analyses of health behaviours during pregnancy in the Growing Up in Ireland longitudinal study found that adverse maternal health behaviours were associated with unfavourable developmental outcomes in 9-year-olds (McCrory and Layte, 2012).

What role for prevention and early intervention approaches initiated during pregnancy?

It is now recognised that improving maternal health pre-conception and throughout pregnancy would be highly beneficial to addressing inequalities in short- and long-term child health and development outcomes (DHSSPS, 2010). However, evidence of what works is unclear. A recent Cochrane Review concluded that little can be deduced on effective practice in health promotion in pregnancy in the health service setting (Whitworth, 2009). In addition to supporting healthy pregnancy behaviours, effective intervention in the ante-natal period can help initiate and embed behaviours that promote child health and development through those pivotal early weeks and months of parenting. For example, the ante-natal period is critical in terms of supporting the decision to breastfeed. Despite a wealth of evidence on the benefits of breastfeeding, breastfeeding rates in the Republic of Ireland and in Northern Ireland remain very low by international standards and are a significant concern with regard to national child health and health inequality outcomes (OECD, 2009; DCYA, 2011; DHSSPS, 2013).

Routine health services based in the primary care setting, including ante-natal care, can offer benefits to mothers in terms of early detection and referral, as well as being a setting for health
Section 2: Improving children's health from a prevention and early intervention perspective

Improving children’s health from a prevention and early intervention perspective

However, late and non-attendance at these services is more common among women from disadvantaged circumstances. Late booking and non-booked pregnancies are associated with a greater risk of adverse outcomes for babies as well as mothers (DCYA, 2011; McAvoy et al, 2006). Prevention and early intervention programmes initiated during pregnancy have the potential to work collaboratively with maternity and child health services to address the excess risk of adverse perinatal outcomes observed among disadvantaged pregnant women. In this way, community-based prevention and early intervention programmes have the potential to contribute to the aims of both maternity and child health policies.

Policy context

In the Republic of Ireland, *Breastfeeding in Ireland – A five year strategic action plan* (Department of Health and Children, 2005a) emphasizes the importance for all families to have the knowledge, skills and support to make and carry out informed infant-feeding decisions, particularly those least likely to breastfeed.

In Northern Ireland, three key strategies are in place to ensure the best possible outcomes for mother and baby. The *Strategy for Maternity Care in Northern Ireland, 2012-2018* aims to provide high-quality, safe, sustainable and appropriate maternity services. The strategy recognises that information and support needs to be available for all parents and a targeted approach to preconceptual care undertaken for those at greater risk of poorer pregnancy outcomes, including those with long-term clinical conditions and through increasing age, social factors and/or ethnicity (DHSSPS, 2012b).

The recent publication of the breastfeeding strategy for Northern Ireland (*Breastfeeding – A Great Start, 2013-2023*) seeks to support mothers in giving their babies a good start in life. The strategy aims to support breastfeeding by fostering health services and communities that actively support ante-natal preparation for breastfeeding, and post-natal breastfeeding initiation and maintenance (DHSSPS, 2013).

The *Framework for the Universal Child Health Promotion Programme in Northern Ireland – Healthy Child, Healthy Future* is based on a whole-child approach, providing support for parents, with increased focus on vulnerable families and an emphasis on integrated services (DHSSPS, 2010). Expected outcomes include:

- improved parent–child interactions and relationships;
- increased breastfeeding, healthy eating and increased physical activity;
- prevention and reduction of some serious diseases and communicable diseases;
- improved school-readiness;
- better short- and long-term outcomes for children who are at risk of social exclusion.

These strategies seek to give every child the best possible start in life by promoting good maternal health, facilitating breastfeeding and providing the appropriate environment for children to grow and develop in the early days, weeks and months of the early years.
Parenting skills

The contribution of parenting to child health and development outcomes

Parents are the most significant influence on children’s development (Bowers et al., 2012). The way children are nourished, cared for, stimulated and bonded with makes a great difference across all the domains of development (David et al., 2003). Characteristics of positive parenting include high expectations, good supervision, appropriate disciplinary efforts and sensitivity to and support for children’s needs (Gutman et al., 2009).

The quality of parent–child relationships is significantly associated with many outcomes relating to child health, including learning and social skills, mental health and health behaviours such as substance use, risk behaviours and, in some studies, obesity. Parent–child relationships remain influential into adulthood for social and behavioural outcomes (O’Connor and Scott, 2007). The Growing Up in Ireland study revealed that parenting styles and the quality of mother–child and father–child relationships were associated with children’s social and emotional outcomes (Nixon, 2012). The parent–child relationship serves as a prototype for future relationships of the child. The more secure a child’s attachment to a nurturing adult, the easier it seems to be for the child eventually to become independent of the adult and develop good relationships with others. The Health Behaviour of School-aged Children (HBSC) surveys reveal that the proportion of children reporting that they found it easy to talk to their mothers/fathers was increasing over time (Gavin et al., 2013). Children who reported being able to talk to their mother and/or father were more likely to report excellent health and feel happy about their lives, less likely to have been drunk, currently smoke or have been bullied (Doyle et al., 2006a and 2006b).

A child’s home environment is the primary setting where they develop skills, interest and enthusiasm for learning (Bowers et al., 2012). Parental behaviours – such as children being read to, going to the library, painting and drawing, being taught letters and numbers, and singing songs, poems and rhymes – were all found to have a significant effect on children’s achievement (Meluish, 2010). Children develop their cognitive skills more in the early years than at any other time in their lives (Feinstein, 1999) and these skills are predictors of many social determinants of health, such as level of education achieved, income and employment (Richards and Wadsworth, 2004; Goodman et al., 2011). Parents’ communication with their children provides the foundation for the child’s speech and language development; enhances the parent–child bond and relationship; and contributes to the child’s cognitive development (Gardner et al., 2003).

Most parents feel stressed at least some of the time (Moran et al., 2004). A combination of factors – such as behavioural difficulties in children, parental depression or anxiety, family conflict, financial and familial pressures – can contribute to parental stress. Parents who are stressed are less likely to be able to provide optimal home circumstances and more likely to use coercive and harsh methods of discipline (Moore and Vandivere, 2000). An analysis of 5-year-old children in Northern Ireland found that parents’ longstanding illness and mental distress were linked to poorer cognitive, educational and behavioural assessments, and general health in the child (Sullivan, 2010). Parenting difficulties may be linked to low self-esteem and self-confidence in parents (Hall and Hall, 2007). Parental self-efficacy (broadly defined as an individual’s appraisal of his or her competence in the parenting role) has been shown to be an important buffer against parenting stress (Bloomfield and Kendall, 2012). In order for parents to feel strong and effective, they must be confident in caring for...
their child and relieving infant distress, and be supported by their family and friends (Coleman and Karraker, 1997).

What role for prevention and early intervention in parenting for child health and development outcomes?

Effective parenting is the bedrock for a child’s cognitive, social and emotional development. Supporting maternal health (including mental health and well-being) and nurturing parenting skills are essential if parents are to form warm and secure relationships with their children, communicate effectively with them and support their learning through a stimulating home environment. Parenting programmes offer valuable opportunities to influence child health and well-being positively through health-promoting environments, establishing good health behaviours, providing support for families and creating resilience. Parenting programmes can be universal or targeted, and delivered in a variety of settings (home and/or centre) using a range of approaches (individual and/or group-based activities). Programme evaluations have demonstrated improvements in a number of child health and development domains. It is important to note that many of the parenting programmes aim to improve child behaviour and reduce the incidence of conduct disorders. A limited number of parenting programmes appear to focus on specific child health outcomes. One such example is the Group Lifestyle Triple P Programme. The evaluation of a 12-week intervention (Group Lifestyle Triple P) was associated with significant reductions in child body mass index and weight-related problem behaviour (West et al, 2010).

Through the UK Parenting Early Intervention Pathfinder, the UK Government funded three large-scale parenting programmes (Incredible Years, Triple P and Strengthening Families Strengthening Communities), delivered to parents of children aged 8-13 years in 18 local authorities over a 2-year period. The programme evaluations measured parental mental well-being, parenting style and child behaviour. There were significant improvements in the outcome scores for all three programmes across child behaviour domains of emotional symptoms, hyperactivity, peer problems, and in particular conduct problems (based on the Strengths and Difficulties questionnaire) (Lindsay et al, 2011). These findings are of interest in relation to both parents’ and children’s mental health and highlight the importance of addressing social and emotional well-being through early intervention approaches. Parenting programmes that aim to improve parent–child relationships, child behaviour, social and emotional development, and reduce conduct disorders are documented in more detail in an earlier CES report (Sneddon and Owens, 2012).

Policy context

In the Republic of Ireland, the 10-year National Children’s Strategy: Our Children — Their Lives (Department of Health, 2000) recommends that children receive quality supports and services to promote all aspects of their development. The Health Service Executive’s strategy Investing in Parenthood (Best Health for Children, 2002) aims to support, reinforce and act as a vehicle for the implementation of relevant aspects of existing national strategies that pertain to supporting parents. The strategy called for universal and targeted support for parents, multi-agency and cross-departmental working, people-centred and community development approaches and the promotion of children’s rights. The strategy clearly recognises the need for early intervention and prevention approaches in parenting support and skills if child health outcomes are to be achieved.
In Northern Ireland, two key strategies seek to address parenting and child health outcomes. *Healthy Child, Healthy Future – A Framework for the Universal Child Health Promotion Programme in Northern Ireland* seeks to improve parent–child interactions and relationships, increase the physical health of the child, improve school-readiness and achieve better outcomes for children who are at risk of social exclusion (DHSSPS, 2010). The *Families Matter: Supporting Families in Northern Ireland* strategy focuses on universal support and preventative and early intervention services to support parents, children and young people (DHSSPS, 2009).

**Supported child development in early years**

**The contribution of Early Years services to child health and development**

As well as enhancing the skills of parents in the home, pre-schools and health services are important as settings in which health can be promoted and supported. Education is an important social determinant of health. Improving educational outcomes among the most disadvantaged groups has the potential to make a positive impact on health inequalities (Higgins *et al.*, 2008). Physical well-being, motor development, language and literacy skills, social and emotional development, as well as cognitive abilities are all important components of a child’s school-readiness. School-readiness is known to be a strong predictor of future academic achievement, employment and behaviour. Research shows that reading ability at the age of 7 is related to school attendance and the staying-on rate at age 16, while academic achievement tests at 8 years influence earnings at age 36 (Doyle and Timmins, 2007). Factors influencing school-readiness include income, family structure, parents’ education, health of the child, diet, the home environment and childcare settings (West *et al.*, 2000).

Concerns over speech and language development are common in terms of children in the early years. Assessment of speech and language development forms a core part of the routine developmental assessment of children in the Republic of Ireland and Northern Ireland. The principle behind such assessments is that early detection and early intervention is important if successful outcomes are to be achieved. Early intervention, such as correction of hearing impairment or appropriate speech and language therapy, is needed if affected children are to achieve optimal outcomes. Overall, the evidence suggests that speech and language difficulties have both short-term and long-term effects on child development. These effects relate to both learning, literacy, behavioural difficulties and social/emotional development (Hayes *et al.*, 2012). A number of the early intervention programmes studied in this report include interventions aiming to promote speech and language development in the early years among children in disadvantaged communities. In addition, alternative models of service delivery for speech therapy were compared with the general service.

**The role of prevention and early intervention approaches in the service setting**

A systematic review of 27 early childhood education programmes identified successful approaches within the programmes, which contributed to improved language, literacy, phonological awareness, mathematical and cognitive outcomes (Chambers *et al.*, 2010). These included aspects of clear definition of specific objectives to allow teachers to monitor children’s progress and carefully planned experiences designed to improve academic outcomes, prepare children for primary school, support for teachers and assessments of fidelity of implementation to help explain the impacts (or lack of) in some studies. The authors of the review acknowledge the need for systematic, large-
scale, longitudinal, randomised evaluations of pre-school interventions in bringing children from high-risk environments to normative levels of academic achievement.

**Policy context**

In the Republic of Ireland, Aistear is the curriculum pre-school education framework for children from birth to 6 years of age (NCCA, 2009). The framework seeks to ensure all children can grow and develop as competent and confident learners within loving relationships with others. These are important outcomes in terms of children’s social and emotional development, widely considered to be the basis for effective cognitive development. The *National Strategy to Improve Literacy and Numeracy among Children and Young People* aims to ensure there is a strong focus on literacy and numeracy skills within a broad and balanced curriculum and a range of settings (schools, pre-school settings and the home environment) (DES, 2011). The strategy recognises that establishing good literacy and numeracy skills brings with it many social, economic and health benefits for the individual and society as a whole.

In Northern Ireland, the Department of Education recently published a second draft of its Early Years Strategy – *Learning to learn: A framework for early years education and learning* (DE, 2012). The strategy recognises the contribution of early years learning to wider educational outcomes and seeks to support a range of universal and targeted early intervention services to contribute to these aims (NCB, 2013). *Count, Read: Succeed – A Strategy to Improve Outcomes in Literacy and Numeracy* aims to support teachers and school leaders in their work to raise overall levels of attainment in literacy and numeracy among young people, and narrow the current gaps in educational outcomes (DE, 2011). Using approaches and interventions that target children from the most disadvantaged areas can help reduce inequalities in educational outcomes, which are known to influence adult socio-economic status and other outcomes, such as health and measures of psychological well-being (Goodman *et al*, 2009).

**Promoting health through school settings**

**The contribution of healthy schools to child health**

Schools have an important role to play in contributing to childhood health in terms of creating an environment in which health is promoted and healthy behaviours are reinforced. School-based health promotion initiatives have been highlighted recently in terms of their role in addressing child overweight and obesity by supporting good nutrition and to the development of the knowledge and skills necessary to be able to make healthier food choices, as well as in the physical activity domain (Department of Health and Children, 2005b; DHSSPS, 2012c).

The 2006 *Health Behaviour in School-aged Children (HBSC)* Survey revealed that children from DEIS (Delivering Equality of Opportunity in Schools) schools in the Republic of Ireland were less likely to

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1 Between the highest and lowest performing pupils, those most and least disadvantaged, girls and boys, and schools themselves.
Section 2: Improving children’s health from a prevention and early intervention perspective

report positive health or feel very happy about their life at present. A range of adverse health outcomes were more prevalent among children in DEIS schools, including less healthy eating and higher levels of tobacco and alcohol use (Molcho et al, 2008).

The World Health Organization (WHO) defines a health promoting school as one in which ‘all members of the school community work together to provide pupils with integrated and positive experiences and structures which promote and protect their health’. This includes both the formal and informal curriculum in health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health (Lahiff, 2008). The Healthy Schools Programme (HSP) intervention discussed in this report is a manualised initiative based on the WHO’s model for a health promoting school.

What role for prevention and early intervention approaches through healthy schools?

A review of international evaluations of health promoting schools found positive development of health promoting schools in the process evaluations (Mükoma and Flisher, 2004). Changes were made to school policies and organisational structures to facilitate the health promoting activities and, in some cases, health promotion was successfully integrated into the school curriculum. Parents and local communities were also involved in various capacities in the planning and implementation of the interventions. However, the review did not find strong evidence for the effectiveness of the health promoting interventions on the health of students, staff and the community, and on the school ethos and environment. This review recommended incorporating appropriate policies within the schools, undertaking activities to support the transformation of the organisational, structural and policy aspects of some of the schools, as well as outside communities with which the schools interacted.

Healthy Schools programmes on the island of Ireland

In the Republic of Ireland, both the Department of Education and Skills and the Department of Health support schools in the promotion of health within the school community. The Health Promotion Strategic Framework (HSE, 2011) identifies education as one of the key settings for health promotion and recommends the implementation of a nationally agreed framework for Health Promoting Schools at both primary and post-primary levels. A framework for the development of a health promoting post-primary school has recently been developed by the HSE (HSE, 2012). The recent publication of Well-being in post-primary schools – Guidelines for mental health promotion and suicide prevention presents a whole-school approach to mental health and well-being, focusing on the entire school community rather than individual young people with identified needs (NEPS et al, 2013). The guidelines highlight the importance of the school environment as a place where young people develop friendships and social networks, and have access to support structures. The Department of Education and Skills has also published its Action Plan on Bullying, based on the Programme for Government commitment to encourage schools to develop anti-bullying policies (DES, 2013).

In the past, a small number of schools in Northern Ireland participated in the WHO Health Promoting Schools Programme, in conjunction with the Health Promotion Agency (now the Public Health Agency) and the respective Education and Library Board. The School Food: Top Marks Programme (HPA, 2008) is supported by the Department of Education, the Department of Health, Social Services and Public Safety, and the Public Health Agency, and is aligned with the current obesity prevention strategy, A Fitter Future.
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for All, which aims to halt the rise in obesity levels in children and young people (DHSSPS, 2012c). The Fitter Future for All policy highlights the importance of a whole-school approach to healthy eating and drinking, the importance of nutrition in the early years of life and the Government’s commitment to providing a range of initiatives promoting healthy eating in schools.

Domestic violence and family conflict

Supporting children at risk of domestic violence and family conflict in the community

Children growing up in disadvantaged communities are more likely to be exposed to home and community environments that at worst threaten, and at best fail to protect, their health and well-being. For example, low family incomes, poor housing and limited access to appropriate food outlets can place families at risk of food and fuel poverty, and social exclusion. Harmful levels of alcohol and substance misuse, less safe home and play environments, and bullying (including gangs) are also features of some disadvantaged areas. Growing up in situations of childhood adversity is associated with a range of adverse health outcomes both in childhood and across the life course, in particular in terms of mental health, none more so than when the child’s family unit is directly affected by issues of alcohol misuse, violence or sexual abuse (Brent and Silverstein, 2013; ESRI, 2013).

A report based on 24 case management reviews of child death and serious injury in Northern Ireland revealed that the majority of such children were living in families where parents were experiencing difficulties with their mental health, alongside misuse of alcohol or drugs, and domestic violence (Devaney et al, 2011). These adult difficulties reduced the capacity of parents to meet their child’s needs and often resulted in children being exposed to risks as a result of lack of care and supervision, a chaotic family lifestyle and inappropriate behaviour towards children by adults.

Domestic violence and family conflict

Domestic violence and family conflict encompasses the whole family, where both children and parents can be both victims and perpetrators (4Children, 2012). Children who are exposed to violence in the home may suffer a range of severe and lasting effects, and are more likely to be victims of child abuse (UNICEF, 2006). Those who are not direct victims have some of the same behavioural and psychological problems as children who are themselves physically abused (WHO, 2002). Children who are exposed to violence in the home may have difficulty learning and limited social skills, exhibit violent, risky or delinquent behaviour, and are at an increased risk of developing mental illness such as depression or severe anxiety. It has been estimated that there are up to 30,000 children and young people living with domestic violence in Northern Ireland (UNICEF, 2006).

On average every day in Northern Ireland, 12 women and 4 men are victims of domestic-related assaults (Northern Ireland Office, 2005). In the Republic of Ireland, approximately 1 in 7 women and 1 in 16 men have experienced severe domestic abuse (Watson and Parsons, 2005).

What role for prevention and early intervention programmes in domestic violence and family conflict?

The Centre for Excellence and Outcomes in Children and Young People’s Services conducted a review of interventions which sought to support children affected by parental conflict, separation and divorce, and domestic violence (Barrett et al, 2010). Evidence from the evaluation of school and community-based support and interventions suggests that school counselling services need to have trained staff and the capacity to refer children for more specialist help and that relationship education at school should begin as early as possible (Walker et al, 2010). The evidence also
supports the inclusion of education in school-based preventative work and that effective preventative programmes on domestic violence need to be delivered both through whole-school and cross-curricular approaches (Ellis 2008; Hester and Westmarland, 2005; Izzidien 2008).

Policy context
In the Republic of Ireland, the HSE (2010) Policy on Domestic, Sexual and Gender-based Violence seeks to implement an integrated and coordinated health sector response to ensure that all families experiencing, or at risk of experiencing, domestic violence and/or sexual violence will receive a continuum of supports from health and community service providers.

The Department of Children and Youth Affairs (2011) Children First: National Guidance for the Protection and Welfare of Children sets out principles and good practice guidelines for organisations that provide services to children. These guidelines have been developed to strengthen arrangements for the protection of children; highlight the importance of interagency cooperation; and outline the procedures to be followed to protect children at risk and try to prevent the recurrence of child abuse.

The Department of Health (2012a) Steering Group Report on A National Substance Misuse Strategy acknowledges the deficit in current data on children whose health, welfare and development are affected by a parent’s harmful alcohol or drug use. The report calls for a comprehensive examination of the extent and impact of parental alcohol problems on child welfare.

In Northern Ireland, the 2005 strategy Tackling Violence at Home – A Strategy for addressing Domestic Violence and Abuse in Northern Ireland focuses on meeting the needs of all victims who experience abuse through the development of better, more equitable, accessible and effective services and on working towards the development of a society in which domestic violence is unacceptable and will not be tolerated (Northern Ireland Office, 2005).

Under the United Nations Convention on the Right of the Child, governments are required to take full account of a child’s best interests. The government must provide children with adequate care when parents or others with legal responsibility fail to discharge their duties. The obligation to provide child protection services is, therefore, based on international as well as domestic law, such as the Children (Northern Ireland) Order (1995) (The Children Order) (DHSSPS, 2003).

Substance misuse raises many concerns in relation to parental care of children, as well as children’s overall health and well-being. In 2008, the Department of Health, Social Services and Public Safety published its Regional Hidden Harm Action Plan (DHSSPS, 2008a). This action plan is underpinned by a number of principles which state that the welfare of the child is paramount; there should be a focus on prevention and early identification to minimise the risk of crisis or tragedy; there should be a shared commitment and response to this issue; and relevant services should be integrated within mainstream children and adult services.

Youth mentoring, child health and health inequalities
A formal youth mentoring programme is one in which a young person (mentee) is paired with a non-parental older, more experienced person (mentor) with the expectation that a close relationship characterised by trust develops, within which the mentor can offer support and guidance to their
mentee, and share companionship, with the intention of fostering the mentee’s growth and development (Broker, 2011).

Youth mentoring programmes can be seen as using an assets-based approach to working with ‘at risk’ youth instead on focusing on problems. Youth mentoring is a unique intervention in that it can offer a micro-level (one-to-one) intervention and an alternative to group-level interventions for ‘at risk’ youth(Dolan and Brady, 2012).

A recent meta-analysis of 73 independent evaluations of youth mentoring programmes in the USA found overall that such programmes were modestly effective in improving behavioural, social, emotional and academic outcomes. However, the long-term effects of mentoring on physical and mental health and well-being remain unclear. Factors that appeared to improve effectiveness of programmes were identified as:

- participating youth with either pre-existing difficulties or were exposed to significant levels of environmental risk;
- a greater proportions of male youth;
- a good fit between the educational or occupational backgrounds of mentors and the goals of the programme;
- mentors and youth paired based on similarity of interests;
- programmes structured to support mentors in assuming teaching or advocacy roles for young people.

Challenges identified in the evaluation of youth mentoring programmes include determining whether short-term benefits are sustained later in life, as well as the failure of evaluations to include outcomes of interest to policy-makers (such as juvenile offending, substance use and obesity prevention) (Du Bois et al, 2002 and 2011). Most large-scale studies have been conducted in the USA. Despite widespread support for youth mentoring programmes in the UK, several reviews of the UK evidence base have found it to be ‘patchy and inconclusive’ (Philip and Spratt, 2007; Hall, 2003). The importance of having high-quality, targeted programmes was highlighted by Meier (2008), who concluded that ‘Good mentoring can work for some young people. There is, however, no evidence that it works for all young people (particularly the most disadvantaged)’.

**Promoting the sexual health of young people**

**Young people’s sexual health, child health and health inequalities**

Positive sexual health is an important component of young people’s physical, emotional and mental well-being. An increasing proportion of young people are sexually active at a young age and this is a particular feature of children in disadvantaged circumstances (Layte et al, 2006). Supporting young people to adopt healthy sexual relationships, protect themselves from unplanned pregnancies and sexually transmitted infections, and negotiate away from situations of sexual coercion and violence are critical elements of adolescent public health. The prevalence of sexually transmitted infections is increasing among young people – a significant public health concern in both jurisdictions (PHA, 2011; HPSC 2012).

At population level, teenage pregnancies continue to decline on the island of Ireland (DHSSPS, 2012d; Department of Health, 2012b) However, teenage pregnancy remains strongly concentrated
among girls growing up in disadvantaged communities in Northern Ireland. The birth rate for Northern Ireland in 2010 was 15 per 1,000 young women aged under 20 and the rate for young women in the most deprived areas was nearly 30 per 1,000 (DHSSPS, 2012d). In the Republic of Ireland, teenage pregnancies declined over the past 10 years, from 20 births per 1,000 females aged 15-19 in 2001 to 12 births per 1,000 females aged 15-19 in 2011. Preventing unplanned teenage pregnancy is particularly important in the context of tackling health inequalities and breaking down cycles of intergenerational poverty. Young motherhood can create significant challenges for girls in terms of completing their education, securing employment and gaining an adequate income – key social determinants of their own health and well-being and that of their children.

**What role for prevention and early intervention approaches for promoting the sexual health of young people?**

Despite the publication of a number of guidelines (NICE, 2011) relating to the development of young people’s sexual health services, surprisingly little is known about their overall impact on young people’s sexual health (Institute of Childcare Research, 2011). Recent reviews suggest that improving young people’s sexual health requires both broad multisectoral action and comprehensive services (e.g. services combining education and contraception services) in order to maximise impact (Elliot, 2013). A review conducted for the Crisis Pregnancy Agency concluded that young people’s sexual health services should be based on appropriate local needs assessment; well-advertised, easily accessed services outside school hours; informal and confidential; and adopt a collaborative model with other youth services (Fullerton, 2004). As well as the quality and effectiveness of the service, variability in the overall provision of sexual health services across Health and Social Care Boards and Trusts in Northern Ireland may be a consideration in assessing the effectiveness of any sexual health service in the region (NICCY, 2008; Institute of Childcare Research, 2011).

**Policy context**

The *Northern Ireland Sexual Health Promotion Strategy and Action Plan, 2008-2013* (DHSSPS, 2008b) emphasizes the importance of ensuring young people have access to sexual health services as a means to promote sexual health and prevent and address unplanned pregnancy and sexually transmitted infection. A Sexual Health Strategy is expected to be published in the Republic of Ireland in 2013.

**Summary**

Child health and child development are inter-related in many ways. It is clear from data from the Republic of Ireland and Northern Ireland that social and economic disadvantage are a major threat to a range of short-term and long-term child health and development outcomes. The development and evaluation of a number of programmes under the Prevention and Early Intervention Initiative in disadvantaged areas is a welcome contribution to the evidence base needed to enhance child health and address inequalities in the Ireland/Northern Ireland setting.

Success in enhancing child health on the island of Ireland requires a ‘social determinants of health’ approach, which facilitates partnership working with a range of existing health service providers, the health promotion workforce and other sectors. Parents and parenting may well represent the cornerstone of a comprehensive approach to fostering optimal child health and development, at
least in the early years. The health and development of a child is determined by maternal health, the mother’s mental health and well-being, the parent–child relationship, the home environment, access to health services, and educational and childcare experiences.

International evidence confirms that the most vulnerable children are least likely to achieve optimal health and developmental outcomes, with the impacts lasting into adolescence and adulthood. Prevention and early intervention programmes can be effective in supporting parents and children to improve child health outcomes and ensure age-appropriate cognitive, social and emotional development. Establishing good health in the early years provides the foundation for all aspects of health and development, including physical and mental health and well-being, academic achievement and employment opportunities in later years.
Section 3: The Programmes in the Prevention and Early Intervention Initiative

Introduction

In this section, a summary is presented of the evaluations of 10 of the programmes and services within the Prevention and Early Intervention Initiative, selected under the health theme by the Centre for Effective Services. Table 1 presents the programmes according to the approach used, while Tables 2 and 3 present the main evaluation findings.

Prior to implementation, and in many instances a number of years before a child or family received a service, organisations engaged in a lengthy process of development, involving epidemiological studies, needs analyses, literature and evidence reviews, preparation of logic models and programme exploration. All organisations engaged in extensive consultations with key stakeholders in the community. Some organisations selected evidence-based programmes, which they replicated with fidelity, with only minor adaptations primarily related to cultural context (Big Brothers Big Sisters, Protective Behaviours). Preparing for Life is a new programme developed in the Republic of Ireland which has drawn heavily on the principles and theoretical components of evidence-based home-visiting programmes. Similarly, the Growing Child Parenting Programme is an evidence-based programme developed originally in the USA, which has been adapted for use here with an additional home visitation component. CDI Early Years, Healthy Schools, Speech and Language Therapy Service, Brook Sexual Health Programme and Eager and Able to Learn were locally developed to address specific issues in children and young people’s lives. Some of the programmes under discussion are delivered in areas of social disadvantage and others delivered across multiple geographical locations.

There is considerable diversity in the evaluation methods used across the programmes, including outcome and process evaluations as well as quantitative and qualitative methodologies. Randomised controlled trial type methods featured in the evaluations of Preparing for Life, Growing Child Parenting Programme, CDI Early Years, Eager and Able to Learn, and Big Brothers Big Sisters. The remaining studies did not use randomisation, but instead compared the outcomes of children participating in the programme to those who did not take part, to historical data or used qualitative methods of enquiry. Findings from Preparing for Life and the Growing Child Parenting Programme represent very early results of the programmes, with further outcomes to be assessed in the longer term.

Programme outcomes are diverse, encompassing many aspects of child well-being and development, as well as outcomes relating to the child’s context (such as their parents’ skills and experience and the safety of their home environment) and the experiences of Early Years professionals and teachers. In the following section, each programme is described, followed by a summary of the main findings from the evaluation. Further detail on the programmes’ design and implementation, as well as the original evaluation reports, can be accessed on the CES website: www.effectiveservices.org/prevention/all-publications
Table 1: Overview of programmes considered in the report

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Service/ Programme</th>
<th>Target group(s)</th>
<th>Duration/ intensity</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northside Partnership</td>
<td>Preparing for Life (PFL)</td>
<td>Expectant parents</td>
<td>Monthly home visits of ~one hour in duration and a range of other support for 5 years</td>
<td>A home-based early intervention/prevention programme that supports families from pregnancy until their child starts school. PFL focuses on child development and parenting, and works with Early Years settings to embed the Síolta quality framework.</td>
</tr>
<tr>
<td>Lifestart</td>
<td>Growing Child Parenting Programme</td>
<td>Parents of children aged 0-5</td>
<td>Monthly home visits of between 30-60 minutes for 5 years</td>
<td>To help parents to support their child’s physical, intellectual, emotional and social development and to promote school-readiness.</td>
</tr>
<tr>
<td>Early Years</td>
<td>Eager and Able to Learn</td>
<td>Children aged 2-3</td>
<td>Delivered over 8-9 months to children and 3 home visits to parents</td>
<td>A comprehensive centre-based and home-based early care and education programme. Aims to motivate children to learn.</td>
</tr>
<tr>
<td>Youngballymun (Ballymun Partnership)</td>
<td>Ready Steady Grow</td>
<td>Expectant parents during pregnancy, infants, toddlers up to the age of 3 and their parents</td>
<td>Ongoing area-based infant mental health strategy</td>
<td>An area-based infant mental health strategy supporting the developmental needs of infants and toddlers, with a particular focus on the parent–infant relationship and social and emotional development.</td>
</tr>
<tr>
<td>Childhood Development Initiative (CDI)</td>
<td>Healthy Schools</td>
<td>Children aged 4-13</td>
<td>A health promotion strategy, delivered throughout the primary school year</td>
<td>Healthy Schools Coordinator based within the schools works to support schools to develop their capacity to address health in accordance with each school’s uniquely identified needs and priorities.</td>
</tr>
<tr>
<td></td>
<td>Speech and Language Therapy Service</td>
<td>Children aged under 6</td>
<td>Referral-based service, with duration of treatment dependent on individual need</td>
<td>The Speech and Language Therapy (SLT) Service is a component of the CDI Early Years Programme and the Healthy Schools Programme. SLT is delivered through Early Years services and primary schools, as well as providing training and support to parents, Early Years practitioners and teachers.</td>
</tr>
<tr>
<td>CDI Early Years</td>
<td></td>
<td>Programme starts when children are aged 2½-3</td>
<td>Pre-school and other types of support for 2 years</td>
<td>Service for pre-school children, providing integrated healthcare, wrap-around supports and professional development elements. The programme also works with the child’s family.</td>
</tr>
<tr>
<td>Fordige</td>
<td>Big Brothers Big Sisters (BBBS) Ireland</td>
<td>Young people aged 10-18</td>
<td>1-2 hours per week for at least a year</td>
<td>Youth mentoring programme which matches a volunteer mentor with a young person (mentee) to promote positive youth development.</td>
</tr>
</tbody>
</table>
**Description and findings from the Prevention and Early Intervention programmes**

**Preparing for Life**  
**Programme overview**

The Preparing for Life (PFL) Programme is a home-visiting programme that aims to improve the school-readiness of children living in disadvantaged communities by intervening during pregnancy and continuing to work with families until their children start school. It is a manualised programme delivered by trained, paid home visitors by a cross-section of different professional backgrounds. The PFL Programme was designed in cooperation with 28 local agencies and community groups led by Northside Partnership.

Programme participants (233 in total) include pregnant mothers who were recruited between 2008 and 2010 to participate in a five-year longitudinal randomised controlled trial. Two levels of the programme are being evaluated – a high treatment group (n=115) and a low treatment control group (n=118). The progress of these families is also being compared to a comparison group from a different community who receive no intervention.

Participants were on average 21½ weeks pregnant when they joined the programme. The average age of pregnant women was 26 years, 85% were not married and 3% of participants had third-level education. Both the high and low treatment groups receive facilitated access to enhanced pre-school, public health information, access to a support worker and €100-worth of child developmental materials annually (including home safety and play items). Both groups are encouraged to attend workshops or programmes in the community – the Stress Control Programme (which involves 6 one-hour weekly sessions), the Healthy Food Made Easy Programme (which involves 6 two-hour sessions) and the Smoking Cessation Programme, among others. In addition, the high treatment group receive regular home visits from PFL trained mentors, during which they are provided with high-quality information about parenting and child development. The frequency of the visits depends on the needs of the families.

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<table>
<thead>
<tr>
<th>Organisation</th>
<th>Service/Programme</th>
<th>Target group(s)</th>
<th>Duration/intensity</th>
<th>Objectives</th>
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</thead>
<tbody>
<tr>
<td>Brook NI</td>
<td>Brook Sexual Health Programme</td>
<td>Young women aged 19 and under, and young men aged 25 and under</td>
<td>Clinic-based sexual health consultations, dependent on individual need</td>
<td>Confidential clinic-based service provides young people with contraception, pregnancy testing, condoms, testing and treatment of sexually transmitted infections, as well as counselling, information and outreach work. Professional advice and training is also provided.</td>
</tr>
<tr>
<td>MCI Ireland</td>
<td>Protective Behaviours Programme</td>
<td>All age groups in primary and post-primary schools, as well as childcare practitioners and those working with children and young people</td>
<td>10 week programme delivered at different times during the school year</td>
<td>There are three strands: the pre-school work focuses on building self-esteem; the primary school work is aimed at developing an instinct for safety; and the post-primary school work addresses teenage dating abuse and healthy and unhealthy relationships.</td>
</tr>
</tbody>
</table>
and availability of the families, with the majority of families receiving fortnightly visits and some monthly (of between 30 minutes to 2 hours). At the 24 month assessment, families in the high treatment group had received an average of 33 home visiting, lasting one hour.

The PFL Programme focuses on 5 areas: pre-birth, nutrition, rest and routine, cognitive and social development, and mother and her supports. Tip sheets are used to facilitate the home-visiting sessions and are kept by the parent. Participants in the high support group also participate in the Triple P Positive Parenting Group Programme when their child has turned two years old.

In total, 618 individual outcomes were evaluated at 6 months, 12 months, 18 and 24 months. Health outcomes measured included maternal health and health behaviours in pre and post pregnancy such as substance use and postnatal depression; neonatal and labour outcomes at birth such as birth weight and method of delivery, and child health outcomes such as immunisation rates, hospitalisations, and eating patterns.

Findings

Overall, a similar number of significant findings were found at 6 and 18 months, with fewer observed at 12 months, and significantly more findings observed at 24 months. This is likely due to the variation in some measures at the different evaluation points. In relation to child health outcomes in particular, the number of significant results increased incrementally from 6, 12, 18 to 24 months. In particular, the number of significant positive changes in the domains of child development and child health doubled at 24 months compared to 18 months.

Maternal pre and postnatal health behaviours

The programme had a limited impact on changing maternal health or health behaviours at 6, 12, 18 or 24 months. No significant differences were evident with respect to health complications during pregnancy, self-reported health in pregnancy or changes in smoking, drinking or drug taking during pregnancy. The intervention was associated with a significantly lower occurrence of birth by caesarean section (Doyle and PFL Evaluation Team, 2012) and a lower occurrence of maternal hospitalisations after birth. Post-natal depression and other measures of material wellbeing did not differ between intervention and control groups at any time point. In addition, there were no differences regarding self-reported health or smoking and breastfeeding rates. At 24 months, mothers in the high treatment group visited their GPs more often, and those who were pregnant were more likely to have planned their pregnancy.

Parenting behaviours

The intervention had significant effects on the multiple domains of parenting. For example, at 6 months parents in the intervention group reported lower parental stress; more and higher quality parent–child interactions; less parental hostility; greater social support and connectedness to family and community; and fewer parents who restricted their child’s independence. At 18 months, parents had significantly more quality interactions with their child and were more concerned about their child’s language development. At 24 months mothers in the intervention group felt more competent as parents, and saw their baby more favourably compared to other babies. They were also less likely to experience clinically significant levels of parenting stress. In addition, at both 6 and
18 months, the programme had positive effects on the frequency of parent-child interactions, home safety and the quality of the home environment. In particular, the children in the high treatment group were exposed to a safer and cleaner home environment and they had more appropriate toys and learning materials.

Child health and development
While the programme had no impact on birth outcomes (i.e. birth weight, prematurity, Apgar scores), the programme demonstrated effects across multiple aspects of child health after birth. At 6 months, children in the intervention group had higher immunisation rates and more appropriate infant feeding patterns. At 12 months, they reported a lower incidence of chest infections, and higher immunization rates, as well as a higher intake of grains and dairy. At 18 months, they reported better overall health and were less likely to spend a night in hospital, in addition to eating more dairy and protein. At 24 months, they reported a lower incidence of asthma and chest infections, better overall health, and less visits to the GP. They were also eating more protein, fruits and vegetables, however they were also eating more fatty foods.

Regarding child development, the programme had limited effects at 6 and 12 months, with more effects emerging at 18 and 24 months. There were no programme effects at 6 months, however both the high and low treatment groups showed better child cognitive functioning than the comparison group, suggesting that some of the common programme components, such as the developmental and reading packs, may have had a beneficial impact on all of those participating in the PFL Programme. At 12 months of age, children in the high treatment group demonstrated a significantly higher level of fine motor skills and were less likely to be at risk for social and emotional difficulties than those in the low treatment group. At 18 months, children in the high support group showed better cognitive functioning and were at lower risk of gross motor and social developmental delays. At 24 months children in the high treatment group showed stronger cognitive development and problem-solving skills. They showed fewer problem behaviours such as dysregulation, sleep problems, or clinically significant levels of internalising and externalising problems.

Further details of the evaluation to date are summarised in Doyle et al (2012a, b and 2013a, b). The PFL Programme is ongoing and its impact will continue to be evaluated when the PFL infants are 36 and 48 months of age.

Growing Child Parenting Programme
Programme overview
The Growing Child Parenting Programme is a parent-directed child-centred learning programme on child development, delivered to parents of children aged from birth to 5 years across the island of Ireland. It aims to help parents to support their child’s physical, intellectual, emotional and social development, and to promote school-readiness. It is a structured month-by-month curriculum of information, knowledge and practical learning activity for parents, consisting of age-specific information on child development supported by art, story, music and movement resources tailored to suit each individual child and family. The programme is delivered by trained paid family visitors in the parents’ own home. It is offered as a universal service to parents regardless of social, economic or other circumstances, and as a targeted referred service based on need. The universal service is the object of this evaluation. Every parent who joins the programme receives a monthly issue based on the Growing Child curriculum.
(www.growingchild.com) and a 30-60 minute home visit from a Lifestart family visitor. Together the issues of the Growing Child and the visit provide age-specific information on what parents can do with their child and what developmentally appropriate materials they might use. The home visit also offers the opportunity to discuss progress during the last month and focus attention according to the family’s needs. Between May 2008 and December 2009, parents and children were recruited for a multi-site randomised controlled evaluation. Of these, 424 parents and children were included in the evaluation: 216 in the intervention group and 208 in the control group.

The evaluation assessed parent and child outcomes following 10-months’ participation in the programme. Parent outcomes included well-being (confidence, stress and fearfulness, social support); parenting skills (parent–child relationship, knowledge of child development); and embeddedness in the community. Child outcomes included cognitive skills (fine and gross motor skills, language acquisition), non-cognitive skills (emotional well-being, behaviour, social development) and health.

**Findings**

Early stage findings were available for effects after 10-months’ participation in the programme (when families had received on average 10 out of the 60 visits) The evaluators acknowledge that it is unlikely, due to duration of the programme to date, that evidence of improvements will be apparent at this stage. Small improvements were noted in 7 out of the 9 outcomes tested. While no significant improvements in parental outcomes were observed, greater parental efficacy was noted among parents in the intervention group compared with the control group. This is consistent with the Lifestart logic model, which suggests that the initial impact of the Lifestart programme is to improve parental outcomes, including confidence and efficacy.

The evaluation reported some positive effect on cognitive development, fine motor development, language development and socio-emotional development, but no statistically significant improvements were noted at this early stage in the programme.

From the qualitative findings, it emerged that parents were concerned about whether or not their child was developing normally. In light of this, parents expressed a need for accessible information on child development and support in improving parenting skills. Parents reported that the Growing Child Parenting Programme had increased their parenting knowledge and it was this change in perspective and behaviour that was helping them to better support their child, further reinforcing the logic model theory.

Based on findings from interviews, parents reported improved social, behavioural and cognitive development in their child, which, with the exception of motor development, reflects the child outcomes described in the logic model.

Further details of the evaluation are available in Miller et al (2010). The progress of these children will be assessed again at 3 years and 5 years, when a fuller picture of programme impact will be evident.
Eager and Able to Learn
Programme overview
Eager and Able to Learn is a comprehensive centre-based and home-based early care and education programme for children aged 2-3 years. It aims to improve the learning environment in the Early Years setting and further children’s physical, social, emotional, linguistic and cognitive development. The Eager and Able to Learn Programme was designed by Early Years Northern Ireland in 2007/2008 as a service targeted at 2-year-old children. It was piloted in 14 settings across Northern Ireland, comprising private day care nurseries and Sure Start programmes, between September 2008 and June 2009. Following the pilot year, between September 2009 and June 2010, the programme was rolled out in a further 28 Early Years settings – 18 day care nurseries and 10 Sure Start programmes. The programme lasted 8-9 months and included developmental movement experiences for children delivered in a group setting; a home learning package; workshops for parents and children; comprehensive training for the practitioners by Early Years specialists; 5 on-site support visits; and resource packs for the settings.

The programme evaluation involved Early Years providers, parents, children and a control group of non-attenders (n= 454 children, 180 practitioners, 390 parents). An impact evaluation, using a cluster trial with a partial cross-over based on pre- and post-programme assessment of child development, was undertaken and the process evaluation was based on surveys with practitioners.

Findings
Participation in the Eager and Able to Learn Programme was associated with significant improvements in social and emotional development. Those children who started with higher scores in social and emotional development and play-related behaviours tended to show the largest improvements in these areas, whereas children who began the programme with lower scores on receptive communication, fine motor behaviour and social emotional behaviour showed positive effects in these areas. This finding may be of particular relevance in respect of laying the foundations for mental health and relationship-building, and is likely to be driven to some extent by the successes observed in respect of parenting skills and experiences and the quality of the childcare experience. Participation in the programme was associated with a negative effect on cognitive development, with the strongest effect being on emergent literacy skills, such as recognising and naming shapes and colours and counting objects such as using fingers. There were no significant effects on the children’s gross motor development.

Eager and Able to Learn significantly enhanced parental behaviour. Parents who participated were more sensitive to how to support their children’s play and they also learned to play with their children in different ways (such as with song and dance, and using different materials). They showed more understanding of how play activities could be relevant to their children’s learning. Improvements were observed in the quality of their interaction and play with the children associated with programme participation. Practitioners reported becoming more open to and

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2 For reasons related to the assessment tool being used to measure child outcomes (Bayley Scale), the age range of children taking part in the evaluation was restricted to children aged 2 years and 2 months and 2 years 8 months at the time of entry into the programme (September 2008).
positive about working with the children’s parents. Participating in Eager and Able to Learn improved the average quality for settings and improvements were most clearly shown in interactions between children and staff, interactions between the children, interactions between parents and staff, and between the staff themselves. Although settings were already scoring highly in these areas, Eager and Able to Learn provided an additional boost, with 20% of the settings moving into the ‘excellence’ range.


Ready Steady Grow
Programme overview

Ready Steady Grow (RSG) is an area-based infant mental health strategy, delivered through youngballymun, to support the developmental needs of infants and toddlers in the Ballymun area of Dublin. Ready Steady Grow aims to improve health and well-being during pregnancy and infancy; to foster, promote and support the parent–infant relationship; and to improve child development outcomes. RSG comprises the Parent–Child Psychological Support Programme (PCPSP), a centre-based intervention for parents and their infants aged 3 to 18 months, other initiatives to support parent–infant relationships and child development (such as Hanen You Make the Difference language programme, and group parent and infant programmes) and capacity-building for local service providers to enhance the promotion of infant mental health. PCPSP is delivered through 6 visits by the parent and baby to the PCPSP Centre over a 15-month period, where the programme is delivered as part of the primary care service by Public Health Nurses and Speech and Language Therapists.

The PCPSP programme evaluation was conducted between July 2011 and December 2012, and involved 333 children (aged 3-19 months) and their families. It comprised both a process and programme evaluation. The process evaluation assessed how and to what extent the RSG service was promoting the use of ‘infant mental health principles’ and practice within existing service structures in Ballymun. The process evaluation included exploratory interviews with key stakeholders (n=23) and a stakeholder survey administered at two time points to a sample of individuals working with the children and their families (Time 1: n=40; Time 2: n=18). The programme evaluation assessed the impact and effectiveness of the PCPSP, examining changes over time in outcomes for parents (parental stress, parenting self-esteem, satisfaction and efficacy, parent–child interaction and satisfaction with the programme) and children (child development and attachment). Child outcomes were evaluated pre- and post-intervention, and some outcomes were compared with those from a comparison group which had been established for the purposes of a separate study.

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3 As an infant mental health strategy, RSG is concerned with the promotion of young children’s social and emotional competence. This is achieved through efforts to engage with the systems and individuals who influence the experiences and development of young children.
Findings

Findings from the process evaluation interviews revealed that the Ready Steady Grow (RSG) Programme was developing building capacity within the service community in Ballymun, with support from the majority of local stakeholders in developing a community Infant Mental Health (IMH) strategy. There was enthusiasm for the IMH training, supervision and support offered by RSG. Potential barriers identified included concerns about the future sustainability of RSG, IMH capacity outside of RSG, possible over-reliance on key staff and limited resources in the long term. Effective collaboration was dependent on organisations having a history of collaboration, common goals, opportunities to meet, available resources to collaborate and physical proximity. Varying levels of engagement were reported, with organisations with common goals, pre-existing working alliances and a shared enthusiasm for IMH more likely to collaborate and engage effectively.

There was no significant decrease in parenting stress between the introductory and 15-month visit. Significant decreases were noted in parental distress and parent–child dysfunctional interaction (as determined by the Parenting Stress Index Short Form (Abidin, 1995)). A significant increase over time was noted in relation to child difficulty, suggesting that mothers had more difficulty managing their child’s behaviour at 15 months. The number of parental visits was significantly associated with lower scores in relation to dysfunctional interaction, indicating that for every additional programme visit attended, mothers’ ratings of dysfunctional interactions with their children decreased. There was a significant increase in parenting self-esteem, parental efficacy and satisfaction over the course of the programme.

Four behaviour types were recorded during parent–child interaction sessions: sensitive (considered to be desirable) and intrusive, protective and disengaged (considered to be undesirable). There was no significant change over time in sensitive behaviours, with statistically significant decreases in protective and intrusive behaviours, which were related to every additional programme visit. There was a significant increase in parental sensitivity over time during periods of ‘non-interaction’ (i.e. when the child is not approaching or engaging with the parent).

For the majority of children, their development (as measured by the Gesell Developmental Schedules) remained within the normal range across the programme’s duration. There were significant changes in children’s developmental trajectories over time. Between the 5- and 18-month visits, children showed a significant decreasing pattern over time in their expected rate of development in global, adaptive, language, fine motor and personal and social development. A significant increasing pattern in expected rates of development was observed for gross motor scores. Over the programme period, there was an increase in the likelihood of children displaying ‘non-normal’ (scores below normal range) development for global, adaptive, language, and personal-social development. A higher number of programme visits was associated with increased global, adaptive and language development, with a decreased risk of developmental delay in these domains. The number of programme visits had no effect on gross motor, fine motor and personal-social development.

No statistical differences between the PCPSP group and the comparison group were observed in terms of child development, which was the only comparable outcome between the two groups. Overall, children who received the PCPSP programme are displaying similar developmental profiles
to the comparison group who did not receive the programme, suggesting the programme had little impact on the developmental domains the programme analysed.

When child attachment was measured at 12 months, the findings indicated that nearly three-quarters of the children (73.5%) in the PCSP were securely attached. There was no association between the number of programme visits and secure attachment classification rating.

Lower engagement and higher attrition were particularly common among more disadvantaged families, while families with positive attributes (such as planned pregnancies, breastfeeding mothers and lower maternal stress scores) were likely to attend more programme visits and less likely to leave the programme prematurely.

Findings included in this report will be published by the Geary Institute and the School of Psychology, University College, Dublin.

**CDI Early Years**

**Programme overview**

CDI Early Years is an early childhood care and education programme designed to support and target all families living in an area of social disadvantage in Dublin, delivered through the Childhood Development Initiative. The programme is delivered through a combination of specialised staff located within existing services over a 2-year period, starting when children are aged 2½-3. It aims to support children by improving their cognitive, language and social development. It also seeks to support parents by reducing parental stress, improving parental estimation of child social skills and behaviour, and improving the home learning environment. In addition, it aims to improve the curricular, process and structural quality of the pre-school setting.

Parents are supported by a dedicated parent/carer facilitator, participation in the Parents Plus Community Course and provision of quality childcare and activities for parents based on their specific needs. Home visits are also undertaken by the parent/carer facilitator and key childcare workers.

The programme was delivered in 2 waves, each lasting 2 years (Cohort 1: September 2008 – June 2010; Cohort 2: September 2009 – June 2011). The evaluation was designed as a randomised cluster trial, where pre-schools were matched against agreed criteria and then randomly allocated to intervention or control groups.

**Findings**

Children were assessed at baseline, after one year and again after 2 years. The CDI Early Years Programme was not associated with significant differences in child cognitive and language outcomes. Fewer children who took part in the programme were classified as having abnormal behavioural problems compared to control children at the end of the intervention, but these differences were not statistically significant. Fewer intervention children than control children were classified as having borderline (4.18% versus 7.8% respectively) or abnormal hyperactivity levels (10.22% versus 13.44% respectively), but these differences were not statistically significant.

The Early Childhood Environmental Rating Scale – Revised Edition (ECERS-R) examined curricular and planning aspects of pre-school environmental quality. All the pre-school settings were considered to
be of ‘good’ to ‘excellent’ environmental quality. The intervention group scored significantly higher than the control group at both the mid-phase and end-phase stages of assessment. This would suggest that better curricular and planning quality in the intervention group was a result of training received by pre-school staff, which was supported by the programme design. The intervention group scored significantly higher compared with the control group at end phase in terms of the type and range of activities offered to children. Intervention pre-schools were more likely to engage children in music-movement, nature/science and mathematics activities compared to settings that did not take part. Intervention schools had a significantly better range of topics targeted at promoting children’s learning and development, and intervention staff tended to plan more than control staff. The Parents Plus Community Course was shown to improve the children’s home-learning environment, even 2 years after the course was attended.

Findings from the qualitative evaluation revealed that staff welcomed training provided by the speech and language therapists, and described how it had taught them to think about the importance of print-rich environments and the power of reading with children, and to tune in to children and their speech and language needs in a deeper way.

Communities of Practice meetings were a structural aspect of the programme to allow for support, shared learning, feedback and consultation with the Quality Specialist and with other pre-schools implementing the programme. These meetings were identified by staff as a support that informed their practice, helped them to reflect and gave them a sense of how manual implementation was progressing in other settings.

Child attendance at intervention pre-school settings varied greatly, ranging from 71 to 153 days out of a maximum of 154 days per year, and may be due to child and family factors such as illness or routine absenteeism. Control settings tended to have lower minimum attendance rates than intervention settings (36 days versus 63 days respectively). It has been suggested that intervention settings may have been better at encouraging attendance for children prone to lower attendance than control settings.

Further details of the evaluation are summarised in Hayes et al (2013).

Speech and Language Therapy Service

Programme overview

The Speech and Language Therapy (SLT) Service is a component of both CDI Early Years and Healthy Schools programmes, and operated in pre-school and DEIS settings. The SLT Service was delivered in the Tallaght West area of Dublin as part of the Childhood Development Initiative. It provided training and support to Early Years practitioners, teachers and parents to promote speech and language development, assess referred children and intervene with regard to their speech and language development.

The programme assessed children within their pre-school and school settings, rather than requiring parents to take children off-site to attend health centres. The SLT Service was provided within 3 primary schools and 10 Early Years services. An interagency organisational structure for interprofessional collaboration between Early Years practitioners and speech and language
therapists was developed. Firstly, training and information was offered by the therapists to Early Years practitioners and school teachers, and secondly, the mode of delivery allowed for the sharing of information on children’s needs, progress and outcomes through a feedback loop facilitated by the regular presence of speech and language therapists in the Early Years services and schools.

A retrospective evaluation of service outcomes was undertaken, comprising two strands. The first strand involved a quantitative evaluation of referral, uptake and outcomes of the service. The second strand, a qualitative process evaluation, examined the experiences of staff and parents with service design and delivery. Between September 2008 and June 2011, 192 children (aged 2-6) with suspected speech and language issues were referred from the CDI Early Years and Healthy Schools programmes and were included in the evaluation. The qualitative evaluation involved parents (n=49), school staff (n=16) and other agencies (n=12) providing speech and language therapy in the area.

Findings
There was considerable diversity in the nature of referrals with multiple speech and language concerns, including both speech delay as well as disorders. Up to 60% of children identified as requiring speech and language therapy (SLT) were new referrals to an SLT service. Around one-quarter of difficulties were classified as severe. Referrals to CDI’s SLT Service were significantly younger in age than referrals to HSE speech and language therapy services. Significantly more boys than girls were referred to the CDI service.

12% of the boys accepted and 28% of the girls accepted were discharged from the CDI service with their speech and language within normal limits, usually after about 6 weeks of therapy. 18% of children no longer required speech and language therapy after intervention. Around half of children required ongoing therapy, with boys over-represented in this group. Parents reported that their children were more ready for school as a result of the intervention and that their child was less likely to be bullied or singled out.

Three-quarters of children from the CDI Early Years Programme who were referred to the CDI SLT Service were assessed within 2 months. Waiting times compared considerably more favourably with waiting times for HSE community speech and language services. Around 1 in 5 of children referred (n=39) were referred for additional services, including assessment by ear, nose and throat (ENT) specialists, audiology and psychology.

On-site provision of the SLT Service within the pre-school/school setting was viewed as an important aspect of accessibility by parents, practitioners and teachers. Parents reported that the pre-school/school-based nature of the CDI service was less disruptive than the alternatives. Child attendance compared favourably with other similar services in terms of first assessment – however, overall parent attendance did not appear to differ.

Staff in pre-schools and schools who received the CDI service reported improved understanding of speech and language issues and greater confidence in responding to children’s needs. Similarly, parents of children who received the service reported an improved understanding of how to address their child’s speech and language difficulties.
Further details of the evaluation are summarised in Hayes et al (2012).

Healthy Schools

Programme overview

The Healthy School’s Programme (HSP) is a manualised school-based health promotion initiative addressing school policies, procedures and practices, and identifying health needs to support the development of a health promoting school environment. The Healthy School’s Programme was delivered in 5 DEIS Band One primary schools in Tallaght West and sought to improve children’s health and well-being and increase their access to primary care services.

Two Healthy Schools Coordinators were appointed to oversee the delivery of the programme. In addition, the programme was supported by a Steering Committee, made up of the school principals from the involved schools, representatives from the HSE, local authority and CDI. The HSP was independently evaluated by comparing the 5 intervention schools with 2 similar comparison schools using qualitative and quantitative methods, involving school children aged 4-12 (n=602) and school management over a 3-year period (2009-2011). Programme outcomes were monitored pre- and post-intervention and a process evaluation explored programme implementation.

Child health outcomes were assessed by self-report or parent proxy appropriate to child age and included mental health, relationships and bullying. Body Mass Index was measured directly by nurses in the schools. Data were also obtained from the school dental service, HSE Immunisation Coordinator and school absenteeism records.

In total, 7 medium- to long-term primary outcomes were identified. These included age-appropriate physical development; access to basic healthcare; awareness of basic safety, fitness and healthcare needs; children are physically fit; children eat healthily; children feel good about themselves; and parents are involved in their child’s health.

Findings

In terms of health and well-being, both the control and intervention groups were within international normal range from baseline through to final year (based on Kidscreen 27 questionnaire and Child Depression Inventory). The Healthy School’s Programme (HSP) had no significant effect on health outcomes when comparing the control and intervention schools in the following domains:

- health-related Quality of Life (as measured through the Kidscreen 27);
- depressive symptoms as measured through the Child Depression Inventory;
- breakfast uptake;
- children’s thoughts of changing their weight;
- incidences of reported bullying;
- intentions to smoke when they are older;
- obesity;
- rates of absenteeism over time.

Some changes in health outcomes were observed within both intervention and control schools. An improvement was observed in autonomy and parent relations (using Kidscreen 27) for children of all ages between baseline and Year 1 follow-up. This improvement was sustained within the older
cohort in Year 2 follow-up. Children aged 6-12 demonstrated significant improvements in mean depression scores between baseline and Year 2 follow-up, coupled with a significant decrease in bullying between baseline (31.9%) and Year 2 follow-up (26.8%) and between Year 1 (33.8%) and Year 2 (26.8%) follow-ups.

While there were no significant differences between absenteeism rates in intervention and comparison schools, mean rates of absenteeism for intervention schools were similar or slightly above (7.43%) the national norm rates (5.74%) and under the average rate for DEIS Band One schools.

Dental and immunisation records were not collected for the comparison group. Therefore, it was not possible to ascertain if the HSP had any impact in increasing uptake of immunisation vaccines or dental services. The level of dental service coverage was 89% across the intervention schools, ranging from 69% to 97%, with no oral health initiatives planned in any of the intervention schools. There was significant variation in primary schools’ immunisation rates for Junior Infants. Over the 3 years of the programme, the level of immunisation uptake varied across schools, ranging from 61% to 95%.

Overweight and obesity was at a significant level in intervention schools – at baseline 29.6% of 4-7 year-olds were overweight or obese, and this increased to 35.2% in Year 2. Children in control schools had lower levels of obesity (6.9%) and overweight (13.8%) compared with the intervention group at baseline (15.7% and 13.9% respectively). At the end of Year 2, there were increases in both overweight (16.7%) and obesity (18.5%) among the intervention group. In the control group, levels of overweight (3.8%) decreased, but obesity (15.4%) had increased after Year 2.

As the Healthy School’s Programme is a school change initiative, the focus of the process evaluation and analysis was on ways in which the programme was contributing to change at the structural and systems level within the schools. In terms of programme implementation, schools reported that they felt poorly equipped to identify the health needs of the children and needed support from both the Department of Education and Skills, and the Health Service Executive (HSE) to ensure the effort being put into the development of health promoting school environments would have support in the long term. The HSP interagency Steering Committee was seen to be a positive vehicle for bringing health and education together at the local level. Parental engagement was viewed by staff in the HSP as a key factor in the promotion of health in the school setting. There were a number of challenges in implementing this model of health promotion.

Further details of the evaluation can be found in Comiskey et al (2012).

**Brook NI Sexual Health Programme**

**Programme overview**

Brook in Northern Ireland provides sexual health clinic services to young people in order to improve their sexual health and relationships, and to increase their awareness in terms of sexual health, positive relationships and teenage pregnancy. The programme provides young women aged 19 and under and young men aged 25 and under with contraception, pregnancy testing, condoms, testing
and treatment of sexually transmitted infections, as well as counselling and outreach work. Professional advice and training is also provided.

The programme was delivered by a Family Planning nurse, doctor and counsellor, and aimed to improve young people’s sexual health and sexual relationships, and to increase their awareness of good sexual health and positive relationships. The evaluation compared the new Brook Clinic in Coleraine with the statutory sexual and reproductive health clinic in the same area and used a questionnaire administered at two time points: Time 1 (September 2009 – March 2010; n=318) and Time 2 (September 2010 – May 2011; n=108). Changes were assessed with respect to young people’s sexual health competencies (such as how healthy their sexual relationships were in terms of consent, protection and informed choice) and their awareness, knowledge and understanding of sexual health and its risks. The study also included a process evaluation of the Brook outreach service in North Belfast, based on interviews with staff, users and management.

**Findings**

A comparison of the Brook Clinic and the statutory sexual health clinic found both clinics were rated highly by users on aspects of service provision, staff, clinic location and facilities. The Brook Clinic was rated slightly higher than the statutory clinic in relation to structural aspects, such as waiting area, privacy, opening times and appointments. No differences were noted in terms of procedural services measures (tests, contraception and advice), staff ratings (friendliness) or geography (finding and travel to clinics).

The evaluation found the Brook Clinic and statutory sexual health clinic were equally effective in terms of measured sexual health outcomes. Young people showed a better level of knowledge about sexual health issues after attending either one of the clinics. Despite there being no overall difference in the clinics in terms of service users’ change in sexual health competence, the Brook Clinic was shown to be dealing with younger, less knowledgeable service users from the outset. Attendees at the Brook Clinic were significantly younger and a higher proportion of male clients were also observed to be availing of the Brook sexual health services. This would suggest that Brook NI may have been more effective in engaging with this client group, encouraging them to make use of the service and understanding their demands from the service and advice requests. The Brook service would appear to be providing a different form of service, one that is better directed and more engaging to younger, less informed users.

The evaluation of the Brook NI outreach service examined how the service was working and how it might be improved. Brook outreach staff highlighted concerns about the location of the service, suggesting that it would have been better located in a busy street where young people could call in without fear of being seen or recognised by family or friends. It was suggested that focus groups with young people would help to make decisions about where best to locate services or that the clinic could be placed in a youth centre, which would make it easy for young people to access anonymously.

It is well established that alcohol and drug misuse can result in sexual risk behaviours. The management team was keen to place Brook among other services to provide a more ‘holistic’
approach to providing services aimed at improving the overall health and well-being of young people, with sexual health being just one of these aspects.

The full evaluation report has been published by the Institute of Childcare Research at Queen’s University, Belfast (2011).

**Big Brothers Big Sisters**

**Programme overview**

Big Brothers Big Sisters (BBBS) is an international youth mentoring programme, operating in 14 countries around the world. It is delivered in the Republic of Ireland by Foróige, the National Youth Development Organisation. Foróige established BBBS Ireland in 2001, with the overall aim to support the positive development of young people through supportive friendships, inspiring them to brighter futures. It aims to improve emotional well-being; improve attitude to school and plans for school and college completion; reduce engagement in risk behaviours; and improve social support, parental and peer relationships. Basically, the programme matches up a young person (mentee) with a trained volunteer mentor and they meet over a period of time. It is a manualised programme with mentors supervised by BBBS project officers. The manual covers all aspects of delivery, including assessments of young people and mentors, volunteer training, matching the young people with the mentors, supervision of the match, closing the matches and record-keeping.

The BBBS programme accepts referrals of young people aged 10-18. Referral criteria relate to young people considered to have limited social skills, low self-esteem, living in economic disadvantage or being shy or withdrawn. In 2009, the HSE made 35% of referrals to the programme, with the majority of other referrals coming from social workers and family support workers.

The programme was delivered in community and school settings in the Republic of Ireland to children aged 10-18 who were newly referred to the BBBS programme (n=164) in 2007. Each young person was matched with a trained volunteer mentor and they both met up for 1-2 hours a week for a minimum of 1 year. The evaluation was conducted between 2007 and 2010, based on a randomised controlled trial design. The evaluation measured emotional well-being; hopefulness; attitudes to school and future academic achievement; perceptions of social support; drug, tobacco and alcohol use; relationships with peers and parents; and social acceptance.

Young people were allocated to either BBBS programme plus regular youth activities (intervention group) or to regular youth activities alone (control group), with outcomes assessed at 4 time points in a 2-year period. Nine longitudinal qualitative case studies of mentoring pairs with multiple respondents (young people, mentors, project workers, parents and teachers) were also conducted. A process evaluation was undertaken to assess if the programme was implemented as planned. This involved staff interviews, collection of monitoring data and review of programme materials.

**Findings**

The process evaluation reported high fidelity with the implementation plan and indicated a strong governance and training framework. Most mentees were aged 10-14, with similar numbers of boys and girls. The average age of mentors was 31 years. 57% of the 72 ‘matches’ met for at least the
minimum time expected. At Wave 4, 59% of young people said they felt ‘close’ to their mentor and 26% felt ‘somewhat close’.

Significant differences emerged between the two groups, with the intervention group (those participating in the BBBS programme) having higher levels of hope and a greater sense of efficacy in relation to the future; higher perceived social support; and parents of mentored young people rated their children’s pro-social behaviour more positively. Positive outcomes in the randomised controlled trial were more likely where the duration and frequency of interactions were higher. The mentoring intervention appeared to be more beneficial for young people in families who did not live in a household with both parents.

No significant differences were evident between the intervention and control groups in respect of social acceptance; liking school and aspirations for future learning, scholastic efficacy, academic performance; drug, tobacco and alcohol use; misconduct and difficulties; and parental trust. However, positive trends were observed within the intervention group over time in respect of social acceptance, education outcomes and drug and alcohol misuse. Participation in the mentoring programme was not associated with any negative effects on child–parent relationships according to the measures used.

The qualitative evidence reveals many aspects of the effectiveness of the BBBS programme in terms of supporting young people. This support included practical support facilitating young people to access new skills and experiences, and enabling their participation in activities that interested them (including sport and music) where previously such participation was difficult. Emotional support was clearly described, with the creation of trusting relationships and safe spaces for one-to-one time and the sharing and discussion of anxieties. Provision of guidance on issues relating to low self-confidence, bullying and family issues was evident. In some cases, the mentoring relationship provided a positive adult relationship where the child–parent relationship may be fractious. Closeness of the relationship appeared to be the most important factor underpinning what was achieved.

Further details of the evaluation can be found in Dolan et al (2010, 2011a and 2011b).

**Protective Behaviours**

**Programme overview**
The Mayo Children’s Initiative (MCI Ireland) was established in 2009 with the aim of addressing ‘the needs of children affected by domestic violence and negative family conflict in Mayo by developing and providing early intervention supports for children and young people’. The initiative includes the delivery of the Protective Behaviours Programme; raising awareness about the issues of domestic abuse and dating abuse, and the impact on young people among young people themselves, the wider community and professionals working in relevant agencies; and providing specialist support and interventions to children and young people experiencing domestic abuse.

The Protective Behaviours Programme has three strands: the *pre-school* work focuses on building self-esteem; the *primary* school work is aimed at developing an instinct for safety; and the *post-primary* school work addresses teenage dating abuse and healthy and unhealthy relationships. The
programme aims to work with all age groups in primary and post-primary schools, as well as with childcare practitioners and those working with children and young people.

MCI Ireland provides a range of therapeutic interventions to support young people, including art therapy, a more generic counselling service and a clinical psychologist to work with children with specific needs.

The Protective Behaviours Programme was delivered by MCI Ireland and St. Vincent de Paul in 3 primary schools and 3 post-primary schools in rural areas of the Republic of Ireland. The programme evaluation was conducted between May 2010 and April 2011, and based on questionnaires with primary school children (aged 4-13; n=95), post-primary school children (aged 14-17; n=238) and parents of primary school children (n=53). Qualitative data relates to focus groups/semi-structured interviews with children (n=33), parents, school staff (n=11) and other related agencies and project workers (n=26).

Findings
Among primary school children, there was good recall of the key messages of the Protective Behaviours Programme and the majority of children reported enjoying the sessions. The programme was particularly effective in terms of raising children’s understanding of their right to feel safe. Key learning also related to the importance of communicating their concerns to others, as well as how to help and care for others.

Among post-primary school children, there was also good recall of the key messages of the Protective Behaviours Programme. These children were most likely to report remembering the content relating to domestic violence, bullying and relationships. Content on alcohol and drug issues did not feature at all highly in the participants’ recall. The majority of participants enjoyed the programme, although boys were more likely to report disliking the sessions. The content on dealing with inappropriate behaviour and domestic abuse was most commonly rated as useful.

There was a high level of awareness among parents of primary school children of the Protective Behaviours Programme. 60% of parents agreed that MCI was effective in raising the profile of domestic abuse and family conflict issues. Four out of 5 participating primary school children indicated that they had discussed their Protective Behaviours work at home with their parents. Post-primary school children were less likely than primary school participants to discuss the programme with parents. Girls appeared to be more likely to discuss it with parents and friends than boys, at both primary and post-primary levels.

Training for teachers was critical in providing them with the skills and confidence to deal with the issues raised through the programme. Most school staff and agencies reported that the programme had helped raise the profile of the issue and that the programme has established good interagency connections. However, issues of clarity of roles and organisational boundaries were evident in some cases. A number of challenges were evident in terms of the practical introduction of the programme into schools, including schedule fit, curriculum fit (including issues of potential replication with existing programmes such as Stay Safe) and cultural fit with the school. Some of the most effective work with young people took place in extra-curricular and out-of-school contexts, indicating that a flexible approach to delivery may be helpful.
Based on its experiences and the recommendations from the evaluation, MCI Ireland has modified its original programme to a one-day workshop for 12-18 year-olds in post-primary schools, called ‘Something in the Way’. This workshop focuses on the issue of teen dating abuse, with an emphasis on healthy relationships. MCI Ireland has also developed a programme for childcare practitioners in pre-school called ‘This is Me and I am Wonderful’, which focuses on helping children develop positive self-esteem.

An evaluation is underway that is examining all the programmatic activity at Mayo’s Children Initiative. Findings included in this report have been published by Stevenson et al (2011). The final evaluation report is expected in November 2013.

**Summary of main findings from the programmes**

A summary of the main outcomes of the 10 programmes evaluated is given in Table 2. As noted above, it is important to remember that not all of the evaluations used the same methods to investigate child health and development. Four out of the 10 programmes used randomised controlled trials and different measures were used across the evaluations to assess outcomes. The findings from the Growing Child Parenting Programme and Preparing for Life also represent interim findings from the early stages of 5-year programmes.

A summary of the overall impact or effect of the programmes on children’s health and development is given in Table 3. This attempts to summarise the overall impact in terms of categorisation as ‘significant improvement’ (statistically significant improvement in one or more measures), ‘positive trend’ (positive effects shown but not reaching statistical significance), ‘mixed findings’ (some positive and some negative effects shown) and ‘no difference’ (no statistically significant effect shown).

### Table 2: Impact of programmes on measures of children’s health and development

<table>
<thead>
<tr>
<th>Programme</th>
<th>Impact on measures associated with child health and development</th>
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| Preparing for Life      | - Children in the intervention group had significantly better fine motor skills (at 12 months) and gross motor skills (at 18 months) and were significantly less likely to be at risk for social and emotional difficulties/delays at 12, 18 and 24 months.
<p>|                         | - Children in the intervention group had higher cognitive development scores at 18 and 24 months. |
|                         | - Children in the intervention group were significantly more likely to eat appropriate foods and eat at appropriate intervals, and score better on dietary indicators (6, 12, 18 and 24 months). |
|                         | - Children in the intervention group were significantly more likely to have been immunised at 6 and 12 months and significantly less likely to have had a chest infection at 12 and 24 months and less likely to have asthma at 24 months. |
|                         | - Children in the intervention group were significantly less likely to spend time in hospital at 18 months and visit the GP/health centre/casually at 24 months. |
|                         | - Children in the intervention group had better general health at 18 and 24 months. |
|                         | - The home environment within the intervention group was significantly safer and had more literacy materials (6 and 18 months). |
|                         | - Children in the intervention group were significantly more likely to engage with a variety of people and activities, and have appropriate play material (6 and 18 months). |
|                         | - Children in the intervention group experienced more parental interactions at 6 and 18 months. |
|                         | - Very few intervention effects on maternal health behaviour during or after pregnancy. |</p>
<table>
<thead>
<tr>
<th>Programme</th>
<th>Impact on measures associated with child health and development</th>
</tr>
</thead>
</table>
| **Growing Child Parenting Programme**         | - Significant reduction in number of births by Caesarean section in the intervention group and mothers were significantly less likely to be hospitalised immediately after the birth of their child.  
- No significant intervention effects on infant birth weight, prematurity, or breastfeeding. |
| **Eager and Able to Learn**                   | - Significantly improved social emotional development.  
- Improvement in how parents used play to support their children’s learning.  
- Improvement in levels of engagement between parents and childcare settings.  
- Improvement in how the day care staff interacted and played with the children.  
- Average quality for settings improved, with 20% of settings moving into the ‘excellent’ range.  
- Negative effect on cognitive development, particularly emergent literacy skills (such as recognising and naming shapes and colours, and counting objects).  
- No significant effect on child gross motor development. |
| **Ready, Steady, Grow**                       | - Developmental scores within the normal range for majority of children.  
- Significant increases in infants’ expected rates of gross motor development.  
- Increased global, adaptive and language development with number of programme visits and decreased risk of developmental delay in these domains.  
- Majority of children securely attached.  
- Significant decreases in infants’ expected rates of development for fine motor, global, adaptive, language, and personal and social development over time.  
- Significant increases in the likelihood of children displaying ‘non-normal’ development over time for global, adaptive, language, and personal-social development.  
- Number of programme visits found to have no effect on gross motor, fine motor and personal-social development. |
| **CDI Early Years**                           | - Parents Plus Community Course was shown to improve the children’s home-learning environment, even 2 years after the course was attended.  
- Significant improvements in curricular and planning quality.  
- Some improvement in the quality of the literacy environment in the pre-school settings.  
- Better range of activities targeted at promoting children’s learning and development.  
- No significant influence on child cognitive and language outcomes.  
- No significant effect on behaviour problems, but trend towards improvement. |
| **Big Brothers Big Sisters**                  | - Significant improvement in how hopeful young people felt about their lives and future.  
- Significant improvement in how supported young people felt overall, and in particular support from non-familial adults.  
- There was no significant difference in alcohol and drug use between the comparison and intervention groups; however, a positive trend was observed within the intervention group.  
- The intervention was associated with a significant benefit in terms of how hopeful young people felt about their future; how supported young people felt, in particular from non-familial adults; and parents’ ratings of their child’s pro-social behaviour.  
- Positive outcomes more likely with higher duration and frequency of interactions, closer relationships and for young people from one-parent families.  
- Majority of participants formed a good bond with their mentor. |
Section 3: The Programmes in the Prevention and Early Intervention Initiative

<table>
<thead>
<tr>
<th>Programme</th>
<th>Impact on measures associated with child health and development</th>
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| MCI Protective Behaviours                      | ● The programme was effective at communicating to the majority of students their right to feel safe, and what to do if they felt unsafe or knew someone was being hurt.  
  ● Recall by participants was high.  
  ● 4 out of 5 primary school students reported discussing the Protective Behaviours Programme at home; discussion with parents was less frequent among boys and among post-primary participants.  
  ● Almost half of all students surveyed thought family and friends should also take part in the programme. |
| Healthy Schools Programme                       | ● No significant difference in depressive symptoms (both groups of students improved over time).  
  ● No significant difference in the numbers of reported incidence of bullying; however, there were positive trends for older students.  
  ● No significant impact on health-related quality of life.  
  ● No significant impact on health-related behaviours (e.g. eating breakfast, intention to smoke when older).  
  ● No significant impact on reducing the number of students that were overweight or obese, with the number of overweight younger students (aged 4-7) significantly increasing, as reported by parents. |
| CDI Speech and Language Therapy Service         | ● Up to 60% of children identified as being in need of the speech and language therapy service were new referrals.  
  ● 18% of children left the service with their speech and language within normal limits.  
  ● 19.8% of children referred were also identified as being in need of additional services (e.g. audiology, psychology, and ear, nose and throat services).  
  ● Children with more severe diagnoses were significantly more likely to require ongoing therapy after the programme.  
  ● Significantly more boys than girls required ongoing therapy after the programme.  
  ● The service succeeded in identifying and treating children at a younger age and with shorter waiting time than typical for standard statutory SLT services. |
| Brook NI Sexual Health Programme                | ● Young people rated the Brook Clinic as being significantly better in the categories of atmosphere in waiting area, privacy, opening times and availability of appointments compared with the statutory sexual and reproductive health clinic.  
  ● Brook was engaging a significantly higher number of younger and less informed clients, in particular young males, compared with the statutory service.  
  ● No significant difference in measured sexual health outcomes between Brook and statutory service. |

Table 3: Summary of programme impact on children’s health and development outcomes

<table>
<thead>
<tr>
<th>Significant improvement (statistically significant on one or more measures)</th>
<th>Positive trend (positive effects shown, but not reaching statistical significance)</th>
<th>Mixed findings (some positive and some negative effects shown)</th>
<th>No difference (no statistically significant effect shown)</th>
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<tbody>
<tr>
<td>Preparing for Life</td>
<td>Growing Child Parenting Programme</td>
<td>Eager and Able to Learn</td>
<td>CDI Early Years Healthy Schools Programme</td>
</tr>
<tr>
<td>Big Brothers Big Sisters</td>
<td>CDI Speech and Language Therapy Service</td>
<td>Ready Steady Grow</td>
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<tr>
<td>Eager and Able to Learn</td>
<td>MCI Protective Behaviours</td>
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<tr>
<td>Ready Steady Grow</td>
<td>Brook NI Sexual Health Programme</td>
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Section 4: Discussion and key learning points

Overview
The last century has seen striking improvements in child health on the island of Ireland. Children are far less likely to die at birth, in infancy and during childhood, and far more likely to enjoy a childhood that is free of potentially preventable infection and injury. However, considerable challenges remain in ensuring that children have the opportunity to grow up healthy and develop to their full potential. Family circumstances and the environment in which children live and grow affect their health from womb to adolescence.

Urgent challenges exist in terms of high levels of childhood overweight and obesity, increases in demand for child protection services and teen mental health issues, including deliberate self-harm and suicide (NOSP, 2013). The number of child protection and welfare referrals in the Republic of Ireland went from 21,000 in 2006 to 40,000 in 2012 (HSE, 2012). Despite overall improvements in child health, stark inequalities remain a feature of many public health outcomes for children.

Prevention and early intervention approaches have the potential to level the playing field for health of both children and adults by directly affecting the health of young people during childhood and their capacity for a long and healthy life once childhood is left behind. Several of the evaluations considered in this report also demonstrate potential in terms of approaches that seek to influence longer-term social determinants of health as well as current health behaviours and health services. Based on international evidence supporting the value of prevention and early intervention programmes, a number of programmes were developed, operated and evaluated in the Republic of Ireland and Northern Ireland as part of the Prevention and Early Intervention Initiative. These programmes employed a wide variety of approaches, operated in several settings (home, school, community and clinical) and sought to improve a diverse range of child health and development outcomes. This report examined learning across 10 programmes and services evaluated as part of the Prevention and Early Intervention Initiative. The learning related to findings from both quantitative and qualitative analysis of programme outcomes, as well as assessments of programme implementation, experience and process issues.

What did we learn about the processes involved in developing and evaluating prevention and early intervention programmes relevant to child health and development?

Understanding and measuring health
Health was understood and measured in many different ways in the prevention and early intervention programmes. In some cases, the selection and measurement of appropriate child health indicators was challenging – this may represent differing understandings of child health and health inequalities arising from different disciplines involved in the design and evaluation of the programmes. Multidisciplinary discussions on child health indicators may be beneficial to the development of this work over time. There is now scope to build on the learning from the early evaluations and work towards the integration of increasingly appropriate child health indicators over time – indicators that are relevant to and integrated with health strategy targets, health promotion practice and local health and social care services. This may pave the way for the
sustainability of valuable initiatives in the longer term. Programme design and evaluation should begin to consider a shift from proximal outcomes to considering the longer term implications for child health and development. For example, assessments of home safety might begin to consider capturing relevant data on child injury, while assessments of social and emotional well-being might consider capturing data on mental health and engagement with mental health services. Positive findings on indicators relevant to the mental health and life skills of parents, children and adolescents were evident across some of the programmes. Linking such indicators with broader mental health and health service outcomes may be particularly beneficial.

Early data – a learning curve for the Prevention and Early Intervention Initiative
Approaches to the evaluation of prevention and early intervention programmes for child health and development are new and as they occur in the real world rather than in a controlled laboratory, this can be challenging. Results from the early evaluation of these programmes are informative and encouraging, but sustainable mechanisms to support the rigorous longer-term evaluation of these programmes is essential. Findings represented here may well represent the steepest part of the learning curve. It was observed that positive outcomes seemed to more consistently observed in programmes which had been established for a longer period of time – this indicates that some ‘bedding down’ of new initiatives may well be at play. The programmes’ value in terms of producing consistent and sustainable child development gains and their contribution to child health cannot yet be ascertained and will only be evident as participant children mature. For many of the programmes, process outcomes were more revealing and relevant than the impact outcomes at this stage and indicate the need for some refinement of programmes in some cases. In addition to the Study children, it would also be useful to assess any potential ‘sibling effect’ arising from the involvement of parents in prevention and early intervention programmes.

Fostering child health in a wide variety of settings – engagement and the ‘hard to reach’
Programmes aiming to impact on child health were operated in a variety of different settings, including the family home, pre-school/childcare settings, schools, health services and in the context of a non-familial mentoring relationship. There was a high level of stakeholder engagement in many cases and particularly in the pre-school and childcare settings; indications were of a high level of interest and commitment of Early Years practitioners to child health issues and a flexibility to adopt new modes of working. However, there were also challenges evident in supporting the ongoing engagement of some parents and in supporting schools to engage on child health issues. Despite the lack of any demonstrable effect on child health outcomes from the Healthy Schools Programme, there is considerable learning with regard to informing practice in designing and implementing school-based programmes. Challenges exist in relation to early buy-in, identification of local needs, engagement with children, whole-school involvement and appropriate time and staff resources. Selection bias and attrition were challenges in the parenting programmes and their evaluations. Lower engagement and higher attrition were particularly common among more disadvantaged families in a number of programmes. This finding would be common to many Early Years programmes. Engagement of ‘hard to reach’ and ‘hard to track’ families will likely remain a challenge common to many Early Years interventions. Resourcing and supporting programme staff to address these concerns may be important in terms of securing the success of the programmes in the longer term and in terms of supporting meaningful data for evaluation purposes.
Gender aspects of prevention and early intervention programmes

Many of the early intervention programmes focused principally on children in the early years and their mothers. In this regard, knowledge on the accessibility, appropriateness and effectiveness of such programmes for fathers is currently underdeveloped and as such they may represent an untapped resource for child development. Future programme design and implementation may benefit from considering potential assets for child development available through both parents and in the context of varying family types. Many of the prevention and early intervention programmes offered essentially gender-neutral interventions and yet there were several differences observed in terms of the outcome, engagement and experiences of boys and girls. Overall, it would seem that a ‘gender lens’ would be beneficial to the design, implementation and evaluation of prevention and early intervention programmes, particularly for older children. Incorporating a gender lens at an early stage in programme design may be the most appropriate approach since post-hoc approaches are less effective.

Empowerment and support, not just advice for participants

Young people need to be supported in identifying their health needs and, through appropriate information and services, given the necessary support to make safe and healthy choices. Health promotion approaches facilitate children and young people to become empowered agents of change in their own lives, rather than passive recipients of policies and services. For schools to influence the health behaviours of children and young people in a positive manner, appropriate training in health promotion practice and leadership among school staff will be required. Parental empowerment and support, as well as education, appear to be critical to the success of parenting skills for children in the early years.

What did we learn about the impact of prevention and early intervention programmes on child health outcomes?

Supporting healthy pregnancy to support child health

Maternal health is an important predictor of child health, not just at birth but across many domains of early childhood development – an issue that has been strongly reinforced by the findings from longitudinal studies of children in the Republic of Ireland and Northern Ireland. The inclusion of a pregnancy-based intervention within some of the Prevention and Early Intervention Initiative (PEII) programmes is therefore of particular relevance to enhancing child health and addressing health inequality. While programmes did not demonstrate significant outcomes in terms of altering health behaviours in pregnancy, there was some suggestive evidence that interventions may have had a positive effect for mothers in respect of Caesarean section and maternal hospitalisation, and this finding warrants further consideration and analysis. The development of partnerships between PEII programmes and maternity care services would seem to be a mutually beneficial development in terms of collaborative working for better outcomes for disadvantaged mothers and their infants. Future evaluations should consider to what degree and in what way interventions with mothers during pregnancy and in the early weeks after birth may have added value to interventions supporting the health and development of their children in subsequent years.
Enhancing healthy eating

Breast milk is the best nutrition in the first 6 months of life. There was no significant effect observed in terms of improvements in breastfeeding. While this is disappointing, it is perhaps not surprising in the context of powerful cultural and intergenerational norms relating to the use of breast milk substitutes among women in disadvantaged communities in the Republic of Ireland (Begley, 2008). As the island of Ireland has exceptionally low breastfeeding rates compared to the rest of the world, continued support and development of this issue is warranted.

Early findings indicate that some programmes were effective in initiating behaviours and patterns supportive of healthy eating in the early years, a finding that may be of particular relevance to addressing childhood overweight and obesity on the island of Ireland. This suggests that early years’ prevention and early intervention programmes could become an important asset within obesity prevention strategies and services. The lack of an effect on healthy eating and overweight/obesity evident in the Healthy Schools Programme may further emphasize the value of intervening in the family home and at an earlier stage of childhood.

Protecting children from harm – infection, parental hostility, safety

The success of the Preparing for Life Programme in achieving higher immunisation rates, reduced asthma rates and fewer chest infections is noteworthy. Children living in disadvantaged communities are more likely to suffer communicable disease risks associated with many factors, including poor nutrition, crowded living conditions and exposure to second-hand smoke in the home. The programme demonstrates capacity not just to improve outcomes for children, but also to enhance the effectiveness of State prevention and primary care programmes by ensuring those children most in need of immunisation are facilitated to receive it.

Early Years interventions resulted in some cases in reduced parental hostility and a safer home environment. This is indicative of the possible impact of such programmes in reducing end outcomes relevant to child health, such as accidental and non-accidental child injury. Further consideration should be given to the potential contribution of Early Years interventions to reducing inequalities in child injury outcomes on the island of Ireland. In this context, Preparing for Life, in conjunction with Temple Street Children’s Hospital, is in the process of undertaking a study assessing rates of hospital admissions and attendances at A&E departments within families in their longitudinal evaluation.

Enhancing parents to enhance child health and development

Many of the programmes demonstrated success in improved parenting skills and confidence, which would support child health and development. Success in this domain was fairly consistent, but not universal across the interventions, adding weight to the evidence supporting the importance of investing in parents as a means of securing child health and development. Some interventions were successful in empowering parents to learn and use practical skills, but also in addressing issues of parental emotional well-being and coping, including aspects of stress, distress and frustration. Improved parental self-esteem and efficacy, as well as better management of the child’s behaviour, were evident in some cases. Establishing quality parent–child relationships were important outcomes emerging from this early stage of the programmes and are likely to have a positive impact on parent–child attachment and interaction, social, emotional and cognitive development of the
child, and parents’ skills and capacity to support their child’s development. An important aspect of enhancing parents’ skills, abilities and confidence was the observation that this facilitated early identification of children’s needs and the introduction of services and supports to address those needs.

Parental health and parental mental health, while addressed somewhat obliquely in many cases, appear to be priority outcomes from parenting interventions. Notwithstanding the fact that these programmes were primarily focused on child outcomes, it may be worthwhile affording these outcomes greater value in their own right. While success in improving parental well-being was not universal across the programmes, the outcomes observed are relevant in terms of the mental health and well-being of children and young people. Strong parent–child bonds, good relationship skills and self-esteem, supported through consistent and quality parenting, may be important in buffering children from the effects of harsh social and economic circumstances, and in supporting their mental health and resilience (Thompson, 2000; Elicker et al, 1992; Miller and Commons, 2010).

Helping children reach their developmental potential
The early evaluations demonstrated some success in respect of child development outcomes. Overall findings were patchy and complicated by the difficulties inherent in tracking changes over time, requiring different measurement tools, etc. Positive effects on social and emotional development were fairly consistent across the programmes. These are likely driven by the successes achieved in parenting skills and well-being outcomes, and the positive engagement and experience of participating childcare practitioners. There were varying findings on effects on motor and cognitive/learning development outcomes. It is possible that the effect on these outcomes may not yet be apparent at this stage of evaluation, but if it emerges the effects on these outcomes are minimal, this would warrant reflection. Factors relating to the specifics of the learning and behavioural outcomes have been dealt with in previous reports synthesising the learning from the PEII interventions (Statham, 2012; Sneddon and Harris, 2013).

Improving access to child health services
Several evaluations revealed the role of the programmes in addressing issues relating to inequities in health service access. There were several concrete examples of innovation in service delivery; for example, the Brook service was successful in attracting a disadvantaged client group to their service, while CDI effectively addressed the lengthy public waiting time for speech and language therapy for children from low-income families. Many aspects of mainstream service delivery for children can compound existing health inequalities, including waiting lists, service accessibility and cost. Early intervention programmes appear to present innovative solutions to inequalities relating to health service delivery for vulnerable young people and families. The location of comprehensive early child development services within a non-stigmatising setting appears to have been an element of the success of many programmes. Co-location of child development services was associated with greater service acceptability and accessibility in a number of programmes.

Establishment of local partnerships for child health
Collaborative and integrated partnerships were established within a number of the programmes as a result of bringing together a range of stakeholders and services. There were several examples of positive outcomes from collaborative and partnership working – including mutual learning, capacity-
building and sharing of resources – and these are particularly important when funding and State services are limited. Partnerships were formed between Early Years services and a range of primary and secondary healthcare services. Such partnerships could form the foundation for more structured and established mutually beneficial service agreements between Early Years services and health service providers, with a joint focus on tackling inequalities in child health. Linkage with integrated and comprehensive primary care teams and integrated care pathways warrant further consideration.

Creating opportunities for health in the education setting
Many programmes promoted the sharing of skills among parents and childcare and education staff in the promotion of children’s development. This approach enabled a wider child development workforce that reinforces the effects of childcare-based or clinic-based interventions. Although the development of health promotion initiatives in the school setting was complex and challenging, there was common learning across the two school-based programmes with regard to informing practice in designing and implementing them. It is important not to underestimate the complexity of health promotion work within schools and put measures in place to cater for the challenge of incorporating health promotion within the existing curriculum and school structures.

Support and life skills for ‘at risk’ children
A number of the prevention and early intervention programmes are relevant to the support and life skills of ‘at risk’ children and in this way were related to a number of child protection, as well as mental health, concerns. For example, the BBBS youth mentoring programme was associated with a number of positive outcomes in relation to engendering a sense of hope, ambition and meaning in the lives of ‘at risk’ young people. This may be of particular importance in the context of young people, and boys in particular, growing up in disadvantaged communities who at higher risk of mental ill-health and self-harm. Similarly, outcomes from the Protective Behaviours Programme, which focused on educating and supporting school children on issues of family conflict and domestic violence, would also be of relevance to both mental health and the physical safety of vulnerable teenagers.

Key learning points
- The early findings from the evaluation of the Prevention and Early Intervention Initiative (PEII) show that such approaches have potential in contributing to child health and development outcomes.
- The evaluation evidence suggests that programmes have the potential to address both immediate health outcomes as well as broader aspects of children’s capacity to thrive and develop. Interventions that support optimal child development can offer added value in terms of their influence on social determinants of health.
- The contribution of such approaches to child health in the longer term should be monitored. The selection and measurement of meaningful health outcomes should be continuously refined.
- Prevention and early intervention programmes demonstrated added value to existing public health programmes, as well as presenting some innovative solutions to inequalities in health service access.
- Integrated child development and health services in the community and linked to the family home present opportunities for multidisciplinary working and synergies in the delivery of child services.
There is scope for making links between the child health outcomes addressed in the PEII and policy priorities within the public health, health promotion and health service sectors. In particular, findings show that programmes in PEII offer potential in terms of evidence-based approaches to:

- increasing childhood immunisation in disadvantaged communities;
- establishing healthy eating in the early years;
- protecting children from harm through addressing home safety and parental skills;
- contributing to the mental and emotional well-being of ‘at risk’ youth;
- enhancing parents’ ability to recognise if their child may be in need of early intervention;
- enhancing parenting skills and abilities, and contributing to maternal well-being;
- helping children reach their developmental potential and be ready for school;
- addressing direct health outcomes, while also fostering a longer-term social determinants of health approach.

The Prevention and Early Intervention Initiative demonstrated some success in the establishment of partnerships for child health between a range of community-based prevention and early intervention programmes and health services.

Support and skills development among both parents and workers in child health and education services in disadvantaged areas was an important aspect of the prevention and early intervention programmes.

Further reflection is required in terms of supporting appropriate prevention and early intervention approaches in the school setting.
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