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Integrated early childhood development services

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Synthesis

How important is it?

Parents fill multiple roles in the life of their children, such as caregiver, teacher, nurse, safety officer, nutritionist, and moral guide. They are also their children's first and most important advocates and care coordinators, seeking help from a variety of services—health, education, child care, social or other family support services. Yet in some cases, parents are not able to find or afford appropriate resources to meet their children's needs. Moreover, disadvantaged families, especially in culturally diverse and deprived neighbourhoods, may have multiple needs.

Children's developmental outcomes may vary depending on the extent to which these services are integrated together to form a cohesive system that can be easily accessed by families. Specifically, fragmentation of services often results in a lack of consistency and continuity for children and families. When children are seen by multiple service providers, parents may receive mixed and conflicting advice, limiting the effectiveness of these services and adding to parents' confusion and stress. Integrated services can provide a more accessible, aligned and coordinated response that is better suited to children's and families' needs.

What do we know?

When children need services in multiple areas, programs and policies that bring together different services lead to better results for children and their families. When focused on the parents as well as the child, validating and supporting parents in their roles, programs can also improve parent-child relationships and children's healthy development across physical, cognitive, social and behavioural development.

Over the past two decades, many programs offering integrated early childhood services have been implemented worldwide. Most of them were created in order to: 1) improve children's health and overall development; 2) provide support to families; 3) decrease gaps in school readiness; and 4) reduce the negative outcomes associated with living in poor neighbourhoods. *Early Head Start*, *Sure Start*, *Better Beginnings*, *Better Futures*, and *Toronto First Duty* are examples of both broad-scale government programs and demonstration projects that have also been the object of an evaluation in previous scientific studies.

Early Head Start

Early Head Start is an American federal program created in 1995 to serve low-income pregnant women and families with infants under the age of three. This program offers high-quality child development services through home visits, centre-based child care, health care, and case management. It integrates two-generation programming and aims to establish community partnerships to increase the availability of services to families. Benefits resulting from the implementation of this program include improvement in children's socio-emotional development starting at age two.

Sure Start Local Programs (SSLPs)

SSLPs have grouped health, social, and educational services to help poor children under the age of five and their families in England since 1999. Over time the mandate to integrate these services has been strengthened, evolving from a variety of community networks to more coherent children's centres. Evidence suggests that greater integration leads to more benefit. Several positive developmental outcomes have been found for all sections of the populations living in SSLP areas, including improvement in child's health at age five (e.g., less severe injuries and respiratory infections) and in several aspects of school functioning for older children. Mothers showed improvement in life satisfaction and the home learning environment, with less harsh discipline.

Better Beginnings, Better Futures (BBBF)

BBBF is a project that examined the impact of integrated services in eight economically disadvantaged communities in the province of Ontario, Canada. Initiated in 1993, it was designed to reduce emotional and behavioural problems in children (0-8 years old) and to strengthen parents' abilities to meet their children's needs. A variety of high-quality services were offered to children and their families, including health, social, educational, and family support services. In terms of impact, the creation of partnerships with community service providers increased the visibility and the funding for programs. It also increased the collaboration among service providers which in turn led to the development of new settings to offer services to children and families. Positive developmental outcomes were found in 4- to 8- year-old children and their families, and measures collected when the cohort was in Grade 12 indicated lasting outcomes. Data collection has continued into adulthood, making this one of the longest Canadian longitudinal studies of an

early child development program.

Toronto First Duty Project (TFD)

TFD is a project that began in 2001 to test the impact of integrating kindergarten, child care, and family support and health services into a single hub for children 0 to 6 years old and their families in the greater Toronto area. Positive impacts of this project included an increase in parental engagement with school and decrease in parental stress from negotiating disconnected kindergarten and child care arrangements. In addition, more intense use of these services benefited children's physical health and well-being, language and cognitive development, and communication and general knowledge.

What can be done?

In order for programs to be effective and part of a cohesive system, some important aspects should be considered. First, given that collaborations across agencies provide the best results, service providers should not work independently but rather try to establish collaborative relationships with other community organizations (e.g., by sharing information). Providers from different sectors (education, health, nutrition, family support, etc.) must be able to refer children and their parents to services outside their professional purview, and coordinate with each other when serving the same child and family.

A crucial step for successful integration is developing common goals to guide their partnership activities. Effective partnerships will depend on commitment at all levels, with clear roles and responsibilities, and regular communication to develop trust. Professionals also need time to manage this organizational change.

Service providers should keep in mind that making the services available is not sufficient. For families to be aware of and benefit from them, services also need to be affordable, accessible, and active in outreach. Some families may lack resources or face social/economic circumstances preventing them from accessing these services. Therefore, coordination between services and development of strategies to reduce barriers are two important aspects to privilege before implementing a program. Evaluation of implementation and continuous monitoring of outreach also need to be built in.

Finally, integration and sustained collaboration among agencies will require program and policy support from different levels of government, as well as strong grassroots support to withstand government and policy changes.

Inter-Agency Working in Europe and the Uk to Support Vulnerable Young Children and Families

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Introduction

Disadvantaged families living in poverty, especially in culturally diverse and deprived neighbourhoods where risks may accumulate, may have multiple needs. “Silo working” is endemic in bureaucracies, including governments, and the resulting lack of communication and integration between services fails families. For example, families may be involved in multiple assessments, with replicated explanations to many different professionals in different locations.

Relevance

An international review[1] found that, of 54 countries, more than half had made moves towards more coordinated provision for children and families. In the context of early intervention, integrated inter-agency working has been tried in many European contexts including the UK as a way to improve support for children and families and to potentially reduce inequalities.[2-9] It has been promoted as a way to provide joined-up solutions for the most marginalised and disadvantaged groups such as cultural minorities, families on low income or recent immigrants, who are likely to experience multifaceted problems that are inadequately addressed by traditional separated services.[10,11]

Examples of inter-agency working are the UK’s *Sure Start* Children’s Centres program, the Greek and Portuguese strategies to enhance educational outcomes for groups such as Roma families, and the Centres for Youth and Families in the Netherlands.[12] Also it is reflected in local policies such as Canada’s *Toronto First Duty* program,[13] the Action Base of Integrated Activity (Baza Akcji Zintegrowanej Animacji; BAZA) in Warsaw, or the inter-agency coordination of services for children and families in the Municipality of Reggio Emilia in Italy.[12]

One underlying assumption is that families with multiple needs are best supported by services working together, sharing information and possibly working from one common location. Joint-working is expected to avoid duplication of effort and fragmentation; pooling of budgets can lead to economy; shared assessment of needs and coordinated plans will lead to more appropriate services; and the quality and take-up will be greater if front-line delivery of services is co-ordinated, with a shared governance structure.[14] The importance of information sharing is explained well in Scotland's recent *Getting it Right for Every Child* policy.[15] The European Union and the Council for Europe have prioritized integration of family support for the most marginalized and disadvantaged groups.[10] However, recent work in nine European countries, investigating policies to support disadvantaged and linguistically or culturally diverse populations, found that national legislation to support this approach was limited, generally focussing on child protection issues, with decisions about integration of other services made locally, where strategies depend on the local political context.[16]

Problems

Firstly, inter-agency collaboration has different forms. There is a lack of clarity about its meaning; rather than being a single strategy it represents a continuum or ladder.[17] The number of 'steps' in this ladder in programs in the UK, for example, has ranged from three to five.[18-20] Case studies in the UK and Norway of successful centres providing co-located integrated services also reveal that several levels of integration may exist within one site.[12]

Secondly, to promote this approach, commissioners and policy makers increasingly want evidence to support their decisions. While closer integration has been extolled as a policy designed to enable disadvantaged young children to be better prepared for formal education,[14] a review[8] concluded there was limited evidence for such an approach, locally or nationally, leads to better outcomes for children or families, although there are some exceptions such as the positive impacts identified for well-evaluated area-specific programs in Canada.[13] This lack of evidence partly reflects the limited resources committed to collecting the evidence.

Recent Research Results

Research on inter-agency working in Europe has focussed predominantly on process, developing frameworks or terminology to conceptualise the policy in practice, and then identifying what contributes to, or hinders, successful implementation.[18-21]

Reviews[22-24] have examined factors related to success or failure of inter-agency initiatives. The most significant facilitator in a series of successful case studies in Europe[12] and in local areas that were home to culturally and linguistically diverse families and those of low-income[16] was 'top down' national policy with the accompanying financial provision. However local 'bottom up' support was also important, in addition to clear management and governance.[12,16,25,26] Also, establishing effective partnerships depends on commitment at all levels of hierarchies; clarifying roles and responsibilities; engendering trust and mutual respect through effective communication; and developing a shared purpose with joint goals with shared protocols, which can be challenging and is dependent upon the professionals involved.[27]

There is substantial consensus about the barriers to successful inter-agency working, often more numerous than facilitators. They can be categorised as contextual, organisational, and those relating to different professional cultures or to commitment.[24] Contextual barriers such as political climate are common; organisational barriers include differences in geographical boundaries of agency catchment areas or problems with data sharing. Interviews have revealed that new European regulations about personal data have heightened this issue.[12,16] But the most commonly mentioned cultural barriers are status inequalities and professional differences or mistrust.[3,16,26,28-30]

European studies of perceptions of impact have described benefits as including the ability to react more flexibly, more effective referrals, and avoiding duplication. Most informants also suggested that families experienced less stress. However, practitioners less often specified improved child outcomes in relation to inter-agency collaboration.[12]

Research Gaps

The extent of new evidence concerning inter-agency working ebbs and flows as governments change their political leadership and their focus on policy for disadvantaged children and families.[31] This lack of continuity has hindered long-term research on outcomes for children and families.[32] Even respondents in case studies selected to represent best practice across Europe were generally reluctant to suggest that improved academic attainment for children living in disadvantage may be associated with high quality integrated provision.[12] Their work is based mainly on principles and values, but well-designed larger-scale studies of impact are needed in order than policy makers and providers can be confident that inter-agency collaboration can be linked with better child outcomes.

Conclusions

Children and parents experiencing disadvantage are likely to require support and services from many different providers. Without coordination between agencies, families need to explain their circumstances numerous times, visiting multiple professionals. Moving to closer inter-agency work will involve devoting substantial time and effort to identify common understanding of factors that enhance or detract from inter-agency collaboration.[33] Policy makers in many countries have promoted closer connections between agencies such as education, health, youth welfare, employment and criminal justice. However, this is often limited to child protection issues that children most at-risk may 'slip through the net' when agencies are not sufficiently joined-up.[34] Consequently, it is common in the European context to have strong legislation regarding collaborative working with regard to child protection.[16] However, such support is important not just for 'fire-fighting' but also for 'fire prevention'. There is good understanding of what helps inter-agency working become a reality. However, barriers will persist if professionals are not allowed time to manage organizational change to enable them to integrate expertise and roles. Also, increasing data protection legislation often hampers sharing of information between services. These issues can be overcome with good planning and political support. Indeed, in many countries, using different models, pioneering policies have allowed agencies to work together successfully. In Warsaw, Poland for instance, two years was spent in planning the BAZA project, with secure local funding. In Reggio Emilia, Italy, there is also local funding and legislation to establish an integrated system for 0-6 year olds.[12]

Implications for Parents, Services and Policy

Agencies working in collaboration, with a common agenda, a shared vision, a common location, and (ideally) a common governance structure, can be responsive and efficient in supporting disadvantaged children and parents. However, it has proved challenging to develop and maintain integrated services for young children and families in the face of fluctuating 'top-down' policies and financial support. Overall, the close collaboration and possibly co-location of agencies providing education, childcare, family support, public health and mental health can be an effective way to develop services for young disadvantaged children and their parents. It is challenging to sustain this style of working as governments and policies change, unless there is also strong 'bottom up' support and proof that this way of working can reduce inequalities. Research on children's outcomes is essential to persuade agencies to develop integrated working.

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Sure Start and its Evaluation in England

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Sure Start Programmes

In 1998 a UK government review concluded that disadvantage among young children was increasing and early intervention could alleviate poor outcomes. It recommended a change in service design and delivery, to be area-based, with all children under five and their families as clients. Among the aims were avoiding the stigmatization often associated with targeted programs while fostering child, family and community functioning. From 1999 the first Sure Start Local Programmes (SSLPs) focused on the 20% most deprived areas, including about half of children living below the official poverty line.[1] Sure Start has evolved over time and, while it has the same aims, it has become a more coherent program (children's centres) with increasing emphasis on service integration.

By 2002, 250 SSLPs were planned, aiming to support 18% of poor children in England under five. A typical program included 800 under-fives. Community control was exercised through local partnership boards, including health, education, social services, private and voluntary sectors, and parents.[2] Until 2006 funding was directly to individual programs, which were independent of local government. While the justification for SSLPs was based on early interventions with unambiguous protocols,[3-5] SSLPs themselves did not have a prescribed "protocol". All were expected to provide: (1) outreach and home visiting; (2) support for families and parents; (3) support for good quality play, learning and childcare experiences for children; (4) primary and community health care and advice about child health and development and family health; and (5) support for people with special needs, but without specific guidance as to how.

The speed and amount of funding was often overwhelming in a sector previously starved of support. Only 6% of the 1999 allocation was spent in that year. Despite this slow start, and

without any information on progress, the Treasury expanded SSLPs from 250 programmes in 2002 to over 500 by 2004. Thus SSLPs became a cornerstone of the campaign to reduce child poverty.

Research Context and Research Results

National Evaluation of Sure Start

Evaluation began in 2001, continuing until 2012, and was challenged from the outset by the diversity of several hundred unique interventions. Government decisions ruled out a randomized controlled trial; hence a quasi-experimental design with consequent limitations was used to compare SSLP populations with equivalent populations not residing in SSLP areas. The evaluation work up to 2005 was summarised[6] with detailed reports of all aspects of the evaluation available at www.ness.bbk.ac.uk.[a] An independent review of the methodology is available.[7]

Communities and Change: SSLPs had the premise that children and families could be affected by the program directly, and indirectly, via community changes. Community changes over 5 years could not be causally linked to SSLPs, but improvements were noted, significantly different to changes across England.[8] For example, SSLP areas became home to more young children, while households dependent on benefits decreased markedly and burglary also declined. Child health improved with fewer emergency hospitalisations, severe injuries, and less respiratory infections. For older children, aspects of school functioning improved. Also, the identification of children with special educational needs or disability increased, suggesting improved health screening. Due to the political decisions on Sure Start policy, with a focus on children's centres rather than communities, community change was not examined after 2006.

Early Effects on Children/Families: An initial cross-sectional study of children and families in SSLP and non-SSLP areas provided mixed findings.[9,10] There were some overall SSLP-related effects, but most effects varied by subgroup. Specifically, three-year-olds of non-teen mothers (86% of sample) in SSLP communities had fewer behaviour problems and greater social competence as compared with those in comparison communities, and these effects for children appeared to be mediated by SSLP effects of less negative parenting for non-teen mothers. Adverse effects emerged, however, for children of teen mothers (14% of sample) in SSLP areas in terms of lower verbal ability and social competence and higher behaviour problems. Also, children from workless households (40% of sample) and from lone-parent families (33% of sample) in SSLP areas scored lower on verbal ability than equivalent children in comparison communities.

Variability in programme effectiveness: The methodology provided estimates of each SSLP's effectiveness for each assessed outcome and thus allowed investigation of why some programmes might have been more effective. Qualitative and quantitative data on 150 programs were used to rate each SSLP on 18 dimensions of implementation.[11,12] Programs rated high on one dimension tended to score high on others, and better implemented programmes appeared to yield greater benefits.[13,14] In particular, better service integration across agencies was one of the distinguishing features of more effective programs.

Changes to SSLPs: As early evaluation findings indicated that SSLPs were not having the hoped for impact, and evidence from another project, Effective Provision of Pre-school Education (EPPE),[15] showed that integrated Children's Centres were particularly beneficial to children's development, the government decided to transform SSLPs into Children's Centres. An Act of Parliament transferred control of the SSLP children's centres to Local (government) Authorities, which ensured that they became embedded within the welfare state by statute, making it more difficult for any future government to eradicate. Thus from 2006 SSLPs became Sure Start Children's Centres (SSCCs) with a more clearly specified set of services and guidelines, and were controlled by local government rather than central government.

Longitudinal Study of Children & Families: Children and families in SSLP areas were compared with those in similar non-SSLP areas followed from 9 months to 3, 5 and 7 years. At 3 years, beneficial effects emerged on 7 of 14 outcomes.[16,17] SSLP children showed better social development, exhibiting more positive social behaviour and greater independence/self-regulation, partially a consequence of parents in SSLP areas manifesting less negative parenting, and offering a less chaotic and more cognitively stimulating home learning environment for their children. Also, families in SSLP areas used more services. SSLP children had fewer accidents and were more likely to be immunised, but these latter two effects could possibly have been time of measurement effects and thus not related to SSLPs.

At age 5, there were mixed effects of SSLPs/SSCCs.[18] Mothers in SSLP areas reported greater life satisfaction, while providing less harsh discipline and a less chaotic and more cognitively stimulating home learning environment for their children. Additionally, their children were less likely to be overweight with better physical health. Mothers in SSLP areas, however, experienced more depressive symptoms and were less likely to attend school meetings. The benefits of SSLPs/SSCCs for child social development found at 3 years were not evident at 5 years of age.

Thus, across 20 outcomes, significant main effects of SSLPs/SSCCs emerged for 8 outcomes.

Considering change from age 3 to 5 years, 5 of 11 outcomes showed evidence of SSLP/SSCC effects. Mothers in SSLP areas manifested greater improvement in life satisfaction and home learning environment, with less harsh discipline. There was also a greater decrease in worklessness for families in SSLP/SSCC areas. Children in SSLP/SSCC areas, however, manifested less positive change in self-regulation than comparison children, which appeared to be because SSLP children manifested greater self-regulation at age 3 and by 5 years, the non-SSLP children had caught up with them. This catching-up by non-SSLP children could have been related to the free early education available for all 3-5 year olds in England from 2004. There was no evidence that the overall SSLP/SSCC effects varied across demographic sub-groups.

At age 7, beneficial effects were identified for four out of 15 outcomes.[19] For the whole study sample, mothers in SSLP areas used less harsh discipline and provided a more stimulating home learning environment. For sub-populations, mothers of boys in SSLP areas provided a less chaotic home environment; lone parents and those in workless households reported better life satisfaction. Looking at change from 3 to 7 years, mothers in SSLP areas showed greater improvement in the home learning environment and more reduction in harsh discipline. No statistically significant SSLP effects were identified for children.

Cost and Benefit

Value for money evidence is limited. Examination of spending revealed that over the first three years program development was limited. For example, finding suitable skilled staff and delays from dealing with local planning regulations for new buildings, meant that many SSLPs struggled to spend their allotted money.[20] Expenditure could be linked to variations in SSLP areas, including size, ethnic minority population, and other local area characteristics. Small SSLPs appeared not to represent an economically viable model. By the end of the evaluation[21] it was concluded that some measurable cost-benefits were shown, linked mainly with increased employment of parents in SSLP areas. Projections suggested that future gains might emerge, based on presumed benefits that may accrue from the enhanced parenting identified by the impact study.

Research Gap

Caution is needed in interpreting evaluation results, because of two methodological limitations. Firstly, government decisions to not allow a randomised controlled trial limit causal inferences about effects. Secondly, because data collections in the SSLP and non-SSLP areas had a two-year gap, time of measurement remains a viable alternative explanation for the positive and negative effects detected, although analyses tried to allow for this where possible.

While SSLPs/SSCCs were associated with more positive parenting when children were 3, 5 and 7 years old, the positive effects on child social behaviour at 3 years disappeared by 5 years. This may have been because from 2004 all 3- and 4-year old children had access to free part-time pre-school education, and 97% took advantage of this. Hence almost all children would have had pre-school education between 3 and 5. Evidence links high quality pre-school education with improved cognitive and social development.[22-24] Hence possibly developmental advantages associated with SSLPs at age 3 were not detected at ages 5 or 7 because, by this time, almost all children were exposed to pre-school education, which may have resulted in “catch up” for non-SSLP children.

Conclusions

The longitudinal findings differ markedly from earlier findings. Earlier the most disadvantaged 3-year-old children and their families (i.e., teen parents, lone parents, workless households) were doing less well in SSLP areas, while less severely disadvantaged children and families benefited (i.e., non-teen parents, dual parent families, working households). The longitudinal evidence at 3 years indicated benefits for all sections of the population. At age 5 the benefits were less but still exceed any disadvantages and they applied to all sections of the population. Nevertheless, why were there such differences in results between the early cross-sectional, and later longitudinal results? Although it is not possible to entirely eliminate methodological explanations, it seems possible that the contrasting results accurately reflect the contrasting experiences over time. Whereas the 3-year-olds in the cross-sectional study were exposed to ‘immature’ programmes—and probably not for their entire lives—children and families in the longitudinal study were exposed to better developed programmes throughout the children’s entire lives.

Also programmes probably learned from the earlier phase of the evaluation, and made greater effort to reach the most vulnerable households. Thus differences in exposure to programs and the quality of SSLPs/SSCCs may account for both the initial adverse effects for the most disadvantaged and the subsequent more beneficial effects for almost all children and families in SSLP areas. In addition, change to Children’s Centres placed greater emphasis on multi-agency

service integration, which was also a theme in government work linked to the 'Every Child Matters' agenda.[b] However, it is of concern that long-term effects were limited to parent outcomes. An in-depth investigation of child care quality in SSLP areas[25] found that it was variable but higher pre-school childcare quality was linked with higher child language development. Since there was evidence that children in SSLP areas with higher child care quality were showing greater language development by age 5, an important step would be to improve childcare quality in all locations.

Sure Start evolved and ongoing research partly influenced this process. Developments clarified guidelines and service delivery, with increasing emphasis on service integration and cohesion. Plausibly the improved evaluation results reflected actual changes in program impact resulting from increasing quality and integration of services, greater attention to the hard to reach, the move to children's centres, as well as greater exposure to services. The results are modest but suggest that the value of SSLPs/SSCCs has improved. The identification of the factors associated with more effective programmes has informed improvements in SSCCs.

While children's centres proved popular with parents, after changes in government the number of centres is declining. The Department for Education reported that more than 350 Sure Start Children's Centres had closed in England since 2010 with spending in 2015-16 47% less than in 2010 with more cuts planned.[26] Nevertheless, some Local Authorities continued to support Children's Centres, and where this occurred with implementation focussing on service integration, subsequent research has revealed very good outcomes for the academic achievement of children living in disadvantaged communities, thus fulfilling the original Sure Start goals.[27]

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Lessons Learned from the Early Head Start Program

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Introduction

Early Head Start (EHS) is a federal, two-generation program to enhance children's development and families' functioning. It serves low-income pregnant women and families with infants from birth to age 3 in the United States. EHS began in 1995 and in 2010, the American Reinvestment and Recovery Act of 2009 allocated $1.1 billion (U.S.) for it, allowing the program to add 50,000 enrollment slots in fiscal year 2009-2010.[1] In 2014, Congress appropriated a half a billion dollars to expand EHS slots through Early Head Start—Child Care Partnerships (EHS-CCP) grants. By 2017, funded EHS slots increased to more than 150,000.[2] Even so, EHS serves less than 10 percent of eligible children.[2]

Programs are charged with providing high quality, comprehensive, developmentally enriching services to children and services to parents that support them in their role as primary caregivers and encourage self sufficiency. These comprehensive services include core early education and child development, health, oral health, mental health, nutrition, family support, and family and community engagement services (per the revised Head Start Program Performance Standards[3]). Programs help ensure that families receive needed services by acting as a bridge to the community to link families to services. Service integration is built into the model because of its two-generation focus and emphasis on providing comprehensive services. Programs must work to establish ongoing collaborative relationships with community organizations to promote access to services.[3]

Subject

It is expected that families need supports beyond the child and family development services provided through home visits and center-based care, and no single program will likely meet all needs. To create comprehensive integrated services, the performance standards require programs

to facilitate communication and cooperation among community providers and document their own efforts to establish partnerships.[3] These partnerships are meant to promote service integration, coordination and seamless access to services.

Problems/Issues

Programs face a number of challenges in providing comprehensive integrated services. Making the services available is necessary but not sufficient; there may be a need to follow up to ensure appointments are kept or to provide other supports (such as transportation). Providing specialized services may be challenging if there are few such providers in the community. Further, programs that partner with community child care providers must ensure that partners also meet Early Head Start quality standards. Another challenge to service provision is the prevalence of non-English/non-Spanish languages in many programs, which can make it difficult to provide services in the languages families speak. Moreover, current immigration policy, presents challenges for some programs that serve immigrants. These programs must combat lack of trust that could prevent families from taking up needed services.

When children reach 2½ years of age, programs plan for their transition from EHS. Transition planning fosters service integration by identifying appropriate placements, then establishing lines of communication, sharing records and communicating the progress and needs of the child and family to the new provider. Ideally, other services also continue after transitions, again depending on service availability and families' continued eligibility (they must re-qualify financially for Head Start, which can be a barrier to entry).

Research Context

EHS has been studied extensively, in terms of its effects on children and families and its implementation. The early work of the Early Head Start Research and Evaluation Project (EHSREP) showed that children and families in the 17 original research programs benefitted from EHS in numerous domains and that benefits in some domains (for example, children's social-emotional development), found at age 2 extended to ages 3 and 5, two years after program eligibility ended.[4,5,6] Implementation studies of the early program showed progress in establishing community partnerships that increased the availability of services for families. Accordingly, impacts were stronger impacts for programs that were fully implemented early in the study.[5,7]

The Survey of Early Head Start Programs (SEHSP)[8] conducted a national survey of program directors to examine program organization (including use of partnerships). More recently, a study of a nationally representative sample of EHS programs, the Early Head Start Family and Child Experiences Survey (Baby FACES 2009),[a] included a census of nearly 1,000 children in two birthday windows (prenatal/newborns or about 1 year old) and followed children and families until age 3 or until they left the program. The study collected information on partnerships, documented service receipt and referrals, tracked program exit, and assessed program quality and parent involvement.[9,10] As part of Baby FACES 2009, the provision and receipt of core child development services in home-based or center-based options were tracked on a weekly basis by program staff. Currently, another national descriptive study of EHS (Baby FACES 2018) is underway to extend the lessons learned from Baby FACES 2009. It focuses on the processes in EHS programs (classrooms in particular) that support infant/toddler growth and development in the context of nurturing, responsive relationships.a Also underway is the study of Early Head Start—Child Care Partnerships (EHS-CCP) that will document the characteristics and features of EHS-CCP partnerships and activities.[b]

Key Research Questions

We know much about the services that programs offer and families actually receive but less about how EHS programs engage with community partners to provide services and how programs integrate services. Understanding how partnerships work in practice and the barriers to full collaboration could spark similar work to help programs become more effective partners and leaders. Also less clear is how programs support responsive relationships between: teachers and children, teachers/home visitors and parents, and parents and children to affect child and family outcomes. Unpacking the black box of program processes would help support teachers and home visitors and improve professional development and quality of services to better meet families' needs.

Recent Research Results

With regard to services provided through partnerships, Baby FACES 2009 found:

1. Nearly all programs (98 to 100%) offered a variety of services to support family self-sufficiency, typically through referral, including financial counseling, education or job training, and employment assistance.

2. Nearly all programs (95% to 98%) offered key child and adult health care services, mostly through referral.
3. Most programs (77%) offered mental health screenings to families and offered therapy services through referral or by a community partner on site.
4. 93% of programs had a formal written partnership with a Part C provider.[c]
5. More than one-third of programs maintained at least one formal partnership with a child care provider, and about 25 percent of children in these programs were served through these partners.

With regard to services families received, Baby FACES 2009 found:

1. The rates of service take-up for core child and family development services (home visit completion and center attendance) are fairly high on average. Families in the home-based option for a full year completed about three-quarters of the home visits offered. Children who are in the center-based option for a full year attended about 85 percent of center days offered.
2. Most mothers of newborns (80%) reported receiving services provided by EHS during their pregnancies, most frequently receiving pregnancy-related information, on topics such as breastfeeding, nutrition, or how to take care of themselves or babies.
3. Apart from services specifically related to pregnancy, families reported receiving a range of services from EHS or from community agencies referred by EHS, including health services, finding good child care, financial support, help with job search or job training, with more than 10% to 20% of families receiving these services. Relatively few families received transportation assistance, help with a job search or job training, financial supports, mental health services, or a variety of other services.
4. About 70% of families received at least one referral in one year—those who received at least one referral averaged six a year. Families who did not receive a referral were more likely to be African American and a single-parent household, and have a mother who is employed, but less likely to have a child who is a dual language learner.

In sum, we know about common types and basic features of partnerships and how they are used in practice but much less about how programs actually work to support and promote responsive

relationships (for example, through professional development, use of data, and service coordination and referrals).

Research Gaps

Research on how services are integrated and whether services match family needs is lacking. In Baby FACES 2009, 35% of families left the program before their eligibility ended.[11] Families with higher risk levels were less likely to be rated as highly involved in the program compared to families with lower risks. Receipt of services while enrolled varied and service use was also associated with risk level. Higher-risk families received fewer services, likely because they were more difficult to engage and serve.[5,7,11] Apart from risk, family involvement in the program may predict early program exit. However, even with the information collected in Baby FACES 2009, we still do not fully understand the circumstances related to early exit and what programs can do to keep children enrolled. We also know less about the uptake of services other than core child and family development services.

Baby FACES 2018 focuses on program processes and functioning, classroom features and practices, and home visit processes. The findings will add to our understanding of how EHS programs support responsive relationships to promote infant/toddler growth and development.

Conclusions

EHS has shown positive effects for the families and children it serves. Service integration seems relevant to the positive effects of the program in that positive impacts were found both for fully implemented programs (which included establishing partnerships to integrate services) and for those that provided both center and home-based services (giving families access to whichever was more appropriate for their needs).[5,6]

Programs have clear practice guidelines in the revised Head Start Program Performance Standards, and evidence suggests that they are successful in establishing community partnerships to offer an extensive menu of services. Many facilitate families' access to services by providing them at the program site. Moreover, most families received core child development services as well as a wide range of other services from EHS or from other community agencies through referrals. Nonetheless, we know little about whether services match families' needs and about gaps in service provision. These gaps are not necessarily a shortcoming of the EHS

program, but may be related to the availability of services in the community. Further hampering understanding is that programs do not use a standard management information system (MIS) to collect data on service use.[8] Although nearly 90% of programs reported using an MIS,[8] individual programs vary greatly in terms of the types of data stored and staff members' technical skills to use them. Hence, there is no readily available national family-level information at this time, although Baby FACES 2018 and a planned Baby FACES 2020 will begin to address this gap.

Implications

Research to find ways of collecting standardized data about service use would help programs to identify any gaps and any families who need more support to take up needed services. Programs that do collect these data might require support to use them effectively.

At a national level, findings on service receipt at the individual family level from Baby FACES 2009 helped identify the characteristics of families and programs associated with higher and lower use of services and with particular types of services used. Such data might suggest strategies for identifying and engaging these families sooner and more effectively. With more findings coming in from Baby FACES 2018, it would be helpful to find ways to add to what we know and make findings accessible to wider audiences so that they can be used by practitioners and the research community.

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[b] See the Study of Early Head Start-Child Care Partnerships, 2013-2018. Office of Planning, Research and Evaluation Web Site. https://www.acf.hhs.gov/opre/research/project/early-head-start-child-care-partnerships-study. Accessed May 1, 2018.

[c] Part C of the Individuals with Disabilities Education Act (IDEA) is a federal grant program. It provides funds to help states operate comprehensive statewide early intervention services for infants and toddlers with disabilities from birth through age 2 and for their families.

What Young Children and their Families Need for School Readiness and Success

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Introduction

Parents are their children's first and most important teachers… and their first and most important nurses, coaches, safety officers, nutritionists and moral guides. They also are their children's first and most important advocates and care coordinators. Most parents, most of the time, are able to fulfill these roles, identifying and coordinating appropriate, affordable services (such as child care and health care) and voluntary supports and activities (such as library visits and recreation and playtime programs) for their children. But there remain far too many instances where parents cannot find or afford the health, education and social services their children need, or the services they locate do not actually meet the children's needs. Some parents live in neighbourhoods that lack places where young children can play and explore the world safely; other parents are isolated from voluntary supports as well as education and health services. This may be because they themselves are struggling simply to get by and are not connected to voluntary networks or support systems or their neighbourhoods do not have those supports, including playgrounds and family-friendly social activities. Increasingly, research has pointed to the centrality of such supports to healthy young child development – sometimes referred to as "protective factors."[1] And there are far too many children whose parents are not able to fulfill the advocacy and care coordination roles without help. This recognition has given rise to efforts to develop integrative "two generation strategies"[2] as well as child-specific ones to foster healthy child development – physical, cognitive, social, and emotional/behavioural.

Problems and Context

These problems are compounded when families or their children have a variety of needs. When children are seen by multiple providers, they and their families may receive mixed and even conflicting direction, at best limiting service effectiveness and at worst adding to families' confusion, frustration and distress. Researchers have argued for some time that early childhood

development services – whether provided through early childhood education programs, health care, family support services, or a variety of specialized counseling and support services for children with special needs – need to be part of a larger, better integrated system. This is particularly true for children with special health care needs that require professional services to address them. Ironically, these services may place new stresses on the parents and children that must be mitigated to create as normalized a home environment as possible.[3]

Service providers and policymakers have been initiating and adjusting their work in the early childhood arena to develop such a cohesive system. However, it is also important that these questions about integration occur in a larger context, one that considers overall availability of supportive services, and the broader community in which services – integrated or not – are provided.

Recent Research Results

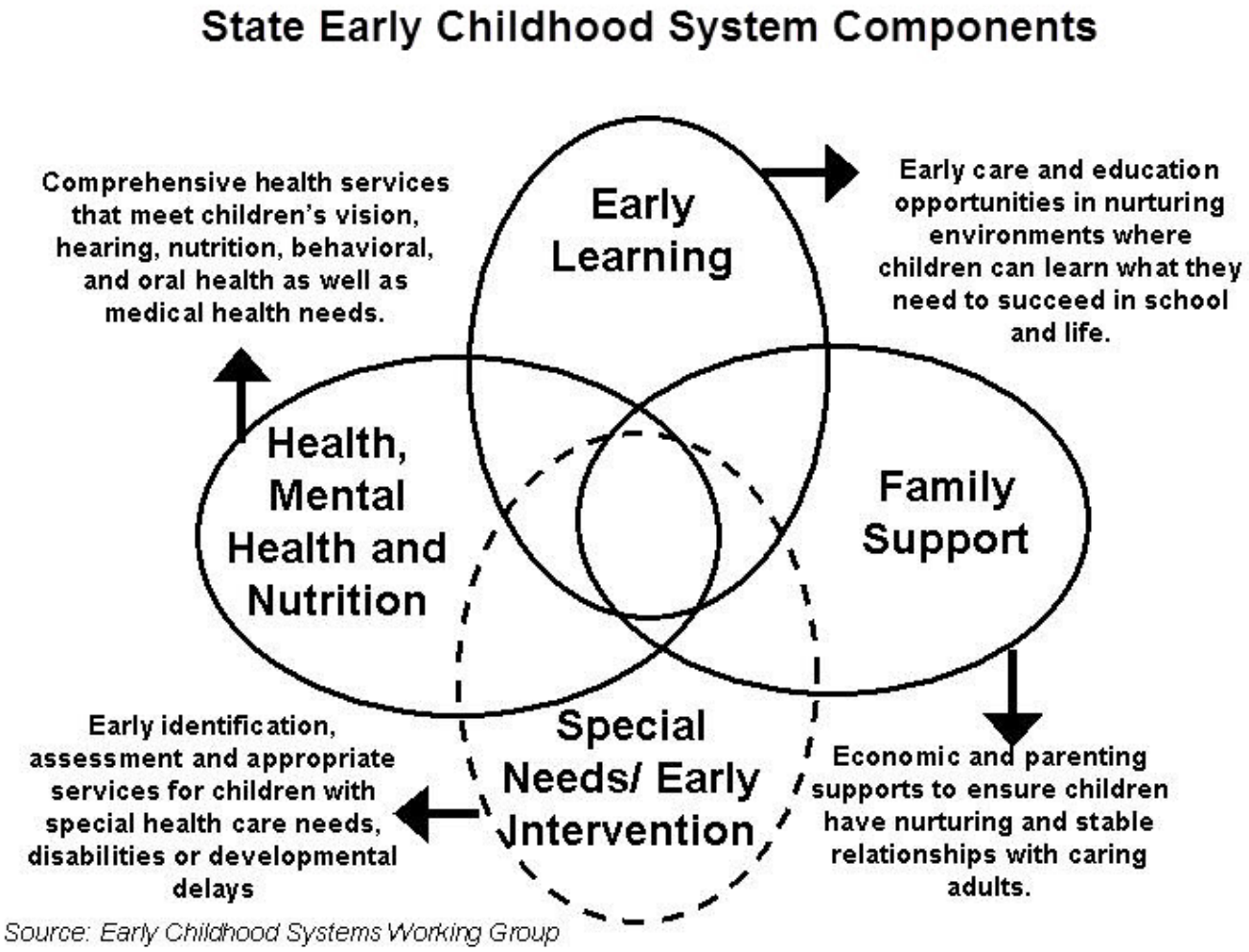
Research is clear that a child's readiness for school and subsequent school success is dependent upon physical, social, emotional and cognitive well-being and development, and that these dimensions of school readiness are interrelated.[4,5] A child with dental pain cannot concentrate fully and is likely to act out. A child with an untreated learning disability is likely to struggle socially and emotionally as well as cognitively. A child whose parent suffers from mental illness is less likely to receive the nurturing needed to foster resiliency and development across all the dimensions of school readiness.[6] Parents who are living in poverty and in a marginal or unsafe community may be expending additional time and their own resources simply trying to get through the day, with little in reserve to seek out new opportunities for development for their children.[7] Children who start school behind their peers on more than one dimension of school readiness are at much greater risk of falling further behind; and children are rarely behind on only one dimension.[8] Up to half of future school problems are already evident by the time children start school.[9]

When children need services in multiple areas, an aligned, coordinated response produces the best results. Exemplary programs suggest that primary-care practitioners who screen for and make effective referrals to developmental services reduce developmental delays among children.[10,11] When focused upon the parent as well as the child, they also can improve parent-child relationships and children's healthy development across physical, cognitive, social, and behavioural development.[12] Early care and education programs with access to mental-health consultants improve children's emotional and cognitive development and reduce preschool

expulsions.[13,14]

Further, programs and their frontline practitioners that build on strengths, validate parents through developing relationships with them, and support parents in their roles, have proved effective in improving parent-child bonding, family stability, and general nurturing that is at the heart of children's healthy development.[15] Research is clear on the need for an ecological, life-course approach to closing current school readiness gaps – one that addresses the child in the context of family, and the family in the context of community.[16] Discrete services such as clinical heath care or preschool can achieve gains that produce positive returns on investment for society, but individually they can only reduce school readiness gaps by a small amount.[9] Ultimately, improving children's health and well-being involves effective professional services and available voluntary supports that are developmentally appropriate and support and strengthen resiliency and reciprocity for young children and for their families through positive social connections – actions that go much beyond discrete, individual service provision.[17,18]

The Early Childhood Systems Workgroup, composed of national leaders from policy and research organizations in the United States, has established a common conceptual framework that recognizes the need for a systemic approach to early childhood development, depicted in the figure below.[19]



Services in each of the four components, or ovals, must be available, affordable, of good quality and accessible to all who need them. Their overlap stresses that the providers in each oval must be able to connect young children and their families to services outside their professional purview, coordinate with other providers when they are serving the same child and family, and help other providers play an appropriate role in responding to children's needs across the dimensions.

While a systemic framework, the model does not imply that better coordinating responses across the four components – e.g., integrating systems – is the sole or even the primary need to improve children's school readiness. For some young children and their families, there may not be affordable, accessible and high-quality services within one or more of the components to address the child's unique and special needs. Some children do not have access to primary and preventive health services, and many families struggle to find consistent, developmentally appropriate child

care for their children.

Even when services are available, families may not be equipped to navigate them or effectively advocate for their children. This can be due to economic circumstances, stress, isolation, family or community violence, mental illness, drug involvement, or lack of parenting confidence and competence. Such family and neighborhood factors, often referred to as social determinants, account for the greatest share of the gaps children experience at the time of school entry.[9] Successful strategies to engage and support these families extend beyond professional-to-client services.[20] In many respects, this involves population-based or public health approaches that strengthen the overall fabric of voluntary supports for young children and their families (parks, family place libraries, recreational programs opportunities, parent support groups, cultural celebrations and events), based upon an “if you build it, they will come” policy direction that goes beyond discrete service approaches matched to individual children.[21]

The emphasis upon early childhood systems-building has resulted in cross-agency planning and governance structures at both the state and community level designed to reduce fragmentation and better integrate services. These efforts often concentrate on developing protocols or agreements across systems that reduce barriers to coordinating services, including sharing information. Policymakers, in particular, are eager to know what governance structures produce the best results; significant attention has been directed toward describing and evaluating these governance structures.[22] However, research also needs to start at the level of the young child and family, to determine how changes within frontline systems can boost young children’s healthy development.

Research Questions and Gaps

In addition to helping develop the Workgroup’s conceptual framework, the Build Initiative has established an evaluation framework for examining systems-building. (The Build Initiative is a project of the Early Childhood Funders Collaborative, composed of national, regional and state foundations focusing upon early childhood, supporting state efforts to build comprehensive early childhood systems.) This framework recognizes that different evaluation methodologies are needed to examine different aspects of systems-building. In particular, it distinguishes between evaluation of system “components” and system “connections.”[23] The former generally involves program-evaluation methodologies, which have been the primary focus of early childhood development research. The latter involves evaluations of cross-system linkages, which have been

subject to very little empirical analysis. To this can be added voluntary, publicly available supports.

Evaluating cross-system linkages and voluntary supports both require a different focus than traditional program evaluation. They require examining cohorts of young children, often identified by place as well as service provision, their involvement with services, and their resulting trajectories of growth and development. These examinations could start with young children coming to the attention of a particular program or they could start from a universal event (birth) or population base (all young children in a certain neighborhood). Research questions regarding these connections include:

1. At what point did any service provider identify needs of the young child and family that fell outside of that provider's capacity to respond?
2. What did the provider do to help the young child and family to secure that response elsewhere, and were those actions successful?
3. When more than one service provider was involved, was their work aligned and coordinated and did it respond to multiple needs?
4. What strategies produced good connections across services, and what were the reasons for poor connections?
5. Did the presence of additional voluntary services and supports result in both greater use of those services and supports by otherwise disconnected families, and did these have a stabilizing or cohesive role in making he overall environment supportive of all young children and their families?
6. Ultimately, did the child start school healthier and better equipped for success as a result of an integrated response to his or her needs?[24]

Actual methodologies include action research, comparative case study review, and, as efforts move from the qualitative to the quantitative, content analysis and goal attainment scaling, including results mapping.[25]

Clearly, the Workgroup's conceptual framework makes theoretical sense for analyzing what young children need to succeed and what public policies can do to support them. Yet it remains a framework and not a theory of change, with testable assumptions.[26,27] It does not provide any

assessment of the relative importance of strengthening connections versus building strong individual programs versus creating greater economic security for families or more young child-friendly neighbourhoods. Depending upon the child, the community and the array of existing services, that assessment may produce different answers.

Clearly, better coordination across overwhelmed systems is unlikely to produce much gain. If services are accessible only to those with the persistence and resources to secure them, they may help individual children but not meet social needs as a whole. In short, integrated services at best are an answer to only some of the challenges that face young children and their families.

Conclusions and Implications for Parents, Services and Policy

The following research question should be added to those stated before and may well be the most important one to address:

- What did families identify as their young children's needs in the context of their hopes for their children, how were families involved in ensuring those needs were met, and to what extent did they feel their children received the help they needed?

No matter how well integrated, public programs cannot ensure the healthy development of vulnerable young children by taking actions without the involvement of or in spite of their families. Services and supports need to start where families are, not where systems would like them to be. One study of families involved in multiple systems found those families to be as frustrated by the lack of consistency of support within systems (as their case managers and workers frequently changed) as across them, and what they most needed often was not addressed by any system. Indeed, parents were generally more knowledgeable of what different systems provided than the workers who offered referrals.[28]

Moreover, there is a strong research base for a relationship-based approach that builds upon family strengths and goals and does not solely look to reduce deficits or meet needs. This approach is particularly noted in the family support, resiliency, and reciprocity literature.[29] Research, common sense and societal values all speak to young children needing and deserving consistency and continuity in their nurturing, supervision and protection. Public and professional services – in health, early learning, family support and special needs – should be coordinated and integrated to ensure they contribute to producing that consistency and continuity. The danger is to define the lack of coordination and integration as the cause for children's school unreadiness

and success and direct sole attention there, where there may be other, much more important gaps, policies or practices that need to be addressed, not the least of which is focusing upon opportunity and virtually all parents' hopes that their children succeed.

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Integrated Early Childhood Services in Canada: Evidence from the Better Beginnings, Better Futures (BBBF) and Toronto First Duty (TFD) Projects

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Introduction

Context for Early Childhood Service Integration in Canada

Integrated approaches to early childhood services have taken a variety of forms in Canada. Demonstration projects, such as Better Beginnings, Better Futures and Toronto First Duty have examined the implementation and effects of merging a wide range of services types at the community level. On a broader scale, a number of provinces are moving to more integrated systems of educare, for example, by folding governance for child care into their ministries of education.[1] However, service integration is not a goal in itself; it is a means to various ends. In fact, across service integration initiatives in Canada, integration not only has multiple forms, it also has multiple social aims such as overall child development, school readiness, prevention of later problems and promotion of healthy development. The aims may also include healthier parenting and work-family balance. In some cases, such as the Aboriginal Head Start program, community development is a collateral aim of supporting child development and parenting,[2,3] as is the promotion of equity and social justice through effective and culturally-competent programming and outreach to the underserved.

Canadian policy interest extends beyond targeted approaches and includes universal programs that integrate traditionally separate services such as education and child care, areas where program quality may suffer with split provision.[4] Quebec moved towards integrating early care and learning to support young children and parents beginning with new family policy in 1997 and the ensuing establishment of Centres de la petite enfance (CPE). CPEs serve children up to five years of age in non-profit centre-based and family child care programs with widespread, but not universal uptake. Benefits and limitations of the system have been addressed in a number of

research reports.[5] Ontario has integrated elements of care with universal education in its recently implemented full-day kindergarten program for all 4- and 5-year-olds, staffed by a teacher and an early childhood educator with integrated roles in the classroom.[6,7]

Despite the widespread and long-standing policy interest on early childhood service integration[8] and many initiatives beyond the well-researched Quebec example, the research has generally lagged behind the interest.[9,10] In Canada process evaluation of Aboriginal Head Start has emphasized the promise of integrated community approaches in bringing together services and community members, while limited empirical analysis has suggested possible benefits for children's readiness.[11] Although the research on the implementation and outcomes of in the Quebec system is extensive, it has not focused on the integration of services beyond the CPEs. To look more deeply at issues of integration, this report presents findings on two well-researched demonstration projects that brought together more comprehensive community programming with intensive research designs that include both process and outcome evaluation.

Research Context and Recent Research Results

The Better Beginnings, Better Futures Project

Better Beginnings, Better Futures (BBBF) is a large-scale, multi-year, longitudinal research-demonstration project designed to reduce children’s problems, promote healthy child development, and enhance family and community environments in eight economically disadvantaged communities in the province of Ontario, Canada.[12] The initial intervention was implemented from 1993 to 1997. Five project sites focused their programs on children from birth to age four and their families (“the younger child sites”), and three project sites on children 4- to 8-years-old and their families (“the older child sites”). One key principle of BBBF was “service integration” in order for children and their families to receive seamless support from the BBBF projects, schools and other services.

Process evaluation of collaboration and partnerships was based on extensive descriptive, ethnographic data (e.g., interviews, field notes) collected and analyzed by site researchers in the eight BBBF sites during the start-up phase from 1991-93,[13] the intervention phase from 1993-97,[14] and in a follow-up study in 2003.[15] Outcome evaluation was based on a broad range of measures collected during the four years of project involvement, and again several years later both in the BBBF project sites and also in demographically matched comparison sites to assess effects on the children, their families and the local neighbourhoods.[16]

Findings on partnerships revealed: (a) the benefits of partnerships, (b) the process of partnerships and (c) the challenges of partnerships. Benefits included increased levels of programming available to community residents, an increased visibility of the projects in their communities over time, joint programming with other agencies, increased funding for programs, changes in attitudes and practices of other service providers in the community, increased collaboration among partner agencies, and the development of new settings in the community designed to improve the well-being of children, parents, and families.[14,15] Process findings on partnerships included learning how to select partners, creating a shared vision for collaboration, developing an organizational structure that facilitated partnerships, the importance of clarifying roles of partners, using a consensus approach to decision-making, the need to decide who represents partner organizations in the BBBF project, and the importance of agency support and resources for the participation of partners.[14,15] Challenges for partnerships included learning how to collaborate, differing levels of agency commitment and support for partnerships, and developing trust and positive working relationships.[14,15]

Positive outcomes were found for BBBF children, their families and the local neighbourhood at the end of the four-year intervention period in both the younger and the older BBBF sites relative to comparison sites.[17] However, follow-up measures indicated positive BBBF outcomes in the older child sites but not in the younger child sites. The positive BBBF outcomes actually strengthened in the older child sites over time in measures collected when children were in Grades 3, 6 and 9.[16] Further, measures collected when these children were in Grade 12 indicated lasting positive BBBF outcomes for the children and their parents, and an economic analysis demonstrated a cost savings to the Ontario Government funders of more than $2 for each $1 originally invested in the project.[18] Data are currently being collected on the longitudinal samples, in both the 3 BBBF sites and the comparison sites, when the participants are age 25 to determine if the long-term outcomes at Grade 12 last into young adulthood. Results are expected by 2020, making this one of the longest Canadian longitudinal studies of an early child development program.

The Toronto First Duty Project

Toronto First Duty (TFD) began in 2001 as a demonstration project testing an ambitious model of service integration across early childhood programs of child care, kindergarten and family support in school-based hubs. Other services such as public health were also part of the service mix. The goal was to develop a universally-accessible service model that promotes the healthy development of children from conception through primary school, while at the same time

facilitating parents' work or study and offering support to their parenting roles. Knowledge mobilization for practice and policy change, as well as research and evaluation were built into the project. Formative feedback on implementation and intermediate outcomes was regularly given to the participating partners: a charitable foundation funding partner, municipal children's services, school boards, and community agencies. Regular reporting also went to professional groups and provincial policy makers. Phase 1 of TFD, with implementation of the model in five community sites, concluded in 2005.[19] Phase 2, covering the period 2006 to 2008,[20] focused on knowledge mobilization, policy change, and further development of the TFD model in one of the original five sites, Bruce/WoodGreen Early Learning Centre (BWELC). Phase 3 of TFD extended to 2011 with focused research on integrated staff teams and learning environments in full day early learning programs, and additional studies on integration of community services for children under four.

The Phase 1 research described the implementation process in terms of variations and adaptations of the model across the five communities, as well as common struggles and successes across the sites. Struggles included issues related to professional turf, missing nuts and bolts of space and funding, staffing and leadership turnover, and working without system support across sectors "siloed" at higher levels of government. Nevertheless the process evaluation also showed successes. Strong leadership and time to meet allowed staff teams to come together over time to improve program quality and delivery. In terms of the process of moving from separate to integrated service delivery, comparisons across the implementation period showed that progress was made in each of the sites on five dimensions of service integration (staff team, programming, access points, governance and parent involvement), as indexed by an Indicators of Change measure developed in the project[21] as well as on program quality improvement as assessed by the Early Childhood Environment Rating Scale-Revised, better known as ECERS-R.[22] Short-term positive effects were also found on children's social-emotional development on the Early Development Instrument[23] and on parents' engagement with school and learning, using comparisons with matched communities without TFD programs.[19] Dose-response analyses within the group of families using TFD, with various demographic controls, showed that more intense use (number of hours) also benefited children's physical health and well-being, language and cognitive development, and communication and general knowledge.[24] Despite the impact on children and families using TFD, there was little evidence of awareness of TFD programs in the communities surrounding them, in "person-on-the street" interviews and in surveys of parents who did not have young children.[19]

Further analyses in Phases 2 and 3 extended the findings on outcomes. For example in a small scale quasi-experimental comparison, integrated provision of care, education and family support in TFD appeared to reduce parental daily hassles in negotiating disconnected kindergarten and child care arrangement.[25] Importantly, the TFD project also contributed to both local policy development in several school boards and municipalities and to provincial policy in Ontario's Best Start and Full Day Early Learning Kindergarten educare initiatives.[26] The successful knowledge mobilization strategy was supported by the Atkinson Charitable Foundation and with the support of the Margaret and Wallace McCain Family Foundation[27] was extended to other provinces. Continuing efforts to improve ECE policy and services with integrative approaches in the maritime provinces are described in reports available on the Margaret and Wallace McCain Family Foundation website. The TFD research has also informed the policy discourse on integrated early years services in Australia.[28]

Conclusions

Process evaluations from both projects converge on factors underlying successful integration. Developing common goals and vision is a crucial step, involving community-level "conceptual integration"[29] to frame and guide the partnership activities. This means arranging time to understand, develop and maintain integration among front-line staff and community members. Ongoing monitoring, review and organizational learning were also important to successful integration in the communities studied. Strong local leadership was a key. In both projects, these strong "bottom-up principles were balanced against general "top-down design principles," such as bringing services into a more seamless system and increasing quality in programs such as child care or integrated care and kindergarten. In both cases, the models were adapted on the basis of local participation to fit the unique characteristics of each community.

Both projects also reported short-term positive outcomes for children and for parents. BBBF, with its broad community development strategy, also found some effects on community cohesion-type measures. The TFD project focused more on the service-parent connections and did not register in community awareness, beyond the participating families. BBBF also conducted longitudinal follow-ups of outcomes for children into Grade 12. Long-term positive effects were found for the children and parents who had participated in the sites with programming for 4- to 8-year-olds. These BBBF prevention outcomes factored into an economic analysis showing savings to the Ontario government as a 2:1 return on investment in these programs.

It is notable that BBBF found no mid- to long-term effects for children from sites focused on birth to 4 years of age. There are number of possible interpretations of why the programs for younger children did not the have lasting effects that the programs for older children had.[9] One is that the modest investment in support per child was not enough to reach a critical level of intensity for younger children, but in the case of older children, the investment was on top of the thousands invested in every child via the public school system, so that BBBF programming was “value added.” A related argument is that schools provide a platform for coordination of services and new supports, but there is no equivalent universal platform for effective and integrated service in the preschool period. The evidence from TFD points to the value of the “school as hub model” as one type of integrative platform for a range of preschool services ranging from quality child care to family supports.[30] The value of a platform for community delivery of integrated programming is also suggested in other research, including reports on Aboriginal Head Start in Canada,[2] on the evolution in UK Sure Start programs towards more integrated programming in Children’s Centres[31] and in Australian experience with "place-based" integration.[32]

Converging evidence from the BBBF and TFD demonstration projects shows the promise of community level partnerships and integration for improving the lives of families and outcomes for children. Putting the design principles into scaled up programs requires broad system level support with policy integration across, and within, different levels of government and service organizations.[33]

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