# II

# ロンドン大学教育大学院

11/11～13/2008

# Institute of Education (IoE) University of London

# 神戸大学大学院人間発達環境学研究科・ロンドン大学教育学院（IOE）第 2 回学術交流研究会「イギリスの子育て支援に学ぶ」

The 2nd International Academic Interchange Meeting between the Graduate School of Human Development and Environment, Kobe University and the Institute of Education, University of London: "What do we learn from the child and family support in the UK?"

## PROGRAMME

### 11th November 2008

14:00~15:15

Ms Mary Sawtell & Ms Helen Austerberry

「連合王国（イギリス）における親と妊娠中の親に対する地域支援 ―シュア・スタート・プログラムにおける家庭訪問施策の評価と今後の発展」

“Community support in the UK for parents and parents-to-be: an exploration of home-visiting schemes, the Sure Start Programme and innovative future developments”.

15:30~16:45

Ms Helen Austerberry & Ms Mary Sawtell

「10代の妊婦の健全さや若い親と子どもの健全さの改善 ―家庭と地域を基盤とした支援を中心とする連合王国（イギリス）流プログラムの評価結果から」

“Improving health outcomes for pregnant teenagers, young parents and their children: evidence from UK targeted programmes that provide home and community-based support”.

18:00~20:00

Joint Reception

### 12th November 2008

15:00~

Field work at the plant satellite ARCH

## 13th November 2008

10:00~10:20

寺村 ゆかの（神戸大学大学院人間発達環境学研究科教育研究補佐員・助産師）

「大学が運営する子育て支援サテライト施設においてドロップインとアウトリーチを組み合わせることの効果」

Yukano TERAMURA (Research & Teaching Assistant, Graduate School of Human Development & Environment, Kobe University / Midwife)

“Effect of the combination of drop-in service and out-reach service: An example of a university satellite for child and family support”

10:20~10:50

Comments from Ms Mary Sawtell and Ms Helen Austerberry

11:00~11:40

倉石 哲也（神戸大学大学院人間発達環境学研究科博士課程、武庫川女子大学 准教授）

こどもへの共感を高める親グループ・プログラムの開発・実践と評価

Tetsuya KURAISHI (Doctoral Student of Graduate School of Human Development & Environment, Kobe University / Associate Professor of Mukogawa Women’s University)

“Development, practice and effect of group-based parenting program for promoting parents' empathy for their children”

11:40~12:10

Comments from Ms Mary Sawtell and Ms Helen Austerberry

＜参加スタッフ院生の声＞

Mary さん、Helen さんは、11 日 12 時頃、神戸大学に到着され、応接室にて担当者と昼食を取り、講演準備に会場の大会議室に向かわれました。昼食の場では、飾り付けてあった折り紙を娘さんに持って帰られるなど興味を示していらっしゃいました。講演では、県や市の担当職員の方や、前月に行われた寺子屋師範塾の受講生、学生などたくさんの方が参加されました。一般への事前告知の機会が多く、他の学術ウィークスの講演に比べて一般の方の参加者が多かったのではないかと思います。講演後には、学術ウィークスの全体レセプションが開催され、ロンドン大学のお 2 人、担当者の他、西オーストラリア大学、オーフス大学、北京大学の方や、その担当者他、学生、教員などが参加しました。各研究分野だけでなく、お子様の話なども多く聞かれ、終始和やかでした。

12 日は、午後からのみのプログラムだったので、お２人は午前中には中華街などを観光されたようでした。あーちでのフィールドワークでは、以前の前年の学術交流のフィールドワークでもお世話になった利用者の方が通訳を引き受けてくださり、施設の紹介の後、日英での新生児・乳幼児保健指導や子育て支援制度についての議論が行われました。その後あーちの利用時間の終了を待って、日本文化紹介として、小山田さんによってお茶が振舞われました。その後、三宮に移動し、和雑貨などのお土産の買い物をして、ロンドン大がくの担当者での夕食会が行われました。

１３日は、午前中に神戸大学側の講演が行われ、お２人にコメンテーターをしていただきました。こちらも、１１日同様、多数の一般の方を含む参加者がありました。講演終了後に、応接室にて担当者と昼食を取った後、記念撮影をして全日程を終了しました。神戸大学を後にしたお２人はこのあと京都観光に行かれたようです。

私は今回、プログラムの作成などから全日程に参加しました。実際に始まるまでは、研究分野などのオフィシャルな情報がほとんどで、英語も入試以来と、とても緊張していました。しかし、実際に始まってみると、とても気さくに話しかけてくださったり、うまく表現できない説明を読み取ろうとしてくださいました。私自身も初日は久々の英語に戸惑ってしまい、なかなか積極的に話をできずにいましたが、２日目、３日目と慣れるにつれ、積極的に説明したり、伺ったりできるようになりました。研究内容では、制度論と実践研究などの違いもあり、知らなかった事ばかりで新鮮なことが多かったです。講演では一般の方が多く参加されていたのはよかったのですが、もっと学生など大学内からの参加者が集められたらよかったと思いました。私自身も、合同レセプションでしか他の分野の方などとのかかわりがなかったので、もっと多く参加できればよかったと反省しています。今回の参加で、参加者や協力者の方々、招聘大学の方々などたくさんの方と関わる事が出来、とても刺激になりました。これらは今後に積極的に活かしていきたいと思っています。

（教育科学論コース１年　宮地ゆき）

私は、2008 年の学術ウィークのうち、ロンドン大学教育大学院の部に参加しました。まず 11 月 11 日の講演会の前に、Mary さん Helen さんと昼食をご一緒しながらお話をしました。お二人ともとても朗らかな方で、緊張していた院生の私たちもリラックスすることができました。午後からは Mary さん Helen さんの公演が行われました。学術交流研究会のテーマが「イギリスの子育て支援に学ぶ」だったので、10 月末の寺子屋師範塾の受講生だった方の参加も多くいらっしゃいました。内容が子どもや親の地域支援に関するものだということもあり、色々な方の参加があったことはとてもよかったと思います。


翌々日 11 月 13 日は寺村さん倉石さんの講演が行われました。写真やデータがとても分かりやすく、Mary さん Helen さんからのコメントも興味深かったです。その後、キャンパスや大学周辺を案内しながら Mary さん Helen さんを駅までお連れしました。お忙しい中来日していただいた Mary さんと Helen さんでしたが、日本や神戸での数日間を楽しんでいただけたのなら幸いです。少しの間でしたが学術ウィークにかかわる事ができ、私もとてもいい経験になりました。ありがとうございます。

（子ども発達論コース２年　佐竹桃子）

今回は，急なことでしたが，フィールドワークとしてせっかく日本に来ていただいたお二人のために，お茶をもてなしました。場所の都合上ある程度簡略化したお点前になり，また，私自身まだまだ未熟なお点前でしたが，お二人に喜んでいただけたので，とてもよかったです。

あーちの見学とお茶のあと，三宮を散策しました。和風雑貨のお店などをまわり、お土産を一緒に検討しました。その後の夕食会では，辞書に頼りながらでしたが，食材の説明，研究についてなどをお話しました。特に和食には，お二人がなかなか食べる機会のない食材もあったので，食文化の違いを感じながら，楽しく会食ができました。

今後も外国から来た方たちにもてなす機会があるときには，今回のフィールドワークの経験を活かしていきたいと思います。

（生活環境論コース２年　小山田祐太）

# Community Support in the UK for Parents and Parents to be

Mary Sawtell and Helen Austerberry
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## Introduction

In this paper we will be covering the following: why support is important; approaches to providing community support in the UK; current and future UK services; some examples of our research in this area. In particular we will describe about one piece of research that we have done evaluating a breast feeding support programme.

## Why support is important?

Research shows that a poor quality early childhood is strongly linked with an increased risk of poor outcomes for children. For example if a child grows up in a household with a very low income we know there is an increased risk of: injury; child abuse and neglect; sudden infant death; respiratory infections. Research into the effects of the quality of early parenting shows strong links between poor parenting with a range of negative outcomes for children such as: behaviour problems; school drop out and poor performance; drug and alcohol abuse; poor physical and mental health in adulthood.

The subject of the health of mothers is an important illustrator of why support is so important. Good health is obviously important for women themselves but it is also very important for the well-being of the whole family. For example in terms of mental health and well-being, rates of antenatal and postnatal depression are high in the UK and we know that outcomes for children are worse when their mothers are depressed. For example rates of both forms of depression are about 10 -15% in UK mothers. The negative impact on children whose mothers have postnatal depression is well known - however there is some new work showing that the children of women with persistent (long lasting) antenatal depression are 50% more likely to show developmental delay than those whose mothers are not depressed in pregnancy (Deave ,Heron et al, 2008).

A poor relationship between parents - including where there is domestic violence - is also damaging to children and is therefore another example of risk to child well-being.

The UK is a highly divided society; we have a huge, wide gap (bigger than most other countries in Europe) between the richest and the poorest families in our country. We are a society with many pressing social concerns. For example:

> 1 in 3 children in the UK currently live in poverty
>
> We have the highest teenage pregnancy rate in Europe (Wiggins, Oakley et al, 2005)

> We have other social problems that are growing - for example family homelessness – with children growing up in very poor quality temporary housing when families of four or more share one small room (Sawtell, 2002).

As the most vulnerable members of society, the impact of this divide falls particularly heavily on young children. Evidence suggests that good quality support, offered early in life, enhances child and family health and wellbeing (Wiggins, Oakley et al 2004).

**Approaches to providing community support in the UK**

In order to try and address the problems in our society that I have been describing to you, the UK Government has introduced a range of policies and legislation. Particularly relevant is the policy document Every Child Matters. Published in (2003) – Every Child Matters launched a programme of change to improve outcomes for every child. The outcomes listed in Every Child Matters were that every child should:

- Be healthy
- Be Safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

The Children Act was made law by the UK Government in (2004) and provided the legislative framework to support Every Child Matters. Another key publication was the report by Lord Laming. This was the report of the independent inquiry into the death of Victoria Climbie published in 2003. I will describe a bit more about this later.

The key aim of current UK Government policy in this field is to develop high quality services for all children and families and specifically to improve services for the most disadvantaged in order to reduce the gap between advantaged and disadvantaged.

There is a range of key characteristics that are considered important for community services in the UK currently. First of all the expectation is that the approach of services is holistic – by this I mean that the child is seen as a whole person. This contrasts with a traditional medical approach where the approach is to consider a person in terms of the different parts of their body or systems.

Secondly services should be joined up – this was a key recommendation from the Victoria Climibié enquiry. To explain, Victoria Climibié was a young girl who was abused and killed by her guardians in 2000. An extensive enquiry into her death found she had been in contact with numerous different services from hospital departments to social services prior to her death. As a result of a lack of co-ordination between these services no one realised how at risk she was before it was too late. The main services that are expected to be working more closely together are health, education, social care and employment support services. This joining up of services needs to happen at top tier level – so at highest management level as well as at the point of delivery.

Next the focus for community provision is firstly protection of the child, and then the focus is prevention followed by early intervention. Prevention and early detection services for new public health priorities such as the rising levels of obesity in children in the UK are becoming increasingly important.

Fourthly Services should be child and family centred –for example they should be as convenient as possible to use, suiting the family rather than the service provider. They should be flexible using a combination of approaches including outreach in non health settings, mobile facilities like buses that drive around rural areas and parents should be seen as partners in deciding what services are developed in their area.

There is now a strong focus on what's called positive parenting- i.e. the belief that parents can and should be taught how to be better parents. I will say a little more about this shortly.

Finally services will be characterised by 'progressive universalism'. This is a new term being used to describe approaches to service delivery in the UK. In the past we described 'universal services' – where the service is for everyone and 'targeted services' – where the service is targeted at a particular group who needs it most. Progressive universalism is a universal service but it gives a continuum of support according to need, so everyone is offered a core service but those with the greatest need get more in addition. For anyone who is interested they might like to look up something called the Child Health Promotion programme which has just been launched in the UK. This programme is going to be a key part of service planning and delivery in the future and is a good example of this idea of progressive universalism (Shribna & Billingham 2008).

To just add to what I said about positive parenting there is now a lot of government attention on teaching parents how to be better at parenting– so making something that has in the past been a private matter a public one. Early evidence suggest that parenting support can be effective as part of a package of support measures. In particular the focus is on supporting a better infant/parent relationship through improved attachment between both mothers and their children and fathers and their children too. There is also a focus on helping parents meet their own goals, including becoming economically independent.

So, I have just described a list of things that are currently considered central to UK community services for children. To summarise - this list included that services are holistic and flexible, that they are child centred and that that teaching positive parenting becomes a focus. I would like to add one more and this is that systems for monitoring and evaluation of services at a local level are made a priority from the start. This allows both the uptake of the service and matters such as user satisfaction to be measured. This allows for development of the service to be ongoing in order to make it as effective as possible. In our research at SSRU it is a consistent finding from our evaluations that prioritising monitoring and evaluation of services in this way at a local level is not something that we are good at in the UK – maybe it is something that you are better at in Japan.

**Current and future UK services**

I am going to describe community services in terms of these three groups: health visitors, general practitioners, midwives; The Sure Start programme; Sure Start Children's Centres.

Health visitors, general practitioners and midwives have historically been the backbone of community child and family health services. General practitioners are doctors while health visitors and midwives are nurses with additional training. Health visitors have been in existence for nearly 150 years and have been the main co-ordinators and providers of community primary health services for children organising immunisations, developmental checks, parenting advice and support to mothers, as well as prevention and early detection of child abuse. In the past these services have been considered universal – however both health visiting and midwifery are now becoming more of a progressive service offering a core service to all families but particularly in terms of health visiting a more intensive one to those who are at risk of disadvantage. Historically health visitors have worked mainly in people's homes, they continue to do this but also often now providing services in Sure Start Children's centres which I am about to describe. I would just like to say that I am a health visitor myself – this was my work for 10 years before I became a researcher. I believe that you have public health nurses in Japan – I would be really interested to know how similar or different the two roles are.

Some of you may have heard of the Sure Start Programme in the UK. It is based on an American programme called Head Start which started in the 1960s and was found to have some long term success in improving educational outcomes and reducing crime in children growing up in disadvantaged circumstances. The Sure Start programme was set up in the UK in 1999 as a pilot or a trial programme. A large scale evaluation looking at its progress and impact has been running alongside the Sure Start programme for the first eight years of its life.

The Sure Start programme combined, at local level, support in the home with support in special Sure Start Centres. These Sure Start centres have now taken the title Sure Start Children's Centres. Early findings from the Sure Start evaluation (in 2005) were considered disappointing – with outcomes for children being worse in the more disadvantaged groups than in similar populations without a Sure Start Programme. More recent findings in 2008 appear more positive revealing positive effects across the target population, showing that parents of three year old children showed more positive parenting skills and provided a better home learning environment, that these children showed better social development and higher levels of positive behaviour and independence, and that families took more advantage of the range of support services available than in areas where Sure Start was not operating (see http://www.surestart.gov.uk/ for more detail on Sure Start and the evaluation).

So what we have today is a Government Strategy that by the year 2010 there will be a Sure Start Children's Centre in every community for every 800 under 5 year olds. There will be a total of 3,500 centres across the country. Areas where the population has a lower income will receive more funding than areas where the population is wealthier.

Holistic health and well-being services will be offered under one roof in what we call a 'one stop shop', but there will also be outreach work in other places in the area.

Sure Start has been a well resourced programme; it's been very high profile and a real government priority with nearly one and a half billion pounds spent on it in the first five years (2.5 billion dollars). I would like to describe for you what a typical Sure Start Children's Centres looks like. I am going to describe what you would see if you visited one in a poor area of the UK.

It is very likely that the centre would be a new purpose built building. The group working on the design would have included architects, service managers, local professionals such as midwives and health visitors, and local parents. The resulting building is likely to be very child friendly – for example inside it will be very brightly coloured and much of the interior will have been considered through the eyes of a child. It will be a large building with space to house a whole range of professionals from education and health and social care. There may well be a nursery on the same site.

The kind of people who would be working there are health visitors and midwives, teachers and social workers, physiotherapists and massage practitioners, speech therapists, dieticians and counsellors. There will also be employment advisors to advise parents on how to get back into work. Members of the community will also be working there both in a paid and a voluntary capacity. The sorts of services they will be offering are the usual child health type services and also a nursery but also a range of other things according to what local people say they need. For example there may be baby massage, parenting programmes, cooking workshops for parents and counselling sessions for parents whose relationship is in difficulties. There will also be breast feeding support – an example of which is going to be described in a minute by Helen. Of course there will always be some parents who won't use the centre and in these cases staff will visit in the home – but the hope is that even these parents will in time feel confident enough to take up the services on offer. All these services are offered free or at very low cost.

As you can see the idea is that you get a joined up service – what we call in the UK a seamless service. At its most fundamental it is hoped that this will avoid what happened with Victoria Climibié who fell through the gaps between services.

**Examples of our research**

We have carried out a number of studies in this field – particularly relevant ones are:

> Social Support and Family Health Study (Sawtell & Jones 2002: Wiggins and Oakley 2004; Austerberry and Wiggins 2004)
>
> Sure Start Kilburn Priory - Breastfeeding Peer Support Programme (Austerberry 2006)
>
> Becoming a Mother Study (2007- ongoing - no publications as yet)

We are now going to describe the Breast feeding Peer Support programme which was part of a Sure Start programme in an area of London called Kilburn Priory.

## Case Study

### Sure Start Kilburn Priory, London
### Breastfeeding Peer Support Programme Evaluation

*Background*
To provide a context, Kilburn Priory, like lots of parts of inner London, is a mixed area with a large minority ethnic population. There are pockets of expensive housing next door to state-owned housing estates. Like all early Sure Start Areas, it has a high level of deprivation overall, despite these wealthy pockets.

*Aims*
The aims of the Breastfeeding Peer Support Programme were: to raise the profile of breastfeeding locally; and to offer support to local women to help them breastfeed.

*Content of the Peer Support Programme*
Each year Sure Start maternity staff recruit, train and support a team of local women as volunteer peer supporters to help local women breastfeed. Peer supporters work in formal National Health Service settings, namely the postnatal ward of a local hospital, local antenatal clinics and child health clinics. Peer supporters also work in informal settings, such as in mother's homes, and at the Baby Café, which his a drop-in support group for breastfeeding mothers

*Profile of peer supporters*
About 12 volunteers were trained per year between 2003 and 2006, by a Sure Start health visitor at the local Sure Start Children's centre. Training was followed up by support meetings.

The peer supporters had a wide ethnic profile – Black British and Black Afro-Caribbean; White British; White European; South Asian; Middle Eastern. There was one Japanese woman. Between them they spoke 16 languages (including English and Japanese), though about half had moved on by the time of the evaluation.

The peer supporters in our study ranged from 23 to 40 years. Their youngest child ranged from 10 months to 10 years. Many had been supported themselves by the programme.

*The Evaluation*
The evaluation of Kilburn Priory Breastfeeding Peer Support Programme[1], which was carried out at the Institute of Education, was a qualitative study drawing on interview

[1] **Austerberry H** (2006) *Evaluation of Sure Start Kilburn Priory Breastfeeding Support Work: Report of findings.* Social Science Research Unit, Institute of Education, University of London

data with peer supporters, breastfeeding mothers, Sure Start breastfeeding support staff and local maternity service staff.

*Evaluation findings*
Interviews carried out during the evaluation with mothers, peer supporters and Sure Start staff suggested that: peer supporters gained training and experience through volunteering. They grew in self-confidence; some secured jobs as a result. The ethos of giving and receiving strengthened the local community. Significant staff time was needed to build the team and keep peer supporters involved, especially when there were a high proportion of Minority Ethnic women in the team. A 'buddy' system between new peer supporters and experienced ones helped new peer supporters settle in and stay motivated.

Findings were that peer support worked well with mothers. Mothers valued the service for: emotional and practical support; solidarity; and friendship.

We finish with a quote from a peer supporter who had been helped to breastfeed herself by the programme:

> *"There's a wealth of written information, when you're a new mum you don't have the time or energy to find out…It was so nice to not to have to go through the whole process of going and booking a doctor's appointment and going in and sitting down and saying, 'I have a problem', but phoning up [a peer supporter]. It was mother-to-mother support that made a difference and it was something so simple."*

**References**

Austerberry H (2006) *Evaluation of Sure Start Kilburn Priory Breastfeeding Support Work: Report of findings.* Social Science Research Unit, Institute of Education, University of London

Austerberry H, Wiggins M, Turner H, Oakley A (2004), Evaluating social support and health visiting. *Community Practitioner* 77: 460–464.

Deave T, Heron J, Evans J, Emond A. The impact of maternal depression in pregnancy on early child development. *BJOG* 2008;115:1043-1051.

http://www.everychildmatters.gov.uk/

Sawtell M. *Lives on Hold: homeless families in temporary accommodation*. Maternity Alliance 2002.

Sawtell M & Jones C. Time to Listen: an account of the role of 'support' health visitors. *Community Practitioner* 2002: 75: 50-52.

Shribna S, Billingham K (2008) Child Health Promotion Programme. DCSF and DH. TSO:London

Wiggins M, Oakley A, Sawtell M, Austerberry H, et al (2005), *Teenage Parenthood and Social Exclusion: A multi-method study*. London: Social Science Research Unit Report, Institute of Education, University of London.

Wiggins, M., Oakley, A., Roberts, I., Turner, H., Rajan, L., Austerberry, H. et al. (2004), The Social Support and Family Health Study: a randomised controlled trial and economic evaluation of two alternative forms of postnatal support for mothers living in disadvantaged inner city areas. *Health Technology Assessment*. 8(32) 134 pages

## Improving health outcomes for pregnant teenagers, young parents and their children: evidence from UK targeted programmes that provide home- and community-based support.

Helen Austerberry and Mary Sawtell
Social Science Research Unit, Institute of Education, University of London

The second presentation that focused on evidence from the UK to support new families looked at home-based and community-based support for pregnant teenagers, young parents and their children.

The high teenage conception rate found in Britain compared with most other developed countries, coupled with the poverty and disadvantage that is associated with young parenthood, helps explain why this group has been a focus of UK Government policy for almost a decade.

The following table shows international comparisons of teenage birth rates in 1994 and 2002.

**Teenage birth rates**

| Rate per 1000 women aged 15 – 19 years | | |
|---|---|---|
| | **1994*** | **2002**** |
| **Japan** | 4 | 6 |
| **European Union average** | 15 | 14 |
| **UK** | 33 | 27 |
| **USA** | 54 | 46 |

* United Nations Population Division
** National Statistics Agencies

We can see that in 1994 the teenage birth rate was over eight times higher in the UK than it was in Japan, which had the lowest rate amongst developed countries. By 2002 the ratio had decreased to about four-and-a-half times. So the rate in the UK is relatively high but it is decreasing. Whereas in Japan (although still very low compared with other countries) it increased by 50% over this period.

***Policy context***
The UK Teenage Pregnancy Strategy (2000 – 2010) is a ten-year government policy with two main aims - to reduce:

- the teenage conception rate;
- and the risk of long-term social exclusion amongst young families.

The second aim of the Teenage Pregnancy Strategy– which we shall be focusing on here – concerns the provision of support to pregnant teenagers, young parents and their children. A specific target is to increase the proportion of teenage parents in education, training or employment to 60% by 2010.

We present findings from evaluations of three UK government initiatives targeted at pregnant and parenting young people that form part of this strategy.

We shall focus particularly on national programmes that we have evaluated at the Institute of Education, University of London. These are: the Sure Start Plus programme, which offered a holistic support package to pregnant teenagers and young parents; and aspects of the Teenage Health Demonstration Site programme concerning support to prevent second conceptions amongst teenage mothers. We also discuss a health-led parenting programme targeted at first-time teenage parents, the Family Nurse Partnership, which is in its early stages of implementation. We explore their key characteristics, and barriers and aids to their success.

***Sure Start Plus programme***

As part of the Teenage Pregnancy Strategy, the Sure Start Plus programme aimed to reduce the risk of long term social exclusion associated with teenage pregnancy through co-ordinated support to pregnant teenagers and teenage parents.

The pilot programme, funded by the Department of Health and the Department for Education and Skills, began in April 2001 and ran until April 2006. Our evaluation at the Institute of Education began in January 2002 and ended in December 2004[1]. It utilised a mixed-methods approach and had four components: a service delivery study; an evaluation of impact using a matched case control study; an analysis of joined-up policy and practice; and an economic commentary on the cost of the programme. Data was collected through interviews and surveys of young people, programme staff and related professionals.

The programme was based in 35 local authorities in England, in areas of high deprivation with high conception rates. These were mainly in inner areas of London and other large cities, which is where the highest rates of deprivation are found in the UK. Rural areas in England tend to be more affluent, which appears to be the opposite picture to that found in Japan.

The national Government expectations of the pilot were that there should be:

- One-to-one support from a lead professional (one professional to co-ordinate the package of care)
- Innovation and local variation in order to learn (to use the pilot programme as an opportunity to try out new ways of doing things – and to follow local need rather than a national template)
- Support for pilot sites through local strategic partnerships (these were committees made up of managers in health, education and youth services and from the Sure Start programme, which was discussed in the previous presentation)

*The aims of Sure Start Plus*

The aims of Sure Start Plus were fourfold. They were to:

[1] **Wiggins M, Rosato M, Austerberry H, Sawtell M, et al** (2005), *Sure Start Plus National Evaluation: Final Report*. Social Science Research Unit, Institute of Education, University of London. 110 pages.

- Improve health
    - early contact with maternity services; smoking cessation
- Improve learning
    - participation in education; gain basic (or higher) qualifications
- Strengthen families and communities
    - increase involvement of family, partner or father of the child
- Improve social & emotional wellbeing
    - better identification and support around postnatal depression

*How did Sure Start Plus look in practice?*
In practice the Sure Start Plus Programme was diverse; this characteristic arose from sites being given freedom to innovate to best suit their locality. There were various models of programme structure in terms of the services they offered and the ways in which they were delivered. For example, they were housed in different sectors, including health authorities, education and youth advice services, and the voluntary/non-profit sector. There was evidence of strong local joined-up working (for instance between staff who helped young women re-engage in education, Sure Start Plus advisers and between specialist teenage pregnancy midwives. The way services were delivered varied in terms of range and ethos. Some local programmes targeted fewer young women in depth, whereas others aimed to reach as many as possible; some emphasised the needs expressed by service users, whereas others emphasised Sure Start Plus targets, like smoking cessation). The range of expenditure varied between local sites, from 37,300 JPY to 130,500 JPY per teenage conception.

*Content of services*
Despite the diversity, all local pilots provided as standard a holistic package of care, which included one-to-one advice and support with: housing, health care, parenting skills, re-engaging with education, childcare

Personal advisers saw young women in their homes, in cafes, or at local projects. They worked by appointment and through drop-ins. They befriended women, counselled them, helped build their confidence, and helped negotiate family relationships. They also helped in practical ways, around access to education, housing or benefits. They worked in an active way, chasing up young women who were in danger of losing touch with the programme. Most had a caseload of about fifty young women.

The programme also delivered group work with teenagers. Groups were mainly informal support groups, antenatal or parenting skills classes, and mother and baby groups. Often advisers would encourage young women to start coming to a group, if they were nervous or shy, by driving them there or accompanying them.

Additional projects that were developed by local pilots were: training modules for professionals (about young parents' needs or about working in youth- friendly and accessible ways); childcare projects; skill-based training; housing associations; and specialist fathers' work.

*How was Sure Start Plus received by young people?*
Young people found the service to be accessible and acceptable. They valued the relationship with their adviser. The only complaint was that contact too short term.

Originally the UK Departments of Health and Education envisaged that the Sure Start Plus programme would provide support to families up to a child reaching four years. In practice sites were not resourced to provide support beyond the child's first birthday.

Here are some quotes from young women we interviewed.

> *"[The Sure Start Plus adviser] was one of those people you could make friends with straight away. She's a warm lovely person…I just throw it all at her! She does help you with [any problem]."* Young mother aged 17.

> *"I liked not just support – you get trips, [Sure Start Plus] organise parents groups. They contact people for you – education, housing, childcare. So they help organise many things. They ask what you need of them and then try and organise what you want."* Pregnant young woman aged 17

*How was Sure Start Plus received by staff?*
Staff thought that the programme was an effective and appropriate way to be working with this client group. Professionals from partner agencies (specialists in maternity services, education services, careers advice services, youth service, supported housing services) saw Sure Start Plus as having improved local support across a range of issues for teenage parents. There was evidence of strong local joined-up working between these agencies and the local Sure Start Plus team of workers.

*Has Sure Start Plus made a difference?*
What did we find from our evaluation of Sure Start Plus? Was the programme successful in reaching pregnant teenagers and young parents and helping them in terms of their health, wellbeing and education?

When we made statistical comparisons with similar areas without Sure Start Plus we were able to show success in providing crisis support to young women in Sure Start Plus areas: decisions about pregnancy outcome; emotional support; relationships with families; housing; and domestic violence.

In terms of education, more young women under 16 years (compulsory school age) were returning to education in Sure Start Plus areas than comparison areas. There was increased participation in education or training for young women aged 16 and over when advisers were based in the education sector.

There was little global impact on reducing smoking and increasing breastfeeding, which were key health goals; however, there were examples of good work in these areas.

*Sarah's story – an example of help with returning to education*

One 16-year-old woman, Sarah, was planning to gain qualifications in order to become a midwife. When she found out she was pregnant she thought her future was over. She was getting on badly with her parents so was living away from her family in supported housing, where she had met her partner. He was happy when she first became pregnant but as time went on her relationship with him deteriorated. She

struggled to cope with pregnancy and a turbulent relationship and stopped going to school. She was referred to a Sure Start Plus adviser by a specialist young woman's midwife at the local hospital.

Before she could think about returning to school, the advisor first helped with:

- Accommodation – found her supported housing that would accept children
- Financial difficulties – she was in debt and unsure about entitlement to state benefits
- Parental relationship – they met her parents together to help improve relations

…then (once her life was less chaotic) the adviser helped with:

- Sarah's education plan to reach her midwifery goal – the Sure Start Plus adviser worked with the local education / career advice agency and she gained secondary school qualifications to enable her to start a paramedic course at college
- Childcare – the adviser helped her access a good nursery and a student mother's grant for childcare

*Young fathers*

Programmes found it challenging to engage fathers at first, partly because they did not make this work a priority, whereas young mothers were at the heart of he programme throughout. Examples of innovative work with fathers emerged later on. One example is given below, from Nottingham, a city in the English Midlands.

*Case study: work with young fathers - at Nottingham Sure Start Plus*[2]

Nottingham Sure Start Plus had dedicated male father's support workers in their team. They held residential weekends with young fathers and their partners to plan services, finding that young fathers would not attend single-sex events. Over the course of a weekend they would hold male-only groups in order that young men felt safe to explore their fears and feelings.

Services that were set up as a result of what young men ask for in planning sessions included support work with fathers and couples. This work: explored roles and responsibilities of young fathers; challenged stereotypes about them; examined relationships with partners and extended families; looked at managing the anger that young men frequently expressed; and developed advocacy services around access to children. Development work with other agencies highlighted the support needs of young fathers.

*Summary of the findings from the Sure Start Plus Evaluation*

Having a dedicated lead professional, providing holistic support, was valued by young people and professionals. Sure Start Plus was successful in providing crisis support and helped to lay foundations for future positive development

*Recommendations from the evaluation*

[2] **Sawtell M, Wiggins M, Austerberry H, Rosato M, Oliver S** (2005) *Reaching out to pregnant teenagers and teenage parents. Innovative practice from Sure Start Plus programmes.* London: Social Science Research Unit, Institute of Education, University of London. 35 pages. ISBN: 0955048710

The evaluation made recommendations for how new integrated children and young people's services throughout England should provide support for pregnant teenagers and young parents in the future.

Children and young people's services should fund personal support workers for teenage parents, who would have a holistic role, and work in depth and longer-term with most vulnerable young people. Advisers should have small caseloads of 25 to 50 young people, with different advisers for young women and men.

A co-ordinator should manage the support service and keep its profile high within children and young people's services. There should be a team of specialist provision for pregnant teenagers and young parents, support for pregnancy options, specialist teenage pregnancy midwives and support for breastfeeding. Local needs assessment should be carried out for services for young parents.

***Targeted Health-led Parenting Programme - the Family Nurse Partnership***

The second UK programme which we outline here is the Family-Nurse Partnership, which is currently being piloted in England. It is a nurse home-visiting programme based closely on a successful US model that is targeted a at first-time teenage parents and their children. It aims to improve health, wellbeing and self-sufficiency, through the formation of a strong therapeutic bond between the mother and nurse.

Evaluation of its early implementation by a team at Birkbeck College, University of London[3], led by Professor Jacqueline Barnes, has found that enrolment rates were high. Most parents had a high regard for their Family Nurses and valued the learning aspects of the programme, although attrition rates in most areas were higher than the target. Family Nurses found benefits to their role and working methods despite the work being emotionally and professionally demanding. High quality supervision and organisational support was seen to be key to successful delivery.

***Teenage Health Demonstration Site programme - preventing second conceptions***

We finish by briefly describing an aspect of the Teenage Health Demonstration Site programme[4]. This programme aims to demonstrate innovative approaches to delivering health and wellbeing services to young people in non-traditional settings. As a result of scoping work additional staff have been employed in programme areas to provide intensive one-to-one contraceptive support to all young women pre- and post- maternity or termination of pregnancy, in outreach and domiciliary settings. Early indications are that services work best when they are both intensive and flexible. We present a case study within one site.

[3] **Barnes J, et al.** (2008) *Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England. Pregnancy and the post partum period*. Institute for the Study of the Children, Families and Social Issues, Birkbeck, University of London

[4] **Austerberry H, Sawtell M, Ingold A, Wiggins M, Arai L, Strange V** (2008) *Evaluation of the Teenage Health Demonstration Programme: 1st Annual Report 2007*. London: Social Science Research Unit, Institute of Education, University of London. 76 pages

*Case Study - Antenatal and post-birth support in Bolton Teenage Health Demonstration Site*

Bolton, a former cotton-producing town near Manchester in the north of England, has developed a new service in the past two years to prevent unwanted second conceptions amongst teenage parents. The sexual health service has employed a 'second conceptions' nurse, who specialises in contraception and young people's health. She works in partnership with maternity services and health visitors. The universal midwifery service refers all under-18 young women, with consent, at booking. She offers the women a home visit at 30-weeks, where she provides a contraceptive assessment and plan which is placed in the maternity records. The maternity services notify the specialist nurse of each birth. She then offers a post-natal home visit before day 21 where we gives the woman a prescription for contraceptives or signposted to support services. Long acting reversible contraception is promoted. At a ten-week follow-up ongoing support offered, via a young people's health centre, as well as housing and other support services. Staff feel that good liaison with the midwife and health visitor is essential. A pre-day 21 visit to the new mother is key, as is continued liaison with health visitors through the early years of the baby's life, to alert the second conceptions nurse if the mother stops contraception.

***Conclusion***

Many of the young parents who access UK support programmes have complex needs. Their backgrounds are characterised by poverty, disaffection with school and emotional abuse or neglect. Pregnancy and parenthood often throw their lives into turmoil, and the difficulties found in their backgrounds are often compounded by lack of family support, poverty, homelessness and social isolation. Evidence from programmes such as these, when looked at together with further promising approaches developed in other counties to support teenage parents, suggests that intensive, holistic interventions in pregnancy and the early years targeted at vulnerable groups can be cost-effective in the long-term.[5]

[5] **Barnes J, et al.** (2008) *Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England. Pregnancy and the post partum period*. Institute for the Study of the Children, Families and Social Issues, Birkbeck, University of London

# Meanings of the Combination of Drop-in and Outreach Services: an analysis of the family support offered by a university satellite

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## Introduction

Our school began practice for child and family support in September 2005 as one of our social contributions at a satellite plant, which used to be a government office building. We have since been offering Drop-in Service to the residents bringing up babies, toddlers and/or young children in order for them to get empowered as parents, which is expected to prevent their strains anxieties, and/or difficulties concerning child rearing (Ito 2008). Actually, many families have come to the satellite, getting to know each other and exchanging information about child raring, child development, talking with our consultation staff and so on; for instance, in the fiscal year of 2007, the number of residents who consumed this service amounted to 19,102 (10,054children, 9,048 parents, open days 244).

However, the author had noticed, through her own professional experience of public home-visiting service as a midwife and her academic investigation (Teramura 2004), that pretty many women in the postpartum period are in need of some kinds of support, because they are busy caring their babies, easily tired out and also unable to go out and enjoy themselves to be isolated from the neighborhood. On the basis of this fact, the author herself did a trial service as an outreach worker of the satellite in cooperation with a local maternity clinic, and analyzed its effects (Teramura 2007, Teramura & Ito 2008). Such service being proved to support effectively the empowerment process from dependency to independency of the subjects, especially of the isolated ones, we decided to start a full-scale service of the satellite as Perinatal Outreach Service; we employed two midwives and they began the service in October 2007 both at the clinic and at the satellite. In this report, the outlines of our Drop-in and Perinatal Outreach Services will be shown first, and then the meanings of the combination of the existing Drop-in Service and this new service will be discussed with our future challenges.

## Outline of Drop-in Service

This service is open to any local family from Tuesday to Saturday (from 10:30 a.m. to 4:30 p.m. each day). Parents and their children try the service, and if they would like to continue to consume it, they are required to apply for the membership. They spend the time in their own ways; parents talk with one another, and watch their children play with the toys and so on at the drop-in space. Spaces for lactation and changes diapers

are available, and they can also enjoy lunchtime, which they can enjoy for many hours if they want. Every day, consultation staff stands by, always being prepared to talk with the parents in need, and many parents easily approach the staff.

**Outline of Perinatal Outreach Service**

Two outreach workers, midwives go to a local maternity clinic, and they join the classes held there for antenatal and postnatal women and their partners. They introduce themselves to the participants, and tell them they are always welcome to the services and/or programs including Drop-in Service offered by the satellite. The workers talk with the women face-to-face at the clinic, face-to-face or on the phone at the satellite or via e-mail according to their choice. Home visits are also offered in response to the women's requests. The workers also accompany the women to any local resources such as public child centers, mothers' social clubs, day nurseries, drop-in centers including our satellite, and so on, right when they would like. The outreach workers write down in the prescribed form the detailed contents of the consultations at the clinic, at the satellite or at the homes of the subjects.

**Analysis of Subcategories of Perinatal Outreach Service**

The number of each subcategory in the service offered to the prerinatal women by our outreach workers was counted separately by period of childbirth, and the result is shown in Table 1 below. It can be strongly said that the women in the antenatal period do not need so much support by our workers, and that the most needed is the consultations in the postnatal period at the outreaching place, i.e. at the clinic, followed by those at the satellite plant. Home visiting or accompanying to some sorts of resources including our plant was not needed so much by these women.

**Table 1 Subcategories of Perinatal Outreach Service and their Distribution in Number**

| | Consultation at the Clinic | Consultation at the Satellite | Consultation via E-mail | Accompanying to Resources | Home Visiting | TOTAL |
|---|---|---|---|---|---|---|
| Antenatal | 11 | 6 | 1 | 2 | 1 | 21 |
| Postnatal | 57 | 28 | 8 | 1 | 8 | 102 |
| TOTAL | 68 | 34 | 9 | 3 | 9 | 123 |

＊Data analyzed is from Oct 2007 to April 2008

**Analysis of Child Age Difference of Enrollees between by Outreach and by Non-outreach**

As stated above, residents who would like to consume our Drop-in Service are required to apply for membership. The application form contains the dates of enrollment and childbirth as well as their names. Then we verified these enrollees with the listed information of clients to whom our outreach workers made approaches or who made some use of the services offered by them. As a result, the total number of parent-child pairs enrolled from Oct. 2007 to April 2008 was 199. Out of them, 38 pairs enrolled themselves through Perinatal Outreach Service, and the other 191 pairs did through Non-outreach beginning.

We compared the age difference of the enrolled children according to the beginnings of Outreach or Non-outreach. Figure 1 shows the frequency distributions of the two groups. The vertical axis is the frequency of the pairs of enrollees, and the horizontal one is the age of the enrolled children in months. As this figure indicates, the distribution of the enrolled ages in months by Outreach (M=5.53/SD=3.62/N=38) seems to be much earlier than those by Non-outreach (M=20.38/SD=19.85/N=161), and the T-test was conducted to show a significant difference between the two groups (t=4.59/df=197/ p<.01). Therefore, it can be clearly said that the age of the children enrolled through our Outreach Service was significantly younger (about 5 months old) than those who have nothing to do with that service (about 1 year and 8 months old).

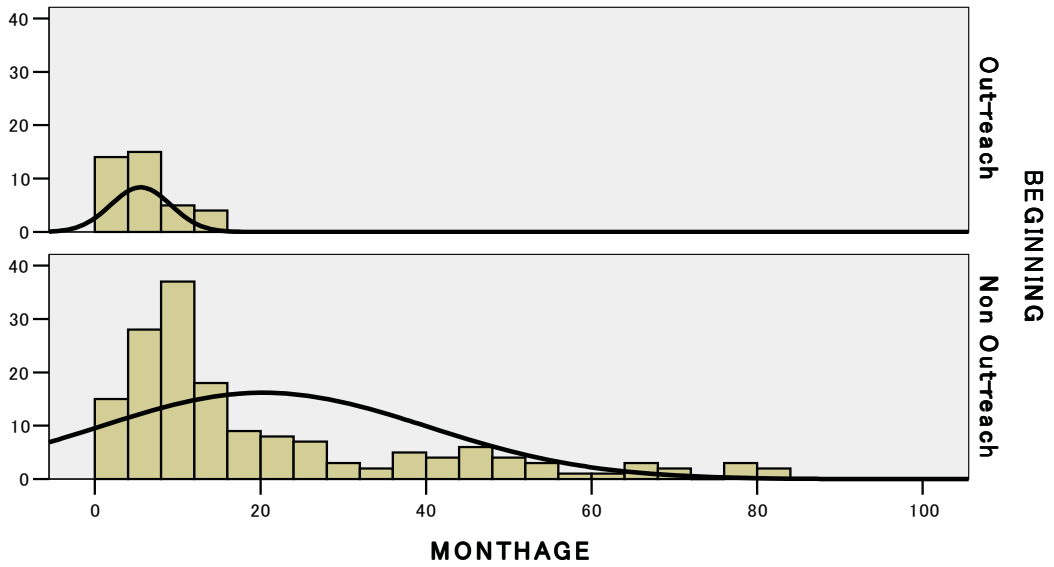


**Figure 1 Age Difference of the Enrolled Children between the Beginnings**

**Analysis of the ratio of the satellite enrollees who have consumed Outreach Service**

As mentioned above, the number of consultations was 102 (68+34), and these were made by 58 women consuming our Outreach Service. Out of these women, 15 (25.9%) enrolled themselves to our satellite, and the other 23 enrollees were just recommended to use our satellite by the outreaching workers. Therefore, a certain portion of the women (38 pairs) approached by our workers is now the members of our satellite, enjoying our Drop-in Service. In other words, about 20% (38/199) of the enrollees from Oct. 2007 to April 2008 were the consumers of the Outreach Service.

**Concluding Remarks and Future Tasks**

The meanings of the combination of Drop-in and Perinatal Outreach Service offered by our satellite were made clear by the three types of analyses stated above; (1) the core need of perinatal women, especially of postnatal women, is the consultation with our outreach workers, and about a quarter of them come and enjoy our other service of Drop-in, (2) during the targeted period, about one fifth of the enrollees of the Drop-in are the subjects of our Outreach Service, (3) our Outreach Service at the maternity clinic is effective in promoting the utilization of our Drop-in Service by local postnatal women with very young infants before six months old on average, which might prevent their isolation and other unstable emotional/social situations caused by their childbirth as early as possible.

Since the outreach workers belong to the satellite, knowing very much about how the local parents and their children are enjoying the Drop-in Service to be empowered, they were totally confident to invite the perinatal women over to the satellite. This may be the reason why a certain number of the consumers of the Outreach Service enrolled themselves to the satellite. Furthermore, relationships of mutual trusts between the women and the workers through consultations might function as the inducement of using our Drop-in Service.

However, we have not yet obtained any substantial evidence about why the consumers of our Outreach Service have come to make use of our Drop-in. Therefore, our future challenge is to make clear, through investigations, such reasons and at the same time how they evaluate both of our services. Additionally, it is necessary to categorize the details of consultations made by the outreach workers, which is to be compared with the result of those made by the consulting staff at the drop-in space of our satellite (Ito 2009).

**References**

Ito A. (2008) Plant management as action research and social contribution in supporting child and family empowerment. *The proceedings of the 1st International Academic Interchange Meeting between the Graduate School of Human Development & Environment, Kobe University and the Institute of Education, University of London*, 70-78.

Ito A. (2009) Categorization of the consultation contents in the Drop-in Service at a university satellite plant. *Bulletin of Konan Institute of Human Sciences, Vol. 10, in press. (in Japanese)*

Teramura Y. (2004) A study on child rearing support from perinatal period; what is the most relevant home visiting for postpartum women and their babies by the clinic midwives. *Graduation Thesis submitted to the Faculty of Human Development, Kobe University. (in Japanese)*.

Teramura Y. (2007) Effects of a tentative practice on prenatal and postpartum women's empowerment through consultation, home visiting and accompanying to community resources. *Master's Thesis submitted to the Graduate School of Cultural Studies & Human Science, Kobe University. (in Japanese)*

Teramura Y. & Ito A. (2008) Evaluation study on a tentative outreach practice for the empowerment of women before and after their childbirth through consultation, home visiting and local resources. *Bulletin of the Graduate School of Human Development & Environment, Vol.2, No.1, 115-123. (in Japanese with English summary)*

# Development, Practice and Effect of Group-based Parenting Program for Promoting Parents' Empathy for their Children

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## History of Our Parenting Program

Outbreaks of serious crimes by the young in Kobe City instigated the development of our program. Kobe Child Guidance Clinic and our staff including me started analyzing such cases of juvenile delinquency in 2000. And in order to prevent such delinquencies, we began to offer a parenting program called Parental Empathic Communication with their Children in Kobe (PECCK in short) in 2001. We have been offering it to three different groups of parents every year since the year, and 23 parent groups (total number of the parents amounted to 162) participated in PECCK in the end of 2008.

During these 8 years, we have studied the effects of this program and continued its progression, the outcome of which is presented at academic meetings as shown below:

- Analyses of program contents for the parents who have problems about their children's behavior, of modification of parents behavior, and of developing process of parent groups; presented at The Japanese Conference of Children and Families (2001).
- Analysis of program development for the parents who have problems about their children's behavior; presented at The Japanese Conference of Children and Families (2002).
- Analysis of development of support program for the parents who have problems about their young children's behavior; presented at The Japanese Conference of Children and Families (2003).
- Effectiveness of support program for the parents who have problems about their children's behavior; presented at The Japanese Conference of Children and Families (2004).
- Development, practice and effect of group-based parenting program for promoting parents' empathy for their children; presented at The Japanese Conference of Social Welfare (2008).

## Participants and Purposes of the Program

Almost all the participants of Parental Empathic Communication with their Children in Kobe (PECCK) are mothers of children from 4 years old (middle grade of kindergarten) to 12 years old (the oldest grade of primary school). Some of these

parents are the voluntary participants having being informed of this program at local resources and the others the involuntary ones recommended to take this program by some child guidance clinics. In these parents' view, their children show some kinds of problem behavior or trouble: they have difficulty in controlling their emotions; they are discouraged to enjoy their living; they have strong hostility; they frequently quarrel with their siblings; they are isolated from friends; they steal stuff from friends or do shoplifting. And the parents also feel negative feelings toward themselves: these are impatient or flurried by time-flow and by external factors such as media, education, parenting, guilty and self-reproach, negative recognition about human relation such as isolation, mistrust and recollection of traumatic experience in their infancy.

The purpose of PECCK is to help these participant parents reduce stress and anxiety caused by their childcare, form relevant relationship with their children, understand intellectual and developmental disorder, understand how to cope with delinquency in earlier childhood, enhance empathic communication skills with their children and acquire coping skills for controlling their children's problem behavior.

The participants expect their children to change their attitude or behavior: reducing violent behavior and rude words; decreasing the frequencies of telling a lie; making friendship with their siblings; reducing dependency; paying attention to their parents; adjusting themselves to rhythm of daily living. They also expect themselves to be changed; understanding how to control their emotion and how to cope with the lies told by their children; getting the heuristics for childcare; making friends with other participants; understanding how to accept the demands of their children.

## Details of the Program

**Picture 1； A Scene of one of the Sessions**

Our program PECCK is a group-based, and a group of about ten participants receive a series of seven sessions, each of them being held from10 p.m. to noon on every Tuesday. The same series is repeated three times (spring, autumn, and winter terms) a year to three different groups. The series is composed of lectures, workshops and discussions. This program is offered at Kobe General Children's Center and 162 participants, as already stated, joined PECCK in 23 terms from 2001 to 2008

The contents of the first and the second sessions are introductory lectures with the assessment of the participant's needs and dividing them into small groups. The theme of the first lecture is "Understanding children's problematic behavior and symptoms shown by children," and the theme of the second one "Understanding communication in parent-child relationship."

The third and the fourth sessions are the combinations of a lecture and a workshop intervention: In the third session, the lecture theme is "Understanding how to accept children," and the workshop task is drawing "Everyday troublesome scene repeated at my family," followed by group discussion; In the fourth session, the lecture theme is "Perceiving communication pattern," and the workshop task is drawing panel cartoon about troublesome parent-child conversation at home, followed by group discussion.

**Picture 2 A Scene of one of the Sessions**

The latter half of PECCK aims at role-play intervention into the participant's recognition of parent-child communication and is composed of role-playings and discussion in small groups. In the fifth session, the role-playing task is "Parent-child conversation," and several pairs of the participants take the role of child or parent. In the sixth session, the role-play task is also "Parent-child conversation," and the same pairs change their roles played in the fifth session. In both sessions, the pairs talk about the feelings while playing their parts after the role-playings. In the last session, the participants look back their own experiences and expressions all through the previous sessions, as well as discuss how they changed themselves during these seven weeks. Almost all of them state positive change of their attitude to children and the relation to their children.

**Purpose of the Interventions in the Program**

The purpose of the interventions by workshops and role-playings is to make the participant parents be aware of their irrelevant communication pattern and/or irrelevant behavior under the conflictive relationship with their children. Through these interventions, participants get the opportunities to change their communication pattern or behavior and also enhance their empathy for their children, eventually to be in parental empathic communication with their children. The down below is the detailed purposes and procedures of the workshops and the role-playings.

About the workshops

"Everyday scene repeated at my family" provides the parents with the time for looking back their typical, troublesome scenes brought about by their conflictive relationship to their children.

"Panel-cartoon drawing about parent-child conversation" provides the parents with the time for recognizing the sequential, deadlocking patterns in parent-child to enhance the change them to the relevant patterns.


**↑Picture 3　Everyday scene repeated at my family'**


**←Picture 4　Panel cartoon drawing about parent-child conversation**

About the role-playings

Role-playings in the two sessions aim at promoting the parents' empathy for their children, and the procedure is as follows:

The participants are divided into several pair groups.⇒One is supposed to take the role of parent and the other is supposed to take the role of child in each pair.⇒The parent-part explains the usual behavior of her child to the child-part under the conflict situation.⇒The parent-part acts to the other as usual at home. ⇒The child-part acts in response to the parent-part's behavior. ⇒The parent-part writes down or talks about what she experienced or felt in a parent's place.⇒Child-part writes down or talks about what she experienced or felt in a child's place. ⇒Finally, the parent-part notices that she actually feels empathy for her child at the spot.

**Evaluation of the effects of the program**

After completing seven sessions, the participants were required to answer the questions, and we analyzed the data commonly obtained among the participants. The questions are to inquire the participants' impression about the program (seminar), their satisfaction level about the workshops and the role-playings, emotional or behavioral change of their children, and effects recognized by the participants themselves.

The result of the impressions by checking the participants' response distributions are shown in Table 1, and it indicates almost all the participants had good impressions about our program, but that about a quarter of them were not satisfied with it.

Table 1 Participants' Impressions about Seminar

| |
|---|
| Question 1: Has the seminar met your expectation?<br>Affirmative answer…82.7%　Negative answer…16.3% |
| Question 2: Was the seminar easy for you to understand?<br>Affirmative answer…95.2%　Negative answer…4.8% |
| Question 3: Do you think the seminar was of good quality?<br>Affirmative answer…96.2%　Negative answer…3.8% |
| Question 4: Were you satisfied with the seminar?<br>Affirmative answer…60.6%　Negative answer…24.9%　No answer…11.5% |

For analyzing the effects of the workshops and the role-playings, we calculated Pearson correlations between the satisfaction level about such interventions and the impressions of the seminar. In Table 2, only the significant correlation pairs are shown, and the followings could be pointed out. The participants' satisfaction level of the workshops is relative with their recognition of the seminar being satisfactory and of quality. Their satisfaction level of the role-playings relates to their recognition of the seminar coming up to the expectation and being of quality. And the same effect is seen when we combined both workshop and role-playing scores together. In other words, the interventions of this program seem to correlate to the participants' evaluation that the seminar comes up to the expectation and it is also of high quality. And it was shown that either workshops or role-playings have nothing to do with the seminar being easy to understand, because this question about understandability rather concerns the evaluation of the lectures in the program. The lowest box in Table 2 just indicates that the satisfaction levels of two types of our interventions are in strong relation to each other.

Table 2 Pearson Correlations among Workshops, Role-playings and Impressions

| | | |
|---|---|---|
| Workshops and Satisfaction in Impressions | r=.508 | P<.01 |
| Workshops and Quality in Impressions | r=.538 | P<.01 |
| Role-playings and Meeting Expectation in Impressions | r=.609 | P<.01 |
| Role-playings and Quality in Impressions | r=.798 | P<.01 |
| Workshops+Role-playings and Meeting Expectation in Impressions | r=.651 | P<.01 |
| Workshops+Role-playings and Quality in Impressions | r=.847 | P<.01 |
| Workshops and Role-playings | r=.888 | P<.01 |

About the children's emotional or behavioral change, we firstly asked the participants whether or not their children changed during their receiving this seminar. Out of 69 who responded this question, 61 participants (88.3%) answered affirmatively. We then asked these 61 to write down freely their children's changes, which were to be classified into the following five categories: Stability of Emotion 24 (33%); Wealthy Communication 13 (18%);

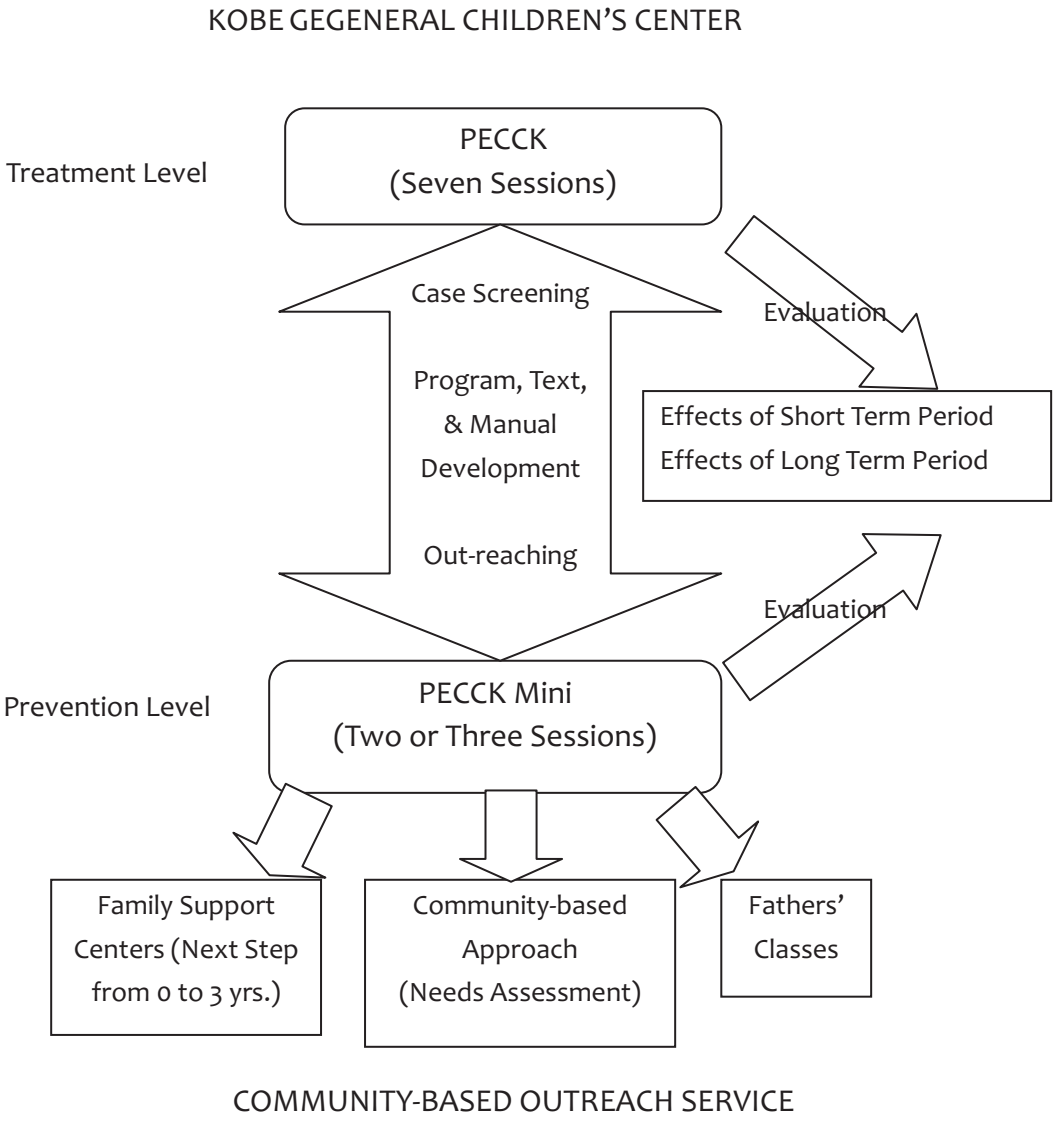


**Figure 1 Our Implementation Plan of PECCK & PECCK-Mini**

Independent Behavior 15 (21%); Control of Hot Temper 15 (21%); Independent Behavior 15 (21%); Reformation of attachment 5 (7%).

As for the participants' recognized effects to themselves, we also asked them to write down freely, and the statements could be classified into the following six categories: Being Accepted in Group Work; Feeling of Self-acceptance; Stability of Emotions; Empathy for their Children; Face-to-face Contact with Children; Positive Modification of their Communication Patterns.

**Discussion and future task**

The results of the participants' evaluation about our program claim that the purpose and hypothesis of PECCK are verified and it is an effective means for enhancing good relationship between parents and children. However, it was shown that a quarter of the participants were not satisfied with the program, and we firstly should find out the reason for this fact.

Totally speaking, PECCK surely meets the needs of the parents in that they actually feel that their children have changed for the better, and they themselves have improved their empathic communication. Thus, we hope this practice will lead to the prevention of the children's juvenile delinquencies in the future. But, in order to verify that this program is effective for such prevention, we have to evaluate the long-term effects by way of, for example, longitudinal method.

Another task of ours is to deliver this program locally to more and more parents in need. We have just created a short program called PECCK-Mini which is composed of 2 sessions of a workshop and a role-playing, and we have just tried it several times as a community-based service. As shown in Figure 1 on the previous page, we would like to build a new support system by combining PECCK implemented at Kobe General Children's Center and PECCK-Mini implemented at several local centers.