Responsive, Sensitive and Reflective Parenting. The Value of Parental Support in Merseyside; A qualitative study.

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Responsive, Sensitive and Reflective Parenting. The Value of Parental Support in Merseyside; A qualitative study.

Background: Throughout the world it is thought that over 200 million children are not reaching their full developmental potential. In the UK it has been estimated that just under half (48%) of children are not reaching a level of 'good development' by the age of 5 years. This is particularly the case in children from inner-city areas such as Liverpool, Merseyside. Research has shown the importance of responsive, sensitive and reflective caregiving in improving a child's development and research has demonstrated the need to support parents with this. The UK government provides parents with support with their parenting via various services and policies including Health Visitors, Midwives and children's centres. It is not clear however, which services parents in Merseyside are accessing and what support they value. In October 2015, the control of funding for all children's services will be passed to local authorities and children's centres' funding is under a 2 year period of review and so it is a crucial time to question what, how and why parents use the support networks and services they do. By doing so we can better cater the services to the needs of the parents and hopefully improve childhood development in Liverpool, Merseyside.

Aim: To understand how caregivers from different backgrounds in Merseyside know and learn to be responsive, sensitive and reflective to their babies. Where they go to for support and what services they value.

Methods: Qualitative semi-structured interviews and focus group discussions were chosen as the main research methods for gathering data. The eligibility criteria included all English speaking caregivers of children aged less than 2 years old. Interviews and focus group discussions were audio recorded and transcribed. Thematic content analysis was used to identify key themes in relation to the study aims.

Results: 22 parents were interviewed, 21 mothers and 1 father. One focus group discussion was held with 5 participants. Parents spoke of requiring additional support when their child was ill, due to their child's sleep routine, to overcome isolation and as single parents. Parents used a variety of services and people to support them with their responsive, sensitive and reflective caregiving. This included their partners, family members, other mothers, children's centres, Health Visitors, BAMBIs breastfeeding support and the internet. It emerged that 'relationships', 'professionalism' and 'experience' were crucial factors in the support valued by parents. This included forming a positive relationship with health care professionals and utilising the expert knowledge of staff running a service. It also included the ability to discuss their child's development with other mothers as well as comparing experiences.

Conclusions: Services which support parents in the early years of their babies' lives should consider the importance of the relationships they form with their parents, especially when delivering advice. Health Visitor leaders should consider deploying the same Health Visitors at weigh-in sessions each week to improve the relationship with parents in the hope that parents will make greater use of this service to support them in their caregiving. Children's centres were a vital support service for parents interviewed as the staff had formed positive relationships with parents, they were professionally trained and centres provided an opportunity for parents to meet other mothers and overcome isolation. Therefore it is hoped the local authorities will consider renewing their funding in two years' time.

"*It takes a village to raise a child"*

Nigerian Proverb

Table of Contents

List of Figures

List of Tables

List of Abbreviations

AAI	Adult Attachment Interview
FNP	Family Nurse Partnership
NAPR	National Academy for Parenting Research
NHS	National Health Service
PEEP	Peers Early Educational Partnership
PDI	Parent Development Interview
RF Scale	Reflective Functioning Scale
SIDS	Sudden Infant Death Syndrome
UK	United Kingdom
USA	United States of America
W.H.O	World Health Organisation

Chapter One

Childhood Development: Introduction and Background to the Study

‘Childhood development’ pertains to the period from birth to adolescence during which critical biological, physical and emotional changes occur to a person as their brain and body grow to take on their adult form. From birth to five years old children make rapid gains in their speech and language, gross and fine motor, communication and independence skills.(1) The areas of development are thus often measured in the following four domains; gross motor, vision and fine motor, hearing speech and language and the final domain, social emotional / behavioural. Research has shown that developmental delay in any or all of these domains can occur due to a number of factors, both genetic and environmental.(1) One of the most important major factors is the relationship a child forms with their primary caregiver. This has been well documented as having a significant impact on a child’s overall development.

1.1. The Importance of Childhood Development

Childhood development is currently of major interest to health and social policy makers and is being placed high on the agenda for the new sustainable development goals, 2015.(2) Evidence suggests that over 200 million children globally may not be reaching their full developmental potential, resulting in adverse consequences in their adult lives.(3) Children not reaching their full developmental potential is not just limited to children growing up in more economically deprived countries, but is also a key issue of concern in many more privileged settings throughout the world.

The World Health Organisation [W.H.O] has been promoting the idea that the early childhood period (defined as perinatal to 8 years old) is the most important stage in defining an individual’s trajectory into adult life.(4,5) Evidence suggests, that early childhood development interventions can be a powerful equaliser and can improve the long-term outcomes of individuals and possibly, the economic outcomes of nations.(6) For the child themselves, studies have shown that healthy development can aid in the prevention of mental and physical health problems, as well as improving educational outcomes such as numeracy and literacy skills.(5) These positive outcomes can then lead to a range of societal benefits including improved educational and employment prospects over the life course, and reduced risk of criminality. Conversely the evidence suggests that there are many negative

consequences of poor development. It is therefore crucial that every child is given the best possible start in life.(5)

In the United Kingdom [UK] many children are not reaching their developmental potential. A report from the Department of Education in 2013 stated that only just over half of 5 year old children (52%) were reaching the government defined level of 'good development' during their pre-school developmental checks.(7) Children are assessed using the early learning goals covering seven areas of learning including, communication and language, physical development, personal, social and emotional development, literacy, mathematics, understanding the world and expressive arts and design.(7) For children growing up in more disadvantaged areas of the country, where there are high levels of child poverty the figures reaching a 'good level' of development is much lower.(7) In Liverpool, Merseyside, 33% of children are growing up in poverty and the overall health and wellbeing of children, including factors such as immunisation uptake, hospital admissions and overall child development amongst other factors is worse than the national average.(8) In 2014 one report showed that only 50% of children in Liverpool were reaching the government's level of 'good development'.(8) With a high population of children within the city, (5,942 live births in 2012) this means that thousands of children are not be reaching their full developmental potential in Merseyside.(8) There is therefore real concern that more should be done to support the development of the children of Liverpool.

1.2. A Global Focus on Childhood Development: The current situation

From a global perspective, Margaret Chan, head of The W.H.O has recently published a letter making it very clear how inadequate, disrupted and negligent care, can have adverse consequences for childhood development. Professor Chan stresses that as a global community we need to be developing policies that can impact earlier in a child's life to prevent these poor outcomes. (4) Throughout the world the importance of caregiving and the positive impact that parents and caregivers can make to their child's development is becoming better documented.(9,10)

Within the UK there, has been a clear focus on utilising evidence based initiatives to provide more support for parents. These initiatives have been mixed and varied in their approach and have come from a range of health, social welfare and education settings, all with an aim of ensuring that children are given the best possible start in life regardless of their social background.(11) The developmental potential of a child in the UK is influenced by both their parents' caregiving, which is in turn influenced by the support their parents receive from their family, friends, local community and the health, education and social care services provided locally.

1.3. Current Gaps in the Evidence

Multiple research studies have demonstrated how responsive and sensitive caregiving is an important factor in a child's development.

The seminal work of Bowlby and his 'Attachment Theory' in the 1950s first demonstrated the critical importance of the early bond between mother and child.(12) This work led on to the development of the concepts of sensitive and responsive parenting. Bowlby worked along-side researcher Mary Ainsworth who developed a tool to measure Bowlby's Attachment Theory, known as 'The Strange Situation'.(13) She concluded that children will develop secure attachments with caregivers who are sensitive and who respond to them, naming the theory the 'sensitivity-responsivity theory of attachment'.(4,13)

Sensitive and responsive parenting has continued to be a widely researched area of child development and is the basis of many successful parenting interventions.(14) In more recent years, researchers have moved a step further and explored newer concepts such as that of Fonagy, who has developed the theory of 'Reflective Parenting' and having the ability to hold your child's thoughts and feelings in mind. This new concept, although not as well established as that of sensitivity and responsive parenting is becoming a more recognised theory exploring the importance of the child-caregiver relationship with some initial research showing its positive impact upon a child's overall development. Initial research supporting the theory of reflective parenting is interesting and compelling, but as yet, it is unclear as to what evidence is available to support these approaches and their promotion in improving

child development, any more than approaches relating to promoting responsive and sensitive caregiving.

1.4. How to Support Parents in a Local Context

Since the introduction of the 'Society for the Prevention of Cruelty to Children' in 1883 the need for the government to support children and their development in the UK has long been recognised and supported through various Acts of Parliament and government policies. This includes a number of National Health Service [NHS] as well as local authority delivered services available to support parents. The most recent government policy which encompasses all aspects of early childhood is the 2010-2015 policy on Children's Health, developed by the 2010-2015 coalition government.(15) This document includes policies directed at supporting parents and their child's development in the first 1001 days of life, from conception to two years of age. The policy outlines actions that should be taken to 'help families to have the best start in life' as well as the services and support that should be available to all UK families regardless of their social or economic background.(15)

From October 2015 local authorities will take over responsibility from NHS England for the delivery of a range of services for children and parents from zero to 5 years old. It is stated within this policy on Children's Health that local authorities will be expected to understand the needs of their local communities' best and to target their services accordingly.(15)

Although the government's document outlines the policies that should be promoted for an ideal health service for children under 5 years old, it is not always certain how these are being implemented, and whether these services are actually available to parents at a local level. It is also not always clear how many people are benefiting from these services and it is often not clear what parents themselves actually want in terms of support and advice. With the control of funding shortly being transferred to local authorities it is an important time to provide evidence to those in charge of service provision outlining the types of services parents themselves value. This is particularly the case in Liverpool, a city with high levels of social disadvantage where children's developmental attainment in the preschool period is lower than the

national average.(8) In this setting, optimal support for children in the early years could make a real difference and help improve early childhood developmental potential and thus improve population health.

1.5. Study Aim

The aim of this thesis is to better understand how caregivers from different backgrounds in Merseyside know and learn to be responsive and reflective to their babies, where they go to for advice and support with their parenting and which services they value.

It is hoped that by doing so I can provide timely evidence for those responsible for children's services in Merseyside as well as the local authority about the needs and wants of the parents of Merseyside at a time when making better informed decisions about the provision of children's services and improving childhood development is high on the political agenda. By providing evidence to the local authority, I hope that this in turn will allow the local authority to target their service provisions more effectively and begin to improve the developmental outcomes of the children of Merseyside. It will also give more of an insight into the types of services parents' value where they turn to for support with their parenting.

1.6. Introduction to the Study

Following the brief introduction in this chapter to some of the key concepts considered in this thesis, I move on to a more in depth consideration of the literature.

Chapter Two outlines key theories of childhood development. I undertake a literature review focused on theories of child development and provide evidence to support the newer theory of reflective parenting. I further explore the evidence available to support sensitive, responsive and reflective parenting, and review the evidence suggesting why parents require support with their parenting. I will also outline what services and support should be available to parents in the UK and Merseyside should

currently be supported as outlined in current UK government policy. I conclude chapter two by evaluating the evidence, exploring the extent to which parents actually value support with parenting. Following this, I will outline the aims and objectives of the study in more detail.

Chapter Three, Qualitative Methodology, outlines the general qualitative methods used in my thesis, along with the justification for using these research methods.

Chapter Four, which outlines the study, presents the specific methods and study protocol used in my qualitative study

In Chapter Five, Results, presents the results of my study.

Chapter Six, Discussions and Conclusions, summarises and discusses the results of my study, relating the new evidence that I generate back to the literature review. I discuss the limitations and strengths of my study and outline how the results of my study could be applied in policy and practices I will also suggest areas for future research. I conclude the chapter with an overall summary of the thesis.

Chapter Two

Theories of Childhood Development and Literature Review

In this chapter I provide an overview of key literature surrounding the importance parenting has on child development. This will be achieved by discussing important theories behind child development, both historically and in terms of the more modern day theories such as 'Reflective Parenting'. I will then explore the research surrounding how demonstrating sensitive, responsive and reflective care can impact upon a child's development. From this I will look at the evidence which questions if parents have a natural ability to demonstrate these traits and why they may need support with their caregiving. Finally I will evaluate the current evidence which supports the use of parental interventions.

In the next section of the review I will continue by outlining the services which should be available to support all parents within the UK and Merseyside. The final section will then review the evidence exploring the value of such support to parents.

Throughout the literature review, I will focus on literature relating to children aged 0-2 years primarily, as well as the 'universal parent'. The age range of 0-2 years has been chosen since this is the most critical period in a child's development. The 'universal parent' concept embraces 'all parents', with a focus on the general needs of parents in the community as opposed to those who may require more targeted support.

When embarking upon this literature review I conducted three main database searches, in order to establish how parenting can effect child development. This included looking specifically at responsive and sensitive parenting, reflective parenting and the role of parental interventions.

Firstly when conducting this review I explored the literature surrounding sensitive and responsive parenting as this is a well-established theory of childhood development. In December 2014 I used the keywords 'sensitive' AND 'responsive' AND 'parenting' to search across the main databases of PubMed, Ovid SP and Scopus, all accessed through the University of Liverpool. This gave limited results across all databases searched, no more than 30 results were found. When reviewing the abstracts amongst these results it was clear that the search terms were not producing publications that was relevant enough to discuss the importance of responsive and sensitive care in the universal parent. I therefore searched for 'sensitive parenting' and 'responsive parenting' as separate searches and this

produced a more varied result. Following title and abstract reviews of these results, 3 studies were found to be of relevance to my work and were consequently reviewed. I also used the work of The W.H.O., searching their databases for their own literature reviews on responsive and sensitive parenting and reviewed the citations within their work to explore further evidence relating to this parenting concept.

To establish the evidence to support reflective parenting a literature search was carried out in November 2014 using the keywords 'reflective' AND 'parenting'. The most results were found using the database 'Scopus' which gave 109 publications. Reviewing the titles it was clear that not all publications were looking specifically at reflective parenting and further searches were commenced by adding the term 'reflective functioning' to ensure these results were specific to Fonagy's definition of reflective parenting. This reduced the results to 51 results and abstracts were reviewed in more detail for their inclusion in the review.

To review the importance and effects of parenting interventions in the UK, the keywords 'parenting' AND 'interventions' were searched in December 2014. The most results produced were using the database 'Ovid SP' which gave 174 results. It was clear that the majority of these publications were based upon interventions which were targeted to a specific cohort of parents or children and did not look at the general picture of 'universal parents'. Therefore the internet search engine 'Goggle' was used to establish what universal parenting interventions are available in the UK and more specifically in Merseyside. From this the evidence to support the use of each intervention or support service could then be reviewed. From these searches I discovered the National Association of Parenting Research's database of parenting interventions and for each intervention recommended, a full literature search was conducted by myself using the intervention title as the keyword in order to fully establish the evidence base of the literature available to support the use of each intervention. A general internet search also led me to establish which specific resources the government provides to support parents of children less than 2 years old in the UK.

Once the resources available to parents in the UK was established I was able to conduct a more detailed literature searches on the evidence to support their use, as well as attempting to establish what literature is available exploring the value of

these services to parents using keywords such as ‘experience’, ‘value’ and ‘opinions’ during my searches.

2.1. Theories of Childhood Development

The first environment with which a child interacts, is the environment provided by their family. The role of the primary caregiver and immediate family therefore is to produce a stable environment and to provide the child with stimulation, support and nurturance so that the child can reach their full potential.(16) For the past 60 years there has been a myriad of theories developed to explore and explain how this environment can influence a child’s development. Psychologists and clinical practitioners have developed these theories over many years and attempt to explore and understand how these environmental, familial and social factors, influence a child’s development from birth and throughout the early childhood period. The most influential have however focused on the importance of the child – caregiver relationship and these have in turn been used as the basis for many parental interventions and programmes across the UK.(17)

In this section I will discuss some of the more influential theories presented over the past 60 years. This will include the works of John Bowlby and his Attachment Theory. Bowlby’s theory of attachment has been a key underlying principle from which many more modern theories of childhood development have been developed, which includes sensitive and responsive parenting and more recently Fonagy’s reflective parenting. I will also explore theories of cognitive development and the work of Piaget, as well as social models of development including the work of Bronfenbrenner and Erikson.

2.1.1. The importance of Attachment in Childhood Development

John Bowlby, Attachment Theory. 1951

Since 1951 when John Bowlby and his team, with the support of the W.H.O, explored the impact of the separation of children from their families during the evacuations of World War II, 'Attachment Theory' has a been a widely recognised theory of childhood development.(12) Bowlby himself believed in a concept known as 'monotrophy' in which a child would form an attachment to just one particular individual, the primary caregiver.(12) He believed that there was a critical period in the first two and a half years of life in which a child would form this attachment. Through his work, Bowlby emphasised that this attachment was crucial for a child's survival and overall healthy development.(18,19) Despite some early criticism of this work relating to the assumed importance of the biological mother's role, Bowlby's theory became the best supported theory of childhood development at the time.(4,12) Today, the 'Attachment Theory' is still recognised as the foundation to many subsequent theories of child development which focus on the importance of the child-parental relationship.(4)

Mary Ainsworth: Strange Situation

The 'Sensitivity- Responsivity Theory of Attachment' was developed by one of Bowlby's collaborators, Mary Ainsworth. She had worked along-side Bowlby, and during work in Uganda she completed observational studies of mothers using the tool she developed to measure Bowlby's attachment theory, 'The Strange Situation'.(13)

The Strange Situation observed the responses of children aged between 9 months and 18 months as they were left to play during which time their parents and strangers entered or left the room. Four types of responses or 'types or attachment', were initially observed; Secure Attachment, Anxious-Avoidant (insecure attachment), Anxious-Ambivalent (insecure attachment) and Disorganised Attachment; (13)

- *Securely Attached:* This is when a child will explore freely when the mother is present in the room. They will engage with the strangers if their mother is in the room, but not if their mother has left. They will be upset on their mother's departure and happy to see them upon return.
- *Anxious-Avoidant (insecure attachment);* A child will avoid or ignore their caregiver. Little emotion is shown when the caregiver departs or returns and the caregiver will be treated in a similar way to the strangers. They may run away from their caregiver and fail to cling to them when picked up.

This style of attachment forms from a disengaged care-giving style where the child's needs are not readily met.

- *Anxious-Ambivalent (insecure attachment);* A child is anxious of exploration and strangers regardless of the caregiver being present or not. Upon the caregivers departure the child will be distressed. Upon their return they will be ambivalent, remaining close to the caregiver but resentful. They may hit out at their caregiver or fail to cling to them when picked up.

This style of attachment occurs when a caregiver is engaged with the child but on their terms only. The child's needs will be ignored until the caregiver has completed another task.

- *Disorganised Attachment;* The child will show disorganised and confused reactions to their caregiver leaving and entering the room. Some show rocking to and fro and repeatedly hitting themselves.

This style of attachment can occur due to a severe loss or trauma felt by the mother around the birth period causing them to become severely depressed.

As a result of this work, Ainsworth concluded that children will develop secure attachments with caregivers who are sensitive and respond to them, calling it the 'sensitivity-responsivity theory of attachment'.(4,13) Sensitive, responsive caregiving continues to be the basis of many parental interventions today.

Maccoby in 1980 developed Ainsworth's description of secure attachment further. He added that showing joy on reunion with the caregiver as well as being orientated

towards a person when separated (listening for their voice or noises) showed a secure attachment.(20) When defining attachment, theorists describe how the strength and security of an attachment can vary. Strength refers to the intensity of the attachment through behaviours, as demonstrated by Ainsworth's strange situation. Security refers to the confidence a child has in the caregiver to be there when needed.(20)

In 1968 Schaffer followed 60 infants over an 18 month period in an attempt to measure the ages at which a child should be forming this 'secure attachment' as described by Ainsworth. Schaffer described three crucial stages in the social development of an infant following his research, which were vital in allowing the child to form an attachment; (21)

- *6 weeks following birth;* The infant is attracted to other human beings rather than inanimate features in the environment.
- *3 months following birth;* The infant begins to distinguish between different people. The primary caregiver is recognised as 'familiar' whereas other are not.
- *6-7 months following birth;* The infant forms their lasting, emotional and meaningful attachment with certain individuals with whom attention is sought.

Sensitive and Responsive Caregiving:

Theories relating around sensitive and responsive parenting and the affects that this parenting has on infant attachment have developed further since Ainsworth and Bowlby's seminal research of the 1950s. Since Ainsworth's work opinions have varied between authors regarding what specifically defines sensitive and responsive caregiving. Warren SB, explains how the definition has varied over time. He states that to some a responsive, sensitive parent could be someone who actively seeks out services and support for their child when needed or that it could be interpreted as someone who has rich conversations and interactions with their child.(22) A more recent and generalised definition of responsive and sensitive caregiving encompasses both these aspects and encourages a healthy relationship between parents and their child. It is defined as when "the care-giver shows characteristics of warmth,

nurturance, stability, predictability and contingent responsiveness."(23) Over the past 20 years this continuing consensus as to what truly defines sensitive and responsive parenting has allowed many good quality studies to demonstrate the impact sensitive and responsive care has upon child development.(22)

Reflective Parenting:

'Reflecting Parenting' is a further theory about how a parent can impact upon a child's attachment with their caregivers and consequently their overall childhood development. Following on from early work, in 1998 Peter Fonagy described how humans use an understanding of mental states, intentions, thoughts, feelings and beliefs to make sense of and anticipate each other's actions. This reflective use of making sense of emotional processes is described as 'mentalisation' and demonstrating this ability is termed 'reflective functioning'.(24) Fonagy believed that a caregiver's capacity to 'hold the child in mind' and understand that they too have their own thoughts and feelings, has been described as crucial in supporting a child in discovering their own internal experiences and the child's own ability to 'mentalise'.(25) This in turn can affect the parent-child relationship and the ability to form a secure attachment. This theory is termed 'Reflective Parenting'. Unlike sensitive and responsive parenting the concept of reflective parenting can only be facilitated if the parents can make sense of their own emotional processes and demonstrate reflective functioning. The concept of reflective parenting and ideas surrounding it are beginning to become more recognised within the UK and are also forming more of a basis for parenting interventions such as the UK based antenatal PEEP courses and building bonds programme in Knowlsey, Merseyside.(25,26)

2.1.2. Piaget's Cognitive Development Theory

As well as focusing upon attachment and the child-caregiver relationship, clinicians and psychologists have also described how the environment can impact upon the cognitive developmental process. This includes the work of Piaget.

Jean Piaget was a Swiss scholar who felt that intelligence developed in children through a series of processes that children must go through to adapt to their environment.(27)

There were three components to Piaget's theory; (27)

1. Schemas; the building blocks of knowledge and a way of organising experience, allowing us to understand and predict the world around us.

2. The Developmental Process; Assimilation, fitting the world into new schemas. Equilibrium which leads to disequilibrium, where new experiences occur that cannot be fitted into existing schemas. Finally, accommodation the changing of existing schemas to fit with new experiences. All stages lead to the formation of new schemas.

3. Stages of Development; Piaget believed in four key stages to a child's development:

- *Sensorimotor 0-2 Years;* As a child reaches 8 months they develop object permanence and this stage focuses on practical interactions with the world through the child's sensory and motor systems.
- *Pre-operational Stage 2-7 years;* Children begin to interpret the world through images, symbols and language. Although the world itself remains concrete and absolute. The child remains egocentric.
- *Concrete Operational 7-11 years*; Children develop cognitive operations. Conservation of numbers, liquids, substance, weight, volume is understood.
- *Formal Operational 11-16 years;* Children are able to start manipulating ideas, develop abstract reasoning and think logically.

Researchers believe it is important for parents to have an understanding of how a child is adapting to the environment around them and their child's cognitive understanding at certain points in time. That way children can be presented with information and stimulation which is suitable to their level of understanding and needs.

2.1.3. Social Models of Childhood Development

As well as looking specifically at the child-parent relationship as an impacting factor on child development, other theories have emerged in the past 40 years which explore how the wider environmental factors not only impact upon a child's cognitive development but also upon the relationships a child forms and therefore their overall development. This includes Bronfenbrenner's Ecological Systems Theory and Erik Erikson's stages of psychological development.

Bronfenbrenner's Ecological Systems Theory. 1979

Bronfenbrenner, an American developmental psychologist used his ecological systems theory of development to demonstrate how the social environment in which we live can influence all aspects of the child's development.(28) Bronfenbrenner describes different, nested levels of the environment that can impact upon the child's development; the microsystem, the mesosystem, the exosystem and the macrosystem;(29)

> The *microsystem* relates to the immediate environment the child lives in, their home. It also includes the caregivers they interact with on a daily basis. These are their primary caregivers when they are younger and spend most time at home and as they become older those adults in their nursery or child care environment.
>
> Some describe the *mesosystem* as the interconnections within the microsystem. How parents interact with family and teachers, or the relationships the child forms with its peers and family.
>
> The child may not have any interaction with the next level, the *exosystem,* but this still impacts upon the child. For example it can be the parents work or social environment.

The *macrosystem* describes the culture in which people live and the wider impact this has upon the child. This includes the relationships the parent themselves have.

The *choronsystem* demonstrates the changes in these levels of environment over time, as the child ages.

In a paper by Halpern R, on child development, he schematically demonstrates a more modern version of Bronfenbrenner's theory and how these levels are represented in modern day society; (30)

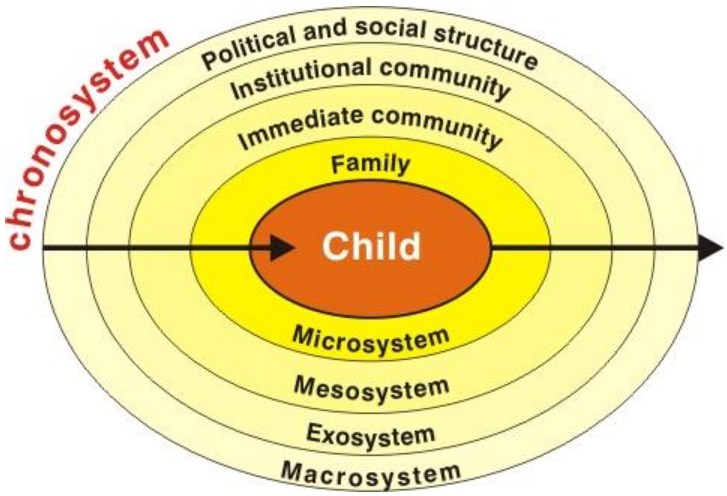

Figure 2.1: Halpern R's interpretation of Bronfenbrenner's theory of child development. (30)

This theory is an important concept to consider when looking at how parents are being supported with their child's development. It demonstrates that there are many additional factors that can influence the parent's daily lives and consequently caregiving abilities, especially when considering the role of the exosystem.

Erik Erikson's Stages of Psychosocial Development, 1956

Erik Erikson, a German born developmental psychologist, developed a theory highly influenced by Sigmund Freud, in which he identified eight stages of healthy development from infancy to late adulthood. Each stage builds upon the previous stage and he believed that if you did not successfully complete at each stage it was likely to reappear as a problem in the future.(31)

Erikson described two stages the child must past through in the early childhood period, both influenced by their parents. These were as follows; (31)

1. 0-2 years – Hopes: trust vs mistrust;

   If the child is well handled and well-loved they will develop trust and security. Badly handled and the child will become mistrustful and insecure.

2. 2-4 years –Will: autonomy vs shame and doubt;

   The well parented child will emerge from this stage with autonomy and feel proud rather than ashamed. The child will also learn through the exploration of their surroundings.

Erikson goes on to discuss other stages but these are later on into childhood, middle childhood, adolescence, adulthood and old age periods of life.

Erikson's stages of psychosocial development are important in demonstrating the impact parents can have upon the psychosocial development of their children.

2.2. Parental Interventions and the Need to Support Parents; The Evidence

Parental interventions can be defined as a variety of services designed to support caregivers with all aspects of parenthood. They aim to improve the natural skills and knowledge of parents in order to benefit the development of their child. In more high income settings parents may have access to many of these information and support services, be it public services, privately run courses or media based interventions which provide all parents with advice, information and support.

Most parenting interventions and programmes within the UK aim to support parents with their sensitive and responsive caregiving. More recently in Merseyside, new courses and interventions are being developed and run through local children's centres which support parents in their reflective parenting. In this section of the review I will therefore explore further the concepts of sensitive, responsive and reflective parenting to establish the impact this can have upon a child's development.

I will also look at the evidence surrounding the theory that a parent's ability to demonstrate these sensitive, responsive and reflective parenting skills is something that occurs naturally. I will explore what affects a parent's natural parenting abilities to explain why parents require support with their sensitive, responsive and reflective caregiving.

The section will be concluded by exploring the evidence available to support the use of parental interventions, focusing on those available to all parents in the UK as well as the evidence from America and Europe. I will explore the benefit these interventions have in improving the parent-child relationship and therefore the child's overall development.

2.2.1. The Importance of Sensitive, Responsive and Reflective Care

Sensitive and Responsive Caregiving

Since Mary Ainsworth first termed the 'Responsive-Sensitive Theory of Attachment' many good quality evidence-based research studies have been conducted to show that responsive and sensitive parenting can have benefits for child development. In the UK the theory of providing sensitive and responsive caregiving also forms the basis of many parenting interventions and is a widely recognised theory utilised in many child development settings.

A recent review by The W.H.O stated that;

> *'Sensitive and responsive caregiving is a requirement for the healthy neurophysiological, physical and psychological development of a child. Sensitivity and responsiveness have been identified as key features of caregiving behaviour related to later positive health and development outcomes in young children.' (4)*

The review continues to explain how a parent who is able to respond appropriately and meet their child's needs in a strong and supportive caregiving relationship has been shown to have many positive effects on a child's overall healthy development. A sensitive and responsive caregiving relationship supports the development of a

child who is physically, intellectually and socially healthy as well as more resilient to the damaging effects of poverty and violence.(4)

Many evidence based studies support this link between sensitive and responsive care with improved child development. Most studies available are of good quality either being case-control studies or observational studies with large cohorts. Most demonstrate the benefits of sensitive and responsive care in improving cognitive, language and psycho-social development both in the short term and over the course of the child's life. Two of the studies found whilst evaluating the literature, which have also been highlighted in reviews completed by the W.H.O. are discussed below in more detail as examples of the type of research that has been conducted into sensitive and responsive care. Both studies were chosen as they were longitudinal observational studies with a long follow up period and large cohort of children from mixed backgrounds.

Landry SH, et al demonstrated how responsive care can impact positively upon a child's cognitive abilities.(32) He observed 283 children at 6 months, 12 months and 24 months as well as at 3 and 4 years. Landry demonstrated that for children whose mothers showed continued responsive parenting they had faster cognitive growth. This was also the case for the 77 preterm children observed within the study.(32)

Responsive and sensitive caregiving can also have a positive impact upon a child's social development.(33,34) One study from the USA found observed 112 mothers with their children at 9 months, 14 months and 22 months.(34) The child's behaviour was assessed using a variety of models and results showed that those parents who were more responsive had all round better social skills and also higher empathy to maternal distress. As well as improving a child's social skills and abilities this and other studies have shown that having responsive and sensitive parents can prevent emotional and behavioural problems into the child's future.(33,34) For preterm children sensitive and responsive parenting has been shown to be particularly important in benefiting long term emotional and behavioural outcomes.(35)

Many further studies were found when reviewing the literature which all demonstrates the benefits of responsive and sensitive care, its impact upon attachment and overall child development. It is clear from the evidence that parents

should be supported in their abilities to demonstrate these skills as it can have a significant impact upon their child's overall development.

Reflective Parenting

Reflective Parenting is a recent popular concept in early child development. Developed from Fonagy's theory of 'Reflective Functioning', which described the human capacity to understand humans' behaviour, despite underlying mental states and intentions, reflective parenting, is when a mother demonstrates reflective functioning in their caregiving style and has the ability to hold their child in mind. They understand that their child too has their own thoughts and feelings. Research has shown that when a parent has the ability to demonstrate this reflective functioning it strengthens the child-parent relationship, particularly in terms of attachment.

Prior to reviewing the literature available to support Fonagy's theory, it is important to understand how reflective functioning is measured. As Ainsworth developed the Strange Situation to measure Bowlby's Attachment Theory, Pater Fonagy's initial research team based at the Anna Freud Institute in London have also developed various tools to measure reflective functioning.

The 'Reflective Functioning Scale' [RF Scale] emerged out of previous research on the 'Adult Attachment Interview' [AAI], where an adult's capacity to reflect on their own parents mental states in attachment situations were assessed.(25) There has been some validation of the relationship between the AAI and the RF Scale, demonstrating the RF scale to be a strong predictor of attachment and security.(36) Further to this, the same team developed the AMBIANCE measure to evaluate the relationship between reflective functioning and infant attachment.(37) A low AMBIANCE score indicates a good ability to demonstrate reflective functioning and inversely a high score shows a person is not as capable at demonstrating reflective functioning, thus impacting upon a child's attachment. More recently and further to Fonagy's work Slade adapted the RF Scale to make it more appropriate for use with parents when scoring reflective functioning; The Parent Development Interview [PDI]. (37) All these tools have been developed by researchers at the Anna Freud Institute and as yet

there is little validation of these today from outside of this research team. Almost all studies found in this literature review utilise these tools and so the validity of the reflective functioning measurement tools is an important consideration we must take into account when determining the strength of evidence.

Limited research was found to demonstrate the link between reflective functioning and the impact this may have on a child's development. These studies, as well as the variety of measurement tools created to measure reflective functioning have largely originated from members of Fonagy's initial research team. Few of the studies found are comparable due to the variety of methods used to measure reflective functioning as well as the use of different tools to measure attachment.(38) I felt it was important to look at these studies in some detail in order to gain a better understanding of how reflective parenting can impact upon child development, especially as the theory is being adapted by child care professionals in Merseyside at this time.

A small scale study by Slade et al, used the PDI to explore a link between 40 expectant mother's state of mind and positive attachment with their infants at one year.(38) It was concluded that good parental reflective functioning (as measured by the PDI) was linked to the strength of attachment in adult and child as well as the quality of the parental interactions with their child, thus impacting upon that child's developmental potential.(38) Another study used a cohort of 45 mothers to understand the link between reflective functioning using the AMBIANCE score and Ainsworth's strange situation as measurement tools.(39) Those who scored a low AMBIANCE score (high reflective functioning) were significantly more likely to demonstrate a secure attachment with their 10-14 month olds and respectively those with a high AMBIANCE score (low reflective functioning) were likely to demonstrate a more disorganised attachment.(39) The number of participants in both of these studies was small and it is not clear if any other cofounders may have influenced the results such as socio-economic status, maternal health, age of the mother. Both studies did demonstrate that parents who have good reflective functioning can positively impact upon a child's attachment.

Some studies have also investigated the impact reflective parenting can have upon a parent's ability to demonstrate responsive and sensitive care. Slade et al, concludes that there is strong evidence to support the idea that a parents ability to mentalise

(demonstrate reflective functioning) plays an important part in their ability to provide care and comfort to a child. These conclusions were drawn from one small scale cohort study of 40 participants.(38) A more recent study of 21 mothers looked into the relationship between a parent's reflective functioning and their ability to tolerate infant distress. This used a 'Parenting Reflective Functioning Questionnaire' to score reflective functioning and a simulated situation to measure parental tolerance.(40) A baby simulator was used to produce a controlled cry which would only cease when the mother demonstrated appropriate soothing as defined by the observer. Those mothers who persisted longer with soothing the child demonstrated higher scores in the questionnaire (higher capacity to demonstrate reflective function).(40) This study suggests that parents who demonstrate higher levels of reflective functioning are more likely to persist with providing responsive and sensitive care and shows a possible link between the two parenting concepts.

Fonagy investigated the role of reflective functioning in 'buffering' maternal childhood depravation.(36) Using his original research group Fonagy compared the reflective functioning and consequent infant attachment within groups of mothers who had high levels of deprivation as children to those with low levels of deprivation. Within the 'non-deprivation' group, of those that demonstrated high reflective functioning, 79% had securely attached children. This compared to 42% of those who demonstrated low reflective functioning abilities.(36) Results were even more conclusive in the 'high levels of deprivation' group where 100% of those who showed high reflective functioning demonstrated a secure attachment with their child compared to only 6% of those with low reflective functioning scores.(36) The numbers within each cohort was small (the largest group containing 39 participants) however the results are statistically significant when comparing each group and suggest that reflective functioning may have an important role in assisting those with high levels of deprivation as a child, to form a secure attachment with their child.(36) Although completed on a small cohort these results could be of particular interest within Merseyside where childhood deprivation levels are higher than the national average for many decades.

Despite most research being conducted by related research teams, there is some strength in their evidence, particularly in their use of validated tools to measure attachment. Although it is harder to compare the studies due to different outcomes

measured, all draw upon similar conclusions in that parents demonstrating good reflective functioning are able to build a secure attachment which can consequently impact upon child development. Fonagy's exploration of the link between reflective functioning and the 'buffering' of social depravation may also have particular significance in places such as Merseyside where many children are growing up in social poverty. Further research would be required to draw to more definitive conclusions.

2.2.2. Barriers to a Parent's Natural Caregiving Abilities

In this section I will review the evidence which questions whether the ability to demonstrate responsive, sensitive and reflective caregiving is something that occurs naturally. I will explore the factors which research has suggested may influence a parent's natural caregiving abilities.

There are a number of studies which have concluded that a caregiver's ability to demonstrate sensitive and responsive caregiving is natural. One study investigating natural caregiving abilities conducted in The Netherlands looked at the caregiving in monozygotic twins. This study aimed to establish whether the genetic make-up of adults influences their natural caregiving responses.(41) It evaluated the responses of 184 twins, both parents and non-parents to a simulated cry, which was mechanically altered to represent different urgencies.(41) Participants were asked to report the response they felt was most appropriate to the cry. Results concluded that genetic factors did in fact influence the sensitivity of their responses with monozygotic twins more likely to demonstrate a similar caregiving response.(41) Although other environmental factors may have influenced these results, this study concludes that the ability to demonstrate sensitive and responsive caregiving is genetically influenced and natural.

Whilst developing the RF Scale, Fonagy himself noted that there were great differences between some adults' natural abilities to demonstrate reflective functioning (24). Some further research conducted, explored pregnant mothers' reflective functioning scored before and after birth and suggested that the ability to demonstrate good reflective functioning is natural.(24,38). This is also suggested in a

study evaluating anxiety levels in children. In this study it is noted that mothers naturally demonstrated higher reflective functioning abilities than fathers, researchers suggesting that this could be perhaps due to maternal instinct.(42)

If as the research suggests a parents ability to demonstrate responsive, sensitive or reflective parenting is natural, it leads us to question what benefits there are for the 'universal' parent who can already demonstrate these skills in having additional support from parenting interventions. It also leads me to questions if parental interventions can improve upon this natural responsive, sensitive and reflective caregiving ability parents have or inversely do not have, or is it something that can be taught? It also leads me to question if there are any influential factors in a parent's life that can prevent their natural ability to demonstrate sensitive, responsive and reflective caregiving?

One of the first investigations into the theory that a parent's natural ability can be influenced by external stressors was discussed in Selma Fraiberg's 'Ghosts in the Nursery', 1974.(43) An extract of the paper is shown below;

> *'In every nursery there are ghosts. They are the visitors from the unremembered past of the parents the uninvited guests at the christening.' (43)*

Fraiberg describes that when a child is born, so are the haunted memories of the parents own past and relationships they had with their own parents. It is hypothesised that those parents who had experienced pain and rejection and had consequently reacted to avoid these feelings with denial and isolation, are unable to respond in a positive way to their new-born baby. In her studies this was tested by exploring retrospective histories of both vulnerable and healthy families. It was found that those conflicts observed between current parents and their new-born infant resembled the parent's description of their early childhood; the ghosts of their past were appearing in the present.(43)

Since this work by Fraiberg, the W.H.O has identified many parental influences that can impact upon a parent's natural caregiving ability.(16) High levels of family stress and poor mental health, particularly in situations of extreme poverty have been shown to impair the parent-child relationship and result in fewer opportunities for learning experiences in the home. Single parenthood has also been shown to have a

high association with depression and result in a poor parent-child relationship.(16) These are important factors when considering a parent's natural caregiving ability, especially in a city like Liverpool where social depravation is high and there are many single families.(16) Some psychologists have suggested that everyday stresses resulting in intrapersonal crises and the modern culture of overloading parents with information, can inhibit a parent's ability to mentalise and maintain their reflective functioning.(44) These factors, along with the overall stress that having a new-born baby can bring, are all important factors when we consider the needs and role of parenting interventions.

2.2.3. The Benefits of Parenting Interventions

In this section of the review, I will explore the evidence for the use of interventions in supporting parents in their responsive and sensitive caregiving within the context of the UK, Europe and America. I will also review the evidence for the newer parenting interventions, designed to support parents specifically with their reflective parenting.

'The Abecedarian Project' has for the past 40 years been looking at the effects of a randomised control trial conducted on 111 children born between 1972 and 1977.(45) Children were randomly assigned to the control group or intervention group where they received intensive, full time educational intervention from infancy to 5 years old. Although this intervention purely targets 'at risk' children of North Carolina, United States of America [USA], it is one of the only on-going trials to continually follow its cohort and the effects the parental intervention has had, throughout their adult lives.(45) Therefore its results are worth noting when considering the overall benefits of parenting interventions.

Now aged 40 years the children of the 'Abecedarian Project' who received the parenting intervention have been shown to have statistically significant higher intelligent levels, are more likely to have attended further education and hold down a job throughout adulthood, when compared to their peers.(45) They were also less likely to demonstrate symptoms of depression, drug use and have teenage

pregnancies. The most interesting results came as part of the follow up at age 35 years where those in the intervention group had fewer measurable risk factors for coronary heart disease (hypertension, obesity and metabolic syndrome).(45) Although there may be many additional factors which have led to these most recent results, it is still interesting to see the possible longitudinal effects a parenting intervention in the first few years of life can have well into adult life.

Like that of 'The Abecedarian Project', it was clear that upon completion of this review that the majority of studies investigating the use of parenting interventions are conducted using specific interventions targeted toward a specific cohort of parents. 'Targeted parents' are those whose child has a specific disease or behavioural concern. When reviewing the evidence it was hard to isolate research focused on the 'universal parent' who didn't have any risk factors or specific concerns but who just required general parenting support. Only three reports were found to evaluate the more general picture of parenting interventions, one meta-analysis which included 70 studies with various cohorts of targeted and universal caregivers, one literature review and one case-control study.

The meta-analysis drew conclusions about the impact parenting interventions have upon parental sensitivity and responsivity as well as drawing conclusions as to the optimum length of time over which interventions are delivered.(46) It looked at data from over 7,939 participants who were evaluated for sensitivity and 1,503 for responsiveness. Participants of the interventions were from a variety of socio-economic backgrounds and the interventions themselves were targeted to different caregivers and children, or aimed universally at all parents.(46) Researchers concluded that most interventions were targeted to a specific problem within families and these targeted interventions were more effective at improving responsiveness and sensitivity in parents when compared to the universal interventions. They also concluded that the interventions that had a 'moderate' number of sessions, lasting a few weeks or months only, were more effective than shorter interventions or those that lasted many months. One reason thought for this was that those parents with multiple problems lost interest over many months.(46)

A more recent literature review also looked at the impact of parental interventions on responsive parenting.(47) Researchers found 13 trials, some of which had been

included in the meta-analysis. Within the review the cohorts of the studies included children of less than 3 years old and the studies investigated a mixture of targeted and universal interventions. Of these trials 75% demonstrated improved parenting skills, specifically responsiveness and 34% showed that these effects were long-term.(47) These positive results were limited to those studies aimed at targeted populations. There was little evidence for the effect of universal interventions on parental responsivity, although some positive outcomes where discussed such as parents maintaining positive parenting.(47)

Although the meta-analysis concluded that parenting interventions taking place over a moderate length of time were more effective, one recent case-control study looked at the long term impact of a brief 2 hour parenting intervention.(48) 66 mothers and 1 father were randomly assigned to either a 2 hour parenting group intervention, where they were taught general parenting strategies or a control group who were placed on a waiting list for the intervention.(48) Both groups reported back to researchers immediately following the intervention and 6 months post intervention. Those parents who had taken part in the programme reported a decrease in behaviour problems and increased parenting experience compared to the control group.(48)

In terms of sensitive and responsive caregiving, the evidence therefore suggests that parenting interventions can have significant positive impacts upon parents' caregiving abilities when targeted to a parent's specific needs. For universal parents who have fewer significant needs compared to those attending targeted interventions and are looking for more general parenting support, the impact parental interventions have on sensitive and responsive care is not as well researched and documented. This therefore leads us to question how universal parents are supported in their sensitive and responsive care if parenting interventions are not always effective.

Evidence was found for one specific parenting intervention with the aim of improving parents' reflective functioning capacity and reflective parenting skills. Developed at the University of Warwick as part of the Peep Early Educational Partnership [PEEP], antenatal PEEP aims to improve a parent's reflective capacity.(26) This group have conducted their own small case-control study comparing 25 parents on their parenting programme in Oxford, UK, with 25 parents (matched for socio-economic status) who did not attend the programme.(26) Using

the PDI as a tool to measure the outcome, initial results demonstrated that parents' reflective capacity had improved at the end of programme and that parents were also demonstrating more sensitive parenting, measured using the CARE index.(26) This is not however the programme currently being adopted in Merseyside.

Although there is some evidence to suggest that a person's parenting ability is natural, with the help of parental interventions or programmes a parent can improve upon their ability to demonstrate responsive, sensitive and reflective caregiving. As 'The Abecedarian Project' has shown, targeted interventions can have real long term benefits for future childhood development and into the child's adult life. The benefits of universal interventions is however not as clear with some research suggesting that parenting interventions can have some positive benefits to improving a parent's ability to demonstrate sensitive, responsive and reflective caregiving in the universal parent, however at this time the evidence is very limited and not well supported.

2.3. Parental Support in the UK and Merseyside

The key statutory services available to support all parents in England are outlined in the most recent government policy, the '2010-2015: Children's Health Policy'. This policy outlines precisely which government services and support should be available for all parents throughout the UK. Within this evidence-based document there are also a variety of actions that should have been undertaken and implemented by 2015 by the local health authorities and government bodies, these include: (15)

- Improving maternity care.
- Helping parents to keep their children healthy through the 'Healthy Child Policy'.
- Encourage healthy living through NHS services.
- Improve the health visiting service.
- Protecting children through immunisation.
- Supporting mothers and children with mental health problems.
- Improving chances of children with vulnerable mothers through the Family Nurse Partnership.

The ‘Healthy Child Policy’ was introduced in 2005 by the previous Labour government and has been updated at various points over the preceding 5 years. It focuses on how all parents should be supported throughout pregnancy and the first 5 years of a child’s life.(11) It promotes overall healthy wellbeing as well as promoting breastfeeding, immunisation uptake and sensitive caregiving to improve a child’s development. When looking in more detail at the recommendations for improving a child’s development it relies on Health Visitors and children’s centre staff to encourage parents to read books, use music and engage in various parenting programmes.(11) It recommends PEEP parenting programmes for universal parents. For those parents with additional needs it recommends programmes such as Triple P and the Family Nurse Partnership. Interestingly, PEEP is not included in the National Academy for Parenting Research’s database as a UK recommended parenting intervention.(14) This database has been developed since these government policies were produced so the reasons for its exclusion are not clear. This policy was first produced over 10 years ago and its most recent update was 6 years ago so some evidence for the policies and recommendations have changed.

For this section of the review I will explore each action outlined in the government’s policy in more detail to understand the structure and type of support all parents of a child less than 2 years old in Liverpool in 2015 should be receiving. I have focused on the support that is encouraged to be available to all parents within this document; Midwives, Health Visitors and children’s centres. I have also discussed the Family Nurse Partnership. It is restricted to those who are less than 19 years of age, but is available to all young parents of Liverpool. Although in reality, those more ‘at risk’ are chosen to be a part of the programme due to limited resources. I will also discuss the online government database set up by the National Academy for Parenting Research which outlines the range of parenting programmes available throughout the UK.

2.3.1. Midwives

The first action outlined by the government policy was that of improving the midwifery service. Their role is outlined as follows,

> *'Across the United Kingdom Midwives are key professionals in ensuring that women have a safe and emotionally satisfying experience during their pregnancy, childbirth and postnatal period.' (49)*

Following the initial publication of this report a review of the midwifery services was undertaken; 'Midwifery 2020: Delivering expectations'. This report outlines a vision of a cost-effective and quality service to be delivered to new and expectant mothers across the UK by 2020.(49)

All parents in Liverpool will have access to support and advice from Midwives. Although the majority of a Midwife's role is during the antenatal period, they are also there to support the mother and baby for the first 10 days of life and in some cases throughout the 28 day postnatal period.(50) During this time they are there to provide the mother with important advice regarding parenting as well as breastfeeding guidance, screening and surveillance of the new born.(49) The encouragement of breastfeeding is a particularly important role as government policies and UK wide campaigns clearly state the evidence to promote breastfeeding as the best form of infant feeding and uptake rates in cities such as Liverpool are extremely low.(6)

2.3.2. Health Visitors

As part of the healthy child programme within the UK, Health Visitors have been expected to play a key role in offering parental support and advice regarding developmental stimulation, as well as ensuring the child is growing up in a secure environment where they can truly reach their developmental potential. They are also expected to conduct child surveillance and screening programmes, particularly for hearing, vision, growth and child development in all children from birth to 5 years. Along-side their Children's Health Policy, the 'Health Visitor Implementation Plan'

was introduced by the government with the aim of coming into full effect by May 2015.(51) It pledged to commit an extra 4,200 Health Visitors and develop a new more accessible health visiting service. The service it pledged to provide to parents is outlined out-lined below; (51)

1. 'Your community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health Visitors work to develop these and make sure you know about them.'
2. 'Universal services from your Health Visitor and team provide the Healthy Child Programme to ensure a healthy start for your children and family (for example immunisations, health and development checks, support for parents and access to a range of community services/resources.'
3. 'Universal plus gives you a rapid response from your Health Visitor team when you need specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.'
4. 'Universal partnership plus provides ongoing support from your Health Visitor team plus a range of local services working together and with you, to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and where appropriate the Family Nurse Partnership.'

The government have outlined five universal reviews at which point all children in the UK, including those in Liverpool will be seen by the Health Visitor during the first 18 months of a child's life. This will come into effect when the service provisions are transferred to the local commissioners in October 2015. They are as follows; (52)

1. During the antenatal period.
2. As a new baby around 10 days old.
3. Between 6-8 weeks.
4. Between 9-12 months.
5. A developmental assessment between 2-2 ½ years.

2.3.3. Sure Start Children's Centres

Many parenting interventions, support groups and Health Visitor drop in clinics are run from children's centres in Merseyside. Originally these were opened as Sure Start Children's Centres, first introduced in 1998 by the then Chancellor of the Exchequer, Gordon Brown as a support programme for parents from pregnancy to school age. The core free services that the Sure Start Centres across the country must provide include: (53)

- Outreach and home visiting.
- Support to families and parents.
- Primary and community healthcare and advice.
- Support for good quality play, learning and childcare experiences for children, both group and home-based.
- Support for speech, language and communication.
- Support for all children in the community, recognising their differing needs.

Within Liverpool there are 17 core centres as well as 9 additional centres which provide children's centre services.(54) This means the parents of Liverpool do not need to travel more than a few miles to reach their local centre. In order to provide the core services they hold a series of drop in sessions throughout the week, which have been developed by the fully trained staff in line with child developmental theories which include those to improve attachment and responsive parenting. Across Liverpool each centre offers a similar service to their parents. For example they all offer an opportunity to meet with a Health Visitor and have your child weighed. Some sessions have however been developed specifically to appeal to the parents and their needs within the locality of the centre. Some (Dingle Lane and Wavertree) are also able to utilise nearby council facilities and provide swimming sessions. Kirkby is the only children's centre in Merseyside which run's a specific course that promotes ideals of reflective functioning and is currently invitation only for those more vulnerable parents.

In January 2015 it was announced that the Liverpool City Council would be reducing the services provided by the Sure Start Centres from 17 centres to 7 due to

government cuts, with the intention of local schools taking over the facilities and running of some services.(55) It was opened up to public consultation and parents and staff reacted strongly to the proposed cuts. In March 2015 the Mayor of Liverpool announced that there would be no cuts to the services provided, but there would be no further funding for the centres for the next two years; they will have to remain open with the resources they currently have. With these recent decisions regarding funding it is likely that the services provided at each centre will be set to change in the near future.

A longitudinal research study evaluating the impact and overall effectiveness of Sure Start Centres was completed between 2001 and 2012 by Birkbeck University. (56) The study used a mixed methods approach with surveys completed in relation to all 260 children's centres in the UK, as well as with interviews completed at 26 chosen children's centres. It also compared children who had attended Sure Start Centres to those who did not.(57) Upon completion of the study statistically significant outcomes were found in 4 out of the 15 outcomes measured. For all mothers who attended Sure Start local programmes it was found that they were engaging in less harsh discipline of their child and providing a more stimulating home learning environment for their children. When evaluating specific 'sub populations' parents who had attended, Sure Start local programmes provided children with a less chaotic home environment for boys (no significance for girls) and they themselves had better life satisfaction (for lone parents and workless households only).(58) The results did not however show any significant improvement in the developmental assessment tests when children started school. These results show that Sure Start Centres can have a positive impact upon factors associated with child development (home environment, stimulation and less harsh discipline) but in this study, no actual impact upon child development. The report states that there were many methodological challenges faced throughout the course of the study, such as two different research teams used over the two year period, which could have impacted upon the results.(58)

A review of 121 English Sure Start Centres in 2012 showed that centres were aiming to provide services with greater outreach to parents with specific needs or who were seen as more vulnerable, rather than those more universal parents.(56) This could make the centre less attractive to the universal parents and therefore leads me to

question where do they go to for support if children's centres are not offering a universal service?

2.3.4. The Family Nurse Partnership

The Family Nurse Partnership [FNP] is well established and available to those who meet the qualifying criteria within Merseyside. The FNP is aimed at first-time expectant mothers aged less than 19 years.(14) Fathers are only allowed to participate with the permission of the mothers.(59) It is an individual home-based intervention lead by trained family nurses with the aim of improving parent wellbeing through advice and support across the following domains; personal health, environmental health, life course development, maternal role, friends and family, health and human services and pregnancy advice.(59) The intervention is delivered from 16 to 28 weeks gestation and continues until the child's second birthday.(59) This is a well-established intervention in the USA which has good evidence from many randomised trials involving high numbers of participants, up to 730 in one case and all with long follow-up periods demonstrating its effectiveness. (60-62) These trials have reported significant outcomes for those children whose parents have been involved with the FNP, which include less chance of suffering neglect, less chance of future substance misuse and future arrests of convictions. For the parents enrolled in the programme, fewer subsequent births and increased wellbeing.(60-62) In the UK there is a randomised trial currently being completed across 18 sites in the UK and involving 1,645 women but as of yet the only evaluation of the FNP complete so far in the UK looked at the data collected from a study investigating the prevention of maltreatment in Surrey.(59,63) Although preventing maltreatment in children is one of many aims of the FNP, it is an important one and the analysis by the research team concludes that despite a proposed increase of over 250 more trained family nurses to implement this programme almost double would be required to provide this service to all of those that are eligible.(63) The 'Nursing Standard', published a report prior to this analysis and states that by 2015 there will be 800 more fully trained FNP staff available to implement the intervention, describing it as the 'Rolls Royce of Family Interventions' (64) Overall the Family Nurse Partnership has some positive evidence

supporting its implementation in the UK, but the results of the upcoming trial will hopefully confirm that further.

2.3.5. National Academy for Parenting Research

In the UK there is a large amount of support available in the form of publically and privately run parenting programmes in addition to those outlined in the 'Healthy Child Policy'. In 2007 the Department of Education recognised the need to ensure that 'practitioners are aware of and applying evidence based parenting research to their everyday practice when working with children, parents and carers'. They consequently funded the National Academy for Parenting Research [NAPR].(65,66) This was a collaboration between the Family and Parenting Institute, Parenting UK and King's College London. Professor Stephan Scott and his research team spent 5 years evaluating the evidence base of parenting interventions available in the UK, producing the Department for Education 'Commissioning Toolkit and Parenting Programme Evaluation Tool'.(66) The aim of this toolkit was to aid parents and professionals in making decisions about which parenting interventions will benefit them best.(66) They evaluated the following aspects when making their decision about the effectiveness of parental interventions; (66)

1. Which parenting interventions have been proven to work – the evidence of them.
2. The parenting styles that meet children's and family's needs.
3. How services are best delivered.
4. Cost-effectiveness.

Parenting interventions were rated using a simple star rating, 1-4 stars, against standards of best practice using the following four domains; (66)

1. The specificity of the programme's target population (who is it for?).
2. The programme's theories and activities (what does it do?).
3. The programme's training and implementation support systems (who delivers the programmes and how?).

4. The strength of the programme's evaluation evidence (how we know the programme works?).

This makes the toolkit an easy and useful online database aiding both parents, health-care professionals and commissioners in quickly reviewing the parenting interventions available for a specific age-range, or specific cohort of children as well as being able to assess the quality of the programme based on its star rating.

The NAPR recommends 13 interventions to children aged 2 years and younger. These were evaluated by myself and results put into a table using the following headings Intervention; Cohort; Universal; Group/Individual; Delivered by; Ages; UK Wide; Duration; NAPR evidence rating which can be found in Appendix A. Of the 13 interventions recommended by the NAPR, 4 are offered universally to all caregivers, one of which is for first time parents only and the remaining were targeted to a specific population. Of those that were offered universally only two claim to be offered throughout the UK, Primary Care Triple P and Nought to Sixes. Having searched many sources for information about these programmes in Merseyside, there is no evidence that either of these two programmes are available in the region.

From the evidence provided through the NAPR as well as that from database searches it is clear that most interventions have good or promising evidence, if they are targeted at specific cohorts. The universal interventions on the other hand, showed limited evidence supporting their effectiveness. It could be argued that without external stressors such as deprivation, family breakdown or illness parents already have a natural ability to demonstrate these qualities and there is no requirement for a long term parenting intervention or programme to provide the additional support. All parents do have times when there will be a need for additional support and this still leads me to question where and to whom they are going to for this support. Are the government services provided sufficient in supporting parents or are they dependent on other sources of help and support such as family and friends?

2.4. The Value of Support to Parents

It is clear that government policies have promoted wide ranging support to parents and that there is evidence to show that this support is beneficial in improving parenting outcomes. In order for people to engage in these services, these services must reach the felt and expressed needs of the population they are trying to serve. This section of the review therefore aims to evaluate the evidence that is available to show what support parents actually value and how the support is best delivered in the eyes of the parents themselves. I will firstly explore the evidence available for each government service previously outlined. I will then look at the evidence to show why parents choose to engage in particular services and what the barriers may be to prevent them from using the support available, such as the format it is delivered in. I will also try to establish what type of support parent's value most.

2.4.1. Parental Views on Government Services

Midwives:

Overall there is limited evidence that wholly explores a mother's experiences of Midwives' support, especially during the postnatal period in the UK. One small scale observational study conducted in a 'typical UK maternity ward' concluded that environmental and working conditions, such as short staffing and time restrictions, acted as a barrier to the implementation of breastfeeding interventions.(67) This study was observational, researchers did not seek the opinions of the Midwives or parents themselves and observation was only conducted on one ward. It is however well known that many wards are understaffed in the UK and there are increasing workloads for Midwives, so the results of this very recent study may portray a similar picture throughout the UK, although not fully addressing parents' views.

One study was found to explore the opinions of mother's experience of the midwifery service. This was a qualitative study, in which 28 obese mothers in Scotland participated in semi-structured interviews. (68) Data analysis concluded that Midwives should be more mindful of the additional factors that obese mothers

may require when receiving care from Midwives. This study did not compare its results to non-obese mothers.(68)

Health Visitors:

A literature review completed in 2015 aimed to examine the public health benefits of health visiting and within this also explored how these services can reduce health inequalities and the effects a Health Visitor can have upon a parent's engagement in services.(69) It evaluated 348 studies, most published since 2004, and compared the results to the ideals of the Healthy Child Policy.(69) The results showed that when Health Visitors are able to identify the needs of their parents appropriately, across a universal caseload, they have an important role in making parents aware of services available when previously they may not have engaged. Evidence also showed that Health Visitors enable parents to have more confidence about their child's development. These studies drew the conclusions that parents are more likely to open up when the visits take place in their own home. Furthermore if they are able to build a good relationship with their Health Visitor parents are more likely to contact them in the future.(69)The author of this review makes many assumptions of how parents feel about the services with limited studies available to support these opinions.

Another study found was from Merseyside, which explored the perceived barriers to health and wellbeing amongst European migrant families based in Liverpool. (70) It used interviews to explore Health Visitors' views, although not the opinions of the service users themselves. The Health Visitors discussed with the researchers the importance of their role in identifying vulnerability especially among low socio-economic families.(70)

Children Centres:

One study exploring caregiver's views of children's centres was found. (71) This qualitative study explored the perceived benefits of the encounters between ethnic minorities, migrants and the white population within children's centres. It found that

migrant parents valued the opportunity to improve their English. An additional benefit not found amongst the white English –speaking population. Conclusions were also drawn discussing the opportunities children's centres gave migrants, to experience encounters amongst the local community.(71)

2.4.2. Why Parents Engage in Support Services

One literature review and one case control study were found exploring why parents chose to participate in parenting interventions. Out of 12 studies included in the literature review, 5 were from the UK, most using qualitative methods of data collection.(72) In 10 out of the 12 studies results showed that when an intervention was targeted it had a much better uptake response from parents.(72) This is perhaps one reason the majority of NAPR recommended interventions are targeted programmes. The review also stated that 50% of studies found the most effective form of recruitment was through other parent's recommendations (word of mouth).(72) A case-control study in Australia suggests a different trend when it came to recommending interventions. They used questionnaires to compare parent's testimonials and resultant uptake, to expert testimonials in 70 parents attending a Triple P parenting intervention.(73) Results were not statistically significant; however the trend was towards that of favouring the expert opinion when choosing to participate in the intervention over that opinion other parents.(73) Thus the evidence is so far limited, as to what influences a parents' decision to participate in parenting interventions.

2.4.3. The Type of Support Parents' Value

Parenting interventions are delivered in a number of different ways which could appeal or not appeal to those who wish to take part. In the UK over 26 million homes have a TV licence and a million more have an internet broadband connection.(74) There is potentially a large market for media and internet based parenting interventions. Most government recommended interventions and children's

centre groups are however face-to-face programmes with a facilitator. There are some programmes which can or have the potential to be provided universally in the UK for parents either though internet based forums or NHS websites. This also includes the Triple P Parenting Programme, available through videos and internet programmes at a cost. Research in the USA has explored parental views on how parenting interventions are delivered in an ethnically diverse sample of 162 parents of 3-6 year olds.(75) The strongest preference was towards self-administered delivery formats such as televisions, online programmes and written materials. The least preferred formats were home visits, therapists and multi-week parenting groups.(75) A feasibility study also based in the USA looked at the experience of parents using a web-based parenting intervention.(76) As part of their literature review researchers had concluded that overall mothers showed higher engagements to web-based interventions and also showed greater satisfaction when using them.(76) No UK based studies could be found, however the NHS along with many UK based privately run websites have dedicated sections to parenting advice suggesting there is a large interest from the parents of the UK. There are many forums on social media and from observing the activity on these sites it appears that many parents, mothers especially, use these as a source of advice and support. The use of technology could however remove the face to face contact and engagement that attending a parental intervention in a children's centre provides.

The 'Zero to Three survey' completed in the USA explored where parents go to get advice and support.(77) They evaluated a large cohort of 1,615 parents of children aged 0 to 3 years from a wide range of ethnic and social backgrounds. Results showed that the way parents were raised themselves and their religious backgrounds were the most powerful influences on parenting, ranking higher than professional input.(77) There are many similarities between the USA and the UK and results could suggest that family may be an important factor in influencing parenting decisions in the UK also. Unfortunately no evidence from the UK could be found to support this theory.

2.5. Conclusions

Over many years many psychologists and clinicians have developed theories of childhood development. These include theories relating to the parent child giver relationship with theories of attachment as well as theories of cognitive development and theories of social development. Many of these theories demonstrate how childhood development can be effected by the primary caregivers. The works of Bowlby and Ainsworth have been particularly important in the development of the concept of sensitive and responsive caregiving, which impacts positively on child's attachment. Further to this, newer concepts are being developed including the work of Fonagy and his theory of reflective functioning.

When evaluating why a parent may need support, it is clear that there is a strong evidence base to show the positive link between sensitive and responsive caregiving approaches and the overall development of the child. Parents must be supported in their ability to demonstrate these skills. Upon completion of this review it is also clear that reflective parenting appears to demonstrate some promising links with child attachment and a parent's ability to demonstrate responsive and sensitive caregiving. The evidence to support this is somewhat limited to that conducted by the initial research team and it will be interesting to see if further research in this area is carried out in the future as more counties like Merseyside adopt reflective parenting into their parenting programmes.

There is some evidence to suggest that sensitive, responsive and reflective caregiving could all occur naturally. Although having a new born baby can be a stressful time on top of which everyday modern day stressors will impact a parents caregiving abilities and all parents will at some point require some form of additional support or advice. Sensitive, responsive and reflective parenting are important concepts and when a parent's natural ability is influenced negatively by external factors, support may be needed. Parental interventions can be used to improve upon these skills and have been shown to have a positive impact for improving a parent's sensitive, responsive and reflective caregiving when targeted to parent's specific needs. There is limited evidence to demonstrate their effectiveness when designed for the universal parent.

The type of support available in the UK and Merseyside outlined in government policy involves specific early childcare support from Midwives, Health Visitors and children's centres. The National Association of Parenting Research also provides a database to aid commissioners and parents in finding parental interventions specific to their child's age and needs and highlights programmes such as the Family Nurse Partnership which should be available to all parents across the UK. However for those universal parents in Merseyside it is not clear if any of these parenting interventions are easily available as internet searches suggests that they are not always provided. This consequently leads me to question, who do parents turn to for additional parenting support, are government services enough, do they use the internet or are they turning to friends and family for advice and support?

When establishing what type support parent's value evidence is limited and focuses on particular services rather than the general picture of parenting support. Very few studies were also found to evaluate general opinions of parents in the UK, exploring why they need support, where they go for support and what they think about the support they receive.

The questions that have emerged from the literature review now lead me to the aims of my study:

> *To understand how caregivers from different backgrounds in Merseyside know and learn to be responsive, sensitive and reflective to their babies. Where they go to for support and what services do they value.*

In order to achieve this aim the following objectives have also been set:

> *A: To understand through caregivers experiences why they require support with their responsive, sensitive and reflective care.*
>
> *B: To understand through caregivers perspectives how they are being supported with their responsive, sensitive and reflective care.*
>
> *C: To understand through caregivers opinions what they value when being supported with their responsive, sensitive and reflective care.*

Chapter Three

Qualitative Methodology

Qualitative Research Methods in the Context of the Research Proposal

When deciding upon the research methods for this project it was important to pick an appropriate technique in order to fully address the aims of the research question, which were;

> *To understand how caregivers from different backgrounds in Merseyside know and learn to be responsive, sensitive and reflective to their babies. Where they go to for support and what services do they value*.

Qualitative approaches are particularly relevant when exploring the participant's views and opinions. As my literature review has shown, those studies which also attempted to make sense of, or explore the opinions and views of their participants tended to be qualitative in nature or take the form of a survey.

A quantitative survey was considered as a data collection method. Well-designed surveys can be completed quickly by the participants, and can provide a lot of information. However it would be hard to formulate an appropriate survey that encompassed all the possible avenues of support that a parent may use in Merseyside. It would also limit the ability for them to express their true views and opinions in detail.

To undertake this work, a decision has therefore been made to utilise qualitative research methods, as these techniques have been identified as being best for allowing the research team to understand the views and opinions of parents in Merseyside. Within this chapter I will discuss the details and chosen techniques of qualitative methods that will be used in the study. I will first outline the benefits of using this methodology as well as my rationale for utilising the specific methods chosen in my qualitative study. Then I will move on to discuss the approaches used to maintain quality assurance within qualitative studies and for ensuring the validity of my results.

3.1. Qualitative Methodology, Background and Reasons for its Use

Qualitative research originally grew out of naturalistic inquiries conducted in the disciplines of sociology, anthropology, and linguistics and can be defined as a way to 'examine subjective human experiences by using non-statistical methods of analysis'.(78,79) Consequently, this exploration of people's experiences gives the researcher detailed information about a person's opinions, beliefs and decisions in the person's own language.

In comparison to quantitative research, which can also be used to explore people's opinions by assigning them numerical values for statistical analysis, qualitative research provides a much more 'in-depth' approach to gathering descriptive data that cannot so easily be expressed in numerical form. Qualitative research can thus more readily address the 'How' and 'Why' questions.

Qualitative studies are now commonplace in health care, but this has not always been the case. When establishing the hierarchy of the quality of evidence-based research Cochrane assigned qualitative research to the lowest category of 'mere opinion' and this is perhaps one reason why qualitative approaches were viewed with some scepticism initially in the 1960s and 1970s.(80) In the 1990's a team from the University of Manchester embarked on making sure qualitative methodology was recognised as a rigorous research method and would be included in the review of evidence, leading the way in ensuring qualitative research is a recognised research method. Since this time qualitative methods have been used more often and are now commonly printed in the British Medical Journal.(80)

Writing specifically about the healthcare setting, Morse J, suggests that qualitative research 'puts the individual back in the picture' when conducting this type of research. As a result, qualitative findings can not only be put directly back into professional guidelines or political agenda but fundamentally they can impact the people themselves.(80) I therefore chose a qualitative approach to my research to allow real immersion in the experiences of caregivers and gain a true understanding of what advice and support caregivers in Merseyside value, in order to better understand the situation through their own words and experiences. It is hoped that upon completing my study I will be able to 'put the individual back in the picture'

and can advise service providers about the type of service their users value and require in the words of the users themselves.

There are a number of approaches to carrying out qualitative research, depending on the type of research undertaken and which questions the researcher is trying to address. There are many well document designs, Creswell suggests that there are five core design approaches; narrative, phenomenological, grounded theory, ethnographic and case study.(81) Each of these methods has been considered carefully for use in my study, but as King N, warns it can be dangerous to approach each of these methods like a 'cookbook'.(82)

With this in mind, my study will encompass a number of the approaches Creswell outlines.(81) I utilise some aspects of phenomenological methodology using interview techniques and approach the study without any preconceptions. This will enable me to truly explore the views and opinions of caregivers as they themselves perceive it. I will also utilise aspects of ethnographic methodology including the use of purposive sampling to recruit a broad range of caregivers from the Merseyside region. There are also aspects of immersion within the culture as I attend children's centres, speak to Health Visitors and gain a true understanding of what these services are like for the parents who will be participating in my study. This will better inform me as the researcher when deciding upon the themes during analysis. These methodologies and decisions will be discussed in more detail throughout the course of this chapter.

3.2. Data Collection Methods within Qualitative Research

There are many different methodologies for collecting data within the field of qualitative research and careful consideration must be given as to which are the most suitable for the aims and objectives of the study. In the next section I will outline the common approaches for collecting qualitative data and justify why I chose semi-structured interviews and focus group discussions for my study.

3.2.1. Questionnaires

I considered the use of a questionnaire in order to produce qualitative or quantitative data on a large scale. Questionnaires can be an effective way to produce a large amount of data quickly as once consent has been given, little input is required from the researcher and they can be designed to be completed by the participants in minimal time. The questions need to be designed to fully address all aspects of the research aims. To do this some researchers use focus groups prior to designing their questionnaire to identify the important issues and to ensure the language is appropriate for participants.(83)

In the context of my study, I felt that the structured format of a questionnaire would not allow for the free flow of ideas from caregivers and would have resulted in more structured, less in-depth findings. Key limitations of questionnaires relate to issues regarding the influence by preconceptions that researchers may have prior to undertaking their study which can lead to biased and judgemental data collection. Whilst completing a questionnaire you are asking the participant to respond to a structured stimulus and therefore they may not be acting naturally, something that would not be beneficial for my study.(83) A semi-structured interview, however, better allows for the free flow of ideas and for the participant to lead the conversation in the direction they choose.

3.2.2. Observational Techniques

Use of naturally occurring data including observational techniques can be an effective way for the researcher to fully immerse themselves within the culture of their research subjects. Observational techniques include fully immersing yourself in the culture over a long period of time; learning the language and participating in social events. Observational techniques can also involve a ‘lived experience’ on the part of the researcher or observing people in their natural environment. For instance in this context watching children playing with their parents to observe their responsive, sensitive and reflective caregiving skills. It could also involve the use of video diaries created by the participant themselves.(84)

I could have used direct observation to aid the exploration of how caregivers demonstrate responsive, sensitive and reflective caregiving, however this would not have addressed how they are gaining this knowledge and ability and what their views and opinions of the services they use truly are. I did use elements of participation observation as a way to gain a more detailed understanding of what happens within parenting groups at children's centres and to give a more detailed understanding of the support available to caregivers. I will go on to use this contextual information to aid with the analysis of the data. I do not however set out to spend extended periods of time within participant's homes observing their caregiving skills, not only due to ethical reasons but also due to time constraints.

As the main aim of my study is to explore the in-depth opinions and views of a wide range of caregivers within Merseyside, I decided that a series of interviews would be the best approach, used alongside focus group discussions.

3.2.3. Interview Techniques

Interviews are used throughout modern day life to gain the views and opinions of people, whether it is in the media (as shown daily on news broadcasts) or in research settings as proposed here.(82) Interviews, when conducted within qualitative research, often involve an interview between the researcher and one participant in which the discussion is recorded and consequently transcribed and verbatim analysed.

Qualitative interviews can be described as semi-structured, in-depth or narrative.(82,85) Narrative interviews or narrative inquiry as it is also known, assumes that people construct their realities through the narration of their life story.(86) Although I set out to explore how parents come to hold the views and opinions they have of service provisions, narrative inquiry involves building a relationship over a period of time and in a lot of cases re-visiting interviews.(86) Due to the strict time constraints this project has, using narrative interviews would limit the number of potential participants and consequent breadth of data.

In-depth interviews primarily use a small topic guide with one or two open questions which allow the conversation to be taken in a direction determined by the interviewee within one subject area. Probes and prompts can be used to ensure the conversation stays within the realms of the research question, although the direction the conversation takes is very much determined by the participant. In contrast semi-structured interviews will have a more structured topic guide with the use of more closed questions than found in in-depth interviews although still allowing for the free flow of ideas.(85)

The quality of the data collected by interview methods is reliant on the ability of the researcher to stay objective and avoid leading or judgemental questions so the opinions and views of the participant are truly explored. A less structured topic guide can help in insuring the objectivity of the researcher as the conversation is very much determined by the participant and topics they choose to discuss.

I chose semi-structured interviews as an appropriate data collection method in order to address the aims of the study; to explore the opinions and views of where caregivers go to get their support and knowledge. The literature search has shown there are many services and resources available to caregivers to support them during the first 2 years after the birth of their child. By undertaking semi-structured interviews and asking open questions, I hope to allow caregivers to discuss resources that are important to them, but not limit the discussion to one specific service.

3.2.4. Focus Group Discussions

I chose to use focus groups discussions alongside interviews as a way of triangulating the data, since they provide a different dynamic of conversation to that of an interview and thus increases the variety of data.

Focus groups have been used for a number of years and their first recoded use in research was in the 1920s when Bogardus tested his social distance scale.(87) They now have a number of different uses within research, for example in the setting of market research and product development as well as scientific research.(82) Focus group discussions capture the conversations between participants. The data is generated by group interaction where the interviewer effectively ‘eaves drops’ on the

conversation. It can work effectively to increase contribution as people are prompted by experiences of other participants and can challenge each other in a way in which the facilitator cannot.(88) They have a different dynamic to that of a one to one interview and can also encourage those who may not be comfortable with the intimacy of a one to one interview to participate. Like semi-structured interviews, focus group discussions also involve the use of a topic guide to give some structure to proceedings. Other techniques used include asking participants to write down ideas on a flip chart and to discuss different aspects, or rank ideas as a group and discuss their choices.

When conducting a focus group discussion it is important to choose your participants with careful consideration. Do you wish to bring together a diverse range of people or have homogeneity to capitalise on a group's 'shared experiences'? (88) Sampling will be discussed further within this chapter, however when recruiting for the focus group discussions in my study purposive sampling will be used. This will ensure that there is diversity within the group in order to represent the 'universal' parent of Merseyside. The principle of homogeneity will also be used, in that all participants will have the shared experience of being a parent in Merseyside.

Research has shown that focus group discussions should take place in a relaxed and comfortable setting in order to establish the right atmosphere to gain the most from your participants.(88) Sessions are expected to last between an hour and two hours, although could take place over a longer period of time dependent on the aims of the study.(88) As with the number of interviews that are required in a qualitative study (discussed further within this chapter) the ideal number of participants within a focus group discussion is also greatly debated amongst academics. The British Medical Journal for example recommends 4 to 8 participants as the ideal number, however Morgan advises on 6 to 10, as below this number it can be difficult to sustain discussion and above ten it may be difficult to control it.(88,89) The specific sample sizes for both interviews and focus group discussions will be discussed further within this chapter.

3.2.5. Topic Guides

Flexibility is key in qualitative interviewing. The researcher must respond to issues that emerge in the course of the interview, exploring the perspective of the participant and the topic under investigation.(82) Therefore using a typical interview guide of a quantitative survey would be inappropriate; a qualitative 'topic guide' should be use. This topic guide should outline the main topics the researcher wishes to cover but have flexibility in the phrasing of questions and the order in which they are asked to allow participants to lead the interaction in an unanticipated direction, truly exploring the views and opinions of the participants.(82) With this in mind Patton argues that there are six types of questions that can be asked in qualitative interviews, each with the aim of eliciting a specific kind of information from the participant. Patton suggests these should be taken into consideration when designing all topic guides for a study, although not used as strict guidelines; (90)

1. Background/ Demographic Questions; Simple questions about participants' characteristics that can be utilised during analysis.

I will use these at the start of the interview so that the characteristics of the participants can be recorded, not only for the benefit of analysis but also when recruiting to ensure that a 'universal' picture of all caregivers in Merseyside is being established.

2. Experience/Behaviour Questions: These focus on specific actions which the participant could have observed at the time.

For instance questions such as 'what support did you turn to at that time' will be used to establish the support systems the caregivers of Merseyside are utilising.

3. Opinions/Values Questions: Questions to explore what the views and opinions are of the participant within the topic area as well as how their thoughts relate to their values.

These will make up the majority of the questions asked throughout the interview as the aim of my study is to explore the opinions of parents about what the value of the support used by caregivers.

4. Feeling Questions: These focus on participants' emotional experiences, although as Patton warns these must not be confused with opinion questions. For example 'how do you feel about that' can be asked in a loose way to mean 'what is your opinion about that'.

These will be important questions to consider in the topic guide as they will truly explore why parents use the services they do.

5. Knowledge Questions: Exploring the factual information that the participant holds, distinguishing it from their opinions.

Understanding how parents know about services will be important. Questions in this category will help to give a better understanding of why they have come to use publically provided services.

6. Sensory Questions: These explore sensory aspects about experience, such as taste, what the participant has heard, smelled or touched in a given situation.

These are unlikely to feature in the topic guide as they are not relevant to the aims of my study.

Probes and prompts can be used in interviews to aid the interviewer in ensuring the interview stays on track and within the research aims. Probes can be described as 'follow-up' questions to encourage the interviewee to expand upon their initial answer, whereas prompts can be used to help seek clarification from the interviewee.(82) These can be formulated over the course of many interviews as the topic guide will change as you develop your interview technique and establish the depth of information each question is producing.(82)

It is highly advisable to keep adapting and improving the topic guide throughout the course of the study, always bearing in mind your overall aims.(82) The first few interviews will thus inform subsequent interviews. To minimise the effect changing the topic guide will have on analysis, for my study the topic guide was piloted prior to the interview period.

The first draft was piloted with a mother of an 18 month old based in Gloucestershire. I discussed the interview with the research team and made

amendments accordingly, such as the exclusion of some questions and the way in which other questions were worded. Dr Lisa Marsland's influence was vital in aiding this due to her experience in the research area.

The second draft of the topic guide was piloted on two mothers based in Warwickshire. These interviews were fully recorded and transcribed in order to analyse fully the responses. The interviews were reviewed by the research team and the final topic guide for the study was then decided upon.

3.3. Sampling in Qualitative Research

Most qualitative research uses 'non-probability' methods of sampling as compared to probability based methods such as random sampling used in quantitative research.(91) Marshall MN, describes why;

> *"Choosing someone at random to answer a qualitative question would be analogous to randomly asking a passer-by how to repair a broken down car, rather than asking a garage mechanic – the former might have a good stab, but asking the latter is likely to be more productive…"*(91)

If you were to use a probability based approach, you do so in the hope that you represent the population as it stands, whereas using a 'purposive' sampling or 'theoretical' sampling approach you will gain participants from a specific cohort. You will not decide upon your cohort by chance. Purposive sampling has been chosen for my study firstly to ensure that caregivers from 0-2 years are targeted within the Liverpool region and secondly (within this) to ensure a range of caregivers in Merseyside are represented in the study not just those who are all of a certain age or all from a certain area of Liverpool. Alongside this, the concept of 'snowballing' has also been used where participants are asked if they can recommend or know of others like them who may be willing to participate. This can help to increase sample size when recruiting becomes difficult whilst still ensuring you are recruiting participants within your inclusion and exclusion criteria. Participants may be more willing to participate if they do so upon the recommendation of a friend or someone who has participated already, removing some of the barriers to recruitment.(91)

3.3.1. Purposive Sampling

Purposive sampling can be described as the ‘deliberate selection of respondents on the basis of features or characteristics that will enable a detailed understanding of the topic’.(92) Many approaches can be taken within the realm of purposive sampling. Homogenous sampling looks for similarity within the population. In the case of my study I will be looking for homogeneity amongst participants – they are all caregivers of children under the age of 2 years. Heterogeneous sampling conversely looks for participants with characteristics that will differ vastly and not be used in my study.(92) Maximum variation sampling, which documents diverse variations and identifies important common patterns, will also be utilised as I wish to gain variety by having differing ages of caregivers, locations within Merseyside and ages of their children.(86) Other types of purposive sampling involve the use of key informants and experts in their field.(92) This would not be appropriate for my study as it is the views of service-users (the caregivers) that I wish to explore, not those of professionals in charge of services. Some aspects of criterion sampling, where all participants must meet the same set criteria, will be used. For instance participants must be caregivers of a child and they must be able to speak English due to the discursive nature of the interviews. However in criterion sampling participants usually meet more detailed predetermined criteria than this.(86)

3.4. Sample Sizes in Qualitative Research

In quantitative research sample sizes are carefully calculated in order to ensure that enough people are recruited to produce a statistically significant result. In qualitative research however, many factors will influence your sample size. Interviews and focus group discussions take time to complete and this can be a major limiting factor. Budget is also a factor impacting on the time available for a study. In the case of my study the strict deadline of completing the project within the time period of an intercalated medical degree placed limitations on the projected sample size.

Heterogeneity of the research population can also restrict your sample size, as there may be a finite number of people eligible to participate, however this is unlikely to be the case in my study.

In qualitative research one key aim is to reach a point of saturation, where common themes amongst your population are reoccurring. There is dispute amongst researchers as to how many participants are ideally required to reach this point. An article by a qualitative research team at the University of Southampton discussed this with 14 qualitative researchers and the conclusion was that the sample size 'depends' on the research question and any external influencing factors.(93)

As outlined previously for focus group discussions, the recommended number of participants lies between 4 and 10 participants. As only one researcher will be conducting the focus group discussions, the British Medical Journals' recommendation of 4 to 8 participants will be used as a more manageable number than 10 participants with the aim of achieving the upper limit of this range.(88)

As I was unsure how many participants would be required I used a sampling matrix to help me identify the sample size.

3.4.1. Sampling Matrix

This technique involves using a grid to map your main sampling criteria to a number of sub-criteria. It is a useful way to diagrammatically represent your sample size.

I set out to include a broad range of caregiver ages amongst my cohort as this was likely to affect where they would go to for support and so the age of caregivers made up the horizontal element of the table. I also wanted to ensure I was capturing the ethical and socio-economic diversity across the Merseyside region. It was likely that those with a similar socio-economic and ethnic background would live in similar regions of the city and so areas of Liverpool made up the vertical aspect of the grid. The number of participants fitting these criteria were between one and two and the overall sample size calculated from this. This gave a proposed total of 24 semi-structured interviews across 4 regions in Liverpool and 3 focus group discussions each containing 4-8 participants and total sample size of 36-48 participants.

3.5. Population and Selection Criteria in Qualitative Research

Any research study, be it qualitative or quantitative, will have a population from which its participants are selected based upon a selection criterion. The population and the criteria from which it is selected, should be that which provides the most abundant and rich data. When deciding upon the criteria the researcher must consider aspects such as the characteristics of participants, their opinions, experiences or views and can use their literature review or previous experiences to determine their selection criteria.

For my study I wish to ensure that within the population there is a broad range of participants. Within Merseyside, Liverpool is a modern British city with many different ethnicities, socio-economic diversity, broad age ranges of caregivers and a variety of religions and therefore the selection criteria must ensure that all aspects of the population of Merseyside are represented. I therefore decided that the inclusion criteria is anyone who deems themselves to be the primary caregiver of a child less than 2 years old.

This doesn't just limit the sample to the mother of the child but can also include the grandparents, adoptive parents, father or other family member who considers themselves to be the primary caregiver, ensuring the sample is truly representative of modern day British society. The age of less than 2 has been carefully considered as research has shown that the first 2 years of life are critical in the assimilation of attachment between the caregiver and child.(24) It is also the period before which the child is likely to be attending nursery and is therefore still spending the majority of its time with its caregiver.

The only exclusion criteria will be that participants must speak English to a standard in which they can converse. For the focus groups discussions this is vital as the use of a translator would alter the group dynamics and distract from the flow of conversation. This is also true for the one to one interviews where the relationship between the researcher and interviewee may be altered with the addition of translator. It would enhance the study to gain an insight into where and to whom caregivers who are unable to converse in English turn to for support and advice in

Merseyside. However, due to financial restrictions and time limitations which would not allow translators to be trained by the research team, it has been decided that non-English speaking participants will be excluded from the study, although this would be something to consider when planning further research in this area.

3.6. Recruitment in Qualitative Research

The way in which a researcher gains access to a study population can vary from study to study and can be one of the main challenges faced when completing any type of research.(82) Recruitment difficulties can occur because the inclusion and exclusion criteria are strict and the population you wish to recruit from is small. Problems could also arise if the focus of the interviews could be considered emotive and people are unwilling to engage.(82)

For my study the aims are such that there is a large population from which the participants could be recruited. However accessing these participants could be difficult and 'gatekeepers' can be used to aid in these circumstances.(82) A gatekeeper can be used as someone to help with accessing the potential participants. They are someone who has the authority to grant or deny permission and able to facilitate such access due to their professional position or potential relationship with the participants you wish to recruit.(82) In my study Health Visitors and children's centre managers will be approached to act as 'gatekeepers'.

3.7. Recording and Transcription of Qualitative Data

Observational notes, notes on flip charts or audio tape recordings are all methods of transcribing the data collected from interviews and focus groups discussions for analysis. When considering the use of an audio-recorder the researcher must consider the impact this may have upon the interview; for instance, will it make it a too formal setting and will the participant be intimidated by its presence.(82) Having taken this into consideration and exploring other researcher's recording techniques, as with most qualitative interviewing methods I will be using a Dictaphone to record the

interviews and focus group discussions as well as making observational notes if deemed appropriate. The use of a Dictaphone allows me to fully engage in the interview without the distraction of writing as I go. This ensures no words will be missed and a word for word account can be recorded. It will also allow me to become fully engaged in the interview, therefore allowing the opportunity to develop a rapport with the participant and ensure it is an environment in which they will feel comfortable and behave naturally.

Following this, the transcription of the data is an important process of the study and initial stage of analysis. I will undertake this quickly following each interview or focus group discussion so that observations during the interview, such as body language or if their child is present, will not be forgotten. When transcribing audio-recordings, computer programs can be used to slow down the recording making it easier to follow as well as using the 'slow play' setting on the Dictaphone itself.

Transcriptions will be reviewed throughout the study period by the research team to ensure the quality is maintained throughout the study.

3.8. Thematic Content Analysis of Qualitative Data

In thematic content analysis, the aims of the analysis are to identify and consequently analyse common themes that occur within the transcripts. *(82)* A theme can be described as;

> *'...recurrent and distinctive features of participants' accounts, characterising particular perceptions and/or experiences, which the research sees as relevant to the research question.'(82)*

Many researchers have suggested ways to aid with the organisation and the hierarchical relationship of the themes qualitative research will produce. Braun and Clarke suggest two hierarchical levels, whereas in template analysis the data can be coded to four or five levels.(82,89)

One can also use a thematic framework, template analysis or matrix analysis as style of thematic content analysis.

As this will be the first time I have undertaken a qualitative project, I have decided that guidelines offered by King and Horricks, outlined in their book, 'Interviews in Qualitative Research, 2010' and based upon Langdridge and, Braun and Clarke, will be used and adapted as the analysis process is undertaken. (82,89,94). I felt this was a method which suited me well following qualitative research courses I have attended and when comparing it to other methods such as framework analysis. I found myself naturally adapting the methods of King and Horricks when coding the initial practice interviews I undertook and therefore decided upon their methods as a robust way of ensuring common themes are not missed.

This approach involves three stages; (82)

Stage 1: Descriptive coding:

- Reading through the transcript, re-reading and immersing yourself in the data.
- Highlighting any relevant material and attaching brief comments
- Defining descriptive codes.
- Repeating for each transcript and refining descriptive codes as you progress.

Stage 2: Interpretive coding:

- Cluster descriptive codes.
- Interpret meaning of clusters, in relation to research question and disciplinary position.
- Apply interpretive codes to full data set.

Stage 3: Overarching themes:

- Derive key themes for data set as a whole, by considering interpretive themes from theoretical and/or practical stance of project.
- Construct diagrams to represent relationships between levels of coding in the analysis.
- At each stage the process can be checked by all members of the research team to ensure quality within the analysis.

As I become more confident in my analytical abilities it is likely that I may stray from these guidelines and adapt them to form my own approach to qualitative analysis.

It is important to organise the data at each stage of analysis, be it by frequency or importance and the use of computer programs such as NVIVO can aid with this process. NVIVO is a 'computer assisted qualitative data analysis software' which aids with the management and shaping of unstructured information.(95) It therefore enables you to work through your data and assign codes which the software will store, thus allowing you to organise your data in a more structured and easily accessible way.

3.9. Ensuring Quality within Qualitative Research

When deciding upon the quality of qualitative research, considerable debates exist as to whether concepts such as reliability and validity used in quantitative research also apply to qualitative research.(96)

To inform this discussion Lincoln and Guba have produced a translation between quantitative research quality terms and qualitative research; (96,97)

Aspect	**Qualitative Term**	**Quantitative Term**
Truth value	Credibility	Internal Validity
Applicability	Transferability	External Validity or Generalisability
Consistency	Dependability	Reliability
Neutrality	Confirmability	Objectivity

Table 1: Lincoln and Guba's comparison of qualitative and quantitative quality of research terms.(96,97)

Credibility; this evaluates whether or not the representation of the data is endorsed by the views of those with whom the research is conducted

Techniques to ensure credibility include having outside auditors validate findings, peer debriefing, verbatim quotes and analysis of data by more than one researcher.(96)

Ways to ensure credibility in my study will include embedding direct quotes from the transcripts within the results chapter and having the analysis reviewed by all members of the research team, most of which are parents within Liverpool themselves.

Transferability: This evaluates whether the research findings are transferable to other specific settings.

Techniques to ensure transferability include providing details of study participants and recording contextual background information. This provides valuable information that will allow the reader to identify the target groups in the study.(96)

It is hoped that by using universal parents as the study population, representative of all British parents across the UK, mythological techniques and results from the study can be transferred to other cities within the UK.

Dependability: This evaluates the process of the research. Is it logical, traceable, documented clearly and are the methods chosen and decisions made by the researchers appropriate? It also questions if the research could be replicated.

Techniques to ensure dependability include peer review, audit trails and the use of different research methods to look at the topic of research. (96)

As part of ensuring dependability stakeholder consultation groups were held at various points throughout the planning stages of my study and will be discussed in more detail within this section of Chapter four. Focus group discussions and interviews have both been chosen as the methods to provide some triangulation of data to study.

Confirmability: This evaluates the extent to which findings do not pretend to objectivity.

Techniques to ensure confirmability include ensuring the researcher has produced sufficient detail of the process of their data collection as well as reflecting upon each stage of the research process and their role as a researcher. (96)

To ensure confirmability it is hoped the detailed methodology will show each process of the data collection methods. I will also reflect upon completion of each interview and focus group discussion throughout the course of the study period and alter the topic guide accordingly. The role of the researcher will also be considered within this chapter.

3.9.1. Stakeholder Consultation Group

Prior to starting the study I consulted multidisciplinary teams in Merseyside associated with childcare and child development about the methods I proposed to use. I sought the advice and opinions of Sian Barker (Head of Health Visitors for Liverpool) and Hazel Patterson (Head of the children's centres in the region). The decisions which were made as a direct result of these meetings included decisions involving the recruitment process and the use of Health Visitors to aid with this. Sian Barker informed me of how a similar recruiting process had been used before and arranged a meeting with lead Health Visitors of Liverpool in order to discuss the project with them, prior to asking them to assist with recruitment. They also helped by suggesting the use of a postcard to accompany the information leaflet given to participants to make it more appealing and easier for participants to contact the research team. This can be found in Appendix B.

Debi McAndrew, (Manager of Granby children's centre) was invaluable in offering her support in promoting the project throughout the children's centres of Liverpool and was able to discuss the feasibility of offering childcare to participants during the focus group discussions.

A meeting was also held with an expectant mother and children's centre workers in Knowsley, Merseyside. This gave me the opportunity to receive feedback from a potential participant, with whom I discussed the format of the proposed study and trialled questions which may be used in the topic guide. This helped me establish the type of language to use when compiling the topic guide and also if caregivers would be interested in being recruited. Speaking to children centre workers also gave me further insight into not only their roles, but also from their experiences of caregivers in Merseyside any potential barriers to recruitment, such as childcare.

Alongside this, the study design was constantly peer reviewed by the supervisory team.

I also attended a variety of qualitative research courses during the year and this aided me significantly in the design of the project. Details of these can be found in Appendix C.

3.9.2. The Role of the Researcher

Objectivity is an important factor when conducting qualitative interviews as the interviewer must detach themselves from the topic area and allow the participant to freely express their views and opinions.(85)

It is important therefore for me as principle investigator to reflect on my role as a researcher undertaking one to one interviews and facilitating focus group discussions with caregivers across Merseyside. Prior to commencing the interviews I must consider my preconceptions, prior to commencing the interviews, of what it is like to be a parent in Merseyside and ensure I remain objective about the services or experiences discussed. Not being a parent myself and not having grown up in the Merseyside region I am somewhat naïve to what it is like to be a caregiver in Merseyside. However through my experiences as a medical student at the University of Liverpool for the past 4 years I have a good understanding of what services the NHS has in place to support parents and the evidence base behind these, so must ensure I do not let my views and opinions of these services come across during the interviews.

I have also asked health visitors and children's centre staff to aid with my recruitment process and again should not allow this to influence any part of the interviews I undertake.

To help aid the objectivity of the research, the research team will periodically review the interviews I undertake to ensure I am remaining objective; this will also aid the credibility of the research. In order to aid this further I also completed a series of 'practice interviews' and attended a series of qualitative research courses. The courses provided simulated focus group discussions and this helped not only in

refining the topic guide before use, but also to practice and improve upon my own technique based on peer advice.

Within this chapter I have explored the methods of qualitative research and the reasons behind why I have chosen these particular methods in the study. Within the next chapter I will present to the reader how these chosen methods were specifically used as I outline the study's methodology.

Chapter Four

Study Methodology

Can You Tell Me about Your Baby; how do caregivers in Merseyside know and learn to be sensitive, responsive and reflective parents. A qualitative study.

4.1. Background

In the UK 52% of children are not reaching a 'good level' of development and in the city of Liverpool this figure is even lower. Research has shown that the attachment formed between a child and its caregiver impacts upon a child's development especially in the first few years of life. There is much good quality evidence to show that responsive and sensitive caregiving can improve this attachment and this can be supported with the use of parental interventions especially when targeted to parents' specific needs. More recently however newer theories of child development have emerged including Fonagy's concept of 'Reflective Parenting' and the ability to hold the child in mind. There is limited research into this new concept and some research suggests that the ability to 'hold your child in mind' is something that occurs naturally. However factors can prevent a parent's natural ability to demonstrate reflective parenting and parenting interventions have been developed to improve a person's abilities including some in Liverpool. Initial trials are showing successful outcomes in improving parenting skills. As a new concept it is important to investigate it further and explore if parents themselves are aware of their reflective capacity and are demonstrating reflective parenting.

The use of parental interventions to improve parenting outcomes and overall child development is a well-researched area. There is good quality evidence to show that the use of targeted parenting interventions is successful in improving parenting skills. There is however a lack of evidence to support the use of universal interventions and a lack of recognised interventions in the UK, one study also suggesting that children's centres themselves are moving towards these more targeted parenting programmes. The Government in the UK does provide all parents, regardless of need, with access to Midwives, Health Visitors and children centres amongst other services, all based upon evidence-based guidelines. Despite outlining the ideal service they wish to provide in government policies it isn't clear how well these

services are utilised and what parents really think of the services they use. Evidence suggests that family and friends can impact upon parenting decisions, as can the way in which a service is delivered such as face to face, in the home or via technology services. Alongside the government services provided there is also saturation in the market of web based advice and forums available to parents. With all these resources available to parents there is a lack of evidence which evaluates the whole picture, where do universal parents go for help and advice to support them in becoming reflective and responsive parents?

For this present study I therefore aimed to gain a better understanding of how caregivers know to keep their babies in mind, in what way they get this information (e.g. Health Visitors, family members, themselves, books, children's centres) and what the barriers are for mothers in doing so. The longer term objective is to utilise this information to understand what approaches (by whom and where) may be best in terms of providing better advice, information and services for families. It is also hoped that it may provide information on how service providers can package and tailor the programmes already provided within health, particularly with regards to health visiting and children's centres. In my study I aim to speak to parents directly through interviews and focus group discussions in order to explore their views and opinions and I hope that through these methods, I can inform the local authorities of which interventions and resources are benefiting and aiding the parents and children. Consequently I can offer advice on the allocation of resources and interventions used, supporting the government's aim that all children reach the expected level of development by school age.

4.2. Aim

To understand how caregivers from different backgrounds in Merseyside know and learn to be sensitive, responsive and reflective to their babies, where they go for support and what services do they value.

4.3. Objectives

A: To understand through caregivers experiences why they require support with their sensitive, responsive and reflective caregiving.

B: To understand through caregivers perspectives how they are being supported with their sensitive, responsive and reflective care.

C: To understand through caregivers opinions what they value when being supported with their sensitive, responsive and reflective care.

4.4. Study Design

A qualitative study was proposed in order to achieve the aims and fully explore the views and opinions of caregivers in the Merseyside region.

4.5. Sponsorship and Ethical Approval

The study was sponsored by Alder Hey Children's Hospital and affiliated with the Institute of Child Health, University of Liverpool, who provided the funding. The study was approved by the National Health Service Ethics Committee following proportional review on the 17th November 2015.

4.6. Setting

Merseyside, in the North West of England was chosen as the setting for this research project, the main city in this region being Liverpool. The 2011 census reported that Liverpool city and surrounding area had a population of 1,507,000 people.(98) In 2012 there were 5,942 live births in Liverpool city with the main maternity unit for the region being Liverpool Women's Hospital.(8) Children in Liverpool are reaching below target levels of development at age 5years and it is therefore an important

region within which to explore the role of parents and the support they receive further.

4.7. Experimental Design

Semi-structured interviews and focus groups discussions were chosen as the main data collection method.

4.7.1. Sampling Criteria

The inclusion and exclusion criteria were kept very broad in order to allow for maximum recruitment and for the cohort to be representative of all primary caregivers in Merseyside. It was necessary to include the exclusion criteria of non-English speaking due to the discursive nature of the data collection methods.

Inclusion Criteria:

Anyone who considers themselves to be the primary caregiver of any child less than 2 years of age, regardless of relationship to the child and gender.

English speaking.

Aged over 16 years.

Exclusion Criteria:

Non-English speaking caregivers.

4.7.2. Sample Size

No formal sample size was completed due to the qualitative research method. However a purposive sample matrix was used in order to determine the number of participants required and ensure there was a range of participants included in the study.

Using the sampling matrix, 3 focus group discussions (N =12 -24) were aimed to be held, and caregivers from across 4 socio-economic regions of Liverpool (N = 24) used for semi-structured interviews giving a total sample size of 36 – 48 participants. (Table 2)

Location: Liverpool Central	Parents 16-24yrs < 2years	Parents 25-35yrs < 2years	Parents >35yrs < 2yrs	Total
Focus Group 1	1-3	1-3	1-3	4-8
Focus Group 2	1-3	1-3	1-3	4-8
Focus Group 3	1-3	1-3	1-3	4-8
Liverpool area 1	2	2	2	6
Liverpool area 2	2	2	2	6
Liverpool area 3	2	2	2	6
Liverpool area 4	2	2	2	6
Total				36-48

Table 2: Proposed sampling matrix.

4.8. Recruitment and Selection Procedure

4.8.1. Interview Recruitment

Using the sampling matrix as a guide it was proposed that recruitment would be undertaken using the Health Visitors of the Liverpool and Sefton regions of Merseyside. Health Visitors were chosen as ‘gatekeepers’ for the main recruiting method as they have access to every child under 2 years old in Merseyside through their compulsory home visits and ‘weigh-in’ clinics. This would therefore eliminate any bias of recruiting through children’s centres where all participants are likely to already use the children’s centres as a service. It was also proposed that if recruitment methods are unsuccessful or not achieving the required numbers through Health Visitors then children’s centres would be used as a base to recruit potential

participants with the help of children centre staff to act as ‘gatekeepers’. Snowballing techniques were also used to aid recruitment.

4.8.2. Focus Group Discussion Recruitment

It was decided that an initial focus group discussion would be organised with the help of Granby children’s centre, Toxteth, as this is a well-attended children centre attracting parents from across the city, therefore would provide a diverse range of participants. Following this, subsequent focus groups can be organised at other children’s centres across the city with the help of willing children’s centre managers.

4.8.3. Information Leaflets

All potential participants were given a detailed information leaflet outlining the reasons for the study as well as, if they wished to participate, what would be involved in the study. These were handed out to parents by myself, by Health Visitors or children’s centre staff and caregivers were given the opportunity to read this prior to participating with the chance to contact myself of Dr Melissa Gladstone if they had any questions about their participation. The template for the information leaflet was taken directly from the University of Liverpool guidelines and adapted to be specific to this research project. This can be found in Appendix B.

4.8.4. Consent Forms

Prior to any participant taking part in the study their full consent to participate was taken. Participants were fully informed about what their participation would involve, that they can withdraw from the study at any point and that their information would be kept confidential in-line with the data protection act. Their consent was recorded using forms created by the University of Liverpool and adapted to be specific to this research project. These can be seen in Appendix B. Consent was taken by myself as

the main researcher at the start of each interview and prior to the focus group discussion from all participants.

4.9. Semi – Structured Interviews

Semi-structured interview were the main source of data collection. A topic guide was used to aid the interviews and underwent some minor adaptations as the interviews progressed.

Interviews were undertaken in participant's homes or an interview room in local children's centres depending on how and where the participant had been recruited.

A Dictaphone was used to record the interview and each interview aimed to last approximately 20-30 minutes, although in practice this did vary dependent on participant's willingness to engage in the interview.

Interviews took place with or without the child present, dependent on the participant's preference as it would be financially and logistically difficult to arrange childcare for all 24 proposed interviews and parents may not have been happy about leaving their child for the period of the interview.

4.9.1. Semi-structured Interview Topic Guide

Following two trials of the topic guide the final version for the start of the study was decided upon.

The opening set of questions were designed to explore why parents need support and included;

1. Can you tell me how you know what your baby is feeling and what it wants?
2. What helps you have this understanding?

There were further questions exploring why parents need support but also where they may turn to when they needed this support;

3. We all have bad days and good days as a parent; can you tell me about what a bad day is for you?
    a. PROMPT: who supported you then? Who did you turn to?
4. Can you tell me about a good day? A day when you feel things went well?

A question that is designed to explore further the concept of reflective functioning was included to probe ideas about parenting and the child-caregiver relationship:

5. What do you think your baby thinks about you?

The next two questions proposed were taken directly from the initial practice interview where a mother described a situation she had witnessed in the supermarket. It is sometimes easier for people to discuss others experiences than their own (especially if this is a negative experience or the parent may feel as though they are being judged by the interviewer);

6. Can you tell me about any times you think a mum has done it well? Why do you think they are doing it well?
7. What about mums that don't do it as well? Why do you think this?

The final questions were a more direct approach to ensure the research aims were being achieved.

8. What would you like to help you more with being a parent?
9. How easy has it been for you to access the things you need as a parent? What has stopped you accessing support you've liked or needed?
10. If this isn't your first child, how different have you found being a parent to your second/third … child?

The following probes were available to ensure all areas of services were being covered, as identified in the literature review. Questions could be asked about if they did or didn't use these types of service if not mentioned during the interview;

- Health Visitors.
- Books.
- Internet.
- Family.
- Children's Centres.
- Midwife.

4.10. Focus Group Discussions

A focus group discussion was also used to generate data for the study.

This took place in Granby children's centres and a separate information leaflet (Appendix B) and consent form (Appendix B) was given to participants that addressed the questions and ethical issues specific to a focus group discussion.

Prior to the commencement of the focus group discussion the study was introduced and ground rules established to make participants feel more comfortable about their participation. Refreshments were also provided to participants.

It was aimed that the focus group discussion would last between an hour and an hour and a half and take place without children present so crèche facilities were provided.

A separate topic guide to that of the interviews was used.

4.10.1. Focus Group Discussion Topic Guide

Questions for the focus group discussions were adapted from the interview topic guide with careful consideration to ensure it would engage all participants in the conversation.

The use of an activity, arranging cards in order of preference of support, was also used to spark conversation in a different way to that of asking straight forward questions.

Topic Guide:

1. Do you ever wonder what your babies are thinking?

2. Can you tell me about what makes a good day for you and your babies?

3. Can you tell me what makes a bad day for you and your babies?

4. There are lots of different supports out there, can you tell me about the support you've received as parents?

5. I have some cards here, they list some places you may go to for support could you place them in order of what you value the most?

6. Why have you chosen … as the most important?

7. Why is … the least important?

8. Can you tell me more about your order, what does everyone else think?

9. Have you wanted anymore help as parents?

4.11. Data Analysis

Upon completion of the interviews, transcripts were transcribed by myself as the primary investigator and the process of analysis commenced. NVIVO was used to aid with the coding and the data analysed using a thematic approach.

Thematic content analysis;

The stages suggested by King and Horricks as described in Chapter Three were followed and I have outlined below how I undertook each stage of the analysis:

Stage 1: Descriptive coding:

Each transcript was recorded and transcribed by myself before being read and re-read in order to emerge myself in the data. At this point hand written comments were added to the first 7 transcripts. From these a basic coding system was established and descriptive codes were created. This was then repeated on the first 13 transcripts using NVIVO software to assist with the coding and organisation of the codes.

Stage 2: Interpretive coding:

At this point the codes were clustered into areas which included; Need for support, Parenting, NHS services, Support from people, Web based support, Experience, Overall Experience. From this the codes could be related back to the research question and the initial process of deciding upon overall themes began.

Stage 3: Overarching themes:

Using Bronfenbrenner's theory of childhood development to help organise my thoughts, it was clear many possible themes were emerging from the data. It was decided amongst the research team that Bronfenbrenner's theory would be a useful tool to organise the concept of 'how' parents were being supported and following this common themes amongst the different support networks could be identified.

The final key themes were decided upon and discussed amongst the research team as a whole. At this point most interviews had been completed and as I had conducted all interviews and transcribed them myself it was clear that I was reaching a point of saturation, these final key themes would be important and emerged across all interviews. From this the remaining transcripts were then coded accordingly and the overall themes and result of the study become clear.

Diagrams were also completed to fully demonstrate the relationships between themes and can be seen amongst the results in the next chapter.

Chapter Five

Results and Findings

5.1. Introduction

In this chapter I will outline the results of the study period. I will discuss the recruitment of the interviewees and focus group discussion participants. I will also outline the demographics of the study population. The results of the thematic content analysis will then be presented and I will outline the pertinent themes of the study.

5.2. Study Period

Ethical approval was sought during November 2014 from the NHS Ethics Committee. The recruitment period began on the 8th of January with a presentation to the lead Health Visitors. The first interviews commenced at the end of February 2015 and the final interviews were completed in June 2015. The focus group discussion was held on the 29th of June.

5.3. Recruitment

I had attempted to recruit participants in two main ways; through Health Visitors and through the children's centres. I had aimed to recruit through Health Visitors in order to reach a mixed as sample as possible from a demographic perspective and from the point of view of meeting mothers who had no necessarily engaged in children's services such as children's centres. To initiate recruitment in this way, I attended the lead Health Visitor meetings in order to fully inform the Health Visitors of the project and ask for help with recruitment through providing information leaflets and contact information of the study staff. Further to this I had also aimed to recruit through the children's centres as this is where all new parents must come to have their children weighed by Health Visitors in Merseyside up to 18 months old. I aimed to recruit mainly at these 'weigh-in' clinics or other clinics where mothers who did not usually or regularly attend children's centres were visiting. Due to recruitment limitations, including restrictions put in place by Health Visitor leads and additional

request for paperwork, it took time to initiate recruitment through Health Visitor and therefore the children's centres became my primary recruitment method.

With the help of children's centre staff who promoted the project to their caregivers either during sessions put on at the centre or by actively asking parents who were registered to be interviewed, I was able to recruit the majority of participants for interview in this way. I would approach those who were attending the Health Visitor weigh-in session at the centres as many of these parents only attended for this reason and were not fully engaged in the other services the children's centres had to offer.

As well as recruiting through centres, I also used snowballing techniques where I asked parents if they knew anyone else who would be willing to participate. This was done in order avoid recruiting through only the children's centres and reduce bias amongst the study population.

As recruiting went on I sampled more purposively in the parents I approached for participation, to ensure I kept within my sampling frame and that I was recruiting a range of parents from different backgrounds. To achieve this purposive sampling I attempted to select parents of different ages and who were of different socio-economic backgrounds by attending different children's centres across the city. I also asked children's centre staff to assist me as they were more aware of the number of children people had, if they were a single parent and could direct me towards the type of parent I was looking to recruit. Of course it was not always guaranteed that person would be willing to participate.

5.4. Participants Included in the Study

Despite some initial difficulties with recruitment the sample size was N=22 participants interviewed, 2 less than was hoped with the sampling frame. One male participant was removed from the study as it was agreed that his confidentiality could not be maintained due to his characteristics making him easily identifiable. One focus group discussion was held containing N=5 participants. This gave a total number of 27 parents who were recruited for the study as no participants interviewed were included in the focus group discussion, with a total of 26 included in the study.

The demographics of both the interview participants and focus groups are outlined below.

5.4.1. Interview Participants

A summary of the demographics of the participants are outlined below in table 3 and full details of participants can be found in Appendix D:

Characteristics:	**Number (%) of participants**	**Additional Notes:**
Gender		
Female:	21 (100%)	
Ages of participants (in context of sample matrix):		
16-24	0 (0%)	
25-35	15 (71.4%)	
>35	7 (33.3%)	
Relationship to Child:		
Mother:	21 (100%)	
Parental Status:		
Single Parent:	7 (33.3%)	
Partner at home:	15 (71.4%)	
Joint custody with family member:	1 (4.8%)	With cousin
Number of children in family:		
1	9 (42.9%)	
2	7 (33.3%)	
3	5 (23.8%)	
Ethnicity as described by participant:		
White British	13 (62.0%)	
White Other	1 (4.8%)	South African
Mixed Black / White British	2 (9.5%)	
Mixed Arab / White British	1 (4.8%)	
Mixed Afro-Caribbean/ White British	1 (4.8%)	
Black African	3 (14.3%)	1 asylum seeker

Regions of Liverpool (as described by participants):		
Wavertree	1 (4.8%)	
Toxteth	4 (19.0%)	
Edge Hill	1 (4.8%)	
Litherland	1 (4.8%)	
Speke	4 (19.0%)	
West Derby	1 (4.8%)	
Kensington	2 (9.5%)	
Mossley Hill	3 (14.3%)	
Aigburth	1 (4.8%)	
Sefton Park	1 (4.8%)	
Kirkby	2 (9.5%)	
Recruitment method:		
Children's Centres	17	
Snowballing Techniques	4	

Table 3: Table showing the demographics of interview participants.

The following map shows the areas from which participants were recruited. The map itself has been adapted from 'World Guides'; (99)

Figure 5.1: Map of participant recruitment across Merseyside.

The following graphs show the ages of the participants in more detail and the ages of the eligible children aged 0-2years:

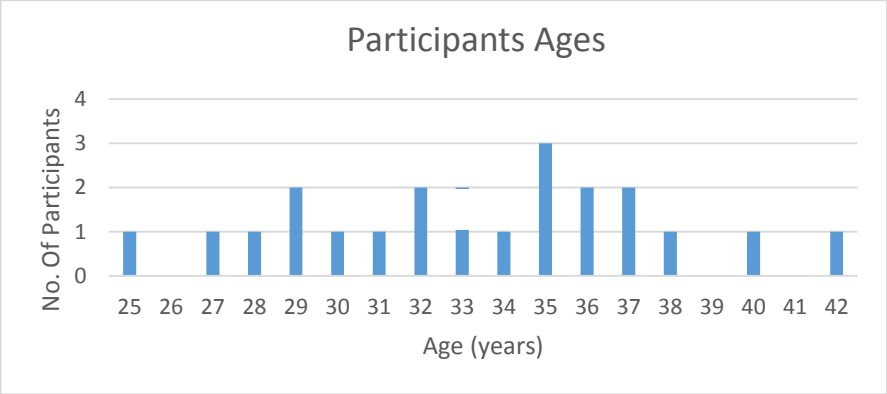

Figure 5.2: Graph of interview participants' ages.

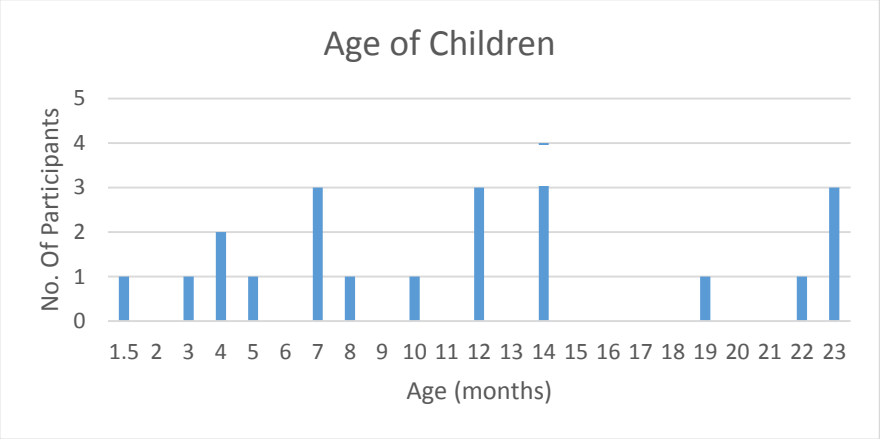

Figure 5.3: Graph of interview participants' eligible children's ages.

5.4.2. Focus Group Participants

There were 5 participants present in the focus group held at Granby children's centre on June 29th. It should be noted that for most participants English was not their first language, although all of were of different ethnic backgrounds and all were recruited with the help of Granby children's centre staff.

The following table shows the demographics of the participants in the focus group;

Characteristics:	**Number (%) of participants**
Gender	
Female:	5 (100%)
Male:	0
Ages of participants (in context of sample matrix):	
16-24	0 (0%)
25-35	1 (20%)
>35	4 (40%)
Relationship to Child:	
Mother:	5 (100%)
Father:	0 (0%)
Parental Status:	
Single Parent:	3 (60%)
Partner at home:	2 (40%)
Number of children in family:	
2	2 (40%)
3	2 (40%)
5	1 (20%)
Ethnicity as described by participant:	
Black British	1 (20%)
Black African	3 (60%)
Black Asian	1 (20%)
Regions of Liverpool (as described by participants):	
City Centre	1 (20%)
Toxteth	2 (40%)
Kensington	1 (20%)
Dingle	1 (20%)

Table 4: Table showing the demographics of the focus group discussion participants.

The following graphs show the participants demographics in more detail including the ages of participants and the ages of their eligible children;

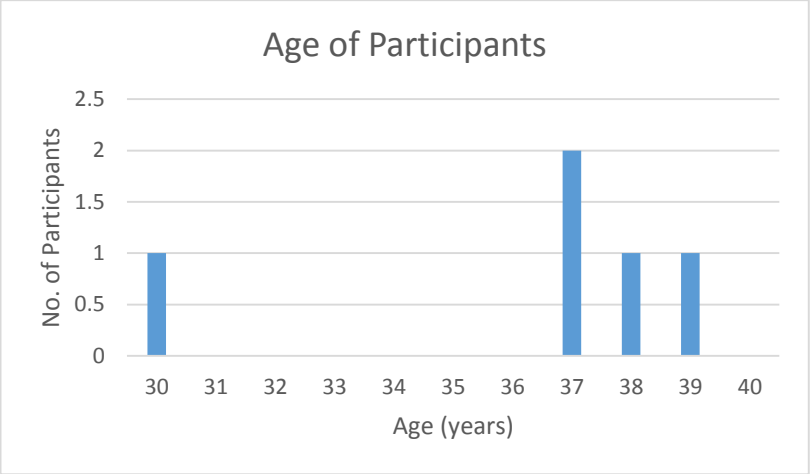

Figure 5.4: Graph of focus group discussion participants' ages.

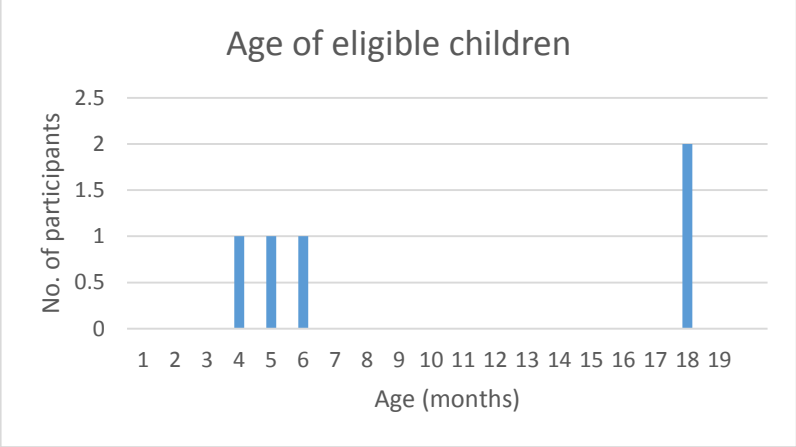

Figure 5.5: Graph of focus group discussion participants' eligible children's ages.

5.5. Data Collection

Due to the iterative nature of qualitative research, throughout the data collection period, I was able to reflect upon each interview and the topic guide underwent some changes to ensure that the questions were always generating data that was in-line with the research aims. Each interview itself was different due to the varying nature

of the characteristics of each participant and in some interviews, as well as making some alterations to the topic guide, further prompting was also required to keep the conversation flowing.

The shortest interview lasted around 10minutes for one mother who had ADHD and was unable to sit still for the duration of the interview; the majority however lasted between 20 minutes and 30 minutes on average. The longest interview was around 45 minutes.

The recorder ran out of batteries during one interview and a few seconds of recording was lost, however notes were made to help fill in the gaps during the conversation.

The focus group discussion, although not as long as expected, lasted just under 1 hour and contained an ethnic mix of 5 mothers. For most participants, English was a second or third language and although they did at times struggle to understand some of the conversation, this mix of ethnicities in the group did also add to the diversity of their answers, views and opinions. There were some issues with the pre-arranged childcare during the focus group discussion, which meant the children were still present in the room. This at times interfered with the recording of the interview as children were interested in the Dictaphones and their mothers being in the room. In this situation 2 Dictaphones were used and the focus group discussions were transcribed to the highest quality possible given the limitations during the recording.

5.6. Themes and Findings of the Study

In coding the transcripts using thematic content analysis as suggested by King and Horrocks, I identified many descriptive codes emerging from the data.(82) As there were many initial codes which emerged, which I felt did not link so well to the aims and objectives of my study, I decided to group the overarching themes which emerged around the three main objective areas of the research; Why parents needed support; How they were supported; What was it about the support they valued. This related the themes back to the main aims and objective of my study. At the start of each interview I was also able to clarify parents understanding of the concepts of responsive, sensitive and reflective parenting and in some cases the extent to which they demonstrated these parenting skills. I also explored the overall satisfaction of

parents in the support they received to gain a better understanding of their overall views of the parenting support and advice they have been receiving since their child was born.

The main themes therefore included:

A. The Parent-Child Relationship.

B. Challenges to being a responsive, sensitive and reflective parent.

C. How parents are being supported in relation to their responsive, sensitive and reflective parenting.

D. Why parents value the support they receive in relation to their responsive, sensitive and reflective parenting.

E. How satisfied parents are with the support they receive in relations to their responsive, sensitive, and reflective parenting.

When reporting the findings of each of these themes I have used descriptive words such as 'many' and 'some' as opposed to statistical figures to represent the proportion of participants who expressed these views. I feel that it is not appropriate to assume the views were not represented by others in the cohort, which would be the case if I were to assign a statistical value to the findings, simply because they did not emerge during the interview. Parents interviewed may not have expressed the views discussed in the findings at the time of interview due to a variety of reasons, such as lack of clarity in the interview question or not deeming it important enough to discuss.

5.6.1. The Parent- Child Relationship

Int: "What do you think he thinks about you?"

Ppt: "Loves the bones of me!! He adores me honestly I am totally his number one he just loves me." Participant 009

Some of the interview questions sought to assess the extent to which parents were able to be responsive, sensitive and reflective with their babies. On the whole parents demonstrated that they were holding their child in mind and considering their feelings and demonstrating responsive and sensitive care;

> *"…she will do things to communicate those kind of needs then if it's a need where she is hungry or upset then she will cry and then sometimes she would just want comforting when she cries now then … for example she was quite sick last night and she was in bed and she was crying so I went into her and I think it was really that she was distressed so what she wanted was for me to comfort her not any other things really." Participant 013*

They also felt secure in their relationships with their child;

> "*I know she loves me! No … she is a daddy's girl but I am for everything else. If she has got a pain or she is upset or she needs comforting she comes to me." Participant 004*

Many commented on how it took time for this relationship to build with their child as they became more confident in their parenting abilities. This was particularly the case for single parents;

> *"His happiness is the main thing for me, it took me a while to sort of realise how safe and secure he felt. Because babies don't give you anything back, until you know a good couple of months in when they start becoming more aware they realise their attachment to you and things like that umm so when he physically you know is walking is crawling things like that um they are the things I get proud of when I notice." Participant 001*

The majority of parents interviewed showed signs of responsive and sensitive care, however for some parents they did appear to struggle. It appeared to be those who were suffering personal issues and those who had an unstable home environment who were prevented them from understanding their babies' wants and needs. This included one such mother who had a traumatic time prior to her child's birth and was consequently claiming asylum in the UK.

Int: "Can you tell me how your baby, how he knows what he is feeling?"

Ppt: "Actually I don't really understand him too well …" Participant 011

5.6.2. Challenges to Being a Responsive, Sensitive and Reflective Parent

Ppt: "She needs nursing to go to sleep."

Int: "How do you find that as a mum?"

Ppt: "Draining … really … it's fine when there's other people in the house but when it's just me …" Participant 016

The challenges of being a parent in Merseyside were explored. It was clear from parents' responses those factors in both the child's life and the parent's life could influence the need for support for parents. Factors related to the child included illness, sleep routine and the perceived temperament. The parents themselves commented how lack of sleep due to the child's sleep routine, overcoming isolation and the help they had at home were key factors to that influenced the amount of support they needed. The following diagram, Figure 5.6 shows these results and each of these factors is considered in more detail below;

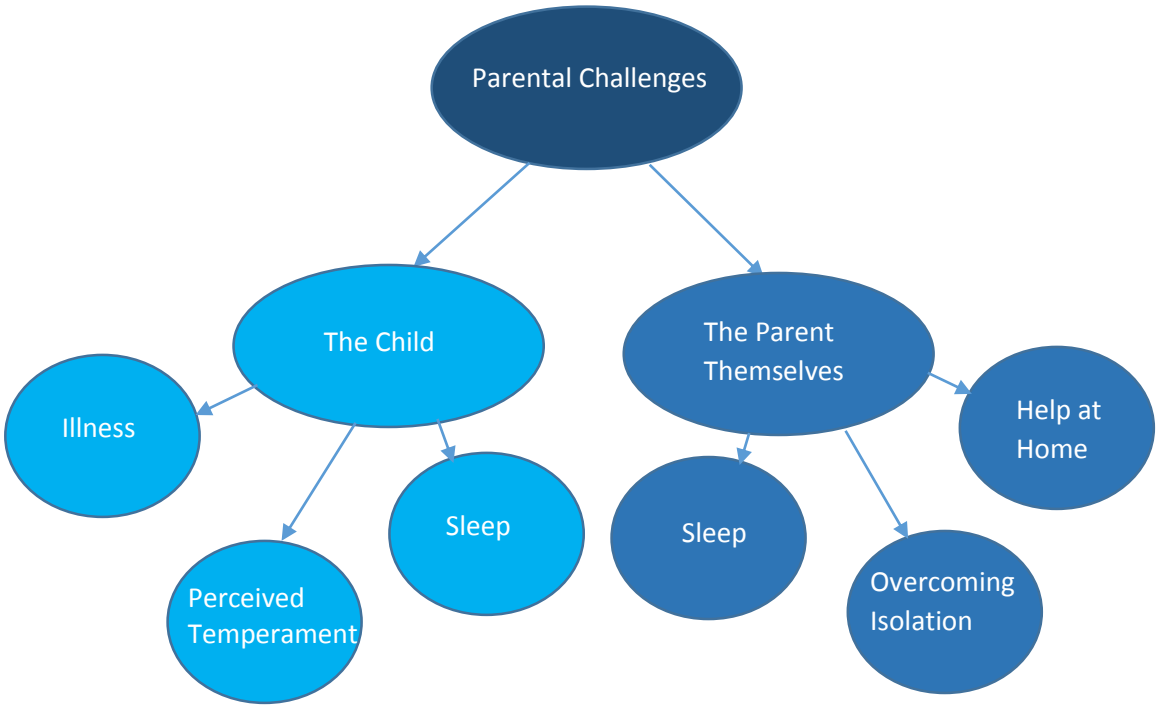

Figure 5.6: Diagram showing the parental challenges reported by participants.

The Child

Parents interviewed often discussed the dependence that a baby has and how this in itself can be difficult for many parents and consequently influence upon their responsive, sensitive and reflective caregiving abilities.

> *"And that is hard because I, you know I love him. Absolutely adore him, 24/7 you know with anyone is full on, you know, and babies are so dependent on you that it can feel like a drain, even when they're not being demanding, just that you don't have that freedom, it's a very hard concept to come to terms with …" Participant 001*

There were particular times when some parents found it harder to demonstrate their usual responsive, sensitive and reflective caregiving skills. Factors such as childhood illness or their child not sleeping, added further stress for most parents. Conversely some parents also commented on how they perceived their child's temperament as 'easy' and they were lucky with how 'easy' it had been to be a parent with this particular child.

Illness

Many parents discussed how sickness or illness in their child affected the ability of parents to feel that they were able to 'know their baby' and consequently be responsive to their needs. Parents felt that when a child was ill this pertained to a bad day and caused them distress as they felt they were unable to help their baby and not know what their child was feeling. It was a time at which they required additional support and would use family, other parents and the internet as places of support. One Father describes his feelings when his child is ill;

> *"Bad day the basic mainly when they get ill! That's the most difficult and most of the time it is really unbearable and the problem is obviously they can't tell the way they feel, is, we just guess and we try to help them but sometimes even though we want to help them it doesn't help them actually. So that's the worst part of it." Participant 012*

The distress of having an ill child was similarly felt amongst both parents who had someone at home to help with parenting, such as a husband or partner, as well as

those single parents interviewed. Although for some single parents they did report childhood illness as impacting more severely on their parenting simply because they didn't have the additional support of a partner or husband at home;

> "*I think bad days the worse it is either when you're going through something really stressful or when you're ill. Being ill with a baby who is also ill is like hell on earth." Participant 001 (single mother)*

Many parents discussed emulating the feelings their child had when they were ill, demonstrating how an ill child could impact upon their sensitive and responsive caregiving;

> *Ppt: "Bad day is when he hasn't slept much or teething, just for him when he is a little bit unsettled."*
>
> *Int: "How does that make you feel?"*
>
> *Ppt: "Makes me feel unsettled." Participant 009*

The way many parents described feeling when their child was ill included feelings of helplessness, even if the child was not severely ill and for example only suffering from a mild cold. This was a key reason parents would seek additional support;

> *"Bad day is when she's not well, full of cold and all you want to do is make it better but you have to let it run its course don't you!" Participant 007*

And similar feelings were felt by parents whose children had more severe illnesses such as one mother who describes coping with a child in a Pavlik harnesses for hip dysplasia, whilst the child also suffered from colic;

> *"…she was suffering from colic, which is the devil, it is evil. And because she couldn't kick her legs, because she had her legs locked up and sprayed out she couldn't kick her wind out. During the day she would be quite uncomfortable and she would get to about ((to husband was it 6 O'clock or half 5? … the colic? .. hmmm)) and it would just be horrendous she would just be screaming and crying and nothing you could do to console her and because she was having problems with the colic effecting her system internally we would end up in Alder Hey." Participant 004*

The Perceived Temperament of the Child

The child's temperament (as perceived by the parent) was described as being very influential in how much parents felt they were able to understand and be responsive to their child. Some parents described their baby as an 'easy baby' and explained that they were lucky and because of this they did not require a great deal of support with their parenting;

> *"Well I think we have fairly good days almost all the time, because he's I say he is very easy. " Participant 015*

This was the same for participants who had only one child and therefore didn't have experience of previous children;

> *"I'm lucky because he is very independent, very happy to do his own thing, very affectionate, he's not a hard baby." Participant 001*

Few parents described difficulties in understanding their child and attributed this to the temperament of the child; they were an easy baby and so it had been easy to understand their wants and needs. Those who did struggle to understand their babies however, tended to have younger children only a few months old and they too associated the level of understanding they had of the child with the child's temperament;

> *"It came quite naturally* [their understanding of the child] *but he's quite a high need baby…sometimes it could be difficult because it could never be the one same thing always bothering him." Participant 002*

Sleep

Sleep was raised as a crucial factor for many parents and influenced their need for support to be responsive, sensitive and reflective and also influenced their understanding of their child. Some parents described how they were tired from lack of sleep but still were managing to maintain their ability to provide their child with responsive and sensitive care;

> *"Yea I mean sleep is just huge ...I'm pretty resilient to lack of sleep now." Participant 014*

Those who had a partner valued the support they provided in allowing them to catch up on sleep and have someone to share the night-time routine with;

> *"…some nights especially towards the end of the week I get really, really tired and just sort of need a nap when he gets home from work, so he is really great with just taking the kids and letting me go nap and yes looking out for me." Participant 021*

Many parents were concerned about their baby's sleep routine and lack of sleep. This was a major factor in why parents were seeking advice and support as they were worried that there was something wrong with their parenting abilities that was causing their child not to sleep;

> *"He's not the best of sleepers, so I've always thought is it something I am doing wrong." Participant 009*

Overcoming Isolation

Many mothers described how community structures, friends, family and institutions enabled them to be much more responsive, sensitive and reflective when caring for their children by simply giving them the opportunity to leave the house and escape the isolation felt if they were to stay at home. For some this was described as achieving part of what felt like a 'normal' routine, getting out of the house like they had done before their child was born.

> *"…when we feel on top of things, we are both up, washed, dressed and both make it out of the house. Usually I like a little trip and that's a good day!!" Participant 003*

For others they would describe it as getting out of the boring routine of housework and daily chores. For most parents leaving the house lead to a sense of achievement and wellbeing especially when they had the chance to meet people at places such as the children's centres;

"Like the centre, it caters for mostly everything, just to know that it's here, even if you want to get out of that roll of routine as it can sometimes feel like it's just dragging you down. To even just come here and have a coffee with someone and have a gab and sit here. And then go home and it's like ahh back to the real world, back to scrubbing!" Participant 010

Or even just being able to get outside to the park allowed them to feel 'normal';

"…we can go off and do something nice now and go to town or the park or something so achieving something normal in inverted commas is good if that makes sense." Participant 017

This opinion was shared by both parents who had a partner at home and single parents and did not appear to differ amongst parents according to the number of children they had. One single mother describes a good day with her child in this quote;

"When I've got stuff done and go out when we go out take her out and stuff like that." Participant 008

The children's centre was seen as a good place to go by many parents when they wanted to overcome those feelings of isolation;

"I think it is helping even for us the mums because sometimes you can be stressed and you say let me just go and pass time in the children's centre and see pictures and all that from other parents because sometimes when you are stressed you find someone you can talk to you feel like better" FGD 05

Support in the Home

Both single parents and those parents who had a partner or spouse at home were interviewed. Both groups of parents noted the importance of having someone else at home involved in the baby's care. Single parents discussed how they would like more support like that provided by a partner in the home. From their responses it was clear that a partner at home would allow them to become more responsive, sensitive and reflective parents as it could give them the opportunity to catch up on sleep or give them time to themselves and improve their overall mental wellbeing;

"I think if you are a single parent, even if you got help, it's not the same as having someone there all the time to come and just pass the baby to. You don't realise, I'll hold the baby for 5 mins while I just hoover up or something like that, you know it all adds up through the course of the day." Participant 001 (single mother)

Further to this a parent also commented how much she valued the support of her husband and therefore had admiration for those who were single parents;

"The biggest support by far is my husband, by far. He's through everything, I don't know how people cope. Honestly having had a child and now a second I just have so much respect for single parents. Honestly I don't know how you do it without having someone to yell at a three in the morning ..." Participant 014

5.6.3. How Parents are Being Supported in Relation to Responsive, Sensitive and Reflective Caregiving

"I think I've been really fortunate I've got a good network of friends and family around me and my Health Visitor .... The children's centre has been good as well, I've dipped into them." Participant 004

Throughout the course of the interviews it was clear that the parents of Merseyside were being supported in a variety of ways, be it from people (family, friends, professionals), groups, NHS services or the internet. To help identify the key areas of support utilised by parents in my study to improve their child's development, Halpern's schematic interpretation of Bronfenbrenner's ecological systems theory of development was used to organise these key areas. Figure 5.6 demonstrates these results; (30)

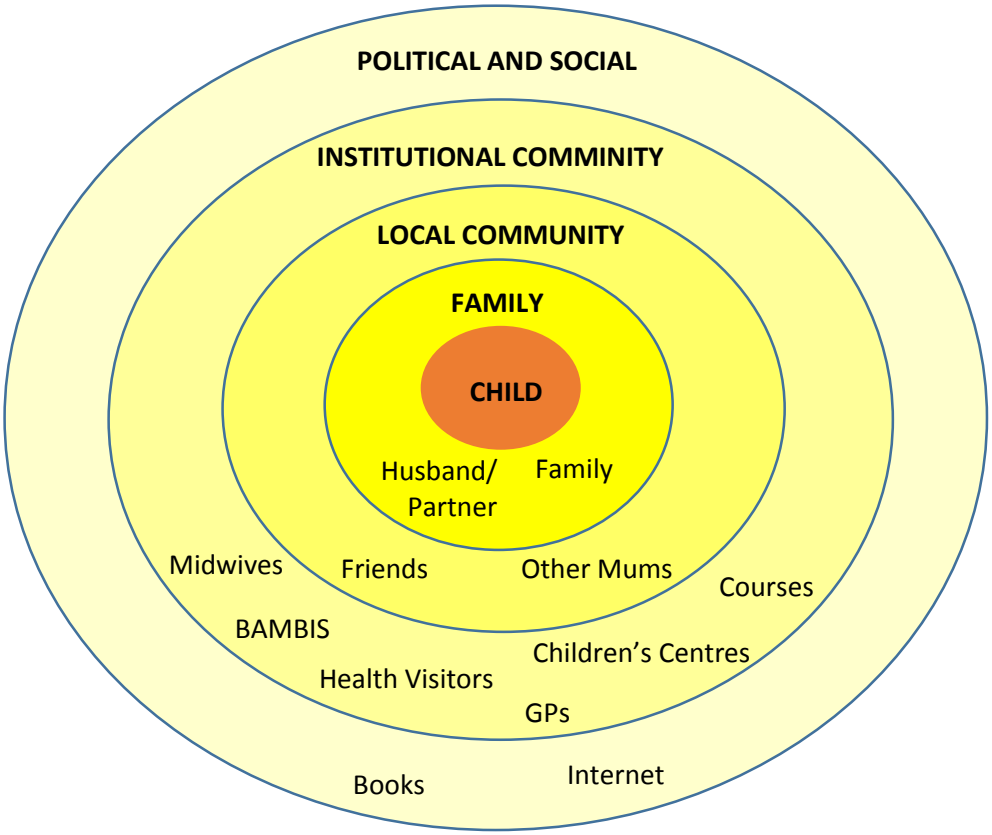

Figure 5.7: Diagram showing where parents went for advice and support.

Husband or Partner

"Biggest support is my husband." Participant 017

Within the child's home, those who had a husband / wife or partner valued the emotional support as well as the extra pair of hands so household tasks could be completed. They also tended to be the first person that a parent would speak to when looking for advice about a particular problem. Figure 5.8 demonstrates the common themes describing when looking at why parents turned to their husband or partner for support and advice;

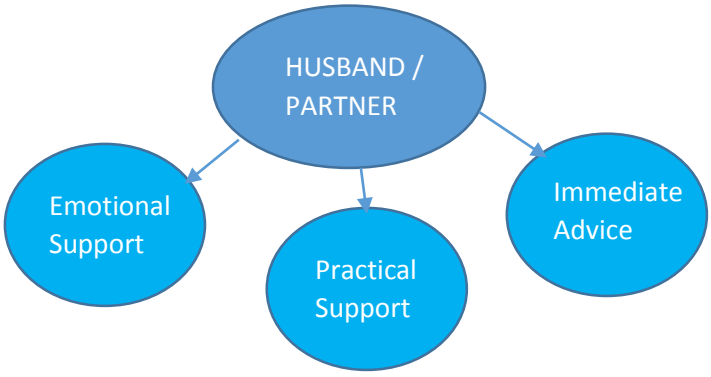

Figure 5.8: Diagram showing how parents were supported by their husband / partner.

Partners were the key providers of emotional support;

> *"I really think having a supportive partner who is by your side, who … it's like gold dust in term of like that kind of feeling okay about everything …" Participant 014*

Parents also described how they provided respite from the child whilst they completed the household chores or have a moment to themselves to refresh. Parents described how this allows them to continue to be responsive to their babies needs without becoming exhausted;

> *"Practically um if you know he can just take the baby for a walk for an hour that's brilliant help that makes a real difference." Participant 017*

Partners also provided a convenient and reliable immediate source of advice and reassurance:

> *Int: "Would for teething for example would you go to the internet first or …"*
>
> *Ppt: "I would probably speak to my husband first …" Participant 013*

Family

> *"My mum's helped out with the children and other family members." Participant 002*

Many parents described how family was really important in supporting them in many aspects of parenting and understanding their child better. They would ask their family, particularly their own mothers' for medical advice before escalating the problem to health care professionals. For women they provided a lot of practical advice, especially when discussing the body changes following birth. Participants suggested this advice was important and lead to both physical and emotional benefits. They also provided child care if they lived nearby, allowing parents some respite. If they didn't live nearby, parents would still be in contact with their family using the internet or telephone. All these forms of support and advice were vital to parents in allowing them to hold their child in mind and continue to be responsive and sensitive to their child's needs.

Figure 5.9 shows how family provided support to parents;

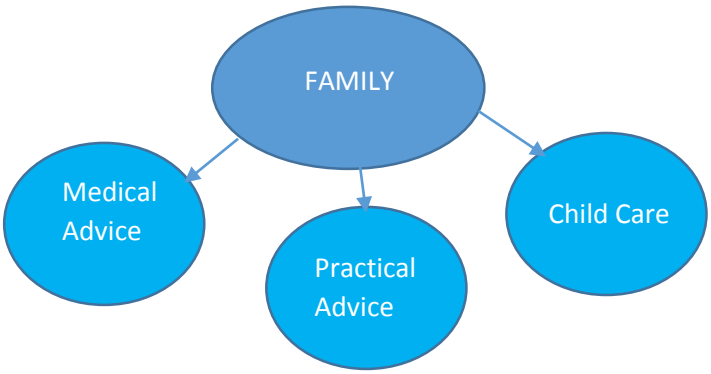

Figure 5.9: Diagram showing how parents were supported by their family.

For many they would ask their own mother questions about their child regarding their health;

> *"Usually, sometimes if she has got a bit of a mark or a rash, I'm like oh mum I found this, what do you think it is?" Participant 007*

One of the most common medical questions parents asked their family for advice about was regarding rashes;

> *"Well if I'm bothered with something I used to ask them [family] and sometimes they suggest why not do this? The time when he was like having a rash on his body I was asking them what do you think it is? Do you think its eczema? Do you think it's a rash? Do you think it's this? They said oh, oh they give your suggestion … some say eczema some say an ordinary rash and it will go in a few weeks." Participant 015*

Parents with family close by would also often approach their own mothers about health care advice before they would seek the advice of a health care professional;

Int: "What sort of questions would you ask your mum?"

Ppt: "Just like, I don't know. So um I still ask her questions now like do you think he's after this, or do you think he wants this. Because she spends a lot of time with him as well especially when I'm in work she minds him so she does know a lot of what is needed as well. So just reassurance so especially if he is unwell. Do you think I should give him some calpol do you think I should ring the doctors or you know just make sure I'm not being an over protective parent but I am asking for help when I need it. So, that's quite … just making sure I do things right." Participant 019

As well as healthcare advice for their child, mothers would also ask their family for advice about their own health. This appeared to be questions which they would not necessarily want to ask healthcare professionals about, due to the more sensitive nature of the question;

"Practical things from sister …. like umm, you know everyone's like you need to get the nipple cream … everyone says have you got it … yes I have … it's good but it doesn't work miracles!" Participant 003

For those who had family members living close by, family emerged as an important place to go to for support with all aspects of their caregiving, as well as providing help with child care. This was particularly the case if they were a single parent;

"I stayed with my parents for three weeks because obviously it was over Christmas as well so it was easier." Participant.001

And even more so if it was their first child;

"But the first time I was with my family a lot." Participant 010

Some parents described that even if their family wasn't close by or if they were living abroad, that they would still make contact using telephone for emotional support or advice, showing the importance of having regular contact with parents;

Ppt: "She [participant's Mother] lives on the other side of the world, she lives in Singapore!"

Int: "Do you Skype her or anything like that?"

Ppt: "No, no just phone her when I need her!" Participant 009

Local Community

"I would probably speak to my husband first and then maybe speak to friends who have got kids." Participant 013

Within the 'local community', friends and other mothers provided a support network for the parents interviewed. It terms of friends for most parents it was the friends who also had children that were the most beneficial in supporting them particularly in their understanding of their child and their developmental milestones and how best to be a responsive and sensitive parent. Parents spoke to friends and other mothers when looking for practical advice and emotional support when away from the home environment. In the interviews it was hard to distinguish between what defined a friend or was just 'another mum' as the words were used interchangeably by many participants. Figure 5.10 shows how parents used their friends and other mothers in the local community to support their parenting;

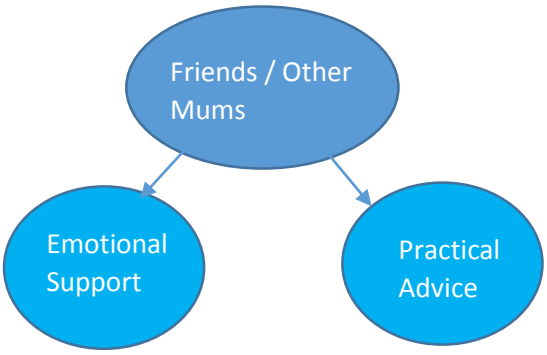

Figure 5.10: Diagram showing how parents were supported by their friends / other mothers.

Friends and other mothers provided parents with emotional support or someone to talk to, particular in the case of single mothers or whose partners worked away from home;

> *"...like sometimes I've had bad days and spoke to one of the girls here or another friend I have met walking from the school, just have a chat with them and then go home and just get on with it!" Participant 005 (partner worked away during the week)*

They also were able to offer practical advice, particularly when it came to shared experiences, giving a sense of reassurance to the parents;

> *"...and other mums actually from my son's school who breast feed their toddlers so I would probably go to them for advice." Participant 002*

Institutional Community

> *"Um we come out to the Sure Start Centres, Mondays and Thursdays and then Tuesday, Thursday he goes to crèche at the church as I do exercising in the church and then Fridays is clean day so he just chills." Participant 005*

Many described the use of institutional support, be it publicly or privately run, in supporting their abilities to be responsive, sensitive and reflective in their caregiving. This included group based facilities such as children's centres where they could attend groups or seek support and advice. BAMBIs who provide breast feeding support emerged as an important support service. Midwives and Health Visitors were also used to answer questions about their child's development, as well as other healthcare professionals who provided advice on the child's health issues as well as the parents own issues. Figure 5.11 demonstrates these results;

Figure 5.11: Diagram showing how parents were supported by the institutional community.

Children Centres

All but one participant used at least one facility at the children's centres. Some only attended for the drop in baby 'weigh-in' sessions. Others described how they would attend activities designed to promote responsive and sensitive care provided at the centres as well as seeking advice and support with their child's development and overall caregiving abilities;

> *"I've always found it easy to access support and advice. And I know how to come to the children's centres if I needed anything." Participant 002*

Many enjoyed the classes designed for children and parents which were run in six week blocks, particularly 'Baby Massage' which is designed to support the child's attachment;

> *"Baby Massage, I think he will enjoy …" Participant 003*

Or the sessions that were run weekly as they could see the overall benefits to their child;

Int: "What benefits do you think R gets from this?" [Attending stay and play sessions]

Ppt: "Overall development, stimulation, getting the opportunity to play umm stimulating environment umm with regards to my toddler helped with his speech and language and social interaction as well." Participant 002

Very few parents mentioned any of the courses that were found in the NAPR with just one parent mentioning their experience of 'Pathways Triple P' and 'Incredible Years' as their previous child had been diagnosed with autism;

"Yea we done the early years one … [Triple P?] … Yea at the time that was really good because we were meeting people in the same situation and stuff. We done …. Same as pathways but not kids with disabilities …. [Incredible years?] …Yea I done that for molly and nothing was no fitting in to what we needed. So we done the pathways one." Participant 006

Courses at the children's centres were also designed to help the parent and their own mental wellbeing and aspects of mindfulness, which in turn would benefit their responsive, sensitive and reflective caregiving abilities;

"I have just finished 'Needs' the course." Participant 007

BAMBIS

Many parents mentioned support from BAMBIS a breast-feeding support service unique to mums throughout the Liverpool area which is run in conjunction with children's centres and Liverpool Women's Hospital. They encourage and support mothers with their breastfeeding which in turn amongst other benefits improves the attachment a child has with their mother;

"I had some home visits from BAMBIs and went to the infant feeding team sometimes …" Participant 003

Most parents who had used this service spoke highly of it, especially as staff would visit them in their homes and were easily contactable via telephone or text message;

"Yes I have, when I was breast feeding at the very start I found it very hard to do because I was sore, my you know, so the lady come out to my house and she told me what to do and I am still breast feeding now so I found it excellent I would definitely recommend it yes really good" FGD 04

Health Visitors and Midwives

Towards the end of each of my interviews, I did ask about services which supported parents directly. Every parent interviewed had experience of a Midwife and Health Visitor;

"My Health Visitor … um I would phone her and ask her for advice …" Participant 010

Although there was some confusion at times amongst many parents as to which of these they were speaking about;

"The Health Visitor that I had, the Midwife that I had throughout my pregnancy she was great." Participant 001

Most parents had experience of at least one home visit from their Health Visitor and the opportunity to see a Health Visitor at a 'weigh-in' session at their local children's centre. However for many parents they didn't see the need to utilise this service as they felt their child was growing and there was no need to have them weighed;

"… in fact I haven't done it for the past [attend a weigh in session] … I didn't do it last month ... because I think you do get more confident because she is gaining weight and she is happy and she has lots of full nappies so I'm thinking let's not worry too much about that now." Participant 017

Doctors

Some parents mentioned seeing their GP for advice or other doctors about their child's medical conditions;

"Right now he is growing and lots of check-ups from consultants." Participant 011

As well as for their own medical needs such as anxiety and postnatal depression;

> *"I mean my doctors I speak to umm when my anxiety got really bad." Participant 001*

Political and Social Culture

> *"Um yea there's a BAMBIs Facebook group, I've not shared a problem on it but you often read things. So reading other people's problems and that's similar to mine. Yea, yea and I have definitely googled things actually as well. Anything from I don't know to babies poo to um when should this happen development, or yes I have totally forgot about that whole realm of advice." Participant 003*

In terms of political and social culture the internet and books were a source of support and advice for parents interviewed. Books and the internet were used by the parents as an avenue for advice in many different ways and for many different reasons in order to support them overall in their responsive and sensitive caregiving. They would use the internet to search quickly for answers to parenting questions but also used internet forums and social media as a way of accessing the views and opinions of other parents. Books were far less popular than the internet but were used to supplement their avenues of advice and support when parents struggled to find the answers elsewhere. Figure 5.12 demonstrates how parents used books and the internet within the realm of the political and social culture to support their parenting; shows how parents used the political and social culture to support their parenting;

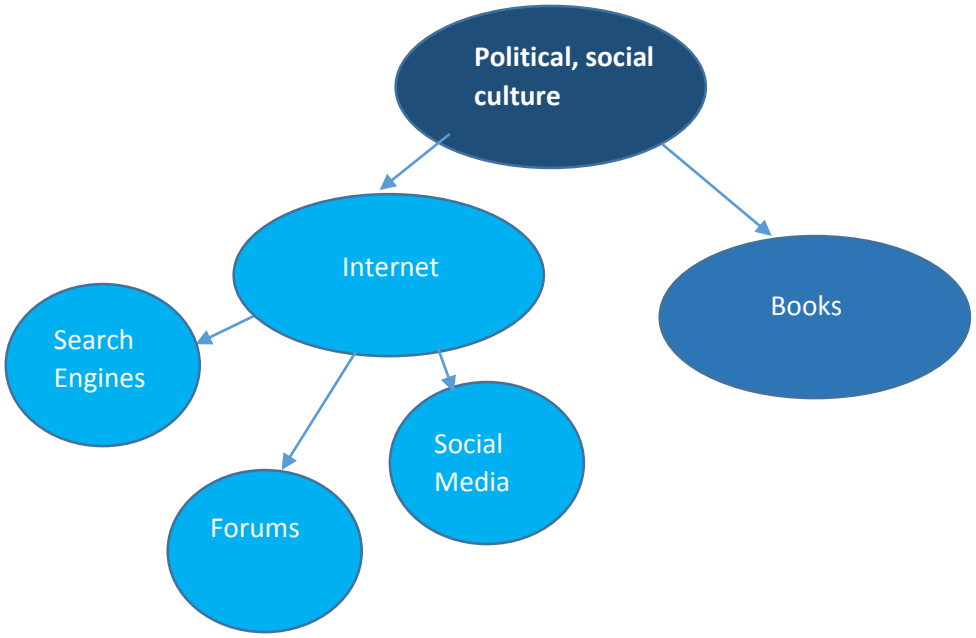

Figure 5.12: Diagram showing how parents were supported by the political and social culture.

For some parents they used search engines to search for answers to their parenting questions, particularly their questions about sleep and sleep routine;

> *"Oh gosh my husband and I have probably 'googled' about 4millions times 'how do you get a child to sleep past 5am?'" Participant 014*

For others they used social media as a basis for forums as well those sites specifically set up as forums for mums to share their ideas, thoughts, feelings and questions. They found these particularly useful;

> *"I'm on a few groups on Facebook, parent groups." Participant 002*

However not one parent admitted to posting on the groups themselves;

> *"I do look on the baby centre where there are forums, I've not joined them but I just lurk and read them!" Participant 013*

Multiple parents mentioned the idea of 'lurking' on the sites, reading what was posted but not contributing themselves;

> *"I'm definitely a lurker! I've never posted on one of the forums but I'm always lurking for sure!" Participant 014*

Some parents mentioned using books. Parents reported using those books that were recommended by family and friends or for some parents who had a background in research or child care they would also search for their own books in the library;

"I did get some books out of the library really at one desperate moment … all these baby books about sleeping!" Participant 013

However for most parents interviewed they preferred the internet over books due to its ease of access;

Int: "Have you used any books at all?"

Ppt: "No I only go on the internet. It's easier to type it!" Participant 015

As described above, there were many, many resources and facilitators mentioned in both interviews and the focus group as supporting parents, enabling them to understand their babies and be responsive, sensitive and reflective parents.

Table 5 therefore outlines all the services and resources the parents interviewed mentioned and have been grouped as they were when the transcripts were initially coded;

Support from People:	Partner
	Family
	Friends
	Peers / Other Mums
Support from NHS Services:	GPs
	Midwives
	Health Visitors
	BAMBIS Breastfeeding Support
	CAMHS
Support from Group Based Support:	Children's Centres
	'Play Groups'
	Church Groups
Web-based Support:	Websites
	Forums
	Social Media
	Mobile Apps

Other:	Books and Library
	Religious Places of Worship
	Public Swimming Bath

Table 5: Table showing where parents interviewed go for parenting support and advice.

5.6.4. Why Parents Value the Support They Receive in Relation to Their Responsive, Sensitive and Reflective Care

Three key themes occurred when establishing what it was that parents valued about the support they were receiving and why they chose to use that support. These were 'Relationships', 'Professionalism' and 'Experience'.

The following diagram demonstrates the areas in which these themes were important to parents interviewed;

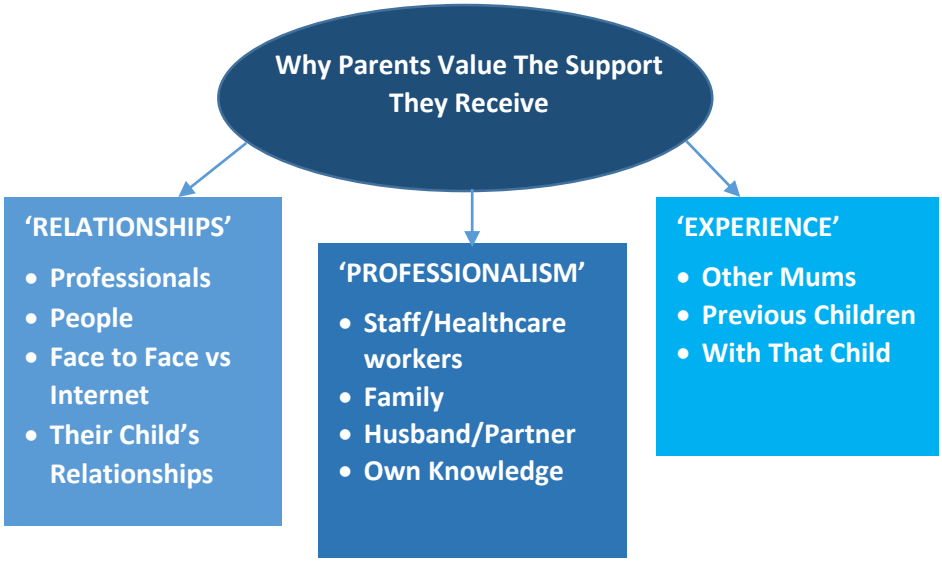

Figure 5.13: Diagram showing why parents value the support they receive.

'Relationships'

When deciding to use a service or to approach a person for support and advice with their parenting, the relationship that a parent had or formed, emerged as being important to the parents interviewed. The relationship with the people who provided

government services, such as children's centre workers or Health Visitors was important. The relationship they had with other people who were also using the service, such as other mothers was also valued. Parents reported that they preferred 'face to face' advice as opposed to the internet. They also valued those services which provided the opportunity for their children to form their own relationships.

In terms of the government services they used, the relationship with the professionals at children's centres was important to parents and one of the key reasons they gave when discussing their engagement in the service. Some parents for example mentioned how much it made a difference, having someone that they knew and would be able to contact directly if they wanted to join activities;

> *Ppt: "M [children's centre worker] would ring me up and say on Thursday we are doing world book day so come dressed up if you want and like get in contact with me.""*
>
> *Int: "So almost checking up on you but …"*
>
> *Ppt: "Yea letting you know. Because one of my friends didn't come for ages and we were like what's wrong with her, she had postnatal depressions and she didn't come out and didn't tell anybody and it was like where the hell is she." Participant 005*

They also valued the support they received for more intimate issues in the absence of family members and therefore have continued to use the children centres because of their experience was a positive one and a relationship was formed. This single mother whose family lived far away describes how the children's centre staff supported her when she was suffering with mastitis;

> *"I think the children's centres are like a breath of fresh air … I remember when I had L I was, L was two days old and I came in here and I was like look at my boobs, what do I do with these! And they were like you should, we'd have come out to you, you shouldn't have come out … and they massaged them and they were amazing. I've always used the children's centres." Participant 016 (single parent when child was born)*

This ability to form a relationship was particularly important when it came to experiences with Health Visitors. For those who had a good relationship with their

Health Visitor, they talked positively about their experience and what a difference it made to feeling comfortable in discussing their parenting;

> *"So it was the first time I just met my, it's a male Health Visitor, he came to me last week so I was happy and I felt comfortable talking to him." Participant 007*

For those who didn't form as good a relationship their views were very different;

> *"And the Health Visitor the last time I saw her she wasn't very forthcoming with practical advice it was just oh well, just cut his milk down. You know blah blah blah and to an extent that advice does work but it is very textbook kind of a thing, it doesn't have much of a personal feel as you would, as I think most parents would want to when you're in a bit of a distress over something... I tend not to umm to contact my Health Visitor." Participant 001*

This was particularly the case when it came discussing co-sleeping with the Health Visitor. Many parents interviewed found it a useful tool to aid them in adapting to the sleep routine of the child, or catching up on sleep themselves and had evaluated the risks prior to co-sleeping. However this is not advised by Health Visitors and the way the advice was given impacted upon the ongoing relationship the mother had with her Health Visitor;

> *"I have co-slept with both of them and the first thing the health visitor tells you is gives you an absolute fear of co-sleeping and SIDs and this is the worst thing you could possibly do so, and I find that really stressful because actually this time round because she slept so much better doing so … it is quite hard to go against because they have to literally have to fill in your red book a form, basically we've made you aware you're going to kill your baby!! It's just and when you're already a bit anxious it's not really that helpful!!" Participant 014*

Parents described how the opportunity to form relationships with people outside of the home enabled them to feel less alone and isolated when they had problems caring for their infants. This was seen as vital in supporting their wellbeing and consequently their responsive, sensitive and reflective care;

"Friday playgroup called city tots which is run by Christ Church Liverpool, which is run by city centre mums and it's just nice, there's babies of all different ages and older kids too. I found that the first few times I went, J was asleep in the buggy and if, it was amazing to get some tea and toast whilst you're there and chat to the mums. I really enjoyed that." Participant 003

One parent who had relocated to Liverpool from London commented on how Children Centres provided an opportunity for parents to come together, form relationships and make new friends when they were new to an area;

Ppt: "If this place [The Children's Centre] weren't here I think a lot of people would struggle."

Int: "How do you think they would struggle? Because they're not getting out of the house?"

Ppt: "Yea I went on a course last week and there was a girl on it and her social worker told her to come on that group and that got her out, because she had moved from Preston and she didn't know anyone either. I didn't know anybody, came on this group and I've got 5 or 6 friends and I didn't know they lived so close across the road ….I'd never known that it I didn't come here. And I've been to the park with her and up the shops." Participant 005

In both interviews and the focus group discussion, parents described how they preferred 'face to face' advice from someone they had formed a relationship with when searching for answers to questions relating to the care and understanding of their babies;

"Yes definitely, definitely face to face definitely yes you feel more, you feel more better you feel like there is someone else there you know someone that's … you don't feel alone." FGD 04

They spoke about why they preferred face to face and gaining medical advice from a healthcare professional because it prevented 'self-diagnosing' or unnecessary worry when compared to the internet;

"I prefer face to face and sometimes with the internet you get stuck looking over stuff and you get off what you're meant to be doing! Yea you end up self-diagnosing yourself with something wrong." Participant 006

Many parents however did describe how they used the internet as way of accessing advice quickly rather than waiting for professionals which took time. They also described how the internet was able to provide advice if you had a specific question;

"I tend to speak to people rather than read something, or I will access things on the internet if I have a specific question." Participant 004

Many parents told me how important it was that their child forms good relationships with other children, even though all the children of parents interviewed were under the age of 2 years. Having the opportunity for their child to form relationships appeared to be important to parents and to have influenced decisions to use group based services and activities such as those at children's centres;

"I know it's good for him [coming to the children's centre] and it's good for him to be with other kids and I, all I get out of it is, I know he enjoys it and if he didn't enjoy it, I wouldn't take him." Participant 009

Even for those parents who had older children at home they still felt it was important for their child to mix with children their own age or closer in age to them than their siblings who were at school during the day;

"Because I want G to mix with other children, I don't want it to just be me and him you know what I mean?" Participant 006

'Professionalism'

Being a 'professional' with expert knowledge about child care or child development was important to parents. In many of the interviews it was clear that this did not necessarily mean expert advice through NHS services or children's centres but that many parents put trust in their own knowledge or that of friends and families. This was particularly the case if individuals (family or friends) had previous working experiences with children or qualifications in areas of childcare.

Knowing that professional staff were trained and experienced in all aspects of childcare was important for parents. Many described this as being the case for children's centres and for BAMBIs;

> *"Oh I do value its, all free services, with qualified staff who are experts trained in child development and the activities that are on are age relevant, it's not just stay and play where the kids do what they want.... I valued the support from the BAMBIS with regards to breast feeding to gain expert advice … because they are trained in that specific area they can be more knowledgeable in that particular area than say the Health Visitor." Participant 002*

Many parents had family or partners with a background in childcare or had completed training in areas of childcare at some point due to their profession;

> *"Yea I mean also you know, my husband is a doctor he gives me fairly reasoned advice." Participants 014*

Family's professional knowledge was very important to those who did not have a partner at home;

> *"Oh gosh loads of our cousin's [works in child psychology] loads of psychology books." Participants 009 (partner absent for first 6months of child's life)*

Parents also described how they trusted their own abilities if they had a background in childcare;

> *"Well because my background in child care anyway I tend to just know it or … research it myself." Participant 002*

Particularly if they were older mothers with more experience;

> *"It probably helps that I work in children's services so I probably more aware of things than maybe someone who didn't." Participant 014*

'Experience'

'Experience' has emerged as a major theme in describing where parents go for advice in supporting and understanding their babies. This may be related to their own experiences or taking comfort in the knowledge that someone who works in a service is experienced. In some instances, this was a key factor in why parents felt they didn't need support with their responsive, sensitive and reflective care particularly when they were a second time mum or a mum of a relatively older child.

The experience of other mums proved to be invaluable when talking to parents. This support came in many different forms including online forums with other mothers;

> *"I go on forums and see if anyone else experience this; 30 women say yea, you know, it is calming you know, okay it's not just my baby, it's not something else that's wrong, it's a general pattern of behaviour that occurs around this time, so think that has probably been the biggest support." Participant 001*

But also from groups that parents attend;

> *"For me to get to meet the other mums because then I think it helps me as well as we can swap ideas and compare thoughts. Which does nothing but help I think, as we have all been there and there are pointers that people have given me that I haven't even thought about and I have put into play with mine and it has either worked of it hasn't." Participant 004*

Their own experience of having previous children also helped support parents as they had done it before and this provided confidence in knowing their baby;

> *"Second time around it's a bit more, because first time round with my daughter I was a bit scared, how I was going to adapt to being a mum … it's a lot more easier the second time round the first time I was scared." Participant 010*

As their child has grown older and they have experienced more time with them, parents felt they understand the needs and wants of the child more and have formed a better relationship, thus needing less support;

"Yea I mean I have definitely picked up, with us it was, as he has gotten older I am very sensitive to everything, when he was a new-born I hated it." Participant 001

5.6.5. How Satisfied Parents are with the Support They Receive in Relation to Their Responsive, Sensitive and Reflective Care

Int: "Would you like anymore support ..."

Ppt: "No I don't think so, I think I've been really fortunate." Participant 004

As well as exploring the themes around what type of support parents value, I also looked at the overall views of the support they received by directly asking if there was any more support they would have liked as a parent. All parents interviewed expressed their satisfaction in the support they were receiving regardless of their background, be it with family nearby or a husband or partner at home;

"I've always found it easy to access support and advice." Participant 002

Similar sentiments were reported by new first time mothers as well;

"I think we feel pretty well supported." Participant 003

These results will be summarised in the subsequent concluding chapter, Chapter Six. Here I will add my further understanding to how these results can be interpreted and how they relate to the previous literature review. I will also outline how these results can influence clinical practice in Merseyside.

Chapter Six

Discussion and Conclusions

In this final chapter I summarise the main findings from my study and then discuss the importance of the findings in relation to recent literature. I then review the strengths and weakness of the study and the implications of the findings for clinical practice before finally suggesting provide some directions for future research.

6.1. Summary of Findings

The majority or parents interviewed reported aspects of responsive and sensitive care with their babies as demonstrated by their answers to some interview questions. Most showed a good understanding of what their babies' wants and needs were and demonstrated aspects of reflective parenting either through learnt experience or advice from other people. My findings did however demonstrate that the parents I interviewed across Merseyside face similar challenges which can impact upon their ability to demonstrate responsive, sensitive and reflective care all the time. These factors relate to sleep routine, childhood illness and their own mental wellbeing during the first two years of parenthood. This was regardless of the number of children they have, their marital status or their socio-economic or ethnic backgrounds.

Childhood illnesses and their child's sleep patterns were felt by many parents to impact upon their ability to feel that they 'understand their baby'. Many parents described how worrying about their child's sleep routine or illness affected their ability to be responsive and reflective in their caregiving approaches and stop them from having their baby's wants and needs in mind. It is in these circumstances, that parents perceived needing family or a professional's help, particularly if that supporting person is an expert and has a good relationship with them. The parents in my study felt that their child's sleep routine often causes them concern, sleep deprivation and the need for further support in understanding their baby. Finally, the perceived temperament of the child was an influential factor in the need of support for many parents. Some parents in my study commented on their 'easy baby' but new parents in particular, who were still adjusting to their new role, described finding it harder to understand their baby.

The parents that I interviewed felt that their own circumstances influenced their ability to be responsive and sensitive carers and understand of their baby. For some simply getting a baby ready to leave the house represented a daily challenge. Leaving the house, escaping the monotony of routine and reaching out to others in the community was seen by many as a big influence on their mental wellbeing and ability to parent and care well for their baby. Lone parents face particular challenges and expressed the need for more support with their parenting.

When seeking support with parenting issues the interviewees sought help from, both local and wider communities. Many parents in my study utilise a wide variety of resources to aid them in all aspects of providing sensitive and responsive caregiving. These resources included their partner, other mothers within the local community, health care professionals and sources of support available through the internet. For most parents their main source of support and information included family, other mothers, children's centres and the internet. For those who required breast feeding support, BAMBIs was a particularly popular service.

When choosing to use services that help parents to be more responsive, sensitive and reflective caregivers, parents in my study valued those services with which they had a strong relationship with the people running the service, when advice was from professional sources and from those who had prior experience of child development.

On the whole, most of the parents interviewed were satisfied with the level of support they were receiving.

6.2. Discussion of Findings

Factors Effecting Parenting in Merseyside

A recent review by the W.H.O has identifies many factors that can impact upon a parent's natural ability to demonstrate sensitive, responsive and reflective parenting and ultimately impact upon a child's development.(16) These include high levels of family stress and maternal mental wellbeing (16) The parents from Merseyside who were interviewed in my study also reported similar challenges that they faced as

parents, which in turn affected their relationship with their child. Both the child and factors in parent's own lives influenced their caregiving abilities.

A child not sleeping through the night and illness, were key concerns and challenges raised by parents. These factors contributed to a bad day with their child.

Sleep Routine

Parents discussed their attempts to utilise multiple avenues for advice and support with their child's sleeping routine. This theme occurred amongst both single parents and those who had a partner to share the night-time routine. Research has shown that during the first few years of a child's life their sleep pattern will vary and their circadian rhythm does not appear to be well established until the child is at least 4 months of age. (100) A survey completed in Australia also showed that 28.6% of parents of children under 2 years reported a problem with their child's of less than 2 years old's sleep behaviour and many parents interviewed in my study reported similar findings.(100) Their child's sleep routine or lack of, provided a source of stress to many of the parents interviewed. Research has shown that parents require information and support specifically from qualified health care providers about the varying sleep patterns of their child. Providing this information can prevent perinatal depression, which in turn significantly impacts upon a parent's responsive and sensitive caregiving. (100) Parents my study suggested that support from health care providers with regards to sleep was limited and sought advice from many other sources including friends and family, other mothers, books, internet and in one case even the library.

Some parents in my study found that co-sleeping with their child was beneficial in allowing them to catch up on sleep or settle their child effectively. However when some parents discussed this with their Health Visitor they felt they were dismissed by the firm and clear message that, co-sleeping is dangerous for a young child. Health Visitors are very clear in their message advising against this practice as co-sleeping has been shown to be a modifiable risk factor for 'sudden infant death syndrome' or SIDS.(101) There is much controversy amongst researchers and health care professionals over whether an adult should co-sleep with their young child, however Health Visitors must stick to this mantra as it is what is recommended by

government guidelines.(102) Discussing the issue of co-sleeping led to a breakdown in the relationship between some parents and their Health Visitor, due to a perceived inflexibility on the part of the Health Visitor. As a result, instead of asking advice from the Health Visitor regarding sleep, they would hide the fact they were co-sleeping with their child and consequently avoid discussing their child's sleep routine at all. They would therefore approach different avenues for advice regarding sleep such as the internet or other mothers.

Studies have shown that a child's problematic sleep routine can have many adverse effects on parental mood and mental wellbeing.(103) The parents in my study were clear that lack of sleep and poor sleep routine had the ability to affect their capacity to demonstrate responsive, sensitive and reflective care. Many parents were keen to have more specific support and advice in this area, as despite seeking support they were not always satisfied with the type of advice they received or they felt they did not feel the advice did not work for them. By providing parent with more advice about their child's sleep routine, from professional sources and from people with whom they have a good relationship, this might alleviate some parents stress allowing them to focus on their responsive, sensitive and reflective caregiving.

Childhood Illness

Childhood illness was a key source of stress for parents in my study; they described feelings of helplessness and stress which in turn interfered with their abilities to demonstrate responsive, sensitive and reflective care. Research has also shown that even the most minor of non-preventable illnesses such as the common cold, can impact significantly on a mother's self-reported feelings of stress.(104) In the UK the NHS provides different levels of support for sick children through NHS 111 service, Health Visitors and doctors in primary and secondary settings. For the parents in my study however their first point of call in assessing the severity of childhood illness was a family member, particularly their own mother; from this they would then escalate the issue to their family doctor. Despite knowledge of the NHS 111 services it was not widely used by parents. When discussing their local GPs many parents reported that they were unable to get an appointment in good time. Furthermore parents would only approach their GP when they or their family members deemed

the illness severe enough. The parents also reported that they wouldn't speak to their Health Visitor for various reasons. Commonly this was due to poor relationships with their Health Visitor, for some because they perceived it taking too long for the Health Visitor to response or for others because as with the use of GPs, they felt their concerns were too minor an issue. This was particularly the case when parents were concerned about a rash or colic. Rashes were a common worry to most parents interviewed.

On the other hand parents did report using children's centres with regard common childhood ailments, seeking advice from staff members and also attending first aid and baby massage courses. Children's centres have developed aspects of their baby massage courses to help parents support their babies when they are suffering with colic, as well as improving the parent-child relationship. From the second week of the six week course, parents are taught how to massage a baby's tummy in a way which will alleviate colic by removing the trapped gasses. There is further evidence that the skin to skin contact experienced specifically in baby massage can have a positive impact upon a child's development.(105) In children less than 6 months old, it has also been shown to have positive impact upon the mother-child interaction and child's sleeping patterns.(106) Baby massage was a popular course amongst parents in my study and those who had attended reported positively on the benefits not just for colic, but also upon forming better attachments with their child. Those who could not attend reported being on a waiting list as it was oversubscribed and hoped to join the course in the near future.

Parental Health and Wellbeing Effecting Caregiving;

The parents in my study reported that their overall mental health and wellbeing and the amount of help they had at home influenced their caregiving abilities.

Studies have shown that poor parental wellbeing can have adverse effects on parent's caregiving ability, which in turn effects a child's development.(107) In the UK it is thought that postnatal depression can effect between 10 and 15 in every 100 women having a baby.(108) Some mothers, when interviewed in my study, opened up about their experiences of post-natal depression and anxiety how helpful NHS service, such as GPs and Health Visitors had been in supporting them with these issues. The NHS

services helped them overcome these illnesses and feelings and consequently provide their child with more sensitive, responsive and reflective care. A small minority of participants within my study experience depressions and anxiety. Many parents did however discuss how their mental wellbeing was affected by becoming a parent. Factors influencing mental well-being their adjustment to parenting, their need for routine, requiring support in the home and sleep deprivation.

Adjusting to life as a new parent can be hard. Parenthood for a long time has been portrayed as being idyllic, fantasised by both writers and society. From as far back as the late 18th century writers were providing idylls and fantasies about motherhood. Rousseau in, Emilie, describes motherhood as "a source of joy and fulfilment for all women and for many it will be".(109) Many recent studies have demonstrate how parents are trying to live up to the idyllic expectations that are portrayed in books and media.(110) As one participant in my study described "it's a minefield out there". Parents interviewed described struggling to live up to these expectations and to provide the care they want to, particularly when feeling like they were sleep deprived or when without the additional help in the home in the form of a partner or family. This all impacted upon their caregiving abilities and contributed to a "bad day". Parents further reported that getting out of the house and having a form of 'normal' routine to their day helped them to feel positive about themselves as parent and consequently they would experience a more positive day with their child. They used family, friends and play groups as places to go and reasons to get out of the house.

Help in the Home

Many parents interviewed reported the importance of help and support in the home, both those with partners and single parents. Research demonstrates that parenting is generally harder for single parents and for those children growing up in a single parent household they are more likely to demonstrate poorer academic performance, psychological health, economic wellbeing and delinquent behaviour in their adult lives.(111) In the UK, following the 2011 census, it was estimated that almost 2 million children are growing up in single parent families.(112) Of those interviewed 10 participants were single mothers, representing over a third (37%) of the participants spoken to. This figure is lower than some areas in Merseyside, in one

ward in Liverpool, 75% of children are growing up in a single parent home and a further four of Liverpool's wards have appeared in the top ten lists of fatherless areas within the UK for the past few years.(113) It is therefore not surprising that single parenthood played an important role in why parents felt they needed support in my study. Parents who had a partner at home commented on how valuable a partner was as a source of support and showed admiration for single mothers. A partner or husband was described as providing emotional support, someone to discuss concerns with and to provide practical support with daily household tasks. For many parents they felt well supported by their partners as they had positive relationships with them and since the birth of the child, many mothers also reported that they had approached parenting together and this gave them a positive sense of wellbeing. Single parents commented on wanting somebody who could "just take the baby for 5minutes" whilst they caught up with their daily routine. Many single parent families interviewed in my study described turning to their immediate family for this kind of support, due to their trusting relationship with them. Families provided childcare, help around the home and emotional support.

For some parents in my study family were not near-by and therefore these parents felt more reliant on the services put in place by the government. The NAPR states in its toolkit that the parenting intervention 'Family Transitions Triple P' should be available UK wide to support single parent families, however this did not appear to be something accessed by the parents I interviewed.(14) Single parents did however speak highly of the support they received from children's centres and church groups, particularly the groups which provided a cup of tea and an opportunity for parents to sit down and socialise with other parents whilst their children play.

The Support Parent's Value

My study identified a number of different services and support networks that the parent's interviewed are using to support them with the care of their child. Common themes were found relating to what parents value about the variety of support services they utilise and these were; 'Relationships', 'Professionalism' and 'Experience'.

'Relationships'

The relationship the parent forms with the service they use or person from whom they are seeking advice and support was very important to the parents interviewed. Research from as early as the 1950s such as that of Bowlby and Ainsworth, have explored the importance of relationships in human development. Using Bowlby's attachment theory, studies have further described the importance of forming a secure attachment with someone when seeking support and advice in adult-adult relationship.(114) Bronfenbrenner also described how the relationships a parent forms within the macrosystem of his ecological systems theory can directly impact upon a child's development.(29) For parents in my study, having a positive relationship with health care professionals was particularly key when discussing their engagement in services. They also valued a face to face relationship in contrast to the internet or books and valued services which allowed their children to form positive relationships with other children. Children's centres, Health Visitors and the internet were key support areas where relationships influenced a parent's opinion and consequence utilisation of that service.

Children's Centres;

Many parents in my study described how children's centres provided them with advice and support throughout the first few years of their child's lives. Parents perceived many benefits for both their child's development and for themselves.

The group drop in sessions and courses held by children's centres are designed to improve and support a child's overall development. The parents described how attending these sessions allowed them to improve upon their parenting skills and build upon their attachment with their child, particularly when the child was young. As the child became older parents described attending the centres mainly to benefit the development of their child rather than their own personal benefits. A survey completed across 117 children's centres throughout the UK also reported similar findings, in that the main reason parents would attend the centres was to benefit their child.(115) For those living in small city houses some parents reported that the groups gave their child the opportunity to run around in a bigger environment and

play with toys that were different to those they had at home. It is important to give children this kind of stimulation, especially if they lack space or a range of toys at home as Piaget explained in his cognitive development theory. During the sensorimotor stage children develop object permanence and develop through their practical interactions with the world using their sensory and motor systems, access to toys and a stimulating environment are particularly important at this stage.(27) By providing the child with different sensory experiences and a space to explore the children's centres contribute in an important way to this stage of their development The parents I interviewed recognised the importance of the 'stay and play' type sessions in providing this opportunity.

One further important factor reported by the parents when attending children's centres, was that they wanted their children to form positive relationships and interact with other children of similar ages. This was also an important reason for parents to attend alternative children's playgroups that were not part of the children's centres, such as those provided by the church. Researchers have shown how vital a social environment is for a child's development and children's centres and playgroups provides ideal places for this social interaction, especially if a child has few family members to interact with at home.(116)

For parents themselves the children's centre provided a place and opportunity to escape the rigmarole of routine and as one parent described, escaping to the centres was like a "breath of fresh air". Research has shown the importance of maternal mental wellbeing and how if maternal mental wellbeing is poor it can have adverse impact on a child's development.(107) By having regular drop in sessions at the children's centres, parents felt that they always had a place to go outside of the home environment where they would be supported by the professional staff of the children's centres. Parents surveyed as part of the Evaluation of Children's Centres in England also reported the importance of children's centres in supporting their mental wellbeing.(115)

For single mothers the relationship they had with children's centre staff was particularly important. Parents reported how these staff provided them with a great deal of emotional support which they were lacking in their home environment. This was also shown in the longitudinal study of all children's centres across the UK,

where lone parents reported improved life satisfaction by attending the children's centres.(58) For some single parents interviewed they even described the children's centre as the hub of the community, particularly if they were new to the region. This was similar to the experiences of those in a study by Parks J, where migrant families reported upon the positive sense of community children's centres gave them.(71) In my study this sense of community is was not limited to migrant families, but parents from a range of different backgrounds.

Although the majority of parents interviewed in my study were mothers it was clear that including fathers at the children's centres was an important reason for parent to attend the centres. Many centres hold sessions specifically for fathers, which mothers commented on their partners attending. The one father interviewed in my study was recruited through a children's centre. Researchers have recently stated the importance of including the whole family in children's centres, as this has a positive impact not only on the parents' relationship, but also the child's relationship with both parents and consequently their overall development.(117) It is clear that children's centres in Merseyside are trying to promote the centres as places for the whole family and this was recognised by parents interviewed in the study.

Overall the parents interviewed in my study highly valued the service provided by children's centres. They felt it provided an environment where they could approach professionally trained staff with which they had a positive relationship. They described many benefits associated with attending the centres and many hoped that the funding would be secured so that future children and parents can benefit from all the centres have to offer.

Health Visitors

The government states that the Health Visitor should be playing a key role in supporting parents and giving advice about many of the parenting challenges the participants expressed during interviews and focus group discussion. The government policy states that: (51)

> *'Universal plus* [The service provided to all families] *gives you a rapid response from your Health Visitor team when you need specific expert help,*

for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.'

On the whole parents in my study did not describe experiencing this service on the whole. Few studies explore factors associated with the uptake of health visiting services. One Scottish review has recently highlighted a shortage of Health Visitors, something which has now been recognised by the UK government who have pledged a further 4,200 Health Visitors as part of their new policy.(118) A shortage of Health Visitors and overstretching of the service may explain why parents aren't always experiencing the ideal service outlined in government policy as there are not enough Health Visitors available to provide it.

When asked who they would turn to for support parents tended to mention family, friends, other mothers and then the internet before contacting Health Visitors. Few parents told me that they had rung their Health Visitors for a 'rapid response' to issues and many said that if they did want to ask questions they would save them for when they attended a 'weigh-in' session. Parents contrasted this to their experiences of the BAMBIS breastfeeding support service where they would regularly contact the service by ringing or text message. Many parents reported not feeling the need to attend 'weigh-in' sessions with the Health Visitor as they believed that if their baby was growing it was not necessary to have them weighed. Parents also expressed concerns that if they made the effort to attend they would be turned away or face a long wait to see the Health Visitor thus they ended up seeing their Health Visitor very infrequently. Where parents had a positive opinion of the experience they had received from Health Visitors, it was clear that these were the views of parents who had additional needs and consequently had several visits from their assigned Health Visitor. Many parents interviewed did not complain about the service they received but reported that they had very little contact with their Health Visitor since the child was born. Those who had older children only remembered seeing them once between birth and the two year developmental check which should not be happening under the new health visiting plans. Many described seeing further Health Visitors when attending weigh in sessions but this was a different person each time and different to the one who had visited the house.

Parents described an overall lack of contact and consistency in terms of which individual Health Visitors they would see. This may be a barrier in forming positive relationships with Health Visitors and utilising the services as the government recommends. Qualitative research by King's College London has shown that parents value their Health Visitor's support when there is continuity of care and that parents have more confidence in their caregiving abilities if they have consistency in which Health Visitor they see.(119) Cowley S et al, also reported the importance of a good relationship when it came to reviewing the health visiting service. He concluded that if parents could build up a positive relationship with their Health Visitor they were more likely to contact them in the future.(69)

Parents in my study mentioned that they had valued the support of their Midwives prior to giving birth and some mentioned they would have preferred to stay under their Midwives care rather than move to their Health Visitor, but understood the impracticalities of this. Under the government's new plans, Health Visitors will be visiting all mothers in the antenatal period, rather than just those they have targeted as requiring additional support.(51) This should help improve the relationship between the Health Visitor and mother as they are guaranteed to meet with them prior to their babies' birth.

A UK based survey from 2007 explored the growing concerns regarding the health visiting service in terms of its accessibility to parents.(120) This survey reported similar findings to my study, although completed 8 years ago. Researchers found that parents thought the service was changing for the worse and that as a result, at a local level, there need to be sufficient resources in order to maintain the relationships between the Health Visitor and mother. Commissioners should be mindful of the results of this and similar studies as Health Visitors play a key role in supporting parents with their child's development. My study suggests that the health visiting service is not being utilised by parents in in the way the government would like and a reason for this is that parents aren't always given the opportunity to form a positive relationships with their Health Visitor.

'Professionalism'

Knowing that the people from whom they sought advice and support were knowledgeable or had professional qualifications was important to the parents interviewed in my study. Similar results were found in across many qualitative studies. In one study 70% reported they prefer the advice of a health care professional over family members in relation to infant feeding.(121) A UK based survey also reported that parents value the professional knowledge about child development and parenting advice provided by Health Visitors.(120) Morawska A, et al also reported that amongst their cohort, parents preferred the advice of professionals over that of other mothers.(73) In my study parents reported preferring the advice of professionals over those who were not and even when deciding to take advice from family members and friends, parents reported still preferring the advice of those that had childcare qualifications over those who did not.

Professionalism was also an important factor for parents when deciding which websites to consult when using the internet. The internet provides parents with access to vast amounts of information which is easy to obtain and free. Many used generic search engines to answer their concerns and questions or as they described 'lurking' on social media forums. When reviewing the transcripts in detail however all parents added a sub-clause of how they don't always believe what they read. Parents said they would rather speak to a professional than trust what they had read on the internet Parents also reported preferring 'face to face' support over the advice found on the internet. The internet was however seen as a useful tool to get information quickly and parents felt they could trust the advice given by NHS websites. My cohort of parents reported different feelings to those expressed by those parents interviewed in the USA study by Metzler O et al, where internet based support was favoured over face to face, showing some potential cultural differences.(75)

'Experience'

Other parent's experiences of childcare were recurring theme amongst participants in whom they would seek support and advice from in regards to their responsive,

sensitive and reflective parenting**.** They valued that other parents had, had similar experiences before them and that they could compare their own experiences making them feel reassured and 'normal' like everyone else. Parents accessed this type of advice and support in a variety of ways; talking to their family members, BAMBI breastfeeding support, using online forums, seeing friends and through other mums at children's centres. When asked who they would turn to for advice and support in the first instance, the majority of mothers would turn to other mothers or peer based support service over that of their Health Visitor or other practitioners. Other similar qualitative studies have also shown the effectiveness and importance of the sharing of ideas amongst their cohorts of mothers.(122)

Other Mums;

The support from other mothers or peer support, was highly valued by many of those interviewed and commonly mentioned as one of the most important avenues of support utilised. When speaking to their families parents tended to talk to those who had, had children before and they would discuss the developmental milestones of their children comparing the various stages they were at. Female relations and other mothers also compared the changes their bodies had undergone following pregnancy and birth. Studies have shown how support and advice from other mothers can have many positive effects on new mothers including the facilitation of intuitive parenting.(123)

Modern technology is playing a key role in linking parents with their peers. Parents reported using many different online forums or social media groups, including Mumsnet, Facebook and mobile apps. Mumsnet was originally set up in 2000 by a mother as a way for parents to share experiences and swap ideas, as its founder recognised the importance of advice and support from other mothers whilst attending antenatal classes.(124) Research has shown that parents value Mumsnet for the advice and support it offers.(125) Many parents in my study reported similar feelings about the use of these type of internet forums, they provided quick, easily accessible advice and support for common parenting problems. Not one parent however reported posting directly on these sites, they preferred 'lurking'. It was not clear why this was but as one study exploring the use of parenting forums suggests

that there are perceived ‘hierarchies’ amongst users and ‘acceptable’ ways of posting which can put many parents off and these feelings may have been felt by the parents of my study.(125)

Children’s centres provide a place for parents to meet together and further opportunity to share their parenting experiences. Many parents discussed this as a reason for attending the groups held at the centres and I was able to also observe this myself whilst attending sessions myself. Parents would swap ideas and ask each other questions in a relaxed and non-judgmental environment. Many reported being at ease whilst discussing concerns they had with common problems such as sleep, teething and weaning and felt supported with many aspects of their responsive, sensitive and reflective caregiving. Research has explored the many benefits of attending group sessions with other mothers like those held at children’s centres.(126) The results of these studies showed that group parenting sessions are important in providing the opportunity for parents to meet and enhance their social support during parenthood, something the parents of my study also reported.(126)

BAMBIs

The breast feeding support group BAMBIs has effectively used the previous experiences of other mothers to support new mothers with breastfeeding advice. This style of professional peer support was highly valued by the mothers spoken to in my study. BAMBIs are a breast-feeding support service run by Liverpool Women’s Hospital and children’s centres across the region.(127) They offer peer support from mothers who have previously used the service and are trained in breast feeding support. Mothers are visited whilst on the wards at Liverpool Women’s Hospital following the birth of their child.(127) Following discharge, mothers are followed up with a home visit and via telephone calls. Parents can also contact them via phone text and a Facebook group forum has also been set up for parents to share their concerns and tips. Mothers reported positively about being able to contact the support when they needed to easily and also liked that they were visited in the home so did not have to leave. Parents also commented on the positive relationship they had with those who provided the support. The advice was not limited to breast-feeding; Mothers also used the service to ask general parenting questions. This

service appears to be unique to Liverpool and was invaluable to the parents who needed their support in my study. Successful breastfeeding is important for many reasons and research has shown that mothers who breastfeed display greater sensitivity.(128) This in turn can have a positive impact upon their child's development and so it is important to continue to support the mothers of Merseyside in this way.

Parent's Own Experiences;

Having had their own previous children or as time went by and they became more experience with their child, parents felt more confident in their own abilities. Parents reflected on previous experiences with their older children and how they had learnt from this. Many commented on how first time round they weren't sure if they were 'doing it right' in regards to parenting, but second or third time round they had more confidence and were assured by their previous experiences.

Shaffer showed that it can take time for a secure attachment to form between mother and child, suggesting that it is not until the child is 6-7 months old that they have formed a lasting, emotional and meaningful attachment.(21) During these first 6 months it is therefore not surprising that some parents reported not feeling as comfortable in knowing and understanding their child and that as they grew older, they become more in tune with their child's needs.

Parental Satisfaction

With the exception of some single mothers, the parents interviewed appear to be generally satisfied with the support they are receiving to support them with their responsive, sensitive and reflective care and overall understating of their children. Besides financial support, they felt satisfied with the support available to them and reported that the type of support they wanted was easily accessible. If they did require additional support they would know where to go, be it from health care professional's family or friends. Each parent interviewed had different needs, different experiences and different types of support networks around them, but all

had found support that suited them and on the whole met their needs. Some had found this support through children's centres, some relying more on family and others their church or religious group as well as the internet and books. When discussing which support they preferred during interview, mothers discussed preference for support from other mothers, be it their own mother or family and friends and also from those services which offered an opportunity for peer support such as Children's Centres and BAMBIs. They did not appear to utilise the support from Health Visitors as often as these other services and preferred that support over books or internet advice.

Parents on the whole also demonstrated positive relationships with their child, talking about situations that clearly demonstrated sensitive, responsive and reflective caregiving. Showing that whatever support the parents are receiving is clearly effective for them.

There were however some inadequacies identified in the support they were receiving and in some cases their personal circumstances also prevented them always demonstrating this positive relationship with their child. From the results of my study we can identify these key areas where parents would benefit from more specific support. These clinical implications as a result of my study will be discussed following a review of the limitations and strengths of my study.

6.3. Limitations and Strengths of the Study

In interpreting the results of my study, there were some limitations which should be taken into consideration.

The study was undertaken specifically for the completion of a Master of Philosophy in Child Health, taken as an intercalated degree as part of an undergraduate degree in Medicine. The time period for conducting the study was therefore limited and affected the ability to continue to recruit a wide range of different participants to the study over a significant time period. Although the recruitment pool appeared as though it would be quite large at first as I had planned to recruit using Health Visitors, initiating recruitment took much longer than expected and the number of

potential participants decreased as a result. Overall the number of participants was therefore smaller than I had hoped for, although I still felt saturation was achieve. There is much debate amongst qualitative researchers as to how many participants should be included in the sample size in order to reach saturation of ideas. One review evaluates the literature available to explore the 'ideal' sample size in qualitative research. It found seven sources which gave specific guidelines to the numbers one should include in a sample.(129) The results ranged from at least 6 participants in phenomological research to 30-60 in ethnographic, with one report suggesting that for all qualitative research the minimum number to reach saturation is 15 participants.(129) In total 27 participants were recruited for my study with a total of 26 being included, 21 semi-structured interviews and 5 participants in the focus groups, which surpasses the 15 recommended. Despite the issues faced with recruitment and the lower than expected number of participants, I managed to recruit a large variation of parents in terms of socio-economic backgrounds, ages, ethnicities and relationships status. This is likely to go some way to representing the views of most caregivers in Merseyside. There was however limited views from younger parents of less than 25 years old which may have altered the results. Younger mothers may seek advice from different support networks to those older parents interviewed, such as the service provided by the Family Nurse Partnership which was not discussed by any mothers interviewed.

Although the overall sample size and number of semi- structured interviews was not as large as I had hoped for, the themes emerging were re-occurring amongst participants and it was likely that I was reaching a point of saturation of ideas. This became clear with each interview as all interviews were conducted by me. It was also agreed amongst the research team whilst discussing the progress of the project, that I was reaching the point of saturation as common themes were emerging and subsequent interviews would not alter results.

The process of recruitment may have biased some of the results that emerged from my study. Despite having attempted to recruit parents at home through the Health Visitors by providing leaflets and information to parents, no parents contacted me in this way. I therefore recruited primarily through children's centres. The majority of caregivers interviewed (N = 17) were recruited at children's centres and were almost certainly using them, which may have focused results in terms of the discussions

held about children's centres and the support that parents received. Attempts were made to reduce this bias and recruit those parents only attending for 'weigh-in' clinics and who weren't using other services, but this was not always possible. As well as attempting to recruit through baby 'weigh-in' sessions, some recruitment also occurred during the 'Baby Massage' sessions as this is usually one of the first groups parents will sign up to. This was done with the hope that some parents were unlikely to have used other services or know the children's centres well at this stage. Many parents reported this in their interviews. The technique of snowball recruitment was also used to recruit parents (N=4) and this resulted in the views of one parent who had not used children's centres at all, although they had used other playgroups. By recruiting participants in this way it did not however stop interviewees discussing other services they had used and results show that in Merseyside parents are using more than just their local children's centres to support their caregiving.

Time restraints meant that only one focus group discussion could be arranged and participants were selected by children's centre managers. Despite practising the topic guide prior to the focus group discussion, English was not a first language amongst most of the participants as I had purposively sampled a mixed variety of ethnic backgrounds and socio-economic status for the group. This caused some difficulty in facilitating the discussion and encouragement of participation amongst the group. Their views however were very similar to parents interviewed and the different backgrounds of the participants added to the richness and the diversity of the parents included in my study.

Strengths of the Study

This unique study is one of the first studies to explore parents' views across all the services and support avenues available to caregivers of children under two years old within the United Kingdom. My study has also been conducted at a critical time when the control of service provisions in Merseyside is to be given to local authorities. It took place within a region where it is thought that many children are not reaching their developmental potential and it is therefore vital that we think

through what services parents' value and need to enable them to be responsive, sensitive and reflective parents for their children, hopefully my study achieves this.

Throughout the study Lincoln and Guba's qualitative research terms were always at the forefront of my mind and it was important to ensure that research quality was maintained throughout.(96,97)

When evaluating the transferability of my study, the cohort of parents interviewed is representational of many modern UK cities and even despite their differing ethnicities, socio-economic background and family dynamics the parents all reported similar views and opinions of why they use the help and support they do with their caregiving.

The number of participants although limited by time restraints, provided enough data to reach saturation and further interviews would have been unlikely to produce much new data.

The research team involved in the study come from many different professional backgrounds; paediatrics, child psychology, public health and a medical undergraduate. Having this diversity in academic professions protected the study from any individual bias or preconceived ideas. This wealth of knowledge amongst the research team also aided in the development of the study aims and objectives to ensure the study would be of benefit and clinical relevance.

Whilst designing the study and deciding on the research methods I discussed the study with a variety of healthcare professionals in Merseyside including Health Visitors, psychologists and those involved in providing community health care in Liverpool. All aided in establishing the appropriate methods used and affirmed the importance of the study at this current time in Merseyside. I also attended a variety of qualitative research courses which gave me the opportunity to discuss the methods involved with people who had experience specifically in qualitative research methods and no vested interest in the study. Most importantly during the planning process this project was discussed with a number of mothers and parents to ensure that the interviews and questions were appropriate; I was investigating something that was important to the people it would go onto effect. This along with embedding quotes within the results section aided the credibility and dependability of my study.

It is important at all times to reflect upon the role of the researcher during the study period and ensure confirmability of the research. Throughout the project I constantly reflected upon my experiences and with each interview improved upon my technique as well as reflecting upon and altering the topic guide to ensure that the information was relevant to the study aims throughout. Great consideration was also taken to avoid bias when it became clear I was limited to recruiting through children's centres and snowballing techniques. Despite this recruitment technique, I took the time to establish the best way of recruiting parents who had minimal experience of children's centres by fully immersing myself in all the centre had to offer and building up a positive relationship with the staff.

6.4. Implications for Clinical Practice

The results of my study have some important implications for how children's services are delivered within the Merseyside area. I will discuss some of these implications and how they might be changed in order to truly meet the needs of the parents they aim to serve.

Local Authorities

In October 2015 funding will be moved into the hands of local authorities. At this stage, I hope that my results will be disseminated and will be taken into consideration by the local authority when they decide how best to run services for parents of children under the age of 2. With financial cuts likely, commissioners should be aware of what support parents in Merseyside value and cater services accordingly to meet these needs. From my study, it is clear that services which promote positive longer term relationships between provider and client will be important. Furthermore, those services which promote professionalism in their staff will be important. Finally, it will be crucial that the local authority considers how it could utilise the experience and expertise of other parents when planning new or making changes to services available to support parents.

Health Visitors

The results of my study identified the importance of a good, trusting relationship with a sense of continuity and confidence between parents and health care professionals. This was particularly important between parents and their Health Visitor. A poor relationship acted as a major barrier to parents seeking advice and support from their assigned Health Visitor. Many of the common parenting problems identified in my study such as difficulties with sleep routine and child illness, are areas which are promoted by the government as being supported by Health Visitors supported by Health Visitors. Due to a breakdown in relationship due to lack of trust or continuity between some health visitors and parents, parents may not always be utilising this support effectively. My study suggests that where possible parents are given more of an opportunity to build up a positive relationship with a Health Visitor through continuity, regular visits and an interactive and more partnered relationship. This should improve with the government's new recommendation that Health Visitors visit all parents in the home before their child is born.(51) However this could be improved upon further by ensuring the same Health Visitor was attending the 'weigh-in' clinic at the same children's centre each week. If the same Health Visitor attended the clinics weekly and parents knew that each time they attended they would see the same person. This could help form a better relationship and parents would be more likely to utilise the expert knowledge of the Health Visitors, particularly as results showed most parents preferred professional advice to say that of the internet.

Many parents did however struggle to attend these drop-in sessions due to the specific time of day in which they were held in most children's centres. Sessions were over-subscribed and many parents missed out on this opportunity to meet with the Health Visitor and discuss problems. In some cases it prevented parents attending as some parents felt they would not be seen. If sessions could be extended or repeated throughout the week this would provide a greater opportunity for parents to meet with the Health Visitor and discuss any problems. In Kirkby parents valued the evening drop in sessions that were held as they could attend after work. In contrast parents reported a positive relationship with children's centre staff and in many cases this was because they had regular contact with the staff at the centres and had built a trusting relationship over time. This relationship allowed parents to open up about

their concerns and problems as they felt they were in a safe environment. If Health Visitors had the opportunities to further build upon their relationship with parents then parents would be more likely to discuss their concerns with them, as they did with children's centre staff.

Sleep routine was a common concern for many parents interviewed and some felt that the way in which information was delivered by Health Visitors regarding co-sleeping lead to a break down in the relationship. Like that of the MMR vaccine, co-sleeping is an important message Health Visitors must deliver to parents but there are many parental concerns regarding the evidence-base of this information. If Health Visitors do not actively engage in conversations, dismissing concerns and not discussing the evidence upon which their advice is founded this can, as my study has shown, lead to a break down in the Health Visitor – parent relationship and parents will not discuss their concerns further. Health Visitors may not feel qualified enough to discuss the evidence surrounding co-sleeping or are unable to devote the time needed to address all the parents' concerns in one short visit but it is an important issue for many parents and my study has shown that most parents valued and trust the advice from professional sources. I hope that the results of my study will make Health Visitors more aware that they must ensure parents are engaged in active discussions when delivering advice, so that the relationship between them can be maintained.

The sleep routine itself was a concern of most parents interviewed. Health Visitors should be mindful that they are delivering parents with enough information about a child's sleep patterns during the first 2 years of life.

It would be interesting to consider whether Health Visitors could take on some of the approaches used by BAMBIS, who provide information to parents quickly when contacted at any time of the day or night through texting and phoning. This immediate response is valued highly by parents and may save Health Visitors visiting the home when the problems or concerns are minor.

Many parents discussed how they valued the professional advice they received from Health Visitors and for those parents who had children with long term illness the additional support they received was invaluable. Although to summarise there are some areas where the service could be improved upon to ensure there is not a break

down in the Health Visitor – parent relationship. Ensuring that, where possible, the same Health Visitor attends the same children's centre for the weigh-in sessions each week. Furthermore that drop-in, weigh-in clinics are held at more accessible times by extending the sessions or holding them at alternative times throughout the week. This might provide more opportunities for parents to build upon their relationships with a Health Visitor. Engaging parents in active conversations about co-sleeping will help parents feel they can continue to approach their health visitor for advice regarding other concerns they have. If the relationship between Health Visitors and parents can be improved, parents are more likely to use this service to support them with their responsive, sensitive and reflective parenting.

Children's Centres

My study has shown how important and valued children's centres in Merseyside are for the parents interviewed. There are many reasons for this. Children's centres are provided parents with a place to seek professional advice and a place to meet other parents who have experienced parenthood. They provide the chance for parents and children to form important relationships with other parents and professionals. All these factors are important in supporting parents with their responsive, sensitive and reflective caregiving and consequently childhood development. It is vital that the local authorities are aware of the importance of the centres to parents in Merseyside when deciding upon their future.

Peer Support

Peer support was seen by parents in my study as vital in supporting them with their sensitive, responsive and reflective care their child's development. Commissioners should note that parents valued the support of other parents who have knowledge and experience. This is important when designing, evaluating or introducing further parenting programmes in Merseyside. BAMBIS breastfeeding support is a key example of how valued a peer support programme can be for parents of Merseyside. Knowing that other mothers have been through the same experiences and faced the same challenges with regards to breastfeeding is valued by mothers. This service is

unique to the Liverpool region and should be considered by other local authorities as it is clearly benefiting those mothers who require additional support with their breast feeding.

Single Mothers

There are many single parent families in Merseyside and we know that single parent families, in some circumstances can have a negative impact upon childhood development. Results from my study show that single parent families would benefit from more support, if possible. It may be useful if commissioners and those managing children's centres and health care in the community could consider which type of support might be most effective and suitable to the needs of these single parents.

Childhood Rashes;

One interesting result from my study appeared whilst parents discussed where they would go to for support and advice. When discussing this, many parents explained their concerns over childhood rashes. My results indicate that many parents of Merseyside may feel ill-informed of common childhood rashes such as eczema, nappy rash, and cradle cap amongst others and could be provided with more information. It is suggested that more time could be taken by Midwives and Health Visitors during the early weeks of life to better inform parents of common or concerning rashes. A simple leaflet or link to a good website with information which was given as part of the initial parenting information pack following birth could provide an easy to access solution to this issue faced by parents. This may be an issue which could also be addressed in the training of Health Visitors and Midwives who may not feel that confident in providing the information.

6.5. Directions for Future Research

In this section I will outline some recommendations for future research which relate to the results of my study.

It is common practice for focus group discussions to be used before designing a questionnaire. This ensures that the questions and results will best answer the research question. In my study a questionnaire would not have explored the views of parents in as much detail and depth as my study. Having now completed my study the results could be used to develop a quantitative questionnaire to explore the opinions and views of parents in Merseyside on a much larger scale. A questionnaire would also eliminate some of the recruitment issues faced during my study. Many parents were unable to commit the time to a 20 minute interview although stated they were willing to take part if it was just a questionnaire they had to fill in. A questionnaire might remove the bias of recruiting through children's centres as could be given to parents in a number of different ways and it would also prevent interview bias. The exclusion criteria in my study omitted non-English speaking parents. A questionnaire could easily be produced in multiple languages and therefore gain an insight into where non-English speaking parents go to for support in Merseyside.

With all UK local authorities taking over the control of funding of their children's services it is an important time for commissioners to look closely at the specific needs of their population. My results once disseminated, may be relevant to other local authorities in the UK, however all settings may need to establish the specific needs and wants of their parents. Although Liverpool has many similarities to other UK cities the methods used and results obtained would not be as applicable to more rural areas of the UK.

Qualitative research into how single parents can be further supported within Merseyside may be very beneficial. The single parents in my study reported difficulties they face as a result of parenting alone. There were not however enough single parent participants included in the study and my study was not designed to fully understand how this specific cohort of parents could be further helped. We do know that there are negative consequences for children growing up in a single parent household and it would be good to address this further.

One universal intervention that was discovered during the literature search was that of the Family Nurse Partnership. Aimed at supporting those mothers aged less than 19 years it is a well-established, evidenced based intervention and is available to those who qualify within Liverpool. However as no parents in this cohort were aged 19 years of below this intervention did not arise during interview. It would be interesting to see if the findings of this study were applicable to those younger mothers in the Merseyside region and if they do utilise interventions such as the FNP. It would be interesting to repeat this study aiming the recruitment at lower age groups of parents. Perhaps recruiting with the help of the FNP nurses as well as finding alternative ways to appeal to younger mothers within the Merseyside region. This would help establish who young parents turn to and what advice and support they value in Merseyside.

6.6. Summary of Thesis

Within this thesis I have outlined the importance of childhood development and how on global scale, we know children are not reaching their full developmental potential by 5 years of age. On a local level in Liverpool, half of children are failing to reach a 'good level' of development, the reasons for which are not always clear. The literature has shown that the concepts of sensitive, responsive and reflective caregiving are necessary in forming a strong attachment between the child-and parent and that this can consequently impacts upon the overall healthy development of the child. There are many factors which can influence a parent's natural caregiving abilities and by supporting parents with their sensitive, responsive and reflective care, we can consequently give children the best possible start in life. In order to do this, the UK government has provided support in a variety of ways including, Health Visitors, Midwives, children's centres and parenting interventions. Parents also have access to privately run services, friends, family, the internet and books. However it is not always clear if parents are accessing these services and if the services provided are valued by parents.

My study aimed to explore the opinions and views of caregivers of children less than 2 years old in Merseyside. Through qualitative methodology it questioned why

parents feel they need additional support with their caregiving, who they are turning to for this support and why they value the support they are receiving. My study comes at an important time as the control of funding is shortly to be given to local authorities. By providing local authorities with evidence into the type of support parent's value they can be better informed when deciding upon changes to local child care services.

Results showed that parents require additional support in a number of ways. This includes; illness in their child, their child's sleeping patterns the protection of their own mental wellbeing and single parenthood. Parents are utilising a variety of resources to support them with these and other parenting issues. This ranged from their friends and family to government and privately run services. When exploring the type of support parents valued three key themes emerged; 'relationships', 'professionalism' and 'experience'. The relationships they formed with the professionals which were trusting and meaningful were just as important to parents as having a place to go where their children could form their own positive relationships. A good relationship was particularly important when it came to parents experiences of Health Visitors. Professional support from health care professionals or friends and family qualified in child care was also highly valued. The experience of other mothers was also important to parents as demonstrated by the peer support of the BAMBIs breastfeeding service as well as their own previous experiences.

Children's centres were highly valued by parents as a place where their child was not only supported in their development but where parents could have had a positive and trusting relationship with professional staff and could meet with other mothers to share experiences of parenthood. The future of these centres is not secure and it is hoped that the results of my study will provide the local authority with the incentive to re-evaluate the future of the children's centres across Liverpool.

It is further hoped that the results from my study will better inform the health visiting service which is also undergoing a period of re-evaluation. The relationship that Health Visitors form with their parents is a vital factor in whether parents will turn to them for support and advice with their sensitive and responsive care. In many cases, parents reported a negative relationship and a lack of opportunity to build the positive relationship they wanted. Therefore it is hoped that Health Visitors will be

supported in actively engaging parents in conversations when delivering new information or answering difficult questions regarding issues such as co-sleeping and rashes. When restructuring services it may be worth considering approaches enabling Health Visitors to have more continuity in one area and also to provide longer and different hours for weigh-in sessions. The quick response via text message or telephone provided by services such as BAMBIS was highly valued by parents and it would be interesting to see if the health visiting service could adopt some of these practices. Parents often don't have concerns but when they do, having advice immediately form an expert that they value, would make a massive difference. All these recommendations will hopefully improve the parent-health visitor relationship for the better allowing Health Visitors to further support parents with their responsive, sensitive and reflective care.

This thesis has provided an in-depth view and opinion of 26 caregivers across the Merseyside region and it is hoped that the results will spark further research into this important area of childhood development. Through the clinical implications suggested it is hoped that universal parents will be better supported in their sensitive, responsive and reflective care and consequently we can go a little way to improving early childhood development in Merseyside.

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Appendix

Appendix A: NAPR Parenting Interventions 0-2years

Intervention	Cohort	Universal: Y/N
Standard Triple P	Parents with mild to serious behaviour concerns	N
Stepping Stones Triple P	Children with physical or learning disabilities	N
Primary Care Triple P	Parents with initial concerns about behaviour or development	Y
Pathways Triple P	Children on child protection register, risk of maltreatment or harm	N
Family Transitions Triple P	Parents going through divorce or separation	N
Family Nurse Partnership	Mothers and Fathers <19years	N
New Beginnings	Mothers in prison	N
Family Foundations	All expectant mothers and fathers, living together, first child	Y if first child
Anna Freud Centre PIP	Parents experiencing difficulties in parent-baby relationship	N
Mellow Parenting - Mellow Babies	Parents with high level social concerns, child protection issues	N
Noughts to Sixes	Parents concerned about child's development	Y
Parents as First Teachers	Parents expecting a child	Y
Parents Plus Early Years	Parents concerned about child's behaviour, especially ADHD	N
The Incredible Years Toddler	Children at risk of developing substance misuse, conduct disorder	N
Fun and Families	Parents concerned about child's behaviour	Y

Group / Individual	Delivered by:	Ages:
Group / Individual, Multiple settings	Trained 'helping professional' QCF level 4/5	2-12years
Group / Individual, Multiple settings	Trained helping professional - health visitor / nurse / educational psychologist	2-8years
Individual, Home - Based	Trained helping professional - social worker/ nurse / psychology	2-12yrs
Group / Individual, Multiple settings	Trained helping professional - nurse /psychology / school councillor / social worke	<12 years
Group - 2 individual follow-up sessions	Trained helping professional - psychology / school councillor / social worker	<12 years
Individual, Home - Based	Trained family nurse	28 weeks gestation to 2 years
Group, Prison	Trained professional	< 1year
Group, Children's Centres, Health Centres, Community Centres	Trained professional - one female one male per session	last trimester, 4-6months old
Individual - grp option available - community setting	Clinical psychiatrist, family/child psychotherapist	<1 year
Group	2 trained professionals, b/g working with families with child abuse / neglect	<5years
Group, Children's Centres, Schools	Training not compulsory	0-6years
Individual, Home - Based - option of group	Health Visitors, Social Workers	pre-birth - 3years
Group / Individual, Multiple settings	Trained 'helping professional' practitioner QCF level 6	1-6years
Group	Trained helping professional - nurse /psychology / school councillor / social worke	1-2years
Group	Prior experience working with parents/children needed	0-11years

UK wide?	Duration	NAPR Evidence Rating:
Yes (website updating)	Ind: 10 weeks , 2hrs / Grp: 8 weeks, 4 groups, 4 ind	4 *
Yes (website updating)	Ind: 10 weeks, 2hrs/ Grp: 9 weeks	4*
Yes (website updating)	3 weekly and one follow - up	3*
Yes (website updating)	Ind: 12 weeks / Gr: 10 weeks	3*
Yes (website updating)	9 weeks, 2hrs, 30min follow-up phone call	2*
90 areas including Liverpool, 11,000 places increasing to 16,000	weekly or fortnightly until 2nd birthday	4*
Only prisons	12 sessions over 6 weeks	3*
? Possibly	5 weekly sessions in last trimester / 4 weekly session	3*
? London	10 weekly sessions	2*
? Scotland-based	14 weeks, up to 5 hour sessions	2*
Yes	7 weekly 2 hours sessions	2*
12 counties UK - not Liverpool	Until third birthday, weekly/fortnightly/monthly	2*
?	8-10 weeks, 2-3hours	3*
Wales	18 -20 weeks 2 hours	3*
Leicestershire only	7 weekly sessions	2*

Appendix B: Information for Participants (final versions)

Postcard handed out by Health Visitors;

Would you like to take part?

Please contact Clare;

07714792978

hlcolive@liv.ac.uk

Or please hand this back to your Health Visitor and we will contact you

Name: _____

Contact: _____

Alder Hey Children's NHS
NHS Foundation Trust

UNIVERSITY OF LIVERPOOL

Parent Interview Information Sheet

Project Title: Can You Tell Me About You and Your Baby?

Research Team: Clare Oliver (MPhil student), Melissa Gladstone (community paediatrics), Dr Lisa Marsland (clinical psychologist), Dr David Taylor-Robinson (senior lecture in public health)

Introduction

We would like to invite you to take part in an interview to discuss how you have gained your parenting knowledge and where you get information from in order to support you and your child as they develop. This would involve you having a discussion with our researchers where you we will be asked your views and opinions on certain aspects of your relationship with your child. Before you make your decision, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If any information is unclear or you would like more information then please feel free to contact Clare or Melissa from the research team (details below).

What is the purpose of this project?

Research has shown that millions of children under five years old are not reaching where they should be in terms of their development worldwide and here in the UK only about 50% of children have reached a level of 'good development' by the time they start school. Many people have researched the importance of developmental stimulation, concepts which include 'Reflective Parenting' and 'responsive parenting' and shown that the early years are really important for children and that the care given to babies, infants and young children by parents can really affect this. In the UK we have resources to support our parents such as Health Visitors, Midwives and Children's Centres, as well as other resources such as the internet and family support. However there is little research into how much parent's value these resources, if they use the resources available and ultimately where they get their information from to support them as a parent. As we know this information is so important and yet services are being stretched, we would like to know what influences parents most. It is more important than ever that we are able to provide parents with the right support in order for them to provide the best outcomes for their child.

Why have I been chosen?

We are contacting you, because you are a parent or care for a child that is less than two years of age in the Merseyside region and you are being seen by your Health Visitor.

How much of a time commitment will this be for me?

We anticipate that each interview will take an hour to an hour and half in total. This will include signing consent forms, introduction and brief presentation of the project. We are planning to hold the interview at your home or local children's centre or another location which suits you and at a time that would be convenient to you. We can look into whether we can help with child care if you have issues with this during the interview.

What will the interviews consist of?

The interviews will be a general discussion with the researcher about aspects of how you care for your child and how you use various support networks or resources such as your local children's centre to support you as a parent.

Do I have to take part?

It is entirely up to you whether or not you take part in this study. If you do not wish to take part, then you can ignore this letter. If you initially agree to take part and then change your mind at a later date, that's also fine.

What will happen to me if I decide to take part in the project?

If you would like to take part, then please return the enclosed reply slip or let your Health Visitor know. Clare or Melissa could then discuss the project further if you would like and answer any questions you may have.

How do I give my consent to take part?

If you agree to take part, we will ask you to sign a consent form on the day of each workshop.

Will I get travelling expenses?

Travelling expenses will be reimbursed if you are required to travel by public transport but it is hoped travelling should be kept to a minimum with all interviews taking part at your local children's centre. We will supply drinks and snacks for the duration of the session.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks from taking part in this study

What are the possible benefits of taking part?

While there are no direct clinical benefits from you taking part in this study, the information you provide could help us to try and improve parental support services available and make them more helpful for families in Merseyside. You may also learn more about some of the services available in your local community that you may wish to use, by taking part in the discussions.

What if something goes wrong and I want to make a complaint?

If you have a concern about any aspect of this study, you should speak to Clare or Melissa who will do her best to answer your questions. If you remain unhappy and wish to complain formally, then you should contact;

- Patient Advisory Liaison service, Alder Hey Children's NHS Foundation Trust, Eaton Road, L12 2AP. Tel: 0151 252 5161. Email: PALS@alderhey.nhs.uk

Will my taking part in this study be kept confidential?

All information discussed during the interview will be kept strictly confidential.

What will happen to the results of the research study?

The results of the study will be shared in reports to Alder Hey Children's Foundation Trust and partner universities. These reports may be published on the Trust's intranet system. Results will also be included in articles for publication in scientific journals to share with other professionals. We will also create a newsletter to report our findings to families who have been involved in the study.

Who is funding this study?

This research is not funded but is part of an MPhil research project. Infrastructure for the project is being supported by Alder Hey NHS Children's Foundation Trust. The researchers will not be receiving personal payments for undertaking this research.

Who can I contact for further information?

If you would like further information on this study please contact

Clare Oliver: 07714792978 (hlcolive@liv.ac.uk)
Melissa Gladstone: 0151 252 5139 (M.J.Gladstone@liverpool.ac.uk)

Alder Hey Children's NHS
NHS Foundation Trust

UNIVERSITY OF LIVERPOOL

Can You Tell Me About You and Your Baby?

Interview

PARTICIPANT CONSENT FORM

Title of Research Project:	Being a reflective parent; opinions from caregivers of how they know to be responsive to their babies. A qualitative study
Researcher(s):	Miss Clare Oliver (MPhil student) Dr. Melissa Gladstone (Senior lecturer in Neurodevelopmental Paediatrics, Alder Hey Children's NHS Foundation Trust)

	Please initial box
1. I confirm that I have read and have understood the information sheet dated [DATE] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
4. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings as part of the study.	☐
5. I understand that confidentiality and anonymity will be maintained where possible within the interview and it will not be possible to identify me in any publications.	☐

6. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐

7. I agree to take part in the above study.

Participant Name	Date	Signature
Name of Person taking consent	Date	Signature
Researcher	Date	Signature

Principal Investigator:		**Student Researcher:**
Name	Dr. Melissa Gladstone	Clare Oliver
Work Address	Alder Hey NHS Children's Foundation Trust	
Eaton Road, Liverpool, L12 2AP		
Work Telephone	0151 252 5250	07714792978
Work Email	M.J.Gladstone@liverpool.ac.uk	hlcolive@liv.ac.uk

Alder Hey Children's NHS
NHS Foundation Trust

UNIVERSITY OF LIVERPOOL

Parent Focus Group Information Sheet

Project Title: Can You Tell Me About You and Your Baby?

Research Team: Clare Oliver (MPhil student), Melissa Gladstone (community paediatrics), Dr Lisa Marsland (clinical psychologist), Dr David Taylor-Robinson (senior lecture in public health)

Introduction

We would like to invite you to take part in a focus group to discuss how you have gained your parenting knowledge and where you get information from in order to support you and your child as they develop. This would involve you having a discussion with our researchers where you we will be asked your views and opinions on certain aspects of your relationship with your child. Before you make your decision, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If any information is unclear or you would like more information then please feel free to contact Clare or Melissa from the research team (details below).

What is the purpose of this project?

Research has shown that millions of children under five years old are not reaching where they should be in terms of their development worldwide and here in the UK only about 50% of children have reached a level of 'good development' by the time they start school. Many people have researched the importance of developmental stimulation, concepts which include 'Reflective Parenting' and 'responsive parenting' and shown that the early years are really important for children and that the care given to babies, infants and young children by parents can really affect this. In the UK we have resources to support our parents such as Health Visitors, Midwives and Children's Centres, as well as resources such as the internet and family support, but there is little research into how much parent's value these resources, if they use the resources available and ultimately where they get their information from to support them as a parent. As we know this is so important but services are being stretched we would like to know what influences parents most. It is more important than ever that we are able to provide parents with the right support in order for them to provide the best outcomes for their child.

Why have I been chosen?

We are contacting you, because you are a parent or care for a child that is less than two years of age in the Merseyside region and you are being seen by your Health Visitor.

How much of a time commitment will this be for me?

We anticipate that each focus group will take an hour to an hour and half in total. This will include signing consent forms, introduction and brief presentation of the project. We are planning to hold the focus group at your local children's centre or another location which suits you and at a time that would be convenient to you. We can look into whether we can help with child care if you have issues with this during the interview.

What will the focus groups consist of?

The focus groups will be a general discussion with the researcher and other parents or people who care for children, about aspects of how you care for your child and how you use various support networks or resources such as your local children's centre to support you as a parent.

Do I have to take part?

It is entirely up to you whether or not you take part in this study. If you do not wish to take part, then you can ignore this letter. If you initially agree to take part and then change your mind at a later date, that's also fine.

What will happen to me if I decide to take part in the project?

If you would like to take part, then please return the enclosed reply slip or let your Health Visitor know. Clare or Melissa could then discuss the project further if you would like and answer any questions you may have.

How do I give my consent to take part?

If you agree to take part, we will ask you to sign a consent form on the day of each workshop.

Will I get travelling expenses?

Travelling expenses will be reimbursed if you are required to travel by public transport but it is hoped travelling should be kept to a minimum with all interviews taking part at your local children's centre. We will supply drinks and snacks for the duration of the session.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks from taking part in this study.

What are the possible benefits of taking part?

While there are no direct clinical benefits from you taking part in this study, the information you provide could help us to try and parental support services available more helpful for families in Merseyside. You may also learn more about some of the services available in your local community that you may wish to use by taking part in the discussions.

What if something goes wrong and I want to make a complaint?

If you have a concern about any aspect of this study, you should speak to Clare or Melissa who will do her best to answer your questions. If you remain unhappy and wish to complain formally, then you should contact;

- Patient Advisory Liaison service, Alder Hey Children's NHS Foundation Trust, Eaton Road, L12 2AP. Tel: 0151 252 5161. Email: PALS@alderhey.nhs.uk

Will my taking part in this study be kept confidential?

All information discussed during the focus groups will be kept strictly confidential and all parents or cares of children will be informed of this within the group before starting.

What will happen to the results of the research study?

The results of the study will be shared in reports to Alder Hey Children's Foundation Trust and partner universities. These reports may be published on the Trust's intranet system. Results will also be included in articles for publication in scientific journals to share with other professionals. We will also create a newsletter to report our findings to families who have been involved in the study.

Who is funding this study?

This research is not funded but is part of an MPhil research project. Infrastructure for the project is being supported by Alder Hey NHS Children's Foundation Trust. The researchers will not be receiving personal payments for undertaking this research.

Who can I contact for further information?

If you would like further information on this study please contact

Clare Oliver: 07714792978 (hlcolive@liv.ac.uk)
Melissa Gladstone: 0151 252 5139 (M.J.Gladstone@liverpool.ac.uk)

Alder Hey Children's NHS
NHS Foundation Trust

UNIVERSITY OF LIVERPOOL

Can You Tell Me About You and Your Baby?

Focus Group Discussion

PARTICIPANT CONSENT FORM

Title of Research Project:	Being a reflective parent; opinions from caregivers of how they know to be responsive to their babies. A qualitative study
Researcher(s):	Miss Clare Oliver (MPhil student) Dr. Melissa Gladstone (Senior lecturer in Neurodevelopmental Paediatrics, Alder Hey Children's NHS Foundation Trust)

	Please initial box
1. I confirm that I have read and have understood the information sheet dated [DATE] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
4. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings as part of the study.	☐
5. I understand that confidentiality and anonymity will be maintained where possible within the focus group discussions and it will not be possible to identify me in any publications.	☐

6. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

7. I agree to take part in the above study.

Participant Name	Date	Signature
Name of Person taking consent	Date	Signature
Researcher	Date	Signature

Principal Investigator:		**Student Researcher:**
Name	Dr. Melissa Gladstone	Clare Oliver
Work Address	Alder Hey NHS Children's Foundation Trust	
Eaton Road, Liverpool, L12 2AP		
Work Telephone	0151 252 5250	07714792978
Work Email	M.J.Gladstone@liverpool.ac.uk	hlcolive@liv.ac.uk

Appendix C: Courses Attended to Support the MPhil

Alongside the reading of literature and books various courses were undertaken throughout the Master of Philosophy year to aid in my work and are discussed here briefly;

Liverpool School of Tropical Medicine: Qualitative Research Methods:
This qualitative course completed in November aided with the decision to undertake this research as a qualitative study. It also helped develop a better understanding of the process of qualitative research and what tools could be used. The course gave me opportunity to practice interviewing techniques and complete a mini qualitative research study amongst those on the course.

University College London: Qualitative Methods: Focus Group Discussion:
This course took place over a day and was available to those currently undertaking a qualitative research project. It allowed for peer review of your own project by other researchers and also the opportunity to trial three questions from your topic guide in a focus group. This further improved my understanding of qualitative research, but also provided a unique opportunity to discuss my project with people who were experts in qualitative research but not associated with my project, as prior to this the project had only been discussed amongst the supervisory team. It also allowed me to consider different techniques to use in my own focus group and refine my ability to chair discussions.

University of Liverpool: Working with Interview Data
This course took place over the course of a day. The morning focusing on interview technique and the importance of a topic guide. The afternoon explored analysis techniques. It was a useful course and gave me a better understanding of qualitative research methods, although was not always applicable to this study as it focuses on narrative interviewing which was not used here.

Appendix D; Participants' Demographics;

Interview Participants;

	Age	Age of Child	Area	Ethnicity	No. Children	Relationship:
001 Cc	25	14 months	Wavertree	Mixed black / white British	1	Mother – single parent
002 Cc	32	7 months	Toxteth	White British	3 – 2 older	Mother – father at home
003 Cc	30	16 weeks	Edge Hill	White British	1	Mother – father at home
004 Sb		22 months	Litherland	White British	2 – 1 older	Mother – father at home
005 Cc	29	5 months	Speke	White British	3 – 2 older	Mother – father at home
006 Cc	35	14 months	Speke	White British	2 – 1 older	Mother – father at home
007 Cc	27	12 months	Speke	White British	1	Mother – father at home
008 Cc	37	19 months	Speke	Mixed – black/white British	1	Mother – single parent
009 Sb	33	14 months	West Derby	White British	1	Mother – partner at home – father away first 6mts
010 Cc	36	12 months	Kensington	White British	2 – 1 older (14)	Mother – single parent, joint custody with cousin
011 Cc	35	12 months (3 mts prem)	Kensington	Black African	2 – 1 older (9)	Mother – single parent, no family claimed asylum
012 Cc	Participant removed from study					
013 sb	31	10 months	Mossley Hill	White British	1	Mother – father at home
014 Sb	32	6 weeks	Mossley Hill	White British	2 – 1 older (2)	Mother – father at home
015 Cc	38	8 months	Granby	Black African	3 – 2 older (6,8)	Mother – father at home
016 CC	42	7 months	Mossley Hill	Mixed Arab / British	3 - 2 older (22 with	Mother – Father at home

					ASD and 5)	
017 CC	36	4 months	Aigburth	White British	1	Mother – Father at home
018 CC	40	4 months	Sefton Park	Mixed white and Afro Caribbean	1	Mother – Single mother
019 CC	29	23 months	Kirkby	White British	1	Mother – Father and grandmother at home.
020 CC	35	23 months	Kirkby	White British	3 – 2 older (11, 18)	Mother – Single (previous hx of domestic violence)
021 CC	28	7 months	Toxteth	White – other	2 – 1 older (3)	Mother – Father at home
022 CC	37	23 months	Toxteth	Black – African	2 – 1 older (5)	Mother – single mother

Focus Group Discussion Demographics;

Participant	Age	Age of Child	Area	Ethnicity	No. of Children	Relationship
FG1	37	5 months	City Centre	Black African	2- 1 older (13)	Mother - single
FG2	30	6 months	Kensington	Asian	2 – 1 older (3)	Mother – partner at home
FG3	37	18 months	Dingle	Black African	3 -2 older (3, 12)	Mother – partner at home
FG4	39	18 months	Toxteth	British – black	3 – 2 older (6, 20)	Mother – single
FG5	38	4 months	Toxteth	Black African	5- 4 older (4, 16, 20, 21)	Mother - single

Appendix E: Letters of Correspondence;

Letter of NHS REC proportional review, NHS Grampian

NRES Committees - North of Scotland
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558474
Facsimile: 01224 558609
Email: nosres@nhs.net

25 November 2014

Miss Clare Oliver
Northend House
The Green, Frampton on Severn
GLOUCESTERSHIRE
GL2 7EY

Dear Miss Oliver

Study title:	**Being a reflective parent; opinions from caregivers of how they know to be responsive to their babies. A qualitative study.**
REC reference:	**14/NS/1061**
IRAS project ID:	**167113**

Thank you for your application for ethical review, which was received on 25 November 2014. I can confirm that the application is valid and will be reviewed by the Proportionate Review Sub-Committee by correspondence. To enable the Proportionate Review Sub Committee to provide you with a final opinion within 10 working days your application documentation will be sent by email to Committee members.

One of the REC members is appointed as the lead reviewer for each application reviewed by the Sub-Committee. The lead reviewer for your application is Dr Mohamed Abdel-Fattah.

Please note that the lead reviewer may wish to contact you by phone or email within the next week to clarify any points that might be raised by members and assist the Sub-Committee in reaching a decision.

If you will not be available within the next week, you are welcome to nominate another key investigator or a representative of the study sponsor who would be able to respond to the lead reviewer's queries on your behalf. If this is your preferred option, please identify this person to us and ensure we have their contact details.

You are not required to attend a meeting of the Proportionate Review Sub-Committee.

Please do not send any further documentation or revised documentation prior to the review unless requested.

Documents received

The documents to be reviewed are as follows:

Document	Version	Date
IRAS Checklist XML		25 November 2014
Non-validated questionnaire Topic Guide	1.0	10 November 2014
Peer Review Comments from 2 October 14 meeting		02 October 2014
Peer Review Comments from 30 October 14 Meeting		30 October 2014
Participant Consent Form for Focus Groups	1.0	10 November 2014
Participant Consent Form for Interview	1.0	10 November 2014
Parent Interview Information Sheet	1.0	10 November 2014
Parent Focus Group Information Sheet	1.0	10 November 2014
REC Application Form	167113/701109/1/324	25 November 2014
Research Protocol	1.0	10 November 2014
Summary CV for Chief Investigator	1.0	10 November 2014
Summary CV for student	1.0	10 November 2014

No changes may be made to the application before the meeting. If you envisage that changes might be required, you are advised to withdraw the application and re-submit it.

Notification of the Sub-Committee's decision

We aim to notify the outcome of the Sub-Committee review to you in writing within 10 working days from the date of receipt of a valid application.

If the Sub-Committee is unable to give an opinion because the application raises material ethical issues requiring further discussion at a full meeting of a Research Ethics Committee, your application will be referred for review to the next available meeting. We will contact you to explain the arrangements for further review and check they are convenient for you. You will be notified of the final decision within 60 days of the date on which we originally received your application. If the first available meeting date offered to you is not suitable, you may request review by another REC. In this case the 60 day clock would be stopped and restarted from the closing date for applications submitted to that REC.

R&D approval

All researchers and local research collaborators who intend to participate in this study at sites in the National Health Service (NHS) or Health and Social Care (HSC) in Northern Ireland should apply to the R&D office for the relevant care organisation. A copy of the Site-Specific Information (SSI) Form should be included with the application for R&D approval. You should advise researchers and local collaborators accordingly.

The R&D approval process may take place at the same time as the ethical review. Final R&D approval will not be confirmed until after a favourable ethical opinion has been given by this Committee.

For guidance on applying for R&D approval, please contact the NHS R&D office at the lead site in the first instance. Further guidance resources for planning, setting up and conducting research in the NHS are listed at http://www.rdforum.nhs.uk. There is no requirement for separate Site-Specific Assessment as part of the ethical review of this research.

Communication with other bodies

All correspondence from the REC about the application will be copied to the research sponsor and to the R&D office for Alder Hey Children's NHS Foundation Trust. It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

14/NS/1081	**Please quote this number on all correspondence**

Yours sincerely

Miss Karen Gauld
Ethics Administrator

Copy to: *Mr Gavin Soady*

Dr Melissa Gladstone

Favourable Opinion Letter and Conditions of Approval

NRES Committees - North of Scotland
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Facsimile: 01224 558609
Email: nosres@nhs.net

8 December 2014

Miss Clare Oliver
Northend House
The Green
FRAMPTON ON SEVERN
Gloucestershire
GL2 7EY

Dear Miss Oliver

Study title: **Being a reflective parent; opinions from caregivers of how they know to be responsive to their babies. A qualitative study.**
REC reference: **14/NS/1081**
IRAS project ID: **167113**

The Proportionate Review Sub-Committee of the NRES Committees - North of Scotland (1) reviewed the above application by correspondence.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager Mrs Carol Irvine, nosres@nhs.net.

Ethical opinion

On behalf of the Committee, the Proportionate Review Sub-Committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
IRAS Checklist XML: Checklist 25112014		25 November 2014
Non-validated questionnaire: Topic Guide	1.0	10 November 2014
Parent Focus Group Information Sheet	1.0	10 November 2014
Participant Consent Form for Focus Groups	1.0	10 November 2014
Peer Review Comments from 2 October 14 meeting		02 October 2014
Peer Review Comments from 30 October 14 Meeting		30 October 2014
Participant Consent Form for Interview	1.0	10 November 2014
Participant Information Sheet (PIS): Parent Interview Information Sheet	1.0	10 November 2014
REC Application Form: REC Form 25112014	167113/701109/1/324	25 November 2014
Research protocol or project proposal	1.0	10 November 2014
Summary CV for Chief Investigator (CI)	1.0	10 November 2014
Summary CV for student	1.0	10 November 2014

Membership of the Proportionate Review Sub-Committee

The members of the Proportionate Review Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

14/NS/1081	**Please quote this number on all correspondence**

Yours sincerely

Professor Helen Galley
Chair