



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 3**

**Southport Parenting 2000  
Case Study**

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# HEALTH IMPACT ASSESMENT CASE STUDY

## The Parenting 2000 Project

### List of Contents

	<u>Page</u>
List of Figures	2
List of Tables	3
List of Appendices	4
Preface	5
Acknowledgements	6
<b>1. Introduction</b>	<b>7</b>
<b>2. Résumé of Parenting 2000</b>	<b>10</b>
<b>3. Methodology</b>	<b>14</b>
<b>4. Findings and analysis</b>	<b>24</b>
<b>5. Conclusions and recommendations</b>	<b>75</b>
<b>6. Evaluation of HIA methods</b>	<b>79</b>
<i>Bibliography</i>	<b>87</b>
<b>Appendices</b>	<b>100</b>

## List of Figures

	<u>Page</u>
<b>Figure 3.1 The Parenting 2000 HIA: Flow Chart of Methods and Procedures</b>	<b>16</b>
<b>Figure 4.1 Regeneration Project Beneficiaries: Areas of Residence for Parenting 2000 Clients</b>	<b>74</b>

## List of Tables

	<u>Page</u>	
<b>Table 4.1</b>	<b>Education-based parenting interventions</b>	<b>37</b>
<b>Table 4.2</b>	<b>Positive Impacts of day-care to mothers and children</b>	<b>42</b>
<b>Table 4.3</b>	<b>Breakdown of CSP population by age</b>	<b>43</b>
<b>Table 4.4</b>	<b>CSP population by gender</b>	<b>43</b>
<b>Table 4.5</b>	<b>Breakdown of CSP population by socio-economic status</b>	<b>44</b>
<b>Table 4.6</b>	<b>Ethnic minority population in Cambridge and Duke's wards</b>	<b>44</b>
<b>Table 4.7</b>	<b>Economic status of CSP population</b>	<b>45</b>
<b>Table 4.8</b>	<b>Parenting 2000 projected and actual outputs</b>	<b>55</b>
<b>Table 4.9</b>	<b>Observed/Potential Health Impacts – Personal factors</b>	<b>62</b>
<b>Table 4.10</b>	<b>Observed/Potential Health Impacts – Socio-economic factors</b>	<b>68</b>
<b>Table 4.11</b>	<b>Observed/Potential Health Impacts - Public services</b>	<b>71</b>

## List of Appendices

<b>Appendix 1.1</b>	<b>Case Study Selection Criteria</b>	<b>101</b>
<b>Appendix 3.1</b>	<b>Interview questions for Parenting 2000 workers</b>	<b>104</b>
<b>Appendix 3.2</b>	<b>Health Determinant Categories</b>	<b>106</b>
<b>Appendix 3.3</b>	<b>Interview Questions for Key Informants and Stakeholders</b>	<b>108</b>
<b>Appendix 3.4</b>	<b>Description of focus group sessions</b>	<b>110</b>
<b>Appendix 3.5</b>	<b>Questionnaire for Parenting 2000 users</b>	<b>112</b>
<b>Appendix 4.1</b>	<b>Target Area's Position on Index of Multiple Deprivation 2000</b>	<b>116</b>
<b>Appendix 4.2</b>	<b>Prioritisation of Health Impacts</b>	<b>121</b>
<b>Appendix 4.3</b>	<b>Characteristics of the Super Profile Geodemographic Classification</b>	<b>124</b>

## Preface

This report describes the health impact assessment undertaken on the Parenting 2000 project in the Central Southport Partnership area of Sefton. It is one of five case studies from the research project *Health Impact Assessment: Measuring the Effect of Public Policy on Variations in Health* commissioned by the Department of Health as part of the Phase 1 Health Inequalities programme.

This report has been produced for senior managers in the Department of Health. However, it will also be a useful resource for senior and middle managers in public health, health policy, and public policy including regeneration.

The format of the report that has been adopted intends to provide the reader with:

- The background and context of health impact assessment (HIA)
- An overview of the Parenting 2000 project
- A description of the methods used in the HIA of Parenting 2000
- The findings from each of the data collection stages
- The analysis of all the data, identification and prioritisation of health impacts
- A series of recommendations for Parenting 2000 to help maximise the health gains and reduce the health inequalities identified
- A review of the lessons learned from this HIA for the development of future HIAs

## Acknowledgements

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And finally to the Department of Health, in particular Ms Christine McGuire for contributing to the project.

# **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 five case studies, all 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 second case study: Parenting 2000. This is a One Stop Family Shop located close to the centre of Southport where parents and families can go to access information and support

## **1.2 Why was Parenting 2000 selected as a case study?**

The selection of Parenting 2000 was done through a procedure that was applied to 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 1.1. These criteria embraced substantive issues such as distinguishing the main health determinant which the project was most likely to impact upon and 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 HIA).

Parenting 2000 is a project that seeks to alter lifestyles and foster empowerment. Initially, it was selected as a comprehensive, prospective case study. However, during the course of our research the project became operational and clients began to use some of the facilities and services. This enabled us to ascertain the views of users of the centre, which we had not anticipated being able to do. As such although it was predominantly a prospective HIA, (i.e. it considered the impacts of services that were not yet operational) there was also a significant concurrent HIA element where the impacts of services already available to parents and families were assessed.

### **1.3 Terms of Reference of 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 Parenting 2000.
- To describe in some detail the methods and procedures which were involved in conducting a Prospective/ In-Project, comprehensive HIA of Parenting 2000.
- To consider the efficacy and appropriateness of these methods for eliciting information about potential changes in health determinants and health status for this particular case study.
- To assess the impact that Parenting 2000 will have and has had on the health of its users, the wider population of its target area and on reducing inequalities in health in general.
- To make recommendations to enhance the positive and mitigate or reduce the negative health impacts of Parenting 2000.

- 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 parents and families.
- To contribute to a wider debate about the function and purpose of carrying out Prospective HIAs.
- To make recommendations that contribute to the development of HIA methodology.

## **2. Résumé of the Parenting 2000 Project**

### **2.1 Aims and objectives**

The main aim of the Parenting 2000 project is to promote positive parenting from an accessible central location in Southport by providing information, advice and support to parents and children who live in the immediate vicinity, in adjacent wards, and more generally in the Southport area. To a limited extent, parents from any area living within a reasonable distance can also use the facilities and services.

The project aims to assist families and to maximise opportunities for both self and family development by providing courses in parenting, first aid, home related skills and, in addition, to facilitate access into education through the provision of courses in Maths, English and basic computer skills.

Parenting 2000 has the specific objectives of identifying the needs of parents and of meeting such needs through the delivery of its services by means of a one-stop shop.

### **2.2 Resources**

#### *Staffing*

The project is run by a small team comprising of a Project Co-ordinator, Administrator and Crèche Manager, all of whom are full-time. In addition, the project employs a part-time cleaner, and a number of sessional crèche workers. At the time of this report, the project had two people working on time limited New Deal contracts. One of these is a part-time crèche worker / administrative assistant. The other person is on an NVQ management course and is gaining project management experience through working right across the project.

### *Physical*

Parenting 2000 is based in a converted building in central Southport. The building is adjacent to, and owned by, Southport College. The College is the lead partner in the SRB funded Parents' Project in which Parenting 2000 is a partner, along with Holy Trinity C.E. Primary School and Linaker C.E. School.

The building has retained the overall attractive quality of a turn of the century family home. The interior, the furniture and decoration, which is of a high quality, is bright and welcoming. The building is well equipped and its physical resources comprise of two training rooms, a meeting room for staff, parents and children, office space, kitchen and rest room facilities. In addition, there is a purpose built nursery and a garden.

### *Financial*

Parenting 2000 receives the majority of its funding from the Single Regeneration Budget through the Central Southport Partnership; it is part of the Parents Project led by Southport College. For 1999, this was as follows:

<i>Capital</i>	<i>£ 50,000</i>
<i>Revenue</i>	<i>£ 50,000</i>

Parenting 2000 has also raised funds from various charitable and private sources including, Carnegie Trust, Children in Need, Lloyds TSB. A grant from the National Lottery of £11,000 was used towards the installation of a lift in the building. Parenting 2000 is currently funded from the SRB until 2002, after which it is intended that the project becomes self-financing. Further bids to the National Lottery and to other government initiatives such as Surestart and the Family Support Fund are anticipated.

## **2.3 Timetable**

Parenting 2000 was formed as a response to the death of James Bulger and was set up as a registered charity in 1998. A full-time co-ordinator was appointed in September 1998. The project was active from January 1999 and commenced operations in its newly converted premises in March 1999. The project is funded until March 2002 - by such time it is hoped that Parenting 2000 will be well established as a core provider of services to families and will, therefore, be well placed to attract substantial funding from other sources.

As the project develops, new initiatives are being introduced, particularly in the form of short courses. The project has recognised the high level of stress experienced by its clients, for example, and from spring 2000 offered courses in relaxation and aromatherapy.

## **2.4 Strategies**

The main strategies deployed by staff at Parenting 2000 to enable and assist the project in meeting its aims and achieving its objectives include:

- operating an open door policy
- creating a positive and friendly atmosphere in which parents can meet, bring their children,
- facilitating access to services, information and learning,
- providing an understanding listener.

The design of the one-stop shop was also considered an important strategy encouraging access to the facility; considerable thought on the layout, decoration and furnishing of the building was given. The project co-ordinator is committed to any measures that can aid the development of confidence and self-esteem of the client group, who may, for a multiplicity of reasons, be, or feel vulnerable and under valued by society as a whole.

In terms of attracting clients to the project, a comprehensive publicity strategy was initially deployed. This included extensive leafleting in the locality, visiting groups (e.g. a credit union, a lone parents group, parent and toddler groups, advertising through both voluntary and statutory agencies (e.g. Sefton CVS, social services).

## **2.5 Intended Beneficiaries**

The intended beneficiaries of Parenting 2000 are families including young children of primary and pre-school age in and around the Central Southport SRB area. There are particular groups within this category that may benefit. These include:

- Parents of school children in Holy Trinity C.E .Primary School and Linaker C.P. School.
- Lone (and other) parents in the SRB catchment area of Central Southport.

Currently, the main beneficiaries are primarily women who are the main users of the services. It is hoped that the project will also have an impact on men but it is recognised by the project co-ordinator that this will be a slower process – the overwhelming majority of lone parents, for example, are women. Children also use the services currently available at Parenting 2000, for example the crèche, school holiday activities schemes.

## **2.6 Regeneration activity**

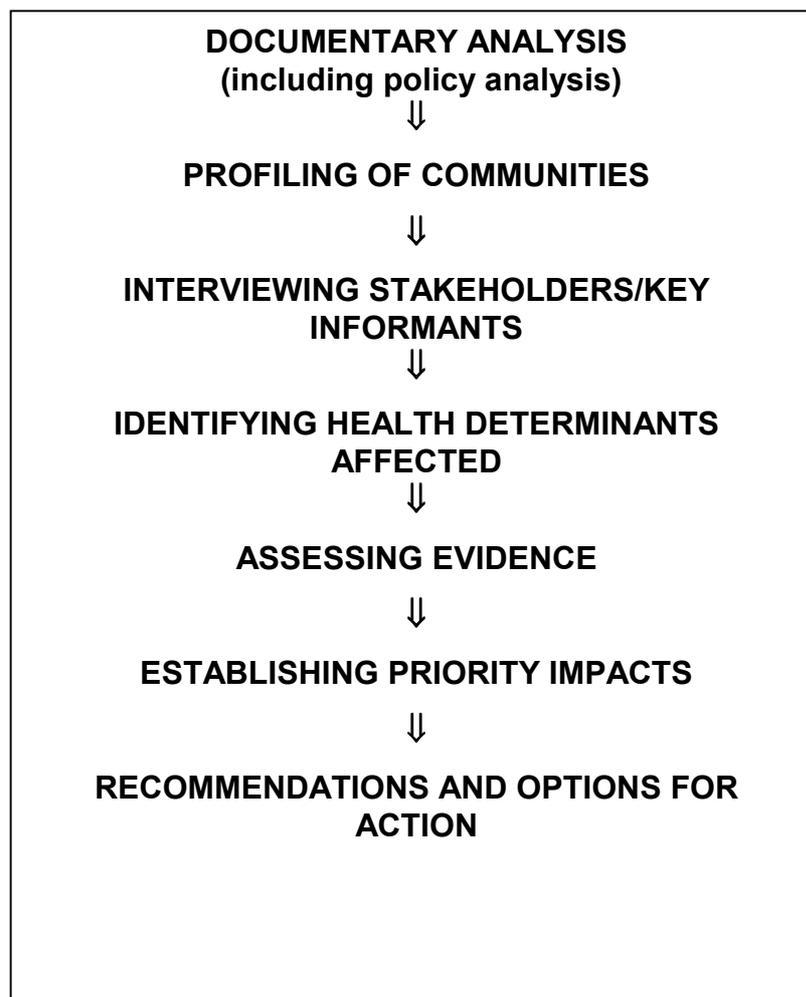
Regeneration activity in the Central Southport area is being co-ordinated by the Central South Partnership. In 1997 the Partnership was awarded £8.2 million from the Government's Single Regeneration Budget that is being used to finance a wide range of projects over a five-year period. In addition to the SRB monies, it was anticipated that funding of at least £36 million would be raised from the public and private sector, the EU and the National Lottery.

Parenting 2000 contributes to the regeneration of the area through “improving access to services by empowerment” and it is through its influence on this form of empowerment (an important health determinant in its own right) that any impacts upon health are likely to arise.

## **3. Methodology**

### **3.1 Introduction**

The HIA methodology applied to the Parenting 2000 case study was adapted from the 'Merseyside Guidelines for Health Impact Assessment' (Scott-Samuel et al, 1998). This approach is often referred to as a 'broad perspective', reflecting a socio-environmental model of health. The methods used in this comprehensive HIA comprised the following stages:



### **3.2 Prospective and 'In-project' HIA**

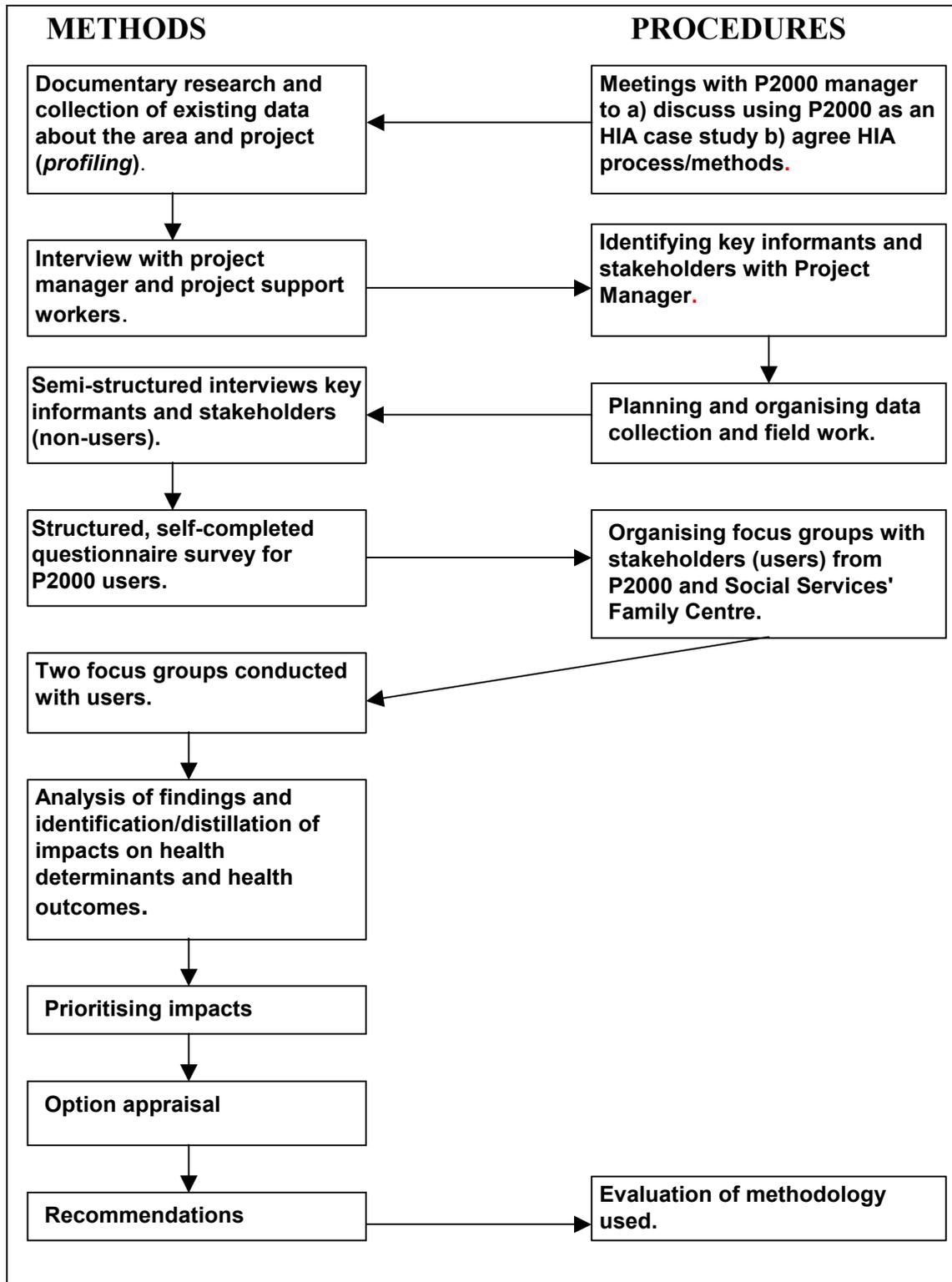
Carrying out this case study involved using methods for both prospective and in-project HIA. The research was concerned not only with the predicted impacts of the project on health determinants *prior to being implemented* but also with the observed and perceived health impacts of those elements of the project *currently in operation*. Although in a comprehensive HIA there is the opportunity to involve both key informants and actual or potential stakeholders, an 'in-project'/concurrent HIA on a project that is up and running usually draws a wider pool of stakeholders.

Prospective HIA takes place before a project is fully operational and ideally, when there is still time to modify aspects of it. When the HIA research on Parenting 2000 began, a schedule of building work on the Project's Parenting Centre and the Project's implementation plan had already been agreed, however, the Project was not ready to receive users or to deliver services. During the course of the this HIA the Project opened, and some services were made available. It was considered that, rather than ignoring the fact that users existed it was better to find ways of ascertaining their views about the centre.

### 3.3 Overview of Methods and Procedures

The Methods and Procedures employed in this case study are set out in the diagram below:

**Figure 3.1 The Parenting 2000 HIA: Flow Chart of Methods and Procedures**



### 3.3.1 Procedures

Conducting an HIA on a project such as this necessitates the co-operation of the project manager. In the case of Parenting 2000, the researchers were fortunate to work with a project manager who was enthusiastic about the research from the start and who was willing to help in any way possible. Whilst conducting this case study, the researchers had the full co-operation and support of the Project Manager.

An initial meeting was held in January 1999 at which the possibility of Parenting 2000 being a case study was discussed. The aims of this meeting were to enable a representative from the research team to find out more about the project and to explain to the project manager about the research and what being a case study would involve. At this meeting the project manager agreed for Parenting 2000 to be a case study.

During the course of the research a number of further meetings and telephone conversations were held between members of the research team and the project manager. At these, the following issues were discussed:

- A timetable for carrying out the research
- The identification of key informants and stakeholders (non - users) who could be contacted and interviewed about the project
- The design of a questionnaire to be completed by centre users
- The setting up of a focus group involving some of Parenting 2000's users

It is perhaps worth noting that at these meetings, the discussion focused more on how best to carry out a particular line of enquiry rather than whether or not it would be possible to have access to that information or that particular group. Knowing that access to the required information would not be a problem made planning and carrying out this case study much easier.

### **3.3.2 Methods used with key informants and stakeholders**

#### **i) Selection of key informants and stakeholders**

There were essentially four categories of informant used in this case study: project workers, professionals with relevant knowledge of the client group, potential project users and actual project users. The original intention was to canvass the views of the first three groups, since the project had not started when work was begun on this case study. However, during the course of carrying out this case study, the project became fully operational and consequently it was considered important to seize the opportunity of finding out about actual users. The methods used to select key informants and stakeholders included convenience sampling and self-selection methods. A mixture of qualitative and quantitative methods was used to assess their knowledge, experience and opinions of the effects of Parenting 2000 on health determinants and health outcomes.

#### ***Project Workers***

Both of the project workers (the project manager and the support worker) were selected to be interviewed at length about the aims of the project, how it works in practice and its likely effects on the health and wellbeing of its users. Shortly after the project became fully operational, a number of volunteers were recruited to work on the Parenting 2000 Project. It would have been interesting to interview some of these. However, unfortunately, owing to time constraints a decision was taken that this would not be viable.

#### ***Professionals with relevant expertise or knowledge***

To obtain a fuller view of the needs of the target group and the existence of other services for them in the area, it was considered necessary to interview a number of professionals with expertise or knowledge of one or both of these areas. It would evidently not be possible to speak to representatives of all of the statutory and voluntary agencies operating in central Southport. It was, therefore, considered important to obtain advice from the Project manager of Parenting 2000 and also a

contact at Sefton Council for Voluntary Services. In addition, the researchers were guided by a desire to interview representatives from each of the following groups:

- Experts with a working knowledge of a similar type of project (not necessarily in the same area)
- Relevant Health professionals
- Relevant Statutory Organisations
- Relevant Voluntary Organisations

The table below shows how those that were interviewed matched up with the above categories.

<b>Category of key informant</b>	<b>Individual/ Organisation</b>
Experts with a working knowledge of a similar type of project	Manager - Partnership with parents in Newton
Relevant health professionals	Health Visitor - Church St Clinic
Relevant Statutory organisations	Manager - Southport Social Services Family Centre
Relevant Voluntary organisations	Worker - Young Mums' Group Manager - Light for Life* Manager - Southport Women's Aid

\*Light for Life is an organisation which works with homeless or vulnerably accommodated young people

### ***Project users and potential users***

To obtain the views of potential project users, a focus group was held at Southport Social Services Family Centre with the agreement of the manager. The views of actual project users were ascertained in two ways: through a focus group and via self-completion questionnaires made available at the Parenting 2000 centre.

## **ii) Data collection methods**

### ***Interviews***

It was decided that semi-structured interviews mainly with open questions but also with some pre-coded questions would be the method most likely to produce the

required information from project workers and professionals with relevant knowledge of the area.

The aims of the interviews with the Parenting 2000 workers were as follows:

- To identify project aims and objectives and strategies for achieving these;
- To obtain their views about the effect the project will have on health determinants and on health;
- To find out about groups likely to be affected by the project and the numbers likely to be involved;
- To find out whether there will be any effect on people beyond those that the project will directly deal with;
- To try to determine what the impact of the project will be on the area as a whole;
- To identify what measures (if any) are in place to prevent leakage (i.e. of services provided by the project) to non-prioritised groups.

Appendix 3.1 shows the questions designed to try to ensure that these aims were met.

Appendix 3.2 shows the health determinants categories used.

The aims of the interviews with professionals with relevant knowledge and expertise were as follows:

- To ascertain (where relevant) what they think the impacts of the project will be on their users;
- To establish the likely impacts and intended and unintended consequences of the project (based on experience of other projects where relevant);
- To obtain further information about the needs of the intended project beneficiaries;
- To find out about existing provision for this client group in the area of central Southport

Accordingly, an interview schedule was devised to facilitate this data collection. It appears in Appendix 3.3.

A major disadvantage of using interviews is that they can be quite time consuming, especially if they are done thoroughly and if the informant has a lot to say. With limited time, therefore, it is impossible to interview everyone who might have a useful contribution to make. It is thus essential that the selection of interviewees is done carefully.

### ***Focus Groups***

The two focus groups enabled the researchers to meet with people who either used the project or who were in the project's target group. The aim of these groups was to gain insights and generate ideas about what and how Parenting 2000 might affect the targeted population in addition to the wider population as a whole. Whilst the survey would enable some basic (quantitative) information to be obtained about the users of Parenting 2000, it was considered important to find a means of obtaining more qualitative information to complement this.

However, focus groups are not only valuable because they enable the researchers to obtain the views of a larger number of people in a shorter length of time. Their particular strength is that they allow group dynamics to come into play. By bringing a group of people together who share some common characteristic (in this case they were all parents), it is possible to have a more rounded discussion than could occur in a one to one interview session. Moreover, participants can be prompted, by something another participant says, to bring up issues they otherwise may not have remembered to mention. Whilst there is always the danger that individual dissonance is lost within the group, if the group does seem to be in agreement about an issue this adds weight to their concerns.

Two focus groups were held: one at Parenting 2000 and one at the Southport Social Services Family Centre, which is located approximately 10 minutes walk from Parenting 2000. The focus group at Parenting 2000 was intended solely for parents who already used the project. A second focus group was deliberately arranged off site in order to enable the researchers to speak to people who were also targeted by the

project but who did not necessarily use it. Detailed descriptions of how both focus groups were carried out is in Appendix 3.4.

### *Questionnaire survey*

In order to obtain more general information about the users of Parenting 2000, a short questionnaire was designed for self-completion. With the agreement and assistance of the project manager, copies of this were made available in the Parenting 2000 centre. A copy of the questionnaire appears in Appendix 3.5. The questions were deliberately designed to be as simple as possible to understand so that people could fill them in by themselves. It was intended that the questionnaire would be quick to complete taking no more than ten minutes. The questions were primarily concerned with a respondent's personal circumstances (for example how many children they had and what their ages were, whether or not they were in employment) and their usage of Parenting 2000. The questionnaire deliberately did not seek to find out personal information about people such as how well they were coping or what particular problems they had that Parenting 2000 was helping them with. It was considered that this would put people off, thereby reducing the response rate. In addition, it would have made the analysis of responses much more complex and time consuming.

## **3.4 Methods employed for documentary analysis**

### *Official documents*

A range of official documents and websites were consulted to provide background, contextual or profiling data relevant to the HIA, including:

- Project specific reports such as the Parenting 2000 Annual Report for 2000 and internal monitoring reports, Central Southport Partnership's Delivery Plan and monitoring reports,
- Census, 1991, Sefton Annual Public Health Reports, Index of Multiple Deprivation, 2000, Sefton MBC Social Services and Education reports, Government departmental reports,
- Central Southport Partnership's, Sefton MBC, Sefton Health Authority, Southport PCG websites

### *Published and unpublished literature*

An extensive search was undertaken of published and unpublished (dissertations)

literature using the datahosts ingenta BIDS and ISI Web of Science, and the PsychINFO database (1997 to present) and citation indexes (SCI, SOCSCI, A&HCI, 1981 to present). Search terms included:

- family relationships,
- family relationships and health,
- family relationships and education,
- family relationships and academic achievement
- parenting education programmes,
- parenting education programmes and health

Over 350 records were identified and all abstracts were reviewed; however a detailed critical analysis of each study was not possible. A parallel search of relevant systematic reviews available from Cochrane, Campbell and the NHS Centre for Reviews and Dissemination databases was also undertaken.

## **4. Findings and Analysis**

### **4.1 Introduction**

This section describes the results from the HIA including the profiling of the affected communities, documentary and stakeholder evidence of the effects of the project, and the identification of priority impacts. It examines the impact of the project on the target population as well as other special interest and socio-economic groups in order to assess the differential distribution of impacts from the project.

### **4.2 Documentary Analysis**

#### **4.2.1 Evidence from the literature**

There is a well-defined literature showing the effect of family relationships on health outcomes and on other health determinants, such as the academic achievement of children. In addition, the family context, for example, family structure, has a significant bearing on the nature and quality of family relationships. The *dimensions* of family relationships include:

- Marital relationships,
- Parent-child relationships,
- Sibling relationships.

Relationships and interactions between family members are important cornerstones for health with strong relationships and family cohesion increasing resistance to illness. Conversely, the impacts of poor relationships, including negative parenting, on the physical and mental health of children, now and in the future, are well reported. Over the last 20 years or so there have been increasing demands placed on families, with both parents often engaged in work outside the home, but an unmatched rise in quality, affordable child care support. This increased pressure has often led to marital disharmony, family break-ups, and single-parent households, impacting on the

physical and mental health of parents and children alike. The theoretical framework explaining the relationship between parenting and health postulates that different parenting or child caring styles can support or inhibit the development of secure attachments between a parent or primary carer and a child. Secure attachment patterns may lead to the development of psychological well being and positive lifestyles, promoting physical and mental health in later years, and relates to the security felt by the child. There is evidence to suggest that insecure attachment is common in families under pressure, for example suffering economic hardship, and that this may play a key role in the transgenerational transmission of insecure infant/adult attachment patterns. It has been argued that this may perpetuate deprivation across the generations because of the effect not only on adult inter-personal relationships but also educational attainment levels, self-esteem and self-confidence.

Evidence on the dimensions of family relationships relevant to families with dependent children, and so to Parenting 2000, and the contextual factors affecting these dimensions, is discussed below.

### *Family Relationships*

A number of factors characterise healthy family relationships. The inter-play between them is complex, but key elements of successful parent-child relationships have been identified as love, acceptance, control and involvement (Schaefer, 1997). This is also the case for parent-adolescent relationships, with the substitution of 'firmness' for 'control' and the recognition of the adolescent's need for psychological autonomy (Steinberg, 2001). It is recognised that family relationships are dynamic over time but also between different individuals; mothers and fathers have different effects on their children's behaviour, and on sibling relationships. Similarly, marital relationships affect parent-child relationships and parent-child relationships affect both parents and children (Dubrow & Howe, 1999; Cox & Brooks-Gunn, 1999). Mutually supportive behaviour has been identified as particularly important for dual-earner couples in maintaining family relationships; one study indicated that women reported providing more emotional support in their family relationships than men (Purohit, 1999). There is also evidence that partners in secure marriages where there is less ambivalence

about the relationship, were more integrated into social networks and felt more competent as parents (Volling et al, 1998). Related to this, good communication between partners has been shown to have a strong association with close partner-partner relationships, and happy relationships with their families (Ferroni & Taffe, 1997).

### *Context of Family Relationships*

There are various contextual factors that affect family relationships. Broadly these can be grouped as follows:

- Socio-economic status
- Health status and caring for family members
- Cultural background
- Family structure
- Critical life events
- Parents' health-related behaviour

A number of studies reveal how poverty and hardship affect family structure and functioning (Vannoy & Cubbins, 2001; Rank, 2000). The structure of families also has a considerable effect on the quality of family relationships - single and to a lesser extent step-parents are more likely to have issues related to resources, for example income, and stressors, such as residential instability (Amato, 2000). Interestingly, at the other end of the socio-economic spectrum, there are also issues for families to contend with where work and over-dedication to careers dominates over family life affecting family functioning (Robinson, 2001; Robinson & Chase, 2001). There are number of other effects of work on the family: 'work stress', short and long term, makes its mark on workers' behaviour and well being on and off the job, 'role balancing' between family and work responsibilities, and 'work socialisation', occupational conditions shaping workers' values (Perry-Jenkins et al, 2000. In the case of women, the type of work, its perceived status and financial reward relative to their partner, affected not only marital quality, but also their daughters' gender-role attitudes (Helms-Erikson et al, 2000).

There is an extensive literature on the effects of the poor health, physical or mental, of a family member on the rest of the family. Sick children have a predominantly

negative effect on the mental health of parents and siblings and on family relationships. There are also other 'costs', financial, personal and social, to parents involved in their children's care (Callery, 1997). Childhood cancer has significant effects on both parents and siblings. In one study approximately half of the mothers and fathers recorded scores of high levels of emotional distress (Sloper, 1996); these were closely associated with reporting negative effects on parental employment, finance, and family relationships. Siblings have also been shown to be at risk of the development of emotional and behavioural problems up to 18 months after their brother or sister was diagnosed with cancer. However supportive relationships were noted to be important resources in coping with the feelings of loss and uncertainty; in some cases positive effects, such as gains in maturity, compassion and understanding were also reported (Sloper, 2000). Fathers of children with special needs, how they cope and adapt, and the effects this has on marital relationships and family cohesion, has been well documented; however the most effective way to support them, and the implications for services, has been less well studied (Lamb & Laumann-Billings, 1996).

The negative effects of eating disorders, including anorexia, on the family have also been examined (Young, 1998); one 8 year study suggests that girls with depressive problems (with and without co-occurring eating problems) experience impairments in both peer and family relationships (Graber & Brooks-Gunn, 2001). Other psychological childhood conditions such as obsessive compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD) have also been shown to have significant impacts on family relationships, school performance and self-esteem (Carter & Pollock, 2000; Robin, 1999). ADHD has been shown to persist into adolescence in 78% of children, predisposing them to high-risk behaviours, whilst OCD may compromise physical health.

Different cultures have been shown to have alternative perspectives on family life and relationships. Studies on migrant and well-established minority communities have shown that where there are seen to be conflicts between the host and native cultures, difficult family relationships are reported, whereas when there are dual cultural affinities there are positive family relationships (Ferron et al, 1997; Nguyen et al,

1999). Lessons from collective cultures, where family relationships are central, such as the Chinese, indicate positive impacts for patients diagnosed with a disease such as cancer. The behaviours associated with this collectivism, such as support, have been shown to have a positive effect on the patients' internal locus of control and on their psychological adjustment to the disease (Sun & Stewart, 2000). Similarly, collective cultures emphasising family obligation generally have a positive effect on family relationships and psychological development of adolescents (Impalli, 1999). Where relationship issues do arise in minority group families, it has been indicated that there is a need to develop culturally sensitive counselling and family therapies (Impalli, 1999; Francois, 1998).

Family structure - single, step or intact families - is a very important contextual factor influencing the health of all family members. The findings from a large community study showed that, based on the mothers' perception of adjustment, children from single and stepfamilies had higher levels of problems and lower levels of pro-social scores than non-stepfamilies. When other factors, such as maternal age, negativity in family relationships, education level, support, depression, were taken into account there was no difference between step and intact families; however, single parenthood remained a risk factor (Dunn et al, 1998). A further dimension to this equation is the relationship between non-married parents and the effects this has on their children. It has been suggested that these children are at risk of deleterious outcomes, but that not enough is known about effective policies, programmes and services to meet their needs (Vosler & Robinson, 1998). In addition to the effects on children's health, there is evidence that men's positive well being is associated with their role as fathers. This was found to be most significant for father's living with their children (Eggebeen & Knoester, 2001).

Critical life events, such as death, divorce and the birth of children, all impact on family relationships. One study provided evidence that early parental loss during childhood is associated with health-damaging psychosocial characteristics in adulthood only when the surviving family relationships are poor (Luecken, 2000). Some commentators believe that these losses and the associated trauma can be turned

around enabling individuals to grow stronger and gain hope by examining the meaning behind them (Harvey & Miller, 2000). Divorce is another major life event that impacts on all of the family, and can affect child and adolescent development (Galambos & Ehrenberg, 1997).

Parental attitudes to health and health-related behaviour are known to influence both family relationships and the lifestyles of their children; the latter point will be discussed later. For example, paternal substance misuse has been shown to have an impact on the father-son relationship and the child's development if their substance use disorder is not controlled before their son's sixth birthday; there was a significant increase in internalised and externalised problem behaviour after this age. Results also suggest that early parental treatment may offset the intergenerational transmission of problem behaviour (Moss et al, 1997). The uptake of smoking by children is associated with whether their siblings and parents smoke, and if their parents appear to condone their behaviour (HEA, 1996).

Finally there are a number other contextual factors, such as inter-generational family relationships (Putney & Bengtson, 2001; Weber & Waldrop, 2000), maternal youth and sociopathy (Brown et al, 1998; Birch, 1998), and religious beliefs (Bernard-Fisher, 2001), that affect family relationships, both positively and negatively.

#### *Impacts of Family Relationships on Health Determinants*

As described above, family relationships can impact on other health determinants, including:

- Health-related behaviour
- Child and adolescent development
- Social competence
- Transgenerational relationships
- Aggressive and delinquent behaviour
- Academic performance
- Work

The evidence for this is as follows:

There is strong evidence showing family relationships as both protective and risk factors associated with a range of **risk-taking behaviours**. One recent study showed that good family relationships acted as a protective factor for both boys and girls against several health risk behaviours: cigarette smoking, drug use, onset of sexual intercourse before age 15, pregnancy, gun carrying, suicidal ideation and attempts (Anteghini et al, 2001). Another study explores the onset of smoking among adolescents as being influenced by parental smoking behaviour and family structure, which may interact with or directly influence family relations (De Civita & Pagani, 1996). Several studies indicate the impact of poor family relations on both adolescent and adult alcohol and substance misuse (Durant et al, 1997; Barnfield & Leathem, 1998; Ma et al, 1998; Swadi, 1999; Slaght, 1999; Vakalahi, 2001). Perhaps unsurprisingly, childhood abuse is also a risk factor for a number of common mental disorders in adolescence, including alcohol and drug-related problems (Downs & Harrison, 1998).

Other risk behaviours such as eating problems have also shown an association with family relationships; a study with adolescent girls showed that those individuals with abnormal eating behaviour had lower self esteem and higher dissatisfaction with their physical appearance and family relationships (Button et al, 1997). Another study showed the interrelationship between disordered family relationships (over-protectiveness and inappropriate parental pressure) and eating disorders (Horesh et al, 1996). Sexual intercourse under 15, safer sex and teenage pregnancy are all associated with family relationships and functioning (Rodriquez & Moore, 1995; Werner-Wilson & Vosburg, 1998; Ditus, 2000). The findings from one study suggest that for some adolescents who experienced conflict-laden family relationships and/or had been sexually abused, pregnancy and motherhood gave them a feeling of control over their life, in a life with few choices (Saewyc, 2000).

The quality of family relationships in childhood has an effect on not only on **child and adolescent development**, but also throughout life influencing future marital and work relationships (Santos et al, 1998; Graber et al, 1996). There is evidence on the impacts of family transitions such as divorce and remarriage on child and adolescent

development as well as factors associated with the adjustment, such as parental conflict level and stepparent role. The impacts include a range of psychological and behavioural responses to the upheaval: externalised and internalised problems, inter-personal and social relationship difficulties, academic difficulties and poor self-perception (Brody & Neubaum, 1996).

The 'internal working model' concept explains how children process and develop sets of social expectations and competencies based on their inter-personal experiences within the family. The **social competence** of pre-school age children was seen to reflect the roles of and relationships with fathers and mothers: socially competent children tended to show the father in a broad range of roles, close relationships with the mother and clear boundaries and order within the family (Page, 1998). This social competence attributable to positive family relationships has been shown to contribute to positive relationships with peers and teachers at school (Vondra et al, 1999). One study revealed that dysfunctional childhood family relationships predicted **transgenerational relationship difficulties**: dissatisfaction and conflict in marital and work relationships. Conflict in marital relationships directly contributed to mental distress, whereas conflict in work relationships had an indirect effect on mental health. The model used showed that work relationship conflict was linked to socio-economic status (Santos et al, 1998).

**Aggressive and delinquent behaviour in adolescents** has been shown to be associated with poor family relationships; in addition these individuals are also more likely to use alcohol and other drugs and engage in unsafe sex (DuRant et al, 1997). Some research suggests that stressful life circumstances contribute to the development of moderately **abusive family behaviour** (as opposed to persistent, serious family violence). Although there are interventions which attempt to prevent and treat family violence, it has been indicated that these need further change, particularly in terms of social services providing more support to families under stress (Emery & Laumann-Billings, 1998). There is some evidence that for women who are in abusive relationships, social support from female friends' in particular, but also close family relationships may be critical to the successful resolution of the abuse. Issues around

seeking support included cultural and societal sanctions, caution in establishing new relationships and forced isolation (Rose et al, 2000).

**Academic performance and educational achievement** is greatly affected by family relationships. Evidence from the Beginning School Study suggest differences in cognitive and non-cognitive outcomes for children in the first 5 years of school depending on the family structure: intact, step and single families (Entwistle & Alexander, 2000). The influence of the family on adolescents' educational expectations has also been examined; the National Education Longitudinal Study (1988) revealed that parents' personal involvement and parents' reports on their own behaviour were related to educational expectations. In addition the social economic status of the family also affected expectations and was closely associated with parental involvement and behaviour (Trusty, 1998). Other research indicates the lifelong effect of the family environment in childhood on the cognitive development and intellectual functioning in adults (Grigorenko & Sternberg, 2001). Some commentators suggest that intelligence stems more from early childhood experiences at home which provide building blocks for creative and analytical thinking and a sense of self; Greenspan warns that new child-rearing practices, impersonal modes of communication, education policies and family patterns are eroding these experiences (Greenspan & Benderly, 1997).

The effect of childhood family relationships on work relationships has already been described (Santos, 1998). There is further evidence from a longitudinal study indicating the intergenerational transmission of the effects of childhood family relationships on occupational attainment and satisfaction (Wadsworth, 1997). In addition there is evidence of the role supportive family relationships play in ameliorating stress at work: a study of nurses indicated that those who reported high job satisfaction and used approach coping methods were more likely to have more family support (Boey, 1998).

#### *Impacts of Family Relationships on Health Outcomes*

Family relationships impact on both **mental and physical health**.

There is overwhelming evidence of the effect of family relationships on the **mental health** of all family members throughout their life; family relationships can influence the mental well being of family members, trigger moderate to severe mental illness, as well as influencing the compliance of treatment and the success of clinical outcomes. Some mental health professionals believe that the role of control in inter-personal relationships such as the family, and the appropriateness of control responses, can explain many psychological disorders (Shapiro & Astin, 1998).

The quality of family relationships has also been seen as an important variable in family adaptation and the ability to cope with stressful life events (Clegg, 1997). The impact it has on the self-esteem of children in the family, their subsequent development and concept of self is also documented (Marjinsky, 1996). Delmonico showed that an individual with higher quality social support resources, higher levels of hardiness, better childhood family relationships, and who did not utilise avoidance coping, was less likely to experience depression (Delmonico, 1997). Family relationships affect the mental health of children, including adult children, and parents. It has been found that parental loss in childhood is associated with health damaging psychosocial characteristics in adulthood, but only if the quality of the surviving family relationship is poor (Luecken, 2000). Parent-child conflict affects both parents and children (Steinberg, 2001; Reder & Lucey, 2000). It has been suggested that there needs to be a new perspective on the family emphasising the different viewpoints that parents and adolescents bring to the relationship. It is believed that there is enough evidence to conclude that adolescents need parents whom are warm, firm and accepting of their need for psychological autonomy (Steinberg, 2001). In older age, it has been shown that quality family relationships in early adulthood had had a significant positive influence on the 'wisdom' (cognitive, reflective and personality qualities) of women 40 years later. This, in turn, had a positive effect on women's life satisfaction, physical health and family relationships (Ardelt, 2000).

Mild to moderate mental illness, such as depression and generalised anxiety disorder, is also associated with dysfunction in family relationships. One study showed that

adolescent mothers with the greatest depressive symptoms were those who coresided with grandmothers under conditions of poor family cohesion (Kalil et al, 1998). Similarly, Kirkcaldy and colleagues revealed that high trait neurosis in adolescents was associated with poor family cohesion and greater parental conflict (Kirkcaldy et al, 1998). In addition, trait anxiety was the most potent predictor of trait depression, together with emotionality, low self-confidence, inferior family relationships, mental health and impulsivity (Kirkaldy & Siefen, 1998). Some evidence suggests that the gender differences in depression begin to emerge in middle adolescence and that the nature and level of family relationships may influence the prevalence and pattern of adolescent depression (Donnelly, 1999). The effect of family relationships on the social competence of young children has already been discussed; in relation to this it has been found that poor attachment and social competence has been associated with more depressive symptoms in 10-13 year olds (Sundby, 2000). Furthermore childhood depressive symptoms predict multiple types of psychiatric symptoms in young adulthood, especially aggression, and were associated with poorer adaptive functioning, including family and peer relationships (Aronen & Soininen, 2000). Control beliefs have also been shown to have an ameliorating or buffer effect on stress and reports of depressive symptoms by adolescents (Herman-Stahl & Petersen, 1999). Childhood maltreatment not only increases the risk of substance misuse problems in later life, but it also often leads to increased feelings of depression and anxiety (Downs & Harrison, 1998); this is also true for older women after a long-term sequelae of domestic violence (Wolkenstein & Sterman, 1998). Severe mental illnesses such as schizophrenia can be triggered by poor family relationships and parental loss; it appears that when combined with a genetic risk for schizophrenia, disruptive early rearing circumstances contribute significantly to later schizophrenia outcome (Schiffman et al, 2001). In particular, there is an association with family expressed emotion and the course of schizophrenic illness (Wearden et al, 2000).

Suicide ideation and attempted suicide are also closely associated with dysfunctional family relationships. In one study which examined all attempted suicides by 9-18 year

olds admitted to a general hospital between 1978 and 1994, 38.5% gave a disturbed parent-child relationship as the primary reason for the attempt (Krajnc et al, 1998). Poor family relations were also on of the reasons given for suicide ideation by recently diagnosed HIV + heterosexuals (Chandra et al, 1998).

The clinical outcome of mental health conditions such as anxiety disorders is also dependent on the quality of family relationships (Yonkers et al, 2000; Paradis et al, 1997). There is a diminished likelihood of a full or partial remission for those patients with poor relationships (Yonkers et al, 2000). Treatment compliance, for example by suicide attempters, or children with epilepsy, is also dependent on good family relationships (Rotherham et al, 1999; Otero, 2000).

The characteristics of family relationships can contribute to or prevent physical ill health and can serve as risk or protective factors in the management of chronic disease. A recent study examining the developmental antecedents of psychosocial traits that are linked to increased risk of heart disease, indicated that parental loss in childhood is associated with health damaging psychosocial characteristics in adulthood but only if the surviving family relationship is poor (Luecken, 2000). Other studies suggest that the relational context of the family affects disease management and that this should be expanded to consider the wider context of the family (Fisher & Wiehs, 2000; Drotar, 1997); more adaptive family relationships were shown to help in the psychological adjustment of children with chronic health conditions and may help the clinical course of patients with cancer (Drotar, 1997; Weihs & Reiss, 1996).

Parents caring for children, particularly single mothers have higher mortality rates than families without dependent children. Interestingly, women with dependent children from manual socio-economic groups have higher rates of disease, disability and illness when they work outside the home; conversely, the same group of women from non-manual households has more favourable physical health. Possible explanations for this have related to job type, income levels and child care support. There is a similar pattern of poor psychosocial health for single parents, particularly mothers, and working mothers from manual households. There is also a growing body

of evidence indicating the health impacts on children caring for siblings and other relatives, such as grandparents and parents (Evandrou, 1996; Power, 1996).

#### *Impacts of Family Relationships on Health and Social Services*

There is some evidence that **health service utilisation** is reflective of the level of social support available to a patient. One study showed that there is a higher use of out patient health services when there are high levels of patient psychological distress and low levels of social support from family, friends or confidantes (Kouzis & Eaton, 1998). The use of health and social care services in older age also shows a link with family relationships. Where there was evidence of family conflict, there were no plans to rely on family members for their future care (Roberto et al, 2001).

Some research suggests that the **relationship between health service staff and families** contributes significantly to the patients' health outcomes. Family-centred care and 'adaptive practice' models emphasising family-provider relationships contribute to greater patient and carer satisfaction and more appropriate, effective care (Van-Riper, 1999; Feldman et al, 1999; Mannion & Meisel, 1998).

#### *Families under pressure*

As identified above, families under pressure and so at risk of family relationship difficulties, include:

- Single parent households, especially single mothers
- Young mothers with poor family relationships
- Young mothers from care
- Step families
- New families
- Bereaved families
- Families living in poverty
- Families in abusive relationships
- Families with parents misusing alcohol or drugs
- Families with 'workaholic' parents
- Families from ethnic minority groups
- Families with health problems

*Impacts of parent education programmes and other interventions*

There is a wealth of literature describing and evaluating different parent and family interventions. Broadly these can be divided into **education-based** and **support-based** interventions. Education-based interventions can be further sub-divided into **developmental, preventative or treatment programmes**.

**Table 4.1 Education-based parenting interventions**

<b>Developmental programmes</b>	<b>Preventative programmes</b>	<b>Treatment programmes</b>
<ul style="list-style-type: none"> <li>• <i>Generic parenting training</i>, for example Systematic Training for Effective Parenting (STEP) and Childwise programmes,</li> <li>• Programmes to involve parents in schooling, for example homework programmes,</li> <li>• Developmental programmes for parents with specific needs, for example parents with mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Preventing risk-taking behaviour in children</i>, for example Preparing for Drug Free Years (PDFY) and Informed Parents and Children Together (ImPACT),</li> <li>• <i>Divorcing parenting programmes in children</i>, for example Parent Education And Custody Effectiveness (PEACE) and divorce seminars,</li> <li>• <i>Preventing violence and disruptive behaviours in children</i>, for example Safe Start and LIFT (Linking the Interests of Families and Teachers),</li> <li>• Preventing child abuse and neglect by parents</li> </ul>	<ul style="list-style-type: none"> <li>• Treating children with behavioural problems, for example ADHD, anti-social behaviour,</li> <li>• Treating children with mental health problems, for example anxiety, depression and grief,</li> <li>• <i>Treating children with clinical conditions</i>, for example Open Airways in Schools (OAS), BFST for families with adolescents with diabetes</li> </ul>

The impacts of generic parenting programmes, such as STEP have included improvements in general family functioning and relationships such as communication, problem-solving, effective responses and behaviour control (Adams, 2001). A systematic review of 20 STEP evaluations indicated that in addition to positive effects on parents' knowledge, attitudes and behaviour, there were also beneficial impacts on children's self-esteem, with latent behavioural impacts (Cedar & Levant, 1990).

Randomised control trials of 2 pilot parenting programmes (training and support) targeting children (infants and pre-schoolers) at risk of mental health problems due to poverty and/or their parents' lack of educational attainment, inexperience or young age suggested that parent-child relationships were enhanced in both pilot studies (Letourneau et al, 2001). Similar results with infants have been demonstrated elsewhere (Heinickie et al, 2000). Mentore indicated that early interventions are important for children 'at risk' (Mentore, 2000). In addition programmes involving 'at risk' families appear to have consistent and replicable effects on children's behaviour, parents' effective use of discipline strategies and on improved family functioning whether the intervention methods target parents alone, parents and children in separate groups or parents and children together (Lochman, 2000).

A ten-week programme for parents on low income whose children have been identified at risk of mental health problems demonstrated that the programme was successful in developing more appropriate discipline and nurturing strategies, reducing verbal and physical punishment (Anderson, 1999). There is also some evidence that this type of parent training to improve the mental development of children helps to reduce socio-economic health differences (Gepkens & Gunning-Schepers, 1995).

Parent education and involvement programmes associated with primary schools have been shown to have an impact on academic achievement. For example, two studies showed that when parents of children with emotional and behavioural disorders participated in a homework programme, they improved their child's homework-related skills and academic performance (Cancio, 1999); other studies reflect these impacts (Meteyer, 1999; Rhoades & Kratochwill, 1998).

Other positive parenting programmes involving specific parent groups, such as parents with mental illness, have also demonstrated improved parent/carer-child relationships, treatment compliance by the parent and a decrease in the number of children in temporary foster care (Bassett et al, 2001).

Parent training programmes such as Preparing for Drug Free Years designed to prevent adolescent substance abuse and other problem behaviours have reported significant improvements in parenting behaviours, and even at 3 year follow ups, there was a reduced growth of alcohol use (Kosterman et al, 2001; Park et al, 2000).

The PEACE programme and parenting seminars for divorcing parents have also been shown to impact on parents' attitudes about their children, their children's behaviour and the parent-child relationship, offsetting the potential for developmental and mental health problems arising in children (Salomone-Grant, 2000; Frieman et al, 2000). Programmes involving children (6-15 years) with or without their parents have also had positive impacts on negative moods states, self-esteem, relationships with family and peers, and home and school-based problems (O'Halloran & Carr, 2000). ImPACT, designed to increase monitoring by parents of African-American youth regarding HIV risk behaviours and protective behaviours showed a shift towards more protective behaviours after the intervention as well as improved parent-youth communication and perceived parental monitoring (Stanton et al, 2000). A population-based randomised trial on LIFT, an intervention for preventing child conduct problems, has shown immediate impacts on various behaviour indicators (Reid et al, 1999). Intensive community based parenting education and support programmes have been shown to be more effective in reducing risk factors associated with child abuse. Parents more involved in the programme during the week (as opposed to for a longer duration overall) were found to make more significant gains, that is reduced parental stress, improved parent-child relationships, reduced physical and verbal aggression, and improved quality of the home environment (Whipple, 1999).

Other programmes for at risk groups, particularly those involving cognitive-behavioural or social learning interventions, were also found to improve parenting and reduce the risk of child abuse or neglect (Macdonald & Winkley, 1999).

Opportunistic parenting education, for example on injury prevention at emergency departments has also been found to be effective in reducing further incidents (Kruesi

et al, 1999). In addition there are various programmes aimed at families in order to prevent youth violence. The most effective are early (pre-school) interventions and include various types of family therapy, programmes for children and home visits; promising interventions include family literacy programmes and support groups for victims (Kellerman & Fuqua-Whitley, 1997-C).

There are a number of studies, which have examined treatment-based parent education programmes. Adolescent conduct problems impact on the individual, family and society as a whole. A recent meta-analysis of the effects of family and parenting interventions for conduct disorders and delinquency in children (10-17 years) has shown they have a beneficial effect on reducing criminal activity (Woolfenden & Williams, 2000-C).

Parent training and school-based interventions for children with behavioural problems can improve conduct and mental well being (NHS CRD, 1997). Intensive behavioural parent training (BPT), family functioning therapy (FFT) and multisystemic therapy (MST) have been shown to be effective in the treatment of adolescents with anti-social behaviour problems in a proportion of cases, with MST being most effective for persistent offenders from low socio-economic groups (Brosnan & Carr, 2000). Some professionals believe that since antisocial adolescents consume much of the resources of the children's mental health services, juvenile justice system, and special educational services there needs to be a different approach that links multidimensional causal models with 'real world' intervention models. These include addressing adolescent characteristics, family and peer relations, neighbourhood context and school (Bourdin et al, 2000).

There has also been a review of the efficacy of family-based interventions for pre-school age children with behavioural problems, with both group and individual parent-training approaches being found to be effective (Corcoran, 2000). Parenting programmes have also been used as part of the treatment regime for children with mental health problems. Attention Deficit Hyperactivity Disorder (ADHD), the most common mental health disorder of childhood has commonly been treated by

medication or behavioural treatment or their combination. A review of the effectiveness of the behavioural component, which includes parent training and school interventions, has shown that the behaviour and academic performance of ADHD children improves significantly (Pelham & Gnagy, 1999). Similarly, a review of interventions for children and adolescents with anxiety disorders revealed the effectiveness of treatments including family based behaviour therapy, parent training and relaxation training, and that brief outpatient interventions are preferable (Moore & Carr, 2000). Another review of effective treatments for depressed children and adolescents, and for youngsters who have suffered bereavement arising from a parent's death, indicated that both bereaved children and parents benefited from family therapy focused on family-based grief work (Moore & Carr, 2000). In addition, education courses for parents of adolescents with mental health problems have been shown to benefit parents by providing more acceptable access to support through an educational frame than a psychoeducational frame (Goldberg & Gartside, 1999).

Finally, there is also evidence of the effectiveness of parent education programmes in helping in the clinical management of conditions such as asthma and diabetes. The Open Airways for Schools (OAS) programme included sessions for parents and children (6-13 years) to help manage asthma symptoms and their feelings towards the condition (Spencer et al, 2000). A randomised control trial of therapies for families of adolescents with insulin-dependent diabetes showed that behavioural family systems therapy was most effective in improving parent-child relations with diabetes-specific conflict, although education and support groups also had some effect (Wysocki et al, 2000).

There is strong evidence that the level of external family support available has profound impacts on the physical and mental health of the family unit as a whole. For example, a programme of home-based support by professional or specially trained lay caregivers to socially disadvantaged mothers tends to be associated with decreased rates of childhood injury or abuse (e.g. Hodnett & Roberts, 2000). They can also improve mental health in children and parents in disadvantaged communities (NHS Centre for Reviews and Dissemination, 1997). Reduced hospital admissions and

mortality in infancy have also been reported, but this evidence is less conclusive. It is also suggested that the absence of family support increases vulnerability, including immune competence. Similarly family support from health visitors, 'community mothers' (or 'doulas') or trained volunteers has been associated with early detection of post-natal depression, higher self-esteem during early motherhood, fewer mother-child relationship problems and child behaviour problems (Laing, 2000-C). An evaluation of 6 family support programmes demonstrated that they enhanced child, parent and family functioning, as well as positively impacting on housing and income in the long and short term (Comer & Fraser, 1998). One recent study investigated the relationship between family structure (intact or step families), life stress, and social support and the effect it has on both parents' and children's physical and psychological well being. It was found that, common to both groups, there was a relationship between life stress and health distress. Life stress had a significant effect on children's adjustment in stepfamilies, and social support had both direct and indirect effects on mothers (Touch, 1997). Highly relevant to Parenting 2000 is an evaluation of a parent support centre project. This used qualitative methods involving participants and workers. The main positive impacts were described as enhanced social support, improved parenting practices and higher self esteem of participants; however, it was also noted that it was less successful with regard to the on-going recruitment of participants (Coady et al, 1999).

The efficacy of day care support for pre-school age children has recently been analysed in a systematic review of 8 randomised control trials in the U.S.A. Regular parent-teacher contact was a major component of the research. This showed that day-care not only provides immediate support to parents, but also has short and long terms benefits to the children and parents (Zoritch et al, 2000; NHS CRD, 1997):

**Table 4.2 Positive Impacts of day-care to mothers and children**

<b>MOTHERS</b>	<b>CHILDREN</b>
<ul style="list-style-type: none"> <li>• Education</li> <li>• Employment</li> <li>• other-child relations</li> </ul>	<ul style="list-style-type: none"> <li>• Intelligence</li> <li>• Development</li> <li>• School achievement</li> </ul>

- 
- Employment
  - Lower teenage pregnancy rates
  - Higher socio-economic status
  - Decreased criminal behaviour
- 

#### 4.2.2 Community profiling: Evidence from official documents

Demographic data on the Central Southport Partnership area was obtained from the Census\* (1991). Additional data was also obtained from recent household\*\* and employer surveys\*\*\* on urban regeneration in Sefton (Prism Research, 2000).

##### *Resident population*

The Central Southport Partnership (CSP) area consists of parts of the wards of Cambridge and Dukes. The CSP population is generally much older than the Sefton average:

**Table 4.3 Breakdown of CSP population by age\***

<b>AREA</b>	<b>Total Residents</b>	<b>0-4 years</b>	<b>5-15 years</b>	<b>16-24 years</b>	<b>25-59 years</b>	<b>60-64 years</b>	<b>65+ years</b>
		%	%	%	%	%	%
CSP	9,707	3.6	5.6	12.7	38.3	6.5	33.2
SEFTON	289,542	6.3	13.6	12.1	44.3	5.8	17.9

**Table 4.4 CSP population by gender\***

<b>AREA</b>	<b>% population who are male</b>	<b>% population who are female</b>
CSP	44.3	55.7

**Table 4.5 Breakdown of CSP population by socio-economic status\***

	<b>CSP</b>	
	<b>Number</b>	<b>%</b>
I - Professional	113	4.9
II - Managerial & Technical	793	34.2
III - Skilled (non-manual)	433	18.7
III - Skilled (manual)	371	16.0
IV - Partly skilled occupations	412	17.8
V - Unskilled occupations	134	5.8
Other	20	0.8
Not stated	41	1.7
All economically active households	2317	100

Data from the Index of Deprivation (DETR, 2000) shows that Cambridge and Duke's wards are in the most deprived quintile of all wards in England and are ranked 14<sup>th</sup> and 15<sup>th</sup> (out of 23) most deprived wards in the borough of Sefton. With reference to the child poverty index, which has particular relevance to the Parenting 2000 project, Duke's ward is the 11<sup>th</sup> highest in Sefton and Cambridge ward is the 13<sup>th</sup>. This is presented in Appendix 4.1.

#### *Ethnic minority groups*

1991 Census data for Cambridge and Duke's wards show that the numbers and percentages of non-white ethnic groups is as follows:

**Table 4.6 Ethnic minority population in Cambridge and Duke's wards**

<b>WARD</b>	<b>NUMBERS</b>	<b>PERCENTAGE</b>
Cambridge	113	0.9
Duke's	227	1.7

### *Household composition*

According to the 1991 Census, 11.8% of CSP households had children (5-16 years), compared with 28.7% of Sefton as a whole. This has reduced slightly to 11% in 1999. Based on 1991 data, 2.9% were from lone adult households.

Comprehensive data on household composition such as the proportion of teenage families in the CSP area compared with other parts Sefton and with England, was not readily available.

### *Economic activity*

There are encouraging signs of increased economic activity with the increase in full-time employment since 1997, however it has not reached the levels recorded in the 1991 Census.

**Table 4.7 Economic status of CSP population**

<b>ECONOMIC STATUS</b>	<b>1991 (%)</b>	<b>1997 (%)</b>	<b>1999 (%)</b>
Employed full-time	27	19	21
Employed part-time	6	8	8
Self-employed	8	8	8
Govt scheme	1	0	0
Unemployed	7	10	10
<b><i>All economically active</i></b>	<b>49</b>	<b>45</b>	<b>47</b>
<b><i>All economically inactive</i></b>	<b>51</b>	<b>55</b>	<b>53</b>

Notes: Figures show the percentage of the total population in each category

Unemployment in the Cambridge ward of the CSP is 5.2% similar to Sefton as a whole at 5.5%, and below the Merseyside rate of 6.8%. However it remains above the UK rate of 3.3%. Dukes is much higher all of these though at 8.5%. A particular problem is long term the unemployment rates across CSP of one in four people (26%).

Interestingly, of those people who did work full time, there has been an increase in the average weekly hours worked. In addition, of those people caring for families or

involved in unpaid voluntary work (approximately 7% of the CSP population) only one in eight (12%) is thinking of getting a job within the next year, with a further 8% looking for work in the next 2-5 years (Prism, 2000).

There has been a slight increase in the proportion of the CSP 'workforce' - people, who are in employment, self-employed, unemployed, in education or training or not working now but planning to work in the future - with qualifications: 72% in 1999, compared with 69% in 1997. However, this is significantly less than the UK proportion of 86%.

There has also been a rise in the proportion of Southport employers who employ someone from an ethnic minority group: 12% in 1999 compared to 6% in 1997. This increases the proportion of ethnic minority employees in Southport from 1.5% to 3%.

#### *Housing tenure and conditions*

CSP has a lower proportion of owner occupied households than Sefton as a whole. In 1991, the number of housing association rented properties was more than nine times higher than for Sefton (Census, 1991). Evidence from the 1997 Baseline Monitoring Survey showed a predominance of semi-detached and detached houses and flats in CSP, in contrast to the predominantly terraced houses found in Sefton's other assisted areas (Prism Research, 1998). From the 1999 monitoring survey there appears to be an increase in the number of properties that have been converted to flats; other indicators suggest a move towards rented accommodation, with a 70%, 30% split between owner occupied and rented accommodation (Prism Research, 2000). However, this is a lower proportion than other areas in Merseyside, where 36% of residents live in rented accommodation (Regional Trends 33, 1998).

There are indications from the monitoring survey that rented accommodation is not being regularly maintained, with only 17% of households having repairs undertaken in the last 2 years compared with 30% in 1997 (Prism Research, 2000). However, the majority of residents (85%) report that they are satisfied or very satisfied with the physical condition of their homes, which is broadly similar to Merseyside residents views as a whole. There are also indications that there are fewer households sharing

basic facilities in 1999, 4% compared with 9% in 1997, although, the figures need to be interpreted with caution.

### *Health status*

Although comprehensive data on the health status of residents in the CSP area was not accessible, the 1999 baseline survey provided a snapshot of self-perceived health needs. One in ten of all CSP residents need help to do everyday things because of disability, health problems or old age; of this group three-fifths are under retirement age. About half of these people do not consider themselves fit for work. The proportion of people registered disabled is 5%, similar to 1997.

More than a third (36%) of all CSP residents do not drink alcohol and the majority of people who do drink do so in moderation. There are indications from the 1999 baseline survey that the levels of alcohol consumed have decreased. There is also a rise in the proportion of people who would like to reduce their alcohol consumption levels suggesting an increased awareness of safe drinking levels.

### *Social support*

There are a range of organisations in addition to the Parenting 2000 Centre to support people in Southport, including CSP residents, and facilities available for community use. These include:

- Central Southport Partnership
- Opportunities Shop
- Sefton Council for Voluntary Services
- Credit Union
- Community Action Fund
- Sefton Pensioners Advocacy Centre
- Alchemy
- Phoenix Youth Project
- Shaw Trust
- Light for Life
- Town Watch/Town Wards
- Southport Swimming Baths

Levels of awareness suggest that local people are not generally aware of the services and support available to them. Under half of residents were aware of the existence of

Credit Union (47%) and only one quarter knew of Town Watch (25%) or Sefton CVS (24%).. Although Parenting 2000 was only just in operation when the baseline survey was undertaken, only 7% of CSP residents were aware of it (Prism Research, 2000).

The views of young CSP residents (11-16 year olds) on social facilities indicate that they are most satisfied with libraries, green space and health facilities and least satisfied with advice and counselling for young people, sports facilities, clubs and activities, and holiday play schemes. This was a similar pattern to 1997. Overall many young people believed there was scope to improve facilities for young people in central Southport, particularly in clubs and activities for young people, sports facilities and playgrounds. Changes in charging policies were suggested.

*Other parenting support/child care facilities*

Particular support for parents and families is available from:

- Home Visiting Team
- Sure Start Team
- 6 Family Centres across Sefton
- Over 50 nurseries and playgroups in Sefton
- A network of childminders across Sefton

In addition various programmes and play schemes operate during holiday time. |

### **4.3 Evidence from stakeholders and key informants**

#### *Survey of Parenting 2000 users*

The results referred to below come from the questionnaire surveys filled in by attendees of the project. A discussion of the intention behind the survey and the questions asked appears in Appendix 3.5. However, it is perhaps useful to re-iterate the following points. The survey was designed for self - completion. It was intended to be simple and quick to fill in. Therefore it was not possible to go into too much detail. The project manager kindly agreed to make copies of the survey available in the centre for people to fill in when they had a spare few minutes. 25 questionnaires were completed, approximately 10% of the clients for that period. Although the results may not be representative of the entire client population it does, nevertheless, provide an indication of who accesses the services.

23 of the questionnaire respondents were female and only two were male. Although Parenting 2000 welcomes all members of the family, it is not surprising that the overwhelming majority of respondents were female since it is still the case that most primary carers are female.

All of the respondents self identified as white. Parenting 2000 has taken steps to ensure that people from minority ethnic groups feel welcome. For example, there is an Equal Opportunities statement on display and some materials are made available in different languages. However monitoring does not include collecting data on ethnic minority groups or gender so it is not possible to say if this is typical of the client population or not.

Interestingly, none of the survey respondents were 20 or under. A small proportion (five, or 20 per cent) were aged 21 to 30 and an even smaller number (two) were aged 51 to 55. However the majority (16, or 64 per cent) were aged 31 to 45. This is significant, as it would suggest that the people who use Parenting 2000, tend to be older parents.

All of the respondents had at least one child under 16. 20 (or 80 per cent) had only one or two children. Five (or 20 per cent) had three or more children. 19 (or 76 per cent) had at least one child under 5. Of these, over half had just one child. 10 respondents (40 per cent) had one or two children over 5 but below 11. Only three people had any children over 11 but below 16. This would suggest that the people who feel that they can benefit the most from the services that Parenting 2000 has to offer are those with fairly young children and at least below secondary school age. However, it could also reflect the fact that there was a holiday play scheme for under 11s during part of the time that the project manager was really encouraging people to complete the questionnaires.

Three respondents described themselves as being disabled or as having a limiting long-term illness. Two of these were registered disabled. Parenting 2000 has tried to ensure that disabled parents and children are able to make use of what it has to offer. Most rooms in the building are accessible to wheelchairs. The toy library has some toys that are suitable for disabled children. Our survey did not ask about disabled children. In hindsight, this would have been useful information.

The respondents were almost evenly distributed between full employment, part-time employment, unemployment and “not seeking work”. Of those “not seeking work”, for the overwhelming majority this was because they were looking after children.

Half of the respondents were first time users. Again, it is likely that this was due to the play scheme being on during part of the time when the questionnaires were available for completion. For many parents, the play scheme was the first reason they had to use Parenting 2000. Of those who had been more than once, there seemed to be emerging a core group who had been five times or more. A number (5) of respondents had also attended a basic skills course of English or Maths.

Probably for the reason mentioned above, half of the respondents gave the play scheme as the reason why they were there that particular day. The other two most popular answers were “to attend a group” and for the “One stop shop”.

The overwhelming majority of respondents (20, or 80 per cent) had learned about the centre through word of mouth. Surprisingly, only four people had heard about it through advertising.

*Focus group with parents*

As explained in a previous Section, the focus group session was held at a drop in group at Southport Social Services Family Centre in September 1997.. The purpose of this was to find out about their usage of Parenting 2000 and further to this, to explore through questions and discussion, the impact, if any, that they feel the project is having, or might have, on health determinants for them and their children.

The Southport Family Centre is run by Social Services and offers a range of support sessions and activities. Approximately 30% of families who use some of these services are referred to the centre through social provision. On Tuesday afternoons there is a “drop-in” session which is open to anyone who has care of a child/children.

Families are referred to the centre for a variety of reasons. The reasons fall broadly into the categories of accommodation and finance related problems, health issues i.e. disability, mental or physical, either of the parent or the child, and child protection issues. Most of the reasons although not all (particularly relating to disability) have social and/or economic disadvantage as a significant contributory cause.

The Family Centre differs from Parenting 2000 in terms of its structure and some areas of service delivery. The Centre is part of Southport Social Services and therefore, delivers its services as part of the overall local authority provision. The Centre manager does however have a considerable degree of flexibility as to how the services are provided, subject of course to budgetary restraints. In contrast, Parenting 2000 is a voluntary sector organisation and funded through a regeneration programme specifically to develop innovative measures to improve the quality of life for parents and their children through access to training and employment. The work of the Centre

is more weighted towards providing support to families whose needs may be greater and more diverse. The Centre is also able to offer some respite care for parents - children will be cared for by nursery staff for short periods, although the Centre is not a day-care nursery.

The Family Centre is bright and welcoming and reasonably well resourced. Staff are friendly and aim to provide a warm and welcoming atmosphere. The Centre is situated approximately one and a half miles from Parenting 2000 and would certainly be described as being in a central location.

The average age of the parents in the group appeared to be considerably younger than those who met at Parenting 2000. Three women certainly were in their mid to late teens. Interestingly, both men appeared older, perhaps late thirties.

Of the 12 members of the group, only three people, two men and one woman, all lone parents, had been to Parenting 2000. All three were very positive about the project. The woman had arrived from Nigeria just over a year ago with a four month old daughter. She had learning difficulties and knew no English when she arrived in this country. She learned of the project through Social Services and, at the time of this focus group, was almost fluent in English. She was taking courses in basic maths and literacy and had relied on the project quite considerably for support and information. She had a very high opinion of Parenting 2000 - her perspective was obviously very particular. The two men were also recent newcomers to Southport and were both working as part-time volunteers at the Family Centre. Jointly they had organised a short course in basic home maintenance for other users of the Centre and were offering their skills to Parenting 2000. These three people were vociferous on the issue of the importance of self-motivation and contributed throughout the session. One of the men particularly was clearly trying to encourage others to express their opinions.

Other members of the group were less positive about Parenting 2000. The perception was that the project was more for the middle class *women* of the area. One woman

said that there was no point in going because the children could not be left there. Another volunteered that the courses offered by the project (and, in fact, anywhere else) were a waste of time as people “like us are never going to get a job anyway, so what’s the point of pretending?” Some parents said that the project was in the “wrong part of town for us”. One woman said that she would not dream of leaving her children there as she did not know the people - an interesting attitude indicating the challenge faced by new projects of gaining the trust of a client group that feels it has been badly let down in the past. It is also the attitude of a client group whose self-esteem is extremely low and who individually face pressures in their daily lives of such magnitude that the government’s New Deal scheme seems as far away as the possibility of a university degree course.

The feeling was that Parenting 2000 would only have any impact on those families living near to it, and from less disadvantaged backgrounds. They saw no other relevance. The view was expressed that there seemed to have been a lot of money spent on it.

In terms of wider concerns for parents, two issues were prominent: money and housing. Money was described as "very tight" with everyone on benefit. 8 parents stated that they never went out in the evening or at weekends without their children, as there was no possibility of childcare in the evening. The collective view was that new government initiatives such as tax credit simply are not applicable to them. Their arguments against training were so heartfelt that they were plausible.

With regard to housing, aspects of the housing situation in Southport are examined in another case study in this research project (see Annex 4), and the views expressed by this focus group certainly give credence to housing being an issue of great concern. All of the people in the group said that they lived in rented accommodation in older properties. All were concerned about heating and the difficulties faced by having high ceilings, draughts, damp walls and floors. These views represent a marked contrast with the positive housing conditions reported in the baseline monitoring survey, and indicate the need for a more in-depth analysis of those particular types of housing, for

example older, private-rented properties. Heating was considered by some to be inadequate and was also very expensive. With the exception of one of the men and the Nigerian woman, all group members wanted to move to newer properties. Most expressed concern for their children's long term health as the primary reason for wanting to move. At the time of this report, the average length of waiting time for a family in Council accommodation with even maximum points was reported to be nine years.

Some members of the group volunteered that nonetheless there were some advantages to living in Southport: "It's near the sea, we've got the sea front" and "at least it's not Liverpool." Several agreed that parts of the town are "nice to look at," but they generally felt that the better areas were not for them but for the more affluent residents and visitors.

*Evidence from other key informants*

There is a range of services provided through Parenting 2000. As previously described the Centre is 'open to all' and this is reflected in its various funding sources. It is estimated that currently 15% of families taking up the services provided by Parenting 2000 come from the Central Southport Partnership area but many come from less disadvantaged suburban areas to avail themselves of what Parenting 2000 can offer. A more in-depth analysis of this is discussed below.

Other data on people who use Parenting 2000 (updated with figures for May 2001) appears in Table 4.8, below.

**Table 4.8 Parenting 2000 projected and actual outputs**

<b>ACCESSING SERVICES</b>	<b>PROJECTED TARGET TO 2002 (No.)</b>	<b>CUMULATIVE TARGET TO JUNE 2001 (No.)</b>	<b>MAY 2001</b>
Trainees gaining qualifications	150	74	
Young people	672	398	
Volunteers	25	17	
One stop shop (parents)			51
One stop shop (children)			7
Mediation (visits)			5
Mediation (clients)			23
<b><i>Drop-Ins</i></b>			
Lone parent advisor (visits)			1
Lone parent advisor (clients)			2
Counsellor (visits)			7
Counsellor (clients)			13
Toy Library visits			23
Marriage care (visits)			5
Marriage care (clients)			20
Parent/child support - health visitor (adults)			25
Parent/child support - health visitor (children)			25
Parents support group (adults)			5
Parents support group (children)			7
Childminders support group (adults)			3
Childminders support group (children)			4
Families need Fathers			10
<b><i>Courses/ workshops</i></b>			
First aid			5
'Stress busters'			6
Computer taster			8

Amongst the non-user key informants and stakeholders there was some concern that their respective service users might not feel confident enough to go to Parenting 2000. In response to being asked what effect the project will have on their client group, there were various views expressed:

“It depends how many of our clients access it. They are a very vulnerable group who are loath to join anything, they have a lack of trust.”

Light for Life.

However, there was some confidence that once people had been “lured in” by one activity then they would see all the benefits that Parenting 2000 has to offer and be likely to become more regular users.

“Some of the single mums will access it, for example they will use the toy library and then they might be drawn in to some of the courses.”

Light for Life.

“The parenting support group that I help run has moved here and I have opened it up to the general public as well. I have advised them to speak to Sue to find out what else is being offered.”

Health Visitor

One respondent was concerned that the courses on offer did not entirely meet the needs of the women she supports.

“The courses offered so far are about basic numeracy and literacy and parenting skills. There is only one person that we see who would need these. We see a lot of women who have a lot of skills. The courses are not appropriate for people like that. A lot of women that we support are very intelligent and have a good level of education.”

Women's and Children's Aid

However, this was a minority viewpoint and most informants were extremely positive about the relevance of the courses on offer to their particular client group.

“Parenting 2000 is quite an easy environment for people to start their education again. It might give them the confidence to go back into more formal education.”

Light for Life

“Parenting 2000 is offering the same courses that we do [at the Social Services Family Centre] - they really make a difference to these families. We have found that running courses with people makes them so confident that they want to run their own courses.”

Social Services Family Centre

One perceived barrier to some people being able to use Parenting 2000 was transport problems. Although it is located in a fairly central location, it was considered that some people living on outer estates might find the prospect of a bus journey in, especially with young children, unappealing.

“Some of the young women live a long way away. It would be good if Parenting 2000 could satellite out sometimes for example to Woodvale.”

Young Mums’ Group

“A lot of our families live out of town and have a real problem getting in. It's a major hassle getting two or three children on a bus or walking in to town.”

Social Services Family Centre

Generally it was felt that there was a need for Parenting 2000 to publicise what it has to offer much more. In particular, some organisations were keen that they were kept better informed about what the Centre was planning to do so that they could tell their clients in good time. It was also thought that, once people had been and enjoyed it, then they would tell their friends about it. Certainly, informants thought that the

success of the Centre was very much tied up in the extent to which people were aware of its existence and felt that it had something to offer them.

“As it gets known more it will obviously have an effect [on Southport as a whole]. It will be a slow thing. It needs publicising well. There needs to be more work selling it to older people.”

Young Mum’s Group

“Parenting 2000 is very new. Until it is well established it’s quite limited. As people get to know that it exists it will be used more.”

Health Visitor

“People need to be aware of the services that are provided.”

SWACA

“Parenting 2000 needs to keep other agencies abreast of where they are up to. They need to let us know what they are doing more in advance. Parenting 2000 should make sure that they keep the social workers informed about what they are doing so they can tell their clients. I am positive that it will be used as long as the information goes out to all the agencies.”

Social Services Family Centre

**Overall, all the (non - user) key informants and stakeholders were extremely complimentary about Parenting 2000 and what it had to offer their clients.** They particularly liked the fact that so much was being offered under one roof. They considered the crèche to be extremely valuable. A particularly positive aspect of the Centre was thought to be that it is open to all and that parents do not have to be referred to it to use it. This means that there is no stigma attached to going there and taking up what is on offer. Not only does it mean that it is more likely that people will go, it also means that whilst they are there they can relax and enjoy themselves more.

The evidence contained in this section would suggest that, whilst Parenting 2000 is perceived as an extremely valuable community resource by most professionals, it has some way to go to convince all parents in Southport, especially the most vulnerable, that it has something to offer them. However once accessed by even deprived families, their experiences are very positive. With such provision there is always an argument about whether they be only for those who are deprived or vulnerable or whether they should be open to all. With the former, as was pointed out by a number of key informants, it is likely that people who have to use a particular service will feel stigmatised. People who are in need of help may find themselves excluded from it because they do not meet the exact criteria. However, when there are scarce resources it is sometimes important to know that they are going to those who are most in need of them. People are likely to be there for a variety of reasons and, most importantly, on a voluntary basis. In the case of Parenting 2000, an “open to everyone” approach is surely the right one. Apart from anything else, it recognises that being a parent is a challenging job for anyone. Although living in poverty is almost certain to make it more difficult, all parents are likely to need support and reassurance from time to time. Within this “open to everyone” framework, Parenting 2000 does need to take steps to ensure that people living in poverty or who are socially excluded in other ways are especially targeted and do feel able to use the building and participate in the courses and activities that are on offer (see discussion around Figure 4.1, below).

#### 4.4 Analysis of Health Determinant and Health Outcome Impacts

The following account summarises the health determinant and health outcome impacts arising from the extensive research review and documentary analyses together with the interviews with stakeholders and key informants. These results are summarised using the Merseyside Guidelines' framework.

*Health Impacts* describe the impacts of the programme on different health determinants and their subsequent effect on health outcomes. *Direction of Change* indicates whether this 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 the assessors, stakeholders and key informants (Appendix 4.2).

##### *Personal, Family Circumstances and Lifestyle Factors.*

Many stakeholders and key informants felt that the main health impact of Parenting 2000 at an individual level would be the benefits to *family relationships and functioning* through, for example, courses on parenting teenagers and enabling young parents to develop coping strategies when under stress. This was supported by the literature, where a number of studies, including randomised control trials, have shown the positive impacts of generic parenting programmes (Adams, 2001). Very importantly, the literature also revealed that these programmes were also effective when targeted at disadvantaged families (Letourneau, 2001; Heinickie, 2000; Lochman, 2000; Anderson, 1999). However, as indicated by stakeholders, there is also documentary evidence showing the difficulties in getting families 'under pressure' to access parenting programmes and the support services that are available (Coady et al, 1999). Within the context of an 'open to all' policy, without concerted targeting of families 'under pressure', by providing support and services to less disadvantaged

families, Parenting 2000 may inadvertently exacerbate health inequalities. In the short and long term, improvements in family relationships will *enhance self-esteem and well being and increase protection from mental and physical health problems* (eg, Clegg, 1997; Steinberg, 2001; Kirkcaldy et al, 1998; Luecken, 2000).

Other impacts suggested by stakeholders included improvements in *self esteem and peer relationships* from, for example, the education programmes, but also the general ethos of the Centre, both of which have also been identified as outcomes in the literature (O'Halloran & Carr, 2000). In addition, the training and volunteering opportunities to be provided by the project will act as 'stepping stones' to further *developments in education or employment*.

As previously described, there is also evidence from the literature of positive impacts in *academic performance* (eg, Cancio, 1999), *preventing risk-taking behaviour and behavioural problems* in children (eg, Salomone-Grant, 2000; Reid et al, 1999), and *treating behavioural and health problems in children* (eg, Brosnan & Carr, 2000; Moore & Carr, 2000; Spencer et al, 2000), from various education-based parenting programmes. In many cases this evidence has been shown to be effective for families on low income.

In addition, there is evidence that family support, professional and 'lay', *benefits physical and mental health* for the family as a whole; this applies also to families from disadvantaged communities (eg, NHS CRD, 1997).

**Table 4.9 OBSERVED/POTENTIAL HEALTH IMPACTS - Personal, Family Circumstances and Lifestyle Factors**

OBSERVED/POTENTIAL IMPACTS	DIRECTION	EVIDENCE	MEASURABILITY	LIKELIHOOD OF IMPACT	PRIORITY
Improvements in family relationships/functioning for some participants in P2K.	+	Key informants/ stakeholders	Qualitative.	Probable.	High.
Levels of self-esteem, development of identity in adolescents influenced by family functioning, parental bonds.	+	McGarvey et al, 1999. Bandoroff & Scherer, 1994. Rotherham-Borus & Wyche, 1994. McWhirter et al, 1994.	Qualitative.	Probable.	-
Family functioning, including disadvantaged families, improved by generic parenting programmes, eg STEP.	+	Adams, 2001. Letourneau et al, 2001. Heinickie, 2001. Lochman, 2000. Anderson, 1999.	Mainly qualitative. Possibly estimable?	Probable.	-
<i>Positive family relationships enhance mental well being and protect against mild to severe mental health problems in all members of the family; these positive effects can last throughout life.</i>	+	Clegg, 1997. Delmonico, 1997. Luecken, 2000. Steinberg, 2001. Reder & Lucey, 2000. Ardelt, 2000. Kalil et al, 1998. Kirkcaldy et al, 1998. Sundby, 2000. Schiffman et al, 2001.	Qualitative.	Probable.	-
<i>Positive family relationships may protect against suicide ideation and attempts.</i>	+	Krajnc et al, 1998. Chandra et al, 1998.	Qualitative	Probable.	-
<i>Positive family relationships can prevent physical ill health, eg reduced risk of heart disease.</i>	+	Luecken, 2000.	Qualitative	Probable.	-
<i>Positive family relationships can enhance treatment compliance and clinical outcomes of disease.</i>	+	Yonkers et al, 2000. Rotherham et al, 1999. Otero, 2000. Fischer &	Qualitative	Probable.	-

			Weihls, 2000. Drotar, 1997.			
Reduction in risk-taking behaviour by children after parenting programmes.	+	Kosterman et al, 2001. Park et al, 2001. Stanton et al, 2000.	Qualitative	Probable	High	
<i>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 P2K</i>	+	NHS Executive, 1998. Acheson et al, 1998. Kaplan & Keil, 1993. Macintyre, 1994.	Qualitative. Probably estimable?	Probable	-	
Increase in self-esteem of some participants involved in P2K education programmes and support services.	+	Key informants/ stakeholders.	Qualitative	Probable	High	
<i>Reduced risk of mental health problems of participants and their families</i>	+	NHS Centre for Reviews & Dissemination, 1997.	Qualitative. Potentially estimable?	Probable	-	
<i>Improvements in self-esteem in young people reduces risk of:</i>	+	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	-	
<ul style="list-style-type: none"> <li>• eating disorders</li> <li>• self-harm (suicide)</li> <li>• anxiety, depression</li> <li>• risk-taking behaviour</li> <li>• unintended teenage pregnancies</li> <li>• becoming a victim of bullying.</li> </ul>	+	Winford, 1995.	Qualitative	Probable	-	
<i>Improvements in self-esteem increase the ability to cope with adversity.</i>	+	Hemingway & Marmot, 1999. Maier et al, 1994. Najman, 1980.	Qualitative	Probable	-	
<i>Improvements in mental health and coping with stress may reduce the susceptibility to heart disease and cancers in later life.</i>						
Enhance employability of some participants involved in P2K.	+	Key informants/ stakeholders.	Qualitative	Probable	Medium	

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Improve employment prospects for unemployed people involved in social support and problem-solving programmes.	+	NHS Centre for Reviews & Dissemination, 1997.	Qualitative.	Definite	-
<i>Reduced risk of hypertension and cardio-vascular disease associated with social instability, unemployment and job insecurity.</i>	+	Schnall & Landsbergis, 1994.	Qualitative. Potentially estimable?	Definite	-
<i>Reduction in risk of cancer, heart and respiratory disease associated with low income (including from unemployment) and poor diets, poor housing.</i>	+	James et al, 1997. Platt et al, 1989. DSS, 1993.	Qualitative. Potentially estimable?	Definite	-
<i>Enhance mental health of some P2K participants by development of positive coping strategies relating to peer pressure.</i>	+	Key informants/ stakeholders.	Qualitative	Probable	Medium
Reductions in risk-taking behaviours by young people, by reducing negative peer influences: <ul style="list-style-type: none"> <li>• smoking</li> <li>• alcohol/drug misuse</li> <li>• eating disorders</li> <li>• unsafe sex</li> </ul>	+	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	-
Facilitates further education prospects of parents through involvement in P2K programmes.	+	Key informants/ stakeholders.	Qualitative	Probable	Medium
Academic achievement of children enhanced by parent education, which enhances employment	+	Cancio, 1999. Meteyer, 1999. Rhoades & Kratochwill,	Qualitative	Probable	-

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prospects and health gain in the future.		1998.			
Reduce risk of behaviour problems in children and adolescents after parenting education programmes, eg LIFT.	+	Reid et al, 1999.	Qualitative	Probable	Medium
<i>Reduce risk of mental health and behaviour problems in children from divorced families after family education problems, eg PEACE.</i>	+	Salomone-Grant, 2000. Frieman et al, 2000. O'Halloran & Carr, 2000.	Qualitative	Probable	Medium
<i>Reduce risk of child abuse/injury with home-based family support as well as parenting education programmes.</i>	+	Hodnett & Roberts, 2000. Gray. Whipple, 1999.	Qualitative	Probable	Low
<i>Improve behaviour and academic performance of children with mental health problems, eg ADHD, after parent education programmes.</i>	+	Pelham & Gnagy, 1999. Moore & Carr, 2000.	Qualitative	Probable	Medium
<i>Improve clinical management of physical conditions in children such as asthma through family education programmes.</i>	+	Spencer et al, 2000. Wysocki et al, 2000.	Qualitative	Probable	Low
<b>INEQUALITY</b>		<b>ANALYSIS</b>			
Parenting 2000 Centre physically and culturally accessible to families from a range of backgrounds.	+	Key informants/ stakeholders.	Qualitative	Definite	High
No evidence of specific programmes for different ethnic minority groups.	-				
Poor monitoring of disadvantaged families accessing P2K.	-	Key informants/ stakeholders.	Quantitative/ qualitative	Definite	High
'Snapshot' survey/focus group evidence suggests low involvement from disadvantaged families.					
Involvement of	-	Coady et al,	Qualitative	Probable	High

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disadvantaged families in parenting programmes difficult to achieve.		1999.			
Programmes targeted at disadvantaged families can be effective.	+	Letourneau et al, 2001.	Qualitative	Probable	High
Access and involvement of Parenting 2000 by less disadvantaged families will further reduce their health risks, but may widen existing health inequalities.	-		Qualitative	Speculative	Low

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### *Socio-economic Environment Factors*

Another major impact of Parenting 2000 is the increase in *social support* that the project is (and will be) providing to families in and around the central Southport area, through drop-ins, home visits and contacts made through courses. Stakeholder evidence shows how valuable parents involved in the project find both professional and peer support. Documentary evidence indicates that *social support impacts on the physical and mental health of the family* in both the short and long term. For example, home-based support or 'community mothers' can help establish positive parent-child relationships very early on (eg, Laing, 2000) and on-going social support provides a buffer against life stress (eg, Touch, 1997). Ultimately social support can be a protective factor against degenerative illnesses such as heart disease (eg, Marmot & Hemingway, 1999). *Day care support* through the crèche, although not identified by stakeholders as a potential impact, is also likely to benefit parents, by enabling them to make use of the facilities, and their children's development. Longer term benefits include enhanced education performance, higher socio-economic status (Zoritch et al, 2000; NHS CRD, 1997).

Parenting 2000 will also provide *education and training opportunities*, as well as work experience for volunteers with the associated potential health benefits that this brings (Marmot, 1997).

For those families who do not access Parenting 2000 they will obviously not benefit from, for example, increased social support, as such they will be relatively disadvantaged compared to users. It is anticipated that those families who currently use Parenting 2000 are already from higher socio-economic groups which means that they are in an even more advantageous position compared to non-Parenting 2000 users. Therefore, although the health impacts of Parenting 2000 are generally positive, they are less than optimal. For the wider community also not accessing Parenting 2000, there may be some indirect health impacts from the project in terms of reduced risks to mental distress, from less anti social behaviour by young people (eg, improved family functioning), but this is speculative.

**Table 4.10 OBSERVED/POTENTIAL HEALTH IMPACTS - Socio-economic environment factors**

<b>OBSERVED/ POTENTIAL IMPACTS</b>	<b>DIREC- TION</b>	<b>EVIDENCE</b>	<b>MEASUR- ABILITY</b>	<b>LIKELI- HOOD OF IMPACT</b>	<b>PRIORITY</b>
Family support networks and systems enhanced for many P2K participants.	+	Key informants/ stakeholders	Qualitative	Definite	High
<i>Family support can reduce childhood injuries, and improve mental and physical health in parents and children.</i>	+	Hodnett & Roberts, 2000. Gray. NHS CRD, 1997. Touch, 1997.	Qualitative.	Probable	-
<i>Social support reduces the effects of stress and promotes psychological well being.</i>	+	Power et al, 1996. Siegrist, 1987. Siegrist, 1986.	Qualitative.	Probable	-
<i>Increasing social support may reduce the risks of heart disease.</i>	+	Hemingway & Marmot, 1999.	Estimable.	Definite	-
<i>Socio-economic gradient in heart disease prevalence. Improving social support in deprived areas may reduce the inequality in heart disease prevalence between population groups.</i>	+	Marmot, 1997.	Qualitative.	Probable	-
Access to education, training and employment opportunities for some families facilitated by P2K.	+	Key informants/ stakeholders.	Qualitative/ quantitative	Definite	Medium
High educational attainment associated with better health outcomes in adult life.	+	Marmot, 1997. Wadsworth, 1997.	Qualitative.	Probable	-
Potential benefits to mothers (eg, education, employment) and children (eg, development, higher socio-economic status) with quality day care support.	+	Zoritch et al, 2000. NHS CRD, 1997.	Qualitative. Probably estimable?	Probable	Medium
Potential reduction in criminal and delinquent behaviour by adolescents resulting from effective parenting.	+	Zoritch et, 2000.	Qualitative	Probable	Low

**INEQUALITY****ANALYSIS**

Families' not accessing Parenting 2000 will not be able to avail themselves of support, education and employment opportunities, widening health inequalities.	-	Qualitative	Speculative	Low
Southport (not CSP) may benefit from, eg, improved family relationships, decreased delinquency and behaviour problems from adolescents.	+	Qualitative	Speculative	Low

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*Public Services*

Parenting 2000 provides a 'one-stop-shop' facility with information, advice and access to a range of services, public and voluntary, for example, welfare rights and housing. When services are not located on the premises, a 'sign posting' facility is available, directing users to the most appropriate contact. There has been a relocation of some services, for example, health visitor family support groups, which may adversely affect some families accessing these services, but not others. Insufficient data were available to indicate whether the direction was overall positive or negative.

Evidence from the literature suggests that with enhanced social support there is less utilisation of health services (Rouzis & Eaton, 1998), although this is not conclusive. Similarly although it is likely that Parenting 2000 will improve the physical and mental health of users and their families, it is much less likely that this will be translated into a reduction in health service use - or at least one that can be readily monitored. There is also evidence that positive family relationships mean that older people are more likely to be cared for at home (Roberto et al, 2001) - positive for social services, but what about the family carers?

In the same vane, it is not possible to say with any great probability whether the change in access, use or availability of health services will only benefit Parenting 2000 users, increasing inequalities between users and non-users.

**Table 4.11 OBSERVED/POTENTIAL HEALTH IMPACTS - Public Services**

<b>OBSERVED/ POTENTIAL IMPACTS</b>	<b>DIREC- TION</b>	<b>EVIDENCE</b>	<b>MEASUR- ABILITY</b>	<b>LIKELI- HOOD OF IMPACT</b>	<b>PRIORITY</b>
Provide information (one stop shop), enhance access to and facilitate more effective use of appropriate public services, eg, housing, health, social care, and voluntary services, eg welfare rights by some P2K users.	+	Key informants/ stakeholders.	Quantitative/ qualitative.	Definite.	Medium/low
Relocation of some public services, eg health visitor family support group, to Parenting 2000, which may be more/less accessible to some families.	?	Key informants/ stakeholders	Qualitative.	Definite	High
Potential reduction in use of health services resulting from increased social support.	+	Rouzis & Eaton, 1998.	Qualitative	Speculative	Low
Potential reduction in acute health services as a result of better disease management of conditions such as asthma.	+		Qualitative	Speculative	
Potential reduction in health service use as a result of reductions in mental and physical health problems from enhanced family relationships social support.	+		Qualitative	Speculative	
Positive family relationships may have long term impact on elder care arrangements.	?	Roberto et al, 2001.	Qualitative	Speculative	Low
<b>INEQUALITY</b>		<b>ANALYSIS</b>			
<i>Potential increase in health inequalities between users/non-users of P2K, by increasing access to health care services to users.</i>	-		Qualitative.	Speculative	Low

## 4.5 Health inequality analysis

Disadvantage is a relative rather than an absolute concept since, by implication, it carries the question: in relation to whom? For people to be disadvantaged others must be “advantaged”. Poverty, on the other hand, is a narrower concept and can be measured without reference to the relative positions of others.

People can be disadvantaged in different ways, for example educationally, socially, culturally, materially and economically. Occasionally, these forms of disadvantage operate in isolation, but it is frequently the case that people suffer multiple disadvantages with different problems (e.g. unemployment, sub-standard housing, family disruption) compounding and reinforcing each other. In this context, the authors take the term disadvantaged to mean those who, for a variety of reasons, are excluded from participating fully in society and who may be unable to share in the benefits of living in a relatively wealthy country.

Since, as discussed above, disadvantage is a relative as opposed to an absolute concept, a group can be disadvantaged in comparison to one group and relatively advantaged in relation to another. A policy, programme or project could be found to have a very beneficial effect on the health of those who are affected by it. However, if those people are all relatively well off middle or high income earners then the effect of improving their health still further could increase rather than reduce inequalities in health. Therefore, an important element in any Health Impact Assessment is the estimation of the differential impacts of the policy, programme or project on socio-economic groups, in particular, the extent to which benefits or deleterious effects are disproportionately concentrated in any one section of the population and the consequent impacts on health inequalities. From this it is possible to make recommendations in the HIA to help ensure, where possible, that resources and benefits are directed at those in greatest need.

One way of doing this is to develop a socio-economic profile of those targeted by a programme. This information can then be used to assess how disadvantaged are those likely to be affected by the action.

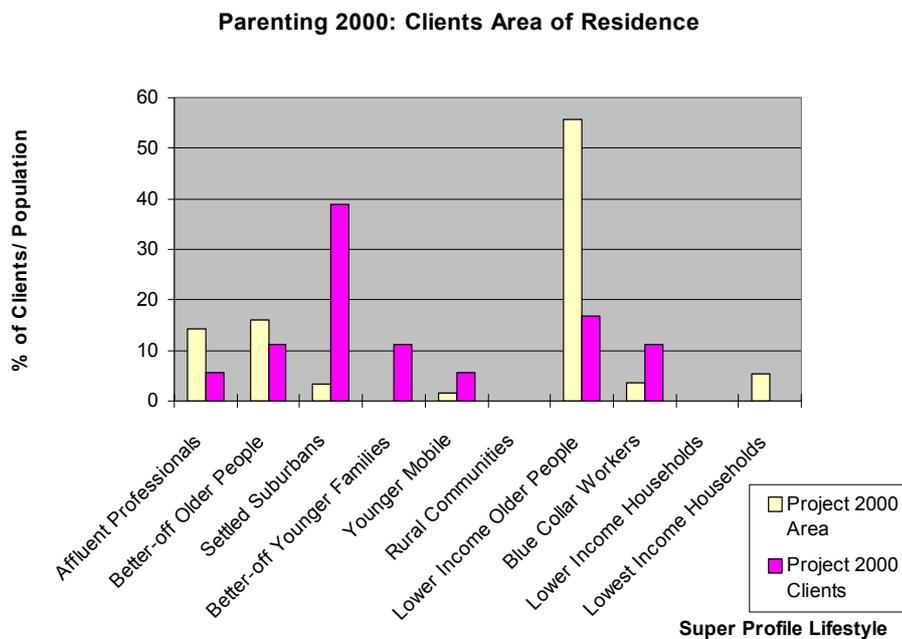
Owing to the limited time and resources available and other constraints placed on the research such as not wanting to ask questions of users that were too intrusive, it has not been possible to build up a very detailed socio-economic profile of Parenting 2000's users. However, certain questions in the survey of users were chosen especially to be illuminating in this regard. In the survey, respondents were asked to give their full residential postcode. From this information it was possible to identify the census enumeration district within which Parenting 2000 users reside. The type of residential neighbourhood that each enumeration district falls into can then be identified using a "Geodemographic" classification. This is a data base that identifies which areas are alike in terms of their demographic, social and housing composition. Every enumeration district in the country is identified as belonging to one or other of ten 'neighbourhood types' describing the social makeup of the areas. The ten area types include a mix of low, middle and high income areas. Examples include 'single people living in areas of sub-divided properties and high population turnover', 'low income council estates with larger than average families', 'wealthy areas with retired professions'. The classification used in this analysis was the Super Profiles classification (Batey and Brown, 1991) Definitions of the Super Profile area types appear in Appendix 4.3.

The residential postcodes of project beneficiaries were used to identify the types of neighbourhood from which the clients of Parenting 2000 came and to contrast this to the social profile of the project's target area (Central Southport).

Significantly, the majority of clients came from non-deprived neighbourhoods and bore very little relationship to the socio-demographic profile of the Central Southport Regeneration Partnership area. This can be seen in Figure 4.1 which contrasts the socio-demographic characteristics of the partnership area with that of the areas of residence of the Parenting 200 clients. The information has been derived using approximately 50 postcodes. Although this is subject to change with more data, it corroborates other anecdotal evidence and information gained from interviews that Parenting 2000 was not particularly targeting the most deprived communities. If the initiative proves to be a success, its impact on reducing health inequalities is likely to be weakened or possibly negated altogether because of its

targeting policy (i.e. addressing general needs rather than the special needs of the most vulnerable communities).

**Figure 4.1 Regeneration Project Beneficiaries: Areas of Residence for Parenting 2000 Clients**



A further indication that the users of Parenting 2000 might be slightly better off than some of the other parents in the area is that fact they had a relatively mature age profile. To reiterate what was written in the previous section, none of the survey respondents were 20 or under and only a small proportion (five, or 20 per cent) were aged 21 to 30. The majority (16, or 64 per cent) were aged 31 to 45. It is likely that the older parents are, the better off they will be financially and also in other respects. It is particularly hard for young parents, especially teenagers, to find the support that they need.

## **5. Conclusions and Recommendations**

### **5.1 Introduction**

This section outlines the conclusions from the health impact assessment and the recommendations for Parenting 2000. The recommendations are directed at Parenting 2000 unless otherwise stated.

### **5.2 Conclusions and Recommendations for the Parenting 2000 project**

The HIA of Parenting 2000 has identified a number of definite, positive health impacts on current project users through the increase in family support that the project is expected to deliver (see Section 4.5, above). In addition, it described other anticipated health impacts on users with the introduction of new services, for example, improvements in family relationships with new parenting education programmes and 'marriage care' support.

However, although these have, and are likely to continue to have, positive impacts on Parenting 2000 users, there is strong evidence to suggest that the families currently accessing the project are not those who would benefit most from these impacts, that is 'families under pressure':

- Single parent households
- Young mothers with poor family relationships
- Young mothers from care
- Step families
- New families
- Bereaved families
- Families living in poverty
- Families from ethnic minority communities
- Families in abusive relationships
- Families with parents misusing alcohol or drugs
- Families with 'workaholic' parents

- Families with health problems

What is more, it has been suggested that this access issue is not from lack of awareness but is due to a conscious decision by some of these families not to attend. The potential consequences of this are that there will be an ever-widening difference between those families who use the project (and tend to belong to middle to high-income groups) and those from low-income groups who do not.

#### **Recommendation P2K1**

**It is recommended that a detailed needs assessment of a cross-section of Project 2000 user families be undertaken, including family support, transport needs as well as awareness and attitudes to Parenting 2000.**

Stakeholders generally felt that Parenting 2000 should remain 'open to all' partly to avoid stigmatising the project by only being accessible to 'problem families', but also so that all families can benefit. Within this framework it was felt that it would be possible to be more proactive in targeting 'families under pressure'. This should have a 'levelling up' effect - providing positive health impacts to all families, but 'families under pressure' at a higher rate.

#### **Recommendation P2K2**

**It is recommended that Parenting 2000 take proactive action to target 'families under pressure' by the development of an access strategy.**

Related to this, there is a general issue concerning monitoring and evaluation, data and processes. The user survey conducted gave an indication of the socio-economic background of who was accessing the project, but this was neither comprehensive nor extensive. A regular user profile of the project needs to be conducted to see what the proportion of 'families under pressure' using Parenting 2000 against the population sub-group is (post codes or a proxy measure could be used); this will reveal if the access strategy is working. In addition, plans for an evaluation or retrospective HIA of the project need to be developed so that the actual health impacts of the project, for example changes in family relationships can be assessed.

**Recommendation P2K3**

**It is recommended that Parenting 2000 compile a user profile on a regular basis to monitor the proportion of 'families under pressure' accessing the project.**

**Recommendation P2K4**

**It is recommended that proposals be developed for a comprehensive retrospective HIA of the project and sources of funding be explored to support this**

The literature review gave an insight into potential developments for the project and also the range of potential health impacts that could be generated. It also brought to light a number of effective interventions that could be considered and possibly implemented to maximise the positive health impacts of the Parenting 2000 approach. Some of these appear in Recommendation 6, below.

**Recommendation P2K5**

**It is recommended that in order to maximise positive health impacts and to bring other benefits that Parenting 2000, in partnership with other appropriate providers and local people, investigate the potential for the development/extension of:**

- **Home-based family support from lay 'community mothers' for new mothers**
- **Peer-led family support networks**
- **Training local people as parenting programme facilitators**
- **'Parents as Teachers' programme - eg, inter-generational transfer of literacy**
- **'PEACE' programme - for divorced, separated families**
- **'STEP' - for generic parenting**
- **'PFDFY' - preventing/reducing risk-taking behaviour in children**
- **'Safe Start' or 'LIFT' - preventing/reducing conduct/behaviour problems**
- **Outreach programmes in primary schools**
- **Links with youth programmes**

**Recommendation P2K6**

**It is recommended that an inter-sectoral 'Positive Families in Sefton' Steering Group is convened consisting of chief officers from the relevant agencies.**

The profiling revealed gaps in the data routinely collected that would be useful in the monitoring of the project, for example the proportion of bereaved families with dependent children, families with dependent children with parents or children with long term physical or mental health problems, other parenting/family support programmes.

**Recommendation P2K7**

**It is recommended that the 'Positive Families in Sefton' identify an ideal core data set, review the existing data on families that is routinely collected at local or national level and develop proposals for meeting any gaps.**

## 6. Evaluation of HIA Methods

### 6.1 Introduction

This Section attempts to evaluate the effectiveness of the methodology used in this case study by critically reviewing the methods selected and the process used to collect, analyse and interpret data. The lessons from this are discussed and recommendations for developments in HIA methodology are outlined.

### 6.2 What are we evaluating?

There are various aspects of the HIA that need to be evaluated.

#### *Research Design and Management*

Comprehensive HIA is a research process involving a range of methods from which data are collected to build evidence on the health impacts of a policy. As such, in order to ensure efficacy in the research process and to minimise sources of error and bias, a number of key research principles need to be considered when developing a comprehensive HIA design:

- 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, quantitative analyses, 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?
- What is the HIA process and a realistic time plan?
- What are the resource implications (financial, human, time)?
- What are the anticipated outputs of the HIA process, e.g. report on findings, presentation to policy proponents, dissemination strategy?

- How will the recommendations from the HIA be negotiated with the responsible agencies?

It is clear that there are both advantages and disadvantages to having an HIA Steering Group. However, although there was considerable help from Parenting 2000 workers and ready access to clients, other stakeholders and other data sources, the HIA process would probably have benefited by the support of a project-specific steering group.

**Most importantly, HIA is about changing the thinking involved in policy planning, which may be more easily facilitated by regular meetings and discussions.**

**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 that is managed by an HIA Steering Group. All HIAs especially comprehensives should be managed the HIA Steering Group.**

*Depth*

Given that projects like Parenting 2000 have relatively small budgets, in the real world it would not make sense to carry out a comprehensive HIA (as was done here) since the cost of doing so would be disproportionate to the total budget available for the project. However, projects like Parenting 2000 would seem to be amenable to rapid or intermediate level HIAs. A very rapid HIA could involve the proponents of the project spending an afternoon considering the health impacts of the project for the various groups that were likely to be affected. A slightly more in-depth HIA might involve the holding of focus groups with stakeholders (principally project proponents and workers), potential users, and workers from relevant voluntary and statutory organisations in the area. Using focus groups instead of interviewing people individually would save time. It would also allow for more interesting discussions to develop and people might feel less like they were being put on the spot. There needs to be further consideration given to an optimal or 'value for money' HIA cost range, for example 0.1-5% of total project/policy costs. 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:**

**It is not particularly useful or good 'value for money' to conduct a comprehensive HIA on a small project. Threshold criteria should be developed providing guidance on what depth of HIA to undertake in different circumstances.**

*Evidence from documentary analysis and literature review*

There was a wealth of data available on family relationships and health impacts, but less on parenting education programmes. In addition to compiling an electronic database of completed HIAs, systematic reviews or meta-analyses of programme evaluations would help to strengthen the evidence to support HIAs. 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 3:**

**An electronic database of completed HIAs should be made available on the HDA website with links to appropriate websites, for example the HDA's evidence base 2000 database, Cochrane & Campbell databases.**

*Profiling affected communities, including vulnerable groups*

As mentioned above the reliability with which estimates of a particular vulnerable population could be made depend on the population estimates that are available and their accuracy. It also depends on the definition of the vulnerable or target population for the particular project. If a clear definition of the vulnerable group is made, it is possible to estimate the numbers and proportion of this population subgroup in the population as a whole, and to subsequently assess how successful

targeting has been. Although clear definitions of vulnerable families in Parenting 2000 were available the data were not readily available or accessible.

**Recommendation 4:**

**All HIAs should define the population sub-group targeted by the policy; estimate the sub-groups numbers in, and proportion of, the total population within the geographical boundary under investigation, and identify the numbers that have or will be targeted by the policy.**

*Qualitative Approaches in HIA*

Although the data obtained from key informants and stakeholders, official documents and the literature reinforced each other, the literature gave a far broader range of impacts. What were invaluable about the stakeholders evidence were their views about the current project users. This would not have been available from documents alone.

An analysis of the impacts identified from the fieldwork suggests that, in addition to the importance of having a skilled facilitator, using an HIA matrix that contains a list of anticipated/preconceived health impacts is inappropriate. An open and more inductive approach is recommended, providing an opportunity both to generate and to test hypotheses.

The methods used should be selected according to the needs of the particular project. For example, in hindsight, semi-structured or unstructured, recorded interviews would have been conducted with Parenting 2000 users and workers.

**Recommendation 5:**

**HIAs of social regeneration policies should employ qualitative methods, where appropriate. Although the methods will vary, as an HIA principle an inductive process should be adopted initially.**

As with quantitative data collection, the sampling methods for selecting qualitative informants is very important and should be explicit to ensure any effects on the bias of the findings are taken into account.

**Recommendation 6:**

**The development and application of a sampling strategy should be adequately built into the procedure for identifying, selecting and recruiting stakeholders.**

*Quantitative approaches*

Although a questionnaire survey was used in Parenting 2000, this was simply to collect basic demographic details of users. Quantitative approaches should complement the inductive, qualitative process. 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. The extensive evidence-base on family relationships and health impacts may make it an appropriate area for such modelling.

**Recommendation 7:**

**Where appropriate, comprehensive HIAs should take a multiple method approach using qualitative and quantitative approaches. The development and use of mathematical and statistical models in concurrent and prospective HIAs should be further explored.**

*Likelihood of impacts*

In Parenting 2000 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 Parenting 2000; the number of people with similar perceptions was also recorded. The prospective/concurrent timing of the HIA indicated that the described impacts were based on observations and perceptions. It was difficult at times to assess the likelihood because of the vague responses. 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 stronger 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 Parenting 2000, is another step that needs to be built into the assessment of the likelihood of an impact.

**Recommendation 8:**

**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 Parenting 2000 involved the assessor ranking the impacts identified as high medium or low priority and stakeholders/key informants commenting on these. The assessor used three criteria to assess the priority: the likelihood, scale and severity of the impact. However, these were only estimated. Where possible a more iterative process needs to be planned, for example:

- Identifying the criteria on which prioritisation will be based, e.g. 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 in preference to ranking bands such as high, medium, low, need to be further considered.

**Recommendation 9:**

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

*Health Inequalities and HIA*

The Parenting 2000 HIA revealed that the lack of appropriate targeting was likely to exacerbate existing inequalities. It is possible to estimate how effective a project is at targeting a specific vulnerable group 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 - can be assessed. It enables a crude analysis to be performed of the

distributional effect of the project to see how the impacts on the users of the project compared with those on the targeted non-users, and also the community. 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 10:**

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

**Recommendation 11:**

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

*Prospective/concurrent HIAs*

The limited health impacts identified by stakeholders in Parenting 2000 was also likely to be due to the prospective nature of the HIA; it is difficult to visualise the potential effects of something that is not yet fully operational.

There are many benefits of conducting a concurrent HIA 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 effect of policy dynamics on health impacts needs to be considered in the monitoring and evaluation stage of HIA.

**Recommendation 12:**

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

This case study report of the Parenting 2000 HIA has discussed the methods and procedures involved as well as the results. It has explored some of the more theoretical, as well as the practical, issues involved in doing an HIA of this type of project. It has shown that by using a variety of methods (interviews, focus groups, surveys, data from secondary sources) it is possible to develop a reasonable understanding of the impacts on health that a project such as this is likely to have. However, whilst some of the principles will remain the same no matter what the case

study, it will obviously be necessary to change, modify or substitute some of the methods and procedures according to the nature of the project.

## BIBLIOGRAPHY

- Adams, J. Impact of parent training on family functioning. *Child & Behaviour Therapy*. 23 (1), pp. 29-42. 2001.
- Amato, P. Diversity within single parent families. In Demo, D, Allan, K, (Eds.), *Handbook of Family Diversity*. NY, USA: OUP. 2000.
- Anderson, M. A manualised parenting program for low-income families. Dissertation. 1999.
- Anteghini, M, Fonseca, H, Ireland, M, Blum, R. Health-risk behaviours and associated risk and protective factors among Brazilian adolescents in Santos, Brazil. *Jo. of Adolescent Health*. 28 (4), pp. 295-302. 2001.
- Ardelt, M. Antecedents and effects of wisdom in old age - A longitudinal perspective on ageing well. *Research on Ageing*. 22 (4), pp. 360-394. 2000.
- Aronen, E, Soininen, M. Childhood depressive symptoms predict psychiatric problems in young adults. *Canadian Jo. of Psychiatry*. 45 (5), pp. 4665-470. 2000.
- Bassett, H, Lampe, J, Lloyd, C. Living with under-fives: A programme for parents with mental illness. *British Jo. of Occupational Therapy*. 64 (1), pp. 23-28. 2001.
- Ben-Noun, L. Generalised Anxiety Disorder in Dysfunctional Families. *Jo. of Behaviour Therapy*, 29 (2), pp. 115-122. 1998.
- Bernard-Fischer, J. Religious commitment as a correlate of mental health and life satisfaction among black American families. Dissertation. 2001.
- Barnfield, T, Leathem, J. Incidence and outcomes of traumatic brain injury and substance abuse in a New Zealand prison population. *Brain Injury*. 12 (6), pp. 455-466. 1998.
- Birch, D. The adolescent parent: A fifteen year longitudinal study of school-age mothers and their children. *International Jo. of Adolescent Medicine and Health*. 10 (2), pp. 141-153. 1999.
- Boey, K. Coping and family relationships in stress resistance: A study of job satisfaction of nurses in Singapore. *International Jo. of Nursing Studies*. 35 (6), pp. 353-361. 1998.

- Borduin, C, Heiblum, N, Jones, M, Grabe, A. Community-based treatments of serious antisocial behaviour in adolescents. In: Martin, W, Swartz-Kulstad, J. (Eds.). *Person-environment psychology and mental health: Assessment and intervention*. NJ, USA: Lawrence Erlbaum Assoc.. 2000.
- Borgelt, C. Traumatic brain injury rehabilitation: Predicting outcomes from staff and family relationships. Dissertation. 1999.
- Brody, G, Neubaum, E. Family transitions as stressors in children and adolescents. In: Pfeffer, C (Ed). *Severe stress and mental disturbance in children*. WA, DC, USA: American Psychiatrist Press. 1996.
- Brosnan, R, Carr, A. Adolescent conduct problems. In: Carr, A. (Ed). *What works with children and adolescents? A critical review of psychological interventions*. KY, USA: Routledge. 2000.
- Brown, J, Cohen, P, Johnson, J, Salzinger, S. A longitudinal analysis of risk factors for child maltreatment: Findings of a 17-year old prospective study of officially recorded and self-reported child abuse and neglect. *Child Abuse & Neglect*. 22 (11), pp. 1065-1078. 1998.
- Button, E, Loan, P, Davies, J, Sonuga-Barke, E. Self-esteem, eating problems and psychological well-being in a cohort of school girls aged 15-16: A questionnaire and interview study. *International Jo. of Eating Disorders*. 21 (1), pp. 39-47. 1997.
- Callery, P. Paying to participate: Financial, social and personal costs to parents of involvement in their children's care in hospital. *Jo. of Advanced Nursing*, 25 (4), pp. 746-752. 1997
- Cancio, E. Utilising parents of students with emotional and behaviour disorders to facilitate a home-based self-management programmes to increase mathematics homework completion and accuracy. Dissertation. 1999.
- Carter, A, Pollock, R. Obsessive compulsive disorder in childhood. *Current Opinion in Pediatrics*, 12 (4), pp. 325-330. 2000.
- Cedar, B, Levant, R. A meta-analysis of the effects of parent effectiveness training. *American Jo. of Family Therapy*. 18 (4), pp. 375-84. 1990.
- Central Southport Partnership. Parenting 2000 Project Appraisal. CSP. 1999.
- Central Southport Partnership. A guide to the Partnership. CSP. 1998.
- Chandra, P, Ravi, V, Desai, A, Subbakrishna, D. Anxiety and depression among HIV-infected heterosexuals - a report from India. *Jo. of Psychosomatic Research*. 45 (5), pp. 401-409. 1998.

- Chow, K, The utilisation of health care services and social services by neurotic patients and their service need. *Int. Jo. of Social Psychiatry*, 46 (4), pp.237-240. 2000.
- Clegg, N. The relationship between parents' perceptions of coping, quality of family relationships and selected sociodemographic and illness-related variables and family adaptation in families of children diagnosed with cancer. Dissertation. 1997.
- Coady, N, Rothery, M, Dennis, D. A multi-year evaluation of a parent support centre. *Canadian Jo. of Community Mental Health*. 18 (2), pp. 33-45. 1999.
- Comer, E, Frase, M. Evaluation of six family support programmes: are they effective? *Families in Society*. 79 (2), pp. 134-48. 1998.
- Corcoran, J. Family treatment of preschool behaviour problems. *Research on Social Work Practice*. 10 (5), pp. 547-588. 2000.
- Cox, M, Brook-Gunn, J. Conflict and Cohesion in Families: Causes and Consequences. NJ, USA: Lawrence Erlbaum Associates. 1999.
- De Civita, M, Pagani, L. Familial constraints on the initiation of cigarette smoking among adolescents: An elaboration of social bonding theory and differential association theory. *Canadian Jo. of School Psychology*. 12 (2), pp. 177-190. 1996.
- Delmonico, L. Stressful life events and resiliency: Coping responses, social support resources, hardiness and perceived childhood family relationships in adult children of alcoholics. Dissertation. 1997.
- Department of Environment, Transport and the Regions. Indices of Deprivation, 2000. London. DETR. 2000.
- Dittus, P, Jaccard, J. Adolescents' perceptions of maternal disapproval of sex: Relationship to sexual outcomes. *Jo. of Adolescent Health*. 26 (4), pp. 268-278. 2000.
- Donnelly, M. Factors associated with depressed mood among adolescents in Northern Ireland. *Jo. of Community & Applied Social Psychology*. 9 (1), pp. 47-59. 1999.
- Downs, W, Harrison, L. Childhood maltreatment and the risk of substance problems in later life. *Health & Social Care in the Community*. 6 (1), pp. 35-46. 1998.
- Drotar, D. Relating parent and family functioning to the psychological adjustment of children with chronic health conditions: What have we learned? What do we need to know? *Jo. of Paediatric Psychology*. 22 (2), pp. 149-165. 1997.

- Dubrow, L, Howe, N. Parental play styles and sibling interaction during problem-solving task. *Infant & Child Development*, 8 (2), pp101-115. 1999.
- Dunn, J, Deater, D, Pickering, K, O'Connor, T, Golding, J. Children's adjustment and prosocial behaviour in step-, single-parent and non-stepfamily settings: Findings from a community study. *Jo. of Child Psychology and Psychiatry and Allied Disciplines*. 39 (8), pp. 1083-10095. 1998.
- Durant, R, Knight, J, Goodman, E. Factors associated with aggressive and delinquent behaviours among patients attending adolescent medicine clinic. *Jo. of Adolescent Health*. 21 (5), pp. 303-308. 1997
- Emery, R, Laumann-Billings, L. An overview of the nature, causes and consequences of abusive family relationships: Towards differentiating maltreatment and violence. *American Psychologist*. 53 (2), pp. 121-135. 1998.
- Entwistle, D, Alexander, K. Diversity in family structure. In: Demo, D, Allen, K. (Eds). *Handbook of family diversity*. NY, USA: OUP. 2000.
- Evandrou, M. Unpaid work, carers and health. In: Blane, D, Brunner, E, Wilkinson, R. (Eds). *Health and social organisation*. London: Routledge. 1996.
- Feldman, H, Ploof, D, Cohen, W. Physician-family partnerships: The adaptive practice model. *Jo. of Developmental & Behavioural Paediatrics*. 20 (2), pp. 111-116. 1999.
- Fellow-Smith, L. Impact of parental anxiety disorder on children. In Reder, P, McClure, M, (Eds), *Family Matters: Interfaces between child and adult mental health*. London: Routledge. 2000.
- Ferron, C, HaourKnipe, M, Tschumper, A, Narring, F, Michaud, P. Health behaviours and psychosocial adjustment of migrant adolescents in Switzerland. *Sweiz. Med. Wochenschr.*, 127 (35), pp. 1419-1429. 1997.
- Ferroni, P, Taffe, J. Women' emotional well being: The importance of communicating sexual needs. *Sexual and Marital Therapy*, 12 (2), pp. 127-138. 1997.
- Fisher, L, Weihs, K. Can addressing family relationships improve outcomes in chronic disease? Report to the National Working Group on Family-based Interventions in Chronic Disease. *Jo. of Family Practice*. 49 (6), pp. 561-566. 2000.
- Flinn, M, England, B. Social economics of childhood glucocorticoid stress response and health. *American Jo. of Physical Anthropolgy*, 102 (1), pp. 33-54. 1997.
- Frieman, B, Garon, H, Garon, R. Parenting seminars for divorcing parnets: One year later. *Jo. of Divorce & Remarriage*. 33 (3-4), pp. 129-143. 2000.

- Galambos, N, Ehrenberg, M. The family as health risk and opportunity: A focus on divorce and working families. In: Schulenberg, J, Maggs, J. (Eds). Health risks and developmental transitions during adolescence. NY, USA: Cambridge University Press. 1997.
- Gepkens, A, Gunning-Schepers, L. Interventions to reduce socio-economic health differences: An evaluation of Dutch and foreign interventions to reduce socio-economic health differences. Institute of Social Medicine. 1995.
- Graber, J, Brooks-Gunn, J, Petersen, A. (Eds). Transitions through adolescence: Interpersonal domains and context. NJ, USA: Lawrence-Erlbaum Assoc. 1996.
- Graber, J, Brooks-Gunn, J. Co-occurring eating and depressive problems: An 8 year study of adolescent girls. *Int. Jo. of Eating Disorders*, 30 (1), pp. 37-47. 2001.
- Gray, E. Early parenting intervention to prevent child abuse: A meta analysis. Final Report. National Council for Jewish Women. NY, USA: Centre for the Child. No date.
- Greenspan, S, Benderly, B. The growth of the mind and the endangered origins of intelligence. MA, USA: Addison Wesley Longman. 1996.
- Grigorenko, E, Sternberg, R. (Eds). Family environment and intellectual functioning: A lifespan perspective. NJ, USA: Lawrence Erlbaum Assoc.. 2001.
- Harvey, J, Miller, E. Loss and Trauma: General and relationship perspectives. PA, USA: Brunner-Routledge. 2000.
- Health Education Authority. Health Update: Smoking. London: HEA. 1996.
- Heinicke, C, Goorsky, M, Dudley, K, Schneider, C, Guthrie, D. Relationship-based intervention with at-risk mothers: Factors affecting variations in outcome. *Infant Mental Health Jo.* 21 (3), pp. 133-155. 2000.
- Helms-Erikson, H, Tanner, J, Crouter, A, McHale, S. Do women's provider-role attitudes moderate the links between work and family? *Jo. of American Psychology*. 14 (4), pp. 658-670. 2000.
- Herman-Stahl, M, Petersen, A. Depressive symptoms during adolescence: Direct and stress-buffering effects of coping, control beliefs and family relationships. *Jo. of Applied Developmental Psychology*. 20 (1), pp. 45-62. 1999.
- Hodnett, E, Roberts, I. Home-based social support for socially disadvantaged mothers. In: the Cochrane Library, Issue 1, Oxford. 2000.
- Horesh, N, Apter, A, Ishai, J, Danziger, Y, Miculincer, M, Stein, D, Lepkifker, E, Minouni, M. Abnormal psychosocial situations and eating disorders in adolescence. *Jo. of the American Academy of Child and Adolescent Psychiatry*. 35 (7), pp. 921-927. 1996.

- Impalli, E. Family obligations, parent-adolescent relationships and psychological functioning among Asian American college students. Dissertation. 1999.
- Kalil, A, Spencer, M, Spieker, S, Gilchrist, L. Effects of grandmother co-residence and quality of family relationships on depressive symptoms in adolescent mothers. *Family Relations: Inter-disciplinary Jo. of Applied Family Studies*. 47 (4), pp. 433-441. 1998.
- Kellerman, A, Fuqua-Whitley, D, Rivara F. Preventing youth violence. A summary of evaluations. Urban Health Initiative Monograph Series, Monograph 1. WA, DC, USA: Publisher unknown. 1997.
- Kirkcaldy, B, Siefen, G. Depression, anxiety and self image among children and adolescents. *School Psychology International*. 19 (2), pp. 135- 149. 1998.
- Kirkcaldy, B, Siefen, G, Eysenck, M, Furnham, A. Gender, anxiety and self image. *Personality and Individual Differences*. 24 (5), pp. 677-684. 1998.
- Knauth, D. Predictors of parental sense of competence for the couple during the transition to parenthood. *Research in Nursing and Health*. 23 (6), pp. 496-509. 2000.
- Knight, J, Green, S, Hinson, W. Chronic pelvic pain: A systematic approach to assessment and treatment. *Families, System and Health*, 15 (2), pp. 135-146. 1997.
- Kosterman, R, Hawkins, J, Haggerty, K, Spoth, R, Redmond, C. Preparing For Drug Free Years: Session-specific effects of a universal parent-training intervention with rural families. *Jo. of Drug Education*. 31 (1), pp. 47-68. 2001.
- Kouzis, A, Eaton, W. Absence of social networks, social support and health services utilisation. *Psychological Medicine*. 28 (6), pp. 1301-1310. 1998.
- Krajnc, M, Schmidt, I, Gergoric, A, Dogsa, I. Suicide attempts in Slovenian juveniles. *Nordic Jo. of Psychiatry*. 52 (6), pp. 487-492. 1998.
- Kruesi, M, Grossman, J, Pennington, J, Woodward, P, Duda, D, Hirsch, J. Suicide and violence prevention: Parent education in the emergency department. *Jo. of the American Academy of Child and Adolescent Psychiatry*. 38 (3), pp. 250-255. 1999.
- Laing, K. The home setting for perinatal care. In: Newton, N, Sprengle, K. (Eds). *Psychological interventions in the home: Housecalls*. NY, USA: Springer. 2000.
- Lamb, M, Laumann-Billings, L. Fathers of children with special needs. In Lamb & Laumann-Billings (Eds), *The Role of Fathers in Child Development*. NY, USA: John Wiley. 1997.

- Lefley, H. *Families Coping with Mental Illness: The cultural context*. CA, USA: Jossey-Bass Inc. 1998.
- Letourneau, N, Drummond, J, Fleming, D, Kysela, G, McDonald, L, Stewart, M. Supporting parents: Can intervention improve parent-child relationships? *Jo. of Family Nursing*. 7 (2), pp. 159-187. 2001.
- Lindahl, K, Clemets, M, Markman, H. Predicting marital and parent functioning in dyads and triads: A longitudinal investigation of marital processes. *Jo. of Family Psychology*, 11 (2), pp. 139-151. 1997.
- Lochman, J. Parent and family skills training in targeted prevention programmes for youth at-risk. *Jo. of Primary Prevention*. 21 (2), pp. 253-265. 2000.
- Luecken, L. Attachment and loss experiences during childhood are associated with adult hostility, depression and social support. *Jo. of Psychosomatic Research*. 49 (1), pp. 85-91. 2000.
- Lustig, J, Wolchik, S, Weiss, L. The New Beginnings parenting programme for divorced mothers: Linking theory and intervention. In: Essau, C, Petermann, F. (Eds). *Depressive disorders in children in children and adolescents: Epidemiology, risk factors and treatment*. NJ, USA: J.Aronson. 2000.
- Ma, G, Toubbeh, J, Cline, J, Chisholm, A. The use of a qualitative approach in fetal alcohol syndrome prevention among American Indian youth. *Jo. of Alcohol and Drug Education*. 43 (3), pp. 53-65. 1998.
- Macdonald, G, Winkley, A. *What works in child protection? Barnado's Barkingdale*. 1999.
- Mannion, E, Meisel, M. Reducing cultural clash in family provider relationships: A bilateral perspective. In: Lefley, H (Ed). *Families coping with mental illness: The cultural context*. CA, USA: Jossey-Bass. 1998.
- Marsh, D, Dickens, R, *Troubled journey: Coming to terms with mental illness of a sibling or parent*. NY, USA: Tarcher/Penguin. 1997.
- Mentore, J. *The effectiveness of early intervention with young children 'at risk': A decade in review*. Dissertation. 2000.
- Moore, M, Carr, A. Anxiety Disorders. In: Carr, A. (Ed). *What works with children and adolescents? A critical review of psychological interventions*. KY, USA: Routledge. 2000.
- Moore, M, Carr, A. Depression and Grief. In: Carr, A. (Ed). *What works with children and adolescents? A critical review of psychological interventions*. KY, USA: Routledge. 2000.

- Moss, H, Clark, D, Kirisci, L. Timing of paternal substance use disorder cessation and effects on problem behaviours in sons. *American Jo. of Addictions*, 6 (1), pp. 30-37. 1997.
- NHS Centre for Reviews and Dissemination. Mental health promotion for high-risk groups. *Effective Health Care*. 3 (3). 1997.
- Nguyen, H, Messe, L, Stollack, G. Toward a more complex understanding of acculturation and adjustment - cultural involvement and psychosocial functioning in Vietnamese youth. *Jo. of Cross-Cultural Psychology*, 30 (1), pp. 5-31. 1999.
- Nicholson, J, Sweeney, E, Geller, J. Mothers with mental illness. Families and the context of parenting. *Psychiatric Services*, 49 (5), pp. 643-649. 1998.
- O'Halloran, M, Carr. Adjustment to parental separation and divorce. In: Carr, A. (Ed). *What works with children and adolescents? A critical review of psychological interventions with children, adolescents and their families*. KY, USA: Routledge. 2000.
- Otero, S, Hodes, M. Maternal expressed emotion and treatment compliance of children with epilepsy. *Developmental Medicine and Child Neurology*. 42 (9), pp. 604-608. 2000.
- Page, T. Linkages between children's narrative representations of families and social competence in child-care settings. Dissertation. 1998.
- Pajari, H, Sinkkonen, J. Psycho-social impact of an x-linked hereditary disease: A study of Alport Syndrome patients on patients and family members. *Child care health and Development*, 26 (3), pp. 239-250. 2000.
- Paradis, C, Friedman, S, Hatch, M, Ackerman, R. Orthodox Jews. In: Friedman, S. (Ed). *Cultural issues in the treatment of anxiety*. NY, USA: Guildford Press. 1998.
- Parenting 2000. Annual Report, May 1999-May 2000. Parenting 2000. 2000
- Parenting 2000. Monitoring Reports, 2000-2001. Parenting 2000. 2001.
- Park, K, Kosterman, R, Hawkins, J, Haggerty, K, Duncan, T, Duncan, S, Spoth, R. Effects of the 'Preparing For Drug Free Years' curriculum on growth in alcohol use and risk for alcohol use in early adolescence. *Prevention Science*. 1 (3), pp. 125-138. 2000.
- Pelham, W, Gnagy, E. Psychosocial and combined treatments for ADHD. *Mental Retardation and Developmental Disabilities Research Reviews*. 5 (3), pp. 225-236. 1999.

- Perry-Jenkins, M, Repetti, R, Crouter, A. Work and the Family in the 1990s. *Jo. of Marriage and the Family*, 62 (4), pp.981-998. 2000.
- Power, C, Bartley, M, Davey Smith, G, Blane, D. Transmission of social and biological risk across the life course. In: Blane, D, Brunner, E, Wilkinson, R. (Eds). *Health and social organisation*. London: Routledge. 1996.
- Prism Research. Urban regeneration in Sefton Metropolitan Borough: Mid-Term Review, 1999-2000. A report of findings from household and employer surveys in the Central Southport Partnership area. January 2000.
- Purohit, Y. Determinants and Outcomes of Social Support provided by Women and Men in Dual-earner Relationships. Dissertation. 1999.
- Putney, N, Bengston, V. Families intergenerational relationships and kin keeping in midlife. In: Lachman, M (Ed.). *Handbook of midlife development*. NY, USA: John Wiley. 2001.
- Rank, M. Poverty and economic hardship in families. In Demo, D, Allan, K, (Eds.), *Handbook of Family Diversity*. NY, USA: OUP. 2000.
- Reid, J, Eddy, J, Fetrow, R, Stoolmiller, M. Description and immediate impacts of a preventive intervention for conduct problems. *American Jo. of Community Psychology*. 27 (4), pp. 483-517. 1999.
- Reder, P, Lucey, C. The impact children on their parents. In: Reder, P, McClure, M. (Eds). *Family matters: Interfaces between child and adult mental health*. London: Routledge. 2000.
- Roberto, K, Allen, K, Blieszner, R. Older adults' preferences for future care: Formal plans and familial support. *Applied Developmental Science*. 5 (2), pp. 112-120. 2001.
- Robin, A. Attention-Deficit/Hyperactivity Disorder in adolescents - common pediatric concerns. *Pediatric Clinics of North America*, 46 (5), p. 1027. 1999.
- Robinson, B. Workaholism and family functioning: A profile of familial relationships psychological outcomes and research considerations. *Contemporary Family Therapy*, 23 (1), pp. 123-135. 2001.
- Robinson, B, Chase, N. *High-Performing Families: Causes, consequences and clinical solutions*. VA, USA: American Counselling Association. 2001.
- Rodriguez, C, Moore, N. Perceptions of pregnant parenting teens - Reframing issues for an integrated approach to pregnancy problems. *Adolescence*. 30 (119), pp. 685-706. 1995.

- Rose, L, Campbell, J, Kub, J. The role of social support and family relationships in women's responses to battering. *Health Care for Women International*. 21 (1), pp. 27-39. 2000.
- Saewyc, E. Meanings of pregnancy and motherhood among out-of-home pregnant adolescents. Dissertation. 2000.
- Salome-Grant, W. An evaluation of the parent education and custody effectiveness (PEACE) programme. Dissertation. 2000.
- Santos, S, Bohon, L, Sanchez-Sosa, J. Childhood family relationships, marital and work conflict and mental health distress in Mexican immigrants. *Jo. of Community Psychology*. 26 (5), pp. 491-508. 1998.
- Schaeffer, E. Integration of configurational and factorial models for family relationships and child behaviour. In Plutchik, R, Conte, H, (Eds), *Circumplex Models of Personality and Emotions*. Washington DC, USA: American Psychological Association. 1997.
- Schiffman, J, Abrahamson, A, Cannon, T, LaBrie, J, Parnas, J, Schulsinger, F, Mednick, S. Early rearing factors in schizophrenia. *International Jo. of Mental Health*. 30 (1), pp. 3-16. 2001.
- Scott-Samuel, A, Birley, M, Ardern, K. The Merseyside Guidelines for Health Impact Assessment. Liverpool: Merseyside HIA Steering Group. 1998.
- Sears, S, Todaro, J, Urizar, G, Lewis, T, Sirosis, B, Wallace, R, Sotile, W, Curtis, A, Conti, J. Assessing the psychosocial impact of the ICD: A national survey of Implantable Cardioverter Defibrillator (ICD) health care providers. *Pace-pacing and Clinical Electrophysiology*, 23 (6), pp. 939-945. 2000.
- Sefton Metropolitan Borough Council. Reports of the Early Years Development and Childcare partnership. Unpublished. 2001.
- Sefton Metropolitan Borough Council. Report with socio-economic data from 1991 Census of Central Southport Partnership wards. Unpublished. Undated.
- Shapiro, D, Astin, J. Control therapy: An integrated approach to psychotherapy, health and healing. NY, USA: Wiley. 1998.
- Slaght, E. Focussing on the family in the treatment of substance abusing criminal offenders. *Jo. of Drug Education*. 29 (1), pp. 53-62. 1999.
- Sloper, P. Experiences and support needs of siblings of children with cancer. *Health & Social Care in the Community*, 8 (5), pp. 298-306. 2000.
- Sloper, P. Needs and responses of parents following the diagnosis of childhood cancer. *Child Care, Health & Development*, 22 (3), pp.187-202. 2000.

- Spencer, G, Atav, S, Johnston, Y, Harrigan, J,. Managing childhood asthma: The effectiveness of the Open Airways for Schools programme. *Family & Community Health*. 23 (2), pp. 20-30. 2000.
- Stanton, B, Li, X, Galbraith, J, Cornick, G, Feigelman, S, Kaljee, L, Zhou, Y. Parental underestimates of adolescent risk behaviour: A randomised, controlled trial of a parental monitoring intervention. *Jo. of Adolescent Health*. 26 (1), pp. 18-26. 2000.
- Steinberg, L. We know some things: parent-adolescent relationships in retrospect. *Jo of Research on Adolescence*, 11, pp. 1-19, 2001.
- Sun, L, Stewart, S. Psychological adjustment to cancer in a collective culture. *Int. Jo. of Psychology*, 35 (5), pp. 177-185. 2000.
- Sundby, E. Attachment and depressive symptoms in childhood: Sociogenic contributions to depression. Dissertation. 2000.
- Swadi, H. Individual risk factors for adolescent substance use. *Drug and Alcohol Dependence*. 55 (3), pp. 209-224. 1999.
- Thomas, R. An investigation of empathic reactions among mental health professionals working with Post Traumatic Stress Disorder. Dissertation. 1999.
- Touch, G. Family patterns, life stress and social support as predictors of health and psychological adjustment in adults and children. Dissertation. 1997.
- Trusty, J. Family influences on educational expectations of late adolescents. *Jo. of Educational Research*. 91 (5), pp. 260-270. 1998.
- Vakalahi, H. Adolescent substance use and family-based risk and protective factors: A literature review. *Jo. of Drug Education*. 31 (1), pp. 29-46. 2001.
- Vanoy, D, Cubbins, L. Relative socio-economic status of spouses, gender attitudes and attributes, and marital quality experienced by couples in metropolitan Moscow. *Jo. of Comparative Family Studies*, 32 (2), pp. 195-217. 2001.
- Van Riper, M. Maternal perceptions of family-provider relationships and well being in families of children with Down Syndrome. *Research in Nursing & Health*. 22 (5), pp. 357-368. 1999.
- Volling, B, Notaro, P, Larsen, J. Adult attachment styles: Relations with emotional well-being, marriage, and parenting. *Jo. of Applied Family Studies*, 47 (4), pp.355-367. 1998.

- Vondra, J, Shaw, D, Swearingen, L, Cohen, M, Owens, E. Early relationship quality from home to school: A longitudinal study. *Early Education & Development*. 10 (2), pp. 163-190. 1999.
- Vosler, N, Robinson, J. Nonmarital co-parenting: Knowledge-building for practice. *Families in Society - The Jo. of Contemporary Human Services*. 79 (2), pp. 149-159. 1998
- Wadsworth, M. Social and historical influences on parent-child relations in midlife. In: Ryff, C, Seltzer, M. (Eds). *The parental experience in midlife*. The John D. & Catherine T. MacArthur Foundation series on mental health development: Studies on successful midlife development. IL, USA: University of Chicago Press. 1996.
- Weber, J, Waldrop, D. Grandparents raising grandchildren: Families in transition. *Jo. of Gerontological Social Work*. 33 (2), pp. 27-46. 2000.
- Wearden, A, Tarrier, N, Barrowclough, C, Zastowny, T, Rahill, A. A review of expressed emotion research in health care. *Clinical Psychology Review*. 20 (5), pp. 633-666. 2000.
- Weihs, K, Reiss, D. Family reorganisation in response to cancer: A developmental perspective. In: Baider, L, Cooper, C. (Eds). *Cancer and the family*. NY, USA: Wiley. 1996.
- Werner-Wilson, R, Vosburg, J. How do contextual factors and gender differences influence college students' safer sex practices? *Jo. of HIV/AIDS Prevention & Education for Adolescents and Children*. 2 (2), pp. 33-49. 1998.
- Whipple, E. Reaching families with preschoolers at risk of physical child abuse: What works? *Families in Society*. 80 (2), pp. 148-160. 1999.
- Wolkenstein, B, Serman, L. Unmet needs of older women in a clinical population: The discovery of possible long-term sequelae of domestic violence. *Professional Psychology: Research & Practice*. 29 (4), pp. 341-348. 1998.
- Woolfenden, S, Williams, K. Family and parenting interventions for conduct disorder and delinquency in children 10-17. In: *The Cochrane Library*, Issue 2, Oxford. 2000.
- Wysocki, T, Harris, M, Greco, P, Bubb, J, Danda, C, Harvey, L, McDonnell, K, Taylor, A, White, N. Randomised, controlled trial behaviour therapy for families of adolescents with insulin-dependent diabetes mellitus. *Jo. of Paediatric Psychology*. 25 (1), pp. 23-33. 2000.
- Yonkers, K, Dyck, I, Warshaw, M, Keller, M. Factors predicting the clinical course of generalised anxiety disorder. *British Jo. of Psychiatry*. 176, pp. 544-549. 2000.

Young, S. Body Talk: Some thoughts on anorexia. *Australian and New Zealand Jo. of Family Therapy*. 19 (2), pp. 63-67. 1998.

Zoritch, B, Roberts, I, Oakley, A. Day care for pre-school age children. In: *The Cochrane Library*, Issue 1, Oxford. 2000.

**APPENDICES**

## **Appendix 1.1**

### **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 information. Partnership 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 3.1**

### **Interview Questions for Parenting 2000 Workers**

## **Appendix 3.1**

### **Interview questions for Parenting 2000 workers**

- 1. Name and job description and what is it that you will do?**
- 2. How many people do you anticipate will use the centre per month/year?**
- 3. Using checklist of health determinants, what will the impact of the project be on:**
  - a) the whole population*
  - b) older people*
  - c) children*
  - d) women*
  - e) ethnic minorities*
  - f) disabled people*
  - g) deprived communities*
  - h) other relevant groups*
- 4. What effect, if any, do you think that the project will have on the area as a whole?**

## **Appendix 3.2**

# **Health Determinant Categories**

## Appendix 3.2

### Health Determinants Categories

<p><b>Social and Economic Environment</b></p> <p>Education and training</p> <p>Employment</p> <p>Housing</p> <p>Community Facilities</p> <p>Transport</p> <p>Social Networks (friends and family)</p>	<p><b>Physical Environment</b></p> <p>Housing Conditions</p> <p>Working Conditions</p> <p>Air Quality</p> <p>Noise</p> <p>Appearance of Area</p> <p>Public Safety</p>
<p><b>Personal/ Family Experiences, Lifestyles and perceptions</b></p> <p>Peer Pressure</p> <p>Discrimination</p> <p>Fear of Crime</p> <p>Culture</p> <p>Community and spiritual participation</p> <p>Family Structure and functioning</p>	<p><b>Service Use, access and quality</b></p> <p>Adult Education</p> <p>Health Care</p> <p>Social Services</p> <p>Welfare Rights/ Advisory Services</p> <p>Leisure</p> <p>Criminal Justice System</p> <p>Voluntary Services</p>

## **Appendix 3.3**

### **Interview Questions for Key Informants and Stakeholders**

## Appendix 3.3

### Interviews with key informants and stake holders

Read out the following information about Parenting 2000:

**Parenting 2000 aims to promote positive parenting by providing a drop in centre located in central Southport where parents and children can gain easy access to information, advice and support which could help them to meet the challenges of family life. It is a Single Regeneration Budget funded project that has funding up to April 2002. It has the resources to employ a full time project manager, a full time support worker, a creche manager, and sessional childcare workers.**

Show Parenting 2000 leaflet

Questions for experts, health professionals and relevant voluntary and statutory organisations

***1. What effects do you think that Parenting 2000 will have on these different categories? (For the community in general)***

(Show health determinant categories and subsections and invite comments)

***2. What effect do you think the project will have on:***

**a) Your client group**

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

**c) Southport as a whole**

## **Appendix 3.4**

### **Description of Focus Group Sessions**

### Appendix 3.4

#### **Focus Group 1 - Users of Parenting 2000, Southport September 1999**

A Focus group session was held at the base of Parenting 2000 in early September with the overall aim of exploring with some of the project users the impact, if any, that the project is having on health determinants for them and their children.

Pursuant of this objective, a number of specific questions were devised by Judith Hendley to elicit relevant information from the group. The questions were, however, deliberately open ended in order that members of the group might feel able to contribute their views and feelings on the wider issues of parenting and its attendant challenges.

The session was held in one of the comfortable rooms upstairs, with tea and coffee provided by the project. The Research team from the university aimed to create as friendly an atmosphere as possible by adopting a relaxed approach.

#### **Focus Group 2 - Users of Southport Social Services Family Centre, September 1999.**

A Focus group session was held with parents and users of the Southport Social Services Family Centre, Talbot Road, Southport in late September. The purpose of this was to find out about their usage of Parenting 2000 and further to this, to explore through questions and discussion, the impact, if any, that they feel the project is having, or might have, on health determinants for them and their children.

The Southport Family Centre is run by Social Services and offers a range of support sessions and activities. Approximately 30% of families who use some of these services are referred to the centre through social provision. On Tuesday afternoons there is a "drop-in" session which is open to anyone who has care of a child/children.

The session was held in the large ground floor children and parents activity room. It was scheduled to start at 1.30 p.m., but parents did not start arriving until about 1.50. By 2.00 there were 5 women and so it was decided that we should go ahead. During the course of the session other people joined, including two men (lone parents) and one male/female couple with their baby. In total, 12 people participated, to a greater or lesser degree and all were parents. About half of the total number were wandering in and out of the room throughout the session. Four parents kept their children with them. The rest of the children were cared for in the outdoor play area.

The fluidity of the group was not ideal for putting questions to the group as a whole, some questions were repeated as people joined the group, particularly questions pertinent to their usage or perceptions of Parenting 2000. After initial reticence however, most people in the room made considerable contributions relating to their concerns as parents in Southport.

## **Appendix 3.5**

### **Questionnaire for Parenting 2000 Centre Users**

## Appendix 3.4

### Parenting 2000 Questionnaire for Centre Users

*We are doing some work with the University of Liverpool looking at who is using this Centre and what they are using it for. We need to do this for our own records and also to make sure that we are reaching the people that we want to help. We would be grateful if you could fill in this questionnaire which will help us to do this. All your answers will be treated as confidential. We will not be able to identify who you are from your questionnaire, however, you can leave out any questions that you do not want to answer. If you would like to know more about this study please speak to Sue Rimmer (Parenting 2000 Coordinator).*

**Thank you for your help.**

1. Are you: Male  Female

What age were you at your last birthday?

How would you describe yourself?

White  Black African  Black Caribbean  Black other

Chinese  Indian  Pakistani

Any other  (Please state)

What is your postcode?

How would you describe your current situation?

Single  Living as a couple  Married

Widowed  Divorced/ Separated

Do you have any children under 16? Yes  No

7a. If yes, how many

What are their ages?

8. Would you describe yourself as having any long term health/ disability problems? Yes  No

9. Are you registered disabled Yes  No

Are you:

In full time work (i.e. 16 hours or more)

In part time work (i.e. fewer than 16 hours)

Self employed

On a government scheme

Unemployed

Not seeking work

If you are not seeking work why is that?

Looking after children or dependent relative

Sick/ disabled

Student

Retired

Other reasons (please specify reason)

Which of the following benefits do you currently receive?

Child Benefit

Disability Living Allowance

Disabled Working Allowance

Family Credit

Housing Benefit

Incapacity benefit

Income Support

Invalid Care Allowance

- Job Seekers Allowance
- Maternity Allowance
- Retirement Pension
- Severe Disablement Allowance
- Statutory Maternity Pay
- Statutory Sick Pay

Other(s) (Please state which)

Is this your first visit? Yes  No

If No, how many times have you been here before?

Why have you come here today? (Please tick all the boxes that apply to you)

- To attend a group (please state which one)
- To use the One Stop Shop
- To use the toy library
- To get general information
- Other (please state what)

How did you find out about this Parenting 2000 centre?

Advertisement  Please state where you saw it

In a newspaper  Please state which one

Word of Mouth

This is the end of the questionnaire. Thank you for your help.

## **Appendix 4.1**

### **Target Area's Position on Index of Multiple Deprivation 2000**

## Appendix 4.1

### Indices of Deprivation 2000 Wards within Sefton

Ward	Ward Name	LA Name	DETR LA code	1a	1b	2a	2b	3a	3b	4a	4b	5a	5b	6a	6b	7a	7b	8a	8b	
				Index of Multiple Deprivation Score	Rank of Index of Multiple Deprivation	Income Domain Score	Rank of Income Domain	Employment Domain Score	Rank of Employment Domain	Health Domain Score	Rank of Health Domain	Education Domain Score	Rank of Education Domain	Housing Domain Score	Rank of Housing Domain	Access Domain Score	Rank of Access Domain	Child Poverty Index Score	Rank of Child Poverty Index	
CAFA	Ainsdale	Sefton	4320																	
CAFB	Birkdale	Sefton	4320	21.03	3363	19.32	3160	13.8	1902	0.66	2031	-1.16	7642	-1.66	8131	0.12	3404	29.23	3095	
CAFC	Blundellsands	Sefton	4320	15.30	4642	16.74	3880	10.56	3024	.30	3070	-1.08	7501	-.61	6268	-.55	6142	25.23	3722	
CAFD	Cambridge	Sefton	4320	15.41	4600	14.75	4517	11.68	2576	.40	2755	-.98	7299	-1.07	7412	-.55	6123	14.76	5913	
CAFÉ	Church	Sefton	4320	32.31	1743	24.85	2067	18.25	997	1.38	609	-.41	5631	.03	4032	-.29	5037	27.52	3363	
CAFF	Derby	Sefton	4320	47.18	686	39.29	558	26.73	242	1.75	258	-.37	5496	.04	4023	-1.05	7587	47.16	1195	
CAFG	Duke's	Sefton	4320	57.88	312	43.02	362	27.27	204	1.79	231	1.21	774	.63	2011	-1.40	8047	58.89	487	
CAFH	Ford	Sefton	4320	37.39	1308	27.28	1702	21.91	580	1.39	598	-.46	5836	.53	2273	-.24	4813	33.71	2528	
CAFJ	Harington	Sefton	4320	53.66	443	45.21	281	27.71	193	1.80	225	-.02	4191	.45	2556	-.70	6684	64.46	268	
CAFK	Kew	Sefton	4320	11.00	6018	9.21	6864	9.66	3457	.08	3834	-1.64	8220	-1.43	7947	.08	3516	7.33	7784	
CAFL	Linacre	Sefton	4320	23.25	2960	22.05	2568	12.05	2436	.49	2491	.23	3280	-.12	4595	-.38	5430	34.79	2403	
CAFM	Litherland	Sefton	4320	71.75	56	56.58	60	36.89	19	2.28	53	1.21	761	.69	1821	-1.30	7947	79.36	25	

CAFN	Manor	Sefton	4320	51.22	520	43.40	348	24.87	342	1.65	335	.47	2506	.50	2379	-.82	7066	61.75	369
CAFP	Meols	Sefton	4320	29.20	2092	25.87	1907	16.79	1256	1.00	1228	-.82	6900	-.30	5266	.21	3095	35.64	2307
CAFQ	Molyneux	Sefton	4320	14.40	4891	15.53	4246	9.53	3524	.29	3124	-.69	6539	-1.68	8153	-.19	4611	21.33	4407
CAFR	Netherton	Sefton	4320	26.51	2411	16.52	3947	15.37	1531	1.01	1196	.11	3692	-.43	5697	.39	2614	20.65	4541
CAFS	Norwood	Sefton	4320	57.36	326	44.56	304	27.69	194	1.92	157	.62	2034	.63	1996	-.47	5819	66.33	215
CAFT	Orrell	Sefton	4320	30.48	1925	28.94	1498	15.96	1400	1.04	1144	-.18	4807	-.03	4263	-.44	5695	35.95	2280
CAFU	Park	Sefton	4320	60.02	272	45.37	272	29.08	139	1.90	170	.87	1408	.78	1591	-.85	7165	62.90	319
CAFW	Ravenmeols	Sefton	4320	16.37	4338	16.34	3999	11.50	2651	.57	2251	-.93	7193	-1.32	7820	-.66	6564	17.59	5214
CAFX	St. Oswald	Sefton	4320	11.95	5715	11.96	5598	10.12	3226	.16	3591	-1.54	8136	-1.25	7720	-.34	5269	12.70	6437
CAFY	Sudell	Sefton	4320	50.68	540	40.69	474	23.82	411	1.70	298	.71	1800	.49	2421	-.54	6089	62.08	357
CAFZ	Victoria	Sefton	4320	18.07	3953	15.46	4264	12.52	2260	.62	2126	-.95	7229	-1.27	7759	-.10	4226	16.09	5578
				18.87	3782	18.46	3406	12.96	2137	.64	2071	-.91	7128	-.94	7136	-.75	6842	20.03	4674

Source: Department of the Environment, Transport and Regions

Indices of Deprivation 2000





## **Appendix 4.2**

### **Prioritisation of Health Impacts**

## Appendix 4.2

### Issues when trying to prioritise health impacts

A concern when carrying out any health impact assessment is deciding which are the most important health determinants that the project in question is likely to, or is, having an impact on. Some criteria that might merit consideration include:

- Number of key informants who mentioned the health determinant
- The expertise, knowledge and experience of the key informant(s) concerned
- How certain they are that the impact will occur
- The strength/ intensity of the health impact
- The number of people who would be affected by it

However, at some stage it always involves a value judgement as to which of these criteria are the most important, since there are inevitable contradictions between them. In particular, is it the number of people who mention a particular health determinant, the conviction of opinion of the people or persons who refer to it, or the knowledge and experience of those people that is significant? There is also the issue of how far the prior knowledge of the person carrying out the health impact assessment should or does influence her views about this matter. If they do, then clearly the field of expertise of the person doing the research becomes an issue. A Public Health specialist, for example, might have different ideas from a university researcher.

In this report no attempt has been made to give any rank order to the health determinants categories identified by the key informants and stakeholders as being important. This is because, whilst there are clearly some health determinants which are more likely to occur than others and which are likely to have a stronger effect, any order that was imposed on these would be to a great extent arbitrary. Rather, they are grouped under appropriate sections.

### *Social and Economic Environment*

Respondents considered that the project would contribute positively to the social and economic environment. Much was made of the fact that it is a new community centre, offering people the opportunity to meet and socialise in a relaxed and safe space.

Although the centre itself has created a very small number of jobs, a number of respondents pointed out that the courses it has on offer provide an opportunity for people to develop their skills and confidence which might help them to find employment.

Likewise it was recognised that although Parenting 2000 could not do anything directly to ameliorate the housing situation in Southport, it could provide people with

information about where to go for help and support. Indeed a number of respondents made reference to the usefulness as a sign post to other voluntary organisations and groups dealing with specific issues.

### ***Physical Environment***

It was noted by a number of informants that the Parenting 2000 building had been nicely adapted and decorated. People were particularly pleased that it had been made accessible for people who use wheelchairs. However, it was generally felt that the project had not made any impact on the physical environment.

### ***Personal/ family experiences, lifestyles and perceptions***

Respondents were positive about the efforts that the project had made to include people from some excluded groups. Materials were available in different languages for people who have English as a second language. By making the building almost fully accessible, the project had ensured that disabled parents and children would be able to make use of the facilities. This is particularly important in Southport where disabled children can go and play with other children. The toy library stocks toys for all children including those with additional educational needs.

The non- judgmental approach of the project workers towards different kinds of domestic and family arrangements was viewed by a number of informants as being extremely important. The courses that were on offer - such as parenting teenagers and groups for parents with younger children - could allow people to explore issues and learn from each other in a safe, supportive atmosphere. It was thought that helping parents, by, for example, showing them how to relax, would have a beneficial effect on their children.

More generally, it was thought that the courses would help to improve people's self esteem which could have positive knock on effects in a number of areas in their lives.

### ***Service use, access and quality***

Most respondents thought that Parenting 2000 would help to increase usage of other services - both voluntary and statutory. The One Stop Shop was extremely useful in being able to provide people with information on a wide range of subjects. Being able to deal with a number of areas under the same roof is extremely important since it may save people having to go from one agency to the next perhaps with children in tow. It may also help to ensure that their problems are dealt with more holistically. Where people do need more specialist advice or help than is available at the project, they can at least be directed to the relevant organisation. The one stop shop itself has posters and leaflets supplied by a wide range of voluntary and statutory organisations and charities.

## **Appendix 4.3**

### **Characteristics of the Super Profile Geodemographic Classification**

**Super Profiles is a socio-economic, residential land classification system. It is based on the 1991 Population 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 spend or to 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.*