Child: care, health and development
Original Article
doi:10.1111/j.1365-2214.2010.01116.x

HENRY: development, pilot and long-term evaluation of a programme to help practitioners work more effectively with parents of babies and pre-school children to prevent childhood obesity

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Accepted for publication 2 April 2010

Abstract

Background Despite epidemic numbers of obese and overweight pre-school children, professionals report a lack of confidence and self-efficacy in working with parents around lifestyle change. HENRY – Health Exercise Nutrition for the Really Young – trains health and community practitioners to work more sensitively and effectively with parents of babies and pre-school children around obesity and lifestyle concerns. Underpinned by the Family Partnership Model, reflective practice and solution-focused techniques, it offers face-to-face training and e-learning. This paper describes the development, pilot and evaluation of HENRY Sure Start Children's Centres.

Methods Twelve Children's Centres in Oxfordshire took part in the pilot involving 137 staff. Questionnaires were administered at the end of training courses. Self-reported confidence ratings were obtained before and after training. Postal questionnaires were sent to Centre managers 2–6 months later to ascertain long-term effects. Nine managers participated in in-depth interviews. A further 535 learners completed the e-learning course and online feedback.

Results One hundred and thirty-one staff (96%) completed the training course and valued it as a way of enhancing skills and knowledge. Mean (±SD) self-reported confidence ratings increased (4.1 ± 0.7 to 7.2 ± 0.7; $P < 0.00001$). An influence on personal as well as professional lives was apparent. Long-term follow-up indicated ongoing impact attributed to HENRY on both Centres and staff. All 535 e-learners successfully completed: 98% would recommend HENRY; 94% thought it enhanced their skills as well as knowledge.

Conclusions HENRY is an innovative approach that offers some promise in tackling obesity through training community and health practitioners to work more effectively with parents of very young children. It appears to have an effect on participants' personal lives as well as professional work. A large-scale long-term study would be required to ascertain if there is the desired impact on young children's lifestyles and risk of obesity.

Keywords
childhood obesity, e-learning, lifestyle change, obesity prevention, professional skills, professional training

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Introduction

Childhood obesity is now recognized as a public health issue of epidemic proportions and epidemiological studies demonstrate that ever-younger children are affected. As many as one in four children in the UK are overweight (body mass index > 85th centile) on starting school (National Child Measurement Programme 2009), and systematic reviews indicate that rapid weight gain in the first months of life is associated with later obesity (Baird *et al*. 2005). In the face of these data, efforts to tackle the epidemic through focusing on school-age children (Summerbell *et al*. 2005; Oude Luttikhuis *et al*. 2009) may be misplaced. There is an imperative to intervene much earlier in life, although systematic reviews show there is a paucity of interventions in children under the age of 5 years (Bluford *et al*. 2007; Campbell & Hesketh 2007; Bond *et al*. 2009).

In 2006 we obtained a grant from the Child Growth Foundation to ascertain key stakeholders' views around obesity prevention and treatment in the pre-school years. Parents of obese babies and pre-schoolers reported their discontent at their experience in primary care, described how the advice given was unhelpful, and at times judgemental or dismissive (Edmunds *et al*. 2007). Health visitors (specialist nurses who deliver the universal child health promotion programme in the UK) reported a lack of confidence in discussing obesity with parents, particularly if they were obese, and highlighted a lack of training and continuing professional development in this area (Edmunds *et al*. 2007). The findings corroborated research in the USA that showed that health professionals lack a sense of self-efficacy when managing child obesity (Story *et al*. 2002; Perrin *et al*. 2005a).

HENRY – Health Exercise Nutrition for the Really Young – was designed with grants from the Child Growth Foundation, the UK Department of Health and Department for Children Schools and Families to address professional needs. It aims to enhance skills so that community and health professionals are more effective, sensitive and confident when working with parents of very young children around lifestyle change and obesity prevention. The programme has been in considerable demand across the UK and has been included in a number of UK government documents, including the Child Weight Management Programme and Training Providers Procurement Framework; the Child Health Strategy Healthy Lives, Brighter Futures (2009); Healthy Weight, Healthy Lives (2008); and the Healthy Child Programme (2009).

This paper describes the development of HENRY, its pilot and evaluation in the short and longer term. The pilot took place within Sure Start, a UK government initiative to improve the outcomes for most disadvantaged families. Sure Start Children's Centres are located in deprived areas, where obesity levels are likely to be high. They provide parents with well-child health care, day care for pre-school children and a variety of other health and community classes and opportunities.

Methods

Development of the intervention

HENRY was designed following review of the literature for lifestyle interventions and discussion with experts in the fields of parenting and obesity. It was refined in the light of a needs assessment involving 12 Sure Start Children's Centres. It was clear from these discussions that a training course to develop the knowledge and skills of the early years workforce would be welcomed. Children's Centre managers identified among their staff a reluctance to address lifestyle issues and obesity with client families through lack of knowledge and fear of causing offence. They expressed the hope that training would offer a holistic approach to help them develop a co-ordinated range of activities for their communities. The majority also mentioned that there was significant obesity among the workforce, and voiced the desire for staff to benefit from training for themselves and their families. The need for consistency across multi-agency professionals was also considered important. Combining parenting skills and a sensitive approach with key information about nutrition was regarded as essential.

The result was a 2-day training course designed to enhance the skills of community and health practitioners when working with individual parents and carers. Acknowledging the discontent expressed with a conventional 'medical' approach, the Family Partnership Model (Davis *et al*. 2002) was chosen to underpin the programme. This was combined with a process of reflective practice (Jasper 2003) and strengths-based support incorporating techniques from brief solution-focused therapy (Selekman 1997) to encourage lifestyle change.

HENRY's core components involve five key lifestyle areas (see Box 1). Its aim is to help practitioners support parents in providing an optimal home and family environment for their babies and pre-school children. The emphasis is on working in partnership and helping parents with family lifestyle change. The HENRY approach is fully described elsewhere (Hunt & Rudolf 2008).

Resources for professionals and parents were developed: a practitioners' handbook (Hunt & Rudolf 2008), an interactive e-learning course (Rudolf & Hunt 2008) to provide

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Box 1. HENRY – Health Exercise Nutrition for the Really Young

Content
Parenting skills
Healthy eating behaviour
Nutrition
Physical activity
Emotional well-being
Approach
Family Partnership Model
Reflective practice
Strengths-based attitude
Solution-focused support
Resources
Tackling child obesity with HENRY handbook for practitioners
Tuning in to mealtimes DVD to promote responsive feeding
Poster: steps in growing, including hunger and fullness cues
Chart: a guide to portion sizes for the under 5s
Placemat: eatwell plate
Food and activity diary
Family reward charts and stickers
Ball and activity ideas sheet
Story books
Game: Let's Go Shopping

practitioners with ongoing access to HENRY and a toolkit of resources for use with families.

Pilot of HENRY training courses

Following recommendations by Children's Centre managers who networked across Oxfordshire, 12 Centres elected to join the pilot, which was conducted between February and June 2008. The courses were delivered to whole teams of staff by an experienced facilitative trainer (CH) with extensive expertise in counselling and parenting education.

The e-learning *Childhood Obesity and HENRY* course underwent an independent pilot. 155 Children's Centres across the country were recruited through a flyer distributed at a national conference for Centre managers arranged by the Department for Children Schools and Families. The HENRY toolkit was offered as an incentive to encourage participation. The pilot was conducted in two phases, March to April, and May to June 2008 allowing for review and modification before its final release in July.

Evaluation process

The evaluation process entailed self-administered questionnaires for individual participants, a postal questionnaire to managers and interviews at the Children's Centres. As this was a service evaluation ethics approval was not a necessary requirement.

Face-to-face training

At the end of each day trainees completed a brief anonymous questionnaire asking for comments, suggestions and views about the usefulness of the topics covered, how the training would help in their professional and/or personal life and the extent to which it met their expectations. Results were collated and the per cent of respondents providing a positive response for each question was calculated for each question. In addition, before and at the end of the training participants were asked to anonymously rate their confidence when working with parents/carers around obesity-related issues using a 10-point scale. A code was used to allow comparison of scores before and after training using the Student's paired *t*-test.

The forms allowed for free comments, which were collated. Themes were identified by two of the team and examples extracted to illustrate reactions to the course, aspects of the training that were particularly valued, negative comments and any additional comments that could help shape the course on future occasions.

E-learning course

Learners on the e-course took an online assessment, providing data on successful completion. They also completed an online evaluation form, which was analysed electronically. Questions related to the usefulness of the course in enhancing knowledge and skills, enjoyment, its applicability to work in obesity treatment as well as prevention, and technical difficulties. As only minimal modifications were required following phase 1, the results from both phases of the pilot were pooled.

Long-term evaluation

Two to six months after their training, managers received a postal questionnaire from an independent researcher (KH) to determine any ongoing effect on staff skills or their Centre. Managers' views were sought about the HENRY approach to obesity and supporting parents, the impact on their staff and its relevance to their particular community. The questionnaires,

which had both qualitative and quantitative components, were analysed by the researcher, and the qualitative comments were analysed under the supervision of an experienced mentor (MB).

Subsequently, managers were asked if one of the HENRY team who had not been involved in the training (JG) could visit the Centre to explore these issues in more depth. These interviews, which lasted for about 1 h, were with the manager and on occasion some staff members too. Notes were taken at the time of the visit and a detailed record of the interviewer's observations and reflections was made immediately afterwards. These were sent to the Centre for corroboration and then were analysed by the researcher and another member of the team (CH) independently for evidence of how well HENRY fitted into the work of the Centre, any impact on staff's work with parents, any changes that the manager attributed to the training and suggestions for improvement. Comments were selected that illustrated the themes that emerged. As funding had not allowed the resources for evaluation, a more rigorous qualitative approach was not possible.

Results

One hundred and thirty-seven staff from 12 Centres were trained: outreach workers who provide home-based support to parents (18%), health visitors (15%), nursery nurses (15%), Centre managers, Foundation Stage teachers, day care co-ordinators, family support, early years and crèche workers. One hundred and thirty-one (96%) completed both days. One thousand and seventy practitioners responded to the flyers about the *Childhood Obesity and HENRY* e-course; 535 from 115 Children's Centres completed the course, of whom 342 submitted the online feedback.

Participants' views

Ninety-nine per cent found the training useful or very useful. Examples of practitioners' comments are shown in Box 2. Many highlighted the value of reflecting on how they approached parents, on their assumptions and judgements and the tendency to give too much advice; others appreciated the clear, straightforward guidance on nutrition. The importance of eating behaviours in preventing obesity was new to many staff. Practitioners often commented on the value of the approach to other aspects of their work.

Box 2. Examples of practitioners' comments following the 2-day training course.

Working with parents using a solution-focused approach
- 'I have changed the format of the information I give. You can see the penny drop when discussing with parents portion control, reading signs for hunger and positive parenting! We are seeing positive results and confident parents!'
- (The best part of the course) 'How to listen and respect what parents are saying.'
- 'I feel very positive and I have got lots of ideas for working with parents/families.'
- 'Extremely interesting and valuable. Useful to take practical stages into the way we work with families.'

Self-efficacy
- 'I'm positive that I can make a change.'
- 'I feel more inspired than I've been for years.'
  'It exceeded my expectations + built my knowledge to allow me to feel confident in talking to parents.'

Team working
- 'It has brought the team together around an emotive topic that needs changing – thank you.'

Change in personal life
- 'It's inspired me to eat more healthily and do more exercise.'
  'I plan to change my personal lifestyles + increase the knowledge of healthy eating with the children I work with.'

General comments
- 'Fantastic! Lots of balance between information/trying things out/group ideas.'
- 'This has been the most meaningful, valid and succinct training I have ever taken part in.'
- 'A really good training with lots of activities and group work.'
- 'Exceeded my expectations and built my knowledge.'
- 'Extremely interesting and valuable.'

The way in which the training was conducted – modelling the strengths-based, solution-focused approach, with the trainer drawing on the group's expertise rather than adopting a didactic style – was valued, and contributed to the increase in staff confidence over the 2 days. Mean (±SD) self-reported confidence ratings increased from 4.1 ± 0.7 to 7.2 ± 0.7; $P < 0.00001$. Many participants commented that the training would trigger healthy changes in their own lives as well as their professional work (see Box 2). There were few negative comments or suggestions for improvement other than requests for further training and a structured programme that

they could use with groups of parents and carers to complement their one-to-one work.

E-learning course

Ninety-eight per cent evaluated the course as useful or very useful, with 97% reporting that it had improved their knowledge about obesity and how to work effectively with young families. Ninety-four per cent unexpectedly reported that they thought it would enhance their skills as well as their knowledge. Ninety-eight per cent said they would recommend the course to colleagues.

Post-training questionnaire to Centre managers

Eleven of the 12 managers responded to the postal questionnaire. They all rated HENRY as excellent or very good in terms of encouraging reflective practice, changing attitudes towards obesity, meeting training needs, being informative and being supportive of parents. Aspects that were rated most highly included developing parenting and relationship skills, and fostering healthy eating behaviour, nutrition and emotional well-being. Nine rated the training as being of direct relevance to their particular community.

Examples of events or changes in the Centres that managers attributed to HENRY included an increase in healthy eating groups, health awareness events, weaning workshops, consideration of food and portion sizes, substitution of fruit for biscuits at snacktimes and a reduction in snacks. Eight had plans to deliver the *Let's Get Healthy with HENRY* course for parents, which was developed in response to participants' requests.

Interviews with managers at long-term follow-up

Nine of the 12 managers agreed to be interviewed. Visits took place 2–8 months following HENRY training. The interviews corroborated the postal questionnaires and added richness to the evaluation. Themes that emerged included the contribution HENRY made to the Centres' ethos, development of activities, ways of working with parents and the effect on staff relationships and personal lives (see Box 3).

The HENRY approach had been welcomed and found to fit well with the existing ethos of the Centres. Managers described a generally raised awareness about healthy lifestyle, reporting that HENRY was core to programmes offered and was being incorporated into strategic plans. Specific examples included healthier food within the Centres and, where food was served, it was more likely to be eaten in a social setting. Many Centres were involved in projects to encourage activity and gardening.

The emphasis on partnership working with parents was valued, and one manager commented that now her staff '*were doing with, rather than doing to*'. Others reported that the staff were judging parents less and felt more confident about exploring lifestyle issues. There was recognition that where changes in

Box 3. Examples of managers' comments in follow-up interviews.

Effect on the Centre
- 'HENRY has become a core part of the programme offered here.'
- 'HENRY training has raised our awareness of healthy lifestyles, and the need to promote the ethos within the centre.'
- 'The magic thing about HENRY is the way it builds bridges, enabling links with other health projects that are happening in isolation which we now see as a holistic lifestyle approach.'

Effect on team working
- 'The opportunity to train as one team was valuable and HENRY is in the back of our minds when we are setting up activities.'

Effect on competence and attitudes when working towards obesity prevention
- 'It has become easier for the staff to explain issues around healthy lifestyles.'
- 'The trainees have held onto the message, as 5 staff attended training it has really helped. It has been support for each other when questioning decisions within the Centre around healthy lifestyles.'
- 'The enjoyment and learning during the 2-day HENRY training really promoted the enthusiasm of the staff team: they returned to the Centre determined to put some of their learning into practice.'
- 'It has given us a greater awareness of how other professionals work and the difficulties that parents face – e.g. it gave us real insight into how the medical / expert model can make it difficult for parents (and for staff who use it, perhaps almost unconsciously . . .) to begin to think about change.'

Effect on personal lives of staff
- 'Two of the staff have lost weight and two have joined a gym.'
- 'Things are going well. The staff has been reflecting on their own lifestyles.'

the Centre were made there was better acceptance when decisions were taken in partnership with parents. Some of the Centres had formed parent advisory and 'think tank' discussion groups.

The finding that staff were implementing changes in their personal lives again emerged. Examples included change in their own and their family's lifestyle, weight loss, healthy food choices, exercising more, supporting others, providing healthier lunch boxes for their children, eating together as a family and being able to say no to their children.

The opportunity to train as a whole team was valued, and contributed to a supportive environment particularly regarding lifestyle change within the Centre and the staff's personal lives. It allowed all staff, as one manager said 't*o be singing from the same hymn sheet*'. Another manager commented that there was a general feeling of positivity among the staff and that they were more open and supportive of each other.

Discussion

There is solid epidemiological evidence that weight gain in babyhood is predictive of later obesity (Baird *et al*. 2005), and that lifestyle behaviours also have their roots early on in life (Rhee 2008). However, guidance for the pre-school years is lacking – indeed the National Institute for Clinical Excellence Obesity Guidelines are limited to individuals over the age of 2 years (NICE Clinical Guideline 43 2006).

A body of research has emerged that shows that health and community professionals, while acknowledging the importance of their role in tackling obesity, feel unprepared for this work. In both the USA and the UK, a lack of self-efficacy when working with parents around healthy lifestyle has been highlighted. (Story *et al*. 2002; Perrin *et al*. 2005a; Edmunds *et al*. 2007). This is compounded by UK Department of Health estimates that 40% of the health workforce is overweight or obese (Healthy Weight, Healthy Lives 2008), and other reports that health professionals are often unaware of their own weight status (Perrin *et al*. 2005b).

HENRY was developed to address a need to work in a different, more respectful way when working with parents of babies and pre-school children. The pilot in Sure Start Centres, located in disadvantaged areas where obesity levels are likely to be high, showed that the training was exceptionally well received, and the approach highly valued. Participants and their managers reported an increase in both confidence and skills when working with parents, and rather surprisingly this was true for learners on the e-course too. Especially encouraging was the finding that many months later Centre managers described an ongoing impact on their team that they attributed to HENRY.

As an intervention, HENRY takes an innovative approach, attempting to tackle obesity through working with parents of babies and very young children. Interventions for this age group are sparse; very few trials are under way (Bluford *et al*. 2007; Campbell & Hesketh 2007; Bond *et al*. 2009) and they tend to deliver a prescribed 'package', usually to groups or to children directly in day care settings. By contrast, HENRY aims to build the skills of practitioners to enable them to work more effectively with parents in any contact they have – opportunistic or planned, one-to-one or in a group. As a result it fits particularly well with the concepts of progressive universalism outlined in the new UK national Healthy Child Programme (Healthy Child Programme 2009).

This approach poses considerable challenges for evaluation. Our ultimate goal is to reduce levels of obesity in children at school entry, but this goal is far too 'downstream' to measure now. Difficulties include families' variable contact with Children's Centres, their mobility and the fact that positive effects on family lifestyle might occur without a measurable change in obesity in the early years. The most immediate and relevant outcome is an improvement in skills when working with parents. By subjective report this did happen; more objective outcomes are also required, and are hard to measure. Nonetheless the findings are encouraging, especially as ongoing changes were attributed to HENRY many months after training took place.

Indicators for how HENRY might be enhanced included more time, although this is problematic as obesity prevention is only one of many competing priorities and training days are restricted. The need for ongoing support was also clear, and with expansion of the HENRY training team, this is being developed. Requests to extend HENRY to groups of parents have resulted in an 8-week *Let's Get Healthy with HENRY* course, now under evaluation.

While the findings are encouraging, it is important to consider limitations. First, the training was delivered by one experienced trainer. Others may not gain the same response, although there are clear signs that new HENRY trainers, as they gain experience, are able to achieve these results too. The other limitation relates to the interviews that were conducted by another of the HENRY team as familiarity with the HENRY approach was essential. Every effort was made to ensure that the analysis of the qualitative data was conducted well, but lack of resources for formal analysis no doubt is a limitation.

Clearly more rigorous, independent evaluation is required before considering these findings to be conclusive, but it does

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suggest that the HENRY approach truly addresses practitioners' needs. It was particularly rewarding to find that practitioners described changes in their personal and family lives, especially as many of the staff were themselves overweight or obese and many had young families. This may well have added value, as practitioners are likely to be more effective and credible if they have successfully grappled with lifestyle change themselves.

There is a pressing need for trials of clinical and cost-effective interventions in the pre-school years. In the face of the epidemic of obesity we cannot afford to simply await their results. In parallel, it is important to address practitioners' skills. George Patton, a distinguished American General once said: 'A good plan executed today is better than a perfect plan executed at some indefinite point in the future.' HENRY offers an approach that practitioners value, impacts on their personal lives and has an ongoing effect on the settings where they work.

Key messages

- Health professionals report low self-efficacy when working around obesity prevention and treatment.
- HENRY – Health Exercise Nutrition for the Really Young – was developed to provide Sure Start Children's Centre teams with training around working in partnership to achieve lifestyle change.
- Staff valued the face-to-face training and e-learning, and unexpectedly reported an influence on their personal as well as professional lives.
- An almost twofold increase in confidence scores when working with parents around obesity prevention was found.
- Follow-up after 6 months indicated an ongoing impact on the Children's Centres and practitioners' competence that managers attributed to HENRY.

Authorship

Mary Rudolf was responsible for the evaluation process and drafted the manuscript. Candida Hunt delivered the training to Sure Start Children's Centre teams, designed the training evaluation forms and provided comments on the manuscript. Jackie George conducted the interviews with Sure Start managers. She and Candida Hunt co-analysed the qualitative data. Kati Hajibagheri designed and analysed the postal questionnaires. Mitch Blair supervised the analysis and provided comments on the manuscript. All the authors read and approved the final version of the paper.

Acknowledgements

This research was conducted through grants from the Child Growth Foundation, the Department of Health and the Department for Children, Schools and Families. We are grateful to the 12 Children's Centres in Oxfordshire, their managers and their staff for their participation in this work. We are also grateful to the Virtual College for the technical design of the e-learning course and collation of the evaluation electronically.

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