Q1 How effective are interventions in the early years in reducing health inequalities?

There is a multitude of interventions applicable to the early years. There are also clear indications of economic benefits through investment in well-selected, well-designed and well-implemented interventions in the early years, and specifically for disadvantaged children. However, these interventions vary enormously in relation to:

- the outcomes they seek to improve
- the robustness of the evidence proving their ability to produce desired outcomes
- their potential to produce meaningful impacts on health inequalities

Some of the outcome areas with the greatest potential to produce meaningful impact on health inequalities involve:

- the alleviation of poverty
- the promotion of breast-feeding
- reducing the incidence of genetic abnormalities
- increasing access to maternity services to support healthy pregnancies and safe deliveries
- reducing exposure to the harmful effects of alcohol, drugs and tobacco (both ante-natally and post-natally)
- ensuring pregnant women and young children receive healthy diets and vitamin supplements
- reducing teenage pregnancy rates
- reducing the incidence of child abuse and neglect
- limiting children’s exposure to trauma and violence
- reducing caregiver stress and improving parental mental health and wellbeing
- identifying high risk groups of children at an early stage
- providing high-quality day-care and education for young children
- strengthening parents’ and care-givers’ capacity to provide secure attachment and nurturing experiences
- promoting children’s social and emotional capabilities

In relation to the last three of these, there is a limited number of interventions with robust evidence of effectiveness in terms of improving outcomes for young children. They include:

- targeted home visiting interventions beginning in the antenatal period and lasting well into infancy or toddlerhood – particularly the intensive Family Nurse Partnership programme
- high quality pre-school education that places equal emphasis on children’s social and emotional development and academic skills
- social-learning theory –based, group-delivered parenting programmes e.g. Incredible Years and Triple P

Each of these has its own well-developed scientifically-sound evidence-base.²,³,⁴ As such, when delivered as intended by the developers, each has a proven track record of consistently being able to deliver positive outcomes for children and their families. They can also demonstrate specific ability to do so cost-effectively. These interventions can also all demonstrate effectiveness in reducing health inequalities. Ideally of course, they would be delivered within an over-arching system of well-resourced primary care, particularly health-visiting.

Q5 Are there any specific initiatives or research evidence from Scotland, UK or internationally that you wish to highlight to the Health and Sports Committee.

The following Initiatives, aimed at producing positive developmental outcomes and reducing health inequalities through early years’ interventions, are currently underway within NHS Education for Scotland (NES).

1) The Psychology of Parenting Project

In 2012, in line with commitments in the Parenting Strategy and Mental Health Strategy, the Early Years Taskforce and Mental Health Division approved the roll-out of the Psychology of Parenting Plan (PoPP). This initiative is geared at developing workforce and organisational capacity to deliver the two most robustly-evienced parenting programmes, for parents who have 3 and 4 year old children with elevated levels of behaviour problems (approximately 9000 children in Scotland). The selected programmes are the Incredible Years and Level 4 Group Triple P. When properly delivered, an extensive evidence-based literature backs the ability of these programmes to re-direct the hazardous developmental trajectories of about two-thirds of these children. By adopting these strongly evidence-based programmes, we can therefore have confidence that positive outcomes can actually be achieved. PoPP holds particular promise in terms of reducing health inequalities because

i. A disproportionate number of young children with behavioural difficulties live in disadvantaged homes and neighbourhoods.

ii. Early onset behaviour problems are associated with several sub-optimal parenting practices and these are more prevalent in disadvantaged families.⁵

iii. Relative to other interventions, the Incredible Years and Level 4 Group Triple P are backed by decades-worth of the highest quality of effectiveness research, including trials conducted in real-life service settings within Great Britain.⁶
iv. Early-onset behavioural difficulties have a high level of continuity into adolescence and adulthood and are associated with a broad range of poor outcomes. For example, by the time they are in their mid-twenties, the 5 per cent of people who suffered from severe behavioural problems in childhood are nineteen times more likely than those with no such problems to have served a prison sentence, six times more likely to suffer from anti-social personality disorder and three times more likely to have attempted suicide. By interrupting this common escalating cycle at an early stage, there is less risk that initial disadvantages will be compounded by other adversities typically encountered by children and young people from disadvantaged backgrounds as they progress down more risk-laden developmental pathways.

v. 5) The programmes have been evaluated to be cost-effective. The average cost of bringing a child with conduct disorder below a clinical threshold as a result of a parenting programme of this nature, is around £1,750 per case. By comparison, the lifetime costs of conduct disorder are modestly estimated to be in the region of £175,000 per case. A mere 1% reduction in those lifetime costs is therefore all that is required to make the intervention cost effective. Bearing in mind that the programmes are capable of moving two thirds of children whose parents receive the intervention out of the clinical range, some impressive savings are waiting to be made.

vi. The effectiveness of these parenting programmes is much the same across a wide range of family types and ethnic groups. The programmes are also at least as effective for children with the most severe behavioural problems as for those with more moderate difficulties. The Incredible Years, in particular, has specifically been shown to be at least as effective with parents from disadvantaged backgrounds, as with those from more advantaged backgrounds. It also has a strong proven track record of reaching disadvantaged parents.

vii. Long-term, by providing children with positive templates to guide their management of future relationships, these programmes also offer hope of impacting on trans-generational cycles of health inequalities as the children currently being helped are more likely to use similar positive parenting practices when they themselves become parents.

The PoPP team is currently working in partnership with four Community Planning Partnerships and another ten have expressed interest in adopting the model. To date, over 150 practitioners have been fully trained in one of these programmes, and approximately 60 groups have already been delivered or are currently being delivered, with a high level of fidelity. Early indications from the outcome data that are being collected is encouraging.
2) The Solihull Approach
There is much interest in training the early years workforce in infant mental health in order to promote the wider use of practices that support the development of secure attachments between babies, toddlers and young children and their parents/caregivers. The Solihull Approach provides a framework for a wide range of child care professionals to think reflectively about their work in relation to attachment with families, and has some preliminary evidence to suggest that it’s use can promote improved outcomes.

With support from the Early Years Taskforce, NES has initiated a roll-out of the cascade training model that can be used to build capacity in this Approach. The intention is to extend the reach of training in this Approach to around 500 members of the multi-agency, early years’ workforce by Spring 2015.

3) The Family Nurse Partnership
We understand that other colleagues will be writing to you separately about this.

Q2. What are your views on current early years policy in Scotland in terms of addressing health inequalities through interventions in the early years?
The strong policy focus on the importance of strengthening our capacity to improve outcomes in the early years has much to commend it. Its effectiveness could be enhanced in relation to addressing health inequalities by focusing more activity on the early identification of those children most at risk of poor outcomes and by promoting the use of scientifically-proven interventions. The Early Years Collaborative is the ideal vehicle to take this forward. Having promoted the use of a common improvement methodology, it now needs to focus on operationalising its stretch aims and integrating evidence-based practices into the activities it is promoting.

Q3. What role can the health service play in addressing health inequalities through interventions in the early years?
Particularly because of its universal access systems, very many members of the Heath Service workforce can contribute to improving health inequalities by delivering strength-based, non judgemental healthcare to all patients and their families. Midwifes and Health Visitors also have key roles to play in the early identification of children who would derive most benefit from effective early interventions and in providing relationship-based care to all families with babies and young children.
The health service should also acknowledge the public health importance of addressing conduct problems in childhood and, in particular, promote the adoption of the relevant SIGN guideline.

Q4. What barriers and challenges do early years’ services face when working to reduce health inequalities?
The current health visiting workforce does not have sufficient capacity to successfully manage the early identification of vulnerable children and support for families from disadvantaged backgrounds.
A silo-mentality, particularly around funding streams, frequently inhibits the capacity for services to work collaboratively on co-delivering interventions that have capacity to reduce health inequalities.

There is, as yet, not sufficient recognition of the value of adopting evidence-based interventions, and facilitating this culture shift by grasping the nettle of stopping doing some things in order to undertake other more effective interventions.

There are major challenges in terms of training the workforce to deliver high quality interventions to address health inequalities. By way of illustration, the effectiveness of parenting programmes is reduced by half or more if they are poorly implemented, e.g. by employing staff who are not properly trained or supervised.

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References


