Evaluating a community-led project for improving fathers' and children's wellbeing in England

Robertson, S, Woodhall, J, Henry, H, Rowlands, S, Esmée, H, Livesley, J and Long, T

http://dx.doi.org/10.1093/heapro/daw090

OXFORD UNIVERSITY PRESS | Health Promotion International

Evaluating a community-led project for improving fathers' and children's wellbeing in England

Journal:	*Health Promotion International*
Manuscript ID	HPI-2016-006
Manuscript Type:	Article
Keywords:	men-s health, fatherhood, community based participatory research, community health promotion, participatory research
Keywords:	
Country:	

Evaluating a community-led project for improving fathers' and children's wellbeing in England

Abstract

Although under-research compared to other settings, there is potential for the family setting to be harnessed to support the development of healthy children and societies and to reduce health inequalities. Within this setting, the role of fathers as health facilitators has yet to be fully understood and considered within health promotion. This paper draws on a two year evaluation of a community embedded intervention for fathers and children in an area of multiple deprivation in North West England. The evaluation integrated a variety of qualitative methods within a participatory evaluation framework to help understand the development and impact of a programme of work co-created by a social enterprise and fathers from within the community. Findings suggest that allowing fathers to define their own concerns, discover solutions to these and design locally appropriate ways to share these solutions can result in significant change for them, their children and the wider community. Key to this process is the provision of alternative spaces where fathers feel safe to share the substantial difficulties they are experiencing. This improved their confidence and had a positive impact on their relationships with their children and with significant others around them. However, this process required patience, and a commitment to trusting that communities of men can co-create their own solutions and generate sustainable success. We suggest that commissioning of services delivered 'to' people could be replaced, or supplemented, by commissioning appropriate organisations to work with communities to co-create solutions to needs they themselves have recognised.

Introduction

The family is increasingly recognised as an important setting for health promotion (Soubhi and Potvin, 2000). Although under-theorised and explored in relation to other settings such as schools, workplaces and prisons (Green *et al.*, 2015), there is potential for the family setting to be harnessed to support the development of healthy children, families and societies (Panter-Brick *et al.*, 2014, Soubhi and Potvin, 2000). Traditional family structures are now being accompanied by structures that are more diverse and heterogeneous. Children may be raised by married parents, co-habiting parents, single parents, step-parents or same-sex parents (Golombok, 2015) and many children move in and out of these varied forms during their childhood years. Despite these changes, families remains situated within a wider social, economic and political climate. Efforts to address the health of families must therefore recognise these influencing determinants. Novilla et al. (2006, p.29)

suggest that the "ecological perspective serves as the unifying framework for defining family health" and McLeroy et al.'s (1988) ecological model of health promotion, drawing prominently on the work of Bronfenbrenner (1977), acknowledges that tackling health and health inequalities is relatively futile without acknowledging micro, meso and macro processes. While structural determinants of health are crucial factors in tackling health inequalities, the contributory role that family relationships and systems play in supporting health within this multi-level context is critical. However, it is arguable if public health practice or policy has fully utilised or embraced families as a viable setting for health promotion interventions (Novilla, Barnes, Natalie, Williams and Rogers, 2006).

One of the critiques of settings-based health promotion is the potential for such approaches to 'exclude' certain sub-sections of the population – unintentionally exacerbating inequalities (Green et al., 2000; Green, Tones, Cross and Woodall, 2015). Within the family context, fathers may be one such group. Fathers have a significant impact on child health and development (Lamb and Lewis, 2013) and yet a recent systematic review suggests that family interventions, such as parenting programmes, rarely target men, or make a dedicated effort to include them (Panter-Brick, Burgess, Eggerman, McAllister, Pruett and Leckman, 2014).

This paper draws on data from a two-year evaluation of a father's project situated in an area of multiple deprivation in the North West of England. It focuses on the key constituents of the project, predominantly fathers and their children, but also on the women (mainly mothers) who were involved on the periphery of the project and on the project staff. The project (anonymised to protect the identity of the participants and wider community) aimed to improve the wellbeing of the men and their children and is described below.

Background

In 2013, a social enterprise, based in the North West of England, pitched a social innovation project to a local clinical commissioning group (CCGs are the bodies responsible for commissioning health services within the NHS). The aim was to investigate the links between fathers and children's wellbeing with a view to improving these. Both commissioner and provider agreed this was an issue because of limited information about links between the two and a perceived imbalance between support for men's wellbeing compared to women's, throughout the life course.

Rather than assess need with a view to delivering services, the proposed social innovation approach was based on the premise that the community itself could find and share its own wisdom to help build resilience and sustainability. The approach chosen was 'positive deviance' (PD), a form of asset-based community development that aims to build on strengths using the existing skills and wisdom of the community. PD has a strong track record of success in countries worldwide (Marsh, Schroeder, Dearden, Sternin and Sternin, 2004) and has been shown to build confidence and self-esteem on issues as diverse as female genital mutilation, re-integrating child soldiers back into communities and overcoming under-nutrition in Vietnamese children. It is based on the recognition that in every community there are certain individuals or groups whose uncommon behaviours and strategies enable them to find better solutions to problems than their peers, while having access to the same resources and facing similar challenges (Marsh *et al.*, 2004).

The specific proposal to the CCG was that, with support and facilitation from the social enterprise, the community itself would identify fathers with uncommon behaviours and work with them to find ways to practice these behaviours father-to-father. The community would literally 'act itself into a new way of thinking' by changing men's current social practices. Within such work, progress is fed back regularly by the local people involved to the wider community enabling residents to follow and become part of the developmental journey.

The work was based on the PD 4-step process (Bradley *et al.*, 2009), locally referred to as the '4Ds':

- **D**efine the problem for dads in this community
- **D**etermine common practices (what people generally do about the problem)
- **D**iscover dads who have found successful ways of dealing with the problem
- **D**esign a means of sharing these successful ways.

An action learning approach was agreed, with the overarching question being: *'If we improve the wellbeing of fathers by sharing the behaviours of successful fathers, will this improve their children's wellbeing too?'*

The next issue was to choose a community. One particular place, in the top 3% in the index of multiple deprivation, was identified as being of interest. Within this area, there were distinct variations in primary school performance, which may or may not be attributed to varying parental input. In addition, the area had not received much developmental input for some time and was often talked about negatively. Thus, finding ways that residents themselves could lead and deliver a step change would be more likely to attract attention and be recognised as significant.

The town has a population of 17,000, spread over 5 quite distinct estates and served by a small district centre. Recent literature identifies that particular groups of white British males (those aged 25–44yrs, with long-term histories of economic and social marginalisation and, often, childhood trauma) are more likely to suffer multiple disadvantage (Bramley and Fitzpatrick, 2015) and so although increasingly multi-racial, this town was also chosen because of the prominence of such men. Local people often were born, grew up and died without leaving the town.

Early engagement provided the following reflections on the community. Generations lived in close proximity and family dysfunction was commonplace. Family structure was mainly matriarchal, with men commonly described as being untrustworthy and disposable. Service providers often described many 'tumbleweed moments' - engagement activities and events often ended in residents staying at home and workers sitting alone. Local workers liked the idea of using PD but doubted it would work in this town. Residents said such pessimism developed because the community had been alienated by years of 'box-ticking managers' who did not really care and let the community down when funding or initiatives ended – projects mainly came and went and lacked sustainability. Despite this somewhat bleak picture, the project team (a part time female project manager, a full time male engagement worker who was a local father from a nearby town) was welcomed. Local workers kept open minds throughout and proved willing to help and respond flexibly as work developed. The importance of independently evaluating the work in a way that understood and shared the projects values was recognised from the outset.

Method

The philosophy of the evaluation was consistent with the PD approach adopted within the project. This included establishing close working relationships with the team developing the work (including phone conversations every two weeks), with the fathers engaged, and adopting a 'participatory evaluation' approach (Zukoski and Luluquisen, 2002) to data gathering which recognised and respected community and stakeholder perspectives. The approach was therefore underpinned by collaborative dialogue and an emphasis on co-production (including co-production of this paper) – key tenets of participatory methods in health promotion evaluation (Green and South, 2006). The notion of 'triangulating' data sources was central to help ensure a holistic picture of the process and impact of the project. Evidence gathered was derived from four primary sources:

1. Project Manager's and Engagement Worker's reflective diary entries completed between August 2013 and May 2015.
2. Six in-depth interviews from fathers participating in the project.
3. Seven semi-structured interviews from women within the local community
4. A participatory workshop with thirteen children (from six families) engaged in the project.

The first three elements of this evaluation were led by (blinded for peer review) and the children's work led by (blinded for peer review). All elements went through appropriate ethics review at their respective institutions.

The interviews with fathers were conducted by the project manager. They were primarily completed in year one. As recognised in other research (Clark, 2008), and described in the background section, this community was wary of 'professional outsiders'. In discussion with the project team it was therefore deemed preferable not to disrupt the emerging relationships being forged by introducing additional 'professional outsiders'. This is in line with participatory evaluation approaches where there is a shared responsibility between the evaluator and participating stakeholders and the evaluator is recognised as a facilitator and critical friend rather than an expert leader (Zukoski and Luluquisen, 2002). These interviews explored the men's experiences of involvement in the project and how this linked to the previous and present context of their lives.

Interviews with women from the community were completed in year two, by which time a level of trust had developed enabling the academic evaluators to complete these interviews. They were recruited via a Facebook post on the project website and through project workers. Attempts were made in sampling to ensure representation across a 'typology' of women that had been identified by the project team: 'fans of the project'; current partners of project members; former partners of project members and; 'critics of the project'. The academic team liaised and negotiated with the project team, the dads who had been most engaged during year one and the women themselves to agree on the timing and venue (a convenient and familiar children's centre). The interviews explored the women's views of the project, the activities that were conducted, and changes (if any) they had seen within men they knew who attended and their children. A female researcher was engaged to conduct these interviews.

Participatory methods with children and young people involved those aged between 18 months to 16 years of age. Recruitment and sampling was done opportunistically through a weekly father and

child Saturday club – data gathering was also done during one of these clubs. Thirteen children from six families took part, two were girls. The approach created a stimulating environment with varied activities which provided opportunities to contribute in a comfortable and facilitative setting. Data collection techniques involved those outlined in Table 1.

Insert Table One near here

Interviews with the fathers were transcribed. The reflective diary data along with the interview data from the fathers and the women were analysed thematically, looking for both semantic (descriptive) and latent (underpinning) elements and developing emergent themes (Braun and Clarke, 2006). Initial coding, categorising and theme development was done by one member of the team. The wider research team then completed a process of iterative reading of interview transcripts to confirm and adjust categories and themes where necessary. For the children and young people, audio or video-recorded data was converted to text manually for framework analysis. The frame was constructed on fields of impact, context, and mechanisms. For the purpose of this paper the above data analysis was then integrated and the following themes formed from this integration: Emotional openness; Offering alternatives; improved relationships; and sustainability. In presenting the findings identifying information has been omitted to help ensure anonymity.

Findings

Findings are presented thematically to show cross-cutting issues. Anonymised quotations are used to illustrate key thematic categories.

Emotional openness

> *"I tell you what, I was very depressed when I first came to the group ...that first day I've never seen a bunch of men open up so much and it was a sight to see"*

Issues of 'emotional openness' were brought up in many and different ways across the datasets. Dads themselves spoke about the problems that lack of emotional relationships with their own fathers had caused (some also spoke of positive experiences they wanted to emulate). Most

numerous were descriptions of traditional breadwinning, distant fathers who, while commended for putting food on the table, provided little in the way of emotional support or advice. In contrast, they characterised a good father as one who could show emotion, affection, closeness and empathy; they recognised the need for emotional sensitivity in meeting their children's needs:

> *"You need to be sensitive when it comes to your children, you need to address their problems at the end of the day."*

The women interviewed talked slightly differently often highlighting the benefits of specifically male company for the men and recognising the opportunity this created for sharing advice and experience. Some recognised that this often involved the interactions having a therapeutic (emotional) element:

> *"It's like a place for counselling each other […] it's not just about going to play with your kids on Saturdays; It's got more layers than that."*

> *"Oh my god it's amazing…it was just very quiet low conversation because these are personal matters they're discussing as opposed to blokes in a pub…There's no bravado with them."*

For the project team, these issues were well recognised, noted in the project managers reflective diary, and the question raised about whether 'emotional openness' is, in and of itself, a positive deviance behaviour for men in such communities. This seems an important question given that being emotionally restricted is linked to less mental health help-seeking for men (Hammer and Vogel, 2010) and implicated as a risk factor in male suicide (Galligan *et al.*, 2010). Simultaneously, responsibility, particularly being an involved parent, allows men to position mental health help-seeking as a logical and rational action (Oliffe *et al.*, 2012).

The creation of a safe space for practical and emotional sharing engendered by the project (alongside the fun and enjoyment of many activities and time with their children) generated strong bonds amongst many of the men and provided feelings of belonging and of being valued (and of caring for and helping others). As one woman states:

> *"I know they were all supporting each other, ringing asking how he was was….I think it's part of feeling belonged and wanted."*

This linking of enjoyment, sociability and the opportunities this creates for alternative ways of being (for generating different and positive social practices), has been recognised as particularly important in health promotion work (Robertson *et al.*, 2013) and mental health promotion work with men (Robertson *et al.*, 2015).

Offering alternatives

The complex challenges faced by individual fathers (alcohol, drugs, gambling), families (separation, violence) and the wider community (social and economic challenges, poverty, unemployment) were factors identified early on by the project team when consulting with dads and community members during the 'defining the problem' stage of the PD approach. Men, and specifically men within areas of multiple disadvantage, are known to show more 'maladaptive coping' mechanisms (drink, drugs, violence and even suicide – Department of Health, 2008) especially during times of stress or emotional anxiety. The interviews with dads showed that many had previously used such negative coping mechanisms and had also often felt isolated and left dealing with problems alone. There were clear inhibitors for the fathers to become the parent that they wanted to be. Several had tried to access informal networks and statutory support services, either directly for parenting advice, or as a way of improving personal health and their capacity to engage as a father. During such encounters, the men commonly described support that was tailored to the needs and preferences of women. There were numerous examples where men had felt 'pushed out' of vital, informal, 'mothers' networks at school, and also from a range of statutory services – including maternity and post-natal services, and children's services in general:

> *"I'd interacted with midwives and hospitals, but it's so female orientated... obviously the focus has to be on the woman because she's pregnant…but there was just no dad and that made me feel that maybe I'm… I shouldn't even be here then! And it was just about the mum and baby, mum and baby. You pick up a book and its mum and baby. So I kind of felt pushed out in a way."*

The project represented and created a male space where people would listen to, share and understand their problems. They felt they could be honest and open amongst other dads who were going through similar issues. This engendered trust and responsibility between and toward each other, providing validation that their experiences were common and that solutions to certain issues,

or support to endure them, could be found. In this context, the men broke free from their isolation realising they were not alone:

> *"... that day ... every bloke stood up and said exactly the same thing as I did. They had exactly the same problem. So it wasn't just me, and that made me feel a whole lot better. Knowing that you're not on your own is massive… because you do start to isolate yourself and you think 'why is it just me?' You start to go into yourself."*

Linked to the issue of 'emotional openness', the project offered alternatives to the maladaptive coping and marginalisation the men previously experienced. Involvement helped create alternative ways of coping (through shared enjoyment in activities, reduced isolation, improved self-confidence and esteem, greater engagement with their children) and allowed them to share experiences and solutions with other men in the community. These more positive social practices were linked to an improved sense of self developed through involvement with the project:

> *"Once I started engaging I felt important for a huge amount of reasons; being talked to like I was human ... I felt important when I was asked to do some judging [during a competition on what children value in their dads]. It's quite official, I loved that and to be asked was a massive thing for me."*

These experiences facilitated increased responsibility and a concomitant sense of valued identity for many dads including motivating them to become involved in volunteering and employment opportunities that they previously would not have felt skilled or confident to do:

> *"...all of a sudden I've got all of these opportunities that... and it's because I've gone with it [the project] and I'm doing these things ... opportunities just keep opening for me that wasn't there before."*

This change in confidence, and the practical changes of helping others and being more involved in the community, was also noted by the women interviewed "*the change in him is just… I don't know what to call it, it's like a miracle… it's changed his life"*. To this extent, the project was often presented as filling a gap for these men in helping them deal positively with difficult life circumstances and shifting previously negative coping mechanisms *"There was a void there and I used [the project] as a ladder really."* Part of the nature of this 'alternative' offered was in creating a

different, more salutogenic (health promoting), space within the community for the men away from previously damaging friendships and settings, as one of the women puts it:

"They're not sitting at a pub they're not drinking all the time wasting their money. It's not costing them so they've still got a place they can go."

The children involved also seemed to value a dedicated, alternative space and time to be with their dad. Commenting on the weekly Saturday club one of the children suggested:

"It has helped me bond with my dad. It is working. Most stuff is with mums, like shopping and days out, but with your dad you can do more men's stuff."

The project had impact then on a range of the men's intersubjective encounters; that is, on their relationships and the way they engaged with others.

Improved relationships

"Now I spend more time with my dad, and it's special time just for me."

The positive impact of the project for the children was at the forefront of many of the men's and women's accounts and well recognised by the project team. Many women also pointed out the positive impact for themselves in terms of having new experiences that they could share as a couple or that the children could share on return from their involvement. They all noted the wider changes in the men's social practices discussed above and recognised some of the shared practical parenting skills gained through the project suggesting the PD approach of sharing good practice 'father-to-father' within the project was happening. As one man states:

"We're all parents, and that's what's important, we're all getting ideas. It was clear from the first meeting that we could learn skills off other people."

The women's narratives about changes they saw in the men's relationships with their children were also prevalent:

"…It's good for children as well as the dads, the kids know that they've got a dad to go too; its two parents not just the one."

…and the data from the children even more compelling:

"Something changed between us. We weren't good together before. Our relationship is better now. We spend more time together; do more things together. It's the same at home and when we go out, too. It wasn't so good before."

The change in the amount of time spent with the children and the nature and quality of that time was clear. One effect of this was that new role-modelling and positive attitudes offered by the dads was mirrored within the children, as evident in this text sent to the project engagement worker:

"Both E and K riding bikes without stabilisers for the first time today! Confidence in myself is rubbing off on them. They never attempted it before. Very proud daddy☺"

The impact on relations was very much apparent within the wider family context. All data sources suggested a more cooperative home and a community spirit that was clearly an 'over-spill' from the effects of the project. Many of the men had experienced difficult relationships with partners and ex-partners, especially in relation to having access to children. At worst, these difficulties generated or exacerbated the range of 'maladaptive coping' mechanisms mentioned earlier making situations worse for all involved. With the changed practices developed through the project these relationships often became less strained as the focus became increasingly child-centred:

"We talk a lot more now… In a way we are doing it for the kids. Before he'd come in and be like 'hi…', but now we are communicating more. That's one good thing… Considering we couldn't stand each other then, now it's 'let's all be friends'. So good."

In this way, the often negative experiences and views women had of men within the community were challenged and shifted. As two of the women note:

"Everybody should experience seeing a group of men acting in this responsible, mature, supportive way. Particularly women like myself who've not seen that growing up."

"A couple of dads have a bad reputation, they've all had a bad reputation in a lot of women's eyes! But now you look at these dads and they're more approachable and not like all those dads we used to hear about."

Given that men, women and families live within sets of intersubjective relations it is clear (though often under-reported in health promotion literature) that the impact on the men involved had benefit well beyond that directly experienced by them reiterating the point about the importance of recognising the potential of the family as a health promotion setting (Soubhi and Potvin, 2000). The difficulty with many community projects though is sustaining them, especially in times of financial austerity.

Sustainability

"When I grow up and have kids of my own I'll bring them to [the project]. I know what my dad's done for me. Everything he's done for me I can pass on to my kids."

There have been conscious strategies by those involved in the project to avoid it being 'a service' delivered 'to' the men, or a 'support group' that serves only the relatively small group of men involved. Instead, there is on-going intent to maintain a focus on the programme as one owned by the community. This has not been easy, as the project manager notes:

"I'm clear that we are not trying to develop [the project] as a service but as part of the resilience of the community, but we are pressured by both services and residents to call it a 'service' and treat it as such, with the risk that residents will become passive not active."

Nevertheless, this strategy is in line with a PD approach and such community ownership is likely to engender sustainability as it is developed through local people's skills, commitment, and social networks which are recognised as vital resources for health (South *et al.*, 2015). The project team have been committed to this endeavour though it was slow to develop through the first year:

"One dad asked if it would be ok to meet some dads on [local venue]. I was pleased, this was my first time as engagement worker where the dads started to take the lead and initiative to plan things for themselves. The fact he asked still shows me that the dads felt they didn't own it totally though."

Progress is encouraging with dads showed increasing control, confidence and sense of ownership of the work throughout the second year. Significantly, the dads became formally constituted at the end of year two. This is particularly encouraging in terms of community capacity for continuing the work as the social enterprise progress their plans to withdraw further from the work in line with PD principles.

In taking increasing ownership the dads are continuing to develop a wider, external focus including making connections with numerous local partners. They are being approached with increasing regularity to talk about the work through various media outlets, including local press and radio, and at national events. Social media, particularly Facebook, continues to be used as a way to engage new local men (and interestingly women) in the project and is also being harnessed as a tool to build external (outward facing) alliances across the community. As well as the existing regular activity for dads alone and with their children, there are on-going 'ad hoc' family-oriented events that have helped ensure positive involvement from the women within the community. Building on this, there are new plans being pursued by the dads (such as developing a local 'Men's Shed') with minimal support now from the social enterprise.

At the point of completing the year two evaluation an entry from the project manager's diary noted:

> *"At the time of analysis we counted 70 fathers, the majority of whom were dads who have hit the bottom and are on their way up, others strong fathers offering help, such as the Rotarians, and also some from several churches we work alongside."*

This is not an insubstantial number, given the small size of the locality and the often stated difficulties of engaging men (Carroll *et al.*, 2014). However, this number does not account for the many other community members that engage in the ad hoc events, nor does it consider the significant impacts, outlined in sections above, that changes in just a few men's lives can have within a community.

Discussion

This project has identified important links between fathers' and children's wellbeing and how improving one can act synergistically to improve both. Indeed, it goes beyond this in highlighting how community and family relations and wellbeing can be positively influenced through approaches

which trust and draw upon the assets and strengths present within a community. Men (including men as fathers) often report not being trusted, cared for or listened to by service providers, and not being able to find male-oriented services (Carroll, Kirwan and Lambe, 2014, Monaem *et al.*, 2007). This issue of 'trust' and 'identifying' seems to be worsening as the social gradient increases with certain communities no longer recognising themselves in those professional 'outsiders' brought in to deliver services leading to what Wilkinson & Pickett (2010) call the 'social evaluative threat'. In contrast, taking a strengths-based approach to working with men, recognising and valuing what they bring, has been shown here, as elsewhere (Macdonald, 2011), to be effective in promoting men's wellbeing and that of those connected to them. As others have noted (Smith and Robertson, 2008), health promotion work with men is not something that happens independently of women and children. Understanding gender as being about sets of relations (rather than about biological sex) implies that engaging men in ways that alter health and social practices has public health impact beyond the individual level. The narratives here from the women and children (alongside those of the men and project workers) are strong testament to this.

Creating a safe (and 'fun') space for men to interact in settings that are male positive but avoid (and indeed eschew) the worst aspects of hegemonic masculinity (e.g. 'avoiding emotions' and being expected to 'succeed' at any cost) provides opportunity for men to identify and engage in new or different social practices; often practices more conductive to wellbeing. The data here supports previous research (Robertson, Zwolinsky, Pringle, McKenna, Daly-Smith and White, 2013) suggesting that such changes are not necessarily consciously thought through. Rather, this new environment introduces the men to new forms of social and cultural capital thereby expanding their repertoire of acceptable (and beneficial) ways to 'be a man'. In doing so it increases the range of coping strategies available to them to deal with the significant issues they face and thereby impacts a range of daily relationships.

It is important to recognise that such approaches are not a panacea for the health and wellbeing issues faced by men and others in such areas of multiple deprivation. They should not be seen as a replacement for addressing the 'upstream' public health policy approaches necessary to influence wider social determinants of health and wellbeing. We would suggest though that they could and should be used in preference to certain other approaches to promoting men's health. Lorenc et al (2013) have identified that certain types of interventions act to increase health inequalities. Williams & Robertson (2006) suggest that individually focused health promotion initiatives (such as 'well man' clinics) likely act to increase inequalities as they mainly attract men of higher socioeconomic status

whose health practices and outcomes are, on average, better than those of men from areas of multiple deprivation. They further suggest that to be effective for men, "public health approaches need to be based on principles of collaboration, equity and participation" (pg.27). The evaluation here certainly shows the effectiveness of putting such principles into action.

The findings offer insight into the conceptual and practical feasibility of recognising families as settings for health promotion in the same way that successful initiatives have been seen in schools, workplaces and prisons (Green, Tones, Cross and Woodall, 2015, Hubley *et al.*, 2013). It is axiomatic that taking an instrumental view of the family setting as a self-contained environment with 'target audiences' for intervention will not be sufficient (Green, Poland and Rootman, 2000, p.23). Findings here suggest a more nuanced view of health and its determinants is required – this was exemplified in this study where men and families were dealing not only with internal family dynamics but with the consequences of social and economic challenges, mainly poverty and unemployment. Indeed Dooris' advancement of settings theory (Dooris, 2013), suggesting that settings must connect 'outwards' and 'upwards', is applicable to the notion of a health-promoting family setting. Connecting 'outwards' relates to all settings working in joined-up ways in order to appreciate the interconnectedness between the places that individuals live their lives and to embrace the complexity of health issues that do not respect physical boundaries. Fathers reported feeling pushed out of statutory service provision and indeed there would be clearer dividends for schools, maternity services and other providers to work more closely with (often diverse) family units. Connecting 'upwards' is about ensuring that broader political, economic and social factors are being addressed through settings programmes effectively developing advocacy and lobbying roles (Dooris, 2013). St Leger (1997, p.101) argues that when adopting a settings framework there is a requirement to always stay with 'the big picture'. As discussed, viewing the family in isolation without recognising socioeconomic determinants may not offer dividends for reducing inequalities or supporting the development of healthy children, families and societies.

Conclusion

It is apparent from this evaluation that when approaches are taken that value, and indeed rely on, the skills of those from within a community to define their own concerns, discover solutions to these and design locally appropriate ways to share these solutions, that significant change can result. Discovering safe opportunities for men to share the substantial difficulties they are experiencing living in an area of multiple disadvantage also helped them find alternative ways to deal with many

of the challenges they faced. This improved their confidence and wellbeing and had significant and positive impact on their relationships with their children and with significant others around them (particularly partners and previous partners). There were clear links then between the fathers' wellbeing and that of their children.

There is government commitment (Department of Health, 2010) to generating policy that "empowers individuals to make healthy choices" (p.2) and also recognition it has not yet "fully harnessed the renewable energy represented by patients and communities" (NHS England, 2014: p.9). Evidence here suggests that people (fathers) can be empowered in this way, through approaches that harness this energy utilising the skills and assets present within localities. However, the evidence also shows this is not an easy process and that it requires time, patience, and a commitment to trusting that communities can co-create their own solutions and generate sustainable success. This suggests that policy implementation requiring commissioning of services delivered 'to' people (often practically actioned as delivering services 'at' people) could be replaced, or at least heavily supplemented, by commissioning appropriate organisations to co-consider the needs of particular localities and communities and co-create solutions to these needs. In relation to promoting the health of men (and those around them), we concur with others (Williams *et al.*, 2009) that, to be successful, such approaches should be placed within a wider policy framework that engenders collaboration and participation and is based on values of equity and social justice.

References

Bradley, E. H., Curry, L. A., Ramanadhan, S., Rowe, L., Nembhard, I. M. and Krumholz, H. M. (2009) Research in action: using positive deviance to improve quality of health care. *Implementation Science*, **4**, 1-11.

Bramley, G. and Fitzpatrick, S. (2015) Hard edges. Mapping severe and multiple disadvantage. The LankellyChase Foundation, London.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3**, 77-101.

Bronfenbrenner, U. (1977) Toward an experimental ecology of human development. *American Psychologist*, **32**, 513-531.

Carroll, P., Kirwan, L. and Lambe, B. (2014) Engaging 'hard to reach'men in community based health promotions. *International Journal of Health Promotion and Education*, **52**, 120-130.

Clark, T. (2008) 'We're over-researched here! Exploring accounts of research fatigue within qualitative research engagements'. *Sociology*, **42**, 953-970.

Department of Health (2008) Progress and next steps. Health inequalities Crown, London.

Department of Health (2010) Healthy lives, healthy people: our strategy for public health in England. Department of Health, London.
Dooris, M. (2013) Expert voices for change: Bridging the silos—towards healthy and sustainable settings for the 21st century. *Health & Place*, **20**, 39-50.
Galligan, S. B., Barnett, R. V., Brennan, M. A. and Israel, G. D. (2010) Understanding the link between gender role conflict, resilience, and propensity for suicide in adolescent and emerging adult males. *International Journal of Men's Health*, **9**, 201-210.
Golombok, S. (2015) *Modern families: parents and children in new family forms*. Cambridge University Press, Cambridge.
Green, J. and South, J. (2006) *Evaluation*. Open University Press, Maidenhead.
Green, J., Tones, K., Cross, R. and Woodall, J. (2015) *Health promotion. Planning and strategies*. Sage, London.
Green, L. W., Poland, B. D. and Rootman, I. (2000) The settings approach to health promotion. In B. D. Poland, L. W. Green and I. Rootman (eds), *Settings for health promotion. Linking theory and practice*. Sage, Thousand Oaks.
Hammer, J. H. and Vogel, D. L. (2010) Men's help seeking for depression: the efficacy of a male-sensitive brochure about counseling. *The Counseling Psychologist*, **38**, 296-313.
Hubley, J., Copeman, J. and Woodall, J. (2013) *Practical health promotion*. Polity Press, Cambridge.
Lamb, M. E. and Lewis, C. (2013) Father-child relationships. In N. Cabrera and C. S. Tamis-Lemomda (eds), *Handbook of father involvement: multidisciplinary perspectives*. Routledge, New York.
Lorenc, T., Petticrew, M., Welch, V. and Tugwell, P. (2013) What types of interventions generate inequalities? Evidence from systematic reviews. *Journal of Epidemiology and Community Health*, **67**, 190-193.
Macdonald, J. (2011) Building on the strengths of Australian males. *International Journal of Men's Health*, **10**, 82-96.
Marsh, D. R., Schroeder, D. G., Dearden, K. A., Sternin, J. and Sternin, M. (2004) The power of positive deviance. *British Medical Journal*, **329**, 1177-1179.
McLeroy, K. R., Bibeau, D., Steckler, A. and Glanz, K. (1988) An ecological perspective on health promotion programs. *Health Education Quarterly*, **15**, 351-377.
Monaem, A., Woods, M., Macdonald, J., Hughes, R. and Orchard, M. (2007) Engaging men in the health system: observations from service providers. *Australian Health Review*, **31**, 211-216.
NHS England (2014) *Five Year Forward View*. London: NHS England
Novilla, M. L. B., Barnes, M. D., Natalie, G., Williams, P. N. and Rogers, J. (2006) Public health perspectives on the family: an ecological approach to promoting health in the family and community. *Family & Community Health*, **29**, 28-42.
Oliffe, J. L., Ogrodniczuk, J. S., Bottorff, J. L., Johnson, J. L. and Hoyak, K. (2012) "You feel like you can't live anymore": suicide from the perspectives of Canadian men who experience depression. *Social Science & Medicine*, **74**, 506-514.
Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K. and Leckman, J. F. (2014) Engaging fathers–recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, **55**, 1187-1212.
Robertson, S., White, A., Gough, B., Robinson, M., Seims, A., Raine, G. and Hanna, E. (2015) Promoting mental health and wellbeing with men and boys: what works? Centre for Men's Health, Leeds Beckett University, Leeds.
Robertson, S., Zwolinsky, S., Pringle, A., McKenna, J., Daly-Smith, A. and White, A. (2013) 'It is fun, fitness and football really': a process evaluation of a football-based health intervention for men. *Qualitative Research in Sport, Exercise and Health*, **5**, 419-439.
Smith, J. A. and Robertson, S. (2008) Men's health promotion: a new frontier in Australia and the UK? *Health Promotion International*, **23**, 283-289.

Soubhi, H. and Potvin, L. (2000) Homes and families as health promotion settings. In B. D. Poland, L. W. Green and I. Rootman (eds), *Settings for health promotion. Linking theory and practice*. Sage, Thousand Oaks.

South, J., Stansfield, J. and Fenton, K. (2015) Putting communities at the heart of public health. *Perspectives in Public Health*, **135**, 291-293.

St Leger, L. (1997) Health promoting settings: form Ottawa to Jakarta. *Health Promotion International*, **12**, 99-101.

Wilkinson, R. G. Pickett, K. (2010). *The spirit level: Why greater equality makes societies stronger*. New York: Bloomsbury Press

Williams, R. and Robertson, S. (2006) Masculinities, men and promoting health through primary care. *Primary Health Care*, **16**, 25-28.

Williams, R., Robertson, S. and Hewison, A. (2009) Masculinity,'men's health'and policy: the contradictions in public health. *Critical Public Health*, **19**, 475-488.

Zukoski, A. and Luluquisen, M. (2002) Participatory evaluation. What is it? Why do it? What are the challenges? *Community-based Public Health Policy & Practice*, **April**, 1-6.

Table 1. Participatory data collection techniques

Activity	Description
Individual and small group interviews	Children and young people were offered the opportunity to talk individually or in sibling groups to a researcher. These discussions were audio-recorded. Other informal discussions occurred without recording but researchers made notes about these immediately afterwards.
Video-diary booth	Participants were allowed opportunity to paint on the walls of this small enclosure before offering a video-record of their thoughts to specific questions, phrased as required for different age groups.
"Post-It" wall	Post-it notes were available for participants to attach to a board with their thoughts and ideas. Contributors were then asked to prioritise the collection of comments.
Play-and-say	Younger children were encouraged to play while talking to a researcher in the simplest terms about their experience and perceptions.
Post-card to the Research Team	Participants were encouraged to write responses to simplified versions of the research questions on a large-scale post-card to be posted to a recognised figure involved in setting up the project.
Wish tree	Participants were able to write their responses on a paper leaf (with help from a researcher if needed) and hang them on the wish tree.