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 in 2009, *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 child obesity. It adopts a holistic approach which brings together these key factors, focusing on:

- parenting
- family lifestyle habits
- nutrition
- activity
- emotional well-being

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 enable them to make the most of every contact with families
- preventive 8-week group parent programme
- targeted 1-to-1 programme for families of children at risk of obesity or already overweight
- parent-led peer support 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. The HENRY programme is now proceeding to Randomised Control Trial (RCT)[2].

Peer-reviewed and published evidence using validated measures shows that HENRY works. Specifically, it has demonstrated that:

- 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 http://bit.ly/2pqS4ta
[2] Bryant et al, Trials, 2017. Available at http://bit.ly/2qSWE6I
[3] Willis TA, et al, Public Health, 2016. Available at http://bit.ly/2gATNMy
[4] Willis et al, Pediatric Obesity, 2014. Available at http://www.henry.org.uk/wp-content/uploads/2015/03/HENRY-Ped-Obesity-2014.pdf
[5] Brown et al, Community Practitioner, 2013. Available at http://bit.ly/2eWjAgP
[6] Willis et al, Journal of Human Nutrition and Dietetics. 2012. Available at http://bit.ly/2ga0UKA

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 consumption of fruit and vegetables
- decreased consumption of energy-dense food
- decreased frequency of TV meals and increased frequency of family meal times
- increased family physical activity
- increased frequency of happiness and decreased frequency of 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