1. Introduction

Economic recovery is a far-off prospect. Families have less to live on, there are fewer jobs, and there is more stress in the typical household. Many could do with a little more support, some a lot more. But the same forces that are boosting need are leaving the state with less money to provide that support.

It isn’t all doom and gloom. Every day brings to light another example of innovation, of people doing extraordinary things to better the lives of children.

Around the world there are people working out how to do more with less. In many ways, this is the moment to pioneer, to dream. It is a time for new solutions to old problems.

How about preventing problems before they occur? There is nothing new in that idea. How many of us have heard the story about the man jumping into the raging river time after time to save a drowning child, a hero indeed, until he is outdone by the woman who walks upstream and mends the fence so preventing any more children from falling into the flood.
We love this story. Each of us wants to be that woman. But we just don’t seem to be able to figure out how to make it apply to the real world we inhabit. Plus we are reluctant to mend the fence when there are children to pull out of the water.

In any case, in the context of the abuse that is heaped on children or the terrible behaviour of some children, it is not always obvious what the prevention fence would look like.

If that wasn’t enough to deter, there’s no surplus cash to invest in prevention. So we hunker down and do the best we can, honing our life-saving techniques.

But even in these difficult circumstances, there are plenty of examples to draw upon of lifesavers becoming fence menders. This pamphlet is a testimony to their successes. It is written to inspire and to encourage innovators in public services, in communities, and in social sector organisations, to prevent bad things happening to our children and, by the same reckoning, to help more children to lead fulfilling lives.

In this pamphlet there are a number of stories about revolutions in the way we nurture our children’s health and development. Hopefully they will inspire more decision makers and frontline practitioners to be inventive about prevention, smarter about financing and sustaining it, and confident about bringing everyone that matters along for the ride.

The scope for prevention is huge. Take one example. There has been a decline in our children’s emotional and behavioural development, which is to say on average our children are less happy and less well-behaved than in previous generations.1

Moreover, the legacy left by adult generations for today’s young people is less than generous. Our children, as they grow up, will find it harder to get work, secure a mortgage on their house and they will be faced with bills not only for their higher education, but also for the irresponsibilities of the past, such as our failure to get to grips with the costs global warming will impose on future generations.

But in other respects the prospects of future generations are more promising. Not everyone will conform to the trend but most children growing up today will live longer than their parents and enjoy better health along the way. The next generation will be cleverer than the previous, repeating a pattern that was established a century or more ago when education became universal.

So what happened? What made our children healthier and smarter? A big part of that story is about prevention. But there is also a lot to applaud in the role of the state, in the way it intervenes in children’s lives directly and indirectly. And developments in evidence have also been invaluable; research that tells us why problems occur, and which prevention strategies are effective.

We can illustrate the point with a simple case study. Almost half a century ago, 8,000 people were killed on our roads each year; today that number is about 2,000.2 In Scotland alone, in the last 30 years, the number of children killed or seriously injured on the roads has declined by more than 1,000.3 This is an amazing success story: 1,000 children every year whose lives will not be ended, or blighted by terrible injury.

How did it happen? The starting point was good, simple, metrics. We began collecting data on how many people were killed or seriously injured on our roads, and why.

We then began to experiment with reducing the speed limit, and then enforcing those limits with new technology, all highly unpopular but effective strategies. We made safer...
vehicles, introducing seat belts into cars, and motorbike helmets, again unwelcome but potent remedies. We made it socially unacceptable to drink and drive.

These innovations were rooted in evidence, and tested to see that they worked. They involved the state, changing laws. They involved local government, introducing traffic calming measures. They involved manufacturers, making cars safer. They involved the public learning to drive more sensibly.

Above all, they involved all of the above working together. When, for example, it came to seat belts, the car manufacturers were keen. Who wants to build a machine that kills? But no single manufacturer, with the exception of Volvo, wanted to go it alone and give up a competitive advantage. So they lobbied for a law to make it compulsory to put seat belts in a new car.4

Wearing the seat belt was voluntary at first, and many, men especially, resisted until the law required them to do what was really needed, to clunk and click, every trip.5

This is real prevention. It is taking action to stop the problem happening in the first place. It is attending to the things that cause the problem to occur, not the problem itself. It is introducing change that is simple and scalable. It taps into the behaviour of ordinary human beings. And it is driven by data, to understand why the problem occurs, to see if specific measures work as predicted and to make sure there is population level change.

These features of prevention are explained with more examples in the following pages. Hopefully it will create a desire to repeat these successes for current challenges in children’s health and development like unhappiness, misbehaviour, obesity and exposure to risks like alcohol, drugs and tobacco.

2. What is prevention?

It is helpful to distinguish between prevention – stopping the problem happening in the first place; early intervention – getting in at the first signs of trouble; and treatment – responding once what could go wrong, has gone wrong.

The Incredible Years parenting programme is a great example of early intervention.6 It is aimed at the parents of children who score high on a measure of misbehaviour, such that, without early intervention, a future conduct disorder is more or less inevitable. The parenting programme intervenes before that disorder occurs.

Functional Family Therapy (FFT) is an excellent example of treatment. It is for young people with a conduct disorder, the kind of children that are frequently in contact with social workers, youth justice and mental health agencies. FFT treats the causes and therefore reduces the conduct disorder.7

Prevention is different. It starts before the problem occurs. It can do this in several ways. Some prevention–based programmes, for example Family Nurse Partnership, target populations of children at most risk of poor outcomes. It works with high–risk, often teenage, first–time mothers, preventing risks to their child’s development before that child is even born, and in the first two years of their lives.8 This is targeted prevention, preventing a poor outcome for a high–risk group.
Universal prevention brings some benefit to all, but particular benefits for those most at risk of poor outcomes. Examples include the early years support offered in many Sure Start Children’s Centres in England and Wales, or écoles maternelles in France, offered to all three and four year olds.

One type of universal prevention is public health prevention. Here the objective is to exploit our tendencies to want to be like everyone else. The key to it is that by improving outcomes for everyone right across the distribution, we can sometimes have a bigger impact on outcomes for those at the bottom of the distribution. Geoffrey Rose charted the distribution of many social problems, such as drinking, smoking, bad driving and poor diet. He found that when it comes to some issues, we are not just a collection of individuals displaying individual traits (for example, smoking or not smoking), but that our behaviour is also affected by what others do. Public health–based approaches therefore seek to change outcomes at the most serious end of the distribution by changing the behaviour of people who display less serious forms of a particular behaviour or trait.

For public health–based approaches to work, three conditions must hold. First, the thing we need to change must be distributed along a continuum – there will some with no exposure to the risk, some with a normative exposure in the middle of the distribution and some at the end or the ‘tail’ with a lot of exposure. Second, there must be a statistical relationship between that risk and an outcome, so for example on a distribution that measures the amount that people smoke cigarettes, those at the higher end of the spectrum are more likely to suffer heart and other diseases. Third, there must be some potential for the behaviour of people in one part of the distribution to be influenced by those at another, for example, for the behaviour of poorly-behaved children to be affected by the improvements in behaviour of other children.

Not all childhood problems fit that pattern. Autism, for example, does not distribute in any even pattern across a population of children, the risks for autism do not have any impact on those without the disorder and there is no potential for autistic children to want to be like non–autistic children. But many childhood problems do fit the bill, and more could be done to exploit the potential.

If these conditions hold, we may be able to have greater impact by reaching a lot of people who are at small risk of a poor outcome than we can have by intervening with a small group at high risk. Translating this into children’s services language, it may sometimes be effective to focus on children at low to medium risk of poor behaviour – the majority of school children – to have an effect on those who are at high risk of poor behaviour. For example, there is some evidence that population–wide approaches to reducing child maltreatment can be effective. But if there is no link between a particular outcome (say poor behaviour) for the average child and children who suffer from the worst outcomes, then a focus on the middle could potentially detract from children with the most significant problems.

3. The evidence and data needed for prevention

‘Evidence–based’ is a popular policy mantra that successive governments have pledged an affinity with. But the reality is that doing things that are evidence–based requires patience and a willingness to engage with sometimes complex evidence and data, something that does not always sit well within our political system.
Several sources of data can boost the chances of a prevention strategy paying off – both in terms of better outcomes and financial benefits for the taxpayer. Three types of evidence and data are needed to construct an evidence-based prevention strategy.

(i) Data on needs
Traditionally, the public sector has measured outputs, for example, how many children go to school, and how many access a particular service such as Child and Adolescent Mental Health Services (CAMHS). So when public systems get interested in prevention, they are often trying to reduce the number of people needing certain services, typically high-end, expensive, specialist services, such as those in the youth justice system.

But reducing the need for these specialist services depends on preventing the risks and impairments to child development that produce that need. In order to do that, we need to measure these risks and impairments, as well as child development itself, in order to get a sense of who we should be targeting with preventative services at the level of the individual child, and what type of services need to be commissioned or provided at the aggregate level.

But measuring risks and impairments to child development is more complicated than measuring something relatively simple like the number of children accessing CAMHS. This data often simply does not exist at the local level. Moreover, what data does exist is often only focused on the children who are already accessing high-level services – when it is too late for prevention and early intervention.

Epidemiology measures these risks and impairments for all children. It can help to focus the prevention on the most important local needs and inform the strategic commissioning of evidence-based services. Without good, sophisticated data about children's needs it is impossible to produce an evidence-based prevention and early intervention strategy. Without this data local authorities and other agencies do not know which aspects of child development may be an issue compared to the country as a whole, and they do not know how to target preventative and early intervention services on the right children. For example, Family Nurse Partnership is incredibly effective for mothers and children that meet its eligibility criteria, but it is not intended to work for all families (for example, second-time mothers), so in these cases would be a poor use of resource.11

Gathering this data used to be prohibitively expensive. But there are now several needs-data tools that can be rapidly applied by local authorities or communities without great expense.

For example, The Social Research Unit at Dartington has developed an epidemiological tool to measure children’s needs, ChildrenCount. This has been applied to over 100,000 children and young people to date in local authorities and communities in the UK, Ireland and the US. Through a household-based survey of parents of children aged 0–8, and a school-based survey of children aged 9–18, the tool measures a range of health and development outcomes covering children’s behaviour, emotional well-being, educational skills and attainment, relationships and physical health. In addition, the tools assess a range of risk and protective factors – emergent in their home-life, school and community – that may positively or negatively influence children’s outcomes.12

The Communities that Care survey is a similar school-based survey, most widely used in the US.13
(ii) Evidence on what works

Evidence on what works is needed to determine the most effective prevention and early intervention strategies for the problems that matter to local people. The problems may be local but the solutions to those problems are likely to be international.

There is now a range of resources available to inform the selection of effective prevention and early intervention, including Blueprints for Success: a ‘what works’ database in improving children and young people’s outcomes being developed by The Social Research Unit at Dartington. Some of these resources are listed in Box 1.

There are two main types of resource. First are online databases, or ‘clearinghouses’, of evidence-based programmes. There are over 30 such clearinghouses. Most are published in English and based in the US but there are also some in Europe.

Clearinghouses typically list programmes and provide information about each one, covering details of how the programme works, what outcomes it seeks to improve, requirements for implementing it in terms of training, materials and costs; how it has been evaluated and with what results.

Clearinghouses have different ‘evidence standards’ to determine what works. There is variation around the standards of evaluation quality and evidence of impact required. Some clearinghouses require evaluations to use an experimental or quasi-experimental method, in which there is a control group with which to compare improvements in outcomes. Others only require evaluations that measure outcomes at the start and end of an intervention, with no control group. This latter method does not allow for firm conclusions about impact to be drawn, as it does not control for ‘selection bias’ (the fact that children most likely to benefit from programmes are most likely to start and finish programmes) and that most children improve in their development trajectories over time without any intervention.

Clearinghouses also vary in terms of their areas of focus, and in their function: some exist to promote the greater use of programmes that meet high evidence standards; others are more about tracking new innovations that sound promising but require further testing.

The second type of ‘what works’ resource is systematic reviews. These are studies that perform an extensive, systematic search of the literature in a particular subject area in order to see what is effective. Systematic reviews tend to focus on a specific question, such as ‘Does Family Nurse Partnership prevent abuse or neglect for at-risk children?’ They take into account different levels of evaluation quality when synthesising information. The best-known sources of systematic reviews are the Cochrane Collaboration, which focuses on health-related subjects, and the Campbell Collaboration, which covers social issues. In many ways, systematic reviews are a more ‘raw’ form of information about what works than the clearinghouses, requiring greater interpretation – but more of this type of evidence exists.

These sources will spark ideas, especially when placed alongside other data sources, about local need for example. Sometimes, it will be possible to select a portfolio of prevention activity from the various databases. Other times, it will be plain that there is no off-the-shelf solution to a local need, in which case the data will provide a context for a fresh innovation.

But it will be rare indeed that the information can be used as a prescription. Even when it indicates a clear course of action, it will be necessary to engage with the data, to go and talk to those who have developed prevention-based programmes that have an evidence base behind them, and to other people who have tried implementing them. And in some
cases, there may not be enough evidence to give a clear steer. We turn to this issue in the next section on diversifying the evidence base on prevention.

Box 1: Sources of information about what works

Examples of clearinghouses:
- Blueprints for Healthy Youth Development [http://www.colorado.edu/cspv/blueprints/]
- Best Evidence Encyclopaedia [http://www.bestevidence.org.uk/]
- Child Trends LINKS [http://www.childtrends.org/LINKS/]

Sources of systematic reviews:
- Campbell Collaboration [http://www.campbellcollaboration.org/]
- Cochrane Collaboration [http://www.cochrane.org/]

(iii) Cost–benefit data

A third and increasingly used data source is information on the costs and benefits of competing programmes, interventions and investment strategies. Some types of prevention programmes may have an impact on health and development, but while improving outcomes, save the state little money in the long run. Other types may improve outcomes and at the same time generate medium- and long-term potential savings through the state, for example through the costs of further services avoided and through increased tax receipts as a result of higher lifetime earnings. Some effective prevention activity carries a high risk of losing money, others a low risk. Data on costs and benefits can help the commissioners and grant-makers to form a portfolio that is right for local conditions.

It is important to distinguish cost–benefit data from two other types of economic evaluation.\textsuperscript{15} The most common type of economic evaluation is probably social return on investment (SROI). This involves asking an organisation’s stakeholders to put financial ‘proxy’ values on all of the perceived impacts of its work, for example the saved costs of a child not coming into foster care following the work of an NGO providing family support. SROI is in essence working out the monetary value stakeholders themselves place on the impacts they perceive to be attributable to the work of an NGO, or a single intervention. SROI therefore can help NGOs think about how their work brings perceived financial value to society but cannot be used as the basis of analysis for working out how much a particular intervention might save the state, or bring benefits for an individual, in the long run.

Cost–effectiveness analysis, in contrast, is based on rigorous evaluation of a programme’s actual impact on outcomes. It then compares the relative cost with impact on outcomes achieved for two or more courses of action. The result is a ratio of pounds, euros or dollars spent for each unit improvement in outcome obtained. Cost–effectiveness research therefore helps policymakers and purchasers of services compare the amount and type of impact on health and development that can be achieved with available resources.

Cost–benefit analysis takes cost–effectiveness analysis a step further by putting a monetary value not only on the intervention but also on the outcomes. For example, cost–
benefit analysis of interventions to reduce smoking would transform a quitter’s improved health or longer life into a monetary value. These values are generally tangible, for example the actual costs saved due to reduced healthcare or the actual benefits that follow from someone living longer, earning more and making a greater contribution to the tax burden. Since these benefits are often long-term, cost-benefit analysis adjusts for the value of money over time, working out how much, say, a prison bed will cost today and also what it will cost next year, the year after and so on. These calculations of costs and financial benefits result in what is called a ‘net present value’. Cost-benefit analysis calculates the financial return to individuals, agencies and society as a whole that accrues from each pound, euro or dollar spent on contrasting interventions.

The rigour of cost-benefit analysis will depend on three things: first, the rigour of the evidence linking intervention to an improvement in a particular outcome; second, the accuracy of the cost data on the cost of the intervention itself, and the cost of any services avoided; and third, the robustness of the methodology used to link improvement in outcomes to financial savings over the long term.

One of the most rigorous methodologies for cost-benefit analysis has been pioneered by the Washington State Institute for Public Policy. It is very cautious in its estimates of potential savings; it has consistently applied the same model across a range of policy areas, which means that policymakers can compare and contrast the results for different programmes in different areas; and it has been used to inform real policy decisions made by the Washington State Legislature. The Social Research Unit is applying this model to the UK in five areas of children and young people’s policy: education and early years, youth offending, child protection, child and adolescent mental health, and drugs and alcohol, in a project called Investing in Children. This data can be found on our website: www.dartington.org.uk/investinginchildren.

Table 1 shows a sample cost-benefit analysis derived from the model for the implementation of FFT in the UK, and Graph X shows at what point in time the financial (non-discounted) benefits are accrued.

Table 1: Cost-benefit analysis of Functional Family Therapy

<table>
<thead>
<tr>
<th>SUMMARY OF COSTS AND BENEFITS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Family Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Cost (per young person)</td>
<td>£2,501</td>
</tr>
<tr>
<td>Benefits to taxpayers</td>
<td>£5,775</td>
</tr>
<tr>
<td>Benefits to participants</td>
<td>£2,177</td>
</tr>
<tr>
<td>Benefits to others</td>
<td>£17,650</td>
</tr>
<tr>
<td>Total benefits</td>
<td>£25,603</td>
</tr>
<tr>
<td>Benefits – costs (Net Present Value)</td>
<td>£23,102</td>
</tr>
<tr>
<td>Cost–benefit ratio</td>
<td>£10.24</td>
</tr>
<tr>
<td>Rate of return on investment</td>
<td>109%</td>
</tr>
<tr>
<td>Measured risk</td>
<td>99%</td>
</tr>
</tbody>
</table>
Together, these three types of data can empower local leaders to design evidence-based prevention strategies.

However, data on what works is severely limited in some areas. Moreover, whether or not the outcomes indicated by evidence are actually achieved will depend on the quality of implementation. It may be more difficult to achieve the outcomes at scale – for example, extending programmes to all eligible children without losing any quality – than if the programme is used with a smaller number of children. While some types of programme have been found to work in very different cultural contexts, others have been found not to transfer as well, so whenever a programme is tried in a very different new context it still needs testing. And even the most rigorous cost-benefit analysis only provides information on savings that can be theoretically realised by local and central government: government will need to have cash realisation strategies to ensure that some savings can be made (for example, to reduce the number of residential care places if certain outcomes are achieved for children at risk of child abuse). We discuss some of these limitations in the following sections.

4. Diversifying the evidence base on prevention and early intervention

There is no single effective prevention strategy. Something as big as a law to require the wearing of seat belts in cars can make a difference but so too can something as small as getting primary school children to mimic a turtle, with hands folded into their imaginary shell, when they get frustrated.
As is becoming evident, a portfolio of prevention activities is more likely to have impact than a solitary big bet. There are no silver bullet solutions.

In recent years, there has been a lot of attention focused on evidence-based programmes, packages of interventions rooted in science and proven to work by repeated experimental evaluation. On the Social Research Unit's Blueprints for Success 'what works' database there are over 50 examples of such programmes that prevent significant impairments to children’s health and development. For example, by altering parenting practices, or by changing the way primary school children relate to each other, or by helping secondary school children have the confidence to say no to drugs and tobacco, or by changing the relationship between a mentally ill adolescent and his parent.

Much of the available evidence does relate to programmes – partly because they best lend themselves to being tested using experimental or quasi-experimental research designs, the best way of assessing whether something works. But there is a range of other evidence-based options. There are practices, things that teachers, social workers, psychologists and other professionals can do differently at the frontline in trying to improve the well-being of children and families. Cognitive Behavioural Therapy is one example, a clinical technique that mental health workers apply in a range of contexts. Contingency management, giving young offenders, for example, rewards for participating in interventions designed to help them, is another. Box 2 describes Motivational Interviewing, which is now being applied in a range of practice contexts from health visiting to preventing adolescent mental ill-health.

**Box 2: Motivational Interviewing**

Motivational interviewing is an evidence-based practice that supports people to change their behaviour. Taking the form of a collaborative conversation between practitioner and client, it is typically used with individuals who are ambivalent about taking steps to alter certain behaviours, like substance misuse. Through a process of semi-directed therapeutic strategies, motivational interviewing is designed to guide the individual's motivation and commitment to change, in order to achieve identified goals.

This technique does not attempt to impose change through praise or sanctions. Instead it works by engaging intrinsic motivation, since a person is more likely to take a course of action if they acknowledge it is in their best interest. Strategies such as reflective listening and open-ended questions are used to draw out an individual's ideas about change. The therapist then guides the transformation of these ideas into a plan for modifying behaviour.

Only a fairly low intensity of intervention is required to work. The recommended duration of motivational interviewing is usually one to three sessions of 30–50 minutes each. It can be delivered individually or in a group setting with five to seven participants. Therapists can easily embed motivational interviewing into their routine clinical practice.

MI was initially developed initially as an intervention for substance-abusing clients, but it is now established in a range of applications. It can be implemented directly with adolescents to improve their outcomes, or via their parents, as part of the Brief Family Check-Up for instance (see Box 4).

It is possible to combine it with other practices such as cognitive behavioural therapy. It is also a component part of many evidence-based programmes, for example the Family Nurse Partnership health-visiting model, and the Brief Alcohol Screening and Intervention of College Students (BASICS) intervention.
There are also evidence-based ways of matching children's needs to services via processes, like rigorously evaluated screening tools that seek to change the way in which children's services process referrals for help, and which indirectly lead to better outcomes. Getting a better fit between children who need help and services to help them is one strategy that has significant potential to improve the productivity of public services and outcomes for children. For example, the Social Research Unit's work in several Scottish and English local authorities reveals that services are supporting around a third of children who could probably manage without that help, but they are not picking up a significant proportion of children who have serious impairments to their health and development who are not supported by mental health, youth justice and special educational services (Box 3). Box 4 describes the Brief Family Check-up, a screening programme in schools that not only identifies those children who need a lot of extra help but also encourages ordinary families to follow simple routines at home that will prevent the need for them to seek extra interventions in the future.

This has implications for how we think about the ‘triage’ functions of public services that GP surgeries perform specifically in relation to health.

**Box 3: Better matching needs to services: an opportunity to improve children’s outcomes**

As outlined above, good data on children’s health and development, and risks to well-being, is becoming more accessible. Several local authorities are now routinely using this high-quality data to help make smarter investments.

Our analysis of needs data suggests that it is not unusual for over a third of children getting a lot of extra help not to necessarily need that help: they have no observable impairments to their health and development (although there may be some concern over their home environment). Their care may not be doing them much harm, but it probably is not to their benefit. The analysis usually also reveals that a significant proportion of the child population as a whole, around 5 per cent, have serious impairments to their health and development but go unreported to mental health, youth justice, and special educational services.

At first glance this finding is rather shocking. But seasoned hands will recognise that the process of sifting through referrals is not entirely efficient, and an understandable desire to err on the sign of caution can keep many children on the books too long.

So outcomes in any local authority might improve significantly by shifting resources away from those children getting support that do not necessarily need it, towards those needing support but not getting it. There might be understandable hesitation in a total exchange of resources but seeing what could be achieved by switching 5 or 10 per cent is probably a safe bet.

Of course the proportions will vary from local authority to local authority, but the opportunity to save money and achieve better outcomes by better matching the needs of children with the services they access is still very likely to exist.
Third, there are evidence-based **policies** - policies such as changing the law on seat belts or on alcohol pricing, that are known to have an impact on outcomes.

However, while evidence exists on all of the above, there is not yet sufficient evidence so there is a range of well-evidenced options commissioners can select from when thinking about commissioning evidence-based services. In addition to those options with a weight of evidence behind them are others, not yet proven but with indications of potential success.

This means we need to think about how we move more innovations up the ‘evidence pipeline’ so they become evidence-based. Programmes and policies do not become evidence-based overnight. There is a journey that people who develop new ways of providing services need to embark upon, that spans:

- **Innovation**: trying a new way of doing things, based on a clear idea of what outcomes the new way of doing things is targeting, available evidence about what risk and resilience factors are known to impact this outcome, and taking into account available evidence about what types of approach are known to work in improving this outcome (this is often known as a ‘theory of change’); to

- **Monitoring outcomes** for children using services before, during and after an intervention (pre- and post- outcomes monitoring); to

- **Proof of impact** demonstrated via experimental evaluation, where the change in outcomes for a group of children receiving a service is compared to a comparable group of those who do not.

---

**Box 4: Brief Family Check-up: the power of screening**

Most of us will have had the experience of going to the dentist and getting the same advice from the hygienist, ‘you need to floss more’. The hygienist cleans our teeth and the dentist treats the decay. But they also ‘screen’, meaning they undertake simple checks that predict future problems, and they use the information they gather to give us advice, like ‘don’t forget to floss’. When the advice changes our behaviour, better outcomes – less decay – often follows.

This simple idea is beginning to take hold in children’s services. A good example was developed by Tom Dishion at the University of Oregon. He employed trainee psychologists to gather a small amount of screening information from parents invited into schools for a ‘check-up’. The data is quickly packaged by a computer into a series of charts that show each family how they are doing in terms of their parenting, and how their children are doing in terms of their development.

The psychologists do little more than share the charts with the parents, and give them some advice, like spending more time reading to your child, or trying to ignore bad behaviour and rewarding the good. The Brief Family Check-up can pick out those children that are at high risk of really poor outcomes, and encourage their parents to seek a range of extra help. But most parents spend little more than an hour every six months ‘being screened’. This illustrates how outcomes for many children may be improved without intensive, direct intervention.

---
If we are to generate an increasing amount of useful evidence about what works in improving children's outcomes, we need to ensure that every stage of the evidence pipeline is thriving – and that we have interventions moving up the whole pipeline.

There are some important caveats. Of course, not every intervention will make it to proven impact; experimental evaluation would only be appropriate for interventions with a tight theory of change and good pre/post outcomes data. And evidence is only one factor that needs to be considered alongside others when deciding how to spend money on children's services – for example, we do not build playgrounds for children because of the evidence that they work in improving outcomes (they may well do) but because we believe children have a right to space in which to play safely.

But these caveats aside, it is certainly the case that policymakers, commissioners and practitioners do not yet have a diverse menu of evidence-based options to choose from. If we are to expand that menu, we have to make the pipeline work better at the impact end. Since there are over 200 children's services departments in England, Scotland, Wales and Northern Ireland, not to mention thousands of voluntary and community sector organisations, there is a real opportunity to move from innovation to proven impact, and to share the learning about success and failure.

One avenue, as yet little explored, is what might be termed improvement through subtraction: stopping doing things that have a negative impact. Most prevention involves addition, a new law or service. But taking some interventions away might have a similar effect if they have a negative impact on child outcomes. For example, the Edinburgh longitudinal study backs up similar evidence from Montreal that shows that arresting young people has the effect of accelerating their criminal career. Put simply, if there are two young people, with equal propensity to do wrong, and one is arrested and the other not, the one who is drawn into the justice system will continue longer and harder with a criminal career. There will always be the need to arrest some young people, for their own good and the safety of others. But a variation in arrest policies may well contribute towards preventing future crime, a proposition that deserves to be tested.

Much could also be achieved by what might be called positive contagion, getting one person to change their behaviour in a way that influences others, who go on to influence others still. Positive contagion is related to how behavioural norms develop within a community. Box 5 tells the story of Felton Earls who transported his findings about the impact of higher levels of collective efficacy on crime levels in Chicago to Tanzania, where they were used to combat the HIV epidemic.
Prevention and early intervention in Children’s services

5. Replication and scale

Prevention should be synonymous with scale: effective prevention and early intervention services need to be available widely if they are to achieve their potential impact. The most effective intervention will have relatively little value if it only reaches a small subset of those children who could benefit from it. But prevention too often is a ‘boutique service’: beautiful, novel and available to a select few.

There are two sides to this argument. While it is true that most things proven to work have not been taken to scale it is also the case that most things taken to scale have not been proven to work. ‘Evidence-based’ and ‘scalability’ are two properties that do not always sit comfortably side-by-side. Often what is evidence-based is tightly defined and, in order to get the same effects, a programme needs to be replicated with fidelity to the features of the programme that make it effective. But scaling up a complex social programme like Family Nurse Partnership with fidelity may be much more complicated than, say, scaling-up the sort of process that successful businesses achieve at scale (such as making a particular brand of takeaway coffee).

The consequence is that much of what we do at scale is not based on evidence – even where evidence exists – and much of what is evidence-based never reaches its full potential in terms of improving children’s lives. If we are to realise the full potential of

---

Box 5: Collective efficacy

Felton Earls and Rob Sampson from Harvard University came up with the idea of ‘collective efficacy’. They studied the development of young people growing up in deprived neighbourhoods in Chicago. They found that although many were similarly at risk of getting involved in crime – being impoverished, experiencing low-warmth, high-criticism relationships at home, being exposed to drugs – not all succumbed.

They found a major protective factor was the neighbourhood in which they were raised. Some communities had more ‘collective efficacy’ – mutual trust amongst neighbours and behavioural norms that mean people in a community are more likely to intervene to advance the common good. When somebody stole from someone else, neighbours felt a sense of responsibility for each other and would intervene. It was sufficient to deter many criminal acts.

Earls also worked in Tanzania, and when the HIV/AIDS epidemic began to ravish that country, he came up with the idea of building collective efficacy to boost the chances of prevention working. He worked with young people identified by their teachers and village elders as future leaders. He trained them to understand the idea at the heart of collective efficacy – that we each have a responsibility for each other – and in simple sexual health prevention techniques.

Through theatre and community conversations the young people reached out to their communities. A large randomised controlled trial showed that those who benefitted from the intervention were better able to promote HIV/AIDS community competence, such as increasing communication and reducing stigma about HIV/AIDS, and organising community HIV testing and counselling health fairs.

These ideas can extend to UK communities, for example to reduce knife crime and gang violence, and to discourage the use of drink and drugs.
evidence-based programmes, practices and processes, we need to learn how to better scale them up and target them at the children who can most benefit from them.

In children’s services, the scale challenge is, perhaps paradoxically, a local one. It is local authorities, schools, health authorities and other local agencies that between them control the vast majority of the money the state spends on children each year, not central government.

Central government can and should be involved where it can. It can give useful steers and signals about what works, and is often relatively well-placed to do so given the considerable analytical resource in Whitehall compared to what would be found within a local authority. This Government, for example, is scaling-up Family Nurse Partnership, a highly effective prevention programme for the children of high-risk, usually teenage, mums. The target is for Family Nurse Partnership to reach just over a third of eligible mothers by 2015. This is a reach much higher than in the United States where FNP originates, but still a long way short of saturation.

But central government injecting cash into top-down initiatives, or even worse, simply telling local agencies what they must do, is not a sustainable way to scale what works. It is more manageable – and appropriate, given our decentralised system – to think about the challenge of scale within each local area. Getting FNP to 80 per cent of eligible mothers in a single local authority, even in Birmingham, the largest, for instance, would mean delivering the programme to around 1,300 parents annually.

Achieving scale requires meeting three important challenges: supply chains, push, and pull.

Developing supply chains relates back to the point that programmes with a strong evidence base behind them need to be replicated with fidelity to the programme model, which specifies things like programme processes, training and content. A badly implemented programme, policy or practice will have little or no effect on children’s health and development. In fact, for many of the proven programmes referenced in this pamphlet, implementing, say, half the programme well does not mean children will enjoy that proportion of the programme’s potential impact on health and development. In many cases, it will mean no impact at all.

Good implementation therefore requires high quality, reliable supply chains, to use business terminology. But that needs to be resolved with the need to create local demand for these programmes, discussed below and in Box 6 on good implementation.

There is no point being able to scale something logistically if nobody wants it. Creating the demand for something new often involves push at first. It is about bringing a new idea to initially reluctant families, practitioners, managers and policymakers. Some early adopters welcome change. But many people will resist.

True scale almost always involves a switch from push to pull, meaning a moment when initially doubtful consumers or providers begin to actively demand a new type of service or way of doing things.

The demand for a service is built from the ordinary desires and motivations of ordinary people. Parents are not banging on the door of their local authority looking for the latest parenting programme. But they may be interested in finding out more when their neighbours tell them how the Incredible Years parenting programme improved their toddler’s behaviour. Tangible change that parents can experience, such as being able to
sleep through the night, or doing the supermarket shop without the children throwing a tantrum, are what will help to create demand.

But making sure the service fits with children and families’ lives – and the way existing services are structured – is also vital to creating demand. When it comes to getting products to scale, adaptation is important. We like to make the things we buy our own, we put our own pictures on our laptops, we add our own apps to our smartphones, we personalise things that are mass-produced ‘for us’. This of course is just as important in terms of getting professionals at the frontline to take up evidence-based services, and in ensuring that services are meeting the needs of families and children.

How does this sit with the need for fidelity to what works? The need for fidelity and for users to adapt can be reconciled. But it means thinking about what is core and unchangeable and what is adaptable. Few of us want to tamper with the hard-wired components of our smartphones, and we should be similarly discouraged from unravelling the core components of a programme like Family Nurse Partnership. But that does not mean that we should not think hard about how those core components are translated to local contexts, for example, the additional services delivered as part of the package, and the language and background of the practitioners delivering services.

Getting families to use a service can be a challenge when they are hard to reach and may be sceptical or dismissive of services, particularly when they have had bad experiences in the past. That is why outreach by trusted members of the community can be effective, for example in persuading families who stand to benefit the most from services, but are least likely to use them, to give it a shot.26

Successful examples of scale, whether in the public or private sector, often involve some combination of a good product and an innovative mechanism for scaling it up. Microsoft produces world-class software, but also developed a licensing system that means its software is automatically bought with virtually every PC in the world. Toyota make great cars, but their pioneering ‘Just in Time’ innovation manufacturing process also means they can make cars on-spec only when the consumer needs them, so resources are not wasted.

All of the prevention and early intervention programmes described in these pages are good products, but they need processes that will ensure they are systematically delivered at maximum efficiency, to as many people as can benefit as is possible, in a way that fits people’s lives.27

Box 6: Further sources of information about implementation

The National Implementation Research Network, based at the University of South Florida: http://nirn.fpg.unc.edu/

At the Social Research Unit at Dartington, we have convened two major conferences on behalf of the Bill and Melinda Gates Foundation examining how to overcome the challenges of scaling impact on global child health. Further information is available at: www.dartington.org.uk/scalingimpact.

The Colebrook Centre has many useful resources about evidence on implementation: http://www.cevi.org.uk
There is growing interest in the UK in replication and scale, and funders such as the Big Lottery Fund are complementing an interest in innovation with new programmes focusing on how to replicate and scale. For example, its Realising Ambition programme is seeking to test the scaling-up of interventions to prevent youth offending that have already been proven to work (see Box 7).

**Box 7: Realising Ambition**

The Big Lottery Fund’s Realising Ambition programme is a £25 million investment in 25 interventions that intervene early to divert children and young people aged 8 to 14 away from pathways into crime, giving them a better chance to realise their ambitions.

The majority of projects have a strong evidence-base behind them – prior experimental research has demonstrated that these projects improve the outcomes of children receiving the intervention compared to those that do not. The remainder of the portfolio looks promising – they have a strong track record of implementation and some evidence to suggest that they work.

All interventions are delivered by experienced organisations. Yet few have experience of replicating in new contexts, or taking existing evidence-based interventions and successfully implementing them. Realising Ambition represents the first major attempt in the UK to support organisations to do so and, in the process, learn about the barriers and catalysts of successful implementation and replication.

### 6. Funding prevention, early intervention and preventative treatment

No publication about services for children in the second decade of the 21st century can evade the question of money. It is an era of austerity and deep spending cuts. So how is this innovation going to be funded?

Between 2010 and 2015, a quarter of the public sector will be stripped away, and while some areas of spending like health and education are, to some extent, protected, there isn’t money for increased investment.38

That is not to say the coffers are empty. We estimate the state spends around £5,000 per child per annum on services such as education, community health, social care and youth offending. In total that amounts to at least £55 billion invested in these children by UK government, most of it at the local level by a mixture of local authorities, the health service and schools (see box 8).

So could any of this money be diverted into prevention? The challenge is to continue to serve those currently being served while finding money to prevent the need for people to be served in the future. A conundrum that is impossible to solve?

There are different options for generating upfront investment in prevention-based services that it is believed will lead to better outcomes, and in some cases to long-term financial returns, when there is little additional public resource available for extra investment.
The first idea is the simplest and most obvious. Central and local government can free up resource from other areas of spending, sometimes even within the same budget lines, where what that resource is spent on is known or thought to be ineffective or not a priority area, a public resource reinvestment strategy.

Despite its simplicity this solution is often difficult to achieve. The politics of stopping doing things are extremely tricky. First, nobody wants to cut or take away a service that provides jobs, often in the voluntary and community sector. Second, there is the issue of political perceptions. So, it may be difficult for a government to disinvest from prisons because of what the political implications are in terms of its perceived approach to crime. Third, siloed budgets at the local level mean that although it may be in taxpayer interest to invest in catch-up reading tuition for six-year olds rather than on remedial reading programmes for teenagers, the investment requires one budget-holder to make the investment (the primary school) without seeing the financial benefits, which accrue elsewhere. This can even be true within a single agency like a local authority - where there may be resistance to a management-level strategy to redirect investment from commissioners controlling small budgets as it requires moving money from one person’s budget to another. Last, reinvesting from what doesn’t work to what does requires not just good knowledge about the evidence base, but also a deep understanding of how the

---

**Box 8: Government expenditure on children**

Rather surprisingly - given the amount of money involved - it is difficult to get reliable information of government expenditure on children’s services; government accounts do not distinguish between services for adults and children.

But knowing how much is spent on children is a precursor to being able to determine whether better value can be got from existing expenditure. Fortunately, it is easier to map what is spent at the local level than centrally. Our work with local authorities and governments in the UK, the US, Ireland and Spain has suggested the figure spent on children’s services is often in the region of £5,000 per child when estimations are made at the local level of the total local and central government spend on each child.

For example, the ‘fund map’ we drew up with Birmingham local authority in 2010 estimated that central and local government together were spending around £686 million a year on education, £150 million on children’s community health, £25 million on early years, £178 million on social care, £11 million on youth offending and £20 million on careers advice: just over £1 billion on the city’s 230,000 children, around £4,700 each. This sum does not, however, include expenditure that is difficult to isolate such as acute hospital care, libraries and leisure, so it is a very conservative estimate.

The exact amount will of course depend on the local authority. But if the state spends in the ballpark of £5,000 a year per child on these sorts of services, that produces a ballpark total in the region of £55 billion a year on all children.

Our fund map for Birmingham identified that in 2010 the following sums were being spent by central and local government on education (£686 million), children’s community health (£150 million), early years (£25 million), social care (£178 million), youth offending (£11 million) and careers advice (£20 million).

These extremely conservative estimate add up to just over £1 billion per annum being spent on the city’s 230,000 children, about £4,650 each. But this sum does not include expenditure that is hard to isolate such as acute hospital care, libraries and leisure.
money flows at the local level, exactly who is being served by what service, and whether those services are meeting needs.

There are, however, examples of forward-looking local authorities who are committed to doing things differently despite the significant challenges, such as Birmingham’s Invest to Save strategy (Box 9) and the approach Gloucestershire, Sandwell and Warwickshire are taking with children in care (Box 13). Another international example is the approach taken by the Washington State Legislature, to redirect funding from a new prison into evidence-based services to prevent young people from offending in the first place (Box 14).

**Box 9: Birmingham’s ‘Invest to Save’ approach**

Working with the Social Research Unit at Dartington, Birmingham City Council was at the cutting edge of attempts to use strategic investments in children’s services to generate an economic return and improve child well-being. The Brighter Futures programme began in 2007 and concluded in 2010. It was the product of two initially unrelated innovations.

When departments of children’s services were created, bringing together education and social care, the new director, Tony Howells, sought a single strategy to which all agencies could commit. This strategy established the outcomes that mattered to the people of Birmingham, the activities that might produce those outcomes, mostly evidence-based programmes, and the investments that would be required if the activities were to be sufficiently funded. But where would the investment be found?

Brighter Futures tied Tony Howells’ strategy with Stephen Hughes’ business planning. The Social Research Unit at Dartington brokered a strategy development process in which £47 million was found for investments in evidence-based programmes and infrastructure change in children’s services, using the Common Language facilitation process (see page 26). What became SRU’s Investing in Children economic model was used to calculate potential benefits from the expenditure devoted to prevention, early intervention and treatment programmes. The conservative calculations put the gains at about £101 million over 15 years.

In the end, not all of the Brighter Futures bets paid off. There were positive results from some but not from others. Most of the people who established the strategy have since left, and the city has struggled with the consequences of a child abuse scandal and the same economic cuts that have handicapped every local authority. The difficulties of realising the benefits from the prevention programmes that worked were not totally overcome.

But valuable lessons were learned, and Birmingham has shown the way to other local authorities seeking to shift more resources into prevention, evidence-based activities and to thereby generate funds that can be re-invested into more prevention still.
The reinvestment case is easier to make at the local level when savings can be made relatively quickly as a result of reducing spending on services that are not effective, ploughing it into prevention and early intervention services that are more effective, thus reducing future reliance on more expensive, high-end services. This was the strategy Birmingham followed. Another approach that might help to get around some of these issues might be to aim to set aside 1 per cent of budgets for prevention (see Box 10).

**Box 10: 1 per cent for prevention**

A simpler, more direct approach than social impact bonds is to dedicate only public funds, and to incorporate the change into the inevitable cutting of services. Since even small amounts of resource channelled into prevention will realise significant gains for children and the budget, we call this idea ‘1 per cent for prevention’.

The starting point comes from costing the delivery of a portfolio of evidence-based programmes at scale, that is to say reaching every eligible child, in a single local authority. We generally select a portfolio balanced between universal, public health and targeted prevention, but from our experience of working with local authorities, a good menu of evidence-based programmes can be delivered for around £50 per child, just one per cent of our ballpark figure for spending on children’s services.

So, if there is a 10 per cent cut in services in a calendar year, a prospect unfortunately increasingly common in these austere times, one strategy is to cut by 11 per cent and devote the additional savings to preventative activity that will not only maintain the number of children getting some help but also increase the chances of health and development getting a boost.

Second, there has been mounting interest in ways of financing upfront prevention investment that relies on the state paying service providers for improved outcomes, rather than for the service ‘inputs’. In *payment-by-results contracts*, government agencies are contracted to pay service providers according to the level of improvements in outcomes achieved as a result of the service provided. These outcome-linked payments usually form part of the payment contract with the provider, the rest being made up by traditional payment-for-service. In these contracts, it is the service provider that takes on the risk of the outcome not being achieved. Project Redirection (Box 11) is an example of a large-scale payment-by-results contract in the state of Florida.

**Box 11: Project Redirection**

Project Redirection was developed in the context of worsening teenage violence rates, overcrowding in residential facilities and a public cash shortage in the US state of Florida. The project was designed to redirect at-risk youth from costly out-of-home placements by providing alternative evidence-based services in their homes and communities.

Project Redirection has so far achieved a 31 per cent reduction in probability of arrest for high-risk redirection completers, and the $16 million invested in the project is reported to have saved the taxpayer over $51 million.30

Pivotal to this success has been the partnership between the Florida legislature and Department of Juvenile Justice, and an independent company called Evidence-based
Social impact bonds (SIBs) are a financial instrument enabling payment-by-results for service providers that may be unwilling or unable to take on that level of risk themselves (for example, small charities). SIBs allow private investors to take on the risk of outcomes not being achieved within the structure of a payment-by-results contact. Private investors invest in a ‘bond’ that is used to finance services provided by a third party. Depending on whether certain outcome benchmarks are achieved, private investors get back their investment from the state, and potentially returns on top of their original investment. The Peterborough social impact bond (Box 12) is the first example of an SIB.

Box 12: The Peterborough social impact bond

In the UK, 60 per cent of criminals who serve short sentences in prison reoffend within a year of leaving. Each prisoner costs the taxpayer approximately £50,000 a year whereas research suggests that greater investment in rehabilitation services could reduce re-offending rates and produce up to £10 saving for the public purse for every £1 invested.

The Peterborough social impact bond was developed by Social Finance in collaboration with the Ministry of Justice and the Big Lottery Fund. It is designed to reduce re-offending rates on a payment-by-results basis. It involves central government contracting with an intermediary organisation, in this case Social Finance, who in turn attract investors from charitable trusts and social investment groups to provide £5 million for a number of experienced specialist organisations to deliver rehabilitation services. In Peterborough these organisations include the St Giles Trust, Ormiston Trust and YMCA.

Peterborough prisoners sentenced to less than 12 months in custody will be supported by mentors who will help them to find jobs and housing and secure treatment for drug addiction (where appropriate) on their release from prison, in an effort to reduce the likelihood that they will go on to re-offend.
The most appropriate way of financing prevention depends on three factors. First, on whether it is possible for government agencies to find money to invest into prevention services from their existing portfolio of activities, as discussed above. If the upfront investment can be found, this is always the preferable option. Using PBR and SIBs to fund upfront investment comes at a cost, because they represent a transfer of risk from the state to others, which comes at a cost.

The second key factor is the level of risk that the expected better outcomes will not materialise. The risk involved can be very high where there is no or very little evidence to support a particular way of delivering a service or way of doing things. But risk still exists for evidence-based approaches. For example, there is what may be termed ‘replication risk’ that a service that works in other, very culturally different, contexts may not work here. ‘Operational risk’ exists where adherence to the model that makes them effective will not be achieved for evidence-based programmes, particularly when they are being delivered at scale.

If the project proves successful, the Ministry of Justice has suggested that the scheme could be implemented across a larger number of prisons in England and Wales.

---

**Box 13 Redirect and Reinvest: system reform for looked-after children**

Over the past decade the number of children looked after has risen and their length of stay is increasing. In 2010, in excess of £2 billion was spent on looking after children in the UK. There is very little evidence, however, that children in care do better than children with similar needs who receive other services. The cost of looking after children presents a major challenge to the resources of most authorities in a very demanding economic climate.

The Social Research Unit at Dartington is partnering with local authorities in Gloucestershire, Warwickshire and Sandwell to develop and implement a strategy that aims to safely reduce the size of the care population and support the redirection of money into interventions that support a greater number of vulnerable children in the community.

The ‘Redirect and Reinvest’ strategy adopts a whole system approach; it focuses on the total size of the population of looked after children, as well as the flow in and out of the system. It is designed to safely reduce the numbers of children and young people entering care, reduce their length of stay and increase the numbers of children who can be returned to their families.

The strategy involves implementing a series of reforms that draw on well-tested methods developed by SRU to implement clear and consistent thresholds for entry into care and to identify those who can return home safely. It also incorporates the use of carefully selected evidence-based programmes as alternatives to being looked after (where appropriate and safe to do so), with the costs of developing such programmes aligned as far as possible to identified savings. The aspiration is
that over time, authorities can begin additional reinvestment into targeted, early intervention services.

In Gloucestershire, Warwickshire and Sandwell work is under way to commission Functional Family Therapy (FFT) as an alternative to care for a particular cohort of adolescents displaying challenging behaviour and who have very difficult relationships with their families. Social workers and their managers agree that on balance, outcomes for these young people are likely to be better served by supporting them to remain at home with their families. An evaluation will be conducted to assess outcomes for adolescents who receive FFT and compare them to outcomes achieved by similar children who entered care.

The greater the risk that outcomes will not be achieved, the more that government might want to consider using PBR contracts and SIBs to pay for services, as both of these allow the state to transfer risks. However, unless the private investment is philanthropic (and investors are willing to take on this risk for government either for free or at a reduced rate) this risk transfer will need to be paid for by government, and thus accurately priced.

The transactional costs that will need to be factored in, for example in pricing the risk and negotiating contracts, mean that when risk is very low, it is always cheaper for government to find the upfront investment itself so the returns are not shared with investors. We are a long way from understanding how to price this risk accurately and having the information needed to do so – which is why we have not yet seen widespread non–philanthropic investment in SIBs.

In one example, the Peterborough Social Investment Bond supports a new untested service with young men leaving prison. It is impossible to know what outcomes will be achieved as it is an example of innovation; it has not been tried before. Everybody involved has done their best to test the proposition but it remains a long-shot. But because the investors are philanthropic, this risk has been priced way below market value, and the investors are prepared to lose their investment proving a new model.

Box 14: Reinvestment in Washington State

The Washington Legislature created the independent Washington State Institute for Public Policy (WSIPP) in 1983. In 1997, the legislature directed WSIPP to examine costs and benefits of policy strategies in youth justice and adult corrections. In the early 2000s the Institute was directed to apply the same evidence–based and benefit–cost approach to other public policy areas, including early years, education, child protection, mental health, drug misuse, and public health.

The charge of WSIPP is to provide consistent, independent investment advice on a range of interventions. It does this by identifying evidence–based policies and programmes that have been shown to improve particular outcomes. The purpose is to provide Washington policymakers and budget writers with a list of well–researched interventions that can, with a high degree of probability, lead to better statewide results and a more efficient use of taxpayer dollars.

When WSIPP worked on youth justice it identified several programmes that had been tried and evaluated elsewhere and had the potential to reduce crime and save Washington taxpayers money. The strategy was to invest state dollars into
In contrast an intervention like Functional Family Therapy, which we know is effective in minimising the worst results of conduct disorder amongst young people already known to social services and the youth justice system, stands a very good chance of improving outcomes quickly, assuming the programme is implemented well. Assuming local authorities can put in place cash realisation strategies, they are likely to be able to realise a return on investment. This is why Gloucestershire, Sandwell and Warwickshire wanted to use their own resources, and not those from external investors.

The third important factor is how long it takes to realise the financial returns of a particular evidence-based prevention strategy. The longer it takes to see financial returns, the more difficult it is for government agencies to find the cash from existing budgets for upfront investment in prevention activity, when the justification is that financial savings can be made (rather than simply better outcomes being achieved). A programme like FFT produces financial savings relatively quickly through the costs of a crime avoided; a programme like Family Nurse Partnership will take much longer because it targets children so young and the benefits accrue later on, for example through increased tax take as a result of increased earnings later in life.

Finally, crucial to all of the above discussion – whether upfront state-funded investment, or private investment is leveraged into the system via a mix of PBR contracts and SiBs – is the extent to which the theoretical financial savings that can be achieved through improving outcomes are actually realised on the ground. Ultimately, it is real-time, cashable benefits that justify the original investment made by the state – or can be used to pay for outcomes via PBR contracts.
6. A common vision

Prevention efforts generally involve lots of partners. Collaboration is becoming part of the culture of modern services. Yet day-to-day there are still all too often institutional, budgetary, cultural and linguistic barriers to people working together across traditional agency borders to commission services together in line with a common strategy, to improve outcomes for children. There is, increasingly, evidence that bringing people together to forge a common vision in the face of those barriers increases the impact of that vision.

Communities that Care is one process designed to bring people together, developed in the US by the Social Development and Research Group (SDRG). It has been designed to work for communities of around 10,000 people – so is ideal for bringing community leaders together at the neighbourhood (or collection of neighbourhoods) level. It supports communities to select interventions from a menu of evidence-based programmes, and provides training and materials aimed at mobilising and empowering coalitions of people in the community to adopt these programmes. It does not focus on a single outcome but instead addresses common risk factors that predict various later problems, such as drug abuse and delinquency. When it works, Communities that Care gets local people passionate about outcomes for children, interventions for achieving those outcomes, and the money spent on the interventions. A US-based evaluation (see Box 15) has found it works in boosting child outcomes.

Box 15: Communities that Care evaluation

A recent study randomly assigned communities to implement the CtC process, or to carry on as normal. Twenty-four communities from across Colorado, Illinois, Kansas, Maine, Oregon, Utah and Washington were paired according to population size, ethnic diversity, prosperity and crime rates.

Evidence-based programmes were implemented gradually over the course of the four-year study in the 12 communities that received the CtC intervention. On average, communities put three new programmes into action annually. Menu choices included: school-based curricula such as All Stars, Life Skills Training and the Olweus Bullying Prevention programme; community programmes such as Big Brothers Big Sisters America; and family-focused interventions such as Strengthening Families, Guiding Good Choices and Family Matters.

The effect of CtC on alcohol and drug abuse, smoking and delinquency was judged using an annual panel survey of over 4,000 children in 88 schools between 2004 and 2007. The study found that students in communities without CtC were 41 per cent more likely to become involved in delinquent behaviour between the ages of 10 and 14. They were also prone to find themselves in more kinds of trouble.

Students in comparable towns where Communities that Care (CtC) was not implemented were 60 per cent more likely to start using alcohol and 79 per cent more likely to start smoking between ages 12 and 14. By the time children were 14 the incidence of drug abuse was also significantly higher in the control group areas. CtC also had an impact on levels of binge drinking.36

The WSIPP cost–benefit model was used to estimate a conservative benefit–cost ratio of $5.30 for every $1.00 invested, rising to more than $10 per $1 under less conservative assumptions.37
Another process, **Common Language**, has been developed by the Social Research Unit at Dartington in the UK, in order to facilitate and empower leaders from local public service agencies to develop prevention-based strategies. It works with leaders from health, education, social care, youth justice and police agencies, people who are directly accountable for resources and how they are spent on local public services. It has been used in England, Scotland, Northern Ireland and the Republic of Ireland. It was the method used to support Birmingham to design its Brighter Futures prevention and early intervention strategy (see Box 9). It differs from Communities that Care in that it is focused more on local agency leaders than community leaders.

At the heart of Common Language is the idea that people from different disciplines, with different responsibilities or in different locations use the same words to mean different things. The very word ‘prevention’ is a good example. To a police officer it might mean preventing a crime, to a prevention scientist it would be preventing the behaviours that lead to crime, to a family member preventing the conflict that is leading their child to act out, and so on. The Common Language process breaks down some of these barriers.

Common Language also works on the premise that many people with responsibility for children’s development will produce a stronger strategy and roadmap for change than any one working alone, or several working in isolation.

The method requires that groups of ‘experts’, including children and families and community activists as well as budget holders in children’s services, come together and focus on a few concepts, such as outcomes, activities, investments, outputs, needs, thresholds and services, that can be locally defined, understood and connected.

The facilitation of these ‘convenings’ holds individual members to account in two ways; it asks whether each statement is logical and second whether it can be supported by evidence, about the circumstances of local children and what works internationally.

The result is a strategy, simply written, accessible to all in the local authority, supported by evidence to which leaders of children’s services and other investors can be held accountable.

**Evidence2Success** (Box 16) is a hybrid of Common Language and Communities that Care, getting both public service and community leaders to share financial accountability for system pounds and dollars. It itself is a product of collaboration between the Social Research Unit and SDRG.

### Box 16: Evidence2Success in Rhode Island and Perth and Kinross

The Evidence2Success framework seeks to improve child outcomes in target communities by helping leaders of public systems shift a relatively small proportion of resources – in the region of 3–5 per cent of expenditure on children – towards evidence-based prevention, early intervention and targeted services. Robust epidemiological data on children’s health and development are collected from all children and young people across a community, and critically, also from those currently served by public systems. Target communities and leaders of public systems are considered jointly accountable for child outcomes and strategic development of services, and come together to forge new strategies and guide the implementation of evidence-based approaches.

The approach is currently being tested in two demonstration sites: Providence in Rhode Island, US, and Perth and Kinross local authority in Scotland.
What all three of these processes have in common is the starting point that the best way to support decision makers to engage with data on needs, evidence of what works, and cost–benefit analysis of what is most likely to generate returns, is not for experts to generate a ‘top–down’ prevention strategy and then leave it to local authorities and community leaders to implement. This would be unsustainable. Rather, it is to empower local service leaders with data and evidence, help them to understand it – but to leave them to collaboratively forge a local strategy that has buy-in from relevant decision makers. The process of developing the strategy is just as important as the content of the strategy itself.

Accountability for decision making is also a key ingredient in a successful strategy. Too often, efforts to bind collaborators together tries to do too much, and shares accountability for things that the collective cannot influence.

For more information about either Common Language or Evidence2Success, please contact the Social Research Unit at Dartington (contact details at the end of this paper).

7. Conclusion

Since there is less money to pull the drowning out of the water, it really is time to mend the fence to prevent any more from falling in.

There is huge untapped potential in public services to shift the balance of expenditure from reactive treatment to prevention and early intervention. The benefit should be to serve more children better, and with less resource.

When we look at the stories of success and failure from around the world, some simple messages about what to do and what not to do emerge.

This shift requires good, clear, simple ideas that everyone can understand. Even small local authorities will directly or indirectly employ thousands of employees to support tens of thousands of children. Complex propositions, ill thought through will disintegrate once injected into the real world. We need simple ideas that everyone involved can comprehend.

Finding focus and vision will be easier if there is good data to hand. The Highlands are not like Glasgow, and Leeds shares with Cardiff little more than the status of a city. If we are going to mend a metaphorical fence we need to find out who is falling in, how many, when and where. If someone else has perfected an effective fence system let’s use it. And since money is now at a premium we want to know how much we might save or benefit and the costs of the different types of barrier we might erect.

The variety of UK contexts should encourage a diversity of innovation. There is no single way to prevent problems in human health and development. In this paper there are examples of laws that reduce the speed of cars, programmes that prevent the worst outcomes for the most vulnerable babies, processes that make sure the people who can benefit from help get that help and practices that teachers, social workers and police officers can build into what they do everyday, that will give the best chance of a good outcome.

Why do we want better prevention? Most will say to improve people’s lives. But the catalyst, in this age of austerity, will be the need to do much more with scarce resources. This means being smart about money. It means matching prevention innovation with financial innovation, developing new ways to accurately cost risk.
Finally, there are the potential benefits of using good methods to forge a common vision. Not all prevention is collaborative. Some is handed down from on high by central and local government. But prevention often works best via the forces of pull, via the intrinsic demand from children, their families and the practitioners that serve them, and working across disciplines, involving all the accountable fund-holders, getting the backing of people in communities who arguably have the most to gain, all of this is known to make a measurable difference to the potential success of prevention ventures.

With all of the above, and just 1 per cent of public sector expenditure for prevention, it should be possible to build a suite of activities that have the capability to, among other things, reduce the number of victims of child abuse, domestic violence and crime; improve the number of children excelling in school or in their vocation; reduce the number of young people whose lives are blighted by mental health disorders affecting their emotions, conduct and relationships.

As much as these things matter to the leaders of public services, many will also have an eye to use this shift to maintain the number of people getting the support they need, and retaining practitioner satisfaction and commitment despite the biggest decline in public sector funding for eight decades.
ENDNOTES


12. For more information, please visit www.dartington.org.uk/childrencount


Acknowledgements

This paper draws upon the work of many colleagues at the Social Research Unit at Dartington. We would like to thank Nick Axford, Vashti Berry, Sarah Blower, Triin Edovald, Tim Hobbs, Louise Morpeth and Dwan Kaoukji for their contributions and comments. Particular thanks are due to Laura Whybra for her support in editing the pamphlet.

Thanks are also due to Nesta for their support in publishing this paper, in particular Ruth Puttick for her input and advice.

Any errors or omissions remain the authors’ own.

The views are those of the authors and do not necessarily reflect those of Nesta.

The Social Research Unit
www.dartington.org.uk/research
unit@dartington.org.uk
Lower Hood Barn
Dartington
Totnes
Devon TQ9 6AB

About Nesta

Nesta is the UK’s innovation foundation. We help people and organisations bring great ideas to life. We do this by providing investments and grants and mobilising research, networks and skills.

We are an independent charity and our work is enabled by an endowment from the National Lottery.

Nesta Operating Company is a registered charity in England and Wales with company number 7706036 and charity number 1144091. Registered as a charity in Scotland number SC042833. Registered office: 1 Plough Place, London, EC4A 1DE

www.nesta.org.uk

© Nesta 2012.