

Issues in Earlier Intervention

Identifying and supporting children with additional needs

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.

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Contents

Executive summary	10
1 Introduction.....	13
1.1 Policy background	13
1.2 Progressive universalism.....	14
1.3 Earlier intervention – the magic bullet?	14
1.4 Methods.....	15
1.4.1 <i>Definitions</i>	15
1.4.2 <i>Aims of the review</i>	17
1.4.3 <i>Study design</i>	17
1.4.4 <i>Search strategy</i>	18
1.5 Structure of the report.....	19
2. Key concepts and issues in earlier intervention	21
2.1 Models of earlier intervention	21
2.1.1 <i>Universal or targeted interventions</i>	22
2.1.2 <i>Earlier intervention as prevention</i>	23
2.1.3 <i>Earlier intervention as protection</i>	23
2.1.4 <i>Earlier intervention as remedial or therapeutic</i>	24
2.2 Early identification and the ascertainment of need.....	24
2.2.1 <i>Identification of those at risk</i>	24
2.2.2 <i>Sensitivity and specificity</i>	26
2.2.3 <i>Identification of problems and thresholds</i>	27
2.3 Timing of interventions	28
2.4 Dosage and intensity	28
2.5 Intervention or support?.....	28
2.6 Ethical issues and risks associated with earlier intervention	30
2.7 Cost effectiveness	31
3. Evidence on the early identification of children’s needs.....	34
3.1 Risk assessment	34
3.2 Referral and signposting.....	36
3.3 Self-referral and help-seeking behaviour.....	39
3.4 <i>Every Child Matters</i> and earlier identification of need	41
3.5 Are the ‘right’ children being identified?.....	44
3.6 Summary	45
4. Evidence on the effectiveness of interventions: is earlier always better?.....	47
4.1 Assessing ‘what works’.....	47
4.2 Levels of intervention.....	48
4.3 Levels of need	53
4.4 Duration and intensity of support.....	55
4.5 A multiple focus	57
4.6 Responsive versus structured interventions.....	57

4.7	Timing of interventions	58
4.7.1	<i>Age of the child</i>	58
4.7.2	<i>Critical periods</i>	60
4.7.3	<i>Readiness to change</i>	60
4.8	The cost-effectiveness of earlier intervention	60
5.	Conclusions	63
5.1	The value of early intervention	63
5.2	Comparing earlier with later intervention	63
5.3	Implications for policy and practice.....	64
5.4	Directions for future research	65
	References.....	69

Executive summary

Introduction

Earlier intervention is a cornerstone of government policy on supporting children and families with additional needs, and the benefits of this are rarely questioned nor the meaning of 'earlier intervention' fully explored. The potential for early support to save money by avoiding the necessity for substantial public expenditure at a later stage has attracted considerable attention, not least from commissioners of services, although attempts to demonstrate this through empirical research have proved challenging.

This review and scoping study was commissioned by the Department for Children, Schools and Families (DCSF) to provide a more nuanced understanding of concepts such as prevention and early intervention; to draw together literature from research and policy evaluations to illustrate these issues; and to suggest how the research agenda could be developed. The three substantive chapters of the report cover: key concepts and issues in earlier intervention; evidence on the early identification of children's additional needs (including any impact of the *Every Child Matters* reforms); and evidence of the effectiveness of selected interventions provided at different levels of need.

Key concepts and issues in earlier intervention

These include:

- whether earlier intervention is conceptualised as preventive, protective or therapeutic;
- how far the inter-relatedness of disadvantaging factors can be taken into account;
- the accuracy of risk assessment (including concepts such as sensitivity and specificity) and the difference between average risk for groups of people and actual risk for an individual or family;
- the acceptability of interventions to participants, and distinguishing between support and intervention;
- issues relating to duration and timing; and
- ethical concerns including labelling and stigma and the potential for earlier intervention to have a negative impact, either on individuals or on the equitable distribution of resources.

The main message is that debates about earlier intervention, and research in this area, need to take greater heed of the complexity of the issues involved and not expect earlier intervention to act as a 'magic bullet'.

Evidence on the early identification of children's additional needs

Approaches to identifying when children may have additional needs include risk assessment (applying risk factors based on statistical analysis of likely outcomes), referral or signposting from universal and other services, and self-referral or help-seeking behaviour. With each approach there are issues that need to be considered, such as:

- the potential for false positives and negatives (children being identified as having a problem or additional need when they should not be, or not identified when they should be);
- the possibility of area-based targeting widening the gap between the more and less disadvantaged, when the latter in a particular area are more willing and able to access services; and
- the difficulty of reaching and providing acceptable forms of support to those who most need them.

While consideration of risk factors can be a useful way of focusing attention on those most likely to need support, the evidence suggests that it is insufficient on its own to identify all, or even most, children with additional needs, and careful assessment of individual children is also required. Health visitors have an important role to play in identifying vulnerable children and families, as do those in regular contact with children (such as teachers and early years workers) who need to see this as an appropriate aspect of their work. Parents themselves are often aware when they need help, and there is some evidence that opportunities for earlier intervention are being missed when parents approach services asking for support which is not forthcoming until their problems have escalated.

The reforms introduced by *Every Child Matters* have created the potential for earlier identification of need, for example through closer working between agencies, provision of additional services in extended schools and arrangements for information sharing. However, many of these innovations (such as the Common Assessment Framework and Contact Point) have yet to become embedded in local authority practice, and there is not yet solid research evidence to demonstrate their impact.

Evidence on the effectiveness of interventions: is earlier always better?

The report illustrates how children's additional needs can be addressed at different levels, using examples of interventions offered in different ways (universal, targeted and indicated) and focusing on two broad types of need: risk of abuse or neglect; and emotional or mental health difficulties (including behavioural problems). Specific programmes selected to illustrate key issues include:

- ***Friends***, a universal intervention based on Cognitive Behavioural Therapy which aims to build emotional resilience and has been tested with whole classes in Australian schools;
- ***Social and Emotional Aspects of Learning*** (SEAL), a programme being implemented in English primary schools which includes both universal and targeted support;
- ***Triple P***, a multi-level approach to enhancing parenting and reducing the risk of child maltreatment, with five levels of intervention from community awareness to intensive individual support;
- ***Dinosaur School***, a school-based version of the Webster-Stratton Incredible Years parenting programme which combines training for teachers in classroom management with a curriculum focused on developing social and emotional skills;
- ***Family Nurse Partnership***, an intensive, nurse-led home visiting service aimed at disadvantaged teenage parents; and

- ***Sallywags***, a secondary prevention programme developed in Cornwall for young children at risk of developing conduct disorder.

There is some evidence for the effectiveness of all of these programmes, but very little empirical research that directly compares earlier with later intervention. This is understandable, as if an intervention is available, and children 'in need' identified, there are practical and ethical issues in providing it for some children and withholding it from others.

Within programmes, children with a higher level of need sometimes achieve more gains than those with a lower level of needs, but in other cases it is those with the highest level of need who show the least improvement in their situation. The common thread linking these apparently disparate findings is that intervention should match level of need. 'Light touch' interventions are unlikely to be effective for 'heavy end' problems, nor intensive programmes targeted at specific difficulties for those without such problems.

Whilst not covered within the remit of this review, it appears likely that interventions to address additional needs at an individual or family level will have only limited impact in improving outcomes, however 'early' they are offered, if they are not accompanied by action to address wider societal factors such as poverty and inequality of opportunity.

The overall conclusion of this study is that a continuum of services is needed, from universal to selected and indicated prevention, as well as treatment for children (and families) with identifiable problems. Some children may have their lives sufficiently changed by an 'earlier' intervention to not require later interventions, but many are likely to need continuing support at later stages. It is unrealistic to think of earlier intervention as an alternative to later intervention when problems have become established: both are needed.

A future research agenda

Future research could usefully build on existing interventions by developing a better understanding of the science and mechanics of what works and what does not work to support children with additional needs and their families. Better information is needed on who is best placed to deliver support services, how children can be identified earlier, and what promotes parental access to and engagement with services. We need to know more about why current types of support do or do not work, and for which participants, informed by knowledge of the dynamics of behaviour change. Such evidence would enable better matching of interventions to needs, regardless of whether those needs are identified early or late.

1 Introduction

1.1 Policy background

There is a strong emphasis in current UK government policy on early intervention to support children and families, especially those at risk of poor outcomes, before their difficulties become severe. *Every Child Matters* (DfES 2004), the *National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2004), *Care Matters* (DfES 2006a) and *Reaching Out: an Action Plan on Social Exclusion* (HM Government, 2006) all emphasise the need for early intervention when children and families are experiencing problems, and one of the five fundamental principles underpinning the Children's Plan is that 'it is always better to prevent failure than to tackle a crisis later' (DCSF 2007a, p6).

The reforms to children's services introduced by the *Every Child Matters* agenda contain a range of measures intended to support earlier identification of need and more coordinated working. They include:

- mechanisms to improve information sharing, in the form of a national database of children aged up to 18 (ContactPoint) showing which professionals are in contact with them¹;
- development of a Common Assessment Framework (CAF) as a tool which practitioners in all agencies can use to indicate that they have early concerns about a child's wellbeing, and to provide support for children with additional needs and their families 'before things reach crisis point' (DfES 2006, p3);
- the identification of Lead Professionals to coordinate support when children are known to more than one specialist agency; and
- increased integration of professionals through multi-agency teams and the co-location of services in and around schools, children's centres and primary care settings.

The role of schools, especially extended schools, in identifying and helping to address children's additional needs is receiving increasing attention, for example in the Laming review of child safeguarding procedures (Laming, 2009) and most recently in the Schools White Paper (DCSF, 2009). The latter notes that schools 'have a key role at the centre of a system for early intervention and targeted support' (DCSF, 2009, p14). Extended schools are expected to help school-aged children and their families to access wider support and additional services when needed, through 'Swift and Easy Access' to specialist support (DCSF 2007b), and children's centres should perform a similar function for younger children and their families.

Many of the specific policy initiatives and programmes developed across government departments in recent years have been concerned with finding ways of identifying and supporting those who are experiencing difficulties, at an earlier stage. Sure Start and the Children's Fund both placed an emphasis on 'preventive' work (the notion of prevention is discussed further in chapter 2). The 'Think Family' approach to preventing social exclusion (Social Exclusion Task Force, 2007) stresses the need for all services to take responsibility

¹ <http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/contactpoint/contactpoint/>

The second delivery phase of Contact Point, involving 17 local authorities starting to use the system, began in May 2009.

for identifying when families may be vulnerable and require additional support. In 2003, the Youth Justice Board established 13 pilot Youth Inclusion and Support Panels (YISPs)². These multi-agency panels are designed to identify and support young people aged 8-13 at high risk of offending before they enter the youth justice system, and the initiative has now been extended across the country. The main emphasis of a panel's work is to ensure that children and their families can access mainstream public services at the earliest possible opportunity. Targeted Youth Support pathfinders, piloted by DCSF in 14 areas between 2005 and 2008 (and since extended to all areas), have a similar purpose, although not focused specifically on reducing youth offending. They encourage agencies to work together to identify problems among young people 'as early as possible' and to respond quickly.³

Significant investment in parenting initiatives, including the establishment of a National Academy for Parenting Practitioners in 2007, reflects the hope that later problems can be averted by enabling parents to do a better job in raising their children. Early intervention is specifically mentioned in the title of the Parenting Early Intervention Programme (PEIP), which aims to increase support for parents of 8-13 year olds at risk of negative outcomes (particularly anti-social behaviour). Between 2006 and 2008, 18 pilot local authorities offered one of three evidence-based parenting programmes through PEIP: Webster-Stratton's Incredible Years, Triple P or Strengthening Families, Strengthening Communities (Lindsay et al. 2008). The programme is now being extended to all local authorities, including a broader range of parenting programmes and with delivery more closely linked to extended schools. Other parenting developments have focused on particularly vulnerable groups, such as teenage first-time parents. The Family Nurse Partnership Programme involves intensive home visiting by family nurses to vulnerable first-time parents under the age of 20, starting pre-natally and continuing until the children are aged two. This programme, based on the work of David Olds in the United States, was launched in 10 pilot sites in 2007 and has since been extended (Barnes et al. 2008).

1.2 Progressive universalism

Alongside this policy focus on earlier intervention, specialist services are also being developed for those who already experience a high level of need, such as Family Intervention Projects, Treatment Foster Care and Family Nurse Partnerships. The government's intention is that there should be a continuum of services, with the more intensive and specialist services reserved for those with the highest levels of need, according to the principle of 'progressive universalism'. Progressive universalism is defined as providing 'support for all, with more support for those who need it most' (HM Treasury and DfES, 2005), and has become a guiding principle of government policy. Ed Balls, current Secretary of State for Children, Schools and Families, has described as a 'false dichotomy' the choice between developing universal services and targeting resources on poverty and disadvantage (Balls, 2005). Both strategies are viewed as necessary, and they should be linked so that one aim of universal services should be to identify those who need additional support.

1.3 Earlier intervention – the magic bullet?

It is generally assumed in policy documents that identifying potential problems at an early stage and intervening before difficulties become severe is likely to lead to better outcomes

² <http://www.yjb.gov.uk/en-gb/yjs/Prevention/YISP/>

³ <http://www.everychildmatters.gov.uk/delivering-services/targeted-youth-support/whatis/>

for children and families, and possibly save money in the long run. The benefits of earlier intervention are seen to be at the individual, family and societal level, and the assumptions are so strong that they are rarely questioned. There is, however, evidence of some earlier intervention 'fatigue' resulting from the huge proliferation of interventions. A leader in the Scotsman (Bill Jamieson: 28th December 2007) describes early intervention as 'the new miracle cure of our age' and 'the mantra of our time'. It notes that 'few will dare to challenge the assumed wisdom of the experts and the efficacious powers of this all-purpose solution', but points out that it puts a large strain on the schools, agencies and organisations that are expected to identify problems and provide earlier support, and that the history of earlier intervention is not wholly encouraging. Challenging the current politics of early intervention, and 'the idea that the totality of our personal and social ills lies in this remedy', he says, 'There is no malady for which early intervention cannot be advanced as a cure, and no condition for which it can be shown to have failed, because any alleged failure would surely be the result of insufficient early intervention, or intervention that is not early enough'.

A number of researchers and academics have also been critical of the notion of earlier intervention, for example on the basis that it involves increased surveillance of families (Parton, 2006); that it takes little account of the 'significant conceptual and practical hurdles involved' (Pithouse 2008, p1537); or that it places too much emphasis upon individual problems and gives insufficient attention to the social and economic conditions that impact on children's lives (Jack, 2006; Morris and Barnes, 2008).

It was in the context of the strong policy emphasis on earlier intervention that the Department for Children, Schools and Families (DCSF) commissioned the current study. The questions posed in the original research specification lie at the heart of the *Every Child Matters: Change for Children* agenda, such as identifying what the evidence says about which interventions are best for which children at which stage of development, and assessing whether it is more cost effective to offer some additional support to a large number of children and families versus more intense interventions targeted at those with a clear need for them. In practice, addressing such questions is a difficult and complicated task. In addition to the potentially vast array of literature to be considered, there are very few studies where an intervention early in the life course of a problem has been compared directly with later interventions, so direct empirical tests of the assumptions are hard to make. It was therefore agreed that the study would take the form of a scoping and review exercise, which would both contribute to a better understanding of key concepts such as 'prevention', 'support' and 'early intervention; and draw on evidence from selected literature (including policy evaluations) to illustrate these issues and to suggest how the research agenda could be developed.

1.4 Methods

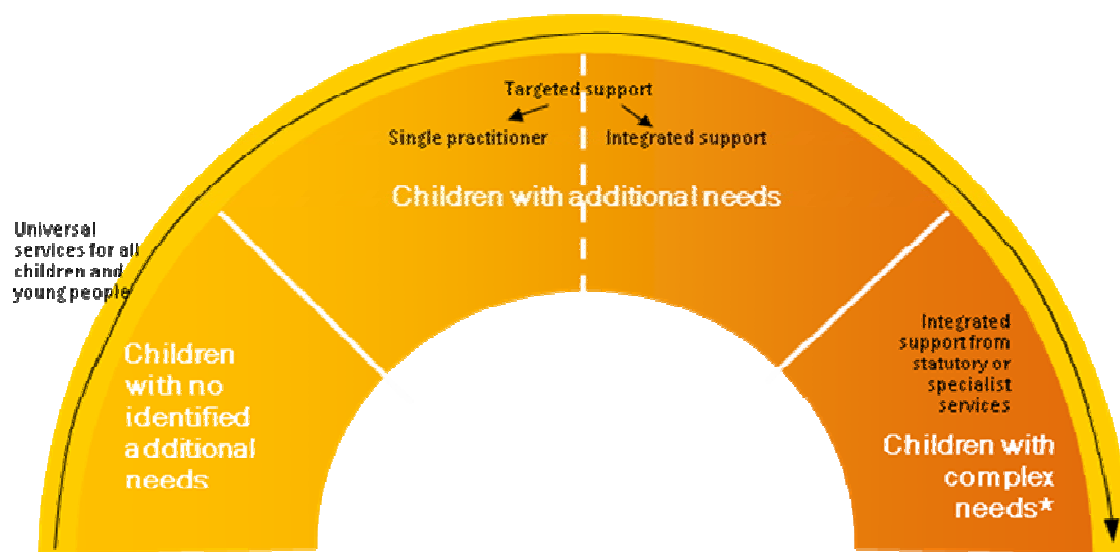
1.4.1 Definitions

An initial task was to define 'children with additional needs' and 'earlier intervention', since both terms are imprecise and require some clarification.

'Children with additional needs' are described in guidance on the use of the Common Assessment Framework (CWDC 2007) as those who are at risk of poor outcomes in relation to the five outcome areas defined in *Every Child Matters*, and who require some support over and above that provided by universal services in order to reach their potential. This

broad definition is expected to apply to as many as 20-30% of children and young people at some point in their childhood. For most of these, their needs will be able to be met through targeted support from practitioners working within universal services, coordinated by a Lead Professional where support is needed from more than one agency. Within this group, a minority of children will have 'significant or severe and complex needs', such as children who are looked after, disabled or subject to safeguarding procedures, and they should receive integrated support from statutory or specialist services. The relationship between needs and services is illustrated with a 'windscreen wiper' model (Fig 1a), which is intended to show how levels of need are not fixed but can alter over time as circumstances change and services are (or are not) provided, so that children may move backwards and forwards along the continuum.

Fig 1a: A continuum of needs and services



* Part of a broader group of children with additional needs

Figure derived from CWDC (2007) *Common Assessment Framework for Children and Young People: Managers' Guide*. p8 Accessed 5/03/09:
<http://www.everychildmatters.gov.uk/files/C90390EA0078D3E9721C7C1A8F04DDBE.pdf>

For the purposes of this review, we have defined 'children with additional needs' as those in the central portion of the windscreen – children who are experiencing or likely to experience difficulties and need extra help and support, but excluding those who have complex needs that require highly specialist services or out-of-home care.

'Earlier intervention' is often regarded as synonymous with 'early intervention' but there are different understandings of the term, and considerable confusion has been reported over whether early intervention means 'chronologically early in life, early in exposure to risk factors, early in relation to development of problem behaviours, or early in relation to the likelihood that available interventions might be successful' (Wolstenholme et al., 2008, p4). Laming (2009) notes that early intervention can be applied to anything from pre-natal assessment to support for children before they require a child protection plan, and adds that 'early intervention certainly should not be seen as something that applies only to babies and toddlers' (Laming, 2009, p24).

In this review, we have defined 'earlier intervention' as intervention early in the life course of a problem, or applied to a population identified as at risk of developing that problem. The aim of earlier intervention is generally a preventive one, to stop the development of a problem. Later intervention normally involves treating or intervening in a manifest problem, so has a distinctly therapeutic or remedial aim. Other relevant terms, such as universal and targeted services, prevention, sensitivity and specificity are discussed in the next chapter.

1.4.2 Aims of the review

The overall aim of the study was to **contribute to a better understanding of earlier intervention with children who have additional needs, in order to inform future policy development and interpretation of research evidence**. A secondary aim was to identify where further research could usefully take this understanding forward.

Specific research questions were refined after discussion with an expert adviser group (see below) and initial scoping of the literature. They addressed three main themes: recognition and identification of need; effectiveness of interventions (focused on two broad types of additional need), and cost effectiveness, as follows:

Recognition and identification of need

- What is known about how children with additional needs are identified?
- How successful is such identification (are the right children picked up, how many are missed, and are some who would not have gone on to develop difficulties 'wrongly' identified?)
- Could children who come to the attention of agencies when their difficulties are severe, have been picked up earlier?
- How successfully are the mechanisms introduced by *Every Child Matters* (Common Assessment Framework etc.) enabling early identification of need and earlier provision of support?

Effectiveness of interventions

- What types of intervention are available to support children whose additional needs involve abuse/neglect or mental health difficulties (including conduct disorder)?
- What is known about the aspects or features of effective services for children with these additional needs (for example intensity, timing, programme fidelity)?
- Is there any evidence that intervening early, before serious problems emerge, leads to better outcomes for children?

Cost effectiveness

- What are the cost implications of earlier intervention (as defined above)?

1.4.3 Study design

The study involved three stages of work: an initial scoping exercise to identify key literature and to produce an 'issues' paper; convening of a group of expert advisers to discuss this paper and advise on the most fruitful avenues to pursue; and a focused review of literature on the effectiveness of interventions for children at risk of abuse or neglect, or with emotional or mental health difficulties (including behavioural problems).

Discussion paper

The first stage was the production of a 'think piece' identifying and evaluating issues, both conceptual and practical, relevant to earlier intervention. This critically explored the meaning of concepts such as prevention, support and earlier intervention, and key issues relevant to these such as sensitivity and specificity, timing and intensity of interventions, and levels of need.

Expert adviser group

The discussion paper was circulated to a working group of expert advisers, chosen to represent a range of disciplines and areas of specialism (see Acknowledgements). The advisers then met with the research team for a half-day workshop, which aimed to assist in identifying and clarifying the issues most likely to generate further understanding and useful messages for policy development in children's services. This was done by:

- Developing further the ideas presented in the discussion paper;
- Advising on the topics to be pursued in the subsequent literature search;
- Identifying key papers and research studies in their own field.

Evidence review

Following the workshop, a more in-depth review of the identified issues was conducted, focused broadly on two types of additional need: children at risk of abuse or neglect; and children with emotional or mental health difficulties (including behavioural problems). Evidence was also sought to address the themes of earlier identification of need in a multi-agency context, and cost effectiveness of earlier compared to later interventions for children with additional needs.

The aim was not to identify all the possible evidence on the effectiveness of intervention across the many aspects of children's lives, but rather to undertake a thematic exploration of the issues involved in earlier intervention (such as ascertainment of need, sensitivity of risk factors, the relationship between support and intervention) and to identify research studies that were able to inform these issues. Given the focus on 'earlier intervention' in many recent government policy initiatives for children and young people, evaluations of relevant programmes were specifically included in the review.

1.4.4 Search strategy

For both the discussion paper and subsequent reviews, it was decided that classical systematic reviewing was unlikely to be a useful or feasible approach within the available timescale, especially given the vast range of potentially relevant literature, and the diffuse focus of much of it in relation to the topics of interest. Nor would such an approach be likely to be particularly helpful in addressing the questions posed. A previous analysis of search methods in systematic reviews of complex evidence found that only 30% of relevant papers were identified by searches of 15 databases plus hand searches. Half were identified by 'snowballing' and 24% by personal knowledge (Greenhalgh and Peacock, 2005). Complex social interventions which act on complex social systems are very dependent on context and implementation. Traditional methods of review which focus on measuring and reporting programme effectiveness often find that the evidence is mixed or conflicting, and provide little or no clue as to why the intervention worked or did not work when applied in different

contexts or circumstances, or with different populations. The present study aimed to develop an understanding of why these differences might occur and the assumptions that are made in interpreting and using the results of such studies.

For the discussion paper, prior knowledge was supplemented by hand and computer searches. For the subsequent review, a more comprehensive search of electronic databases was undertaken, using both free-text and indexed terms. Databases searched included Medline, ASSIA, SCIE, CINAHL, ERIC, Cochrane and Campbell. Terms included: abuse, neglect, additional needs, at risk, needs or assessment, recognition, services, referral or identification, and various intervention terms. The resulting studies were screened using hierarchical inclusion criteria for country, population, and study design characteristics.

Studies were excluded if they were published before 1998; were undertaken outside the UK (unless they appeared particularly relevant); or concerned services for adults. Since the focus of the review was on interventions for children with additional needs, studies were *included* if they addressed targeted or indicated services - offered when children are at risk of, or showing early signs of, abuse/neglect or mental health problems. They were *excluded* if they focused on children and young people in out-of-home care; were concerned with universal services offered to all children (unless these were specifically designed to prevent problems, but offered on a universal basis to avoid stigma); or examined the effectiveness of strategies to improve material living conditions (such as anti-poverty measures). Interventions addressing additional needs outside the two selected areas (abuse/neglect and children's mental health) were also excluded, except where the findings were particularly relevant to the research questions. Some 1500 references identified in the formal literature search were reduced by this initial screening process to approximately 200, and of these just 35 were judged to be sufficiently relevant to inform the review.

Alongside this formal literature search, other methods were used which identified a greater proportion of the relevant material. These included drawing on the existing knowledge of the two main researchers, use of internet search engines (primarily Google and Google Scholar), searching of key websites such as the Department of Children Schools and Families (especially for reports of policy evaluations), and reference harvesting from key papers.

1.5 Structure of the report

The implications associated with the concept of 'earlier intervention' are explored in the next chapter, including issues such as sensitivity and specificity when assessing risk; the meaning of terms such as prevention, intervention and support; issues of dosage, intensity and timing of interventions; and possible ethical and moral concerns that may arise with earlier intervention. The chapter is an edited version of the discussion paper prepared for the Expert Adviser Group in the early stages of the project.

Chapter 3 is concerned with how additional needs are identified, and whether early identification has improved in the context of the reforms introduced by *Every Child Matters*. Differing approaches to identifying additional needs are considered (risk assessment; referral or signposting from universal services; self-referral and help-seeking behaviour) and research is reviewed that has addressed these issues, including the barriers that deter parents and children from seeking help when it may be needed.

Chapter 4 returns to the issues raised in chapter 2, and aims to illustrate and expand on these through a selective review of literature. This focuses on interventions addressing two broad types of additional need: children at risk of abuse or neglect; and children with emotional or mental health difficulties (including behavioural problems). The absence of research comparing earlier with later intervention makes it difficult to directly address whether earlier intervention is more effective, but research was selected for inclusion in this chapter on the basis of it having something useful to contribute to further understanding of the issues. Chapter 4 also provides a brief overview of evidence on the cost effectiveness of earlier intervention. The final chapter concludes with a summary of what has been learnt about earlier intervention for children with additional needs, policy implications and identifies potential areas for further research.

2. Key concepts and issues in earlier intervention

Despite the strength of the assumptions of positive benefits and cost efficacy, there are implications associated with earlier interventions that are rarely questioned or explored. Yet these issues have significant implications for the development of policies to support children who have additional needs, and for evaluating evidence in this field. The intention of this chapter is to contribute to a greater understanding of the complexity of the concepts and issues underlying the policy goal of 'earlier intervention'. It is hoped that this will enable evidence of efficacy and impact, including that presented in chapter 4, to be evaluated and interpreted in a broader and more meaningful context, as well as highlighting the limitations of much existing evidence.

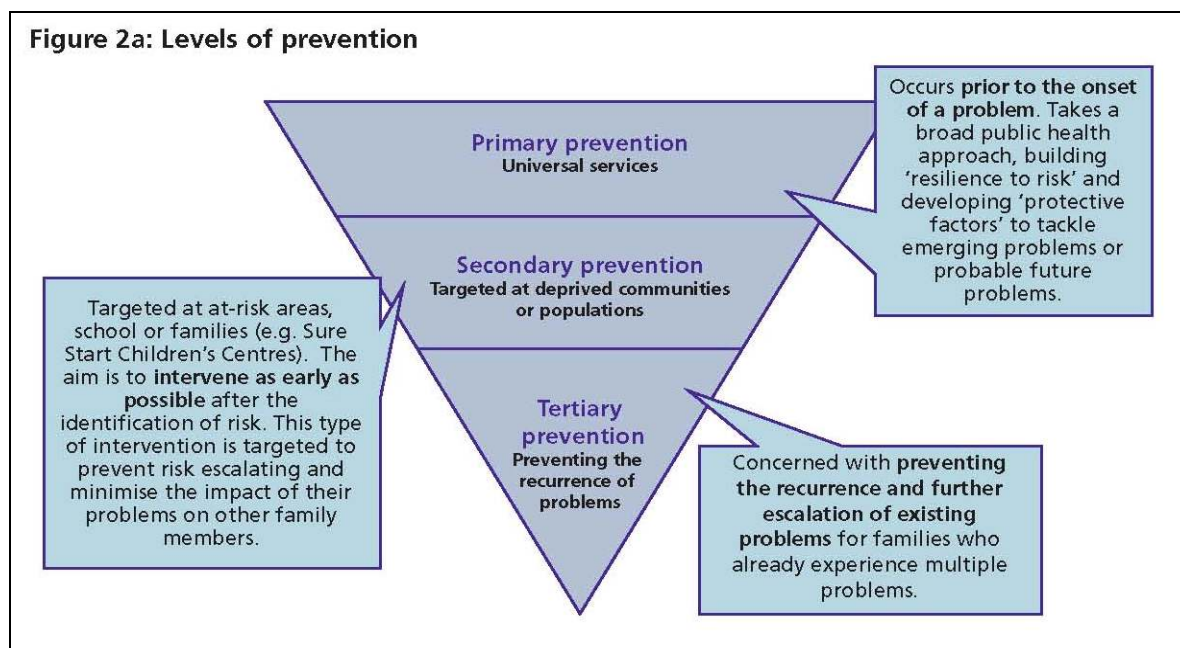
For the purposes of this chapter, 'earlier intervention' is defined as intervening early in the life course of a problem, or with children and families at risk of developing a problem, rather than intervening once difficulties have become entrenched and severe. Other terms used in this chapter include 'prevention', which implies stopping the development of a problem; and 'remediation', 'therapy' and 'treatment', which imply an improvement in the condition or status of a problem that was already present, sometimes to the extent that it is no longer a problem. However, these definitions imply a spurious precision to concepts that are themselves 'slippery', often not clearly distinct, and open to interpretation.

2.1 Models of earlier intervention

The concept driving earlier intervention is that by acting sooner a worse outcome is avoided – the principle of 'a stitch in time saving nine' or 'prevention is better than cure'. These concepts, and the idea of a single modifiable problem, are easier to explain and understand within a medical model, but this may not be the appropriate model to use to try to explain or to understand social interventions in relation to children with additional needs.

Different disciplines use the same words differently, and we have tried to account for this in our interpretation. In epidemiology, prevention is classed as primary, secondary or tertiary. Primary preventions are health promoting and used to describe interventions to stop or reduce the risk of a problem occurring (generally universal interventions), while secondary prevention refers to interventions specifically within at-risk populations, often identified by screening, to stop or reduce the risk of problems occurring, or to reduce their severity (therefore generally targeted interventions). Within a medical context, secondary prevention normally also implies monitoring and the early detection of problems within an at-risk population, with an aim of minimising any resulting impacts. Tertiary prevention refers to treatment or remedial interventions to improve the situation for those with already established problems. This classification framework has been adapted within social care contexts (e.g. Hardiker, 2002), and forms the basis of the 'inverted pyramid' model in Fig 2a, which is taken from the Social Exclusion Task Force document *Reaching Out: Think Family* (2007). This identifies different levels of prevention, and highlights the need to focus on prevention at all levels (primary, secondary and tertiary) in order to prevent social exclusion. Prevention can thus mean both support to those at risk of future adverse outcomes *and* interventions to stop situations getting worse for those already experiencing problems

Figure 2a: Levels of prevention



Source: Social Exclusion Task Force (2007) Reaching Out: Think Family, p32. London: Cabinet Office.

While some (for example, Little and Mount, 1999) have questioned the usefulness of such classifications, they do have a utility in the current context as they distinguish earlier interventions on the basis of the problem stage, and the aim of the intervention. Earlier interventions can be conceived of as **primary** interventions if applied universally in the absence of any identified problems or indications of specific risk, or regardless of risk status; or **secondary** interventions if they are individually targeted or local interventions in at-risk populations, but without any identified or 'labelled' problems. **Tertiary** interventions apply to those with identified problems of some sort, so an earlier tertiary intervention would aim to improve the situation for a child or family early in the life course of the problem.

In an equivalent classification, Rae Grant (1994; cited by MacLeod and Nelson, 2000) describes a 'social stress process model', which classifies preventive interventions along a continuum from the promotion of wellness at one extreme to intervention for established problems at the other, and three stages of intervention from universal through selective (targeted on those at risk), to indicated, for those with already established problems.

2.1.1 Universal or targeted interventions

Universal interventions are generally defined as those that are applied to whole populations irrespective of risk, while targeted interventions are those that apply to an identified population deemed to be at greater risk of a negative outcome. In practice the distinction between universal and targeted interventions is not clear cut, since interventions can be targeted at individuals, or 'clusters' of individuals located in geographical areas. Universal and targeted strategies may also become less distinct over time, as illustrated by Children's Fund projects some of which started off with a targeted approach and others with open access. With the benefit of experience, some targeted projects broadened their inclusion criteria whilst other open access projects began to focus support on those who were thought to need it most (Hine, 2005).

Griggs et al. (2008) make the distinction between person based and place based targeting. Sure Start is a good example of place based targeting where deprived areas were identified, but there was a universal intervention within the identified neighbourhood areas. Since intervention outcomes are normally assessed at the individual level, there are implications for the identification of risk at the neighbourhood level and thus blurring of boundaries between universality and targeting.

Griggs et al. (2008) point out that the policies to tackle disadvantage relating to person and place 'have developed separately within their specific domains, reflecting the different responsibilities of government departments and influenced by their different approaches and traditions. However, this separation does not reflect a reality in which poverty and disadvantage are mediated by place'. This has implications for risk assessment which will be discussed below.

Universal and targeted interventions differ in their scale, aims, and in how they are expected to work. Universal interventions are likely to be larger in scale than targeted interventions, and there are potential trade-offs between the scale and intensity of the intervention, with targeted interventions often presented as more efficient economically.

The aim of primary or universal interventions is generally preventive, while targeted interventions which are operating in the presence of risk factors, aim to protect or inoculate children or their families from those risks. And at the tertiary stage, earlier intervention aims to remediate or improve a problem situation. These different mechanisms – prevention, protection and remediation – are considered in turn below. Also relevant to the mechanisms of action are issues of 'dose' and timing (including questions of whether earlier interventions are effective at lower 'doses' than would be necessary for later interventions), and the issue of sustainability - whether starting an intervention earlier means that repeated doses or top ups are necessary, or whether earlier gains are sustained. These are considered later in the chapter.

2.1.2 Earlier intervention as prevention

The most common understanding of earlier intervention is that it is 'preventative', although that depends on how prevention is interpreted and the stage in the life course of the problem that the intervention takes place. For example, it could mean preventing a problem occurring, or preventing it from getting worse. 'True' prevention is often thought of as stopping a problem occurring, with the presumption that if the intervention is successful no further involvement or intervention will be needed.

2.1.3 Earlier intervention as protection

Interventions in 'at risk' populations are designed to protect individuals against the possible causal impacts of the risk factors, so they aim to be protective and 'inoculatory' in their action. Inoculation also acts as a preventive mechanism, so these interventions are designed to be preventive in their action, but specifically in the presence of risk factors. This is similar to notions in interactional models of the relationship between risk and protective factors (see for example, McCarthy, Laing and Walker, 2004), where the intervention is specifically designed to be protective against or to increase resilience to the risk. So the intervention may act as a 'buffer' against the effects of the risk, or it may aim to act to break a link in a chain or spiral of risk factors.

Another interpretation of inoculation applies to (universal) interventions that subsequently protect children or families when they are exposed to risk factors (see below).

2.1.4 Earlier intervention as remedial or therapeutic

In the context of earlier intervention, tertiary or remedial interventions are those which target minor problems or problems in the early stages of their development and before they become intractable or entrenched.

Earlier intervention also has a utility as a method of screening to identify those needing more sustained or therapeutic interventions. Schwartz (2005), for example, has argued for a model where relatively short-term early intervention acts as an effective screening for those at risk who are more likely to need long-term support. In this model the early intervention serves as an opportunity for 'dynamic assessment' and provides information on the child or family's ability to benefit from longer term intervention.

Some interventions provide examples of all three of the mechanisms (prevention/ protection/ treatment) operating simultaneously, such as the Friends programme described in Chapter Four.

2.2 Early identification and the ascertainment of need

2.2.1 Identification of those at risk

Earlier interventions at the secondary level imply the identification of a population 'at risk' of some poor outcome. This normally implies targeted or selective interventions rather than universal interventions, although there are many examples of interventions applied universally to target those 'at risk' in the population (for example, the Friends programme described in chapter 4).

In social contexts the ascertainment of risk or need in this way is normally based on the average outcomes for a group, for example, children of lone parents. If these are generally negative, when compared with outcomes for children not belonging to that group, then children of lone parents are deemed to be in a risk group. In relation to children and their families, risks can be ascertained at a number of different levels, including societal or community (for example, members of ethnic minorities), environmental, school, familial or at the individual level. Looked at another way, risks can be based on material or structural variables such as poverty, living in a poor environment; or family type or status; or based on functioning of either the family or child, for example, poor parenting, family violence, parental mental health problems or child behaviour.

In social situations, there is unlikely to be a single factor related to a single poor outcome, since for any negative outcome there will be a number – in many cases, a large number - of known risk factors, and some risk factors or clusters of them will have more than one negative outcome. The particular risk factors, and their relative importance, will vary somewhat for different outcomes, but in general there is greater similarity than difference in the constellation of factors that put children at risk of many different negative outcomes, such as child abuse, poor educational outcomes, behaviour problems including anti-social or offending behaviour, and mental health problems (Bynner, 2001). It is also the case that the risk factors tend to cluster, as do the negative outcomes, so that children exposed to one risk factor are more likely to be exposed to others, and children with one identified poor outcome, such as poor educational attainment, are also at greater risk of other negative outcomes, such as behaviour problems.

While the field of preventive interventions may have moved on significantly in recent years, it has not yet developed a sophisticated method for understanding or tackling the inter-relatedness and interdependence of the different factors that are disadvantaging to children and young people - the 'clouds of inter-correlated events' as described by Sandra Scarr. This is particularly pertinent in relation to socially disadvantaged or socially excluded populations, where disadvantaging factors tend to cluster together, and patterns to repeat in successive generations (Maughan and Rutter, 2001; Smith and Farrington, 2004). Most interventions target one or a limited number of aspects of risk, and cannot realistically be expected effectively to change the life chances of children or their families experiencing multiple problems. Incorporating and understanding the causal and largely cyclical chains of disadvantaging factors that characterise multi-problem families is essential if such families are to be helped effectively. There is talk of tackling 'root causes' at one end of the process, and criticism of 'sticking plaster' solutions at the other end, but in practice for most negative outcomes there is unlikely to be any single identifiable 'root cause', except in the most general sense, since they are the product of a chain of causal events, and one that is largely cyclical. It does, however, emphasise the importance of understanding how an intervention works, and this is an area that merits further research

To give an example of the chains of inter-related events, marital breakdown has been associated with generally poor outcomes for children in a number of different ways, but marital breakdown is likely to be only one factor in an inter-related and inter-dependent constellation of events. These events, some of which will predate the partnership, and have their 'causes' in the parent's family of origin, include early marriage and child-bearing, marital disharmony, maternal depression and inter-partner conflict or violence. Any or all of these may impact negatively on parenting, and more directly on children. Events following a marital breakdown, such as a change in financial circumstances, changes in housing, loss of contact with extended family, and repartnering, are also part of the continuing causal chain of events, and are also likely to impact on child wellbeing.

The distinction between 'proximal' and 'distal' variables is relevant to attempts to understand risk as it applies to individual children. Proximal variables are those affecting the child directly, such as maternal behaviour, whereas distal variables are those further down the causal chain, including structural and material factors such as poverty. While distal variables may have a direct impact on children's well being, they mainly impact on children through intervening variables, for example by causing an increase in maternal stress, poor maternal mental health and inter-partner conflict. These in turn tend to lead to poor or disrupted parenting. Although statistically associated with negative child outcomes, distal variables are not normally directly causal, but rather act as markers for the proximal variables like parenting that impinge more directly on child well being. It follows that effecting change in a distal variable will not necessarily lead to change in child outcomes, unless it is followed by change in proximal variables. Interventions that are based on addressing distal variables – such as welfare benefits to reduce child poverty – need to ensure that change is also happening at the proximal level if they are to be effective in improving outcomes for children.

This also means that identification of risk status on the basis of distal variables (such as living below the poverty line) will result in less accurate ascertainment of 'true' risk, and poorer predictive validity. Distal variables are more easily measured, but do not represent the real complexity of risk for children as their main impact on children is via their influence on other, more proximal, variables.

Within the intervention literature, proximal variables are often referred to as protective factors. For example, a good relationship with a parent might be seen as protective to a child in a poor neighbourhood.

At the same time, 'problems' in children and young people such as anti social behaviour, mental health problems or drug or alcohol abuse, cannot be attributed to a single cause, however precisely measured. Farrington (2000 – cited by France and Utting, 2005) observes that, 'no single factor among the risk factors consistently identified in children and young people's lives, can be said to cause later problem behaviour, but by reducing them, their incidence can be reduced'. Equally, where children are exposed to a number of risk factors, it is more likely that they will experience problems.

In the midst of this gloomy picture of inter-related risks, it is important to remember that people can break out of disadvantaging circumstances and stop or reverse downward spirals of negative events. Interventions targeted at one aspect of functioning can sometimes have unexpected benefits in other directions. For example, an intervention to involve parents in their children's reading and so improve children's reading skills, also improved other aspects of children's academic performance, probably via a change in parents' attitudes to education and schooling and by enhancing mothers' feelings of self efficacy and competence (Hewison, 1988). The interplay of individual factors such as resilience, coping strategies and help-seeking behaviour, and individual protective factors, with interventions, is little explored. It may be that a better understanding of somewhat intangible concepts such as self-belief, self esteem, and willingness or readiness to change (acknowledged as important in relation to interventions to treat alcohol and drug abuse) will further understanding of which interventions will work, for whom and when.

2.2.2 Sensitivity and specificity

Not all families or children 'at risk' or with minor problems go on to develop more serious problems. Equally, a proportion of those without the risk factor will go on to develop the problem. In statistical terms, the sensitivity of the risk factor is the proportion that would (in the absence of any intervention) go on to develop a problem, while the specificity is the proportion of those without the risk factor who are correctly identified as not having, or developing problems. As identified above, ascertainment of risk is an imprecise science, and the earlier the attempt to identify risk the more imprecise it is likely to be. Interventions targeted at populations identified by risk factors with poor predictive validity will have low sensitivity, and since they will also fail to identify those truly at risk of developing problems in the future, low specificity. Issues of sensitivity and specificity are clearly relevant to estimates of the efficiency and potential cost benefits of earlier as oppose to later interventions.

An estimate by Scott, published in the Government's consultation paper, *Every Child Matters*, in 2003, shows the progression and continuity of risk of anti-social behaviour in children from the age of five to 17 years of age. Of the 15% of children labelled as oppositional or defiant at five years only half were antisocial or offending at the age of 17 years. At each of the four successive stages, some children - estimated at a fifth - 'escape' from the risk, and some children who have not previously shown anti-social behaviour enter it. Thus half the children identified as at risk of potential offending early on were inaccurately identified, and the earlier the identification was made the less accurate it would be in terms of both sensitivity and specificity.

Identification of risk on the basis of multiple risk factors, rather than a single risk factor, tends to increase sensitivity. In an example provided by McCarthy, Laing and Walker (2004),

ascertainment based on a single risk factor had very poor predictive validity, correctly identifying only 3% of a group of boys aged 12 – 17 years as serious or persistent offenders, while identification based on four or more adverse factors, correctly identified over half of those who went on to become serious or persistent offenders, (57%). This still leaves nearly half incorrectly or unnecessarily identified.

Targeted interventions based on assessments of risk at the community, rather than individual, level, will tend to have low sensitivity and specificity, since community level variables are poor predictors of individual outcomes. This reflects that fact that there is considerable variation and heterogeneity within any community in the proximal variables – such as family functioning and relationship variables – that will impact most profoundly on child outcomes.

2.2.3 Identification of problems and thresholds

Even in medicine, with the exception of single gene disorders, there is no precision or certainty in relation to problem (disease) definition. For this reason, diagnostic criteria, such as the WHO International Classification of Diseases, now in its tenth revision (ICD-10), and the US Diagnostic and Statistical Manual of Mental Disorders now in its fourth revision (DSM-IV), have been developed, specifying criteria and thresholds to guide the diagnosis of particular illnesses or diseases.

No such manual exists in relation to social problems, although the Common Assessment Framework, which all agencies are now expected to use to identify children who need additional support, is expected to lead to more systematic and comprehensive assessment of family needs, and thus earlier identification of need. The extent to which such multi-agency frameworks are improving early identification of need is considered in chapter 3.

Despite the various frameworks that have been developed for conceptualising and classifying need, such as the pyramid of levels of need in *Every Child Matters* and the ‘windscreen’ continuum of services presented in chapter 1, it remains the case that the definition of a problem or need is not normally made with great precision. This reflects the fact that in practice most social problems do not onset suddenly, or come from nowhere, so the distinction between being ‘at risk’ and having an identified ‘problem’ is generally an imprecise and inexact one. Problem definition, and the point at which a minor problem becomes a significant problem, depends on the application of thresholds, ascertainment and the precision and completeness with which this can be achieved, and labelling. Service capacity and the availability of provision are also relevant factors in problem definition and in the thresholds applied to problem definition. Other factors, such as help-seeking behaviour, or conversely the failure or unwillingness to engage with services, may mean that problems are more or less likely to be identified.

The failure or unwillingness to seek help or to engage with services is likely to impact on the ability to identify problems at all levels of intervention, since these children or families are less likely to be involved in universal interventions, and in screening that might identify them for secondary interventions, as well as being less likely to seek help for a tertiary intervention that might treat or remediate a problem at an early stage.

In some cases it is possible to apply precise criteria for the definition of problems, in the form of criterion thresholds. For example, a ‘young offender’ might be defined as a young person between specified age limits who has been convicted of an offence in a court of law. The

population identified as a result of applying this criterion is likely to vary considerably in terms of the severity and (real) duration of offending behaviour.

2.3 Timing of interventions

Although there are references in the literature to the critical nature of the timing of earlier intervention, there does not appear to be much evidence of the systematic exploration of this. While much of the literature appears to conclude simply that the earlier the intervention is started the better (MacLeod and Nelson, 2000) – for example, preventive child protection programmes started prenatally - there are also references to the concept of critical periods in relation to the life course of risk and problem development. One theory is that a timely intervention may halt or reverse the negative chain of events and the consequent downward spiral caused by accumulating disadvantaging factors, which might otherwise result in negative child outcomes (Rutter, 1987). While this might apply to individuals, it seems unlikely for most problems that are the subject of interventions that critical periods can be easily identified on a population basis, as they will depend on individual problem trajectories and the interaction and interplay of different disadvantaging factors, resilience and protective factors, as well as individual coping styles and strategies.

One way in which interventions are ‘timed’ relates to the identification of critical events to trigger intervention – for example, the point at which a young person first comes into contact with the law; or signs of reading difficulty at the end of the first year of schooling. When these critical events relate to the severity of the problem they are generally those that also reclassify the intervention from primary to secondary, or secondary to tertiary, but there are other events, such as actively help seeking, which may be indicators of individual resilience thresholds and coping strategies, and may indicate a critical period for intervention.

2.4 Dosage and intensity

In the light of the discussion about ascertainment of risk and problems it should not be surprising that most ‘problems’ are not prevented or rectified by a simple or single intervention. For the majority of children with additional needs there will be a number of inter-related, and often inter-dependent disadvantaging factors which impinge on them, their families and apply to the environment in which they live, and any intervention, however comprehensive and multi-faceted, will not tackle all of these. It is also the case that some known risk factors are rarely targeted by interventions. Despite the wealth of evidence on the importance of good parent-child relationships to child well being, and on the negative impact of inter-parent conflict and adult relationship problems (both more likely to occur in circumstances where there are other difficulties), there are few preventive interventions that have aimed to strengthen family relationships, or to address these aspects of risk.

Many ‘effective’ interventions are focussed on tackling only one identified issue, but it is frequently acknowledged that the identified intervention population is likely to be multiply disadvantaged, and to need sustained support in a number of areas.

2.5 Intervention or support?

The term ‘intervention’ is generally used to cover the whole range of programmes from those that are mandatory, and parents or children are required to attend (for example, programmes parents are required to attend as a result of parenting contracts and orders for behaviour) to

those such as Out of School clubs or parenting classes which interested children and parents attend from choice. Excluding the mandatory programmes, there is a subtle but important distinction between programmes that are perceived as voluntary and *supportive*, and as helpful and wanted, and those which seek to change some aspect of children's or parents' behaviour, and may be perceived as intrusive or interfering, and unwanted to some extent. The latter might more accurately be described as interventions than supports. In relation to children, the distinction between intervention and support is exemplified by adults "doing things to' (rather than 'with') young people under the auspices of 'we know best' and 'it's in your own best interests'" (Case, 2006).

Optimally this distinction between intervention and support should not be evident, and all interventions should be perceived by participants as helpful and supportive, and in their interests, whether this is through education, psychological or emotional support, or through the acquisition of new skills to achieve behaviour change. Parents who engage in and attend programmes to provide parenting support generally find them helpful and supportive, even if their attendance has been mandatory (Barlow and Stewart-Brown, 2001), but overall families perceived to be most 'in need' are least likely to take up offers of help or support.

The acceptability of programmes to participants and the degree to which they share the aims of the intervention, highlights the tension between the perceptions of those such as social workers or health visitors, for example, who may see children or parents as potentially benefiting from an intervention, and the perceptions of the intended participants. Conley (2007) questions whether the 'preventative strengths-based' interventions offered to families at 'moderate' risk of child maltreatment can be called voluntary, if child protection services are informed if families do not accept the offer. She points out that few studies have investigated the nature or truth of the voluntary claim in child protection services, and those that have 'hint that some level of coercion may still be involved'.

This tension may go some way to explaining why many parenting programmes tend to report relatively low participation rates, and high drop out rates. Spencer (2003) points out that only 10% of a group of parents invited to attend a parenting group expressed a definite interest in doing so, and in another study involving parents who had already identified their children as having behaviour problems, only 30% agreed to participate in a randomised control trial. Drop-out rates from parenting programmes such as the Webster-Stratton programme tend to be of the order of 50% or higher, and where such information is available, it is clear that there is social patterning in drop-out, with more disadvantaged parents less likely to complete the course (Spencer, 2003). There is scant systematic information on whether drop-out rates for parents from ethnic minority groups are higher, but as minority ethnic groups tend to be over-represented among the disadvantaged population, this would follow the known pattern of characteristics of those who do not participate or drop out. The fact that most parenting interventions have a white middle-class origin may result in a lack of sensitivity, or 'fit' of the programme to parents from other social or cultural groups, with the result that these parents may feel the programme is not relevant to them, or that their way of parenting is being disapproved of.

There may also be evidence of a 'lack of fit' between what is being offered, with needs or wishes. It has, for example, been reported from Sure Start programmes, that the most disadvantaged children and families in Sure Start areas do not benefit from the programmes (National Evaluation of Sure Start Team, 2005). This is interpreted by the national evaluation team as resulting from the relatively advantaged families in the generally disadvantaged areas being better able and more likely to use the services and resources, which effectively

squeezed the more disadvantaged families out. An alternative and equally plausible interpretation is that the more disadvantaged families find what is offered less acceptable or relevant to their lives and way of parenting – more an intervention than a support - and are therefore less likely to participate, or if they do, more likely to drop out. Either way, it identifies one of the hazards of demographic or area based risk assessment.

2.6 Ethical issues and risks associated with earlier intervention

Although not often acknowledged or recognised in this context, there are risks and legitimate ethical and moral concerns associated both with earlier intervention, and with decisions *not* to intervene early. There are, for example, ethical issues relating to the nature of problems and their subsequent treatability if intervention is delayed – the concept of prevention being better than cure. As identified earlier, for some individual children demonstrating anti-social behaviour, their problems become more intractable and less likely to respond to any intervention if they are not dealt with early on (Kazdin, 1993).

The over-riding ethical and moral concerns of earlier intervention relate to issues of social justice, and whether it is ethical *not* to intervene when the indications are that an individual or population is at risk or some poor outcome. The original US Head Start programme was part of a programme of 'War on Poverty' (Gray and Francis, 2007) and the current government policy of 'risk-focussed prevention', is described as 'a moral and political project' with policy makers as well as social scientists involved in a 'major political project', seeking 'to understand social problems and find solutions that not only achieve better outcomes, but are also cost effective' (France and Utting, 2005; citing Freeman, 1999). There are, however, some risks and ethical concerns that follow from a decision to intervene earlier, rather than later.

Some of these are to do with cost effectiveness, and issues of waste with the allocation and use of scarce resources for interventions involving the larger group of people who may not need them, rather than strategic deployment to the smaller number with identified needs. The aim of any sort of targeted earlier intervention is to deploy resources optimally, in an efficient and more concentrated way to those most likely to be in need. The ethics of targeting versus universal interventions have been discussed (for example, by Guterman, 1999; and others). Guterman points out (in relation to early home visiting) that a targeted approach may be less politically sustainable, as it targets scarce resources away from the mainstream and to unpopular 'special' groups.

Applying to both universal and targeted interventions, are the risks of intervening inappropriately or ineffectively. This might be the result of interventions that are not evidence based, or are poorly designed or conceptualised (for example, inappropriately imposed top-down interventions), that do not apply what is already known about early interventions, prevention or risk. These concerns also apply to later interventions, but are more salient to earlier interventions as a result of the generally larger scale of earlier interventions, and the fact that they may not be necessary or effective for some individuals.

There may be psychological costs associated with an intervention, both for individual children and their families, and these may apply even if the intervention is 'successful'. Concerns about individual rights and the ethics of interfering in people's lives are relevant to interventions with a preventive aim, although in relation to parenting and children, issues of social justice and children's rights are likely to prevail.

In relation to screening and the ascertainment of risk at an early stage, there are concerns to do with the proper ascertainment and identification of populations or individuals at risk or experiencing problems, and issues of the sensitivity and specificity of the assessment (discussed earlier). Associated with this is the risk of stigma or self-blame that may follow labelling or special treatment, such as attendance at special classes, and the potential psychological cost and negative impact of identification on children and their families. Equally, for some young people, the negative impact of being labelled as anti-social or at risk of offending may be self-fulfilling, since identification in this way may provide greater access to negative role models, a lack of positive expectation, and may lead to offending behaviour. Risk-based targeting of this sort can result in groups being (further) marginalised or even criminalised (Case, 2006).

When a population at risk has been identified, there may be issues of the right not to know about risk status, as well as the ethics of prolonged assessment or repeated screening, and the risks of unnecessary and sometimes protracted involvement in interventions for those who may be at risk but are not showing any signs of problems, and would do well, or would not be any worse off, without it.

These risks are not independent, and may interact in complex ways. The dangers of stigma may be exacerbated as a result of using risk factors that have low levels of predictive validity to target interventions (as described earlier under the heading of ascertainment of need). Incorrect or imprecise identification of children as being at risk can result in children being inappropriately labelled. And incorrect labelling may have a heavier psychological cost than 'correct' labelling. As identified earlier, the evidence documented in the consultation paper *Every Child Matters* demonstrated that only half of those 'labelled' anti-social at eight years of age were subsequently anti-social at the age of 17 – which means that half the population were incorrectly and unjustly labelled in terms of future risks. The use of factors with low levels of predictive validity to identify 'risk' will fail to identify some children who genuinely are at risk and will go on to develop problems.

It should also be remembered that a label that turns out to be accurate can still be stigmatising, and that being labelled may in itself have a direct negative impact on future outcomes in terms of marginalisation and disenfranchisement, lowering expectations, and creating a sense of failure or hopelessness.

A further ethical issue is that it is possible for early interventions to have a negative effect, although such findings are less likely to be reported, reflecting publication biases. Even if the overall results of an intervention are deemed to be successful, within any intervention applying to a group of significant size individual responses will vary, and some participants will have better outcomes than others. This latter group, although rarely specifically identified, is likely to contain some children or parents who do no better as a result of the intervention – that is, they do not respond to it, and may also include some who respond negatively. Additionally, if those who fail to respond or respond less well are those with the highest level of disadvantage, there is a risk that earlier intervention will risk widening rather than narrowing the gap.

2.7 Cost effectiveness

Questions about cost effectiveness are of great interest to policy makers, commissioners and service providers, and a recent research initiative focused specifically on costs and outcomes in children's social care (Beecham and Sinclair, 2007). One possibility is that

money spent on earlier intervention will reduce the need for later, more intensive support; and allow resources to be shifted towards more universal provision. However, it has proved difficult to find evidence, especially from the UK, to support (or refute) this particular holy grail. There are a number of reasons for this, both practical and conceptual. On the practical side, while progress has been made in calculating the unit costs of various children's social care services (Beecham and Sinclair, 2007; Ward et al., 2004), data on the amount of service a child receives are often poorly recorded in case files, and the multi-faceted nature of many interventions to support children with additional needs means that costs may be spread over a variety of agencies.

Calculating cost effectiveness requires robust data on outcomes as well as costs. It aims to answer the question 'what works best in relation to cost?' and this cannot be done unless the question 'what works best?' is first answered. Yet there are relatively few studies of social interventions that meet the criteria for good effectiveness research. Economic analysis is more straightforward if an intervention is distinct and well-defined, with a large, short-term and measurable outcome (Sefton, 2000). Few interventions for children with additional needs meet these criteria. Also, whilst there may be studies that compare later life outcomes for those experiencing early intervention programmes (such as Headstart) with outcomes for those who did not experience such programmes, there is very little research directly comparing earlier with later intervention, which is the focus of our review.

Another issue is the timescale over which outcomes are measured. The impact of preventive services may take time to work its way through the system and savings, if any, are likely to be produced some time in the future. Few evaluations are sufficiently long-term to allow such effects to show up (a well-known exception is the High/Scope Perry Preschool programme, which followed children through to adulthood: Schweinhart and Weikhart, 1997). More common is the experience reported by NICE (the National Institute for Clinical Excellence) in England, where an economic appraisal of whole-school interventions to promote mental health in primary schools was unable to find sufficient evidence to make any recommendations about cost effectiveness, in part due to the lack of long-term data on possible 'sleeper' effects (McCabe, 2007).

The cost effectiveness of early interventions is sensitive to both the specific outcomes which are being measured, and the timeframe over which they are expected to occur. For example, good quality daycare provided for children in disadvantaged families has an impact in reducing later youth offending, but appears to be less cost-effective in doing so than, say, offering incentives for young people to stay on in education (McKeown and Sweeney, 2001). But this needs to be interpreted in the knowledge that the primary objective of the early intervention programme was to improve educational outcomes and parent-child relationships, with crime prevention emerging as one of the desirable secondary effects, and that cost effectiveness was lower because early childhood programmes are comparatively expensive and the benefits are longest in coming – yet there were other beneficial outcomes. This illustrates another common problem in conducting cost effectiveness analyses in the social care field, which is that it is relatively unusual for there to be a single over-riding objective for an intervention, and this is realistic for social interventions, since social problems are almost invariably multi-factorial in origin. This means finding ways to compare one intervention with another that perhaps has a better outcome on one criterion, but worse on another (Holtermann, 1998).

The distribution of costs and savings is also important – who benefits, and are there hidden costs (for example, to volunteers or to low-paid foster carers?). There may be benefits, or

costs, to individuals, to society, or to the public purse. One example, a study of out-of-home daycare for families living in a disadvantaged area of London, found that from a societal perspective the intervention was cost saving (the value of the mothers' employment outweighed the cost of services used) but from a public sector perspective, the provision of good quality daycare exceeded the income tax revenue (Mujica Mota et al., 2006). In the case of interventions for children with additional needs, cost savings from earlier intervention by one agency may well benefit other agencies than the one offering the preventive service. In such situations, how costs and benefits are distributed and accounted for becomes a particularly relevant issue.

A final issue that needs to be borne in mind is that preventive services may actually increase costs, at least initially, by identifying new needs and bringing to the attention of specialist services some children and families whose needs may otherwise have gone unrecognised and unmet. This 'case finding' role reinforces the importance of economic evaluations adopting a broad and long-term perspective. A longer-term perspective would also permit the inclusion of the costs of top-up interventions if these are required to maintain benefits, or the cost of later treatment for those who initially did not appear to need support but then went on to develop problems. All such costs would need to be taken into account in a fair comparison of the costs of earlier and later intervention, but this is rarely done (Shanahan and Barr, 1995).

3. Evidence on the early identification of children's needs

A pre-requisite for earlier intervention (defined as intervening early in the life course of a problem rather than once difficulties have become entrenched) is early identification of need, so that children and families can be supported with appropriate services before their difficulties become severe.

This chapter sets out evidence relevant to answering the following review questions:

- What is known about how children with additional needs are identified (in what circumstances and by whom?)
- How successful is such identification (are the right children picked up, are some 'wrongly' identified who would not have gone on to develop difficulties?)
- Could children who come to the attention of agencies when their difficulties are severe have been identified earlier?
- Is there any evidence that *Every Child Matters* reforms (including the Common Assessment Framework) have improved the identification of children with additional needs?

A number of differing approaches have been used by practitioners to identify when children have additional needs and may require support to prevent difficulties either occurring or getting worse. They include risk assessment (applying risk factors based on statistical analysis of likely outcomes, as described in the previous chapter); referral or signposting from universal services; and self-referral or help-seeking behaviour.

3.1 Risk assessment

Structural and individual variables that may indicate actual or potential vulnerability of a child and/or family to poor outcomes include living in poverty, growing up in a disadvantaged neighbourhood, experiencing problems in school, poor parenting, substance misuse, domestic violence and levels and quality of formal and informal support (Wolstenholme et al., 2008; Daniel et al., 2009). However, as noted in the previous chapter, gaining indications of vulnerability by exploring the way risk factors interact is complex and there is still much to be learned about the outcomes produced from the influence and interaction of individual risk factors across children's lives; and about the influence of coping strategies, protective factors and children's resilience. Some factors, such as being part of a large family, appear to have the potential both to increase risk or alternatively to enhance protection (Wolstenholme et al., 2008).

An overview of findings from Serious Case Reviews carried out between 2003 and 2005 (Brandon et al., 2008) discovered that over two thirds (68%) of children aged four and over who subsequently died or experienced significant harm had been showing signs of poor school attendance. Such retrospective analyses are not particularly helpful in predicting future harm, since the great majority of children missing school do not go on to be seriously

harmed, but it does indicate the potentially important role of schools in noticing when children may be experiencing difficulties and need additional support.

The interactions between different factors that can influence behaviour, and which make risk assessment difficult, are illustrated by a study that attempted to predict children's behaviour problems in a sample of 463 children aged 5 or 12 living in three disadvantaged neighbourhoods in England. These ages were chosen because it is known that the time of starting primary and secondary school can create particular stresses for children and families. The findings of the study highlight the interaction of individual, family and neighbourhood characteristics. For example, although a strong link was found between parental mental health problems and child behaviour problems, this was explained statistically by positive and negative neighbourhood factors, parental personality and parent-child interaction when these were taken into account using multiple regression analysis (Barnes and Cheng, 2006).

In the USA, data on the development of mental health problems among 328 children involved in a longitudinal study of child development suggested that those who went on to develop 'recurrent co-morbid symptoms' in early adolescence (i.e. both internalising and externalising problems, such as depression or anxiety *and* conduct problems or aggressive behaviour) could have been fairly accurately identified in kindergarten, from questionnaires completed by mothers and teachers. The researchers therefore suggest that universal screening for childhood mental health problems could be carried out at school entry, so that those most at risk could be offered early support. However, the results need to be treated with caution, as the children were assessed at four points in time (kindergarten and grades 1, 3 and 5), and although all ten children identified as 'high risk' in kindergarten went on to develop recurrent co-morbid symptoms at grade 5, there was a high rate of false positives (almost a half) among the grade 1 'high risk' group (Essex et al., 2009).

Evaluations commissioned by DCSF into the operation and impact of national programmes to support children and young people targeted on the basis of 'risk' provide another source of evidence on how such children are identified. Youth Inclusion and Support Panels (YISPs) were developed in England to support young people aged 8 to 13 who were judged at high risk of offending and anti-social behaviour, before they entered the youth justice system. The evaluation found that fewer children were referred to the 13 pilot schemes than had been expected, possibly because of ignorance about the new initiative or an inability to identify high risk children, but also because some professionals were concerned about 'net-widening' - pulling children who had not yet offended into the criminal justice system (Walker et al., 2007). The YISP example illustrates how the potential for targeted interventions to label and potentially stigmatise children, discussed in Chapter 2, may operate to prevent them being offered support.

To be referred to a YISP, an assessment had to indicate that a child had four or more risk factors and the child's behaviour needed to be of concern to two or more of the partner agencies and/or to the child's parents/carers. Assessment was done using ONSET, a referral and assessment tool which required key workers not only to rate risk and protective factors, but also make a judgement about the likelihood that the child would offend in the future given the problems identified. In practice, many key workers found this distinction difficult to make.

Difficulties with risk assessment and targeting were also reported by the national evaluation of the Children's Fund, one strand of which examined different approaches to ensuring services reached those who most needed them (Hughes and Fielding, 2006). The 26 partnerships studied had used a mixture of area-based, social group and individual targeting, but the evaluation team reported that practitioners experienced difficulties in conceptualising and identifying those 'at risk', and there were disagreements over how to decide who was eligible for services. It was not possible to judge the effectiveness of particular targeting strategies in meeting Children's Fund aims and objectives, although there was some evidence that project workers had been relatively successful in helping children and parents to access other services in the community (Evans et al., 2006; Pinnock and Evans, 2008).

Surveys of school children undertaken as part of the national evaluation of On Track (a programme aimed at preventing youth offending) showed that although the risks that were measured in the survey increased the odds of children being involved in problem behaviour, there were many children apparently at 'high risk' who were not involved in such behaviours. (Armstrong et al. cited in Hine, 2005). Similarly, analysis of the UK Birth Cohort data (Feinstein and Sabates, 2006) found a potentially very high level of predictability in the extent to which it was possible to identify children at risk of 'high cost/ high harm' outcomes in adolescence or adult life, using early childhood information about family context and child development, plus children's levels of achievement and teacher ratings once they started school. However, this relationship was 'not deterministic, mechanistic or inevitable': there were both false positives (where children at risk did not have negative outcomes in early adulthood) and false negatives (where later problems were not predicted by early experiences). The rate of 'true positives' (correct prediction of later problems) was highest when many different factors were taken into account, but it was rarely possible to say that a particular risk factor would lead to a particular outcome.

On the other hand, some interventions that are targeted on particular groups on the basis of one known risk factor do appear to reach those who need them most. An evaluation of the early implementation of the Family Nurse Partnership programme in 10 pilot sites in England showed 'promising' results, in terms of reaching the intended group (first time mothers under 20 and their partners) and meeting short-term objectives such as increasing confidence and awareness of child development. Although recruited for the most part with a simple age criterion, the young people reached were disproportionately from households with low income, had few educational qualifications and many vulnerabilities including mental health problems (Barnes et al., 2008).

3.2 Referral and signposting

Generally, the literature on risk assessment suggests that while consideration of risk factors can be useful as a way of focusing attention on those most likely to need support, it is insufficient on its own as a means to identify children with additional needs, and good assessment of individual children is also required. For example, a review by Daniel and colleagues (2009) of studies on identifying and helping children who are neglected, found that overall, the research pointed to the importance of considering compromised development and behavioural problems as potentially indicative of neglect. But findings were rarely clear-cut and could not be used predictively without large numbers of false positives and negatives. For example, various studies in the US that have screened for risk of child maltreatment, in child protection settings, have reported false positive rates (where children

are judged 'high risk' but do not go on to be maltreated) of up to 26%, and false negative rates (where children are not judged high risk but are later maltreated) of up to 63% (Lyons et al., 1996).

Relatively little UK literature was found describing who actually undertakes such assessment of individual children's needs, and how effectively this is done. **Nursery nurses** were identified as a major source of referral for preschool children with behavioural problems in a study in one English city (Coe et al., 2008), although a significant majority of these providers had not received any specific training for this role. **Family centres** and **Sure Start local programmes** have been shown to play an important role in 'signposting' and referring children on to more specialist provision (Statham, 1994; Tunstill, Aldgate and Hughes, 2006), and the children's centres that have replaced them are expected to continue this function. Services which get to know the child well, and have an opportunity to see parent/child interaction, are particularly well placed to identify the kind of 'proximal variables' (such as child behaviour problems and difficult relationships between parents and children) that are known to be linked to poor outcomes.

As the main service for children, **schools** have a potentially key role to play in identifying children who may have additional needs, and there is some indication that the work of social care professionals in extended schools (see 3.4 below) is enabling easier access for parents and children to support before they reach the point at which children's social services would normally become involved. However, a review of how child maltreatment is recognised and responded to (Gilbert et al., 2009) was critical of the under-reporting by education staff of concerns about children. Reasons given by school staff included lack of access to qualified social workers to discuss cases, insufficient feedback when concerns were reported, and a lack of confidence in the anticipated response of children's services. Linking social workers to specific schools, through outreach work, link posts or a base in the school, can facilitate the development of a more trusting relationship between school staff and social workers and encourage the former to share any concerns (see 3.4).

The Pyramid programme is one way in which some schools are attempting to identify children who are facing difficulties in their social and emotional development, with a particular focus on those who are quieter, shy or more withdrawn and tend to internalise their difficulties. Identification of children considered suitable to attend a Pyramid Club is generally a two-stage process beginning with a universal stage. First, a whole year group in the school is selected for screening, usually Year 3 or Year 6, and screening is generally undertaken by class teachers using a measure such as the Strengths and Difficulties Questionnaire (SDQ). Results from the screening are then taken to a multi-agency meeting which discusses those children who are displaying any sort of difficulty in order to identify some suitable support for them. Agencies involved in this meeting should include school staff (class teachers, head or deputy head, Senco, learning support assistants, learning mentors) and other children's services like educational psychology, education welfare, behaviour support, CAMHS, school nursing and so on. The aim is to identify local resources that can help to meet the children's needs. Up to ten children whose additional needs arise from being withdrawn or having problems in establishing good peer or adult relationships may be offered a place at a Pyramid Club, an after-school activity run once a week for 10 weeks by trained volunteers following a manualised programme. Although there have been a number of small-scale evaluations of Pyramid Clubs which suggest they may help to improve children's social emotional health, at least in the short term (e.g. Ohl et al., 2008), little information is

available about the effectiveness of the whole-class screening in identifying the 'right' children for the programme, or about the effectiveness of the multi-agency meeting in mobilising support for other children identified as having additional needs but not selected for the Pyramid Club.

The recently published national strategy for children and young people's health (DH and DCSF, 2009) suggests that **health visitors** can be key professionals when it comes to identifying children and families with additional needs, and this is supported by existing research evidence. For example, Daniel's review of research on identifying and helping neglected children (2009) found that health visitors were often able to pick up early signs of neglect, even if they were not always then sure what they could do or how to access resources to provide support. Health visitors were one of the commonest sources of referral of children to social care services in cases involving domestic violence and/or parental substance misuse (Cleaver et al., 2008). In a study in North Wales, health visitors were able to effectively identify three- and four-year old children on their caseloads who were most at risk of developing conduct disorders, and to successfully recruit them to a parenting programme (Webster-Stratton's Incredible Years) designed to help such families (Hutchings et al., 2007). Although this was a targeted programme, stigma was avoided by the use of a non-judgemental approach when the health visitor first approached the parents about attending, and by making the programme accessible and attractive - for example by providing a crèche, transport, meals and raffle prizes for attendance and homework. Health visitors with additional training who delivered an intensive home visiting programme to vulnerable families were able to increase the identification of infants at risk of abuse or neglect (Barlow et al., 2007).

However, Cowley and colleagues' (2007) national survey of health visitors notes that the early identification role depends on health visitors having sufficient time to spend with all families, which has been made more difficult by the increased focus of the service in recent years on child protection and vulnerable families. They comment that their research *'calls into question the premise, upon which progressive universalism rests, that all families receive a sufficient service for proactive health promotion, and for additional needs to be identified in a timely way'* (Cowley et al., p878). UK child health promotion guidelines expect health visitors to assess family needs before infants are aged four months and to offer a more targeted service after this point. However this is often insufficient time for early identification of 'high need' families. A study of the *Starting Well* intensive family support project in Glasgow (Wright et al., 2009), which aimed to assess how accurately families' needs could be predicted within the first four months of the child's life, found that less than half (47 per cent) of families subsequently rated as 'high need' were identified within this early period, and that continued input by health visitors with some sort of universal service offered for at least the first year was needed especially for families living in deprived areas. Proposals in the national child health strategy (DH and DCSF, 2009) for additional health visitors attached to children's centres may help to address this issue.

The potential of **adult services** to identify when children may have additional needs is emphasised in the 'Think Family' approach to preventing social exclusion (Social Exclusion Task Force, 2008). Previous research has suggested that adult services in general, and those supporting parents with mental health problems in particular, are not good at noticing when the children of their clients may have unmet needs (Kearney et al, 2000; Cleaver et al., 2008; Parker et al., 2008), and indeed often did not even know whether their adult clients

had children (Jacobsen et al., 1997). The 'Think Family' approach encourages local services to follow a principle of 'no wrong door', where contact with any service should provide access to a system of joined-up support. In particular, services for adults are expected to take account of whether their clients have children, and to consider the impact that the adults' mental health or substance misuse problems may have on their children. It is also suggested that professionals such as housing officers may be well placed to identify and engage families at risk, since they already make home visits to families in social housing and often have strong networks within local communities, but little information is currently available on the extent to which this is happening. A Family Pathfinder programme was launched in May 2008⁴ to develop the 'Think Family' approach, and to test out ways of improving links between adult and children's services in order to support vulnerable families, but the evaluation of these projects is still ongoing.

Important evidence of opportunities for earlier intervention being missed is also provided by a follow-up study of children from the large-scale British Mental Health Survey in 1999, which included telephone interviews with 60 parents who had been in contact with children's social services in the two to three years following the original survey (Gugliani, Rushton and Ford, 2008). Nearly half of these had themselves made contact with children's services to ask for help with their child's emotional or behavioural difficulties, but most had not got past the duty desk. The researchers note that 'while this may be appropriate in terms of social care needs, an opportunity to direct families to mental health or educational services may have been missed' (p194).

3.3 Self-referral and help-seeking behaviour

The Laming review points out that 'a key factor in identifying children and young people who need help is ensuring services are designed to encourage contact from members of the public, parents and children and young people as well as by other agencies' (Laming, 2009 p25)

Several studies show that parents are often aware of the need for help for themselves and their children, and have sometimes unsuccessfully sought help before their problems become severe. The research on neglect reviewed by Daniel et al. (2009) indicated that parents of children subsequently identified as neglected could themselves often identify risks and were aware of potential harm to their children, for example from their substance misuse, although the evidence was unclear whether they had tried and failed to seek help or avoided it. In the evaluation of Youth Inclusion and Support Panels (Walker et al., 2007) parents had often been aware of problems and asking for help for a long time but without getting the support they needed, suggesting that YISP children could have been identified earlier, particularly by parents and teachers. The researchers note that 'some if not all' of these children might have benefited from YISP referral at an earlier stage, but they tended not to be identified until their behaviour or troublesome situations began to worsen. Attracting early referrals of children who could benefit was judged to be 'a key challenge' for the YISP programme (Walker et al 2008, pxxiii- xxiv).

The need for professionals to *hear* when children and parents are asking for help is a key requirement for earlier identification of need. This includes hearing and responding

⁴ <http://www.everychildmatters.gov.uk/parents/pathfinders/>. Accessed 12 March 2009

appropriately when those outside the family – neighbours, childminders, school staff and so on – report concerns about a child's welfare. Various studies, as well as enquiries into cases where children have been severely harmed or killed, have been critical of the way in which agencies have failed to respond to such expressions of concern, which could have identified children's needs had they been adequately recorded and followed up (Brandon et al., 2008; Laming, 2009). On the other hand, those on the 'front line' responsible for responding to such concerns report that calls about child maltreatment are sometimes motivated by disagreements between neighbours or ex-partners, and when acted upon turn out to be 'false positives' without any substance (Statham and Cameron, 2004).

There are some types of difficulty where parents may be particularly reluctant to seek or accept help, for example with mental health issues. A review for the Social Care Institute of Excellence of research on prevalence, detection and interventions in parental mental health and child welfare (Parker et al., 2008) estimated that in an average primary school class, around six or seven children are likely to live with a mother with a common mental health problem such as depression or anxiety. Other estimates have been lower at around 8% in women with children (Smith, 2004). Despite the relative frequency of this situation, the SCIE review found that both parents and children were often reluctant to have parents' mental health problems identified, and referral for specialist support was often not taken up because of fears about child protection processes. Where parental mental health problems were not very severe or at crisis, other issues like financial or housing problems tended to be seen by parents as higher priority, and dealing with anxiety or depression was often viewed by them as 'tinkering at the edges'. The evidence reviewed supports the need for services to work more holistically, and for families to be able to develop a continuous relationship with a trusted professional who can encourage them to access appropriate support.

Katz et al. (2007) reviewed barriers to the inclusion and engagement of parents in support services, noting that this is a particular issue for earlier intervention because, unlike more intensive 'crisis' services where there is often a degree of compulsion, preventive services usually rely on parents actively seeking help or voluntarily accepting help offered to them. Often those who may need help the most are those who do not seek it out or who are unwilling to accept services that are offered. Refusal and drop-out rates can be high. For example, of 433 'at risk' women referred to an intensive health visiting service, 120 refused to participate and a further 31 dropped out later (Barlow et al., 2007).

Making services accessible, attractive and (where relevant) affordable is therefore a key aspect of successful earlier intervention. The Katz et al. review identified *physical and practical* barriers (such as lack of knowledge of local services and how they could help, or physical access problems due to geographical location or disability) and *social* barriers (cultural, language, disability, female ethos of services, poverty, suspicion and stigma). Successful approaches to increasing engagement included the development of trusting personal relationships between providers and service users; practical issues (such as whether the parent had previous experience of being turned down when asking for help, opening times, availability of childcare and cost of services); service culture; and responsiveness to what parents want. Other reviews have also summarized the characteristics of services that parents and children in need of support value and take up: easily accessible, practitioners who are approachable and responsive, culturally sensitive services, attention to strengths as well as needs, and a focus on supporting both child and parent (e.g. Statham, 2004; Quinton, 2004; Wolstenholme et al., 2008).

A review of international approaches to parenting support (Boddy et al., 2009a) notes a distinction made in some countries, such as Germany, between parenting programmes and support services with a 'go-structure', whereby the worker goes to the family, and those with a 'come-structure', whereby the parent must come to the service (although it is relevant to note that the descriptions are 'professional-centric' rather than being from the perspectives of the parent or family). 'Go-structure' approaches were reported to improve access to difficult-to-reach populations, since they were able to overcome factors such as parents' inertia, uncertainty, lack of confidence or fear of rejection, which could deter them from taking up provision. A similar conclusion was reached by researchers analysing qualitative data from the national Sure Start evaluation, which identified three different 'styles' of parental service use (Garbers et al., 2006). The first was 'autonomous', where parents hear about a service and take it up of their own accord. The second style was described as 'facilitated', where parents need to be encouraged to use a service through the use of befrienders or provision of facilities such as an interpreter, crèche or transport. The third is 'conditional', where parents will only access a service, at least initially, under particular conditions, for example, if it is brought to them at home. The importance of paying attention to this third group is reflected in practice guidance for children's centres in England⁵, which requires an emphasis on outreach and home visiting, especially with families who are unlikely to visit a children's centre.

3.4 Every Child Matters and earlier identification of need

As outlined in the introduction to this report, a key aspect of ECM is the emphasis on closer working between all agencies involved with children, to be achieved through mechanisms such as the creation of children's services departments and Children's Trusts, introduction of the Common Assessment Framework, the *Team Around the Child* model and the role of Lead Professional, improved information sharing through a national database (Contact Point) and the rollout of children's centres and extended schools. The intention is that these reforms should enable children with additional needs to be identified and supported earlier.

The LARC (Local Authorities Research Consortium) study is a collaborative project which aims to allow the 14 authorities taking part to 'tell their own story' about how well the service integration aspects of the *Change for Children* agenda are working, using a four-stage model of impact. A report on the first year of the project found some evidence of change at level 1 (changes to inputs, processes and structures) and level 2 (changes to experiences and attitudes). Local authority staff reported increased use of tools and frameworks such as CAF, multi-agency panels and integrated referral systems; and improved working practices including a greater focus on prevention and earlier intervention. However, evidence of impact on children was less quantifiable, and it was judged too early to see any evidence of such changes becoming embedded (Lord et al., 2008). The national evaluation of children's trusts, which described and compared the experience of the 35 'pathfinders' integrating children's services, likewise reported that change had focused mainly on management structures and practices rather than on service delivery (Bachmann et al., 2009).

A comprehensive review of studies of multi-agency working in children's services concluded that there was some evidence (based largely on practitioners' reports) that multi-agency

⁵ Sure Start Children's Centres Practice Guidance. <http://www.surestart.gov.uk/doc/P0002374.pdf>

working facilitated earlier identification and intervention, and could prevent the need for access to more specialist services. As suggested in Chapter 2, this earlier identification could result in an increase in referrals to specialist services, for example when children's mental health problems were picked up earlier, leading to added pressure on mental health services (Atkinson et al., 2007). The research evidence on basing social workers in settings away from children's services district offices, such as in children's centres and schools, is small-scale so far, but shows generally promising results. Studies have suggested that by having social workers operating in an outreach capacity in community settings, the stigma related to contact with social services may be reduced, and it is possible to detect and address difficulties earlier (e.g. Moran et al., 2007; Boddy and Wigfall, 2007, Wigfall et al., 2008). Access to social workers is easier for parents and children when the worker is based in a community setting that they visit anyway, thus breaking down to some extent the distinction between 'go' and 'come' services. Staff in Sure Start Local Programmes have also been shown to be more confident about bringing concerns about a child's safety to the attention of children's services when they are able to liaise with an out-posted social worker or a link worker who is already known to them (Tunstall and Allnock, 2007).

An early survey of the children's workforce, commissioned by DfES in 2005 to assess awareness of the ECM agenda (Deakin and Kelly, 2006), found that school staff felt less engaged in ECM than any other section of the workforce, and almost a third reported being unaware of the 'change for children' agenda. Since then, government emphasis on the important role of schools in identifying children with additional needs, and the growth of extended schools, has resulted in far greater awareness of the wider role of schools in supporting children and families. In a survey conducted in autumn 2008, three quarters of schools claimed to offer 'Swift and Easy Access' – part of the core offer of extended schools which involves helping parents and children to access other support services when they experience difficulties. According to more than a thousand parents surveyed, 40 percent of their children had accessed such support in the previous school year, although this most commonly took the form of seeing a school nurse or doctor for health issues. Just two percent reporting seeing a social worker or social care professional through school (Wallace et al., 2009).

Social care professionals based in schools or children's centres appear for the most part to be family/pupil support workers or care officers, rather than qualified social workers (Wilkin et al., 2008). A survey of English local authorities between September 2006 and August 2007, which achieved a response rate of 38%, found that these workers were generally dealing with children, young people and families who were below the threshold for accessing specialist services, and the majority of their work focused on proactive, preventive interventions. The kind of support offered included anger management courses, mentoring, signposting to specialist services and family advice and support programmes. A key challenge was managing the high expectations from education colleagues about what could be achieved for some young people, and the timescales for doing so. Although the study concluded that locating social care professionals in extended school settings and children's centres is likely to be an effective way to increase prevention and early intervention services, significant challenges were also noted, especially in relation to different professional cultures (Wilkin et al., 2008).

In France, the *Programme de Réussite Educative* (PRE, Educational Success Programme) provides an interesting parallel to the operation of extended schools in England (Boddy et

al., 2009a). The PRE programme was established in 2005 and targets six to 16 year-old children in primary and secondary education who have been identified as showing signs of 'fragility' in their social behaviour, health, educational achievement or in cultural terms. Local areas bid for funds to provide multi-disciplinary teams (including teachers, pedagogues, psychologists, child psychiatrists, social workers, and representatives of healthcare services) who organise support for children and parents, provided outside of normal school hours. Like extended schools, a key objective of the PRE programme is to identify and support children with additional needs. A key difference, however, is that such work in France is generally undertaken by professionals with a high level of qualification. Many French schools employ specialist social workers (*assistante sociale scolaire*), and may also have a psychologist working in school one day a week (Boddy et al. 2009b). The routine presence of such expertise on-site in schools is currently exceptional in England.

The Common Assessment Framework (CAF) is intended to be a key tool in earlier identification of children with additional needs. An early evaluation studied CAF and Lead Professional (LP) activity in 12 areas chosen to trial these processes ahead of the national roll-out (Brandon et al., 2006). In these authorities, most CAF work was being undertaken by practitioners from the education and health sectors. Implementation had been slower than expected so the evaluation focused primarily on how CAF and LP working was being implemented, rather than assessing whether it was enabling earlier identification of children with additional needs. A more recent study, which analysed 280 completed CAF forms from four local authorities (White et al., 2008), also had little to say about whether the CAF was bringing children's needs to attention at an earlier stage, although the researchers were critical of the impact of CAF forms on the ability of child welfare professionals to 'tell a story' about the children and families they worked with. Like Brandon et al., they found considerable variation between and within local authorities in how the CAF was used, and by whom, concluding that there was little 'common' about it. In one authority, initial users were mainly schools, particularly referring children to educational psychologists and learning support services, whereas in another authority, the CAF had been introduced more widely. 'Considerable variability' in the extent to which CAFs were completed by staff in agencies other than social care was likewise reported in the third joint chief inspectors' report on arrangements to safeguard children. Most progress was being made in community health centres, schools and children's centres (Ofsted, 2008a).

Another study, although small-scale, also painted a fairly negative picture of CAF assessments (Gilligan and Manby, 2008). The researchers examined all CAF assessments undertaken by two pilot projects in a town in northern England over a six-month period. Despite initial enthusiasm from managers and practitioners, only 26 CAFs were completed by the two projects during this time. Practitioners appeared reluctant to complete the form if they knew that additional resources were unlikely to be available to support the needs uncovered. Also the children selected for CAF assessments were usually those whose behaviour caused agencies (typically schools) the most concern and who already had a relatively high level of problems, despite the intention that the CAF should be a tool to identify unmet need at an early stage.

However, more promising findings were reported in research investigating the use of an early version of the CAF in one local authority in England. All cases referred by external agencies to social services in this authority in the 12 months before the new tool was introduced were compared with all cases referred by agencies in the 12 months after the

pilot began. The common form was judged to have improved the amount and quality of information provided by referring agencies, and the study also found that the referral rate to social services dropped as other agencies decided they could meet the needs of families themselves or that no further action was needed. This suggests that other agencies were not only becoming more involved in the work of initial screening, but also providing services to children and families at the first and second levels of intervention. The researchers note that this may require some re-allocation of resources, or a common budget to which staff from other agencies can apply when identifying needs that can best be met without further referral (Ward and Peel, 2002). The issue of where costs fall is one that has to be taken into account in cost benefit analyses of earlier intervention.

3.5 Are the 'right' children being identified?

Using the terminology introduced in chapter 2, methods for earlier identification should have high sensitivity (not missing those who go on to develop problems) and high specificity (not leading to additional services being offered to many children who would not have developed problems anyway). As discussed earlier, area-based interventions (where services are open to all in the community) tend to have low specificity and sensitivity, since there is considerable variation within communities even if the area as a whole scores highly on deprivation indicators, and because many children in need live outside such areas. Area based initiatives can avoid services being stigmatising, but may result in those who are most in need of support having less access to services than those who are more able (and willing) to take advantage of provision. There is evidence that when support and services are targeted on an area basis rather than through individual referral, parents and children with a higher level of additional needs may be less likely to obtain support than those who are more advantaged. A widely reported finding from the first impact report of the Sure Start national evaluation was that Sure Start appeared to benefit the relatively less deprived living within the deprived areas where the programme operated, at the expense of more disadvantaged families (mothers who were teenagers when the child was born, lone parents and workless households). At the age of three, children in these families tended to do less well in Sure Start than in comparison areas (National Evaluation of Sure Start Team, 2005; Rutter, 2006), although in a subsequent report on the effects of fully established Sure Start local programmes on 3-year old children and their families, such disparity was not evident (Melhuish et al., 2008).

Usage of extended school provision, such as after-school activities and childcare services, has also been shown to be lower among parents of pupils eligible for free school meals and/or with only one or no parent in work (Wallace et al., 2009). Ofsted inspections have also reported that schools do not do enough to reach out to particularly vulnerable children and families (Ofsted, 2008b)

Assessing needs on an individual basis and targeting support at particular children and their families is likely to have greater specificity than area based approaches or those which rely on parents seeking help, but may also miss those in need of support who go on to develop problems. There is well documented evidence of the high thresholds for accessing family support provided by children's social care services, and of children 'slipping through the net' who go on to develop difficulties that could perhaps have been prevented with earlier support (e.g Macdonald and Williamson, 2002; Walker et al., 2007; Gugliani et al., 2008).

There is very little research to show whether services are provided to children with additional needs and their families when such support might *not* have been needed. Griggs et al. (2008) point out that very few policy evaluations have been assessed against a 'counterfactual', that is, 'an estimate of what would have happened had the policy intervention not been introduced.' At the level of identifying individuals, Sheppard (2008) examined outcomes at six months for 69 mothers who were referred, or referred themselves, for social work support from a single children's services department in England, and who received an initial assessment but were not given further intervention. Although these were indeed high need families, six months later the majority were found to have improved significantly without formal support (as measured by the level of children's behavioural and emotional difficulties and reported parenting problems). Most families in the study seemed to have found a way to ameliorate their problems and manage without formal support. A minority did not improve or actually deteriorated, but these cases were not clearly distinguished based on factors evident in the initial assessment. It had been predicted that mothers with a higher score on a measure of internal 'locus of control' would be more likely to improve than those who perceived events as outside their control, but this relationship was not upheld by the findings. It is suggested that the amount of informal support a family has access to may be a key factor in predicting those who are likely to improve their situations without additional help, and that eligibility criteria should take this into account, although no evidence is provided to show that this is more than speculation.

Evaluations of HomeStart, where trained volunteers visit and support families with young children who are experiencing difficulties, have also tended to show that families receiving such support do not improve more than control group families who do not receive additional help. In one such study (McAuley et al., 2004), outcomes for both groups had improved 12 months later. This could indicate that the services provided were not necessary as mothers would get better anyway, or that the services provided were not effective in achieving their aims. However, a third possibility is that the support was effective in helping families to cope better, but that these improvements were in the form of faster 'recovery' from their difficulties, and that this effect had washed out and was no longer evident when outcomes were measured twelve months later.

These findings contrast with those from evaluations of projects such as the extensive Springboard family support initiative in Ireland, where the evidence suggests that vulnerable families do not tend to experience 'spontaneous remission' in their problems, and that 'the option of "doing nothing" is often tantamount to permitting further deterioration in their well-being' (McKeown et al., 2001).

These somewhat disparate findings suggest the need to distinguish identification of additional needs based on 'crisis' from that based on chronic problems: families identified at crisis points will tend to get better (on the basis of regression to the mean) while no such process will operate for those with chronic problems, which are unlikely to change.

3.6 Summary

This chapter has examined different approaches to identifying when children may have additional needs, including risk assessment, referral from mainstream and universal services, and parents themselves identifying when they or their children need additional support. Overall, the evidence suggests that although aspects of the ECM agenda have

created the potential for earlier identification of need and greater multi-agency support, there is still a way to go to make this a reality.

There is a lack of research comparing the different approaches to identifying additional need. However with each approach there are issues that need to be considered, such as the potential for false positives and negatives, the possibility of area-based targeting widening the gap between the more and less disadvantaged, and the difficulty of reaching and providing acceptable forms of support to those who are least likely to access services. Earlier identification of need is neither as straightforward as it might first appear, nor necessarily a solution to preventing later difficulties, even when earlier identification leads to earlier provision of support and services. In the next chapter, we expand on the issues considered in chapter 2 in relation to intervening at an earlier stage, following identification of additional needs or in the expectation that they might arise.

4. Evidence on the effectiveness of interventions: is earlier always better?

As described in the introduction to this report, it was decided to focus the second part of the study on two broad types of additional need: children at risk of abuse or neglect, and children with emotional or mental health difficulties (including behavioural problems). This provided some parameters for limiting the literature searching, although in practice children's needs rarely fall neatly into separate categories and there was a degree of overlap in the literature in these two fields. It was also decided, again with the aid of the Expert Adviser group, that the review would focus on identifying findings that would illustrate and increase understanding of the issues involved in earlier intervention with children with additional needs, rather than attempt to review all potentially relevant literature on effectiveness in these two areas. This chapter thus expands on issues raised in Chapter 2, providing further examples from the research literature on the effectiveness of different types of intervention to prevent or address abuse/neglect or mental health difficulties in children. After discussing some of the difficulties involved in assessing effectiveness, the chapter presents selected examples of universal, targeted or indicated services and considers whether there are differential effects according to a child's level of need; duration and intensity of support; the effectiveness of structured (manualised) programmes compared to those that are adapted in the field; and the impact of timing of interventions (age, life stage, readiness to change). A final section briefly reviews evidence for the cost effectiveness of earlier intervention with children with additional needs.

4.1 Assessing 'what works'

A basic problem hindering the assessment of the efficacy of earlier interventions (before difficulties become severe) is that few of them have been systematically and rigorously evaluated, especially in 'real life' situations rather than as demonstration projects. Judgement of effectiveness will also be influenced by the timescale over which any impact is measured, since effects may either fade out over time (Wise et al., 2005), or conversely not show up until years later in the form of a 'sleeper' effect. For example, a programme for schoolchildren aiming to prevent problems such as depression arising might not be expected to show effects in the short-term, but some months or years later, when children experience challenging life situations (Possel, 2004). The progress of children and families who have additional needs is complex, with improvements and setbacks that may have more to do with other events in their lives than with the impact of a particular programme (Statham, 2000).

As discussed in chapter two, whether services are judged to 'work' also depends on what outcomes are valued, and the emphasis given to different kinds of evidence (Quinton, 2004; Beecham and Sinclair, 2007). Much of the American literature evaluating early intervention focuses on cognitive test scores. The fact that initial gains in such tests often fade out over time is seen as illustrating the failure of the interventions. Yet even if such interventions fail to make children more 'intelligent' in the longer term, they may be successful if they help children to get along better in the classroom, avoid stigmatising special education programmes, and have higher aspirations for their lives. Ultimately most interventions are aiming to improve the life chances of children in some way. This can be assessed by measuring particular outcomes in children directly, or changes in parents' behaviour – which it is hoped will translate over time into improved outcomes for children. Outcomes can also

be assessed in less direct ways, such as by changes in parents' attitudes, views or intentions. These may be precursors to behaviour change, but they are several steps further away from measurable outcomes in children, and may not be followed by any behaviour change in the parent. Not surprisingly, outcomes involving changes in children's or parents' behaviour tend to be more difficult to achieve than outcomes involving reported changes in attitudes or intentions (Ghate et al., 2008), so again, the particular outcomes chosen will affect the assessment of 'success'.

A particular difficulty for assessing the effectiveness of earlier, as opposed to early, intervention is that problems are often multi-faceted, and children may be at different points on the prevention spectrum in relation to different factors. There is also a tendency in many studies to conflate 'early in life' with 'early in the development of a problem', so that it is difficult to separate the effects of the two (Webster-Stratton and Taylor, 2001).

4.2 Levels of intervention

As discussed in chapter 2, there are various ways of classifying interventions according to the population they aim to reach, all of which can have a 'preventive' function – either preventing problems from occurring in the first place, or preventing them from getting worse. Whilst the prevention of problems through measures to improve the social, economic and political environments in which children and families live, and to reduce inequalities is clearly of great importance, and arguably a key factor in addressing additional needs (Morris and Barnes, 2008), this broader context was outside the parameters of this review.

Table 4.1 lists some examples of programmes addressing emotional problems or abuse/neglect that aim to intervene at different stages of 'additional needs': through a *universal preventive approach* focused on all children in a geographic area or class, through a *targeted or selective approach* aimed at children or young people at risk; and programmes involving *indicated* interventions provided when children are already experiencing problems.

Table 4.1 Examples of interventions provided at different levels

	Universal (preventive)	Targeted/selective	Indicated
Emotional/ mental health	Friends programme SEAL (wave 1) Webster-Stratton Dinosaur School	SEAL (waves 2 and 3)	Sallywags
Child abuse/ Neglect	Universal Triple P	Family Nurse Partnership	Triple P (levels 4 and 5)

Brief descriptions of these selected interventions are provided in boxes 4.1 to 4.6. Evidence from evaluations of these (and other) programmes is subsequently used to illustrate some of

the issues raised in chapter 2 concerning 'earlier' intervention for children with additional needs.

Box 4.1 Social and Emotional Aspects of Learning (SEAL)

The SEAL programme, which is now used in over three quarters of primary schools in England, is delivered in three 'waves of intervention'. The first centres on whole-school development work, designed to create a supportive ethos and climate within the school, for all children. The second wave of intervention delivery involves small group interventions for children thought to require additional support to develop their social and emotional skills. The final wave involves one-to-one interventions with children who have not benefited from the whole school and small group provision. This may include children at risk of or experiencing mental health issues.

The SEAL programme (Box 4.1) is an example of 'progressive universalism' in practice, where an initial whole-school approach is supplemented by additional support for those children who need it most. The first phase of whole-school development work was evaluated as part of the Behaviour and Attendance Pilot and was reported to have a positive impact on children's confidence, social and communication skills, relationships, behaviour and attitudes towards school (Hallam et al., 2006). Evaluation of the second wave, focused on children with additional needs, found mixed evidence of effectiveness: there were small but positive improvements in some of the outcomes measured but a deterioration in others. Evaluation of the one-to-one intervention programme is still ongoing. Although the SEAL evaluations do not permit a comparison of whether it is better to intervene earlier or later, they do suggest the need for different levels of intervention matched to a child's needs, with 'top-up' and further support available when earlier support is insufficient (Humphrey et al., 2008).

Box 4.2 Friends

The Friends programme is a universal prevention and early intervention project that can be used by schools and in clinical settings. It aims to build emotional resilience in order to prevent common mental health problems such as anxiety and depression in children by teaching them how to cope and manage anxiety, now and in the future. The programme involves 10 structured sessions plus two booster sessions, and is based on Cognitive Behavioural Therapy. It originates in Australia, where it has been widely tested and shown to be effective, and is based on a clinical programme (The Coping Cat) from the USA.

The Friends programme (Box 4.2) provides an example of all three mechanisms discussed in Chapter 2 as possible explanations for how earlier intervention might work: prevention, protection and treatment. Friends has been demonstrated in Australia to be effective in reducing anxiety and improving coping skills, compared to a control group, and this applied both to the whole group (*prevention*) and those who scored above the threshold for anxiety (*treatment*) (Barrett, Lowry-Webster and Turner, 1999). Improvements were maintained at follow up a year later (Lowry-Webster, Barrett and Lock, 2003), when nearly all (85%) of the children in the intervention group who had been above the threshold for anxiety or depression remained below the threshold (protection), compared to less than a third of the children in the control group. There was also evidence of the programme having a *protective* or *inoculating* effect, as children who had been in the intervention group were significantly less likely to be judged at high risk of emotional disorder after 36 months, than children in the control group. The FRIENDS programme has not been widely used in England, although its use is increasing. An initial evaluation of its delivery in three schools by trained school nurses to classes of 9 and 10-year-old children showed promising results, which were still

evident a year later, although no control group was measured for comparison purposes (Stallard et al., 2007; Stallard et al., 2008).

Box 4.3 Dinosaur School

A school-based version of the Webster-Stratton Incredible Years programme combines training for teachers in classroom management with a curriculum (Dinosaur School) for children aged 4 to 7 that is focused on developing social and emotional skills. It is delivered over 30 classroom lessons a year. Teachers follow lesson plans that cover key areas such as emotional literacy, learning school rules, anger management, communication skills and interpersonal problem-solving. The curriculum is delivered through 15-20 minute large group circle time followed by 20 minutes of small group activities. A wide range of supporting materials is provided, including life-size dinosaur puppets, videos, games and homework activities.

A randomised controlled trial in the USA of the Incredible Years Teacher Classroom Management and Child Social and Emotional Curriculum (Dinosaur School, see Box 4.3) compared whole classes in 'high risk' schools with classes in matched schools acting as a control group. Schools were selected on the basis of high rates of poverty. This was a relatively large-scale study (153 teachers and 1768 pupils took part), and outcome measures included classroom observation at the beginning and end of the school year by people who did not know whether the class was in the intervention or control group. Overall, the intervention teachers were found to use more positive classroom management techniques and their pupils showed more social competence and emotional self-regulation and fewer conduct problems than control teachers and pupils (Webster-Stratton et al., 2008).

Box 4.4 Triple P

The 'Triple P' Positive Parent Programme was developed by Sanders and colleagues in Australia as a multi-level approach to enhancing parental competence and preventing or treating inadequate or abusive parenting practice. It includes five intervention levels of increasing intensity and narrowing population reach. The first is a whole-population, public health approach (Universal Triple P) which involves providing information on positive parenting through a variety of media such as a website, local radio and newspapers, newsletters in schools and mass mailings to families. Levels 2 and 3 provide advice and information on 'normal' parenting problems through brief individual consultations or parenting seminars with large groups, supplemented by skills training for those parents who require it. The Level 4 programme, delivered either in Standard (individual) or Group format, is for indicated populations where children already have detectable problems, and Level 5 (Enhanced Triple P) is an augmentation of the standard programme, addressing additional issues such as communicating with a partner, managing moods and coping with stress.

An evaluation in the USA of the Triple P programme (Box 4.4) claimed to be the first study randomising geographical areas and showing that a population-based, public health approach to improving parenting practice could be effective in preventing child maltreatment (Prinz et al., 2009). Eighteen medium-sized counties in one American state were randomly assigned to either the Triple P system, which involved training the existing workforce and allowing sufficient time (two years) for them to deliver the preventive interventions to many families; or to a control group where services were provided as usual without implementation of the Triple P programme. Outcome measures were child welfare indicators at a population level (substantiated child maltreatment, child out-of-home placements and child

maltreatment injuries). Reductions were found in all of these compared to controls. However, the evaluation is not comparing the effectiveness of earlier (whole population) levels of intervention with later levels targeted at parents and children already experiencing difficulties. Instead, it is investigating whether the whole multi-level package can be shown to have a preventive impact on child maltreatment at the population level.

Box 4.5 Family Nurse Partnership

The Family Nurse Partnership (FNP) is an intensive, nurse-led home visiting service for vulnerable, first time, young parents. First developed in the USA, it involves regular structured home visits by specially trained health visitors or midwives from early pregnancy until the child is two years old. The programme aims to build a close, supportive relationship with the whole family and guide mothers to adopt healthier lifestyles, improve their parenting skills, and become self-sufficient. The programme is voluntary and has been taken up by 90 per cent of the families that have been offered it.

The Family Nurse Partnership programme, based on David Olds' work in the USA (Box 4.5), was introduced as part of the government's Social Exclusion Action Plan in September 2006, and is an example of an intervention targeted at an 'at risk' group. Early evidence from the initial ten pilot sites was promising in terms of acceptability and reach, with indications that the programme was successful in reaching the target group and was accessible to fathers as well as mothers (Barnes et al., 2008). The programme has since been extended to a further 20 sites.

Box 4.6 Scallywags

Scallywags is a secondary prevention programme developed in Cornwall for young children at risk of developing conduct disorder. The programme has been designed based on research evidence, and is an intensive multi-modal intervention lasting for six months, involving work with parents, teacher, child and peer groups. Children join a local scheme consisting of a team of three support workers each working with four children, supervised monthly by a senior support worker and/or a psychologist. Each child has an individualised programme, with a key support worker spending up to three hours at home and five hours at school with them each week. There is also a school holiday programme, advice for teachers, and parents' groups comprising 12 sessions of two hours led by senior staff with support staff running a crèche. The parenting materials are used on home visits if parents are reluctant to attend the groups. A maintenance programme is included, whereby the support worker contacts parents one and three months after participation. At six months post intervention, a home visit is made to review progress, and parents or schools can request further visits or telephone advice at any time after they have finished the programme

The Scallywags programme (Box 4.6), like the higher levels of Triple P, is designed to be offered when problems are already evident. Children are accepted onto the programme if an individualised assessment and pre-intervention test scores confirm parental and professional concern that they are at risk of family breakdown, social exclusion or educational failure as a consequence of significant emotional or behavioural factors. The intervention aims to include families who are described as 'hard to reach' or otherwise may be excluded from conventional parent-training programmes. An analysis of the progress of 80 children participating in Scallywags two to three years after completion of the programme (Frampton et al., 2008) found that it worked better for some children than for others, and identified

different trajectories depending in part on the child's level of initial need. These illustrate different ways in which early intervention may have an impact, for example as primary or secondary prevention or by reducing problems in the short but not the longer term. Children were measured on the Eyberg Child Behaviour Inventory (ECBI) before being placed on the programme, immediately after completing it, at six month follow up and two to three years later. They fell into four groups defined by the researchers as

- primary preventive (n=12): children who scored below clinical cut-off on the ECBI at initial pre-assessment, and remained below the cut-off at post-intervention follow-up and at longitudinal follow-up;
- secondary preventive (n=26): children who were above the clinical cut-off at the start of the study, improved significantly into the below clinical range post-intervention, and remained in this range in the longitudinal follow-up;
- relapsers (n=25): children who were above the clinical cut-off before intervention, improved significantly into the average clinical range after the intervention, but relapsed back into the clinical range at longitudinal follow-up;
- responders (n=17): children who were above the clinical cut-off at the start of the intervention and improved significantly during the intervention, but remained above the clinical cut-off for problem behaviours both after the intervention and at longitudinal follow-up

Those who did less well long term – the last two groups – were far more likely to have an autistic spectrum and/or hyperkinetic disorder reported by parents in the initial interview, and it is suggested that the programme could be augmented by routine screening of all referrals for such disorders, with additional input then offered to this group including relapse prevention measures.

The selected programmes described in the boxes above provide useful examples of interventions to address additional needs at different stages. However, they are limited in their ability to provide evidence to inform the original focus of this report: the *comparative* effectiveness of interventions provided at different stages in the development of a problem. We were able to identify many existing reviews that have already drawn together evidence from studies of effectiveness in relation to the two areas focused on in this report: preventing and treating child abuse (see for example Dufour and Chamberland, 2004; Zwi et al., 2007; Barlow et al, 2008; Macmillan et al., 2009; Reynolds et al., 2009; Barlow and Schrader-Macmillan, 2009); and preventing emotional and conduct problems in children (see for example Barnes and Freude-Lagevardi, 2002; Spence and Shortt, 2007; Tennant et al., 2007; Adi et al., 2007).

What we were *not* able to find were reviews that directly compare universal, targeted and indicated approaches to these problems. Some reviews consider the effectiveness of programmes of a particular type, such as universal, school-based interventions designed to prevent depression among children and adolescents (Spence and Shortt, 2007). This found little solid evidence for the effectiveness of such universal programmes, and concluded there was little justification for their widespread dissemination. Other reviews have focused on

indicated provision, for example a meta-analysis of 130 mental health programmes targeted at children and young people with early signs of maladjustment, aiming to intervene before full-blown disorders develop (Durlak and Wells, 1998). This concluded that on balance such programmes significantly reduced problems and increased competencies.

A number of reviews do consider interventions offered at different stages in the development of difficulties (universal, selective and indicated). Webster-Stratton and Taylor (2001), for example, report 'good evidence' that interventions at all of these stages can improve outcomes compared to control groups. However, no direct comparison is made of the effectiveness of earlier as compared to later interventions. Instead, the authors recommend '*a continuum of service from universal to selected to indicated prevention, as well as intervention for children with identifiable problems*' (p167).

Macleod and Nelson (2000) conducted a meta-analytic review of (American) programmes to promote 'family wellness' and prevent child maltreatment. They found a pattern whereby proactive interventions (offered before there were evident problems) had larger effect sizes at follow-up than immediately post intervention, while reactive interventions showed the opposite with larger effect sizes at post-intervention than at follow-up. The researchers conclude that there are 'strong indications' that gains made through proactive interventions are sustained and may even increase over time, whereas those made through reactive interventions tend to fade. However, they also acknowledge that the difference may be due to the difference in populations served, so that perhaps the 'high risk' participants of proactive interventions would not maltreat their children even without the intervention, whereas the participants of reactive interventions have already done so.

A review in the Lancet journal of interventions to prevent child maltreatment and associated impairment (Macmillan et al., 2009) addresses interventions aimed at prevention of maltreatment before it occurs (including both universal and targeted approaches), and prevention of recurrence and adverse outcomes associated with maltreatment. Similarly, a review focusing specifically on emotional maltreatment (Barlow and Schrader-Macmillan, 2009) also organises the evidence according to 'what works' to prevent child emotional maltreatment before it occurs, and to prevent its recurrence. Again, both reviews find examples of effective programmes at each stage, but make no comparison between the different approaches.

Two separate research reviews were commissioned by the National Institute for Health and Clinical Excellence (NICE) to inform the development of guidance for schools aimed at promoting good mental health among primary school children. One review addressed whole school approaches, the other targeted /indicated activities for children already at risk of or experiencing emotional problems. Although each provided evidence for the effectiveness of particular programmes, the combined overview report (NICE, 2007) concluded that there was insufficient evidence to make recommendations about whether universal, targeted or indicated approaches were more effective, or the appropriate balance between them.

4.3 Levels of need

Within any programme, there will be individuals with differing levels of need. It is possible that relevant information about the effectiveness of intervening earlier might be obtained by

considering any differential impact depending on severity of need *within* as well as between programmes. Among those children receiving a universal preventive, or a targeted or indicated service, do those with a higher level of need when they enter the programme do better or worse than those with lesser or no problems?

Symons and Feinstein (2008) have argued that little is known about the relationship between the effectiveness of interventions and existing levels of 'human capital'. They suggest that it is possible that focusing resources on those most in need may not be cost effective – in other words, although it improves their situation, it does so less than a similar investment for less disadvantaged children. Alternatively, the 'law of diminishing returns' may mean that those with the lowest levels of human capital may benefit most from public investment, as they have received little other support so have the most to gain.

We sought information to address this question. As before, the intention was not to review all the potential literature in this field, but to seek examples that might suggest avenues for further exploration.

A number of studies have found that it is the children and young people who experience a higher level of difficulties when entering an intervention who show the *most* benefits. The 'On Track' evaluation, for example, found that the children with the highest level of need showed the greatest improvement in peer relationships – they reported the largest decrease in peer problems, and gained the greatest number of new friends (having started with the smallest networks) (Ghate et al., 2008). However, this 'high need' group also received the highest intensity of service, so it is not clear whether the differentiated effect was because a higher 'dose' led to better results, or simply because the high need group had more room for improvement. In the evaluation of Youth Inclusion and Support Panels, it appeared that the higher the child's starting risk, the greater the likely level of risk reduction (Walker et al., 2007). Similarly in a study of preventive services for adolescents (Biehal, 2008), the young people with the most severe difficulties at referral showed the greatest improvement in scores on tests for child and family functioning six months on (although this could be because they were facing a crisis situation at referral and their difficulties eased when this was addressed. The young people who showed the least improvement were those living in families with chronic, long-term problems and little motivation to change).

Early findings from an ongoing evaluation of the UK Resilience Programme, a universal class-based intervention being tested with year 7 pupils in 22 secondary schools (Challen et al., 2009), showed a reduction in pupils' scores on measures of depression and anxiety compared to controls, with larger effect sizes for pupils with the worst initial scores for depression or anxiety. In universal intervention programmes, children with few problems often show little benefit (Webster-Stratton et al., 2008). For example, in an evaluation of the Incredible Years programme in schools (see Box 4.3), the improvements in children's social competence and emotional self-regulation was strongest in classes where pupils had the poorest initial scores, and this differential effect was replicated at the individual pupil level, with children with higher baseline conduct problems showing more improvement. This is perhaps not surprising, as programmes are generally not designed to benefit those with few or no problems

By contrast, other studies reporting a differential impact of interventions according to initial level of need have suggested that it is the more disadvantaged or needy children and

families who benefit the *least*. The national evaluation of Sure Start, as described earlier, found that the most disadvantaged children and families in Sure Start areas tended not to benefit from the programme (NESS, 2005). This could be because they were less likely to take up the services offered, however, rather than because they used the services but with fewer positive effects.

In a review of six intervention programmes for children at high risk of developing antisocial personality disorder, Utting, Monteiro and Ghate (2007) conclude that 'what little evidence exists suggests that within a 'treated' population, it is the most needy, challenging families and young people who are least helped by the programmes' (p84-5). Their review included three interventions delivered early in a child's life and provided at a relatively early stage of difficulties (two parenting programmes and the Family Nurse Partnership home-visiting programme); and three interventions designed for families of high-need children and young people (Multi-systemic Therapy, Multidimensional Treatment Foster Care and Functional Family Therapy). All six programmes were shown to be effective in achieving better outcomes. Both earlier and late intervention, using appropriate programmes, can therefore 'work'. However, the research evidence was not available to show whether, had the children and young people requiring the intensive specialist support programmes been offered help earlier, they would not have reached such a crisis point.

Statham and Holtermann (2004) in a small-scale study also found that among families offered packages of support services to prevent their children needing to be accommodated, those with the highest levels of need reported the least improvement in their situation. There is evidence that when problems, for example with mental health, are entrenched, they are often difficult to treat and unlikely to respond to brief interventions (Fonagy et al., 2002). Even moderately intense support, such as that offered by the Scallywags programme (see Box 4.4) was less successful with children with the most problems.

The common thread linking these apparently disparate findings is that intervention should match level of need. 'Light touch' interventions are unlikely to be effective for heavy end problems, nor intensive programmes targeted at specific difficulties for those without such problems. This issue of duration and intensity of support is considered next.

4.4 Duration and intensity of support

In general, longer duration, more intense (assessed by the number of visits) home visiting programmes have been shown to have better outcomes in terms of child maltreatment measures than shorter, less intense programmes, with effect sizes increasing as the length of the intervention increases. A meta-analysis by MacLeod and Nelson (2000) included programmes ranging from under six months to over 60 months duration, and offering from three to over 350 visits. The lowest effect sizes were associated with programmes of less than six months or with 12 or fewer visits. In another review, of 37 randomised controlled trials of parent training programmes for the treatment of children with conduct disorder (Dretzke and Frew, 2005), there was a trend towards more intensive interventions (e.g. longer contact hours, additional child involvement) being more effective, at least in the short term (measured up to four months post intervention).

Moran and colleagues (2004) draw conclusions which support the point made above about duration and intensity needing to be matched to level of need, rather than 'more' necessarily

being better. From their comprehensive review of evaluations of English-language parent support programmes, they conclude that longer, more intensive programmes are more appropriate for parents experiencing severe difficulties; while shorter, low-level interventions are more effective with parents experiencing less serious problems.

There is some evidence that a longer duration may be necessary to achieve changes in behaviour rather than in 'softer' outcomes such as attitudes, intentions and confidence. While improvements in the latter were commonly reported for those participating in the 'On Track' programme, changes in young people's actual behaviour were much less evident (Ghate et al., 2008). In an evaluation of Family Connections, a demonstration program in the USA specifically designed to prevent child neglect, a three-month version and a nine-month version both had a similar positive impact on risk and protective factors, but only the nine-month version led to greater improvements in child behavior (DePanfilis and Dubowitz, 2005). This also illustrates the impact of choice of outcome measure on assessment of cost effectiveness. In a subsequent economic analysis, the three-month version was judged more cost effective in enhancing protective factors and reducing the risk of child neglect, whilst the longer programme was more cost effective in reducing problematic child behaviour (DePanfilis and Dubowitz, 2008).

In terms of 'dosage', research into the Reading Recovery programme suggests that an intervention may need to be sufficiently intense to bring children up to a particular level in order to improve longer-term outcomes. The programme (Clay, 1985) identifies children in their first year of school showing early signs of failing to read, and provides them with an individually tailored intensive programme of half an hour's tuition every day, which finishes (usually after about 15 or 20 weeks) when the child is able to cope well with reading and writing and to work with the average group in the class. The point at which the Reading Recovery programme stops appears to be crucial, as once it has ended, reading level trajectories in intervened groups and normal groups remain parallel. That is, they do not converge or diverge over time, so unless the intervention children are brought up to the average level, they remain on a lower trajectory thereafter (Vellutino et al., 2004). It has, however, been demonstrated that children can be brought up to a normal reading level trajectory, and if this is achieved will remain on this trajectory. Not every child succeeds with Reading Recovery – there are, in intervention terms, some non-responders, but one further advantage of the earlier intervention is that the small number of 'resistant' children can be identified for more sustained and longer term remedial help. More recent research (Hurry and Sylva, 2007) suggests that while children's reading and writing skills are effectively remediated by early intervention schemes such as Reading Recovery, this is not sufficient in the longer term for the generally socially excluded population served, and that disadvantaging social factors continue to exert an influence – that is, the early gains do not 'inoculate' children from later problems.

Support offered by children's services to families experiencing difficulties is often time limited, sometimes deliberately so in order to avoid users becoming 'dependent' on the service (Statham et al., 2000; Aldgate and Bradley, 1999; Pinnock and Evans, 2008). But parents themselves would often like support to be available for longer, and it has been suggested that a low level of ongoing contact and the ability to re-access services when needed might help to avoid the 'revolving door' syndrome that characterises the relationship of many high need families with children's services (Thoburn et al., 2000). Targeted, time-limited interventions need to be part of a continuum of service provision, with the opportunity

for top ups and further support when needed. A general finding of many studies is that the positive effects of early interventions often 'fade out' over time (Anderson et al., 2005; Wise et al., 2005; London Economics, 2007).

4.5 A multiple focus

When children and their families have a relatively high level of additional needs, brief, single-focus interventions are unlikely to produce a significant or lasting effect. The research evidence suggests that a multi-faceted approach to supporting children with additional needs is likely to be the most effective. Webster-Stratton and Taylor (2007) reviewed different types of intervention (parent-focused, child-focused, classroom-focused and various combinations of these) to prevent young children going on to develop behavioural problems as adolescents. They concluded that there are effective examples of all of these, although interventions that address multiple risk factors (at home, school and within the child) seem to have the best results, and child-focused interventions need to be combined with parent or teacher training to achieve generalisable behavioural improvements. Considerable research has identified greater benefits for the children if the professionals systematically address issues beyond child management in parent training programmes, by focusing, for example, on aspects of functioning likely to disrupt parenting, such as marital difficulties, depression and social isolation. Parents experiencing these associated difficulties are also less likely to drop out of parent training when they are helped to deal with these other issues.

Evaluations of national intervention programmes in England have often come to a similar conclusion. Results from the qualitative aspects of the 'On Track' evaluation suggested that the ability to work in a cross-disciplinary way with families was an important factor in successfully meeting their needs, especially when both children and their parents were accessing services. The ability to produce simultaneous change in both parent and child was seen by workers as important for sustaining good outcomes (Ghate et al., 2008). Youth Inclusion and Support Panels were multi-agency structures that could access support for young people and their families from a range of agencies simultaneously, and this multi-faceted approach (with a key worker coordinating the support for each young person) emerged from the evaluation as the most important factor in enabling YISPs to deliver positive outcomes (Walker et al., 2007).

4.6 Responsive versus structured interventions

Beecham and Sinclair (2007), in their overview of findings from the Costs and Outcomes research programme, distinguish between 'specialist' preventive services – clearly defined types of support provided to individuals with particular characteristics – and 'responsive' preventive services, which aimed to respond to the felt needs of their recipients and often dealt with a wide range of needs. The more specialist services showed more promising results, at least within the timescale of the research, than did the responsive ones. Examples of effective services included in the overview were a project for young schoolchildren with behavioural difficulties (Supporting Parents on Children's Education, or SPOKES), which involved work with parents as well as children; and an intensive health visiting service (similar to the Family Nurse Partnership model) provided by specially trained health visitors. Both had a clear rationale, were delivered by staff with appropriate training, and were monitored to ensure that the programme was delivered as intended. The importance of 'programme fidelity' and well trained staff in leading to positive outcomes has

been noted in other evaluations, for example, in relation to the Webster-Stratton parenting programme in Wales (Hutchings et al., 2007), and commented upon by Rutter (2006). It is, however, easier to achieve such programme fidelity as part of a research study (the professional supervision for leaders in the Hutchings study was funded as part of the evaluation, as well as additional incentives for parents to continue with the programme), and may be harder to achieve in ordinary situations. It is uncertain whether the positive results would be replicated if the interventions were implemented more widely. The known impact of charismatic leaders and the high level of enthusiasm that new interventions often attract may be difficult to achieve and maintain when the intervention is rolled out on a larger scale.

Examples of 'responsive' services evaluated in the Costs and Outcomes research programme were Home Start, and therapeutic family support provided on a one-to-one basis by family support workers. These were not particularly effective in the terms set out by the researchers, although they were popular with their users and were relatively low cost services. Whilst earlier evaluations of Home Start in the 1980s and 1990s reported beneficial impacts for families, these studies did not include control groups. The evaluation included in the Costs and Outcomes research programme, on the other hand, did include a comparison group. It found that although Home Start families improved, so did the group not receiving Home Start support (McAuley et al., 2004). Another quasi-experimental evaluation of Home Start, which focused on the impact on parenting and the home environment of home visiting by community volunteers during or soon after pregnancy, also found few differences in outcomes between those receiving support and the comparison group (Barnes et al., 2006). In both cases however, parents liked the service offered and felt that it helped them.

In practice, the distinction between responsive and specialist services is not always clear-cut, and manualised interventions (where there are written protocols for delivering the service and all relevant materials are supplied by the programme designer) are often adapted in practice to fit local needs and circumstances (Rose et al., 2009). Interventions need to be clear about what they are aiming to achieve and the underpinning rationale for the work, but also flexible enough to respond to individual needs. The conclusion of a comprehensive review by the RAND Corporation of early interventions is that:

The evidence is strongest for targeted programmes that follow a clear protocol, but that address multiple issues rather than having a single focus, and can be varied according to individual need and professional judgement (Karlovy et al., 2005).

4.7 Timing of interventions

As discussed in chapter 2, there are a number of ways in which timing may be relevant to the notion of earlier intervention. These include the age of the child; and the existence of critical periods where intervention may be more effective, or potential participants more willing and able to change.

4.7.1 Age of the child

One difficulty in assessing the effectiveness of 'earlier' intervention is that it is often difficult to disentangle the influence of the age of a child from the level of difficulty or additional need that they are experiencing. 'Early in life' is often conflated with 'early in the development of problems', on the basis that the problems facing younger children have had less time to become entrenched, and that intervention in early childhood can 'nip problems in the bud'

(Webster-Stratton and Taylor, 2001). It has been argued that 'early problems may result in a synergistic cycle of cumulative events that increasingly compromise children's development over time' (Webster-Stratton and Taylor 2001, page 166). The rationale for interventions such as the Reading Recovery programme is that poor reading ability will contribute to the development of other problems. Children who fall behind in the key skills of literacy are subsequently likely to be disadvantaged in other aspects of education, and once they have fallen behind, the achievement gap is likely to widen (Bynner and Parsons, 1999).

Where studies have compared the effectiveness of an intervention according to the age of the children or young people participating, there does appear to be some evidence that younger children benefit more than older ones – although the actual age of the children concerned varies between studies. For example, the *On Track* programme had a greater impact on younger (primary school) than older (secondary school) children (Ghate et al., 2008). The Friends programme described above was found to be more effective with younger primary age children than with adolescent children (Lock and Barrett, 2003), and longer term follow up showed that the gains in younger children were still largely evident two and three years later (Barrett et al., 2006). Hawkins and colleagues' study (1999) of an intervention in US classrooms designed to reduce risky and antisocial behaviours among adolescents, found that it had considerably better outcomes for young people at age 18 if the intervention began in elementary school and continued to grade 6, than when it was provided later in grades 5 and 6 (although the design of this study means it is not possible to separate the impact of longer duration from the earlier start).

Younger children were also more likely to benefit from the 'Yes I Can' programme, another American school-based intervention delivered to whole classes with the aim of reducing aggressive behaviour (Metropolitan Area Child Study Research Group, 2002). 'Yes I Can' was offered as a two-year, whole-class intervention delivered over 40 lessons, with training and support for teachers and additional support for 'high-risk' children in the form of small-group peer training. The researchers compared the effects of starting the programme at different ages, and found that the most significant results occurred when it was offered early, and these effects were doubled when this was followed by an additional 'booster' 2-year intervention in grades 5 and 6. It was not effective in preventing aggression among older elementary school children, and in fact the additional small-group intervention for high-risk children actually worsened aggressive behaviour among the older children. The authors comment that other studies have also found similar adverse effects when aggressive, hostile children are brought together in small groups, unintentionally providing a kind of 'deviancy training', and illustrating the potential for negative outcomes from targeted interventions.

Data from a longitudinal study of children living in poverty in a North American city (Appleyard et al., 2005) showed that the presence of multiple risks in the early childhood period was particularly powerful in predicting adolescent behaviour outcomes, even after including the effects of risks in middle childhood. The researchers conclude that the results support the need for interventions to be provided early in children's lives (to help prevent the initiation of 'maladaptive pathways') and to be comprehensive (addressing the wide variety of risk factors). However, the data also supported a linear rather than a threshold model of cumulative risk. In other words, the likelihood of problematic outcomes increased as the number of risk factors increased, but there did not appear to be a sudden increase once a certain level of problems was experienced.. The researchers suggest this means that later interventions are also worthwhile, since '*there does not appear to be a point beyond which*

services for children are hopeless, and [...] every risk factor we can reduce matters' (Appleyard et al., 2005 p235).

4.7.2 Critical periods

The notion that 'it is never too late to act preventatively' is one of the principles underpinning the government's 'Think Family' report (Social Exclusion Task Force 2007, p32). The report also suggests that throughout life there are key moments of opportunity when families are likely to be more receptive to support, such as childbirth, starting school or moving into independent accommodation. The two studies referred to earlier as examples of structured interventions (a specialist health visitor service provided to new mothers and the SPOKES project) both fit this description, and both demonstrated positive outcomes for participants. The SPOKES intervention was offered to children with early signs of behavioural problems at the beginning of their primary school career (years one and two), and involved parents as well, showing them how to help with their child's reading. Parents appeared particularly willing to engage in such an intervention as their child had just started school, before any major educational problems emerged. Presenting the programme as being about reading, rather than their child's behavioural difficulties, also helped to avoid stigma.

A strong case has been made for the importance of providing parent education programmes during pregnancy and when babies are very young, because of accumulating evidence about the long-term consequences of maternal substance misuse during pregnancy, and of mothers' early interactions with their infants on brain development (Webster-Stratton and Taylor 2001; Shonkoff and Phillips 2000).

4.7.3 Readiness to change

The findings from a number of studies testify to the importance of willingness to change. Biehal, in a study of preventive services for adolescents with a high level of additional needs, found that the young people with the least successful outcomes tended to live in families where problems were long-term and entrenched, often including marital conflict, domestic violence and parental mental health problems. These families commonly had little motivation to change and to engage with services, and although they needed help the most, were the group least likely to benefit from support, whether this was offered by a specialist adolescent support team or by mainstream social workers (Biehal 2008). The evaluation of Youth Inclusion and Support Panels (Walker et al., 2007) identified parental support and the enthusiasm of the child for the activities offered as key factors in encouraging successful engagement with YISP interventions. The experience of YISP key workers was that children (and their parents) had to be motivated to benefit from early intervention services, and to acknowledge that they had difficulties. The evaluators highlighted the importance when planning early intervention programmes of assessing readiness to change, and suggest that resources should perhaps be focused where they have the maximum chance of making a difference in a child's life.

4.8 The cost-effectiveness of earlier intervention

A large number of studies have attempted to assess the cost-effectiveness of interventions to support vulnerable or disadvantaged children and their families, and there are several reviews (systematic and otherwise) which provide useful overviews of their findings (e.g. McKeown and Sweeney, 2001; Romeo et al., 2003; Papps and Dyson, 2004; Dretzke et al., 2005; Karoly et al., 2005; London Economics, 2007). Most conclude either that the data are

insufficient to permit robust conclusions, for example because of the lack of good evidence on effectiveness or the complexity of determining costs and outcomes when programmes consist of many different elements; or they report that a particular intervention does have the potential to save costs compared either to another intervention or to doing nothing. There is, however, very little research that directly addresses the issue of concern for this review: is it more cost effective to provide a larger number of the population with a relatively low-cost, earlier intervention, in the expectation of preventing later problems; or to wait until difficulties emerge in a smaller number and make sure that resources are spent where they may have most effect?

A conclusion of the Costs and Outcomes research initiative referred to earlier (Beecham and Sinclair, 2007) was that the savings expected to follow from earlier intervention may not be large, and will certainly take some time to show up. The researchers note that the possibility of savings depends on the following assumptions:

- it is possible to identify those who would otherwise go on to develop poor outcomes
- those who are identified will wish to take part in the intervention
- the intervention is effective, and
- the intervention will not result in many more families receiving a costly service who would otherwise not have 'done badly' if left unsupported.

Evidence relating to these assumptions has been reviewed earlier in this report, but does not provide a strong basis on which to make an assessment of the cost effectiveness of earlier as compared to later intervention. In general, targeted approaches tend to be judged more cost effective than universal approaches; and there is some evidence that within targeted programmes, such as The Nurse Family Partnership and the Webster-Stratton Incredible Years parenting programme, cost effectiveness is likely to be greater for the individuals with higher levels of need (Olds et al., 1997; Edwards et al., 2007). The RAND Corporation review of early childhood interventions (Karoly et al., 2005) concluded that the economic benefits are likely to be greater for programmes that effectively serve targeted, disadvantaged children than for programmes that serve lower risk children; and a cost benefit analysis of interventions with parents conducted for DCSF (London Economics, 2007) concluded that there appear to be greater benefits to participants from more targeted programmes, although the evidence is not robust. However, universal programmes have also produced positive outcomes, so it is possible that expanding the population receiving a service simply dilutes the positive effect. In this case, policy makers '*need to consider the trade-off between greater individual benefit from a more focused intervention against the smaller benefits from broader participation*' (London Economics 2007,p51).

The information that would inform such a trade-off, if considered in purely monetary terms, is largely lacking. Heckman and Masterov (2007) argue that interventions targeted on disadvantaged young children have higher returns (money saved compared to money spent) than later interventions, such as reduced pupil-teacher ratios, job training, convict rehabilitation programmes, tuition subsidies or expenditure on the police. This is based on the assumption that interventions during early childhood are more likely to have a sustained impact, and that early interventions which increase children's resilience and achievements are likely to improve their motivation and sense of their own capabilities – in other words, 'success breeds success'. Doyle and colleagues at the University College of Dublin (2007)

have argued that interventions when children are very young (including interventions with their mothers before birth) achieve the best returns, because research in neuroscience suggests that there are sensitive periods within the early years when there are 'windows of opportunity' for certain developments to take place. By investing early, the benefits are also enjoyed for longer, which increases the return to investment. However, it is also noted that although the literature generally argues that the earlier the better, concrete evidence about the optimal timing of intervention is lacking (Doyle et al., 2007 page 4).

Symons and Feinstein (2008) have used data from the National Child Development Study to assess the optimum age for childhood interventions to produce the best returns on investment, and conclude that earlier in a child's school career is more cost effective since this has more impact on educational attainment. However, none of these analyses directly address the issue of whether identifying and meeting additional needs at an earlier stage for a relatively large number of children is more cost effective than intervening with a much smaller number of children only once problems are very evident.

In general, the less targeted an intervention, the greater the scale and hence also the costs. For example, an intervention targeted on specific 'at risk' individuals, such as the Family Nurse Partnership, costs relatively little (£30 million was allocated to develop the scheme over three years in 20 sites) compared to a national programme targeted on families living in disadvantaged areas, such as Sure Start, which had a budget of over £1.5 billion by 2005-06, before it was incorporated into a policy of developing children's centres in all communities. The cost of universal provision, such as part-time education for all three and four year olds, is higher still. Yet there is little comparative evidence to determine which approach might be most 'cost effective'. The evidence presented in this chapter has suggested that it is unlikely to be a question of 'either/or'. What is needed is a range of interventions able to provide support at different levels of need.

It is also the case that there are other criteria in addition to cost effectiveness that might inform policy on identifying and supporting children with additional needs. Symons and Feinstein (2008) distinguish between two different goals for public policy – maximising average achievement in the population (efficiency), and reducing the disadvantage of those whose family background and personal circumstances put them at risk of the worst outcomes (equity). Alternative rationales for providing services include promoting equity and social justice, a universal entitlement to support, and avoiding stigma and social exclusion.

5. Conclusions

5.1 The value of early intervention

This study set out to contribute to the debate about earlier identification and support for children with additional needs. The concept of early intervention lies at the heart of the *Every Child Matters* agenda and subsequent government policies for children and young people, and is the subject of a forthcoming report by the Department for Children, Schools and Families (DCSF, 2010). In this report, we have argued that there is a need to think more deeply about what is meant by ‘early’ and ‘earlier’ intervention, and how evidence about the effectiveness of such interventions should be interpreted and assessed.

This is not to suggest that early intervention is a waste of time or money. On the contrary, there are many projects and programmes that provide support to children and families who are at an early stage of experiencing difficulties, or are likely to experience problems without additional help, and which have been shown to improve outcomes. In addition to the specific examples provided in the previous chapter (such as the Friends programme, Nurse-Family Partnership, Webster-Stratton Incredible Years and Triple P), they include early childhood care and education services (Karoly et al., 2005), parent training (Barlow and Parsons, 2003), and some school-based interventions to promote children’s emotional well being (Pugh and Statham, 2006).

Early intervention on its own, however, is unlikely to be sufficient to improve longer-term outcomes for vulnerable children and families. This study has highlighted a number of issues that need to be recognised and understood in order properly to evaluate the evidence on the impact of interventions in general, and ‘earlier’ intervention in particular.

5.2 Comparing earlier with later intervention

A number of different models and rationales for intervening earlier rather than later have been explored. For example, earlier intervention can be preventative (stopping problems from developing), or protective and innoculatory (protecting those with risk factors against developing problems later on), or it can be remedial or therapeutic (improving the situation for those in the early stages of problems). There are also instances where earlier intervention acts as a screening for those who will need more sustained or intensive interventions later. Interventions can be universal (offered to all), targeted (offered to those at risk of developing problems) or indicated (offered when problems have already begun to emerge). Earlier interventions are more likely to be larger-scale than later, more targeted interventions. This reflects the fact that ascertainment on the basis of risk factors is inexact and imprecise, and many, if not the majority, of those with risk factors will not go on to develop later problems, while some without the risk factor will do so. As well as resource implications, this also raises ethical issues relating to the labelling of children and families as at risk, and the potential stigma of such identification. As others have also pointed out, some preventative interventions are intrusive and potentially harmful, and should be used with care given the large number of children who do not develop problems despite having the early signs (Dartington Social Research Unit, 2004).

The theoretical proposition, and strong assumption, behind the concept of earlier intervention is that by intervening before problems have formed, either with ‘at risk’ groups or

those in the early stages of difficulties, the situation can be ameliorated and problems either avoided or improved without becoming serious. As was discussed in Chapter 2, this raises issues at a number of levels, and is not easily testable in the simple sense of being able to compare an earlier intervention with a comparable later intervention. There are a number of reasons why it is not practical or ethical to withhold available interventions from some of those identified as at risk, while providing it for others in the same situation. One circumstance which could provide an opportunity to do this, is random allocation as a fair means of rationing scarce resources, as was done with places for a model day care facility (Toroyan et al., 2000).

One relevant issue is definitional: how are 'additional needs' defined before problems are evident, and on what basis is this done? It implies the existence of reliable indicators of those at risk of developing problems, and accurate means of ascertaining the population at risk, avoiding (as far as possible) false positives and false negatives. The evidence, however, suggests that identification of 'real' or proximal risk factors (those most likely to have a negative impact on individual children) is quite poor, as opposed to identifying statistical risk factors that affect certain groups as a whole. It is notable that some well established and important risk factors are rarely targeted by interventions. For example, there are relatively few interventions focussed on relationship support, or on reducing parenting stress (*Mellow Parenting* is an exception), despite the fact that disharmonious relationships and parenting stress are known to be important factors in relation to child outcomes.

It could be concluded that a shift towards identification of additional need based on proximal or 'causal' risk factors would improve the situation, since these would be based on a better understanding of the mechanisms underlying poor outcomes for children. However, this would be difficult and expensive to achieve in practice, while the more commonly used 'proxies' (statistical indicators such as income level, family status or poor environment) are relatively easy and inexpensive to measure. It is worth considering, however, whether the additional resources expended in improving ascertainment might be recouped in the savings from more efficient identification of those really at risk of poor outcomes. There is little research evidence to address this point.

5.3 Implications for policy and practice

The overall message from the research reviewed is that it is inappropriate to view earlier intervention as an alternative to later intervention, when difficulties have become established. The problems in many, if not most, situations where children have additional needs, are multi factorial and may persist and transfer down generations. It is unrealistic to believe that they can be easily resolved simply by being identified at an early stage. Many children and families are likely to need continuing support, and interventions at a number of points. Rather than conceptualising earlier intervention as an alternative to later intervention, a better model would be a continuum of graduated interventions that are appropriate at different stages in the life course of problems, with the key issue being to identify the most appropriate intervention to match specific needs at a particular point. Some children and families may need repeated support, while others may have their life/problem trajectories sufficiently changed by an 'earlier' intervention to not require later interventions. Other children with problems will not, or cannot, be identified early for a number of reasons, including the fact that the predictors are unlikely ever to be good enough to predict all cases.

Some children will only be identified once their problems are established, and hence are likely to need more intensive support.

This conclusion that a continuum of services is required, resonates with the assessment of other commentators on earlier intervention. Brookes-Gunn (2002), for example, argues that to expect the benefits of early intervention programmes to persist in disadvantaged or stressed populations without attention to what is needed after early childhood is to engage in 'magical thinking'. Leventhal (2000) notes that whilst it is encouraging that some studies demonstrate that families can be helped by home visiting, and the positive effects sustained over years, home visiting – like other early interventions – is not a 'magic bullet'. The need for interventions to be available at a range of levels is well summed up by Michael Little (1999)

Prevention is no more an alternative to early intervention than early intervention is to treatment or social intervention. It is the combination of these activities that can make a difference to children's lives' (p314)

Whilst not covered within the remit of this scoping study, it appears likely that interventions to address additional needs at an individual or family level will have only a limited or short term impact in improving outcomes, however 'early' they are offered, if they are not accompanied by longer term action to address wider societal factors such as poverty and inequality. Analysis of comparable data across developed societies has shown that those with higher levels of income inequality have higher levels of a wide range of social and health problems, and it has been suggested that this is due to the impact of inequality (mediated through increased stress) rather than the impact of low income *per se* (Wilkinson and Pickett, 2009).

Although such findings suggest the need for major structural changes to improve outcomes for children and families with additional needs, there are a number of other areas where the situation could perhaps be modestly improved without major changes. For example, there is some evidence that many professionals and para-professionals who are in regular contact with children – such as those working in schools and early years settings – need better preparation to enable them to identify when children need extra help or are at risk of harm, and to have confidence to act on their concerns. Health visitors and midwives also have a crucial role to play in early identification of need, and in referring children and families for appropriate support, and their remit and caseloads need to ensure that they are able to carry out this function. The potential of universal services to further marginalise those who are already disadvantaged, because they are less able or willing to take advantage of the provision offered, needs to be countered by effective outreach strategies, and serious attention paid to finding out what kinds of support and help such families would value and use. Interventions that directly attempt to reduce parental stress, or to address relationship problems, could have positive benefits for children by dealing with the immediate factors that often contribute to poor parenting.

5.4 Directions for future research

As Pithouse (2008) has noted, 'there are pervasive ethical, treatment and economic arguments for intervening early, yet...there remain fundamental difficulties in identifying **who** does **what**, **when** [and] **with whom**' (p1538, our emphasis).

In relation to the **'what'**, there is a need for research, using a range of methodologies, to tell us more about the mechanisms of intervention – what are the active ingredients of a programme that is effective for most of the participants? In-depth qualitative work is needed to understand the processes and aspects of service delivery that are associated with better outcomes for children and families. Research is needed which takes account of the situations in which services are provided and the context in which people live their lives. It will be important to consider factors outside the content of the programme or intervention that may make a difference, such as the quality of the relationship between service providers and service users, or the characteristics of individuals (such as resilience, coping mechanisms, help-seeking behaviour) that make them more or less ready and able to change.

This also relates to the **'when'** of intervention. Whilst it would be difficult, but not impossible, to design a research project directly comparing earlier with later intervention, it would be useful to investigate whether support is more likely to achieve positive outcomes if it is offered at particular times or stages in the life course when individuals may be more open to change – for example, support to the birth family when a child first enters care, or parenting programmes provided when a child first starts school or transfers to secondary school. The optimum timing of interventions was one of the areas explored in this review, but we could find very little research evidence to inform this question.

Research on behaviour change in relation to adult obesity and behaviours such as smoking has developed theoretical models of the 'stages of change', that predict which adults are likely to benefit from interventions to support their intended behavioural change, and at what point (Prochaska and DiClemente, 1992). Although there is little hard evidence that interventions based on the stages-of-change approach are more effective than other approaches (Riesma et al., 2002), it would be useful to test the applicability of similar constructs to earlier interventions with families and children with additional needs, aiming to help practitioners to identify the best times to offer and engage families in services.

In relation to **who** delivers early intervention, further research could usefully examine the composition of the children's workforce, especially the skills and qualifications needed to identify when children have additional needs and to act on this. A number of reviews, including Daniel (2009) have noted the absence of rigorous studies into the role of schools and teachers in recognizing early signs of neglect. Given the increasing emphasis on the role of schools in identification of need and early intervention, this would appear to be a fruitful topic for future research. It would be valuable to compare different methods of providing children and families with easier access to social work support, and to investigate the ways in which other professionals, such as housing officers, can be involved in earlier identification of children with additional needs.

An early intervention research agenda could benefit from a cross-national comparative element, to learn from experience in other countries. As described in Chapter 3, the routine presence of professionals such as psychologists and social workers in schools is much more common in some European countries than in England, and their role in both identifying and meeting additional needs within a universal community setting could provide helpful pointers for the delivery of extended services within schools in England.

Turning to the question of **'with whom'** early intervention activities engage, this is an area requiring substantial additional work. A recurrent theme in many studies is that those families who most need support may be least likely to access it, and more likely to drop out if they do. Successful development of earlier intervention would be strengthened by a stronger evidence base on what promotes parental access and engagement with services. Much of the available evidence takes the form of practice guidance, based on 'common sense' and anecdote, or small descriptive studies of selected groups of parents or practitioners. Future research topics could include:

- Comparing the effectiveness of different methods of engaging with parents, especially those whom services often fail to reach;
- Effective ways for services to engage with families' informal support networks to offer sustained help to the most vulnerable parents. Some studies have suggested that those parents who are most in need prefer to approach trusted adults rather than professionals;
- An analysis of parental motivation and help-seeking behavior. Why do parents experiencing difficulties decide to engage with support services, or decline to do so?
- Further research with both children and parents to ascertain their views on the types of services and support that they themselves would find most helpful.

Most existing research has focused on the views and experiences of parents, children and young people who *do* access services, rather than those who do not. The latter are admittedly a much harder sample to identify and engage, but are also the group where the most serious problems are likely to become apparent, and research involving non-users would be particularly valuable.

Even 'effective' interventions do not impact equally on all participants. Some of the most well known and widely used programmes, such as the Webster-Stratton parenting programme, have significant drop out rates, and will only impact positively on a proportion of the parents attending. Research could be commissioned to look at existing programmes, focusing on questions such as:

- which sort of programmes work for which families, and at what point/stage in their lives?
- how acceptable is the intervention to the intended population?
- does better matching of an intervention to the family reduce dropout and attrition, and increase the acceptability of programmes to those invited to take part in them?

Longitudinal research following up participants in interventions to see if immediate impacts continue, wash out or even reverse, would provide useful information on the longer-term effectiveness of early intervention, although such studies require substantial resources.

There is no lack of research describing a wide range of early interventions for children with additional needs. In this review, we presented selected examples from two specific areas of

need – children’s mental wellbeing, and emotional abuse/neglect – in order to illustrate a number of issues raised by the concept of ‘earlier intervention’. Studies commissioned within a future research agenda will need to take account of these issues, including participants’ perspectives on the services offered (as a support or intervention?); the extent of ‘false positives and negatives’ when identifying children and families on the basis of statistical risk factors; the optimum timing of interventions; and the inter-related chains of events through which factors such as poverty can exert an impact on outcomes for children.

Early intervention deserves its status as a key plank in government policy, but as many commentators have pointed out it is not a panacea. A critical awareness of the issues surrounding the concept of ‘earlier intervention’, and a research agenda informed by these issues, will hopefully clarify the place of early intervention among the continuum of services needed by children and their families.

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