



Research report: The effective engagement of families in targeted child and family weight management programmes

Vikki Butler

Sept. 2015



communities first *cymunedau yn gyntaf*



Llywodraeth Cymru
Welsh Government



ACKNOWLEDGEMENTS

This research and consultation project was funded by Cwm Taf Preventing Childhood Obesity Steering Group. C.A.R.P. Collaborations are grateful to the commissioners for working in partnership in order to secure fieldwork sites for focus groups and guidance on developing a relevant service model.

C.A.R.P. Collaborations extend thanks to all of the staff within Rhondda Cynon Taf County Borough Council, Merthyr County Borough Council and Cwm Taf Health Board for supporting the research and consultations with families.

Lastly, we are extremely grateful to the families who contributed their opinions and experiences with no incentives except to further service development. Without their contribution, this project would not have been able to continue or succeed.

C.A.R.P. Collaborations Research Team:

| | |
|-----------------|--|
| Isabel Griffin: | literature review |
| Hattie Hendra: | fieldwork coordination and delivery |
| Sonja Hookway: | fieldwork delivery |
| D Murphy: | telephone interviews with professionals and analysis |
| Vikki Butler: | project manager, fieldwork design, analysis and report |

CONTENTS

| | |
|---|----|
| Executive summary | 4 |
| Chapter 1: Research rationale, methods and ethics | 5 |
| Chapter 2: The motivating factors for family engagement in weight management initiatives | 9 |
| Chapter 3: The importance of participation in healthy living programmes and weight management interventions | 15 |
| Chapter 4: Creating holistic approaches to healthy living | 20 |
| Chapter 5: The importance of joint working in delivering healthy living programmes | 24 |
| Chapter 6: Barriers to family engagement on child weight management programmes | 29 |
| Chapter 7: Factors affecting the longer term impact of healthy living programmes | 35 |
| Chapter 8: A service model for reducing overweight in childhood | 37 |
| Chapter 9: Conclusions and recommendations | 42 |
| Appendix: Literature review | 44 |

EXECUTIVE SUMMARY

This consultation engaged with 43 family groups who were participating in community based healthy living services. Within focus groups and interviews, researchers explored what families felt was needed for services to effectively engage them within weight management programmes. Researchers also undertook phone interviews with professionals and practitioners to discover identified good practice in delivering weight management programmes and identify problems within current provision.

Families identified a range of factors that motivate them to attend weight management programmes, but stressed that their participation in all aspects of planning and delivery of services was key to their engagement. Additionally, they identified that programmes must engage all of the family and be relevant to their specific circumstances and their local community. Whilst there were examples of good joint working, services need to work more closely together to ensure delivery of consistent messages and enable clear referral paths from mainstream services to specific services and to follow up services that deliver support at group and individual level after attendance on a programme. The content of programmes needs to maintain a focus upon nutrition, cooking skills and exercise but also include positive family dynamics, healthy body image and emotional wellbeing.

The suggested service model, based upon the findings, includes a stepped approach that comprises mainstream services, such as health visitors, schools and family support as entry points to specific healthy living services. These should include the programmes that are currently offered but extend to drop-ins, child focused initiatives and one to one support for families. There should be clear exit points from healthy living programmes with referrals back to mainstream services and follow up services to enable families to implement their learning from participating in specific healthy living services.

CHAPTER 1: RESEARCH RATIONALE, ETHICS AND METHODS

Rationale

This research project sought to answer the question ‘What needs to be in place for family weight management programmes in the Cwm Taf Health Board area to effectively engage families?’ and, based upon the research evidence gained, aimed to provide a model for future family weight management interventions. Within this overriding research question, the issues to be explored included:

- What current good practice exists locally and nationally? (addressed within the secondary data review)
- What are the barriers and opportunities identified by current professionals?
- How do children and families talk about the issues of weight loss?
- What encourages or discourages families to engage with weight management programmes?
- What difficulties and opportunities do families identify which may have been overlooked by researchers and practitioners?

Research methods

In order to explore the research questions, the project involved a literature review, which is within the appendix of this document, interviews with practitioners and professionals, focus groups with families, who were attending existing healthy living or other community based services providing support to families, and interviews with families.

Semi-structured phone interviews were used to engage with professionals and practitioners because they enable the interviewee to fit the interview into their own schedule without the need to leave their workplace or accommodate a confidential space for a researcher to conduct a face to face interview. The research team was guided by the commissioners with regard to the most appropriate professionals to approach to interview and, in some instances, researchers discussed the purpose of the research with team managers to enable them to identify the best member of their team to interview, or decide whether it should be themselves to offer a strategic perspective or a team member to offer a front line experience perspective.

The researchers undertook focus groups to engage with families to establish generic issues regarding general engagement in healthy living activities. Ten focus groups were undertaken with families in community settings. The focus groups used creative methods to enable fun and accessible engagement, regardless of children’s ages or participants’ literacy levels. The groups were pre-existing and selected according to certain characteristics. Researchers aimed for at least five groups that were participating in healthy living courses, engagement with children of different ages, but primarily aged between 5 and 11; a balance of local authority areas and weighted towards areas of multiple deprivation. Their design was flexible so that if groups were engaged in activities, such as cooking, the activities could be adapted to ensure that data could be gathered without interrupting the purpose of the

group. To accommodate the needs of different groups, some focus groups were adapted to short group interviews with groups of families, others were group conversations and others involved facilitating participatory activities. The focus groups asked families about their experience of healthy living programmes if delivered within a healthy living group. All focus groups explored issues regarding the best and worst delivery approach; the engagement process, the barriers to engagement with services that are faced by parents and children; and motivating factors for families to engage with services. Where relevant, these issues were specifically focused upon the delivery of healthy living services.

To gain in depth data specifically about weight loss programmes and the prevention of obesity through healthy living programmes, we asked families in focus groups to volunteer to be interviewed on a one to one basis. Researchers undertook ten face to face interviews with families within their own homes. These interviews were specifically focused upon weight loss and healthy living programmes discussing the impact that programmes can have upon family life and how engagement could be improved.

Ethical considerations

Whilst this project was consultative research, it was important that an ethical framework was implemented because of the subject matter and the engagement of children. All staff with direct contact with children had an in date CRB check or DBS check and were aware of C.A.R.P. Collaborations' safeguarding policy.

Prior to facilitating any focus groups, information leaflets were sent to practitioners delivering the services and they distributed the information to participants and checked whether they wanted to be involved in the project or not. Once dates were confirmed for focus groups, researchers would start the focus group by checking with participants that they had received information about the project, knew what to expect during the focus group and what the research was for. Researchers handed out leaflets and talked through the issues of confidentiality, anonymity and the need for child protection. All participants were asked for verbal agreement to participate in the consultation and, in the case of children, parents were asked to give parental consent for children to participate but children were also asked to agree to consent themselves. The design of the groups was flexible so that people could choose not to participate, children could decide to miss certain activities if they wanted to, and any participants were able to withdraw from the research activities if they wanted to. The leaflets for families included the contact details of the researchers and commissioners so, if participants had any queries at a latter date, they would be able to approach someone from the research team.

Consent was again sought with all participants who agreed to be individually interviewed. Families could choose whether they wanted children present at the interview or not. Some families felt that the child's perspective should be heard, whilst others wanted the opportunity to talk freely about childhood obesity without their children present. Where children were present, the interviews specifically set out to include their perspective and appropriate consents were sought. Interviews were recorded through written notes. Since interviews took place in participants' homes, C.A.R.P. Collaborations set up a phone-in system to ensure worker safety and adhered to their lone worker policy.

Within the interviews for professionals, all participants were made aware that what they said would be included in a report but that all opinions would be kept anonymous and confidential. Researchers checked throughout the interview that information, such as job roles or geographical locations, would not identify people. We also reassured interviewees that should there be an incident of whistle-blowing, C.A.R.P. Collaborations would follow the whistle-blowing policy of Cwm Taf Health Board.

Research cohort

The 10 focus groups engaged with 43 different family groups which comprised of 43 mums; 4 dads, 3 extended family members, 26 girls and 22 boys. The focus group service spread was:

- 3 communities first cooking clubs
- 2 'go for it!' programme groups
- 2 incredible years parenting classes
- 2 flying start parent support groups
- 1 mother and baby group.

One to one family interviews were facilitated with six families recruited from the focus groups and four additional families who had attended weight loss programmes. Two of these families were single parent families and eight were families with dual parents. The data gathered was regarding the experiences of 19 children – 15 of whom were under 7 years old, three of whom were aged 7 to 13, and one of whom was over 13. Five of the interviews were conducted with mothers: two with mothers and a child, and three with both parents but no children present. The families had all aimed to lose weight and implement healthy living through attending the following programmes.

Three families had attended Communities First cooking clubs; one family had attended the Go for It exercise and nutrition programme; three had attended MEND courses; two families had attended parenting support classes and one family had attended Slimming World. The two families who had attended parenting classes had lost weight as a result of information they had learnt regarding nutrition, family meals and child behaviour.

Ten professionals were interviewed from across the Cwm Taf Health Board area. They included managers of preventative and responsive weight management programmes, delivering community based healthy living initiatives; a head teacher; a paediatric dietician; managers of early years and family support services; and managers of community and social regeneration programmes who were engaged in delivering community health activities.

Definitions of 'weight management initiatives' used within this research

This report uses a wide definition of 'weight management initiatives' to include any programmes of activities delivered at a community level, which directly relate to health living. These included prevention programmes, such as community cookery clubs, exercise

and healthy living clubs, and responsive programmes that involved specific weight management and health monitoring.



CHAPTER 2: THE MOTIVATING FACTORS FOR FAMILY ENGAGEMENT IN WEIGHT MANAGEMENT INITIATIVES

Introduction to the chapter

Before examining the content and structures of preventative and responsive weight management programmes that aim to reduce childhood obesity, it is useful to first outline the motivations that families themselves identified in joining and maintaining attendance upon programmes. Professionals discussed the incentives needed to enable families to continue with programmes but, in both focus groups and one to one interviews, families highlighted some key feelings and behaviours that helped to motivate them towards healthy living interventions.

Motivations for parents and children to join a weight management programme

Families identified six main motivators for wanting to attend healthy living programmes.

1. *Wanting to be active with children*

Many parents said they needed to be healthy and fit in order to 'keep up' with their children with comments such as:

'Needing to be active with the kids and interact with them and do stuff with them; they're on the go, morning to night, I need to be too! Healthy living gives me the energy to be an active mum and a good mum.'

'I'll be able to run around with my kids. I'm big and I struggle to run around with her.'

Other parents felt that they should be doing things with their children, but struggled to find affordable or accessible activities. Therefore, when something local was available they were motivated to join:

'I'm quite motivated and I think that if there's something on for the kids then you should do it.'

Parents tended to reflect upon their own childhoods, particularly where poor health had impacted upon their own childhood experience. Some simply felt that being healthy:

'... make[s] you live longer. I want to see my kids grow up.'

Whilst others wanted to provide positive healthy role models for their children in a way that their own parents had not been able to:

'I follow my mum on being on the big side. I want to break the cycle of it being passed from generation to generation. I've given up smoking and my next target is to lose weight. I want to find a balance so I can help her [daughter] find that balance in terms of health and fitness, but also body image.'

2. Having personal ill health

Parents and children who had experienced, or were at risk of experiencing, personal ill health were motivated to adopt healthy living lifestyles. Children talked about the risks to their health later in life, whilst parents tended to act quickly after a bout of poor health.

'X [mother] had always been involved in sport and had a heart attack during a martial arts grading in 2014. She feels this was because she knew little about nutrition and ate a lot of fast food. Since learning much more about cooking in a healthy way, she feels less at risk from further heart attacks and knows that she is helping protect her daughter's future health.'

'X had a serious illness affecting her ability to work and parent.'

3. Wanting better personal wellbeing

Parents and children spoke about wanting better emotional wellbeing as an incentive for joining healthy living programmes. Parents spoke about issues such as 'not feeling very happy with our bodies' and linked being overweight with emotional and mental dissatisfaction. Words such as 'depressed', 'sad', 'uncomfortable', 'not enjoying going out' and 'unhappy' were used by parents to describe the emotional experience of being overweight and lacking in exercise.

Children, on the other hand, described concrete fears and experiences that led to poor emotional wellbeing, particularly their awareness of having a different body image to their peers and fears of bullying. The following quote offers a consensus example of the way in which children talked about their emotional wellbeing:

'This [healthy living] is important for me because I go up to comp this year and I was starting to worry about being bullied for being fat. I was too scared to go swimming with my class because I thought everyone would notice that I was a different shape.'

11 year old girl.

Other children talked confidently about body image, and their experiences of feeling left behind by their peers because they were unable to keep up, how bullying is a concern and the relative social isolation they experience because they are physically slower in games and play.

4. Having the support of wider family and social networks

Families explained that having extended family networks or close friends supporting healthy living changes helps to join a programme and recognise the changes that are made within family life. One couple commented that it would be much more difficult for people who did not have the support of their family and friends to manage to sustain weight loss. This issue was also picked up by professionals and practitioners who talked about 'granny culture' referring to how extended family could sabotage efforts to implement healthy living, particularly when unhealthy food is used as a treat or for indulgence. Supportive family can act as a motivator for joining a programme, but family can also undermine efforts to implement healthy living.

5. To create more positive family dynamics

Some parents described healthy living in a wide sense; suggesting that healthy living starts with positive family dynamics and positive parenting. These parents particularly spoke about how meals and food were a part of family life and that the impetus for wanting healthy living within family life comes from information in mainstream services, including breast feeding groups, mother and toddler groups, support with early years, support with parenting, healthy schools, sports clubs and play. Some parents explained how their motivation to attend healthy living initiatives stemmed from wanting positive mealtimes, routines and family-based activities:

‘There are a lot of other girls [mothers] in the same situation, with kids, struggling to deal with the same things; sleeping patterns, behaviour.’

6. Good referral processes and communication about the initiative

Referral processes are discussed in detail in chapter 5 but they can have a significant impact on motivating families to join a programme. Clear communication about programmes and reminders of when sessions are held and what will be covered are crucial for families when deciding if a particular course of activities is right for them. This issue becomes highly significant when programmes rely upon self-referral and word of mouth.

Motivations for parents and children to continue attending a weight management programme

Once families are attending programmes, there are certain activities and factors that serve to maintain the motivation for continuing to attend.

Learning and doing new things

There was unanimous agreement that a highlight of the programmes was learning new things, gaining new experiences and being able to try out new activities and foods. Specific methods were described to be more conducive to learning than others, and this is covered in the following chapter regarding involvement and participation; but, within this section, variety of new learning and the experience of mental stimulation and physical activity served to motivate families to keep attending. Different aspects of the courses were described by the research participants. Some commented upon the new food and cookery skills:

‘I’ve learnt a lot through the process, for example, new food I’d never cooked before, like mushroom omelette...also healthy options/alternatives, for example low fat curry, or making crumble using Weetabix, and serving it with yoghurt instead of cream or custard.’

Others particularly enjoyed learning about nutrition and portions:

‘...for example, we used a chart about what is on a “healthy plate”, and another about what contributes to your “5 a day”, and had discussions with the kids about them.’

Children mentioned new physical activities that they had not done before and enjoyed being involved with their parents in food preparation, and exercise, particularly games such as basketball and street dance. All families enjoyed the family days out to the countryside which were provided within taster activities. Some parents felt that there was so much to learn that they had not had enough time to process and implement all the information.

Socialising

Families enjoyed and were motivated by the high level of socialising that stemmed from programmes and courses. Learning from peers was a crucial element of a successful initiative, and this is explained more in the following section regarding participation. However, relevant to this section is how attachments were made between families, parents and children. Firstly, parents said that they enjoyed the company of each other, particularly when they had children of a similar age. Where friendships were fostered, many parents said that the support and friendship continued outside of the group setting and had carried on into other aspects of family life. Children also stressed how important it was that they made friends, particularly with children of similar ages who were trying to implement similar life changes.

A minority of parents described how cooking classes within a community helped strengthen neighbourhood relations:

‘Cooking as a community means we can have a chat without worrying about the children which helps reinforce friendships.’

Within this particular group, tasks were allocated between families so some parents would play with the children and allow others to do other tasks, and these roles were swapped on a week to week basis.

Positive group facilitation

Worker ability to ensure groups work well together and individuals feel able to confide and cooperate with each other is a large factor in maintaining family motivation. Families talked not only of socialising, but being able to help each other ‘undertake teamwork’ and get on in a safe environment. Participants welcomed workers who were able to ensure participants could be honest with each other, challenge opinions and ultimately agree to disagree without relationships within the group becoming fraught.

Children particularly welcomed not having any ‘nasty comments’ and a group that was small in size so they were not overwhelmed by the number of adults around them. All family members also felt that the group dynamic needed to include everyone; and they went on to mention extended family members such as grandparents, different ages, working and non-working families and families from different backgrounds and areas.

Good worker interpersonal skill and knowledge

In addition to being able to facilitate positive group dynamics, families discussed how workers needed to be able to interact with them and be able to deliver groups in a way that felt positive and motivated them to come back. Certain attributes within worker skills were described as enabling families to feel motivated and relaxed; both of which will encourage

them to return for subsequent sessions. These attributes included being able to help families engage quickly through being confident but:

‘... not dominant or bossy, she knows how to ask, who to ask and how to be confident and friendly without being pushy.’

Other key attributes included being easy to talk to, having in-depth knowledge of the surrounding community and trust from the community:

‘Workers such as X in the ‘Go for it’ team are in a perfect position to have these difficult conversations because they know all the families in the community very well indeed, and this helps them build trusting relationships. Having good relationships is the best way to bring up sensitive topics.’

Additionally, workers were expected to have skills for working with children; particularly being able to listen and interact with children to engage their motivation. Many parents described how their children wanted to undertake healthy living suggestions in order to please the workers that they had built attachments to:

‘he [child] was keen to please the MEND team. They were so nice. They made a different motivation level...directing, and pleasing...’

Workers also motivated participants when it was clear they had a depth of knowledge about healthy living. Participants built trust in practitioners who clearly demonstrated what they knew but without lecturing or making judgements:

‘The depth of knowledge of the workers was very helpful and this is reflected in how well-trained their staff are. They gave scientific information to families in a form that people understood. Even though I am a roots person, sometimes you need a worker from the community to have a higher educational stand so that you can trust their advice.’

Lastly, workers were also expected to be role models and reflect the content of the course. Participants felt that where workers were overweight themselves they should join in the healthy living activities with the participants. It was felt that this would break down barriers, but also show that workers were aware of what they were teaching and promoting. One course had very slim young women delivering cookery and very muscular young men delivering physical activities. There were numerous opinions regarding how the workers were not role models for the participants, that they were too young and appeared to lecture rather than have empathy with family life and they were also upholding gender stereotypes. Whilst it is difficult to expect the workforce to conform to anticipated role models, a service design can allow for these difficulties; so this issue is returned to in the final chapter which outlines a service model based upon the findings of this report.

Providing incentives and low cost

All parents said that programmes have to be free and function on a low cost for them to be able to participate. However, additional incentives serve to motivate families to stay on programmes. Some of these incentives are practical, some celebratory and some financial.

Practical incentives are included within the content of the courses or programme, such as offering a free healthy meal to the family at the end of cooking, ensuring children are involved and engaged, or offering free exercise sessions that would usually be paid for, such as new sports or places to go on family days out.

Celebratory incentives vary but involve acknowledging achievement within families as well as for individuals. For children, examples cited included certificates, stickers and treats. For example:

‘Kids had to pick activities that they wanted as a reward... (incentive) R’s was a computer game, and he earned £1 for every day he walked to school, until he’d earned himself the computer game.’

These kinds of incentives are treats that are based upon consistent activity e.g. walking to school every day, which helps to embed new habits. Additionally, celebratory incentives enable individual family members to set their own goals and targets which contribute towards their personal motivation. This issue is discussed in more depth in the following chapter regarding participation.

Financial incentives included offering food hampers with vegetables and fruit that had been cooked during the programme, free vouchers for activities within the local community or sports kits for children. These served to ease the cost of healthy living and enable families to sustain what they had learnt.

Incentives throughout programmes and at the end of interventions serve to support families to continue their attendance and help families feel that they are working towards something.

Concluding remarks regarding motivating factors for families to engage with healthy living programmes

There are a number of motivating factors that can be built upon and used to refer families to attend healthy living programmes as well as built into programmes to encourage families to continue attending sessions. These motivating factors should form the basis of any service design model.

CHAPTER 3: THE IMPORTANCE OF PARTICIPATION IN HEALTHY LIVING PROGRAMMES AND WEIGHT MANAGEMENT INTERVENTIONS

Family involvement in all aspects of healthy living programmes is key for continued attendance and for the success of programmes. Parents, children and professionals all spoke about the different elements of participant participation and how this aids the impact of interventions. Research participants spoke about participation in design and content of programmes, participation through methods and participation in delivery.

Family participation in the design and content of programmes

Professionals and families spoke about the importance of being consulted and involved in the planning and content of different programmes. One professional said:

‘We have just run a programme with 7 families, we consulted with them first, we took their feedback, what was important for them...Consult first, think about who your audience is, one programme won’t fit all audiences, you must tailor it, it must meet their needs...’

The sentiment and experience of all the professionals was that through consulting with families before programmes begin and continuing to consult throughout the programme, the content will be specifically relevant to the participating families and lead to maximising learning and sustaining attendance.

Families also welcomed the opportunity to be consulted and involved and spoke about how it made them feel that they were involved in the programme, motivating them to implement the learning and continue attendance, as the following quotes exemplify:

‘It’s been good that we’ve been asked all along about our opinion on things, we’ve filled in evaluation and feedback forms, with lots of room to write on.’

‘We were also consulted on which exercise activities were put on.’

‘The kids were asked each week what they wanted to do next week, in terms of cooking, and activities also.’

Additionally, families appreciated having choice and control over what they were learning and doing, equating this with being respected and listened to.

‘Having a choice in activities and involved in session planning’

‘I have had some control and being consulted helped me’

Family participation in methods of delivery

Unanimously, parents and children described how methods used within courses and initiatives engaged them and maintained their interest in healthy living. Whilst methods

inevitably varied according to the specific focus of each programme and session, common themes identified by families were that they must engage the whole family and be fun and creative. Lesson based learning was particularly disfavoured whilst games and physical activity were perceived to be the best approach, particularly from children's points of view.

Whole family engagement

To successfully enable children to manage their weight, it is clear that children need to be involved in preventative and responsive initiatives. It was very important for families that children were engaged from the start, were fully respected, were given choices, and that the process was enjoyable for them.

'Throughout, the kids were addressed as people in their own right. This came through in the way they were spoken to, and in the trust and respect that the workers and volunteers build up.'

'One of the things X [child] loved about the course was the positive feedback she had from the community workers. They consistently asked her her opinion and showed her respect.'

In order to achieve this, workers needed to have skills for working with children and be able to facilitate methods and group dynamics that would engage the whole family; thus ensuring that there was a family focus as opposed to just focusing upon children or adults. Families did not mind if there were periods of separate information – for example, exercise for children and information for parents, but it was generally felt that, overall, the whole family needed to be engaged and learn as a family group. Additionally, family group is meant in its widest sense and could involve siblings, either or both parents, extended family networks and even close friends if they eat meals, cook, or shop together.

'Making it fun for the kids is essential, and encourages them to eat different things'

'Learning alongside the kids'

'Time with your kids and other people's kids'

'Good to be able to come as a family'

Methods of learning

In order to enable a family focus, methods of learning need to be flexible, creative and fun. Lots of children described games they had played which involved understanding nutrition and portion sizes:

'On the topic of nutrition X felt lots of information was delivered both in practical demonstrations and participation in cooking, also leaflets and games. A favourite game for the children was to place food groups on a plate in the right order. X also valued the pack of information given to all families about nutrition and good cooking.'

'X (worker) was great, and turned it all into a game for them.... they learnt all about different fruit one week, and then she'd play a game about it the following week. Most importantly she made it FUN.'

Parents and children enjoyed the experiential learning, involving trying out new recipes and exercise activities rather than just being told:

'Getting kids involved with preparing food'

'Each week, the kids sat there with the peelers, getting hands on with fruit and veg preparing.'

'Instead of coming in and lecturing us, the course was experiential, e.g. veg curry, tasting and cooking; before that we would've ordered a veg curry, but now I can cook it, and I do, regularly. It's lower in fat, and full of fresh vegetables.'

'I've never been one to sit and listen to people talk, I don't want to be lectured to, I don't like being told what to do, but I found it really interesting, and realised I wasn't going to be preached at.'

Other methods included practical advice and tips. For example, a few parents described:

'a shopping trip to ASDA, doing a "normal shop", with MEND there saying "you can't/shouldn't have that".... and suggesting healthy alternatives....'

This shopping trip was successful because it started with the foods that families normally ate and was, therefore, targeted at individual family's habits but also gave suggestions as to how they could eat the foods they liked but ensure they were buying healthy alternatives. Other practical examples were length and regularity of exercise, such as walking to school distance.

Some programmes distributed information packs for children and adults. They contained items such as games, T-shirts, information packs, and magnifying glasses to read small print labels. The packs that were most appreciated and used were the ones which were fun and felt like 'a goodie bag'. Researchers observed that some of the written materials given out in packs appeared very pristine and not used, suggesting that information also needs to be given in accessible fun methods.

Family participation in delivery of programmes

In addition to all family members being involved in the planning of weight management courses, they described how they also benefited from involvement in delivery of programmes. Involvement in delivery, enabled families to feel personally attached to the programme, thereby having an impact upon final outcomes and helping to sustain behaviour change. Parents and professionals spoke about involvement through self-

assessment and personal goal setting, and parents also focused upon the role of peer learning and incremental involvement.

Self-assessment and goal setting

Professionals described how including self-assessment and reflection on goals was integral to enabling the content of a programme to be embedded into family habits. Group support upon achieving goals serves to motivate individuals, and workers facilitated a variety of games and methods to ensure this occurred. This is summed up by one professional:

‘We are total believers in self-assessment. With an intervention you have to ask how they feel. We use a Progress Tree.’

Families spoke about how they liked to work towards their own targets, and this was particularly a common feature in responsive weight management programmes. Some families felt that weighing could be undertaken between children and more self-assessment and group support could be built into the programmes because it would help children to have ownership of their aims. Commercial brands, such as Slimming World, also use this technique to provide participants with ‘buy-in’ to the service they provide.

Peer learning

Peers create a huge resource for families attending weight management programmes; offering advice, support and friendship. Sharing with peers was a fundamental part of learning about, and implementing, healthy living. Many parents perceive healthy living holistically and, therefore, during sessions, would share ideas on parenting, tips on how to overcome food fads, favourite games etc, as well undertake deeper reflection in group work regarding, for example, emotions and food. Three mothers explained the value of peer learning which was echoed within all of the interviews and focus groups:

‘Grouping together with other mums, conversing, and sharing experiences around parenting.’

‘It’s always about doing things together and in a group and involving the kids, and helping each other.’

‘Also it was good to talk to other parents. I felt less alone. It was nice to talk to parents facing the same challenges, learning strategies and things to try from each other.’

Being a part of a supportive group was important to families as it made them feel they were not alone in the issues they were trying to overcome and provided support to do it. This is also one of the reasons why workers’ ability to facilitate positive group dynamics is so important for motivating participants, as explained in chapter 2 regarding motivating factors. Peers also offer support outside of the sessions, ensuring that newly learnt material can be implemented within everyday life.

Incremental involvement

To enable families to consolidate what they had learnt and move on from a programme, families wanted some form of follow up after a time limited programme. One of the barriers

to successful impact was the fact that most of the courses were time limited and there was little, if any, post course provision. This is addressed in chapters 6 and 7 with regard to barriers to success and addressed within the service model in chapter 8. Those families that did feel they had successfully implemented healthy living talked about how they were able to have a role after the end of courses. Some continued to other courses in order to generally remain active:

‘I started going to courses....craft, dance fit, cooking.’

Other course participants returned to the programme to volunteer with the next tranche of participants. Community volunteers were found to play an important role, not just for themselves, but for the new participants because they provided role models and peer support in a way that paid workers could not.

‘By the end I’d become a volunteer with Communities 1st.’

In a focus group, a worker explained that this grass-roots rolling out of skills across the community was integral to the initiative’s design. ‘Training up’ members was crucial to cascading skills and interest in healthy living and provided work experience for young people and those who were out of work within deprived communities. Where volunteering was not an option, participants wanted to volunteer in order to practise what they had learnt, sustain the changes they wanted to make and help others within their community to learn about healthy living.

The people who had attended Slimming World spoke about the value of being able to continue to attend the groups once they had reached their target weight because they still needed the group support to provide impetus to maintaining healthy eating habits.

Concluding remarks

Participation at all stages of a programme appears to impact upon the success of a programme and the ability of families to implement what they have learnt. This success is maximised when all participants are involved, children as well as parents, and when there is some form of progress through a programme and onto a different role or into different opportunities.

CHAPTER 4: CREATING HOLISTIC APPROACHES TO HEALTHY LIVING

Families tended to have a wider concept of healthy living than professionals; linking healthy living to positive family life and being a good parent, suggesting that healthy living filters through different aspects of family life and has links to emotional wellbeing. However, professionals tended to be more focused upon holistic support at different levels – the individual, the family and community. All participants spoke about the need for healthy living to include information about body image and healthy body weight; alluding to the issues of underweight, malnutrition and the fear of children developing eating disorders.

What is meant by healthy living?

Professionals described healthy living according to the context within which they were delivering programmes. Therefore, those working in preventative initiatives mainly focused upon cooking, healthy eating and exercise, and those working in specific weight management programmes spoke additionally about weight loss. Families were clearly motivated towards implementing nutrition and exercise, and had enjoyed the information they had received, but they talked about healthy living in relation to family life.

For example, one parent said that what was important to her and her daughter was not just the information given by the groups. Of far more importance was the great effect on their relationship. Sometimes she had found her daughter quite difficult to get along with and in the past did not really include her in the household tasks like cooking. However, they cooked together in the group and this was immediately beneficial to their relationship, so the way in which they now relate means that this particular mother now involves her daughter much more at home. Others described healthy living as:

‘Healthy living is important for physical health and emotional and mental health too.’

‘Everything – the health and wellbeing of the whole person.’

One of the weight management programmes included a session on food and emotions but general consensus was that this was rushed and families would have liked more about it. Families who attended preventative programmes said they would have liked more information about food, children’s behaviour and how unhealthy foods are used in everyday family life. This was particularly spoken about by parents who had received parenting support and is discussed further in relation to joint working between agencies within the next chapter.

Weight management and healthy living

With the exception of one programme and Slimming World, families reported that they had not learnt about weight loss, healthy body management or body image. Additionally, when asked about weight loss and healthy living, many families felt that this should have been a

part of the programme, even if only signposting to other agencies or initiatives that deal specifically with this issue:

‘There was not enough time and this led to the information about healthy weight management being very vague ... it would have been good to have had more specific information on weight management, and also information on how to access weight loss programmes if needed. More specific information on weight management should be included.’

‘One thing that X wanted was more time for discussion and detailed information about weight and healthy eating.’ [from researcher field notes describing participant]

Families liked the idea of body image and healthy weight because it takes the stigma out of terms such as ‘obese’ and linked the emotional element of body image to the physical. Whilst approached in a different way, Slimming World takes this concept through its focus upon lifestyle rather than diet.

Healthy living at the personal level

Families who had experienced one to one support within the home had found it invaluable but only a minority of participants had had this experience and most family members had not considered whether one to one support would be of value to them. This is common in consultations, whereby people often ask for more of what they have experienced and so ideas outside of immediate experience do not often become discussed. However, almost all the professionals spoke about the value of one to one support and described changes in habits they had seen because of one to one support. Researcher opinion is that, based upon the professionals’ evidence and the limited data from families, if more families had had this opportunity, the impact of programmes might be increased. Most professionals commented upon the need for one to one provision to accompany community and group provision:

‘There is merit in open community events, but we found what actually works is working in the home, providing bespoke programmes for the families. Community activities are good, but the changes that have to happen are personal.’

‘Build trust and understand the whole picture. Community events are great but to effect change you need to work one-to-one.’

‘We need more doorstep provision, that’s what we want to get back to.’

‘Run a follow-up programme, maybe going into parents’ homes, into their kitchens, to encourage them to continue what they’ve learned, personalise the support.’

‘It has to be more flexible, different families want and need different things, “no one size fits all” it needs to be tailored to families’.

‘Home visits make a huge difference, giving them quality time.’

‘Get practical information from them, we only found out in week 7 that 2 of the 7 families didn’t own a cooker. They were trying to cook on throwaway BBQs. We applied for funding to get them cookers.’

Professionals and families highlight that healthy living and weight management programmes have to start at the personal level and relate to the circumstances within the family home.

Healthy living at the community level

As well as implementing healthy living initiatives within the home, it is clear that micro communities have different resources and accessibility problems. Services can often be planned at a ward level, or even larger, but availability of fresh food, transport and shops will vary hugely within an electoral ward area, let alone between electoral wards. People on low incomes in isolated communities face barriers to healthy living through cost, transport, unavailability of shops, and limited opportunities for physical activities. These barriers are discussed in chapter 6, but they can be overcome if programmes focus upon what is available locally, i.e. the information within a programme takes account of the community resources and barriers that surround the participants.

Professionals tended to highlight the problems for community members:

‘Access to services, transport. There is no bus after 6pm on most of the council estates, they can’t get down to the town. And they have no money for transport. Need fresh fruit and veg in the shops.’

‘Access to fresh food, access to leisure services. A lot of the local shops don’t stock fresh food as it goes off. Parents can’t afford the bus to go down the town, it’s a problem.’

‘Accessibility is a big problem – buses and trains are very expensive, and the buses are unreliable, things need to be run locally.’

However, all of the suggestions for overcoming these problems, from both professionals and families, were to ensure local provision, so that programmes are held locally, work is undertaken with local shops and services enable physical activities within communities:

‘Only use what’s local – facilities, events. Food co-ops, allotments.’

Concluding remarks

There are two elements to provide holistic healthy living programmes – one is to ensure that the initiative is rooted in local communities and tailored to the particular resources and barriers that people face within that community. However, community provision must be accompanied by family support to enable changes within the family home to be

implemented. Secondly, holistic provision refers to the content of programmes, ensuring it is applicable to family life and makes links to wellbeing, weight management and body image. In summary, healthy living programmes must be holistic to ensure that they are completely applicable to the experience and practicalities of each family's everyday life.



CHAPTER 5: THE IMPORTANCE OF JOINT WORKING IN DELIVERING HEALTHY LIVING PROGRAMMES

Whilst there may be a number of organisational reasons to promote joint working, both professionals and families spoke about how joint working in relation to healthy living can improve the opportunities for community members and enhance existing provision. Joint working was discussed in relation to different organisations, within organisations, joint working with communities, and consistency of information.

Joint working between organisations

Most experiences of joint working are positive as summarised below:

‘I’ve been working in this area, in partnerships for 10, no, 12 years. We’re a small area, so we all know each other, we’ve always had to work closely together, it works really well being a small borough.’

‘School working with Communities 1st is KEY. It was the school that brought Communities 1st in to do one of the cookery classes, and the school was actively involved in advertising/promoting the classes.’

However, there were problems aired to researchers; particularly in relation to matching strategic direction with direct service delivery and between organisations that provide a service, compared with those who work directly in community or family support:

‘We do need a partnership, but they often have no idea what is going on at the coal-face.’

There are a number of sectors, and within that, a number of organisations, working to prevent and respond to childhood obesity. These include various health services, schools, community services, sports development, leisure services, a range of third sector and charitable organisations and social or family services:

‘There is a mix of NHS, Local Authority and 3rd Sector working on weight management, we need to do it together.’

Barriers identified by professionals included different sectors or organisations not understanding the work that partner organisations do and work cultures that work on different timescales. For example, one community worker described having 20 families signed up to a preventative programme but being let down by another organisation who was undertaking the administration and information for the programme. As timescales slipped, the families lost interest. Another example was a primary school not being willing to distribute information from community services regarding family healthy living courses. It must be stressed that these and similar examples are isolated incidents and by no means the standard of joint working within the Cwm Taf Health Board area. Where this is a lack of

joint working, programmes find it hard to recruit families, families feel they get inconsistent information, and workers feel more siloed and alone in the work they are trying to achieve:

‘...if a GP sees a patient or child who is overweight, they will refer them to a dietician and to the Leisure Centre for a 16-week programme for half-price. Why can’t the GP refer to community organisations who are running weight management programmes? You can’t get to see GPs to talk to them about this.’

Professionals mentioned public sector cuts and the fact organisations have to compete for the same funding pots, but some services have overcome these barriers through closer joint working.

Joint working within organisations

Large organisations are not always able to facilitate joint working between different departments and within hierarchies. In the course of delivering this research and consultation project, there were some elements of service provision that had communication problems between strategy, managers and front line staff. For example, some front line staff did not see the value of the consultation and, therefore, did not respond to researchers without significant intervention from managers. This is within the context of cuts to budgets and staff capacity – a research project can appear like a waste of money or time to someone who is trying to deliver excellence on a dwindling budget and with limited time. Similarly, some managers did not communicate to their staff about the purpose of the project and, therefore, when fieldworkers arrived, staff had no knowledge of what was expected. Some programmes were described by managers to exist but in fact were not currently operating. Communication in busy work schedules can be exceptionally difficult, particularly when operating in communities away from offices where mobile phone reception can be limited.

Joint working with participants and communities

The importance of participation is discussed in detail in the previous chapter, but it should be explicitly remembered that joint working includes a partnership approach to all work with families and communities.

Joint working for consistency of information

Professionals were aware of giving mixed messages if they did not work together closely enough. However, families also noticed when they were being given inconsistent information and it served to frustrate, confuse and in some cases disengage from services. For example, some families spoke of their frustration regarding school lunches not following information given within a specific weight management programme:

‘X eats baguettes at school every day (bought from the canteen). We have asked the school not to let him have a baguette and packet of crisps every day, but the dinner

ladies won't help with it. There's nothing in school on healthy eating. They coax him into activity in PE.'

Other parents spoke of the frustrations of having conflicting advice between health visitors and Communities First nutrition and cooking clubs.

The role of mainstream services and non-specific healthy living services in promoting healthy living

Whilst professionals focused upon specific preventative and responsive programmes and initiatives, families explained how a number of mainstream and family support services had an active role in healthy living, which contributed to their frustration at conflicting messages – they did not know which advice to take. Families discussed how different services were the starting point of their understanding and perceptions of healthy living.

In early years, health visitors and family support services, such as Flying Start, were described as having a role in laying foundations for healthy living:

'My health visitor is involved in delivery too, and often fields healthy eating questions, and provided advice around weaning.'

'Parents, Babies and Toddlers series, promoting language, emotional, social and physical development'

In primary and later years, schools and play or youth services are in a position to give information to children and young people. Additionally, services specifically for positive parenting and family support offer parents information about using food as treats and behaviour management and food, particularly at mealtimes. Many parents felt that these services had played a vital role in helping them understand aspects of healthy living. They mentioned:

'Behaviour management strategies'

'Play, and behaviour management'

'Parenting classes include information on healthy living and food as treats, rewards and pacifiers. Also family time and playing outside or being active. These should be more joined to healthy living programmes.'

'Cross overs between nutrition and parenting. Food is used as a treat or rewards and can lead to controlling behaviour and food fads.'

Joint working to maximise referrals

Preventative programmes tended to be open access whilst responsive programmes operated under agency referral. However, both initiatives were reliant upon joint agency

working for recruiting families. Families were eager to discuss the referral processes they had experienced and professionals discussed how referral needed to avoid stigma.

There was no consensus among professionals as to whether referral from an outside agency, particularly health professional, was effective. However, families discussed how helpful health professionals had been when telling them about courses and programmes that were available. Of particular value were GPs, school nurses and health visitors:

‘I was talking to the school nurse about something else – I think she telephoned me – and it came up in conversation in a really natural way she asked me if I had any other worries or concerns about X [daughter]. So I said I think X is overweight and needs some help, what can I do and that is when she told me about the MEND program. The nurse then offered X a place on the course and I agreed to go too. I cannot remember the reason that the nurse gave for the call – I just remember the outcome and the conversation about X being overweight – I felt ok and didn't feel like a bad parent.’

However, the way in which referral occurred had a big impact on whether families felt they had been sent or whether they had been helped. The anecdotal evidence was that if families feel sent they will drop out after one or two sessions, best summarised by a manager of positive parenting programmes:

‘Referrals from GPs, School Nurse, Health Visitors don't work. It's pressure, they might attend for a week or two but they don't last, they've come under pressure. They need to come because they know they will benefit from it.’

Professionals advocated self-referral to programmes but without hearing about programmes and overcoming a substantial set of barriers, which are discussed in the following chapter, families are unlikely to self-refer. Families themselves advocated referral via word of mouth or leaflets from trusted professionals, i.e. a mixture of signposting and recommendations:

‘From having seen the leaflet, and a friend suggesting we go together, I started going to the group.’ They were good leaflets.... a fun picture, and lots of useful factual info (time, date etc) describing a fun way to learn WITH your kids. The word ‘Family’ was used a lot. The leaflets were given to the kids by their teachers, who read out the leaflets and explained to the kids what it is about...’

‘Word of mouth through a friend’

‘The best way to advertise is word of mouth; I'll listen to what other people say.’

‘I'd gone to look at the Gym, which I'd heard of through word of mouth’

‘Once involved in 1 Communities First project I heard about others’

The preferred referral processes from families is why joint working is so important. To impact upon family, health professionals need to be able to recommend each other's services and be well placed to ask community members to speak to other community members. Posters and leaflets work to a certain extent if they are within an existing trusted service, whether that is a school, GP surgery or children's centre. Posters and leaflets should be accompanied by a conversation which invites families to attend programmes rather than instructs them to. It is also vital that children are directly involved within the initial conversations rather than involving children via parents.

Some professionals felt that weight management programmes were too targeted and that they should be open to everyone in order to reduce the stigma of needing support for children to lose weight. However, families stated that they liked to be in a group where they were all trying to achieve the same goal and were not in judgement of each other. Closer joint working for referrals may help to reduce stigma if families were more regularly referred between preventative and responsive programmes and had follow up support after attending a time limited programme.

Concluding remarks

The author would wish to highlight how difficult joint working can be, particularly between community and office settings, between different organisations with different strategies and when in competition for scarce resources. Additionally, this research is not an evaluation on current services. Therefore, the importance of this chapter is to examine the impact that joint working can have upon community members and identify practice that can be replicated as well as current gaps within joined up provision. It is evident that current joint working has a significant positive impact upon communities and families' motivation for joining and sustaining attendance upon healthy living initiatives.

CHAPTER 6: BARRIERS TO FAMILY ENGAGEMENT ON CHILD WEIGHT MANAGEMENT PROGRAMMES

There are substantial barriers that families need to overcome before they begin to engage with a healthy living programme. These barriers fit into three main categories – practical barriers, personal barriers and procedural or structural barriers. Each of these categories is discussed in turn within this chapter. Where families gave suggestions for overcoming any barriers, these are included within the discussion to ensure that barriers are not presented as insurmountable. Some participants spoke about barriers to implementing healthy living whilst others spoke about the barriers to engaging with healthy living programmes.

Practical barriers

Work times and shifts

Many families felt that their poor eating habits stemmed from not having enough time at home to cook properly or working long days. This was particularly the case for shift workers and families where parents did not have much time together because of work commitments. This was explained fully by one couple:

‘Our eating habits had started when we were both doing office shifts until 9pm, and would get chips/take out on the way home from call-centre work. At work there was a subsidised canteen, so we were eating two meals a day and a take out on the way home.’

‘[We need] to have groups that take account of local people's shift work – so having drop-in sessions too would help.’

Clash with other family commitments

Many families said that, often, groups were arranged on the same night and pointed out:

‘Successful groups need to work around what else is going on in the area.’

Before times are set, families suggested that some work is undertaken to find out what children’s activities occur locally on which night in order to avoid as many clashes as possible. They particularly said this could be undertaken in relation to the age of children that courses are targeted to.

Lack of childcare for babies/very young children

Parents with young children or babies found it particularly difficult to attend evening groups if they did not have extended family nearby who would be willing to look after children. This was a particular source of frustration for parents who wanted to undertake healthy living learning with older children:

'Yes, and I put my name down for one, [healthy living group] but my partner is doing a lot of overtime just now, and he couldn't have the little one (2 year old), so I couldn't go to it with my eldest.'

'Involving the kids is very important... I wanted to go to a healthy living group, and managed a few sessions but the childcare was tough.'

[mother in baby and parent group]

Inaccessible/ unknown venue

Choice of venue is crucial to enabling engagement or creating barriers. Children can be reluctant to attend at a school in evening hours but parents feel reassured because they are familiar with the school and staff within it:

'As it [cooking club] was held at X's school she [child] was initially reluctant to attend, although she gave it a go and loved it straightaway.'

'X community centre was well known and used. Its location is excellent and it has many facilities; for example, a gym, swimming pool, park, cafe – I and many families go there for all sorts of different reasons. No stigma in parenting classes [and assume none for weight management].'

It was a common theme among parents for a venue to be one that was known and trusted. Additionally, children and parents highlighted that the venue needed to be in an accessible location that was close to home, particularly for people without private transport.

Poverty and financial barriers

All participants raised the issue of low income, and families spoke about the need for services to remember that people in paid work could be on a low income as well as families who were not in paid work. All professionals mentioned how unhealthy food is cheaper than healthy food and some added that, often, families' kitchens were not equipped for cooking. Researchers heard stories of families not being able to afford white goods; not having blenders or basic equipment and not being able to afford fuel to cook food.

Very few professionals mentioned the cost of undertaking activities and physical exercise, although both of these aspects of healthy living were discussed by families:

'To buy all fresh food is too expensive, and there's too much waste. I'm lucky, I've got a dog, and he keeps me active, but fitness classes and gym cost money...'

'Being free. It's something for the kids...in a community where there is nothing here.'

'The expense of healthy eating.... I'm inspired by Jamie Oliver's show...."Healthy eating on a budget".... ideas like that would be good. We go swimming every Sunday; it's free 6-8pm, so we go as a family every week, and take the kids' pyjamas with us. If it wasn't free we'd only be able to go occasionally.'

Every focus group and interview mentioned these fundamental issues and many families felt that they were unable to implement what they had learnt because of cost. However, few

appeared to have knowledge of their local food cooperatives which can provide fresh food cheaper than supermarkets and without any travel costs.

Personal barriers

Fear of unknown people and workers

Many participants spoke of the fear they felt in attending a course and this was the biggest barrier to initial engagement with healthy living programmes. Many of the families had low confidence and did not want to enter a room full of strangers and not know what was going to be covered in the first session:

‘X found a group in Mountain Ash, because she didn’t want to be in a room full of strangers, and knew people in the group already.’

‘We know that it’s a safe environment. You know going in that you’ll not be judged...on ANYTHING.’

‘When I walked in I needed to lose 6 stone, and I was the only man.... I’d put it off for weeks, thanks to fears about what people would do or say when I walked into the room.’

‘Being overweight makes you very self-conscious.’

This barrier can be overcome through families being told that they can bring a friend or extended family member, knowing exactly what to expect, for example how long the session is, what they will do, roughly how many people will be there etc. The biggest effect of overcoming this barrier appeared to be a programme that was delivered by workers who were known and trusted, or if it was recommended by a known and trusted worker. This suggests that joint working is key to enabling families to engage.

Low motivation

A minority of mothers felt that other mothers in their community did not have the motivation to attend a programme with their children:

‘I think it’s lazy to choose to stay at home for three hours rather than take the kids out to do something and learn, when there’s no reason not to.’

‘There are some mums that go all the time [to healthy living courses], a lot of other kids miss out... if the parent wasn’t expected to get involved there would be a lot more kids there.’

Whilst ‘laziness’ is a judgement on behaviour, it does appear that some families have low motivation to attend healthy living groups; the reasons for which can only be guessed upon. However, some programmes could be developed that were aimed at children, particularly with regard to physical activity and nutrition knowledge. Children choose their school meals and have some choices with regard to their activities, so it could be possible to develop a

play based series of activities aimed to raise children's awareness of healthy living in the context of the choices that are available to them.

Lack of existing knowledge of healthy living

All of the professionals spoke about families' lack of knowledge in healthy living; particularly lack of cooking skills and nutrition. Examples were given whereby families did not know about the difference between hot and sweet peppers, what to do with a bag of salad or what the vegetables were within food cooperative boxes. Some of these examples were expressed in some judgemental ways whilst others were suggesting that these are the areas which programmes need to focus upon. This lack of knowledge was not mentioned by families in the same way. Families found learning new things a huge motivating factor rather than a barrier, and, therefore, in engagement upon healthy living programmes, acquiring new knowledge about how to cook and different foods can be an engagement tool rather than a barrier to overcome.

Procedural and structural barriers

Poor or unclear referral processes

If families do not know what programmes focus upon or are not clear on who the target audience is for a programme, they will not engage in the service. Even words such as 'family' need to be explained. For example, questions such as 'Can extended family attend?', 'Does it need to be the whole family?' are crucial in encouraging families to attend. Families liked posters and leaflets but they needed to be accompanied by conversations about the activities being advertised. Children also liked information that included them. One mother explained that she had seen a poster in the doctors' surgery and it had sparked her interest. She wrote down the number and web address, but when she looked at it online, the way it was worded, and the use of the word 'family' gave her the impression that the whole family had to be involved. She knew that her partner would be resistant, which put her off. Referrals from GPs and other health professionals sometimes did not have enough information so families did not attend before asking friends and workers in other services about the programme they had been told about.

Poor branding

Participants liked the branding that came with commercial weight loss brands because they knew exactly what they were about. Slimming World and Weight Watchers were directly about losing weight but within the explanation of healthy lifestyle. Some participants explained that community initiatives did not have the same message. For example, one group was called 'healthy start', but all the mothers referred to it as 'kids' club' and did not associate it with healthy living, active lifestyle or losing weight. Similarly, one professional told a story about the MEND programme:

'One parent said to me about MEND, "we're not broken, why are they trying to fix us?" Change the name!'

Very few participants felt that losing weight was the purpose of the initiatives they had attended and felt it was not present in the description of the programme or the content. Families would engage more if weight loss was made clearer, but within the wider context

of healthy exciting lives and new lifestyles. Branding could be improved so that it did not act as a barrier.

Poor staff knowledge/role models

One of the motivating factors outlined in chapter 2 was the knowledge of staff, their ability to engage the whole family and the role modelling that they provided for healthy living. A structural barrier to engagement occurs when workers do not seem knowledgeable, do not engage with the whole family or do not appear to be role models:

‘They were teaching us about nutrition, but didn’t engage with the kids so well. They focussed on the parents.... but not in a good way. The parents felt blamed, and felt that the female workers had the attitude that all the parents were overweight, picky eaters. X [child] especially felt very judged. She came home feeling depressed and just wanting to eat chips and chocolate.’

‘It looked like they were working from a script, they were robotic rather than knowledgeable. Inexperienced in what they were trying to deliver – one week one of them got really stropky at a sensible question being asked by another parent.’

‘The workers were condescending and patronising. They were stick thin anorexic looking girls... The blokes were well built and healthy, but not the girls. It all left the parents feeling as though they were being told “It’s quite simple; just eat less and exercise more... that’s all you’ve got to do”.’

‘We wanted info on adult and child portions.... they only had info on the child portions, and told us “this is about your child”.... we thought it was about the whole family and that we were in this together....’

Such experiences will stop families attending programmes, particularly if children feel depressed or unengaged in the process. Workers cannot always have a role model appearance; but this could be compensated for by enabling previous participants to volunteer within programmes.

Medicalising

Parents did not raise the issue of medicalised content but most of the professionals did. Parents did not mind medical information as long as it was delivered in a fun creative way and children did not mind being weighed as long as it was with other children and a part of the learning process. However, professionals felt that measuring BMI repeatedly and weighing children was detrimental to their own self body image and gave many reports of how:

‘All the parents say “We don’t like our children being weighed, we don’t like them being asked how they feel about being overweight” – all the parents said the same thing.’

The authors suggest that the sample of families within this consultation who had attended programmes that involved BMI measuring and weighing was small and the professionals’ concerns should not be dismissed. Families did request more information in programmes

about losing weight, but this should be approached within the methods and ethos that families themselves have said motivate them; namely, participatory fun methods with a positive focus upon lifestyle changes and new opportunities.

Concluding remarks

There are a number of barriers that families face in both their engagement on healthy living programmes and to implementing healthy living. These barriers are not insurmountable and in some aspects, mirror the motivating factors outlined in chapter 2. The stigma associated with being overweight will remain a barrier, but families want to learn about healthy living and suggest positive branding and clear information about body image. To an extent, the use of healthy body image can be used to reduce the need to talk about weight and can enable discussions regarding fears of children becoming underweight or developing eating disorders. Low income is an ever present barrier and can only be overcome through supporting families to cook low budget meals and informing them of local food cooperatives and food growing schemes.

CHAPTER 7: FACTORS AFFECTING THE LONGER TERM IMPACT OF HEALTHY LIVING PROGRAMMES

Time limited programmes

All participants spoke about the problems associated with time limited programmes, with families and professionals stating that one-off 10 week programmes is not enough time to learn about nutrition, cooking skills, and exercise, as well as implementing the learning and changing family habits:

‘Like I said already, they can’t just be one-offs. A whole maintenance programme is needed.’ (professional)

‘I’d like to see what they will come up with that will be better than MEND. Whatever it is it has to be long term, 10 weeks will never do it.’ (professional)

Many families who had attended responsive intervention programmes felt that the shortness of the courses lowered the potential impact:

‘X [her daughter] has regained the half stone that she lost so this was disappointing for both of us. We wanted the programme to be longer.’

Children particularly stressed:

‘Having plenty of time and not being rushed’ [teenage boy]

and were vocal in focus groups and interviews that they also wanted the programme to be longer:

‘The course was 13 weeks long. It was too short.’ [12 year old]

Follow up after the end of programmes

Families stressed that they wanted follow up to the time limited courses to help provide motivation and guidance to implement what they had learnt. The following three accounts of how weight loss was not maintained was a common thread within the research with families:

‘We were meant to meet up after 3 months, but because the funding ended that didn’t happen. Things have slipped since.... like activity. X’s attitude to activity improved, but has lapsed again. In 13 weeks he lost 5lb in weight and 6/7 inches off his waist. He needed new trousers. Since then he’s just put it back on, and levelled out where he was before. R also gained confidence, but there has been a step back here too.’

'X (child under 11) did lose some weight, but since the end, it's all gone back on. It needed follow-up.'

'And follow up.... it might have helped with maintenance.... There was talk of follow up on the activity side of things, with an ongoing weekly session, but it didn't happen.'

Professionals spoke about the additional support that follow up services can provide and how this has an impact upon families sustaining healthy eating:

'If we can keep kids on the course then we find we have some good success stories, like the 12 year old boy who went from the MEND programme to the After MEND programme we ran as a one-off with Communities First and now he plays for the school rugby team.'

'When you work with partners, you can follow up on how the families are doing, you can track their progress because they are involved with other partner organisations, like through Families & Schools Together.'

Where there was no service provision for supporting families who had attended courses, families tended to go on other similar courses, or sign up for the same course again:

'There's been three "healthy start" courses, and I've gone to all of them.'

Some professionals explained how they delivered repeated courses in other areas of family support to enable families to fully implement what they are learning:

'It's no good offering a one-off 6–10 week programme. These need to be repeated. We run our Parenting Programme 3 times. The first time they dip their toe in, see what it's all about. The second time they understand its importance, and the third one embeds the message.'

Researchers experienced three healthy living groups which had the same participants in them. Whilst this may be beneficial to the participants if there is no follow on provision, it does suggest that the same families are repeating courses, which reduces a service's ability to undertake outreach to new community members. There is also the possibility that it would be more effective to provide follow on services rather than repeat the same courses for the same participants. Some community members felt that there was not enough outreach for the courses and, therefore, they were not engaging with the widest community possible.

Impact continues with small behaviour changes

The data suggests that healthy living courses have an impact when they relate to small behaviour changes that can easily be made. Professionals described the small changes that they observed for the families they work with:

‘It’s a slow process, we consider it a success if families stay engaged with us and are making small changes.’

‘They had a meal at the beginning, and they usually chose the healthy option, the salad, and the children were bringing in bottles of water instead of pop, we were seeing the difference.’

Families also described the practical changes they were encouraged to make:

‘On a practical note we were encouraged to make small differences like children walking to school rather than taking the bus.’

These small steps suggest that expectations should not be towards large lifestyle changes after a time limited programme, but incremental and small changes are important steps in creating new habits. Neither professionals nor families spoke about celebrating these small steps or whether they were a part of a change process or targets set by families.

Impact is enhanced when applicable to family life and local communities

The data from families suggests that the impact of programmes is sustained if the programme relates to everyday family life and the local community. For example, when families are introduced to a local food cooperative where they can buy affordable fresh vegetables without having to travel to the town centre, they are more likely to cook with fresh food. If a family is working long hours, or shifts, learning quick easy meals means they are more likely to cook. If children are fussy eaters, parents will need to cook food they like. The evidence from one to one support is that when programmes are completely applicable to everyday family life and the community within which families live, barriers to implementing healthy living can be solved more easily, particularly in relation to food poverty, ownership of white goods and other issues that may be in the home.

Concluding remarks

This project did not solely focus upon the impact of healthy living programmes and does not seek to provide robust measurable evidence about their success or impact. Instead, this study details what families have said with regard to what they feel has helped or hindered them in sustaining healthy living. There are some links regarding these findings on holistic approaches to healthy living with the need for joint working and the need for participation. It does appear that some follow up services to time limited programmes is crucial for sustaining impact.

CHAPTER 8: A SERVICE MODEL FOR REDUCING OVERWEIGHT IN CHILDHOOD

In devising a model for the delivery of services aiming to prevent and reduce overweight in childhood, the researchers have attempted to build upon what is already good practice, as identified by families and professionals, and address gaps that were identified. To fully discuss a suggested service model, this chapter presents a diagram overview of the model (presented on the following page) and proceeds to explain it in terms of structure, content and process.

Structure

Step 1 services are mainstream services and non-specific healthy living services, which families are already in contact with and have relationships with. These services will have an element of healthy living. The list below is non-exhaustive and provided to suggest areas where healthy living is likely to be included in their service delivery and to ensure consistency of message. Families themselves identified these services as the instigators of healthy living messages.

- schools: safe routes to schools, PE, health schools, elements of the curriculum, content of school meals and dinner staff knowledge, school nurse
- parenting classes: food and behaviour, treats and rewards, positive family dynamics at mealtimes, food fads and child behaviour
- early years: weaning, moving to solids, cooking for babies, dealing with behaviour, routines, childcare settings, parent and toddler groups
- GP: all aspects of personal health
- play and leisure: youth clubs, play schemes, leisure centres
- community services: e.g. regeneration, community employment support.

Step 2 services are specific preventative and responsive weight management services. Examples include:

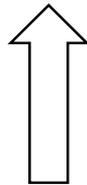
- targeted programmes e.g. MEND
- community cooking and nutrition courses and exercise and cooking skills courses.

Step 3 services act as follow on services to ensure learning becomes embedded. This could include follow up one to one support as suggested by professionals, community days and events as suggested by families, and volunteering and mentoring opportunities in the courses. Volunteering and mentoring would enable new participants to have the peer support that was found to be invaluable, as well as past participants to embed what they have learnt. Children could also mentor each other, similar to buddy schemes operated in some schools.

Service model for delivering weight management programmes to reduce childhood obesity

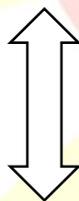
Step 3 Services: providing explicit follow on support.

- Volunteering and mentoring in programmes
- Moving on services e.g. growing schemes, play streets,
- One to one support



Step 2 Services: 3 potential different strands all with specific focus upon healthy living

| | | |
|---|--|--|
| Responsive: Weight management programmes | Preventative: Community based healthy living programmes (incl. a weight loss component) | New services: Drop in support for advice, shift workers, one to one follow up whilst attending other step 2 services Non targeted child food and play sessions |
|---|--|--|



Step 1 Services: mainstream and non specific healthy living services e.g.

- Schools
- Early years and family support
- Sport play and leisure

Content

Step 1 services

The content of healthy living will vary within step one services because they have a number of different aims and purposes. However, some mapping or scoping could be undertaken to ensure that the wide variety of partner services are giving the same information. There was some suggestion from families that they received conflicting advice which served to demotivate engagement with services. Step 1 services have a key role to play in signposting and verbal referrals to step 2 services. This is examined more in the process section below.

Step 2 services

Families report that preventative programmes vary in their content with some focusing upon cooking, some on cooking and exercise, and others upon nutrition, exercise, cooking and changing habits. Responsive services were described to also include weight loss information. Families were clearly asking for more learning regarding weight loss and information about healthy body image. A review of current content could be undertaken to look at how to strengthen the content regarding weight loss and ensure it is not too medicalised but instead focuses upon practicalities as well as including this information in preventative programmes. Suggested content for step 2 services is a fivefold focus:

- nutrition
- cooking skills
- exercise
- motivation and behaviour change
- healthy body image and weight loss.

There was some discussion within interviews about including malnourishment and underweight in childhood. Whether the target audience is widened to include this cohort of potential participants is a decision for commissioners but, if it were referred to within the content of programmes, it would reassure parents who are concerned that, by focusing upon weight loss with their overweight children, there may be unintended consequences of obsessing over slim body image. Additionally, many professionals appear to feel that underweight and food fads are a growing problem and, therefore, even if this is not borne out in statistics regarding weight in childhood, it is something that could be referred to in order to provide a holistic approach.

All of the content in step 2 services needs to be relevant to family life and the local community. It, therefore, could include some one to one support with individual families to ascertain the level of poverty, level of knowledge regarding cooking and individualised support with changing family habits. The content also needs to refer to local community resources and overcome local community barriers and refer to all of the issues identified within the chapter regarding holistic approaches.

Step 3 services

These need to provide follow up from the learning and experience of attending a step 2 service. Step 3 services would reduce the repeated attendance on step 2 courses and be targeted for implementation of knowledge. The content of these services is to provide

incremental learning and involvement in healthy living, to continue peer support and deliver peer learning. To this end, the services could include involvement in local food cooperatives, community growing projects, play streets, volunteering and mentoring as well as further learning opportunities regarding motivation and behaviour changes.

Process

Step 1 services

These are services that participants are already familiar with. However, if links regarding the aspects of healthy living that they cover are made more explicit and joint working is expected of staff, the process of moving from step 1 to step 2 services should be clearer and more referrals should take place. Step 1 services need to be equipped with a conversation for families regarding how to recommend healthy living programmes, a leaflet that has all the information and an explanation as to how the healthy living programme complements the work that the step 1 service does.

Step 2 services

Participants clearly need to know what the process is for joining a programme, what they can expect when they come through the door, if they can bring family members (or if they can attend alone with one or any of their children), if they can bring a friend and if they will know any of the workers. Having this knowledge helps bridge many of the barriers that participants raised. The process of being involved in a programme needs to follow all of the aspects of holistic approaches and participation as outlined in chapters 3 and 4. There should be some movement between preventative and responsive programmes, but in either case clear movement to step 3 services. If step 2 services implement good participation and build on motivation factors outlined in chapter 2, step 3 services will feel like an incremental progression. There could be an analysis of how to create drop-in services as well as regular courses, or flexibility between step 2 programmes, to accommodate community members who have childcare difficulties or work shift patterns.

Step 3 services

Step 3 services are wide ranging, but must continue with involvement in the service, acknowledge what families have achieved and include an element of one to one support, even if through buddying volunteers, to sustain implementation. They need to be able to refer back to step 1 or step 2 services, but with clear rationale, not because there is no other provision.

CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

The service model detailed in chapter 8 is founded upon the findings of this consultation. Whilst there are practical, personal and structural barriers that families face to engaging in weight management programmes and implementing lifestyle changes (detailed in chapter 6), there are actions that can be taken to overcome many of these barriers. In summary, the opportunities for engaging families within responsive and preventative weight management programmes rely upon three main criteria:

1. **Understanding the families' perspective and actively enabling them to become involved in the programme**

Professionals and practitioners can be most effective through working with the motivating factors that families have to join a programme which are:

- wanting to be active with children
- having personal ill health
- wanting better personal wellbeing
- having the support of wider family and social networks
- to create more positive family dynamics
- good referral processes about the initiative.

Once families are engaged within a programme, practitioners and professionals can motivate families to maintain their attendance, through ensuring they are:

- learning new things
- socialising
- positive group facilitation
- good worker interpersonal skill and knowledge
- providing incentives and keeping it low cost.

Additionally, families suggest that their own participation in the design and content of programmes, the delivery of programmes and the use of methods that will engage the whole family, will enable them to learn and change habits. The suggested service model includes these elements within the outline of its process, that is, how the services are delivered.

2. **Working with other organisations to ensure good partnership approaches that include consistency of messages and clear referrals into, and out of, specific time limited programmes**

Most joint working between organisations was reported very positively. However, there were some problems expressed regarding matching strategic direction to service delivery and between organisations providing a specialist service and those working directly in the community. This is unsurprising given different work cultures and constraints between different sectors. However, joint working is imperative in order to maximise the effectiveness of weight management initiatives; particularly in relation to referrals into and

out of programmes and in delivering clear consistent messages. Additionally, there needs to be a joint approach to healthy living between mainstream and specific healthy living services. Families clearly felt that healthy living messages start with mainstream services such as health visitors, schools, community services and physical activity (e.g. community based classes).

Services and families have different definitions of 'healthy living'. Whilst practitioners and professionals perceive healthy living to refer to nutrition, diet, exercise and sometimes weight loss, families have a wide definition that includes positive family dynamics, positive body image and emotional wellbeing. Services can use the same definitions as families in order to successfully work in partnership with community members and address the concerns that families have within these topics through healthy living information.

The suggested service model outlines these issues through having a clear three tiered structure comprising mainstream services, specialist services and follow up services, but also through the suggested content of programmes, which must include healthy living and family dynamics, healthy body image and emotional wellbeing as well as nutrition, exercise and cooking skills.

3. Structuring weight management services so that a time limited programme does not represent the entirety of healthy living services

It was clearly apparent from the research findings that the impact of healthy living programmes is reduced if programmes are time limited. The suggested service model outlines tiered services that ensure time limited programmes are maintained but suggests the need for follow up services to enable participants to embed what they have learnt. Change in habits can take time to implement and, therefore, planning incremental lifestyle changes and ensuring that programmes are applicable to family life and the local community is critical to creating a sustained impact. Referrals after programmes can be either to mainstream services or follow on services, but support is needed to enable families to implement learning. Additionally, support does not have to be only from group programmes and, therefore, the model suggests drop-in services, child focused programmes and one to one family support.

Conclusion

Families identified areas of good practice and spoke about what is effective to engage them in weight management programmes. The service model builds on these identified areas of good practice and suggests a planned approach in terms of joint agency working in structure, a participative and tiered approach in process and a highly relevant family and community focused content. In combination, these elements should enable a sustained impact from healthy living programmes and effectively enable families to implement lifestyle changes that prevent or reduce childhood obesity.

APPENDIX: LITERATURE REVIEW

Introduction

This document is a rapid review of the evidence as it pertains to family-based weight management programmes, with particular focus on successful and sustained engagement.

Childhood obesity is one of Europe's most serious public health challenges. Around 20% of European children are overweight and one third of them obese and as childhood obesity has the status of a disease, it is now classified as an epidemic. The prevalence of childhood overweight and obesity is already so high in Europe that obesity-related diseases and complications in later life, such as type 2 diabetes, cardiovascular diseases, cancers, and psychosocial disorders, may very well lead to many European children living much shorter lives than their parents.

(European Childhood Obesity Group, 2014)

Overview

Child obesity is a well-documented problem across the world and increasingly so. Child obesity is a growing problem in Wales; levels are amongst the highest in Europe and the highest in the UK (National Assembly for Wales, 2014b). Childhood obesity is a strong indicator of future serious health problems and is closely linked to social deprivation with all of the attendant risk factors this brings. In particular, there is a growing disparity between socio-economic groups with children experiencing deprivation more likely to be obese (Stewart and Williams, 2013).

Several publications were provided by the commissioners specifically relating both to the brief and Cwm Taf University Health Board services. One was an analysis of family-based weight commissioned by Public Health Wales (Stewart and Williams 2013); the other a report from workshops commissioned by the local Families First Pioneer Consortium (IPC 2014). Both publications reference a range of important national studies, research papers and policy documents in their analysis, many of which will be familiar to the audience for this review. Of these, the two most significant for the purposes of this review were the National Assembly for Wales 'Inquiry into Childhood Obesity' (2014) and the NICE guidance, 'Managing overweight and obesity among children and young people: lifestyle weight management services' (2013).

To avoid unnecessary duplication, this review has, for the most part, looked for relevant research and papers published during and post 2013 that focused on engagement in family-based interventions. The aims of this review are therefore to:

- 1) Provide detailed evidence compiled through an online review of secondary data of the most and least effective methods for engagement and delivery of family-based weight management programmes.
- 2) Consider the wider issues relating to obesity such as (but not solely) reduced active play opportunities; healthy eating; and issues that arise from multiple deprivation.

The intention was to seek studies, evidence and research from Wales, then the UK and beyond. The first aim was not fully achievable because detailed evidence does not exist since extensive data regarding the methods of family engagement has not been collected. This applies not only to effective methods of engagement but for weight management programmes with families generally. The nature of and mechanisms for engagement, both successes and failures, feature as a small strand in the total volume of work produced to date. Engagement with families *is* referred to as a concern, though rarely the primary focus of research. It is extraordinary that despite decades of research, there is no clear evidence base for what works in dealing with childhood obesity in an effective and sustainable way (Upton et al, 2014).

There is a very limited and inconclusive evidence base for family interventions in the UK and a paucity of high quality research evidence internationally on effective child overweight management (Randall et al, 2014). We have sought out the limited number of relevant case studies including meta-analyses and other review documentation.

The second aim, considering wider issues, was easier to address and has been the subject of increasing amounts of cross discipline discussion and documentation for decades. In fact, internationally, there was a 30% rise in papers on child obesity prevention between the late 1980s and 90s and over 1,000 published works in 2013 (Lobstein et al (2015).

Despite the huge rise in the amount of research relating to childhood obesity, it is largely inconclusive as to establishing the causes of child obesity. This is due to a range of factors interacting in a complex mix of triggers for child overweight and obesity. The causal factors include the personal, social, educational and environmental with impact at local, community, regional, national and international levels. (Wang et al 2013; National Assembly for Wales 2014b). Additionally, the interventions that aim to reduce and prevent child obesity are varied in themselves and establishing which elements have efficacy is problematic (Stewart and Williams, 2013).

It could be assumed that both the perceived causes of obesity and thus the planned interventions would impact upon the mechanisms for engagement. The received wisdom is that a combined approach with multi-site, multidisciplinary teams, working to tackle existing childhood obesity through coordinated action on health, education, transport, environment, social services, planning and research is the best approach for delivering obesity programmes (Loureiro & Freudenberg, 2012; Lobstein et al, 2015; Fabian Commission, 2015).

However, once again this focuses on effective service delivery rather than engagement and the evidence base for successful engagement and intervention in community based settings in the UK is at best unclear (Law et al 2014).

What is indisputable is that child overweight and obesity is disproportionately affecting children and families living in socio-economic deprivation (Law et al 2014; Fagg et al 2014 a&b). On the one hand we have a society that to a degree blames parents and families for their child's overweight (Douglas et al, 2014), yet it is the same society that has created

obesogenic environments and systematically removed the resources needed to tackle the attendant rise in childhood obesity (Merry 2012, Fabian Commission, 2015).

Alongside the concern that we have an epidemic on our hands, the most common thread running through the literature is that researchers agree that more robust research is needed. Suggested areas of further exploration include: the causes of childhood obesity; models of treatment and their efficacy; family engagement during interventions and beyond; the cost effectiveness of programmes (Lucas et al, 2014; Randall et al 2104; Law et al, 2014).

The Welsh context

'We agree that childhood obesity is a complex issue and that the required response will necessarily be complex...Tackling childhood obesity requires a multi-faceted approach. If Welsh Government is going to tackle this issue successfully, it needs to harness all of the tools available to it.'

(National Assembly for Wales, p5-8 2014a)

Everything raised in the above overview was discussed and commented upon to a greater or lesser extent in the National Assembly for Wales 'Inquiry into Childhood Obesity' (2014a) including the shared concern that there is little evidence for the cost effectiveness of existing programmes and concerns regarding future funding (NICE, 2013; National Assembly for Wales, 2014; Fagg et al 2014).

Various recommendations were made that largely chime with those outlined in the existing reports relating to Cwm Taf University Health Board's commitment to tackling childhood obesity. This includes the recommendation that professionals and practitioners from overlapping disciplines must work together and share resources to identify need and provide holistic, tailored services to suit individual families (Stewart and Williams, 2013).

In advance of the Inquiry findings, another report, from the Preventing Childhood Obesity Steering Group, 'Turning the Curve on Childhood Obesity in Wales' (2014b) likened obesity prevention as a challenge akin to climate change in that it requires societal change to be successful.

The Inquiry itself expressed misgivings regarding the outputs and value for money of family-based programmes. The steering group, mindful of limited public budgets, suggested no or low cost interventions with examples of successful practice from around the UK that could be remodelled and replicated across Wales. Cost effectiveness concerns are shared in other literature and will be discussed later in this review.

There is no doubt that the gravity of the situation with all the attendant implications – the enormous economic, social, welfare and human costs – is fully understood and appreciated by politicians, health professionals, educators, academics, community leaders and workers in Wales.

Family-based interventions, barriers and effective engagement

There is overwhelming agreement that tackling childhood obesity requires a range of measures and that these should include family and community based interventions (WHO, 2012; NICE, 2013; National Assembly for Wales, 2014.) To date, the modest achievements of family-based interventions are largely attributed to a lack of engagement with parents (Davison et al, 2013).

A recent meta-analysis of community engagement in health settings found that it can be effective, and recommended incorporating engagement into the design of interventions. However, more evidence is needed on the models of effective engagement (O'Mara-Eves et al, 2014). A systematic review of family-based childhood obesity interventions established that there is insufficient evidence to suggest how the inclusion of parents and/or the wider family may have an impact on the effectiveness of the programmes (Upton et al, 2014).

Most family-based weight interventions in the UK are short term programmes that combine a number of elements which are usually physical exercise, nutrition, healthy eating and psychosocial wellbeing (Randall et al, 2014). The fact that there is limited evidence for their success in changing behaviours in the medium or long term, or as value for money, does not appear to influence their use (Lucas et al, 2014; O'Mara-Eves, et al 2014; Law et al, 2014).

There is a view that any improvement even if only delivered to a small number of people with limited impact is better than nothing (National Assembly for Wales, 2014) and that, if sustained change can be achieved, then cost savings can be significant (WHO, 2012). However, the counter argument is that interventions must be designed and implemented to ensure sustainable health equality (Fagg et al 2014a).

Research, to date, shows that whole family interventions that engage adult family members and combine lifestyle change (dietary choices, physical activity and nutrition education) have some success (Watson et al 2011, Randall et al 2014). For some, this is because they see parents as the primary agents for change and that such interventions offer an opportunity to address whole family weight given that many obese children have family members who are also obese or overweight (Randall et al, 2014). It is also important that children and young people, themselves, are viewed as 'competent social actors' in their own lives and therefore central to health decisions that impact upon them (Rees et al, 2013).

Meta-analyses and comprehensive review studies suggest that the most effective interventions appear to be delivered through combining school-based diet and exercise changes with home and/or community involvement (Wang et al 2013; Fagg, 2014 a&b; Randall et al, 2014: Law et al). However, researchers qualify their findings due to the quality of data, the limited body of research and the complex range of factors and variables associated with child obesity. Consequently, they are concerned that findings can be exaggerated and generalised by policy makers when there is very little hard evidence of success and recommend that further research is undertaken (Kipping et al 2014, Randall et al 2014). However, in times of austerity, there are cost implications for existing programmes let alone committing further resources to developing new models of engagement (National Assembly for Wales, 2014a).

The research into family-based interventions consistently flags up the high rate of dropout and the barriers to engaging in the various programmes (Twiddy et al, 2012; Upton et al, 2014) but only a few consider the issue of pre-intervention engagement which throws up considerations of perception, sensitivity, training and approach for professionals.

In terms of good practice, professionals and policy makers advocate participative models that involve families and communities in programme planning and design as well as governance delivery and evaluation. They make recommendations for engaging end users and stakeholders and making the most of existing social structures, amenities and multidisciplinary team working. They neither suggest specific mechanisms for implementing their recommendations nor provide exemplars of good practice that have achieved sustained results. (World Health Organisation, 2012; NICE, 2013; All Party Parliamentary Group, 2014; IPC, 2014).

The studies that evidence some success in family intervention programmes argue the need to establish, understand, acknowledge and accommodate the individual perspectives of the participants – trainers, parents and children. Interventions need to empower the participants, involve them in decision making, prioritising actions and outcomes (Watson et al, 2015) but there is very little literature available specifically focusing on the engagement process in family- based weight management programmes and, once again, no mention of the mechanisms for successfully doing so.

The advice on best practice and research based evidence tends to focus on the ‘what’ rather than the ‘how’ in delivering interventions as King et al highlight. (2011, cited in WHO, 2012).

Establishing engagement: pre-intervention

Consulting and engaging with parents, children and young people in the planning and design of services and programmes is recommended across the guidance (WHO, 2012; NICE, 2013; Welsh Government, 2014) but the mechanisms for successfully facilitating this successfully are not clear.

We know that childhood obesity has complex causes and that, albeit equivocal, the limited research suggests that by actively involving adult family members, positive outcomes for weight loss and psychosocial wellbeing in obese and overweight children can be achieved (Randall et al, 2014).

At the outset of planning and implementing any programme is the need to identify potential participants. Under the current models, the first hurdle that has to be overcome is addressing the issue of overweight and obesity with children and their adult family. There seem to be two distinct and intertwined problems in overcoming this. The first is the family’s reluctance or denial of the problem and the second is the ability of the professional in raising the issue (Douglas, 2014). Therefore, it is unsurprising that, for example, less than 0.5% of eligible families in the UK were referred onto, took part in, or completed the MEND programme (Law et al, 2014).

We know that children who are obese are over-represented on family intervention programmes (Visram et al, 2012; Fagg et al, 2014b), that is, there are more obese children participating than those who are overweight but not obese. Given that there is a greater number of overweight (rather than obese) children in the general population, it is reasonable to assume this would be reflected in intervention uptake. Visram et al (2012) found that health professionals used visual identification, and thus more obese children were targeted for intervention programmes, due to a reluctance to discuss weight directly.

Some research suggests that lack of engagement could be due to other pressures including a reluctance or lack of readiness to embrace change (Riggs et al, 2014). Other researchers have identified an inability and/or reluctance on the part of families to recognise that a child is overweight and that they therefore decline to engage (Visram et al, 2012). This could in part be due to the normalisation and acceptance of overweight in public perception (Saxena et al, 2014). Recent research found that almost a third of parents underestimated their child's weight (British Journal of General Practice, 2015, cited in The Guardian 30th March, 2015). Where children are overweight: 79% of parents do not recognise this fact and 41% do not perceive overweight to be a health risk (Saxena et al, 2014).

As health and other professionals feel ill equipped to tackle the subject of weight, the opportunity to begin engaging with families is missed. Saxena et al (2014) report that in 40% of instances, GPs miss the opportunity to discuss children's weight with their overweight patients. At the same time, the Chief Medical Officer for Wales (Welsh Government, 2013) reported that 38% of patients find it difficult to make a convenient GP appointment and improving access to primary care remains a challenge.

This review found no clear training or guidance for professionals on how to sensitively and appropriately address the fact that a child is obese; however, there is discussion in the literature and recommendations for training to be put in place across the health sector (RCPCH, 2012; Rees et al, 2013; All Party Group, 2014, Parliament).

Clearly, there is stigma surrounding obesity and anxiety on the part of professionals whose role is to address it (IPC, 2013) and there is also the broader ethical and moral debate relating to obesity and family interventions (Merry, 2012; Voight, 2012; Peterson, 2012). A key message from a recent World Obesity Federation paper was the need for a 'healthy growth' strategy (Lobstien et al, 2015). The purpose of this is to avoid the creation of underweight in tackling obesity and also to deal with childhood undernourishment. While they are not the subject of this review, they do have a key bearing on the planning and commissioning of services and are rarely referred to in the wider literature.

Aside from the anxieties of professionals and adult family members is the need to ensure consideration of the perspectives of children and young people as the target beneficiaries. The stigma and experience of overweight and obesity by young people themselves has to be factored into all elements of interventions. The same engagement mechanisms should be used with children and particularly young adults to encourage empowerment and choice as part of self-determined physical and psychosocial wellbeing (Rees et al, 2013).

It is arguable that the lack of clarity, understanding, knowledge and training at the pre-intervention stage are contributory factors in the very small proportion of the eligible families that are engaged in interventions (Riggs et al, 2013; Law et al, 2014; Fagg et al, 2014 a&b). This suggests that pre-intervention work could be the single most important aspect of commissioning effective family engagement programmes. If the barriers are addressed at this stage, then an increase in uptake could be anticipated and thus bring about an improvement in weight management, in the short term at least.

On a purely practical basis, written invitations to an appointment are used by some schemes for initiating engagement, with some studies reporting the use of multi-lingual literature as needed (Fagg et al, 2014b) but none addressing the potential literacy barrier. The MEND programme uses a referral scheme that involves a follow up phone call but there is no examination in the research reviewed here that considers the efficacy of this approach.

A meta-analysis of health equalities and community engagement found that community designed and/or delivered interventions, were effective as partnerships were created and sustained, having a positive influence on engagement as well as on the impact of programmes (O'Mara-Eves et al, 2013).

This review has found a case study specifically relating to family-based weight management that encouraged active participation from the outset with low income/socio-deprived families and thus a different model of working (Jurkowski et al, 2013; Davison et al, 2013). The study started from the premise that parents are the experts on their own families; they understand the ecology, dynamics and day to day functioning. Parents, therefore, were seen as absolutely critical to creating change and the single most important tool in the kit to addressing childhood obesity. By treating parents as knowledgeable, capable decision makers, advisers and equal partners from the outset, rather than clients, these studies empowered and encouraged them to play an active and leading role in the participatory research, advocacy, conflict resolution, governance and programme design.

Consequently, though qualified by the need for further research, the study found that the interventions were more tailored, culturally and community sensitive, had added value in terms of knowledge and expertise and achieved significant improvements in obesity outcomes.

The single biggest difference in this model from other interventions was the use of payment (in tokens) to parents for recognition of their contribution to the project. It was an acknowledgement of the equal partnership and that the other delivery partners were salaried and the research found that it had a positive impact. Interestingly, O'Mara-Eves et al, (2013) found the same thing in their study; that paying community members (and participants) influenced participation in a positive way.

The principles of effective parental engagement in family and community based programmes described by Jurkowski et al (2013) and Davison et al (2013) chime with the findings of the IPC (2014) report on the Families First Consortium workshops on child and family obesity. This document highlighted the need for: highly trained delivery practitioners, robust multi-agency working, clearly targeted services, a systematised approach to delivery,

and embedded evaluation and research methodologies across Cwm Taf University Health Board.

Engagement in intervention delivery

A number of family-based weight management intervention programmes are used across Cwm Taf University Health Board and have been comprehensively described by Stewart and Williams (2013).

Recent UK studies of these and other established interventions, show that there is evidence of short term benefits to both psychosocial wellbeing and weight management in family-based programmes (O'Mara-Eves, 2013; Law et al, 2014; Randall et al, 2014; Watson, 2015).

Unfortunately, how these short term impacts are achieved by including the family are unclear (Upton et al, 2014). As with all the studies reviewed for this paper, the researchers qualify their findings and recommend further research.

The various analyses make reference to the triggers and motivation behind participation which include experience or fear of bullying, transition from primary to secondary education and, to a lesser extent, health concerns. They also qualify that the desired outcomes for each participant will vary. For parents, the priority may be more to do with improved psychological wellbeing in their child (Twiddy et al, 2012) whereas the motivation for children and young people's participation is most often related to body image (Rees et al, 2013).

Most programmes on offer run for up to 12 weeks offering a mix of group and tailored family activities depending on the specific intervention. There is small initial uptake overall and significant drop with the various programmes, offering little understanding of maintaining weight loss in the medium and longer term (Randall et al, 2014).

There is a great deal of common ground in identifying the barriers to maintaining access; these have been well documented both in the past and present and include issues generally relating to:

- accessibility – the time of programme sessions, the suitability and location of a venue
- transport – availability, cost, distance travelled
- content – appropriateness, communication, enjoyableness, leadership, size of group.

Each of the studies reviewed referred to the uptake of and drop-out rate for interventions and gave some consideration to this.

Researchers found that during the intervention period, families and parents struggled with participating in an already busy family routine with competing time commitments (Lucas et al, 2014). On the one hand, families found it difficult to attend sessions regularly yet, on the other, they felt they needed support to maintain their commitment to the programme.

Researchers also found that leaders of programmes varied in empathy, understanding and life experience. However, where they did manage to maintain attendance, participants experienced improvements in self-efficacy even if their weight and other physical health improvements were negligible (Law et al, 2014; O'Mara-Eves et al, 2013).

One specific finding relating to programme leadership was the correlation between drop-out rate and the number of programmes a manager had run; the more programmes, the higher the drop-out, but no explanation was given for this (Fagg et al, 2014b).

More significantly, the same study also discovered that while the intervention had the potential to deliver positive outcomes, the families who dropped out were those experiencing most deprivation. Consequently, there is a need to examine exactly who starts and completes weight-based interventions relative to need to ensure that future services achieve both health equality and sustainability.

The size of a group and the nature of the activities on offer were also factors that contributed to drop-out rates. Larger groups have a higher drop-out and a range of activities in appropriate settings are needed to appeal to the variety of participants (Law et al, 2014). For children and young people, labelling is an issue and social support a key element for sustained attendance. Children experiencing the most psychosocial distress are less likely to complete a programme and whole family programmes can reduce the pressure on overweight and obese children (Rees et al, 2013; Law et al 2014). At the same time, there is concern that the focus of weight management can negatively impact on children's self-esteem (Watson et al, 2015).

Longer programmes may well be beneficial as facilitators to establishing and supporting lasting behaviour change. It is notable that the WHO (2012) refers to anything under a year as short term intervention that tends to be both expensive and unsustainable.

Watson et al (2015) undertook an evaluation of the GOALS (Getting Our Active Lifestyles Started!) programme which was unusual in the UK as it lasted for six months; MEND, HENRY, Alive n Kicking and other programmes run for up to 12 weeks.

GOALS was designed as a holistic intervention through offering tailored packages to families through combined varied multidisciplinary elements. The service offered multiple routes for referral, counselling, group activities, sessions for parents, children, parents and children together. It also initiated the 'GOALS graduates' scheme at the request of parents who wanted ongoing support. The pilot was dropped due to financial pressure and because of attendance drop off. Unfortunately, the reasons for this this were not explored by the research (Watson et al 2015). There was sufficient evidence to suggest that participation in GOALS had contributed to sustained changes in dietary behaviour, wellbeing, and personal attitudes but, due to the small numbers in the cohort, cannot be generalised.

All of the research suggests that for effective service delivery and sustainable successful outcomes to be possible, a range of factors needs to be taken into consideration. These include staff training including understanding of the therapeutic relationship, communication skills, goal setting, duration of programmes, and the barriers to accessing programmes which cover the realms of the physical, emotional, environmental, social,

resilience, continuity and sustainability (Fagg et al 2014; Randall et al, 2014; Upton et al 2014; IPC, 2014).

We have looked for research literature demonstrating effective engagement in delivering better health outcomes and found there is evidence that community and family engagement can bring about positive improvements in health behaviours (O'Mara-Eves et al, 2013; Koerting et al, 2013). O'Mara-Eves et al conducted a meta-analysis across various health conditions including examples of programmes addressing healthy eating, nutrition, overweight and obesity in the general population, children and young adults. They found that empowerment was the key element of successful engagement.

Taking into account some of the engagement discussions in weight-consideration, coupled with a poor evidence base, it may be beneficial to consider the success from evidence elsewhere.

Within education, mental health and community development, there is well established practice and evidence base that demonstrates effective parental engagement strategies need to be inclusive, collaborative, proactive, sensitive and empowering (Meister, 2009; Goodhall et al, 2011; Best Start Resource Centre, 2011; Koerting et al, 2013). This review has selected a handful of these for the purposes of illustrating the transferable and adaptable mechanisms that have proven efficacy. These can be drawn upon to inform the development of appropriate localised models that can deliver effective family engagement for weight-based interventions, particularly as the intention of Cwm Taf University Health Board is to work holistically as recommended by the WHO (2012), NICE (2013) and National Assembly for Wales (2014 a&b).

Each of the examples considered evidence of the need for a mix of elements to take account of situational and psychological barriers to professional sensibility; the recognition that engagement takes time and parents may be cautious to commit and need autonomy; and the recognition that good inter-agency collaboration has to be seen in practice. The literature also found that practical considerations have to be taken into account and often experienced the same problems as the weight-based programmes. Good practice has to run through all elements of service development from planning and commissioning to delivery, research and evaluation, and participation by all stakeholders at each stage is essential to ensure best outcomes.

Engagement post intervention

Despite the short term benefits gained by participating in a family-based programme, the research is unequivocal in stating that there is insufficient data to demonstrate any long term changes in behaviour or weight loss maintenance. One key challenge identified by the research to the sustainability of successful outcomes is bridging the move from a supported intervention to maintaining behaviour change in the home (Watson et al, 2015; Law et al 2014). To work in the long term, ongoing support and resourcing is essential (Goodall et al, 2011) and there is a need for evidence to establish which models of community engagement lead to sustainable outcomes in health improvement (O'Mara-Eves, 2013).

It should be noted that Fagg et al (2014a) found that, although it is believed that an obesogenic environment impacts negatively on childhood obesity, there is very little evidence to demonstrate this has an impact on weight interventions.

However, when considering long term weight management, it is essential to consider the broader picture and political landscape in which childhood obesity has become such a serious problem.

The obesogenic nature of the communities in which people live play a significant role in the initial problem of obesity (Lobstein et al, 2015) and in maintaining change after participation in weight management programmes.

Structural issues including worklessness, housing conditions, nutrition security, access to fresh, affordable food within the locality, access to transport, fuel poverty, safe play areas and sports facilities and other deprivation factors all have a bearing on sustainable weight management. The research shows that participants on programmes do not tend to maintain weight loss. There is some evidence to show that some of the facilitators that enable participation in a programme become barriers to maintenance; with transport and social support being regularly identified (Fagg et al, 2014a; Law et al, 2014; Watson et al, 2015).

On a larger scale, other authors argue that policy reversal is needed to address the vested interests of the food and advertising industries (Merry, 2012; Lobstein et al 2015). This is seen as an urgent requirement at both national and international level whether through legislation or regulation (All Party Group, 2014; Fabian Commission, 2015).

Conclusion

The NICE Guidance (2013) remains the most comprehensive, systematic and detailed up to date review on child overweight and obesity in the UK. It explores all aspects of the problem, fully considers the research evidence for each component and contains comprehensive recommendations for action. It also identifies gaps in evidence and recommends areas for further research in detail. However, it does not provide answers regarding the mechanisms for engagement which appear to be the crux of the matter. Below is a summary of the key elements of the NICE Guidance coupled with the essential findings from this review.

- There is a child obesity epidemic and the most deprived are most affected. Family-based weight-intervention programme research shows that these children's families are the least likely to engage with interventions and the most likely to drop out. Appropriate and effective engagement with this group is essential to tackling the obesity crisis.
- Obese children suffer physically and mentally and are more likely to be obese adults. Obesity in childhood is a strong indicator of adult obesity and reduced mortality. Psychological distress is a barrier to sustained engagement in intervention programmes. Children's knowledge and understanding and views on their situation

must be listened to, respected and factored into all intervention planning if they are to be successful agents for change in their own lives.

- Health practitioners and other professionals are neither trained nor confident in discussing obesity with families. Health services are seen as the main delivery partner for tackling childhood obesity albeit with cross sector, multidisciplinary working. If professionals do not feel equipped to deal with the stigma of raising obesity with families, then children suffer further. Training packages to deal with this, devised in consultation with families, need to be prioritised. There are other child health interventions that are equally sensitive where good practice models can be applied.
- Families do not tend to recognise overweight or obesity in their children or understand the health implications. If professionals find it difficult to raise the issue of child obesity, it is unsurprising that families fail to acknowledge it. There appear to be a number of reasons for families' inability to recognise their child's situation but other families are well placed to act as mentors and advocates for intervention programmes.
- There is poor uptake and high drop-out rates from current family-based interventions. There are a range of barriers to uptake and completion of interventions that are well documented if not comprehensively quantitatively researched. Again, children and families themselves are the best reliable resource for planning facilitators to engagement as well as considering examples of successful interventions.
- We do not know what works, although multi-component, holistic, tailored packages that involve adult family members appear to have some efficacy in the short term. All the available guidance and limited research base suggests that this is the best we have to offer for now. Bridging the gap between interventions and 'normal' life needs to be planned for. Options include longer interventions, follow up sessions, peer support and structural changes at community level to try and alleviate some obesogenic environmental factors.
- There is a small evidence base that engaging families in designing and developing the engagement process and service delivery may deliver better results in the short and longer term. For interventions to work effectively, all the key stakeholders must engage for them to succeed. This means that participants must be empowered and enabled to be agents of change for sustainable results.
- There is no evidence that family-based interventions, as they are currently structured, work in the longer term. While obesity has been an increasing problem, community and family-based interventions are relatively new and little researched. Any effective engagement must include robust evaluation and research, preferably participatory in nature.
- Structural factors, such as obesogenic environments, the food industry, and reduced public service budgets need to be taken into account for sustained weight loss and

management. These bigger issues impact directly on the lives of overweight and obese children and their families. They have causal influence on the problem itself, effective engagement and sustained outcomes. Resilience against these wider influences needs to be incorporated into interventions as part of the empowerment process.

- Other research areas can provide evidence of effective family engagement that will inform practice for weight management programmes. There is an enormous body of established good practice and research for engaging families for sustained successful outcomes. Social care, mental health and education services in the public, private and third sectors will be some of the delivery partners in holistic child obesity interventions. They and other partners can bring a wealth of experience to service commissioning and planning. The third sector particularly has long advocated for service user participation and has a track record in enabling and empowering individuals and communities.

BIBLIOGRAPHY

All-Party Parliamentary Group on a Fit and Healthy Childhood, (2014) **Healthy Patterns for Healthy Families: Removing the Hurdles to a Healthy Family.**

British Journal of General Practice, [Child obesity cut-offs as derived from parental perceptions: cross-sectional questionnaire](#). The Guardian, 30th March, 2015

Davison K., Jurkowski J., Kaigang L., Kranz S., and Lawson H. (2013) **A childhood obesity intervention developed by families for families: results from a pilot study.** International Journal of Behavioral Nutrition and Physical Activity, 10

Douglas F., Clark J., Craig L., Campbell J., and McNeill G. (2014) **'It's a balance of just getting things right': mothers' views about pre-school childhood obesity and obesity prevention in Scotland.** BMC Public Health, 14:1009

European Childhood Obesity Group, (2014) **24th Annual Congress: Congress Book.** Salzburg: ECOG

Fabian Commission on Food and Poverty, (2015) **A Recipe for Inequality: Why our food system is leaving low income households behind.** London: Fabian Society

Fagg J., Chadwick P., Cole T.J., Cummins S., Goldstein H., Lewis H., Morris S., Radley D., Sacher P., and Law C. (2014) **From trial to population: a study of a family-based community intervention for childhood overweight implemented at scale.** International Journal of Obesity, 38: 1343–1349

Fagg J., Cole T.J., Cummins S., et al (2014) **After the RCT: who comes to a family-based intervention for childhood overweight or obesity when it is implemented at scale in the community?** Journal of Epidemiology and Community Health, 10.1136/jech-2014-204155

Goodall J., and Vorhaus J. with Carpentieri J., Brooks G., Rodie Akerman R., and Harris, A. (2011) **Review of best practice in parental engagement.** Research Report DFE-RR156 (2011)

Institute of Public Care/Cwm Taf Public Health Team, (2014) **Report on the outcomes of the Joint Learning Set Workshops Child and Family Obesity.** Oxford: IPC

Jurkowski, J.M., Green, L.L., Mills, H.A., Lawson, M.C., Bovenzi, R.Q., Davison, K.K. (2013) **Engaging Low-Income Parents in Childhood Obesity Prevention from Start to Finish: A Case Study.** J Community Health, 38:1–11

King, L. et al. **Best practice principles for community-based obesity prevention: development, content and application.** Obesity Reviews, 2011, 12(5):329–38. I cited in WHO, 2012

Kipping, R., Howe, L.D., Jago, R., Campbell, R., Wells, S., Chittleborough, C.R., Mytton, J., Noble, S.M., Peters, T.J., Lawlor, D.A. (2014) **Effect of intervention aimed at increasing physical activity, reducing sedentary behaviour, and increasing fruit and vegetable**

consumption in children: Active for Life Year 5 (AFLY5) school based cluster randomised controlled trial. *BMJ*, 348:g3256

[Koerting J](#), [E. Smith](#), [M. M. Knowles](#), [S. Latter](#), [H. Elsey](#), [D. C. McCann](#), [M. Thompson](#), [Sonuga-Barke](#), E.J. (2013) **Barriers to, and facilitators of, parenting programmes for childhood behaviour problems: a qualitative synthesis of studies of parents and professionals' perceptions.** *European Child Adolescent Psychiatry*, 22(11): 653–670

Law C., Cole T., Cummins S., Fagg J., Morris S., Roberts H. (2014) **A pragmatic evaluation of a family-based intervention for childhood overweight and obesity.** *Public Health Research*, 2(5)

Lobstein T., Jackson-Leach, R., Moodie, M., Hall, K., Gortmaker, S., Swinburn, B., James, W., Wang, Y., McPherson, K. (2015) **Obesity 4 - Child and adolescent obesity: part of a bigger picture.** World Obesity Federation

Loureiroa, M., and Freudenberg, N. (2012) **Engaging municipalities in community capacity building for childhood obesity control in urban settings.** *Family Practice*, 29:i24–i30

Lucas P., Curtis-Tyler K., Arai L., et al. (2014) **What works in practice: user and provider perspectives on the acceptability, affordability, implementation, and impact of a family-based intervention for child overweight and obesity delivered at scale.** *BMC Public Health*, 14:614

Merry, M. S. (2012) **Paternalism, Obesity, and Tolerable Levels of Risk.** *Democracy and Education*, 20 (1), Article 3

National Assembly for Wales: Children Young People and Education Committee (2014a) **Inquiry into Childhood Obesity.** Cardiff: National Assembly for Wales
National Assembly for Wales: Preventing Childhood Obesity Steering Group: Final Report Effective Services for Vulnerable Groups Programme (2014b) **Turning the Curve on Childhood Obesity in Wales.** Cardiff: National Assembly for Wales

National Institute for Health and Care Excellence (2013) **Managing overweight and obesity among children and young people: lifestyle weight management services.** NICE Public Health Guidance 47

O'Mara-Eves A., Brunton G., McDaid D., Oliver S., Kavanagh J., Jamal F., et al (2013) **Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis.** *Public Health Res*, 1(4)

Peterson, B. A. (2012) **Maternalism as a Viable Alternative to the Risks Imposed by Paternalism. A Response to 'Paternalism, Obesity, and Tolerable Levels of Risk'.** *Democracy and Education*, 20 (1), Article 9

Randall J., Slater, M., Stewart, A., Pugh, G., Lewis, K., Levy, C., Alessandri-Gray, P. (2014) **The Effectiveness of Non-Surgical Weight Management Interventions for Obesity in the UK: A Review and Meta-Regression Analysis.** *Open Journal of Medical Psychology*, 3, 235-249

RCPCH (2012) **Position statement Childhood Obesity**. Royal College of Paediatrics and Child Health

Rees R., Caird J., Dickson K., Vigurs C., Thomas J. (2013) **The views of young people in the UK about obesity, body size, shape and weight: a systematic review**. London: Institute of Education

Stewart, R., Williams, R. (2013). **Evidence Review: Family-based weight management programmes**. Merthyr Tydfil: Cwm Taf Public Health Team

Twiddy M., Wilson, I., Bryant M., Rudolf, M. (2012) **Lessons learned from a family-focused weight management intervention for obese and overweight children**. Public Health Nutrition, 15(7), 1310-1317

Upton P., Taylor C., Erol R., Upton D. (2014) **Family-based childhood obesity interventions in the UK: a systematic review of published studies**. Community Practitioner, 87(5):25-9

Visram S., Hall, T.D., Geddes, L. (2012) **Getting the balance right: qualitative evaluation of a holistic weight management intervention to address childhood obesity**. Journal of Public Health, 9: (1–9)

Voigt, K. (2012) **Childhood Obesity and Restrictions of Parental Liberty. A Response to 'Paternalism, Obesity, and Tolerable Levels of Risk'**. Democracy and Education, 20(1), Article 8

Wang Y., Wu Y., Wilson R.F., Bleich S., Cheskin L., Weston C., Showell N., Fawole O., Lau B., Segal J. (2013) **Childhood Obesity Prevention Programs: Comparative Effectiveness Review and Meta-Analysis**. Comparative Effectiveness Review No. 115

Watson P.M., Dugdill L., Pickering K., Bostock S., Hargreaves J., Staniford L., Cable N. (2015) **Service evaluation of the GOALS family-based childhood obesity treatment intervention during the first 3 years of implementation**. BMJ Open, 5:e006519

WHO, (2012) **Population-based approaches to Childhood Obesity Prevention**. Geneva: World Health Organisation