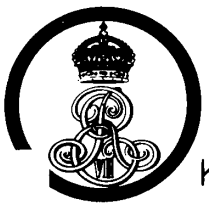
CARING FOR HEALTH

A report on

health issues for one parent families



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ISBN 0 901582 82 4

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Health issues for one-parent families

Report of a conference organised by
the National Council for One Parent Families
in collaboration with the King's Fund,
held at the King's Fund Centre on
12th October 1984.

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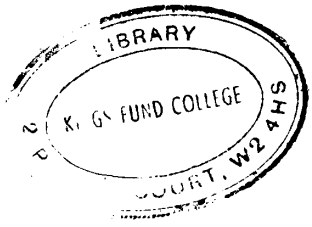

INTRODUCTION

The National Council for One Parent Families has always had an interest and concern in issues of health, both of parents and of children. In 1983 a grant from the King Edward's Hospital Fund enabled us to start a new project to investigate this important area of work. We initiated a pilot project in London to explore lone parents' views on their own health and that of their children. We talked to groups and individuals about the effects on their physical and mental health of becoming a one-parent family, of child care and job pressures, of unmet need and housing problems. We also discussed lone parents' experience of the health service and health professionals'. Finally we then involved a number of health professionals in our discussions.

The conference, Caring for Health, of which this is the Report, was held to consolidate our work in this area and to enable a wide range of single parents and health professionals to participate in our discussions. Our starting point was the idea that good health was not simply an absence of sickness, but a positive state of well-being and an ability to live life to the full. We are well aware that many of the constraints faced by lone parents, through lack of income or support may, prevent this.

The conference focused on five key issues:

* Do one-parent families have special health needs?

* Do health workers recognise the health needs particular to one-parent families?

* What can we reasonably expect from health professionals?

* How can we change attitudes?

* What concrete proposals can we draw up for future action?

In discussing these questions, two factors were found to be especially important for the health of one-parent families. The first, poverty, has already been mentioned. The opening speaker, Dr Hilary Graham, presented some disturbing facts about poverty as it exists in Britain today. From this she drew conclusions about the links between poverty and ill-health and the need for all mothers to have access to adequate resources to protect their families' health.

The second factor, - discrimination, is less tangible but no less real to those who experience it. The majority of lone parents are women and consequently face varying degrees of gender discrimination particularly in the field of employment. Single mothers all too often find themselves disandvantaged in employment because of their sole responsibility for child care. Clearly women's responsibility for children should be acknowledged by better conditions of employment for women workers and more adequate child care facilities. Black lone parents face additional discrimination. Their lives are made more difficult by having to deal with racism, both institutional and personal, from the white community. A point made forcefully by Mavis Clarke in her contribution.

The conference was also concerned with the role of health workers. We considered how far they were able to help meet the needs of lone parents and their children, and whether, negative attitudes from doctors and health visitors could contribute to health problems. Jenny Smith, a London health visitor, explored the difficulties faced by health visitors in making contact with one-parent families in the first place, and then maintaining that contact in the face of other pressing commitments.

Both professionals and parents agreed that the health service should be geared to the needs of clients rather than to administrative convenience. The training of health workers also ought to be changed to include information on the poverty, unemployment and racism which produces much of the ill-health in our society. As a contribution to this, all those who attended the conference were given a copy of the Caring for Health pack*. Health workers often face situations where advice on benefits, guidance on how to apply for a housing transfer or the address of a self-help group is what a family most needs. The pack brings together a variety of information sheets to assist health professionals to provide necessary information to lone parents. Included are guides to welfare benefits, housing and legal rights, and a list of helping and self-help organisations to which lone parents can be referred for specialist help.

Whilst recognising the vital importance of the health service and health workers, both speakers and those attending the conference emphasised the importance of people having access to adequate resources, both financial and emotional, to maintain their own and their children's health. The successful Women's Action for Mental Health project, on the White City Estate in Hammersmith, demonstrates that when people are in control of their own lives they are able to take action to change the circumstances which oppress and undermine them. Julie Kaufmann described the unique role self-help groups can have in restoring confidence and well-being to lone parents finding it hard to cope with life.

The National Council for One Parent Families has campaigned for a great many years on the issues of an adequate income for one-parent families, better terms of employment and day care. This conference on the health needs of one-parent families has further convinced us of the importance of achieving these aims for lone parents and their children.

Carol Smart
Director, One Parent Families
February 1985.

*Caring for health - health pack is available from One Parent Families, 255 Kentish Town Road, London NW5 2LX, price £1.95 incl. p&p.

KEEPING THE FAMILY ON A LOW INCOME:

ONE-PARENT FAMILIES AND TWO-PARENT FAMILIES COMPARED

by

Dr Hilary Graham, Lecturer in Social Policy, Bradford University

I hope to set the scene for today's conference by discussing some of the health issues which confront families with young children. I look particularly at the position of mothers in families living on low incomes, identifying some of the complex issues they face and have to find ways of resolving.

There are two parts to this paper which set the scene in two rather different ways. In the first half, I raise some general issues which relate to the health experiences of families with young children. I focus on three such issues: the increasing poverty among families with children, the organisation of caring in families and the distribution of money and other material resources in families.

A recognition that these questions - of poverty, the organisation of caring and of the distribution of resources - are health issues, provides the framework for the second part. This second part has a more 'real world' feel. Here I am concerned with how mothers go about the everyday work of keeping themselves, their partners and their children healthy when money is short. I will be presenting, in a very preliminary way, some of the data from a survey I have recently completed. I want to draw on the comments and insights of the mothers we interviewed in one and two-parent families on low incomes, to describe how parents cope with the task of keeping the family healthy when money is tight. Some of their comments and insights also find their way into what I want to consider now: namely, the complex links between poverty, the organisation of family life and health.

Influences on family health: three health issues

1. Poverty

Throughout the nineteen-sixties and seventies, it was the elderly who dominated the landscape of poverty. But from 1979, the picture began to change. Today, it is parents with children who form the largest group among Britain's poor: larger than the elderly or single people or couples without children. Within this group, we find many of Britain's one-parent families.

The increase in family poverty raises urgent questions for those concerned with the welfare of mothers, fathers and children. They raise particularly urgent questions about health.

Poverty is known to be linked to poor health. More ill-health, both physical and psychological, is found among parents and children living on low incomes in areas of poor housing and poor employment opportunities. Social class statistics on health provides a measure of the effect of material deprivation on parents and children. If you look at social class statistics the impact on health comes out clearly. Perinatal mortality (the number of babies who

die in the first week and still births) is taken as the most accurate and sensitive measure of the health of the nation. The recent figures for 1983, provisional though they are, highlight the class differences that still exist. Among babies born to mothers in social class I, six out of 1000 are still born or die in the first week of life. Among mothers of social class IV and V, where material deprivation is concentrated, the figure is 16. Infant mortality rates and the rates of death in childhood and adulthood all climb steadily as we descend the social class ladder.

These patterns of ill-health are widely known: most people recognise that material disadvantage and poor health often go together. What is less widely appreciated is that ill-health is bound up with the way governments think about, and measure, poverty. It is this fact, that ill-health is built into our accepted definitions of poverty, that I want to briefly discuss.

There are two standard measures of poverty on which most of the statistics are based. The government takes the current level of Supplementary Benefit as its measure of poverty. However, the stringency of this measure of poverty has led researchers to broaden the band of poverty to include those whose incomes are above the level of Supplementary Benefit. The poverty line most commonly employed is drawn at 40 per cent above the level of Supplementary Benefit. Applying this measure to the latest 1981 statistics on families with children reveals that 28 per cent are poor. In 1981, three million children were growing up in poverty.

What I want to highlight is not only the scale of hardship revealed by these definitions of poverty. I want to draw attention to the way both definitions are linked to ill-health. The concept of a poverty line used in statistics has a particular meaning: it is a level of household income deemed just sufficient to keep the family healthy. Living in poverty, therefore, means living on an income insufficient to buy the basic necessities of shelter, warmth, food and clothing needed to maintain health. Poverty, in other words, is a level of income which threatens health. Thus, for those who accept the less stringent definition of poverty, based on a poverty line 40 per cent above Supplementary Benefit, living on Supplementary Benefit is a threat to health. It means fighting a constant, and often losing, battle to keep one's family in health and keep them out of debt. One mother in our survey who was living on Supplementary Benefit with her partner and her two children explained it in this way: "you can't really cut down because we only buy what is essential...There's nothing really I can cut back on. But if you don't pay your bills, you go to Court and I don't want to do that... I still say it's not enough for a family to live on." What this mother is trying to alert us to is the fact that being in poverty means choosing between financial survival and health (physical) survival.

To understand more about how parents cope when money is short, we need to appreciate two aspects of family life. One concerns how the work of keeping the family in health is organised; the other concerns how the resources for family health are organised.

2. Caring within the family

This second dimension of family health is one of which I suspect many one-parent families have first-hand experience. Caring for the family has been, and remains, women's work. While nationally the majority (53 per cent) of mothers with dependent children are in paid employment, most still carry

the major responsibility for keeping the family healthy. When we look at the kinds of work women do in the home, as when we look at statistics on poverty, it is not immediately apparent that they are about family health. We tend to think of health-promoting activities in a rather narrow way: we think of jogging and aerobics, perhaps, or trips to the child health clinic or routine breast examination: a limited range of activities conjured up by the campaign to 'Look After Yourself'. But looking after the health of the family is much broader and more basic than this. Protecting the family involves all the everyday domestic activities we call housework: cleaning, washing, shopping, cooking. It involves all the caring, supervising and teaching activities we associate with motherhood. And it involves nursing the sick and dealing with professionals, with doctors, midwives, health visitors, social workers.

Caring is a highly labour-intensive activity. However much of it's a labour done for love, it is still very demanding and very tiring. One of the mothers in our survey commented, "caring for children is the hardest job going, it's very demanding in time, energy and affection, 24 hours a day." It is also likely to be stressful. Ninety-five per cent of the mothers we spoke to agreed that stress was part of the experience of looking after children both in two-parent and one-parent families.

But keeping a family healthy depends on more than hard work. It also demands money for the rent or mortgage, money for the fuel bills, money for food and clothes and toys, money for playgroups, money for transport. To care successfully for family health, parents - whether mothers or fathers - need access to money and the material resources that it buys. Where resources are inadequate, carers tend to compensate by going short themselves. By giving themselves less, they can act as a buffer against poverty for the rest of the family. Looking after the health of others can thus take its toll on the health of carers. Keeping the family health can be unhealthy work.

To understand more about the complex and confusing position in which mothers find themselves, we need to consider in more detail how material resources are distributed in the home, the third area I want briefly to discuss.

3. Sharing out the family resources

Statistics on poverty, like the ones that reveal that over a quarter of Britain's families are poor, make a crucial assumption about family life. They assume that individuals in poor families are equally poor: that hardship is shared equally among all family members. Similarly, they assume that poverty is confined to poor families: they assume that in families above the poverty line, all family members enjoy a reasonable standard of living. Yet, there is much evidence to suggest that this assumption is invalid: that living standards vary within families as well as between families. In poor families, some members are poorer than others: in rich families, there can be hidden poverty.

The existence of these inequalities within families has prompted researchers to look more closely at the distribution of resources between mothers and fathers in two-parent families. What they have found is that while mothers need access to a wide range of resources to fulfill their caring responsibilities, the expectation prevails in many families that the father should have first claim to the household assets. Two examples, I hope, will illustrate how the distribution and control of health resources can be out of

line with the division of health responsibilities.

The possession of a car is often taken as an indicator that a family is reasonably well off. In our survey, 85 per cent of the two-parent families had a car. But what we like to think of as a 'family car' was, in most cases, 'daddy's car'. Only in the minority of families where there was a second car, did women have access to a car during weekdays. During the vital 9.00 to 5.00 period where most of her health-related journeys - to the shops, clinic, playgroup, hospital - are concentrated, most mothers in car-owning families were in the same position as mothers in families without a car. This is not to cast a slur on those fathers who drive off to work and leave their partners carless, but simply to point out that we cannot assume that the possession of a car improves the quality of daily life for all the family.

A second, and more important, example is money. The money women spend on the family is commonly referred to as the housekeeping money. It should more accurately be seen as healthkeeping money: the money they have available to keep the family healthy. For two-parent families with young children, this money is typically paid out of the man's wages and supplemented by Child Benefit and any wages she may earn. In our survey, the most popular system was one in which a fixed sum, usually between £25 and £40, passed from the partner to the respondent, generally on a weekly basis. In other households, the arrangement was more flexible and more negotiated. Yet, while three-quarters of the two-parent families had incomes above the poverty line, only half of the mothers in these families felt that the money they had for housekeeping was sufficient to meet the expenses of caring for the family.

The comments of lone mothers shed further light on the way in which money is distributed in two-parent families. Among the one-parent group, only two had incomes which lifted them above the poverty line. Yet, when we asked them whether they felt they were better off financially than when they were living with their partners, over half said they were. This was not because family income had risen: most respondents made it clear that they were actually poorer as single parents. It was because they controlled a larger share of the family income that their economic circumstances had improved. As two lone mothers explained:

> I'm much better off. Definitely. I know where I am now, because I get our money each week and I can control what I spend... oh he was earning more than I get but I was worse off than I am now. I'm not so poor on £43 a week for everything for me and two children as I was then.
>
> I'm better off, believe it or not. I know the money I've got now and it's more than I had before.

Another amplified the same point:

> Believe it or not, I am far better off financially on my own than I ever could be with him. But it took such a long time to get them finances sorted. DHSS, trying to get money from them and statements and solicitors. But when that was done, it was okay. After about a year, it all got sorted out... At least now I know where the money's being spent and it's not being spent. It might not last long, but at least it's

being put into provisions for the home.

Recognising the way in which the distribution of income and other resources in marriage can work against women, and their health-responsibilities to their children, makes us consider carefully the question of health in one-parent families. One-parent families, and lone mothers in particular, are more likely to be living on poverty-line incomes, where they can only maintain their family's health by spending all their money on basic necessities. Yet, while more vulnerable to the poverty induced by low income, they are protected against the poverty which results from the unequal distribution of resources found in two-parent families. One lone mother made the same point more simply. The end of her marriage had brought a change from life with a reasonably paid but profligate husband to life on Supplementary Benefit. She observed 'it's always been hard financially, now and when I was married, but for different reasons.'

This comment ends my discussion of some general issues surrounding family health. I now want to turn to the survey I have just completed, for more information on the complex question of how one and two-parent families cope when income is low.

Keeping the family on a low income: how mothers cope

The research is financed by the Health Education Council and is based on 102 families living in Milton Keynes, all of whom have at least one child under five. The sample came from a much larger survey that Milton Keynes Development Corporation carried out on ten per cent of its residents. We approached mothers who had a child under five and who agreed to take part in a further interview. This gave us a sample of 38 lone mothers and 64 mothers in two-parent families. I have selected from this sample those whose income from wages and from benefits is less than £105 a week. There are 36 single parents in this group and 20 mothers living with their partners.

Milton Keynes is a new town and therefore untypical of the kinds of environment in which many poor families live. The quality of its housing, and its public sector housing in particular, is much better than that found in many inner city areas. Most of the low income families, around 75 per cent, live in council rented accommodation. Offsetting this, many young families are newcomers to the area. Nearly half (47 per cent) of the mothers had moved to Milton Keynes in the last five years, often, but not always, leaving behind families and friends. Again on the negative side, the open-space city-in-the-country design of Milton Keynes causes particular problems of access to shops and services for families on low incomes. When walking (and walking with young children) is the only mode of transport, the central shopping area can be a very long way away.

There were broad similarities in the circumstances of the low income families. Among both one and two-parent families, one or two children was the norm. About three quarters of both groups lived in Milton Keynes Development Corporation rented accommodation and about a quarter were on the phone. Over half the mothers in both groups smoked, as did over half of the partners of the mothers in two-parent families. There was one interesting difference between the two groups: the low income two-parent families were much more likely to have a car. Threee quarters of the two-parent group had a car, compared to one quarter of the one parent group.

Turning from their material circumstances to the question of how they coped on a low income, differences become more apparent. As I noted earlier, when a family lives on or near to the poverty line, all money needs to be devoted to health expenditures if the health of all is to be maintained. Additional expenditures, on debt repayments for example, or H.P. commitments taken on when times were better, make economising essential. When asked "Are you economising now?" the answer is "Yes, it becomes a way of life." Where and how economies are made is thus a vital health issue.

We asked the mothers where they would cut if further savings had to be made. Amongst the low income group, some of the lone mothers said there was nothing left to cut down. But most of the lone mothers and all the mothers living with partners identified something they could economise on. For both groups, cutting back on family spending was seen as a question of cutting her personal consumption. Few referred to measures which involved partners or children.

Some expected areas did not feature on their list of personal cutbacks. Clothes were not mentioned: clothes were something most mothers had long since sacrificed in the struggle to survive. One single parent said "I don't buy any clothes. At birthday times my mother sends me cash or clothes". A mother in a two-parent family said "I don't spend any money on make-up or clothes for myself, so I couldn't save on that". Expensive leisure activities and social life, too, were noticeably absent. One single parent said "I don't really have a social life, not one where money's involved". "I can't really give up on my social life because we don't really have one", was the comment from a two-parent family.

An important area for cut-back identified by half the mothers in both groups - nearly all smokers in fact - was her cigarettes. This may seem an obvious area for savings, yet we cannot dismiss smoking as a non-essential area of consumption for women in hard-pressed circumstances. As one mother put it "cigarettes is all I could cut down. Cigarettes are my one luxury and at the moment they feel a bit like a necessity!" Later in the interview, cigarettes were cited as a major way of coping with the stress of children. After leaving the room, having a cigarette was the most effective means of keeping calm when the children were getting too much.

Sacrificing cigarettes to save money can thus, at the same time, make the struggle to make ends meet more difficult. The second area for cutbacks, cited by half the two-parent families and one quarter of the one-parent families, was food. Again, when mothers spoke of cutting down on food, it was their diet they had in mind. "If I need something for the children, the money's got to come from somewhere. So I just do without for a few days. I cut down on myself, not the children. They have what they always have". As this lone mother went on to explain, her food is about the only area in which cutbacks could be made. A non-smoker living on Supplementary Benefit, with her rent and fuel paid direct, her room for manoevre was highly restricted. As she put it "it has to be me cutting down on what I eat. It's the only way to find the extra money you need really." This point was made in other ways by other lone mothers:

> Food's the only place I find I can tighten up.
> The rest of it, they take it before you can get
> your hands on it really. So it's the food ...
> The only thing I can cut down is food because

> I use as little heating as I can and I don't smoke.

While both groups of mothers saw their diet as an important area for cutbacks, some mothers in two-parent families noted that the savings that could be made in this way were limited. One reason lay in their partner's food preferences, which meant that they were committed to spending relatively large sums on meals for him. Having made this outlay, they could save little by not eating the meal themselves. As one married mother put it "I don't believe in cutting food. I mean, my husband likes his joint of meat once a week and that's it."

A significant area for savings for one-parent families, but hardly mentioned by two-parent families, was heating. Reflecting this, one-parent families used their heating much more sparingly. While two-parent families tended to have the heating on all day or mornings and evenings, lone mothers tended to heat small areas for short periods of time. As in the area of food and cigarettes, cutting back on heat involved sacrifices by the mother, as one mother explained: "I put the central heating on for one hour before the kids go to bed and one hour before they get up. I sit in a sleeping bag after they've gone to bed."

"When the children are in bed, I turn the heating off and use a blanket or an extra cardigan." Such options were not so readily available for mothers living with their partners. Again, as in the area of food, their partner's preferences made it difficult to achieve savings on fuel bills. As one married respondent explained "I turn it off when I'm on my own and put a blanket over myself. Sometimes we both do in the evening but my husband doesn't like being cold and puts the heating back on."

Given the high proportion of car owners among the two-parent families, it is surprising, perhaps that more mothers did not identify it as a 'cutable' item. But the car was not part of her jurisdiction: it fell outside her area of personal consumption. The car couldn't be cut "because it's essential for his work" or because it was "his hobby". "I know he wouldn't give up his car... it's his car, he says and I don't think he'd be prepared to sell it unless we got in real financial difficulties... But I'd get rid of the car and give myself at least £5.00 more housekeeping. I don't drive, I walk everywhere."

In terms of the material struggle to survive, our data suggest that there are certain advantages to being a single parent. But, of course, it means struggling alone. Materially easier, it may thus be more difficult in terms of one's physical and emotional resources.

I want to end by briefly looking at some of the data we collected on loneliness and stress. Here, the data points to some strong and, perhaps surprising, similarities in the experiences of low income mothers in one and two-parent families. The majority of mothers had the support of local friendship networks. Nearly half of the mothers in both groups saw a friend every day and over three quarters had a friend they could turn to with personal problems. Despite friends, most mothers found children made heavy demands. Interestingly, about 75 per cent of both groups said that looking after children made it impossible for them to be ill. My expectation had been that with a deputy carer in the home two-parent families would have found it easier. A similar proportion of the one and two-parent mothers

commented that they were not getting enough sleep (about 75 per cent) and that they had to keep going when they felt ill (again about 75 per cent). And over 90 per cent found that their children could be stressful.

There were, nonetheless, differences between the lone mothers and the mothers living with partners.

Firstly, mothers in low income one-parent families were more likely to assess their life overall was stressful: one half compared to one third of the mothers living with their partners. Becoming a single parent for most women was a highly stressful experience, and an experience which left behind a legacy of problems. Explaining why her life was stressful, a lone mother commented "it's various little bits and pieces of stress all put together, to make a big one." High among the list of little bits and pieces were worries about money, about access and the responsibility for caring alone for children.

Secondly, lone mothers experienced not only more stress, but more loneliness. One half of the low income single parents said they were lonely compared to one third of the mothers living with partners. Evenings were identified as the worst time when the friendship networks of women had closed for the day.

> It's evening time, you know, when you've finished everything during the day and you're sitting here on your own and something comes on the telly and you think, you know, you lack conversation then, there's nobody to share it with, there's nobody to talk to about it, then it can be very lonely. But during the day, the old routine starts again, the kids and you've got friends coming round, but night-times, yes, can bring loneliness and boredom. Very much so.

If we are looking at forms of intervention for one-parent families we have to remember the time structure of people's days and realise that services in the day may not be meeting the needs created in the evening. But it is important to remember that a third of the mothers in two-parent families also admitted to being lonely. Again, evenings and weekends were identified as particularly lonely times. 'At weekends my husband works all day Saturday and I can't see my friends because it's the weekend. I'm lonely in the evenings.'

Conclusion

From this rather brief review of our data, I will finish with an even briefer conclusion. I would like to make three concluding comments.

Firstly, I think the data from the survey, incomplete at present though it is, brings to life the health issues that I introduced at the beginning. The answers the mothers gave in the interviews highlight the kind of material constraints in which women work for family health. They highlight the poverty of mothers and the impact of poverty on health practices. This poverty stems not only from the low level of benefits and incomes on which an increasing number of families live. It stems, too, from inequalities in the way income and other resources are shared out in families. There is all too often a mismatch between the distribution of 'health work' and health resources between mothers and fathers. In a nutshell, my first conclusion is that because mothers are the keepers of family health, their access to

adequate material resources is of crucial importance for their health and the health of their families.

Recognising the importance of access to resources brings me to my second conclusion. I think that the data I have presented warns us against making any simple assumptions about health and family life in one and two-parent families. One-parent families are poorer than two-parent families and their greater material deprivation places both parents and children at risk of ill-health. Yet, at the same time, they are protected by the very fact that they are single parents, released from the system of resource-distribution which often works against mothers in low-income two-parent families.

So my third, and final, conclusion is to recommend that we adopt that annoying habit of social scientists and recognise that the situation is complex and needs more careful analysis. Where many conflicting forces are at work, the temptation is to build a simplified picture which gives undue emphasis to the positive or negative aspects of life in a one-parent family - a picture in which 'everything is wonderful' or 'everything is dreadful'.A conference such as today's provides an occasion to resist stereotypes; an opportunity to learn and understand more about the health problems which face one-parent families.

Note

I would like to record additional thanks to Mary Strode, Research Officer, Milton Keynes Development Corporation; to Richard Austen, Academic Computer Service, Open University and to the interviewers who helped me with the fieldwork: Miki Ashton, Vicki Bennetts, Jackie Hockings, Janet Maybin and Julie Penfold.

HOW SELF-HELP GROUPS CAN HELP

by

Julie Kaufmann, Director, Gingerbread

When we talk about one-parent families we are talking about vulnerable families. Vulnerable families because one adult, single-handedly takes on responsibility for all those aspects of family life which are normally divided between two.

Lone parents can undergo a great deal of personal trauma and stress as the break-up of the marriage occurs, or as the family structure alters. Even if a single parent is happy that the marriage is dissolved there may still be feelings afterwards of ambivalence and insecurity. If the parent did not want the marriage to end there is anger, bitterness, fear, and loss of self-esteem. All these feelings can reduce the single parents' ability to cope at a time when she (or he) needs all her strength and resources to deal with the fundamental changes that are taking place in her and her families' lives.

Even after the initial trauma of the marriage breakdown subsides, the single parent family is still vulnerable simply because of the absence of another pair of hands around the house. One American sociologist calls this "the absence of reserve capability". Even if during marriage a husband has not actually done a great deal to help there is still that small amount of reserve capability. If one of the children falls down and breaks his leg there is somebody to look after the other children while you visit the hospital or there is somebody to do the odd little job around the house. All that goes when the parent is left with the sole responsibility. This can result in a lot of isolation. It also produces a certain amount of task and responsibility overload. The symptoms of task and responsibility overload, when manifested in business men, are taken very seriously indeed. Symptoms in a single parent can be of the same kind. Gradually, their health is affected in all sorts of ways- headaches, stomach aches, backaches, listlessness, or crying all the time.

The health of the lone parent and her ability to cope with day to day life may deteriorate and this at a time when she has the burden of looking after the children, perhaps also a job, all by herself. Such parents often end up in the doctor's surgery. I have never found a doctor to take my symptoms seriously and know many other single parents have had the same experience. I am appalled at the number of single parents, who, when they first come to a group are taking valium and sleeping pills.

These kinds of symptoms and the subsequent visit to the doctors' surgery are often, of course, a cry for help, very often practical help. It is not enough for someone to sit and talk to you and suggest that you can organise things a little better if when you go home you still have the job, and the children, and the tap doesn't work, and the shelf has fallen down and you can't replace the saucepans and there's only one burner left on the cooker. One source of practical help is the self-help group for single parents.

There are many self-help groups for one-parent families throughout the country. Gingerbread has 400 registered groups, but there are others. The

self-help groups that Gingerbread has are all very different. They range in size from ten to 600 members. Some are small rather unsophisticated groups, which operate on the level of sharing experiences perhaps through meeting each other for a drink or a coffee morning. Some of the groups have people who will respond any time of the day or night either by telephone or by visiting someone in distress. Other groups help by organising nursery schools, latch-key schemes, housing co-operatives, and helping each other out with child-minding. In this huge variety the common factor is that all the groups reduce the sense of isolation for the single parent; all provide some kind of social life to replace the one that has been lost.

These groups are not run by professionals - they are run by the single parents themselves and we feel this is very important. Let me give an example of how it works. People generally approach groups feeling very down. They come, not for mutual aid, but for help. What they find when they get there are other single parents who may have similar problems or worse problems than themselves. Within a very few weeks you will find that a lone parent who was upset and felt she couldn't cope, is beginning to get her own problems in perspective. Gradually, instead of taking help this person starts giving it. Very soon their confidence grows and they find they know more than some of the new people coming into the group. They start giving advice and get caught up with organising the group, maybe even sitting on the committee. Six months to two years later, the lone parent who came along to the group because they simply couldn't cope with life at home, the children and the job, is not only coping with all these but is also helping to run a Gingerbread group. As part of the process there is a gradual development of self-esteem and self-confidence and some of the symptoms of fear and insecurity and overload start to disappear.

The group that the single parent joins might not even be a wonderful group in someone else's eyes. Some months ago I met a member of a group that the staff members at head office always regarded as fairly inactive. When I asked how she was enjoying the group, she told me that it had been a life-line. "I joined it about two months ago and until that time I just used to burst into tears everytime someone spoke to me. I didn't dare go out because I was always crying. But now I'm involved, and I've got the job of welcoming new people into the group and talking to them." This shows that it isn't so much what the groups are doing that's important, it's the process of becoming involved and realising that other people have the same kind of problems. Groups give single parents the opportunity to develop new skills, to take on a bit more responsibility, to help other people, and to learn how to do it with others.

Involvement with groups may not suit everybody, but for many people group membership can be a platform from which they start to cope with their life again. Because of their involvement with the group many members have started going along to courses about giving welfare rights advice, or group management; or start courses on book-keeping because they've been given the treasurer's job. Their experience in the group has given them the confidence to take on paid employment or develop their voluntary work. This is a testimony to the success of the self-help movement and is something that professionals cannot provide. But professional health workers need to be aware of these groups and try to encourage people to join them.

THE SINGLE PARENT FAMILY AND THE HEALTH VISITOR

by

Jenny Smith, Health Visitor, Ealing Health Authority

When I first started thinking about the issues of health relating to one-parent families I was concerned to find so little information. Certainly there have been some small scale studies involving health visitors but nothing much in terms of measuring health and how one-parent families manage.

For those who are unfamiliar with the role of the Health Visitor I will briefly define her as a worker who is concerned with all aspects of preventative health care by identifying need and promoting health through education.

There is a little fable which I have adapted to exemplify our approach. A nurse and a health visitor are standing on a river bank when they see hundreds of people drowning in the the water. The nurse jumps in and starts giving mouth to mouth resuscitation. She sees the health visitor running up the river bank and calls "Where are you going? You can't leave all these people". The health visitor looks back and says "Sorry I've got to go upstream and find out why they are all falling in".

But what then is the role of the health visitor in relation to one-parent families? In many ways the same health issues crop up whether there is one parent or two. The major difficulty for the one-parent family however, is they have to cope on their own. There is only one parent to think about and organise all aspects of the family's life including health.

One of the main difficulties I have come across is actually making and then sustaining contact with this client group. Health visitors normally make contact through home visiting, clinic contact, or through invitation - to ante-natal classes for example. But how do we decide who to go and see in the first place? All we automatically know is how to contact families with children under five years, because we are notified of them. One of the criticisms made of health visitors in relation to one-parent families is that we are interested in the children but forget about the parents. What about the families with children over five years? We have less to do with this group since the development of the school nursing service. If any health input is needed we rely on good communication with the school nurse or medical officer to enable us to reach families. What about the families with adolescents? We have even less contact with this group since encouraging teachers to take more of a role in Health Education in school.

Who then is going to provide the health visitor with the vital information to make contact with one-parent families? It's clearly not easy.

Let us imagine that we actually have made contact with a family. How do we maintain it? For example, many single parents work. If you visit and they are at work, you leave a note. Then you wait for the note to be answered or you may phone. What if there is no phone? Another problem is that with fairly large caseloads health visitors could not claim to see families as often as they would wish due to other responsibilities.

We can make contact via clinics, but again this isn't very successful for a working mother or father. Clinics tend to open between 10-12 or 2-4. Perhaps we should think more about evening clinics for working parents and changed hours, for example, 11-1 and 1-3 for those non-working parents who have to take and collect children from school. Why should you attend the clinic anyway? Although clinic attendance is important for the children it does not necessarily help single parents themselves.

There are ways we as health visitors can overcome difficulties and deal with the health issues concerning children but there is a problem of time to give to the parents. Listening is not always enough.

What about the single parent for whom just going out is difficult? What about the depressed single parent? Perhaps for these parents we need to spend more time locally putting them in contact with others, perhaps on a one to one basis first to build confidence. We should also think about evening activities which include arrangements for children so that parents can attend and improve social contact.

WOMEN'S ACTION FOR MENTAL HEALTH

by

Sue Holland, Clinical Psychologist, Hammersmith and Fulham Social Services
and
Janet Brown, Women's Action for Mental Health, White City Estate, Hammersmith

Sue Holland

The idea for Women's Action for Mental Health grew out of the work that I am doing as a clinical psychologist dealing with mental health issues, mental health and what we call mental illness. But, unlike a lot of mental health workers, I don't find it satisfactory to concentrate on the problem of illness as an individual issue which we have tended to do in the National Health Service. I favour the view that we have to also look at the social and political issues if we really want to tackle the problems of mental health. For me, Jenny Smith's joke about what the health visitor does spells out exactly what is wrong with the health service. Instead of jumping in and rescuing individuals health workers should be running up the river bank where they might find a very destructive, malicious and oppressive state that is throwing people into the river. That is where the problem has to be fought.

That is why, in my work with very depressed women and their families on a particular estate in Hammersmith, I don't find it enough to do psychotherapy alone. Having got the women out of the most profound depression they go on to find mutual help with others in similar situations which enables them to do the more social and structural things about changing their lives and the lives of people around them.

The project is about doing individual work of a very specific kind, psychotherapy, and it is about developing the mutual social structures that hopefully in the future, even though it might take a long time, will help change the nature of depression and mental illness in that area, even if it can't eradicate it.

Depression in itself is a strange phenomenon, because it is a uniquely human ability to be depressed. As psychologists we believe that unless somebody can be depressed they cannot be humanised, they cannot be civilised, they cannot be socialised. Depression is about caring about somebody enough to be afraid that you might lose them and also about being afraid that your own behaviour might have contributed to losing them. That is the psychodynamic view of depression, but there are many others, particularly the medico-psychiatric view which says depression is about chemicals and about genetics and about inheritance which is why there are so many people on tranquilisers and anti-depressants. A lot of my work has been trying to wean people off pharmacological solutions by doing individual work with them and then by moving them on into groups.

I will briefly describe the main structure of my work as a professional. I am employed within the social services system and not by the health system where clinical psychologists are normally employed. This gives me a relative amount of freedom. People on the estate, who are depressed, or feel that

they have got a problem of that nature can come to me. I work with them doing intensive sessions, going into their background and past and how these relate to the present social, individual and, very often, political situation that they live in.

The project on the White City Estate has been going on for about four years. It is funded by the Department of the Environment and administered through the social services. It is an experimental project and is due to end in October next year.

At this point we need to go back to some of the theory about depression because of the way it links with single parenthood. Depression is, in my view, ultimately about loss. It is about loss that can go very far back to earliest relationships with parents in which something has gone wrong in terms of a separation. It could be through death, rejection or a number of other reasons, but what is left in the individual's sense of self, in their psyche, in how they see themselves, is a deep feeling of badness because they have been left and they have lost the loved person.

Some of the previous speakers have said that a depressed person finds it very difficult to actively go about doing things, whether it's meeting in groups or talking to other people, or fighting for what they are due. If an individual feels disabled, because they somehow carry a sense of wrongness and badness about themselves, you can't expect that person to look to the outside world for what's wrong and to fight it. So in order to get that person to run back up the river and find out what's really going on we've got to be able to liberate the energies and feelings that are tied up in that person. That's why we use psychotherapeutic methods. These methods can be dangerous because they can be very reducing, they can individualise people, they can be used in a very reactionary way.

But we would lose some very important weapons in the fight if we discount doing individual work with a depressed person. When you're really depressed you don't want to get out of bed, you don't want to eat, you don't want to talk, you don't like people, you don't like yourself, you wake up early, you go to bed late, your bowels go wrong, you over eat, you under eat, you have all kinds of things go wrong with your body and your mind and it affects all your relationships. You're in no position to pull up your socks and go to a group and do all the things that you ought to do to change the rotten system around you. Psychotherapeutic methods can be very helpful in order to really stop with the person long enough to go back over what's wrong, what's holding them up, what's preventing them doing those things we know they should do in order to change the situation.

I think the previous speakers did overdo the negative aspects of being a single parent because there are some pay-offs. It follows that somebody who is depressed and has been depressed for many years, starting from childhood is going to fall into a whole cycle of relationships which turn sour and they'll end up being single parents because they get drawn into relationships that are going to be rotten and they're going to have to keep getting out of them.

A depressed person always wants to be loved and in a state of romantic love. We have to blame western culture and society for teaching us that marriage and relationships are a romance. We've done quite a lot of work on this in our groups. We've got one group that the women themselves call 'mixed

blessings' because it is about living in relationships and having children with men from other cultures. One way in which the political structure impinges on something like a very confidential personal therapy group about marriage and sexual relationships is that many people mentioned that they felt their marriage had split up because they felt that the man only wanted them so they could get a British Passport. As if there was something bad about that and that our normal way of going about things, romantic love, is good. Yet nobody could actually say what romantic love was. When you say somebody only wanted me for a British Passport, but they didn't love me, no-one could actually say what it was to be loved. We had to go back to the fact that the Home Office can destroy a marriage relationship between people of two cultures, planting all sorts of suspicions about a relationship that might in fact have been working quite well until the Home Office came along and said this person should not be here.

I have found that in order to get people out of a depression you've got to have a next step to move them onto. One of the things that we found useful is something I call the study group. This is a basic education group which meets weekly and which the women join when they feel ready. I give them a talk and then there is a discussion. The talk could be about mental health in Britain, about the Welfare State, about family relationships, about the effect of the social structure on mental health and vice versa, and what individuals can do about it. This group has now run for about four years.

It's difficult to see that something as simple as allowing a woman to have the time to go and think about something other than staying alive and domestic work and looking after the children was quite a radical move. We found that women hadn't actually experienced that kind of feeling, that kind of stimulation to think about a topic that was other than their own personal problems and their own personal family. I put it in these terms to the women when I was doing individual work with them: that what we've done so far is just about inside and now we've really got to talk about the outside, and about how really the things that are going on outside had probably contributed very deeply to how you feel inside. So that draws people out, when they're ready, into that kind of discussion group. And it is from that kind of discussion group that the women got together, set up their own kind of structure for dealing with and looking into some of the issues that we met on that particular estate and which caused a lot of the pain for the women themselves. I'll hand over to Janet to talk about this.

Janet Brown

First of all I would like to say that the other speakers have made me feel really depressed about single parents. I'm a single parent with five children and I like being a single parent!

We run a group on White City Estate where a lot of single parents live called Women's Action for Mental Health. We give support, advice, counselling, run cookery classes, sewing classes, pottery classes, and many other things. But we don't all feel bad. I wish some of them had come here today. I'm sure that they would have been up in arms. The other speakers make it sound as if there is something wrong with being a single parent, or being black. Most of the people that live on White City are black. They don't feel that way. We don't feel that way at all.

Let me tell you about a book I read, lent to me by Sue Holland written by

Erin Pizzey called Prone to Violence. In it she said that White City was a breeding ground for dustbin families. After reading that I sat down and wrote this paper about White City and what there was there. There was an adventure playground, there were nurseries, there was this, there was that. I went off to Hammersmith Town Hall with some other women from the study group. We presented the paper to Valerie Wise, and got an application form for a grant from the GLC. That started the project. We are now GLC funded, but we're waiting for our premises. We've squatted for six weeks as a protest against the council not giving us anywhere. We've got all kinds of publicity and been on television. Now we'll be moving in in about two weeks time. And that is from being the depressed single mother who didn't know what to do, couldn't go to the shops, didn't want to go to the shops, didn't want to look at anything because I knew I couldn't afford it.

But now - I can see myself like that and when I go and visit the women I can help them. I take them to the social security and I demand that they get their money.

We have all got this little bit of knowledge now. I've been going to Sue's group for four years and it has got me interested. I'm not only interested in babies and prams anymore, I want to know what is going on and find out what I have been missing. And now here we are running Women's Action for Mental Health.

RACISM AND THE HEALTH OF BLACK ONE-PARENT FAMILIES

by

Mavis Clarke, Project Co-ordinator, Training in Health and Race

When I was asked to talk about single parent families within the black community I found it difficult to do so without first looking at the experiences that we've had, or are having as black people in this country.

I want to begin by talking about the black community and their experience of racism in this country.

Racism affects the whole black community and exists in all the institutions in this country. It affects them in health matters, and in housing, education and employment.

When I speak of racism, institutional racism, I'm talking about white racism and how this has constantly stopped the black community from making a headway in this country. I am also talking about individual racism because institutions don't operate on their own, they are operated by people and people who are in positions of power. These people need to take on board the issue of racism and take it quite seriously because we are speaking of an endemic problem that runs through the very fabric of British society. They must think about the way forward and about how these institutions can change to meet the needs of everyone.

The project that I work for, Training in Health and Race, was set up mainly to look at health issues and the fact that the health service was not meeting the needs of the black community. No national policies currently exist which look seriously at the health care needs of the black and ethnic minority population. Even though the black community suffers from various health problems that are different from those of the indigenous population. For example, the Afro-Carribean community suffers from sickle-cell problems, and the Greek and Cypriot communities suffer from thalacemea, a blood disorder very similar to sickle-cell. Just recently the DHSS has started a campaign to look at the health care needs of Asian women, but this is 30 years on since black people have lived in this country. We shouldn't make the mistake of referring to the 'problem' of black health needs. It isn't a problem that the black community has various health needs but it is a problem that the health service is not responding to these needs.

In the light of this black single parent families in this country suffer more than such families from other ethnic groups. Black single parent families like all single parent families suffer economic problems and they also suffer particularly because most of them are women. I don't suppose you will find many black single men who are on their own looking after their children, and that is very much to do with the sexism that all women in society suffer from.

But black single parents experience worse housing problems than the indigenous population. Hackney and Lewisham carried out some research recently in the housing department which showed that black families are put on the worst estates. If you couple together the experiences of being black

and a single parent you can see that this group will suffer from the worst housing problems. They are quite likely to be sent to the high rise blocks, they are likely to suffer racial attacks. They also suffer dreadful isolation.

This is a big problem for the black community now and in the future because the situation is not getting any easier. In fact it is getting worse because of the present employment position of young black people. At least the older generation could get jobs even if they were the worst possible ones in hospitals and factories. But today there is hardly any chance of black young people getting employment. These young people get very little support from the various institutions, whether the social services or the health service, because of racial discrimination. And we're not just talking about the major institutions but about places like nurseries and creches. How many young black people are able to get their children places? Very few. And further education is also another matter, because if you are depressed you are not likely to want to bother. You are not likely to want to improve yourself. If you constantly come up against the system you will tell yourself that there is no way they will listen to you.

All these factors have resulted in very serious health problems. Mental health is one of the areas about which there is deep concern within the black community. Drugs are on the increase and drinking is also a problem.

So what is to be done about these problems? I believe that those people who have the responsibility to plan for the future should look very seriously at the plight of the single parent families in the black community, because it is so easy for them to be forgotten.

Listening to the discussion this morning it seems to me that people are not really thinking seriously about the fact that we live in a multi-racial society. We seem to lack political analysis because although we are talking about disadvantaged groups the black community has only been mentioned in passing. This is the way in which our society operates, whereby one section of the population is forgotten about.

There is a lot wrong with the way in which health visitors are not meeting the demands of their black single parent families. And I am saying this from my experience of working with a project training health workers to be more sensitive to black and ethnic minorities, that is, to be less racist. In every area people should be thinking about the needs of the black community; it should be the focus and not the area left out.

I believe that professionals have a responsibility to meet the needs of the whole community, therefore the whole community needs to be thought about. Any research that is undertaken should have a multi-racial perspective, and black people should be involved in carrying out the research. All groups should make sure that they involve black people within them, and consider the fact that black people might not want to be part of the groups and organisations unless racism is on the agenda for debate.

You can't leave the multi-racial perspective out, because if you do it means that you are not doing your jobs properly. All kinds of excuses are made for not appointing black people to jobs. My response to them is to say that white people are not trained to work in a multi-racial society so therefore they are not adequately qualified to work effectively.

PLENARY SESSION

Four workshops addressed five issues:-

1. Do one-parent families have special health needs?

2. Do health workers recognise the health needs particular to one-parent families?

3. What can we reasonably expect from health professionals?

4. How can we change attitudes?

5. What concrete proposals can we draw up for us/them to pursue?

The following views and recommendations emerged:-

* The one-parent family is the place where poverty and racial and sex discrimination are most exposed.

* The poverty faced by one-parent families both contributes to health problems through bad housing, inadequate heating, poor diet, lack of recreation and leisure; and makes it more difficult to deal with the ensuing poor health.

* One-parent families have different needs at different stages. The creation of a one-parent family was a particularly stressful time and likely to create ill-health.

* The norm of the two-parent family should be challenged. Single parents often have to justify their existence in terms of being as good as a two-parent family.

* Many women find employers reluctant to give jobs to mothers in case they take time off for sick children. Women's responsibility for children should be acknowledged by better terms and conditions of employment for women workers. Better day-care facilities are essential. Employment enables single parents to have an independence which is important for their mental health.

* Single parents need more control over their financial resources. The social security system not only gives people very little money, but gives them even less control over the money they do have.

* In order to avoid creating negative attitudes and labelling, one-parent families should be looked at in the context of poor women and children in general. Attention needs to be directed to the particular health needs of women as individuals and as organisers of family health care.

The role of health workers

* Health visitors' work has to be rethought in the context of poverty and unemployment. Training, resources and structure all need to be changed to meet new needs. Training in welfare rights and race awareness is particularly necessary.

* Health workers should co-operate with social workers in a multi-disciplinary approach. Both should co-operate with local groups set up by women themselves and not by professionals.

* Negative attitudes from professionals are a great problem for one-parent families. Health workers should concentrate on issues like race, isolation, housing and unemployment which affect a wide range of people rather than focusing on specific groups of clients.

* Clinics should be designed to take account of the needs of people with children. Changes could be made in opening times, perhaps by running a shift system. The health service should find out what clients want and be geared towards users rather than the workers within it.

* Attention needs to be directed to the particular health needs of women as individuals and as organisers of family health care. A husband is not always the solution to a family's health problems.

Appendix 1

CARING FOR HEALTH

Friday 12th October 1984

PARTICIPANTS

Joy ANDRIES	Ackee Housing Project	
Vivienne BAKER	School Nurse	Enfield HA
Helen BENNETT	Senior Clinical Medical Officer	Bloomsbury HA
Sue BLENNERHASSETT	Information Officer	CHIRU
Mary BOLLAM	Medical Sociologist	Bedford College
Sylvia BOLTON	School Sister	Wandsworth HA
Janet BROWN	Women's Action for Mental Health	Hammersmith
Merle BROWN	School Nurse	Islington HA
Pat BROWN		
Alice BURNS	Women's National Cancer Control Campaign	
Anne BUTLER	Health Visitor	Islington HA
Maggie CARR	One Parent Families	
Ianthe CARSWELL	One Parent Families	
Sue CLARKE		
Mavis CLARKE	Project Coordinator	Training in Health & Race
Sue CLEMENTS		
Leona CLERY	UJIMA Housing Project	
Sue COMMONS	Camden Gingerbread	
E. DAWID	General Practitioner	London, N7
Deborah DERRICK	One Parent Families	
Sonia DOWNES		
Lyn DURWARD	Maternity Alliance	
Tony EARDLEY	One Parent Families	
Josephine FALLON	School Clinic Nurse	Bloomsbury HA
Betty FLEMING		
Pauline FRANCIS		
S. FREUDENBERG	General Practitioner	Kentish Town Health Centre
Kay GOLOWICZ	Hackney One-Parent Action Group	
Val GIBSON		
Barbara GILZENE	UJIMA Housing Project	
Margaret GOLDING	School Nursing Sister	Newham HA
Susan GOLOMBOK	Researcher	Institute of Psychology
Romie GOODCHILD		
Chris GOWDRIDGE	One Parent Families	
Hilary GRAHAM	Lecturer in Social Policy	Bradford University
Jeanette GREEN	UJIMA Housing Project	
Pamela GREENSIDE	UJIMA Housing Project	
Ulla GUSTAFSON	Medical Sociologist	Bedford College
Margaret HAMILTON	Health Worker	Claudia Jones Organisation
Helene HAYMAN	Maternity Alliance	
Sue HOLLAND	Clinical Psychologist	Hammersmith & Fulham Social Services

Jane HUGHES	Project Officer	King's Fund Centre
Heather HURFORD	Social Worker	St. Bartholomews Hospital
Mary HURST	Worker	Albany Health Project
Pauline HUTCHISON		
H. JEFFREYS	Health Visitor	Hammersmith & Fulham HA
Sue JENKINS	Paediatrician	Community Paediatric RU
Yvonne JEREMIAH	Health Visitor	Haringey HA
Claire JOHNSON	Health Visitor	
Debbie JONES	Worker	Albany Health Project
Tessa JOWELL	Assistant Director	MIND
Julie KAUFMANN	Director	Gingerbread
Nancy KOHNER	Health Education Council	
Anastasia LEWIS		
Joma LONGMORE		
J LOO	School Nurse	Lewisham/ N.Southwark HA
Jan LORD	One Parent Families	
Janet LOWE	Senior Clinical Medical Officer	Victoria HA
Margaret LYNCH	Health Visitor	Paddington/ N Kensington HA
Laura McALISTER	UJIMA Housing Project	
Claudette McARTHUR		Merton & Sutton
Carol MANNING		
Harriet MONTEZ		
Maeve NOLAN	School Clinic Nurse	Paddington/ N Kensington HA
Leona CLERY	UJIMA Housing Project	
Linda O'LEARY	School Nurse	Hampstead HA
Gloria PAHAD	Principal Clinical Psychologist	Islington HA
Rami PARAVEZ		
Madeline PATTERSON	Scottish Council for Single Parents	
Maureen PESTAILLE	One Parent Families	
Heather PETERS	Health Visitor	Claudia Jones Organisation
Sue PHILLIPS	Health Visitors Association	
Jennie POPAY	Researcher	South Bank Polytechnic
M PUCKNELL	Health Visitor	
P A QUATTRUCC		Merton & Sutton
Miranda RAVETTO-WOOD	One Parent Families	
Salman RAWAF	Registrar in Community Medicine	North West Thames RHA
Moira REARDON	Hackney One-Parent Action Group	
Angela RICHARDSON	One Parent Families	
Sue ROBERTSON	Scottish Council for One Parent Families	
Sue RODMELL	District Health Education Officer	Hounslow & Spelthorne HA
Catherine SADLER	Journalist	Nursing Mirror
Angela SALFIELD	Rapporteur	
Margaret SCHOFIELD		
Carol SMART	Director	One Parent Families

Appendix 2

CARING FOR HEALTH: HEALTH ISSUES FOR ONE-PARENT FAMILIES

PROGRAMME

In the chair: Dr Carol Smart, Director, National Council for One Parent Families.

9.30 Registration and coffee

10.00 INTRODUCTION TO THE CONFERENCE
Dr Carol Smart

10.10 KEEPING THE FAMILY ON A LOW INCOME: ONE-PARENT FAMILIES AND TWO-PARENT FAMILIES COMPARED
Dr Hilary Graham, Lecturer in Social Policy, Bradford University

10.45 QUESTIONS

11.00 Coffee

11.15 PANEL PRESENTATIONS
Julie Kaufmann, Director, Gingerbread
Jenny Smith, Health Visitor, Ealing Health Authority
Mavis Clarke, Project Coordinator, Training in Health and Race
Sue Holland, Clinical Psychologist, Hammersmith and Fulham Health Authority
Janet Brown, Women's Action for Mental Health, Hammersmith

1.00 Lunch

2.15 WORKSHOPS TO DISCUSS ISSUES RAISED BY SPEAKERS

3.15 Tea

3.30 PLENARY SESSION

4.15 CONCLUDING COMMENTS AND CLOSE


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