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Introduction

The theoretical foundations of the Early Childhood Intervention centres are rooted primarily in early education programs such as Early Head Start, Sure Start and the programs developed since 1979 (Appel&Karlan, 2012). This paper delves into the details of intervention programs started by Sure Start.

British Service Sure Start was created in 1999 and it is based on the delivery of services aimed at improving the life chances of children living in communities with multiple deficiencies and risk factors (The National Evaluation of Sure Start Research Team, 2008; National Audit Office, 2006). Thus, these programs seek not only to improve the health and welfare during early years, but increasing opportunities for children to enter the school ready to learn, be successful in school academically, socially successful in their communities and occupationally successful in adulthood (NESS, 2008).

However, the Sure Start program differs from the program by focusing on Early Health Services of all children between 0 and 5 years of age of a particular territory (chosen previously for its high levels of risk and vulnerability), without discrimination based on targeting criteria in individuals with certain profile: if the child lives in the area or community addressed by the program, then that child is immediate beneficiary of Sure Start (NESS, 2008; Rutter, 2006).

In contrast to the American Early Childhood Intervention programs, the Sure Start program has not implemented a model derived from a centralized and universal design, but it has adopted a policy of developing community assessments, together with local agents, gaps and

shortcomings of observable services in a particular community. From this diagnosis, each Sure Start program designs the services offered, with an emphasis on ecologically sensitive proposals for the needs of each community (NESS, 2008). This embodiment presented a number of difficulties in assessing their results, especially for understanding what aspects of its design are showing greater impact on the objectives of program (Rutter, 2006).

Socio-Political Constructs

In recent decades, research and practice has established in early childhood (0-3 years) as one of the multidisciplinary areas that most impact has had in the generation of public policies in various countries (Beeber et al., 2007). These policies have opted to turn in the design and implementation of various types of Early Childhood Intervention, which despite showing a wide variability, share the common objective of supporting the social, cognitive, physical and mental development of infants and preschool children through health services, education and / or social care offered to them and their families (Love et al., 2006; Gray & McCormick, 2005; Shonkoff& Phillips, 2005).

Availability and accessibility to early care and education services provided by the state are influenced by three factors: coverage policies and access to quality services; maternity policies and paternity leave, and cultural family traditions. Access to these programs is not uniform in many countries. In countries such as United States, Australia, UK, and New Zealand, access is less, the provision of services for children under three years is the responsibility of the non-governmental sector (the religious associations, NGOs, community groups and the private sector); and the cost is generally high for the bulk of the population (Byron, 2015). In a significant number of OECD countries such as Sweden, Denmark, Finland, Netherlands, New

Zealand, England and Australia, there is a tendency to unify early childhood care policy, i.e. care the child of three, with the care of three to six years.

UK had with a disjointed care for the child in early childhood system; however, in recent years have promulgated a series of regulations and laws where the first childhood becomes the responsibility of the education sector. The aim is to integrate the care and education dimensions(Byron, 2015). The policy document laid the foundation for the early childhood policy from birth to nine years, and both Care Act (2006) Plan unified policy attention to the children under the Sure Start Unit within the new Department of Children as School and Family.

In the UK it has been raised to create a parent Charter, a document that describes the minimum level of support that parents should expect local authorities in the centers of Sure Start. Also the use of an individual record for each child development suggests from birth to eleven years it remains with parents. Finally it also proposes to work with counsellors' support to parents from schools to improve attendance and behavior or give advice. They have made available financial resources for series of pilots to identify the most appropriate local strategies that seek a greater parental involvement.

An arrangement that is used in UK to inform parents and family on the objectives of preschool education, activities, etc., are the Web pages. On Web pages include documents covering aspects related to parents' rights regarding access to education and care programs; parenting guidelines, and how involved in the activities of their children in the centre. The Ministry of Education of United Kingdom have a Web page specifically for parents of children. The early years parenting information is published, activities to do at home, and information on policies and programs of the ministry.

On the other hand they have also been funded research documenting the effects of parental involvement in the education of their children. One of these programs is Provision of effective Early Childhood Education in the UK.

Sure Start program, initially, defined services in general terms, leaving hands of local operators the necessary adjustments and applying relevant contents (NESS, 2008; Rutter, 2006). Recently, there has unified standards of good practice on the basis of the experience gained since 1997 in the implementation of various Early Childhood Intervention services. Thus, at present there are 500 Sure Start Local reconverted Programmes, Neighbourhood Nurseries and more than 3,500 Early Excellence Centres in the new Sure Start Children's Centres (NESS, 2008; National Audit Office, 2006).

In UK, Sure Start has implemented a variety of programs which include components aimed at parents. In the United Kingdom are the Centers for Children / as Sure Start (that provide support services to parents actions focusing on the links between parents and children and modelling behaviors, among others activities. Another program was the demonstration Project on Early Learning Partnership which was implemented between October 2006 and March 2008, and supported the family to turn learning support their children. Another initiative was *Starting School and Moving on* implemented by the Sure Start. Currently schools in the UK are implementing a series of reforms to provide parents support through joint learning workshops for parents and children, information sessions on the key phases of transition and development of classrooms for parents to promote formal and non-formal learning.

SLPP functions as an agency that integrates all the necessary services for the family since before birth, making it a measure of attention and prevention for children and, in any case, in an

exemplary organizational model. Working with parents and children has proven to be the best way to provide resources, benefiting more about and others.

Sure Start services start in the first family interview which is antenatal. From there, it provides information on the pregnancy, monitoring is managed, guidance is provided on the back to work after the first maternity and any support. All it is managed from a contact point. Coordination between professionals, parents and the community itself: the processes are supervised by the community so that there is complete transparency, any action aimed at children or families. It is based on daily communication therewith.

Specific services included in its current form the Sure Start program are: home visits; comprehensive early education and child care; evaluation of babies by health visitors; physicals; classes and services and pre post natal; development of language and speech; parental training sessions; play sessions; baby massage; play sessions in community settings; support parents and children with special needs; mobile libraries toys; network support; referrals to employment centers; and registration employment opportunities (National Audit Office, 2006).

Intervention

Early Childhood Intervention programs are based on assumptions regarding firmly established critical impact of early life for all posterior human development (Shonkoff& Phillips, 2005). However, it has not been easy to transfer the accumulated knowledge of child development in Early Childhood Intervention programs to achieve successful results in the previously explicit goals. The development of such programs in various parts of world has been plagued by methodological problems and ill-defined designs (Shonkoff& Phillips, 2005), guided by ideological principles rather than by foundations anchored in theory and research, with the

result that often taken public policy decisions rather on the basis of anecdotal experiences on the substrate of evidence-based practices (Olds et al., 2007).

Early Childhood Intervention programs have shown positive results when it comes to experiences developed under strict control conditions, generally linked to university projects. For example, Gray & McCormick (2005), examined the impact of nine such programs of high level and quality, which in turn had been evaluated rigorously through experimental studies, finding that groups intervention performed better than control groups, including: (a) cognitive, emotional and educational gains for the child; (b) improvements in relationships and interactions between parents and children; and (c) long-term benefits for child, such as greater participation in the labour market, less dependence concerning the system of social welfare, more income in adulthood and a reduction in criminal behavior. However, the results become much less stimulating experiences when investigations are reviewed developed in the context of implementation in the "real world" (Olds et al., 2007).

The knowledge accumulated to date has shown that clarity of design, quality of services offered, the level of competence and fidelity equipment of these program design also as ensuring the involvement and user participation, are key variables in the results obtained by the early intervention programs, regardless of their focus of action (Olds et al., 2007; Love et al., 2006; Gray & McCormick, 2005).

Importantly, most Early Childhood Intervention programs have shown significant and lasting effects which are very expensive, associating this cost to the intensity required to overcome disadvantage conditions intended to supply. Therefore, it is necessary to accumulate evidence regarding whether it is possible to achieve efficiency under more "weak" variants of

Early Childhood Intervention programs models, especially in countries that does not have the financial resources of a developed country for implementation of their policies in childhood.

With respect to its assessment, it has had two phases: the first phase introduced some encouraging results, mainly associated with the lack of rigor of program design and therefore the presence of a great variability in the actions by each intervention team (Rutter, 2006). This situation was reversed in the second phase of the study demonstrating a number of benefits in the intervention group at three years of age, compared to the control group (NESS, 2008). Thus, children living in areas with Sure Start Local Programs showed, compared to the control group, improved social development, exhibiting more positive social behavior and greater self-regulation and independence. Also, better parenting skills in families and development were observed homelike best learning environments for their children (NESS, 2008).

Sure Start Local Programme (SSLP) Program is an initiative launched in 1999 and, since then, has continued extending to cover almost all disadvantaged areas of England. The programs have been designed in order to provide (Rutter, 2007):

a) Outreach and home visits;
b) Support for families and parents;
c) Support for gaming experiences, learning and child care with children, whether they are of good quality;
d) Primary and community health care, and advice on child health, Family health and health in development
e) Support for people with special needs, such as help accessing specialized services

SSLP centers have managed to add extra services to meet local needs (for example advice on debt, employment and subsidies) and have made specific efforts to maximize the accessibility of families. SSLP centers were founded with the aim to serve all children under 4 years and their families in the designated areas(Rutter, 2007). This strategy allows providing regional basis to a supply of relatively effective services to those living in disadvantaged areas without stigmatize beneficiaries: the look is put in needy areas, but within each region thus defined, services are universal. Community control is exercised through collaboration with local stakeholders, bringing together all the people from the local community interested in children, including parents and representatives of the health, care sectors, educational, private and voluntary.

Because of local autonomy, which is a fundamental characteristic of community control in the SSLP, the centers do not have a "protocol" prescribed service that promotes compliance as a preset pattern, although all must provide a set of essential selected services, based on specific experiences. Thus, each program has the freedom to improve and create services so as more appropriate, for general purposes and some specific objectives (for example reducing the incidence of low birth weight or promote language development), but without the obligation to detail exactly how they have to provide such services. This local freedom has been a great diversity in the programs (Evangelou et al., 2009).

Some of the basic features of Sure Start Intervention programs are:

- The Sure Start programs were designed for disadvantaged communities;
- The nature of the program is tailored to local needs and, therefore, presents varied content

Since in each of the areas served the program is universal, the stigmatization risk of individuals is reduced. Among European countries there are differences in development services

and how policies and global schemes services priorities attributed to different approaches. A National Evaluation of Sure Start (NESS, 2008) was commissioned the task of studying the Sure Start Local Programs (Sure Start Local Programmes: SSLP), analysing the nature of the communities in which it operates SSLP, implementation of programs and impact on children, families and communities, as well as its profitability (Belsky et al., 2007).

Voice of the Child

In the United Kingdom (England and Wales), the Law on Care for children (Childcare Act 2006) requires Parents are involved in planning, development, implementation and evaluation of educational services. In England educational programs for children Sure Start attach great importance to the involvement of parents by providing support and facilitating access to training. Parents play an important role in the functioning of the Sure Start local programs and partnerships are composed of parents and members of the community equally. In the UK (Scotland) is required to establish effective ways of collaboration and maintain regular communication with parents(Evangelou et al., 2009). The education authorities have a duty to encourage the involvement of parents in schools publicly funded, even in the field of early childhood education.

Sure Start program was implemented in England and revised assessment impact analysis carried out in 2009. This program is aimed at the poorest areas of the country and seeks to support young children and their families by offering services of child care, early education, health and family services. The objective of program is to improve health and well-being of families and children so that they have a better chance of having a good school performance.

According to the information presented in the assessment it can be inferred that among the main strengths of the program is the fact that the program provides adequate parental advisory, which has been reflected an improvement in the way parents relate and educate their children. Furthermore, it is considered that strength is that the program has a long-term strategy (10 years) which allows having clear objectives which will work throughout the weather. Furthermore, the program operates by results, so allowing a large variation in processes and products offered by each centre. In this sense, here it is considered that although this feature could hamper program evaluation, allows enormous freedom and could stimulate competition and innovation in best practices.

Different studies have analysed the beneficiary behaviour of children and families with children and families in similar conditions but did not have the presence of program in the community. The data come from two projects: one called Millennium Cohort Study (MCS) that conducted the survey data in two stages, 2005 and 2007; the second source data came from information collected by the national assessment of program impact. Thus, the data served to MCS get the information in the control group while the beneficiaries' information was taken from the second source. The impact assessment analysed data of 9000 families in 150 areas of the UK, there was a random selection of beneficiaries as well as the control group and statistical analysis was done with a pairing model for propensity score.

The study sought to analyse the effects the program has on children and their families. Overall assessment identified a positive impact of the program in the way parents relate and educate their children, as well as the development of children. An important finding is that the positive effects of program is universally distributed among the beneficiaries and not concentrated in any particular subset. The study (Craig et al., 2008) revealed that parents of

beneficiary children showed negative parental attitudes to a lesser extent towards the control group. Also, the beneficiary children had better social development, better independence and self-control, and showed a positive social attitude more often than the control group. It seems that the effects of positive social behavior due to good advice on how to educate children at home.

The beneficiary children showed higher immunization rates and lower propensity to have accidents. This evaluation used an appropriate methodology to meet its target.

The first phase of the evaluation compared the behavior of thousands of children from 9 months and 36 months of age, and their families, who lived in 150 areas covered by the SSLP with counterparts in 50 communities designed to accommodate new Sure Start programs in the near future. The results showed small positive and negative effects (Belsky et al, 2006). While relatively less disadvantaged families drew some benefit from the program, for neediest families the effects were found to be contrary.

In particular, in areas where it operated the SSLP practiced a less negative parenting and children 3 years of age showed less behavior problems and increased social competition. However, children in localities with centers coming from unemployed families or living with one parent, or were children of adolescent mothers, had worse than their counterparts in terms of verbal ability and, in particular, the children of teenage mothers also had more behavioural problems and less social competition. Negative data may result from the SSLP it failed to intervene precisely in families who most needed his help(Rutter, 2007).

In a second phase of the evaluation, observed children with their families during the first phase, when they were 9 months old, were studied again at the age of 3 years, and they were

compared with counterparts in disadvantaged areas with similar situations where there was no SSLP centers. The results of the second phase showed multiple benefits of SSLP exposure and practically no negative effect: compared with their peers, parents working areas where the SSLP used more services, is pawned more comprehensive way in nurturing and had children with greater social competition (Melhuish et al., 2008b).

The quantitative increase in the exposure of children and families to SSLP and improvements in the quality of the services offered by the centers over time may explain why the first phase of the impact assessment revealed some negative effects of the program in the case of children and the most disadvantaged families and why the second phase of the evaluation showed, however, beneficial effects for virtually all children and families living in areas where SSLP was present (Melhuish et al, 2008a).

Various assessments made this longitudinal study of children / as (since they were in kindergarten and throughout school) document that the home environment and parental involvement in their children's education are crucial to improving learning achievement of children. Parental involvement can be even more important than the educational level, occupation or parental income.

Conclusion

Sure Start offers many intervention programs for early childhood which helps children and their families. Since its implementation, the Sure Start program has been the most widely applied preventive and most researched in the UK. The results of evaluations of Sure Start are not entirely conclusive, especially when compared with other "major" programs. The benefits

and costs of the Sure Start show that the benefits to both participants and society, systematically exceed the costs.

The short-term benefits of Sure Start are clear and are measured primarily in terms of academic skills, vocabulary and numeracy. They have been found effect sizes between 0.1 and 0.2 in recent experimental evaluations of good quality. But the evidence, equally abundant, long-term gains are more delicate. The research which compares children receiving Sure Start with others who do not found significant benefits in terms of completion of high school education, college attendance and less involvement in criminal activities.

The question is how much more investment is needed to implement Sure Start intervention Program. To answer this question, it can be helpful comparing the impact produced in language development by Sure Start. The Sure Start shows early benefits of approx. 0.25 of a standard deviation, but these disappear within three or four years. In addition, these benefits are lower in black minority children. These discrepancies lead the authors to discuss the nuances of the different evaluation strategies. Most agree that the best way to understand the impact that causes a prevention program in health and development is an experimental evaluation, but there are important methodological differences.

Most evaluations of Sure Start used the strategy include assessments to all those randomly assigned to the treatment group and all assigned to the control group, regardless of whether they had actually started or not to receive the program, i.e., whether or not they accepted the treatment (Method "Intent to treat"). If only include those who receive the program (Method "Treatment on the Treated") with those who do not receive it, the effect size tend to increase 0.1, and sometimes more. These methodological considerations are possibly overlooked by most

politicians and legislators, but may be important in deciding where to invest scarce dollars for prevention.

Either way, the conclusion of this discussion can be summarized as follows:

First, no prevention program has enough "reach". Sure Start is the most widely developed and best established of intervention programs at an early age. But only reaches a small portion of children aged 0 to 4 years of age living in UK.

Second, invest in Sure Start and most other prevention programs seem not to be enough. One can see how scientists are engaged in discussions about the relative economic advantages of different programs for pre-schoolers. Resources are limited; politicians have to make difficult decisions about which program to use. But a more logical strategy, investing as soon as possible in the lives of children / as to obtain the maximum benefits in the future, would make irrelevant all those comparisons.

The large number of studies conducted with the Sure Start Program reminds us how much we still have to learn. Some studies on Sure Start interventions raise big questions about understanding the effect size and the relationship between short- and long-term, and consider the relative benefits of different evaluation strategies.

Sure Start Early intervention programs are slated to be implemented with low rate users per operator: this aspect was considered in the design of the Sure Start Centers since the current rate allowing personalized and individualized to the needs of each family treatment. Interventions are slated to be intensive or otherwise, prolonged in time (i.e., it is not advisable to develop brief interventions with low contact intensity): the intervention of the Sure Start centers lasts about 2 and a half years and intensity of contact is at least one home visit per week. A

critical aspect in the strength of the model is the low proportion of children which allows greater contact with users.

It ought to ensure the establishment of good links between the program and the home of the child. This aspect is central in the design of Sure Start centers, and justifies the inclusion of mothers in the community, since the intention is to provide the maximum trust between users and intervention teams.

It is not recommended to use models that are based mainly or solely in handling case, given its low proven effectiveness, but is encouraged mix with predesigned case management interventions, community health services, education and resolution of social issues, including: the intervention model arises multidimensional and multi addressing family specific, community aspects of institutional approach with various strategies and constant coordination with relevant actors from other areas (clinics, schools, ministries, Municipalities, etc.). Also, currently it is progressing in the workshops design and support materials to develop home and psycho-educational interventions.

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