A healthy start in life:
the HENRY approach and evidence-base

Rooted in best available research about risk and protective factors for child obesity

HENRY is an innovative intervention to promote a healthy start in life and prevent child obesity by focusing on babies and children aged 0 – 5 and their families. It was developed in response to an identified gap: for a practical intervention to deliver the evidence-based messages contained in Professor Mary Rudolf's report commissioned by the Department of Health, *Tackling Child Obesity through the Healthy Child Programme: a Framework for Action*[1].

The HENRY intervention addresses the research evidence on risk and protective factors for a healthy start and child obesity. It adopts a holistic approach that brings together these key factors, focusing on parenting, family lifestyle habits, nutrition, physical activity, and emotional wellbeing.

This approach is multi-layered and brings together:

- **workforce development**: equipping health and early years practitioners with the skills, knowledge and confidence to tackle sensitive lifestyle issues and make every contact count
- **family programmes**: intensive multi-week programmes (group or 1-to-1) for preventive and targeted work for families of children at risk of obesity or other poor health outcomes
- **workshops**: subject-specific sessions on starting solids, fussy eating, active play & oral health
- **peer support**: volunteer-led schemes to promote a healthy family lifestyle in local communities

Evaluation of the HENRY programme

HENRY has the strongest evidence-base currently available for any UK early intervention programme to prevent child obesity. Professor Mary Rudolf, paediatrician and expert in child growth, is HENRY's academic adviser and supports the programme's on-going development and evaluation. Long-term academic partnerships have enabled robust evaluation and contributed to research knowledge and understanding about successful interventions to tackle child obesity. A pilot Randomised Control Trial (RCT)[2] of HENRY programmes is now underway funded by NIHR.

The Early Intervention Foundation (EIF) includes HENRY in their well-respected **Guidebook**:

- Following a rigorous process EIF awarded HENRY the maximum possible effectiveness score for interventions without a published Randomised Controlled Trial (RCT).
- EIF also awarded HENRY the best possible cost score meaning the programme has a low cost to set up and deliver compared to other interventions they reviewed.

Peer-reviewed and published evidence using validated measures shows that HENRY works:

- Families participating in the HENRY programme make statistically significant improvements in family lifestyle and parenting efficacy[3] which are sustained over time[4] (details below)
- Brief HENRY training has a sustained impact on practitioners' professional and personal lives[5]
- HENRY training leads to improvement in nutritional policy and practice at Children's Centres[6]

[1] Rudolf M, 2010. Available at https://bit.ly/2NhgcKs
[2] Bryant et al, Trials, 2017. Available at https://bit.ly/2Fhp9CD
[3] Willis TA, et al, Public Health, 2016. Available at https://bit.ly/2NjXkKR
[4] Willis et al, Pediatric Obesity, 2014. Available at https://bit.ly/2NkUbdo
[5] Brown et al, Community Practitioner, 2013. Available at https://bit.ly/2JsPcVU
[6] Willis et al, Journal of Human Nutrition and Dietetics. 2012. Available at https://bit.ly/2NUGmnk

Family lifestyle changes

Statistically significant lifestyle changes made and sustained by families who joined a HENRY programme found by Willis et al (2014 and 2016, see references above) include:

- increased fruit and vegetables consumption
- decreased consumption of energy-dense food
- decreased frequency of TV meals and increased frequency of family meal times
- increased family physical activity levels
- increased emotional wellbeing (including increased happiness and decreased stress)
- increased parenting self-efficacy

Replication and system readiness

The HENRY programme is currently delivered in nearly 40 local authority areas. HENRY has embedded evaluation and delivery processes in place to ensure programme fidelity and outcomes:

1. Intervention specificity: target group, outcomes, components and theoretical underpinning are clearly articulated and a detailed manual supports programme delivery
2. Quality assurance: practitioners receive initial training and on-going supervision to equip them with the skills, knowledge and confidence to deliver the programme and are authorised against specified criteria
3. Evaluation of impact: all participating parents are asked to complete pre-, post- and follow-up questionnaires which incorporate validated instruments used successfully in previous HENRY evaluations (Willis et al, Pediatric Obesity, July 2014) and adapted for community settings:
    - 5-item Parenting Self-Agency Measure[7]
    - Hammond's Food Frequency Questionnaire[8]
    - Golan's Family Eating and Activity Habits questionnaire[9]

Incorporates evidence-based practices

HENRY was developed by Professor Mary Rudolf and Candida Hunt, parenting educator and behaviour change specialist. The HENRY approach to supporting families to change entrenched lifestyle and eating habits incorporates proven models of behaviour change:

- **Family Partnership Model**[10]
  Emphasises the importance of the parent-practitioner relationship and integrating parents' expertise with that of helpers. Associated with positive outcomes including improvements in family relationships, and children's development, behaviour and emotional functioning[11] [12] [13].
- **Strengths-based, solution-focused support**
  Based on highlighting strengths and identifying solutions, and widely used in clinical settings (in the form of solution-focused brief therapy), with positive treatment effects[14] [15].
- **Motivational interviewing**[16]
  Person-centred collaborative form of guiding to elicit and strengthen motivation for change.

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[7] Dumka et al, *Examination of the cross-cultural and cross-language equivalence of the parenting self-agency measure*. Fam Relat 1996
[8] Hammond et al, *Validation of a food frequency questionnaire for assessing dietary intake in a study of coronary heart disease risk factors in children*. Eur J Clin Nutr 1993
[9] Golan et al, *Reliability and validity of the Family Eating and Activity Habits Questionnaire*. Eur J Clin Nutr 1998
[10] http://www.cpcs.org.uk/index.php?page=about-family-partnership-model
[11] Davis H, Dusoir T, Papadopoulou K, et al. (2005) Child and Family Outcomes of the European Early Promotion Project. *Int J Mental Health Promotion* 7, 63-78.
[12] Davis H, Rushton R (1991) Counselling and supporting parents of children with developmental delay: a research evaluation. *J Ment Defic Res* 35, 89-112.
[13] Davis H, Spurr P (1998) Parent counselling: An evaluation of a community child mental health service. *J Child Psychol Psychiatry* 39, 365-76.
[14] Gingerich WJ, Eisengart S (2000) Solution-Focused Brief Therapy: A Review of the Outcome Research. *Fam Process* 39, 477-98
[15] Kim JS (2008) Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. *Res Soc Work Pract* 18, 107-16.
[16] Motivational Interviewing, Miller and Rollnick 2009