November 2006

# National evaluation report

# Outreach and Home Visiting Services in Sure Start Local Programmes

SureStart

Report 017

Evidence & research

Research Report
NESS/2006/FR/017

# *Outreach and Home Visiting Services in Sure Start Local Programmes*


**ISBN 978 1 84478 848 4**

**The National Evaluation of Sure Start (NESS) is based at the Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London, 7 Bedford Square, London WC1B 3RA**

**Core Team**
Professor Edward Melhuish, Institute for the Study of Children, Families and Social Issues, Birkbeck (Executive Director)
Professor Jay Belsky, Institute for the Study of Children, Families and Social Issues, Birkbeck (Research Director)
Dr Alistair Leyland, MRC Social and Public Health Sciences Unit, University of Glasgow (Statistician)

**Impact Module**
Professor Edward Melhuish, Institute for the Study of Children, Families and Social Issues, Birkbeck (Director)
Professor Angela Anning, Department of Education, University of Leeds (Investigator)

**Implementation Module**
Professor Jane Tunstill, Department of Health and Social Care, Royal Holloway, University of London (Director)
Mog Ball (Investigator)
Pamela Meadows, National Institute of Economic and Social Research (Investigator)
Professor Sir David Hall, Sheffield University

**Cost Effectiveness Module**
Pamela Meadows, National Institute of Economic and Social Research (Director)

**Local Context Analysis Module**
Professor Jacqueline Barnes, Institute for the Study of Children, Families and Social Issues, Birkbeck (Director)
Dr Martin Frost, Birkbeck (Investigator)
Beverley Botting, Office of National Statistics (Investigator)

**Support to Local Programmes on Local Evaluation Module**
Professor Jacqueline Barnes, Institute for the Study of Children, Families and Social Issues, Birkbeck (Director)

The following members of the NESS Implementation Team contributed to this report:

| | |
|---|---|
| Mog Ball | Investigator |
| Judi Chrysanthou | Research Officer |
| Claudia Garbers | Research Officer |
| Joanna Goldthorpe | Research Officer |
| Anita Morley | Research Officer |
| Lisa Niven | Research Officer |

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education and Skills.

**CONTENTS**




Thanks to all the managers, staff, volunteers and family members in Sure Start Local Programmes and their neighbourhoods, who willingly shared their time and knowledge with us for this study.

## EXECUTIVE SUMMARY

### Introduction

The Implementation module of the National Evaluation of Sure Start (NESS) has carried out a series of snapshot studies of aspects of the work of Sure Start Local Programmes (SSLPs). This report looks at outreach and home visiting services, which were included as a core requirement of SSLPs *"to ensure that services are accessible to all families, particularly those who are most isolated (either geographically or socially) as they are often the ones who are reluctant to use mainstream services but need them the most."*

### Aims

The themed study addressed the question: how is outreach and home visiting contributing to the overall aim of Sure Start, *"to work with parents-to-be, parents and children to promote the intellectual and social development of babies and young children – particularly those who are disadvantaged."*

### Methodology

The study was carried out using applied research methods and drew on data collected by other modules of NESS to develop an overview of outreach and home visiting services, and to look at practice in greater detail in 22 areas. Case studies included document searches and interviews with users and staff from within and outside the SSLPs.

### Background

A core requirement of SSLPs was to improve 'reach' (i.e. the size and shape of programme areas) this was to be achieved through: consultation with parents, the provision of attractive new venues, and a willingness to be flexible and fit services to the needs of the community. Existing services, like midwifery, health visiting and family support – often provided by voluntary organisations – were already visiting families at home programmes. SSLPs therefore had to understand what was going on already and build upon these activities.

Research evidence showed that services could have difficulties enrolling, engaging and continuing to work with families, and that where they were effective, the changes that resulted were often modest. It recommended that outreach services, as part of a range of services, be sensitive and flexible and be offered to all families with a new baby therefore targeting both the children and their families (Gomby et al 1999). Good practice in outreach services included the use of trained staff with realistic expectations. All these recommendations had been implemented in the SSLPs studied.

Impact on children was found in the evaluations of programmes that integrated home visiting with centre-based group education and where the activities were delivered in the home to a curriculum structured in terms of personnel, timing, content and procedures (Schweinhart 2003). There were no examples of an intervention of precisely this type being delivered by SSLPs studied, though there were some with elements of this approach.

Research evidence on the effectiveness of health visitors did not link with health outcomes but did show that they were accepted by families, their role could be extended by the use of para-professionals and that they could provide the linchpin for multi-agency working. (Elkan et al. 2005)

## Different Approaches by SSLPs

The outreach and home visiting services were delivered by SSLPs in the following ways:

**Information**
All SSLPs produced written information, sometimes with the help of parents, often in community languages, which provided an opportunity for interaction with families. **Good Practice was evident when** information was:

- given by a knowledgeable worker or volunteer;
- short and to the point
- developed in partnership with families, and
-offered persistently.

**Moving Services Closer to Users**
SSLPs also paid attention to the venues from which services were delivered making these accessible. **Good practice included:** building new, welcoming and convenient venues, using new community bases like mosques, and taking services to families in buses. Working through voluntary organisations already based in the community – like playgroups and family centres - and expanding the work of some which were already engaged in home visiting were also examples of good practice.

**A Gateway for Services**
Outreach and home visiting are a way to gain the confidence of a family as a prelude to continuing involvement in services. **Good practice** respected culture and language and made sensitive approaches to parents who were lacking in confidence. SSLPs planned this type of outreach, aiming to get families out of the home after a standard number of visits. Parents were sometimes accompanied, met at the setting, and received follow-up calls and visits. In some areas the accompanying role was carried out by other parents. Visits were used as a way to assess the needs of families more accurately.

**Delivering Services through Home Visits**
The direct delivery of services through home visits was less common. Many SSLPs considered that interaction with other families, out of the home, was more beneficial to children than one-to-one interaction with Sure Start staff. Service delivery in the home was often offered only to the most vulnerable and hard-to-reach families. It was rare for SSLPs to deliver a structured programme completely at home, but the first elements of such a programme might be offered, with the rest delivered in a group setting. SSLPs felt that home visits took up a lot of time and could make families dependent on SSLP staff. **Good Practice** was evident when SSLPs called on families who had

never used SSLP services, when they followed up on reports by neighbours about isolated families, and when they used health information systems to identify families and undertake visits.

## The Role of Outreach and Home Visiting in an Integrated Programme

NESS Cost Effectiveness research showed that SSLPs made one sixth of their expenditure on these services, and that they are responsible for 13% of costs once programmes are operational. Expenditure tends to be a little higher in areas with large populations of families of Asian origin. Where health managers were involved in the design of programmes, midwifery and health visiting services were likely to be central to the outreach approach. Where there were paraprofessionals involved, it was to support midwives and health visitors. In SSLPs with a strong community development ethos, outreach and home-visiting was mainly carried out by community workers, paraprofessionals and parents. Health workers and other specialists were called upon where specialist help was requested or deemed necessary.

The most common ways to organise outreach and home visiting were:

**A: Whole System**
This involves most of the staff in the SSLP. The majority of the visits are made by a midwife and a family support team who call on other members of the integrated SSLP staff – speech therapists, community workers, play workers, dieticians, CAB workers – as families require them.

**B: Generic Team**
Designed for a very diverse area, a large outreach team has a manager and speakers of the main community languages, as well as play development, nursery nurse, family support and bilingual speech and language workers.

**C: Multi-Team**
This is used in local authority areas where there is more than one SSLP. It uses separate teams – Health Visiting; Early Intervention (early years worker, speech therapist, midwives, teenage parent worker, domestic violence specialist); Peer Support (trained volunteers); Education Outreach (nursery teachers delivering Start Right curriculum in the home). The model works on interagency referrals and could be appropriate for Children's Centres.

**D: Community Development**
All SSLP employees, including many recruited from the local community, receive outreach training and work in home-visiting. In pairs they visit the houses where parents with young children live. The same workers visit the same group of houses approximately once a fortnight. They deliver information about Sure Start and are trained to respond to any immediate problems which parents may raise about behaviour, for example, and to signpost them to specialist services if necessary.

**E: Focussed Intervention**
An outreach team of nursery nurses carries out early assessments to screen for child development delays, these are followed by an intervention if they are detected, which is delivered by home visits. Screening of every child takes place at 18, 24, 30 and 36 months in the home, children who do not meet thresholds are referred for support in the home, where activities are carried out and modelled for the parent.

**F: Health Team**
This is the most widespread model, it builds on existing services. The teams comprised Sure Start staff and local health visitors, midwives, psychologists, and other health professionals (CPNs, occupational therapists). They deliver ante and post-natal support and screen for postnatal depression. Emphasis is on the well being of the parent and ensuring attachment to the child and healthy behaviours.

**G: Voluntary Sector**
Services are commissioned from voluntary organisations and delivery is through existing infrastructure. In the examples seen, a group of home visitors worked partly for SSLPs and partly for their own organisations. Supervision is given by psychologists. The home visiting team give social and emotional support and give information to families.

**H: Home Assistance Model**
This involves the provision of practical help through Maternity Care Assistants (MCAs). The MCAs clean and provide other help, friendship and emotional support to mothers for six weeks after a birth. They are drawn from the minority community from which many of the SSLP families come.

**I: Minimal Outreach and Home Visiting Services**
Some SSLPs do little or no outreach work. They consider it expensive, spending too much time on a small a number of families, intrusive and disempowering. All efforts go into group- based services.

Variations in models of service delivery include the size of the team (which tends to be larger in areas with a diverse population); the combination of skills in the team; the construction of the family and its relation to Sure Start, and the relation of the delivery team to the rest of the SSLP programme.

## Essential Elements in Managing Outreach and Home Visiting

• **Coordination** – is usually undertaken by a dedicated post. Work is allocated through this post, often by a process of referral.

• **Clearly Defined Role for Workers** – achieved through statements clarifying the purpose of outreach and home visiting and the relationship of workers to families and other agencies.

• **Training** – this covers: where to get back-up advice in supporting families, and how to signpost them to it; risk assessment; personal safety;

confidentiality procedures; courses on specific subjects like domestic violence and child protection, and issues for the SSLP community. Longer training is required for paraprofessional staff.

• **Protocols** – to cover matters like working in pairs, behaviour in family homes and confidentiality.

## Impact of Outreach and Home Visiting

### Families

In many areas SSLPs found that services were taken up most enthusiastically by the least disadvantaged families, and this could put off the families who were in more need of them. Outreach and home visiting were a way of targeting those in most need and persuading them to attend groups and other services. There were few examples of structured programmes delivered to children in the home, but where these occurred staff felt that families did not carry out the recommended activities between visits. There were mixed messages about family response to paraprofessional workers – some SSLPs felt families preferred them, others felt they preferred professional staff. Parents expressed high levels of satisfaction with outreach and home visiting services and reported improvements in their children as a result.

### Staff

Health visitors and midwives responded well to the SSLP integration of services because they could refer families to a much more extensive range of back-up services. Not all pre-existing health visitors had collaborated with Sure Start, the influencing factor being the attitude of their managers. Over time relationships could improve, often because the services themselves became more focused and existing services could see that they were having an effect. Staff noted many benefits, to themselves and their work, of being part of a multi-agency team.

### Voluntary Organisations

Some voluntary organisations specialising in or experienced in outreach, found their resources stretched by working with Sure Start. Others felt that their aims and objectives differed and preferred not to be involved. Where a relationship broke down, it was often over monitoring requirements, which the voluntary partner found onerous or unnecessary. There was evidence that staff from the statutory sector working in SSLPs did not understand the potential role of voluntary organisations, assuming, erroneously, that all their work was done by volunteers.

## Lessons for Practice

• Outreach and home-visiting represent the gateway between families and integrated services. Creating relationships with families to gain their trust and interest was essential for SSLPs but it was a delicate business requiring sensitivity and persistence. In the best practice examples parents felt equal partners, ‘inviting’ the programme to work with them.

• SSLPs had a wide range of options available to them in creating outreach and home visiting services, including where the services came from, what sort of people delivered them, how these people related to one another and how they were organised. Any combination of services and personnel appeared to work as well as any other, provided that

- the services were coordinated;
- there was a clear vision;
- no one service felt they were more important than another;
- there was an understanding of the role of voluntary organisations;
- there was a centralised database, a key worker system and written protocols;
- there was good communication with regular meetings, some co- location of staff, and regular professional supervision of those going into family homes.

• Levels of 'reach' (percentage of eligible families using SSLP) have been disappointing, with monitoring records showing an average use of between 25 and 30% and with very few SSLPs reaching 60% of the population. Families who take up services first are those in least need, but over time the take-up by a wider population gradually spreads. Programmes aiming to work with low-income families need a long time to establish their profile.

• SSLPs have designed specialised services for hard-to-reach groups. Care is needed to ensure that these services, and Sure Start services in general, do not become stigmatised.

• Where direct services to children in the home were offered by SSLPs, these were usually where a deficit had been identified (i.e. speech and language delay, a behavioural or a special need). Programmes should consider developing integrated packages of stimulation/education delivered from more than one site (an early education setting plus the home, for example) as a normal part of service delivery.

• Home visiting services aimed to get parents to participate in a service outside the home. There was good practice in SSLPs which saw this as a first step in a chain of services which moved parents towards self-reliance, training and employment.

• SSLPs with a community development approach used outreach and home visiting services to contact all families in the area. They aimed to create voluntary and paid jobs for local families, with the goal of making the services sustainable in the future.

• It was essential that health services – midwifery and health visiting – were integrated into the outreach and home visiting programme and accommodated themselves to the Sure Start approach.

• Getting *all* families who may benefit from them to use services requires persistence. Families themselves report that they are glad to have 'taken the plunge', and feel it has been good for them and their children.

# Section 1: Background to the Study

## 1.1 Introduction Sure Start Local Programmes, Outreach and Home Visiting

Sure Start Local Programmes (SSLPs) were first announced by the Government in 1998 and were designed to improve the prospects of children under four years old who were living in poverty in neighbourhoods which scored high on the Index of Multiple Deprivation. The programmes were well-resourced with both revenue and capital monies and were required to coordinate and enhance existing services and provide new services for children and families in response to local need and demand. Local areas were allowed considerable flexibility in the ways in which they developed these responses, but all were required to provide the following core services:

- Outreach and Home Visiting
- Support for Families
- Good Quality Play, Learning and Childcare
- Primary and Community Health Care
- Support for Children and Families with Specialised Needs

Outreach and Home Visiting stands out from this list. As well as being a specific service in its own right, it was also the means through which the other four core services of Sure Start Local Programmes were delivered.

The theoretical basis for the Sure Start approach is that the provision of services will lead to improved outcomes for children. Some approaches, like the core services listed, were required of SSLPs, others were recommended to them in Guidance from the central government Sure Start Unit. All requirements and recommendations cited research evidence of improved outcomes. They drew also on evidence about the nature of poverty and of disadvantaged communities, and evidence on the use of services and the most effective ways in which services could be managed and delivered. Studies of a whole range of public services had suggested that these services were:

- less likely to be available to disadvantaged families (Howarth, Kenway, Palmer, Miorelli, 1999)
- more difficult for disadvantaged families to access,(Ghate and Hazel, 2001)
- and less likely to be used by disadvantaged families when they were accessible and available, (eg. Grimshaw and McGuire, 1998; Singh and Newburn, 2000)

The need to make Sure Start services accessible to and encourage their use was thus a matter of central importance for SSLPs.

## 1.2 The National Evaluation of Sure Start

This study of outreach and home visiting services was carried out as part of the National Evaluation of Sure Start (NESS). NESS is divided into modules that look at: the Impact of Sure Start rounds 1-4 on children and families living in SSLP areas; the Implementation of the programmes and how they work, the Local Context of programmes and their Cost Effectiveness.

**Investigating Implementation**
To understand how SSLPs work, the Implementation Module has surveyed SSLPS and conducted case studies of a selection of them. In addition the themed studies, of which this is one, look in detail at policy and practice in local programmes, focusing on subjects that may not have been investigated by other means. Themed studies draw on the knowledge generated by other aspects of the Implementation research, the Local Context and by the Support module, where NESS has helped SSLPs as they conducted their own local evaluations.

## 1.3 The Themed Study

### 1.3.1 Aims
This study was conducted between June 2004 and October 2005. It aimed to answer the question:

*How is the Outreach and Home Visiting aspect of Sure Start Local programmes contributing to the overall aim of Sure Start – to work with parents-to-be, parents and children to promote the intellectual and social development of babies and young children – particularly those who are disadvantaged – so that they flourish at home and when they get to school, and thereby break the cycle of disadvantage for the current generation of young children?*

### 1.3.2 Applied Research Methods
It used applied research methods, drew on data collected by other modules of NESS, and progressed from a broad view of pre-existing national data to a detailed analysis of a smaller number of sites, chosen for their ability to shed light on particular issues.

### 1.3.3 Selection of Study Sites
Information available from the National Survey of 260 SSLPs in the first four rounds of the programme led to the creation of a set of 'model approaches' to Outreach and Home Visiting. These covered matters like the types of personnel involved, the percentage of their time spent on outreach and home visiting and the nature of the services they provided. Additional variables were identified, such as management arrangements, bases, and the use of volunteers. There were contextual variables too, like geography, demography and programme round, which were added to the mix.

Mapping and modelling provided the basis for a selection of representative SSLPs which were subjected to a case study investigation. In total 22

programmes were visited. Semi-structured interviews were conducted with staff and focus groups and individual interviews were carried out with users. SSLP documents and records were examined where these were available.

### 1.3.4 Interviews

Research informants, for interview and focus group in study sites, were selected by purposive sampling for type along with a random selection of individual participants. The following groups were involved:

- Sure Start Board Members (where directly linked to Outreach and Home Visiting Services: PCT directors, voluntary sector directors, local authority early years staff etc.)
- SSLP managers
- Other SSLP staff
- Outreach and Home Visiting staff in SSLP area
- Volunteer home visitors
- Health visitor management
- Senior and line managing staff from agencies like health, social services, family centres and the voluntary sector
- Parents/carers

The questions covered were:

- the design of the Outreach and Home Visiting programme
- the integration of this core aspect with the rest of the SSLP services
- preparation and training available to home visitors
- relationships between practitioners
- practice issues (including changes in practice)
- perception of the service by users.

All interviews were based on a framework devised to cover these questions.

### 1.3.5 Framework

What Model of Outreach and Home Visiting is in use?
What is the Aim of Outreach and Home Visiting in the SSLP?
Quantitative Information about O/HV
The Role of the Outreach Worker
Specific Training for O/HV staff
How is O/HV managed and supervised?
How are issues of confidentiality handled?
How does O/HV relate to other services provided by the SSLP?
How do Staff respond to the O/HV approach?
How do Families respond to the O/HV approach?

Detailed records were kept of interviews and focus groups.

### 1.3.6 Documents

Local documents were examined for each SSLP studied and these included:

- programme monitoring records

- referral data for SSLP services
- user satisfaction surveys
- local evaluation reports.

A 'Framework' analysis was used to analyse the qualitative data. This is 'a systematic process of sifting, charting and sorting material according to key issues and themes" (Ritchie and Spencer 1993). See Framework above.

Consent was obtained from all participants involved in the study and permission to record was requested from all interviewees and members of focus groups.

## 1.4 The Importance of Reaching Families with Services

The Theory of Change which lies behind the Sure Start approach postulates that by changing existing services, and supplementing them where necessary, the delivery of services to families will improve and the functioning of children, families and communities will be enhanced as a result. For this approach to be effective it is essential for services to be used by families.

### 1.4.1 Why Families do not Use Services

When researchers prior to Sure Start had explored why families were not using services, they found a long list of reasons. Families said:

- they did not know about the services, either generally, or in the kind of detail that would enable them to use them (where or when they took place, for example); (Daro 1999; Tisdall 1998; Tunstill 1998)

- they did not find the services convenient to use: they might be available in buildings that were inaccessible because of distance, building design, transport costs; they might only be available at inconvenient times of the day or week; there might be other kinds of difficulty associated with them; (Nash et al 1996)

- the services were 'stigmatised' or had a reputation which put families off using them. This objection was commonly raised in relation to family services offered by local authority social services departments, which were seen as associated with child protection (Oliver, Smith and Barker 1998)

- the experience of services, particularly the attitudes of staff to users, had put families off using them; they felt patronised and judged by professional staff delivering services; (Prinz and Miller 1994)

- services were often fragmented, delivered by various agencies in different places, and families were passed from one to another like parcels. They could find themselves giving the same

information over and over again to different practitioners. (This complaint was heard particularly from the parents of children with special needs) (Cross-Departmental Review 1998).

### 1.4.2 Further Difficulties for Families

These reasons were to do with the services themselves. But research studies also suggested that some of the reasons why families were not using services were to do with family circumstances:

- where families were on low incomes they could not afford any extra costs involved in reaching services, and feared any hidden costs that might be involved in participating in services; (Cartwright 1979; Mayall and Foster 1989, cited in Oliver, Smith and Barker 1998)

- parents could feel too shy or self-conscious to join in group activities, and as they became more and more isolated it was harder for them to contemplate this. Family support workers reported that a kind of agoraphobia could grow among these parents, with curtains kept drawn all day and parents rarely leaving the home; (Daro 1999; Baker 1995, 1999)

- there was no tradition in a family or a community of using services to support child-rearing, early learning or health, and parents were unable to venture into this unfamiliar territory without the approval of their own parents or of older generations (Saxena et al. 2002).

### 1.4.3 Home-Visiting: A Reliable way to Get Services to Families

If these families were to be reached then one reliable way to do this would be to deliver services to them directly in their homes. A review of the literature on interventions with babies at risk of low birth weight, (an indicator of later disadvantage for the child) had argued that the most effective intervention took place when the baby was very young. The authors characterised the huge literature on this topic according to the duration and intensity of the interventions and the extent to which they were parent- focused or child-focused. It was concluded that interventions with parents in the child's home were more effective than those which delivered the intervention to the child. Working with mothers was more effective and this justified 'a continued focus on parents and an emphasis on the improvement of educational and interactional routines at home' (Blair and Ramey 1997, cited in Oliver, Smith and Barker 1998).

### 1.4.4 Building 'Reach' into Programme Design

The inclusion of Outreach and Home Visiting as core services in all SSLPs was an acknowledgment of the difficulties of reaching families which had already been documented. There were other requirements in the guidance to Sure Start local programmes which were also designed to tackle this issue:

**a.** Size: SSLPs were to cover an area with between 800 and 1000 children under four living in it. Although the prescribed number varied

in the guidance issued to different rounds of SSLPs, (the programme was established in 'waves' of about 60 programmes at a time) it was always quite small in comparison with much local authority service delivery. The implication was two-fold: that all families would be reached by the services, and that the services would be sufficient and adequate for all families. This was reinforced by the requirement in Guidance: *"to ensure that every family entitled to services knows about what is available and is encouraged to use the most appropriate services for their situation"* (DfES 2001).

**b.** Neighbourhood: The programme area was to be a neighbourhood, a community with a natural coherence that was understood by the people who lived in it as the place where they belonged. Literature on community development had shown that residents of neighbourhoods shared a common understanding of place and were able to make common cause because of it (Stewart, M and Taylor, M. 1995). A neighbourhood was easier for residents to find their way round: in the earliest guidance for local programmes it was recommended that services should be delivered from sites that were 'pram-pushing distance' from family homes. In most neighbourhoods distances were likely to be walk-able, so problems about transport and cost could be minimised.

In fact, it was not possible in some areas to find a suitable neighbourhood of this type, with the appropriate numbers of small children living in it, and the indicators of deprivation that made it suitable for Sure Start.

**c.** Integrated Services for the whole local population: Sure Start local programmes offered services to everyone in the neighbourhood. This approach was intended to avoid stigmatisation of the services. They were not targeted at the poor, except that they were not universal across the country. On the whole SSLPs have managed not to be labelled, which is partly because the services themselves have been so well-resourced and 'desirable', but also because SSLPs have approached families as 'partners', and responded to their preferences, an approach which was also recommended in Guidance.

**d.** Attractive Venues for Services: All SSLPs had a substantial capital sum which most invested in new buildings or substantial conversions of buildings for the delivery of services. In most cases these have been accessible, clearly aimed at families with small children and welcoming (National Evaluation of Sure Start. 2005b). The resources available to SSLPs enabled them to highlight venues and services with 'fun' events and parties.

**e.** Consulting with Parents: The inclusion of parents at every level of programme design, management and service delivery, including on the management board of local programmes, was a requirement of Sure Start funding. The intention was that services would be what parents

wanted, and delivered to them in ways that were convenient and suitable – that is, to avoid some of the objections to services that had been discovered by research. The evidence, particularly from community development interventions, was that where people felt that services were 'owned' by the local community, rather than 'imposed' on them by professionals, they would be more likely to use the services. This 'partnership with parents' would also affect the style of service delivery and the attitudes of professional staff: they would not patronise families or be seen as patronising.

**f.** Being Flexible and Innovative: Guidance encouraged SSLPs to be creative in responding to what they heard from local parents, delivering services that fitted local preference, and doing things in new ways to make sure families got help when they needed it. This extended to the places services were delivered and the mechanism for delivery. Some parents who did not want to attend groups might accept a service delivered in their own homes. Research evidence was available to show that services delivered one-to-one in the home could gain from intensity, the relationship between professional and parents, and in the appropriateness for the specific child involved. There was also evidence of the specific benefits of group work. SSLPs were in a position to offer each service to each family in the way that would be most effective to achieve an outcome for the child.

### 1.4.5 Building on Existing Services

Sure Start Local Programmes were asked to coordinate existing services, discover where there were gaps in these, and develop new services to supplement them where they were needed. Among the existing services available to all parents in all Sure Start areas were two that had Home Visiting at their core: Midwifery and Health Visiting.

### 1.4.6. Health Outreach and Home Visiting

Midwifery services are supplied and managed by Acute Trusts, which are hospital-based, although midwives themselves may work in hospitals, in the community and in both - to maintain their registration these practitioners have to deliver a number of babies each year. Health Visiting services are the responsibility of Primary Care Trusts, and until the late nineties health visitors were almost always based in GP practices, working with the patients registered with the practice.

Community midwives offer pre-natal surveillance, education and support to pregnant women and their partners, and immediate postnatal support. The latter is usually given for 10 days after the birth (though it can be continued for up to 28 days). Support from a health visitor is introduced at 10-14 days after the birth with the health visitor taking over this function from the midwife. Immediate post-natal support is given through home visits (National Evaluation of Sure Start 2005c).

Health visitors have also been central to the child health surveillance system, (CHS) which is the responsibility of GPs. Routine health checks have been

offered to all children at 6-8 weeks, 6-9 months, 18-42 months and 39-42 months. These involve physical checks of the children and some health education for parents. The checks are carried out in clinics and family homes, by doctors, doctors and health visitors together and health visitors alone or sometimes in pairs (The check at 6-9 months involves a hearing test which needs two practitioners) (Hall 1996).

These two existing services have offered SSLPs a spring-board from which to develop Outreach and Home Visiting services. Because:

• The midwifery service had information on families with new babies in the SSLP area.

• Health visitors had information about the under-fives registered with their GP practice.

• Clinics were already being held in health buildings and other buildings convenient for community use.

• Both kinds of health practitioner were delivering whole-population services and thus there was no/diminished stigma attached to what they were offering.

• Many of these practitioners were already known and trusted by local communities.

• They routinely visited families at home, hence both services were equipped with the necessary protocols to ensure the safety of home visiting, and had useful expertise about delivering services in this way.

There were some less helpful considerations, however.

• Because they were separately managed, relationships between these two services were not harmonious in every area, which meant that SSLPs could be caught in the crossfire.

• The neighbourhood populations that SSLPs were serving were one part only of the midwifery responsibility, and one part of the responsibility of many health visitors – since the patients using GP surgeries rarely came exclusively from SSLP areas, and, in fact, SSLP populations often use several GPs. This raised a logistical problem for both services – could they work differently with families in the Sure Start area, and was it fair to families from elsewhere to do so?

• In some instances the arrival of Sure Start was seen as threatening by one or both of these services. Although this reaction could be overcome, it could take time and effort for this to happen.

• Some families had a negative reaction to health visiting services. There was evidence that such attitudes were most likely to be found among low income and high risk families - just the ones that SSLPs were trying to reach (Moran 1997; Schonveld and Kingswell, 1996).

However, changes in health visiting which emphasised its public health role in the prevention of health disadvantage were resulting in practitioners moving out of bases in GP surgeries and into community teams with shared case-loads. A shift was underway from child health surveillance to child health promotion, reflecting the recommendations of the Hall Report (1996). These changes were led by the DOH and were dove-tailing neatly with the Sure Start approach (DOH 1999). Where health visitor managers were involved with SSLP planning from the early stages, and were enthusiastic about the new directions for their profession, they saw the SSLP as a way to advance these changes (McDonald, Langford and Boldero, 1997; Billingham and Hall, 1998). But there was resistance to changes too, both from GPs and from within the health visiting profession.

### 1.4.7 Family Support, Outreach and Home Visiting

In some SSLP areas family support services were already using outreach and home visiting as a mechanism for service delivery.

a. Statutory Services.

These were delivered from Social Services Departments or from family centres. Such centres are building-based sources of integrated support for families and have long had a reputation for reaching those in need through flexibility about where and by whom services are delivered. They might " *operate activities from a 'scattered centre', using members houses or rented church halls"* (Smith 1987) as well as the groups and services offered in a central building. SSLPs were encouraged to base services on existing family centres where these already existed (In some SSLP neighbourhoods there were as many as three existing centres).

In other SSLP areas, particularly on peripheral estates, there was an established community development approach to working with families, with community work staff in Social Services, Youth and Community and other departments who became part of the SSLP. This working style is based on contacting people in the places they visit in their daily lives – in shopping centres, clubs, pubs, at school gates and so on. The experience of such workers provided an illustration of how other Sure Start practitioners might develop their practice in new ways. (It is interesting, for example to see that as health visitors began to adapt their style to the 'public health' approach, their need for community development skills became more apparent. *"It [the new approach] involves working alongside local people to enable them to find ways of addressing the issues that they see as affecting their health by generating local partnerships and action"* [DH 2001]. Audits of health visitors' skills at this time showed this was the area where most needed more training. [Swann and Brocklehurst 2004).

b. Voluntary Services.

National and local voluntary organisations were also running family centres in some SSLP areas, and in many of these there was an outreach tradition, and some home visiting too. The most widespread voluntary family support organisation was Home-Start, which took referrals from Social Services, health workers and families, and matched trained volunteers with families under pressure. Home-Start recruits the volunteers, principally people who have brought up families themselves, sometimes people who have been supported by a Home-Start volunteer in the past. The volunteers befriend the families and visit them at home, where they carry out a range of functions for short, medium and longer-term periods. The families visited are not necessarily in the Sure Start age-band (with a child under four years), and Home-Start services are delivered beyond Sure Start neighbourhood areas. This service was well established in parts of the UK prior to Sure Start.

Home-Start organisations are independent local structures with their own management committees and charitable status. They operate in the majority of English local authorities, but they have a very specific geographical spread. There are none in the North East conurbation, for example, and few in the South West. They are supported by an intermediary body which offers training, support and campaigning help, and which has given the approach a national profile. Home-Start was represented on the partnership which managed the SSLP in many areas, and was the lead partner in some, though this arrangement was generally short-lived as the small local organisations did not have the capacity to take on this big responsibility for long. In several SSLPs the Manager was formerly a Home-Start organiser, from this or another area. Local Home-Starts are well acquainted with the geography of family need in communities and understand how to approach families and gain their confidence (Frost et al. 1996).

Other voluntary organisations offer a specific service which includes home-visiting. Newpin, for example, focuses on alleviating maternal isolation and depression, and encourages a strong relationship between parent and child. Parents (usually mothers) are referred by practitioners and can refer themselves. They are then visited at home by the Newpin co-ordinator, matched with a befriender and encouraged to attend a local centre regularly, where they receive a personal development programme lasting from one year to eighteen months. Though the home visit is an integrated part of this service, it is a limited part and usually seen as introductory (Oakley et al. 1993).

### 1.4.8 Early Play and Learning

Prior to SSLPs, play and early learning services were also often being delivered through outreach. Voluntary sector preschool playgroups in particular were running in all manner of community sites, and play activities were being brought to remoter areas by means of play buses.

Again, some organisations incorporated home visits into their practice. The Peers Early Education Project (PEEP) offered a home visit to all families with new babies about four weeks after the birth. *“The home visit is a time to*

*discuss any special needs a family might have in terms of accessing PEEP, thus enabling group leaders to offer a warm, confident, informed and appropriately resourced welcome to all new families"* (PEEP 2000). The welcome was to weekly group sessions where parents and children sang, told stories, shared books and were helped and encouraged to continue similar stimulating activities with their children at home. Here again the home visit acted as a gateway to the full service.

Playlink, a scheme offered through a few local authorities prior to Sure Start, used play events to outreach to parents, in the street or a local playground. Having made contact in this way, scheme workers paid weekly visits to families to help parents develop shared play with children, giving them imaginative ideas for playing and singing and helping to extend the child's speech and language skills. Again, home visits could be a prelude to the family using drop-in play sessions provided by the scheme.

Researchers had found that, when compared with a control group, 16 Playlink children showed significantly greater concentration during table play and had fewer speech and language problems on starting at nursery. They also showed greater ability, skill and self-confidence in talking to other children and to adults (Daines et al. 1989).

Portage uses home visiting to help parents and children with special needs. Portage staff visit the home to assess the needs of young children, agree goals with the parents and develop a programme of activities to stimulate the child's development. The teacher models techniques for parents to use with the child and visits the family weekly to tailor the programme to the child, and build on what he or she can already do. This is intensive one-to-one work , which research evidence shows can lead to successful skills development in children (White 1996)

### 1.4.9. Contrasts in Outreach and Home Visiting Services prior to Sure Start

There are some interesting contrasts in the outreach and home-visiting services which SSLPs inherited. As well as covering all four of the essential core services required by Sure Start, they could be delivered by:

a. highly trained professional staff (eg. health visitors)
b. trained people from the local community (eg. Home-Start volunteers)

The content of the home visit might be intended:

a. to transfer skills to the parent in an intensive, one-to-one setting;
b. to gain the confidence of parents and encourage them to join groups;
c. as part of a programme which has elements delivered in other settings.

The onset, length and intensity of the home visiting programme varied, beginning:

a. in late pregnancy
b. at birth
c. later, including after assessment

and lasting from:

a. one short visit
b. one to three months at weekly intervals
c. two to three years at weekly to monthly intervals

This analysis does not cover all the variables presented by the existing services, but it does show something of the complexity facing SSLPs as they sought to build Outreach and Home-Visiting services into their work. As well as the research referred to above, they had a considerable further body of evidence on which to draw in designing their services

## 1.5 The Evidence Base for Home Visiting Services

Besides the evidence already cited in this introduction for the impact of outreach services and home visiting programmes, there existed considerable further research on home visiting, much of it conducted in the United States.

### 1.5.1 Stand Alone Home Visiting Services: US Experience

In 1999, as SSLPs were being set up, a review of this research (not confined to that which examined services for pre-school children and families) noted that home-visiting services, in particular, focussed on: *"the importance of children's early years and on the pivotal role parents play in shaping children's lives, and by the sense that one of the best ways to reach families with young children is by bringing services to them, rather than expecting them to seek assistance in their communities. Home visitors can see the environment in which families live, gain a better understanding of the families needs, and therefore tailor services to meet those needs"* (Gomby et al. 1999).
The review noted that in most of the home-visiting schemes that had been evaluated, there had been a struggle to enrol, engage and sustain families. Where there had been demonstrable benefits from schemes, these had been found for only some of the families who took part in programmes, they did not occur for all the goals of the programmes and they were often quite modest. In the light of this conclusion the authors recommended that *"practitioners and policymakers recognise the inherent limitations in home visiting programmes and embrace more modest expectations for their success, and that home visiting services are best funded as part of a broad set of services for families and children"* (Gomby et al 1999).

Other conclusions of the review found that home visiting services should:

- be offered on a voluntary basis to all families with a new baby. (A situation which largely existed through the services offered by midwifery/health visiting in the UK);

- have multiple goals, addressing the needs of both children and parents in various ways;

- be flexible in intensity and duration;

- be sensitive to the unique characteristics and circumstances of individuals and families;

- use well-trained, dedicated staff. Where para-professional staff are used they should be supervised and supported by professional colleagues;

- be seen realistically as offering opportunities to make 'modest' improvements in children's development. The research at this stage contained no studies of home visiting programmes which had resulted in large or long-term benefits for parents and children.

The generation of community support networks and the improvement of access to formal and informal health and welfare services are seen as the key to effective interventions by a number of US practitioners and researchers (Olds et al. 1986, 1988,1993). Underpinning the home visiting programmes described in these studies is the idea that beneficial outcomes arise from integrating isolated families into the community and contributing more generally to the enrichment of life in disadvantaged communities. But there are also recommendations from these studies that interventions be targeted at families at high risk.

### 1.5.2 Integrated Home Visiting: US Experience

Beyond the studies of home visiting programmes, there have been studies of interventions in which home visiting has a part. The most notable remains the Ypsilanti Perry PreSchool project, which is often understood as a group early education (daycare) intervention but which included bi-weekly home visits by the project teachers to the family of each child involved.

Research on the Perry Preschool project has shown significant outcomes over time for the children who experienced it. In a discussion on how these were achieved one commentator has said:
*"I find myself asking why these programmes have produced larger IQ gains than any other programme of which I know. I find myself wondering if the home visits may not be the key to this gain…If they are, they promise not only to make the gains of the children more permanent but also… to offer a basic enrichment to the lives of the parents themselves...* (Weikart, D et al 1978).

The way home visiting was delivered in the Perry Preschool project needs to be understood, and will need to be replicated exactly if comparable outcomes for children are to be achieved. Some significant aspects of implementation in this programme were:

• that the personnel who carried out home visits were the same teachers who taught the children in the group education classroom for 2_ hours every morning during term-time (Home visiting was done in the afternoon).

• each home visit lasted for 1_ hours.

• each child received 24 home visits during the duration of the programme.

• teachers completed a Home Visit Report after each visit which covered the setting, the behaviour of the mother and the curriculum. These reports included observations on whether or not the mother and/or the child had used the materials left by the teacher on the previous visit: in other words – there was a cumulative intention in the programme of visits.

• the set of programme of activities delivered to the child in the home complemented those experienced by the child in the classroom. Teachers, in reporting on the curriculum of the home visit, described the goals for the child and the educational activities undertaken. (Home visit activities were based on distinct curricula – these could vary but from the point of view of assessing the significance of the home visits, it is important to note that whatever the curriculum chosen, there was a curriculum and the activities within it were described in detail).

Whatever the curriculum (and these Perry Preschool studies tested different approaches, which produced some variations in outcomes), the home visiting aspect of each were prescribed and structured in terms of personnel, timing, content and procedures (Schweinhart 2003).

**1.5.3 Home Visiting by Health Personnel: British Experience**

A British systematic review of international studies and the British literature on the effectiveness of domiciliary health visiting published in 2000 noted that:

• health visitors have been successful in gaining acceptance by a range of different individuals and families, but there was a lack of evidence that linked what they did with them to health outcomes;

• there was some potential for using para-professional members of the community in extending the role of health visitors;

• health visitors were good at working in inter-disciplinary and inter agency ways and that they could be *"the linchpin in a network of professional and voluntary agencies"* on behalf of vulnerable families;

• though there was little research on how health visitors were relating to each individual and family they were likely to be *"most successful when functioning in a non-directive, supportive way, encouraging their clients to set their individual health agendas"* (Elkan et al. 2005).

This review surmises that a diminution of health visiting that had started in the early 1990s may have left families unsupported during the 'normal' crises that occur in family life, though there was no evaluation evidence to support this interpretation.

### 1.5.4 Home Visiting by Educators: British Experience

British programmes originated around the same time as the Perry Pre-School programme in the US also showed significant early effects. For example, home visiting programmes for preschool children aged 18 months to three years established in Educational Priority Areas (EPAs) in the seventies resulted in gains in measurable abilities in the children against those in a comparison group. Improvements were seen in areas like language development, problem-solving, concentration and ability to relate to and communicate with adults. The programme involved weekly home visits for a period of eighteen months. Each visit lasted between one and two hours and the home visitor introduced toys for the child to play with, discussed what the child was doing and learning with the parent and talked to the parent about any problems or aspects of the child's development which were thought to be important. These interventions were not studied over the long-term, however. (Smith, 1975; Armstrong, 1979)

### 1.5.5 Home Visiting to Support Families: British Experience

The family support services offered by Social Services Departments and voluntary organisations, especially those based on family centres, often included a home visiting component. Whole services and the home visiting aspects of them were frequently subject to research studies and evaluations, but most of these are of a descriptive, qualitative type. Anecdote suggested that families benefited from the close relationship with a home visitor, but it was not until 2004 that a research study tested this more rigorously. The results of this work were rather late to influence the original designs of SSLPs. The study (of Home-Start volunteer schemes) found that mothers under stress following the birth of a child valued the support of a volunteer, but improvements in their health, well-being and relationship with the child were not significantly greater than those among mothers with similar problems who had not received volunteer support. (But they may well have received support from statutory services.) (McAuley et al. 2004)

### 1.5.6. Some Observations on the Research Evidence available to Sure Start Local Programmes

Most of the studies and reviews noted above were available to SSLPs as they designed their services. They do offer somewhat conflicting indicators for the design of integrated services, however. The questions which remained about them, and that the SSLP experience can help us to understand are:

- what is the distinction between 'outreach' and 'home visiting', and where do they overlap?

- what part do these approaches play in an integrated programme of services, and how far do they need to be modified in the light of different purposes for services (eg. services aimed at parents, children, the family or the community)?

- what operational choices are available to organisations like SSLPs and Children's Centres in designing services to achieve both reach and effective outcomes for children and families?

- what works in outreach and home visiting (ie. what does the SSLP experience of delivering services in this way tell us)?

## Section 2: The Scope of Outreach and Home Visiting Services, and the Distinctions between Them.

## 2.1 Outreach: Reaching People through Information

All SSLPs were required to ensure that all households with children under four in the programme area knew about the programme and its services. They used several ways to do this.

### 2.1.1 Written Information

All SSLPs produced written information about the local services. Typically this included leaflets, newsletters, regular timetables of events. Some SSLPs provided all families with diaries, laminated cards with useful numbers and addresses, and so on.

The amount and quality of these written materials varied. In some areas the SSLP manager or members of staff had a particular interest in design and developed the materials during the life of the programme, with local titles and logos. Significant numbers of SSLPs employed a core staff member with responsibilities for information and/or administration and/or evaluation, who had responsibility for this type of communication.

**2.1.2** In some areas parents and families had become involved in the production of the information. Where this has happened Sure Start Managers report that the materials can be surprisingly different from those designed by staff. In one example the original SSLP leaflet was filled with words describing activities. The parents' version contained several photographs of local families and children engaged in SSLP activities with a short caption under each. The message from this SSLP and others was that a picture was worth a thousand words.

**2.1.3** Translation of written materials into community languages was generally undertaken for those languages spoken by groups of a significant size in the SSLP community. Where communities were very diverse, materials were not translated into languages spoken by a few families only. It was reported from some areas with high ethnic populations that parents, particularly mothers, were not accustomed to accessing information in this way and sometimes could not read.

**2.1.4** All the SSLPs consulted, saw written materials as essential to the outreach function, but considered that what they said was less important than the opportunity they gave for interaction with local families. This was particularly evident where, in the setting up stages of a programme, local people had been given written information and had then been asked to complete, or help a worker to complete, a survey questionnaire about the area and about their own needs. This use of written information tended to change as the SSLP became established, with later information being of the monthly timetable of activities type. But this, too, could act as a basis for the continuing development of relationships.

**2.1.5 Using Written Materials in Outreach**

All SSLP staff, part and full-time,(approximately 52 people) are involved in Outreach and Home Visiting. The Sure Start area is divided into three sections, then sub-divided into small groups of streets. Staff work in pairs, each pair servicing the same group of streets regularly, delivering leaflets and other paper information about Sure Start activities directly to parents in the houses where Sure Start children live. Every month each household receives an average of 1.7 visits. Staff wear distinctive shirts and have a distinctive bag. When leaflets are delivered staff engage parents in conversation of the 'How's it going?' variety.

The aim is to engage all parents of 0 to 4 year olds by raising the visibility of the SSLP, reminding them of the SSLP at regular intervals, and making immediate links to SSLP services when the occasion arises. A parent described her experience of the regular leafleting:

*"Before Sure Start workers called to my home I didn't have many visitors. That's how I like it. I don't really go anywhere. They bring me leaflets about all sorts. I'm in two minds about taking my daughter swimming because I don't really like deep water. Well, it doesn't have to be deep, I just don't like it and can't get my courage to go. The Sure Start worker told me she would go with me and get in with her and I could sit at the side and get used to it. It's good that they would do that for me and my daughter. The last thing I want is for her to be scared of water too. I am grateful for their offer and one day I will take them up on it…It's something I think about all the time. I will get there" (Single mother of three, SSLP North).*

**2.1.6 Using gifts**

Many local programmes had a gift pack which was given to new parents and/or new users of Sure Start. Commonly this included small items for children like bibs and teething rings, and items for parents like Sure Start pens. This practice, derived from that used by midwifery services, where sometimes samples have been made available for new mothers by private companies, was described by local programmes as a way of 'marking' the contact between the parent and Sure Start, of presenting contact as beneficial, and of raising awareness of the programme. Most introductory packs would also contain written information about SSLP activities.

### 2.1.7 Using events and activities

To draw attention to the new programme most SSLPs ran fun days and other events, with entertainers and games for children and various information stalls and activities for parents. These events were usually very popular, though it was common to find that the numbers who attended them did not proceed immediately to participation in Sure Start. However, they also were used as an opportunity to engage with parents and to consult with them about what they wanted to see in the new programme. SSLPs varied in the extent to which they continued to sponsor events of this sort as the programme proceeded. They tended to be occasional: where a Sure Start building was developed, there was usually a high-profile launch, for example. But in some areas these types of events were an integral aspect of Outreach. For example, one SSLP had a regular stall in public places like the library, was present at public meetings and organised regular parties and barbeques.

### 2.1.8 Using Events as Outreach

In an SSLP which operated in a diverse area, and had an Outreach Team of seven staff, a programme of summer activities for children was offered. These included: African Caribbean drumming and interactive music; story-telling and toys; along with arts and crafts and music. The Outreach Team collaborated with other local organisations to plan and deliver summer and winter fundays. The latter might celebrate Eid, Hanukah, Diwali and Christmas. These events were very popular with the community and helped to generate awareness of Sure Start across a broad audience.

The programme manager notes that in the area: *"There is a gap between cultures. Each culture seems to operate in isolation. To get round this and to try to bring communities together we hold 'international days' for which all communities bring different types of food, and summer trips, where families from different groups enjoy themselves together. But you also need culturally specific events to reach some parents – though it means you won't be bringing them together. We had an information day where the Bengali project worker presented her activities, and the health project gave away fruit and veg at the end. You need to do that."*

### 2.1.9 Using Information to Reach Out: Some Lessons

SSLPs report that:

• written information should be offered personally by a knowledgeable worker or volunteer who can give information and answer questions;

• parents should be involved in the design and production of all materials;

• parents do not have time to read much and have a lot of information from stores and in the post: written information should be brief;

• written information and events offer a pretext for workers to talk to families, find out about them and encourage them to participate. This can take a long time. Persistence may be necessary, as this parent describes:

*"..I wasn't interested but they kept calling regularly after that with all kinds of different things but I never went…I then saw them coming again through the gate and wondered what was on offer this time but they asked me 'What would I like to do?' …I started doing the Fitness and Boxing every week and enjoyed every minute of it."*

## 2.2 Outreach: Moving Services Closer to Users

SSLPS were aware that a further reason why families had not used services in the past was that they were inconvenient, and reaching them could be difficult and expensive. The neighbourhood design of SSLP areas was an attempt to combat difficulties of access, a further strategy was to deliver services in a range of venues around the area. With their capital most SSLPs developed at least one Sure Start building in which staff were based, daycare services were situated and other services were delivered. The most common pattern of building development, however, included satellite venues, nearer to family homes (NESS 2005b).

### 2.2.1 Using new venues

A number of non-early years specific sites are reported as used by most SSLPs – GP surgeries, libraries, church halls and primary schools are commonly listed (86.9% of households in urban SSLPs were within 1km of a GP surgery, over two thirds were within 1km of a library and 73.9% were within 1km of a child health clinic [NESS 2004a]). 30-40% of SSLPs developed a building with a shop-front, located among retail outlets where families shop. *"This is likely to be used as an information point, sometimes with a small drop-in facility and with a limited number of core administrative staff based there"* (NESS 2005a). Community venues already familiar and popular with local people took on new roles as bases for Sure Start activities: 150 fathers attended Ramadan workshop sessions on 'the roles and responsibilities of fathers' at the East London Mosque, for example; health clinics and other services have been offered in local authority and private sector Leisure Centres. A family support worker in a North Western programme said: *"Some families – travellers – will NEVER come to a centre. I go out to a portakabin on the travellers site. It's funded by Sure Start, the council and a housing association. I've been going there for two years now and we're just starting a crèche there."*

### 2.2.2 Taking services to families

The small number of rural SSLPs developed buses on the Playbus model, and these were also used in a few urban programmes. In one London SSLP a play and learning bus visited a different part of the neighbourhood each day offering health as well as educational services. In this area transport for families was problematic: community transport services had been withdrawn because of vandalism. The SSLP initiated a 'Toddlers' Transport' scheme to provide transport round the catchment area and to service venues, but take-up by local parents was slow and the project ceased. Poor transport was often a top issue for parents in the early consultations by SSLPs, but the experience described in this London programme was familiar in other SSLPs

as well. Transport schemes tended to be expensive, complex to run (buses need drivers and garages) and under-used.

**2.2.3 Working through voluntary organisations**
Another way of getting services close to users was to commission already familiar and accepted mechanisms to deliver them: local voluntary and community organisations. National organisations (Barnardos, The Children's Society) were running the outreach arm of SSLPs in some areas; locally managed organisations (Home-Start) in others. In these examples the nature of what was described as 'outreach' tended to be confined to 'home-visiting', with the more general information and awareness raising aspects remaining with the host SSLP.

**2.2.4** Voluntary organisations working in this way report that they take referrals from Sure Start itself and then deliver a service in the home which focuses on the need of the family. *"Sometimes the referrer tells us what we need to do: failure to thrive, speech and language delay, maybe domestic violence (that comes through regularly). We focus on the one area and work out with the family what is needed"* (Local Manager, Barnardos). The Coordinator of Home-Start in the Midlands described how local schemes had been commissioned by SSLPs to deliver an outreach service to families by recruiting, training and matching volunteers. *"There are two models: sometimes the Home-Start Coordinator is based in the SSLP, sometimes they work under the local Home-Start umbrella but support the volunteers who visit Sure Start families."* Apart from the local goodwill that may exist for voluntary schemes of this kind – they often avoid the stigma that has accrued to local authority services – they drew on existing infrastructure and had the advantage of being quickly established.

**2.2.5 Reaching Families with Outreach Services: Some Lessons**
SSLPs had found that:

• it is more effective to use what is already liked and trusted (venues, organisations, styles of doing things) and develop these, rather than constantly emphasising that services are 'new';

• services which are child-focused attract parents. Activities which look like fun for children draw parents especially when:
- families do not have to sign up to anything or make any kind of commitment in order to take part
-families do not have to give a name or register
-services are providing what families want not just what they need
- the services are shaped by what families ask for

• services are flexible, offering support in response to how families feel from week to week, rather than expecting families to fit into a model decided in advance.

• services build on people's strengths, they are not offered to people because they have problems

• services give priority to those who are the hardest to reach, rather than aiming for the highest numbers.

• time is allowed for the most disadvantaged families to come to trust the services. This may mean a long-term commitment, with little concrete evidence of success emerging at first.

• services are open to all families, so that there is no stigma in taking part

## 2.3 Outreach as a Gateway to Services

Perhaps the most widespread understanding of what Outreach could do in the integrated model of an SSLP, was to act as the frontline in involving families more fully in the programme. Families with young children in disadvantaged areas can be isolated and have poor networks of friendship and support. Research studies have shown that the most disadvantaged – young mothers, with fewer educational qualifications – are more likely to refuse the offer of services (Barlow et al. 2005). *"The offer of home visiting is often seen as a means of involving 'hard-to-reach' families and overcoming obstacles commonly associated with group support such as reluctance to discuss problems in public, needing transportation to a venue, possibly needing childcare and its reliance on the motivation of individual families to get themselves to the venue"* (Barnes et al. 2006).

### 2.3.1 Gaining the Confidence of Families by visiting them at home

A visit at an early stage in pregnancy in order to develop a relationship with mothers and support them antenatally and through to the post natal stage, usually working with local midwifery services, was standard practice in all SSLP areas. Where children were older (for example when families moved into the area) initial visits might be from other types of worker. In all cases, however, the importance of this visit for the continuing relationship with Sure Start was clear.

### 2.3.2 Sensitivity -Essential

Where practitioners or volunteers are entering people's homes, the balance of the relationship is shifted towards the parent. The home is their territory and the practitioner or volunteer is a guest. Appropriate behaviour is often affected by cultural norms.

• *"Without interpreters we wouldn't have gone ahead with outreach in Asian families. The interpreters have an understanding of the culture, too. Health visitors visited with interpreters until confidence had been built up, then other workers came on board – maybe to do play. Respect for culture and language is an important part of relating to families"* (Sure Start manager, North West).

• *"Some women will not step outside their door and the only way to make progress is to go to them over and over again. Some are not allowed out, or their emotional well-being is so low that they are unable to go out. Of course, our goal is to help them feel better, but it is also important to their children that they see the outside world"* (Manager, voluntary organisation working with an SSLP).

• *"Is it intrusive to keep turning up at people's doors? I think it could be. It could be oppressive to turn up on the doorstep if what we are offering isn't inviting to the family. We always make appointments."* (Outreach Coordinator)

**2.3.3 Helping Families Out of the Home**
Home-visiting as an aspect of outreach is usually conducted according to a plan. Plans may be generally devised, so that the families visited get a standard number of visits (say three) after which they are expected to come to a group, or an individual plan may be drawn up according to the particular situation facing the family.

*"I do a plan of action for them to go to the Sure Start centre. You must not lose sight of what you are trying to do. Families can become very reliant on your visits, it is almost like a social occasion for them. I want them to be able to do without me, and I have to gauge whether they are really needing me or just want things to continue in the same way. So my plan will be to get them to the Sure Start centre and I will go with them for the first time, at least. Which is very time-consuming"* (Special Needs Coordinator, SSLP).

**2.3.4** The outreach team in one area noted that their presence in the Sure Start venues was as important as their visits to families at home. They provided a consistent link and a recognizable friendly face at groups and classes, able to introduce parents to other staff and users. Parents here commented that they would not have made the initial visit to the SSLP without the persistence of these support workers and the fact that they were accompanied: *"I had Post Natal depression and wouldn't even have left the house if it wasn't for (support worker)".*

**2.3.5** Workers involved in this aspect of outreach and home visiting felt that they had to find a balance between being persistent in encouraging families to use SSLP services and harassing those who were less keen. In one area workers made three visits in an attempt to contact a family, sometimes posted leaflets offering further appointments and inviting the family to phone the SSLP to make a more suitable appointment if they wished. If no contact was made, the SSLP writes to the family with a telephone number and a note to the effect 'we're here if you need us' and allows a period to elapse before trying to make contact again.

**2.3.6 Home Visitors Providing Encouragement to Families**
There are three Sure Start Home Visitors in this SSLP, who go to the family home, usually after a referral from a health visitor. They discuss with the parent what opportunities are available through Sure Start or in the wider community, to enable the parent to identify activities which will benefit them or

their family. The visitor explores ways to encourage participation in activities, including offering practical assistance. For example, the home visitor may offer to give the family a lift to an activity, arrange to meet them at the door of the venue, or meet them at home and walk there together. 'We follow the parents' lead'. There are follow-up visits and calls, and a once-yearly visit to check on how the family is doing and remind them that SSLP is still available.

In some SSLPs confident mothers are identified who act as unofficial mentors to other parents. They chaperone mothers living in the same block or area to a Sure Start group or service, arranging to meet at a certain time and encouraging them to keep attending.

**2.3.7** As well as being a way of getting families to leave the home and use services, the home visits are also a way of identifying which services might be most helpful to families:

*"It's about reaching the hard-to-reach families, those that are less confident who don't come to the centre and who may not be able to read. Working with families in the home allows us to pick up things that wouldn't normally be identified and issues can be dealt with in a safe place"* (Outreach worker).

In some areas this has become a more formal system of assessment, so that referrals are made by home visitors to specific Sure Start services, which may or may not be delivered in the home. In one area, for example, a Sure Start midwife described how the bulk of her work came via referrals from mainstream midwives who, on their home visits, had identified women who needed additional support. *"The model for this work is based around the Sure Start health targets: breast-feeding, smoking, teenage pregnancy, infant death and so on. If the midwifery team detects a risk, they refer to Sure Start midwifery services for extra input."* (Sure Start midwife).

## 2.4 Delivering Services through Home Visits

The direct delivery of services through home visits does occur in SSLPs. It is less widespread than the use of the home visit as a prelude to getting parents out of the house. SSLPs generally consider that for children and families there are more benefits to be had from interaction with other parents and children than there are from one-to-one interaction with Sure Start practitioners. In fact, some Sure Start services are delivered in the home, but the majority of SSLPs visited saw such a response as an intermediary stage rather than an end in itself. This means that service delivery in the home tended to be offered mostly to particularly vulnerable or 'hard-to-reach' families, and then for a limited period only.

**2.4.1** The Implementation Module of NESS has identified groups of parents which 'the programme knew they would have to make a more purposive and/or consistent effort to reach':

- parents/carers with drug and/or alcohol problems
- families experiencing domestic violence
- families with children who have special needs
- asylum seekers and refugees
- mother experiencing post-natal depression
- fathers/male carers
- families with special cultural requirements
- teenage parents

The Implementation module reports that some SSLPs also see working parents as 'hard-to-reach'.

**2.4.2** SSLPs report using the following ways of discovering and getting in touch with families whom they consider hard to reach. These include:

- Calling on all families with children under 4 who have not used SSLP services;

- Consulting with other agencies about families who have not responded to them, following up with an informal home visit to offer information;

- Talking to other families who do use services, and following up on any reports of a neighbour who may be isolated or has recently moved in; and

- Obtaining full details of all families by health information systems to make sure that knowledge is complete. Visiting all families.

*"The ones least likely to engage with us are the ones most likely to need us. Outreach is the only way we have to get to know them" (Midwife).*

**2.4.3 Services in the Home for Hard-to-reach Families**
A London SSLP classified the following groups as hard-to-reach:

Traveller families,
Asylum Seekers and refugees
Parents under 20
Lone mothers.

Practitioners in all its service areas might go into a home and work with an individual family: family support (Home-Start volunteer, health visitor, Citizens' Advice Bureau) early play and education (play bus workers, toddler group leaders, play therapist, Portage worker); parenting issues, (health visitors, Home-Start).

The time spent with the family might be
- one-off;
- a main visit and follow-ups to check if further help was needed;
- continuing.
The most common areas for continuing visits were Portage (where an individual child would be likely to have a planned ongoing programme over months) and early play and learning.

**2.4.3** The decision to deliver services in the home was influenced by the design of the SSLP. If Portage was included in the programme (it wasn't everywhere) then there was likely to be significant service delivery to individual families at home. Another model which favoured some home service delivery was the health-visiting team with nursery-nurse back-up. Health visitors could assess the level of parental interaction with the child on routine visits (often accompanied by the nursery nurse), could illustrate the kind of support available from the worker and then arrange a series of subsequent visits by the nursery nurse alone. In those areas where this resource became available to health visitors via Sure Start it was highly valued and in some cases has received extra or continued funding from PCTs.

**2.4.4** However, it was not usual for SSLPs to deliver a standardised, structured intervention in the home either in tandem with a centre-based service, or as a home-delivered service. So, for example, although parenting support programmes have a curriculum which is delivered in a set number of sessions over time, in most areas the delivery of parenting support in the home was confined to one or two introductory sessions only. In an SSLP area where all staff undertook some home-visiting duties, they were trained to respond immediately to requests for help with matters like managing behaviour, eating and sleeping difficulties and so on, but were not able or encouraged to embark on a whole parenting curriculum.

**2.4.5** Although SSLPs note that home delivery of services is a means to reach hard-to-reach families, the time such services take, the high input requiredfrom trained staff, and the dangers of developing dependency among families were cited as reasons for sparing use of the intense approach.

*"We don't put a lot of emphasis on home visits because we try to get people to come to us. There are a small group of families who take up the bulk of home visiting time: it's a big time commitment for the team. There are a number of women who find it hard to leave the house, and it is easier for us to go into the house for them, but it can create tensions. Hard-to-reach families can take up all the outreach time we have"* (SSLP Manager).

**Delivering Services in the Home: Some Lessons**

SSLPs have found that it is important to be clear about why a service might best be delivered in the home. This can be because:

• it will be easier for a practitioner (health visitor, midwife) to assess how a child is doing in his or her own environment;

• it will be easier to help a parent to respond to the child's needs by demonstrating activities, conversation and other interaction;

• it is necessary to see the home circumstances in order to organise suitable support – for example, to ensure safety, or to provide aids where there is a disability.

• it may make the parent feel more confident about disclosing information about matters like domestic violence, debt or health worries.

• there will be some families for whom this is the only means by which services can be regularly delivered.

# Section 3: The Place of Outreach and Home Visiting in an Integrated Programme

## 3.1 Predominant Approaches

There are many different designs detectable in the ways SSLPs have chosen to deliver services under the Outreach and Home Visiting label, and in the ways these relate to the whole range of SSLP services. In this section a range of designs, each taken from an actual example, is described.

### 3.1.1 Spending on Outreach and Home Visiting

SSLPs are integrated programmes and it is difficult to disentangle spending patterns on the various required services. A recent interim report on SSLP expenditure notes that SSLPs tend to develop all types of service simultaneously rather than concentrating on one service area and then adding others. As we have seen, outreach and home visiting overlaps with the other four service areas and may be obscured somewhat because it is delivered within them, (for example, by health visitors who may be funded under the 'health' aspect of Sure Start expenditure). As far as the NESS Cost Effectivessness study could gauge, however, SSLPs made one sixth of their expenditure on outreach and home visiting, with this area responsible for 8% of costs in the first year of operation rising to 13% in subsequent years. This accords with expenditure on other required services, *"Activity grew as the programmes grew"* (NESS Report 15. 2006).

**3.1.2** However, the report on Cost Effectiveness report does note a difference in expenditure on outreach in those SSLP areas where the population is predominantly from the Indian sub-continent. In such programme areas expenditure averaged 14%.

**3.1.3** Although this study found no link between the type of lead body of a local Sure Start partnership and the type of expenditure in the programmes, there was some evidence of influence on the design of Outreach and Home Visiting element of an SSLP according to the representation of different agencies on the partnership board. Where local Health Visitor managers joined the Sure Start partnership at the planning stage, it was likely that the health visiting service would be the structure on which the Outreach and Home Visiting service was built. Where Maternity services were also represented on the Partnership by a manager (which was much less usual), an integrated response by these two services was likely. When this happened there was unlikely to be a major input from para-professional home visitors, other than as a support resource for this health team.

**3.1.4** Where SSLPs had a strong community development ethos the opposite model was more likely, with the outreach and home-visiting work spear-headed by community workers and para-professionals, many of them local parents, with health and other practitioners called upon where specialist input was requested by visiting parents or considered necessary by home visitors. In both models the trained practitioners spent time in training support workers, though for a different role in each case.

**3.1.5** This indicates a first key variable in patterns of outreach and home visiting service:

Where home visits are conducted by health visitors/midwife: families may be referred for extra support to para-professional and other practitioners. Then extra support may be offered in the home, at least in the short term.

Where home visits are carried out by para-professionals: families may be referred for specialist support to health/visitors/ midwifes and other practitioners. The specialist support is offered outside the home, usually in a group.

**3.1.6** In order to demonstrate further variations in the design of services, a number of illustrations are given below.

**Service Design A: Whole System Model**
In this model the Outreach and Home Visiting work leans strongly towards family support. It was most likely to be found in SSLPs where the local authority led the managing Sure Start Partnership.

**Who is involved?**
Most of the staff in the SSLP. The majority of home visits are made by:
•a Sure Start midwife
•the family support team – 5 staff

Other visits are made as part of their caseload by:
•members of the speech therapy team
•community involvement worker
• lifelong learning worker
• play development worker
• Dietician
• CAB worker

The midwife makes regular visits based on the child's developmental stage and the needs of the family, including antenatal visits.

**What do they do?**
The family support team consists of three full-time workers and two part-time, who are locally recruited parents. The team is lead by the Family Support Coordinator. The full-time workers are allocated families with more serious needs, the part-time workers from the SSLP services, arrange events

designed to increase reach and offer support by accompanying parents to classes and events at the Sure Start centre and doctors/hospital appointments. The full-time workers make weekly visits to families on their case loads. Caseloads are allocated by the coordinator, using a points system: families are given points according to their level of needs, and referred to the most appropriate worker.

There is no health visitor in the team or contributing to it. Workers in this programme dress informally and carry identity cards issued by the local authority, with a photograph and telephone number. They are given parent-friendly titles designed to reduce any stigma which may be attached to professional services. For example, preventative speech and language work is carried out by a 'language development worker' rather than a speech therapist.

**Service Design B: The Generic Team Model**
This team is designed to reach families in a very diverse area, where there are communication and cultural issues which require a sensitive service.

**Who is involved?**
An Outreach Team comprised of:
- full-time Outreach Manager
- full-time Punjabi worker
- part-time Punjabi worker
- part-time Pakistani worker
- part-time Saudi and Arabic worker
- part-time French, Dutch and Somali worker
- part-time French worker (concentrates on asylum seekers)
- full-time outreach worker (social work diploma) (concentrates on families where there are child protection issues)
- full-time parent involvement worker
- part-time nursery nurse (Arabic speaking)
- full-time play development worker
- two bilingual speech and language support workers
- two family support workers

The SSLP has service-level agreements with speech and language service, a fathers' worker and a CAB adviser. The Sure Start midwife is seconded from an Acute Trust. She is a link between Sure Start and the generic services, including the health visiting service. Referrals are passed through her to the Outreach Manager, who assigns them to the most appropriate worker to carry out the home visit. Each outreach worker covers the Sure Start area taking cases appropriate to their skills/role. *"The roles of the outreach workers are different…Some focus on language issues, some on childcare, special needs and asylum seekers, but they all have the same job description"* (Sure Start Midwife).

**What do they do?**
The range of activities undertaken by these workers means that they have to

be able to work independently. They could include working with children with special needs, family support, working with issues like domestic violence, and organising or facilitating support groups. Their job description includes:
working in partnership with parents in the home;
guiding and assisting them to develop early learning;
working with families on specific issues and problems;
providing practical help for some families with short-term difficulties;
setting up and running support groups in the community;
working alongside professional staff to ensure delivery of a Sure Start service.

**Service Design C: A Holistic Multi-Team Model**
This model has been used across local authority areas where there is more than one SSLP . The teams may work with all of them (As they do in the example below).

**Who is involved?**
Health Visiting Team:
• Co-ordinator
•10.5 full-time equivalent health visitors (of whom 4 full-time health visitors are funded by the SSLPs)

Early Intervention Team:
• early years worker
• speech therapist
• 2 midwives
• a teenage and young mothers worker
• worker for families experiencing domestic violence.

Peer Support team:
• complement of 20 trained volunteers

Education Outreach team:
• 4 qualified and trained nursery teachers (part of a larger, a borough-wide team) who deliver the Start Right curriculum, one-to-one, in the home.

**What do they do?**
This is a complex model, which works on a system of mutual, interagency referrals. The first point of contact is usually the midwife or health visitor, though users can self-refer or enter the network through a voluntary agency such as the Peer Support Team. Each Outreach and Home Visiting team has its own priorities and expertise, but there are common aims: to access those hard-to-reach families which would most benefit from contact with the SSLP, to support and facilitate access to services and to identify the needs of individual families and ensure that they are met appropriately.

With such a large Home Visiting Team, an important aim is to avoid duplicating services or have too many workers visiting a family at once. Each family is given a calendar (designed by the SSLP and depicting its users and activities) to display in the home. Each SSLP worker writes their next

appointment on the calendar, providing a record for the parent and any other visiting workers. Each of the partner teams has a project manager, responsible for the Sure Start element of the team's work.

**Service Design D. Community Development Model**
**A grass roots approach, where services are not targeted on particular groups and the aim is to be inclusive, universal and non-stigmatising**

**Who is involved?**
All Sure Start employees – approximately 52 people, full and part-time, including professional staff, practitioners and locally recruited workers. *"From the start the SSLP recruited, developed and integrated a multi-disciplinary workforce comprised of workers with theoretical-learnt skills and workers with experience-learnt skills. Some were seconded from professional areas like Health, Counselling, Speech and Language, Nutrition and Complementary Health. A large proportion of workers were actively recruited from the local community where attitude and commitment were recognised as equally important"* (SSLP Annual Report). All staff receive a basic training in Outreach. The Programme Manager and Deputy also work as Outreach staff.

**What they do?**
Staff work in pairs, and each pair services the same group of streets regularly, delivering leaflets and other paper information about Sure Start activities directly to parents in the houses where Sure Start children live. During an average week there are 28 outreach 'slots' when two workers go together to knock on the doors of the houses which they visit fortnightly. Each 'slot' involves between 12 and 17 families.

*"Outreach door knocking is an ongoing and continuous process….maintaining the contact that is so valuable to parents consistently and beyond the promotion of specific groups"* (SSLP Annual Report).

Publicising groups is the main reason for regularly knocking on doors, however, and the staff wear distinctive shirts and carry a Sure Start bag. Every month each household receives an average of 1.7 visits. When leaflets and information have been handed over, staff engage parents in conversation of the 'How's it going?' variety. If parents raise issues the SSLP staff may offer an immediate intervention. For example, if a parent says *"She's playing up when I put her to bed," the workers' response might be "Would you like me to give you a few ideas about how to handle that?*" Or they may signpost parents to a group or service or arrange for specialist help to call. Staff have basic training in parenting education, speech and language support, basic baby care and so on.

**Service Design E: Focussed Intervention Model**
This outreach team carries out an early assessment of children's progress in order to screen for delays in key areas, especially speech and language, followed by an intervention if necessary, delivered by home visits.

**Who is involved?**
•9 nursery nurses
(who had previously worked as play facilitators and family support workers in SSLP groups and also provided home visiting services to back midwives and health visitors).

**What do they do?**
They carry out a screening assessment of every child in the Sure Start area at 18, 24, 30 and 36 months in the home. If children do not meet threshold scores of 75% overall or 85% in relation to speech and language, they are referred to the SSLP multi-disciplinary allocation meeting where the needs of children who are not meeting thresholds are discussed.

If the meeting agrees to provide Intermediate Team support, then the level of need is assessed from the screening profile produced by the nursery nurses, and an individual plan drawn up for the child. This is usually delivered in the home by a nursery nurse over twelve weeks for an hour a week (Precise times and amount vary according to the assessment). The outreach staff carry out activities with the child, model behaviour for the parents and give advice on interaction with the child.

Although the aim of this intervention is to develop parental involvement in the intervention process, staff believe that only a minority of parents carried out recommended activities between visits. The input for most children is believed to come from the outreach worker.

When the programme of work is completed the nursery nurse reassesses the child's progress. At that point additional intervention at home may be offered, or the child may be referred on to a specialist agency. During the first year of operating this screening programme through home visits, 468 assessments were carried out, and 31% of the children did not reach the threshold scores. Approximately three quarters of these children were referred on to the allocation meeting and just under half received intervention in the home. Some were referred directly to a specialist service and in some cases parents did not want the child to receive an intervention.

**Service Design F: Health Team Model**
This approach, or elements of it, were the most widespread in use in SSLPs, probably because they build on the services that already existed in the SSLP. It was common in SSLPs that were led by PCTs.

**Who is involved?**
- a full-time Sure Start health visitor
- two local health visitors
- a Sure Start midwife
- local community midwives
- a clinical psychologist
- an occupational therapist

**What do they do?**
This team delivers antenatal and post natal support to parents according to the standard practices and timetables of NHS care, but is flexible about aspects of this – the number and length of visits to a family, the handover period from midwife to health visitor. Screening for post natal depression is carried out and used as a basic for enhanced services in the home and for referring mothers to support groups. The emphasis in this service is on both parents and ensuring that attachment to the child is established and that healthy behaviours (breast-feeding, not smoking) and the relationship between parents is robust. Referrals are made to other Sure Start support – early education, family support – but other services are not delivered in the home.

**Service Design G: Voluntary Sector Model**
In this approach, services may be commissioned from one or more voluntary organisations and delivered by them through their existing infrastructure (Home-Start, for example, may be funded to recruit and train an enlarged volunteer workforce and place volunteers with families from the Sure Start area). In the example described, however, the home visiting team are all seconded employees from a group of local voluntary organisations.

**Who is involved?**
• 2 part-time psychologists who provide group supervision for the home visiting team and support for families where mental health/post natal depression problems have emerged
• 9 home visitors (each working for Sure Start for four days a week, and their own organisations for one day)

**What they do?**
Members of the home visiting team give information and social and emotional support to families. Three of the team have been recruited as speakers of the two most commonly spoken non-English community languages. They give information and social and emotional support, and refer families to specialist help. They accompany people to appointments, provide advice and assistance on welfare issues such as debt and housing, and can arrange an emergency move in cases of domestic violence. The home visitors aim to build a relationship of trust with families, to enable them to use mainstream services which are delivered in venues outside the home, usually to groups of parents.

**Service Design H: Specialist Home Assistance Model**
Here the help that is provided to families is very practical – on the lines of the home help service – and is designed to offer relief and respite for a limited period.

**Who is involved?**
• 2 Maternity Care Assistants (MCAs), working 25 hours a week each.

**What do they do?**
The MCAs provide health and social care in the home – cleaning, befriending

and emotional support – daily or less frequently, for six weeks after a baby is born. They have received some hospital-based training which allows them to carry out some other tasks, like blood tests, but the main focus of their work remains social care for the parent. Families in this area expressed preference for help from their own community and the SSLP tried to recruit unqualified parents to take on the role of MCAs, but has not found it easy to recruit them.

In this SSLP area, midwives have expressed some concern that the MCAs may erode their traditional relationship with mothers, and the MCAs have complained that they can become a mere functionary of midwives. This dilemma seems to reflect a wider concern about the relationship between professional and para-professional services for families.

**Model I: Minimal Outreach and Home Visiting Services**
Some SSLPs do not emphasise these services or have begun to emphasise them less as the SSLP has become established. In the areas where this decision had been taken the reasons given are:

- cost

*"This is a very expensive service – we have to be careful we don't step in where another agency could be used"* (SSLP Manager).

- time

Home visitors may spend disproportionate time with a small number of families

- It disempowers families

*"Some families don't want us to withdraw. We say 'You are doing brilliantly' but they don't like it. We have to gradually wean them off us, usually by putting in a volunteer to help instead"* (Family Support Coordinator, SSLP).

- It is intrusive

Evidence was given in some areas that families disliked home visits
*"Many do not want you to come to their home – they don't like their home, maybe they are ashamed of it"* (SSLP Manager).

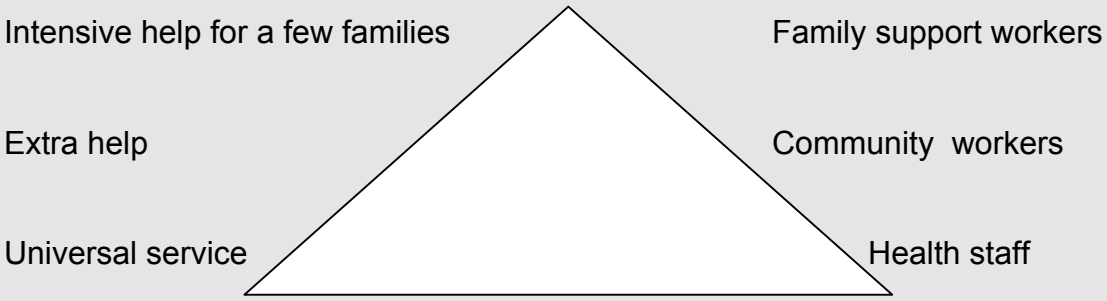
- Group based services are seen as preferable:

for the reasons outlined above and also because they offer social possibilities that cannot occur in the home.

*"We don't put a lot of emphasis on it because we try to get people to get out and come to us. There is a small group of families who take up more of home visit time than we appreciate. We find a number of women who find it difficult to get out of the home. It is easier for us to go there, but that can create tensions. Maybe they don't come to sessions because they have no money. It is not about them being hard to reach but us being difficult to access"* (SSLP Manager).

**3.1.7.Good Practice in Designing Outreach and Home Visiting in an SSLP**

This SSLP has designed its outreach and home visiting services on a triangle. At the base, health staff (midwife, health visitor and nursery nurse) provide universal services. At a narrower level community workers assist families to access universal provision, going to homes and running services in outreach sites. And at the top of the triangle, the families who need most support are given intensive help by home visits from family support workers.




## 3.2 The Choice of Outreach and Home Visiting Model

These models illustrating SSLP practice do not include every approach, but they do show some key themes which relate to SSLP context and ethos. Among the variables are:

• the size of the team. In complex, multi-cultural local areas it is likely to be larger, in order to include members who reflect all the local community interests. This would account for the finding in the Interim Cost Effectiveness Report that this type of area is spending rather more on Outreach and Home–Visiting than the average for SSLPs. Where the SSLP ethos is to deliver home services to those where the needs are most acute: families in crisis, with special needs children – the team is likely to be smaller and to undertake specific focussed work based on referrals.

• the combination of skills in the team: here the extremes are the complex multi-team model, contrasted with the highly specialised home assistance team, working with new parents on a limited number of support tasks for a limited period.

• the construction of the family and its relationship to Sure Start services. Here there is a classic division between the community development approach which sees parents as partners, compared with the intervention which focuses on a failure to meet a measured milestone in children. This is reflected in the regular, general information-sharing visit by staff in one programme, with the aim of families eventually engaging in activities outside the home, in one case, and the screening and testing of children which will lead to an individual programme of work in the home, with the child, if necessary.

• the relation of the Outreach and Home Visiting team to the rest of the SSLP programme. On the one hand Outreach and Home Visiting may be the frontline service, finding out who lives in the area, getting to know them, eventually helping them to access services they might like to use. On the other it may be a flying squad, receiving notice from other SSLP services (referrals, in other words) about families who need extra, concentrated help and delivering this to them on a one-to-one basis.

• finally, there are local variations in what is acceptable in the way services are delivered. Some areas report that non-professional home visitors are not acceptable, whilst professionally qualified staff are. In others the reverse is reported. In some areas professionals are considered threatening (especially if there is an association with Social Services Departments) and para-professionals from the local community are welcomed. Particular sensitivity is required in understanding the local context and preferences: the equation between outreach services and hard-to-reach groups in the population is not a simple one. Very young parents, in particular, were reported as disliking home visits by anyone, whom they saw as 'inspecting' or 'checking up' on them.

## 3.3 Coordinating Outreach and Home Visiting Staff

The composition of the teams described in these models is complex. It is made more so by the fact that members may not all be direct employees of the SSLP. In some cases they are seconded to Sure Start by their statutory employer, in others they simply work in the area and collaborate with Sure Start. SSLPs report that outreach work requires coordination, usually by a dedicated manager. This task varies according to the size of the team and the role they carry out.

**3.3.1** Almost all SSLPs have a member of staff who is responsible for the Outreach and Home Visiting programme. Only rarely was this the SSLP manager him or herself. It was more likely to be either a deputy manager or a coordinator line-managed by a deputy manager.

**3.3.2** Coordinators manage the allocation of work. In an SSLP where the Outreach team respond to referral requests this works in the following way. The SSLP has a formal request form and a process by which requests for service are addressed. All first time requests for service go through the coordinator to ensure appropriate allocation of services. Workers are based in the same building, which makes joined-up working easier and enables mutual support between them. There are consequently good lines of communication, *"It's easy to have informal discussions with other workers"* (Play Development Worker, member of a Whole Systems Model Outreach team).

**3.3.3** In an SSLP area where the Outreach services have all been commissioned from outside voluntary organisations and are line managed within them, there is still a coordinator in the SSLP who maintains a relationship with this organisation and meets with the line managers of the

staff to discuss the progress of the work and the achievements of individual visitors. This coordinator speaks daily to the visitors, meets them individually where required and meets all together fortnightly. The coordinator keeps up-to-date with events or services in the community that might be of interest or help to local families *"Anything might pop up with home visits and workers need to be in touch with what is available"* (Family Support Coordinator).

**3.3.4** There were reports that when members of outreach teams for Sure Start were based with their own organisations, it was important that the organisational representatives on the Sure Start partnership acted as the conduit for information through the line manager to the outreach staff. In other words, seconded staff could respond better to their own management structure than to the Sure Start line of command. Staff from statutory agencies were reported as being particularly hard to engage by some Sure Start programmes. One SSLP programme manager said*, "It so much depends on the people, and sometimes you have to battle to get this way of working. If you have a supportive line manager and a committed worker, then it's a great success….We all went through a lot of changes. Sure Start was a pilot project and we had to do the work to change the structures and processes of people. It's great to see that government policy has changed and now recognises this way of working. Sure Start changed the way of service delivery, thanks to the people"* (SSLP Manager, London programme).

**3.3.5.** Most coordinated teams have a stipulated time for continuing home visits to a family. Six weeks was the commonly quoted period. At this stage the home visiting would be reviewed, and a further (usually shorter) time limit was adopted. These periods of involvement are short, but SSLPs noted that it was not possible to offer intensive services to sufficient numbers of families if they were extended. The aim of moving families into groups or centre-based services was necessary on logistical terms. Some SSLPs staff were concerned that the programme should not be too identified with home visiting. *"It's very hard, you have to be strict – they like us visiting even if they don't really need us!"* (Educational Support Worker, SSLP)

**3.3.6** It was also normal for the home visitor to become a key-worker for a family, continuing as a point of contact for them in the SSLP, acting as their greeter, advocate and informally monitoring their progress. This process is most developed in the SSLP where all relevant households in two streets are the responsibility of pairs of SSLP staff.

## 3.4 The Role of the Outreach Worker

Some SSLPs outlined the general philosophy of their outreach work, including the role of outreach workers, in their Annual Reports. The gist of all of these was similar: that outreach staff worked closer to families, keeping contact and communication with them.

**3.4.1** In a training pack for outreach workers produced by one SSLP, the general demeanour required by staff is described.
*"The role is to offer information and support and work in partnership with families. It is not our role to take over a family's problems and issues. We are there to support them in doing for themselves, to present families with choices and to respect and abide by the decision made by the family"* (Training pack, SSLP North Region).

**3.4.2.** The programme manager and members of the outreach team in another SSLP gave a description of an outreach worker's role which echoed the above: to offer support and advice and to listen and respond in a respectful, non-judgmental and flexible way. To ensure that users feel comfortable enough to make comments or complaints and are therefore involved in service evaluation. To engage with other agencies appropriately and to promote the services on offer at the SSLP. These definitions identify the outreach worker as a bridge between families and services and vice versa.

**3.4.3** But in other SSLPs there was no over-arching statement of this sort, and it was clear from their responses that outreach staff from different backgrounds saw their roles differently. For example, the responses from workers in one SSLP suggest that different types of practitioner saw the role differently:

• *"It's a public health role: to be an advocate for Sure Start and for the parent, relating on their level"* (Two midwives).

• "*I provide outreach to increase the number of young mothers I can get to see…I can tailor services to suit, give advice and refer on to other services"* (Teenage/young mothers' worker).

• *"To try to get women with post natal depression to come and use the services*" (Parent Volunteer Worker).

• "*To reach vulnerable families…to respond appropriately and not to react to the home environment, not to comment on the home…to get the whole family to join in"* (Family learning support worker).

• *"To cater for vulnerable families who don't access mainstream…to promote and link in with mainstream speech therapy"* (Speech Therapist).

• *"To motivate people to go out there and use the services…to increase self esteem…to give out information packs and to register parents onto the peer support database"* (Peer Support Workers).

• *"To reach women who wouldn't normally access services…to go along and accompany women to groups and appointments" (*Worker from voluntary organisation).

**3.4.4** It was apparent in areas like this that varied approaches could be combined into an effective outreach team comprising different types of practitioner providing there was:

- some mutual understanding of each other's function and approach;
- regular coordination (see 3.4 above);
- co-location of staff, or regular meetings; and
- joint training.

## 3.5 Training for Outreach

**3.5.1** "*Dealing with people in their own homes becomes easier with experience – you reflect on what you've done and get advice. That's part of the learning curve,"* a Family Support Worker said in response to a question about the kind of training she had had to help her in outreach and home visiting. But while experience matters, there was evidence that an important part of her prescription was the getting of advice, and that training enabled workers to know where to find it.

**3.5.2** Essential training for all staff covered the avoidance of risk and confidentiality procedures. Usually this included risk assessments, the personal safety of the worker and basic practical self-protection steps. In most areas there were established procedures which outreach staff are taught. In most SSLPs they are required to record where they are going to be each day on a chart kept in the Sure Start offices so that other members of staff know where they will be. If they are due to make a visit out of working hours outreach workers often 'sign off' via a telephone call to another member of staff.

**3.5.3** The components of training for outreach staff are extensive, since these workers need to be prepared to respond to a whole variety of questions and needs. Typical ingredients include courses on domestic violence, child protection, first aid, confidence building, peer support/breast feeding, drugs, Islam awareness training, child and adolescent mental health, early childhood and learning, baby massage, baby yoga, speech and language, signs and symptoms of postnatal depression and general mental health.

**3.5.4** Sometimes the training is about specific issues for the local community: *"Every other week we have an in-house training session or get in a speaker. We have had a food worker in, someone from the local mosque and next week we are having someone from a national asylum support group"* (Outreach Manager). Sometimes it is more general*: "I have done a La Leche training for trainers, a group facilitation course and smoking cessation"* (Sure Start midwife).

**3.5.5** The amount of training it took to 'qualify' a worker for outreach duties varied from hardly any (in the case of professional staff like health visitors and community workers) to one year, in the case of an SSLP where home education workers received ongoing specialist training and were not

considered fully qualified to undertake outreach work alone for a year. In this case the training focused on home visits, interpersonal skills and working in partnership with parents.

**3.5.6** SSLPs using volunteer or paraprofessional home visitors/outreach workers noted that coordination, training and support for them had to be more intensive and longer than anything offered to qualified practitioners. Home-Start, which has managed the volunteer home visitors for several SSLPs gives each 40 hours of training, usually through a ten-week course of 4 hour sessions. *"It covers all aspects, from confidentiality, child protection, why families might need support and how to play with children. It's a very comprehensive training programmes that's constantly being reviewed; very participatory so that we can find out about volunteers views and how they would react to families. The crucial elements are confidentiality and child protection"* (Home-Start Regional Coordinator).

**3.5.7** In some SSLPs the experience of training volunteers to a position where they would be able to carry out home visits had not been a happy one: *"Volunteers are more trouble than they are worth. If you are using local parents they need careful supervision. If you are recruiting more widely you will find it hard to recruit volunteers to work in this area: people don't want to come here due to its reputation. It ended up costing us £300 per volunteer visit"* (Programme Manager, North East). But this view was not universal, and the most common view was that the local knowledge and informal approach of volunteers more than made up for a lack of professional qualification. *"We have an initial three-month probationary period for all staff to iron out the difficulties, for new employees and for professional recruits. The local staff need to be as good as the professionals, sometimes better, and they need to feel that they are"* (Outreach Coordinator, Northern programme).

**3.5.8** An interesting and effective way of getting a mixed team, of professionals, practitioners and para-professionals or volunteers from the community to work together and to develop consistent skills is to get them to train one another. One programme has monthly team meetings, the main purpose of which is for outreach staff to share information, but members of the team are invited to deliver training during these sessions and also at six training days through the year. It is widely reported that speech and language therapists have trained all other outreach workers to detect speech and language problems.

**3.5.9** The benefits of a multi-disciplinary training for outreach work offered by an SSLP were summarised by a professional worker:

*"Initially I was asked to introduce myself to the community and was then given a structured timetable consisting of practical and theoretical work. This involved outreach tasks like distributing leaflets at schools and home visits, and was complimented by theory presented in training sessions, looking at things like Emotional Literacy and the Green Paper. This was useful because I had access to up-to-date information and was able to get advice on how to deal with issues. If, for example, a worker had witnessed a fight one week,*

*time would be spent looking at group dynamics. Time was allocated for appropriate research and peer group support was given in debriefing sessions. And we had access to specialist resources like a psychologist, a health visitor and a speech and language therapist"* (Health professional).

**3.5.10** In addition, in this SSLP area were there is in-depth training, and in others where training is less extensive, outreach visitors work in pairs. It was also reported as normal for outreach work to be carried out unaccompanied, and, in some areas, for initial visits to be carried out by two workers (especially if the family is unknown to the SSLP) but for subsequent visits to be unaccompanied. SSLPS made these choices largely in response to the preferences of families, although issues of the personal safety of the workers were also part of the equation. Several SSLPs reported that they gave training on how to deal with violence or aggression to all workers.

## 3.6 Confidentiality

Policy and protocols about confidentiality have been developed and apply across all SSLP services, outreach and home visiting included, but they are particularly important in this latter service, because workers who visit families at home have an intimate relationship with them and may see, hear or be told about private matters. Families can be wary of services because of fears about confidentiality and will need to be reassured. It was reported that this was a consideration in work with Asian families in some areas, and asylum seekers. *"In this area a lot of Asian families do not access a GP because of fears about confidentiality – a family member might see them" (Manager, two SSLPs). "Some families request non-Asian workers because they fear tittle-tattle and don't believe our confidentiality – they assume an Asian worker will tell"* (Manager, voluntary organisation working with an SSLP).

**3.6.1** This was an issue about which SSLPs were well-prepared. All those visited had their own policy, to which workers adhered and about which all staff were clear and in agreement. Procedures and consent forms had been devised. Consent was required from families before there could be a referral to another agency or another worker. Information sharing was on a 'need to know' basis and families were kept informed of who had been given details of any situation. A parent's confidence would only be broken if there was a child protection concern.

**3.6.2** Where SSLPs register parent users, the registration form contains a statement about why personal information is required and what it is used for. In one area, which has a borough-wide service request form, this asks the family to state anyone with whom they do not want the SSLP to be in contact with. Families can review their case notes every six weeks with a family support worker and sign to say that they agree with any referrals or exchange of information. They are able to see notes made about them whenever they wish.

**3.6.3** The need-to-know principle was illustrated by an outreach worker in one SSLP: information concerning the benefits a family receives would not be

shared with other staff, but changes in family circumstance or concerns about the welfare of a child would. Child protection is a priority and concerns about the safety and welfare of a child take precedence, with the family being informed of any action that may be taken.

**3.6.4** SSLPs were aware of the sensitivity surrounding home visits and took action to reduce this where possible: *"We have to be very careful about confidentiality in this area as many Asian families don't what others to know they are using Sure Start. We have reversable coats, so that if we are doing a Sure Start event we can have the name of Sure Start visible, but if we are escorting a family to a hospital we can reverse the coat so that they are not stigmatised"* (Outreach worker).

**3.6.5.** Generally it has been reported by NESS researchers that Sure Start services have not been seen as stigmatising by families who live in SSLP areas. A concern about home visits was raised by SSLP staff in a small number of study areas, however, all with significant minority ethnic populations It may be that home visits have a different status because they are made to individual families, they are visible and they resemble visits made by local authority child protection staff (NESS 2005a). It is essential that staff consult with families on their feelings about home visits and the manner in which they are to be conducted. If families ask staff to be discreet, this request should be scrupulously implemented.

# Section 4: The Impact of Outreach and Home Visiting

## 4.1 On Families in SSLP Areas

Family members were interviewed for this study, but only those who were actually using SSLP services, so they are respondents for whom the Outreach and Home Visiting services have been effective, at least at the level of letting them know what services are available.

**4.1.1** Parents were not in a position to comment on 'outreach' per se, since if they were in touch with services this was often because they had been successfully engaged through outreach but were not aware of this definition of the approach. (Or even of the word 'services'. This is a professional/practitioner/policy makers' word. For the rest of the world it is more likely to refer to buses or church). Home visiting services were more easily discernible and parents expressed high levels of satisfaction with them, and sometimes linked them to changes in their children.

**4.1.2** For example, a parent commented on a structured intervention delivered in the home to children with speech and language delays:
*"He came on in everything – before if you sat playing with him he would get bored, now he will sit and read and play – his speech is fantastic – he is saying a lot more"* (Mother).

And on the worker who delivered the intervention:
*"She made it very easy for me – she explains everything before she does it and explains what she wants the child to do and what she wants your reaction to be*" (Mother).

On the weekly home visits of a family support worker:
*"I saw the support worker for five or six months, she was more like a friend, you could always chat even if you saw her out. Because of her I can now stand back and see things in perspective"* (Mother of four, accessed family support visitor through health visitor).

On the regular visits of a parent volunteer:
*"She's not judging the way I treat my kids, she knows what it's like, she's got three of her own. I think some people expect you to live in an ideal way and never shout, never get stressed out. But we all do and I think Sure Start understands that it's not easy to bring up your kids. They don't judge you, they help you get on with it and I've got a lot of time for them"* (Mother of four children, two teenagers, two under four).

### 4.1.3 Persistence

The main goal of home visiting in many SSLPs is for parents to leave their homes and join groups and services run by Sure Start or other providers. The comments of parents about their own engagement suggest that many need a lot of support to leave the home. In one SSLP several parents said that they would not have been able to attend Sure Start without a lot of support: *"I*

*needed a little push to come"* said one mother. Another mentioned that her health visitor arranged to meet her at the Sure Start centre, another that if it rains she can ring and a staff member will come and collect her as she has a long walk. Several parents commented on the persistence of staff who keep ringing up and following up periods of non-attendance. *"They don't let you go – they keep you on an elastic band, ready to spring you back if you need to."* This persistence was seen as positive and enabling access to all the services: *"They don't give up on you".*

**4.1.4** Some parents needed persistent support before they could make any moves or changes on their own or their children's behalf. The model of change with which many home visiting staff are working is of the 'confident parents, confident children' type, seeing parents' attitudes as crucial to children's feelings about themselves. (The comment quoted on at para 2.1.4 on page 21, from a parent who is a single mother of three children, illustrates this point.) In this approach to parents and children an important factor in affecting change is seen as contact with others – parents and children. Indeed, there is anecdotal evidence from users of Sure Start services that contact with other parents has been an agent of change in their lives. This pathway is described by the following Sure Start service user. She was referred by a paediatrician to the speech and language therapist for a home visit because her son's speech and language was not developing. Note how the focus shifts from the child to the parent in her story:

*"He wasn't coming out of himself at all, not communicating. We've had so many hurdles – he would only wear one pair of shoes. I was really frustrated and he was really frustrated. The speech and language therapist came to do an assessment and I burst into tears, I was going through such a bad time. A home visitor started coming for a few weeks and she listened and encouraged me."* Mother and son started to attend a weekly Opportunity Group and met other families: "*They are going through the same things. They have been such a support for me, a real booster."*

For the SSLP the trajectory for this family has been successful: with support they have moved out of the home, into a group where support is available from the community beyond Sure Start staff so they have moved one step further from dependency on Sure Start. No comment was volunteered about the child's subsequent language development.

**4.1.5.** In one of the very few examples of a structured programme delivered to individual families via home visits over time, (children are screened and allocated to the programme if they are not meeting development threshold scores) a local evaluation report notes that staff believed that only a minority of parents regularly carried out the recommended activities between intervention visits. The input for most children was thought to come almost entirely from the Sure Start worker on the scheme. In order to engage parents more effectively, links between the home visiting intervention and work in three local Sure Start settings was being established.

**4.1.6** Continuing with this example, the local evaluation identified another 'challenge' as far as engaging parents was concerned: *"the widely held belief that communication development is ultimately the responsibility of speech and language therapists".* This programme is delivered in the home by trained nursery nurses. A comparison can be made with Portage, where home visiting specialists visit families where a child has special needs and devise a programme of activities which is implement regularly by the parents between visits. Portage workers report a high level of engagement by parents, but this may be because they trust the diagnosis they have received and also because there is quick and conspicuous improvement as a result of the Portage programme. In contrast the evaluation of the structured programme described above notes that parents, offered the programme, could feel:

- the child was too young to need help at such an early stage
- that the child did not have a problem – parents would compare their child's development with that of other children in the neighbourhood and say that their skills were similar (These children might also need support, of course.).

In addition, parents who were not implementing the programme between visits may have felt that they were not as competent as programme staff to carry out the tasks. Mothers on this programme were full of praise for home visitors and their skills in relating to their children. The evaluators note *"For other parents, significant adverse life events or onerous caring responsibilities may preclude significant participation. In such circumstances attempts to provide support to the parent themselves may be most useful either within sessions or by directing parents to other forms of support within the programme"* (Potter et al. 2005).

**4.1.7** Some families from ethnic minority communities expressed a preference for contact with professionally trained staff on home visits. Sure Start staff in several areas where there was a significant Asian community commented that mothers from this community might need the permission of their husbands or mothers-in-law to have contact with Sure Start. Husbands were more likely to agree to this if the service was being delivered by a professionally qualified worker, especially by a health professional. But the messages about what worked best for these communities were very mixed: several SSLPs observed that outreach workers from a particular community were essential, because they could speak the relevant language and understand cultural nuances. Conversely, it was reported that members of some minority communities were suspicious that workers from their own community would not preserve confidentiality.

**4.1.8** The preference for someone local and familiar who spoke your language was not confined to minority ethnic groups. In one SSLP area a midwife noted that she had found it easier to gain the confidence of local women because she had been born and brought up on the estate where the programme operated. This was a former mining community and within it there were some very specific traditions about housekeeping and child rearing.

**4.1.9 Good Practice in Engaging with a Parent**

An SSLP employs a specialist Muslim Project worker and a Portage worker. Both undertake some home visits. A Pakistani mother with four children was suffering from depression and was referred to Sure Start by a GP. One of her children was autistic and another child had started to copy the behaviour of the autistic child. The Muslim Project worker and the Portage Worker paid a joint visit to the family to gain the trust of the parents and continued to visit together weekly until the mother agreed that her son needed help. The child now receives Portage services and attends a nursery, the parent is less depressed and has become able to mix with people from different culture – of whom she was once afraid. This outcome has occurred because the Muslim Project worker enabled the Portage worker to gain access to the family.

**4.1.10** No objection to contact from volunteers or para-professionals was expressed by any parent interviewed. Parent users tended not to distinguish between types of outreach staff, simply referring to all as 'Sure Start workers'. However a parent volunteer felt that parents were more responsive to an approach from a non-professional and could express themselves more freely, *"We can say to a parent 'Maybe your child could do with a bit of help with his speech, why don't you let the speech therapist do some work with him? And they don't mind at all, whereas they maybe wouldn't want to go to an appointment or have the speech therapist visit them" (*Volunteer outreach worker). This view was also expressed by some professional staff working with Sure Start.

**4.1.11** The following observation was made in a report by a research officer on a visit to an SSLP to conduct interviews with parents about their experience of Outreach and Home Visiting services.

*"I attended a baby group and a stay-and-play craft session …. I spoke with a mother who said that not many white families use Sure Start as it is seen as an 'Asian thing'…Some of the mothers here had come to Sure Start after a home visitor had checked their home safety and suggested they contact Sure Start for equipment, then they had started to use other services. One said, 'We are not really the type of mums Sure Start is trying to support, but I live in the area so I use it.'*

**4.1.12** This is a dilemma for SSLPs in mixed areas: services are more likely to be used by the families who need them least, and this may well put off more disadvantaged families, who may need them more. SSLP managers were well aware of the dilemma and many programmes were trying to redress the balance by developing services for specific groups and using outreach and home visiting services to recruit specific types of users: a parenting course aimed at Muslim women parents, for example, and a life-skills course aimed at teenage mothers.

## 4.2 Impact On SSLP Staff

### 4.2.1 Increased resources to offer families

The strongest approval for the outreach and home visiting approach came from staff who had already been involved in it before Sure Start: midwives and health visitors. They had seen the resources available to families increase dramatically. One health visitor said that in the past she did not dare to introduce certain ideas to families because she knew that they were not feasible, available or affordable. Because Sure Start had developed a wide range of back up services she could now get into a conversation with a family about needs, and have somewhere to refer them to meet those needs. Elsewhere a midwife described similar benefits: *"We try to link in with groups run by other organisations as well. I've worked with people I wouldn't have thought of, like the Job Centre. It's about tailor-made care, we refer the family to the appropriate people"* (Midwife). These two pre-existing services often refer to themselves as the 'gateway' to Sure Start. They may invite other workers to make joint visits with them.

### 4.2.2 Multi-agency working

Outreach and home-visiting staff responded particularly enthusiastically to the multi-agency team model. It has two main benefits: providing team members with support and providing families with flexible responses. *"Even within Sure Start the different communities have different natures. What works in one area may not work in another. Home visits work very well in some areas. You go out to people where they feel safe, introduce yourself and the other services gradually then draw them out to one of the centres"* (Health visitor in multi-agency outreach team). Here again, the success of home visiting was seen as getting someone out of the home and into a Sure Start centre.

### 4.2.3 Importance of the relationship with existing health services

There were indications that pre-existing outreach teams in some areas had not been initially welcoming to SSLPs. Health visitors were reported as having been resentful of the initiative, feeling 'we are doing it already' and 'Sure Start has all the resources'. In the areas where there was this attitude it had sometimes proved difficult for SSLPs to get the basic data about families in the area held by Health Trusts. This contrasted with the welcome given by health staff elsewhere. The main reason for the difference was the attitude of senior health managers. Where they had been thinking along 'preventative' lines for their services, and had taken on board the various recommendations for changes in health visiting and midwifery practice, health managers were willing to back the involvement of their staff in SSLPs. But this was not true everywhere and the message from management was reflected in the attitudes of field staff. In SSLPs where relationships were poor it was reported that:

- information about families had not been shared with the SSLP
- there were few referrals in the antenatal period
- there were no referrals for smoking cessation
- health visitors did not understand what SSLP had to offer
- SSLP home visitors, like the one quoted here, were anxious about stepping onto health territory.

*"My original target was to provide support for families at home. This is rather woolly and it would have been easier if I had been approaching families as an 'expert' of some sort. I made my first visit to each family with the health visiting team, but they were not very helpful, and then I did six weekly visits on my own. I had had training in safety and child protection but there were many things I couldn't do, and I had to keep saying 'Ask your health visitor' – which made me feel a bit useless and inadequate"* (SSLP Family Support Visitor).

**4.2.4** Over time relationships with pre-existing services could improve, though a good deal of time appears to have been wasted before this happened. As the quotation above suggests, a lack of focus in the early stages of the SSLP outreach and home visiting programme could also contribute to poor relationships. A change of direction by the SSLP – often to providing a specific service in the home like accident prevention – made things work better, and the demonstration of effects from the SSLP home visits proved persuasive. *"The provision of services in the Sure Start area is now more effective. Pregnant mothers need to go to the maternity unit, but there were lots of no shows. We have a service now in the Sure Start centre and we visit families the day before and make sure they are able to come. No shows are right down. The PCT are aware of this – we are helping them to meet their targets, so they value us now"* (Outreach manager, SSLP).

**4.2.5** Outreach staff noted difficulties and benefits of working in family homes. Namely:

- it is time-consuming
- time is wasted when families are not at home for pre-arranged visits (or do not answer the door)
- space to work (especially when working directly with the child) may be limited presence of other family members, friends, pets, noise from televisions and so on can interfere in the relationship between worker parent and child
- opportunity to see the child's home environment could be helpful in understanding the background to the child's development and could reveal pressures previously unknown
- parents sometimes felt able to confide problems (domestic violence, debt, relationship difficulty) which they were unable to discuss outside the home, perhaps because they felt more concerned about confidentiality
- it could be hard to manage the boundaries of the relationship with an individual family – some could become 'dependent' on the home visitor.

**4.2.6** Workers noted the benefits for themselves of being part of a visiting team, especially where this was multi-agency. They were able to get a range of advice on how to respond to different needs in a family, and were supported to deal with matters like dependency and concerns about child protection. It was also straightforward to change the key worker for a family if a relationship did not become established.

## 4.3 Impact on Voluntary Organisations

SSLPs were encouraged to work with voluntary organisations, especially those already operating with families in the area. Because Sure Start was a well-resourced programme, and many voluntary organisations are preoccupied with the limitations in their resources and the need to find more, research interviews with these organisations about their contribution to outreach and home visiting services often became sidetracked into complicated stories about who was paying for what and what could realistically be expected of them. Good practice could clearly emerge from the relationships that had developed, but there were examples of poor practice too.

**4.3.1** Good practice often involved the integration of the voluntary service into the SSLP. The coordinator of a voluntary programme described how this worked in her SSLP: *"I am based in the programme. The other people I am based with are in the Outreach team, so sometimes I do things that aren't officially in my remit – if, say, a parent walks in and I'm the one who is in the office….I go to the team meetings and I go to all the referral meetings, which are held every two weeks where we discuss all the referrals and who goes to see who, whether it's a social worker, me or the speech and language therapist…Within the Sure Start area I receive most of my referrals through the Sure Start team, but I do get the occasional referral from my own organisation"* (Home-Start organiser).

**4.3.2** In another SSLP area the same organisation were not continuing to work on contract with Sure Start because *"the boundary restrictions really restricted the work we could do. We felt that we could just offer a much better service to people if we were not bound by Sure Start"* (Home-Start organiser). Among the difficulties in this area and others were the monitoring requirements of a contract with an SSLP. *"For us, our work is about changing people's lives. It's not just about seeing a family or calling a family and having a five minute conversation. We need to make that clear. So with every contract we know we have to meet the numbers that we agree to reach and we understand that, but it's not our driving force. And even just looking at the numbers that we agreed in this contract, we were constantly having different opinions on how the results looked"* ( Home-Start Organiser).

**4.3.3** A regional organiser for the same voluntary organisation described two models of collaboration with SSLPs, one, like that described above, had voluntary coordinators based directly in SSLPs. In the other the coordinators work in Home-Start offices but support volunteers who visit families in the SSLP area.
*"When it works well, it works really well. What's interesting is, it's about trust in each other, and that's taken quite a long time to sort out. Home-Start had to accept that we are not the only people who can support people in their own home. It's a multi-agency process. We can make referrals, too – if we are working with a family that needs extra help around speech and language, we can make a referral within the SSLP team. I think that's how a partnership should work. Different people have different skills and we should use those skills positively"* (Home-Start Regional Coordinator, North).

**4.3.4** Unwillingness to work in this collaborative way was not always attributable to SSLPs. Voluntary organisations and their staff could cling very tightly to their own identity. This was partly because of their long-term need to seek funding for discreet services for which they were responsible: the collaboration with SSLPs could blur exactly what it was they were achieving with families. But there was also the need to retain the distinctive features of a voluntary organisation. *"As a voluntary agency we are seen differently by parents – we are seen as separate from statutory services. Although Sure Start has been set up at arm's length from the council, it still has that connection with a statutory body, in the eyes of families. Statutory agencies have legal duties, they are required to do A, B and C. Sure Start is the same. (This organisation) don't have such a brief and it gives us freedom and autonomy"* (Manager, national voluntary organisation).

**4.3.5** There was extensive evidence that staff from statutory agencies were unaware of the skills and knowledge embedded in voluntary organisations and made assumptions about them - such as that all their staff were volunteers. For example, in one area where a voluntary organisation specialising in support for children with special needs had been contracted to provide such support for SSLP families, the SSLP worker said 'I don't know that they have the expertise for me to work with them with regard to special needs" (Special Needs Facilitator). A possessive attitude towards families visited – sometimes revealed by the use of possessive pronouns, ("my mums" was particularly common among health personnel, "our families" among SSLP staff) - gave other clues as to why collaborative working might have failed in some areas.

# Section 5: Conclusion

## Lessons from SSLP Experience in Implementing Outreach and Home Visiting Services

Sure Start Local Programmes have been operating in an interesting hinterland where the people to whom they offer services are under no obligation to receive or accept them. The legislation under which SSLPs work requires intervention when children are deemed to be 'at risk' or 'in need'. Much that SSLPs offer is geared to the prevention of need and risk, rather than to intervention in a crisis. Creating the pretext for relationships with families in order to make these offers of services to them is therefore both essential for the programmes yet difficult and delicate to carry out.

The outreach services of SSLPs have been in the vanguard of building a relationship with families and persuading them to be involved in Sure Start. They have had to advertise, market and sell Sure Start. If their approach sometimes appears over-sensitive, this is because SSLPs are aware that if they get it wrong and if they put families off, they may not get another opportunity to build a relationship with them. The space between parent and child is essentially a private area, and if SSLPs are to intervene in it, they need to be invited in.

## 5.1 Reaching the families who might need Sure Start

**5.1.1** SSLPs monitor the use of their services and send the results on annual returns to the Sure Start Unit. These show that in the majority of SSLPs the percentage of families using the programme is well below half of those with children under 4 in the area. The average use is around 30% of eligible families, and can be as low as 10%. The areas with the highest penetration manage 60%. One could postulate that a programme of this integrated design could only make a full impact when its services had become part of the daily life of all children under four in the local area. But children encounter Sure Start services through the agency of their parents, and the advertising, marketing and selling of Sure Start is directed at them. Nevertheless, it is interesting that many parents say they attended a local Sure Start event or entered a Sure Start building or went on a trip or into a playground *"Because it's nice for the kiddies",* (Mother at SSLP stay and play). A direct association between Sure Start activities and young children is the best vehicle for outreach.

**5.1.2** SSLPs have found that the families who take up services most readily are those in least need. This is a common finding about service-use: research studies on the early use of Children's Information Services, (which are services generally available to all families) found that the first users were *"teachers and social workers"* (that is, the kind of people who trust services because they are involved in delivering them) but that over time the profile of users moved towards those on lower incomes. Other studies have also shown

that the most successful marketing for services comes from *"word of mouth",* but this too takes time to spread, and can spread more rapidly among members of professional groups. Programmes aiming to work with the low-income families need a long time to establish their profile. They also need to combat colonisation of services by those least in need. SSLPs have been doing this by designing specialised services for harder-to-reach families. But there is a tightrope to be walked here, between general, desirable services and targeted, stigmatised services, and it is a hard balance to maintain. Most SSLPs tried very hard to do keep this balance and had been successful.

## 5.2 Focus of Outreach services

The other balance to be struck is between the needs of parents, children and the wider community. The target for SSLPs is the development of children, but the access to children of this age is through their parents, and it is the experience of SSLPs that the needs of parents have often become paramount. The focus of most home visiting is family support, even when it is delivered by health, play or early education, speech and language or special needs workers. All types of home visitors report that they encounter large numbers of mothers with a kind of low level depression which is sometimes called 'malaise', and which includes mild levels of agoraphobia and anxiety. SSLPs are able to call on services which are directly helpful to parents suffering these difficulties – there are often direct links to the CAB, women's aid organisations, CPNs and MIND, for example. But the focus shifts from the needs of the child to the needs of the parents. Of course this can be rationalised by the argument that the child will be affected by the parent's mental health, and will benefit if the parent is feeling better. But this shift in focus can mean that the child is less likely to be the beneficiary of a direct service.

### 5.2.1 On the child

It has been clear from this examination of Outreach and Home Visiting services in SSLP that there are very few that are:

- delivered to children in the home
- over a significant length of time
- to a structured curriculum
- by a trained professional.

That is, there are very few examples of the kind of programme described as effective in benefiting children by evaluation studies.

Where there are examples of home delivery of this kind, they are because a child has been assessed to have a deficit of some sort: speech and language, behavioural or a special need. SSLPs had not developed integrated packages of stimulation/education which were delivered from more than one site (an early education setting plus the home, for example) as a normal part of service delivery. Because these children are very young, parents were not always willing to accept an intervention when there had been an assessment of a deficit, feeling that it might right itself later, or being unwilling to label the child from an early age.

In a small number of interventions offered by voluntary organisations as part of SSLP services in some areas (PAFT, PEEP) there was an emphasis on the potential of small children to learn and develop further and faster when exposed to stimulus and interaction – but these approaches had spread into all aspects of even these SSLPs. Much of the focus of professional services was in identifying a child's problems rather than reminding the family that he or she could be a thing of wonder.

### 5.2.2 On the Parent/Family

Home visiting services by SSLPs are most likely to focus on the needs of parents. The goal of these services is likely to be to get the parent to participate in a service outside the home, usually delivered in a group. SSLPs have become adept at this process and are often successful at it. Some have also developed a chain of services to move parents along a route towards self-reliance, further education and training and employability (NESS Report 6 2004b).

### 5.2.3 On the Community

A few SSLPs had made a deliberate decision to use Outreach and Home Visiting services as a means to contact the whole community of local families by visiting them all. The aims of this approach were to maximise the numbers involved in the programme, build relationships between families, and bed down the approach in the community so that it could be sustained with the minimum of infrastructure in the future.

### Operational Choices

SSLPs had a wide variety of options available to them in creating Outreach and Home Visiting services, as the models described in Section 3 illustrate.

**Operational Choices**

**Where the Services Come From**

- Delivering outreach and home visiting services directly, through SSLP (employed or seconded) staff
- Delivering some services directly, and some through contracts with other organisations (statutory or voluntary/community)
- Contracting all services out to other organisations

**What sort of People Deliver them**

- Professionally trained specialists (eg health visitors, teachers, social workers etc)
- Trained para-professionals (eg nursery nurses, family support workers, play workers)
- Trained volunteers, local parents)

***How these People Relate to one another***

- Elements of all three (professional, para-professional, volunteer) sharing all tasks
- Professional leadership (para-professional, volunteer back-up)

- Para-professional, volunteer leadership (referral to professionals)
- Professional and paraprofessional only
- Volunteer only

**Organised in**
- multi-agency teams
- area or building-based teams
- specialist teams
- community-focused teams (where an SSLP has distinct communities)

**5.2.3** The evidence of this study was that these choices and combinations could all work provided that:

- there was coordination and a clear understanding of what they were trying to achieve;
- no one service felt that they were in the ascendancy or had more claim to expertise in what families wanted or in the community;
- the SSLP management (Partnership Board and Programme Managers) understood the structure of the voluntary sector and the management and resource constraints under which voluntary organisations work; and grasped the benefits which the good reputation of local and national voluntary organisations with local communities could bring to the SSLP;
- there was a centralised database, of all the children in the age-group living in the area;
- there was a key-worker system, so that every family had one person whom they knew and who was their main point of contact with the SSLP;
- there were written protocols on matters like confidentiality and child protection;
- there were regular meetings and good communications between workers and services, and, ideally, that they were co-located (say in a Sure Start building); and
- there was regular professional supervision (via their own profession and from the SSLP) for all workers going into family homes.

**5.2.4** It is essential that health services are integrated into the outreach and home visiting programme. These are the services which parents expect to be available to them, so they have the virtue of being recognizable; and they are the backbone of services for young children in the UK. The evidence from SSLPs was that where health services were semi-detached from a

programme, it took longer to get going and consequently to make a difference. Health services needed to accommodate SSLP approaches, that is, working in partnerships with families and not telling them what they must do. But there has been every sign from the Sure Start experience that they have been ready to learn this, and to appreciate the usefulness of other skills in supporting child development. This learning curve needs to begin in the areas where it has not yet started, and to continue everywhere else.

### 5.2.5 Focus for the Future

Outreach services will still have to wrestle with the difficulty of contacting and engaging people who hitherto have been 'hard-to-reach'. Sure Start experience so far suggests that they need to persist. Small gains are made, usually ascribed to particular individuals – community workers, teachers, interpreters, nurses, volunteers – who listen, make relationships and persuade people to step somewhere new. The usual motivation for families is that their children will benefit, and the invitation that works is *"Do you want your children to do well?"*

We know that programmes can make a difference to young children, but too often in the UK the path of change is constructed as being to change the parents in order to change the children. The services can then get snagged up on the parents – who are often very needy – and lose sight of the children. Outreach services need to enthuse parents about their children's potential and help them to see beyond their own difficulties.

## References


Armstrong, G and Brown, F (1979) Five Years On: A follow-up study of the long term effects on parents and children of an early learning programme in the home. Social Evaluation Unit. Oxford

ATD Fourth World (2006) Not Too Hard To Reach: developing a tool to reach the most disadvantaged families. ATD Fourth World. London

Baker, AJL, Piotrkowski CS and Brooks-Gunn J (1999) The Home Instruction Programme for Preschool Youngsters (HIPPY) The Future of Children 9:116-133

Baker, AJL, Piotrkowski CS (1995) The Home Instruction Programme for Preschool Youngsters: An innovative programme to prevent academic underachievement: Final report. National Council of Jewish Women. New York

Barlow J , Kirkpatrick S, Stewart-Brown S and Davis H (2005) Hard-to-reach or out-of-reach? Reasons why women refuse to take part in early interventions Children & Society 19:119-210

Barnes J, MacPherson K and Senior, R. (2006) Factors influencing the acceptance of volunteer home visiting support offered to families with new babies. Child and Family Social Work 11:107-117

Billingham K and Hall, D (1998) Turbulent future for school nursing and health visiting in BMJ 316: 406-407

Brooks-Gunn J, Burchinal M, Lopez M (2001) Enhancing the cognitive and social development of young children via parent education in the Comprehensive Child Development Program

Burchardt T, LeGrand, J and Piachaud D (1999) Social exclusion in Britain 1991-1995. Social Policy and Administration 33 (3): 227-244

Cross-Departmental Review of Provision for Young Children (1998) HM Treasury. London

Daines, R. Turner, A. Taylor, P. Clench, J. Gould, D. Fry, K. Granger, N and Ring, H.
(1989) Pre-school project: Evaluation of the nursery intake East Sussex County Council/Brighton Polytechnic.

Daro DA and Harding K (1999) Healthy Families America: using research to enhance practice. The Future of Children 9: 152-176

DfES (2001) Planning and Delivering Sure Start: Fourth Wave Edition. Sure

Start Unit. London

DOH (1999) Making a Difference: Strengthening the midwifery and nursing contribution to health care. The Stationery Office. London

DH (2001) Health Visitor Practice Development Resource Pack. Department of Health. London

Elkan R, Kendrick D, Hewitt M, Robinson JJA, Tolley K, Blair M et al (2000) The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. Health Technology Assessment. 4 (13)

Frost, N. Johnson E. Stein, M. and Wallis L (1996) Negotiated Friendship: Home-Start and the Delivery of Family Support Home-Start. Leicester

Ghate, D and Hazel, N (2001) Parenting in Poor Environments: Stress, support and coping Jessica Kingley. London

Gomby, D. Culross, P. and Behrman, R. (1999) Home Visiting: Recent Programme Evaluations – Analysis and Recommendations in The Future of Children 9 (1) 4-26

Grimshaw, R and McGuire C. (1998) Evaluating parenting programmes: A study of stakeholders' views National Children's Bureau, London and JRF, York

Hall, D (1996) Health for All Children Oxford University Press. Oxford

Howarth, C. Kenway, P. Palmer, G. and Miorelli, R. (1999) Monitoring Poverty and Social Exclusion JRF. York

Love, J, Kisker E, Ross C, Schochet P, Brooks-Gunn J, Boller K, Paulsell D, Fuligni A and Berlin L (2001) Building their Futures: How Early Head Start programs are enhancing the lives of infants and toddlers in low income families US Dept of Health and Human Services. Washington DC.

McAuley C, Knapp M, Beecham J, McCurry N and Steed M. (2004) Young Families under Stress. Outcomes and Costs of Home-Start Support. Joseph Rowntree Foundation. York

McDonald A, Langford, I and Boldero, N. (1997) The future of community nursing in the United Kingdom: district nursing, health visiting and school nursing. In Journal of Advanced Nursing 26: 257-265

Moran, C (1996) What women want to know after childbirth. In Birth 24 (1): 27-34

National Evaluation of Sure Start (2004a) Report 5. Characteristics of Sure Start Local Programmes 2001/2 DfES. London

National Evaluation of Sure Start (2004b) Report 6.Improving the Employability of Parents in Sure Start local programmes. DfES. London

National Evaluation of Sure Start (2005a) Report 10. Implementing Sure Start Local Programmes: An Integrated Overview of the First Four Years. (DFES. London)

National Evaluation of Sure Start (2005b) Report 11. Buildings in Sure Start Local Programmes DfES. London

National Evaluation of Sure Start (2005c) Report 12. Maternity Services in Sure Start Local Programmes. DfES. London

National Evaluation of Sure Start (2006) Report 15. Cost Effectiveness of Implementing SSLPs: An Interim Report. DfES. London

Oakley, A, Mauthner, M, Rajan, L, Stone S, & Turner H (1994) An Evaluation of Newpin Institute of Education. London

Olds DL, Eckenrode J, Henderson CR, Kitzman H, Cole R, Tatelbaum R (1999) Prenatal and Infancy Home Visiting by Nurses: Recent Findings Future of Children 9:
44-65

Oliver C, Smith M and Barker S (1998) Effectiveness of Early Interventions in Cross Departmental Review of Provision for Young Children. Supporting Papers Vol 1. HM Treasury

PEEP (2000) Learning Together with PEEP Peers Early Education Project. Oxford

Potter C, Carpenter J and Griffin M (2005) Child Progress Model, Sure Start Peterlee (unpublished)

Prinz RJ and Miller GE (1994) Family-based treatment for childhood antisocial behaviour: experimental influences on drop-out and engagement. Journal of Consulting and Clinical Psychology 62: 645-650

Ritchie J and Spencer L (1993) Qualitative Data Analysis for applied policy research in Byman A and Buyers RG (eds) Analysing Qualitative Data (9) 173-194 Routledge. London

St Pierre R, Layzer j, Goodson B and Bernstein L (1997) National Impact Evaluation of the Comprehensive Child Development Programme: Final Report ABT Associates. Cambridge. MS

Saxena S, Eliahoo J and Majeed A (2002) Socioeconomic and ethnic group differences in self-reported health status and use of health services by children and young people in England: cross sectional study. BMJ 2002:325-

Schonveld, A. and Kingswell, S. (1996) Improving maternity information: a consultation process. Health Promotion Services. Coventry

Schweinhart L (2003) Benefits, Costs and Explanation of the High/Scope Perry Preschool Programme. High/Scope Educational Research Foundation. Ypsilanti, Michigan

Singh, D. and Newburn M (ed) Access to maternity information and support: the experiences and needs of women before and after giving birth. NCT. London

Smith, G (19750 Educational Priority: The West Riding Project. HMSO. London

Smith, T. (1987) Family Centres: prevention, partnership or community alternative? in Macfarlane J.A (ed) Progress in Child Health 3: 176 – 189. Churchill Livingstone. Edinburgh

Stewart, M. and Taylor, M (1995) Empowerment and Estate Regeneration: A Critical Review. Policy Press. Bristol

Swann, B & Brocklehurst N (2004) Three in One: the Stockport model of health visiting in Community Practitioner 77:7 251-257

Tisdall E (1998) Review of Current Provision in Scotland for Children aged 0-7 Vol. 1. HM Treasury. London

Tunstill J (1998) Problems of access to existing services by families at risk in Cross Departmental Review of Provision for Young Children Vol 1. HM Treasury. London

Wagner M and Clayton SL (1999) The Parents as Teacher Program: Results from two demonstrations Future of Children 9: 91-115

Weikart DP, Epstein AS, Schweinhart L, Bond JT. (1978) The Ypsilanti Preschool Curriculum Demonstration Project: Preschool Years and Longitudinal Results. High/Scope Foundation. Ypsilanti, Michigan.

White, M (1996) A Review of the Influence and Effects of Portage in Wolfendale, S. (ed) Working with Parents of SEN Children after the Code of Practice David Fulton. London

Copies of this publication can be obtained from:

DfES Publications, PO Box 5050, Sherwood Park, Annesley, Nottingham, NG15 0DJ; Tel 0845 6022260; Fax 0845 6033360; Textphone 0845 6055560; E-mail mailto:dfes@prolog.uk.com

Please quote reference: NESS/2006/FR/017



ISBN 978 1 84478 848 4