THE UNIVERSITY
*of* LIVERPOOL

*Department of Civic Design and*
*Department of Public Health*

# Health Impact Assessment: Measuring the Effect of Public Policy on Variations in Health

# ANNEX 1

## The Stepping Out Case Study

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**HEALTH IMPACT ASSESMENT CASE STUDY**

**The Stepping Out Project**

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# 1. Introduction

## 1.1 The Health Impact Assessment Research and Development Project

In July 1998 a multidisciplinary team from the Departments of Civic Design and Public Health at the University of Liverpool secured funding from the Department of Health Inequalities Research Initiative for a two year project on Health Impact Assessment (HIA). The study has explored the processes through which public policy impacts on inequalities in health and is developing methods for HIA. It has done this through a series of six case studies, most of which are urban regeneration projects funded through the Single Regeneration Budget and are prime examples of inter-agency collaboration. This report presents the findings of the first case study: Stepping Out – a project that works with vulnerable and excluded young women in Bootle, a deprived area of Sefton in Merseyside. As the first case study to be undertaken, conducting the HIA and producing the report was very much a learning exercise. The authors view the development of the work as an iterative process. Indeed, it is expected that as the research continues there will be cause to re–evaluate the efficacy and appropriateness of the methods described in this report.

## 1.2 Why was Stepping Out chosen as a case study?

The selection of Stepping Out was done through a procedure that was repeated for all of the other case study projects. To assist the choice of projects as case studies a list of criteria was drawn up. This appears in **Appendix 1**. These criteria embraced substantive issues such as distinguishing the main health determinant which the project was most likely to impact upon to more practical considerations such as the stage in the project's development, costs, scale of activities, duration and location. In terms of the requirements of the research objectives, it was necessary to select two projects that had not yet started (for prospective analysis) and three that had (for 'in-project'/concurrent analysis).

Stepping Out was selected as a project that seeks to alter lifestyles and foster empowerment to be a comprehensive, 'in-project'/concurrent case study.

## 1.3 Terms of Reference of the Report

This report is likely to be of interest to a number of audiences – with different needs and interests – including:

- ***Public health practitioners***
- ***Policy makers***
- ***Academics***
- ***People interested in HIA***
- ***Evaluators of regeneration initiatives***

This report is aimed at those with an interest in HIA and a concern for how it can be applied to regeneration programmes.

The terms of reference are:

- **To provide a general overview of Stepping Out**
- **To describe in some detail the methods and procedures which were involved in conducting an in-project, comprehensive HIA of Stepping Out**
- **To consider the efficacy and appropriateness of these methods for eliciting information about changes in health determinants and health status for this particular case study**
- **To assess the impact that Stepping Out has had on the health of its users and the wider population of its target area**
- **To consider the extent to which the HIA methods used here are transferable to other regeneration projects more generally but particularly those that focus upon the altering of lifestyles and empowering of socially excluded young people.**
- **To contribute to a wider debate about the added value of doing concurrent HIAs**

# 2. Résumé of the Stepping Out Project

## 2.1 Aims and Objectives

The principal aim of Stepping Out as identified in the project's delivery plan is:

***"To empower and assist young women in South Sefton in developing to their full potential through the advancement of education and participation in social, arts and cultural facilities."***

(Stepping Out Partnership, 1997)

It has five main objectives:

- ***To tackle crime and improve community safety***
- ***To respond to problems in the area in relation to crime***
- ***To enhance the employment prospects, education and skills of disadvantaged young women***
- ***To promote equality of opportunity***
- ***To enhance the quality of life for local people, ensuring they have a say in their environment***

Stepping Out was originally set up to meet the needs of vulnerable young women in the area. In this context 'vulnerable young women' refers to young women who are socially excluded for various reasons and/or who at risk of demonstrating anti-social or criminal behaviour.

The Stepping Out Partnership is a multi-agency partnership comprising twelve agencies with Merseyside Police Authority acting as the accountable body. The Partnership Board met at least bi-monthly to monitor the progress of the initiative, to search for financial resources to cover the running cost and programme of the project and to ensure that agreed outputs were being met.

Attachment to the Venus Resource Centre has provided Stepping Out with a base from which to build relationships with young women and local residents, carry out administration and network with other agencies. Access to and use of the Venus Resource Centre represents an important contribution 'in kind' to the project. The

Centre provides young women with a safe environment where they can participate in activities or just drop into for a chat.

The operational or target areas of the project are shown in **Figure 2.1**. These areas cover residential enclaves in and around the town centre of Bootle.

**Figure 2.1 Map of the Stepping Out operational area within Merseyside**


Research carried out prior to selecting the target area and intended beneficiaries of the project has been amalgamated into a 'baseline survey of need' for the project. The research included consultation with a number of agencies and analysis of both national and local statistics. Several factors were considered including urban deprivation and crime in Bootle and magistrates and cautioning data for South Sefton during 1994. Other research includes an examination of national crime rates for young women, as well as, the types of offences committed by young women. Consultation with a number agencies such as, the local police Youth Liaison Officer and the Strand Outreach Project, was undertaken to discover the extent of the problem of young women at risk within the area and to provide some knowledge of the key issues for the various agencies. Through speaking with the various agencies in Bootle, the project's initial appraisal highlighted the lack of multi-agency co-operation in providing a

cohesive range of services, to support young women influenced by the 'negative culture' of Bootle.

## 2.2 Intended Beneficiaries

Stepping Out is unusual in that it works exclusively with young women, aged 11 to 25. It is based in Bootle and its target area comprises the wards of Linacre and Derby. However, the project also works with young women who come from outside of this geographical area, for example those who have been referred to the project by social services.

It is targeted particularly at young women who are vulnerable and who are excluded, or in danger of being excluded, from society. This includes young women who:

- *Are excluded from or not attending education*
- *Are offending or displaying offending behaviour*
- *Are in care or care leavers*
- *Have learning difficulties*
- *Are involved in prostitution*
- *Are drug users*
- *Are having housing difficulties*
- *Are disadvantaged by poverty*
- *Experience one or more of the above*
- *Experience one or more of the above as a lone parent*

## 2.3 Strategies

Specific strategies were adopted by the project in order to identify, engage with and assist young women at risk in fulfilment of the project's aims and objectives. Not all of the strategies adopted by the Stepping Out Team are employed by youth work projects that engage with less disadvantaged young people.

A five stage process which is central to the project's attempts to develop young women's self esteem, confidence and self-image. It works as follows:

***1) Affirmation***

*Achieved by emphasising the positive aspects of young women's lives, focusing on their achievements and skills, involving young women in activities in which they can achieve, in which they can gain new experiences, develop positive relationships and experience alternative youth cultures.*

***2) Support***

*Support will be given to address and stabilise some of the negative factors which may put young women at risk, such as; poverty and inadequate housing, through information and advocacy around welfare rights and referrals etc. Awareness raising activities on issues such as drugs and sexual health is included.*

***3) Opportunities***

*Within the opportunities offered by Venus, young women will be encouraged to explore issues and influences within their lives such as drugs and peer pressure.*

***4) Decision Making***

*When considering issues related to their offending behaviour or those which put them at risk of offending and the effects and implications of this, emphasis will be placed on the development of problem solving and decision making skills and through increasing awareness, promote more informed decision making.*

***5) Action Planning***

*Action Planning support will be incorporated to develop avoidance strategies and alternative directions through which young women can identify further project and skill development ideas particularly, around practical and life skills.*

(Stepping Out Partnership, 1997)

Strategies through which the project is meeting its stated aims and objectives include:

- project work,
- group work,
- self support groups,
- one to one - support and listening ear,
- training and practical skill development,
- residentials (i.e. organised activities involving over night stay(s))

One of the methods used is detached youth work. A team of youth workers goes out on to the streets two evenings a week to meet with young women who congregate and socialise on the streets rather than in more formal centre-based provision (e.g. youth clubs) or elsewhere. This is an important means of reaching young people who might not feel comfortable in a conventional youth club environment or who might benefit from Stepping Out but would not feel sufficiently confident to make contact with the project of their own accord. In the early stages of the project, the youth workers carried out 'reconnaissance' work in the area in order to establish the number of potentially vulnerable young women and the locations in which they socialise. This enabled them to plan their routes and to identify how best to target youth workers in order to maximise their contacts with young women.

Data on contact with young people is important because this is the population for whom detached youth work projects can make a difference. One of the difficulties is being able to distinguish in a consistent way the number and depth of the contacts made by youth workers with vulnerable young people. Hirschfield and Bowers. (1998) have identified three different levels of contact with young women: **Casual Contacts, Closer Engagements** and **Participatory Engagements**. These have been defined by Venus (the umbrella organisation under which Stepping Out operates) workers as follows:

| | |
|---|---|
| **Casual Contact** | *"when workers are initially reconnaissing* [sic] *an area, pass many young people and begin to become recognised and say hello see you around."* |
| **Closer Engagement** | *"young women are waiting for workers and approach them directly with tales of recent events, or questions, or inquiring about accessing an activity."* |
| **Participatory Engagements** | *"young people approaching workers directly with ideas regarding activities i.e. a group of young women last week came down to our offices and said they had ideas for redecorating our bathroom and had a scheme in mind, then they prepared the paint work, etc."* |

Casual contacts are defined as young persons present when the first verbal contact or approach is made by youth workers to one or more young persons within the target area. This is the point at which the engagement process begins, although, some young people may never get beyond the casual contact stage. Closer encounters are more in-depth contacts between young people and youth workers and may be associated with the disclosure / confrontation of problems faced by young people. These also include direct approaches made by young people to youth workers. Finally, participatory engagements involve young people "doing things" that would not have happened without the active participation of both the youth worker(s) and the young people. They include the involvement of young people accessing services and facilities, participating in activities locally or away from the area (e.g. day trips) and participating in residentials.

A fourth category of counting young people is the ‘reconnaissance count’. These are essentially estimates of the numbers of young people on the streets which are made by youth workers observing young people at a distance without establishing any contact. These estimates provide some indication of the number of young people who may be vulnerable (i.e. the potential population at risk). Although their number will be substantially smaller than the number of young people resident in the target area, they are, nevertheless, likely to provide a much more realistic denominator for calculating youth project participation rates for young people (i.e. those engaged by detached youth work per 1000 at risk) than young people in the residential population, many of whom will not be vulnerable.

The type of work offered by Stepping Out that differs the most from conventional youth club provision is One to One Support. This is a procedure whereby young women who are vulnerable or who need support in dealing with certain aspects of their lives are allocated a youth worker. This worker then works with the young woman on a one to one basis to offer non–judgmental support, to help her make decisions and, where necessary, to accompany her to meetings with other organisations. The frequency of these meetings and the length of time that a young woman receives one to one support varies from individual to individual and on what is going on in a young woman’s life.

In the past, Stepping Out has also organised group work activities with and for young women. These have included producing their own Crime Drama, participating in a weekend workshop on Sexual Health (as this involved an overnight stay it was termed a 'residential'), arts and crafts works shops and trips to the cinema or going roller-blading. These group work activities aim *"to promote personal and social development"* (Hirschfield 1998). They enable young women to get used to working with other people and they provide a safe space for young women to consider issues of concern to them.

## 2.4 Timetable

The project began in August 1997 and finished (in its original form) in July 1999. The first few months of the Stepping Out Initiative were spent building up awareness of the project amongst the potential client group. For the 18 or so months when the project was fully up and running it operated a whole range of activities, including: one to one support, detached work, workshops and groups, residentials and a conference entitled "Voices of Women". In addition, Stepping Out and Venus workers set up a multi-agency forum "What about young women?" to address the issues for this group in South Sefton. The final few months were spent applying for alternative sources of funding and devising strategies for continuing to provide some of the services at the end of the funding period.

Since the fieldwork for this case study was completed, the research team has been informed that the future of the Stepping Out Partnership is in jeopardy. This has forced the project to stop group work activities and to limit the amount of one to one support it is able to provide. Street work has been reduced to one evening a week. It remains to be seen whether funding can be found to enable it to resume its full programme of work.

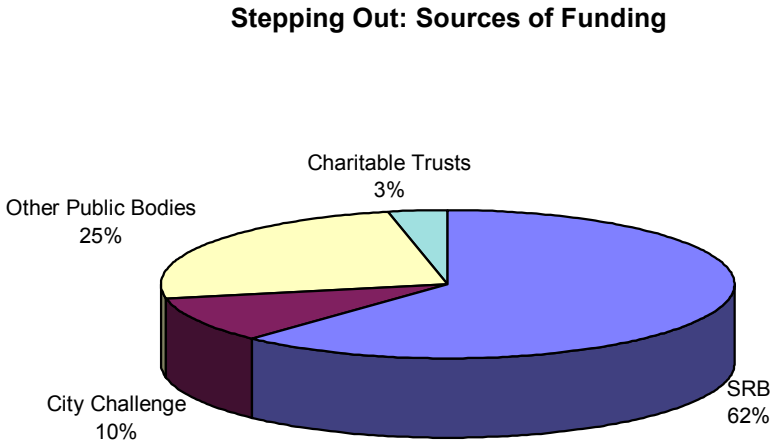
## 2.5 Resources

The budget for the Stepping Out Project was £161,122 over two years. The budget breakdown is set out in **Table 2.1** and sources of funding appear in **Figure 2.2**, below.

**Table 2.1: Stepping Out Project Budget Breakdown (Total All Years)**

| Cost Category | Expenditure | % Spend |
|---|---|---|
| *Staffing* | £73, 436 | 48.3 |
| *Running costs* | £46, 696 | 30.7 |
| *Programme* | £32,000 | 21.0 |
| ***Total Revenue*** | £152,132 | 100 |
| *Capital Expenditure* | £9,000 | |
| ***Grand Total*** | £161,132 | |

**Figure 2.2: Stepping Out Project: Funding Sources**



The staffing breakdown was as follows:

- 1 full time Co-ordinator *(35 hours per week)*
- 3 detached Youth workers *(10 hours per week each)*
- 1 part time Book keeper *(24 hours per week)*
- 1 crèche Supervisor *(16 hours per week)*

It was recognised that existing staff working additional 'voluntary' hours frequently added to the official staff resource levels of the Project.

# 3. Methodology

## 3.1 Overview of the stages in the Methodology

The nature of the research has been divided into two types: Procedures and Methods. The methods employed are explained in some detail below. In this section the reasoning behind the order in which the work was carried out is explained. The methodology is set out as a flow diagram in **Figure 3.1,** below.

The research was designed so that each stage in the process informed the next. The logical place to start was a review of the documentary evidence already in existence. This included: monitoring and evaluation reports of the project, the Crime and Disorder Audit for the Borough of Sefton, in which the project is located, a full geodemographic profile of the two wards that the project serves and the score on the Index of Local Deprivation. This information enabled the researchers to develop a good understanding of the demographic, social and policy context in which the project works and knowledge of the type of work that it undertakes.

It was then considered appropriate to interview the project manager and a number of the workers in order to ascertain their views about the nature of the intervention, the needs and issues of the client group and the geographical area in which the project operates. Following one of the interviews, one of the researchers was invited to accompany two of the detached youth workers in their street work. The route that was taken was through the two wards (Linacre and Derby) that comprise Stepping Out's target area. This exercise was extremely useful since it enabled the researcher to talk informally with the workers and to observe their interactions with the groups of young women that they went up to or who were approached by them.

Having gathered the youth workers' perceptions of the service Stepping Out provides and the impact it has on the young women that they work with, the sensible next step was to find out the views of the users. In the first instance, this was done through a series of face-to-face interviews carried out by the One-to-One workers with their clients using a semi-structured questionnaire (an explanation as to why the

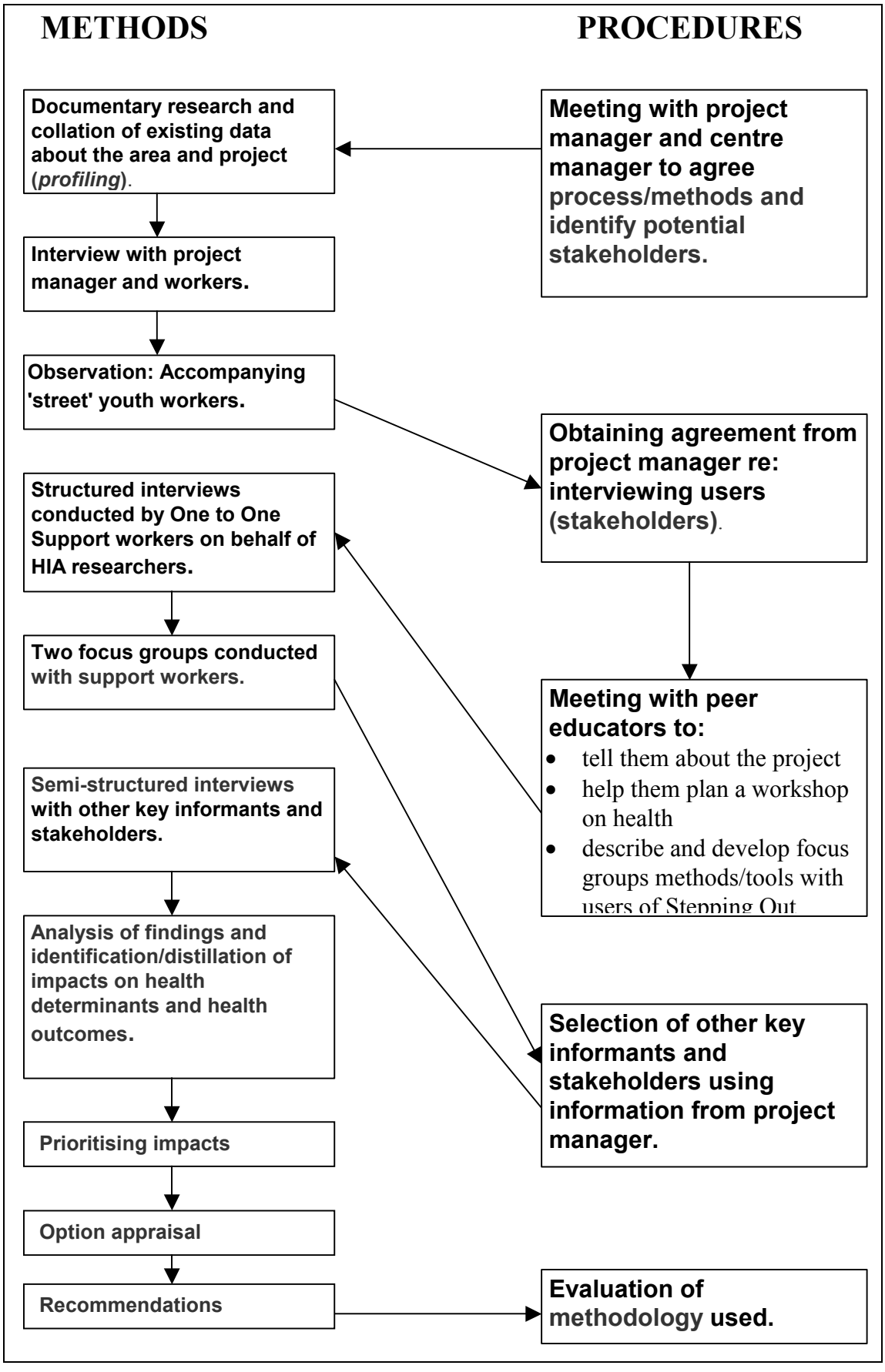
research team was unable to conduct the interviews is given below). The research team also had access to the results of a survey (the Self Assessment Questionnaire – SAQ) designed by the research director for another purpose and filled out by over twenty of Stepping Out's users. Finally, one of the researchers carried out two focus groups at Venus, the centre in which the Stepping Out Partnership is based.

The last stage of the research entailed speaking to other key informants and stakeholders who are not directly associated with the project as either employees or users. Having obtained the views of both of the latter groups, it was considered important to speak to people outside of the organisation but who still had some involvement with it or an understanding of the work in which it is engaged. Had there been more time and resources available it would have been useful to speak to people, other than users, who might have been affected by the project. This group could have included parents and guardians of Stepping Out's users, local businesses and residents.

This order of documentary evidence, stakeholders directly involved in the project, and other key informants and stakeholders seemed to work well. This basic framework is something that possibly could be successfully transferred to the other case studies.

Interviews were held with project staff to explore the impacts of detached youth work on health determinants. The definition of health, which underpinned the interviews, was based on the socio-environmental model. This is described in **Appendix 3.**

**Figure 3.1: The Stepping Out HIA: Methods and Procedures**



## 3.2 Procedures

The nature of the case study project and the methods involved in conducting an HIA, necessitated the compliance and co-operation of project staff. At the pre-selection stage, a meeting was held with the Venus centre manager in order to establish whether Stepping Out would be suitable. Once the research into Stepping Out began, a further two meetings were held. These were attended by two members of the research team and the Venus centre manager and the Stepping Out Project manager. At these meetings, the following issues were discussed:

- **The type of youth work in which Stepping Out specialises**
- **The nature of Stepping Out's client group**
- **The (socio-environmental) model of health that is being used for this research**
- **Additional project information to which the researchers would like access**
- **Access to project workers and project users**
- **Spin offs/ benefits for the project**

At the meetings, the vulnerability of Stepping Out's users became apparent. The project workers felt, because of this, that it would not be possible to allow us direct access to one group of clients who use the project: those who receive One to One support. The researchers considered that the vulnerability of this group and the extent and nature of their problems made their views particularly important. It was therefore agreed that the research team would design a semi-structured questionnaire interview format that the one to one workers would conduct with their clients during the sessions. The reasoning behind the questions and the extent to which they were successful in eliciting the information that was needed is discussed above. The views of the project manager as to the way that the questions should be phrased - in order that they were meaningful to the project's users - were particularly helpful. A researcher would brief the workers beforehand so that they understood the nature of the research.

Stepping Out has a group of young women who are Peer Educators. These are age 16 to 25 and have participated in training about working with other young women at a similar level (in similar circumstances) to discuss issues of concern. The project workers and research team agreed that it would be useful for one of the researchers to attend a meeting of the Peer Educators. The aims of this meeting were:

- To meet the peer educators and to explain the research to them
- To suggest that they might want to include a workshop about health at their conference and, if so, to volunteer to help them plan it.

One of the researchers also attended a subsequent meeting of the Peer Educators to ask for their help in planning and conducting focus group sessions with two of the groups that Venus runs.

Involving the Peer Education Group was as important for making sure that Stepping Out got something out of being a case study project, as it was for informing the research. This was time consuming for the researcher involved, however it would probably be a fair assessment to state that the extra effort was worth it in order to maintain good relations with the case study project.

The assistance of the Project Manager was also required at a later stage in the research to provide names and contact details of key informants and stakeholders from external organisations.

## 3.3 Documentary research and collation of existing information about the project area

In order to place the Stepping Out area of operation into context, a set of demographic, land use and crime risk profiles was produced drawing upon data sets available in an area profiling system developed by members of the research team (Hirschfield and Bowers, 1997). These appear as **Tables 3.1, 3.2 and 3.3**. Each table shows the position of the Stepping Out area compared with that of the Borough of Sefton and Merseyside County.

The Stepping Out area contained just under 25,000 residents with an average daytime population of 31,000. The area is densely populated and had a higher proportion of its residents in the 10 to 15 and 20 to 24 age group compared with elsewhere (**Table 3.1**). Levels of disadvantage, as measured by unemployment, low income (i.e. the percentage of households without a car), and the percentage of children in non-earning households, were significantly higher than in Sefton or Merseyside generally (**Table 3.2**).

**Table 3.1: Stepping Out Area: Population and Land Use**

| Indicator | Stepping Out Area | Sefton Metropolitan Borough | Merseyside County |
|---|---|---|---|
| **Residential Population** | 24,696 | 289,554 | 1,403,642 |
| **% Residents Aged:** | | | |
| **10-14** | 8.0 | 7.3 | 7.5 |
| **16-19** | 5.4 | 5.4 | 5.4 |
| **20-24** | 8.3 | 6.7 | 7.3 |
| **'Daytime' Population** | 31,048 | 264,094 | 1,392,118 |
| **Population Density** | 43.1 per Ha | 18.9 per Ha | 21.4 per Ha |
| **Population Density Residential Areas** | 128.6 per Ha | 59.7 per Ha | 67.1 per Ha |
| **% Population Change 1981-91** | -6.4 | -5.3 | -9.1 |
| **% Change in Economically Active Males 1981-91** | -14.4 | -10.9 | -16.3 |
| **Number of Residential Properties** | 9,972 | 112,914 | 574,878 |
| **Number of Non Residential Properties** | 983 | 6,077 | 36,658 |
| **Social Meeting Places** | 31 | 252 | 1,284 |
| **Schools** | 19 | 210 | 1,247 |
| **Public Houses** | 40 | 163 | 1,288 |

Notes: Ha = Hectares; Population Density Residential Areas = Residential Population per Ha of residential land. Information in rows 1 through 9 are either from or based upon the 1991 Population Census. All other information relates to 1996.

**Table 3.2: Stepping Out Area: Neighbourhood Type and Social Disadvantage**

| Indicator | Stepping Out Area | Sefton Metropolitan Borough | Merseyside County |
|---|---|---|---|
| ***% Residents in Super Profile:*** | | | |
| **Affluent Professionals** | 2.6 | 12.6 | 8.2 |
| **Better off Older People** | 0.0 | 12.4 | 8.3 |
| **Settled Suburbans** | 2.1 | 22.1 | 14.4 |
| **Better-off young Families** | 9.0 | 12.9 | 14.5 |
| **Younger/ Mobile** | 0.0 | 0.3 | 1.7 |
| **Rural Communities** | 0.0 | 0.1 | 0.08 |
| **Low Income Older People** | 3.3 | 10.0 | 5.5 |
| **Blue Collar Workers** | 4.6 | 8.0 | 10.5 |
| **Lower Income Households** | 13.6 | 5.2 | 10.0 |
| **Lowest Income households** | 64.8 | 16.4 | 26.9 |
| **TOTAL** | *100.0* | *100.0* | *100.0* |
| **% Households without a car** | 66.1 | 37.2 | 45.0 |
| **% Persons Unemployed** | 25.1 | 11.5 | 15.9 |
| **% aged 16-24 Unemployed** | 41.8 | 26.4 | 33.8 |
| **% Children in lone adult unemployed households** | 23.4 | 10.8 | 15.4 |
| **% Children in 2 adult unemployed households** | 18.3 | 9.3 | 13.5 |
| **% Recent (1 year) Migrants** | 10.0 | 7.1 | 7.3 |
| **% Non White** | 1.1 | 0.9 | 1.8 |

Notes: n adult unemployed households = households with children where none of the adults is in employment. All indicators in this table are based upon the 1991 Census

Youth unemployment affected over 41% of economically active 16 to 24 year olds in 1991 and a similar proportion of children lived in households without a wage earner.

The Stepping Out area had a significantly higher proportion of households in accommodation rented from a private landlord than elsewhere and a sizeable share of Housing Association properties, although, levels of council housing were close to the Merseyside average. Significantly, the area had higher levels of domestic burglary; assault, neighbour disputes, minor disorder and juvenile disturbances compared with elsewhere (**Table 3.3**). The relatively high levels of assault and disorder might, in part, reflect the fact that the area has a mix of land uses and contains residential, commercial, industrial properties as well as entertainment foci (one quarter of Sefton's public houses in 1996 were concentrated in the Stepping Out area).

The distribution of different types of residential neighbourhood within the Stepping Out area was identified using the Super Profiles Geodemographic classification (Batey and Brown,1995). Geodemographic classifications use a combination of census variables and other data to identify which residential neighbourhoods are similar in terms of their demographic socio-economic, ethnic and housing composition. In the case of Super Profiles, some 120 variables were used to collapse Britain's 146,000 enumeration districts (i.e. small areas with populations circa 500 persons) 40 'Target Markets' and 10 broader 'Lifestyle' categories. Pen picture descriptions of the demographic and social characteristics of the 10 clusters comprising the 'Lifestyle' level of the classification are shown in **Appendix 2**.

Super Profiles was adopted in the mid 1990s by the Department of Health and has been used to relate variations in mortality, morbidity, and the use and provision of health services to socio-economic conditions (see, for example, NHS Executive North West,1988).

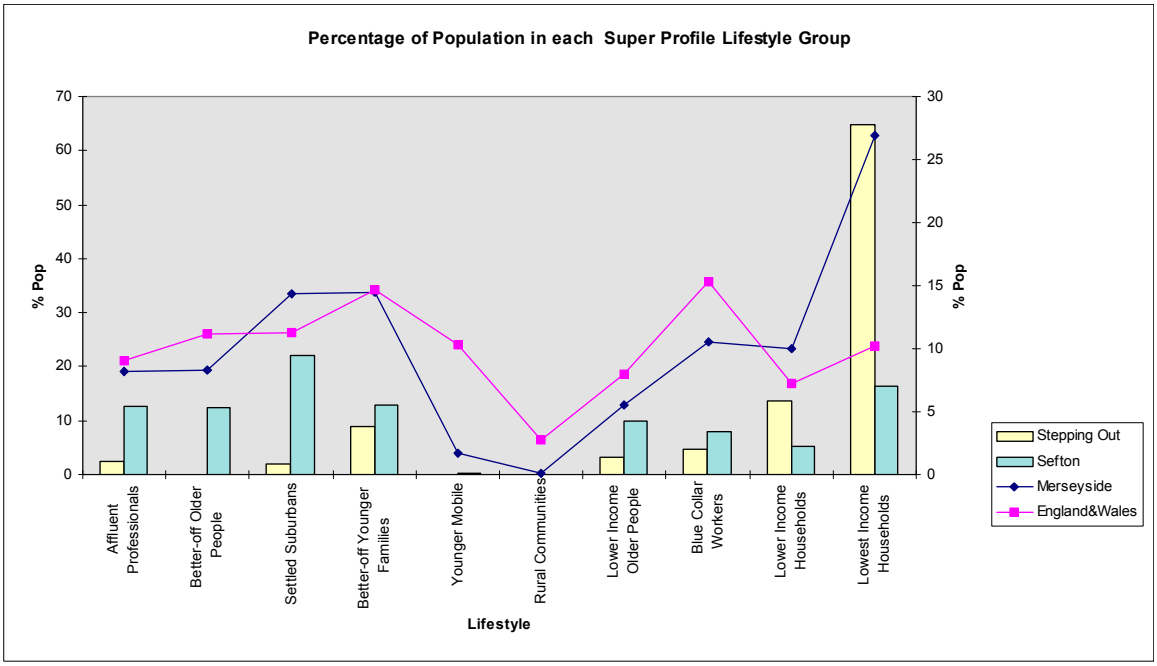
The majority of households in the Stepping Out area (65%) lived in the most deprived neighbourhood type ' Lowest Income Households'. This compared with only 16% of Sefton's households and just over one quarter of those on Merseyside. Lower Income households comprised the second largest category accounting for 13.6 % of the area's households. Thus, over 78% of Stepping Out's population resided in the most deprived areas. The difference in social composition between Stepping Out and the comparison areas is clearly demonstrated on the graph that appears as **Figure 3.2**.

**Table 3.3: Stepping Out Area: Housing Tenure and Calls to the Police**

| Indicator | Stepping Out Area | Sefton Metropolitan Borough | Merseyside County |
|---|---|---|---|
| ***% Households in Accommodation*:** | | | |
| **Owner Occupied** | 45.7 | 72.9 | 63.1 |
| **Council Rented** | 24.6 | 13.5 | 22.8 |
| **Private Rented Furnished** | 3.1 | 3.0 | 2.4 |
| **Private Rented Unfurnished** | 10.9 | 5.3 | 5.2 |
| **Housing Association** | 14.5 | 4.2 | 5.3 |
| **Other tenure** | 1.2 | 1.1 | 1.2 |
| **TOTAL** | 100 | 100 | 100 |
| **CRIME & DISORDER** | | | |
| ***Calls to the Police per 1,000 residents reporting:*** | | | |
| **Domestic Burglary** | 19 | 13 | 17 |
| **Assault and Wounding** | 7 | 4 | 6 |
| **Disputes with Neighbours** | 20 | 10 | 12 |
| **Juvenile Disturbances** | 36 | 19 | 26 |
| **Minor Disorder** | 76 | 41 | 58 |

Notes: Information on housing tenure is derived from the 1991 Population Census. Information on Crime and Disorder was produced using calls for service to Merseyside Police covering the period 1992 – 1995 inclusive.

## Figure 3.2: Socio-demographic characteristics of the Stepping out Area




Of the 27 young people who filled out Self-Assessment Questionnaires, 21 gave their full unit postcode of their home address. Fifteen of these young people (72%) lived in the two most deprived Super Profile Lifestyles, 'Lowest Income Households' (57%) and 'Lower Income Households' (14%). A further four lived in the next most deprived areas. Only 2 of the 21 lived in relatively affluent areas. This suggests that Stepping Out had been targeting young people living in the most deprived areas as well as those displaying vulnerability at the individual level. Thus it is not unreasonable to assume that any positive health impacts among this group arising as a result of exposure to the project would be a step in the right direction as far as reducing health inequalities is concerned.

## 3.4 Provision for young people in the area other than Stepping Out

There are a number of agencies and smaller associations in Sefton, which work with and for young people in the immediate and adjacent areas in which the Stepping Out Project operated. Although Stepping Out is funded to provide its services to young women in the Linacre and Derby Wards it does work in partnership with a number of the listed agencies and its own services would appear to be complementary to those of other service providers.

The local authority, Sefton Council, ensures that there is statutory provision for young people through Sefton Youth Service, Social Services and the Probation Service. The South Sefton Youth Service is the main agency engaged in youth work on the streets of Linacre and Derby wards and has been operating a detached youth work project since January 1998. However, work is with both genders and is not specifically targeted at vulnerable young women.

The Borough's detached youth workers have liaised with the Stepping Out Project but the service which they provide is complementary and does not duplicate the very specialist role of Stepping Out.

There are a number of other organisations providing services for young people in the area on a wide range of issues. These are accessed by young women in the area, often via the Stepping Out Project. They include the following:

***Litherland Youth Centre, Sefton Lane, Bootle : funded by the National Lottery.***

***Independence Initiative, Balliol Road, Bootle : provides advice, training and support to drug users.***

***Sefton Women's Advisory Network, Knowsley Road, Bootle.***

***Sefton Women's and Children's Aid ( S.W.A.C.A.), Bridge Road: offers support to victims of domestic violence.***

***Merseyside Youth Association, 408: offers support and counselling to young people, drop-in centre.***

***W.H.I.S.C.: runs an abuse therapy group for women: based in Liverpool city centre but can be accessed by young women from Sefton.***

***Homestart, a national organisation with local branches: offers support on housing related issues.***

***The Brunswick Centre: Bootle: Youth centre, support work, drama workshops.***

***Hubnub, Orrell Community Centre, Orrell Lane, Bootle.***

***Seaforth Youth Centre: Bootle: very near to Venus.***

***P.A.C.E.: Bootle: offers sexual health services.***

***The Bridge Project: Bootle: offers services relating to drugs issues. (S.O. project partner ).***

***The Pheonix Project: Southport: multi-agency detached youth work and support project. Venus is one of the managing partners , with responsibility for detached youth work.***

***S.I.N.G.: Bootle : Seaforth neighbourhood project, provides a variety of local services and activities.***

## 3.5 Gathering expertise, knowledge and views from key informants and stake holders

### *i) Selection of Key Informants*

There were essentially three types of informants used in this case study: **project workers, project users** and **professionals from other organisations** in the area. It was considered important to speak to representatives of each of these three groups since they were all likely to have different perspectives of Stepping Out and what it is trying to achieve.

Three project workers were selected to be formally interviewed: the project manager and two one to one support workers. They worked 50 plus, 35 and eight hours a week respectively and thus had different levels of involvement with the project. In addition to these interviews, one of the researchers was able to talk on an informal basis to a number of other project workers, including one of the volunteer detached youth workers. After these three interviews had been conducted, it was not considered necessary to carry out any more since it was decided that the information provided was sufficient to give the researchers a good understanding of the workers' perspective.

It was evidently important to obtain the views of the project users. The project was not big enough to allow a random sample of users to be taken. Instead, a questionnaire was designed which was to be filled in with any young woman who received one to one support (both existing and new clients). It is important to note that it was down to the discretion of the youth workers to determine with whom of their clients they filled in the questionnaire. Evidently if a young woman was having a crisis, dealing with that had to take priority. It could be that those who were interviewed were the most vulnerable since they would receive the more frequent sessions thus allowing more time for the interview. Conversely, it could be those who were slightly less vulnerable who were more likely to be interviewed given that they maybe had fewer pressing issues to sort out in their one to one sessions.

The one to one interviews were in addition to the use Self Assessment Questionnaires which had previously been filled in by 27 of the project's users, some

of whom had completed a second or even a third questionnaire for the purposes of a broader evaluation exercise.

With the two focus groups it was unfortunately not possible to speak exclusively to users of Stepping Out, since the project was not doing any group work at that time. Instead, participants in two other groups that are run by Venus: the Activity Group for 11 to 16 year olds and the 'Young Mums Group' were used. Some, but by no means all, of the attendees of these groups used Stepping Out. Questions must inevitably be raised about the extent to which the perceptions and experiences of the young women in these groups are likely to be similar to those of Stepping Out's clients. Similarities may lie in the fact that they are of the same age range, of the same gender, living in the same area and making use of single sex youth work provision. Differences may lie in the extent and nature of the vulnerability and the type of support that they require. It was unfortunately not possible to differentiate between what was said by focus group participants who used Stepping Out and those who did not.

The final stage of the empirical research involved identifying and interviewing a third set of key informants and stakeholders: professionals from voluntary and statutory organisations working in the north Sefton area. There are a substantial number of such bodies that Stepping Out works with and it was, therefore, impractical to attempt to interview representatives from all of them. Instead, it was necessary to select a sample of them. This was facilitated by means of the matrix that appears in **Table 3.4**, below:

## Table 3.4: Relevant professionals from voluntary and statutory bodies

| **Category of Professional** | **Organisation** |
|---|---|
| Representatives of affected communities | ***Stepping Out and Venus*** |
| Proponents of Project and Project workers | ***Stepping Out workers***<br><br>***SRB Partnership Board*** |
| Experts with relevant knowledge | ***The Shaw Trust*** |
| Relevant Health professionals | ***South Sefton Clinic***<br><br>***PACE (Pregnancy Advice Counselling and Education)*** |
| Relevant Statutory organisations | ***Educational Welfare***<br><br>***Child Protection***<br><br>***Social Work***<br><br>***Merseyside Probation Service***<br><br>***Merseyside Police*** |
| Relevant Voluntary organisations | ***For example, The Shaw Trust, Venus Centre*** |
| Key decision makers | ***For example, SRB Partnership Board members*** |

As far as possible, an attempt was made to speak with at least one person from each of these categories. However, for practical reasons, in particular time constraints and difficulties in getting hold of people this was not achieved for the following categories: Experts with relevant knowledge not from the locality, experts from relevant voluntary organisations and key decision makers. As well as project workers and beneficiaries, the researchers were also able to interview professionals from the following organisations:

**Merseyside Probation Service**

**The Shaw Trust** – An organisation that works with unemployed people who are disabled and who are looking for work

**South Sefton Clinic** – An NHS clinic which deals in child and adolescent psychiatry

**PACE** – An organisation that works with young people to encourage them to make positive and informed choices around sex.

### *ii) Means of obtaining information from key informants and stakeholders and questioning used*

a) Project Workers

The aims of the interviews with the project manager and project workers were as follows:

- to obtain their impressions about the effect the project has on health determinants and on health;
- to obtain specific examples of where the project has made a difference to individuals;
- to ascertain the number of project users and the extent of their involvement;
- to establish whether there is any effect on people beyond those that they directly deal with;
- to try to determine the impact of the project on the (whole) population in the target area;

The questions used to structure the interviews with the project manager and the project works are listed in **Table 3.5.** They were designed to facilitate the accomplishment of these aims. Asking them about their job description and what it involves (Q1) and the number of clients they have and how they work with them (Q2), was intended to find out the nature of their work in Stepping Out. This would allow the researchers to understand the basis on which the worker arrived at her views.

Question three involved the use of the health determinants matrix. The interviewee was shown the list and asked to comment on any areas in which she thought Stepping Out had had an impact. It was intended that answering this question would require the bulk of the interview time. (Going through the matrix involved the interviewer drawing out responses from the informants and reassuring them that they did not have to provide an answer to every single type of determinant).

**Table 3.5: Questions used in the Interview with Project Manager / Project Workers**

1. **Name and job description and what is it that you actually do?**

2. **How many clients do you have? And what do you do with them? (How often and for how long)**

3. **Using checklist (Does the project have an effect and how?)**

4. **What has been the impact of the project on:**

- ***The whole population***
- ***Older people***
- ***Children***
- ***Women***
- ***Ethnic minorities***
- ***Deprived communities***
- ***Other relevant groups***

5. **What has been the impact of the project on the area as whole?**

6. **What factors limit the efficacy of the project?**

Question four attempted to disentangle the impact of the project on different groups within the population. It was considered important to do this in order that any groups who were particularly benefiting or being adversely affected by it could be identified. With the exception of the category "The Whole Population" and "Other relevant groups" all the other groups listed could be described as vulnerable. It was thus determined to be of some considerable importance to examine whether the project would impact negatively upon them.

Question five sought to ascertain the extent to and ways in which Stepping Out has had an effect on the area in which it is based. This was asked so as to establish whether the impact of the project is contained to just the users or whether is has a wider effect than this.

Asking: "What factors limit the efficacy of the project?" (Q6) was a way of finding out, if the project is having a beneficial effect, what could be done to improve it. To a certain extent it is a counterfactual question since the project is operating within the limits of its resources and influence and what it could do if it did not have these constraints is speculative. However, this question is relevant to the evaluation of the project and dissemination about lessons that other projects that are just setting up can learn from.

b) Clients

As previously stated, the views of young women were obtained in two different ways: through semi-structured interview questionnaires and via two focus groups.

The aims of the interviews with the users of one to one support were:

- To find out the extent and nature of their involvement with Stepping Out
- To obtain their views about the influence that Stepping Out has had on their life, in particular their confidence in their ability to articulate their feelings and their optimism about the future
- To establish the state of their health before and after becoming involved with Stepping Out and to gather their views about what affects their health more generally

A questionnaire was designed for use specifically by the one-to-one project workers in their interviews with Stepping Out clients. The full questionnaire appears as **Appendix 4.**

Questions two to four were designed to uncover the type of involvement that the young woman has with Stepping Out, how long she has participated in the various activities and the intensity of that involvement. Question five is an open-ended question that is intended to allow the respondent scope to give any answer that she likes. Questions six and seven are about the respondent's perception about whether or not the project has improved her life and, if it has, how it has done this. Questions eight, nine and ten attempt to gauge the respondent's capacity to self-advocate before and after becoming involved in the project. Where applicable, the interviewee is then

asked to explain what it is that had made her feel differently about being able to do this. Questions eleven, twelve and thirteen are a similar set of questions: they concern the participant's optimism about the future before they used Stepping Out and now. Again, they are asked to explain any discrepancy between the two answers.

The following questions deal specifically with health. The respondent is asked to rate her health before Stepping Out and now on a scale from Very good to Very poor. Those who describe their health as poor or very poor are asked to explain what it was or is about their health that was not or is not good. They are then asked the same two questions again based on their health now. Questions 18 and 19 are very much connected. The former asks them to consider what affects their health and the latter how their state of health has an effect on their life. They are then asked to describe any changes to their health as a result of their being involved in Stepping Out (Q20). A question asking whether there is anything else that has affected their health that is separate from Stepping Out follows this. Finally, they were given the opportunity to add any other information that they would like to give (Q22).

The aims of the two focus groups were:

- to find out their feelings about using the Venus Resource Centre (where Stepping Out is based)
- to find out their views about the issues that are affecting their lives
- to discover what health means to them

The content of the two focus group sessions is shown in **Appendix 5**.

c) Other key informants and stakeholders

The aims of these interviews were to gain the impressions of knowledgeable outsiders about:

- The effects that the project has on health determinants for the young women who use it
- The effects that the project has on health determinants for others including those who are close to the project clients, vulnerable groups and Bootle as a whole.
- The effects that the project closing will have on its clients and on others in the area?

The short questionnaire used for these interviews appears in **Table 3.6**, below.

Question One is designed to find out what experience, knowledge and expertise the key informant has. This is important since it may explain why they hold a certain view about the impacts of Stepping Out. This is important, especially if their view turns out to be a minority one. For example, a social worker could identify an issue around child protection not picked up on by other key informants because they are not so aware of this. This observation, therefore, would still be considered valid even though it was only made by one person.

The second question involved the use of the health determinants matrix. The interviewee was shown the list and asked to comment on any areas in which she thought Stepping Out had had an impact. It was intended that answering this question would require the bulk of the interview time. (Going through the matrix involved the interviewer drawing out responses from the informants and reassuring them that they did not have to provide an answer to every single type of determinant). This is the same question that was used for workers of the project.

Question Three asked the key informant to think about any effects the project had on other groups besides its actual users. This was designed so that consideration could be given to the limits of its impact: Were they confined to project users or did the effects go wider than this?

## Table 3.6: Questions used in Interviews with Key Informants and Stakeholders

**Read out the following information about Stepping Out:**

***Stepping Out aims to empower and assist young women in South Sefton in developing to their full potential through the advancement of education, protection of health and participation in social, arts and cultural facilities. It provides One to one support, group work activities and engages in detached youth work. The project began in August 1997 and its two-year funding ended in June of this year. Further funding to enable the project to continue is actively being sought. The project employed a full time worker and five part time workers, as well as a number of volunteers.***

**1. Please tell me a bit about your job and what it involves**

**2. What effect do you think that Stepping Out has had on these particular categories (Show health determinants check list) thinking about your client group in particular?**

3. **What effect do you think that the project has had on:**

***a) Others who are close to, or have contact with, the young women that you see***

***b) Others and vulnerable groups ( people on low incomes, older people, ethnic minorities, disabled people, children and young people, women)***

***c) South Sefton/ Bootle as a whole***

**4. As you may be aware, Stepping Out's two-year funding has now come to an end. Although further funding is being sought it is now looking likely that there may be a time lapse before the project operates fully again. It is also possible that the project may not be able to procure the necessary funding. What effect do you think that these two scenarios will have on the quality of life of the young women who use Stepping Out?**

The final question tried to consider the Health Impact Assessment from another angle. Instead of looking at the effects of the project's existence it instead attempts to get at the effects on its users of it no longer being there, or offering a reduced level of service.

# 4. Findings and Analysis

## 4.1 What effect has Stepping Out had on health and on determinants of health in relation to its users?

The data collected about Stepping Out from key informants and stakeholders has uncovered a large number of ways in which Stepping Out has had an effect on health determinants and on the health of its users. This section of the report proposes to go into detail about the most significant eleven of these. (Significance is measured by the number of informants who mention a health determinant). Since more users were consulted than any other group, this means that the results are weighted in favour of their views. However, since they are the intended beneficiaries this seems reasonable. It is nevertheless recognised that the issue of whose views to ascribe weight to is not an easy one to resolve since it must inevitably rely on the subjective value judgements of the researchers. Consideration will also be given to a selected number of other health determinants that did not come in the top 11 but which nevertheless, in the opinion of the researchers, are worthy of discussion. This might be, for example, because the informant who mentions it is privileged by the position that they hold to recognise the importance of that particular determinant. This is again based on the value judgements of the researchers. It would be expected that the manager of Stepping Out, who regularly worked over 40 hours a week would have a more in depth knowledge of the impact of Stepping Out than a part time worker or a worker from another organisation. Equally, the probation office was likely to have a far greater understanding of the preventative work that Stepping Out has done in this area than perhaps other professionals in different fields.

**Table 4.1** below, shows how the three key informant groups ranked the importance of the different health determinants. From this it can be seen that there is some variation in the importance that different groups ascribe to certain health determinants. Self esteem was the most frequently cited health determinant impact by project workers and clients. However, only one professional from outside of Stepping Out mentioned it.

**Table 4.1: Number of Key Informants identifying Health Determinants Impacted on by Stepping Out in Rank Order**

| **PROJECT WORKERS** (TOTAL=3) | ***NO.*** | **YOUNG PEOPLE** (TOTAL=14) | ***NO.*** | **PROFESSIONALS** (TOTAL=4) | ***NO.*** |
|---|---|---|---|---|---|
| ***Self Esteem*** | **3** | ***Self Esteem*** | **10** | ***Social Networks*** | **4** |
| ***Peer Pressure*** | **3** | ***Social Networks*** | **8** | ***Social Services*** | **3** |
| ***Education and training*** | **3** | ***Employment*** | **4** | ***Education and training*** | **3** |
| ***Family*** | **3** | ***Education and training*** | **3** | ***Employment*** | **3** |
| ***Employment*** | **2** | ***Housing*** | **2** | ***Community Facilities*** | **2** |
| ***Housing*** | **2** | ***Peer Pressure*** | **2** | ***Leisure*** | **2** |
| ***Social Services*** | **2** | ***Recreation*** | **2** | ***Peer Pressure*** | **1** |
| ***Community Participation*** | **2** | ***Culture*** | **1** | ***Discrimination*** | **1** |
| ***Recreation*** | **2** | | | ***Culture*** | **1** |
| ***Risks*** | **2** | | | ***Family*** | **1** |
| ***Health Care*** | **2** | | | ***Self Esteem*** | **1** |
| ***Diet*** | **2** | | | ***Criminal Justice System*** | **1** |
| ***Criminal Justice System*** | **2** | | | | |
| ***Fear of Crime*** | **2** | | | | |
| ***Discrimination*** | **1** | | | | |
| ***Social Networks*** | **1** | | | | |
| ***Culture*** | **1** | | | | |

Education and training and employment are mentioned by approximately the same proportion of people from each group.

**Table 4.2** below, shows the order of the health determinants by how many key informants and stakeholders from all groups referred to them out of a total possible of 21. (The number alongside is the number of respondents who did this). The results of the focus groups are dealt with separately.

## Table 4.2: Ranking of most frequently mentioned Health Determinants

| CATEGORY OF HEALTH DETERMINANT | WORKERS | YOUNG PEOPLE | PROFESSIONALS | TOTAL FOR ALL GROUPS |
|---|---|---|---|---|
| *Self Esteem* | 3 | 10 | 1 | 14 (67%) |
| *Social Networks* | 1 | 8 | 4 | 13 (62%) |
| *Education and Training* | 3 | 3 | 3 | 9 (43%) |
| *Employment* | 2 | 4 | 2 | 8 (38%) |
| *Peer Pressure* | 3 | 2 | 1 | 6 (29%) |
| *Family* | 3 | 0 | 1 | 5 (24%) |
| *Social Services* | 2 | 0 | 3 | 5 (24%) |
| *Housing* | 2 | 2 | 0 | 4 (19%) |
| *Recreation* | 2 | 2 | 0 | 4 (19%) |
| *Risk Taking Behaviour* | 2 | 0 | 2 | 4 (19%) |
| *Health Care* | 2 | 0 | 2 | 4 (19%) |
| *Culture* | 1 | 1 | 1 | 3 (14%) |
| *Criminal Justice System* | 2 | 0 | 1 | 3 (14%) |
| *Community Facilities* | 0 | 0 | 2 | 2 (10%) |
| *Discrimination* | 2 | 0 | 1 | 2 (10%) |
| *Fear of Crime* | 2 | 0 | 0 | 2 (10%) |
| *Community Participation* | 2 | 0 | 0 | 2 (10%) |
| *Diet* | 2 | 0 | 0 | 2 (10%) |
| *Leisure* | 0 | 0 | 2 | 2 (10%) |

### *Self Esteem*

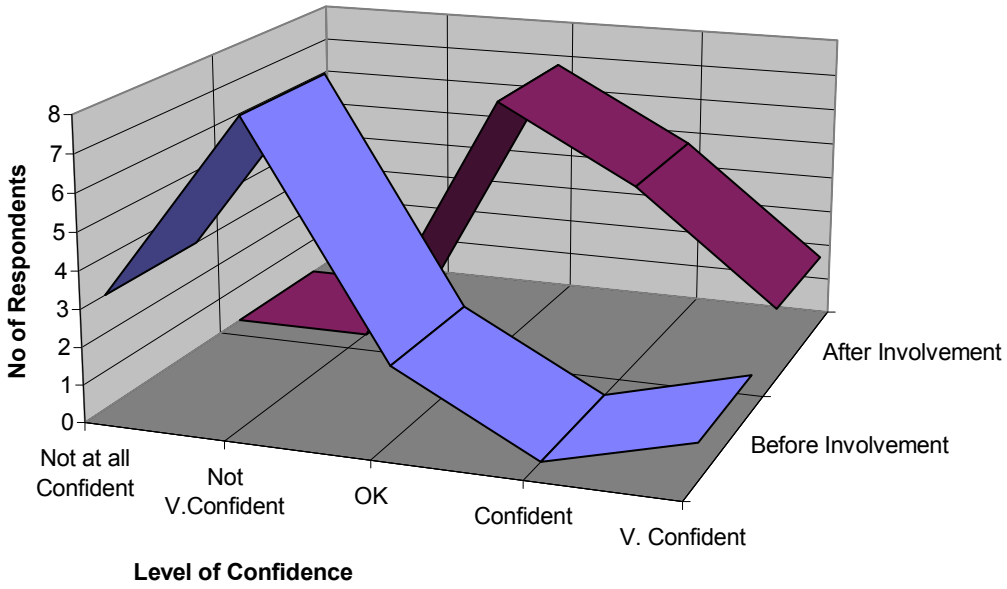
Self-esteem can be defined as "how one describes or evaluates oneself" (Eysenck, 1998). It concerns the perception that a person has of herself and how she rates her self worth.

A closely related concept is that of self-efficacy – "people's beliefs that they have the ability to cope with a given situation and produce the desired outcomes". Clearly high self esteem is a prerequisite for self efficacy since the person has first to have enough self worth to believe that she has a right to act on her own behalf.

The results of the One to One interviews reveal a marked difference in the young women's perceptions of their ability to speak up for themselves before and after becoming a user of Stepping Out. The results from this analysis are shown as a three dimensional line graph in **Figure 4.1**.

Only two people stated that they had felt very confident, confident or okay about revealing their feelings before they became clients of Stepping Out. Twelve people stated that they had felt either not very confident or not at all confident. By contrast, no one stated that they felt not very confident or not at all confident now. Seven people now felt okay and the same number now felt either confident or very confident. Remarkably of the thirteen young women for whom there was a positive difference, eleven of these attributed the change to Stepping Out.

**Figure 4.1: Confidence in expressing feelings to others before and after involvement in Stepping Out Project**




A number of their answers focused on the support and encouragement that they received from the Stepping Out workers:

*"Stepping Out has helped build my confidence and has also helped me to learn how to express my feelings"* (ST31)

*"Because the support is there, it is someone to throw a tantrum at!"* (ST59)

*"Because you have helped me"* (ST42)

*"I feel more confident now because I have been encouraged"* (ST45)

Another popular type of response was that which focused on the feelings of the young women that they were being listened to and taken seriously by the workers. An important part of this trust was the understanding that what they told the workers would be treated as confidential:

*"Meeting with a person from Stepping Out each week has enabled me to talk about things I felt uncomfortable talking about with friends and family. This is mainly because I know what I discuss with Stepping Out is confidential and I won't be judged."*

*"I have gained more confidence and I've realised that by* [sic] *letting people know how I feel is a positive thing and it means that I don't have to be alone if I'm worried about anything."*

*"At the time before Stepping Out I was in a rough time at college and on a downer and feeling low. Now I'm happy and show people how I feel. Even when I am not happy I can show how I feel and people (friends) can help me through."*

Interestingly, these issues of self-esteem and self-efficacy did not come up a great deal in the two focus groups. They were not spoken about at all in the Activity Group. This could be for one of two reasons. First, simply that self esteem is not an issue for this age group or is not recognised or articulated as such by them. Second, that the participants did not feel comfortable talking about very personal feelings in this type of environment. For the Young Mums' Group, the issue of self-esteem manifested itself in the way that they perceived they were viewed and treated by other people:

*"You shouldn't have to prove yourself to anyone"*

*"You do a good thing and you expect people to say 'well done' but they don't."*

*"Who is anyone to say that they are better than me? Millions of people live by the show factor, that having a nice home and nice clothes makes you a nice person."*

*"If they had an hour to spend with you they'd see a different side to you."*

These young women felt very strongly that they were always being judged and criticised by other people and never praised when they did well. Overwhelmingly, they perceived the atmosphere of Venus as being different from this, although not in all cases:

*"Sometimes I've come in here and I've been very patronised when I've been off my head. It just gets you down a little bit more."*

All three of the Stepping Out workers considered self esteem to be an important issue for their clients and an area which the project was seeking to work on. They recognised that a lack of self-esteem was having a major impact on the lives of their clients.

"[Self esteem] *is a big problem. They have no self-confidence. I try to work with them one to one to make a difference. They might not have anyone to tell them that they are doing well. They think they are fat and ugly. The whole ethos of this place is about building self confidence."* (A project worker)

" [Stepping Out is about] *empowering young women to make decisions for themselves, not creating a culture of dependency but of independence. Trying to raise expectations without making false promises…"* (A project worker)

Clearly self-esteem is not just an important health determinant in its own right, it also has a significant effect on other health determinants. A young woman who has low self esteem and low feelings of self efficacy will be less likely to take action that would protect her health and well being (Bandura, 1977). This fact was clearly recognised by the Stepping Out workers:

*"Self esteem comes into everything. If people have low self-esteem they are more vulnerable. For example in a sexual relationship they find it harder to say no or demand condom use. It is harder for them to assert their rights or to speak out about abuse."* (Project Manager)

*"One of them is very vulnerable and easily led, if one of them suggests something* [a drug] *she'll try it – it's all connected with self esteem and self confidence and feeling that you fit in."* (A project worker)

*"One woman has very low self esteem – it ties in with her wanting to do escorting."* (A project worker)

Because self esteem is such an important issue, it is addressed in all the work that Stepping Out does. This includes work around such diverse subjects as employment, body image, peer pressure, sexual relationships, drinking and self-harm.

Although only one of the external key informants actually mentioned self-esteem, all four of them referred indirectly to it. One of the key informants, an employee of an organisation that works with disabled people who are looking for employment, described how Stepping Out can help young women who are disabled to be assertive and to speak out for themselves. A worker from another organisation considered that:

*"For the young women that do accept them they offer incredible, valuable support."*

A probation officer cited the example of one young woman who self harmed whom he had referred to Venus. She was offered counselling to try to find the reasons why she was self-harming. Although she put a stop to it before they uncovered the reason why, it nevertheless had a beneficial effect on her life. They were able to help her find a job, which, although it only lasted a week, was still progress because she had not had the confidence to work before. She was also now in a relationship, which she had never had before.

***Social Networks***

These are informal structures of support and friendship that help people to have a better quality of life. Absence of these social networks for anyone can lead to isolation and loneliness with all their contingent problems. All the professionals outside of Stepping Out and 8 out of 14 of the young women mentioned this category. Interestingly however, only one of the project workers refers to it as being something that Stepping Out has influence on.

The group work activities and residentials that Stepping Out organised were important means of enabling young women to socialise with each other and to meet people that they might not otherwise have met. In an interview with the project manager, she stated that they deliberately do group work where young women have to work together with people that they might not necessarily know. The effectiveness of this is shown by some of the answers given by the young women who were interviewed by their one to one workers. A substantial number of them made comments about Stepping Out enabling them to "meet new people".

*"I've met a lot of nice new people and made new friends."*

*"Stepping Out has help* [sic] *me to make friends more easily."*

An indirect way that Stepping Out influences the young women's ability to make friends is by increasing their confidence so that they can meet people outside of the project:

*"It's made me talk to people that I haven't seen before. Before it groups of girls used to pick on me but now they talk to me and if I am upset they ask if I'm alright."*

According to the project manager, enabling the young women to build up social networks is very important since many of them do not have adequate social support:

*"A lot of young women are isolated in their neighbourhoods…As are young women who have been excluded from school."*

Young women in both of the focus groups also talked about the value of Venus as a place to form new friendships and to strengthen existing ones:

Q: What do you like about coming to Venus?

*"You meet new people"*
(Young woman from the Activity Group)

*"*[I've] *got people to talk to"*
(Young woman from the young mums' group)

*"Meet people that you already know"*
(Young woman from the young mums' group)

One of the questions from the Self Assessment Questionnaire asks the young woman how she feels about her relationships with her peers. The graph below in **Figure 4.2**, shows the results for this question from each client's first questionnaire. As is shown below, the majority of respondents viewed this relationship as being "O.K". Nine people felt either very good or good and only two people felt bad or very bad.

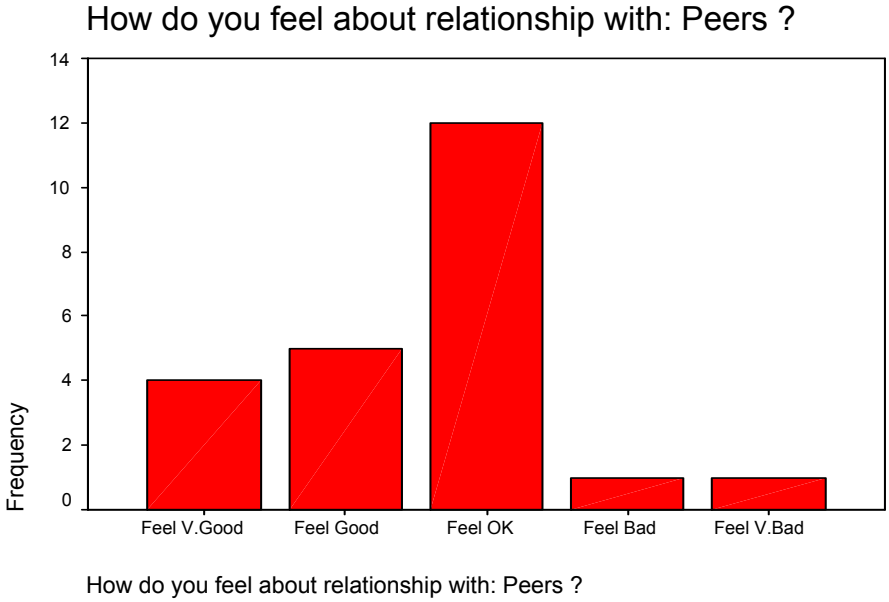



**Figure 4.2: Attitudes of young women towards peers**

Unfortunately, of the 27 clients who completed a first questionnaire, only 11 filled in a second one and only four went on to do a third. The intention was that by comparing the results of the same question for the same individual over time, it would be possible to track changes in their feelings and perceptions. However, because such small numbers are involved, it has been very difficult to do this. Of the four young women who filled in two questionnaires and answered this question, for one young woman there was no change (she felt "very good" both times). For the other three there was a change for the worse (two went from feeling "very good" to "good" and

one went from feeling "good" to "O.K"). Of the four clients who answered this question three times, two kept the same answers throughout (O.K and very good). One went from Don't know to O.K. The fourth went from feeling O.K to feeling very good. One explanation for some trajectories going from positive to negative could be that the project has raised the awareness of their clients about some issues that they may not have thought about before, for example peer pressure.

All four of the professionals interviewed mentioned the importance of Venus and Stepping Out for helping young women to develop social networks. Interestingly, this was the only category for which this was the case. Key informants from the Shaw Trust and SAFE made reference to the particular problems that young women who are disabled can face in terms of feeling isolated. Clients from these organisations were referred to Venus because it was considered that, as well as empowering them to speak out for themselves, the organisation would also enable them to meet other young women of their own age. A representative from South Sefton Clinic similarly referred to the particular needs of his client group, which he thought Venus was able to address. The young women whom he treats are often very isolated and withdrawn, lacking in confidence and self esteem. He considered that they would find the average youth group intimidating since it would involve mixing with groups of young people in an uncontrolled setting. Because Venus works at the level of the individual it can provide a safe, non threatening environment where young women can form friendships on their own terms, as and when they are ready.

***Education, training and employment***

The Stepping Out project was not set up to create job opportunities and thus the influence that it has on young women accessing employment is indirect. It therefore seemed appropriate to deal with these issues under the same section. A total of nine people (3 adults, 3 young women, and 3 professionals) cited education and training as an area over which Stepping Out has influence. A similar number (8) mentioned employment (2 workers, 4 young women, and 2 professionals).

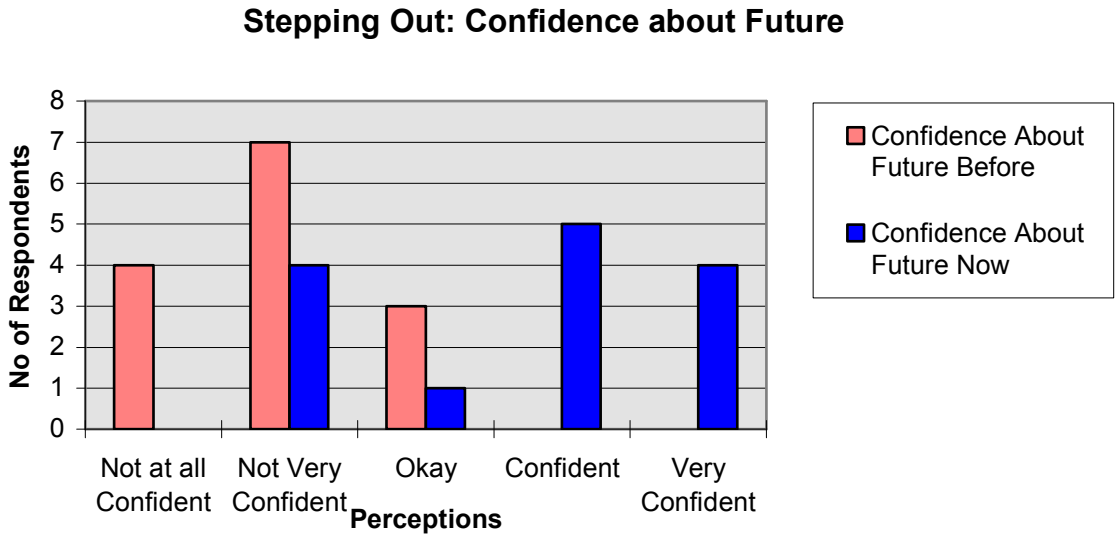
The project manager detailed a number of ways in which Stepping Out seeks to deal with the problem of young women who are not attending school. These include using the one to one sessions to explore with the young woman why this is the case. It could be for a number of reasons for example that she is being bullied or that

she is being kept at home to look after younger siblings. If the young woman does decide to return to school she will be need to be given support to catch up with the work that she has missed. It will also be necessary to ensure that she is not hassled by the teachers about her non-attendance, which could cause her to want to truant again. Stepping Out has also run a project targeted particularly at young women who are not attending school or who have low educational motivation. For the young women for whom mainstream education is clearly not meeting their needs, Stepping Out tries to find them alternative forms of education which are more appropriate for them. For example, another worker described how they try to get round the problem of young women who are 16 and who do not see the point of staying at school since they only have 10 weeks left before they can leave. By holding discussions with the school alternatives can be found such as offering the young woman an extended work experience placement.

At Venus young women are encouraged to think about their future and what they would like to do. This has included a "Jobs for the Girls" project which enabled the participants to learn about different options and to meet women in fields that they were interested in. They have also run a computer course and have done workshops with Sefton Enterprises around self-esteem.

Responses to questions about confidence in the future appear in **Figure 4.3.** Prior to their involvement in Stepping Out, none of the young women who completed a questionnaire felt particularly confident about their future. However, a marked shift in this perception occurred following participation in the project after which **the majority** of young women expressed confidence in their future. This change in outlook was encouraging and reflects the increase in self esteem predicted as an important health determinant impact in discussions with other stakeholders.

## Figure 4.3: Levels of Confidence prior to and following involvement in Stepping Out




The support that young women receive (which could include accompanying them on visits to colleges) can give them the confidence to decide to go to college, which will give them a better chance of getting a good job. A number of the young women gave a response related to education and employment when asked to explain the difference in how confident they felt about the future before they got involved in Stepping Out and afterwards.

*"I feel I will be in a job that's stable, probably going through college as well."* (150)

*"Venus is helping me to think about my future as before I didn't"* (ST63)

*"I know what I want to do and Venus has helped me to sort out what I have to do to get where I want."* (ST18)

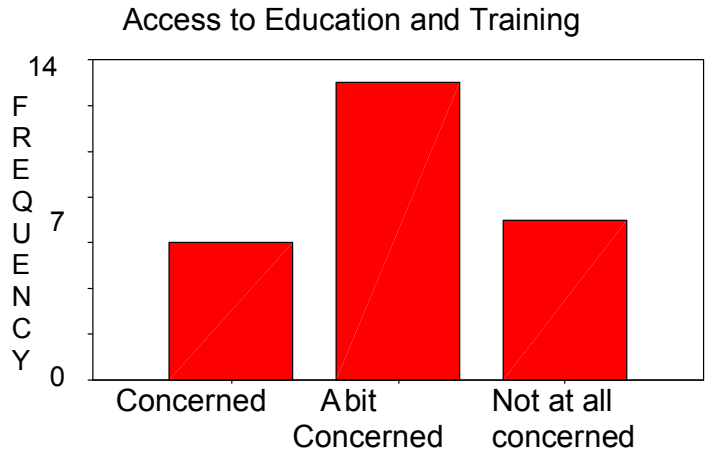
*"Stepping Out has given me more confidence. It has also helped me find employment and given me advice about starting college in September."* (ST43)

*"I am also at college which will help me get a job in the future to provide for me and my son."*
(ST31)

The Self-Assessment Questionnaires provided some indication about levels of concern about access to education and training. The graph below shows the results of the first questionnaire. Of the 26 clients who answered this question, half (13) felt a 'bit concerned' about access to education and training. The remaining responses are

divided almost equally between those who felt very concerned and those who were not at all concerned.

**Figure 4.4: Concerns of Young Women about Education and Training**




Of those who completed more than one questionnaire (nine), there is no pattern to be found. If anything, there is a shift towards being concerned rather than not concerned. This is not necessarily a bad thing. It could be that the client's awareness of the importance of this issue has increased as they have grown older or as a result of their being involved in Stepping Out.

When it comes to finding a job, Stepping Out can help young women to look at what is available and to fill in application forms and write their CVs. However, the project manager recognises that the onus cannot be entirely on the young women and that there is a need to look at the culture of local businesses as well to see whether or not they employ young women.

Interestingly, neither the activity group nor the young mums' focus groups mentioned that Venus had had any effect on them in terms of education, training or employment. However, the young mums' group did discuss the difficulty of surviving on social security benefits.

> *"Being skint all the time is shite. You can't even go for a day out on the socsh* [sic]. *If you had enough money you'd lead a better quality of life."*
>
> *"You can't moan about the socsh* [sic] *you do get enough to feed you but nothing else."*

*"Even clothes for kids are expensive because they grow so fast."*

Of course education is not just important for enabling people to access employment, it is also valuable in other ways. One of the professionals from outside of the organisation who mentioned education did so in this second sense: referring to the work that Venus does around developing life skills. The other professional stated that Venus has links with the careers service.

***Peer Pressure***

Peer Pressure was identified as an issue that Stepping Out had an effect on by all three of the workers, just two out of 14 of the young people and one out of four of the professionals from outside of Venus. Peer pressure can be defined as a person being forced or feeling that they are being forced to behave in a certain way by people who are of the same age or status as them. It is most frequently used to in relation to young people and most often in the negative sense – i.e. that a person is coerced into changing their behaviour for the worse, for example by taking up smoking or drinking or having sex before they are ready. However, peer pressure can surely take place at all stages of the lifecycle (although the argument goes that young people are most vulnerable to it) and can be a positive as well as a negative force. For example, peer pressure could cause someone to stop displaying racist behaviour.

The respondents in this case study all saw peer pressure as a negative force. The workers perceived their roles as being about raising the self esteem of their clients and educating them so that they were less likely to take actions which were bad for them or which they did not feel comfortable with.

*"Stepping Out is running a peer education course looking at the pressures that young women are put under to fit in and conform. It is an issue with smoking and alcohol – they pretend to be drunk because everyone else is drinking, they sleep with someone because their mates are sexually active. It all comes down to self esteem."*
(Project Manager)

Of the two young people whose answers fell into what can be described as peer pressure, one talked about the fact that she hangs around with people who drink

and smoke and the other said that Stepping Out has given her more confidence in dealing with her friends.

The professional outside of the organisation who picked up on it spoke of the atmosphere within Venus that makes it a safe space for young women to be in. This is important since many of the young women may feel uncomfortable with conventional provision for young people because a safe space cannot be guaranteed.

> *"Peer pressure is a very big problem amongst young people. Venus is small and well supervised. I have never had anyone report back to me that they were bullied at Venus."*

***Family***

Family as a determinant of health that Stepping Out can have an influence on was referred to by all three of the project workers, none of the young people and one of the professionals from outside of the organisation. The project manager was well aware of the impact that a young woman's family situation can have on her life and therefore acknowledged the need to work with young women in a way that recognises this fact.

> *"* [Family] *has the biggest influence on a young woman's life. Stepping Out recognises that it is necessary to work with the family.* [The sort of problems that are around are] *abuse, violence and neglect. Some have caring responsibilities for younger siblings – a lot are kept off school to do that…The family is an area of work that is expanding because if you are supporting a young woman then you have to understand the family context that she is coming from."*

However, there are pitfalls in a young woman's family being aware that she uses Stepping Out:

> *"Some parents see Stepping Out as behaviour monitors and try to get them to persuade the young women to go to school. Stepping Out explain that this is not their role."*
> *"All the families know that my clients are receiving one to one support. I have told the families that they can call me if they want to but I can't tell them what my client has been talking about."* (Project Worker)

One area in which Stepping Out can have an impact is in reconciling families and young people through mediation.

*"The law brings families directly into conflict with the Criminal Justice System. The courts can make parental bind overs which attach responsibility to parents. This can bring a rift between the young person and their parents. A lot of people that go to court end up homeless. Stepping Out has managed to prevent homelessness and to achieve mediation.*
(Professional)

*"How young women are getting on with their parents can be an issue. For example there may be conflict at home because they are not at school or they don't get on with their parent's partner."* (Project worker)

In the example given above the project worker stated that she would try to support the young woman to make decisions. Venus can also help by being an alternative place to go when things at home are getting too much.

***Social Services***

A significant number of Stepping Out's clients will have used or will need to use social services. Stepping Out can help facilitate access by supporting the young woman in her dealings with them and acting as an advocate where necessary.

*"Young women are not treated very well unless a worker goes with them. The benefits agency will make her wait for hours and then she will come back with half of what she was meant to get. Stepping Out has to go with them to places to make sure that they get their point across and that they get treated like an adult."*
(Project Manager)

Stepping Out can also help to break down the barriers by trying to change the young women's perceptions of social services.

*"Some of the young women still believe that social services can take your children away. Stepping Out try to get young women to understand that Social Services can offer support."* (Project Manager)

Interestingly, Social Services was not mentioned as a factor that Stepping Out had an influence on by any of the young women.

One of the professionals pointed out that Stepping Out offers continuous support whilst with social services a young woman can be passed from one worker to the next or one home to the next.

***Housing***

Stepping Out can clearly have no direct impact on housing conditions in its target area. However, they are able to provide their users with advice and support about this issue and to act as advocates of the young women to providers of housing.

***Recreation***

Since many of the young women do not have much money, they are not able to access the recreational facilities in the area. Stepping Out enables them to make use of these and therefore participate in the culture of Bootle by taking them out to places (for example the cinema and for coffee) either on their own in one to one sessions or in a group.

***Risk taking behaviour***

Stepping Out has the capacity to have a significant impact on the lifestyle choices of its users by raising their self-esteem and making them aware of the consequences of their actions. Young women can be encouraged to give up or cut down on smoking. By increasing their self-esteem they are less likely feel pressured into drinking, taking illegal drugs or having sex before they are ready. A number of the young women self harm. One to one sessions are used to deal with the causes of this behaviour and a self-help group has been set up at the centre.

***Health Care***

Stepping Out can increase young women's access to health services and the quality of the service that they get. They can do this by accompanying young women to the doctor's and to "family planning" centres. They can also act as advocates for the young women and make sure that they get the help that they need.

## 4.2 What effect has Stepping Out had on health and on determinants of health in relation to the wider population in the target area?

This is a difficult question to answer. It should first of all be recognised that Stepping Out is a small project with a small budget and that therefore it is unlikely that it will have made much difference beyond its client group and their immediate contacts. It should also be pointed out that during the course of this research we have not asked the general public about the effect this project has had on them. We are instead reliant on the opinions of the project workers and key informants.

The Stepping Out workers themselves found it very difficult to say what the impact of the project was on the area as a whole. They all considered that the work they did with the young women would also be of benefit to their families. However, they were unable to say whether the impacts went further than this. Only one of the key informants was able to give a clear example of how Stepping Out has benefited people in the area. He described how residents and shop workers in the area now feel safer because the detached youth work which goes on in the streets gives them the impression that someone is doing something. Although the young people may not be doing anything wrong anyway, the presence of youth workers mitigates the effect of their presence on local adults. It reduces their fear of crime because they perceive that the youth workers are somehow controlling the behaviour of the young people.

It is very difficult to say with any confidence whether Stepping Out has had any influence on the health of the wider population other than the example given above. However, any effects are likely to be minimal and extremely difficult to pin down to the project as opposed to other factors.

## 4.3 Summary of Health Determinant and Health Outcome Impacts of the Project

In addition to the evidence from key informants and stakeholders, evidence from, for example, systematic reviews of related studies (Contributors to the Cochrane and Campbell Collaboration, 2000) indicated that Stepping Out may have a range of other unanticipated effects. In this section, this evidence of health determinant and health outcome impacts is summarised usingresults table format found in the Merseyside Guidelines.

*Health Impacts* describes the impacts of the programme on different health determinants and their subsequent effect on health outcomes. *Direction of Change* indicates whether this is impact is a health gain or loss. *Evidence* refers to the source of the evidence from which the health impacts have been identified, for example key informants, stakeholders and published/unpublished literature. *Likelihood of Impact* indicates the probability with which the impact will occur, *definite, probable* and *speculative*. *Measurability* refers to the measurability of the impact, that is *quantitative* (direct, quantitative data from a survey of stakeholders for example), *qualitative* (opinions or perceptions), *estimable* (indirect, quantitative data from for example modelling). *Priority of Impact* indicates the rank of the impacts against each other given by stakeholders and key informants.

***Self Esteem: Impacts upon Health***

All stakeholders and key informants involved in the interviews, survey and group work identified that the improvement in self-esteem of the young women who were involved in Stepping Out was the main health impact of the project. However the low numbers involved in the case study mean that no definitive statement about the impacts of the project on all, or even most of its participants can be made.

Self- esteem is a useful indicator of psychological health and wel- being in children and adolescents, and lack of it has been suggested as a predictor of suicidal tendency/behaviour (McGarvey et al, 1999; Weber, 1996; Rittner et al, 1995).

The link between self-esteem and eating disorders has also been established; effective school-based interventions to prevent eating disorders focus on promoting self-esteem (O'Dea, 2000). The ability of adolescents to cope with adversity and stressful

**Table 4.3: OBSERVED/POTENTIAL HEALTH IMPACTS – Personal, Family Circumstances and Lifestyle Factors**

| *OBSERVED/ ACTUAL IMPACTS* | *DIREC-TION* | *EVIDENCE* | *MEASUR-ABILITY* | *LIKELI HOOD OF IMPACT* | *PRIORITY* |
|---|---|---|---|---|---|
| Increased self-esteem of some young women involved in SO. | + | Key informants/ stakeholders. | Qualitative/ Quantitative | Definite | High |
| *Improvements in mental health of young people involved in socially based interventions*. | + | NHS Centre for Reviews & Dissemination, 1997. | Qualitative. Potentially estimable | Definite | - |
| *Improvement in self-esteem reduces risk of:*<br>• eating disorders<br>• self-harm (suicide)<br>• anxiety, depression<br>• risk-taking behaviour<br>• unintended teenage pregnancies<br>• becoming a victim of bullying. | + | O'Dea, 2000. McGarvey et al, 1999. Weber, 1996. Rittner et al, 1995. Baird, 1996. Davis, 2000. McCauley, 1995. Boulton & Smith, 1994. | Mostly qualitative | Probable | - |
| | + | Winford, 1995. | Qualitative | Probable | - |
| *Improvements in self-esteem increase the ability to cope with adversity.*<br><br>*Improvements in mental health and coping with stress may reduce the susceptibility to heart disease and cancers in later life.* | + | Hemingway & Marmot, 1999. Maier et al, 1994. Najman, 1980. | Qualitative | Probable | - |
| Enhanced employability of some young women involved in SO. | + | Key informants/ stakeholders. | Qualitative/ Quantitative. | Definite | High |
| Improved employment prospects for unemployed people involved in social support and problem-solving programmes. | + | NHS Centre for Reviews & Dissemination, 1997. | Qualitative. | Definite | - |

| ***OBSERVED/ ACTUAL IMPACTS*** | ***DIREC-TION*** | ***EVIDENCE*** | ***MEASUR-ABILITY*** | ***LIKELI HOOD OF IMPACT*** | ***PRIORITY*** |
|---|---|---|---|---|---|
| *Reduced risk of hypertension and cardio-vascular disease associated with social instability, unemployment and job insecurity*. | + | Schnall & Landsbergis, 1994. | Qualitative. Potentially estimable | Definite | |
| *Reduction in risk of cancer, heart and respiratory disease associated with low income (including from unemployment) and poor diets, poor housing.* | + | James et al, 1997. Platt et al, 1989. DSS, 1993. | Qualitative. Potentially estimable | Definite | |
| *Enhanced mental health of some SO participants by development of positive coping strategies relating to peer pressure*. | + | Key informants/ stakeholders. | Qualitative/ quantitative | Definite | High |
| Reductions in risk-taking behaviours, through negative peer influences:<br>• smoking<br>• alcohol/drug misuse<br>• eating disorders<br>• unsafe sex | + | Mason & Wendle, 2001. Gaughan, 2000. Kaminer, 2000. Lloyd et al, 1998. Smith & Stutt, 1999. Vincent & McCabe, 2000. Sim, 2000. Mizuno et al, 2000. | Qualitative | Probable | - |
| Improvements in family relationships/functioning for some young women in SO. | + | Key informants/ stakeholders | Qualitative/ quantitative. | Definite. | Medium. |
| Levels of self -esteem, development of identity influenced by family functioning, parental bonds. | + | McGarvey et al, 1999. Bandoroff & Scherer, 1994. Rotherham-Borus & Wyche, 1994. McWhirter et | Qualitative. | Probable. | - |

| | | | | | |
|---|---|---|---|---|---|
| | | al, 1994. | | | |
| Family functioning, adolescent self-esteem, behavioural problems improved by interventions involving cognitive behaviour therapy, social skills training, problem-solving, outdoor activity, counselling. | + | Fredman, 1996. Bandoroff & Scherer, 1994. O'Halloran & Carr, 2000. NHS Centre for Reviews and Dissemination, 1997. | Mainly qualitative. | Probable. | - |
| Prevention/reduction in risk-taking behaviour by some young women involved in SO. | + | Key informants/ Stakeholders. | Qualitative/ quantitative. | Definite. | Medium |
| Improvements in health-related behaviour of adolescents involved in youth development programmes. | + | Roth et al, 1998. | Qualitative. Probably estimable? | Definite. | - |
| Reductions in young people starting smoking when involved in community-based interventions. | + | Sowden & Arblaster, 2000. | Qualitative. Probably estimable? | Definite. | - |
| Effectiveness of risk prevention/ reduction programmes for children/young people depends on objectives/methods used: develop social competencies, use interactive, developmental and peer-led approaches. | + | Tobler et al, 1999. Tobler & Stratton, 1997. Bruvold, 1990. Posavac et al, 1999. Black et al, 1998. Tobler, 1986. | Qualitative. Probably estimable? | Definite | - |
| Risk reduction/prevention programmes for 'at risk' children/young people effective when specifically targeted, started early and used a range of methods. | + | White & Pitts, 1998. Durlak et al, 2000. Hardern et al, 1999. Tobler, 1986. | Qualitative. Probably estimable? | Definite | - |
| *Potential reductions in the unequal distribution of risk factors between socio-economic groups, and in the incidence of cancers and heart disease in later life, by SO.* | + | NHS Executive, 1998. Acheson et al, 1998. Kaplan & Keil, 1993. Macintyre, 1994. | Qualitative | Probable | - |

circumstances is also related to self-esteem; self-esteem and self-efficacy have been shown to be important protective mechanisms (Winfield, 1995). Anxiety and depression have also been shown to be associated with low self-esteem (Baird, 1996). Some studies have shown a link between risk-taking behaviour and self-esteem; for example the interaction of self-esteem and sensation-seeking behaviour was seen as more reliable predictors of risk-taking behaviour than sensation-seeking behaviour on its own (Davis, 2000). There was evidence also that low self esteem was associated with a higher incidence of unintended teenage pregnancies (McCauley, 1995). Also self-esteem tends to be lower in victims of bullying (Boulton & Smith, 1994).

The onset of puberty tends to bring about important changes in self-perception, and self esteem is linked closely to ideas of identity, thought to be a significant developmental phase in adolescence.

Various interventions have been shown to have a positive influence on adolescent self-esteem. For example, adolescents from emotionally disturbed backgrounds responded well to an initiative called the Wilnerness Project. This primarily involved hiking and educational and outdoor activities (in the 'wilderness') with group and individual counselling. Young people participating in the scheme were reported to have improved their self-esteem, self concept and group cohesion (Freedman, 1996). A family version of the Wilderness project also produced positive results with improvements in family functioning and self-esteem, and reductions in behaviour problems (Bandoroff & Scherer, 1994). Positive experiences such as success in sports can also increase self-esteem (Biddle, 1993). The evidence from the case study is consistent with many of these studies and as such increases the robustness of the evidence obtained from the key informants and stakeholders. There is evidence that there may be other longer term health benefits associated with improving self-esteem, well being and social inclusion, such as a possible reduction in the susceptibility to heart disease and cancer in later life (Hemingway & Marmot, 1999; Maier et al, 1994).

### *Social Networks: Impacts upon Health*

Stakeholders and key informants saw social networks as the second highest priority impact. There is evidence from the literature to support this finding. For

example, social skills training has produced significant improvements in children's levels of social interaction and cognitive problem-solving abilities; these results were far greater for children who were socially isolated (Erwin, 1994). An earlier review of 30 evaluation-orientated studies with aggressive adolescents concluded that there was evidence of their effectiveness in different settings, with different young people and target skills (Goldstein & Pentz, 1984).

The importance of social support mechanisms in ameliorating the effects of stress and promoting psychological well being is well documented (Power et al, 1996; Siegrist, 1987; Siegrist, 1986). Lack of social support has been postulated to be one of the social variables contributing to the inequality of heart disease prevalence (Marmot, 1997) and to increased risk (Hemingway & Marmot, 1999).

***Education and training: Impacts upon Health***

The Stepping Out Project's role in facilitating access to education and training, whether through returning to school after a period of unofficial absence or by attending a course organised by the project, was seen as the third highest priority impact. Educational achievement is a predictor of the future health of an individual. The level of education may act as a marker of other influences such as socio-economic status, occupation and lifestyle (Marmot et al, 1997). It also may directly affect health-related behaviour; high educational attainment tends to lead to healthier lifestyles in adult life (Wadsworth, 1997).

***Employment: Impacts upon Health***

Helping with employment applications and so on was seen as the 4$^{th}$ highest impact of the Project. These findings were reflected by other studies, which showed that social support and problem solving programmes improve the employment prospects and mental health of unemployed people (NHS Centre for Reviews and Dissemination, 1997).

Social instability, unemployment and job insecurity are associated with high blood pressure and raised mortality rates from cardio-vascular disease (Schnall & Landsbergis, 1994). Low income households, including unemployed families, tend to have poorer diets; poor diets are associated with an increase in risk of certain cancers and heart disease (James et al, 1997).

***Peer Pressure: Impacts upon Health***

Peer pressure was ranked as the 5th most important impact of the Project by a combination of key informants and stakeholders.

It is clear that peer relationships are important determinants of adolescent mental health and in the development of self-concepts (Ungar, 2000). However, studies on the extent of the effects of peer influences on adolescent behaviour show a range of results. For example, although peer influences were identified as predictors of alcohol and substance in some studies (Mason & Wendle, 2001; Gaughan, 2000; Kaminer, 2000), Taylor (2000) identified adolescent depression as a more likely antecedent to substance misuse. Mason and Wendle (2001) also identified school performance and religiosity as predictors of alcohol use, as well as an indirect association with family support. Smoking behaviour is also affected by peer influences; this relates to concepts of identity and image (Lloyd et al, 1998), but family smoking and beliefs also affect adolescent smoking behaviour (Smith & Stutt, 1999). There is evidence that peer and family influences are predictors of adolescent body image and eating behaviour (Vincent & McCabe, 2000; Sim, 2000). Condom use in women and men is also affected by peer behaviour (women) and peer pressure (men) (Mizuno et al, 2000). Although it has been reported that peer pressure influences attitudes favouring aggression (Farrell et al, 2000), another study has shown that it is a less critical factor when making decisions about involvement in criminal activity (Fried, 2001).

There was also evidence of different strategies employed by young people for coping with peers and family pressures (Griffith et al, 2000). A number of commentators identified the inadequacies of existing models and the need for more testing on interventions (Kaminer, 2000; Ungar, 2000; Hopkins, 1994; May, 1993).

However, peer pressure can also be exerted in a positive way. Some study reviews have shown that peer-based interventions have been found to be more effective in influencing health-related behaviours (Posavac et al, 1999; Black, Tobler, Sciacca, 1998; Tobler, 1986). A review of evaluations of HIV prevention initiatives targeting women found that the most effective interventions in terms of increased condom use during sexual intercourse were those that emphasised gender-related influences, were peer led and used multiple intervention sessions (Wingood &

DiClemente, 1996). Other reviews of HIV/AIDS prevention programmes found that the most effective interventions were skill-based, used interviews or role play with peers or clinical psychologists in community settings to target behavioural or combined knowledge or behavioural outcomes (Oakley et al, 1994). However, other studies indicated the need to design more effective interventions for high risk young people such as gay/bisexual young men, injecting drug misusers, homeless young people and inconsistent school attenders (Peersman et al, 1996).

***Family Influences on Health***

The total score given by key informants and stakeholders ranked the Project's impact on the family as 6th; interestingly no young people identified it as affecting their family life. As identified above the family's influence in the development of their children's identity and their self-esteem is of central importance, particularly during adolescence. This in turn affects their mental health and health-related behaviour. The work in Stepping Out with the young people needs to be balanced with other work focusing on the family.

**Table 4.4: OBSERVED/POTENTIAL HEALTH IMPACTS - Socio-economic Environment Factors**

| OBSERVED/ ACTUAL IMPACTS | DIREC-TION | EVIDENCE | MEASUR-ABILITY | LIKELI HOOD OF IMPACT | PRIORITY |
|---|---|---|---|---|---|
| Social networks and support systems enhanced for some SO participants. | + | Key informants/ stakeholders | Qualitative/ quantitative. | Definite | High |
| *Social support reduces the effects of stress and promotes psychological well being.* | + | Power et al, 1996. Siegrist, 1987. Siegrist, 1986. | Qualitative. | Probable | - |
| *Increasing social support may reduce the risks of heart disease.* | + | Hemingway & Marmot, 1999. | Estimable. | Definite | - |
| *Socio-economic gradient in heart disease prevalence. Improving social support in deprived areas may reduce the inequality in heart disease prevalence between population groups.* | + | Marmot, 1997. | Qualitative. | Probable | - |

| | | | | | |
|---|---|---|---|---|---|
| Access to education and training opportunities for some SO young women facilitated. | + | Key informants/ stakeholders. | Qualitative/ quantitative | Definite | High |
| High educational attainment associated with better health outcomes in adult life. | + | Marmot, 1997. Wadsworth, 1997. | Qualitative. | Probable | - |
| Slight increase in community participation/involvement by some SO young women. | + | Key informants/ stakeholders. | Qualitative/ quantitative. | Definite | Low |
| Significant increase in empowerment of women through community involvement and action when use combination of 7 EMPOWER methods. | + | Kar et al, 1999. | Qualitative. Probably estimable? | Definite | - |
| Increase in community involvement generates community spirit and social support networks. | + | Health gain conference, 1992. | Qualitative | Probable | - |
| Increased social cohesion may contribute to reductions in the incidence of crime. | + | Kennedy, Kawachi et al, 1998; 1997. | Qualitative | Probable | - |
| Slight reduction in fear of crime for some SO young women and residents in the SO area. | + | Key informants/ stakeholders. | Quantitative/ qualitative. | Definite. | Low |
| Reduction in youth delinquency/violence/vandalism from various *early* interventions, including:<br>• community-based,<br>• non-therapeutic,<br>• social responsibility focus,<br>when targeted at children 'at risk' or high-risk behaviours. | + | Mentore, 2000. Kellerman et al, 1998. Cox et al, 1995. Barker & Bridgeman, 1994. | Qualitative. Probably estimable? | Definite. | - |
| Reduction in crime when all or combination of 7 interventions used, including community development programmes. | + | Linden, 1990. | Qualitative. Probably estimable? | Definite. | - |
| Increase in competencies, reduction in | + | Durlak et al, 1998. Durlak | Qualitative. Probably | Definite. | - |

| | | | |
|---|---|---|---|
| delinquency and 'risky' behaviours of participants involved in mental health programmes. | & Wells, 1997. | estimable? | |

**Table 4.5: OBSERVED/POTENTIAL HEALTH IMPACTS - Public Services**

| OBSERVED/ ACTUAL IMPACTS | DIREC-TION | EVIDENCE | MEASUR-ABILITY | LIKELIHOOD OF IMPACT | PRIORITY |
|---|---|---|---|---|---|
| Enhanced access to and more effective use of appropriate public services by some SO participants. | + | Key informants/ stakeholders. | Quantitative/ qualitative. | Definite. | Medium/low |
| Potential change in type of service needs from vulnerable young women - eg, from crisis management to prevention/support. | ? | | Qualitative. | Speculative. | - |
| *Potential reduction in health inequalities between population groups, by increasing access to health care services for vulnerable young women.* | + | | Qualitative. | Probable. | - |

The Stepping Out project was seen to have a medium to low impact on public services such as social, housing and health services as well as the criminal justice system. This was primarily in terms of the advocacy role the Project played by facilitating access to the required service and liasing with them on behalf of the young women. However, Stepping Out also provided information about the different services helping the young women make effective decisions about service use. With the likely reduction in anti-social or criminal behaviour from Stepping Out participants it is likely that the involvement with the criminal justice system will also decrease; although the figures involved are anticipated to be small there may be some financial savings in this area. The demand on other services may also have changed from emergency or critical use, for example from social services to a more supportive and preventative role.

It was unclear what proportion of Stepping Out young women are homeless,

living in temporary or inappropriate accommodation; however any influence on the availability and quality of housing for these young women will have benefits on their physical and mental health.

Evidence from various studies show that communities most at risk of poor health have the least satisfactory access to a full range of primary care services, the 'inverse care law' (Goddard & Smith, 1998; Carr-Hill Et al, 1997; Benzeval & Judge, 1996). Using nine indicators of primary care services, the most deprived areas of Liverpool and Birmingham were shown to be the least well served (Flynn & Knight, 1998).

Thus by increasing access to and use of health and other public services, Stepping Out has a greater potential than currently realised to influence the health of the young women and health inequalities between communities of differing affluence.

Although Stepping Out also had a liaison role with schools to help reintegrate disaffected pupils back into education, it was unclear how successful this was and if the Project linked with alternative educational programmes, for example.

*Public Policy*

There was no evidence of if and how Stepping Out was influencing local public policy. The nature of the formal Project progress-reporting arrangements was unclear although it is assumed that the opportunity to provide feedback to the Regeneration Partnership or to lobby its members was available.

## 4.4 Inequality Analysis

The extent to which the project can contribute to the reduction in inequalities as described above has involved assembling evidence to answer two specific questions, namely:

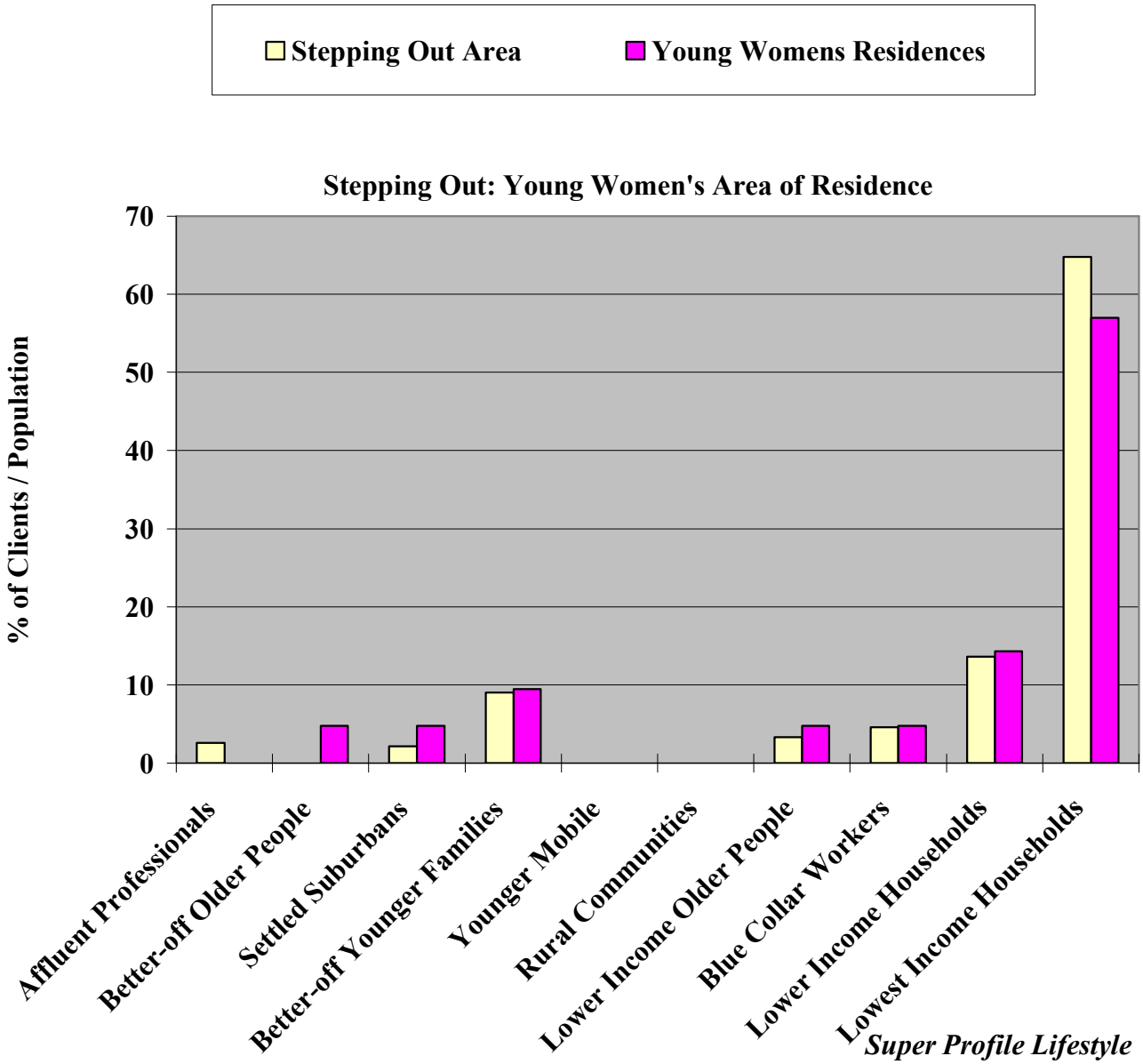
1. ***Are users of the project from the most deprived areas ?***
2. ***What proportion of the "at risk" population has the project reached ?***

In response to the first question, the extent to which Stepping Out users came from the most disadvantaged areas is possible to discern using a correspondence table that links residential postcodes to enumeration districts. Since each enumeration district falls into one of ten residential neighbourhood types in the Super Profiles system, it was possible to identify the social characteristics of the users' areas of residence from their postcodes. The results appear in **Figure 4.5.**

There was a very close correspondence between the composition of the Stepping Out targeted area and that of the users' areas of residence. Even where users' homes were outside of the target area, the neighbourhoods that they were drawn from had similar characteristics and levels of deprivation to the Stepping Out target area.

The majority of young women came from Super Profile Lifestyle 10, the most deprived area type (see Appendix 2). Given the needs, vulnerability and social exclusion of the young women involved it is clear that they were multiply deprived individuals living in deprived areas. The project was indeed reaching some of its intended beneficiaries and the targeting was on course.

**Figure 4.5 Stepping Out users: Areas of residence**




The extent to which Stepping Out was able to meet the needs of all vulnerable young women in these areas (Question 2, above) is a very different question. Targeting can be accurate whilst, at the same time, the **volume** of those assisted is wholly inadequate. There is nothing contradictory about that. However, the question of how much of the global predicament of social exclusion and vulnerability within the target area is tackled by a relatively small and labour-intensive project needs to be asked if the impact of the project is to be judged realistically and in proportion to its resources.

A common dilemma confronting all forms of evaluation and impact assessment is that of the mismatch between the deployment of the resources, on the one hand, and the scale needed to detect an impact on the other. For example, it would be unrealistic to expect that a modest training programme providing skills to 20 unemployed young people in a deprived inner-city ward alone is going to make a statistically significant difference to the inner city's unemployment rate or even to that of the ward. This is one example of this type of mismatch.

The dilemma surrounding this mismatch is illustrated in the diagram in Figure 4.6. This is a hypothetical map showing the distribution of four population groups. The entire map represents all young women aged 11 to 24 in the project's target area. The largest sub-division on the map (Area A in light grey) depicts women aged 11 to 24 who are neither vulnerable nor deprived. The second largest subdivision (Area B, in darker grey) shows young women aged 11 to 24 who are on the margins of deprivation but who are at low risk in terms of vulnerability (e.g. in terms of long term unemployment, peer pressure, anti-social/criminal behaviour). Area C (in dark grey) represents young women in the age cohort who are vulnerable, deprived and lack self-confidence but who have *not* received any assistance or support from the project because sufficient resources have not been available to help everyone in need. The smallest sub-division (Area D, in very dark grey) represents young women aged 11 to 24 with levels of vulnerability and need equal to those in the neighbouring area (Area C) but who have directly benefited from the detached youth work project by engaging with youth workers and through participation in activities and special events involving trips out of the area (i.e. residentials).

When assessing the impacts of Stepping Out, including those on health determinants, one would expect the greatest impact to be on Group D and a much smaller impact on Group C through diffusion effects and spill over (e.g. where those assisted by the project behave more responsibly and positively to their peers and family outside of the project's influence). However, one would not expect a significant impact on Group B and none at all on Group A. Attempting to measure an impact on the entire area (A+B+C+D) would be unreasonable and would be a clear case of not matching the scale to detect the impact with the deployment of resources.

As for estimating the proportion of the at risk group that the project has actually reached, this is a very different question to resolve. Several calculations can

be performed to put the number of young people assisted into an appropriate context. These include:

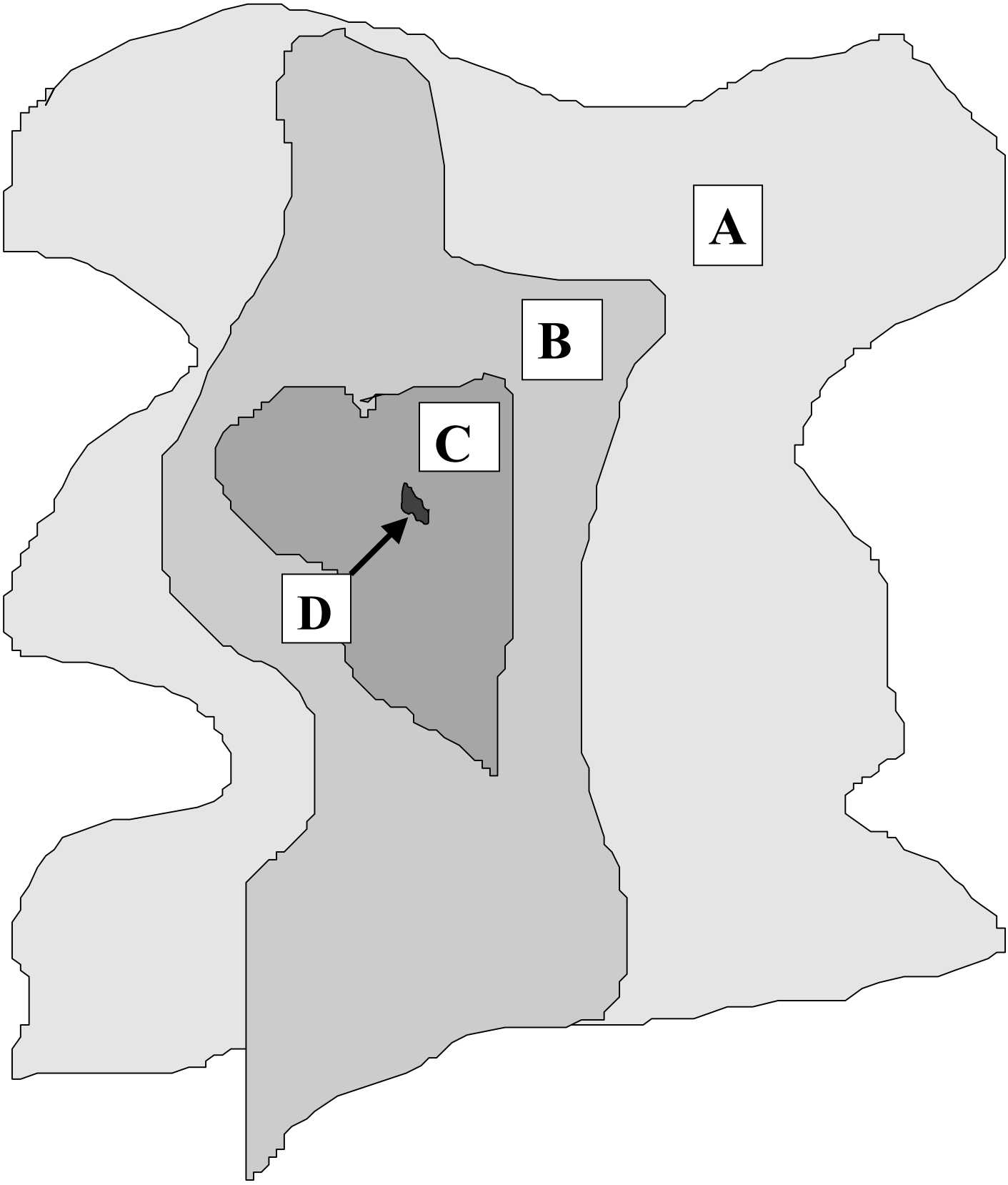
1. Arriving at an estimate of the number of young women aged 11 to 25 living in the project's two target wards (Linacre and Derby). Census information could be used however this is now eight years out of date. The Planning Department at Sefton Council does not hold any more up to date information than this.

   Merseyside Information Service has been able to provide population estimates of young women for 1997. Their estimates are based on Office of National Statistics District level information, the electoral register and General Practitioner records. It will only be possible to test the accuracy of these figures when the results of the 2001 Census become available. The figures are set out in the table below.

**Table 4.6 Female Populations in the Stepping Out Area**

| **Ward** | **Females 11 –14** | **Females 15 –19** | **Females 20 - 24** | **Total** |
|---|---|---|---|---|
| Derby | 368 | 415 | 382 | 1165 |
| Linacre | 335 | 350 | 356 | 1041 |
| **Total** | 703 | 765 | 738 | **2206** |

**Figure 4.6: Mismatch between the deployment of resources and the scale used to detect impacts**

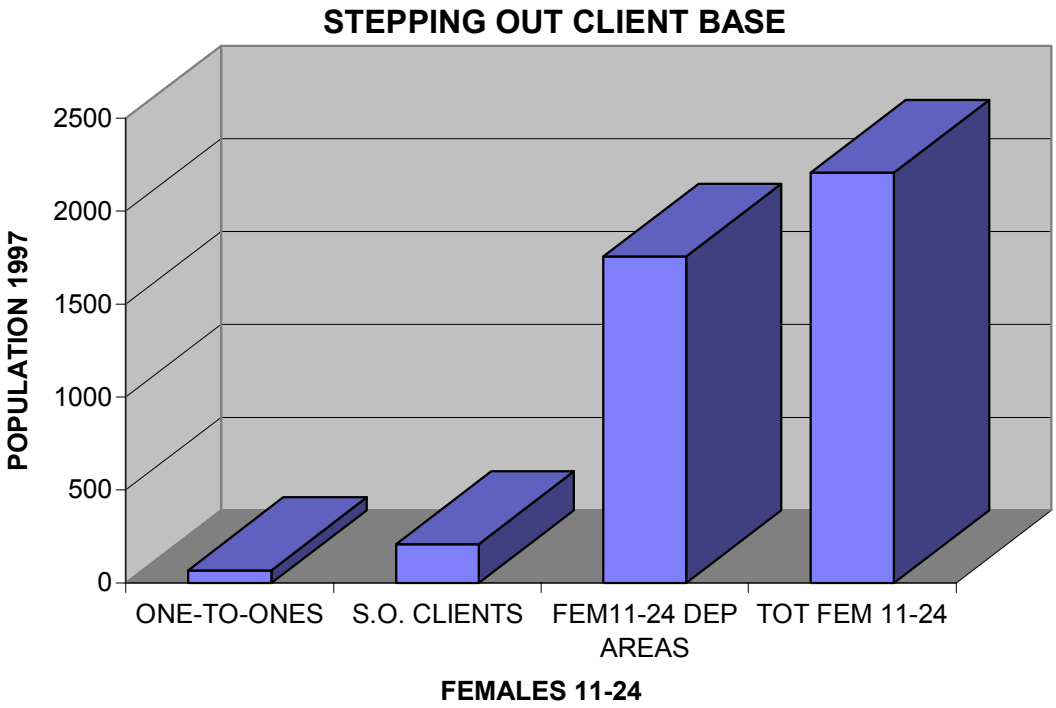


2. Arriving at an estimate of the proportion of this population who could be described as vulnerable. It is possible, although unlikely, that Sefton Youth Service will hold this information. Otherwise it will be necessary to arrive at proxies for vulnerability, for example, the number of young women on the "at risk" register or the number of children living in households where both parents are unemployed. However, even if it were possible to obtain this information it is questionable as to what extent this could be taken as an accurate reflection of the numbers of vulnerable young women. For example, not all vulnerable young women are on the "at risk register" and not all children living in households where both parents are unemployed will be vulnerable. An alternative is to identify who among the group of 11-25 year olds lives in the most deprived Super Profile Lifestyle (i.e. Lifestyles 9 and 10, see Appendix 2). The drawback of this is that it will tend to over estimate the size of the vulnerable population.

3. Obtaining information from Stepping Out about the number of young women that they have reached. This information is already available. Stepping Out has a database of approximately 210 people who have been to an activity organised by the project and 70 people who have used or who are currently using one to one support.

Putting all of this together, it is possible to estimate the number of young women reached by the project as a percentage of all vulnerable young women in the target wards. The results appear in **Figures 4.7 and 4.8**. They are based on calculating the population cohort (females 11-24) using the official Registrar General's mid year population estimate, defining the vulnerable sub-group as those living in the most deprived enumeration districts and, finally, dividing the Stepping Out clients receiving one to one support and more general assistance into the vulnerable population.

**Figure 4.7 The Stepping Out Client Base and Females aged 11-24 living in Linacre/ Derby wards: Broad definition of vulnerability**




**Notes: FEM11-24 DEP AREAS = Females aged 11-24 living in deprived areas (Super Profile Lifestyles 9 and 10) within the two Stepping Out Wards; TOT FEM 11-24 = Females aged 11-24 living within the two Stepping Out Wards.**

Those receiving one-to-one support accounted for 4% of the estimated 'vulnerable population' and those in receipt of other types of assistance accounted for 12%. Thus, overall, Stepping Out reached 16% of its target population (**Figure 4.7**) but this leaves 84% of the population untargeted. However, given the rather loose definition of 'vulnerable 11-24 year olds' (i.e. females 11-24 living in a deprived area) this should be regarded as an **over-estimate** of the total numbers in need and, consequently, an **under-estimate** of the proportion of young women at risk who have been assisted by Stepping Out.

If a tighter definition of what constitutes vulnerability is used then the numbers deemed to be at risk fall and accord more closely with the numbers receiving assistance through the project. A revised estimate of the number of vulnerable young women in the Stepping Out area was produced as follows:

1. The number of dependent children aged 0-15 in households without any working adult was identified from the 1991 Census at enumeration district level. Adjustment factors were derived drawing upon information in other tables and were then applied to calculate those who were female and aged between 11 and 15.

2. Unemployed females aged 16-24 were then extracted at enumeration district level and added to the number of dependent female children in wholly unemployed households to produce a total number of 'potential females at risk' for each enumeration district in the two wards.

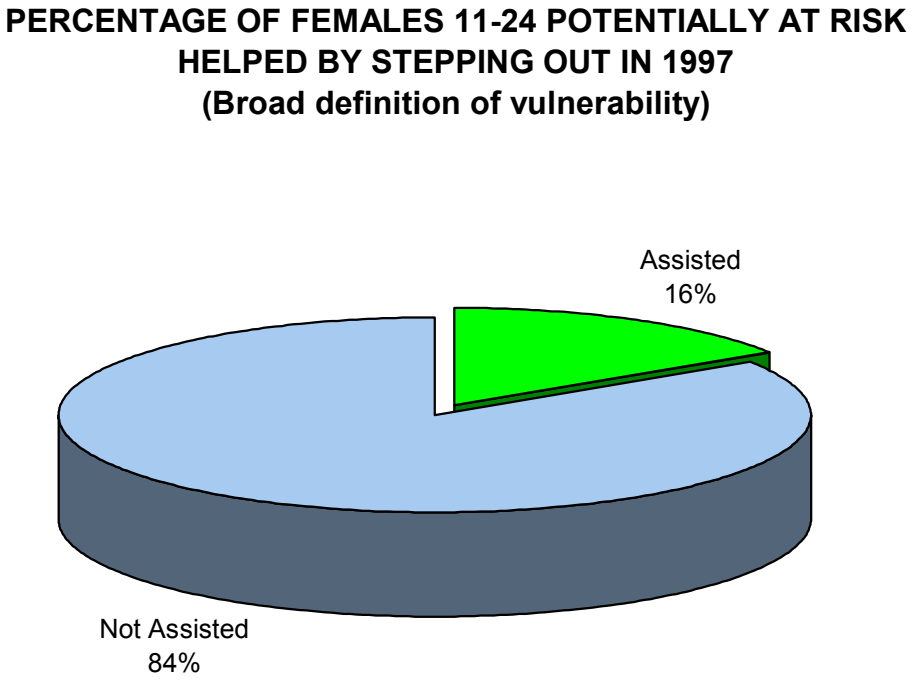
3. The Super Profile Lifestyle of each enumeration district was then examined and those falling into Lifestyles 9 or 10 were selected and all others disregarded.

4. The number of females aged 11-15 in deprived circumstances (i.e. either in wholly unemployed households as children or unemployed as young adults) **and living in deprived areas** was then calculated by summing the populations of the selected enumeration districts.

5. The estimates were then adjusted to the 1997 mid year estimates to produce a more up-to-date population.

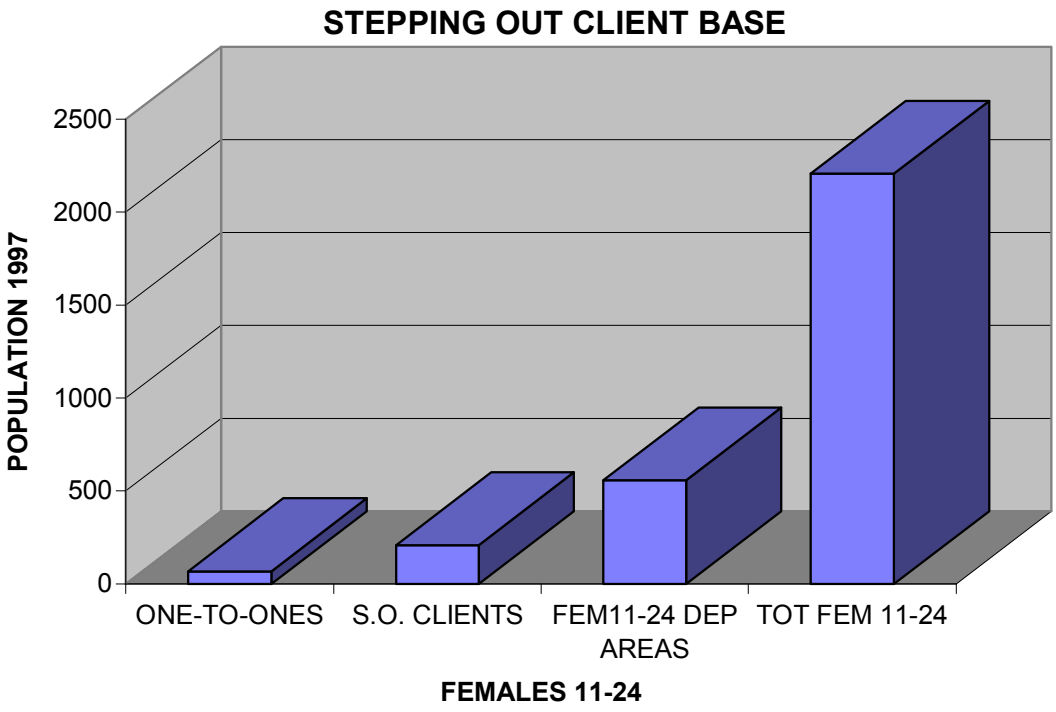
When this tighter definition of vulnerability was applied the number of females aged 11-24 who were 'at risk' fell from 1,756 (females 11-24 in deprived areas) to 559 (deprived females aged 11-24 in deprived areas) and the proportion of vulnerable young women receiving one to one support rises from 4% to 12 % and those receiving other forms of assistance rises from 12% to 37%. The number of young people at risk helped by Stepping Out rises from 16% to 50% !

**Figure 4.8 Estimated proportion of the 'at risk' population reached by Stepping Out**



This is more likely to be an **under-estimate** of the numbers of women at risk and consequently an **over-estimate** of the share of the population in need who actually received assistance through Stepping Out. The effect of the tighter definition in counting vulnerable people is shown in **Figure 4.9**.

**Figure 4.9 The Stepping Out Client Base and Females aged 11-24 living in Linacre/ Derby wards: Narrow definition of vulnerability**




**Notes: FEM11-24 DEP AREAS = Females aged 11-24 in households without an employed adult living in deprived areas within the two Stepping Out Wards (Super Profile Lifestyles 9 and 10); TOT FEM 11-24 = Females aged 11-24 living within the two Stepping Out Wards.**

The true proportion who have been assisted is likely to be in between these two extremes and to fall somewhere in the middle of this range at around 33% of those in need.

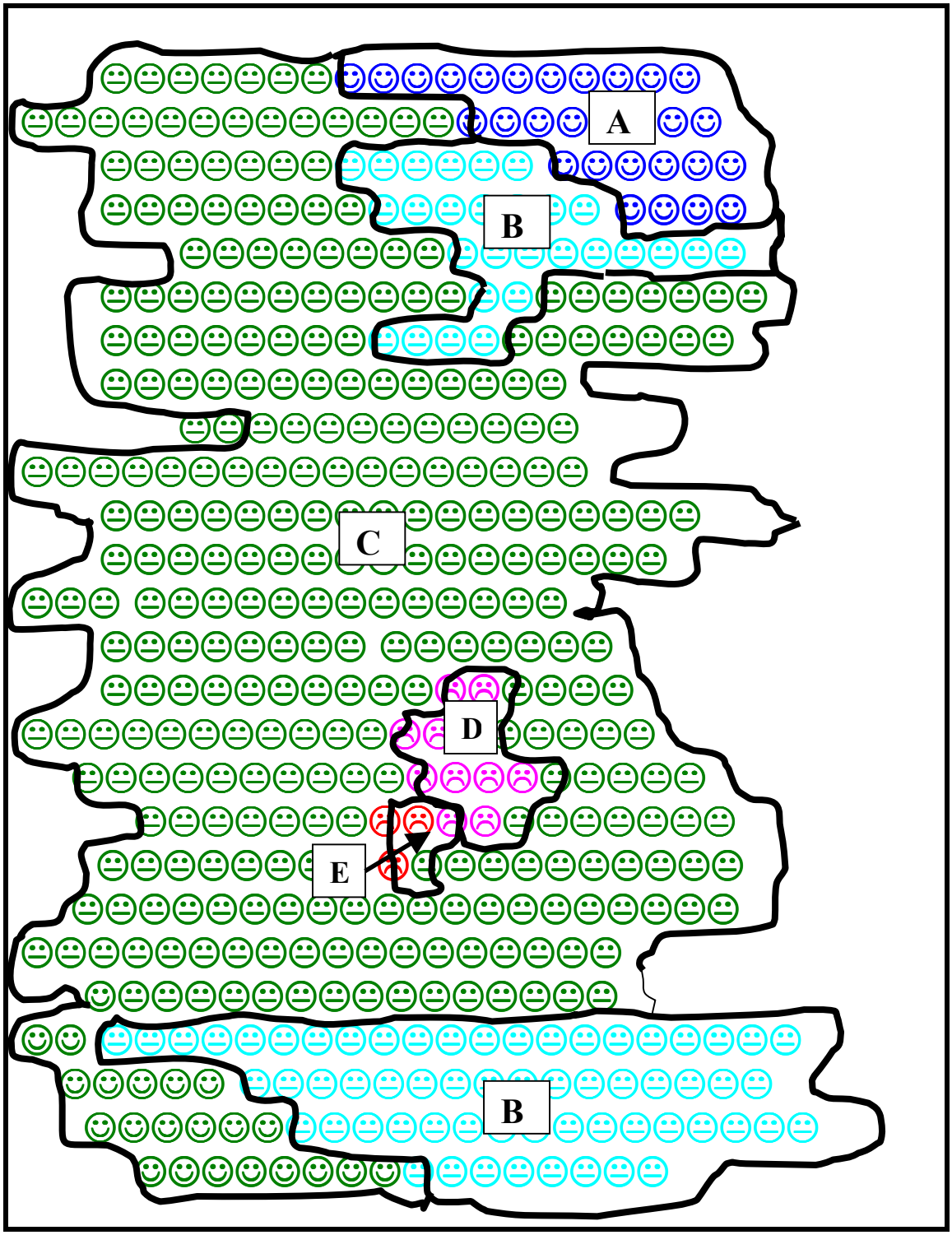
The implications for Health Impact Assessment is that where positive impacts on health determinants are likely as a result of detached youth work, their coverage will be limited to a rather small group of beneficiaries. Even if all of these

beneficiaries are disadvantaged people living in disadvantaged areas, the effect on health inequality is likely to be negligible because of the small numbers involved. This last point raises some fundamental questions about the feasibility of carrying out Health Inequalities Impact Assessments of small-scale regeneration projects. The meaning of health inequalities in this context also requires closer scrutiny. A key question is that of inequality between whom ? In other words, which is the base group (i.e. the affected community) and which is the comparison group (i.e. the group with whom health status is being compared)? These questions are not as straightforward as would appear at first sight.

**Figure 4.10** is an attempt to depict a range of scenarios that might apply in a Health Inequalities Impact Assessment. The deep blue smiling faces (Group A) represent the affluent minority within the community. The light blue faces (Group B) are people on above-average incomes. The majority of green indifferent faces (Group C) represent the majority of the population who are on average or near average incomes. The pink sad faces (Group D) are those who experience disadvantage but who, for various reasons (e.g. inefficient targeting, residence in the wrong area) do not benefit from regeneration projects. Finally, the much smaller group of sad red faces (Group E) are disadvantaged people who are being reached and who may well be on an upward trajectory in terms of their health and quality of life.

The question is, should a Health Inequalities Impact Assessment examine changes in the health gap between disadvantaged policy beneficiaries (Group E) and disadvantage non- beneficiaries (Group D) or between disadvantaged policy beneficiaries (Group E) and those on average incomes (Group C) . Alternatively, should comparisons between the disadvantaged (Group E) and the privileged (Groups A and B) or between any other set of combinations? Each comparison would require different data sets to invoke and would produce results which would need to be interpreted in different ways.

**Figure 4.10 Inequalities between whom ?**



# 5. Evaluation of HIA Methods employed in this Case Study

## 5.1 Introduction

This was the first HIA case study to be completed by the project. As such, it was very much a learning exercise. To a certain extent, it can be described as an example of what not to do, as opposed to what to do. Whilst we were able to generate some useful data from the research, the data are not as comprehensive as we would have wished which has meant we have not been able to build up as complete a picture as we would have hoped. For example, the numbers of Stepping Out clients and range of key informants involved in the HIA was limited. There are a number of things that we would do differently if we were to conduct this case study again. These are explored in some detail below.

## 5.2 Discussion and Recommendations

*Research Design*

There are a number of points concerning HIA, research design and rigour that became apparent with Stepping Out. Comprehensive HIA is a research process involving a range of methods from which data are collected to build evidence on the health impacts of policy. A number of key research questions need to be considered prior to undertaking a comprehensive HIA:

- What are the aims and objectives of the HIA?
- What is the methodological perspective being followed, and the associated values, including the model of health being applied?
- What is the intended literature search strategy?
- Who are the population groups of interest and other stakeholders?
- What are the sampling methods and sample size (for stakeholders)?
- Who are appropriate key informants and how will they be selected?
- What is the geographical location under investigation?
- What data collection methods and validated measurement tools, eg community profiling, questionnaire surveys, mathematical modelling, are being used?
- What are the data processing and analysis methods, including specific HIA tools such as the health impact recording matrix?
- How is rigour to be achieved at each stage of the HIA?
- Is the timetable for the HIA realistic ?
- What are the resource implications (financial, human, time) of doing this work?

- What are the anticipated outputs of the HIA process, eg report on findings, presentation to policy proponents, dissemination strategy?
- How will the recommendations from the HIA be negotiated with the responsible agencies?

In addition to ensuring the HIA process was more robust it was felt that another of the obstacles in this case study - the lack of access to stakeholders and other data sources - may be avoided. Developing proposals with stakeholder representatives at the outset was thought to help partners feel involved and have ownership of the process; this approach was thought to be more likely to generate support.

**Recommendation 1: All HIAs should prepare a detailed proposal prior to the assessment being undertaken, in conjunction with a steering group established to direct the HIA. Once agreed, these proposals should be incorporated into the Terms of Reference of the HIA.**

*Managing the HIA process*

The experience from Stepping Out indicates the value of establishing an HIA Steering Group. Many of the logistics such as access to clients, other stakeholders and other data sources may have been facilitated by adopting this approach. Although there are some disadvantages in taking this approach, it was felt that there would have been a net time gain for this project. The fieldwork alone for Stepping Out took six months; a large proportion of this time was spent building up trust and a rapport with project staff and clients and negotiating interview times around their schedules. There may be a law of diminishing returns that can be applied to HIA - investment beyond a certain limit does not generate further insight into the project's health impacts.

**Recommendation 2: All HIAs, but especially comprehensive HIAs, should establish an HIA Steering Group with representation from the commissioners, stakeholders, key informant groups and assessors. This should develop the Terms of Reference, including access to data sources, time plans, financial resources.**

*Evidence from documentary analysis and literature review*

Another common issue was the availability of evidence to support the HIA. Although documentary evidence on the project itself was supplied, information from

similar regeneration projects, for example findings from evaluations was less readily available.

**Recommendation 3: A database of Government regeneration strategies should be made available on the DETR website and should include monitoring and evaluation data, and linked to the appropriate websites, for example the HDA's evidence base 2000 database.**

Population estimates from official statistics were available, but their reliability will only be known after the 2001 Census is published. This will in turn affect the reliability of identifying and assessing whether target populations have been reached by the project. This will be discussed below.

In some health determinant categories, for example impacts relating to personal, family and lifestyle factors, there was a good range of strong evidence available from systematic reviews of similar projects and their effects on health determinants and health outcomes. The Campbell Collaboration in conjunction with Cochrane and the Centre for Reviews and Dissemination at York has compiled much of this as part of a review of evidence relevant to the wider public health agenda. The strength of this evidence has enabled assessors to indicate the likelihood of impacts more clearly and the reliability with which they may be reproduced. Its easily accessible form also saved considerable 'literature search' time for the assessors. These benefits suggest that having easily available electronic databases of evidence should be extended across a wider range of health determinant categories.

**Recommendation 4: Promote and extend databases of systematic reviews of evidence on the effects of non-health care policies, programmes and projects on key health determinants, and their consequences for health outcomes.**

*Profiling affected communities, including vulnerable groups*

The extent to which estimates of a particular vulnerable population can be made depends on the availability of appropriate data. Ideally, comprehensive information would exist that identifies everyone at risk within the community.

However, in practice, this is usually not available and proxies need to be found. If a clear definition of the vulnerable group is made and it is possible to estimate the numbers and proportion of this population sub-group in the population as a whole assessments can then be made of how successful targeting has been. In Stepping Out an attempt was made to estimate the numbers and proportion of the defined vulnerable population that, in turn, enabled some estimation of how effective Stepping Out had been in targeting its services but the share of the needy population served could only be expressed as a range.

**Recommendation 5: All HIAs should move towards defining the size of the population sub-group targeted and those served or reached by the policy. This should include estimating the numbers reached as a proportion of all vulnerable persons within the geographical boundary of the policy under investigation.**

*Qualitative Approaches in HIA*

It is quite clear from the findings that the evidence obtained from the key informants and stakeholders provided a different emphasis on the Project's impacts compared with that obtained from the documentary analysis and literature review. It is unlikely that a rapid ('desk-top') HIA would have produced the same set of impacts. This indicates the real value of using qualitative methods in HIA methodology. The psychosocial objectives of the project were felt to be particularly relevant for qualitative approaches, where descriptive data were being collected. However, it was felt that the particular qualitative methods used should be selected according to the needs of the project. For example, in hindsight, semi-structured or unstructured, recorded interviews would have been conducted with Stepping Out participants.

*Quantitative approaches*

Although survey methods were used in Stepping Out this was as part of an inductive process. An inductive approach would be recommended for all HIAs at the outset, but a comprehensive retrospective or concurrent HIA, provides an opportunity to both hypothesis-generate and hypothesis-test. As such in conjunction with more in-depth qualitative approaches, the findings from structured surveys using validated instruments may enable some estimation of future impacts to be projected. It is

recognised that modelling has not been widely used in HIA but that its application in a multiple method process could be readily applied within the Merseyside Guidelines methodology.

**Recommendation 6: Where appropriate, comprehensive HIAs should take a multiple methods approach using qualitative and quantitative techniques. The development and use of more sophisticated quantitative techniques (e.g. mathematical models) in concurrent and prospective HIAs should be further explored.**

*Likelihood of impacts*

In Stepping Out the strength of the evidence for each impact was used to help define the likelihood of the impacts occurring. The evidence provided by stakeholders and key informants described their perceptions of the impacts from Stepping Out; the number of people with similar perceptions was also recorded. The concurrent timing of the HIA indicated that the perceptions were based more on observations than retrospective assessments. Collectively, the number of stakeholders identifying the same impact, and the timing of the HIA, indicates a strong likelihood of the impact occurring. The strength of evidence from other research was graded according to whether the studies were, for example, systematic reviews or not; evidence from systematic reviews was considered to be strong and the impacts identified from this defined as definite. In spite of this, the process of assessing the likelihood of impacts was still felt to be too arbitrary and subjective. Defining and making explicit the criteria for assessing the likelihood/probability of an impact will help but if other HIAs are using other criteria it will be difficult to make direct comparisons *between* them. In addition data triangulation although not used in Stepping Out, is another step that needs to be built into the assessment of the likelihood of an impact.

**Recommendation 7: Development work on classifying the 'strength of evidence', qualitative and quantitative and criteria for assessing the 'likelihood of impacts' needs to be undertaken. The use of data triangulation needs to be built into the process.**

*Prioritisation of impacts*

The prioritisation process undertaken with Stepping Out involved stakeholder/key informants ranking the impacts identified, and then the assessor totalling up the scores for each impact to give an overall ranking. Where possible a more iterative process needs to be planned, for example:

- Identifying the criteria on which prioritisation will be based, eg the likelihood of the impact, the number of people affected, the type of health outcome (death, illness),
- Undertaking an initial ranking of impacts with stakeholders,
- Collating and ranking other evidence,
- Discussing the other evidence with stakeholders and undertaking a final ranking of impacts, where appropriate.

Issues such as whether or not to rank numerically or use ranking bands such as high, medium, low, need to be further considered.

**Recommendation 8: Development work on models to facilitate the health impact prioritisation process needs to be undertaken.**

*Health Inequalities and HIA*

The Stepping Out HIA revealed that it is possible to estimate how effective a project is at targeting specific vulnerable groups by comparing the number of the project's clients from this vulnerable group with the total number within a given geographical area. From this the scale of the health impacts on one population sub-group - the clients - was assessed. It also indicated a mechanism that could be used by regeneration projects to help with more effective targeting. However it did not look at the distributional effect of the project to see if any other population sub-groups from the area under investigation were affected - positively or negatively. This analysis of the distribution of health impacts across a population is very important as it enables the net effect of the policy to be assessed, as well as indicating if there is a widening or narrowing of health inequalities between the population sub-groups.

**Recommendation 9: All HIAs should examine the distribution of health impacts across a given population.**

**Recommendation 10: HIA methodologies need to be further developed to enable more in-depth health inequality analysis of policies etc to be undertaken.**

*Concurrent/'in project' HIAs*

There are many benefits of conducting a concurrent HIA such as Stepping Out as it allows the experiences from the implementation of the project to generate data on the health impacts, whilst enabling the findings and recommendations from the HIA to be fed into the project revision cycle. However the revised project will have different health impacts by virtue of this revision. The implication of policy dynamics on health impacts needs to be considered in the monitoring and evaluation stage of HIA.

**Recommendation 11: The methodology for concurrent or 'in-project' HIAs need to be further developed.**

Having been extremely critical of the way we carried out this case study, it is now important to focus on what we got right. Despite all the flaws in the research, we have still been able to gain a great deal of information about the project and the effect that it has on determinants of health for the people who use it. We have also been able to draw out some of the possible causal mechanisms that have an effect on health determinants. Although biases have been introduced into the research process, we have, to a certain extent, been able to corroborate our findings and, as such, we have reason to believe that the health impacts that we consider Stepping Out has had an effect on are fairly accurate.

## 5.3 Lessons for HIAs on other social regeneration projects

There are a number of other lessons that we have learned from conducting this case study that may be of use to others intending to carry out an HIA of a social regeneration project.

Firstly, for projects targeting vulnerable groups, there needs to be recognition of the role that the project workers have in supporting and to some extent in protecting their clients. This needs to be respected by HIA researchers and steps need to be taken to ensure that the research does not adversely affect the relationship the project workers have with their clients. This may require special training for researchers or, as was the case in this study, using others (e.g. youth workers) to collect information on behalf of the HIA team.

Secondly, there are many 'spin off' benefits that can result from the HIA process. For example, the development of partnerships between stakeholders which continue after the HIA has been continued, engaging and empowering communities through their involvement and building capacity in communities by the sharing of knowledge, skills and experiences.

Finally, when conducting an in-project HIA, and probably a retrospective HIA as well, researchers need to be aware of the vulnerability that some project workers may be experiencing, if for example the HIA is being linked to a re-application for funding.

# 6. Conclusions

As previously stated, this is the first Health Impact Assessment case study carried out by this project. As such it has been very much an experimental exercise and it has highlighted a number of issues which need to be worked on if more robust methodologies are to be developed. Such issues include procedural matters such as getting past the gatekeepers and working with vulnerable groups. There are also methodological points that need to be worked on – not least the extent to which people's opinions can be taken as evidence of the effect of a project on health determinants for another group. It is hoped that these and other concerns can be explored further in subsequent case studies carried out by this project.

As stated in the introduction, this has been a concurrent HIA, where the project (Stepping Out) was already underway. It is the opinion of the authors that there is a case for conducting concurrent HIAs and this needs to be explored further. However, having access to project users and beneficiaries does present challenges and opportunities not afforded with prospective HIA and these need to be managed in order to achieve optimum outcomes.

This Health Impact Assessment of Stepping Out has shown that it has had positive impacts on determinants of health for its users. It is considered that the biggest determinant of health that the project has had a positive effect on is self-esteem. However, there are also other health determinants that it is deemed to have affected for the better including Social Networks, Education and Training, Employment and Peer Pressure. In addition there is evidence from the literature that the effects the project has had on health determinants will also have short and long-term benefits on health outcomes such as mental health and heart disease.

There is some evidence from key informants and stakeholders to suggest that the project may also be of benefit to the wider population by way of reducing fear of crime.

Although the majority of health impacts were identified as positive and there was evidence from a range of data sources to corroborate these findings, it is believed that there is further opportunity for the project to build on the health gains that it has already made.

There were a few negative health impacts identified. Firstly, there an absence of a no smoking policy covering the premises; as a consequence smoking is allowed in the building, which does nothing to encourage existing smokers to cut down and is a risk to everyone in terms of passive smoking. Secondly, the long hours worked by the project staff contravenes the EC Working Time directive and has implications for the mental and physical health of these workers. Finally, the advocacy role the project has will affect the demand on public services, however it is not known if this will be a positive or negative impact.

The evidence would suggest that the project has done well in attracting the most vulnerable and deprived young people. At any rate, the users of Stepping Out are fairly representative of the population of vulnerable young women in Bootle.

Based on the above we would like to make the following recommendations to the project sponsors and management committee:

*Targeting*

Although Stepping Out was effective in reaching vulnerable young women, the client base represented only one third (approximately) of those who may be eligible for support. This is primarily because of insufficient resources, but this may also reflect ineffective targeting.

**Recommendation 1 for Stepping Out: Explore ways toreinstate and extend financial support for the project.**

**Recommendation 2 for Stepping Out: Extend the client base of Stepping Out to include referrals from schools (e.g. school nurse, form teacher), psychologists, social workers and the police.**

*Interventions*

There was evidence from other studies of the effectiveness of specific interventions and methods, for example the Wilderness programmes and the use of peer learning that may be appropriate for Stepping Out and help to maximise the health gains.

**Recommendation 3 for Stepping Out: Review and compare the evidence base of effective community-based development programmes targeted at vulnerable young women (see section 4.3).**

*Management of Stepping Out*

The involvement of young women on the management committee of Stepping Out will not only support their development and empowerment, but it will also provide a forum for policy making which will enable sensitive issues such as a no smoking policy to be discussed openly. In addition, advice and support from a child psychologist would also contribute to the development of the project.

**Recommendation 4 for Stepping Out: Extend the membership of the management committee to include representation from the young women and a mental health specialist.**

*Monitoring and Evaluation*

One of the difficulties in assessing health impacts from Stepping Out was the lack of project data from, for example validated instruments to measure changes in the self esteem of clients. Targeting has already been mentioned and the effectiveness of targeting also needs to be monitored.

**Recommendation 5 for Stepping Out: Develop comprehensive mechanisms to monitor and evaluate the outcomes of the project using validated measures, including changes in self-esteem of clients, and the effectiveness of targeting.**

*Health Education*

The literature indicates the opportunity Stepping Out has to influence not only the self-esteem and general development of young women, but also their health-related behaviour. The most effective methods to achieve this need to be explored and built into the Stepping Out programme (section 4.3).

**Recommendation 6 for Stepping Out: Review the evidence base on effective youth development programmes for women, which foster healthy behaviours.**

*Family Involvement*

Although evidence from Stepping Out stakeholders suggested that the impact of the project on family life was limited, other evidence indicates the key role that the family has in the development of self-esteem of adolescents. As such the expansion of the programme or the development of a partner project addressing parental needs and family functioning would ensure that these young women were getting optimal support at home and through the project.

**Recommendation 7 for Stepping Out: Develop a partner project aimed at how parents can support the emotional needs of their children.**

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# Appendix 1

# Case Study selection Criteria

Since regeneration initiatives encompass a wide range of projects that seek to achieve physical, social and economic improvements, it was considered important to select as broad a range of projects as possible. Regeneration projects can strive to:

- Modify the physical environment
- Enhance employment prospects
- Reduce stress, anxiety and fear
- Alter lifestyles
- Empower communities
- Improve access to facilities
- Enhance relations between agencies and residents

As well as varying by the strategies employed, there are a number of other ways in which regeneration projects differ. These include amount of funding available, scale and scope of the activity, and time scale. There are also other variables to be borne in mind, examples being the project location and whether it is local authority or voluntary sector led or a combination thereof.

The tight time scale and limited resources of this research programme necessitated that there was an element of practicality in the project selection process. It was regarded as crucial that the key project workers were amenable to the research taking place and that they were in a position to provide assistance and access to data as required.

By comprehensive it is meant that a full HIA will be carried out as opposed to a rapid HIA which is largely a desk based exercise where the views of people likely to be affected by the project are not sought.

**The selection criteria used appears in the box overleaf.**

- **Cost of project** (what is accepted for a revenue project may not be accepted for a capital project so our minimum expenditure will be different for capital and revenue schemes)

- **Priority/ status the project is given by the partnership**

- **Scale**: number of people affected
  number of people employed

- **Availability and ease of collection of baseline data**

- **Ease of identifying client group/ people affected by the project** (by geography or shared interest)

- **Timeliness** (need to select projects which fit in with our time scale and which allow for some degree of flexibility – we can't have 4 projects which all start in January!)

- **Helpfulness of the partnership**Willingness and ability to provide us with requested informationPartnership and Project manager agreeing

- **A need to choose projects which impact on different health determinants**

- **Location of the project**:

  - Drawn from different partnerships

  - Drawn from different types of area

- **Duration of Project**

# Appendix 2

# Characteristics of the Super Profile Geodemographic Classification

Super Profiles is a socio-economic, residential land classification system. It is based on the Census and uses 120 variables to classify enumeration districts. This classification can take place at a very detailed level of 160 categories or using the broader, standard ten categories, which are described below.

**Lifestyle 1 : Affluent Professionals Population: 1,977,551 [9.0%]**
High income families with a lifestyle to match. Detached houses predominate, reflecting the professional status of their owners. Typically living in the stockbroker belts of the major cities, the Affluent Professional is likely to own two or more cars, which are top of the range, recent purchases, and are needed to pursue an active social and family life.Affluent Professionals have sophisticated tastes and aspirations. They eat out regularly, go to the theatre and opera and take an active interest in sports (such as, cricket, rugby union and golf). They are able to afford several expensive holidays every year.Financially aware, with a high disposable income, this group invests in both quoted and privatised companies. They are happy to use credit and charge cards and are likely to have private health insurance.

**Lifestyle 2 : Better-off Older People Population: 2,445,660 [11.2%]**
Older than Affluent Professionals, possibly taking early retirement, Better-off Older People still retain a prosperous way of life. Their detached or semi-detached homes have now been purchased and most of their children have left home. This leaves money to spent or invest in the luxuries of life, such as a superior car. Better-off Older People eat out regularly, take one or two holidays a year and enjoy playing golf and going to the theatre.They are financially aware and set aside some money for investment on the Stock Exchange and for private health insurance.

**Lifestyle 3 : Settled Suburbans Population: 2,470,265 [11.3%]**
These families are well established in their semi-detached suburban homes.
The Settled Suburbans are employed in white collar and middle management positions. The presence of many part-time working wives ensures a fairly affluent lifestyle. For example, this group can afford to take one or two packaged holidays every year and purchase newer cars. They have taken advantage of government share offers in the past and are happy to use credit cards for their purchases.

**Lifestyle 4: Better-off Younger Families Population: 3,218,899 [14.7%]**
"Thirtysomethings" who have recently started a family, Better-off Younger Families are middle management, white collar workers. Although there are two incomes, the mortgage on their home accounts for a large slice of their income.
Having young children, and a relatively small amount of money for luxury purchases, means that Better-off Younger Families rely on home based entertainment. They may have more than one car, which are often cheaper, older models.

**Lifestyle 5 : Younger Mobile Population: 2,262,828 [10.3%]**
This cosmopolitan, multiracial group reside in areas of major cities which are undergoing gentrification but still retain a significant proportion of poorer quality housing.These young adults live in terraced houses or flats and have high levels of disposable income, which is spent on eating out, expensive holidays, keeping fit, going to pubs, clubs, concerts and the cinema. Close to where the action is, there is little need for a car, the bus, tube and train are preferred means of transport.

**Lifestyle 6 : Rural Communities Population: 612,118 [2.8%]**
Rural in nature, this group lives, works and plays in the countryside. Many live on farms or in tied cottages, which are concentrated in East Anglia, Scotland, Wales and the South West. Car ownership is high, given the distance to local facilities, and direct mail is widely utilised, reflecting the absence of retail outlets.

**Lifestyle 7 : Lower Income Older People Population: 1,750,297 [8.0%]**
An elderly group living in small, possibly sheltered accommodation. Many have moved into retirement areas and there is a high proportion of lone single female pensioners. The Lower Income Older People will live within their means, however limited this may be, with their key recreation activities being passive, such as the pub and television. They also prefer to shop at convenience stores in their own neighbourhood.

**Lifestyle 8 : Blue Collar Workers Population: 3,358,632 [15.3%]**
These more affluent blue collar workers live in terraces or semis. Many are middle aged or older and their children have left home. The Blue Collar Workers work in traditional occupations and manufacturing industries, where unemployment levels have risen to a significant degree. Most are well settled in their homes, which are either purchased or still rented from the council.

**Lifestyle 9 : Lower Income Households Population: 1,565,854 [7.2%]**
Living in council estates, in reasonably good accommodation, unemployment is a key issue for these families. Most work is found in unskilled manufacturing jobs, if available, or failing that, on Government Schemes. The parochial nature of this group is emphasised by an inability to either move home or go on holiday.

**Lifestyle 10: Lowest Income Households Population: 2,225,250 [10.2%]**
Single parent families, living in cramped, overcrowded flats is the everyday reality for this group which is composed of young adults with large numbers of young children. These are the underprivileged who move frequently in search of a break. However, with two and a half times the national rate of unemployment, and with low qualifications, there seems little hope for the future. Many are on Income Support, and those who can find work are in low paid, un-skilled jobs. There are very few cars and little chance of getting away on holidays.

# Appendix 3

# The Socio-environmental Model of Health

This overall HIA research programme, of which this case study project is one component, is working within the socio-environmental model of health (Lalonde, 1974 and Labonté, 1993). This model is based on the recognition that the causes of health and ill health are multifaceted and amount to much more than simply the provision of health care. Four principal categories of health determinant have been defined for use in the analysis of regeneration projects, building upon the model of health determinants laid out in the Merseyside Guidelines for Health Impact Assessment (Scott-Samuel, Birley and Ardern, 1998). These are as follows:

- ***Social and Economic Environment***
- ***Physical Environment***
- ***Personal/ family experiences, lifestyle and perceptions***
- ***Service use, access and quality***

The four main categories were arrived at after a great deal of deliberation. Between them they are intended to cover all the determinants of health that are likely to be affected by any kind of regeneration programme in the U.K. The influential factors within each of the categories appear in the table, below.

| **Main Category** | **Influential Factors** |
|---|---|
| ***Social and Economic Environment*** | Education and training<br>Employment<br>Housing<br>Community Facilities<br>Transport<br>Social networks (friends and family) |
| ***Physical Environment*** | Housing Conditions<br>Working Conditions<br>Air quality<br>Noise<br>Appearance of area (aesthetics)<br>Public Safety |
| ***Personal/family experiences, lifestyles and perceptions*** | Peer Pressure<br>Discrimination<br>Fear of crime<br>Culture<br>Community and spiritual participation<br>Family structure and functioning<br>Diet<br>Physical activity<br>Recreation<br>Risk taking behaviour and substance use (includes cigarettes, alcohol, drugs and sexual behaviour)<br>Self Esteem |

| | |
|---|---|
| ***Service use, access and quality*** | Adult education<br>Health Care<br>Social Services<br>Welfare Rights/ Advisory Services<br>Leisure<br>Criminal Justice System (e.g. probation, courts, police)<br>Voluntary services |

**Notes**:
Whilst some of the categories are the same as those in the Merseyside Guidelines, they have been added to and a number have been altered or omitted. For example, during the early interviews, two further categories were included: Biological and Policy. The decision was made to remove the former on the grounds that it is rarely possible to change biological determinants. It was recognised nonetheless that it is important to consider the impact that a regeneration project has on people with pre-existing conditions. The decision was taken to remove the latter since this is not applicable at the SRB project level.

# Appendix 4

# One-to-One Support Workers' Questionnaire for Administering to Clients

# Questions for One to One Support Workers to ask clients

**1. Unique Personal identifier code** _____

*First I would like to ask you a few questions about your involvement with Stepping Out and Venus.*

**2. What services/ activities do you use/ participate in?**

| E.G MENTION THE FOLLOWING TO THE INTERVIEWEE: |
|---|
| One to one Support<br>Talking with the detached youth workers on the streets<br>The crèche<br>Activities/ workshops/ drop ins/ training/ in Venus |

**3. For the ones that you have listed, can you remember how long you have been using them for?**

| Please ask the young woman to state separately for each one e.g. One to one support – 6 months, Jobs for the girls – 2 months. |
|---|

**4. Again, for the ones you have listed, how often do you use them?**

| As above, please ask the young woman to state separately for each activity e.g. chatting with detached youth workers twice a week. |
|---|

**5. How do you feel about your involvement with Stepping Out?**

**6. Has Stepping Out helped you to improve your life?**

YES/ NO

**7. If Yes, how?**

**Now I am going to ask you a few questions about your life before you were involved with Stepping Out and now.**

**8. Thinking about your life before you got involved in Stepping Out, how confident were you about letting people know how you felt?**

Very confident [ ]
Confident [ ]
O.K [ ]
Not very confident [ ]
Not at all confident [ ]

**9. How confident are you about doing this now?**

Very confident [ ]
Confident [ ]
O.K [ ]
Not very confident [ ]
Not at all confident [ ]

**10. If you feel differently now why is that?**

**11. Again, thinking about your life before you were involved in Stepping Out, how confident did you feel about your future?**

Very confident [ ]
Confident [ ]
O.K [ ]
Not very confident [ ]
Not at all confident [ ]

**12. How confident do you feel now?**

Very confident [ ]
Confident [ ]
O.K [ ]
Not very confident [ ]
Not at all confident [ ]

**13. If you feel differently now why is that?**

***Now I would like to ask you a few questions about health***

**14. Before you got involved in Stepping Out what was your health like?**

Very Good [ ]
Good [ ]
O.K [ ]
Poor [ ]
Very Poor [ ]

**15. If poor or very poor what was it about your health that wasn't good?**

**16. What is your health like now?**

Very Good [ ]
Good [ ]
O.K [ ]
Poor [ ]
Very Poor [ ]

**17. If poor or very poor what is it about your health that isn't good?**

**18. What things most affect your health as a person?**

**19. How does your health affect your life now?**

**20. What difference, if any, has being involved in Stepping Out had on your health? (Can you please tell me what aspects of your health have been affected?)**

**21. What other things have affected your health that have had nothing to do with Stepping Out and how?**

**22. Do you have anything else that you would like to say?**

**That is the end of the interview. Thank you very much for answering our questions. All your answers will be confidential. If you would like to know more about the research that Liverpool University is doing with Stepping Out please speak to Emily.**

# Appendix 5

# Content of Focus Group Sessions

# Appendix 5.1

## Focus Group Session with Activity Group

1. Ground Rules
2. Fruit Salad
3. Brainstorm – what is health?
4. Wall of Treats
5. Body activity

**Break**

6. Focus Group Element
   Questions for discussion:

   ***a) How do you feel about your involvement within Venus?***
   ***b) What do you like about coming to Venus?***
   ***c) What comes into your head when you think of health?***

   ***d) What issues do you think are facing young women today?***
   ***e) Where do you see yourselves in five years time?***
   ***f) If you were the Prime Minister what would you do?***

7. Role plays (about physical, mental and emotional health
8. Evaluation (Heidi's faces)

# Appendix 5.2

## Focus Group Session with Young Mums Group

1. Ground Rules
2. Game (to be decided)
3. Brainstorm: What is health?
4. Wall of treats
5. Aromatherapy, hand and head massage and relaxing exercise

**Break**

6. Focus Group element
   Questions for discussion:

   ***a)*** ***How do you feel about your involvement within Venus?***
   ***b)*** ***What does health mean to you?***
   ***c)*** ***Has Venus helped you improve your quality of life?*** **If yes, in what way?**

   ***d)*** ***What could Venus do, or do differently, that it is not doing at moment that would make it even better?***
   ***e)*** ***What issues concern you most at the moment?***
   ***f)*** ***How do you feel about your future?***

7. Guided Dream
8. Evaluation (with Heidi's faces)