

# Social and emotional wellbeing: early years

Public health guideline

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## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS37 and QS128.

## Overview

This guideline covers supporting the social and emotional wellbeing of vulnerable children under 5 through home visiting, childcare and early education. It aims to optimise care for young children who need extra support because they have or are at risk of social or emotional problems.

NICE has also produced guidelines on [social and emotional wellbeing in primary education](#) and [social and emotional wellbeing in secondary education](#).

## *Who is it for?*

- Commissioners and practitioners
- Members of the public

## Introduction: scope and purpose of this guidance

### *What is this guidance about?*

This guidance aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The recommendations cover:

- strategy, commissioning and review
- identifying vulnerable children and assessing their needs
- ante- and postnatal home visiting for vulnerable children and their families
- early education and childcare
- delivering services.

This guidance does not cover the clinical treatment of emotional and behavioural difficulties or mental health conditions, or the role of child protection services. (For related NICE guidance, see [section 7](#).)

### *Who is this guidance for?*

The guidance is for all those responsible for ensuring the social and emotional wellbeing of children aged under 5 years. This includes those planning and commissioning children's services in local authorities (including education), the NHS, and the community, voluntary and private sectors. It also includes: GPs, health visitors, midwives, psychologists and other health practitioners, social workers, teachers and those working in all early years settings (including childminders and those working in children's centres and nurseries).

The guidance may also be of interest to parents, other family members and the general public.

### *Why is this guidance being produced?*

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce this guidance.

The guidance should be implemented alongside other guidance and regulations (for more details see sections [4](#) and [7](#) on implementation and related NICE guidance respectively).

## *How was this guidance developed?*

The recommendations are based on the best available evidence. They were developed by the Public Health Interventions Advisory Committee (PHIAC). Members of PHIAC are listed in [appendix A](#).

The guidance was developed using the NICE public health intervention process. See [appendix B](#) for details.

Supporting documents used to prepare this document are listed in [appendix E](#).

## *What evidence is the guidance based on?*

The evidence that PHIAC considered included: 2 reviews of the evidence on effectiveness, a review of risk factors, economic modelling, the testimony of expert witnesses and commissioned reports. Further detail on the evidence is given in the considerations section ([section 3](#)) and appendices [B](#) and [C](#).

In some cases, the evidence was insufficient and PHIAC has made recommendations for future research.

More details of the evidence on which the guidance is based, and NICE's process for developing public health guidance, are on the [NICE website](#).

## *Status of this guidance*

The guidance complements, but does not replace, NICE guidance on: child maltreatment; pregnancy and complex social factors; antenatal and postnatal mental health; mental health disorders in children; looked-after children and young people; and the social and emotional wellbeing of children and young people (for further details, see [section 7](#)).



## 1 Recommendations

The evidence statements underpinning the recommendations are listed in [appendix C](#).

The Public Health Interventions Advisory Committee (PHIAC) considers that the recommended interventions are cost effective.

For the research recommendations and gaps in research, see [section 5](#) and [appendix D](#) respectively.

The evidence reviews, supporting evidence statements and economic modelling report are available at the [NICE website](#).

### *Background: social and emotional development*

A complex range of factors have an impact on social and emotional development. Knowledge of these factors may help encourage investment at a population level in early interventions to support health and wellbeing. This would ensure children (and families) who are most likely to experience the poorest outcomes get the help they need early on in their lives.

Knowledge of these factors, aside, practitioners' experience and expertise will be paramount in assessing the needs and risks of individual children and their families.

### *Home visiting, early education and childcare*

The recommendations cover home visiting, early education and childcare for [vulnerable children](#).

The recommendations:

- Adopt a 'life course perspective', recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing.
- Focus on the [social and emotional wellbeing](#) of vulnerable children as the foundation for their healthy development and to offset the risks relating to disadvantage. This is in line with the overarching goal of children's services, that is, to ensure all children have the best start in life.
- Aim to ensure [universal](#), as well as more [targeted](#) services, provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing. (Key services include maternity, child health, social care, early education and family welfare.)
- Should be used in conjunction with local [child safeguarding](#) policies.

The term 'vulnerable' is used to describe children who are at risk of, or who are already experiencing, social and emotional problems and who need additional support. See [vulnerable children](#) in the glossary for factors likely to increase the risk of problems.

### *Whose health will benefit?*

Vulnerable children aged under 5 years and their parents.

### *Recommendation 1 Strategy, commissioning and review*

#### **Who should take action?**

All those responsible for planning and commissioning (including joint commissioning) services for children aged under 5 in local authorities, the NHS (primary, secondary and tertiary healthcare) and the voluntary, community and private sectors. This includes:

- Clinical commissioning groups.
- Health and wellbeing boards.
- NHS Commissioning Board (up to 2015)<sup>[1]</sup>.
- Public health, children's services, education and social services within local authorities.

#### **What action should they take?**

- Health and wellbeing boards should ensure the social and emotional wellbeing of vulnerable children features in the 'Health and wellbeing strategy', as one of the most effective ways of addressing health inequalities. The resulting plan should include outcomes to ensure healthy child development and '[readiness for school](#)' and to prevent mental health and behavioural problems. (See the Department of Health's [Public health outcomes framework indicators](#) for early years.)
- Directors of public health, directors of children's services and commissioners of maternity care should ensure the social and emotional wellbeing of under-5s is assessed as part of the [joint strategic needs assessment](#). This includes vulnerable children and their families. Population-based models (such as [PREview](#), a set of planning tools published by the Child and Maternity Health Observatory) should be considered as a way of determining need and ensuring resources and services are effectively distributed.

- Health and wellbeing boards should ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers. The aim is to ensure:
  - vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services
  - targeted, evidence-based and structured interventions (see recommendations 3 and 4) are available to help vulnerable children and their families – these should be monitored against outcomes
  - children and families with multiple needs have access to specialist services, including child safeguarding and mental health services.

Also see NICE guidance on: [antenatal and postnatal mental health](#); [attention deficit hyperactivity disorder \(ADHD\)](#); [autism in children and young people](#); [conduct disorder in children – parent-training/education programmes](#); [depression in children and young people](#); [looked-after children and young people](#); [pregnancy and complex social factors](#); [when to suspect child maltreatment](#).

- Local authority scrutiny committees for health and wellbeing should review delivery of plans and programmes designed to improve the social and emotional wellbeing of vulnerable children aged under 5.

## *Recommendation 2 Identifying vulnerable children and assessing their needs*

### **Who should take action?**

- Early years settings (including children's centres and nurseries).
- Primary schools (independent, maintained, private and voluntary) and school nursing services.
- The NHS: general practice, health visiting services, maternity services, mental health services (perinatal, child and adolescent and adult) and paediatrics.
- Voluntary and community sector organisations.
- Child safeguarding services.
- Police.

- Local authority housing departments.

## What action should they take?

- All health and early years professionals should develop trusting relationships with vulnerable families and adopt a non-judgmental approach, while focusing on the child's needs. They should do this by:
  - identifying the strengths and capabilities of the family, as well as factors that pose a risk to the child's (or children's) social and emotional wellbeing
  - talking about the aspirations and expectations for the child
  - seeking to understand and respond to perceived needs and concerns
  - discussing any risk factors in a sensitive manner to ensure families do not feel criticised, judged or stigmatised (see [vulnerable children](#) for factors that may affect a child's social and emotional wellbeing).
- Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. This includes factors that could affect the parents' capacity to provide a loving and nurturing environment. For example, they should discuss with the parents any problems they may have in relation to the father or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support.
- Health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development. They should use the 'Early years foundation stage' assessment process to help identify and share any needs and concerns. Specifically, they should look for risk factors that were not evident at an earlier stage. For an infant or child, this could include:
  - being withdrawn
  - being unresponsive
  - showing signs of behavioural problems
  - delayed speech
  - poor language and communication skills.

For parents, this could include indifference to the child or insensitive or harsh behaviour towards them.

- Family welfare, housing, voluntary services, the police and others who are in contact with a vulnerable child and their family should be aware of factors that pose a risk to the child's social and emotional wellbeing. They should raise any concerns with the family GP or health visitor (working in the context of local safeguarding policies).
- Health and early years professionals should ensure procedures are in place:
  - to make referrals to specialist services, based on an assessment of need
  - to collect, consistently record and share information as part of the common assessment framework (relevant child and adult datasets should be linked)
  - for integrated team working
  - for continuity of care
  - to avoid multiple assessments.

### *Recommendation 3 Antenatal and postnatal home visiting for vulnerable children and their families*

#### **Who should take action?**

- Maternity services.
- Health visiting services.
- Early years services.

#### **What action should they take?**

- Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support (see recommendation 2).
- The trained nurse should visit families in need of additional support a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes)<sup>[2]</sup>. Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:
  - maternal sensitivity (how sensitive the mother is to her child's needs)

- the mother-child relationship
  - home learning (including speech, language and communication skills)
  - parenting skills and practice.
- The nurse should, where possible, focus on developing the father-child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities.
- Health visitors or midwives should regularly check the parents' level of involvement in the intensive home visiting programme. If necessary, they should offer them a break, to reduce the risk that they will stop participating. If the parents do decide to have a break, the nurse should continue to communicate with them on a regular basis.
- Managers of intensive home-visiting programmes should conduct regular audits to ensure consistency and quality of delivery.
- Health visitors or midwives should explain to parents that home visits aim to ensure the healthy development of the child (see recommendation 2). They should take into account the parents' first language and make provision for those who do not speak English. They should also be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting.
- Health visitors or midwives should try to ensure both parents can fully participate in home visits, by taking into account their domestic and working priorities and commitments. They should also try to involve other family members, if appropriate and acceptable to the parents.
- Health visitors and midwives should consider evidence-based interventions, such as [baby massage](#) and [video interaction guidance](#), to improve maternal sensitivity and mother-infant attachment. For example, this approach might be effective when the mother has depression or the infant shows signs of behavioural difficulties.
- Health visitors and midwives should encourage parents to participate in other services delivered by children's centres and as part of the Healthy Child Programme.
- Health visitors and midwives should work in partnership with other early years practitioners to ensure families receive coordinated support. This includes psychologists, therapists, family support workers and other professionals who deliver services provided by children's centres and as part of the Healthy Child Programme.

## *Recommendation 4 Early education and childcare*

### **Who should take action?**

- All those involved in providing early education and childcare services. This includes childminders and those working in children's centres, nurseries and primary schools (maintained, private, independent and voluntary).
- Health visiting services.
- Local authority children's services.
- School nursing services.

### **What action should they take?**

- Local authority children's services should ensure all vulnerable children can benefit from high quality childcare outside the home on a part- or full-time basis and can take up their entitlement to early childhood education, where appropriate. The aim is to give them the support they need to fulfill their potential. Childcare and education services should:
  - offer flexible attendance times, so that parents or carers can take up education, training or employment opportunities
  - address any barriers that may hinder participation by vulnerable children such as geographical access, the cost of transport or a sense of discrimination and stigma
  - be run by well-trained qualified staff, including graduates and qualified teachers
  - be based on an ethos of openness and inclusion.
- Managers and providers of early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn. Services should:
  - promote the development of positive, interactive relationships between staff and children
  - ensure individual staff get to know, and develop an understanding of, particular children's needs (continuity of care is particularly important for younger children)
  - focus on social and emotional, as well as educational, development.

- In line with the Department for Education's [statutory framework for the early years foundation stage](#), managers and providers of early education and childcare services should:
  - provide a structured, daily schedule comprising a balance of adult-led and child-initiated activities
  - ensure parents and other family members are fully involved (for example, by contributing to decisions about service provision, or by participating in learning or other activities, as appropriate)
  - ensure the indoor and outdoor environment is spacious, well maintained and pleasant.

## *Recommendation 5 Delivering services*

### Who should take action?

- Early years settings (including children's centres and nurseries).
- Primary schools (independent, maintained, private and voluntary) and school nursing services.
- The NHS: general practice, health visiting services, maternity services, mental health services (perinatal, child and adolescent and adult) and paediatrics.
- Voluntary and community sector organisations.
- Child safeguarding services.

### What action should they take?

- Health and early years providers should put systems in place to deliver integrated universal and targeted services that support vulnerable children's social and emotional wellbeing. This should include systems for sharing information and for multidisciplinary training and development.
- Health and early years providers should ensure a process is in place to systematically involve parents and families in reviewing services and suggesting how they can be improved. As part of this process, vulnerable parents and families should be asked about their needs and concerns – and their experiences of the services on offer.
- Health and early years practitioners should be clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families. This involves



developing and agreeing pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services within a given locality.

- Health and early years practitioners should be systematic and persistent in their efforts to encourage vulnerable parents to use early years services. (This includes parents who do not use universal services such as primary care.) Activities should include:
  - targeted publicity campaigns
  - making contact by using key workers and referral partners
  - encouraging other parents to help get them involved
  - sending out repeat invitations
  - using local community venues, such as places of worship and play centres to encourage them to participate and to address any concerns about discrimination and stigma
  - home visits by family support workers.
- Health and early years practitioners should use outreach methods to maintain or improve the participation of vulnerable parents and children in programmes and activities. Parents who may lack confidence or are isolated will require particular encouragement. (This includes those with drug or alcohol problems and those who are experiencing domestic violence.)
- Health and early years practitioners should work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and early years services. The difficulties may be due to their social circumstances, language, culture or lifestyle.

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<sup>[1]</sup> The NHS Commissioning Board is responsible for commissioning health visiting services up to 2015. From 2015, local authorities will take over this responsibility.

<sup>[2]</sup> It is not clear from current evidence <sup>[2]</sup> how many home visits are needed. The Family Nurse Partnership, an evidence-based, intensive home visiting programme, provides weekly or fortnightly home visits for 60–90 minutes throughout most stages of the programme (with more in the early stages and less later).

## 2 Public health need and practice

### *Policy*

Government policy puts a significant emphasis on early intervention services to ensure all children have the best possible start in life. The aim is to address the inequalities in health and life chances that exist between children living in disadvantaged circumstances and those in better-off families.

The importance of social and emotional wellbeing in relation to healthy child development is set out in a joint Department for Education and Department of Health publication, 'Supporting families in the foundation years' (2011). The primary aim of the foundation years (years 0–5) is defined as: 'promoting a child's physical, emotional, cognitive and social development so that all children have a fair chance to succeed at school and in later life'.

In addition the new 'Statutory framework for the early years foundation stage' (Department for Education 2012a) makes personal, social and emotional development a cornerstone of early years learning and education.

Other relevant policy documents and related reviews include:

- 'Fair society, healthy lives' (Marmot Review Team 2010).
- 'Healthy child programme: pregnancy and the first five years of life' (DH 2009).
- 'Healthy lives, healthy people: our strategy for public health in England' (DH 2010a).
- 'Healthy lives, healthy people: update and way forward' (DH 2011).
- 'No health without mental health: a cross-government mental health outcomes strategy for people of all ages' (HM Government 2011).
- 'Support and aspiration: a new approach to special educational needs' (Department for Education 2011a).
- 'The early years: foundations for life, health and learning' (Tickell 2011).
- 'The importance of teaching' (Department for Education 2010).

## *Benefits of social and emotional wellbeing*

Social and emotional wellbeing is important in its own right, but it also provides the basis for future health and life chances.

Poor social and emotional capabilities increase the likelihood of antisocial behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity. For example, aggressive behaviour at the age of 8 is a predictor of criminal behaviour, arrests, convictions, traffic offences, spouse abuse and punitive treatment of their own children (Farrington et al. 2006).

## *Factors that impact on social and emotional wellbeing*

The child's relationship with their mother (or main carer) has a major impact on social and emotional development. In turn, the mother's ability to provide a nurturing relationship is dependent on her own emotional and social wellbeing and intellectual development – and on her living circumstances. The latter includes family environment, social networks and employment status (Shonkoff and Phillips 2000).

Most parents living in poor social circumstances provide a loving and nurturing environment, despite many difficulties. However, children living in a disadvantaged family are more likely to be exposed to adverse factors such as parental substance misuse and mental illness, or neglect, abuse and domestic violence. Consequently, they are more likely to experience emotional and behavioural problems that can impact on their development and opportunities in life (Farrington et al. 2006; Shonkoff and Phillips 2000).

For example, measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5, compared to children from more affluent backgrounds (Sabates and Dex 2012; Waldfogel and Washbrook 2008).

There are less opportunities after the preschool period to close the gap in behavioural, social and educational outcomes (Allen 2011; Field 2010).

## *Current services*

Services that support families and children during their early years are generally not well coordinated and integrated either at the strategic or local level (Allen 2011a; Field 2010; Munro 2011; Tickell 2010).

The level and quality of early childcare and education services varies, with the most disadvantaged children likely to get the worse provision (Ofsted 2010). In addition, only an estimated 50% of children aged 2 and 2½ years in England are being assessed as part of the Healthy Child Programme – and not all women are being offered antenatal and parenting support services (Care Quality Commission 2010; DH 2010b).

The approaches and interventions used to address specific problems (such as abuse, maternal mental health problems and poor parenting) also vary widely and, while some interventions have been proven to be effective and cost effective, others have not. Where evidence-based interventions are used, they are not always being implemented effectively (Allen 2011a; Field 2010).

There is limited UK data on the indicators that provide an overall measure of the social and emotional wellbeing of children aged under 5 years. Independent reviews recommend that measures should be developed to assess children's cognitive, physical and emotional development at ages 3 and 5 years (Allen 2011b; Field 2010; Tickell 2011).

## Costs

Early intervention can provide a good return on investment (Knapp et al. 2011). For example, an evaluation of the US-based Nurse-Family Partnership estimated that the programme made savings by the time the children of high-risk families had reached the age of 15. These savings, which were over five times the cost of the programme itself, resulted from reduced expenditure in the welfare and criminal justice systems, higher tax revenues and improved physical and mental health (Karoly et al. 2005). (The cost effectiveness of the UK Family Nurse Partnership (FNP) model is currently being investigated as part of the FNP trial.)

The cost of not intervening to ensure (or improve) the social and emotional wellbeing of children and their families are significant, for both them and wider society (Aked et al. 2009). For example, by the age of 28, the cumulative costs for public services are much higher when supporting someone with a conduct disorder, compared to providing services for someone with no such problems (Scott et al. 2001).

### 3 Considerations

The Public Health Interventions Advisory Committee (PHIAC) took account of a number of factors and issues when developing the recommendations.

- 3.1 PHIAC focused on local interventions to improve children's social and emotional wellbeing – either directly, or by improving the ability of parents to provide a nurturing and loving family environment. However, such family-based services can only form one component of a broader, multi-agency local strategy within a supportive national policy framework. Other elements may include, for example, policies to improve the social and economic circumstances of disadvantaged children.
- 3.2 PHIAC noted that a range of early years child development programmes that were beyond the scope of this guidance are effective. This includes, for example, certain parenting programmes. PHIAC also recognised that these programmes would complement the home visiting, early education and childcare interventions recommended in this guidance.
- 3.3 PHIAC was mindful of ongoing policy developments in relation to public health commissioning. It took into account the greater role local government will play in improving and protecting the health and wellbeing of local people. For example, local government will take over responsibility for children's services from the NHS Commissioning Board in 2015. (These services support women in pregnancy and children aged up to 5 years and are delivered as part of the Healthy Child Programme. They include health visiting.)
- 3.4 Traditionally, child development policy and practice has focused on physical health and cognitive development. However, a series of independent reviews on early intervention, early education and child protection have underlined the importance of social and emotional wellbeing. (The reviews include Allen [2011a; 2011b]; and Department for Education and DH [2011].) Social and emotional wellbeing forms the basis for healthy child development and 'readiness for school'. It can also help prevent poor health and improve education and employment outcomes in adolescence and throughout adulthood.

- 3.5 There is a lack of consensus on how to define and measure young children's social and emotional wellbeing. Much of the evaluation literature concentrates on the consequences of someone lacking mental or social and emotional wellbeing. Evidence on interventions aiming to improve or sustain social and emotional wellbeing is comparatively limited – and the quality varies significantly. There are a small number of high-quality, long-term UK studies. However, the main body of evidence is from the US and it was sometimes difficult to determine how relevant this was for early years services in the UK.
- 3.6 Most of the available evidence on early years interventions related to mothers. However, PHIAC recognised the importance of including the father in interventions, where this was possible.
- 3.7 Within the guidance, the term 'parent' includes mothers, fathers, carers and foster parents. PHIAC noted that both parents are important to children (whether living in the same household or in a relationship with each other or not). PHIAC noted that programmes to encourage the participation of all parents, at all stages (before birth and throughout the early years) and that support their needs, may benefit their children's social and emotional wellbeing greatly.
- 3.8 Independent reviews (Allen 2011; Field 2010) stressed the critical role of the whole family, including fathers and grandparents, in influencing a child's social and emotional wellbeing and subsequent life chances. There is limited evidence on the most effective ways that fathers and grandparents who provide childcare support can promote social and emotional wellbeing. However, PHIAC recognised that an approach that involves the whole family is important.
- 3.9 Difficulties with speech, language and communication may contribute significantly to social and emotional wellbeing problems and the resulting behaviour that may ensue. For example, PHIAC noted that, according to one longitudinal study (Silva et al. 1987) 59% of children aged 3 years with language delay had behavioural problems, compared with 14% without language delay. PHIAC also noted that those working with young children and their families have an important role in highlighting the importance of language and communication and in identifying any difficulties in this area.

- 3.10 The recommendations build on important national developments to promote and protect the social and emotional wellbeing of children, especially vulnerable children. These developments include:
- Expansion of the health visitor workforce.
  - The new core purpose of children's centres: 'to improve outcomes for young children and their families with a particular focus on the most disadvantaged, so that children are equipped for life and ready for school, no matter what their background or family circumstances' (Department for Education 2011b).
  - Free early education extended to 40% of infants aged 2 years, starting with those who are from disadvantaged families (Department for Education 2012b).
  - The designation of personal, social and emotional development as 1 of the key themes in the new early years foundation stage (Department for Education 2012a). (This statutory framework sets standards for learning, development and care for children from age 1–5 years for all early years settings).
  - Stronger links between the Healthy Child Programme and early years foundation stage processes of assessment and review to help identify and respond to children with particular needs.
- 3.11 Expert testimony relating to the Family Nurse Partnership programme showed that this model can have a positive effect on children's emotional and behavioural development. (The evidence was derived originally from long-term randomised control trials [RCTs] in the US of targeted, intensive interventions.) PHIAC noted that the current UK randomised control trial, based on the same programme, will provide valuable evidence of its effectiveness in this country. It also acknowledged that long-term follow-up and an analysis of the costs and benefits will be crucial.
- 3.12 PHIAC was aware of the financial constraints on public sector services and the need to ensure value for money. Members noted that the Allen reviews (2011a; 2011b) set out a strong economic case for early years 'preventive' services. The reviews showed that the greatest cost savings could be achieved by intervening during the early years of life.

- 3.13 PHIAC judged that, if effective evidence-based interventions are systematically implemented, then cost savings are likely to be achieved over 3 to 4 years – and also in the longer term.
- 3.14 While prevention of child abuse is not the primary focus of this guidance, neglect and abuse are major risks to a child's social and emotional development (as well as to their overall health and wellbeing). PHIAC believes the recommendations should help prevent child abuse.
- 3.15 Evidence showed that effective interventions were structured, replicable and auditable. PHIAC also noted that effective interventions require 'high implementation fidelity' with original programmes, that is, they have to be based on the original programme design.
- 3.16 PHIAC put an emphasis on arrangements that could be widely and systematically implemented to deliver evidence-based interventions.



## 4 Implementation

NICE guidance can help:

- Commissioners and providers of NHS services to meet the quality requirements of the Department of Health's (DH's) [Operating framework for the NHS in England 2012/13 \(2011\)](#). Specifically, it can help them to deliver on the following requirements from the [NHS outcomes framework](#):
  - Domain 2: enhancing quality of life for people with long-term conditions, and targeted support for children and young people at particular risk of mental health problems (such as looked-after children);
  - Domain 4: ensuring people have a positive experience of care, this includes continuity in all aspects of well-coordinated and integrated maternity care
  - Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm. This involves robust safeguarding arrangements, including work in partnership through local safeguarding children boards (LSCBs) and local safeguarding adult boards.
- Local health and wellbeing boards deliver on [Healthy lives, healthy people \(DH 2010\)](#).
- Local authorities, NHS services and other local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.
- Commissioners and providers of NHS services to deliver on domain 1 (to improve the wider determinants of health) of the DH's [Public health outcomes framework for England](#). This includes:
  - reducing the number of children in poverty
  - increasing the numbers who are 'school ready'
  - reducing pupil absences
  - reducing the number of first-time entrants to the youth justice system
  - positive child development at 2–2.5 years
  - positive emotional wellbeing of looked-after children and ensuring all children's self-reported wellbeing.

- Early years providers to deliver on the Department for Education [Early Years Foundation Stage \(EYFS\) statutory framework \(2012a\)](#).

NICE has developed tools to help organisations put this guidance into practice. For details, see [our website](#).

## 5 Recommendations for research

The Public Health Interventions Advisory Committee (PHIAC) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful/negative side effects.

- 5.1 How effective are interventions to promote social and emotional wellbeing among, and reduce the vulnerability of, different groups of vulnerable children aged under 5 years?
- 5.2 How can the factors that pose a risk to, or protect, the social and emotional wellbeing of children aged under 5 years be identified and assessed to determine how children can benefit from different interventions?
- 5.3 What approaches can be used to ensure fathers and grandparents help protect or improve the social and emotional wellbeing of vulnerable children aged under 5 years?
- 5.4 What types of home-based intervention are effective in promoting the social and emotional wellbeing of vulnerable children aged under 5 years without involving the parents? (This could include childcare provided by other family members or childminders.)
- 5.5 How can interventions which have been proven effective in other countries be assessed for their cultural relevance to the UK? What measures should be used to assess how transferrable they are?
- 5.6 What organisational mechanisms can ensure interventions to improve the social and emotional wellbeing and 'readiness for school' of vulnerable children aged under 5 years are effectively implemented? How do these differ according to the local context?
- 5.7 What are the short, medium and long-term economic benefits of interventions aimed at developing the emotional and social skills of vulnerable, preschool children – for the individual, family and wider society? How should these be assessed?

- 5.8 What indicators and datasets should be used to measure and predict social and emotional wellbeing over time? Which indicators and datasets can be used to assess the long-term benefits of interventions aimed at improving the social and emotional wellbeing of vulnerable children aged under 5 years?

More detail on the gaps in the evidence identified during development of this guidance is provided in [appendix D](#).

## 6 Updating the recommendations

This guidance will be reviewed 3 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted at the [NICE website](#).

## 7 Related NICE guidance

### *Published*

[Autism in children and young people](#). NICE clinical guideline 128 (2011)

[Looked-after children and young people](#). NICE public health guidance 28 (2010)

[Pregnancy and complex social factors](#). NICE clinical guideline 110 (2010)

[Social and emotional wellbeing in secondary education](#). NICE public health guidance 20 (2009)

[When to suspect child maltreatment](#). NICE clinical guideline 89 (2009)

[Social and emotional wellbeing in primary education](#). NICE public health guidance 12 (2008)

[Attention deficit hyperactivity disorder \(ADHD\)](#). NICE clinical guideline 72 (2008)

[Antenatal care](#). NICE clinical guideline 62 (2008)

[Antenatal and postnatal mental health](#). NICE clinical guideline 45 (2007)

[School-based interventions on alcohol](#). NICE public health guidance 7 (2007)

[Interventions to reduce substance misuse among vulnerable young people](#). NICE public health guidance 4 (2007)

[Conduct disorder in children – parent-training/education programmes](#). NICE technology appraisal 102 (2006)

[Bipolar disorder](#). NICE clinical guideline 38 (2006)

[Postnatal care](#). NICE clinical guideline 37 (2006)

[Obsessive compulsive disorder \(OCD\) and body dysmorphic disorder \(BDD\)](#). NICE clinical guideline 31 (2005)

[Depression in children and young people](#). NICE clinical guideline 28 (2005)

## *Under development*

Preventing and reducing domestic violence. NICE public health guidance (publication expected February 2014)

## 8 Glossary

### *Baby massage techniques*

Interventions to promote infant massage. Benefits are reported to include improvements in parent and/or child sleep patterns, their interaction and relationship.

### *Child safeguarding*

Safeguarding policies and activities aim to ensure children receive safe and effective care, are protected from maltreatment and have their health and development needs met. Legislation and related policies describe how individuals and agencies should work together to safeguard children.

### *Family Nurse Partnership*

The Family Nurse Partnership (FNP) is the UK name for the US-developed Nurse-Family Partnership (NFP). The partnership provides an intensive, structured home-visiting programme for young, first-time mothers from a disadvantaged background and their partners. The emphasis is on building a strong relationship between a specially trained (family) nurse and the parents. Support is available from early pregnancy until the child is aged 2 years. The aim is to improve pregnancy outcomes, the child's health and development and the parents' economic self-sufficiency.

### *Joint strategic needs assessment*

A joint strategic needs assessment (JSNA) provides a profile of the health and social care needs of a local population. JSNAs are used as the basis for developing joint health and wellbeing strategies.

### *Readiness for school*

In the context of this guidance, 'readiness for school' refers to a child's cognitive, social and emotional development. Development during the child's early years may be achieved through interaction with their parents or through the processes of play and learning.

### *Social and emotional wellbeing*

Social and emotional wellbeing provides the building block for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental



illness. For the purposes of this guidance, the following definitions are used, in line with the Department for Education's Statutory framework for the early years foundation stage:

- emotional wellbeing – this includes being happy and confident and not anxious or depressed
- psychological wellbeing – this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive
- social wellbeing – has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully.

### *Targeted services*

A targeted service may be distinct from, or an adaptation of, a universal service. For example, a tailored home visiting programme by a nurse, midwife or health visitor may be provided for young parents from a disadvantaged background. This would be separate from the universal home visiting service provided for all new families and might, for example, include longer sessions, goal setting and a range of specific interventions. (See universal services below.)

### *Universal services*

Universal services, such as general education and healthcare services, are available to everyone. For all children aged up to 5 years, universal provision includes: maternal healthcare, midwife home visits soon after birth and routine health visitor checks.

### *Video interaction guidance*

Interactions between a parent or carer and a child are recorded using audio visual equipment. This is later viewed and discussed, typically with a health or social care professional. Parents and carers are given a chance to reflect on their behaviour, with the focus on elements that are successful. The aim is to improve their communications and relationship with their child.

### *Vulnerable children*

A number of factors may contribute, to varying degrees, to making a child vulnerable to poor social and emotional wellbeing. In addition, a child's circumstances may vary with time. However, in this guidance vulnerable children include those who are exposed to:

- parental drug and alcohol problems

- parental mental health problems
- family relationship problems, including domestic violence
- criminality.

They may also include those who:

- are in a single parent family
- were born to parents aged under 18 years
- were born to parents who have a low educational attainment
- were born to parents who are (or were as children) looked after (that is, they have been in the care system)
- have physical disabilities
- have speech, language and communication difficulties.

These indicators can be used to identify groups of children who are likely to be vulnerable. However, not all of these children will in fact be vulnerable – and others, who do not fall within these groups, could have social and emotional problems.

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## **Appendix A Membership of the Public Health Interventions Advisory Committee (PHIAC), the NICE project team and external contractors**

### *Public Health Interventions Advisory Committee*

NICE has set up a standing committee, the Public Health Interventions Advisory Committee (PHIAC), which reviews the evidence and develops recommendations on public health interventions. Membership of PHIAC is multidisciplinary, comprising public health practitioners, clinicians, local authority officers, teachers, social care professionals, representatives of the public, academics and technical experts as follows.

#### **John F Barker**

Interim Children's Services Manager; Assistant Director of e-Government, IdEA; Programme Co-ordinator, Better Government for Older People, Deputy Director of Social Services, Solihull Metropolitan Borough Council

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## *External contractors*

### **Evidence reviews**

Review 1 was carried out by the School of Health and Related Research (SchARR), University of Sheffield. The principal authors were: Susan Baxter, Lindsay Blank, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

Review 2 was carried out by SchARR, University of Sheffield. The principal authors were: Lindsay Blank, Susan Baxter, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

Review 3 was carried out by SchARR, University of Sheffield. The principal authors were: Lindsay Blank, Susan Baxter, Josie Messina, Hannah Fairbrother, Liddy Goyder and Jim Chilcott.

### **Cost effectiveness**

The economic modelling was carried out by SchARR, University of Sheffield. It was split into two parts – part one is the econometric analysis and part two is the economic model. The principal authors for part one were: Mónica Hernández Alava, Gurleen Popli, Silvia Hummel and Jim Chilcott. The principal authors for part two (which included the review of economic evaluations) were: Silvia Hummel, Jim Chilcott, Andrew Rawdin and Mark Strong.

### **Commissioned expert reports**

Expert report 1 was carried out by Warwick Medical School, University of Warwick and The Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London. The authors were: Anita Schrader-McMillan, Jacqueline Barnes and Jane Barlow.

Expert report 2 was carried out by The Social Research Unit, Dartington. The principal authors were Nick Axford and Michael Little.

Expert report 3 was carried out by the Personal Social Services Research Unit (PSSRU) London School of Economics and Political Science. The principal author was Madeleine Stevens.

## **Fieldwork**

The fieldwork was carried out by Cordis Bright.

## Appendix B Summary of the methods used to develop this guidance

### *Introduction*

The reviews, primary research, commissioned reports and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Interventions Advisory Committee (PHIAC) meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in [appendix E](#) and are available at the [NICE website](#).

### *Guidance development*

The stages involved in developing public health guidance are outlined below.

1. Draft scope released for consultation
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic modelling undertaken and submitted to PHIAC
6. PHIAC produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PHIAC amends recommendations
9. Final guidance published on website
10. Responses to comments published on website

## *Key questions*

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by PHIAC to help develop the recommendations. The overarching questions were:

1. What are the most effective and cost-effective early education, childcare and home-based interventions for helping improve and maintain the cognitive, social and emotional wellbeing of vulnerable children and their families?
2. Which progressive early education, childcare and home-based interventions are effective and cost effective in terms of promoting the cognitive, social and emotional wellbeing of vulnerable children and their families at: 0–3 months, 3 months to 1 year, 1–2 years, and other early-life stages?
3. How can vulnerable children and families who might benefit from early education, childcare and home-based interventions be identified? What factors increase the risk of children experiencing cognitive, social and emotional difficulties? What is the absolute risk posed by these different factors – and in different combinations?
4. How can home-based interventions reduce a child's vulnerability and build resilience to help achieve positive outcomes? In particular, how can interventions help develop a strong and positive child–parent attachment?
5. How can early education and childcare interventions reduce vulnerability and build resilience to help achieve positive outcomes and generally prepare children for school?
6. Which characteristics of an intervention are critical to achieving positive outcomes for vulnerable children and families?
7. What lessons can be learnt from current UK-based programmes aimed at promoting the social and emotional wellbeing of children under 5?

These questions were made more specific for each review (see reviews for further details).

## *Reviewing the evidence*

### **Effectiveness reviews**

Two reviews of effectiveness were conducted. One looked at review-level evidence (review 1), the other focused on primary evaluation studies of UK programmes (review 2). The latter included related qualitative evidence on factors influencing uptake and implementation.

### *Identifying the evidence*

A number of databases and websites were searched for review level and evaluation studies from January 2000. See each review for details of the databases searched.

Additional methods used to identify evidence were as follows:

- reference list search of included papers (for reviews 1 and 2)
- cited reference searches of included studies in the Web of Knowledge, Scopus and Google Scholar
- additional searches in Medline and the Web of Knowledge for key UK programmes
- consultation with an expert advisory group.

### *Selection criteria*

Studies were included in the effectiveness reviews (reviews 1 and 2) if the:

- populations included vulnerable children aged 0–5 and their families
- interventions were 'progressive' and
- were provided at home, within early education or childcare settings and
- aimed to improve the social and emotional health and cognitive ability of vulnerable under-5s and their families.

Studies were excluded if they focused on:

- tools and methods used to assess the risk and diagnose social and emotional problems or a mental health disorder

- clinical or pharmacological treatments
- support provided by specialist child mental health services.

See each review for details of the inclusion and exclusion criteria.

## Other reviews

Review 3 focused on the risk factors associated with children experiencing social, emotional and cognitive difficulties.

### *Identifying the evidence*

The [Millennium Cohort database](#) (maintained by the Centre for Longitudinal Studies) was searched for review 3. All records were hand-searched at the title/abstract level to identify relevant publications. See the review for details.

## Selection criteria

Studies were included in review 3 if any aspect of a child's social and emotional wellbeing were reported (including behaviour, development and mental health).

## Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for the development of NICE public health guidance' (see [appendix E](#)). Each study was graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

### *Study quality*

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

- Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

## Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see [appendix A](#)). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

### *Commissioned reports*

Three expert reports were commissioned.

- Expert report 1 summarised the evidence from primary evaluation studies on progressive interventions to promote the social and emotional wellbeing of vulnerable children aged under 5 years. The evidence came from the UK, US, the Netherlands and elsewhere.
- Expert report 2 looked at programmes to promote the social and emotional wellbeing of vulnerable children aged under 5 years. It included the results of applying the 'Evidence2Success' standards of evidence.
- Expert report 3 looked at the costs and benefits of intervening early with vulnerable children and families to promote their social and emotional wellbeing.

### *Cost effectiveness*

There was a review of economic evaluations and an economic modelling exercise.

### **Review of economic evaluations**

A systematic search of key health and medical databases was undertaken for relevant economic evaluation studies. The inclusion and exclusion criteria were the same as for the systematic review of UK interventions (review 1). Included studies were then quality-assessed.

### **Economic modelling**

The economic modelling comprised two parts: an econometric analysis and the development of an economic model.



An econometric analysis of longitudinal data was undertaken to:

- understand the factors determining aspects of social, psychological and cognitive development in early childhood
- establish a link between early childhood development and adult outcomes
- predict the effects of childhood interventions on long-term outcomes.

An economic model was developed to determine the long-term outcomes of the intervention (home visiting, early education and childcare). It incorporated data from the reviews of effectiveness and the economic evaluation and outputs from the econometric analysis.

The results are reported in the economic modelling reports – see [appendix E](#).

## *Fieldwork*

Fieldwork was carried out to evaluate how relevant and useful NICE's recommendations are for practitioners and how feasible it would be to put them into practice. It was conducted with commissioners and practitioners who are involved in early years services in local authorities, the NHS and the community, voluntary and private sectors. Parents and carers of vulnerable children aged under 5 were also consulted.

The fieldwork comprised:

- Sixteen discussion groups with commissioners and practitioners. Two were held in each of 8 local authority areas (Barking and Dagenham, Birmingham, Cambridgeshire, Luton, Northamptonshire, Reading, Sheffield and Tower Hamlets).
- Eight discussion groups involving a total of 41 parents and carers. These were held in 8 local authority areas (Barking and Dagenham, Birmingham, Cambridgeshire, Luton, Northamptonshire, Reading, Sheffield and Tower Hamlets).

The main issues arising from the fieldwork are set out in appendix C under fieldwork findings. See also the full fieldwork reports 'The social and emotional wellbeing of vulnerable children (early years): views of professionals' and 'The social and emotional wellbeing of vulnerable children (early years): views of parents and carers'.

## *How PHIAC formulated the recommendations*

At its meetings in January 2012, the Public Health Interventions Advisory Committee (PHIAC) considered the evidence, expert reports and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

PHIAC developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see [appendix C](#) for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

## Appendix C The evidence

### *Background*

This appendix lists the evidence statements from 3 reviews provided by external contractors (see [appendix A](#) and [appendix E](#)) and links them to the relevant recommendations. See [appendix B](#) for the meaning of the (++) , (+) and (-) quality assessments referred to in the evidence statements.

Appendix C also lists 3 expert reports and their links to the recommendations and sets out a brief summary of findings from the economic analysis.

The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from. The letter(s) in the code refers to the type of document the statement is from, and the numbers refer to the document number, and the number of the evidence statement in the document.

**Evidence statement 1.1** indicates that the linked statement is numbered 1 in review 1. **Evidence statement 2. ES1** indicates that the linked statement is numbered 1 under the heading 'Effectiveness studies' in review 2. **Evidence statement 2.PS1** indicates that the linked statement is numbered 1 under the heading 'Process studies' in review 2. **Evidence statement 3.1** indicates that the linked statement is numbered 1 in review 3.

The 3 reviews are:

- Review 1: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): Systematic review level evidence'
- Review 2: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): UK evidence review'
- Review 3: ' Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties'

The reviews, expert reports, economic analysis are available at the [NICE website](#). Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

Where the Public Health Interventions Advisory Committee (PHIAC) has considered other evidence, it is linked to the appropriate recommendation below. It is also listed in the additional evidence section of this appendix.

**Recommendation 1:** evidence statements 1.1, 1.2, 1.4, 2.ES1, 2.ES3; Additional evidence expert report 1, expert report 2; expert testimony: PREview project

**Recommendation 2:** evidence statement 3.1; Additional evidence expert report 1; expert testimony: PREview project

**Recommendation 3:** evidence statements 1.1, 1.2, 1.4, 2.ES1, 2.ES3, 2.PS1, 2.PS2, 2.PS3; Additional evidence expert report 1, expert report 2; expert testimony: Family Nurse Partnership

**Recommendation 4:** evidence statements 1.3, 2.PS1, 2.PS2; Additional evidence expert report 1, expert report 2

**Recommendation 5:** evidence statements 2.ES3, 2.PS1, 2.PS2, 2.PS4; Additional evidence expert report 1

## *Evidence statements*

Please note that the wording of some evidence statements has been altered slightly from those in the evidence reviews to make them more consistent with each other and NICE's standard house style. The superscript numbers refer to the studies cited beneath each statement. The full references for those studies can be found in the reviews.

### **Evidence statement 1.1: Home visits during pregnancy and the post-partum period (0–1 years)**

There is moderate evidence from six review papers<sup>1,3,4,5,6,7</sup> (four [-], one [+] and one [++]) suggesting that postpartum home visits interventions may be effective for improving parental outcomes in at-risk families, with one suggesting that nurse-delivered interventions may be more effective than those delivered by para-professionals or lay visitors. One additional (++) review paper<sup>2</sup> suggests that there is insufficient evidence regarding the effectiveness of postpartum visits to women with an alcohol or drug problem.

These studies were carried out in populations described as: families at risk of dysfunction or child abuse; mothers at risk for postnatal depression; mothers identified as having additional needs;

families living in a deprived area; teenage mothers; African-American women; drug users; economically deprived women; socially at-risk women; preterm infants and mothers with maternal risk.

In regard to specific outcomes: one of these reviews (-)<sup>6</sup> provides evidence for the effectiveness of programmes delivered by nurses on intimate partner violence and reducing child abuse potential in low-income families, ethnic minority families, substance abusing mothers, and families at risk for child abuse.

Three reviews (one [+]<sup>7</sup> and two [-]<sup>5,3</sup>) provide evidence that interventions may impact on maternal outcomes (such as psychological status, postnatal depression, maternal self-esteem, quality-of-life and contraceptive knowledge and use, interaction with the child and parenting). One (-) study<sup>3</sup> suggests that child development outcomes may be improved in preterm infants.

Two further reviews provide evidence that postpartum interventions may be effective for parental outcomes in adolescent mothers. One (-) review<sup>4</sup> describes positive outcomes such as improved self-confidence and self-esteem following support-education interventions for postpartum adolescent mothers. A second (++) review<sup>1</sup> suggests that interventions may have a positive impact on parent outcomes such as improving maternal-child interaction and maternal identity.

<sup>1</sup> Coren and Barlow (2009)

<sup>2</sup> Doggett et al. (2005)

<sup>3</sup> Kearney et al. (2000)

<sup>4</sup> Letourneau et al. (2004)

<sup>5</sup> McNaughton (2004)

<sup>6</sup> Sharps et al. (2008)

<sup>7</sup> Shaw et al. (2006)

## **Evidence statement 1.2: Home interventions for wider populations (in addition to or not including pregnancy/postpartum)**

Seven reviews provide evidence<sup>1,2,3,4,5,6,7</sup> (two [++], four [+] and one [-]) regarding the effectiveness of home visiting on interventions for at-risk families. Small to medium effects are reported on maternal sensitivity and the home environment, a moderate effect size on parent-child interaction and measures of family wellness, and a small effect size on: attachment security; cognitive development; socio-emotional development; potential abuse; parenting behaviour; parenting attitudes; and maternal lifecourse education. One (+) review<sup>3</sup> provides mixed evidence regarding the impact of parenting interventions on childhood behaviour problems.

The study populations in the primary papers were described as including: ethnic minority teenage mothers; pregnant and postpartum women who were socially disadvantaged or substance abusers; low birthweight newborns; children with failure to thrive; low socioeconomic status families; low income families; families at risk of abuse or neglect and families considered to be at risk. One (++) review<sup>7</sup> concluded that interventions delivered in the home for participants with low SES had lower effect sizes than those with mixed SES levels. A second (++) review<sup>2</sup> similarly concluded that interventions with low SES or adolescent populations had lower effect sizes than middle class non-adolescent parents. One review noted that lower effects were found for studies using HOME (Home Observation and Measurement of the Environment) or NCATS (Nursing Child Assessment Teaching Scale) as outcome measures compared with other rating scales or measures.

It is unclear how the timing, intensity and other characteristics of interventions influence effectiveness, particularly with respect to levels of risk and needs. One (+) meta-analysis<sup>5</sup> reported that characteristics of more successful interventions across all the studies were that: video feedback was included; interventions had less than 16 sessions; interventions did not include personal contact (but provided equipment); interventions started after the age of 6 months. Another (-) review<sup>6</sup> concluded that interventions were more successful when of a moderate number of sessions (5–16 versus more than 16) in a limited time period, and were carried out at home either prenatally or after the age of 6 months. Another (++) review<sup>7</sup> in contrast concluded that effect sizes were higher for interventions of 13 to 32 visits and lower for interventions of 1 to 12 visits and 33 to 50 visits. Also, that effect sizes were lower for interventions without a component of social support than for those that included social support. One (++) review<sup>2</sup> suggested that there may be some reduction in intervention effect over time, and highlighted that the multifaceted nature of interventions provides challenges in ascertaining which element or elements of an intervention are most effective.

<sup>1</sup> Bayer et al. (2009)

<sup>2</sup> Kendrick et al. (2000)

<sup>3</sup> Bernazzani et al. (2001)

<sup>4</sup> Sweet and Appelbaum (2004)

<sup>5</sup> Bakermans-Kranenburg et al. (2005)

<sup>6</sup> Bakermans-Kranenburg et al. (2003)

<sup>7</sup> MacLeod and Nelson (2000)

### **Evidence statement 1.3: Programmes delivered in educational or centre settings**

Four reviews provide moderate evidence<sup>1,2,3,4</sup> (three [+] and one [-]) regarding the effectiveness of interventions delivered in an educational or daycare setting. The detail of interventions and distinctions between daycare and childcare were not well defined.

Most evidence related to cognitive outcomes. Other outcomes included social competence and child mental health. One (+) review<sup>1</sup> found that more than 70% of positive effects reported were regarding cognitive outcomes. Most of the programmes were described as being conducted with economically disadvantaged populations. However, some reviews included both universal and progressive interventions with little detail provided regarding the precise content of the programmes or the population.

Most of the programmes had multiple strands –and varied in intensity. Few reviews examined daycare and preschool education without the addition of centre or home-based parenting support. Most of the programmes were for children aged 3 years and above.

Positive cognitive effects were reported for some programmes for: vocabulary; letter and word identification; letter knowledge; book knowledge; colour-naming; reduction in number of children kept back a year; increased IQ scores; verbal and 'fluid intelligence' gains; school readiness; improved classroom and personal behaviour (as rated by the teachers); reduced need for special needs education; a reduction in delinquent behaviour; fewer arrests at aged 27. Reported effectiveness however varied across programmes with one review reporting that 53% of the studies demonstrated no effect.

Beneficial effects reported on child mental health included reduced anxiety and the ability to externalise behaviour problems. However one (+) review<sup>3</sup> highlighted the potential for making difficult behaviours worse. Improvements in social competencies were reported across a number of programmes, including improvements in mother–child interaction and communications. A study of the effective provision of preschool education project found improved self-regulation and positive behaviour if children attended a centre rated as high quality. One (+) review<sup>4</sup> of eight daycare interventions in the US concluded that out of home daycare can have beneficial effects in relation to enhancing cognitive development, preventing school failure, improving children's behaviour, and improving maternal education and employment. The authors suggested that the chance of success is higher for interventions if the intervention starts at age 3 rather than age 4 years.

<sup>1</sup> Anderson et al. (2003)

<sup>2</sup> Burgher (2010)

<sup>3</sup> D'Onise et al. (2010)

<sup>4</sup> Zoritch et al. (2009)

#### **Evidence statement 1.4: Longer-term outcomes of early interventions in adolescence**

Two good quality (both [+]) meta-analyses<sup>1,2</sup> of outcomes following early developmental prevention programmes provide good evidence of lasting impact in adolescence, particularly as measured by cognitive outcomes. Overall, effect sizes are small to medium. Study populations were described as at risk or disadvantaged with many including a high proportion of participants from African-American backgrounds. Interventions included structured preschool programmes, centre-based developmental daycare, home visitation, family support services and parental education.

One (+)review<sup>1</sup> reported that the largest effects were seen for educational success during adolescence, reduced social deviance, increased social participation, and cognitive development, with smaller effects for family wellbeing and social-emotional development. It was highlighted that programmes with more than 500 sessions per participant were significantly more effective than those with fewer. The second (+) review<sup>2</sup> reported a similar pattern of outcomes. It was noted that programmes with direct teaching components in preschool and those that followed through from preschool to school tended to have the greatest cognitive impacts. Longer programmes tended to produce greater impacts on preschool cognitive outcomes and on social and emotional outcomes at school age. More intense programmes tended to produce greater impact on preschool cognitive outcomes and grade 8 parent-family outcomes.



<sup>1</sup> Manning et al. (2010)

<sup>2</sup> Nelson and Westhues (2003)

## Evidence statement 2.ES1: Home visiting programmes

Evidence from seven studies (eight papers – four [++] and four [+])<sup>1,2,3,4,5,6,7,8</sup> suggests that some home visiting programmes may be effective in directly improving social and emotional wellbeing of vulnerable children. The extent of effect depends partly on the type and nature of intervention being delivered, and the particular outcomes measures. Some outcome measures were indirectly linked to the social and emotional development and cognitive development of the child, concerned with parental support and home environment. Many of the outcomes were self-reported introducing potential biases into the studies.

The heterogeneity of interventions across the small number of studies made it difficult to identify clear categories; and difficult to discern clear relationships between particular types of interventions and outcomes. However some distinction was evident. The more structured intensive interventions (with a focus on child-mother interaction) delivered by specifically trained nurses during the first 18 months appears more likely to have positive effects (the 'Family partnership model'). The lower intensity, less structured interventions involving lay providers (Home Start, peer mentoring) are less likely to have positive effect on the social and emotional wellbeing of vulnerable children.

Two studies<sup>6,7</sup> (both +) evaluated 'Starting well', an 'intensive home visiting' programme delivered by health professionals and health support workers to socioeconomically deprived parents of newborn children aged up to 24 months (Glasgow). Positive effect on home environment were reported; but methodological limitations meant the studies provided little robust evidence of effectiveness on social and emotional wellbeing.

An (++) evaluation<sup>2</sup> of Home Start, a volunteer home visitor programme, showed a positive effect on parent-child relationships; but no effect on maternal depression. This programme offered 'unstructured' mainly social support to vulnerable families with newborns consisting of two or more visits over 12 months provided by lay, local volunteer mothers.

The (+) study<sup>4</sup> of a small scale home visiting (intensive compensatory education) programme showed a positive effect on academic readiness and inhibitory control. This intervention consisted of weekly visits for 12 months delivered to infants aged 3 years by project workers (in an

economically disadvantaged area of Wales). The intervention was a parent-delivered education programme aimed at improving school readiness.

The (++) evaluation<sup>2</sup> of the 'Family partnership model', a home visiting programme consisting of 18 months of weekly visits from a specifically trained health visitor in two UK counties, showed a positive effect on a small number of outcomes, including maternal sensitivity and infant cooperation.

The 'Avon premature infant project' was a home visiting programme with parental child developmental education and support (using a counselling model) delivered over 2 years by nurses. The (+) evaluation<sup>5</sup> showed that at 5-year follow-up a development advantage was identified, but at 2 years this was not evident.

'Social support and family health' was a home visiting programme delivered by a health visitor providing 'supportive listening', weekly and then monthly over 2 years (in London: Camden and Islington). The (++) evaluation<sup>8</sup> reported a possible effect on maternal health.

The (++) study<sup>3</sup> of a peer mentoring home visiting programme reported negligible effects on social and emotional wellbeing. This programme was delivered by recruited existing mothers twice-monthly during pregnancy and monthly for the following year (in deprived areas in Northern Ireland).

<sup>1</sup> Barlow et al. (2007)

<sup>2</sup> Barnes et al. (2006; 2009)

<sup>3</sup> Cupples et al. (2010)

<sup>4</sup> Ford et al. (2009)

<sup>5</sup> Johnson et al. (2005)

<sup>6</sup> Mackenzie et al. (2004)

<sup>7</sup> Shute and Judge (2005)

<sup>8</sup> Wiggins et al. (2004)

## Evidence statement 2.ES3: National evaluation of Sure Start

Moderate evidence from two studies (reported in four papers: two [++]<sup>1,2</sup> and two [+] <sup>3,4</sup>) shows that the Sure Start programmes are effective in improving some outcomes among infants aged 9 months and 3 years relating directly and indirectly to the social and emotional development and cognitive development of preschool children (including child positive social behaviour, child independence, better parenting, home learning environment).

There was variation in effects between subgroups and over time (evaluation periods). The earlier evaluation findings showed the small and limited effects varied with degree of social deprivation. Children from relatively more socially deprived families (teenage mothers, lone parents, workless households) were adversely affected by living in Sure Start local programme areas. Later evaluation results differed from the earlier findings in that beneficial effects could be generalised to all subgroups, including teenage mothers and workless households. The findings of the impact evaluation study reported the link between implementation (fidelity) and outcomes, and attributed improved outcomes to children being exposed longer to more mature local programmes (see UK process studies: evidence statement 5 below).

It is important to note that this evidence relates to the effect of Sure Start local programmes as a whole. Although Sure Start local programmes had common aims set by central government, the types and mix of interventions were not necessarily common between delivery sites. It is likely that interventions included home visiting, early education and daycare, and the education/daycare components were strengthened after the initial phase (although the evaluation was not dependent on these being present). There are a broad spectrum of outcome measures but not all of these relate directly to emotional and social wellbeing.

<sup>1</sup> Belsky et al. (2006)

<sup>2</sup> Melhuish et al. (2008)

<sup>3</sup> Melhuish et al. (2008)

<sup>4</sup> Melhuish et al. (2005)

## Evidence statement 2.PS1: Engaging families and the take up of early interventions services

Moderate evidence from eleven papers<sup>1,2,3,4,5,6,7,8,9,10,11</sup> suggests that the uptake of early interventions among vulnerable families is influenced by mothers' perception of benefits, timely

provision of information about the interventions, personal circumstances and views, the reputation of the services, recruitment procedures, perceptions about quality of interventions and their physical accessibility.

Three papers (two [+]<sup>1,10</sup> and one [-]<sup>11</sup>) reported that the perceived benefits for parents in their child attending childcare/early education were described in terms of building networks, providing an opportunity to take a break from parenting and a facilitator for employment

Five papers (four [+]<sup>2,3,4,7</sup> and one [-]<sup>9</sup>) reported that a perceived lack of need influenced parents' decision not to take up home visiting. In some cases their needs were seen as being fulfilled by support from friends, family, or other services. The 'wrong type of support' was described by one (+) paper<sup>3</sup> with parents needing practical support rather than other support.

Parental lack of knowledge regarding the content and potential benefits of available services was reported in four papers (three [+]<sup>1,5,8</sup> and one [-]<sup>6</sup>). One good quality (+) paper<sup>4</sup> described how mothers were unclear regarding what a programme offered, with women not understanding or not remembering information. Some women reported that the offer of the programme might have been preferred after the birth of their baby.

Two (+) papers<sup>3,4</sup> described the influence of personal choice with some women changing their minds or not being interested in a programme, and one (+) paper<sup>7</sup> highlighted that needs changed over time. Waiting lists for interventions meant that some women no longer needed the service when it was offered to them.

Three papers of mixed quality (one [-]<sup>6</sup> and two [+]<sup>8,5</sup>) described the influence of personal circumstances and views in influencing uptake. These included personal and family reasons and perceived cultural and language differences.

Personal choice may also be influenced by the confidence levels of parents. Two papers (both [+])<sup>1,5</sup> described how personal time factors could present barriers to uptake; with difficulty fitting the intervention into a personal routine or multiple demands.

Four mixed quality papers (two [+]<sup>1,10</sup> and two [-]<sup>6,12</sup>) highlighted the importance of marketing, outreach, and recruitment processes for programmes. Studies suggested the use of key workers and targeted publicity, door-knocking, making use of referral partners and ongoing invitations. Two good quality papers (both [+])<sup>1,5</sup> suggested the influence of the reputation of early education programmes in uptake. The reputation and feedback from other parents could be influential, and also a perceived stigma that services were 'for certain groups'.

Two good quality papers (both [+])<sup>1,10</sup> described parental worries regarding the cleanliness of venues, staff prying into their personal lives and concerns for their child.

The importance of the location of a service was discussed in three papers (two [+]<sup>5,8</sup> and one [-]<sup>6</sup>). The papers highlight that the accessibility of a site is important, with settings being visible and accessible to the public through adequate positioning on a busy street and clearly signposted. There was the suggestion that associating the nursery service with nearby schools made the programme appear more 'official' to parents and provided continuity of services.

<sup>1</sup> Avis et al. (2007)

<sup>2</sup> Barlow et al. (2005)

<sup>3</sup> Barnes et al. (2006)

<sup>4</sup> Barnes et al. (2009)

<sup>5</sup> Coe et al. (2008)

<sup>6</sup> Kazimirski et al. (2008)

<sup>7</sup> MacPherson et al. (2009)

<sup>8</sup> Mori (2009)

<sup>9</sup> Murphy et al. (2008)

<sup>10</sup> Smith et al. (2009)

<sup>11</sup> Toroyan et al. (2004)

<sup>12</sup> Tunstill (2005)

## **Evidence statement 2.PS2: Parents experience of services and ongoing engagement in early interventions**

Moderate evidence from thirteen papers<sup>1,2,3,4,5,6,7,8,9,10,11,12,13</sup> suggests that ongoing engagement with early interventions among vulnerable families is influenced by perceived benefits to children,

perception of a quality service, timing of the programme, the involvement of parents and personal reasons.

Three good quality (all [+]) papers<sup>1,10,12</sup> described that parents who took up the childcare/early education interventions valued the approach, and believed that it was beneficial to their children. Parents continued to use services as they valued how the programme was delivered, structured, and the way information and advice was given in a non-intrusive manner. Perceived benefits for children were the ability of children to mix, play, and learn with other children.

Three papers (two [+]<sup>10,12</sup> and one [-]<sup>7</sup>) suggested that parental perception of quality of provision influenced ongoing engagement. It was reported that smaller groups are preferable to parents, but if the staff and venue were perceived to be of high quality, maintaining smaller group sizes was of less importance.

Three papers (two [+]<sup>10,12</sup> and one [-]<sup>7</sup>) suggested that feedback to parents is an important factor in the success of an early education intervention. One (-) paper<sup>8</sup> highlighted a need to make parents feel more comfortable with taking part in activities that were designed for parent and child.

Three papers (all [+])<sup>1,6,10</sup> suggested that a lack of programme flexibility precluded some parents from engaging with programmes. Some parents indicated that they would value events outside of typical centre hours, with a desire for increased programme flexibility particularly among students and part-time workers.

Three papers (all [+])<sup>2,8,13</sup> highlighted that making a large time commitment to in-home support programmes could be a barrier to engagement. One (+) paper<sup>5</sup> reported that parents did not like the frequency of visits or fragmented visits. The timing of visits was noted as a problem in one (+) study<sup>9</sup> with mothers feeling disrupted by the timing and scheduling of visits. Two studies (one [+]<sup>4</sup> and one [-]<sup>11</sup>) reported that flexibility on the part of the visitor to the needs of the client to ensure the service was delivered at a suitable time, was key.

One (+) paper<sup>5</sup> suggested that a home visitor should be proactive in recognising warning signs of losing a client, offering the family a break from the programme, changing the content delivered, and working with families to meet their needs and achieve goals. Another (+) paper<sup>8</sup> highlighted that it made it easier for families to engage in other services once they were taking part in one programme.

Four (all [+]) papers<sup>3,4,5,13</sup> described personal reasons for not engaging with a service such as losing interest in the programme, missing too many appointments, moving out of the area, infant illness and other commitments.

<sup>1</sup> Avis et al. (2007)

<sup>2</sup> Barlow et al. (2005)

<sup>3</sup> Barnes et al. (2006)

<sup>4</sup> Barnes et al. (2008)

<sup>5</sup> Barnes et al. (2009)

<sup>6</sup> Coe et al. (2008)

<sup>7</sup> Kazimirski et al. (2008)

<sup>8</sup> Kirkpatrick et al. (2007)

<sup>9</sup> MacPherson et al. (2009)

<sup>10</sup> Mori (2009)

<sup>11</sup> Murphy et al. (2008)

<sup>12</sup> Smith et al. (2009)

<sup>13</sup> Wiggins et al. (2004)

## **Evidence statement 2.PS3: Home-based interventions and staff-parent relationships**

Moderate evidence from eight papers<sup>1,2,3,4,5,6,7,8</sup> suggests that the nature of the relationship between staff and parents is an important factor influencing the ongoing engagement of vulnerable families in home-based interventions.

The importance of building relationships was highlighted in six papers (five [+]<sup>1,3,4,5,6</sup> and one [-]<sup>8</sup>) with regular interaction resulting in parents feeling at ease and being able to 'open up', and with

home visitors acting as a mentor, friend, and teacher. Women reported that they liked that home visitors did not impose their views, and took an honest, open, humane and egalitarian approach. Some younger women however reportedly viewed a health visitor intervention as somewhat authoritarian, almost like advice from parents and some women were worried about how they may be perceived by home visitors, believing that they were being checked up on, and were concerned about visitors passing judgment on their lifestyle and parenting skills. One (+) paper<sup>3</sup> found fathers were pleased with the programme but took a few sessions to become engaged.

Support was a theme described in all six papers. Parents reported that having someone there to listen and provide additional support was beneficial, visitors offered assistance in difficult times, allowed parents to vent frustrations, and encouraged parents to develop life skills and confidence.

Parents valued the support of a peer home visitor, especially if they had little existing social support, with some women describing how they were reluctant to seek emotional support from family or friends.

<sup>1</sup> Barlow et al. (2005)

<sup>2</sup> Barnes et al. (2006)

<sup>3</sup> Barnes et al. (2008)

<sup>4</sup> Barnes et al. (2009)

<sup>5</sup> Kirkpatrick et al. (2007)

<sup>6</sup> McIntosh et al. (2006)

<sup>7</sup> MacPherson et al. (2009)

<sup>8</sup> Murphy et al. (2008)

## Evidence statement 2.PS4: Professional roles and practices

Evidence from eleven papers<sup>1,2,3,4,5,6,7,8,9,10,11</sup> suggests that issues relating to professional roles and working practices impact on service delivery and performance. Staff perceptions of the work being rewarding, the need for skilled staff, clarity about professional roles and inter-agency team working



are seen as linked to the success of a programme. Concerns relating to high stress and complex workloads were highlighted, and the need for training and support.

Two papers (one [-]<sup>3</sup> and one [+]<sup>6</sup>) indicate staff's belief in the programme was related to perceptions that the nature of the work was particularly rewarding. This was noted as a key factor for success.

The level of skills among staff was noted as important to the success of programmes in four papers (three rated [-]<sup>3,9,10</sup> one no rating<sup>4</sup>). Particular elements were: empowering users and staff; ongoing monitoring; staff keeping families notified of services and the results of any outreach and a supportive and flexible centre manager. Also one (-) paper<sup>10</sup> highlighted that clear roles and responsibilities for staff must be in place to avoid the potential for staff to face conflicting management and loyalty pressures between their original home organisation and their new roles.

Five papers (three [+]<sup>1,2,8</sup> and two [-]<sup>7,11</sup>) described concerns from staff regarding home-based programmes. Stress due to a larger caseload, stress related to the job, fatigue from extended hours of working and the complex nature of issues presented during home visits was described.

Three (+) papers<sup>5,8,11</sup> described how home visitors harboured frustrations with not being able to reach clients. They struggled with losing clients they wished they could help, and had to balance the needs of varying clients and had concerns that interventions were too short. One (+) paper<sup>1</sup> highlighted the potential for professional roles to be undermined, with concerns apparent regarding role clarity especially when working in mixed teams. While mixed team working was perceived as advantageous in helping at-risk families, there was a blurring of roles and boundaries which created confusion, and in some instances tension within teams.

There were mixed views of supervision found in three further studies (two [+]<sup>1,8</sup> and one [-]<sup>7</sup>). One reported satisfaction with management, while another described a need for safer working conditions and better management. In one study<sup>7</sup> peer mentors reported that at times, they felt unprepared for some of the cultural and ethnic differences that they encountered in the home while visiting mothers, and felt they could not provide adequate support. The need for visitors to be well supported by peers and supervisors was highlighted in one (+) study<sup>2</sup>.

<sup>1</sup> Barnes et al. (2008)

<sup>2</sup> Barnes et al. (2009)

<sup>3</sup> Kazimirski et al. (2008)

<sup>4</sup> Mathers and Sylva (2007)

<sup>5</sup> McIntosh et al. (2006)

<sup>6</sup> Mori (2009)

<sup>7</sup> Murphy et al. (2008)

<sup>8</sup> Smith et al. (2009)

<sup>9</sup> Toroyan et al. (2004)

<sup>10</sup> Tunstill et al. (2005)

<sup>11</sup> Wiggins et al. (2004)

### **Evidence statement 3.1: How can those vulnerable children and families who might benefit from early education and childcare interventions be identified?**

It may be possible to identify children and families who might benefit most from early education and childcare interventions by considering the factors which research suggests are likely to increase their risk.

The models for predicting future likely child health outcomes could be used at a population level to direct early intervention investment towards those children and families that are most likely to experience the poorest outcomes. However, the model is dependent on the robustness of the longitudinal data sets in identifying all the key risk factors and the availability of local data to map these factors. Certain factors are not well represented, including those relating to parenting and parental mental health problems. The relationship between cultural factors and child outcomes is not well understood.

Also, such models cannot be used to predict outcomes at an individual level. The models may inform practitioners about risk factors, however, practitioner knowledge will also be vital in validating the model for use for individual risk-assessment purposes.

## *Additional evidence*

Expert report 1: 'Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5'

Expert report 2: 'Programmes to promote the social and emotional wellbeing of vulnerable children under 5: messages from application of the Evidence2Success standards of evidence'

Expert report 3: 'The costs and benefits of early interventions for vulnerable children and families to promote social and emotional wellbeing: economics briefing'

Expert testimony on the Family Nurse Partnership: Kate Billingham, Department of Health

Expert testimony on the PREview project: Helen Duncan, Child and Maternal Health Observatory (CHiMAT) and Kate Billingham, Department of Health

## *Economic modelling*

The review of cost-effectiveness interventions found little UK evidence. By contrast, the US literature indicates that preschool education and/or home visiting programmes for at-risk populations may be cost effective.

Two econometric models were developed to understand what determines aspects of social, psychological and cognitive development (or 'ability') in early childhood. They also aimed to establish a link between early childhood development and adult outcomes.

Measures of cognitive and behavioural development were found to have a very important effect on long-term outcomes, as was parental 'investment' in the early years – through its effect on cognitive and behavioural development.

The authors noted a number of limitations in the econometric models, however, including reliance on self-report data, limited common variables in the datasets, use of observational data and associated problems with direction of causality.

An economic model was used to conduct an economic analysis of interventions to improve the social and emotional wellbeing of infants from a public sector perspective. Seventeen scenarios were modelled, drawing on evidence from the UK and US and reported in review 2.

The results were not conclusive. Interventions which improved child cognition could be cost-saving to the public sector, through improved educational outcomes, higher wages and tax revenues.

Modelling of the long-term effects of behavioural changes in childhood yielded more modest financial benefits. Improvements in behaviour in childhood improves adult educational outcomes, reduces the probability of being on benefits, being economically inactive or being involved in crime. All these factors yield cost savings for the public sector, but the sums are relatively small compared to the effects of improved cognition.

The authors concluded that there is potential for interventions with vulnerable preschool children to be cost effective or cost saving, even without taking into account other potential benefits. (Other benefits might include avoiding child neglect and improving the socioeconomic outcomes for the children's descendants.)

A number of limitations were noted including:

- The limited number of outcomes that can be used to generate financial benefits.
- Uncertainty introduced by mapping variables across different ages and data sets.
- The limited nature of the evidence base.
- The need to estimate the effects of social and emotional wellbeing on long-term outcomes (such as the probability of a criminal conviction, economic activity and unemployment).

## *Fieldwork findings*

Fieldwork aimed to test the relevance, usefulness and feasibility of putting the recommendations into practice. PHIAC considered the findings when developing the final recommendations. For details, go to the fieldwork section in [appendix B](#), 'The social and emotional wellbeing of vulnerable children (early years): views of professionals' and 'The social and emotional wellbeing of vulnerable children (early years): views of parents and carers'.

## **Views of professionals**

Fieldwork participants who work with vulnerable children aged under 5 years were very positive about the recommendations and their potential to promote the social and emotional wellbeing of these children. Many stated that the recommendations complement aspects of the Department for Education's [Statutory framework for early years foundation stage](#) and government policy for early years services.

Participants said the recommendations needed to acknowledge the role of the father and other family members or carers in promoting the social and emotional wellbeing of children under 5.

They believed wider, more systematic implementation of the recommendations would be achieved if there was:

- a clearer definition of what makes a child 'vulnerable'
- better identification of who should take action
- clarity about which action points were intended to be targeted or universal.

### **Views of parents and carers of children aged under 5 years**

The guidance was well received by parents and carers. In particular, there was strong support for multidisciplinary working and the need to ensure effective information sharing among services.

In addition, they strongly supported the recommendations to provide high quality education and childcare, but stressed the need to promote free education for children aged 2 years.

The stigma associated with labelling families as 'vulnerable' was a concern. They accepted that the term (and identified risk factors) may help find children and families in need of help. However, they were concerned that those identified would feel criticised or blamed.

Parents and carers also emphasised that practitioners should not assume that all those identified as being part of a high-risk group are vulnerable.

## Appendix D Gaps in the evidence

The Public Health Interventions Advisory Committee (PHIAC) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There is limited UK evidence on the effectiveness of interventions (home visiting, childcare and early education) to improve the social and emotional wellbeing of vulnerable children aged under 5 years.
2. There is limited UK evidence on the cost effectiveness of early interventions to improve the social and emotional wellbeing of vulnerable children aged under 5 years. This includes evidence on the distribution of costs and benefits across all relevant sectors including health, education, social care, welfare and criminal justice.
3. There is a lack of nationally agreed definitions and measures of vulnerability and risk relating to the social and emotional wellbeing of children aged under 5 years. This makes surveillance, planning and evaluation difficult.
4. There is limited evidence on the effectiveness of different methods of delivering early interventions.
5. There is limited evidence on the differential impact of early interventions on the social and emotional wellbeing of particular groups of vulnerable children aged under 5 years and their families. (This includes, for example, the impact on particular minority ethnic groups and on children whose parents have mental health problems.)

The Committee made 8 recommendations for research into areas that it believes will be a priority for developing future guidance. These are listed in [section 5](#).

## Appendix E Supporting documents

Supporting documents include the following (see [supporting evidence](#)).

- Evidence reviews:
  - Review 1: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): Systematic review level evidence'
  - Review 2: 'Promoting the social and emotional wellbeing of vulnerable preschool children (0–5 years): UK evidence review'
  - Review 3: 'Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties'
- Economic modelling:
  - 'Economic outcomes of early years programmes and interventions designed to promote cognitive, social and emotional development among vulnerable children and families. Part 1 – econometric analysis of UK longitudinal data sets'
  - 'Economic outcomes of early years programmes and interventions designed to promote cognitive, social and emotional development among vulnerable children and families. Part 2 – economic model'.
- Commissioned expert reports:
  - Expert report 1: 'Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5'
  - Expert report 2: 'Programmes to promote the social and emotional wellbeing of vulnerable children under 5: messages from application of the Evidence2Success standards of evidence'
  - Expert report 3: 'The costs and benefits of early interventions for vulnerable children and families to promote social and emotional wellbeing: economics briefing'.
- Fieldwork reports:
  - 'The social and emotional wellbeing of vulnerable children (early years): views of professionals'

- 'The social and emotional wellbeing of vulnerable children (early years): views of parents and carers'.

- A pathway for professionals whose remit includes public health and for interested members of the public.

For information on how NICE public health guidance is developed, see:

- 'Methods for development of NICE public health guidance (second edition, 2009)'
- 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)'.



## About this guidance

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

This guidance was developed using the NICE [public health intervention](#) guidance process.

The recommendations from this guidance have been incorporated into a [NICE Pathway](#). Tools to help you put the guidance into practice and information about the evidence it is based on are also [available](#).

### Your responsibility

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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## Accreditation

