PROGRAMME PROVIDER REFLECTION ON "FOUNDATIONS FOR LIFE: WHAT WORKS TO SUPPORT PARENT CHILD INTERACTION IN THE EARLY YEARS" REPORT BY THE EARLY INTERVENTION FOUNDATION

The Evidence Journey: Case Study & Testimonial

Programme: The Social Baby

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Research over the past decades clearly shows that the way in which children have developed by age two is one of the most important predictors of their long term development: children who are persistently aggressive at this age have a greatly increased risk for future aggression and violence; children's IQ at age two predicts their later IQ and their school achievements; children who are insecurely attached at age two are at increased risk for later relationship difficulties and general adjustment problems. All these areas of child development are strongly influenced by the quality of care the child receives and, in turn, parents' capacity to give good care is affected by their mental health and the presence of adversity in their lives. The primary aim of our programme was to support vulnerable parents from pregnancy through the early postnatal months to reduce the risks of depression and parenting difficulties, and ultimately to promote their children's development. To do this, we trained community workers (South Africa) and Health Visitors (UK) in a home visiting programme that combined counselling with support for the parent-child relationship.

We evaluated how well our aim was achieved by carrying out Randomised Controlled Trials, in which we compared parents and children who received the intervention with those who did not. We made rigorous, *objective* assessments of parenting and child development, and used gold-standard measures of parents' depression, that were conducted 'blind' to whether the parents received the intervention or not.

How evidence standards (like EIF's) can help

It is critical that programmes such as ours receive rigorous, independent, scrutiny, and EIF helps encourage these standards. Unless programmes are evaluated with robust methods, there is a danger that erroneous conclusions will be drawn. This may be a particular problem when self-reports, rather than objective independent assessments are the principal outcomes.

We learned many lessons from our programme. In South Africa, we learned that the *specific content,* rather than *the general supportive nature,* of parenting interventions is likely to be important- our programme focussed on aspects of parenting of particular relevance to child

attachment, but did not contain elements to foster child cognitive outcome, and we found that child attachment benefited, but cognitive development did not (Murray et al., 2016a). Accordingly, we have now developed a rather different, and successful, book-sharing intervention to support parenting for child cognitive development (Vally et al., 2015; Murray et al., 2016b). We are now combining this with our original programme in a whole community roll out programme in South Africa.

In the UK, the same form of the parenting programme did not bring benefits. We attribute this to two main factors. The first concerns the brief nature of the intervention- it finished at eight weeks postpartum, unlike in South Africa where is lasted through to six months. The evidence is now clear that the parenting difficulties that are associated with particularly poor chid outcome occur principally where mothers experience severe and persistent depression, and thus our early and brief intervention was inadequate to address mothers with these problems. We are now addressing this issue, in collaboration with Professor Alan Stein, by conducting an RCT of a longer-lasting home visiting intervention for mothers with more severe and persistent depression.

A second possible reason for the relative failure of the UK programme to have a significant benefit was motivation. In the UK sample, although we, as researchers, identified antenatal risk factors for parenting difficulties, such as poor partner support, previous history of depression, many of the participants did *not* seem to perceive themselves to be in particular need of support or parenting guidance. (In fact, although our take-up rate was very good, the women with the highest level of risk, as identified by our screening questionnaire, were the most likely to refuse the intervention, and their pregnancy, birth and breast-feeding outcomes were particularly poor (Murray et al., 2004)). Thus, while recruited participants were willing for the Health Visitors to come to see them at home and offer support, they often did not appear motivated to change a situation that they did not regard as problematic in the first place. Here, the contrast with South Africa was striking- in this latter context, parents were generally highly motivated to do anything they could to foster their children's life chances, and they were able to make clear links in their minds between their children developing well in their early years and their long-term life trajectory. This same sense of the possibility for change in the UK sample was not apparent to us.

This interpretation is leading us to try to focus on the most vulnerable parents (i.e., those who are both in most need and likely most motivated to change), as we are doing with Professor Stein. We are also trying to better communicate to parents the potential benefits to their children of supporting their development, and to find means of doing so that are relatively simple to implement. In fact, our book-sharing intervention in South Africa, which brought about benefits to child socio-emotional, as well as cognitive, development, is a promising route that we are now pursuing in both South Africa and other LMIC's, as well as hoping to do in the UK.