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Literature review

The value of early interventions and the role of improving outcomes for children, young people and their families, with focus on parenting programmes and the FNP.

Introduction

Despite the drive for holistic approaches to improve outcomes for children, young people and their families, inequalities and child poverty continue to exist, and prevent vulnerable and disadvantaged groups from realising their potential in all aspects of their health, development and wellbeing (Department of Health, 2004). Intervening early in a child’s life is considered imperative in shaping health, social, educational and cognitive outcomes for children, and this is reflected in all contemporary policy, guidance and research which supports a move towards child centred services and care provision (Parton, 2008; Ramey & Ramey, 2008). Rather than providing services based on reactionary or crisis management models, transformational changes have been called for, which move services towards the provision of early support, prevention and intervention (Scottish Government, 2008).

As part of the renewed focus on providing early interventions to those most in need, the requirement to offer parenting support has become increasingly apparent, reflecting the view that parents are best placed to improve the outcomes of their children (Allan, 2011). Parenting support can take various forms, including the provision of parenting programmes, delivered either in group settings or within the home. Consequently, there is a role for evidence based parenting programmes to be delivered in the UK to parents who would benefit from this additional support to ensure the needs of children and young people are met in a timeously manner (Department of Health, 2009). Although a plethora of parenting programmes exist in the UK and internationally, the Family Nurse Partnership (FNP) is one programme offered widely throughout the UK. The Family Nurse Partnership is an evidence based home visiting programme involving 64 home visits beginning ante-natally, until the child is aged 2 years, and is delivered by highly trained nurses. The programme originates in the USA but has been replicated throughout the UK and internationally due the robust evidence base, and plethora of studies by its founder Olds, confirming the benefits to child and family outcomes (Olds, 2006). This paper will review the literature around the provision of early interventions to vulnerable or disadvantaged children and families; the early years are critical in shaping the lives of children and therefore the potential impacts of early experiences on infant brain development will be explored. Additionally, the role of parenting programmes, and in particular the literature that evaluates the Family Nurse Partnership in the UK will be explored and critically evaluated.

Early interventions

It has been argued for many years that early childhood prevention strategies should be central to policies for children and families, and early interventions are now considered pivotal and fundamental to improving outcomes for children (Parton, 2008). The evidence gathered over the last four decades has highlighted the significance of early interventions in shaping the health, academic, cognitive and social outcomes of children (Ramey & Ramey, 1998), and subsequently interventions range from those delivered within universal services, to those that are highly targeted (Allan, 2011). Allan (2011) also emphasises that the quality of a child’s relationships and learning experiences in the early years strongly influences their future achievement and wellbeing, and this view is reflected in current

research including a variety of cohort studies and randomised control trials (Farrington et al, 2006). Additionally, studies have claimed that early interventions lead to longer term benefits for individuals and society, by means of reducing criminality and violent offending as well as drug and alcohol misuse (Heckman & Masterov, 2007).

Costs of intervening early

It is well documented that those who have had adverse early years' experiences incur significant costs to society through addressing their behaviours or managing their effect, and their contribution to society (Allan, 2011). Therefore, it has been suggested that investment in the early years is cost-effective, and returns on investment from birth to eight years are substantial (Engle et al, 2011); however, it is argued that this return reduces the later this support is provided (Scottish Government, 2011).

Although it is recognised that there are significant costs associated with supporting children who have experienced abuse and neglect (Browne & Jackson, 2013), and despite literature confirming the economic benefits of early interventions, in times of austerity it is argued that service providers may not prioritise services whereby gains are not realised for years to come (Engle et al, 2011).

Furthermore, despite the evidence for early intervention and associated efficiency, it is argued that spending on early interventions is low, with only 4% of total health budgets being spent on intervening early (Allan, 2011); furthermore, it is argued that £10 of savings can be generated for every pound spent, and the current spending patterns are ineffective, with majorities of budgets going to older children aged 12-17 years, which contradicts theory and evidence on child wellbeing (Organisation for Economic Co-operation and Development, 2009).

Brain development

The foundations of the brain's architecture are laid in early life and are determined by genetic, biological and psychosocial influences (Walker et al, 2011), and the early development of the brain and neural pathways are responsible for language acquisition and emotional regulation which have long term implications for forming relationships and social development (Shonkoff, 2000).Early experiences in childhood influence a child's future emotional and physical development and wellbeing; in order to promote optimal brain development and ensure brain architecture is constructed in a sequential manner, children in the early years require the development of strong secure attachments with care-givers that are based on responsive and consistent and stimulating parenting (Allan, 2011). Secure attachment leads to the development of empathy and trust and enables the regulation of emotions and development of social skills (Walker et al, 2011).

In contrast, children who do not experience parenting based on such values, and who experience neglectful or abusive environments, are at risk of poorly developed social skills, lack empathy and have difficulty regulating their emotions, which can also lead to mental health, relationships and anti-social problems (Engel et al, 2011).

Therefore, the experiences a child experiences in the very early years has a direct influence over brain development and sets the blueprint for future life. Professionals therefore have a role in identifying those families who may require additional support to provide consistent and high quality parenting which is based on quality interactions and stimulation, and does not feature stress, aggression, violence, and other factors that affect a parents' capacity to provide attentive, consistent care (Allan, 2011).

Parenting & parenting support

Parenting support has a role in protecting children as well as improving outcomes. Child abuse and neglect are major public health issues (Barlow & Calaman, 2011), and it is argued that home visiting programmes like the FNP produce significant savings when compared to the costs associated with child abuse. Bronfenbrenner in (1974) suggested that educating parents could potentially improve a child's language development, educational attainment, and social development, therefore the concept of early interventions and parenting support is not only a contemporary issue; but one that has been considered for many years. Additionally, studies in the 1980s and 1990s also confirmed that parenting support during times of stress could promote wellbeing (Shonkoff, 2000).

Parenting has a strong influence over emotional and physical health of children and adults, and research suggests that the care received in the early years is influenced by the attitudes of parents and the parenting practices experienced in childhood (Department of Health, 2004). Parents are considered to be most receptive in a child's early years and contemporary literature places a renewed emphasis on parenting support, whereby parents are supported to provide sensitive parenting, based on supportive relationships and quality parent-child relationships (Department of Health, 2009). Parenting programmes are interventions designed to improve parental knowledge, skills and confidence, and are considered key to improving outcomes for vulnerable or disadvantaged children and families (Centres for Disease Control and Prevention, 2009).

There are a plethora of parenting programmes being delivered across the UK and internationally, aimed at improving parenting practice as well as addressing conduct and behavioural problems (Scott, 2009) and are delivered either through universal services, or more commonly through targeted interventions (Whittaker & Cowley, 2010). Although various programmes exist in the UK, they vary greatly in terms of their quality, fidelity, evaluation, impact, intervention specificity and system readiness (Allan, 2011). Therefore, it is argued that despite a variety of programmes being available to families, many interventions lack robust evaluation, and are often associated with poor fidelity, which contributes to their poor evaluations and measurable outcomes (Paulsell, 2012).

The Family Nurse Partnership

Designed by Olds (2006), the FNP is a preventative home visiting programme targeted at young first time mothers under the age of 19, with principle aims of improving maternal health and pregnancy outcomes, child health and development and parental economic self-sufficiency. It is often considered superior to other parenting programmes due to its significant evidence base demonstrating both long and short term benefits to children and their families (Trotter, 2012).

The FNP programme is offered widely across the USA to approximately 26,000 families per year, and is has also been rolled out across Canada, the Netherlands and the UK (Olds et al, 2013); Olds suggests his use of randomised control trials (RCTs) in differing national contexts, with contrasting populations is important in developing a robust evidence base which confirms the value of his programme.

Results from trials have found children involved with FNP sustain fewer injuries, experience improved emotional and speech and language development, improved school readiness and attainment, fewer behavioural difficulties and reduced use of alcohol and substances (Olds, 2006; Landy et al, 2012). Furthermore, women receiving the programme experience fewer subsequent pregnancies and improved employment opportunities (Olds, 2006).

Randomised control trials are often considered the most reliable and valid research methodology (Parahoo, 2014), and Olds (2006) has undertaken many RCTs over many years to provide the evidence behind the FNP intervention. It is argued however, that other than Olds, very little evaluation has been undertaken of this model, which suggests it may be open to bias (Parahoo, 2014). Additionally, the FNP has its history in the USA, and therefore it is argued that the transferability into

UK contexts may not reflect equally positive benefits to those who receive it (Jack et al, 2012).

Jack et al (2012) explored the transference of FNP to Canada and highlighted that the replication of findings to a setting out-with the USA should be done with caution. The FNP is a licensed programme and therefore countries adopting the FNP are required to adhere to the programme fidelity, however feasibility studies are required to determine if they can be transferred into other contexts whilst retaining programme fidelity (Jack et al, 2012). However, Jack et al (2012) claims that FNP provides positive outcomes that impact across generations with effects seen up to 19 years post intervention compared with controls. This highlights the potential financial and social cost savings associated with the programme continue to be seen long after the interventions has been completed.

It has been suggested that the FNP can be successfully delivered in the UK. Early evaluations of the implementation of the FNP in England were positive suggesting the use of harsh punishments used by parents was reduced, parents were positive about their children, and women had longer spaces between pregnancies (Barnes & Henderson, 2011). However, successful implementation of FNP in England was found to be dependent on smaller caseload sizes than Olds (2006) had originally suggested. Barnes and Henderson (2012) report that adaptations may be required to meet the needs of specific cultures and nationalities, however consideration needs to be given to ensure fidelity to the model is maintained.

Previous evaluations of the FNP in England are promising, however Robling et al (2016) undertook a non-blinded randomised control trial with 18 health and local authority organisations in England and found that FNP was no more effective than universal health visiting services in reducing the number of women smoking during pregnancy, and the number of premature or small babies; equally it did not prevent women falling pregnant again within two years, and the programme did not appear to reduce hospital admissions or involvement of social work. Furthermore, the study found that the FNP costs organisations more than universal health visiting services, which conflicts with findings from other research which suggests it creates savings (Barlow & Calaman, 2011).

Although this conflicts with earlier studies, and in fact the majority of FNP studies, Robling et al (2016) recognise that children of families receiving the FNP demonstrated better language skills than children receiving only universal health visiting services. Robling et al (2016) also acknowledges various limitations of the study, and this includes the transferability of the FNP into a UK context, whereby young first time mothers have access to a variety of other support services. Furthermore, it is possible that the sample population was subject to less stringent criteria, and therefore a less disadvantaged sample was used than in studies where intervention effects have been previously reported.

The findings from Robling et al's study (2012) conflict with Barnes and Henderson (2012) who undertook an evaluation of the first phase and found promising findings. It is important to recognise however that Robling et al's (2012) quantitative study only considered short term impacts, and did not consider long term outcomes for children.

Similarly, Ball et al (2012) also suggests that findings from three evaluations of the FNP have influenced how it is delivered, and have found that FNP has replicated well in the UK. The differing view arising from these studies is worthy of further exploration to give a clear indication of the future role of the FNP. Although the FNP has been delivered in the UK for several years, evaluations are continuing to highlight the strengths and challenges of delivering the FNP in line with the USA license, and work continues to adjust and deliver the programme that fits with UK health care services and within public health frameworks (Ball et al, 2012).

Despite Robling et al (2016)'s more modest findings, the international literature is overwhelmingly positive, and therefore FNP continues to be recognised as a favourable programme to be used with vulnerable families, and implementation into the UK continues, and will continue to require ongoing evaluation.

Conclusions

Early interventions are considered pivotal to improving outcomes for vulnerable or disadvantaged children and their families. What children experience in their early years has a strong influence over their future health, development and wellbeing, with positive parenting and relationships promoting strong attachments which enhance their self-regulation, empathy, social skills and cognitive abilities (Allan, 2011).

Contemporary research continues to emphasise the importance of supporting families in the early years to provide nurturing parenting, and reduce inequalities that continue to exist throughout the UK as well as internationally (Department of Health, 2008). Parenting support is reflected in most current UK policy affecting children and families, with emphasis on the provision of parenting programmes as one method of supporting parents to improve outcomes for their children. Although a variety of parenting programmes are delivered throughout the UK, they vary greatly in terms of their fidelity and effectiveness; the FNP has been robustly evaluated, and consequently is being delivered throughout the world.

A review of the literature is predominantly positive, highlighting that children involved in the programme benefit from improved emotional regulation, improved speech and language development, improved school readiness and attainment, fewer behavioural difficulties, reduced use of alcohol and substances, and sustain fewer injuries (Olds, 2006; Landy et al, 2012, Barnes, 2012). Additionally, mothers have increased spacing between pregnancies, and fewer subsequent pregnancies, as well as improved employment outcomes (Landy et al, 2012). A more recent study by Robling et al (2016) questions the outcomes of the FNP and reports little improvement in outcomes compared to children receiving universal health visiting services. It is also suggested that the transferability into UK settings continues to need evaluation in order to ensure fidelity to the licence.

This conflict in findings requires further exploration, as it contrasts greatly from the plethora of FNP literature that exists. Despite the contrasting findings, the FNP continues to be delivered to vast numbers in the UK and internationally as the role of parenting support remains critical to improving outcomes for children and their families.

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