Exploration of the information support needs of parents

May 2012

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Acknowledgements

NHS Health Scotland (particularly Dr Kate Woodman) and its national early years advisory group, provided welcome advice and consistent assistance throughout this research project.

A variety of Children in Scotland member organisations and other children's sector colleagues contributed to this project. They responded helpfully in the recruitment of parent participants for the focus groups, interviews and the online survey, as well as in the conduct of the work itself. Recruitment to the parenting information project, commissioned by Health Scotland, was also assisted by a number of organisations to which advisory group members and other partners in health and education offered sign posting and introductions.

Children in Scotland is especially grateful to the parents of young children who participated directly in this research project. We hope they share our view that it was an enjoyable and worthwhile experience. We hope too that they agree that, we have accurately summarised the views, insights and advice they generously shared with us.

Executive Summary

Aims

The aim of this qualitative research project was to explore the information support experiences, needs and preferences of selected groups of parents with young children, especially very young children, living in Scotland. The scope of the work included how parents obtain information and support in relation to both parenting, in general, and child health issues, in particular.

It is a companion study to a 2011 research report commissioned by NHS Health Scotland on parenting information support.[1] This preceding study by other researchers offered the providers' perspective, whilst the research reported on here focused on parental perspectives within three specific targeted groups: fathers, young parents and parents with literacy issues.

Definitions

Only parents with young children (and living in Scotland) were eligible to participate in this research. 'Young' children were defined as those aged eight years and under, whilst 'very young' children were defined as those aged birth to three years. 'Father' could be either the biological parent or another male in the role of father. 'Young parents' were defined as those aged 24 and under. 'Parents with literacy issues' were those for whom there were concerns about; "the ability to read, write and use numeracy, to handle information, to express ideas and opinions, to make decisions and solve problems as family members, workers, citizens and lifelong learners."[2]

In this research, 'information support' was understood as the knowledge, skills or assistance provided by formal and informal sources to enable good parenting. It focused on facilitating the acquisition and application of information and abilities amongst parents in relation to: the antenatal and postnatal periods; daily rearing of young children; child health/development milestones, and accessing and understanding medical care for their children.

Participants and methods

A total of 132 parents of young children took part in this research. 90 of them were in the core (qualitative) sample recruited among the three target groups of parents. Young parents (a group that ended up including solely young mothers) participated exclusively through focus groups held in three NHS Board areas. Fathers were involved in both focus groups and interviews conducted in two NHS Board areas. Parents with literacy issues were primarily involved through individual or joint interviews held in four NHS Board areas. Of these 90 parents, 66 were engaged in this research through focus groups and 24 by individual or joint interviews. The core sample resided within the boundaries of the following six NHS Health boards: Fife, Glasgow & Clyde, Grampian, Lothian, Tayside and Western Isles.

Sixty of the 90 parents in the core sample lived in areas of high deprivation (according to postcode data using the Scottish Index of Multiple Deprivations). Seventy-one were not in

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[1] Birch, A. and Martin, C. (2010). *Health and parenting information: meeting the needs of all parents*. NHS Health Scotland, Edinburgh. Available from: http://www.healthscotland.com/uploads/documents/14027-Healthandparentinginformation.pdf

[2] *Adult Literacy and Numeracy in Scotland* (2001). Scottish Executive, Edinburgh. Available from: http://www.aloscotland.com/alo/files/ALNCurriculumFramework.pdf

paid employment; 42 lived in cities, while the remainder lived in towns, villages or rural areas. Thirty-six were the only adult in their household, while 52 lived with other adults. Half of the sample had one child and the rest had two or more children. Seventy-five of the 90 participants identified themselves as White (as per the census categorisation). Twenty-two parents were aged between 16 and 19 years and twenty-nine parents were aged 35 years or over.

42 “supplementary” parents of young children completed a survey that explored the same topics as the qualitative research. Parents in the supplementary sample lived within the following 8 NHS Board areas: Fife, Forth Valley, Glasgow & Clyde, Grampian, Highland, Lanarkshire, Lothian and Western Isles. This supplementary sample provided an alternative means of participation to parents from the three target groups who either could not (or chose not to) participate in the project’s focus groups or interviews. It also enabled a little more geographic and socio-economic diversity within the overall parent population.

The supplementary sample did not result in the recruitment of young fathers. However, it increased the number of employed parents (22 of 42), as well those from areas of low deprivation (28 of 42). The supplementary sample also attracted a greater proportion of parents from the three target groups who had two or more children (27 of 42) and who were older than the core sample, (35 of 42 parents in the supplementary sample were at least 25 years old).

Children in Scotland sought parent participants through repeated e-distribution and web posting of a request for nominations (and a project summary) to its membership. This reached voluntary sector organisations, local authorities and other groups working with children and/or their parents across the country. Expressions of interest and offers of assistance were followed up by the research team to determine the eligibility of potential participants.

A basic screening process was used to determine the feasibility of conducting qualitative research with the nominated parents. It was also used to get a sense of the appropriate distribution of parents across the three target groups, NHS Health Board areas and relevant demographic characteristics of potential participants. This process, conducted on a ‘first come, first served’ basis among eligible participants, ended when the maximum number of the core sample (90 parents spread evenly across the three groups) was reached.

Preference for participation was given to existing groups of eligible parents that matched one of the three target populations, e.g. a ‘young mums’ social group. Such preference was exercised not only because of time and resource constraints, but also because of an expectation that these parents would be more comfortable (and thus more likely to share their views, experiences and preferences in a more focused and candid manner) than in focus groups comprised of strangers and/or a mixture of the three eligible parent groups.

Parents selected for inclusion in the core sample were sent additional information in advance, including a consent form and a more detailed description of the research and what their participation would involve. Confidentiality and anonymity in any reporting were assured. Although formal ethical approval was not required for this research, nonetheless, ethical considerations and guidelines were followed. Accordingly, prospective participants were offered the opportunity to contact either Children in Scotland or NHS Health Scotland to ask questions, seek clarification or discuss any concerns in advance of agreeing to participate. Following participation, parents were given either £10 (supplementary sample) or £20 (core sample) to cover any expenses incurred as a result of their participation.

Data were collected by members of the research team, using an agreed topic guide and set of protocols. This topic guide was appropriately amended for use in the conduct of focus groups or individual/joint interviews with the core sample. These topics/questions also formed the basis for the survey that was completed by the supplementary sample. Throughout the research the emphasis was on soliciting parents' experiences, views and preferences in relation to parenting/child health information and information support. Parents were asked not only to reflect upon their past and present realities, but also to offer their opinions about a range of future information support possibilities.

Data from the focus groups and interviews were analysed in relation to the following explorations: (a) to establish the differences and commonalities of views expressed by parents; (b) to assess the strength of views expressed; (c) to establish the extent to which the expressed views were central to the research objectives; (d) to identify the type and degree of diversity that emerged both within and across the 3 parent groups and (e) to consider the implications of the key parental messages for policy and practice with regard to responding to their information/support needs in relation to parenting and child health.

Nine mini case studies were produced; three from each of the parent target groups. These were intended to offer additional information about the lived experiences, challenges and opportunities described by parents. The case studies were largely selected because of the extent to which each broadly reflected the shared perspectives within each of the target groups.

Overarching themes emerging from parental perspectives and preferences

The 3 overarching themes that emerged from this research were as follows:

1. Parent information/support is undermined when parents feel marginalised
2. 'Trust' shapes how information is sought, received and used
3. Parents respond most positively to personalised information and support.

Theme 1: Parents across the three target groups widely expressed a sense of being marginalised in relation to receiving information support. Many reported feeling discriminated against by virtue of their group identity. This sense of exclusion (or struggle to obtain the information and support that they valued) was not perceived as being related to an individual relationship issue, but rather as a result of simply being a father, young parent or a parent with a literacy issue. Membership of each of these groups was perceived as carrying negative stereotypes in society as whole, but especially in the minds of the professionals and providers with whom they had dealings. This perception of being 'discounted' or treated differently/negatively was reported as having a significant impact by most parents; affecting the amount/quality of information support they received and parents' willingness to seek, believe or use various sources of parenting/child health information and support.

Theme 2: 'Trust' appeared as a major concern for most parents and was central to their experiences of and perspectives about parenting information support. Thus, in instances in which sources of information support were felt to be trustworthy, parents were far more likely to seek (and act upon) the available information or advice that was made available to them. Parents had different views regarding whom they felt they could trust and why. All three groups made sharp distinctions between 'trust' in relation to medical information and support, particularly when this was immediately required to assess the significance of and to deal with a child's illness or injury, and 'trust' in relation to information/support received in relation to broader parenting and longer-term child development issues.

Theme 3: Parents voiced a strong preference for individualised solutions to parenting and child health issues. Most commented that a 'one size fits all' approach could not meet their information/support needs. Although parents recognised the universality of many issues, (ranging from concerns about sleeping patterns to issues about eating habits and nutrition), they repeatedly expressed their need to understand how general information about a range of issues applied to their own child and their own specific circumstances.

Parents also indicated that information and support should be on-going and cumulative. If one idea or suggestion did not work for them, then they wanted help and information that would build upon what they had already tried. Their dissatisfaction with standardised or generic answers was two-fold (1) these were neither responsive to the specific realities of their child/situation, nor (2) took account of their own beliefs and preferences as parents.

Parents frequently encountered challenges in their attempts to obtain parenting and child health information support in a way that met their needs. However, they suggested that such challenges could be minimised if stereotyping was resisted and relationships of trust were built. Within this context, parents appreciated individualised responses to their needs that enhanced their parenting capacity.

Findings about parental confidence

Parents across all three target groups generally reported feeling confident in their parenting role – a sense of confidence that had emerged over time. With some exceptions, by the time babies were around six months old, parents' confidence was noted as being markedly higher. For many, this coincided with the establishment of regular parenting routines and was most true for first time parents, although also reported amongst those with more than one child.

Confidence was most strongly expressed in relation to three key areas: (1) providing basic care for their child; (2) a sense of being an 'expert about their own child' and (3) awareness about how to access immediate medical care for their child in response to urgent/emergency situations. While the third area was not a focus of the research team, it was repeatedly volunteered by participating parents as one of the areas in which they felt good about their knowledge and actions.

Participants were also asked to identify aspects of parenting about which they felt less confident. This was taken as a proxy for areas of parental need or interest; and thus, indicative of their desire for, and willingness to accept, further information/support. The researchers primarily prompted responses about parental confidence as experienced at the present time. Nevertheless, many parents chose to reflect on their anxieties, (i.e. instances of lacking confidence) about caring for their newborn babies. All three groups noted that they were neither as well informed, nor as well prepared, as they wished they had been in the initial stage of their parenting journey.

With regard to areas about which parents expressed a lack of confidence, many focused on the key issues that they were currently encountering at the particular age and stage of their child's development. While this gave rise to different and specific concerns, there were four broad topics about which many parents said they were keen to learn more (1) feeding and diet (2) behaviour management (3) personal relationships and (4) emotional well-being/mental health.

Findings about parental views of information/support sources – current and future

Parents shared their thoughts about specific current parenting information support sources, as well as their preferences regarding potential future developments in this area. They overwhelmingly expressed a need and desire for personalised information sources that would enable practitioners/professionals to 'translate' broad information and generic advice into ways that were relevant to their child, their circumstances and their values/beliefs. More impersonal sources of information and support, including written materials, the media and the Internet, were discussed as being potentially valuable, but almost always as secondary/complementary adjuncts to the establishment of good relationships with trusted practitioners/professionals.

Current information/support

The comments of participating parents highlighted several key points. These are outlined below:

- Parents wanted more detailed, but also more understandable (Plain English) information about the specific illnesses, injuries and medical conditions affecting their children. As parents said happened too often, they did not want to simply be given a diagnosis without an explanation that was meaningful to them about what the medical issue was, what was likely to happen, what treatment was being provided and what they as parents could do to help. This information was much more likely to be believed if given to parents by a respected medical practitioner.

- Parents appreciated and preferred a two-way conversation about their child's health, development, well-being and parenting issues. However, in their view such dialogue was now the exception, rather than the rule. In particular, parents wanted to be able to ask questions and to explore what they as parents could do to help their child. Generally, they trusted and respected practitioners/professionals who listened to them and acknowledged their expertise in relation to their own child.

- The usual sources of personalised information and support, e.g. health visitors, social workers, GP surgery staff and Early Years educators/carers were not automatically accorded trust and respect by these parents. Instead, parents expressed widely differing opinions about their experiences with such professionals and about the value/credibility of the information/advice provided by them. Parents tended to judge the non-medical, child development and parenting information/advice that they received according to the empathy, practical knowledge/experience and the quality of the relationship of the information giver, rather than upon the professional's/practitioner's formal credentials, role, status or academic knowledge.

- Parents expressed their clear belief about the value of peer support/social networks, but these were rarely described as the primary source of child health, medical or parenting information. This positive view of such networking may reflect the fact that many participating parents were active members of peer support groups.

- Among the more impersonal sources of information and support parents tended to most highly rate NHS 24, certain commercial products/producers and websites and publications carrying either the NHS or the Scottish Government 'brand'. With some notable exceptions, parents tended to less favourably rate (and/or pay little attention to), television, radio, newspapers, magazines and commercial publications as crucial sources of child health information or guidance.

Future information support

Parents had less to say, and expressed less definite opinions about potential/future sources of information and support about child health and parenting. Again, they voiced a very clear preference for more personalised, equality-based relationships with their "human" sources of information. The key messages from parents across the target groups were as follows:

- Using the Internet to search for relevant information and advice was familiar to and valued by parents, (even those with literacy issues). However, skepticism was expressed about the credibility of unfamiliar sources, i.e. those that lacked a known and respected 'brand'. Even websites eliciting a positive reaction among parents were perceived as inadequately responding to their very specific, individualistic questions and concerns about their child in their situation. Websites could not (yet) provide the bespoke, contextualised information and support that was most wanted by participating parents. Accordingly, these websites were viewed as useful sources of questions to ask of professionals/ practitioners, avenues to explore further or opportunities for confirming the information and advice that they had received personally.

- Social media (such as Facebook) and newer technologies (such as mobile phone applications), were largely perceived as being unimportant as primary sources of child health information or parenting support. A minority of parents appreciated that these might evolve into something more meaningful/useful, but currently, they felt that there was too much uncertainty about what might be eventually possible via social media to evoke stronger, more definite reactions from them.

- There was a limited, but generally positive expression of interest (when prompted) in educational DVDs as a medium for showing valuable child health information and graphically demonstrating good parenting practices. One advantage noted was the convenience of being able to watch such DVDs at times and places that were suitable to parents. However, television, radio programmes, and traditional media as a whole, did not elicit favourable reactions in relation to being future sources of information support.

Findings about group-specific parent information/support issues and needs

In addition to the views and preferences expressed across the sample distinctive findings emerged from the three parent groups. Although there were similarities across the groups there was also considerable diversity within and between them. This emphasised the need to *not* to treat parents and subgroups of parents, as a homogenous group, but rather to recognise and respond to the individual characteristics and circumstances presented by individual parents and children.

Key findings from each of the parent groups are outlined below.

Fathers: This group comprised those who were the primary or lone carers of their children; fathers living with their children and the mother (or other partner) and fathers who did not live with their children, but who had regular contact with them. The other distinction among fathers was between first-time fathers of young children and those who already had other children of varying ages.

Four distinctive findings emerged from fathers as a group:

1. The importance of gender-specific information and support that is explicitly directed to improving the knowledge and engagement of fathers.

2. The perceived roles and responsibilities of fathers. These have been changing rapidly at both a societal level and at a personal level, e.g. the expectation that fathers would be more equally and positively involved in raising children (as opposed to the traditional role of being 'breadwinner and disciplinarian').

3. Fathers saw themselves as (or aspired to be) active agents, not passive recipients, of child health and parenting information/support.

4. Sources of information and support for 'parents' should directly seek out and involve fathers from the pre-birth period forward.

<u>Young mothers</u>*:* This was the most homogenous group in relation to their demography. The majority had no education beyond school level, with a good proportion having no qualifications. Nearly half of these young mothers reported being the only adult in their household, whilst others lived in different household arrangements, for example, with their partner, family or a friend. Many young mothers reported either finding a new partner since becoming pregnant or having no partner. Most were not in paid employment and thus had limited access to early childhood education and care services for their children under the age of three. This in turn reduced their access to potentially valuable sources of information and support.

The three distinctive findings that emerged from young mothers as a group were as follows:

1. Their traditional valuing of 'mother' as the person who is responsible for parenting (with little reliance upon the involvement of biological fathers or other males).

2. Their reliance on a 'common sense' approach to parenting. This was largely described as both following their own feelings/instincts and mirroring the parenting styles and models with which they were most familiar or most comfortable.

3. Their having to deal with numerous life transitions since becoming pregnant and a new mother, e.g. leaving school, changes in living arrangements and means of support, increased responsibilities, loss of previous relationships and marked changes in how they spent their time.

<u>Parents with literacy issues:</u> These parents were the most divergent in relation to their socio-economic and cultural backgrounds. However, communication difficulties, (of varying types and degrees) were common across this target group. Such communication issues were compounded for parents who had not been born or raised in Scotland. Many also frequently encountered difficulties related to understanding the cultural dimensions of the communities in which they lived or how public services worked. However, even Scots-born parents identified a variety of factors (from speech and language concerns to

unsatisfactory schooling experiences) that contributed to or resulted in their experience of literacy/communication issues.

Despite diversity, there were four distinctive points made by these parents as a group:

1. A desire for alternative sources of information and support, e.g. having staff in the offices of service providers who would explain written communications received by these parents.

2. The importance of cultural factors in dealing well with parenting and child development issues.

3. Speech and language as a priority child development issue.

4. Difficulties accessing health services (particularly among immigrants who had an incomplete understanding of how 'the system' in Scotland worked).

The findings summarised above were derived from parents in the core sample who participated in focus groups and interviews. Their views were similar to those expressed by the 42 other parents of young children who were part of the supplementary sample and who participated in the research by completing a survey that explored the same topics as those raised with the core group of parents.

Recommendations

The researchers offer policy and practice recommendations that are based upon their exploration of the information support experiences, needs and preferences of the parents with whom they engaged. These included a set of cross-cutting recommendations for improving information/support for all three groups of parents, followed by specific recommendations about offering better information support to fathers, young mothers and parents with literacy issues.

Regarding all three target groups of parents

We recommend that:

- Continuing professional development opportunities for professionals and support staff are provided to encourage and assist them to provide more personalised information and support in ways that parents understand and appreciate. Such opportunities would help professionals to overcome the issues related to the stereotyping/marginalisation of fathers, young mothers and parents with literacy issues. Additionally, it would help professional sources of parenting and child health information and support learn to develop trusting relationships with parents, based on mutual understanding, respect and effective two-way communications between parent and professional.

- Parent's information and support sources should develop alternative formats/products/services that more fully take account of the needs, views and preferences of young mothers, fathers and parents with literacy issues. These should begin with new information/support around the four topics identified across the three target groups (1) feeding and diet (2) behaviour management (3) relationships and (4) emotional well-being and mental health. Some of these new developments may be technological, (e.g. mobile phone applications), however, they should emphasise the media and strategies for which parents in these three groups have indicated a preference, namely face-to-face sessions bringing together parents and information sources for discussion and explanation. These should be easily available in places routinely frequented by these target groups and should be developed (co-produced) with parents from these three groups.

- Both face-to-face peer support groups and virtual social networks of parents in each of these three target groups should be more widely available and better supported. These should function not only as a source of empathy and empowerment, but also as a forum for acquiring, sharing and discussing child health/parenting information. Parents in these target groups expressed a preference to be connected with and to learn from/with, both formal and informal sources of information and support. This preference should be honoured in practice.

Specifically regarding fathers

We recommend that:

- Fathers are equally represented in relation to the images and content of resources developed for ‘parents’ and that their different situations, (e.g. lone fathers and non-resident fathers) are reflected/represented appropriately in such resources. Father-specific resources should be developed and fathers should be involved in the creation of information and support that is specifically intended to be used by them.

- Providers of information/support are encouraged to offer father-specific information/support and services that are equally accessible to and comfortable for, fathers and mothers. This inclusion of fathers should encompass the complete parenting journey, from the preparation stage for eventual fatherhood through to the antenatal stage, and should continue throughout their life as parents.

- Guidelines and policies are appropriately implemented thereby ensuring that fathers (as well as mothers/carers) will receive copies of all significant information sources about their child from health, education and children’s services, irrespective of which parent is resident with the child. The exception would be where there are child protection concerns.

Specifically regarding young mothers

We recommend that:

- Opportunities presented by Scotland’s *Curriculum for Excellence* (and the emerging National Parenting Strategy) are built upon to increase the quantity and quality of education about and preparation for motherhood. This should include information and support about contraception, family planning, relationships and child health/development.

- Inter-agency training (CPD), for professionals and practitioners around meeting the diverse needs of young mothers is encourage and strengthened. This should include an emphasis on how to successfully engage with this target group.

- Young mothers’ access to high quality information and support for continuing their education, enhancing their job readiness, securing employment and dealing well with childcare issues is improved.

Specifically regarding parents with literacy issues

We recommend that:

- Health services are well known to, fully accessible by, and welcoming of parents of young children who find it difficult to communicate effectively (for whatever reason) through written and/or spoken English. Sometimes this will require written or oral translations into a broader range of languages. At other times this will require improved communication by friendly staff who take the time to listen and explain well.

- More opportunities for connecting parents of young children who have similar literacy issues are created. This would enable these parents to find and network with each other on a voluntary basis. These opportunities should be built around existing information and support sources that this target group find comfortable and helpful, e.g. some adult education units or community groups/centres.

- There is increased production of a greater quantity and better quality of printed, audio and web-based resources on child health and parenting for this target group, e.g. in relation to wording and graphics/font type/size. Parents with literacy issues should be encouraged and assisted to actively engage in developing such resources.

Conclusion

Parents in this research study overwhelmingly preferred personal, empathetic support from individuals in dealing with their specific needs for information and support on child health and parenting. They were not opposed to technological resources but regarded them as a supplement to, not a substitute for, individualised information and two-way respectful communication. They were keen to rely on medical and other health professionals to provide technical and immediate care for their children when required.

In relation to more routine, less urgent parenting and child development issues young mothers, fathers and parents with literacy issues drew upon a broader range of influences. These included informal sources, (e.g. family, friends and social networks) that helped shape their parenting style and preferences. Those parents who were otherwise reluctant to engage with professionals, showed greater willingness to take account of current health/ parenting messages in instances where professionals demonstrated trust and empathy (that is when parents had a sense of being listened to and being taken seriously). In turn, these parents responded favourably to professionals and other information sources who showed their willingness to address parents' specific queries and provided advice that resulted in meaningful solutions to parent's concerns about, and hopes for, their children.

1. Introduction and background

1.1 Definition of terms

Only parents having young children residing in Scotland were eligible to participate in this research. ‘Young’ children were defined as those aged eight years and under, whilst ‘very young’ children were defined as those aged birth to three years old. ‘Father’ could be either the biological parent or another male in the role of father for a young child. ‘Young parents’ were defined as those aged 24 and under. ‘Parents with literacy issues’ were those for whom there were concerns about: “The ability to read, write and use numeracy, to handle information, to express ideas and opinions, to make decisions and solve problems as family members, workers, citizens and lifelong learners” (Scottish Executive, 2001). The same Scottish Executive report, *Adult Literacy and Numeracy in Scotland* -- also noted that: “Literacy and numeracy are skills whose sufficiency may only be judged within a specific social, cultural, economic or political context” (Ibid).

In this research, ‘information support’ was understood as the knowledge, skills or assistance provided by formal and informal sources to enable good parenting. It focused on facilitating the acquisition and application of information and abilities amongst parents in relation to: the antenatal and postnatal periods; daily raising of young children; child health/development milestones; and, accessing and understanding medical care for their children.

The earlier parenting information research report commissioned by NHS Health Scotland (Birch and Martin, 2010) suggested that further definition of the concept of information support is required. In this report, information support was understood as the assistance provided by others to enable the realisation of active parenting, facilitating acquisition and application of knowledge and skills amongst parents in relation to pregnancy and raising young children. Thus, information support in this context implies more than a simple imparting of knowledge to parents, but can be perceived as encompassing active engagement that helps to maintain and sustain parenting input.

In this study, the nature of information support was interpreted broadly. The specific objectives listed earlier were reflected in the topic guides created for this research, (see Appendix 9), but modified by parental explanations of the information support they wanted and received. This incorporated how parents understood and addressed issues that arose throughout the early parenting journey, such as their health-related choices about pregnancy and childbirth and their perceived role as primary carers for babies and young children.

General parenting information, child health issues, child development milestones and accessing and monitoring medical care for their children were topics either raised by researchers, (see 2.4.3) or voiced repeatedly by the target parent groups as being of importance to them. Researchers also explored parental views and preferences in terms of alternative formats and new technologies for information support.

1.2 Context

This section sets the scene for this research study and briefly outlines the current policy and research context that informs the work undertaken in relation to parenting information support needs, experiences and preferences.

1.2.1 Policy

In recent years, there has been a growing awareness of the importance of the early years (particularly pre-birth to three years of age) for the long-term health, wellbeing, learning and life chances of Scotland's population. This has been reflected within an increasing consensus in Scottish policy and practice regarding the need to strengthen support for young children and their parents or carers and those who work with them, (Deacon, 2011). This mirrors a European trend, as in the Early Childhood Education and Care EC Communication, (European Commission, 2011; and Children in Scotland, 2011).

However, debate continues in relation to the precise nature and delivery of such support, particularly given the diversity within society where families are likely to require different solutions depending on their individual characteristics and circumstances. Health Scotland's commissioning of research on information support for parents of young children is an example of governmental interest in, and awareness of, this reality. Another significant policy development was the Scottish Government's announcement that it is developing a National Parenting Strategy in which parenting from pre-birth through primary school would be one of this Strategy's three priorities, (The Scottish Government, 2011 a).

The Scottish Parliament Finance Committee's 2010-11 *Inquiry into Preventative Spending* (Scottish Parliament, 2011 a) recommended prioritising funding for early years' initiatives in recognition of the importance of positive child development upon national wellbeing across a wide range of indicators. Similarly, The Scottish Government's Scottish *Spending Review 2011 and Draft Budget 2012-13* identified 'preventative spending' as a core theme and accorded strong emphasis to investment in early years provision, including the announcement of an Early Years Change Fund (The Scottish Government, 2011 b).

In relation to child health, there has been a great deal of recent national policy development around maternity services and early years provision. The 2005 Annual Report of Scotland's Chief Medical Officer documented the consequences of poor health in childhood and emphasised that: 'Good health for children is important morally, politically and economically. The importance of good health in childhood cannot be overstated', (The Scottish Executive, 2006, which includes citation of Antonovsky, 1967). Similarly, *Equally Well*, *the report of the Ministerial Task Force on Health Inequalities,* (The Scottish Government, 2008) made clear the connections between health inequalities during the early years and later health inequalities and poor health outcomes. These national reports have been followed by a raft of Scottish Government and NHS early years health policy initiatives and guidance, including:

- *A Refreshed Framework for Maternity Care in Scotland* (Maternity Services Action Group, 2011). Available from: http://www.scotland.gov.uk/Publications/2011/02/11122123/11
- *A Pathway of Care for Vulnerable Families (0-3)* (The Scottish Government, 2011 c). Available from: http://www.scotland.gov.uk/Resource/Doc/347532/0115722.pdf
- *Improving Maternal and Infant Nutrition* (Scottish Government, 2011 d). Available from: http://www.scotland.gov.uk/Resource/Doc/337658/0110855.pdf
- *A New Look at Hall 4 – the Early Years – Good Health for Every Child* (The Scottish Government, 2011 e). Available from: http://www.scotland.gov.uk/Resource/Doc/337318/0110676.pdf
- *SWHMR Combined Pregnancy and Postnatal Record (version 6)* (NHS Scotland, 2011). Available from: http://www.healthcareimprovementscotland.org/default.aspx?page=12484

In addition, two key policy initiatives in Scotland both reflect the growing priority placed on early years provision and act as a catalyst for further action and improved, integrated practice. The first of these is the 10-year national strategy called *The Early Years Framework* (Convention of Scottish Local Authorities and The Scottish Government, 2008). The other is *Getting it right for every child* (GIRFEC), a multi-agency approach to assessment and support for children throughout Scotland (The Scottish Government, 2010 b). Both policies have been incorporated into national guidance published as, *Pre-birth to Three: Positive Outcomes for Children and Families* (Learning and Teaching Scotland, 2010), which is targeted at practitioners working with young children and their families.

A common feature of current Scottish early years policies is the adoption of family based approaches to ensuring positive child development. This can be seen in Government-led initiatives such as the Family Nurse Partnership programme operating in some parts of Scotland (The Scottish Government, 2011 f). It also is manifest in resources targeted specifically at parents. These include the publications and websites, *Ready Steady Baby!* (NHS Health Scotland, 2012) and *Ready Steady Toddler! (*NHS Health Scotland, 2010) as well as The Scottish Government's *Play Talk Read* initiative, available from: http://www.playtalkread.org.

Complementary approaches are apparent in other social areas, such as *The National Carers' Strategy for Scotland 2010-2015* and ideas about community capacity building founded within the field of community development, (The Scottish Government, 2010 a). These acknowledge parents and carers as key partners (alongside professionals) in promoting the health and well-being of young children.

Through work to build upon assets of parents, relatives and other community members in encouraging positive child health and development, the role of professionals is increasingly conceptualised as largely one of facilitation - preparing, supporting and assisting parents to act effectively as their child's first and primary educators, protectors and health promoters. The Scottish Government's aforementioned National Parenting Strategy is likely to help shape local policy objectives and priorities regarding models of professional interventions to better prepare and support families. It is envisaged that effective information support will comprise a major component of future policy and practice that seeks to enhance capacity and competence in parenting.

The Scottish Government has indicated that the National Parenting Strategy will be based upon the idea of 'progressive universalism', in which some services and support are available to all prospective and actual parents, whilst additional support will be made available to only to those requiring it to reach a basic standard of parenting. Recent parent support initiatives in Scotland, e.g. the Family Nurse Partnership programme, Sure Start, Healthy Start, mother and toddler/parent groups or parenting classes, have only been accessible in a limited number of localities with eligibility for inclusion restricted to certain parents.

Other sources offer access to information and support on a more universal basis, e.g. antenatal classes, one-to-one assistance (e.g. contact by health visitors in the post-partum period, as well as appointments, as needed, with GPs or other health care providers). There also are relevant telephone helplines / websites in Scotland, e.g. NHS 24, ParentLine Scotland and Enquire. Supporting information is available in printed or electronic formats such as the *Scottish Antenatal Parent Education Pack* and materials from Parenting across Scotland. However, all of these potentially universal services and sources of information support have a history of less than universal take up. Despite these challenges, it is encouraging that in a time of diminishing public sector resources, Scotland's agencies and voluntary sector organisations have continued to give priority attention to parenting, particularly in relation to the pre-birth to pre-school years.

1.2.2 Research

Scottish early years policy and practice are informed by a growing body of Scotland-specific evidence. At the same time, it is bolstered by, and draws upon, a substantial international evidence base about the importance of the early years period in establishing life trajectories adult health and well-being outcomes. Examples include: *Foundations of Lifelong Health Are Built in Early Childhood* (Center for the Developing Child, 2009); *The wide-ranging adverse health consequences of adverse childhood experiences (*Edwards *et al,* 2005 and *Science to Practice: Dissemination of LONGSCAN findings*, 2012)[3]3.

Beyond this scientific and professional literature about early childhood, there is significant emerging evidence in Scotland on the influence of parenting on early child development. To illustrate, NHS Health Scotland has recently completed a three-year initiative to develop mental health indicators for children and young people, which includes an extensive evidence base on both early years provision and on the influence of parents of the mental health of their children, (NHS Health Scotland, 2011).

As already noted, the research presented in this report is the second stage of research commissioned by NHS Health Scotland on exploring the information needs of parents. The earlier research report written by the Scottish Centre for Social Research (ScotCen) conducted a mixed method approach to explore information support needs of parents of young children in Scotland from the perspective of the providers of such information support, (Birch and Martin, 2010). Practitioners reported they believed many parents experienced considerable barriers to receipt of information and emphasised the need for a more sophisticated understanding of how a diverse range of information needs can be met across the parenting population. Recommendations were made regarding further exploration of information support needs from the perspective of specific groups of parents.

Building upon this first piece of research, Children in Scotland was commissioned to consult three specific groups of parents regarding their information support needs, as set out in 1.1 and discussed further in Chapter 2 of this report. Further relevant research has been commissioned by Health Scotland in recent years that adds to knowledge about parenting, including: *Exploration of parent education delivered in the antenatal and immediate postnatal period in Scotland*, (Dobbie *et al*, 2010). The specific contribution the research presented in this report will make is to add to this emerging Scottish evidence base about information support experiences, needs and preferences from the perspective of three groups of parents of very young children.

In tandem with research commissioned by national NHS agencies in Scotland, a large-scale, quantitative, longitudinal study of children (and, to a certain extent, of their parents) is also being undertaken. This project - *Growing Up in Scotland* (GUS) – also adds considerably to what is currently known about child development and parenting – for instance through an event report called: *Supporting parents to be all they can be* (The Scottish Government, 2011 g). In particular, a series of reports issued by GUS includes evidence about parenting from the first five years of this longitudinal study, including *Parenting and children's health,* (Parkes and Wight, 2011) and *Maternal mental health and*

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[3] www.iprc.unc.edu/longscan

its impact on child behaviour and development, (Marryat and Martin, 2010). These reports further the evidence presented in their Research Briefing 4: *What parents say about children's health and professional support* (Growing up in Scotland, 2010).

Whilst some research highlights the importance of social networks in the provision and receipt of caring roles generally (Bowling, 1991; Phillipson, 2001; Wilmott, 1986), it is unclear how such support mechanisms operate to influence values and attitudes towards parenting of young children. It is acknowledged in the Early Years Framework that parents in disadvantaged communities are less likely to access formal services that can assist in the parenting role, (Convention of Scottish Local Authorities and The Scottish Government, 2008) and are, therefore, more likely to depend upon informal sources of support for guidance and advice. One relevant report from the GUS study does highlight the issue of informal support in parenting, (Mabelis and Marryat, 2011). However, further qualitative work is required to develop an in-depth picture of how such influences shape values and attitudes towards parenting, as well as how they affect parenting styles and information support within Scotland.

At the present time, for instance, little is known about intergenerational familial value transmission or community influences in relation to parenting. A useful example of qualitative work that adds to this knowledge is *Perspectives on Early Years Services: Qualitative Research with Service Users* commissioned by the Scottish Government's Learning Directorate, (Reid and Banks, 2008). In line with the aforementioned GUS reports, this research also found that parents seek information specific to their situation and indicated that much advice and support they receive is more general than they would ideally wish. The research presented in this report adds to this emerging body of literature.

2. Methodology

2.1 Introduction

This chapter sets out the methodology for the research presented in this report. The research adopts a largely qualitative approach to ascertaining how selected groups of parents with young children seek and utilise parenting and child health information support. A variety of data collection methods were used to obtain the views and preferences of participating parents, both in relation to information support for parenting on a day-to-day basis, as well as those needs that arose on an *ad hoc* basis, such as during times of their children's illness or injury. Fieldwork took place during September through to the beginning of December 2011.

The chapter initially sets out the research design, including data collection methods and analysis, before concluding with issues specific to the research process, including ethical considerations and reflections on the methods used.

2.2 Research topics and questions

The overall aim and specific objectives of this research were presented earlier (see 1.1). The research topics and questions used during the fieldwork were derived from these specific objectives and reflected in the project's topic guide (see Appendix 9). Information support, as defined in Chapter 1, included all forms of parenting and child health information in any format known to parents and whether accessed through personal contact, written materials or technological means.

The main topics explored with the three target groups were:

- General confidence as a parent
- People as information sources
- Physical access to information and support
- Information gaps
- Media and (established) technological information sources
- New and potential technological sources
- Preferences about the way forward for information support.

As an *aide-memoire* for researchers during the fieldwork, these topics (and the study's specific objectives) were incorporated into a set of questions that served as a checklist to ensure consistency and comprehensiveness. These included:

- What expectations do parents have of information and information support?
- What factors gave rise to good or bad parental experiences of information and information support?
- What are parents preferred and most trusted/respected, information sources about child health and parenting?
- What explains these parental preferences and views?
- What are the major perceived gaps in terms of information and information support?
- What circumstances contribute, or serve as a barrier, to effective and successful information support?
- What impact does the relationship between parents and sources of information/support have upon parental confidence and behaviour?

- What are parental views about, and level of interest in, new formats and sources of future information and information support about child health and parenting?

2.3 Recruitment, selection and characteristics of parent participants

Three specific, targeted groups of parents were included in the research: fathers, young parents and those with literacy/numeracy issues. Parents in these groups were considered by Health Scotland to be among those parents who had been less successfully engaged by previous information support efforts than was the norm for Scottish parents.

2.3.1 Core sample

It was agreed with Health Scotland that a core sample of 90 parents would be sought to participate in this study. These were the parents who would be invited to take part in either a focus group or an interview with one or more members of Children in Scotland's research team for this project. The criteria established were that these parents:

- Had at least one child aged 8 or younger who resided in Scotland
- Must either reside, or be in regular contact, with this young child
- Would be evenly divided among three target groups (fathers, young parents and parents with literacy issues)
- Would reside primarily, but not exclusively, in postcode areas within the more deprived quintiles on the Scottish Index of Multiple Deprivation [Note: although the SIMD is an imperfect proxy for socioeconomic status, Health Scotland's evidence-based view was that such parents were more likely to have been less successfully served by current information/support sources on child health and parenting]
- Would reflect some degree of demographic diversity (e.g. not be skewed to include parents only from central city neighbourhoods or only from rural areas)
- Would reflect some degree of service area diversity, (e.g. not all reside within the same local authority or health board area)
- Would reflect some degree of diversity in terms of their relevant affiliations (e.g. not all be involved in the same programme or with the same agency/organisation).

Children in Scotland sent out a series of e-mails to its nationwide membership of children's sector groups, including local authorities, voluntary sector organisations and professional bodies, as well as a variety of individual members and other colleagues/contacts who were in a position to identify or nominate eligible parents. These e-mails were accompanied by the posting of basic information on the Children in Scotland website (and reminders in weekly e-updates to members) about the research study and requesting assistance in recruiting eligible participants. Responses to this request were collected by, and coordinated within, the research team.

The research team was comprised of six individuals, all of whom worked on a limited, part-time basis during the life of the study. Given time constraints and divergent areas of expertise (although there was shared experience in qualitative research), it was decided to allocate a lead team member for each of the three target groups (fathers, young parents and parents with literacy issues) and for the other team members to assist colleagues, as needed. All team members came together periodically for project design, planning, progress review, data analysis and reporting purposes.

The lead researcher for each group, supported as needed by colleagues, followed up on the responses received and made recruitment/selection decisions about potential parent participants on the following basis:

- Adherence to the eligibility criteria noted above
- Feasibility/practical issues, e.g. not using limited resources to conduct one face-to-face interview in a remote location
- ‘First come, first served’, not only because of time constraints, but also to eliminate researcher preferences as a possible source of selection bias.

A Parent Information Project Participant Recording Grid (see Appendix 7) was developed and regularly monitored to note the number, characteristics and distribution of parents interested in participating. Discussions across the team ensured that the diversity criteria across the three target groups of parents were met.

The responses included nominations of several pre-existing social groups; particularly of fathers and young mothers. It was decided that such groups offered two advantages: a) a degree of comfort among participants that could lead to more candid discussions in a ‘one off’ focus group setting than would likely be the case with either ‘strangers’ or a mixed group combining parents across the three target populations; and, b) a more efficient use of the resources available to conduct this research.

Following screening using the aforementioned criteria, eligible individuals and groups were provided with one or more of the following documents, as appropriate: a) Parent Information Project - Information for Staff (see Appendix 3); b) What Parents Should Know about the Parent Information Project (see Appendix 4); c) Parent Information Project Participant Consent Form (see Appendix 5); and, d) Parent Information Project Biographical Information Form (see Appendix 6).

In addition to providing details about the nature of this study and the uses to which parental contributions would be put, these documents also explained the basic ethical principles and procedures that were in force. For example, prospective participants were assured that their confidentiality would be protected and that their comments would be anonymised and not be traceable back to them. Although Health Scotland had already determined that formal ethics review/approval was not required for this research, ethical considerations and guidelines were routinely assessed and followed.

The maximum number of 90 parents in the core sample was attained and divided, as intended, into the three groups. However, there was a degree of overlap among the groups. For instance, six individuals recruited and regarded as fathers or parents with literacy issues could also be categorised as young parents. Later, the researchers also learned (in part because of the difficulties revealed in completing the required forms) that some fathers and young parents could also be categorised as parents with literacy issues.

The core sample resided within the boundaries of the following six NHS Health boards: Fife, Glasgow & Clyde, Grampian, Lothian, Tayside and Western Isles. 60 of these 90 core sample participants resided in areas of high deprivation (according to postcode data using the Scottish Index of Multiple Deprivations). 71 were not in paid employment, 42 lived in cities, while the remainder resided in towns, villages or rural areas. 36 were the only adult in their household, while 52 resided with other adults. Half of the sample had one child and the rest had two or more children. 75 of the 90 participants identified themselves in one of the Census categories of “White”. The age distribution ranged from

22 parents aged 16-19 to 29 parents aged 35 or over (see Appendix 1, *Participant characteristics of the core sample (n=90),* for further, detailed information).

2.3.2 Supplementary sample

It was agreed with Health Scotland that a supplementary sample of parents from the three target groups would be recruited and included in this study. There were two reasons for doing so. First, Health Scotland and the research team wanted to offer alternative methods of engaging with parents interested in being part of this study, but who might not have wanted, or been able, to be involved through a focus group or face-to-face interview. Second, researchers anticipated that there might be either selection biases or less diversity than desired within the core sample. Recruiting additional parents offered a way of dealing constructively with these possible problems.

Recruitment of the supplementary sample could not begin until researchers had secured, and knew the characteristics of, the core sample. However, all parents who were offered a place in a focus group or the opportunity to be interviewed in person were also given the option of becoming part of the supplementary sample instead. Specifically, it was stated in the background documents that the research team was available to conduct telephone/Skype interviews or an online or paper survey covering the same topics as for the core sample. Assistance in completing the survey was offered on an ‘as needed’ basis by researchers.

However, there were very few parents who had been invited to participate in a focus group or interview who instead opted to use any of these alternatives means to express their views and preferences. And, using the criteria for inclusion listed (see 2.3.1), there were not very large gaps that had to be filled. The three gaps were in relation to young fathers (aged 24 or under), employed parents and those living in villages or rural areas.

The same criteria were employed for the supplementary sample as for the core sample. The same screening and selection processes were used again by the research team with this sample, too. The project’s recording grid (see Appendix 7) was used once more to monitor the distribution of eligible parents and to aid in the selection process. The only significant differences were that: a) there was no recruitment through pre-existing social groups of targeted parents (which countered a selection bias in the core sample); and, b) there was an emphasis on specific sub-groups who were under-represented in the core sample (young fathers, employed parents and those from villages and rural areas).

Although there was a maximum set of an additional 90 parents for the supplementary sample, 42 actually ended up becoming involved and completing a survey (either online or a hard copy version). This sample did not result in the recruitment of young fathers. However, it did increase the number/proportion of employed parents (22 of 42), as well those from areas of low deprivation 28 of 42). The supplementary sample also attracted parents from the three target groups who had two or more children (27 of 42) and who were, on average, older than the core sample (35 of 42 were at least 25 years old). For more detailed information about their characteristics, see Appendix 2: Participant characteristics of the supplementary sample (n=42).

2.4 Data collection and analysis

2.4.1 Research tools

Bespoke research tools were developed for the project. The same semi-structured instruments were created and used at all focus groups and personal interviews. For these, a set of project posters (also available as handouts) were designed (see Appendix 8) to capture the main issues raised within the research objectives. These were primarily discussion prompts used by the research team with participants, and helped shape discourse around information support issues. The survey questions used with the complementary sample also covered the same topics (see Appendix 9).

Through an iterative process, the research objectives were translated into language parents were perceived as feeling comfortable using, and contained the following broad topics agreed by PIP and Health Scotland:

- What I feel confident/comfortable about in relation to my child's health
- What I feel less confident/comfortable about in relation to my child's health
- Who I turn to for advice/information about parenting and child health
- How I get parenting and child health information now
- Parenting and child health topics I can't find enough information/advice about
- If, how and why I actually use the following 'old' information sources
- If, how and why I actually use the following 'new' information sources
- How I would prefer to get parenting and child health information/advice in the future.

2.4.2 Participant distribution by method

Within the core sample, young parents were engaged exclusively through focus groups, parents with literacy issues primarily by personal interviews and fathers through a combination of focus groups and personal interviews. In addition, parents across each of the three groups were included in the survey, with the greatest number of participants in the complementary sample being fathers. Numbers of participants, by group and method of engagement are set out in Table 1 below.

Table 1 – Methods of engaging with parent participants (n=132)

	Fathers	Young Parents	Parents with literacy issues	TOTAL
Focus groups	24	31	11	66
Personal interviews	3	0	14	17
Joint interviews	3	0	4	7
Online surveys	19	7	5	31
Paper surveys	2	0	9	11
TOTAL	51	38	43	132

A total of ten focus groups were held (ranging in size from five to twelve parents in each). The focus groups each lasted approximately two hours. A total of twenty-four individual or joint (e.g. two or more eligible parents together) interviews were also conducted, lasting between one to two hours. Core cohort activity with eligible parents took place in the following six NHS Board areas: Fife, Glasgow & Clyde, Grampian, Lothian, Tayside and Western Isles. Survey participants resided in the following eight NHS Board areas: Fife, Forth Valley, Glasgow & Clyde, Grampian, Highland, Lanarkshire, Lothian and Western Isles.

2.4.3 Core cohort data collection

At the beginning of the focus group or interviews, the purpose and background to the project, as well as the expectation of confidentiality (‘what is said in the group stays in the group’ for instance) were explained verbally to participants. Although efforts were made to ensure written consent was obtained in advance from each participant, in reality, most chose to complete this form on the day. A monitoring form was also completed by each participant prior to data collection, with assistance given where necessary by a project team member. Following participation, parents were given £20 to cover any expenses incurred.

The focus groups were each conducted by two members of the team; one in the lead role and the other in a support role. Personal interviews were usually conducted by two staff, sometimes two team members and sometimes one team member and a local support staff person known to the parent. All focus groups sessions and interviews were audio recorded. Based upon their areas of expertise, different team members played the lead role with each of three targeted groups of eligible parents. To promote consistency and quality across groups, two detailed research and procedural protocols were written for the project team, one for focus groups; the other for interviews.

Immediately following each focus group or personal interview a Key Messages recording sheet (see Appendix 11) was completed by the respective team members. This subsequently was followed by a more detailed write-up of each interview or focus group. All recordings and notes were stored in locked or password-protected filing systems in accordance with confidentiality and data protection procedures agreed between Children in Scotland and Health Scotland.

2.4.4 Data analysis

Data analysis occurred initially within groups and thereafter across groups, broadly following a thematic framework analysis technique, (Richie and Lewis, 2003). This allowed emerging findings to be identified specific to respective parent groups, as well to ascertain which were common across groups. The approach to data analysis is described below.

Data obtained from the various methods were initially organised, reviewed and analysed by the lead researchers for each targeted parent group and jointly scrutinised by the two involved staff members to compare and contrast their observations and findings. Partial transcripts of focus groups and selected interviews occurred to facilitate analysis. Due to the relatively small numbers of questionnaires completed per complementary parent group within the survey, analysis of these data was incorporated into the wider data set. In the following chapters quotes from parents are ascribed to their target group, along with details about the number and age of their children. The number that precedes this brief description relates to the data segment from which the quotation has been derived to ensure that a “dominant” voice does not prevail.

3. Overarching parental themes about information/support

This chapter is the first of three chapters in this report that present the research findings. It sets out the three factors that parents repeatedly and strongly asserted were the keys to understanding their experiences, views, preferences and behaviours in relation to information and information support about child health and parenting.

Essentially, parents told researchers that these were the primary ‘filters’ that informed their perspective and their actions, for example, parents did not express blanket judgments (positive or negative) about health visitors and the health visiting service. Instead, parents told research team members that they assessed and responded to individual health visitors based upon one or more of the three criteria noted below.

The three overarching themes emerging from participating parents in this research were:

1. Parent information/support is undermined when parents feel marginalised
2. ‘Trust’ shapes how information is sought, received and used
3. Parents respond most positively to personalised information and support.

These parent-led themes broadly address the objectives of this research (see 1.1) and provide a context for the more detailed parental comments in Chapters 4 and 5 relating directly to the research objectives. Although there were nuanced differences in how these themes were experienced, both within and across groups, broad commonalities existed across all three parent groups. These themes arose first and foremost from the focus groups and interviews with the core sample. However, they proved to be consistent with the responses to the surveys completed by parents in the supplementary sample.

Three other introductory points may be useful. Firstly, it was apparent, and not unexpected, that parents could not always separate the notion of ‘parent information support’ from their daily experience of parenting. Secondly, parents often chose to regard ‘child health’ as being about the medical care of their child, which informed the examples they used to illustrate their points. As reported later in the findings, parents also frequently drew a distinction between child health information/support and medical information / support, a distinction that informed the differing ways in which they spoke about advice about medical care versus advice about child development. Thirdly, all quotes appearing in this chapter are from parents in the core sample, made during focus groups or interviews.

3.1 Parent information/support is undermined when parents feel marginalised

The three parent groups targeted in this research (fathers, young mothers and parents with literacy issues) were selected by Health Scotland, in part, because of prior evidence that these were parent populations that had been less successfully engaged than the norm in child health and parenting information/support. This lower level of engagement may have been the result of feeling negatively stereotyped, disrespected, ignored, misunderstood and not listened to or taken seriously, i.e. marginalised.

This was background information for the researchers and not a topic that was explicitly raised or prompted during the focus groups or interviews, (or later in the survey). However, the degree to which participants across the sample raised this concern and reported feeling marginalised was striking. Having been broached by parents themselves, researchers followed-up and probed what they meant and how this sense of marginalisation applied to information/support about child health and parenting.

There were some significant commonalities voiced by parents across the target groups. The first was that this perception of how they were viewed and treated was not universal or ever-present. It did not apply to those people with whom they had already established positive and close relationships, e.g. they did not feel marginalised by their friends. Rather, these parents said that they felt marginalised primarily in their interactions with professionals; some other parents (who they thought ‘looked down’ upon them) and in most public/social settings, (where they felt that they were likely to be judged unfavourably as a parent). What follows are the main parental explanations of this perceived reality.

3.1.1 Marginalisation was based upon group identity

Parents repeatedly and forcefully confirmed they felt marginalisation in relation to accessing parenting information support, with some reporting feeling discriminated against by virtue of their group identity. This sense of exclusion or struggle to obtain support appeared less related to individual relationship issues (e.g. a personality clash), but rather flowed from their group status as a father, young mother or person with a literacy issue.

Of course, qualitative research of this kind cannot provide either independent verification of such treatment or prove that group identity was the crucial factor. What it can do is report how widespread this perception was among the whole sample of parent participants. The following quotes are representative of what researchers heard from parents in the focus groups and interviews, not exceptional or extreme examples.

> ‘You walk in there (‘mother and toddler’ group) and nine times out of ten, unless you’re really lucky, you feel as if you are treading on sacred territory of someone else and, you know, “how dare a man come in here!”‘ (122, father of 1 child, aged 2 years)

> ‘I felt like I was victimised when I had my baby ‘cause of my age. I was put in a bay with first time mums and they were older mums and the nurse said in front of everyone “Ok, look you’re a second time mum, you can show everyone how to do it” and they all turned and looked as if “you can’t be having your second”’. (230, young mother of 2 children, aged 7 months and 3 years)

Such treatment was also a common occurrence of such treatment (as reported by parents) among the professionals and support staff dealing with these parents. Parents often highlighted the negative assumptions or unfavourable/incorrect judgements made about them based (parents believed) upon their group identity.

> ‘I just tell them I need help. Some people in the doctor’s surgery can be quite stuck up. They can’t be bothered helping you. They think you’re just lazy; say, “Are you sure you can’t?” Some of the questions are quite hard’. (301, young mother (also with a literacy issue), of 1 child, aged 18 months)

> ‘They think that we’re all stupid wee lassies that got up the duff, so treat us different’. (203, young mother of 1 child, aged 2 years)

Parents across the sample told researchers that they felt uncomfortable when faced with such attitudes and disliked being treated in this manner. That this dynamic had implications for parent information/support is an issue explored below.

3.1.2 Marginalisation impacted upon both seeking and receiving information/support

Parents made it clear to researchers that, when they experienced marginalisation, it had an adverse effect upon the way in which information/support was both sought and received. Responses to perceived marginalisation varied from parent to parent.
Some parents said that, under such conditions, they gave up trying to obtain parenting and child health information that they had wanted or needed. Others sought to reduce their level of contact with those they perceived as discriminating against them or treating them unfairly (e.g. by trying to leave the hospital maternity unit at the earliest opportunity). The most determined parents said they would persist in efforts to engage, but expressed a degree of disappointment or resentment that they found it a struggle to be heard and taken seriously. As one core sample parent stated: ‘It took me one and a half years to get listened to. I felt like I was basically of no importance’. (118, father of 5 children; 3 aged 8 and under, i.e. 2, 5 and 8 years)

Comparing what they were being told by parents across the three target groups led the research team to observe two patterns as they shared what had been learned with each other. Firstly, there were roughly equal levels of parents voicing examples of their marginalisation across the groups. Secondly, there were different responses described ’with the fathers in this sample being most likely to resist or challenge such treatment; young mothers most likely to withdraw and become isolated; and, parents with literacy issues having more individualised responses.

An example of the response from young mothers in this sample can be found in their behaviour in relation to antenatal classes. Many said that they had not regularly attended antenatal classes (and some participated in none at all). One young mother told a fairly typical story among the focus group participants in explaining her behaviour.

> ‘I went down to that health drop-in place and asked about the antenatal classes. The woman there said “You’re very young. Are you sure you want to have a baby? I could book an abortion for you”. And, I was like, out of there and I just got up and walked out’. (227, young mother of 1 child, aged 1 year)

Parents frequently voiced that they did not feel listened to, respected or adequately engaged with by health staff.

> ‘There was a thing in my surgery for… kids first aid… And when I went and asked about it… They says: “It’s just going to be women – do you really want to go?” I said “yes”… They were like: “We’ll give you a phone back”. I never heard anything back from them’. (106, father of 4 children, aged 12, 8, 7 years and 4 months)

> ‘A midwife came in and just grabbed my boob and forced her on me. And the next day, I just asked for a bottle because they put me off’. (209, young mother of 1 child, aged 2 years)

One mother from Mexico with literacy issues said that she ‘knew’ her child required medical treatment when her daughter became ill with an accompanying high temperature. Having taken the child to hospital, she reported that, (in her view) only a cursory medical examination was undertaken by medical staff and she was told her daughter would be fine. She said it was only through her insistence upon further investigation that it was discovered the child had a bacterial infection, which was then treated successfully with antibiotics.

In another case, a father whose son had a peanut allergy said that he found his son's nursery unable (or unwilling) to deal satisfactorily with this condition. He expressed his concerns about his son's safety and health, but stated that he was not listened to nor taken seriously by the staff:

> 'When we told them he's allergic to peanuts, one of the nursery staff said: "Well, I like peanuts, so I'm not going to stop bringing them in"…If he got one of them on the floor and the child picks it up – even if he touches them he comes out in hives. If he eats it, his heart stops'. (113, father of 1 child, aged 3 years)

Therefore, a parent had to always be at the nursery with this child. In this situation, the father said he could not understand why such simple training would not be given to nursery staff when a child presented with a specific condition, such as a severe allergy.

There may be alternative explanations for the treatment that these parents reported. Perhaps their relatively low socioeconomic status (rather than, or in addition to, their group identity) explains why they experienced behaviour they said was unsatisfactory. However, this research confirmed that the participating parents perceived themselves as being marginalised and gave examples of how the negative attitudes and treatment they reported adversely affected the extent to which they sought or received information/support about child health and parenting.

3.2 'Trust' shapes how information is sought, received and used

'Trust' was repeatedly and strongly voiced by participating parents as being central to their experiences with, and perspective on, information/support. Where sources of information and support on child health and parenting were deemed to be trustworthy, parents were far more likely to take account of information or advice provided. As in the above theme parents expressed differing views regarding whom they felt they could trust and why. Differences in perceptions between groups are reported later in this report, especially Chapter 5. However, at this point, the theme of trust will be discussed particularly in relation to ideas around the type and diversity of available information support.

3.2.1 'Trust' in relation to pressing medical concerns

Parents drew a sharp distinction between 'trust' in relation to medical information and support, (particularly when immediately required to assess the significance of, and deal with, child illness or injury), and 'trust' in relation to broader parenting and longer-term child development issues, (see 3.2.2 regarding this latter issue).

Although it was not an issue emphasised by the researchers in the focus groups or interviews, parents (across all three target groups) frequently raised medical care as a priority concern of theirs. In potentially urgent medical situations, parents across the core sample reported placing their trust primarily in medical care providers. In such situations, parents said that their trust was based upon their perception of the specialised, technical knowledge and expertise of medical practitioners.

Parents reported making different choices as to who to contact first when a pressing medical concern about their child arose, e.g. A&Es, NHS24, or GP surgeries. They said that practical considerations, such as the nature and perceived severity of the problem, as well as the time/day of the week, entered into their decision-making. For example, even if they had a very positive, trusting relationship with a specific health professional, most parents said they were disinclined to contact that medical care provider out of normal working hours (if they knew of another acceptable alternative). The reason usually cited by parents was that they did not feel comfortable ‘imposing’ on this provider when off-duty. NHS24 or the closest A&E unit were the out-of-hours services most often cited by participants as acceptable alternatives of which they were aware.

Three of the young mothers spoke of their baby turning blue and having to be rushed back to the hospital within the first couple of weeks after birth. They reported not having been aware that this urgent medical situation was a possibility. Consequently, they all said that they found the experience upsetting, especially since they felt unprepared to deal with it. However, as all their babies survived, it was cited by these young mothers as an example of gaining trust in the medical care providers who were helpful at that critical moment.

3.2.2 ‘Trust’ in relation to daily parenting

Ways of meeting less pressing information/support needs were discussed in a qualitatively different manner by participants. ‘Trust’ in relation to daily parenting concerns, (such as feeding, behaviour or monitoring overall child well-being), was a topic of conversation among parents across the core sample. They said that they used a different set of criteria for trustworthiness in these areas (compared to those used in the context of immediate medical care).

For this type of parenting information/support, ‘trust’ was far more likely to be vested in those people who parents perceived as empathetic, respectful and willing to listen -- and who they believed had a positive, non-judgemental attitude toward them. Most parents spoke about these qualities/criteria as the ones they rated more highly than occupational status, technical knowledge or formal credentials in relation to parenting.

A significant proportion of parents, especially young mothers, said that empathy from professionals was of great importance to them. Although a more extreme example than the norm, one young mother expressed her preference for empathy over formal credentials/professional knowledge, as follows:

> ‘If they haven’t got any kids, why are they a midwife? They can’t advise you on anything or tell you; explain how it feels. Just say: “It’s not that sore”. They don’t know’. (202, young mother of 1 child, age unknown)

Indeed, numerous parents across the groups said that if professionals were also parents, then this facilitated trust in relation to information from them about parenting, child health and child development. Conversely, a significant minority across the core sample indicated that not being a parent created a barrier to trusting professional information and advice.

Some parents reported they had initially trusted health care providers on broader parenting and child health issues, but said that their initial trust had evaporated in the face of what these parents described as indifference, rudeness or disrespect by professionals. In such reported cases, parents tended to personalise their negative treatment, (e.g. ‘she was useless’), instead of generalising it to the whole staff or profession.

At the opposite end of the spectrum, parents across the core sample cited examples of making a considerable effort to remain connected with a professional source of information/support on parenting or child health and whom the parent trusted and regarded as being notably supportive and helpful. For instance, one parent spoke about changing GP practices in order to maintain contact with a ‘very good’ health visitor who had been relocated.

3.2.3 ‘Trust’ in relation to differing professional opinions

As discussed in 3.3 below, parents expressed the need for personalised solutions to specific problems and issues encountered in day-to-day parenting. Partially, this appeared to stem from the complexity and diversity of information about child health and parenting encountered in modern society. Participants said this created the need to sift and analyse information in a way that had meaning for them, their child and their circumstances.

Parents discussed this as another kind of ‘trust’ issue. Specifically, the lack of consistency in child health and parenting information was cited as making it harder for parents to know what information/advice to believe and whose word to trust. As one parent explained:

> ‘I’m more confused. Different people saying different things, health visitor saying one thing, doctors saying another’. (220, young mother of 2 children, aged 2 and 1 year(s))

Such inconsistency appeared to create (or reinforce) doubt amongst parents regarding the validity and credibility in health messages from professionals. Despite this, the great majority of participating parents considered the NHS ‘brand’ as a trustworthy source of information. Websites were noted as a medium where it was not always easy to trust the source of the information. However, parents across the core sample described NHS and Government websites as being particularly credible:

> ‘I use NHS24; ‘cause if you just use websites, you don’t know. With NHS, you know it’s NHS and not just somebody sitting typing in stuff’. (201, young mother of 1 child, aged 6 weeks)

> ‘I need to know clearly that I’m on a site that I can trust and…I do know that if a webpage is ending in ‘.gov’, then it’s been approved by the government’. (305, mother (with a literacy issue) of 2 children, aged 7 and 14 years)

However, parent comments in focus groups and interviews made it clear that all three target groups felt decisions about parenting, child development or child well-being did not necessarily have one right answer, or a single durable, definitive truth that must be adhered to rigidly. This perceived range of acceptable answers/decisions was described by participants as giving them the freedom and power to determine what to do themselves. At least on some issues, parents said they didn’t feeling pressured to adhere to unified professional advice. As one parent stated:

> ‘I think we had to come down to our way of doing things. Every couple does, I think’. (129, father of 2 children, aged 5 and 3 years)

As has been mentioned already and will be described in later chapters, participants did not describe trust as a stable or permanent phenomenon. Although there was a voiced parental predisposition to trust certain professionals and the NHS initially, they also made it plain that their trust had to be earned by the particular information/support providers they encountered in order for trust to be maintained.

3.3. Parents respond most positively to personalised information and support

An unambiguous message voiced by core sample participants was their need and preference for individualised solutions to parenting issues and consequently, their opinion that ‘one size fits all’ approaches cannot meet their information/support needs. When explored in more detail, parents indicated that such personalisation was most likely to occur in the context of an established, positive, two-way relationship with the source of the needed and wanted information/support. How could it be personalised, they asked, if there was no personal knowledge of the parent or child by the information/support source?

The desire for personalised information/support was most frequently mentioned in relation to parenting and child health issues that arose at particular stages and times in a child’s life, e.g. when weaning or teething or around toileting or sleep issues. In other words, parents sought solutions to the particular dilemmas or concerns with which they were dealing at that particular phase of their child’s development. Participants displayed far less interest in what they regarded as more general or future-oriented health and parenting information, e.g. the long-term effects of passive smoking on child development or how best to prepare their two year-old child for success in primary school.

These parents of young children said they wanted information and support that enabled them to respond well to their children’s needs in the here and now. They expressed a preference for information, advice, assistance that was based upon the provider having a more than superficial understanding of (and taking into account) their personal situations as parents and the specific ways their children presented an issue. Parents also indicated that support should ideally be on-going, so that if one idea or suggestion didn’t work, further knowledgeable support could be offered to build upon what had already been tried. Standardised or generic answers were not felt by these parents to be particularly useful.

3.3.1 Responsiveness to parent and child realities

As noted in 3.1.2, many participants did not feel genuinely listened to and taken seriously by professionals. However, effective personalisation of information support is predicated upon effective listening. Not being heard properly led these participants to perceive a lack of responsiveness from such professionals. As voiced by one parent:

> ‘Some of them don’t really listen properly to the person, to the mum’s instinct. Even though that person is older, they don’t really listen to me and it’s like the mums’ instinct to feed their baby’. (206, young mother of 1 child, aged 16 months)

However, many parents in the three groups also cited positive examples of people who had been responsive to their particular situations in what they said felt to them like appropriate, helpful and appreciated ways. One mother cited this example:

> ‘She’s (health visitor) nice enough. Lucy had a rash. She was bleeding on her leg, I phoned her (health visitor). She said it was probably the washing powder, but she said “Come down”. She fell off the bed once, I called for that. She had spots all over her back; I thought it was chicken pox. I phoned for that’. (301, young mother (with a literacy issue) of 1 child, aged 14 months)

When information/support was personalised, the actual advice and assistance being offered were much more likely to be accepted, and acted upon, by parents. They tended to express enthusiasm and gratitude for those who knew the family situation and could give an individual response with positive feedback. Two parents described such experiences:

> ‘The same receptionist has been there for a long time – very helpful. They’ll say: “Do you know what you need to do for this?” and are used to us coming round. With the

> doctor knowing, the health visitor knowing, the surgery knowing, the support's there if need be'. (302, father (with a literacy issue) of 2 children, aged 4 and 3 years)

> 'I went back to my health visitor again and she referred me to… a behaviour specialist… She gave me a few interesting tips about behavioural issues… it was quite useful… I felt great because she said: "You've got a great rapport with your daughter – everything's fine"'. (125, father of 3 children, aged 14, 13 and 1 year(s))

As will be described in more detail in Chapter 4, parents across the core sample noted that their sources of personalised information/support could be a diverse group, including professionals, educators, family and friends/peers (especially those having children, too). What they said mattered was that these were sources with whom a relationship existed; and thus, there was a personal connection enabling personalised assistance/advice.

3.3.2 Discussing and explaining information and advice discussed

Participants frequently indicated that child health and parenting information/advice would be best absorbed and acted upon by them if: a) they understood the reasoning and facts behind the advice; and, b) they could see how the information/advice applied in practice to their situation. One young mother described this point by stating:

> 'You hear about the 'terrible twos', but you don't actually hear about what it involves. My wee boy's fifteen months, but he's taking tantrums now and I think he shouldn't be doing that 'cause he's not two. But, the health visitor gives you *Ready Steady Baby!* and explains the terrible twos and that'. (211, young mother of 1 child, aged 1 year)

People who took the time and made the effort to explain their advice (not simply impart it and expect parents to accept and act on it) were described by participants in all three target groups as valued sources. They said this was because such explanations enhanced their parenting capacity and confidence and made challenging situations more tolerable (or at least more understandable).

For instance, one parent with literacy issues grew anxious when her son developed worrying changes in his behaviour following an MMR vaccination. After researching the situation on the Internet, she said she had become concerned that he may have autism. However, this mother expressed doubt that the health professionals to whom she had access would take her concerns seriously. So, she raised this matter with a family member (a former primary head teacher) who answered her questions to the mother's satisfaction and offered advice and support that this mother found helpful. What mattered was having an information/support source who she believed would address the worries on her mind.

Parents indicated that personalised explanations, information and advice helped them achieve peace of mind. They said it also helped them to parent more effectively by, for instance, gaining greater understanding or new skills. Follow-up conversations were greatly appreciated when provided and missed when absent. As one father pointed out:

> 'My son was just diagnosed… with ASD (Autism Spectrum Disorder)… He's been quite slow in learning all the way through nursery… Even though I knew that, it was still quite hard for me to accept, even when he got diagnosed… As soon as they tell you, there's no follow-up. Nobody comes to you afterwards and says… we're going to make an appointment for you to speak to somebody about this and see how you feel and how your son feels'. (107, father of 1 child, aged 8 years)

Parents in the core sample most often shared stories of negative experiences, i.e. those in which there was minimal or no follow-up; explanations nor discussions. Many said that they understood that GPs and other professionals worked under serious time pressures. But, that realisation did not diminish their stated desire for a deeper understanding of their children's problems, conditions or needs. These parents expressed their hope that more in-depth, personalised information and support would become available to them.

It should be noted that the responses in the surveys completed by the 42 parents (fathers, young mothers and parents with literacy issues) in the supplementary echoed and confirmed the findings reported here about the core sample (see Appendix 12). These same three themes about marginalisation, trust and personalised information/support also emerged from the data provided by these additional parents involved in this research.

3.4 Summary

This chapter set out three key overarching themes that coloured and shaped the lived experiences of child health and parent information/support amongst participants from all three target groups. It is clear from these accounts that parents frequently encounter major and persistent challenges in their attempts to obtain parent information/support in a way, or to a degree that they regard as meeting their needs adequately.

However, parents also expressed the hope that (and occasional instances when) stereotypes and marginalisation could be overcome; trusting relationships with sources of information/support established and maintained; and, personalised assistance and advice provided. When this occurred, the knowledge, capacity, decision-making and behaviour of participants around child health and day-to-day parenting can be enhanced. The following two chapters build upon these broad themes by describing the research findings in greater detail; firstly in terms of commonalities across the groups and then in terms of the differences among the three target groups of parents.

4. Cross-cutting findings about parental views on information/support

Chapter 3 reported parental perspectives of the key factors they said made the most difference in terms of their ability and willingness to successfully seek and receive information/support about child health and parenting. This chapter also presents the needs, experiences, and preferences that all three parent groups shared with researchers. The cross-cutting findings in this chapter more directly address the research objectives and topics (see 1.1) discussed with the 90 participants through focus groups and interviews.

The research team found commonalities across the core sample beyond those already addressed in Chapter 3. There were consistent patterns in terms of what parents said about the specific topics in which they had the most (and least) amount of confidence. ‘Confidence’ was used in this research as a proxy for ‘needs in relation to child health and parenting information and information support’.

It offered a positive, non-technical way of introducing this area of investigation to parents. It also prompted an opening discussion on those subjects about which they felt good in terms of their knowledge/actions and then, those subjects that elicited more uncertainty or self-awareness of gaps in their knowledge or behaviour as parents (see Appendices 8 and 9 [posters and topic guide]). The working assumption of the research team was that topics about which parents already felt very confident were less likely to be ones for which they would seek further information/support; whereas, those about which parents reported feeling least confident would be the ones for which additional information/support would be most welcome. The final area of commonality reported here concerned their preferences about a variety of past, present and potential sources of information/support.

4.1 Common areas of confidence among participants

Overall, the great majority of parents across the three target groups reported feeling confident and positive about their knowledge and performance in their parenting role. They said that this sense of confidence had emerged and grown significantly over time. Whilst there were individual variations, by the time babies were around six months old, parental confidence was described by participants as being markedly higher than in the immediate post partum period. This was most true for first time parents, but was also reported by those parents in the core sample having more than one child.

As described in Chapter 2, researchers used posters and/or a topic guide to prompt and focus parental responses, as well as to provide consistency. However, it was also deemed to be important to offer latitude to parents to express their views and priorities (even if unanticipated or absent from the research protocol). What all three groups of parents said was that ‘confidence’ was most strongly felt in relation to three key areas discussed below:

1. providing basic, day-to-day care for their child
2. a sense of self as being the ‘expert’ in terms of knowing their child and
3. an awareness of how to access medical help for their child in urgent/emergency situations.

Across the core sample, parents described themselves as being confident about most aspects of daily parenting and most issues about basic child health and safety. The rise in confidence coincided with their voiced sense of a new ‘normal’ in their daily lives. For all the groups, but cited most explicitly by young mothers, the key to feeling confident was the establishment of routines involving schedules, regular patterns of activity and predictable responses from their babies and young children. The remark of one young mother was representative of the responses recorded.

> 'It took me a while before I got them into a good night-time routine. I had to change his bath time three or four times before I found one that suited him. It's just trial and error'. (211, young mother of 1 child, aged 1 year)

Building from this emerging sense of regularity and predictability, parents stated that they felt they knew their child better than other people did. As primary carers who had spent considerably more time than anyone else with their child (and in a range of situations), parents reported a growing sense of being 'an expert' about their own child. Discussions in focus groups and interviews indicated they derived comfort, a sense of empowerment and heightened confidence from their shared feeling.

Parents noted that whilst professionals had greater professional/technical expertise than them about babies and children, generally, no one knew or understood their child as well as themselves. Related to this broadly held view among participants, some parents (especially fathers) made explicit reference to the importance they accorded to feedback received directly from their child.

> 'Positive reactions from my child – that really did give me a lot of confidence in my parenting'. (102, father of 2 children, aged 2 and 1 year(s))

> 'I think when your child's happy and she shows it by cuddling you, kissing you, it shows that you've done something right'. (112, father of 2 children, aged 8 and 3 years)

In addition, a cross-section of parents reported generally being confident about their ability to access satisfactory medical care for their child in urgent/emergency situations, such as sudden declining health or injury. Having said this, some parents who had found themselves in this position did report barriers to accessing such support, but ultimately managed to obtain it in time to meet their child's presenting needs (see Chapter 5).

4.2 Common areas of less confidence (and need for information/support)

After exploring areas of greatest confidence, participants were then asked to identify aspects of parenting and child health about which they felt significantly less confident. This was taken as a proxy for parental need or interest, and gave researchers an indication of where participants might be especially receptive to further information and support.

Researchers emphasised an interest in current parental feelings of confidence (or lack of confidence). However, parents across the target groups chose to also highlight the extent to which many of them lacked confidence in the post-partum period. Anxieties about caring for newborn babies were common expressed by parents in the core sample. Many parents reported feeling unprepared, scared and uncertain about how to care adequately for such their newborn sons or daughters. The following comments were representative.

> 'When I first saw [my son] in hospital, I was too scared in case I hurt him. [He] could fit in my hand almost'. (113, father of 1 child, aged 3 years)

> ‘I wouldn’t bath my baby until about 3 weeks ago because he was so wee’. (201, young mother of 1 child, aged 6 weeks)

While common, participants did not universally describe a lack of confidence in relation to newborn care. Such concerns were less prevalent (less commonly stated) among those parents in the target groups who said they received helpful antenatal information classes and support. Newborn care was also less commonly cited as a confidence issue by those participants who already had other children of their own or who noted that they were already experienced in providing extensive childcare to babies, e.g. much younger family members.

Beyond newborn care, numerous participants across the core sample described themselves as being significantly less confident about the four topics discussed below. Researchers discovered that parents were describing a lack of confidence about the same four basic topics, even though the specific examples cited by parents differed in terms of the age and stage of their children. For instance, whether the story told by parents was about what they regarded as the child’s excessive crying, or being uncooperative or saying things in public that parents described as inappropriate, the underlying common concern was a lack of parental confidence about behaviour management.

4.2.1 Feeding and diet

From breastfeeding versus bottle feeding to weaning and nutrition issues, a majority of participating parents across the core sample said they had not received sufficient personalised information/support to feel confident. As one father noted:

> ‘My wife was maybe sometimes anxious and exhausted… She had mastitis with every baby and I didn’t understand what that was… the early signs. You learnt as time went on, and that was quite scary for her and us. I think giving some knowledge about breastfeeding to the dad would be better’. (128, father of 3 children, aged 6, 4 and 2 years)

Young mothers, in particular, found professional advice on the amount of milk to give (and when to wean to solid foods) counter to meeting their perceived needs of their babies. This frequently resulted in such parents becoming more reliant on informal sources of advice and to be led by what these parents stated were their babies’ demands:

> ‘My health visitor went mad, flipped her lid when she found out my daughter was getting rusks at three months old. She slammed out the door and said she wasn’t coming back and said it was a disgrace; that it was just a quick way of getting out of feeding a bairn that was hungry. And I said: “It wasn’t a quick way, as she’s not taking a full bottle…I’m not going to sit back and see my bairn totally crying cause she wasn’t just wanting milk”, she wanted something with it’. (203, young mother of 1 child, aged 2 years)

Milk hygiene, appropriate amounts and types of milk or food, suitable recipes for the post-weaning stage and dealing with ‘fussy’ eaters were all areas about which parents indicated they would welcome more information and advice. For instance, one mother (326, non-native English speaker with literacy issues, age of child unknown) wondered about the advisability of feeding her daughter the foods she would have used in Africa during the weaning process, such as millet, sorghum or maize porridge. However, as discussed in Chapter 3 this information/support, although desired, will be effective only if offered, or made available, in ways that do not elicit a negative parental reaction.

4.2.2 Behaviour management

Finding positive ways to establish behavioural boundaries (or to deal well with challenging behaviour in ways that worked and ‘felt right’) were a repeated area around which parents expressed a lack of confidence amongst these parents. Therefore, this is a broad topic on which numerous participants indicated that they wanted additional information and needed practical guidance. Parents across the core sample indicated that behavioural management was a particularly significant issue for them in public spaces, (e.g. where home based techniques may not be possible and/or where fears about being judged negatively as parents were felt most keenly).

Examples were given by some parents that highlighted the stress (and well as lack of confidence they felt when dealing with what they said was their child’s unacceptable or ‘bad’ behaviour. Some participants from all three groups indicated that part of the information, advice and support they wanted was just as much about dealing with their own emotions as with the behaviours of their child. One young mother’s comment was illustrative of this point:

> ‘I don’t hit because if I am angry enough to hit I won’t be able to stop’. (219, young mother of 2 children, aged 4 and 1 year(s))

Parents said that they wanted and needed two particular kinds of help here. Firstly, they were seeking information/support that went beyond platitudes, (e.g. advice to ‘Count to ten’) and offered practical strategies for dealing with their child’s challenging behaviour at the times and places when it occurs. Secondly, they would like to better understand multiple options and ideas, (i.e. notions of having ‘Plans B, C and D’) that they could try when what they were currently doing, (or what they think should succeed) proved not to actually work with their child. Not knowing what to try/do next in terms of behavioural management was said to erode parental confidence and cause frustration among many parents.

4.2.3 Relationships

Especially, but not exclusively, to young mothers, having a baby was described by parents as having changed (often in negative ways) previous relationships with partners, friends, family and peers. Parents who reported this concern indicated there had been very little available helpful information or support to help them prepare for, or deal well with, the possibility of strained/changed relationships. Tensions arising between partners were reflected in the following two comments.

> ‘It’s totally different when it’s not the bairn’s dad. They think they’re trying to help, but it’s like “Don’t tell me what to do”’. (209, young mother of 1 child, aged 2 years)
>
> ‘Me and my boyfriend don’t get on now that we have a baby. It’s because you can’t just do what you want when you want ‘cause you’ve got a baby together. He doesn’t live with me. He lives with his mum and he thinks he can just come in and out when he wants’. (227, young mother of 1 child, aged 1 year)

Similarly, numerous parents across the core sample agreed that there were tensions and generational differences between them and their own parents, in terms of beliefs about child-rearing. Their voiced experience was that families could be judgemental, and that relationship difficulties and disagreements within extended families were both upsetting and detrimental to feeling confident in relation to child health and parenting matters.

Such strains with partners and families were not universal among participants. A minority of participating parents across the three target groups noted that they relied upon, and were often helped and supported in a variety of ways, by their family (whether partners or their relatives). They said that such informal support was a crucial source of welcome parenting advice and assistance.

However, for the majority of participants who indicated that relationships (beyond that with their own child) were often less than positive influences, there was a voiced interest in such information/support from professionals (or other non-involved sources). There were, however, hardly any explanations or ideas offered by parents about precisely what they would find most helpful.

4.2.4 Emotional well-being and mental health

Participants in these target groups expressed an understanding that their own (and/or their partners') emotional well-being and mental health had an impact, not only on their confidence as parents, but also on their interactions with their children. A minority of parents across the core sample talked about experiencing low mood and the feelings of isolation, monotony or stress that can accompany caring for babies and young children. As the following quotation indicates, some parents would welcome further information/support on how to address their (or their partners) emotional/mental health.

> 'I think there's probably a whole mental health issue that's bubbling just below the surface that people don't put a lot of focus on. The focus is very much on practical stuff, the physical. So, I think that there's a lot more that could be done on this'. (128, father of 3 children, aged 6, 4 and 2 years)

Some parents spoke about a sense of isolation in their parenting role. For young mothers, this was compounded by comparison with their peers who did not have children:

> 'When I fell pregnant...like "Are you coming out this weekend?" and even although I'm young, I can't just go. It's like time, money and babysitting…I can't just drop everything and go out'. (211, young mother of 1 child, aged 1 year)

> 'You lose a lot of friends when you have a baby'. (229, young mother of 1 child, aged 5 months)

How to deal with concerns about emotional/mental well-being and how to feel more positive about the day-to-day realities of parenting was not only a 'confidence' issue, noted by some parents, but also one where they said that greater information/support would be welcome. Sometimes, they thought professional help might be required.

However, as noted in Chapter 2, the core sample included many parents who were members of peer support groups (social networks) that were organised around geography, gender, and sometimes the age of the parent or child. These were not child health groups or parent education classes. Nonetheless, many of the participants spoke favourably about the benefits of these social/peer groups including being with empathetic people who understood their situation/issues, to functioning as a group with whom to experience enjoyable parent/child activities together. Their comments suggested that this kind of positive engagement was a boost to their confidence as parents and to their overall sense of emotional/mental well-being.

4.3 Parental views on sources of information/support

As discussed in Chapter 3, participants overwhelming favoured personalised information and support delivered by others whom they trusted, and with whom they had a positive relationship based on mutual respect. More impersonal sources of information and support, including written materials, the media and the Internet, were seen as potentially valuable, but almost always as secondary, supplementary sources. No form of technology generated the expressed level of enthusiasm as expressed by parents in response to personal sources of information support. The following comment by one parent voiced this often made point:

> ‘I know we’re discussing all these new ways to get information, but it still comes down to good old fashioned word-of-mouth for a lot of information’. (125, father of 3 children, aged 14, 13 and 4 years)

Furthermore and as already noted in Chapter 3, parents distinguished between immediate needs for medical intervention and broader parenting/developmental concerns. Parents generally said that their former needs were exclusively through established health care routes. However, they indicated that advice and assistance with general parenting (and broader child health and development issues) could also be addressed successfully through a wider range of formal and informal sources of information/support.

Participants shared their thoughts about specific current parenting information support sources, as well as their preferences regarding potential future developments. The most often voiced, priorities, expressed across the core sample were the following:

- **Receiving easily understandable, accurate information, following up on any specific diagnosis of a child’s illness/injury and including what they can do as parents to help their child.**
  Parents indicated their preference for such information to be conveyed personally by a health care professional. Alternatively, they said they were open to gaining this additional information and advice via a DVD, written information and/or signposting to relevant, trustworthy help lines or support groups.

- **Explanations and answers to questions, using meaningful terms in parent-friendly ways about a prognosis, including practical considerations, in relation to having a child with a long-term condition or disability.**
  As with shorter-term illness/injury, other supplementary materials and signposting to other information/support sources was something parents said they would welcome, especially if these sources offered on-going, cumulative advice. However, what parents wanted most was at least one detailed conversation with a trustworthy, knowledgeable professional about their child’s condition and their role as parents in dealing successfully with it.

- **Being listened to, respected and valued as the ‘experts on their own child’ by professional sources of information and support.**
  Parents were keen to be perceived and treated as part of the team helping their child along side the practitioners providing professional advice or assistance. They felt what they knew from regular observation and intensive experience with their particular child should be taken seriously and ‘count’ when decisions are made.

- **Preferred lack of reliance upon books, newspapers and magazines as key ways of sharing vital information with, and providing support to, parents of young children.**
  A minority of parents said that they had each read several parenting and child health publications, (and one parent brought a copy of *Ready Steady Baby!* as well as a commercial parenting book to show the researchers). However, the majority of the core sample indicated that they were not motivated to read parenting or child health books. Most ignored newspaper coverage of these issues and dismissed them as being too 'sensationalistic' and 'unhelpful' and were largely unfamiliar with parenting magazines, which some reported as 'not for them'.

- **Preference for topic-specific leaflets and short publications from the NHS or other Government sources would be welcomed by some.**
  Such literature would be more likely to be accessed when placed in prominent places normally frequented by parents. Alternatively, they were open to the possibility of such information being posted or (for some) emailed to their homes. These parents expressed their *disinclination to actively seek out* such publications. Some parents with literacy issues expressed the need for more relevant and appropriate materials of this kind, e.g. 'They are in Urdu. I don't speak Urdu. They need to be in Arabic and French'. (317, mother, (non native English speaker with literacy issues), of 1 child, aged 3 years)

- **Interactions with health visitors and social workers evoked very divergent reactions amongst parents in all three target groups.**
  These professionals were either highly praised or strongly criticised by participating parents. This depended upon their approach and attitude as individual practitioners, (see Chapter 3). In general, social work was viewed with more suspicion/wariness, whilst health visiting was viewed more positively across the core sample. The attitudes and behaviour of individuals in their role, as opposed to the role itself, were what parents described as the keys to parental reactions and their subsequent willingness to engage with these professionals.

- **For the majority of parents imparting parenting or child health information via television and radio was not considered as particularly helpful or potentially useful.**
  Radio was rarely mentioned although some television programmes were enjoyed by a range of parents, e.g., *Supernanny* and *Teen Mums*. However (like newspapers), the majority of parents viewed these programmes with scepticism, although a few reported getting ideas and tips from them. Educational DVDs, (but only when prompted by researchers), attracted some minority interest across the groups.

- **Using the Internet was familiar to, and valued by, most parents (including those with literacy issues), but was currently seen as a secondary source of information and support about parenting and child health**.
  Many parents had conducted online searches about child development/health issues, but specific parenting and child health websites were not commonly used by most. Some parents undertook searches of health websites, (e.g. NHS24) and reported these as more productive than general searches, (e.g. using Google). The latter was said to result in information that was either too general/short or too detailed and technical to be of help. Unfamiliar websites evoked parental wariness.

When asked about child health and parenting websites they knew and/or used, participants rarely conveyed any awareness of such potentially useful websites, such as NHS Inform, *Ready Steady Baby!* and *Ready Steady Toddler!*

- **Commercial products were reported by many parents as being useful (and used) sources of information.**
  Products parents encountered in hospital maternity units, at shops or through television advertising were most commonly mentioned, e.g. Cow and Gate or Bounty. Parents, read labels for information, (e.g. regarding weaning), signed up to receive packs and mailings, clicked ‘like’ on Facebook and so received information and access their websites directly. This was particularly true of young mothers.

- **Employing social media, (such as Facebook) and newer technologies, (such as mobile phone apps) were not currently seen by parents as important, primary sources of child health information or parenting support; however, a minority felt that these might eventually develop into something more meaningful.**
  Mobile phones and texting were valued for communication, but were not seen as current key information sources, e.g., Facebook, was discussed as a way of staying in touch with family and friends, but it was not used as or desired as a main information and support source by other than a small minority.

- **Relying upon family and friends (i.e., social networks) evoked very different reactions and meanings amongst participants in each of the core sample groups.**
  These are discussed in Chapter 5.

- **Tapping the potential of NHS24 more fully generated a good deal of interest among many parents.**
  The majority of parents were familiar with NHS24 and some praised this service. They held an experience-based belief in the value and reliability of this service. However, parents did not expressed ideas about how this potential could best be developed.

- **Belonging to peer support groups, (e.g. the ‘young mothers’ and ‘fathers’ groups or adult education classes), was rated very highly by most parents.**
  In part this was a predictable consequence of the familiarity of the core sample of parents with such social groups (see 4.2.4).

Parents across the three groups reported preferences for accessing information support in similar ways. There was a clear and unequivocal preference for trusted sources of information/support that could be shaped to the particular situations and presenting needs of parents and their children. Currently, the kind of knowledge, advice and assistance most highly valued by parents is provided personally, (i.e. through individuals), rather than via technology. However, it was clear that to a lesser degree, parents used other sources (particularly textual forms) to supplement or confirm information/support provided through relationships with professionals and other personal providers of help.

It should be noted that the responses in the surveys completed by the 42 parents (fathers, young mothers and parents with literacy issues) in the supplementary sample for this research project, echoed and confirmed the findings reported throughout Chapter 4 about the views, experiences and preferences of the core sample, (see Appendix 12).

4.4 Summary

This chapter has discussed what was learned from parents about the topics and sources of information/support about child health and parenting in which they voiced a particular interest or preference. Generally parents felt confident in their day-to-day parenting; accessing medical care for their children when urgently required; and being regarded / treated as ‘experts about their own child’. Parents reported that their confidence had grown over time, as they developed routines and skills in response to the needs of their young child.

Parents also spoke about being less confident about caring for newborns and similarly less confident about the issues of feeding/diet, behaviour management, relationships and emotional/mental health. This lack of confidence carried with it their interest in acquiring additional information, advice and assistance to help improve their knowledge. Parents reported accessing a range of parent information/support sources and talked about their preferences. They also indicated their openness to using a more diverse and more technological set of information/support sources. However, parents made it clear that they particularly valued sources that provided personal, individualised, cumulative solutions to the issues and situations that they were currently facing in relation to their child.

5. Differences in views and preferences among target parent groups

As noted in chapter 2, research has indicated the need for targeted information support tailored to specific groups of parents. Chapters 3 and 4 presented the research findings that revealed the shared responses across the core sample of parents. By contrast, this chapter focuses on the distinctive features in each of the three parent groups.

As can be seen from the findings described below, there was diversity even within each of these groups. Although patterns have been found and reported within and across these the groups, the diversity evidenced by participants is a reminder of the wisdom of not treating parents, even subgroups of parents, as a homogenous group. Rather, as parents themselves indicated, it would be better for information/support providers to recognise and respond to the individual characteristics and circumstances presented to them.

5.1 Fathers

The fathers of young children included in this research, (see Appendices 1 and 2) were playing their role under very different circumstances. There were fathers who were the primary or sole carers for their children (referred to as ‘lone fathers’); fathers living with their children and the mother (or other partner); and, fathers who did not live with their children, but who had regular contact with them. The other major distinction within the group of fathers was between first-time fathers of very young children and those who already had other children of varying ages and thus had extensive parenting experience.

With one exception, there were no major differences in the views and preferences expressed by these subgroups of fathers regarding parenting information/support. For instance, they all shared a strong preference for personalised information/support about child health and parenting over written materials or technology-based sources.

The exception was found in the specific topics in which each subgroup expressed an interest. The topics of greatest interest to lone fathers tended to be somewhat different (e.g. ‘female development issues’ of their daughters) from those of non-resident fathers (e.g. being routinely informed by professionals of their children’s progress/problems). So too, the issues most pressing for first time fathers of very young children (e.g. post-partum depression) were distinct from those voiced by the fathers of multiple children (e.g. maintaining emotional health through life transitions). This mirrors the findings presented in Chapter 3 and 4 about the tendency of parents across the core sample to focus on the issues and concerns immediately confronting them in relation to their children, rather than issues that already had been resolved or those that might arise in the future.

Participating fathers talked about a shared interest in four issues that were less often a priority for either young mothers or mothers with literacy issues. They were:

1. The importance of gender specific information and support
2. Generational changes that had happened and were continuing
3. Parents as active agents, not passive recipients, of information/support
4. The need to keep fathers engaged throughout the parenting journey.

5.1.1 The importance of gender specific information and support

Fathers talked often and with emotion, about the extent to which existing parenting and child health information/support was directed towards mothers, for instance, they spoke of feeling literally ‘out of the picture’ in the materials on parenting and child health that they encountered. They perceived and expressed exclusion from publications/websites, as well as from a variety of services, groups and activities described as for ‘parents’. As the following representative comments reveal, fathers in this research voiced their objection to not being perceived or treated as equal partners in the parenting of their children.

> ‘It’s ‘mothers and toddlers’ not ‘parents and toddlers’ on the leaflets you get’. (119, father of 2 children, aged 12 and 2 years)

> ‘If mothers are willing to be involved in the kid’s upbringing, then they will get a lot more help and support than fathers’. (107, father of 1 child, aged 8 years)

Fathers in the sample expressed a clear desire to be accorded equal status as primary carers even if there was a mother present and to have their involvement in their child’s upbringing recognised and taken into account. They frequently reported that there were distinctive patterns of parenting by fathers that should be understood and built upon by information/support providers. (e. g., more outdoor activities and more ‘rough and tumble’ play). Most fathers reported wanting assistance and advice on how to become better fathers and to compliment, not duplicate, what mothers and other female carers offered. The majority expressed a preference for father-specific information and support in the future.

While widely noted by participating fathers, feelings of being excluded from parenting resources and being treated as less significant in their child’s development than mothers, was described as being particularly inappropriate by lone fathers. The following vignette (mini case study) about Robert (127) is illustrative of the point that some fathers have primary responsibility for their children’s care and upbringing. It is a more positive example of receiving valuable (and valued) information/support than was the norm among participating lone fathers, but is included to highlight that progress can be made. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Father Vignette 1 – Robert

Robert is a lone father, who is the sole carer for his children. He has 2 children, aged 8 and 4, who both live with him full time. The children currently have supervised contact with their mother.

He has an extremely good relationship with an individual health visitor, who he frequently turns to for information and advice as a first point of call for both health and parenting issues. He values the relationship that he and his children have established with the health visitor so much that when she moved to a new health centre, he chose to follow her. She has provided him with regular face-to-face, as well as telephone, contact and actively encouraged him to call or text her whenever he needs advice. Her support has gone beyond purely health related matters. He has found her explanations of some of the meetings he has had to attend relating to custody issues helpful and confidence-boosting.

His former partner was very suspicious of professionals such as health visitors and social workers and sought to minimise contact with them. While they were living together, this substantially impacted on his own interactions with social workers in particular, as he felt that he ‘had to side with her’. Talking about his relationships with professionals generally, he still finds dealing with social workers can be difficult sometimes and he really prefers to deal with the one social worker whom he feels knows his case and whom he trusts. He has found doctors, teachers and nursery staff all very helpful.

Robert is concerned that his daughter has issues about not having a female presence in the home and about her sometimes challenging, behaviour. He has discussed ways of managing this with his health visitor and has also phoned the One Parent Families Scotland helpline for advice, (‘really helpful to me’).

Robert has collected a lot of written information, particularly about behavioural issues. He keeps hold of this and finds it quite useful to refer back to, as required. He has also taken out books from the library on parenting, which he has found helpful as a check that he is ‘doing the right thing’. Robert has also received a lot of useful information and advice through the fathers’ support group he currently attends. He was interested to hear about a PEEP DVD on child behaviour that another group member had found useful, and planned to try to access this through the child and family centre. He feels confident that he can always turn to these sources for information about a range of issues connected to parenting. The support he has received has helped him to understand that ‘It’s not about always having two parents it’s about the quality of parenting’.

Robert has also been concerned about the on-going emotional impact on his children of access visits with their mother. On his social worker’s advice, these have to take place in public places. His daughter finds these visits upsetting and Robert has been looking for the best way to support her. He feels reassured that his daughter has recently been benefiting from monthly Place2Be sessions with a child psychologist, through her school. Although they cannot share details of what is discussed during these sessions, he has confidence that the school would communicate with him if any issues of serious concern arose. This has greatly eased his mind.

5.1.2 Impact of generational changes

The fathers in this study rarely stated that they viewed their fathers or grandfathers as role models for their own child-related ideas and behaviours. They frequently noted that a generational shift in relation to what ‘fathering’ meant had already occurred to some extent and that it was continuing to evolve rapidly. They described themselves as increasingly playing caring roles traditionally associated with ‘mothering’, but said that they did not want to emulate mothers either.

Participating fathers expressed dissatisfaction with ‘traditional’ ideas about male parenting roles in which fathers were perceived primarily as ‘breadwinners’ and disciplinarians having fairly low or sporadic levels of positive interactions with their children. They spoke of their commitment to a different, more active and positive kind of fathering than had been the norm and the expectation in earlier generations. However, some fathers said they felt uncertain about how best to operationalise this commitment. They indicated that they were unaware of the existence of a sufficient quantity and quality of information and support resources (especially personalised ones) to help them make these generational changes.

5.1.3 Parents as active agents, not passive recipients, of information/support

Whilst parents across all three groups described themselves as active agents in undertaking their parenting role, fathers most strongly voiced their desire to seek out and utilise existing sources of parenting information support. In practice, this meant that participating fathers frequently characterised themselves as being ‘proactive’, i.e. looking for timely information and coherent support from professionals to help them with parenting issues and/or dealing with their child's health issues. Furthermore, they tended to present themselves as the most determined of the three groups in continuing to seek information and support in the face of barriers. Thus, many reported that regardless of how long it took, they would maintain efforts to obtain the information/support they sought.

Most often, it was fathers in the core sample who talked about not relying exclusively on one source of information about parenting or child health. Fathers often said that they looked for reassurance or confirmation from professionals to supplement what they learned from other sources, e.g. from a website or advice given by friends or colleagues. Some fathers also indicated that this cross-checking occurred in the other direction, too, e.g. following up on professional advice with other sources or challenged the information (or often, the lack of information) provided by health care providers. As one father said:

> 'We're parents who always ask questions. So, whenever I'm in the hospital [with my child], we're always demanding to know if they're happy with what's happening… whether it's normal…I've often gone in quite sceptically or demanding answers and wanting to know why isn't there a bigger picture we can look at?' (129, father of 2 children, aged 5 and 3 years)

The second vignette focuses on Alistair (128). It was selected because it is representative of the tendency of fathers to be determined in seeking out more in-depth information than they said was usually offered to them. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Father Vignette 2 – Alistair

Alistair is married and lives with his wife. He has three children, aged 6, 4 and 2 ½. When they were expecting their first child, he and his wife attempted to get onto an NCT antenatal course, but they were unable to access one at a time they could both manage. Alistair did attend a Dads2b course before the birth of his first child, which helped to build his confidence. He particularly liked the suggestion that fathers can take the lead in bathing, giving them important one-to-one time with their baby from the start.

As he said: 'Involvement before the baby's born, that gives you confidence that you've got a voice…It's about trying to find some balance and having the confidence to be able to have that balance…We were being given reinforcement that you've got a key role. You're not a secondary caregiver you can have two primary caregivers'.

Alistair considered himself fortunate that his work flexibility allowed him to attend antenatal appointments with his wife. They bought books on pregnancy, which they both read. Being told they could have a home birth and the active role that gave him in the birthing process made a substantial difference to him as a father: 'We went to an active birthing course… I felt really part of the birthing experience'.

Alistair's wife struggled with breastfeeding their eldest child and the first 6 months were very difficult, although she did receive good assistance from an NHS breastfeeding support group. He felt there was an important role for him during this time as a support for his wife and baby, but was frustrated that NHS did nothing to encourage or help him identify this role or assist him as the father to be as helpful as possible.

Two of their children have asthma and Alistair said that hospital staff members were not always good at communicating full information to parents about procedures and treatment options. He reported that health professionals did not tend to encourage dialogue with parents and were often poor at explaining why decisions had been taken: ‘I think it’s about trying to have an equal relationship with health professionals, so you can query and question them. And so that you feel you’re informed, because at times…they’re giving you just what’s needed…sometimes if you don’t query what they do, they don’t explain it’.

Alistair compared his experiences to those of friends living abroad whose child was given a much earlier diagnosis and treatment. Alistair and his wife were given two different devices by their GP’s surgery and hospital, respectively. He talked about some of the advice they received being contradictory or not easily implemented. Similarly, he said that information was lacking as to why inhalers are not given to children below a certain age or in relation to concerns about a child’s breathing.

As he pointed out: ‘We’ve known [the child’s] asthmatic for a while, but they don’t give inhalers until a certain age. So, you’re almost waiting for a crisis to happen before you can get them… You had to be the expert patient almost and demand…This is definitely an area that needs more clarity – also that takes in the parents’ perspective’.

Alistair felt strongly that the mental health and emotional wellbeing of parents generally is under-supported (especially that of fathers). He noted that the use of the questionnaire designed to pick up postnatal depression that mothers are routinely asked to complete. Although he felt some screening was better than none, he doubted the efficacy of the questionnaire: ‘Some of the questions are quite brutal and it’s hard to put them on a scale. I don’t know if it’s really a robust tool and I wonder whether there’s over-reliance on that’.

He felt too little attention is paid to the substantial societal pressure placed on both mothers and fathers to be ‘good parents’. Alistair suggested it would be better to talk about ‘learning parents’ and to acknowledge more openly the stresses associated with parenting young children and the strains this places on relationships.

5.1.4 The need to keep fathers engaged throughout the parenting journey

Some fathers talked about wanting to be involved in their child’s health matters and parenting ‘from the start’, but said that this did not happen routinely. Early involvement was expressed as having two meanings. The first was to be a full partner in antenatal classes and in the pregnancy/birthing process. The second was to get help when the need for it first became apparent to them.

Fathers in this sample said that they generally found it difficult to access professional support from health visitors, social workers (or other appropriate professionals/services) until the family reached crisis point (or the mother was no longer willing or able to provide care). They reported that they had often recognised that help was needed long before this point. Not yet meeting the threshold for significant intervention was a frustration to them, as it meant that potentially preventable problems were not prevented. Fathers indicated that it was also a major source of frustration to have felt inadequately engaged with by sources of information/support in the absence of the mother, or to be perceived initially by some professionals/services as a perceived risk to their child, (as opposed to an asset in their child’s upbringing).

While non-resident fathers voiced this issue most often, other fathers shared the sentiment, too. Many of them described being left out of conversations and consultations (even when physically present) with professionals. Furthermore, fathers repeatedly reported not receiving copies of significant documents about their children's health, wellbeing or progress, e.g. letters from health care providers or schools addressed solely to the mother. In order for all parents (or other primary carers) to operate equally in making decisions and taking actions, fathers expressed the clear opinion that they should be given the same access to information/support as mothers.

The third and final vignette about fathers features Jamie (102). It illustrates a few of the points summarised in this section and sheds light on the particular situation of some of the sample who are non-resident fathers. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Father Vignette 3 – Jamie

Jamie has two children, aged 2 ½ and 1. His eldest child lives with Jamie's parents and he sees him regularly. He is separated from his children's mother and currently does not have contact with his youngest child. His ex-partner suffered from severe postnatal depression following the birth of their first child and Jamie found himself coping with a very difficult situation, taking on most of the caring responsibilities:

'I was getting-up during the night to do the feeds, changing nappies… everything – and I didn't have a clue what to do…I was even making bottles up and putting them in the fridge… then just heating them up…The Health Visitor would come in and say: "Why have you got bottles in the fridge?" Going absolutely ballistic at me, but not actually explaining it to me… I had conflicting information as well from health visitors and midwives'.

From his own experiences, Jamie feels strongly that expectant fathers should routinely receive support and information during the antenatal period to help them to prepare for fatherhood: 'I think if people know that the girl is pregnant and the father is there in the relationship, then they should… during that nine months help the father as well as the mother…There's classes that the mum goes to while she's pregnant. Why can't the dad go and do certain things as well? Like, go and learn how to bath a child. I was really, really scared to bath my son'.

As his partner decided not to breastfeed when his son was first born, Jamie looked for advice from professionals on which bottle feed to use. He understood that the emphasis was on breastfeeding, but was still bewildered to be told that they were 'not allowed' to recommend any brand.

Jamie found it extremely frustrating to have repeatedly and unsuccessfully asked for help from health professionals as a new father:

'I was asking social work, I was asking doctors I was asking loads of people for help with my parenting, and also with a lot of other things and nobody was willing to give me the information, or just point me in the right direction, at all'.

Jamie reported eventually receiving some of the support he had been seeking, (including taking an 'Incredible Years' course) accessed through a Sure Start fathers group he had joined. However, he voiced the opinion that welcome information/support, was mostly a matter of ‘luck’. Specifically, Jamie said that his health visitor had met a fathers’ support worker at a conference, found out through him about the services available locally and referred Jamie to them.

A substantial, recurrent source of frustration for Jamie was what he described as the failure of health professionals to communicate information directly to him as a concerned father about the health and wellbeing of his children. He reported that this was particularly true in relation his youngest child, with whom he currently has no direct contact. As Jamie explains: ‘His [my second son’s] health visitor will not phone me at all to tell me how he’s doing, how his weight is, how he’s developing or anything like that… I would have felt a lot better just to have that information. To have that phone call every couple of months… That should be information that I’m getting automatically. Also, at times when [either] of my sons have gone into hospital and I’ve not been with him, especially my eldest son when he was with his mum… I’ve not known that he’s been in hospital… Whenever my son’s been in hospital, I’ve phoned my ex-partner and told her, and she’s come… there has never, ever been a dispute or an argument’.

5.2 Young mothers

This was the most homogenous group within this research project’s sample, in demographic terms (see Appendices 1 and 2). For instance, all of the young mothers in the core and supplementary samples identified themselves as being ‘White Scottish’ in terms of the Census’ race/ethnicity categories. This was not the case with either fathers or parents with literacy issues.

The main findings from/about young mothers that distinguished them from the other two target groups of parents of young children were as follows:

- Agreement that a child’s ‘mother’ has primary responsibility for parenting
- Reliance on a ‘common sense’ approach to parenting
- Young parents had to deal with numerous, significant life transitions.

5.2.1 Agreement that a child’s ‘mother’ has primary responsibility for parenting

The young mothers who participated in this research said that they were the main care providers and had either the dominant or the sole responsibility for raising their children. They expressed very limited expectations for, and equally low levels of reliance upon, the biological fathers of their children. They also said that they regarded any new male partners in their lives current in the same light.

This was in part, a pragmatic reflection of their lived experience, i.e. few reported living (or in a close relationship) with their child’s father. However, their words also conveyed an underlying attitude that child health and parenting issues were ‘women’s work’. This was reflected for example in their responses that the major sources of informal information and support were female relatives. In one fairly typical observation, a young mother said:

> ‘My boyfriend wasn’t there when I was pregnant and when they’re not there…you don’t see it as theirs’. (203, young mother of 1 child, aged 2 years)

Young mothers repeatedly indicated that they prioritised their children to the exclusion of their male partners (or fathers). Several reported their willingness to end a relationship if a significant issue arose between their child and the men in their lives. As one noted:

> ‘Her [my daughter’s] dad was around ‘til she was a month old and he didn’t really take to her that much, and now his girlfriend is pregnant and this time he is going to be at the birth and everything. So it is going to be different. Is [our daughter] going to be left out? I feel like saying: “Just leave, like. If you’re going to treat them differently, then go”.
> (203, young mother of 1 child, aged 2 years)

Accordingly, these young parents indicated they saw themselves (and women in general) as being the ones responsible for childrearing in their communities, especially within their own family/social circles. Female relatives, particularly mothers, aunts and grandmothers were heavily relied upon as sources of information and support about childraising.

Some male relatives were viewed as having a circumscribed, ‘back up’ role in relation to childcare. For instance, they were reported as occasionally being willing to help with practical tasks, such as changing nappies. Still, young mothers indicated that they were less likely to be sought out as sources of information/support in comparison with female relatives (who they generally said they viewed as the ‘experts’ on childcare issues).

The first young mothers’ vignette features Kate [224, mother of 1 child, aged 5 months]. Her attitudes and actions as described here were fairly representative of what other young mothers told the research team. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Young Mother Vignette 1 – Kate

Kate attended secondary school in northeast Scotland when she discovered she was pregnant. During her pregnancy, her friends were largely supportive, and someone she considered a close friend had been her birthing partner. Following the birth, she found her mother helpful during the early days of being a parent and yet, found her mother’s interventions somewhat too directive. So, she moved in with her grandmother temporarily, before moving in with her partner.

Her current partner, a somewhat older man, also had a child, (who visited regularly) from a previous relationship. Conflicting opinions regarding parenting was a cause of conflict in their relationship and Kate said she viewed the child, Chris, as more her responsibility than the father’s. Dealing with relationship issues was an area about which Kate would like more information; for instance, guidance on dealing with step-parenting or disagreements between parents. Furthermore, Kate perceived that her partner’s family was judging Kate’s parenting skills, rather than being helpful to her.

Kate gradually saw less of her friends, as their interests centred on forms of entertainment, e.g. going out drinking and partying, that Kate indicated were incompatible with parenting well. She reported only rarely seeing the friend who had been her birthing partner. Kate had, therefore, experienced rapid change and increased responsibility within her daily life as a result of having a baby. She reported experiencing low moods due to the monotony and ‘tie’ of parenting a baby and was prescribed anti-depressants.

Despite this, Kate said that she basically felt confident in her parenting role. Her confidence in parenting had gradually increased over time as she got to know her baby and developed a routine. She would take her cue from the baby as to what information to seek out, e.g. in terms of meeting developmental milestones or if the child was ill. Furthermore, she believed mothers were best placed to know what was right for their child:

'Nobody should be saying how to do, that you are doing it wrong, 'cause it's the mother's instinct. Somebody could tell you you're doing it wrong, but that's the way you do it'.

She said that she would frequently seek out information by going to NHS websites and searching within these as a means of finding targeted (but easily understood) information about the health of her child, showing awareness of how to navigate the Internet to good effect. She was able to access the Internet on her mobile phone, and was keen about the possibility of an NHS application developed on parenting. She had also watched parenting programmes such as *Teen Mums* and *SuperNanny*. Kate spoke about Facebook as a useful way of obtaining information from her friends about how to deal with parenting situations and also as a means of offloading pressure and receiving sympathy/empathy from friends when she had a difficult day.

On-going support and advice also continued to be provided by Kate's parents, particularly her mother. For instance, when Kate felt her daughter was becoming hungry and ready for weaning, her health visitor advised her not to do so yet (as she was born four weeks prematurely) and suggested that Kate wait. Rather than follow this advice, and concerned about the opinions of others, (e.g. having a baby that cried a lot), she turned for guidance to a female relative she felt had more knowledge in this area and that is the advice she followed.

The perception that others were judging her negatively led to concerns about how best to manage her child's behaviour in public. However, Kate had forged a good relationship with her health visitor, but this professional had left to join another primary care team. Kate was considering changing her affiliation to this other practice, as she was not as happy with the new health visitor at her old GP's surgery.

5.2.2 Reliance on a 'common sense' approach to parenting

The young mothers in the core sample consistently said that they relied upon a 'common sense' instinctive approach to parenting and child health issues. This was described to researchers as meaning that they largely followed their own feelings/intuitions/instincts as a mother – and also tended to mirror the parenting styles and models with which they said they felt were most familiar and comfortable.

They expressed a clear preference for what those in their family and social circles believed to be true about child health and parenting (and what these informal, female sources with whom they had a relationship experienced as 'working' well for them in the past). They also said they had a degree of trust about the information they received from commercial sources of baby/child products. Young mothers often cited their children's reactions as a guide to what was, or was not, the right thing to do. As one participant commented:

> 'I just look at the back of the packets in the shops. I didn't really speak to the health visitor 'cause they just say "wait until six months". But, I don't really want to -- I think he needs food now. It's not like I'm giving him three meals a day'. (224, young mother of 1 child, aged 5 months)

The young mothers in this sample discussed the parent information/support from professionals as frequently being subject to misunderstandings and potential conflicts. Thus, the miscommunications and negative encounters they reported about the antenatal and birthing process had a lingering adverse impact on their respect for, and desire to seek, professional guidance and assistance. For example, one young mother recalled the following incident and said that she still felt unhappy about it.

> ‘When I went to the doctor to tell them I was pregnant, they said: “Fine, I’ll book you in for a termination”. But, I said: “I don’t want a termination. I want folic acid”. And they said: “Oh, jolly good”’. (226, young mother of 1 child, aged 1 year)

Other young mothers reported simply not answering the door when health professionals arrived uninvited, or discounted their opinions that ran counter to their ‘common sense’ and what they knew from trusted, informal, female sources. For instance:

> ‘They tell you not to give them dairy cause it gives them asthma and all this rubbish. They come out with all these rubbish things’. (201, young mother of 1 child, aged 6 weeks)

The consistently voiced reliance upon ‘common sense’ and instinct was a distinctive feature of the young mothers in this sample. However, it is connected to the larger concern (and potential area of conflict with, or maintaining distance from, professional sources of information/support) presented in Chapter 3. The points about ‘trust’ shared across the three target groups (see 3.2.2) apply keenly to the participating young mothers.

The second young mothers’ vignette provides a summary of Sasha’s story [229], shared by her with the research team. She expresses a level of distrust in professionals that moderately exceeds the norm for the participating young mothers. However, it highlights the influence of these issues and concerns about approaches to, and preferences for, information and information support on parenting and child health. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Young Mothers Vignette 2 – Sasha

Sasha (17) lived with her daughter who is nearly 2, as well as her sister and niece (who is approximately one year older than Sasha’s daughter). She had no academic qualifications and reported having frequently avoided school. She said she had a good relationship with her family, including her grandmother. Sasha had a non-resident partner who was not her child’s father.

Sasha indicated a reticence towards engagement with professionals, whom she said she regards as ‘outsiders’. For example, Sasha reported her concern that any potentially embarrassing or negative information she shared with professionals would not be kept confidential by them.

In the absence of using printed materials, traditional forms of media, (such as TV and radio) or local professionals as sources of health information, Sasha stated that she relied heavily upon informal support, particularly from family members, for her parenting and child health knowledge. Much of her advice on parenting was received from women in her family: her mother, grandmother and sister. It was also indicated that her sister’s slightly older child helped Sasha become aware of her own child’s forthcoming developmental stages.

Sasha said she felt it was a mother’s responsibility to rear children -- and felt that professionals (or the males in her life) were not as competent as she was at making decisions regarding her child. On one occasion, Sasha recalled that her partner had observed her daughter limping when walking. Sasha had not noticed initially, as the toddler had only just learnt to walk and was unbalanced anyway. When Sasha realised there was a problem, she reported becoming increasingly agitated and arguing with her partner over how to respond to the situation, finally ‘screaming at him’ to leave her home, and ‘calling her Gran’ to take her child to the hospital.

She commented that she was suspicious of hospital staff, partly because she had heard from another mother that staff would suspect parents of child abuse if more than three accidents occurred at home. Although such an accusation or action against a parent was not described as a confirmed, first–hand experience of any members of Sasha’s ‘young mums’ group, researchers observed that it was perceived as being true among focus group participants. Multiple participating young mothers then cited this belief/fear as a disincentive to them seeking help.

More generally, Sasha said that she felt adults outside her family and circle of friends viewed her as a “silly wee lassie” for becoming a young mother. She also noted that she had hated being in hospital to give birth because of what she perceived to be negative attitudes of other mothers and staff towards her as a teen mother.

Sasha indicated that she received most of her information about parenting through informal face-to-face sources, especially those within her own family. She valued the peer group she attended and reported being more willing to raise issues/concerns with support staff for this group than with child health or social work professionals. She was also a member of a closed Facebook ‘group’ that this ‘young mums’ group had set up to network and share information. Sasha had access to the Internet via her mobile phone, but this was not how she did, or wanted to, learn more about parenting and child health.

5.2.3 Young mothers had to deal with numerous, significant life transitions

Many of the young mothers in this sample had become pregnant whilst living within their parental home, and some whilst still attending school. Following the birth of their child, most had moved into their own residence and none were at school at the time of the study. None were in paid employment, and many were either in, or about to commence, part-time further education. Thus, their living situation, relationships, means of support, plans and responsibilities had been altered significantly over a short period.

These young women indicated that they had been able to be adaptive and to cope with these life transitions to varying degrees. They did not describe themselves in a way that indicated they had experienced severe difficulty in managing such a high degree of personal and situational change. There was a recurring expressed desire on the part of these women to improve their personal situation, although they appeared somewhat uncertain how best to achieve this improvement.

In effect, this meant their desire for information/support extended beyond child health and parenting. They wanted and said they needed help with moving ahead with their own lives as young adults in a positive manner and indicated that improving their own situation was a common strategy for helping their young children succeed too. Thus, they spoke about their interest in receiving: benefit advice, options for continuing their education; employment possibilities; and, affordable, trustworthy childcare. Parents in one young mother’s focus group discussed their anxieties regarding finding trustworthy sources of childcare. As one participant said:

> ‘My friends are putting me off (nurseries) and I don’t want to put my kids in now’. (221, young mother of 2 children, aged 2 years and 6 months)

The last young mothers vignette, concerns Pauline [226]. It does not exclusively address the challenges of dealing with life transitions (as this was a topic that young mothers mentioned repeatedly, but did not dwell on while talking with researchers). This vignette was selected because Pauline’s lived experience is a good summary of the situation, views and preferences of many young mothers in this sample. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Young Mothers Vignette 3 – Pauline

Pauline (20) has a daughter aged 14 months old. She lives alone in a town in eastern Scotland, but is in a long-term relationship with the child’s father (who still resides with his own birth family). Pauline said that she remains very close to her family; a number of whom have small children. Pauline is comfortable with children and reported feeling confident about being around and caring for babies and young children.

Pauline states that she has had good and bad experiences with professionals. She said the key is the attitude and behaviour of the individual, not the job title or role. Following the birth of her baby, she found daily visits from health professionals helpful. Pauline reported having a good relationship with one health visitor who understands her situation and provides her with practical advice that makes sense to.

Her experiences with health professionals during her pregnancy and throughout labour were less positive. For instance, she felt health professionals were dismissive of her worries when she experienced early pregnancy bleeding (leaving her feeling anxious and disinclined to believe that she was being heard and respected). Furthermore, she felt questioned by health professionals as to why she was having a child so young. Pauline indicated that this had the effect of discouraging her – and, as consequence, she did not attend antenatal classes. During labour, she said she felt that hospital staff did not take her seriously or listen to her concerns. Despite having told several midwives that her waters had broken, staff tried to break them later the same day. She reported believing some health professionals simply dismissed her as being incapable due to her age.

Pauline tried to breastfeed her baby, but decided to bottle feed while still in hospital as she found breastfeeding difficult. She did not feel she was provided with enough information or support about being successful with bottle-feeding.

Pauline said that she listens primarily to her mother’s advice on practical issues such as feeding, weaning and sleeping patterns, as she considers her mother to be experienced and knowledgeable about raising children. Pauline talked about knowing that her mother’s advice often goes against the current official parenting guidelines offered by professionals. Pauline expressed view is that, since her mother has raised three healthy children on her own, her advice can be trusted. Pauline said that she finds it hard to trust professionals who do not have personal experience of giving birth or being a mother. Empathy is something that Pauline values highly and thus, says she finds it frustrating to listen to information and advice from health professionals who do not have children themselves. This had the reported effect of leading her to dismiss their advice, e.g. about when and how to wean her child onto solid foods.

If she has worries about her baby's health or well-being, Pauline tends to call the doctor. She has used NHS24 a number of times for advice. She says that she trusts and relies on it, but finds it frustrating when they ask questions unrelated to the reason about which she is phoning. When her baby received an injury, she phoned her GP surgery before using NHS24.

Pauline reported that the key relationships in her life changed dramatically since she gave birth, particularly with close friends and with her boyfriend. She does not live with her boyfriend and, because of this, has experienced some difficulties in parenting together. She is unsure about what type of parenting information or advice would be useful in the future. She used written materials to help her find out about parenting, e.g. she said she read *Ready Steady Baby!* a lot during her pregnancy. She was pleased when the health visitor gave her *Ready Steady Toddler!*, as she was unaware it existed. She finds it helpful to understand her daughter's development and what to expect over the coming months. Pauline has watched a number of parenting programmes, including *SuperNanny*, and finds them useful, particularly on issues relating to behaviour. She uses Facebook as a means to keep in touch with friends, but also to sometimes ask for advice on child-related issues.

Pauline told researchers that she found her daughter's early life quite boring and reported feeling isolated, which she felt was not good for her or her child. A friend recommended the 'young mums' support group. She reported enjoying it because she can get informal advice; chat to other parents; and, her daughter gets a chance to play with other children. Pauline said she valued making new friends among other young mothers with whom she has a good deal in common.

5.3 Parents with literacy issues

The sample of parents with literacy issues was the most divergent in terms of their socio-economic and cultural backgrounds, (see Appendices 1 and 2, as well as 1.2 and 2.3.5). One common characteristic was that parents in this group had difficulties, to varying degrees, with some aspect of communication. This could include difficulties with reading, writing or numeracy or with the spoken word, for instance, speaking in English or understanding spoken English. Some of these were attributable to learning difficulties/disabilities of varying types and severity.

Such communication issues were compounded for parents who were not born or raised in Scotland. Many also frequently encountered difficulties understanding cultural dimensions of the communities in which they lived or how public services worked. To illustrate, one African immigrant mother wanted to carry her baby on her back tied with a cloth, (i.e., according to local custom in Africa), but she was not sure how to do so properly and was also concerned about whether it would be approved of and considered safe, in a Scottish context.

Despite this heterogeneity, four distinctive findings were found in the expressed views and preferences of those parents with literacy issues:

1. A desire for alternative sources of information and support
2. The importance of cultural factors in dealing well with parenting and child health
3. Speech and language as a priority child development issue
4. Difficulties in accessing and understanding health services.

5.3.1 A desire for alternative sources of information and support

Parents with literacy issues expressed a strong preference for medical specialists and health care providers to be their primary support sources, not only for diagnosis and treatment of their children's illnesses and injuries, but also for information and advice on child health and child development. A significant minority expressed positive views, saying that they highly valued the support they had received from these medical/health sources. However, they reported only occasionally being able to spend what they regarded as sufficient time with such experts to get the information, care and support that they, or their child, needed because of the barriers described elsewhere in this report.

Instead of becoming discouraged and giving up, the majority of these parents reported pursuing alternative sources and means of information/support for example, some used their local chemist to explain health information or advice that they did not fully understand, or to ask for referrals to other helpful sources of information and support in the community. Adult education tutors and teachers were also frequently noted as valuable providers of explanations, offering signposting and sometimes even advocating on their (or their child's) behalf within NHS systems and other public services.

Some of these parents had partners who did not share their communications limitations. In these situations, the partner was often the lead interpreter or family advocate. Parents reported that sometimes a Scottish voice seemed to generate a better response from front-line staff members.

Family, community or ethnic (but generally not religious), social networks also served as alternative sources of assistance and advice for many parents in this group. This was especially important, given their limited awareness of, and perceived lack of effective access to, established peer support groups, e.g., for fathers or young mothers. A minority indicated they had not been able to secure alternative information/support sources and thus reported a degree of isolation that was not characteristic of the whole group of parents with literacy issues.

5.3.2 The importance of cultural factors in dealing well with parenting and child health

Most of the immigrants within this sample reported their desire to live in Scotland over the long-term and were generally keen to deal with parenting and child health issues 'the Scottish way'. They perceived it as both necessary and desirable that their children be able to integrate well into Scottish society without renouncing the parents' language or culture. As such, they reported being keen to get advice about locally appropriate ways of doing things. Examples included a mother (317), who was pleased that the health visitor demonstrated locally appropriate ways of holding her baby during breastfeeding and a Muslim father (328) who was glad that his brother lived in the UK and could advise him regarding the appropriate way to raise his adolescent daughter in this cultural context.

Parents with a different cultural background described parenting as a 'balancing act' at times, and said they needed to understand the cultural context of Scottish parenting to do so. They cited the need to understand aspects of diet, playing outside and dealing with unwelcome child behaviour by way of example, in order to make informed choices about how to strike the right balance between what they were familiar with in their home country and what was the norm in Scotland. Many of these parents were highly literate in their own language, but found Internet searches about parenting and child health in their own language from outside the UK were rarely as helpful as they had hoped for because the cultural contexts were so different.

The initial vignette about a parent with literacy issues involves a mother called ‘Mai’, (304). Her story is summarised here because the research team thought that it was a reasonably illustrative of several of the typical points, concerns and issues described above about non-native English speaking parents who are now part of Scottish society. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Vignette 1 – Parent with literacy issues (non-native English speaker) – Mai

Mai is an Asian woman in her early thirties and has a Scots-born husband. Together, they are the parents of an approximately two year-old son, David. They live in a small town north of the Central Belt. She has been in Scotland for the last three years; is not yet fluent in English; and, receives one-to-one language tuition with an adult education tutor from whom she also gets support with everyday life and health issues. Mai reported no significant problems experienced here apart from a few associated with her pregnancy and her son’s development.

Mai indicates however, that she feels rather isolated. She talks online to her mother (a nurse) in her home country but this is not altogether helpful to her life in Scotland, as the cultures are so different. She discusses parenting and child development/health issues with her husband, but reported not being close to, or receiving information/support from her in-laws or extended family that live here. Friends were mentioned, but these mostly seemed to be her English teachers who provided a lot of support, including accompanying her to the hospital when she had a problem with post-partum bleeding.

David was born in the local hospital and Mai spoke highly of the care she received and of the Scottish health care system in general. When pregnant, she saw a midwife and doctor regularly and was treated by a consultant: ‘Very good experience. They looked after me and the baby absolutely perfect. I never see anywhere else better than in this hospital. Very good. They tried to understand foreigner language’.

Subsequently, she saw a health visitor regularly, every week and then every month and again was complimentary. Mai reported that this professional was: ‘Very good, can ask lots of questions and she answers’. Now, though, she is not seeing her frequently. This lack of a trusted, consistent source of information and support is evident in her repeatedly expressed anxieties about child development issues in relation to David.

Her most frequent source of information is now the local chemist, who provides advice and information about appropriate medications and about where else she can go for help. ‘[name of chemist] very, very good. Ask them high temperature, they give me tablets, [tell me] where to go, really got good help from the chemist. They understand my English. They patient. They tell me what good for that situation’.

Nevertheless, Mai remained very uncertain about a number of issues concerning David’s development. One example cited, in particular, was the language issue, (she speaks to him in both her mother tongue and in English, but David will only respond in English). Mai also spoke about being worried about his physical growth, (he is tall, but not putting on weight); his behaviour, (‘He likes to throw everything; I don’t know why’); potty training, (‘Get different answers on the potty on the Internet’); and his teeth, (‘He has lots of black teeth’). For reasons not explained to the researchers, Mai indicated that she does not find her husband to be an excellent source of or gateway to, information/support on these matters. Thus, she says that her only point of reference was her own development as a child: ‘Why he not same as me?’

Mai is learning English; learning about a new culture and health care system and learning to be a mother. She made it plain that she was keen to have more and more personalised information, advice and support about parenting, child health and child development but, she indicates that she no longer has a consistent, knowledgeable source of such help as the mother of a young child growing up in Scotland.

5.3.3 Speech and language as a priority child development issue

Concerns were expressed by a number of parents with literacy issues about their child’s developing ability to communicate effectively through their speech and language development. Parents from overseas would have liked to receive additional information support to help them help their child to learn English, whilst also maintaining their own first language. Several reported asking for advice from health visitors regarding which language they should speak at home. However, they shared with researchers that this was a topic on which the professionals with whom they interacted did not seem well informed and thus offered different, and sometimes contradictory advice.

Scots-born parents in this sample of parents with literacy issues were keen to secure the information and support that would enable their children not to repeat their history of literacy and/or communications issues. This was especially true of the minority of parents with learning disabilities. Yet, nearly all the Scots-born parents in this group were keen to do whatever they could to ensure that their children would not suffer the kinds of literacy problems they had experienced.

The next vignette about a parent with literacy issues focuses on Anna (301). It was selected as an example of how a parent who has experienced lifelong communications challenges is dealing with motherhood and trying to create a better life for her daughter. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Vignette 2 – Parent with literacy issues – Anna

Anna (20) experiences a significant level of dyslexia and has other health difficulties. She reported working around the resulting challenges using a range of strategies; indicates that she is assertive on her own behalf, and on Lucy’s (her 14 month-old daughter); and, shields herself from situations where she says she is ‘made to feel stupid’. This involves reliance on good relationships with health and other professionals, but also involves a wider range of people she encounters being flexible about her needs. She says that she would like greater sensitivity on their part.

Anna has had lifelong contact with health professionals on account of her health issues, in addition to additional contact arising from pregnancy and parenthood. She said she wants to protect Lucy from the (hereditary) disabilities she has experienced, but is aware of the limitations on anyone’s ability to do so however, she is keen about early monitoring. So far, Lucy doesn’t seem to be affected and her development is normal: ‘She was not like me when I was young. I just stood there, she says ‘hi’ to everybody’.

Anna’s preferred means of receiving health information is by interpersonal contact and she expresses considerable confidence about dealing with health professionals, (e.g. midwife, health visitors, GP and specialists concerning her medical condition). She said this was despite the fact that her experience has not been uniformly good. She has an ongoing issue with people not taking her seriously or not respecting her as a person and a mother.

During her pregnancy, her original health visitor wanted to involve a social worker to decide if Anna was competent to raise children. She had an assessment from a learning support worker, who said that there was no problem at all: ‘The first one [health visitor] I had was horrible. She thought she was better than me. She wanted to get social workers involved because I had problems with reading’. Anna noted that she did not receive this intervention well and perceived the health visitor’s attitude as hostile. She subsequently changed her GP surgery upon moving house, and spoke of liking both the new GP and the new heath visitor. She said that the new health visitor is accessible for answering questions about minor ailments and Anna is at ease about calling her whenever needed.

Anna has developed ways of dealing with her reading problems. Her main strategy is to ask people to read written communications to her. She explained that when she receives a health service related letter, she will phone and ask the sender to explain it to her (if the number is on the letter). She talks about being confident and practiced in doing this, but at the same time admits that she gets frustrated by people who won’t respond; who assume that she is just being lazy; or, who just can’t be bothered. This has included occasions when she has to complete forms at the surgery and staff say that they are too busy to help her. She also uses different people for different types of information and indicated a preference for talking with health professionals individually, rather than in front of a group.

Anna pointed out that she has learned how to cope satisfactorily with medical and health issues for herself and Lucy. Anna uses a range of strategies, but states that she is overwhelmingly dependent on direct interactions with people. In her opinion there is no substitute for sources of information/support being patient, helpful and taking her needs into account as she continues learning how to be a good mother to Lucy.

5.3.4 Difficulties in accessing and understanding health services

Many immigrant parents in this sample experienced problems accessing health services in Scotland. This was partly related to being relatively new to the country and partly to uncertainty about asserting themselves. For example one mother (317), was unable to get a GP to register her when she arrived in Scotland, seeking refuge from a life-threatening situation, and was only able to register through the intercession of staff at the shelter where she was staying. Another mother (324), wished to be re-housed as her temporary accommodation was damp and her daughter was asthmatic. However, she did not feel that she could ask her GP for a letter to support her re-housing application, as that she felt that would be imposing on him.

Such issues were not exclusive to immigrants in this sample. Scots-born parents with literacy difficulties may be fluent in English, but some still reported experiencing communications difficulties (of varying kinds) and practical barriers in actually getting the information, advice, attention and assistance that are needed for their children when and where it is required.

The final vignette is about a mother called Louise (316), whose story illustrates both strategies leading to good information/support and provides an example about a time when a different kind of communication difficulty was experienced. Names and other identifying information have been changed or removed in order to protect confidentiality and maintain the promised anonymity of participants.

Vignette 3 – Parent with literacy issues – Louise

Louise (aged late 20s) has two children: Ben (6) who lives with her ex-husband and Laura (4) who lives with her. She attends a local adult literacy class. Since separating from her husband, she has lived in temporary accommodation in a city outside the Central Belt. Her major health issues were around her pregnancies and childbirth when signs of pre-eclampsia caused her ‘a lot of stress’.

In the end, she had a Cesarean for both deliveries. She suffered severe post-natal depression with her first born and relied heavily on her husband. Most of her support during pregnancy and childbirth came from the midwife, although Louise reported that the doctors were also very supportive. However, she was ‘strong willed’ and directed her own care in deciding whether to stay in hospital or go home following different procedures leading up to the birth.

She feels her children are healthy and developing normally and has had no major health concerns about them. She is aware of good dietary principles and spoke about making sure that they eat properly, including a lot of fruit and vegetables. She understands about minor ailments and is confident enough not to immediately contact the doctor about these: ‘For a little cold, I wouldn’t bother the doctor’. She ascribed her self-confidence in child rearing to being around children a lot as her sister has four children and she had her first child when Louise was nine; ‘I knew the basics, as I helped my sister since I was nine. So, been changing nappies and my ex also had previous children’.

Most of Louise’s support has come from her family. Her ex-husband was very supportive, attending all the antenatal appointments with her and backing her in decisions about what she wanted to do. Her mother came to appointments he couldn’t attend. She also reported having support from her sister, her brother and his girlfriend, friends and friends’ parents. In other words, Louise described her strategy for coping with her literacy issues as one of constructing and maintaining as dense a network of personal support as possible around her and her children.

But, this strategy is not infallible. Her daughter, Laura, was violently sick and complaining of pain several days prior to involvement in this research study. Louise said she was worried about the possibility of appendicitis.

Louise mainly uses her phone for texting and she indicated that this is an important form of communication for her. She could not phone NHS24, as she didn’t have any credit left on her phone, but was able to text her father in Fife, who called her back. She explained the situation and asked him to call NHS24, who in turn called her back. They had to follow this procedure a couple of times until a doctor finally called her back, by which time Laura was asleep. The doctor told her to bring her in to the hospital the following afternoon. Louise said that she had been frustrated that the hospital could not arrange for Laura to be seen sooner and that the communication needed was awkward, even if eventually effective.

Louise is comfortable with her knowledge of child health and development and describes herself as being sure about her judgments. She is familiar with, and knowledgeable about, how the health service provides services. However, she relies on her phone for communication and is constrained by financial limitations on her phone use. For the future, she is more concerned about getting quicker responses to emergencies and urgent medical situations than about receiving additional long-term parenting and child health information.

5.4 Summary

Although the parents in the study reported similarities in their parenting information support experiences, this chapter highlights the considerable diversity within, as well as between the parent groups. Examples of successful and less successful attempts to both seek and provide information support to these groups of parents have been highlighted.

It can be seen that barriers to parenting information support exist, and are likely to be specific to particular groups of parents. Furthermore, a variety of individual experiences exist, in relation to how information support is sought and received. Such differences have consequences for the type of parent information support offered and the ways it is delivered. These will be discussed in the final chapter.

6. Recommendations

Arising directly from what participating parents said about their experiences, needs and preferences, the researchers offer a set of policy and practice recommendations. These included a set of cross-cutting ideas for improving information/support for all three groups of parents; followed by specific recommendations about better aiding fathers, young mothers and parents with literacy issues.

6.1 Recommendations applicable to all three target parent groups

- Provide continuing professional development opportunities to professionals and support staff that will encourage and assist them to provide more personalised information and support in ways that the parents in all three of these target groups will understand and appreciate, (see Chapter 3, especially 3.3). The goals should be to: assist professionals in overcoming the stereotyping/marginalisation of fathers, young mothers and parents with literacy issues, (see 3.1); and to help professional sources of parenting and child health information and support learn to develop trusting relationships between parents and professionals, based upon mutual understanding, respect and effective two-way communications, (see 3.2).

- Parental information and support sources should develop alternative formats/products/services that more fully take into account the needs, views and preferences of young mothers, fathers and parents with literacy issues, (see Chapter 4). These should begin with new information/support around the four topics identified across the three target groups: feeding and diet, (see 4.2.1); behaviour management, (see 4.2.2); relationships (see 4.2.3); and, emotional well-being and mental health, (see 4.2.4). Some of these new developments may be technological, (e.g. mobile phone applications), but they should emphasise the media and strategies for which parents in these three groups have indicated a preference, (e.g. face-to-face sessions that bring together parents and information sources for discussions and explanations, see 4.3). These should be easily available in places routinely frequented by these target groups and should be developed/co-produced with parents from these three groups.

- Both face-to-face peer support groups and virtual social networks of parents in each of these three target groups should be more widely available and better supported (see 4.3). These should function not only as a source of empathy and empowerment, but also as a forum for acquiring, sharing and discussing child health/parenting information. Parents in these target groups expressed a preference to be connected with, and to learn from/with both formal and informal sources of information and support, which should be honoured in practice.

6.2 Recommendations specific to fathers (see 5.1)

- Ensure that fathers are equally represented in terms of images and content of resources developed for ‘parents’ and that different situations, (e.g. lone fathers and non-resident fathers) are reflected appropriately, (see 5.1.1). Fathers should be involved in the creation of information and support specifically intended for them (see 5.1.3).

- Encourage providers to offer information/support and services that is equally accessible by and comfortable for, fathers and mothers. This inclusion of fathers should encompass the complete parenting journey from preparation for eventual fatherhood through to the antenatal stage and continue throughout their life as parents, (see 5.1.4).

- Implement guidelines and policies ensuring that fathers, (as well as mothers/carers), will receive copies of all significant information about their child from health, education and children's services, irrespective of which parent is resident with the child. The exception would be where there are child protection concerns, (see 5.1.4).

6.2 Recommendations specific to young mothers (see 5.2)

- Build upon opportunities presented by Scotland's *Curriculum for Excellence* (and the emerging National Parenting Strategy), to increase the quantity and quality of education about and preparation for, motherhood. This should include information and support about contraception, family planning, relationships and child health/development, (see 5.1.1).

- Encourage and strengthen interagency training (CPD), for professionals and practitioners around meeting the diverse needs of young mothers. This should include an emphasis on how to engage with this target group successfully, (see 5.1.2).

- Improve young mothers' access to high quality information and support for continuing their education, enhancing their job readiness, securing employment and dealing well with childcare issues, (see 5.1.3).

6.3 Recommendations specific to parents with literacy issues (see 5.3)

- Ensure that health services are well known to, fully accessible by and welcoming for parents of young children who find it difficult to communicate effectively (for whatever reasons) through written and/or spoken English, (see 5.3.2 and 5.3.3). Sometimes this will require written or oral translations into a broader range of languages and, at other times it will require friendly staff to take the time to listen and explain well.

- Create more opportunities for parents of young children with similar/compatible literacy issues to find and network with each other on a voluntary basis, (see 5.3.4). These should be built around existing information and support sources that this target group finds comfortable and helpful, e.g. some adult education units or community groups/centres.

- Produce a greater quantity and better quality of printed, audio and web-based resources on child health and parenting for this target group, e.g. taking appropriate account of wording and graphics/font type/size, (see 5.3.1). Parents with literacy issues should be encouraged and assisted to actively engage in developing such resources.

6.4 Conclusion

Parents in this research study overwhelmingly preferred personal, empathetic support from individuals in dealing with their specific needs for information and support on child health and parenting. They were not opposed to technological resources, but regarded them as a supplement to (not as a substitute for) individualised information and two-way communication. They were keen to rely on medical and health professionals to provide technical and immediate care for their children when required but they were less likely to do so in relation to more routine, less urgent parenting and child development issues.

In these latter areas, these target groups drew upon a broader range of influences. They included informal sources, (e.g. family, friends and social networks), that helped shape their parenting style and preferences. Parents who were generally not keen to engage with professionals were likely to be more willing to take account of current health messages regarding parenting in instances where trust, empathy and a sense of being listened to and taken seriously were demonstrated. These parents responded favourably to professionals and other information sources, who exhibited willingness to address specific parental queries and to provide advice, leading to meaningful solutions to their concerns about, and hopes for, their children.

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Appendices

Appendix 1: Participant characteristics of the core sample (n=90)

CORE SAMPLE	Young parents	Parents with literacy and/or numeracy issues	Fathers	TOTAL
Biological mother	30 (1 did not complete)	27	N/A	57
***De facto* mother**	0	0	N/A	0
Biological father	0	2	30	32
***De facto* father**	0	0	0	0
Adoptive parent	0	0	1	1
Step parent	0	0	1	1
Foster parent	0	0	0	0
Usually resident with child	30	28	25	83
Resident some of the time	1	0	3	4
Non-resident with contact	0	1	3	4
Only adult in household	13	10	13	36
Other adults resident in household	18	19	15	52
Aged 16-19	22	0	0	22
Aged 20-24	8	4	2	14
Aged 25-34	N/A	15	9	24
Aged 35 and over	N/A	10	19	29
One child	23	14	7	44
Two or more children	8	15	22	45
Living in a city	14	24	4	42
Living in a town	14	5	21	40
Living in a village or rural area	2	0	5	7
Living in area of high deprivation	27	18	15	60
Living in area of low deprivation	1	1	9	11
Living in areas of neither high nor low deprivation	2	9	6	17
White Scottish	31	13	22	66

Other White British	0	0	6	6
White Irish	0	0	0	0
Other White	0	2	1	3
Indian	0	1	0	1
Pakistani	0	2	0	2
Bangladeshi	0	0	0	0
South Asian	0	1	0	1
Chinese	0	0	0	0
Caribbean	0	0	0	0
African	0	4	0	4
Black Scottish and other black	0	0	0	0
Arab	0	3	0	3
Any mixed group	0	1	0	1
Other ethnic group	0	2	0	2
Not stated	0	0	1	1
In paid employment	0	7	8	15
Not in paid employment	28	21	22	71
In full time education	3 PT	1 (and 3 in PT)	1	2 (6 in PT)
Other	0	0	0	0
Disabled/ASN parent	2	1	3	6
Disabled/ASN child	1	6	6	13
Post secondary qualifications	6	18	10	34
Highers (or equivalent)	3	1	1	5
Standard Grades (or equivalent)	8	6	13	27
No standard grades/primary level/Lower than standard grade	7 Access/ABE +5= None	1 special school 1 PRIMARY	4	18
Native English speaker	30	14	23	67
Fluent English speaker	1	8	6	15
Not fluent English speaker	0	2	0	2
		14 had another language as their first language	1 speaker of other language	15 had another language as native
TOTAL INTERVIEWED	31	29	30	90

Appendix 2: Participant characteristics of the supplementary sample (n=42)

SUPPLEMENTARY SAMPLE	Young parents	Parents with literacy and/or numeracy issues	Fathers	TOTAL
Biological mother	7	11	N/A	18
***De facto* mother**	0	0	N/A	0
Biological father	0	3	20	23
***De facto* father**	0	0	0	0
Adoptive parent	0	0	1	1
Step parent	0	0	1	1
Foster parent	0	0	0	0
Usually resident with child	7	14	16	37
Resident some of the time	0	0	3	3
Non-resident with contact	0	0	2	2
Only adult in household	3	4	4	11
Other adults resident in household	4	10	17	31
Aged 16-19	4	0	0	4
Aged 20-24	3	0	0	3
Aged 25-34	N/A	9	2	11
Aged 35 and over	N/A	5	19	24
One child	6	5	4	15
Two or more children	1	9	17	27
Living in a city	3	5	12	20
Living in a town	2	2	5	9
Living in a village or rural area	2	7	4	13
Living in area of high deprivation	2	4	5	11
Living in area of low deprivation	3	11	14	28
Living in areas of neither high nor low deprivation	2	0	1 UNKNOWN	2
White Scottish	7	8	12	27
Other White British	0	2	7	9
White Irish	0	0	0	0
Other White	0	0	0	0
Indian	0	0	0	0
Pakistani	0	0	0	0
Bangladeshi	0	0	0	0

Other (South Asian)	0	0	0	0
Arab	0	2	0	2
Chinese	0	0	0	0
Caribbean	0	0	0	0
African	0	2	0	2
Black Scottish and other black	0	0	0	0
Any mixed group	0	0	1	1
Other ethnic group	0	0	0	0
Not stated	0	0	1	1
In paid employment	1	4	17	22
Not in paid employment	3	9	4	16
In full time education	3	1	0	4
Other	0	0	0	0
Disabled/ASN parent	0	4	4	8
Disabled/ASN child	0	6	6	12
College/Uni	0	9	20	29
Secondary	7	4	1	12
Primary	0	0	0	0
None	0	1	0	1
Native English speaker	5	10	18	33
Fluent English speaker	2	3	2	7
Not fluent English speaker	0	1	0	1
OTHER	0	2 Arabic, 1 Ateso, 1 Luganda	1	5
TOTAL	7	14	21	42

Appendix 3: Parent Information Project – information for staff

Parent Information Project
Information for Staff

How do parents across Scotland find out what they want/need to know about the health and development of their young children – and how best to raise them to be as healthy and happy as possible? How are their information needs currently being met (or not met)? Who do parents turn to when they need information about their children's health? Looking ahead, what are their preferences in terms of *what* they want/need from *whom* and delivered *how*?

Children in Scotland is conducting some qualitative research for NHS Health Scotland to help answer these questions. Our research team will be conducting a series of focus groups and interviews with parents of young children (birth to 8) to develop insights about what is happening and why. NHS Health Scotland is keen to understand not only the views of a small, illustrative sample of parents in Scotland, but also the stories behind their likes and dislikes.

Health Scotland is especially concerned with parents who have been *under-represented* in, or *inadequately served* by early years information services and support. So, we will concentrate on three groups of parents: **fathers (biological or *de facto*), parents having literacy/numeracy issues and young parents (under the age of 24)**. We began this research in July and will finish by December of this year. The final report will be completed by March 2012.

You may be working with parents in the groups described above and know some who might like to participate in focus groups, or individual interviews. This provides an opportunity for them to have their say, share their knowledge/experience and help influence government policy and planning. Those who participate will be modestly compensated for their time. Of course, all information provided by parents will be subject to full confidentiality and anonymised reporting. We will also be conducting an online survey and using other means to reach eligible parents who prefer not to participate in focus groups or face-to-face interviews.

Parents may contact us directly themselves, or you may contact us on their behalf (if they so wish) to find out more. We can send some further information for parents about taking part. Please contact Sara Collier, Assistant Research Officer, Children in Scotland soon at scollier@childreninscotland.org.uk or on 0131 222 2412**, if you would like further information or have an interest in working with us to arrange a focus group or a set of interviews in your area.**

Appendix 4: What parents should know about the Parent Information Project

Parent Information Project (PIP)

What parents should know about PIP

You have been given this information because we are inviting you to take part in this project. Before you decide whether or not to take part, it is important for you to know why this research is being done and what taking part would involve. Please take time to read the following information carefully and feel free to contact us directly to ask any questions.

What is the Parent Information Project (PIP)?

NHS Health Scotland has asked Children in Scotland, a national children's charity, to find out what parents of young children think about information about parenting and about child development. NHS Health Scotland wants to learn more about what is helpful and unhelpful, and what kinds of information (and ways of receiving it) you would prefer.

Before March 2012, Children in Scotland's job is to ask you about these things, listen to what you say and accurately report your views and ideas back to NHS Health Scotland. For example, we will ask about who you turn to, or consult, as parents when you need information about your child's health. We also will ask about whether you prefer to learn from conversations, websites, publications or a variety of other sources. We want to talk with, and learn from, at least 100 parents across Scotland. This will be done through a series of group discussions or personal interviews.

Why have I been asked to take part?

We have asked you to take part in a group discussion or personal interview because you are a parent of a young child (0-8 years) in Scotland – and because you play a regular and active role in your child's life (whether or not you live in the same household).

NHS Health Scotland is particularly interested hearing the views of fathers, young parents and parents who might sometimes have difficulty reading and writing, or expressing their thoughts and ideas.

Do I have to take part?

No. It is up to you whether you take part or not. If you decide to take part, then you will be given a copy of this information sheet to keep and asked to sign a consent form (we are happy to answer any questions that you have). If you do agree to take part, then you are still free to stop at any time, for any reason.

Is there any direct benefit to me taking part?

Taking part in this research will give you the chance to have your say about information that is given to parents and how this might be improved. To thank you for your time and contribution to this study, but particularly to contribute to any expenses you might have because of taking part, we would like to offer you a gift of £20. This will be given to you after completing the group discussion or interview with Children in Scotland staff.

What does taking part in PIP involve?

Taking part in this study will most likely involve telling us what you think about the parenting and child development information you get – and would to receive in the future. This will happen through either a discussion group with up to nine other parents – or a personal interview with a Children in Scotland researcher.

We may ask you to take part in a follow-up interview or ask you a few more questions about your experiences and opinions. This is so that we can better understand what you know and what you want, which we may write up as an individual story (without anyone reading the story knowing your identity). You can say ‘no’ to this part.

There are two documents that you must complete in order to participate. We can talk through the information on these forms and help to complete them if you want. One is a ‘consent form’ that you sign to confirm you are aware of what participating means, what will (and will not) happen and how what you tell us will (and will not) be used. We want to make sure that there are no unpleasant surprises for you, and that you understand and freely agree to do what we are asking of you. Please discuss with us any questions or concerns you might have before signing.

The other document includes personal background information about you (from the number of children you have to whether you live in a city or rural area). This can be completed before (or at the end of) your discussion group or interview. We are gathering this information from every participating parent in order to know that we have heard from a diverse group of parents across Scotland, and in our analysis of results. Information that is specific to you will not be accessible to anyone outside the project team.

We will make an audio recording of every discussion group and interview. We are doing this so that we can make sure that we accurately report what you say. No one outside the PIP project team will hear this recording. If you do not want to be recorded, then we will offer you another way of participating.

We would like you to be able to talk freely to us if you take part in a focus group or interview. So, we ask that you participate on your own. The payment you receive for participating can, of course, be used towards paying for childcare.

Only the project team at Children in Scotland and NHS Health Scotland can access your information, and we will only use it for research. We may quote what you say, but never use your name. All information collected about you will be kept stored securely, reported anonymously, and kept confidential. However, if you tell us about someone whose safety, life or health is in danger, then we have to report this information to the appropriate agency. All other information gained through PIP will be kept by the project team for a period of seven years after we complete the project, and then securely destroyed.

What will we do with what you choose to share with us?
What parents tell us will be written up as part of a report to NHS Health Scotland, who will use what it says to help plan how best to provide information on parenting and on child health and wellbeing. Other organisations might also find this report helpful in their work to provide useful information to the parents of young children across Scotland.

If you would like to receive a copy of the research report, then we are happy to send one to you. Signing up to receive your free copy is part of the ‘consent form’.

Contacts for further information
If you have any questions about your participation (or change your mind later and no longer want to participate), then please feel free to contact Sara Collier, Assistant Research Officer, Children in Scotland, at scollier@childreninscotland.org.uk or on 0131

222 2412.

If you have any concerns about the study, then please contact Dr Jonathan Sher, Director of Research, Children in Scotland at jsher@childreninscotland.org.uk or on 0131 222 2418 or Dr Kate Woodman, Public Health Adviser at NHS Health Scotland, on 0131 313 7550, or kate.woodman@nhs.net.

Thank you for considering helping us!
September 2011

Appendix 5: Parent Information Project participant consent form

Parent Information Project (PIP)

Participant Consent Form

As part of this study, we are asking you to take part in a discussion group or personal interview. All the information that you give us will be used for research purposes only, be anonymised and held securely and confidentially by Children in Scotland and NHS Health Scotland. Please read and think about this form **before** your focus group or interview.

Please feel free to contact Sara Collier, Assistant Research Officer, Children in Scotland at scollier@childreninscotland.org.uk or on 0131 222 2412, if you have any questions or concerns before signing and returning this form. Please return it to a member of our research team at the focus group or interview.

		Please initial box
1	I have read and understood What parents should know about PIP (dated September 2011) and have had the chance to ask any questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	☐
3.	I agree to take part in the PIP study.	☐
4.	I agree to being contacted by a Children in Scotland researcher to discuss a possible second interview for this research.	☐

Please tick box

		Yes	**No**
5.	I agree to my interview or focus group being audio recorded.	☐	☐
6.	I agree to the use of anonymised quotes in publications or presentations.	☐	☐

Please provide your contact details. We will use this for any follow up contact to which you agree and to send you a free copy of the final PIP report, if you want one (see below).

Name: ____

Address: ____

____

Post code ____

Telephone Number: ____

Email Address: ____

I would like to receive a copy of the research report ☐

I do not want to receive a copy of the research report ☐

________________________	_____________	________________________
Participant name (please print) Signature		Date

________________________	_____________	________________________
PIP team member (please print)	Date	Signature

Participant's Unique Identity Number ____________________

Appendix 6: Parent Information Project biographical information form

Parent Information Project (PIP)

Biographical information form

As part of this study, we need to ask you some questions before the end of your focus group/interview. All the information that you give us will be used for research purposes only, be anonymised and held securely and confidentially by Children in Scotland and NHS Health Scotland.

Please feel free to contact Sara Collier, Assistant Research Officer, Children in Scotland at scollier@childreninscotland.org.uk or on 0131 222 2412, if you have any questions or concerns before completing this form. Please return it to a member of our research team at the focus group or interview.

Name:
Date:
Participant's Unique Identity Number ________________________________

I am:

Female ☐ Male ☐

My age is:

16-19 ☐ 20 - 24 ☐ 25 - 34 ☐ 35 and over ☐

I have:

One child ☐ Two or more children ☐

The age (s) of my child/children are: ____________________________

I am a:

Birth/natural parent ☐
Adoptive parent ☐
Step parent/carer ☐
Foster parent/carer ☐
Grandparent/kinship carer ☐

I live with my child/children:

All of the time☐ Some of the time☐

I do not live with my child, but I have weekly /monthly contact with them ☐

Are you the only adult in the household?

Yes☐ No☐

My Ethnicity is:

White Scottish ☐
Other white British ☐
White Irish ☐
White Gypsy/Traveller ☐
White Polish ☐
Other White ☐
Indian, Indian Scottish or Indian British ☐
Bangladeshi, Bangladeshi Scottish or Bangladeshi British ☐
Pakistani, Pakistani Scottish or Pakistani British ☐
Chinese, Chinese Scottish or Chinese British ☐
African, African Scottish or African British ☐
Caribbean, Caribbean Scottish or Caribbean British ☐
Arab, Arab Scottish or Arab British ☐
Mixed or multiple ethnic groups ☐
Other ethnic group (please write in) ____

I am:

In paid employment ☐
Not currently in paid employment ☐
In full time education ☐
Other (write in) ____________________

I live in:

A city ☐
A town ☐
A village or rural area ☐
What is the name of the city/town/village?
What is your complete postcode?

Does your child/children have a disability or require additional support for learning?

Yes☐ No☐

Do you have a disability or require additional support for learning?

Yes☐ No☐

What is the highest level of educational qualifications you have?

Primary School ☐

Standard Grades/GCSE (or equivalent) ☐

Secondary School Highers/A Levels (or equivalent) ☐

Post Secondary School (eg College or University) ☐

Other (write in) ______________________________

I am:

A native English speaker ☐

Fluent in English ☐

Not fluent in English ☐

A native speaker of another language (write in) ________________

Appendix 7: Parent Information Project participant recording grid

	Young parents	**Parents with literacy and/or numeracy issues**	**Fathers**	**Other parents (non-eligible)**
Birth mother				
***De facto* mother**				
Biological father				
***De facto* father**				
Adoptive parent				
Step parent				
Usually resident with child				
Resident some of the time				
Non-resident with contact				
Only adult in household				
Other adults resident in household				
Aged 16-19				
Aged 20-24				
Aged 25-34				
Aged 35 and over				
One child				
Two or more children				
Living in a city				
Living in a town				
Living in a village or rural area				
Living in area of high deprivation				
Living in area of low deprivation				
Living in areas of neither high nor low deprivation				
White Scottish				
Other White				

British				
White Irish				
Other White				
Indian				
Pakistani				
Bangladeshi				
Other (South Asian)				
Chinese				
Caribbean				
African				
Black Scottish and other black				
Any mixed group				
Other ethnic group				
Not stated				
In paid employment				
Not in paid employment				
In full time education				
Other				
Disabled/ASN parent				
Disabled/ASN child				
Post secondary qualifications				
Highers (or equivalent)				
Standard Grades (or equivalent)				
No standard grades/primary level/Lower than standard grade				
Native English speaker				
Fluent English speaker				
Not fluent English speaker				
TOTAL				

Appendix 8: Project posters

Poster 1

What I feel confident/comfortable about
in relation to my child's health

Working out when my child has a problem that requires help/advice

Knowing where and how to get good information/advice

Making sense of different information/advice from professionals, e.g. doctors, nurses, teachers, social workers

Understanding written information (online/newspapers/books/magazines)

Making decisions about my own and my child's health

Living up to my own/others' standards

That I will end up getting the help/advice/information needed

Poster 2

What I feel less confident/uncomfortable about
in relation to my child's health

Working out when my child has a problem that requires help/advice

Knowing where and how to get good information/advice

Making sense of different information/advice from professionals, e.g. doctors, nurses, teachers, social workers

Understanding written information (online/newspapers/books/magazines)

Making decisions about my own and my child's health

Living up to my own/others' standards

That I will end up getting the help/advice/information needed

Poster 3

Who I turn to for advice/information about parenting and child health

Family members

Friends

Other parents

Professionals I know (my GP, teacher, health visitor, social worker, chemist)

Professionals I don't know, but who I trust (A&E staff, Parentline or NHS 24)

Poster 4

How I get parenting and child health information now

I ask for it from professionals (GP, health visitor, social worker, teacher)

I just Google it or go to favourite websites

I pick up whatever leaflets or other written information I come across

I call a helpline and ask for it to be sent to me

I ask people I know to share whatever information they have

I get it mostly by accident and without having to look for it

Poster 5

Parenting and child health topics I can't find enough about

Relaxing and enjoying my child more
Preventing injury
How to care for my child when I'm not okay myself
Dealing with my child's (or another child's) behaviour
Eating/diet/nutrition
Immunisations
Domestic abuse
Play/fitness/exercise
What's "normal" development/behaviour
Preparing my child for pre-school or school
Toileting
Becoming a less stressed/happier parent
Sleep (for me and/or my child)
Preventing illness

Poster 6

If, how and why **I actually use the following 'old' information sources**

TV programmes featuring parenting or children

Newspapers/magazines

Advertisements about products for parents or children

Parenting or child health leaflets/books

DVDs or films featuring parents or children

Poster 7

If, how and why **I actually use the following 'new' information sources**

Facebook/Twitter

YouTube videos

Helplines

Websites and Internet searches

Blogs

Phone apps

Poster 8

How I would prefer to get parenting and child health information/advice

By looking at social networking sites and blogs

By using my smartphone or e-mail

By picking up leaflets, pamphlets and other written documents in lots of places I already go

By talking or meeting with professionals (such as nurses, teachers, GPs, social workers, health visitors, chemists)

By using a Scottish website devoted to parenting and child health

By talking with other parents who are like me, but who know more than me

By using well-known books and guides on parenting and/or child health

Appendix 9: Topic guide

Topic Guide for PIP Focus Groups and Interviews

Opening Questions: Being a parent

What’s good about being a parent?

What’s the down side?

Topic 1: General confidence as a parent

As a parent what do you feel confident/comfortable about (using prompt poster 1 and exploring issues through use of the following probing questions).

Prompt poster 1: Probe - *How, who, what, where, when, why?*

What I feel confident/comfortable about
in relation to my child’s health

Working out when my child has a problem that requires help/advice

Knowing where and how to get good information/advice

Making sense of different information/advice from professionals, e.g. doctors, nurses, teachers, social workers

Understanding written information (online/newspapers/books/magazines)

Making decisions about my own and my child’s health

Living up to my own/others’ standards

That I will end up getting the help/advice/information needed

Topic 1: Related Exploration

- Are there other things that we haven’t talked about already that make you more confident as a parent?
- What would boost your confidence?
- What knocks your confidence?

Prompt poster 2: Probe - *How, who, what, where, when, why*

What I feel <u>less confident/uncomfortable</u> about
in relation to my child's health

Working out when my child has a problem that requires help/advice

Knowing where and how to get good information/advice

Making sense of different information/advice from professionals, e.g. doctors, nurses, teachers, social workers

Understanding written information (online/newspapers/books/magazines)

Making decisions about my own and my child's health

Living up to my own/others' standards

That I will end up getting the help/advice/information needed

- Thinking of your own experience as a parent, is there anything you want to add to the discussion about confidence or lack of it?

Topic 2: People as information sources

Who are the people you turn to/trust for advice?

Prompt poster 3: Probe - *How, who, what, where, when, why?*

<u>Who</u> I turn to for advice/information about parenting and child health

Family members

Friends

Other parents

Professionals I know (my GP, teacher, health visitor, social worker, chemist)

Professionals I don't know, but who I trust (A&E staff, Parentline or NHS 24)

Topic 2: Related Exploration

- You’ve been talking about the people you trust to give you advice/information as a parent. Can you tell us a bit more about what it is about these relationships that makes them work for you?

- What are the difficulties that you have come across in getting information/advice/ support from other people?

- What do you think would help you overcome these difficulties?

- How important is it to feel valued as a person/parent by the person giving you the information (or is this irrelevant/does not come into it?)

- Is it important for you to value the person giving you the information you need? Why? Why not?

- Some of you have talked about **not** trusting people to give you advice/information. Can you tell us a bit more about why this might be?

- Thinking of your own experiences as a parent, is there anything you want to add to the discussion about people you do (or don’t) turn to for information and advice?

Topic 3: Physical access to information and support

How do you physically access information? What barriers, if any, have you met?

Prompt poster 4: Probe - *How, who, what, where, when, why?*

How I get parenting and child health information now

I ask for it from professionals (GP, health visitor, social worker, teacher)

I just Google it or go to favourite websites

I pick up whatever leaflets or other written information I come across

I call a helpline and ask for it to be sent to me

I ask people I know to share whatever information they have

I get it mostly by accident and without having to look for it

Topic 3: Related Exploration

- Parents physically get hold of their information in different ways. Imagine there is another parent, very much like you, who lived nearby and who had a child about the same age, BUT they had been given some training about the kind of information that you need
  Would this be a good way to get information?
  Why? Why not?

- Thinking of your own experience as a parent, is there anything you want to add to the discussion about physically accessing information?

Topic 4: Information gaps

Before looking at *how* to get information to parents in the right way, it might be worthwhile checking whether you as parents have concerns/issues that you would like more information about.

Prompt poster 5: Probe – getting a sense of consensus, (or otherwise), from parents

Parenting and child health topics I can't find enough about

Relaxing and enjoying my child more
Preventing injury
How to care for my child when I'm not okay myself
Dealing with my child's (or another child's) behaviour
Eating/diet/nutrition
Immunisations
Domestic abuse
Play/fitness/exercise
What's "normal" development/behaviour
Preparing my child for pre-school or school
Toileting
Becoming a less stressed/happier parent
Sleep (for me and/or my child)
Preventing illness

Topic 4: Related Exploration

- Are there any other subjects/topics that you would want to find out about that aren't on this list?
- There are a few items about you as parents, but more about your child. Why do you think that this might be?
- Some parents have said that getting too much information can be as bad as getting too little. What do you think?
- Thinking of your own experience as a parent, is there anything you want to add to this part of the discussion?

Topic 5: Media and (established) technological sources

We've been talking about how *people* give you support, but want to move on to the other ways of getting advice/information that you want/need as a parent

We'd like to hear about whether you use the following sources of information, and if so, how you find using them

Prompt poster 6: Probe – *for each one, explore what is good/down side*

***If, how and why* I actually use the following 'old' information sources**

TV programmes featuring parenting or children

Newspapers/magazines

Advertisements about products for parents or children

Parenting or child health leaflets/books

DVDs or films featuring parents or children

Topic 5: Related Exploration

Probing the favoured sources, e.g., newspapers/magazines,

- How much do you trust/not trust these sources? Why? Why/not?
- Why do you not trust the other ones in the same way?
- How do you *decide* if information can be trusted or not?
- Is it important where the information comes from -- for example, if it has a logo from the Scottish Government, or NHS Health Scotland? Why? Why not?

- Do you, as parents, tend to watch/read/click onto websites if the source is already known -- or is newness a good thing? Why? Why not?

- What guides where you look among these sources?

- Is there still something that you would be wary of? Why? Why not?

- Thinking of your own experience, is there anything you want to add to the discussion about these old/established information sources?

Topic 6: New and potential technological sources

We've looked at the usual/standard ways that you as parents get the information that you need/want. Now, we'd be keen to hear whether these are still ok or need to be updated.

Prompt poster 7: Probe - *for each one, explore what is good/down side*

***If, how and why* I actually use the following 'new' information sources**

Facebook/Twitter

YouTube videos

Helplines

Websites and Internet searches

Blogs

Phone apps

Topic 6: Related Exploration

- How much do you trust/not trust these "new" sources? Why? Why not?

- How do you *decide* if information received in this way can be trusted (or not)?

- Is it important if it says where it comes from, for example, if it has a logo from the Scottish Government, NHS Health Scotland or some other source? Why? Why not?

- Is there still something about using the newest technologies for getting information that you would be wary of or concerned about? Why? Why not?

Topic 7: Preferences about the way forward for information support

Reflecting on all that’s been talked about so far, how do you think parents can be best supported as they look for information/advice? We are looking for realistic ideas.

Prompt poster 8: Probe why they would prefer to receive advice through each method

How I would prefer to get parenting and child health information/advice

By looking at social networking sites and blogs

By using my smartphone or e-mail

By picking up leaflets, pamphlets and other written documents in lots of places I already go

By talking or meeting with professionals (such as nurses, teachers, GPs, social workers, health visitors, chemists)

By using a Scottish website devoted to parenting and child health

By talking with other parents who are like me, but who know more than me

By using well-known books and guides on parenting and/or child health

Topic 7: Related Exploration

- In the short term, how should the government and other sources get information to parents *right now*?

- Taking a longer term view, from your experience, how should the government and other sources be preparing to get information to parents over the next, say 5-10 years?

- Thinking of your own experience and how you use new sources when they appear, is there anything you want to add to the discussion about the way forward?

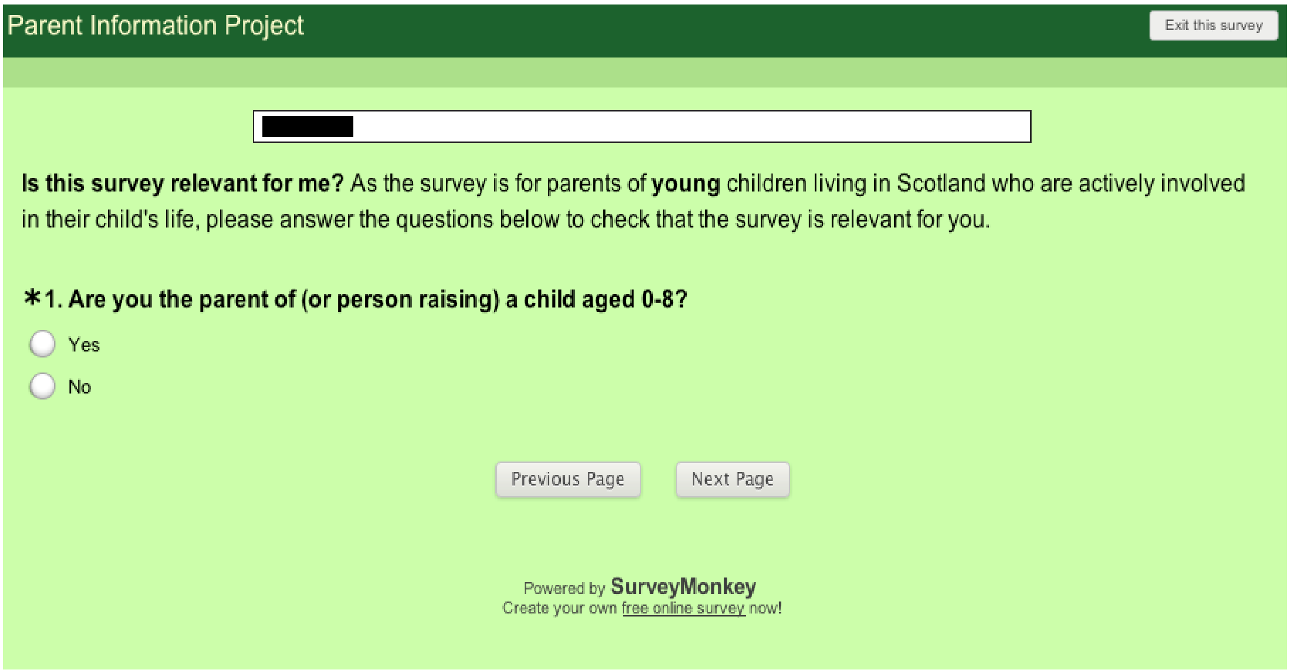
Checklist of topics/questions from research objectives

This is only intended as an aide-memoire, to be used towards the end of a focus group or an interview to check whether any key questions or issues have been missed. It is only for your use as the facilitator or interviewer. It incorporates the specific research objectives of this NHS Health Scotland commissioned study.

- What expectations do parents have of information and information support?
- What factors gave rise to good or bad parental experiences of information and information support?
- What are the parents preferred, and most trusted/respected, information sources about child health and parenting?
- What explains these parental preferences and views?
- What are the major perceived gaps in terms of information and information support?

- What circumstances contribute – or serve as a barrier – to effective and successful information support?
- What impact does the relationship between parents and sources of information/support have upon parental confidence and behaviour?
- What are parental views about, and level of interest in, new formats and sources of future information and information support about child health and parenting?

Appendix 10: Supplementary sample questions (online survey)

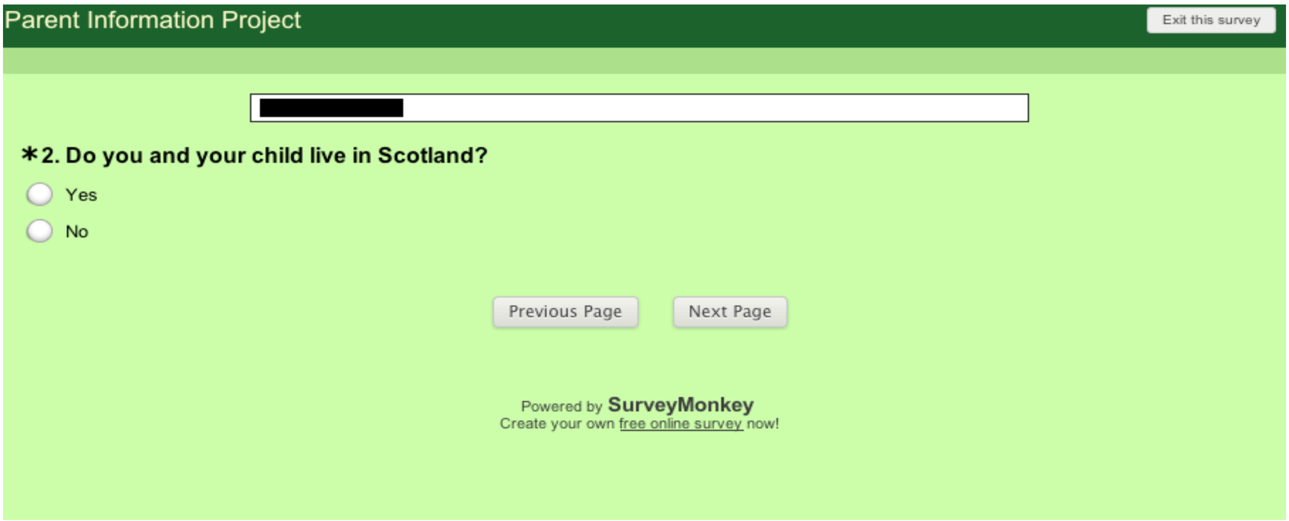


Is this survey relevant for me? As the survey is for parents of **young** children living in Scotland who are actively involved in their child's life, please answer the questions below to check that the survey is relevant for you.

***1. Are you the parent of (or person raising) a child aged 0-8?**

○ Yes

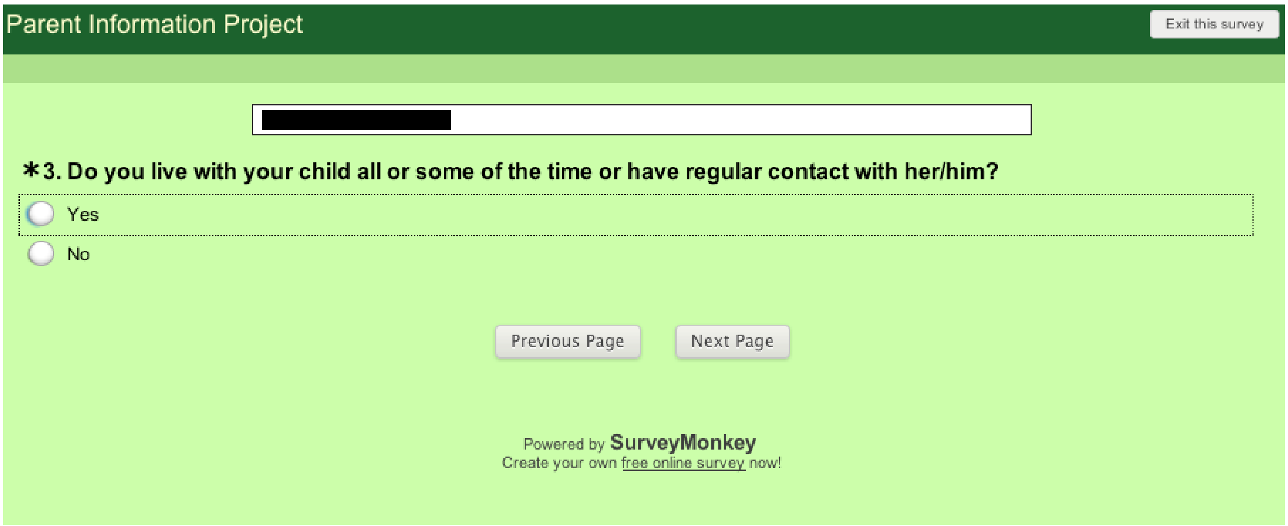
○ No



***2. Do you and your child live in Scotland?**

○ Yes

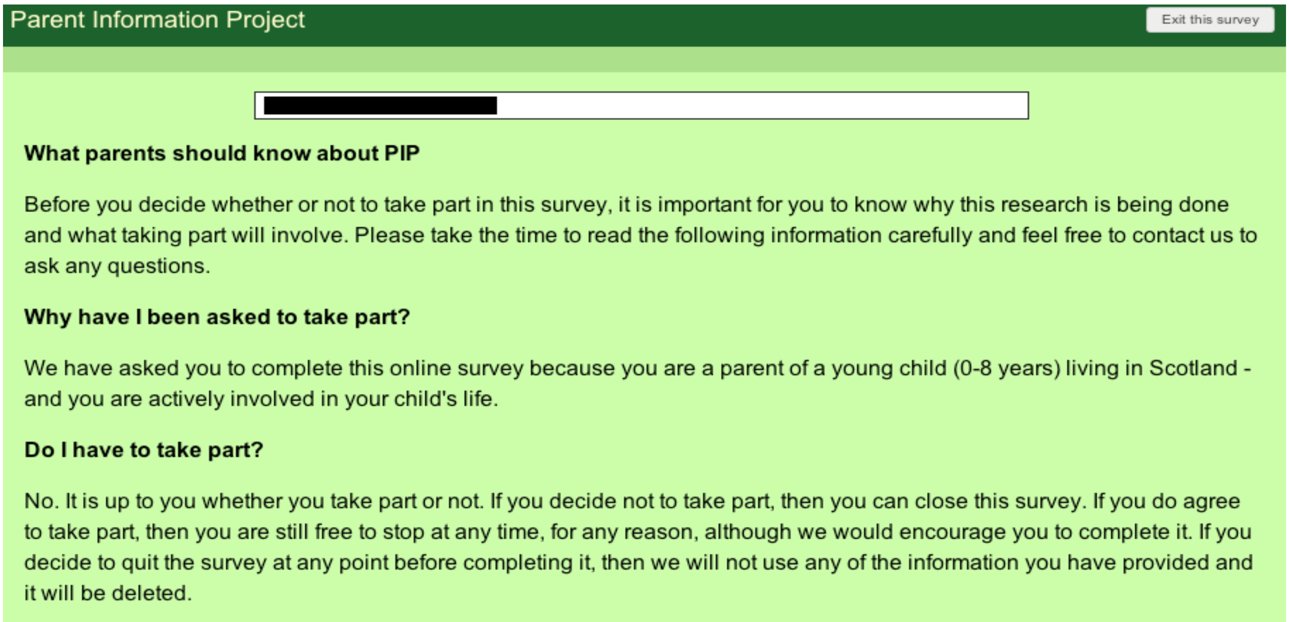
○ No



***3. Do you live with your child all or some of the time or have regular contact with her/him?**

○ Yes

○ No



What parents should know about PIP

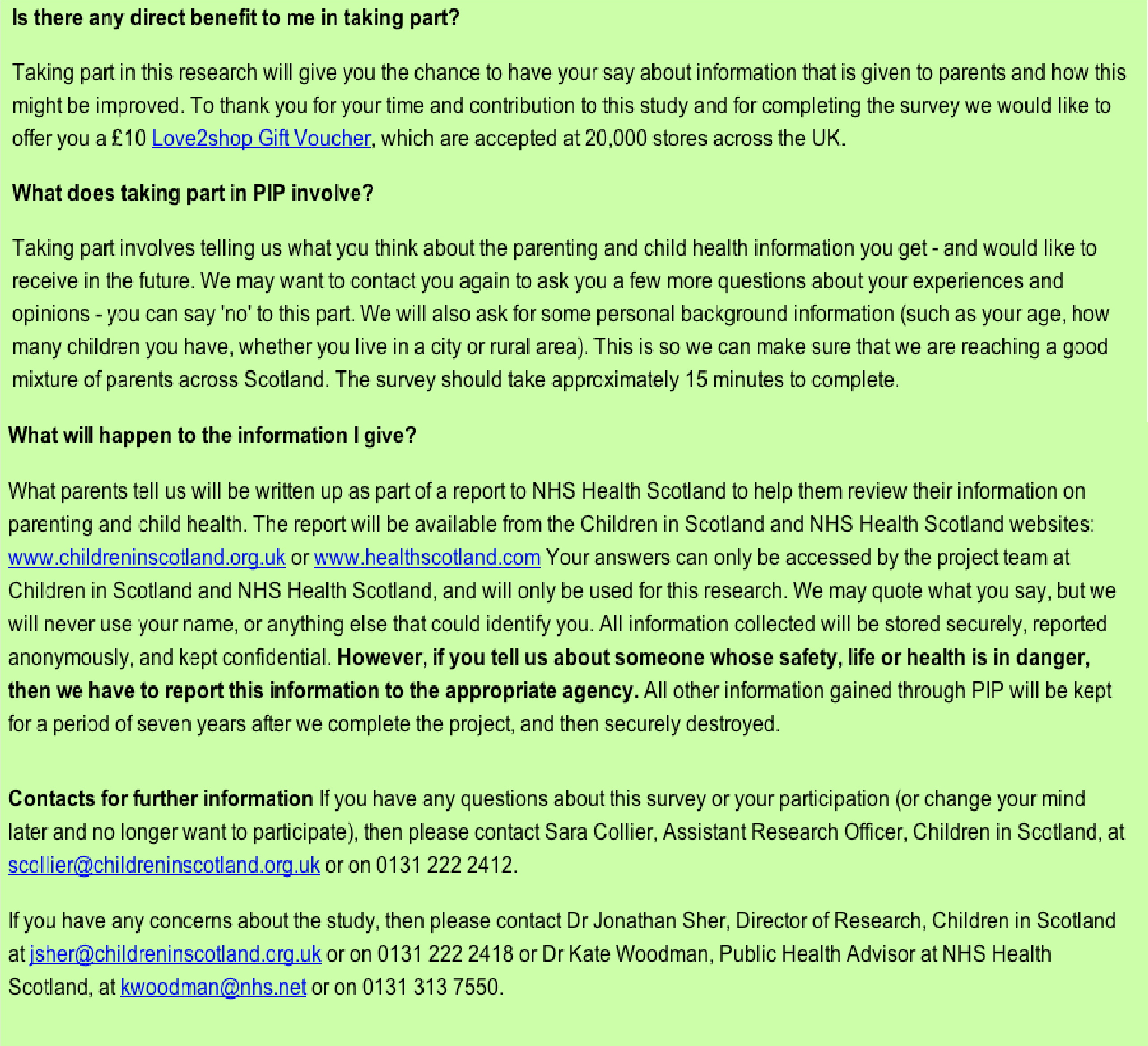
Before you decide whether or not to take part in this survey, it is important for you to know why this research is being done and what taking part will involve. Please take the time to read the following information carefully and feel free to contact us to ask any questions.

Why have I been asked to take part?

We have asked you to complete this online survey because you are a parent of a young child (0-8 years) living in Scotland - and you are actively involved in your child's life.

Do I have to take part?

No. It is up to you whether you take part or not. If you decide not to take part, then you can close this survey. If you do agree to take part, then you are still free to stop at any time, for any reason, although we would encourage you to complete it. If you decide to quit the survey at any point before completing it, then we will not use any of the information you have provided and it will be deleted.



Is there any direct benefit to me in taking part?

Taking part in this research will give you the chance to have your say about information that is given to parents and how this might be improved. To thank you for your time and contribution to this study and for completing the survey we would like to offer you a £10 Love2shop Gift Voucher, which are accepted at 20,000 stores across the UK.

What does taking part in PIP involve?

Taking part involves telling us what you think about the parenting and child health information you get - and would like to receive in the future. We may want to contact you again to ask you a few more questions about your experiences and opinions - you can say 'no' to this part. We will also ask for some personal background information (such as your age, how many children you have, whether you live in a city or rural area). This is so we can make sure that we are reaching a good mixture of parents across Scotland. The survey should take approximately 15 minutes to complete.

What will happen to the information I give?

What parents tell us will be written up as part of a report to NHS Health Scotland to help them review their information on parenting and child health. The report will be available from the Children in Scotland and NHS Health Scotland websites: www.childreninscotland.org.uk or www.healthscotland.com Your answers can only be accessed by the project team at Children in Scotland and NHS Health Scotland, and will only be used for this research. We may quote what you say, but we will never use your name, or anything else that could identify you. All information collected will be stored securely, reported anonymously, and kept confidential. **However, if you tell us about someone whose safety, life or health is in danger, then we have to report this information to the appropriate agency.** All other information gained through PIP will be kept for a period of seven years after we complete the project, and then securely destroyed.

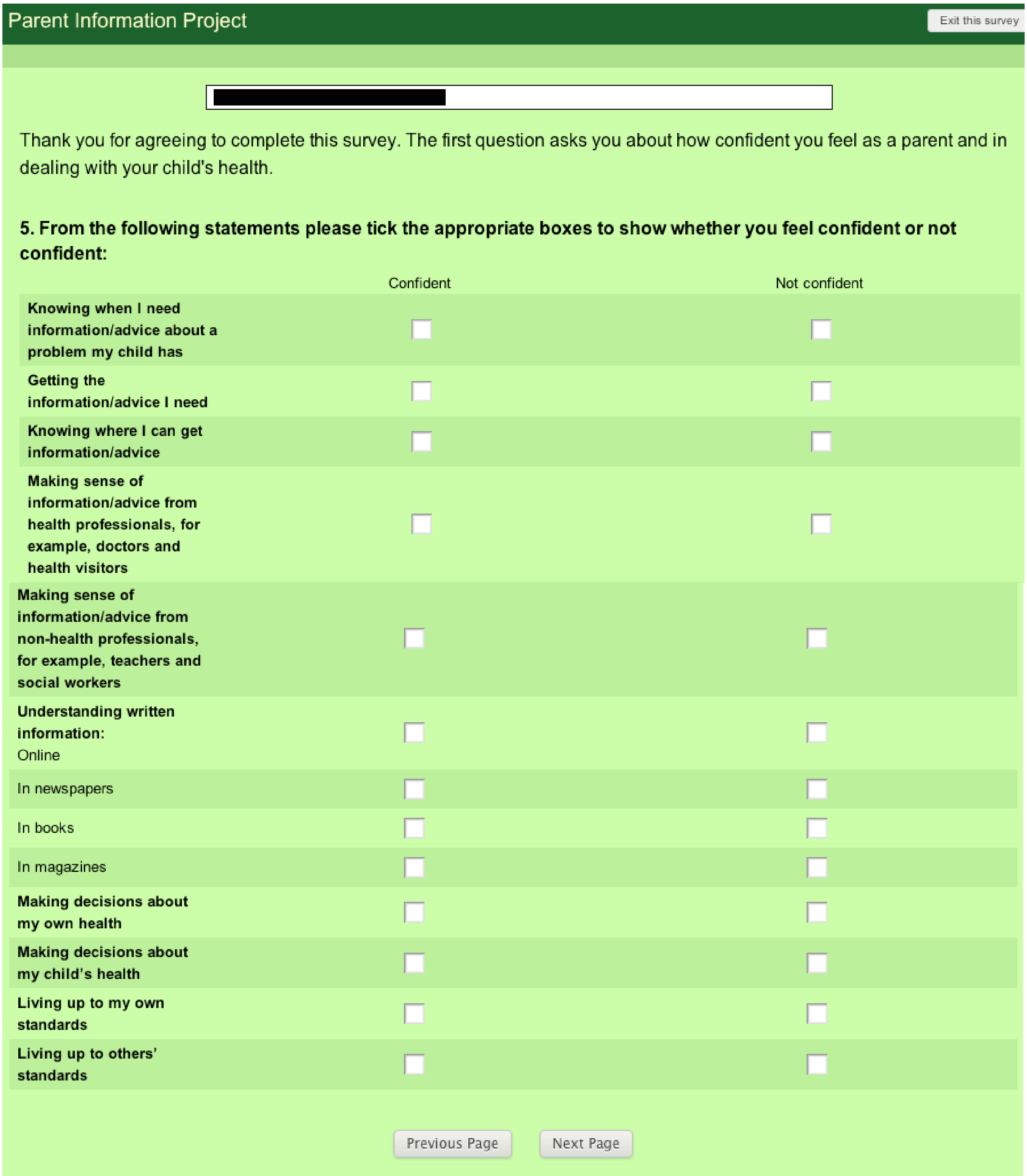
Contacts for further information If you have any questions about this survey or your participation (or change your mind later and no longer want to participate), then please contact Sara Collier, Assistant Research Officer, Children in Scotland, at scollier@childreninscotland.org.uk or on 0131 222 2412.

If you have any concerns about the study, then please contact Dr Jonathan Sher, Director of Research, Children in Scotland at jsher@childreninscotland.org.uk or on 0131 222 2418 or Dr Kate Woodman, Public Health Advisor at NHS Health Scotland, at kwoodman@nhs.net or on 0131 313 7550.

∗4. I understand the above information and am happy to take part in this survey.

○ Yes

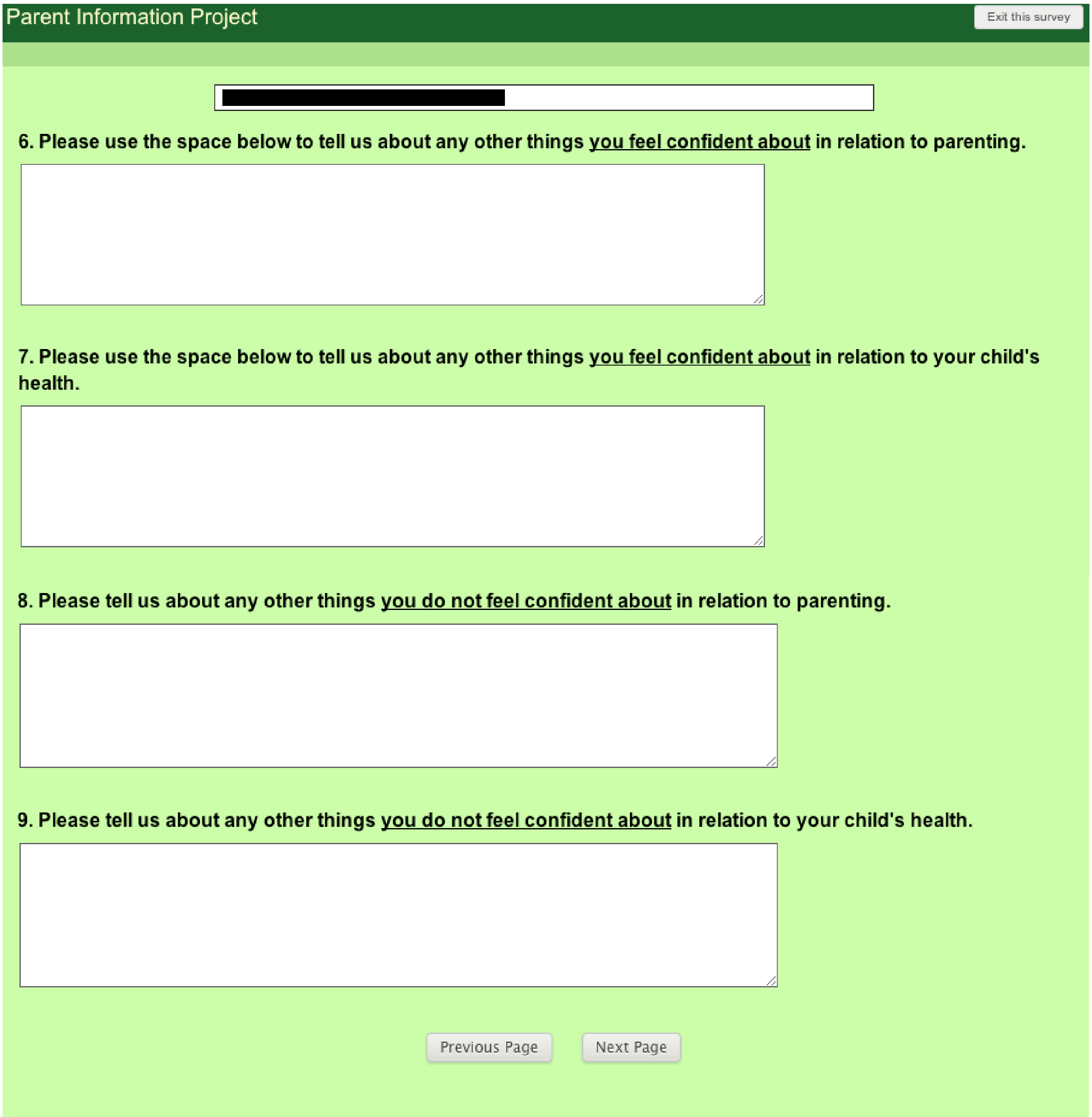
○ No



Thank you for agreeing to complete this survey. The first question asks you about how confident you feel as a parent and in dealing with your child's health.

5. From the following statements please tick the appropriate boxes to show whether you feel confident or not confident:

	Confident	Not confident
Knowing when I need information/advice about a problem my child has	☐	☐
Getting the information/advice I need	☐	☐
Knowing where I can get information/advice	☐	☐
Making sense of information/advice from health professionals, for example, doctors and health visitors	☐	☐
Making sense of information/advice from non-health professionals, for example, teachers and social workers	☐	☐
Understanding written information: Online	☐	☐
In newspapers	☐	☐
In books	☐	☐
In magazines	☐	☐
Making decisions about my own health	☐	☐
Making decisions about my child's health	☐	☐
Living up to my own standards	☐	☐
Living up to others' standards	☐	☐

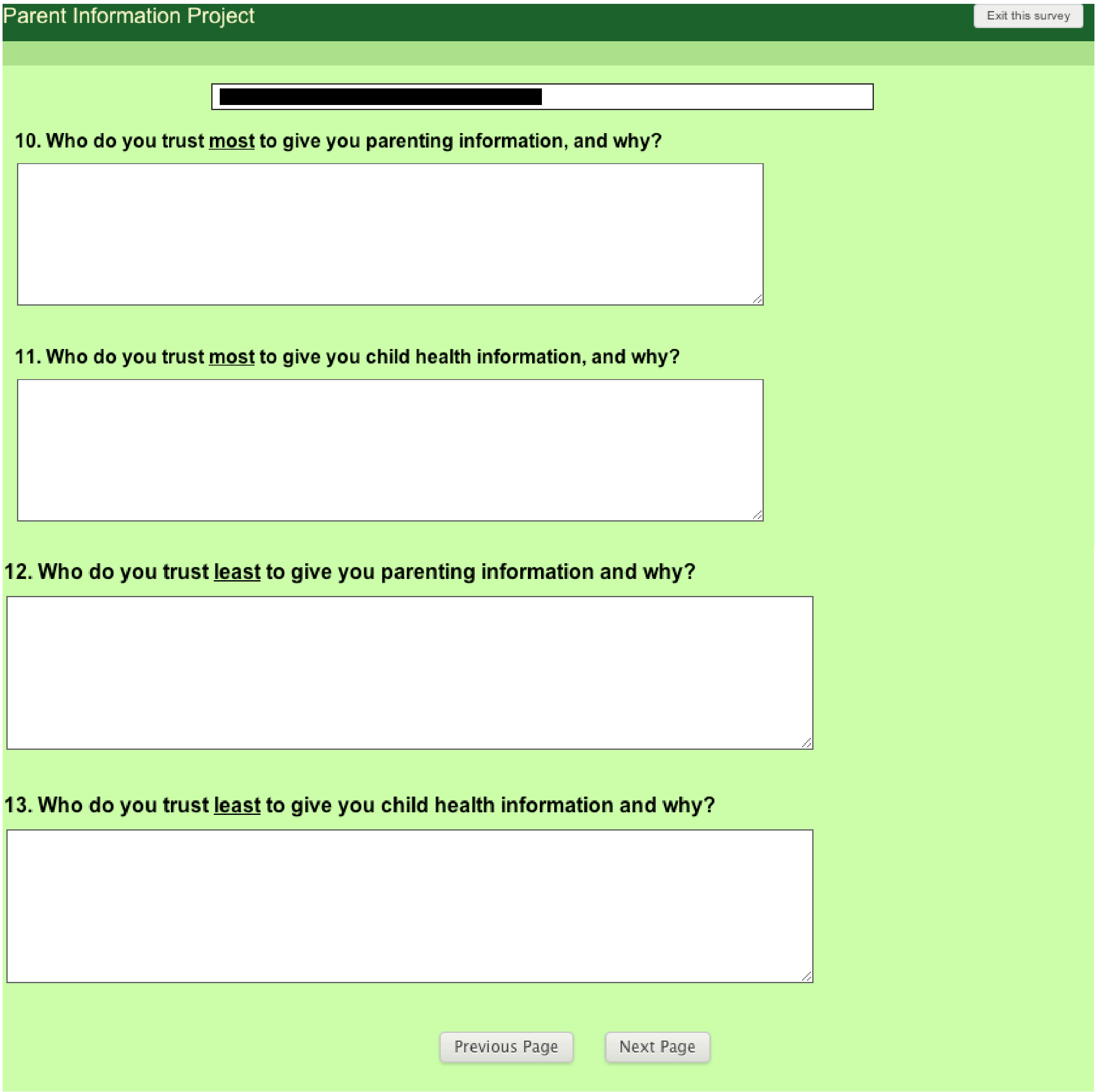


6. Please use the space below to tell us about any other things <u>you feel confident about</u> in relation to parenting.

7. Please use the space below to tell us about any other things <u>you feel confident about</u> in relation to your child's health.

8. Please tell us about any other things <u>you do not feel confident about</u> in relation to parenting.

9. Please tell us about any other things <u>you do not feel confident about</u> in relation to your child's health.



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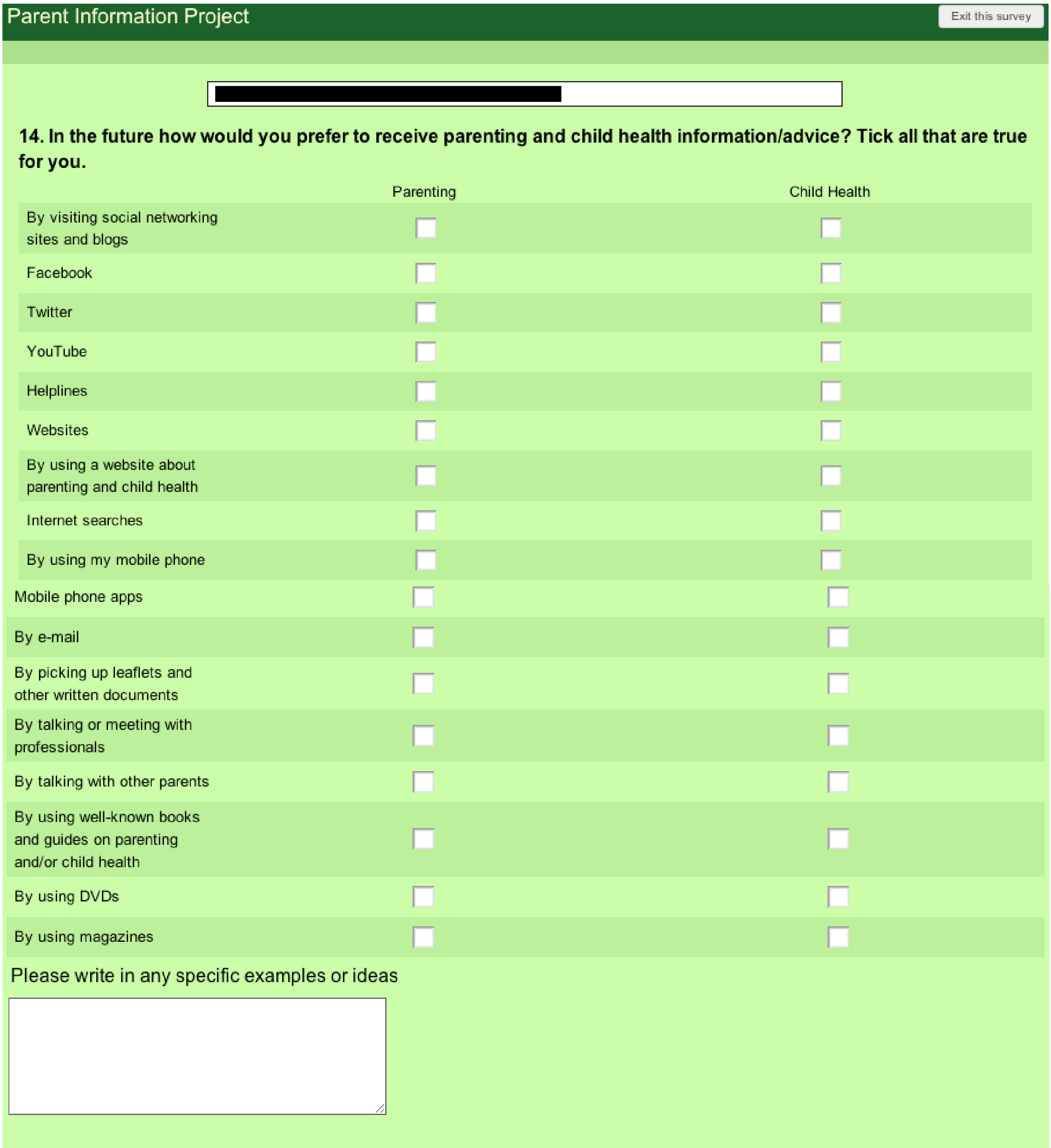
10. Who do you trust most to give you parenting information, and why?

11. Who do you trust most to give you child health information, and why?

12. Who do you trust least to give you parenting information and why?

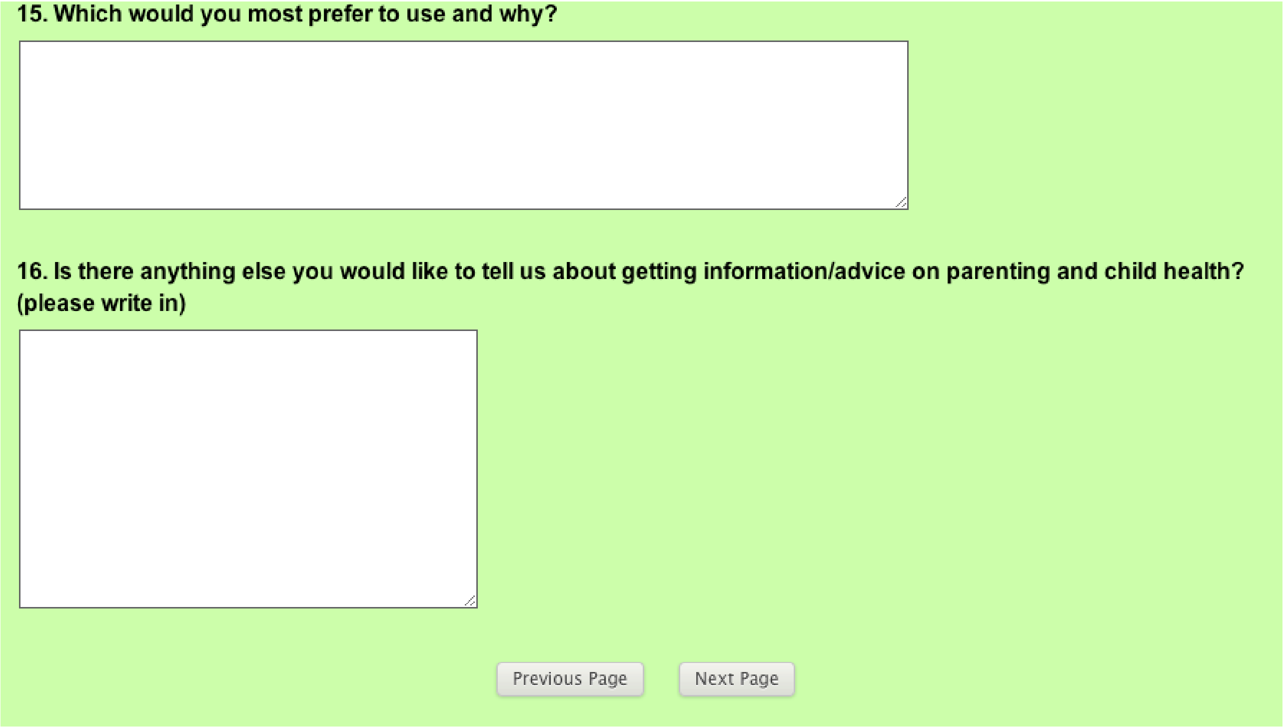
13. Who do you trust least to give you child health information and why?



14. In the future how would you prefer to receive parenting and child health information/advice? Tick all that are true for you.

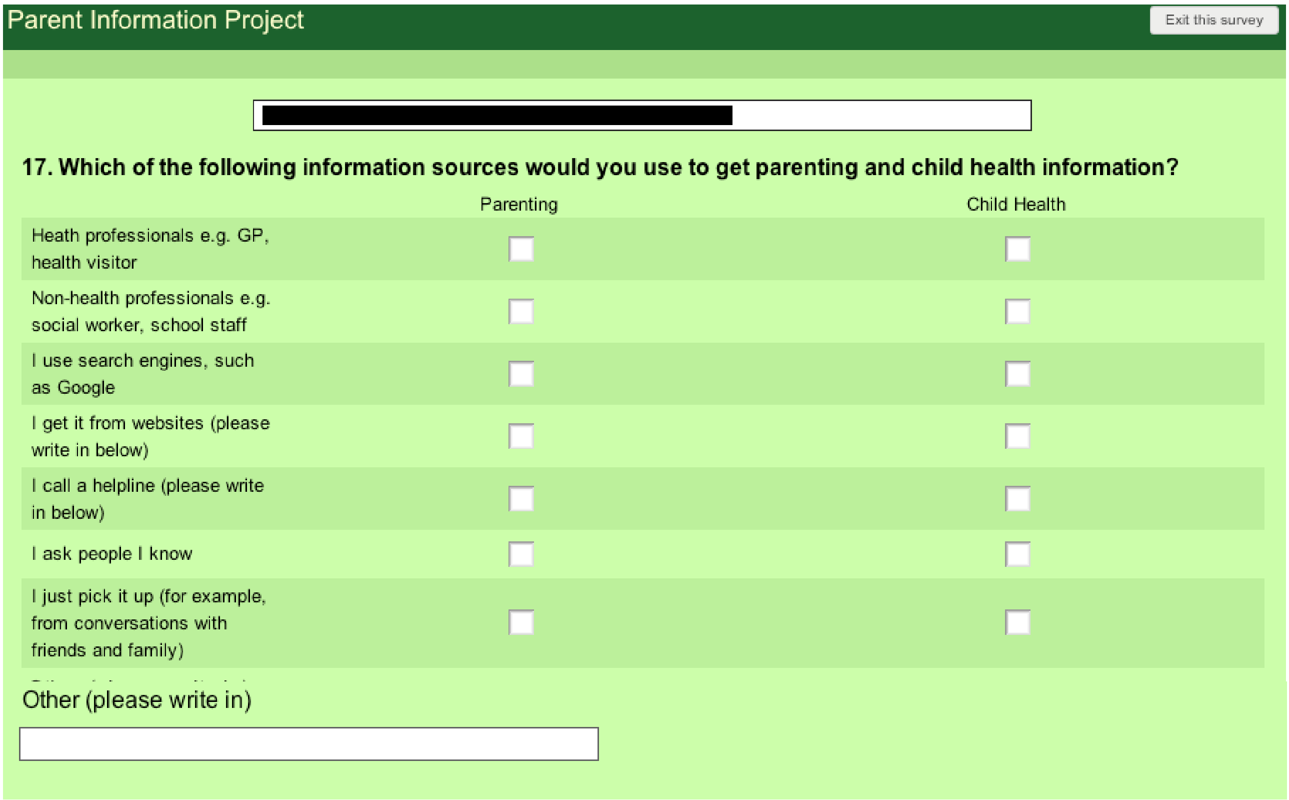
	Parenting	Child Health
By visiting social networking sites and blogs	☐	☐
Facebook	☐	☐
Twitter	☐	☐
YouTube	☐	☐
Helplines	☐	☐
Websites	☐	☐
By using a website about parenting and child health	☐	☐
Internet searches	☐	☐
By using my mobile phone	☐	☐
Mobile phone apps	☐	☐
By e-mail	☐	☐
By picking up leaflets and other written documents	☐	☐
By talking or meeting with professionals	☐	☐
By talking with other parents	☐	☐
By using well-known books and guides on parenting and/or child health	☐	☐
By using DVDs	☐	☐
By using magazines	☐	☐

Please write in any specific examples or ideas



15. Which would you most prefer to use and why?

16. Is there anything else you would like to tell us about getting information/advice on parenting and child health? (please write in)



17. Which of the following information sources would you use to get parenting and child health information?

	Parenting	Child Health
Heath professionals e.g. GP, health visitor	☐	☐
Non-health professionals e.g. social worker, school staff	☐	☐
I use search engines, such as Google	☐	☐
I get it from websites (please write in below)	☐	☐
I call a helpline (please write in below)	☐	☐
I ask people I know	☐	☐
I just pick it up (for example, from conversations with friends and family)	☐	☐

Other (please write in)

18. Please write in any websites, helplines etc mentioned above

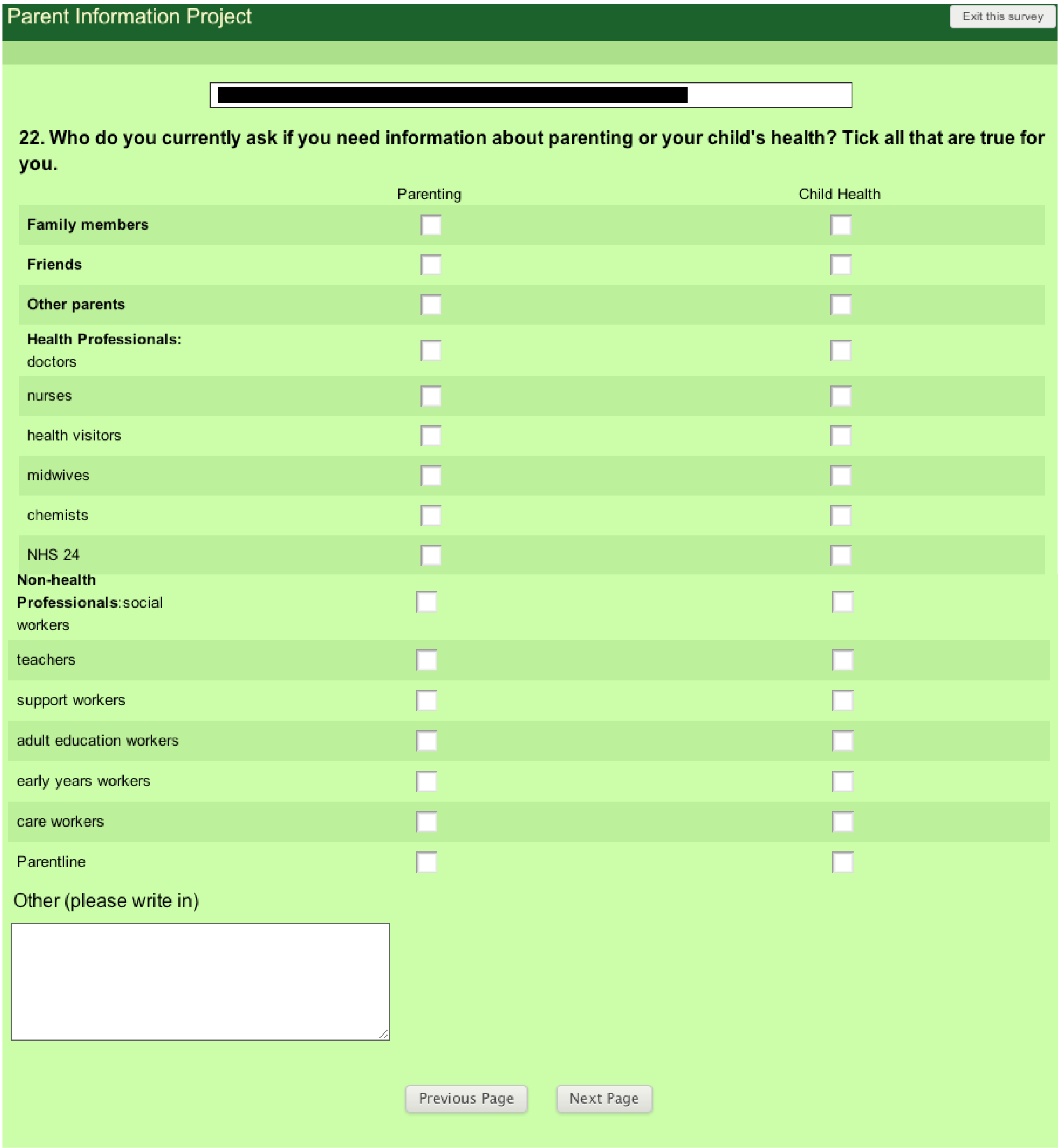
19. Of all of these, which is the one you trust most to give you parenting and child health information - - and why?

20. Of all of these, which is the one you trust least to give you parenting and child health information - - and why?

21. From the topics below, please tick whether you find it easy or difficult to find the information you need about:

	Easy	Difficult	Not applicable/I don't need this information
How to relax and enjoy the time I spend with my child more	☐	☐	☐
Preventing my child from getting injured	☐	☐	☐
How to care for my child when I'm not okay myself	☐	☐	☐
How to deal with my child when they are not behaving well	☐	☐	☐
Eating/diet/nutrition	☐	☐	☐
Immunisations/Injections/Jags/Jabs	☐	☐	☐
Play/fitness/exercise	☐	☐	☐
What's "normal" development/behaviour	☐	☐	☐
Preparing my child for starting pre-school or school	☐	☐	☐
Toileting	☐	☐	☐
Becoming a less stressed/happier parent	☐	☐	☐
Sleep (for me and/or my child)	☐	☐	☐
Preventing illness	☐	☐	☐

Other (please write in)



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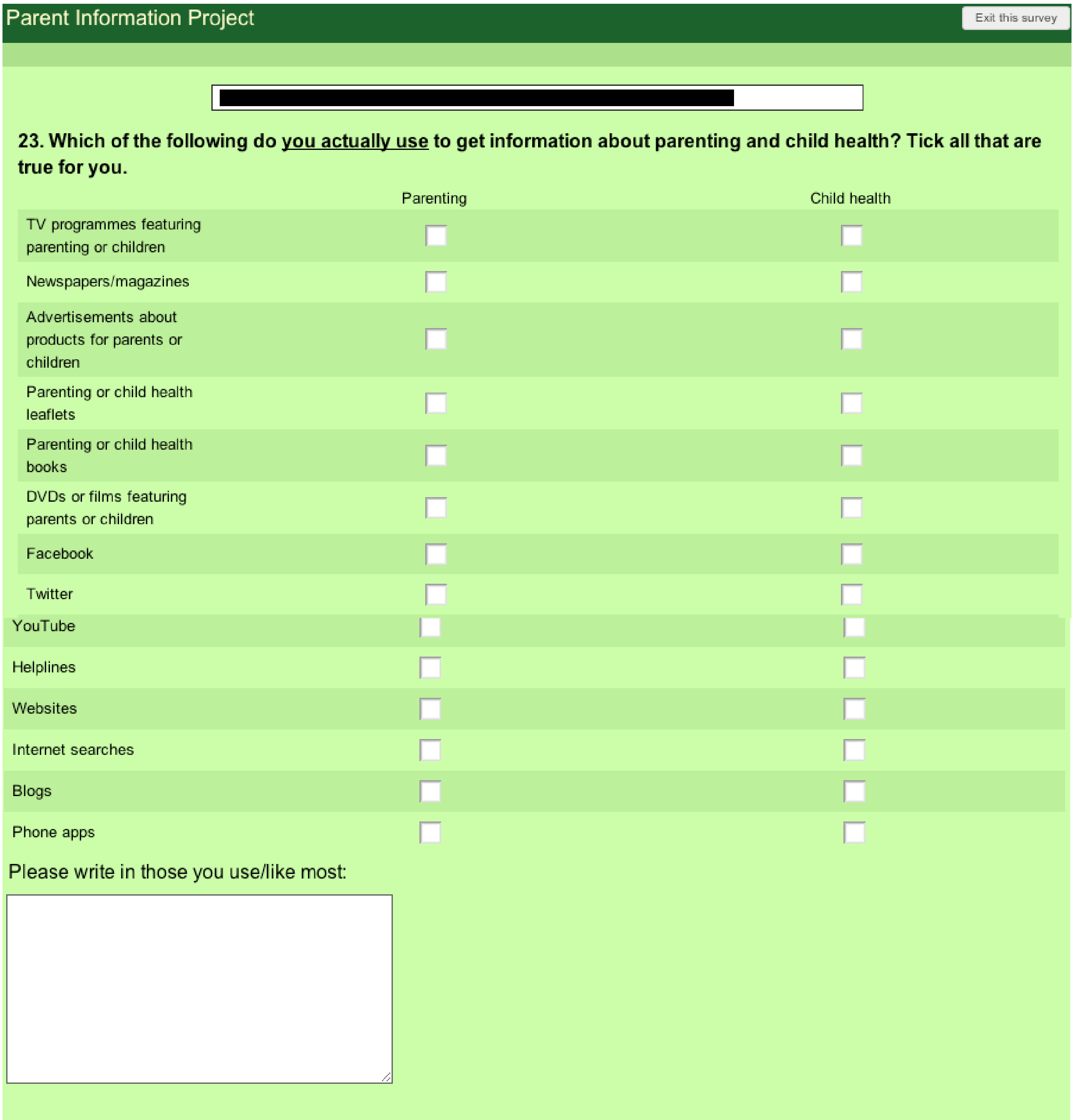
22. Who do you currently ask if you need information about parenting or your child's health? Tick all that are true for you.

	Parenting	Child Health
Family members	☐	☐
Friends	☐	☐
Other parents	☐	☐
Health Professionals: doctors	☐	☐
nurses	☐	☐
health visitors	☐	☐
midwives	☐	☐
chemists	☐	☐
NHS 24	☐	☐
Non-health Professionals:social workers	☐	☐
teachers	☐	☐
support workers	☐	☐
adult education workers	☐	☐
early years workers	☐	☐
care workers	☐	☐
Parentline	☐	☐

Other (please write in)



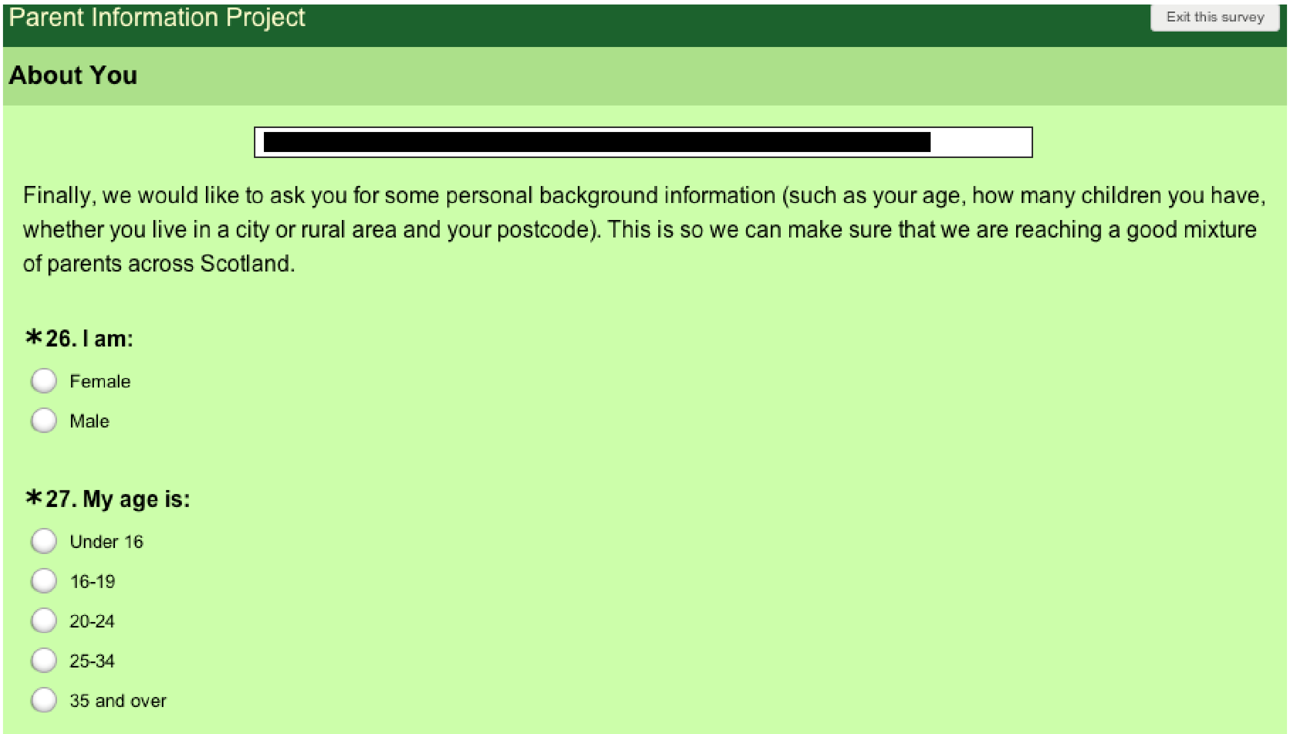
23. Which of the following do you actually use to get information about parenting and child health? Tick all that are true for you.

	Parenting	Child health
TV programmes featuring parenting or children	☐	☐
Newspapers/magazines	☐	☐
Advertisements about products for parents or children	☐	☐
Parenting or child health leaflets	☐	☐
Parenting or child health books	☐	☐
DVDs or films featuring parents or children	☐	☐
Facebook	☐	☐
Twitter	☐	☐
YouTube	☐	☐
Helplines	☐	☐
Websites	☐	☐
Internet searches	☐	☐
Blogs	☐	☐
Phone apps	☐	☐

Please write in those you use/like most:

24. Which do you use most for parenting information? Why?

25. Which do you use most for child health information? Why?



About You

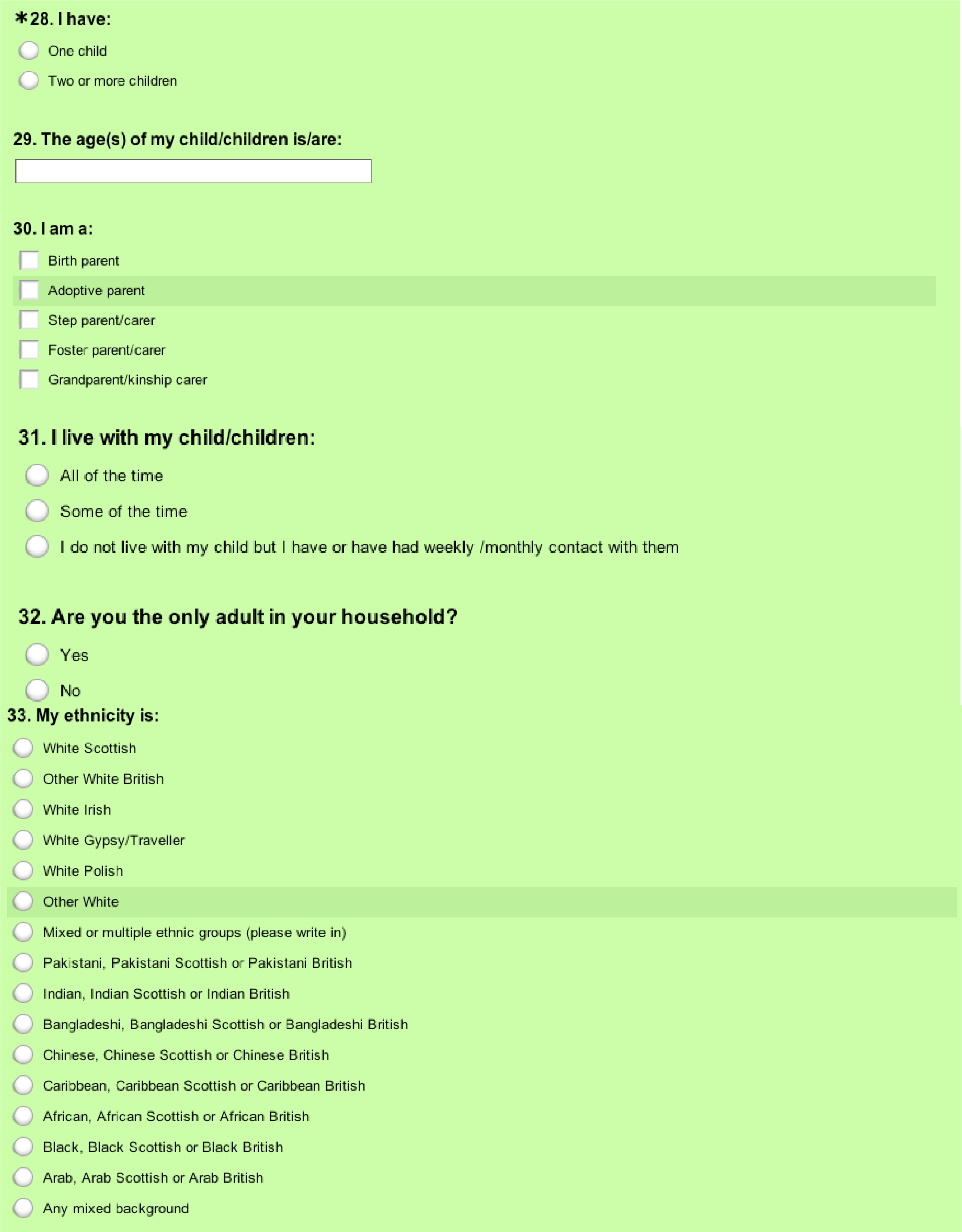
Finally, we would like to ask you for some personal background information (such as your age, how many children you have, whether you live in a city or rural area and your postcode). This is so we can make sure that we are reaching a good mixture of parents across Scotland.

***26. I am:**

○ Female
○ Male

***27. My age is:**

○ Under 16
○ 16-19
○ 20-24
○ 25-34
○ 35 and over



***28. I have:**

○ One child

○ Two or more children

29. The age(s) of my child/children is/are:

30. I am a:

☐ Birth parent

☐ Adoptive parent

☐ Step parent/carer

☐ Foster parent/carer

☐ Grandparent/kinship carer

31. I live with my child/children:

○ All of the time

○ Some of the time

○ I do not live with my child but I have or have had weekly /monthly contact with them

32. Are you the only adult in your household?

○ Yes

○ No

33. My ethnicity is:

○ White Scottish

○ Other White British

○ White Irish

○ White Gypsy/Traveller

○ White Polish

○ Other White

○ Mixed or multiple ethnic groups (please write in)

○ Pakistani, Pakistani Scottish or Pakistani British

○ Indian, Indian Scottish or Indian British

○ Bangladeshi, Bangladeshi Scottish or Bangladeshi British

○ Chinese, Chinese Scottish or Chinese British

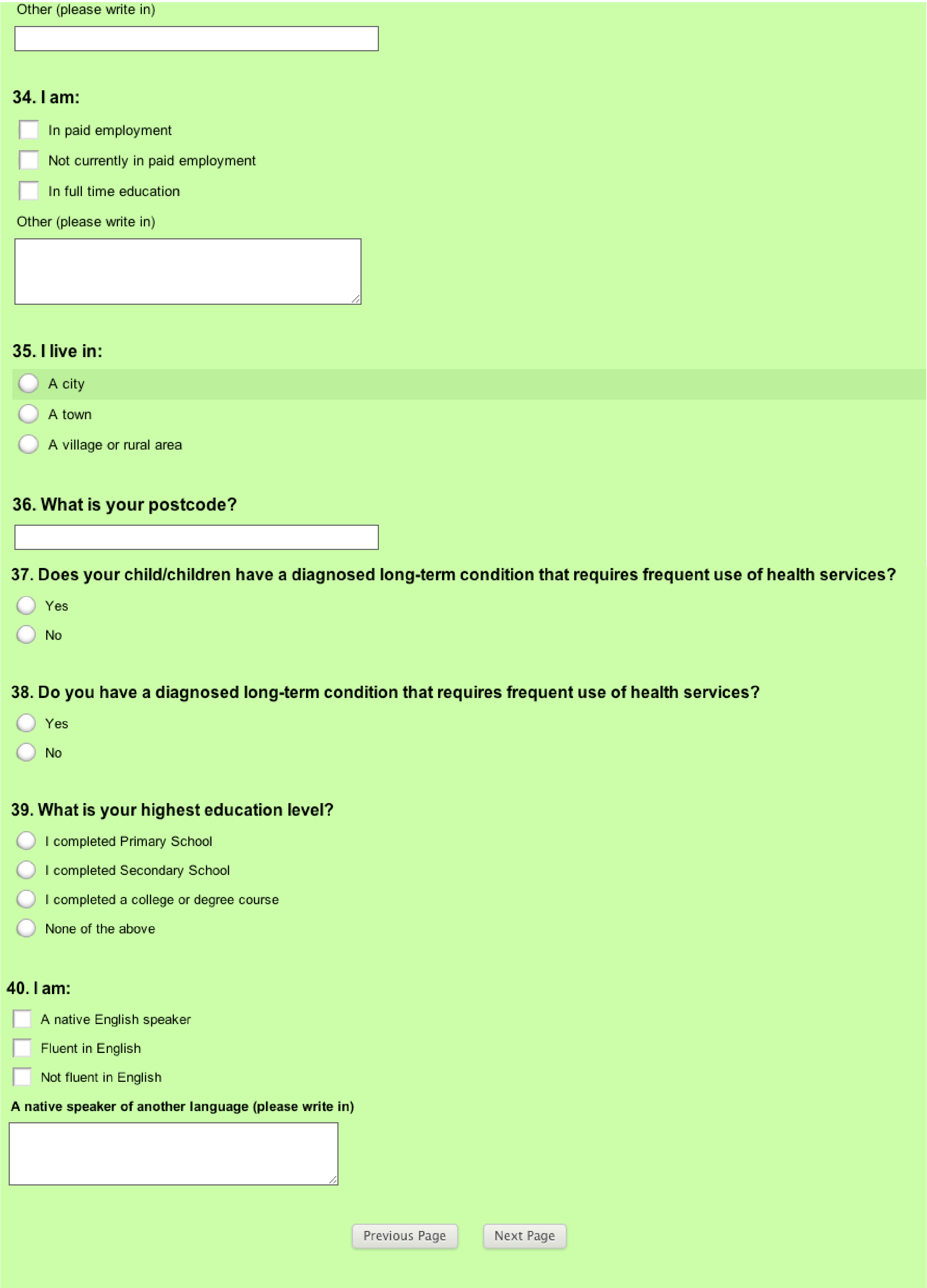
○ Caribbean, Caribbean Scottish or Caribbean British

○ African, African Scottish or African British

○ Black, Black Scottish or Black British

○ Arab, Arab Scottish or Arab British

○ Any mixed background



Other (please write in)

34. I am:

☐ In paid employment
☐ Not currently in paid employment
☐ In full time education

Other (please write in)

35. I live in:

○ A city
○ A town
○ A village or rural area

36. What is your postcode?

37. Does your child/children have a diagnosed long-term condition that requires frequent use of health services?

○ Yes
○ No

38. Do you have a diagnosed long-term condition that requires frequent use of health services?

○ Yes
○ No

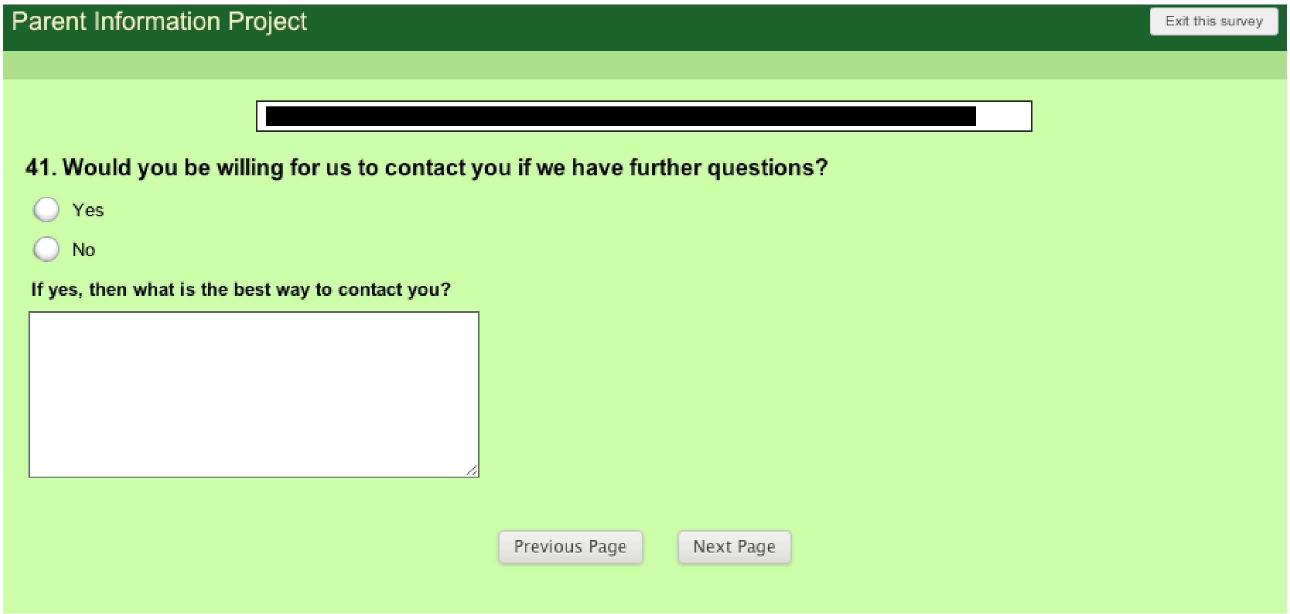
39. What is your highest education level?

○ I completed Primary School
○ I completed Secondary School
○ I completed a college or degree course
○ None of the above

40. I am:

☐ A native English speaker
☐ Fluent in English
☐ Not fluent in English

A native speaker of another language (please write in)



41. Would you be willing for us to contact you if we have further questions?

○ Yes

○ No

If yes, then what is the best way to contact you?

42. Thank you for completing the entire survey. In order for you to receive your £10 Love2Shop Voucher for taking part, please enter your name and address below. If you have any problems with this please contact Sara Collier scollier@childreninscotland.org.uk or call 0131 222 2412.

Name

Address

Postcode

Appendix 11: Key messages recording sheet

Parent Information Project

Key Messages Recording Sheet

At the end of each interview, please take a few moments to jot down some immediate impressions of the group/interview. These are off the cuff comments such as you might make to a colleague in the lift immediately after an event. It is not meant to be part of your data analysis, only immediate headlines that might characterise the interview, and will not be used outside the research team.

Name of group/interview:
[Please use identifier codes, not names]

Date of interview:

The main messages from this group/interview were:

A)

B)

C)

Other Notes:

Name of interviewer:

Please return to Sara with other post interview materials. Thank you.

Appendix 12 – Summary of supplementary sample (online survey) findings

Young parents (young mothers)

19 young parents were screened and sent the survey link directly via email or via a professional contact. Paper copies were also sent out for completion. 7 surveys were completed.

All of the 7 respondents were female, with 4 aged 16-19 and 3 aged 20-24. All but one had only one child. Ages ranged from 1 week to 4 years, with most aged 2 or under. All were birth mothers living with their child full-time. 3 were the only adult in the house. All were White Scottish, 3 were in full-time education and 1 was in employment, 3 lived in cities, 2 in towns and 2 in village/rural areas. There was a fairly even split between areas of low deprivation, high deprivation, or neither.

None of the respondents or their children had a diagnosed long-term medical condition, and all had a secondary school level of education. All categorised themselves as native English speakers or fluent in English.

Most respondents said they were confident in the aspects of parenting listed (knowing when my child has a problem, knowing where to get and how to make sense of information and advice received, understanding written information, and living up to their own and others expectations).

Other things young parents felt confident about in relation to parenting and child health were meeting developmental milestones and needs, and approaching health professionals such as health visitors for help and advice. Examples of things respondents did not feel confident about included temper tantrums, weaning and teething – for example, one saying:

> “My son is a big healthy boy and I felt he was ready for solids at 4 months, I got a lot of criticism for weaning my son at this age and this made me less confident in doing so. I perhaps feel that there should maybe be supports for parents on how to deal with a child who is teething and perhaps some more information on weaning”. (241, young mother of one child, aged 4 months)

Some also noted that they had found it difficult to locate certain information or had received conflicting advice, for example about weaning.

When asked who they trusted most to give them parenting and child health information the young parents response was either their own parents, other parents and professionals such as their health visitor or support worker. Doctors were particularly noted for child health (medical) information.

Of the 7 respondents, all but one said they would not trust those without children to give them parenting and child health information.

When asked new ways in which they would like to receive parenting and child health advice in the future, the most selected options were: through websites (i.e. a website about parenting and child health); by using their mobile phone; through leaflets and written documents; and, better ways of talking with professionals and other parents.

> “I think a DVD should be given when a woman first finds out their pregnant and then another one after they have delivered their baby containing all the relevant health and parenting information that they will need as a DVD is easy to understand and will fit most people needs. Also, people are more likely to watch a DVD than read”. (241, young mother of 1 child, aged 4 months*)*
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> “I prefer internet searches as I can see other parents in forums and I think 'ah, so I'm NOT the only one having this trouble' it's tough when you think you're alone doing it all by yourself but the Internet forums give me a chance to talk to other parents about the kids, and not drift off into other conversations as I probably would at a mother and baby group.” (247, young mother of 1 child, aged 8 months)

The information sources most often used for information on parenting were search engines and by asking people they knew. Information on child health was more likely to come through asking professionals such as health visitors or other people they knew. Two specific websites mentioned were Mumsnet and Bounty. The most trusted sources were other people – for example their own parents, health visitors and GPs. Websites were viewed with some suspicion due to conflicting or misleading information.

Parents were asked to rate the topics they found it easy or difficult on which to find information. The easiest included a wide range of topics from eating to immunisations, behaviour and illness. The topics selected as being more difficult to find information on were: 'how to care for my child when I'm not okay myself'; and, 'how to deal with my child when they are not behaving well'. The people who these young mothers most frequently asked for information on parenting were family members, friends, other parents and health visitors. Family members, other parents, health visitors and chemists were most likely to be asked for information on child health.

When asked about the sources they actually used, TV Programmes, books leaflets and websites on parenting and child health were the most popular choices. There was no clear consensus on which was used most often – each respondent had a different preference, from their support worker to the parent who would “just quickly type it into google”. (247, young mother of 1child, aged 8 months)

Fathers

30 fathers were screened and sent the survey link directly or via a professional contact. Paper copies were also sent out for completion. 21 surveys were completed.

All but two (both aged 25-34) of the fathers was aged 35 or over. Most (17) had two or more children. All but 1 were birth parents, 1 was an adoptive father, and one of the birth parents was also a step father. Most lived with their children all of the time – 3 lived with them some of the time and 2 were non-resident, but had regular contact. All but 4 lived with another adult. 12 self-identified as 'White Scottish', and 6 as ‘Other White British’. Only 4 fathers were *not* in paid employment, with two noting themselves as being self-employed.

Most fathers (12) lived in a city, with 5 living in towns and 4 in rural/village areas. Most fathers lived in areas of low deprivation.

4 of the fathers had a long-term health condition and 6 had a child with a diagnosed long-

term medical condition. All but one of the fathers had a stated high level of education, completing a college or University course; the other had completed secondary school. All were either native speakers of, or fluent in, English with two native speakers of other languages – namely German and Scots.

Most participating fathers said they were confident in the aspects of parenting listed (knowing when my child has a problem, knowing where to get and how to make sense of information and advice received, understanding written information, and living up to their own and others expectations). Two areas in which some fathers said they did not feel as confident was in making decisions about their child's health, and living up to others' standards.

Other things fathers felt confident about in relation to parenting, included nurturing and creating a safe and loving environment, and moral framework. Also mentioned by more than one dad was supporting their child's education. One father said:

> "Forming a positive balance of fun, love, education and guidance. Understanding needs of my kids in terms of development whilst not taking myself too seriously. Understanding what it is to feel unconditional love for another human being". (147, father of 2 children, aged 3 and 5 months)

Issues which fathers were confident about in relation to child health were which professionals they would turn to in the event of a problem, nutrition and having a healthy balanced diet, exercise and physical activity.

Issues which fathers were less confident about in relation to parenting were varied, but one which was raised by a number of fathers was disciplinary issues and dealing with children's behaviour and aggression. One father said:

> "Sometimes I lose my temper and shout then have to apologise - wish I felt in better shape myself more of the time - need to get more rest etc. I am not really sure how much 'learning' I should be doing with them. In many ways I regret the long days they spent in nursery from just a few months old and worry we have stunted their intelligence as a result". (152, father of 2 children, aged 5 and 7 years)

For the fathers who were not living with the child's mother, they expressed that they did not feel they were playing a full role in parenting and indicated that they were being denied their right through systems – for example, not having direct access to their child's doctor.

In relation to the child health issues which fathers were less confident about, concern was expressed over specific medical conditions such as asthma and epilepsy, and some mentioned weighing up the advice they were given and wondering when and where to seek medical assistance.

> "I'm not confident about making dispassionate judgements on health issues and the impact that delaying may have. To explain: I favour the wait and see approach when my son is ill, because that is how I treat my own health, but I know that some conditions (e.g. meningitis) become dangerous if not caught quickly. Of course as a parent, you never know how you will react in such situations until they happen, but I am wary that I won't make the right decision". (146, father of 1 child, aged 2 years)

Fathers generally trusted their wife or parents and wider family and friends to give them parenting advice. Some mentioned specific support groups – for example for single, contact dads. One father who did not live with his child mentioned the child's teachers as the people he trusted most:

> “This is because they have direct access to my child on an almost daily basis. This is however fraught with the danger of upsetting his mother and, of course, as she is his main carer, subject to her approval and the regulations the teachers have to abide with”. (141, father of 1 child, aged 7 years)

Alongside the aforementioned family and friends, doctors and GPS were the most trusted sources of child health information. Different answers were selected to the question on which sources were least trusted to provide parenting information, with a number selecting the media and tabloid newspapers – ‘fad driven and sensational’. Two mentioned those who were not parents themselves “*but write books on parenting that make people feel bad about themselves*” *(147, father of 2 children, aged 3 and 5 months)* - one naming a particular author. Similar responses were given in answer to the sources least trusted on child health information – although a couple did mention GPs and health visitors as sources they didn't trust.

When asked ‘In the future, how they would you prefer to receive parenting and child health information/advice?’ the most popular responses were via a website about parenting and child health; talking or meeting with professionals; talking with other parents and by using well-known books and guides on parenting and/or child health. When asked for specific examples, NHS 24 and other NHS publications and fact sheets were cited. One suggested an:

> “Annual single-sheet update to all parents of particularly helpful sources of information re parenting/child health”. (144, father of 2 children aged 5 and 7 years)

Most mentioned written or Internet sources as ones they would most prefer to use, due to their immediacy – backed up by face-to-face to interaction with professionals. One father expressed concern that NHS 24 might be cut back or closed – viewing it as “an excellent source of child health advice especially in deciding whether specific symptoms required a visit to the doctor”. (156, father of 2 children aged 2 and 5 years)

The sources most likely to be used to get parenting and child health information were health professionals, people they know, search engines or ‘just picking it up’. NHS 24’s website and helpline and other NHS sites were cited by most fathers.

The most trusted sources were health professionals and NHS sources, such as NHS 24 and other parents they knew. Least trusted were general internet searches and less specialised or non-official websites. Two also mentioned health visitors at this point.

> “Health visitors - our experience has been that the HVs have been disinterested and unengaging with the children and only interested in observing parents. Even when asked specific questions they are evasive and unhelpful”. (150, father of 3 children, aged 6, 4 and 2 years)

Fathers were asked to rate the topics they found it easy or difficult to find information on with most finding it easy to access this on a wide range of topics from eating to immunisations, behaviour and illness. The topics which were selected as being more difficult to find information on were: 'how to care for my child when I'm not okay myself';

and, 'how to deal with my child when they are not behaving well'. The people who these fathers most frequently asked for information on parenting were family members, friends and other parents. Doctors, NHS 24, nurses, chemists and family members were most likely to be asked for asked for information on child health.

The most commonly used sources of information on parenting and child health were books, leaflets, websites and Internet searches. Again, NHS 24 was cited as a favourite and one father mentioned a first aid app on his phone.

The sources used most for parenting information were the Internet, leaflets books and others experiences – friends or people online e.g. at babycentre. The same sources, with the addition of NHS 24, were most used for child health information.

Parents with literacy issues

15 parents were screened and sent the survey link directly or via a professional contact. Paper copies were also sent out for completion. 14 surveys were completed.

All but three respondents in this group was female, 9 were aged 25-34 and 5 were aged 35 and over. Most (9) had two or more children. All were birth parents and lived with their children all of the time. Most lived with another adult, and most were white Scottish, although two were of Arab ethnicity, and one was born in Africa. Most were not in employment, with some identifying as carers, or housewives/homemakers. The majority lived in a village/rural area (largely due to the survey being disseminated to a support group for those with children with additional support needs in a rural area of Scotland). Most of these parents lived in an area of low deprivation.

Around half (6) the survey respondents had a child with a long-term medical condition (again due to the support group filling it in), but only 4 parents had a condition themselves. 9 had completed a college/university course and 4 had completed secondary school. All but three were native English speakers.

The areas in which these parents felt confident were making sense of advice form health and non-health professionals, understanding written information, decisions about their own and their child's health, and living up to their own standards. They were slightly less confident about knowing where to get information and obtaining it.

The areas of parenting in which these respondents felt comfortable were the day-to-day care and upbringing of their children. Varied responses were given with reference to confidence about child health from providing a balanced diet, to spotting serious symptoms and knowing who to go to with a problem.

Some expressed concern about the effect their parenting now would have on their child when they grew up, for example:

> "*I am aware of the lasting effects in childhood and the knock on effect it has in adulthood and worry about this from my own experiences but all this is all quite irrational and just me worrying too much". (341, mother, one child aged 2).*

Those most trusted to supply parenting information were other parents, health visitors, and their own family. Health professionals (GPs in particular) were trusted to supply information on child health. Least trusted on parenting information were those who didn't have their own children, although one parent said:

> “I don't not trust anybody to give me information. I take on board all information am giving but I feel I know what’s best for my child”. (342, mother of 2 children, aged 7 and 1 year(s))

Of all the listed sources, parents most trusted health professionals - health visitors, GPs and consultants on child health matters. Least trusted were: ‘googling things’ and general Internet sites.

These parents were asked to rate the topics they found it easy or difficult to find information on. There was no real consensus, with different parents in this subgroup finding different things easy/difficult.

Those most commonly asked for information on parenting were family members, friends and other parents. Health visitors, GPs and NHS 24 were the most consulted for child health information.

In terms of what these non-personal information sources parents actually used, leaflets and TV programmes were most commonly used for parenting and child health information. Non-personal sources used most for child health information varied from parent to parent, e.g. from Internet searches to leaflets and TV Programmes.

When asked how they would like to receive parenting information/advice in the future, this group of parents cited: meeting or talking with professionals; other parents; and, being given leaflets and other written documents. Talking with professionals and leaflets were preferred for child health information/advice. A couple of respondents expressed caution at taking advice from websites or online forums.

When asked what sources they would use for information on child health, health professionals were the preferred source, followed by people they knew. A couple also mentioned websites on specific medical conditions their children had as useful sources.