University of Essex

Home-Start Essex Happy, Healthy, Connected Families Programme Evaluation

Final Report
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Institute of Public Health and Wellbeing
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We have a first-rate research profile, and our expertise include the application of psychology and sociology to real-world issues, participatory research and evidence-based practice. We draw upon the wide range of expertise within in the School of Health and Social Care as well as health researchers in other university departments including the Essex Business School, Economics Department, School of Sport, Rehabilitation and Exercise Science, and Mathematical Sciences.

Our staff include academics and clinicians with quantitative and qualitative expertise in a range of health and care related research areas including chronic illness; gerontology; health and clinical psychology; mental health; nursing; oral health; occupational therapy; physiotherapy; pharmacy; medical sociology; social exclusion; social policy; social work speech and language therapy; sport science; and substance abuse.

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Executive summary

The University of Essex were commissioned by Home-Start Essex (HSE) to evaluate the two-year Happy, Healthy, Connected Families (HHCF) project funded by a successful Essex County Council (ECC) Public Health Accelerator Bid (PHAB). The evaluation used a mixed method approach to assess the outcomes of the initiative amongst families and gain insight into the experience of the programme for families and the HSE delivery team. This report presents the overall findings of the two-year evaluation.

HHCF aims to improve the ongoing deterioration of parental and child mental health, evident amongst service users who engage with HSE services, by facilitating and empowering parents to develop confidence and resilience through early intervention. The type of service that the project offers will also likely inform favourable consequences for the physical health of families, children's mental health and behaviour, and community cohesion. As many of the struggles and overall sense of helplessness experienced by most families who engage with HSE services are associated with increasingly prevalent social issues such as poverty, social isolation, and the cost of living, the project directly engages with the social determinants of health. The project therefore also carries a more long-term potential to mitigate some of the detrimental impact that stark contemporary social conditions are likely to have upon the healthy development of those currently navigating childhood.

The report illustrates that:

- HHCF provides local families with sought-after services that are favourably received and, because of the way the services are structured, provide unintended yet unparalleled impacts that reach beyond the immediate aims of the project. In particular, first-time mothers who attended the MiM programme reported how aspects of the service met needs which NHS maternity services had left unfulfilled.
- The HHCF programme appears to achieve various physical, mental and overall wellbeing benefits for parents and their children, especially in comparison to more conventional and informal mother and baby groups. The fundamental mechanism which facilitates the fulfilment of such outcomes seems to be that all parents begin and end the programme at the same time and so move through the relevant topics and well-structured content as a collective.
- Parent experiences overwhelming support the public narrative that *nothing prepares you for parenthood*. It was within this context that mothers reported how essential and important the service was to them in the first three months following birth, adding significant quality to their everyday life and supporting with the expected yet sudden adjustment to becoming a mother. In particular, mothers were provided space to discuss and work through new understandings of 'alone time'.
- While information from various sources about becoming a new parent can be useful in preparing for parenthood, once situated within parenthood the amount of information available as well as conflicting expert advice becomes overwhelming. Through attending the MiM programme, parents were able to better navigate the plethora of parenting advice and were more confident that, most of the time, the

situated and specific knowledge they had developed about their own children was more useful than generalised information available elsewhere.

- The HHCF programme provides parents with vital practical support that immediately makes easier the organisation of everyday life. This included financing transport to sessions, meal preparation, establishing connections with other support services, and meeting other parents living nearby.
- The Behaviour Support element of the HHCF programme is unique in that some service users attend with intentions that diverge considerably from the aim of the programme, sometimes to the extent that service users are opposed to what the sessions seek to deliver. Although the Behaviour Support programme is the most popular aspect of the HHCF, the overall impact of the programme is likely constrained by service users who attend as a requirement to receive a neurodiversity diagnosis for their child with little interest in using the course content.
- The aim of attempting to instil more resilience in the most underprivileged population of parents was not achieved. In real terms, underprivileged parents are amongst the most resilient in UK society, especially within the current cost-of-living crisis.

Background Context

The Supporting Happy, Healthy, Connected Families (HHCF) project is an expanded and extended programme of family-focused health and wellbeing services designed and delivered by Home-Start Essex. The project was developed in response to increasing levels of need among families living in Mid, South and West Essex with young children, particularly in relation to parental mental health, social isolation, financial stress, and children's behavioural and developmental challenges.

The rationale for acquiring the funding for the HHCF project and expanding Home-Start Essex services included:

- A 14% increase in families supported by Home-Start Essex in 2023-24 compared with 2022-3 who also reported mental wellbeing needs, associated with confidence or isolation.
- A 21% increase for families reporting 'parenting skills' as a need during 2023-2024, creating a 4-month waiting list for the behaviour support programme, with 200 families added to the waiting list in the last year
- 15% of people aged 16-64 living in Essex with a common mental health disorder, which are likely to be higher post-pandemic and due to current cost of living pressures.
- Various wards in Basildon have between 33.8-39% of children living in poverty.
- In Braintree, 13.5% of households in Bocking North live in fuel poverty.
- In Toddbrook, Harlow, 26% of all households live in social housing, compared to 7% across Essex.
- In Pitsea North West, 29.4% of adults are classed as obese compared to the national average of 24.1%

As well as targeting these wards, the programme also looked to support families who have significant levels of need in surrounding areas more generally. This includes support with mental health, financial difficulties, living in poverty, poor housing, children and/or adults with neurodiversity, additional needs or behaviour that challenges, school readiness and engagement, isolation, domestic abuse and unpaid carers.

The expanded service provision aimed to improve parental and child health and wellbeing through early intervention, practical support, and enhanced social connection. The services were designed to address both immediate wellbeing needs and wider social determinants of health, with a particular focus on families living in areas of relative socio-economic deprivation. The provision covers four core service strands:

1) Behaviour Support: Delivered one-to-one and in group formats, supporting parents to better understand their children's behaviour and develop positive behaviour management strategies.

2) Healthy, Happy Families (HHF): Delivered one-to-one and in group formats, focusing on parental mental wellbeing, lifestyle factors, and barriers affecting family health, including finances, physical health, and social support.

3) Mothers in Mind (MiM): A perinatal mental health and wellbeing group supporting mothers experiencing mental health difficulties during the perinatal period, alongside play-based activities for pre-school children.

4) Family, Fitness and Fun (FFF): A group-based service for parents and pre-school children combining physical activity, healthy eating, and school-readiness activities in a supportive environment.

Evaluation Methods

Service level data

Routine service level (administrative) data were collected and reported monthly by HSE across the two-year period of the service delivery and immediately shared with the evaluation team. This data includes service reach, socio-demographic characteristics, and recorded personal circumstances. The data was collated by the evaluation team and summaries reported.

Family context and complexity

A comprehensive set of personal circumstances indicators was collected through routine service records to capture the complexity of families' lived contexts across the Supporting Happy, Healthy, Connected Families services. These indicators span a wide range of social, economic, health-related and contextual factors that are known to influence family wellbeing and engagement with support which were grouped into eight broad domains. Each domain reflects key dimensions of family life and context that are known to influence wellbeing, engagement with services, and the type or intensity of support required. The eight domains used in this evaluation are outlined below:

- **Family structure and caring responsibilities:** This domain includes lone parenthood, early parenthood, pregnancy or infants under 12 months, and primary or secondary caring responsibilities within the family.
- **Economic hardship and financial insecurity:** This domain includes indicators of low income, poverty, unemployment, debt, foodbank use and eligibility for targeted financial support.
- **Housing instability and living conditions:** This domain includes social or temporary housing, homelessness or risk of homelessness, overcrowding, poor or unsuitable living conditions, and residential instability.
- **Mental health needs:** This domain captures recorded mental health conditions and perinatal mental health needs among parents.
- **Psychosocial vulnerability**: This domain includes experiences of domestic abuse and substance or alcohol use disorder within the family.
- **Physical health problems:** This domain refer to physical health problems including presence of one or more of the following conditions: physical impairments, learning disabilities, neurodivergence, long-term health conditions and sensory impairments.
- **Access barriers**: This domain captures practical obstacles to service use, particularly transport-related difficulties.
- **Social exclusion**: This domain includes English not being a first language and asylum seeker or refugee status, reflecting broader structural marginalisation.

Personal circumstances data were recorded at the service level, and service user populations differ across the service strands. Accordingly, domain-level findings were calculated using ranges of observed prevalence within services, reflecting the lowest and highest proportions recorded across individual indicators within each domain.

In addition to the personal circumstances included within the eight thematic domains, a small number of additional indicators were collected through routine service records. These indicators were not incorporated into the domain framework as they were either child-specific in nature or had very low prevalence and limited interpretive value within the

context of the main analysis. These are school readiness which was identified as a child-focused indicator rather than a household-level circumstance. Similarly, indicators relating to a main family carer being in prison, offending behaviour within the family, and household membership of the armed forces were recorded for a very small number of service users.

Parent-reported outcomes

A quantitative repeated-measures design was used to assess changes in parental physical health, wellbeing, resilience, family functioning, parenting confidence, and lifestyle outcomes among participants in the Home-Start Essex Happy, Healthy, Connected Families programme. Parents were invited to complete an online baseline survey at the start of their engagement with Home-Start services and a follow-up survey approximately 3–6 months later. Each parent was assigned a unique identifier to allow matching of responses across timepoints.

This component of the evaluation consisted of:

1. A baseline cross-sectional dataset including all parents who completed the baseline survey;
2. A matched pre-post subsample of parents who provided data at both timepoints.

Measures and scoring

A set of validated quantitative measures, together with a small number of custom items developed for the programme, were used to assess changes in parental physical health, wellbeing, resilience, family functioning, parenting confidence, and Health-related knowledge, awareness, and behaviours. All measures were administered at baseline and again at follow-up for participants who completed both surveys.

1) Physical Health – WHOQOL-BREF Physical Health Domain

Physical health was assessed using five items from the physical health domain of the WHOQOL-BREF, covering pain, daily activities, sleep, energy, and need for medical treatment. For scoring, all items were rated on a 5-point Likert scale (1–5). Negatively worded items (physical pain and need for medical treatment) were reverse-scored so that higher scores indicated better physical health. Items were scored and transformed to a 0–100 scale following WHO scoring guidelines, with higher scores reflecting better physical health–related quality of life.

2) Wellbeing – WHO-5 Wellbeing Index

Subjective wellbeing was assessed using the WHO-5 Well-Being Index, a five-item scale measuring positive subjective well-being over the previous two weeks. Items are rated on a 6-point scale ranging from “At no time” (0) to “All of the time” (5), summed to produce a raw total (0–25) and multiplied by 4 to generate a 0–100 score, with higher scores indicating better wellbeing. Scores ≤50 were considered indicative of low well-being, in line with commonly used WHO-5 recommendations.

3) Resilience – Brief Resilience Scale (BRS)

Resilience was measured using the six-item Brief Resilience Scale, which assesses the ability to recover from stress. Three items are positively worded and three are negatively worded. Negatively worded items were reverse-scored and the final score computed as the mean of the six items (range 1–5), with higher scores indicating greater resilience. Scores were categorised into three levels in line with commonly used thresholds: low

resilience (mean score < 3.0), normal resilience (mean score 3.0–4.3), and high resilience (mean score > 4.3).

4) Family Functioning

Family functioning was assessed using five items. Three items were taken directly from the General Functioning subscale of the McMaster Family Assessment Device (FAD-GF), assessing core aspects of family communication, emotional expression, and mutual support. Two additional items were included to capture shared family interactions and positive communication practices, selected for their conceptual alignment with the FAD-GF construct and relevance to the programme context.

Responses were rated on a 4-point Likert scale ranging from strongly agree to strongly disagree. For ease of interpretation and consistency with other outcomes, all items were reverse-scored so that higher scores reflected more positive family functioning. A mean score across the five items was calculated (range 1–4), with higher scores indicating better overall family functioning.

5) *Parenting confidence*

Parenting confidence was assessed using two custom single-item self-report questions developed specifically for the evaluation. These items are not part of a validated standardised questionnaire. The first item measured perceived parenting competence, asking how often participants felt they had the skills and knowledge required to handle parenting challenges. The second item assessed confidence in accessing parenting support, asking how confident participants were in their ability to identify an appropriate resource or service if needed. Responses to the two items were treated as separate indicators and analysed at the item level. Responses were summarised descriptively using frequencies and percentages for each response category.

6) Health-related knowledge, awareness, and behaviours

A set of researcher-developed items was used to assess parental lifestyle behaviours and health-related knowledge and awareness relevant to the programme aims. These included domains such as nutritional awareness (e.g., knowledge of sugar content and food labels), understanding of caffeine and energy drink consumption, awareness of factors influencing mood (e.g., diet, alcohol), and practical aspects of healthy living (e.g., cooking skills, access to affordable food). Some items also captured health-related behaviours (e.g., monitoring caffeine intake, checking food labels). Responses to Likert-scale items were recorded on a 5-point scale ranging from strongly disagree (1) to strongly agree (5), with higher scores indicating greater agreement. Agreement with items reflects higher self-reported knowledge, awareness, or engagement in the specified behaviours, depending on the item. For ease of interpretation, responses were summarised using the proportion of participants who agreed or strongly agreed with each statement.

Physical activity was assessed using items adapted from the World Health Organization's Global Physical Activity Questionnaire (GPAQ). Participants reported engagement in vigorous- and moderate-intensity recreational (leisure-time) physical activities lasting at least 10 minutes continuously. For each intensity level, respondents indicated frequency (days per week) and duration (minutes per day).

Data preparation and analysis

Parent-report data were exported from Qualtrics into SPSS (Version 28). Prior to analysis, data were inspected for completeness, valid unique identifiers, and out-of-range values. Responses were retained only where the participant provided a valid client ID at both baseline and follow-up, enabling construction of a matched dataset for pre–post comparisons.

Descriptive statistics including means, standard deviations, median (IQR), ranges (min-max), and frequencies (percentage) were produced for the baseline dataset to characterise the sample and provide an overview of physical health, wellbeing, resilience, family functioning, parenting confidence and health-related knowledge, awareness, and behaviours at programme entry. Statistical comparisons of change over time were conducted only for participants who completed both baseline and follow-up surveys and provided valid matching identifiers.

For individual-level case-series analysis, change was categorised as “improved”, “no change”, or “deteriorated” using outcome-specific criteria. For the WHOQOL-BREF physical health domain and the WHO-5 Well-Being Index, a change of 10 points on the 0–100 scale was used to indicate meaningful improvement or deterioration, with changes within ±10 points classified as no change. This threshold was selected as a pragmatic indicator of meaningful change, consistent with commonly used distribution-based estimates (approximately 0.5 standard deviation) in quality of life and wellbeing research. For resilience, total scores were categorised into three levels in line with commonly used thresholds: low resilience (mean score < 3.0), normal resilience (mean score 3.0–4.3), and high resilience (mean score > 4.3). Individual-level change between baseline and follow-up was classified based on movement between these categories. An improvement was defined as a shift to a higher resilience category, deterioration as a shift to a lower category, and no change as remaining within the same category across time points. For family functioning, change was assessed using mean scores derived from items adapted from the General Functioning subscale of the McMaster Family Assessment Device, with improvement, deterioration, or no change defined by increases, decreases, or little/no change in mean score between time points.

For outcomes without validated cut-offs (parenting confidence, confidence in accessing parenting support services, physical activity, and health-related knowledge, awareness, and behaviours), change was assessed through direct comparison of baseline and follow-up responses at the individual level, with improvement or deterioration defined by movement towards more favourable or less favourable response categories, respectively. For the health-related knowledge, change was first determined separately for each of the ten constituent items by comparing baseline and follow-up responses. Each item was classified as improved, unchanged, or deteriorated based on response direction. An overall outcome-level change classification for each individual was then derived by considering the collective pattern of item-level changes across all ten items.

Interviews

The Home-Start Essex team manager put out expressions of interest for interviews along with contact details of the research team, so that those interested could get in touch to arrange an interview. After obtaining consent to participate, interviews were recorded and then transcribed and analysed using thematic analysis. A thematic coding framework was developed following familiarisation with the transcripts and broadly followed the interview guide. Prior to the interview, participants also completed a demographic survey. The

qualitative research involved in-depth one-to-one interviews with ten HSE professionals and nine parents (all mothers). HSE professionals interviewed included service managers, wellbeing, support and area coordinators, service delivery specialists, and volunteers. Demographics of interviewed service users are reported below.

Interviewee Demographics

Demographic		Frequency
Age	20-29 years	1
	30-39 years	8
Disability	Yes	2
	No	7
Level of Education	University	5
	Further Education	1
	School	
	Other	2
	N/A	1
Occupation	Managerial, Administrative, Professional	3
	Intermediate	1
	Routine, Manual	3
	SAHM	2
UK Postcode Area	CM7	1
	CM18	1
	CM20	2
	SS7	1
	SS8	2
	SS11	1
	SS15	1
Area of Residence	Urban	8
	Rural	1
Relationship Status	Married	6
	Cohabiting	1
	Divorced / Dissolved	1
	Single	1
Ethnicity	White British	6
	Filipino	1
	Polish	1
	Latin American	1
Religion	Christian	3
	Roman Catholic	1
	Catholic	1
	None	4

Ethics

Ethical approval was provided for all elements of the project by the University of Essex Ethics Sub Committee 1.

Survey Results and Analysis

Service reach and engagement

This section summarises routine service (administrative) data provided by Home-Start Essex via Excel reporting for the reporting period used in this report.

Across the reporting period, the expanded service provision supported a substantial number of families across multiple districts in Essex (Table 1). Families accessed support through one or more of the four service strands, reflecting the varied and often complex needs of the population served. Service uptake varied across the four strands:

- **Behaviour Support** accounted for the largest proportion of families supported during the reporting period (n=219), indicating high demand for support related to child behaviour and parenting challenges. Of these 168 families engaged in group-based behaviour support, while 51 families received one-to-one support.

- **Healthy, Happy Families** services also supported a substantial number of families (n=84), engagement across group delivery and one-to-one support were 51 and 33 families, respectively.

- **Mothers in Mind** engaged a smaller number (n=31) but highly specific group of mothers with perinatal mental health needs, consistent with the targeted nature of this service.

- **Family, Fitness and Fun** supported 47 families seeking opportunities to improve physical activity, healthy eating, and early childhood development in a group setting.

Table 1. Number of families supported by service strand across reporting periods

	1/9/24 to 31/3/25	1/4/25 to 31/1/26	Total
Family: Behavioural Specialist 1:1	13	38	51
Family: Behavioural Specialist Workshop	53	115	168
Family: Wellbeing Group	19	32	51
Family: Wellbeing 1:1	12	21	33
Family: MiMs Groups	12	19	31
Family: Fitness And Fun	16	31	47

Socio-demographic distribution by service

A detailed breakdown of the demographic characteristics of families supported, including age, gender, ethnicity, and area-level deprivation, is presented in Table 2.

Across all services, most parents supported were aged 25–44 years, reflecting the primary parenting age group for families with young children. Smaller proportions of service users were aged under 25 or aged 45 years and over, with minimal variation across service types. A small number of cases had age not recorded.

The services were attended predominantly by women, with particularly pronounced gender concentration in Mothers in Mind, which exclusively engaged female participants, consistent with its perinatal mental health focus. Very small numbers of male participants

were recorded in Behaviour Support and Healthy, Happy Families services, while no male participants were recorded in Mothers in Mind or Family, Fitness and Fun.

Table 2. Socio-demographic characteristics of service users by service

	Behaviour Support		Healthy, Happy Families (HHF)		Mothers in Mind (MiM) (n=31)	Family, Fitness & Fun (FF&F) (n=47)
	One-to-one (n=51)	Group (n=168)	One-to-one (n=33)	Group (n=51)		
Age groups (years)						
- 18-24	6(11.8%)	9(5.3%)	4(12.1%)	5(9.8%)	3(9.7%)	0(0.0%)
- 25-34	20(39.2%)	84(50.0%)	8(24.2%)	24(47.1%)	18(58.1%)	23(48.9%)
- 35-44	23(45.1%)	65(38.7%)	18(54.6%)	17(33.3%)	9(29.0%)	24(51.1%)
- ≥ 45	0(0.0%)	4(2.4%)	2(6.1%)	2(3.9%)	0(0.0%)	0(0.0%)
- Not recorded	2(3.9%)	6(3.6%)	1(3.0%)	3(5.9%)	1(3.2%)	0(0.0%)
Gender						
- Female	50(98.0%)	63(97.0%)	32(97.0%)	51(100%)	31(100%)	47(100%)
- Male	1(2.0%)	3(1.8%)	1(3.0%)	0(0.0%)	0(0.0%)	0(0.0%)
- Prefer not to say	0(0.0%)	2(1.2%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)
Ethnicity						
- White	46(90.2%)	142(84.5%)	28(84.8%)	31(60.8%)	24(77.4%)	36(76.6%)
- Asian/Asian British	3(5.8%)	5(3.0%)	2(6.1%)	1(2.0%)	3(9.7%)	3(6.4%)
- Black/Black British	0(0.0%)	12(7.1%)	1(3.0%)	12(23.5%)	2(6.5%)	4(8.5%)
- Mixed/Multiple ethnic groups	1(2.0%)	6(3.6%)	2(6.1%)	2(3.9%)	1(3.2%)	4(8.5%)
- Other	1(2.0%)	3(1.8%)	0(0.0%)	4(7.8%)	0(0.0%)	0(0.0%)
- Prefer not to say/Not recorded	0(0.0%)	0(0.0%)	0(0.0%)	1(2.0%)	1(3.2%)	0(0.0%)
Deprivation						
- Most deprived areas	31(60.8%)	120(71.4%)	20(60.6%)	43(86.0%)	23(74.2%)	39(83.0%)
- Least deprived areas	20(39.2%)	48(28.6%)	13(39.4%)	7(14.0%)	8(25.8%)	8(17.0%)

In terms of ethnicity, the majority of families supported across all services identified as White, with representation from Black, Asian and minority ethnic communities observed across each service strand. Although numbers within individual ethnic minority groups

were small, the presence of ethnic diversity across services suggests that the provision was accessible to families from a range of backgrounds.

A key feature of the population served was the high proportion of families living in the most deprived areas. Across all services, between approximately 60% and 86% of families were resident in the most deprived areas, with particularly high representation in group-based Healthy, Happy Families and Family, Fitness and Fun services. This indicates that the expanded service offers successfully reached families experiencing higher levels of socio-economic disadvantage, consistent with the project's objectives to address health inequalities.

Family context and complexity

Table 3 presents the prevalence of individual indicators within each personal-circumstance domain across services. Most domains included in this section comprise multiple indicators reflecting different aspects of family circumstances. For these domains, the table reports the maximum observed prevalence across component indicators to summarise the upper extent of recorded need at the service level. In contrast, the domains Physical health problems and Access barriers each draw on a single core indicator, for which additional detail was collected only following a positive response. As a result, these two domains are presented using single percentage estimates rather than domain-level maxima.

Table 3. Personal circumstances of service users across different services

	Behaviour Support		**Healthy, Happy Families (HHF)**		**Mothers in Mind (MiM)** (n=31)	**Family, Fitness & Fun (FF&F)** (n=47)
	One-to-one (n=51)	Group (n=168)	One-to-one (n=33)	Group (n=51)		
Family structure & caring responsibilities	44.2%	41.6%	51.5%	45.1%	66.7%	47.8%
Economic hardship & financial insecurity	45.7%	54.3%	36.4%	61.7%	65.2%	33.3%
Housing instability & living conditions	49.0%	46.4%	45.5%	52.0%	23.3%	19.1%
Mental health needs	60.8%	44.9%	65.6%	70.0%	77.4%	30.0%
Psychosocial vulnerability	21.6%	20.8%	27.3%	40.8%	20.0%	17.0%
Physical health problems	53.3%	37.6%	42.4%	59.6%	67.7%	10.9%
Access barriers	16.0%	16.8%	24.2%	38.0%	19.4%	2.2%
Social exclusion	9.1%	14.6%	9.1%	30.4%	6.5%	60.9%

Percentages shown represent service-level values based on recorded responses for both time periods. For domains comprising multiple indicators, values reflect the highest proportion observed for any single indicator within that domain. Physical health problems and access barriers are reported as single percentages, as each is based on a single indicator with conditional follow-up questions.

Overall, the findings indicate relatively high complexity, with different types of challenges faced by families using HomeStart services. Families frequently experienced multiple,

overlapping challenges spanning structural, economic, health-related, and social domains, rather than presenting with a single isolated need. The highest observed levels were generally seen for indicators relating to economic hardship, housing instability, and mental health needs, highlighting these as common features of the contexts in which families accessed support. Physical health problems were also prevalent across services and often co-occurred alongside these core challenges.

Indicators of psychosocial vulnerability, access barriers, and social exclusion were also present within services, although at lower frequency. While these indicators were not uniformly observed across all service users, their presence points to additional layers of need among some individuals engaging with support.

Parent-reported outcomes

A total of 54 parents completed the baseline survey at the start of their engagement with Home-Start Essex services. A total of 24 parents completed the follow-up survey approximately 3–6 months later, of whom 13 provided valid matched pre-post data based on unique participant identifiers. This subsample of 13 matched cases forms the basis of the change analyses.

Socio-demographic characteristics of survey participants

Table 4 presents the socio-demographic characteristics of parents who completed the online survey at baseline and at follow-up. At baseline, educational attainment varied across respondents, with over half reporting college-level education (54.7%), alongside representation from participants with secondary, vocational and graduate or professional qualifications. The follow-up sample showed a higher proportion of respondents reporting graduate or professional qualifications (53.8%).

In terms of employment status, just under half of baseline respondents reporting being unemployed and around one-third were in employment at the time of survey completion. Smaller proportions reported being self-employed, students, or categorised their status as other. Among follow-up respondents, more than half were unemployed (53.8%) and the remaining were employed (46.2%).

Geographical information based on partial postcode areas indicates that survey participants were drawn primarily South and Mid Essex, with some representation from adjacent London fringe and North Essex areas. At baseline, over half of respondents were located in Southend-on-Sea and surrounding areas, with further representation from Chelmsford and Mid Essex, Ilford/East London, the Enfield/North London fringe, Basildon, and the Colchester area. A comparable geographical pattern was observed at follow-up, with the majority of respondents again residing in Southend-on-Sea and surrounding areas, alongside continued representation from Chelmsford and Mid Essex and Ilford/East London.

Table 4. Socio demographic characteristics of study participants at baseline (n=54) and matched follow-up (n=13)

Variable	Baseline	Follow-up
Education	**(n=53)**	**(n=13)**
- None or Primary school	2(3.8%)	1(7.7%)
- Secondary school	8(15.1%)	0(0.0%)
- Vocational school	3(5.7%)	0(0.0%)

- College	29(54.7%)	4(30.8%)
- Graduate/Professional degree	10(18.8%)	7(53.8%)
- Prefer not to say	1(1.9%)	1(7.7%)
Employment status	**(n=54)**	**(n=13)**
- Employed	17(31.5%)	6(46.2%)
- Self-employed	4(7.4%)	0(0.0%)
- Unemployed	26(48.1%)	7(53.8%)
- Student	3(5.6%)	0(0.0%)
- Other	4(7.4%)	0(0.0%)
Postcode area	**(n=50)**	**(n=13)**
- Basildon (SS14, SS15)	2(4.0%)	0(0.0%)
- Chelmsford & Mid Essex (CM1, CM2, CM3, CM8)	11(22.0%)	4(30.8%)
- Colchester area (CO5)	1(2.0%)	0(0.0%)
- Enfield/North London fringe (EN9)	3(6.0%)	0(0.0%)
- Ilford/East London (IG1, IG7, IG10)	6(12.0%)	1(7.7%)
- Southend-on-Sea/South Essex (SS1, SS4, SS7, SS8)	27(54.0%)	8(61.5%)

Characteristics of survey participants completed baseline survey

Table 5 presents baseline descriptive statistics for physical health, wellbeing, resilience, and family functioning among parents completing the baseline survey (n=54). Mean physical health scores indicated moderate levels of physical health–related quality of life at programme entry. In contrast, mean wellbeing scores were comparatively low, with substantial variability across participants. Mean resilience scores fell predominantly within the low to normal range, indicating limited perceived ability to bounce back from stress for many parents at baseline. Family functioning scores were generally high on the adapted 1–4 scale, suggesting relatively positive perceptions of family relationships and communication at programme entry, albeit with notable variation across respondents.

Table 5. Baseline descriptive statistics for physical health, wellbeing, resilience, and family functioning measures

	Scale range	Mean (SD)	Median (IQR)	Min-Max
Physical health total score (n=54)	0-100	64.3±18.8	65(20)	10-100
Wellbeing total score (n=53)	0-100	45.7±22.5	44(40)	8-100
Resilience totals core (n=54)	1-5	2.84±0.76	3(1)	1-4.67
Family functioning totals core (n=54)	1-4	3.12±0.60	3.2(1.0)	1.8-4.0

Baseline distributions of key wellbeing risks, resilience categories, parenting confidence, physical activity engagement, and health-related knowledge, awareness, and behaviours are presented in Table 6. Over half of respondents were classified as being at risk of low wellbeing at baseline based on WHO-5 scores, highlighting the high level of mental wellbeing need among families entering the programme. Nearly half of parents were categorised as having low resilience, with very few demonstrating high resilience at programme entry. Parenting confidence levels showed that most respondents reported feeling confident either always or most of the time; however, a substantial proportion reported only sometimes feeling confident, indicating scope for improvement. Engagement

in leisure-time physical activity was low, particularly at vigorous intensity. Baseline health-related knowledge and awareness varied by domain, with high awareness observed for alcohol and energy drink effects, but lower levels of knowledge and behavioural engagement relating to food labelling and added sugars.

Table 6. Baseline distributions of risk of low wellbeing, resilience status, parenting confidence, physical activity levels and health-related knowledge, awareness, and behaviours

	Frequency (%)
Risk of low wellbeing (n=53)	31(58.5%)
Resilience (n=54)	
- Low resilience	26(48.1%)
- Normal resilience	27(50.0%)
- High resilience	1(1.9%)
Perceived parenting competence (n=54)	
- Always	3(5.6%)
- Most of the time	28(51.8%)
- Sometimes	20(37.0%)
- Rarely	3(5.6%)
- Never	0(0.0%)
Confidence in accessing parenting support services (n=54)	
- Very confident	11(20.4%)
- Somewhat confident	21(38.9%)
- Neutral	12(22.2%)
- Not very confident	9(16.7%)
- Not at all confident	1(1.8%)
Leisure time physical activity	
- Any moderate-intensity physical activity (Yes)	15(27.8%)
- Any vigorous-intensity physical activity (Yes)	5(9.2%)
Health-related knowledge, awareness, and behaviours	
- Awareness of anxiety management techniques (Strongly agree/agree) (n=53)	30(56.5%)
- Awareness of caffeine effects on mood (Strongly agree/agree) (n=53)	37(69.8%)
- Caffeine intake self-monitoring (Strongly agree/agree) (n=53)	38(71.7%)
- Awareness of alcohol effects on mood (Strongly agree/agree) (n=52)	49(94.2%)
- Awareness of energy drink risks and reduction strategies (Strongly agree/agree) (n=52)	48(92.3%)
- Awareness of food effects on mood and energy (Strongly agree/agree) (n=52)	38(73.1%)
- Knowledge and ability to identify added sugars in food products (Strongly agree/agree) (n=52)	22(42.3%)
- Checking food label for added sugars (Strongly agree/agree) (n=51)	15(29.4%)
- Awareness of healthy cooking methods and meal preparation (Strongly agree/agree) (n=53)	42(79.2%)
- Awareness of access to affordable healthy food options (Strongly agree/agree) (n=53)	32(60.4%)

Baseline physical activity is reported as the proportion of participants engaging in any moderate or vigorous leisure-time activity due to small numbers and missing data on number of the day and duration. For health-related knowledge, awareness and behaviours items, percentages represent the proportion of respondents selecting “Agree” or “Strongly agree” for each item

Individual-level changes at follow-up

Table 7 presents individual-level changes at follow-up for the 13 participants with matched baseline and follow-up questionnaire data. Patterns of change varied across participants and outcome measures, reflecting the heterogeneity of experiences and needs among families engaged with the programme. Improvements were most frequently observed for wellbeing, family functioning, and health-related knowledge, awareness, and behaviours, while resilience tended to remain stable for most participants.

Changes in parenting confidence and confidence in accessing support services showed mixed patterns, with some individuals demonstrating improvement alongside others experiencing deterioration or no change. Physical health and physical activity levels were more commonly characterised by stability rather than marked change over the follow-up period. Overall, the case-series findings suggest that while change trajectories differed across individuals and outcomes, positive shifts were evident for several parents across psychosocial and family-related domains.

Perceived programme impact at follow-up

At follow-up, additional questions were included to capture parents’ perceived impact of the programme on family physical activity levels and overall wellbeing linked to nutritional information provided. For perceived changes in family physical activity (n=12), only a small proportion of respondents agreed that average physical activity levels had increased (n=2), while the majority reported neutral responses (n=6) and a smaller number disagreed (n=4). This suggests limited perceived change in family physical activity over the follow-up period. In relation to the perceived impact of nutritional information on overall family wellbeing (n=12), a small number of respondents reported agreement (n=3), while most selected neutral responses (n=7) and a smaller number disagreed (n=2). These findings indicate that while some parents perceived benefits from nutritional information provided, changes in perceived overall family wellbeing were modest within the timeframe assessed.

Table 7. Individual-Level Case-Series Summary for Matched Participants

	Physical health	Wellbeing	Resilience	Family functioning	Perceived parenting competence	Confidence in accessing parenting support services	Physical activity	Health-related knowledge, awareness, and behaviours
A	No change	Deteriorated	No change	No change	No change	No change	No change	Deteriorated
B	No change	No change	No change	Deteriorated	No change	No change	No change	Improved
C	No change	Improved	No change	Improved	No change	No change	No change	Deteriorated
D	Improved	Improved	No change	Improved	Improved	Improved	No change	Improved
E	No change	Improved	-	-	-	-	Deteriorated	-
F	No change	Deteriorated	No change	Improved	Deteriorated	No change	No change	Deteriorated
G	No change	Improved	No change	Improved	No change	Deteriorated	No change	Improved
H	No change	No change	No change	Improved	Deteriorated	Deteriorated	No change	Improved
I	Deteriorated	No change	No change	Deteriorated	No change	Improved	No change	No change
J	No change	Deteriorated	No change	Improved	Deteriorated	Deteriorated	No change	Improved
K	Improved	Improved	No change	Improved	Improved	No change	Improved	Improved
L	No change	No change	No change	Deteriorated	Deteriorated	No change	No change	Improved
M	No change	Improved	No change	Deteriorated	Deteriorated	Deteriorated	No change	Improved

(-) Indicates missing data for that outcome

Parental and Professional Perspectives

Interviews were conducted with nine mothers who engaged with one or more support services (MiM, Behaviour Support, FFF and HHP) and ten professionals involved in the planning or delivery of the services.

Themes generated from interviews with mothers were:

- **Going 'through it together' and starting at the same time**
- **Respite from a broken and isolating three months**
- **Support with navigating a new understanding of 'alone' time**
- **Beyond educating and encouraging: scrutinising 'expert' parenting advice against situated knowledge**
- **Feeling part of a supportive structure: the reassurance of 'knowing they are there'**

Themes crafted from interviews with HSE professionals were:

- **Practical support for the social needs of families under strain**
- **Working toward serving targeted populations and unexpectedly covering gaps in maternity service provision**
- **Restricted liberation: legitimating the control of children while trivialising the resilience of underprivileged parents**
- **Providing parenting advice and negotiating 'I've tried everything' narratives**

Parent interviews

Analysis of semi-structured interviews with nine service users, all of whom were mothers, generated five over-arching themes of the impact that attending HHCF sessions had upon mothers and their everyday family lives. For the reason of anonymity, pseudonyms are used to present the data provided by interviewees.

The themes are:

- Going 'through it together' and starting at the same time
- Respite from a broken and isolating three months
- Support with navigating a new understanding of 'alone' time
- Beyond educating and encouraging: scrutinising 'expert' parenting advice against situated knowledge
- Feeling part of a supportive structure: the reassurance of 'knowing they are there'

Going 'through it together' and starting at the same time

All mothers, especially those who had given birth to their first child in the past few months, cited how valuable the HHCF sessions had been in meeting and sharing their experiences with other mothers in a similar position,

> I didn't really know anyone else on the island… and now I know seven or eight mums… I have to get out and about, but… not really knowing anyone that's in the same boat at the same time as you… because you can have all these friends but if you've got no-one to actually support you… it's nice that you all go through it together. (Vicky)

As well as the common ground of navigating parenthood together, central to feeling comfortable with sharing stories about more challenging aspects of parenting, the interaction and open structure of sessions helped to normalise the difficulties and frustrations of becoming and being a mother,

> With this group… it's like you can get your frustrations out about being a new mom or how difficult it is, because they're moms… they don't make you feel like it's odd to have difficulties with being a mom. But yeah, there are similar grounds to work on. So, you're not scared to share your own experience with them. You don't get that judgement. (Grace)

The openness of sessions and the authentic discussions that developed offered a welcome contrast from trying to conform to the widespread ideal that motherhood should be a paradise, while often hiding their isolating struggles,

> I've got a few good groups of friends, but I don't know, in this day and age, people don't want to like express if they're like finding it hard or that they feel lonely or whatnot because everyone's just like, 'oh yeah, motherhood's great'… you just have fun and have a laugh… but when you go to a group like this, it's kind of already out in the open that all the mums are there because they're

> struggling. Like that's the reason that you sign up for it. So there's no hiding it when you first start… other people were talking about it. So it made you feel like it wasn't so much of a secret and it wasn't so much that you needed to hide… it made you feel less alone. (Emily)

Alongside feeling safe to speak openly about parenthood and the endless challenges of motherhood, disclosing these experiences to fellow mothers tasked with navigating the care of young children also had a cathartic function,

> It's really nice just to vent a bit. You know, like your struggles… so it's good, with people that are also going through the same because a lot of the babies are the same age. So we can share things and see that we are kind of holding it together rather than on my own. (Reena)

> It just gives you that hour out of the day or out of the week, really, to sort of sit and chill and vent with people that get it and people that are like you because motherhood's hard anyway. (Emily)

Unwanted judgements about parenting practices, which HHCF sessions provided refuge from, had been encountered by mothers from various sources, ranging from strangers to family members and friends,

> As soon as I could see it was a judgement free zone, it was like, nice because, you know, everyone was going through similar sorts of things. So you could talk about things without feeling like people are watching. (Poppy)

When attending HHCF sessions, and away from the anxieties of constantly feeling judged, mothers also enjoyed the freedom of feeling comfortable while breastfeeding in the presence of others,

> One of the ladies basically just breastfeeds in front of you… you know, it's very open to that extent that there's no judgement. 'I'm feeding my kid' kind of a thing. But if you did that in public, you still get that judgement of 'why are you doing it here?' (Grace)

The deeply supportive environment constructed by both HSE staff and service users themselves also unintentionally gave some of the mothers the opportunity to open-up about complications during birth, which they had yet to discuss at length with anyone other than their partner. For at least one of the mothers, such discussions were transformative, and resulted in her no longer blaming herself for the traumatic events at the hospital,

> Basically, I have defects and they left part of my placenta in… I blamed myself for a very long time… it was nice to reflect… and I think it made me recognise how strong my body was and that I was thankful that we've got through it… it made me recognise that it wasn't my fault. (Simone)

Mothers also made the most of the safe space to discuss the experience of giving birth more generally. For Grace, HHCF sessions were the only space where she felt the process of giving birth combined with the expectation to immediately start caring for a child was properly acknowledged as being traumatic and unmanageable,

> For women, you don't get that much back… even if you elaborate how painful your body is from recovering the trauma that you've been through during the labour, or how you feel isolated. Other people outside the box don't understand the extent that it can go… you basically have to deal with that trauma while you're dealing with your child. It's kind of like difficult to balance it… I tried to explain to the receptionist at the GP… But yeah, if you have mums in one place, who've been through labour and that recovery phase as well… their experiences of how they got from A to B, I think are quite beneficial to hear. It helps you to survive.

Some mothers also provided useful insight into why they felt HHCF support sessions offered by HSE maintained a safer psychological environment and greater sense of community compared to other parenting groups they had previously attended. Although some of the topics covered in HHCF sessions were similar to other parental support programmes they had engaged with, mothers felt the collective spirit was easier to maintain, as everyone starts the programme at the same time and moves through the weekly schedule together,

> When I come out [of hospital] I had no mum friends, and what was nice, although I only started in the second week, we all sort of started at the same time. We all got to know each other over those 10 weeks, whereas other groups you attended, [it's] very much everyone starts at different times, and it can be a little bit tricky. (Simone)

Such was the camaraderie developed within both MiM and FFF sessions, that groups tend to stay in touch to continue to support one another through motherhood,

> It was a 10-week rolling programme. We had our last one to two weeks ago. We all got on and I actually organised a little WhatsApp group. So, I've got all the mums' numbers, and we've got a little group which is lovely… it's nice to sort of keep that support. (Simone)

Respite from a broken and isolating three months

All mothers also referred to the role played by HHCF sessions in reducing their sense of isolation by providing an immediate sense of purpose that was located outside of the house,

> In the morning, we always have problems… getting up from bed… then organising breakfast… but when you have like an appointment… it's good and easier… as you know there will be something good happening in that time when you're out of the house. It's good for your mental health… [you're] not just sitting at home and crying because of something. (Madison)

Again, the extent of the benefits of the programme were most pronounced amongst new mothers while they underwent abrupt identity adjustment,

> You feel less isolated ‘cause the very first three months is very difficult. You're on your own, you're scared to go out because you don't know how to go out with a newborn... so, it offers you that sort of like social group and having adult conversations, not just watch[ing] nursery rhyme TV. It makes you look forward to something… it repurposes you on a weekly basis… there are dark sides of, like, you know, motherhood… ‘cause you still have the trauma to deal with mentally, and then you've got the physical side of it to recover while looking after someone. There might be instances of identity being lost because you basically stop your career and just be a mom to look after a new human being… you kind of lost your self-identity in the process, but at the same time, when you’ve got this social group, it kind of helps you to look after yourself again. (Grace)

The time-period of ‘the first three months’ was frequently cited by most of the mothers as especially isolating. Accordingly, mothers conceived of the first three months following birth as the stretch of time during which support from HSE programmes had been most needed and powerful,

> It’s (HHCF) basically like how to survive the first three months… like what to eat if you're breastfeeding… sleep regression… and what to look forward to… basically how to survive… it's like a survival kit. (Grace)

Even for new mothers who had spent extensive time reading and preparing for parenting, engaging with HSE’s programmes in tandem with caring for a newborn was appraised as being crucial to supporting with the transition and highly recommended,

> The fact this service is there is a huge help because you can read as much as you want to, but I don't think you will ever kind of… until you've had that experience, you will never be able to comprehend how it will change your life. (Vicky)

Overall, following the initial struggles of giving birth and becoming responsible for the care of another human and how together these factors created a largely isolating context, sustained involvement with HHCF sessions gradually reinvigorated the excitement about being a parent that had developed throughout pregnancy,

> You have your labour and basically like part of you dies in the hospital and then part of you evolves after a few days because you have to, not because you want to… you become more excited about being a mom and in a way, it clears up your head. It's like the light at the end of the tunnel… you go there, you're kind of broken, but they fix you. (Grace)

Little else highlighted the desperation expressed by some mothers for some form of support following their disturbing birth experiences than disclosing that the HSE sessions were the first time they had been given the opportunity to discuss their harrowing memories and recollections with anyone other than their partner,

> Because of the [extreme] trauma I had, it was so easy just to forget about it. Push it away and not deal with it… It was nice to kind of go ‘actually, no, you’ve got this, you’re OK, you’re strong’. (Simone)

In Simone's case, she is due to access further support from the NHS to re-visit and start to process her birth experiences. However, due to the stress of also going through the official complaints process and having to wait a few months post-pregnancy before being able to access the service, she was yet to have the opportunity to talk with anyone in a professional setting tailored to her current frame of mind.

> I was meant to do birth reflections, but it got cancelled because I'm going through complaints and to see through everything that happened, but one of the girls in the group had her birth reflections and was really anxious about it one week. And I really felt for her 'cause that is something I've wanted, but also didn't want because it brings back all the trauma. But I spoke with her the week after and she was saying how helpful she found it. I think having watched her experience, as and when I do go forward for it, I won't be as anxious.

Consequently, HSE sessions, and MiM in particular, meet a need that is not comprehensively provided by NHS services, with a willingness and the professional capacity to offer a forum for highly sensitive discussions about birth experiences as soon as mothers themselves decide they are comfortable to do so. MiM sessions are also person-centred, and so HSE professionals are comfortable with viewing birth experiences and the adjustment to parenting as part of the same process, rather than trying to clinically separate the maternal self.

Support with navigating a new understanding of 'alone' time

As well as support with the sudden isolation of mothering a newborn and contemplating birthing experiences, mothers reported that HHCF programmes were helpful in establishing some boundaries between the intensive demands of caring for a newborn and scheduling some time to take care of oneself,

> Just to sort of sit there and have someone else look after and watch her… then I could just sit there and switch off. That was very helpful, what I needed at the time… not to worry about anything and just have your time and that's it. (Vicky)

The very structure of the sessions was important in this regard, as childcare was provided, which also meant new parents had to 'put children to one side' for the first time.

> At first, I was scared to just leave her on one side and then do something for myself… like every time that she cries, they're like, 'don't worry about it', you know? And then (HSE professional) comes and says, 'give her a toy', and then you kind of feel like settled and, 'OK, I can just carry on and do my workout'. It offers you a safe place to go back to being you… you can turn off your mom hat a little bit and then you can look after you. (Grace)

FFF sessions in particular, offered a setting where mothers could participate in a leisure activity to primarily benefit themselves, while knowing that their child was cared for and

safe, but they could also quickly check on their child if they wanted to without leaving the class,

> I love it because with [child's name redacted], it's very difficult to fit in any exercise. So that's kind of like my only exercise for the week. And it's just nice that it's targeted to mums and I can take [child's name redacted] with me as well. So, yeah, I really love it. (Reena)

In these ways, the environment provided at FFF sessions was especially conducive to supporting new mothers with transitioning into their new identities in a way that also encouraged them to find some time to look after themselves,

> I leave the place very like happy and energised because obviously doing exercise sort of gives you that dopamine hit… it's a moment for me… I struggle with mental health issues, so it's also very good on that front because I'm doing something for me. Rather than… I will always be doing something for [child's name redacted] when we're in the house. (Reena)

However, mothers were still in the process of adjusting to the idea of taking the time to look after oneself and 'switch off', as although children may have been out of sight, they were never out of mind. For first-time mothers, this new and unrelenting responsibility was central to some of the comments made about 'alone' time. In one way, mothers reported feeling as though they were 'stuck at home alone' for long periods when with the baby, but when they did experience some valuable time away from their baby, most of this time was spent thinking about the baby. Mothers explained how the HHCF sessions enabled them to familiarise themselves and reflect on feeling alone when with the baby but then struggling to think about anything but the baby when apart from them, and actually alone,

> Obviously, you're a mom. You can't really go back to not being a mom and it's like there's no refund, you know? So, in a way they (HSE) give you an insight of how to be a mom and how to look after them. You're not alone 'cause you have assistance (from HSE), but at the same time you can never have that sort of real alone time. (Grace)

Mothers also felt that the childcare provided by HSE as part of the sessions was instrumental in developing their child's confidence with being apart from them, while also encouraging children to explore and learn to play with one another,

> I took my little boy to the group. At first, he was really upset. And like he kept following me around the room all the time, but then the second time I went, he got better, and he left my side and started playing. And that's how the group helped him. (Gina)

Mothers suggested that attending the sessions also carried subsequent benefits for their partners, by providing an additional outlet for mothers to release their frustrations,

> Your husband is dealing with that stress level that you have… and because there is another way for you to be able to let the frustration out by exercising or having safe people to talk to… to give you more information how to deal with

> that stage of your life or transition. I think it's quite essential to have that sort of group, to have someone else you can vent things to. (Grace)

For Simone, the journalling exercises that HSE staff facilitated provided a further method for organising and unloading her thoughts, and a practice that she associated with directly improving the quality of the relationship with her partner, to better express herself,

> So I've come home, I've spoken to my partner, [name redacted]… because the other night I couldn't sleep, so I actually came downstairs and did a bit of journalling and then he came downstairs and he was like, 'oh, why couldn't you sleep?', and I thought, 'show him the journal to explain to him why'… by journalling I was able to sort of work through what I was worried about and could talk it through with [name redacted]. Before I probably would have had a meltdown and end up in tears or in anger… I wouldn't have been able to communicate that with [name redacted]. I've got more confident as a mum, and I guess more relaxed.

Beyond educating and encouraging: scrutinising 'expert' parenting advice against situated knowledge

Parents also drew attention to the range of information provided by the HHCF sessions on a variety of topics conducive to the care and wellbeing of their children. However, this is also brought about some quandaries and dilemmas for mothers, as with a plethora of information already widely accessible, it was difficult to distinguish which information was more of a priority and worth acting upon. The person-centred and context specific support provided by HSE staff during sessions meant that mothers left the programme with a greater sense of self-assurance when presented with generic and idealistic expert advice about how they should care for their child,

> It's had a massive impact, to be honest. It's made me feel a lot calmer about sort of the whole parenting thing… with all the information and things you should and shouldn't do and with everything with illnesses with food and with breastfeeding and things like that. There's so much information out there and it's hard to differentiate between the right and the wrong, it (the MiM programme) gave me the outlook that… whatever you're doing, it's fine. (Vicky)

Again, further reassurance was also provided during the sessions by other mothers in attendance,

> I was trying to do the baby-led weaning and things like that, and it gets to a point now where I see these groups and they're like, 'oh, like my baby doesn't eat this and doesn't eat fruit' and things like that… really, as long as you're taking care of the child, it doesn't need anything else... As long as it's surviving it's absolutely fine. It (the MiM programme) very much kind of reassured me… with conversations that I had with the other parents… It is what it is, you just muddle through, no-one knows everything. (Vicky)

The practical outlook and context sensitive type of support offered to mothers at HHCF sessions was best highlighted by Grace, who emphasised that significantly more was offered by HSE beyond, and in addition to, encouragement and education,

> I remember when I first joined, she (HSE staff member) was giving away air fryers for new moms… you know, to help you to eat healthily, but at the same time, it cuts that bottleneck of not being able to prepare meals, especially if you're on your own at home and your partner is working. It breaks that boundary of not being able to eat hot food. (Grace)

For Reena, it was the general everyday support and experiential knowledge available at FFF and HHF group sessions that proved to be the most impactful, more so than the intended and more specific benefits of the HHCF programme which she also cited, such as improved parenting confidence and feeling less isolated,

> One example is when he's actually started teething, I didn't know what product to use so it was nice to speak to other parents that maybe already have gone through the teething stage and were able to tell me 'oh, buy this product, this one was the one that really works'… I was like a month trying to figure out if [child's name redacted] gets sick, it's like, 'Oh my God, what do you guys do? what does actually work and what doesn't work?' rather than me having to figure it out on my own. It's just nice to have other people there that have probably already gone through it and can give you a bit of advice.

Situated knowledge of caring for children offered by HSE staff and fellow mothers at HHCF programme sessions also freed parents from trying to work towards toilsome yet elusive ideals of 'perfect parenting',

> I've learned to do things differently, but also being around other people that are in the same boat as you, it just gives you confidence that it doesn't matter if you get stuff wrong because everyone gets stuff wrong and no one's a perfect parent. Although I did the Mothers in Mind course again with my second [child], I already felt so much more confident in my parenting when I had her compared to my first because, I mean, a) you get the experience, but I'd also spent such a lot of time in those groups with other people that were the same as me that it kind of just drummed it into my head, 'Do you know what?... you're doing fine, you're doing a good job'. (Emily)

> It (Behaviour Support programme) gave me a better understanding of, how their (child's) mind works and being a bit easier on them about things, like not making them just sit down and eat their dinner… let them get up if they wanna get up and walk around the room and eat… It made like things less stressful and I had less pressure on myself to just do things perfectly… they're (child) probably a bit happier as well. I'm less stressed, so they're less stressed… things are just more easy going… less arguments. (Poppy)

The practical advice and knowledge on offer at HHCF sessions about negotiating the day-to-day challenges of parenting, especially for new mothers, was valued by service users to the extent that some mothers suggested that developing a bespoke and regular forum broadly based around navigating parenthood could improve HSE's service provision in the

future. The main perceived benefit of such a service relates back to supporting parents with developing interpretive skills to discern between information and advice worth devoting extensive time and attention to and parenting guidance that is more peripheral and relevant only in specific circumstances,

> To help with things that pop up along the way of parenting, like potty training, that kind of thing. That might be useful… like when they start nursery or when they start school, just like milestones so that you don't have to navigate them alone... sort of learn about the common things and what to worry about, what not to worry about, especially if you're a first time parent, so you're not at your doctor every week for a different rash. (Emily)

As well as the way parenting advice grounded in ongoing experiences seemed to also implicitly address the intended HHCF programme outcome of feeling less alone, it was seen as more beneficial in the long-term than receiving repetitive therapeutic advice about how to improve one's mental health,

> It could be an opportunity to provide tools on how to balance family life and your home… how to do day-to-day things… in terms of mental health, I have seen all of this before, you know, how to control your anxiety, how to do all this stuff. So, for me, it's like a repeat of things I already know. So I didn't find it (MiM sessions) helpful on that front… a lot of the moms there… we were all like, 'how do I manage all this stuff?' so it would be nice to have a course focused on that. I'm not sure what would be said but… like when I was trying to find the right product for teething, for example. It would be nice to have a support there that tells you 'OK, this is how you will, like, do the meals… this is how you sort things out around the home'. It's silly but sometimes you just need that there or somebody to tell you... because [child's name redacted] is gonna be a toddler soon, and I'm like, 'I don't know anything, so what's next? What do I do?' (Reena)

Feeling part of a supportive structure: the reassurance of 'knowing they are there'

To an extent, the wish for an ongoing practical support community of peers to move through motherhood with had already been addressed in a more informal way for some mothers, through staying in touch after completing a HHCF programme together,

> I now know there's other mums out there the same as me, but I could always reach out to them and be like, 'Oh, this is a really stressful stage. Have any of you experienced this?' And even if I hadn't spoken to them in a few weeks, they'd be like, 'Yeah, totally like that's exactly how it is'. So it's like this community that's just kind of in the background. (Emily)

This sense of becoming part of a comprehensive support community also extended to relationships some parents had established with their HSE Family Support Coordinator. Importantly, once mothers had first-hand experience of attending a Behaviour Support or MiM programme, the awareness that such relevant support was available through HSE

and their support co-ordinator was readily available if they required further support carried a protective impact in keeping mothers from falling back into an isolated state,

> It's really nice that they’re there and, you know, we’ve got the opportunity to use these services and they have called me up a few times asking if there's anything else that I need… it’s just, it’s nice to have that support. (Poppy)

Professional interviews

Analysis of semi-structured interviews with HSE professionals involved in service provision or delivery generated three overarching themes regarding their experiences and interpretations of HHCF programme planning, delivery and impact. For reasons of anonymity, numbers are used to identify data provided by different professionals.

The themes are:

- Practical support for the social needs of families under strain
- Working toward serving targeted populations and unexpectedly covering gaps in maternity service provision
- Restricted liberation: legitimating the control of children while trivialising the resilience of underprivileged parents
- Providing parenting advice and negotiating 'I've tried everything' narratives

Practical support for the social needs of families under strain

HSE professionals explained how the selected content of and locations for the HHCF programme delivery were informed by evidence about the needs of parents residing across West and South Essex with at least one child under five years of age.

> We definitely looked at indices of deprivation to find out where the most deprived areas were. We looked at employment level, schools and school attainment levels, transport and if people can get to the service, or if there were venues that we could use where there were other services [already] running… we wouldn't want to replicate a service… we're not just in it to chase the money. If there was a service that we felt could come in under budget and would meet our outcomes record, that would give us more steer. (Professional 1)

Deciding where to locate services also involved HSE professionals considering the social demographics and physical landscape of residential areas where new or additional service provision could make the most difference and, as a result, mostly achieved the intended impact of reducing social isolation,

> Families of different nationalities have been the greater percentage of parents that we've had come in. So, families that don't have other families or friends in the community… it's about confidence. Especially with the families that are not British nationals. I don't think there's maybe the same confidence to sort of look and think that they can come to groups like what we offer. (Professional 4)

> Harlow and Epping Forest have the highest demand, which are the more built-up areas. Maybe there's less access to parks where parents would take their children to. You know, to feel freer with them. In a more rural area, you might be able to take them for a walk or something. (Professional 5)

HSE staff also drew attention to how their offering extended beyond the content of sessions by also providing practical support to enhance everyday family life, especially in relation to accessing food and meal preparation,

> We were lucky enough to be awarded some air fryers from another funder, and previously we'd been awarded some slow cookers, which I feel really compliment the healthy eating side of service… to be able to offer out these cooking items with our recipes and talks about the benefits of eating healthily… the parents were delighted with them because they actually went away with something. They've obviously not got lots of money, so often that's the deciding factor on whether they can actually carry through what they've learned, so going away with actually an item to cook with. (Professional 5)

Such practical and immediately useful support also included arranging and reimbursing mothers' travel costs to and from programme sessions,

> One of the other things we've got is the permission to remove the barriers to access… we try and provide bus tickets to get parents to attend… if we had to provide the occasional Uber, we would… if parents drive themselves to the group session or service, we can then reimburse them with a mileage claim… there's no 'you owe us money back'. It's just a gentle support, so that parents can have the barriers removed to access [our services]. (Professional 1)

To directly support children and their parents prepare for attendance at school, some of the children's activities supervised by HSE professionals during FFF sessions are informed by school readiness principles,

> The school readiness activity that we do, I was trying to fit that in around the healthy eating aspect. We did a hungry caterpillar… we make plates with paper, food and things like that… asking children, 'what's your favourite fruit and veg? What would you put on your plate?' So yeah, definitely meeting that target, I think… trying to get the little ones engaged can be difficult but then just coming into the group… that in itself is a bit of school readiness. (Professional 4)

Overall, HSE professionals took great pride in explaining how the HHF service provision offered parents more practical support than more conventional and informal 'baby groups'. Such claims were also evidenced by parents themselves during interview and are reflected in the above theme 'beyond educating and encouraging'.

Much Like HHCF service users, some professionals were of the view that future HSE service provision could be enhanced with a programme focused more specifically on the day-to-day challenges of navigating parenthood. It was suggested by one professional that such sessions may only be accessible to parents who have already completed a HSE programme, but may want additional support with how the knowledge they have acquired can be practically implemented within their personal context,

> Having an opportunity to maybe build and then help the parents implement it more… so when they do a behaviour support course or a wellbeing course they perhaps are coming back for further support with us and then we can help them put into practice what they've learned. So I suppose it's a little bit like training

> courses as if you do a training course and then don't use it (the training) for a few months, you potentially lose what you've learned… it's trying to build those habits and embed that learning that they've got for a little bit longer… it might be something where actually, if we know somebody's been on the behaviour support that we kind of focus the support a little bit afterwards. You know, 'is there anything you still want to cover? Is there anything you still need to pick-up?' and just have a bit more of a directive link there, perhaps. (Professional 9)

Working toward serving targeted populations and unexpectedly covering gaps in maternity service provision

During interview, multiple HSE professionals referred to the high rate of sustained engagement from families across the various programmes, 'once they come in the door'. However, more problematic was successfully encouraging parents to attend in the first instance. This meant that a MiM programme in South Essex and a FFF programme in West Essex were not as well attended as predicted despite an observable social need amongst families residing in both areas,

> It's always been a hard sell to parents on Canvey Island. Rather than, you know, open the door, build it and they will come, it's build it, promote it, sell it and they *might* come. (Professional 1)

> Trying to get them to engage, that can be challenging… you do the initial assessment over the phone, and they say that they're gonna come in and then they don't come in. So, drop them a text, 'missed you this week, hope to see you next week'. 'Oh yeah, really sorry, gonna come next week'… I spoke to a mum yesterday, and for three weeks now, she said, 'I really want to come', and she's not turned up again… once we've got families in and they've come in and we've done one or two sessions, they want to come back. (Professional 4)

The three HSE professionals interviewed who were directly involved in service delivery all commented that variable initial attendance at sessions amongst parents who had expressed intentions to engage with the HHCF programme was indicative of the severity of social isolation amongst those with young children living in the local area. It was suggested that such isolation comprised both a psychological element of reduced confidence and everyday circumstances that conspired to constrain mothers' participation in public life. Yet, this debilitating context is what professionals felt underlined how transformative the initial attendance at HHCF sessions could be,

> A lot of our mums who come along haven't ever gone to [support] groups and they found that our less intimidating environment has seen them through the door. Just giving them that little bit of confidence… they've then spoken to another mum that they wouldn't necessarily have met… they would reduce their isolation. Actually, getting out and about, it helps boost their routines and they've actually got somewhere to go and be at certain times of the day. We also are able to signpost them to other services. (Professional 3)

One of the MiM programmes was particularly well-placed to connect mothers with further services, as it took place within a family hub,

> Where we facilitate the group at the moment is actually the family hub. So, while they're coming along to the group, there are facilities there to do baby weight and speak to health visitors and so that's all good in terms of working as part of a bigger network. (Professional 3)

Although, HSE staff involved in coordinating and delivering the Behaviour Support programme had formed the view that in some cases, parents struggle to engage because they were overwhelmed with an excessive number of referrals which they would not be able to follow through with, especially in the context of demanding everyday childcare responsibilities. Meaning that despite trying to support parents, referral into HSE services could also place further burden on parents by becoming a further commitment to try and fit-in to their busy schedule.

> It's frustrating when a parent really needs support and they won't engage… we don't judge because these families have so much going on, it's not surprising that they forget or just can't face it… so we always keep in touch with them. Some families, they've got a lot on their plate. (Professional 8)

Behaviour support staff also remained aware of the continuous demands encountered by those parents who had managed to attend sessions. This included designing an aspect of the programme that focused on how to get the most out of engaging with professionals and referrals,

> In Week 6, we look more at how parents have increased or altered their sense of self. So their self-esteem, their self-confidence, self-identity as well as having more confidence to advocate with other professionals, to actively seek support from other agencies. We signpost to a lot of a lot of external agencies as well. And these are all things that parents are often too overwhelmed to do when they come to us in Week 1. So it's very much about holding their hand along this journey, giving them the information but supporting them in building themselves in terms of their sense of self as well. (Professional 6)

Nevertheless, and despite their best efforts, Behaviour Support staff too were still left feeling disappointed with the drop-out rate of parents who had started the course as well as the number of parents who had been referred into the programme, confirmed they would engage, and then did not attend,

> The hardest thing is the lack of engagement. We put a huge amount of time into trying to get people to engage. We spend a lot of time in the build-up of the course trying to make sure that people know when it is, that they've got the [video call] link to join us and they're fully buying into attending and then people just don't turn up, and that's really frustrating. So that's the hardest bit. (Professional 10)

Conversely, and as already illustrated by data provided by mothers, alongside the strategic purpose of the HHCF programme to develop confidence and reduce feelings of isolation

amongst mothers in relatively underprivileged areas of West and South Essex, MiM sessions in particular did frequently engage and support mothers with distressing and unresolved experiences during their time under the care of maternity services,

> Mothers in Mind is really good at supporting that lower end of mental health… mums that have come away from perinatal mental health. It's just that hand-holding in between. Closing from one service and then being in the community without any other additional support. (Professional 3)

The purpose of such crucial mental health support was eloquently described by Professional 3 as trying to prevent mothers' state of mind from 'spiralling',

> The feeling of anxiety and what that does to your body and recognise those feelings and being able to sort of calm yourself before you end up spiralling… while they're with us, things are unravelling, unfolding, and then we're able to signpost.

As well as regularly working with mothers with unmet perinatal mental health needs arising from traumatic birth experiences, there also appeared to be a gap in the provision of family health visitors for families residing in Mid Essex who attended MiM sessions,

> Health visitors are not so readily available now. It's not a case of you have your baby and you have someone come and visit you at home for x, y and z weeks. So, mums can come along with their babies and ask questions… and 'how do I get a health visitor?'…. a question I didn't think people would actually be asking, that they are now unfortunately. So, we can just do a little bit of hand-holding for those people who haven't got an idea of who to speak to or how to go about things. (Professional 3)

Restricted liberation: legitimating the control of children while trivialising the resilience of underprivileged parents

HSE professionals directly involved in service provision and those with service planning and design duties highlighted the various ways in which all sessions on the HHCF programme are distinct from conventional 'baby groups'. The intentional design and provision of sessions as different in structure and experience to more informal community-based meeting groups for parents and newborns was seen as essential to facilitating sustained attendance and consistent increases in confidence amongst parents,

> During the weeks, you see people growing in confidence, they start to share more. They open up, they feel more comfortable. They feel that it is a safe space. They can be themselves; there's no judgements. I think with a lot of typical, if you like, 'baby groups'… there's a little fear of judgement and people not going back [because of] feeling uncomfortable. So, I think we work quite hard to make sure that nobody feels excluded or judged or left out. (Professional 2)

> A lot of our parents come to us and say, ‘I don’t access groups cause my first experience was my child did such and such and I left early because the other parents were looking at me’. Hmmm, so I think that’s what gives parents comfort about our group, is that they’re closed groups… everyone who's there will be struggling with some of the same things. (Professional 5)

The interview data from HSE professionals also added further weight to the significance of parents learning and moving through the programme together, which was also highlighted by mothers themselves and mentioned above,

> They’re on their own… we were trying to bring like-minded mothers together to share learning with each other and also to learn from the facilitators about effective mechanisms, routine structures. (Professional 1)

While HHCF sessions were delivered by qualified professionals, making themselves relatable to parents was seen as being as important as the content of expert advice,

> The topics that we discuss… it’s not like a therapy circle, but it’s very therapeutic… if we’re talking about anxiety… I think it probably helps a little bit, I’m quite real about my issues as well… I don’t sit there coming from an ivory tower, I have anxiety, I’ve got children, I struggle, so we’re quite real as well as practitioners, about our own struggles, not to the point where we can’t deliver, but where we’ve got a bit of an understanding and a bit relatable, as we’ve kind of been there with some of them. (Professional 2)

One of the other ways in which HSE professionals facilitated greater confidence and an initial sense of empowerment amongst parents was to normalise the often frustrating experience of parenting and emphasise that they were not alone in feeling overwhelmed at times,

> Whilst we’ve never had your child before, we have had many children come through and, you know, life can be tough for young parents. But a lot of people have been through the support, and it left them feeling ‘actually, I’m not alone, there are other parents, other mums, other dads, other children with the same issues as mine, and actually, it's OK to talk about them’. It's OK to say, ‘I just lost my rag’ and ‘I just felt like losing it’. ‘I just felt I was at the end of my tether’ and it's OK to say that and there's support in place for that… we've got anecdotal evidence from parents that say, ‘I feel less isolated’. ‘I didn’t feel I could leave the house because my child was always screaming or throwing a tantrum or whatever and now, I feel like I can, I’ve got the confidence’. (Professional 1)

Although, the most liberating and empowering philosophy of the HHCF programme was to facilitate the rebalanced of control within some parent-child dynamics in the favour of parents,

> We’ve seen children’s behaviour… as a result of the project… their behaviour has improved or has changed and been controlled better. A few parents have said, ‘I didn’t realise that it was OK to say, ‘world, I'm in control here, not you’’. It’s really, really interesting how some parents thought that they had this child

> and then they would turn 18 someday and their job will be done, but actually there's a whole long, long journey in 18 years to get there. Some parents have said, 'I'm taking back the control of my children and not accepting their tantrums or not thinking it's my fault all the time'. (Professional 1)

The means by which parents were encouraged to take back this control involved making changes to the approach utilised to interacting with children, requiring sustained and meaningful engagement by parents,

> I think for the people who engage well, it can be really transformative. It's very much down to the family how much they get out of it… how much they put in. If they turn up and if they listen and if they take on board what we're saying, some of them have had quite significant transformations in the way that they've interacted with their children. (Professional 10)

However, this sense of increased empowerment was somewhat offset by the intended remit of the programme to instil greater resilience in parents,

> Building a mum's resilience… once they finish the programme with us, their resilience would remain and their ability to not immediately rush to A&E for every issue… being resourceful, independent and stronger parents in themselves and therefore not feeling the need to rely heavily on overburdening NHS waiting rooms. (Professional 1)

This is problematic when understood in the context of HSE's overall approach. As HSE programmes are specifically aimed at parents of young children with relatively limited economic resources. As such, many of these parents will have spent most of their lives learning to be more resilient and resourceful on a daily basis. While resilience and resourcefulness are favourable attributes for many to possess while living through a cost-of-living crisis, it is somewhat misplaced to identify and target the most underprivileged section of the parenting population as those who are most in need of becoming more 'resilient'. In practice, this implies a lack of individual resilience amongst mothers from underprivileged circumstances, who are likely to already be incredibly resilient, and contradicts the 'ivory tower' positioning that HSE delivery staff were consciously trying to avoid.

Providing parenting advice and negotiating 'I've tried everything' narratives

Tasked with offering advice to parents about how they might attempt to better manage their children's behaviour, Behaviour Support practitioners cited how it was common for parents to say, 'I've tried everything' upon beginning the course. Upon working in more depth and over time with parents, practitioners explained how the representativeness of this claim was extremely variable, which had consequences for the intended impact of the course. In the one extreme, parents seemed to be more interested in attending the course as a requirement for receiving a neurodiversity or learning disability diagnosis for their child,

> We do see some parents who say they've 'tried everything' when actually they haven't really tried anything much, so that it's just another thing that they can say, 'oh, I've tried that and it doesn't work. So, clearly my child's different', or 'somebody else needs to do something about it'. (Professional 10)

In such instances, HSE professionals were constrained in the degree of impact that they could achieve while trying to work with parents who had alternative motives for attending. Whereas parents who had exhaustively tried various ways of managing their children's behaviours without success were easier to work with and presented at Behaviour Support sessions with motives more readily aligned with the aims of the programme,

> It's not right for everyone, and it can be quite a perspective shift for parents. But what we tend to find is that many of the people who sit in front of us have tried everything else. They're absolutely desperate, and they're looking for an alternative… so they're quite open minded. I know from personal experience that it can be really isolating when you are confused by behaviour… you're experiencing behaviour challenges… it's really helpful for families to feel less isolated and they're not alone in terms of what they're going through, there are other people who are going through similar things… and having the opportunity, having access to that kind of environment… you can almost see it and feel it during the session with the families and that's been really positive. (Professional 6)

Overall, the Behaviour Support element of the HHCF programme is unique in that some service users attend with intentions that diverge considerably from the aim of the programme, sometimes to the extent that service users are opposed to what the sessions seek to deliver. Equipping parents with strategies to help manage children's behaviour is the aim of the programme, which is not immediately compatible with supporting parents to get a learning disability or neurodiversity diagnosis for their child. Therefore, it might be in HSE's interests to develop a separate programme that focuses on neurodiversity.

Recommendations

- Maintain the existing structure of programmes where, ideally, all parents start and finish at the same time in the interests of promoting a supportive collective spirit amongst attendees.
- The MiM programme could make a significant contribution to improving perinatal mental health by emphasising the importance of being referred into the service during the first 3 months of motherhood. Some NHS Trusts advise that a period of a few months is preferable before reflecting on birth experiences, but the relatively small body of qualitative evidence collected here suggests otherwise.
- The MiM programme might benefit from a more specific and intentional session on 'alone time', which emphasises the importance of having time to oneself but also that the experience of such time is likely to have changed considerably.
- Continue to provide parents with essential practical support to assist with everyday activities such as transport and cooking and enhance or expand this offering where possible.
- HSE services are well-placed to develop a toolkit to support new parents in navigating the overwhelming amount of parenting advice available. Especially how, in most cases, the situated knowledge they have developed of their own children carries more weight than widely available and generic guidance.
- HSE service users who have attended and complete a HHCF programme might benefit from the development of a new programme that concentrates more explicitly on navigating the practical day-to-day challenges of parenthood, which may also improve the mental health of mothers.
- That a portion of service users who attend the behaviour support programme are primarily interested in receiving a neurodiversity diagnosis for their child is problematic for the professionals trying to deliver the sessions and likely constrains the potential impact of the programme. Developing a separate programme for parents interested specifically in neurodiversity would likely be well-attended whilst also improve the outcomes of the behaviour support programme.
- The HHCF programme improved the overall wellbeing of most participants who completed the survey and most survey respondents also accrued additional health-related knowledge to translate into their behaviours. Therefore, the programme seems to be conducive to encouraging beneficial health and wellbeing amongst socio-economically deprived households in Mid, West and South Essex. However, any improvements to health and wellbeing were not accompanied by increases in physical activity participation.
- Although improved parental resilience was intended as an outcome of the HHCF programme, there was no change reported by service users who completed both the baseline and follow-up surveys. There was also little to no mention of this by parents during interview. Even when asked directly about resilience, parents were indifferent about the possibility of this, with some parents preferring to discuss improvements in their sense of parenting confidence. Therefore, there may not be much value in HSE continuing to try and develop resilience amongst Core20 families and communities, who are already likely to be highly resilient while living through a cost of living crisis in relatively deprived social conditions.