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Sure Start Loxford Evaluation 2003/4  
Infant Mental Health Spotlight Service

## Introduction

Sure Start Loxford is a second wave programme, and as such has been up and running for the last 4 years. Whilst Sure Start has an established presence in the Loxford community, the service is still evolving to meet new government strategies, in particular the development of Children's Centres.

For 2003/4 Sure Start Loxford commissioned Cordis Bright Consulting to conduct its annual evaluation. The parameters of the evaluation are to assess three projects funded by the programme. These 'spotlighted' services are:

- ❑ **Family Support Workers' Service:** as provided at Albert Road (AR FSW) and South Park Clinic (SPC FSW)
- ❑ **Muslim Women Welfare Association:** Dress-making class and English classes (MWWA)
- ❑ **Infant Mental Health Project (IMH):** Clinical intervention, training and research

Whilst the nature and structure of the three projects is distinct, the evaluation for each of the three projects has shared objectives, and these have been examined across 6 key dimensions.

- ❑ **Strategic Dimension:** The extent to which they support the achievement of Sure Start objectives and key principles
- ❑ **Operational Dimension:** Efficacy of operational processes and procedures, including extent of partnership working with external agencies
- ❑ **Implementation Dimension:** Overall quality of services; including the extent to which services meet user needs and expectations
- ❑ **Unit-Cost analysis:** including bench-mark costs
- ❑ **Future Strategy and Planning:** strategic analysis of exit strategies and opportunities for mainstreaming of projects
- ❑ **Cost-benefit Analysis:** Overall conclusions, identification of best-practice, value-for-money by taking into account qualitative context and long-term outcomes

This report focuses on the service evaluation of the Infant Mental Health Project, and was conducted between February and May 2004. There are a number of strands to the Infant Mental Health service, including clinical intervention, training for other service providers and a research project (conducted in conjunction with University College London). This evaluation focuses on the clinical intervention and training strands of the project, as the research aspect is still awaiting ethical approval and hence is not fully underway.

## Methodology

To gain an understanding of the service on the six key dimensions, the evaluation necessitates a number of levels of analysis. These include background and desk-top research, consultation across the partnership, qualitative and quantitative analysis of data. Interviews have been conducted at all levels of engagement; with service users, paid staff, and service co-ordinators. This multi-level approach ensures feedback is obtained from people engaged at all levels of service provision and use. A variety of consultation methodologies have been employed and are listed below.

- ❑ **Interviews with Service Manager (18<sup>th</sup> March 2004):** A one hour semi-structured interview with the project manager, who is also a child psychiatrist working on the project.
- ❑ **Staff Interviews (18<sup>th</sup> March 2003)** A 1 hour semi-structured group interview was held with the psychotherapist on the team. A further interview was conducted with the clinical supervisor for this post.
- ❑ **Client interviews (18<sup>th</sup> April 2004 – 4<sup>th</sup> May 2004)** Six structured interviews were conducted with both users and ex-users of the service, using a combination of face-to-face and postal survey techniques. The interviews were conducted by the project team. Whilst this may cause some degree of interviewer bias, it is considered a priority to minimise any negative impact on client relations. All interviewees were informed that interviews would be treated as confidential.
- ❑ **Stakeholder Focus Group (25<sup>th</sup> March 2004)** A focus group was held with a range of stakeholders in the IMH project to understand their perceptions of the value and efficacy of the service. Attendees included health visitors, family support workers, service managers, community development workers, and the post-natal depression co-ordinator.
- ❑ **Observation of Service and Intervention Techniques (18<sup>th</sup> March 2004)** Due to the nature of service provision observation of one-to-one counselling sessions was considered intrusive. However an innovative intervention technique employed by the IMH project (namely, video recording of parent-child interactions) allowed observation of the technique and impact on users.

- Unit cost analysis This was undertaken using the basic unit cost model which deduces what the average cost of a contact is by reference to the total Sure Start contribution, using data from 2003/4 and the total grant made available in 2003/04. Various benchmarking costs are provided to enable comparison of unit costs for the purposes of assessing cost effectiveness.

## Service Profile

The Infant Mental Health project has been running for approximately one year to date. The service profile details the clinical and training intervention independently from the research aspect.

## Clinical and Training Services

### Objectives

The over-arching objective of the service is to improve the emotional health of parents and children. This includes key sub-objectives, including;

1. Reducing emotional and behavioural problems for carers and children
2. Raising awareness and providing training across service providers and wider stakeholders (e.g. across CAMHS) of infant mental health
3. Providing a cost-effective service

### Targets

There are no project specific targets.

### Format

One-to-one one hour counselling sessions are provided to parents or carers at a clinic setting. The nature of the session provided is dependent on the needs of the mother and child, but does include innovative practice (such as using video recordings of the parent-child interaction to demonstrate unhealthy behaviour to clients). The paradigm of the intervention is based in attachment theory, and as such focuses on the relationship of the parent and child.

### Staff

There are two core staff members on the project; a child psychiatrist and psychotherapist. The Health Visiting team is also associated with the project as they have been trained by the Infant Mental Health team in identification of infant mental health problems and post-natal depression assessment tools (specifically the Edinburgh Post Natal Depression Scale, EPDS).

### User Profile

Those accessing the project are from a range of ethnic backgrounds, indicating that the harder-to-reach groups are being accessed (such as

ethnic minorities and asylum seekers). (See Appendix 2, graph 3 for full details). The majority of clients suffer from post-natal depression, however refugees/ asylum seekers also present with neurotic disorders, such as post-traumatic stress disorder. This reflects community need as Loxford has 6<sup>th</sup> highest rate of refugees in the country.

## Costs

The total cost for the Infant Mental Health Project is £27,475.

## Research Project

Part of the Sure Start Loxford funding is supporting a research project on attachment issues in infants. This project is conducted by the IMH project team in conjunction with UCL. The project is currently awaiting Ethics Committee approval.

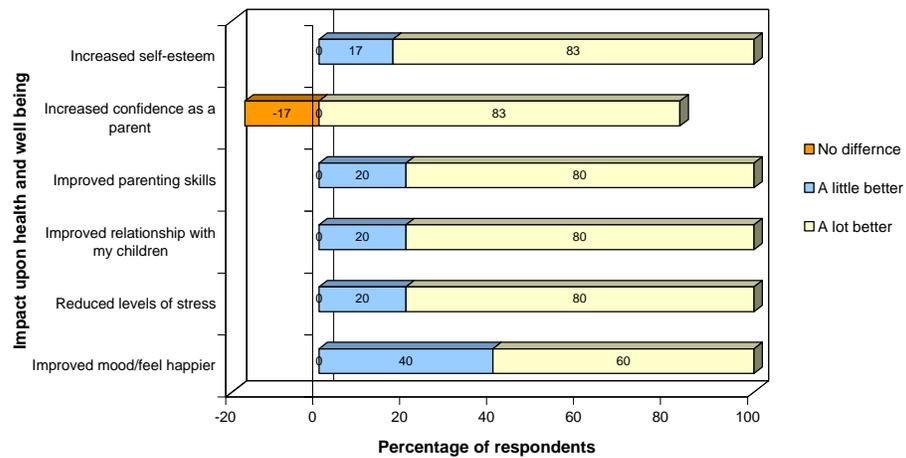
The research aims to further understand the impact of the intervention provided by the IMH within the parameters of attachment theory. The research will target 50 Sure Start parents using the service to assess impact.

## Strategic Dimension

The strategic dimension of the evaluation provides an analysis of the extent to which the project objectives and outcomes work towards achieving Sure Start objectives and key principles. The IMH objectives are strongly aligned with all four Sure Start objectives, and the impact of the IMH project stretches across all four objectives.

The IMH project makes most direct impact on *Objective 1: Improving social and emotional development* and *Objective 2: Improving health*. (see appendix 1 for more details). This is evidenced by the results of the client survey, indicating that a range of social and emotional aspects for carers were significantly impacted by the service.

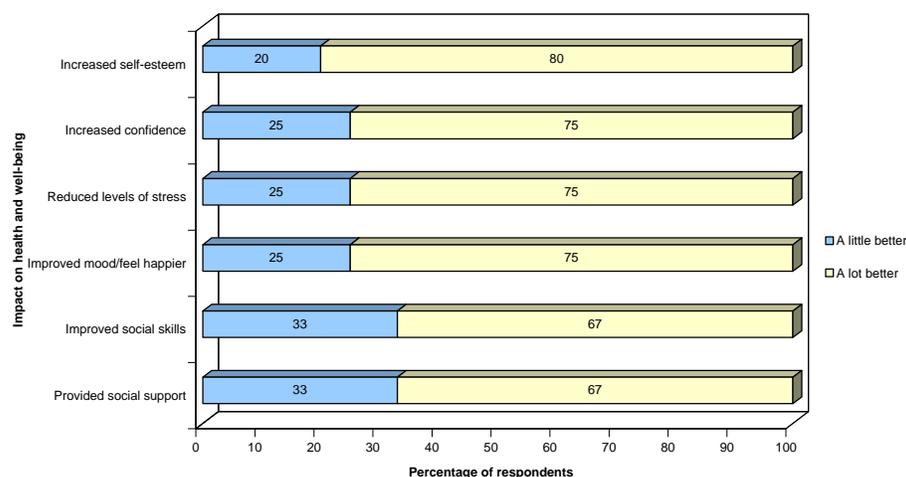
**Graph A: Impact of IMH service upon carer’s health and well being**



(Base = 6, excluding *Don't Knows*)

Similarly carers perceived a significant impact on their child’s health and well-being.

**Graph B: Impact of IMH service upon child(ren)'s health and well being**



(Base = 6, excludes *Don't Knows*)

For both parents and children the impact was perceived as significant across all health and well-being indicators. This was supported by statements provided by clients, such as;

*“the impact was totally life changing for both myself and my son. I believe my (our) quality of life would be very low if not for the service we received”.*

Corroborating this, service providers perceptions were also of significant impact on clients health and wellbeing, stating that clients could not have had their needs met for post-natal depression so effectively without them.

These results give an indication of the short term impact of the service on parents and children. This is supported by a growing body of research evidencing significant benefits from early intervention.

*“early preventative interventions have the potential to improve in the short term the child's health and welfare (including better nutrition, physical health, fewer feeding problems, low-birth-weight babies, accident and emergency room visits, and reduced potential for maltreatment), while the parents can also expect to benefit in significant ways (including educational and work opportunities, better use of services, improved social support, enhanced self-efficacy as parents and*

*improved relationships with their child and partner). In the long term, children may further benefit in critical ways behaviourally (less aggression, distractibility, delinquency), educationally (better attitudes to school, higher achievement) and in terms of social functioning and attitudes (increased prosocial attitudes), while the parents can benefit in terms of employment, education and mental well-being." Professor Fonagy (1998:132.)<sup>1</sup>*

However, the nature and content of infant mental health interventions can vary significantly. Young Minds<sup>2</sup> identifies the major deficiency in Infant Mental Health services as the lack of focus on the *relationship* between the child and carer. As the platform for the IMH project is attachment theory, this is the key focus of the intervention provided by the Sure Start IMH project, indicating optimal service intervention. Indeed, the project is targeting a nationally recognised unmet need within health services, with CAMHS largely only receiving referrals from 5 years and upwards.

Clearly, the suggested impact of the intervention provides strong support for Sure Start Objectives 1 and 2. In addition, there is also a strong body of evidence indicating the impact of early intervention on future learning capabilities (*Objective 3: Improving learning*) and in improving later behavioural problems (*Objective 4: Strengthening families and communities*). Young Minds Charity, in its policy document 'Infant Mental Health' states;

*"Failure to identify the need for support may result in poor educational achievement, anti-social behaviours such as criminality and substance abuse, and adult mental health problems"*<sup>3</sup>

In terms of project strategy then, the IMH can be considered to be providing a service to meet a nationally and locally recognised need in the optimal manner.

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<sup>1</sup> Fonagy, P. (1998) Prevention, the appropriate target of infant psychotherapy.

<sup>2</sup> Young Minds for children's mental health: Mental Health in Infancy @ [www.youngminds.org.uk](http://www.youngminds.org.uk)

Shonkoff, J. P. & Phillips, D. A. (Eds) (2000) From Neurons to Neighborhoods: The Science of Early Childhood Development.

<sup>3</sup> Young Minds: Children's Mental Health: Infant Mental Health @ [www.youngminds.org.uk](http://www.youngminds.org.uk)

## Operational Dimension

This dimension examines the efficacy of operational processes and procedures, including extent of partnership working with external agencies.

### Organisational structure and management

The IMH project is situated at Loxford Hall. This is a Child and Family Consultation Centre, with a multi-disciplinary child and adolescent mental health team providing assessment, therapy, advisory and consultative services for children under 18 years with relatively severe complex emotional, behavioural or mental health difficulties.

The IMH project is based in the centre. It was established, and is developed and managed in an on-going capacity by Dr Trudie Roussouw, (child psychiatrist).

### Integration with other service providers

Young Minds<sup>4</sup> states that for an effective infant mental health service; *'A multi-disciplinary, multi-agency team is required with professionals drawn from CAMHS and other areas of health care such as Health Visitors/Public Health Nurse and occupational therapists, as well as practitioners from social services and early years services, including Sure Start.'*

The IMH project has achieved this through a number of strategies. Firstly the project is based at a Child and Family Consultation Centre, where a multi-disciplinary team is co-located, allowing for awareness and integration of services beyond Sure Start Loxford. However the staff situated at Loxford Hall have a strong focus on mental health, and do not to include associated professionals, such as occupational therapists or speech and language therapists.

This is overcome through a number of additional relationships establishing integration with other service providers. The IMH project has delivered training to other front-line service providers, specifically health visitors. FSW also received an introductory session to the IMH service, raising awareness and increasing integration.

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<sup>4</sup> Young Minds: Children's Mental Health: Infant Mental Health @ [www.youngminds.org](http://www.youngminds.org)

Moreover, on-going contact is maintained with associated service providers to ensure clients are supported in accessing the IMH service (e.g. FSW help ensure that clients attend meetings).

Finally there are also ad-hoc client meetings, Sure Start milestone and project meetings and regular informal contact.

## Communication with other service providers

There is a high level of communication with other service providers.

### Awareness

There is a high level of awareness of the IMH project amongst other service providers. The Postnatal Depression Audit<sup>5</sup> indicates that the South Park Clinic HV refer approximately 8.5% more parents suffering from post-natal depression (at 10% of new births) than other clinics in the area (averaging at 1.5% of new births). As the prevalence of post-natal depression stands between 10 and 12% nationally, it can be concluded that the IMH project is far more effective in identifying and meeting need than other comparable health teams.

In addition, services are advertised through effective networking of the project team at board meetings, presentations and external research with UCL. This has successfully increased awareness of services across the mental health teams, including the NELMET Infant Mental Health Group (a partnership between funding streams to develop a strategic overview of funding) and CAMHS.

### Referral/ assessment

The bulk of referrals made to the project, particularly to the psychotherapist, are from the health visitors. These referrals are mostly made through assessment using the Edinburgh Post-Natal Depression Scale (EPDS), or concerns that arise from observation of unhealthy behaviour. Other referrals are received from GPs, social workers and mid-wives and include more complex cases, such as post-traumatic stress. As a result of the training provided to the HVs nearly all referrals are suitable, and hence nearly all are accepted.

Most referrals are seen within one or two weeks. Service-providers stated that the IMH project had efficient procedures in place for taking on new referrals and that waiting times were very short. These effective procedures were seen as a unique aspect of the IMH project.

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<sup>5</sup> Redbridge Primary Care Trust, Postnatal Depression Audit (May 03 – Oct 03)

Services referred to include paediatrics for neurological assessment (King George Hospital), Kenwood Children's Centre, FSWs and other Sure Start services.

### Feedback Mechanisms

Feedback tends to be regular, but mostly informal, due to good integration between service providers. The project team are regarded as very approachable and helpful by service providers (and the support staff at Loxford Hall were also universally complimented on their helpfulness!)

Health visitors had the most successful communication flows from the project, and were regularly sent updates from the service providers. Family Support Workers did not have such regular contact with the IMH staff, but information was usually accessible from IMH secretaries.

### Training

Training provided to HV re: EPDS. HV identified as being in pivotal position within multi-disciplinary mental health teams, as in position to refer<sup>6</sup>. Previous studies have shown that health visitors, given brief training in the detection and support of women suffering from depression, can have a significant impact on the course of the disorder (Holden et al, 1989; Gerard et al, 1993). Training has included infant observation and attachment theory. FSW have also received an introductory session.

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<sup>6</sup> Young Minds for children's mental health: Mental Health in Infancy @ [www.youngminds.org.uk](http://www.youngminds.org.uk)

## Implementation Dimension

This dimension of the evaluation assesses the overall quality of services; including the extent to which services meet user needs and expectations

### Profile of service-use

The sample surveyed were long-term clients, who accessed the service frequently.

- Length of service-use** Two-thirds of clients had been using the IMH service for between 1 and 2 years (see Appendix 2, graph 10 for full breakdown).
- Frequency** The average frequency of receiving services is 1.6 times a week. Half the respondents accessed the one-to-one support one or more times a week, and 34% accessed the groups one or more times a fortnight. 17% accessed the groups once a week.

### Quality of service provision

The service was perceived by service users and providers to be of universally high quality, including accessibility, waiting times, capacity and staff.

#### Accessibility

The IMH service has been very successful in providing an accessible service. 100% of respondents agreed that the length and times of the visits were suitable. Further, 100% of the sample found it easy to make on-going appointments with the psychiatrist.

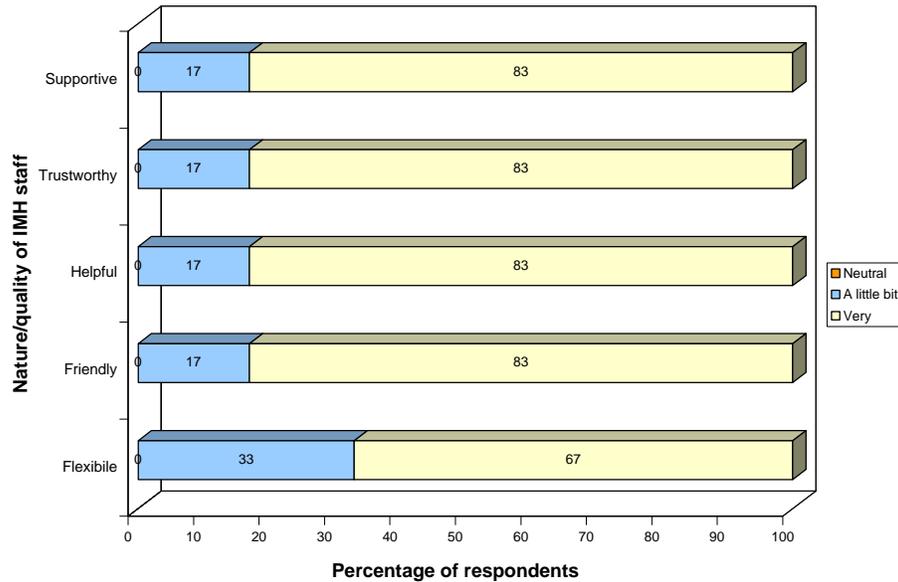
#### Waiting times

100% of clients found the time between requesting services and receiving them to be efficient. When appointments were not kept it was not recorded as being the fault of the service-providers, but due to unexpected event or child illness. Service-providers suggested that reducing missed appointments would be an area to improve upon. However additional support is provided to clients through FSW supporting them to access the service.

## Staff

Service users perceptions of the qualities of the IMH team are extremely positive, scoring very highly on qualities of friendliness, helpfulness, trustworthiness and supportiveness (see Graph C below)

**Graph C: Opinion of the nature/qualities of the IMH service**



This was corroborated by service user comments, describing the staff as “outstanding”; “professional, patient and friendly” and “the psychologist and psychotherapist of Loxford Hall are one in a million”

The positive assessment of the nature and suitability of the staff was also stated by the service-providers, who claimed that knowledge of the characters of IMH workers increased their confidence to refer to them.

## Communication with Users

Communication with service users is a two-way path, enabling information to flow between service-users and service-providers in order to improve the service for all parties. This can facilitate a more needs-led output.

## Advertising/Awareness

Awareness of the IMH service amongst users originates from a range of service providers. 50% of service users heard about services though the

health visitor, with the other 50% hearing through social services and Sure Start services.

### **Feedback**

None of the service users were aware of a complaints or feedback procedure. Feedback from service users can help to shape and improve the services on offer and a system for allowing regular feedback should be implemented.

### **Signposting to other services**

Integration with Sure Start and statutory services is good, indicating effective pathways for information flow.

## Unit–Cost analysis

The unit-cost analysis is based on average or approximate data due to the high degree of flexibility of working practice across all services. The unit-cost analysis includes on-costs, such as administration expenditure, capital costs etc.

The unit-costs for the IMH service are based solely on the clinical intervention and training aspects of the project, excluding the research project as this is not yet underway, and hence is assumed to be taking negligible time.

The total cost for the Infant Mental Health Project is £27,475. This supports two sessions with Dr Trudie Rossouw (clinical psychiatrist) and six sessions with Amanda Jones (psychotherapist) per week. Each session lasts 3.5 hours and allows for consultation with one or two clients.

This means each session costs £67.34, for both Dr Trudie Rossouw and Amanda Jones, based on the maximum one-to-one contact of two clients per session. This equates to £33 per person per one-to-one for both types of intervention.

With a current case-load of 20 clients for the project, this averages at a Sure Start case-load of 5 clients for Dr Trudy Rossouw and 15 clients for Amanda Jones. Whilst it needs to be remembered that there is huge variance across client contact, this averages at 42 one-to-one sessions per client per year, resulting in a total cost per person of £1, 386 per year.

## Comparative Analysis

Comparative analysis has been conducted to counselling and psychiatric intervention services as studied as part of *Unit Costs of Health and Social Care 2003*

**Table 1: Comparative costs of service provision for Infant Mental Health service**

Service provided	IMH team worker	Consultant Psychiatrist – Unit Costs	Clinical Psychiatry Team Member –	CAMHS - Unit Costs	Clinical psychologist	Counselling Service in Primary Medical Care
Average contact cost per hour	£33	£260	£65	£59	£66	£32

## Future Strategy and Planning

As a result of effective future planning and key strategic links in wider stakeholder partnerships, IMH project has a well-formed strategy in place to ensure mainstreaming. Indeed this has already been put into effect, with an application for funding from the Redbridge Health Authority to substitute £10,000 of the Sure Start budget. If this is successful, and funding can be increased by the same amount annually then the project will be mainstreamed within three years. This will develop the project as part of the CAMHS team, which is aligned with the proposed provision of services by Young Minds.

*Whilst an infant mental health service needs its own ethos, i.e. its own referral arrangements and its own space, it is best developed as part of Child and Adolescent Mental Health Services (CAMHS) to ensure seamless support for babies with longer-term disorders. This also allows the service to stay in touch with the family as new crises occur, and to monitor the older children.<sup>7</sup>*

This places the project in an excellent position for further development and expansion of the service, and this is happening across a number of levels.

- Redbridge Health Authority has provided additional funding to provide four supplementary sessions outside the Sure Start boundaries.
- The IMH project would like to grow the ante-natal aspect of the service. A local need has been identified for intervention before birth, to impact on any mental health issues that may be on-going or trigger problems post-nataly.
- The project is considering developing the service to provide group intervention for those clients who could benefit. This would tend to be those clients who have less severe mental health issues, and would benefit from additional support. However, as the service becomes more generally supportive, care would need to be taken that services were not duplicated within the Loxford area.
- Once Ethics Committee approval is obtained for the research project, this will develop the service provided and augment awareness of IMH needs and interventions.

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<sup>7 7</sup> Young Minds: Children's Mental Health: Infant Mental Health @  
[www.youngminds.org](http://www.youngminds.org)

## Cost-Benefit Analysis

One of the key issues to be addressed for the IMH project, in terms of a cost-benefit analysis, is the relatively high costs of mental health intervention by highly skilled professionals. On average each client receives 42 one-to-one sessions per client per year, resulting in a total cost per person of £1,386 per client (see unit-cost analysis p17 - 18). The key question is whether this high cost represents value-for-money.

The evaluation indicates that the IMH project performs extremely well on a range of indicators of good service provision.

- It is a highly integrated service, with a high degree of shared objectives, values and means across a wide range of other services (including Sure Start)
- The project is strongly aligned with all four key Sure Start objectives
- It has effective communication mechanisms in place with other services
- Both clients and other stakeholders (including other referring organisations) hold the service in high regard, both in terms of operational practice and quality of service provided

Within themselves, each of these aspects can be considered a significant success for the IMH project. However, the key question is whether the service makes a difference to the lives of parents and children in terms of the intervention, relative to the cost. This evaluation concludes that this is certainly the case.

In our evaluation 100% of clients stated that the service had impacted positively on their health and well-being and their children's health and well-being (see Strategic Dimension p.8-10). Moreover, there is a growing body of evidence indicating that the earlier intervention occurs the greater the long-term benefits. Finally, the nature and content of the IMH project's intervention is evidenced as being most effective in making impact, with its focus on the relationship between parent/carer and infant.

Concluding therefore that service impact is optimal, this, in turn, has been shown to make significant savings across the range of public services.

*“Analyses of the economic costs and benefits of early childhood intervention for low-income children have demonstrated medium- and long-term benefits to families as well as savings in public expenditure for special education, welfare assistance, and criminal justice”.*<sup>8</sup>

Indicators of need also suggest that the IMH project is effectively meeting local need for post-natal depression, with referral rates of around 10% of new births matching national prevalence of post-natal depression, estimated at between 10% and 12%. This is also relatively far more referrals than other comparable centres of health care, and hence the assumption can be made that is far more effective in meeting need relative to other service providers.

However, the project is currently not running to capacity. An average intervention of 42 weeks (as evidenced in results from the client survey) is a significant period of time, and as many episodes of post natal depression remit spontaneously within six months of onset, and only a minority follow a chronic course<sup>9</sup>, therefore this may be considered too long an average.

This can be accounted for in the more complex nature of the client problems that present. The majority of clients accessing the service not only have post-natal depression, but also concomitant diagnosis such as post-traumatic stress disorder, or more deep lying depressive personality problems. These do not resolve with 6 to 8 sessions of counselling and require a longer duration of treatment.

This evaluation therefore concludes that the Loxford Sure Start IMH project provides good value for money. Moreover, the strategic direction, operational practice and nature of implementation are examples of best practice for other infant mental health projects. In addition, the future plans to increase the geographical boundaries and target client group (i.e. developing the ante-natal focus of the service) should allow the project to optimise service provision.

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<sup>8</sup> Robin Balbernie (1998) *An Infant Mental Health Service: The Importance of Early Years and Evidence-Based Practice*, available at the Association for Infant Mental Health website [www.aimh.org.uk](http://www.aimh.org.uk)

<sup>9</sup> <http://www.pndtraining.co.uk/articles/SRS1.htm>

# Appendix 1

## Sure Start Targets (PSA's)

Public Service Agreement Targets are targets which have been set in order to measure Sure Starts' progress against them.

### **Objective 1: Improving social and emotional development**

In fully operational programmes, achieve by 2005-06 a percent increase in the proportion of babies and young children aged 0 – 5 with normal levels of personal, social and emotional development for their age.

- The target is to improve the personal, social and emotional development of young children aged 0 -5.

### **Objective 2: Improving health**

In fully operational programmes, achieve by 2005-06 a six percentage point reduction in the proportion of mothers who continue to smoke during pregnancy.

- The target is to reduce by 6 percentage points the proportion of women who had a live birth in the measurement period and continued to smoke during pregnancy

### **Objective 3: Improving learning**

In fully operational programmes, achieve by 2005-06 a per cent increase in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation stage and an increase in the proportion of young children with satisfactory speech and language development at age 2 years.

- Target levels will be set so they aim to narrow gap between children in areas targeted by SSEYCU programmes and children generally.

#### **Objective 4: Strengthening families and communities**

In fully operational programmes, to achieve by 2005-06 a 12 percent reduction in the proportion of young children (aged 0-4) living in households where no one is working.

- The target refers to a reduction in the number of children aged 0 – 4 (up until fifth birthday) living in fully operational programme areas that are living in households where no adult of working age is in paid employment.
- 

#### **Service Delivery Agreements (SDA's)**

Service Delivery Agreements support and compliment the PSA targets and objectives. The SDA's are wider and also contain more specific detail which can effectuate delivery of PSA's as well as procure other positive benefits.

*In order to make it easier for all parents to find the childcare they need when they need it, in particular in the most disadvantaged areas, so that they can work.*

**Public Service Agreement target for fully operational programmes, by March 2006: a 12% reduction in the proportion of young children living in households where no-one is working.**

*Sure Start Unit will contribute to the DWP PSA target to reduce the proportion of children in households with no-one in work over the 3 years from Spring 2003 to Spring 2006 by 6.5% and to the joint HMT/DWP PSA target to reduce the number of children in low-income households by at least a quarter by 2004, as a contribution towards the broader target of halving child poverty by 2010 and eradicating it by 2020.*

#### **Service Delivery Agreement Targets, by March 2006**

1. To create 250,000 new childcare places for at least 450,000 children, (approximately 280,000 children net of turnover) *in addition to the new places for 1.6m children to be created between 1997 and 2004.*
2. To create 180,000 new childcare places in the 20% most disadvantaged wards (and smaller areas of disadvantage).

3. To create, by 2006, 95,000 new high quality out of school club childcare places for children of school age.
4. To establish Children's Centres in areas of disadvantage extending core Sure Start services to a further 300,000 children, so that by March 2006 at least 650,000 children have access to Children's Centre services.
5. To increase the percentage of childcare providers inspected by Ofsted rated as good or better by 2006. *Level to be set by 2004 when Ofsted system in place and initial baseline data available.*
6. To at least double the number of users of the Childcare Link website and local Children's Information Services.

## **Objective**

### **Improving learning**

*In particular by promoting high quality care and education which supports children's development and early education, especially in disadvantaged areas and especially through early identification of and support for children with special needs.*

**Public Service Agreement for fully operational programmes, by March 2006: Ancrease in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation Stage and an increase in the proportion of young children with satisfactory speech and development at age 2 years.**

### **Service Delivery Agreement targets, by March 2006**

- 7.95 per cent of Foundation Stage provision inspected by Ofsted rated good or better by 2006.
8. To increase the number of children who have their needs identified in line with early years action and early years action plus of the SEN code of practice and who have either a group or individual action plan in place. *Target percentage increase in number of children to be set by end of 2003-2004 when baseline date available.*
9. To increase the use of libraries by families with young children. *Target percentage increase to be set by 2004 when baseline data available.*

## **Objective**

### **Improving social & emotional development**

*In particular in the most disadvantaged areas:*

- *promoting greater parental understanding of and engagement in children's development;*
- *supporting early years and childcare providers in early identification of difficulties;*
- *increasing the contribution out of school provision makes to older children's development as citizens.*

**Public Service Agreement target for fully operational programmes, by March 2006: An increase in the proportion of babies and young children aged 0-5 with normal levels of personal, social and emotional development for their age.**

### **Service Delivery Agreement targets, by March 2006**

10. All families with new born babies in Sure Start local programme and Children's Centre areas to be visited in first 2 months of their babies' life and given information about the services and support available to them.

## **Objective**

### **Improving children's health**

*By improving awareness of healthy living amongst children and their service providers and, in particular in disadvantaged areas, by helping parents to support their children's healthy development before and after birth.*

**Public Service Agreement target for fully operational programmes, by March 2006: a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy.**

11. Information and guidance on breastfeeding, nutrition, hygiene and safety available to all families with young children in Sure Start local programme and Children's Centre areas.

12. Reduce by 10 percent the number of children aged 0-4 living in Sure Start local programme and Children's Centre areas admitted to hospital as an emergency with gastro-enteritis, a lower respiratory infection or a severe injury.
13. Ante-natal advice and support available to all pregnant women and their families living in Sure Start local programme and Children's Centre areas.

## **Objective**

### **Strengthening families and communities**

*By encouraging all providers of children's services to take a wider view of their role in the community and, in particular in disadvantaged areas, by involving families in building capacity in the community and creating pathways out of poverty.*

### **Public Service Agreement for fully operational programmes, by March 2006: a 12% reduction in the proportion of young children living in households where no-one is working.**

14. An increase in the proportion of families with young children reporting personal evidence of an improvement in the quality of family support services. *Target levels to be set, as percentages for families in disadvantaged areas and in all areas, by end of 2003-2004 when baseline data available.*
15. Local Authorities, Sure Start local programmes and Children's Centres to have effective links with Jobcentre Plus, local training providers and further/higher institutions.

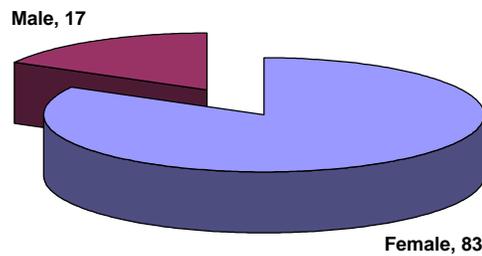
## Appendix 2

### Demographics

The charts following illustrate demographic details of the respondents surveyed, and some respondent details and experience of the service.

#### Gender

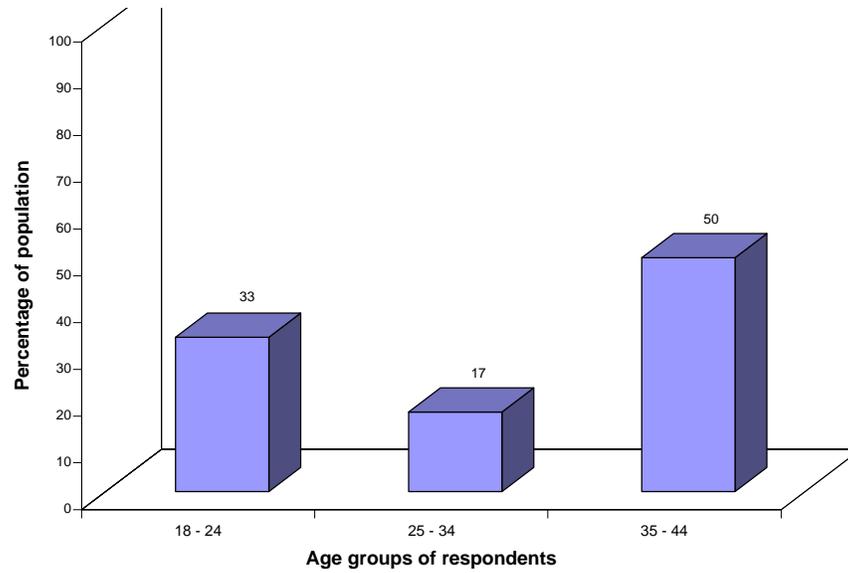
**Graph 1: Gender of sample population**



Base = 6

## Age groups

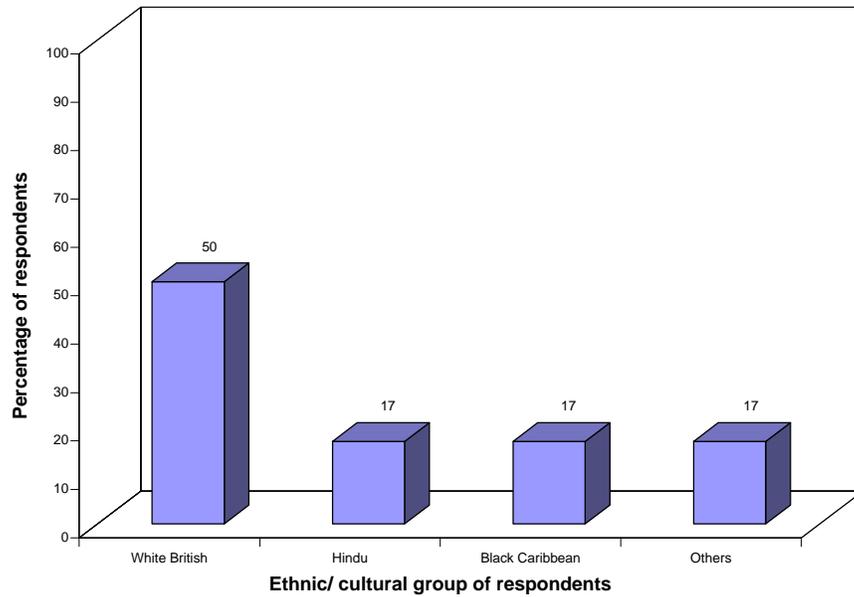
**Graph 2: Age groups of sample population**



Base = 6

## Ethnic/cultural identity

**Graph 3: Ethnic/ cultural group of respondents**

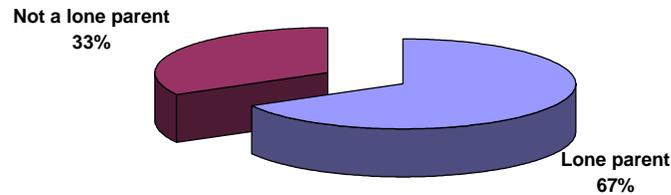


Base = 6

## Family status

None of the sample were pregnant

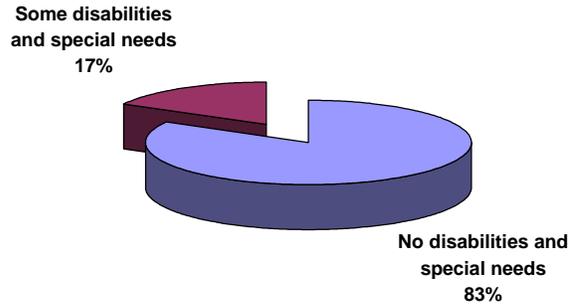
**Graph 4: Lone parent status**



Base = 6

## Additional needs

**Graph 5: Additional needs**

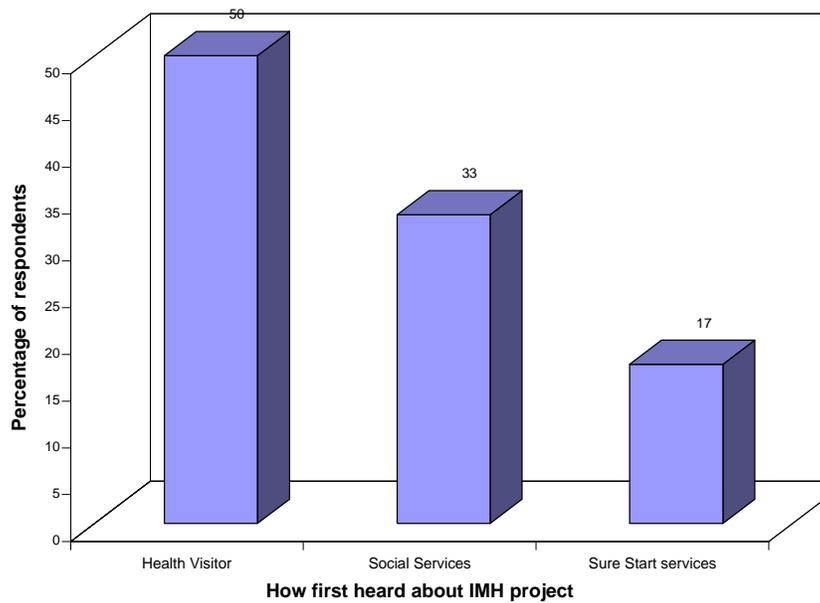


Base = 6

- None of the sample had any difficulty understanding English

## Communication of the IMH project

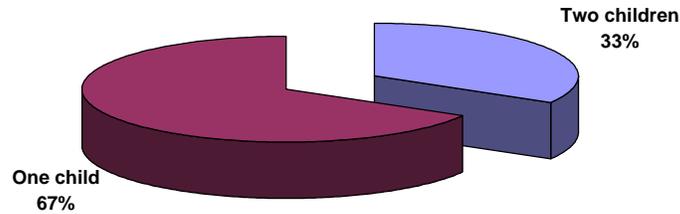
**Graph 6: How first heard about IMH project**



Base = 6

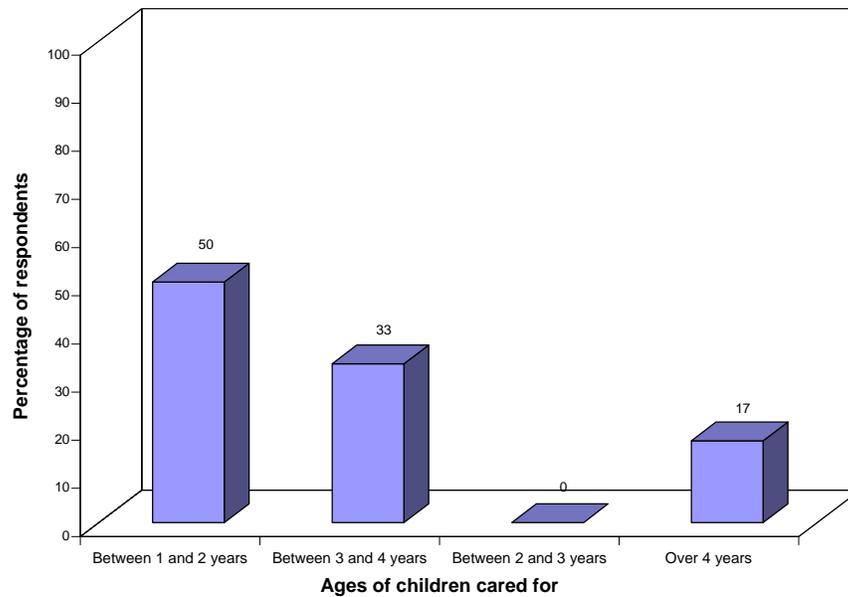
## Children cared for by respondents

**Graph 7: Number of children cared for**



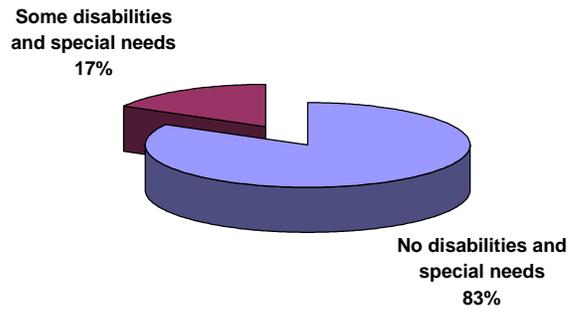
Base = 6

**Graph 8: Age of children**



Base = 6

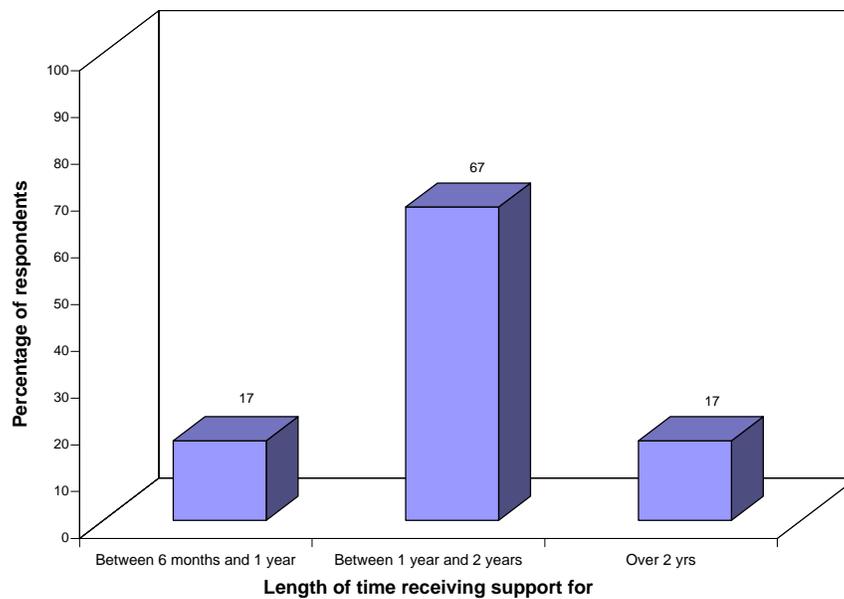
**Graph 9: disabilities/special needs of children**



Base = 6

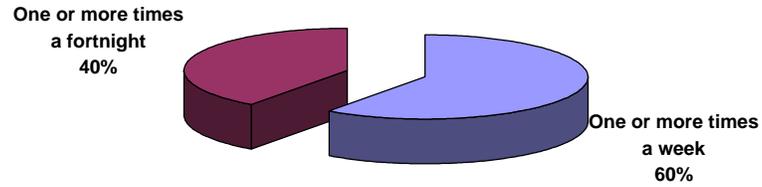
Service-access

**Graph 10: Length of time accessing IMH service**



Base = 6

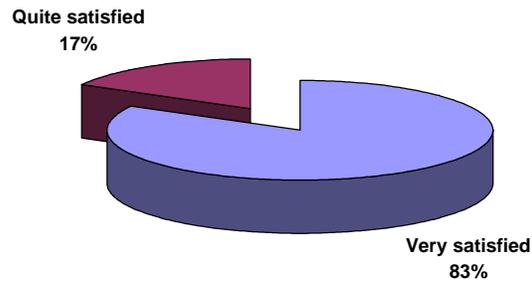
**Graph 11 Frequency of receipt of support from IMH**



Base = 6

**Overall satisfaction**

**Graph 12: Overall level of satisfaction**



Base = 6