

Partnership working and the involvement of parents in the health education of 7–11 year-olds

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This article reports on findings from a one-year national evaluation of the Primary School/Primary Care Health Links (PS/PC HL) initiative, commissioned in 2003 by the National Drug Prevention Development Team, on behalf of the Department of Health (DH). The primary aim of the PS/PC HL initiative was to develop links between primary and community health care professionals and primary school children in order to increase the children's knowledge and understanding of a range of health issues. This involved developing innovative ways in which parents could engage in the health education of their children at primary school level. As part of the evaluation, a questionnaire was sent to parents ($n = 69$) and children ($n = 464$) to discover to what extent discussions about health issues, in particular substance misuse, were held at home and what messages children were receiving. In this context, substance misuse includes drugs, alcohol and tobacco. This article also examines children's attitudes towards smoking and alcohol, and considers how parental influence affects children's ideas about the acceptability of these substances. The findings indicated that whilst over 65% of parents thought that their children knew a lot about exercise and healthy eating, only 20% thought that their children were well informed about alcohol and drug misuse. Despite 80% of children in our survey reporting that they would prefer to discuss health problems with their parents, substance misuse appeared to be a topic rarely discussed at home. The findings confirm, (i) the need for family and community cohesiveness and (ii) reinforces the need for an increase in parents' knowledge and motivation in order to (iii) raise their confidence in their conversations with their children about substance misuse. Partnership working between teachers, health professionals and parents would appear to be the ideal in effectively reinforcing health messages to children; however, the authors suggest that the culture of accountability both in the teaching and health professions often hinders this process.

Key words: parental involvement; partnership working; primary schools; substance misuse

Introduction

Schools have been increasingly recognized as having a key role in promoting the health of young people and providing them with knowledge and skills, which may benefit their whole lives. As a

result, a series of policy and curriculum changes have aimed to use the school setting to improve the health of young people (Denman, 1998). Most primary schools now include teaching about healthy eating, exercise, sex and relationships, as well as substance misuse in their Personal, Social and Health Education (PSHE) and Citizenship programmes. Initiatives, such as the National Healthy School Standard (DfEE, 1999); the National Five-a-Day Programme (DH, 2003) and the Food in Schools Programme (DH, 2003) have

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reinforced health messages received in schools. In addition, government guidelines have emphasized that drugs education should begin in primary schools (DfEE, 1998) and research by Lloyd *et al.* (2000) also confirmed the need for parent and community involvement.

The government's White Paper *Tackling Drugs to Build a Better Britain* (DH, 1998) outlined a ten-year strategy aimed at reducing the numbers of young people under the age of 25 years reporting the use of Class A drugs by 25% by 2005 and 50% by 2008. The strategy included four elements aimed at tackling drug misuse, one of which was targeted specifically at young people in order to help them 'resist drug misuse in order to achieve their full potential' (p. 2). The emphasis was firmly placed on prevention rather than reaction, and pointed to the need for partnership working and collaboration between health and educational professionals. It was suggested that strengthened links between a wide range of agencies would increase the effectiveness of this strategy and would have a far greater impact than a range of disparate activities. The role of parents was thought to be crucial. Parents are recognized as being potentially powerful intermediaries in reinforcing behavioural change strategies aimed at young children, but they often lack confidence, knowledge and skills when talking about drugs (Hart *et al.*, 2003). Further, Burgess (1996) believes that the different social situations and backgrounds of young people inevitably impact on their knowledge and acceptance of drugs, alcohol and smoking, thus, parents are well positioned to contextualize controversial issues for their children within their own cultural and social background.

The government Green Paper *Every Child Matters* (DfES, 2003) highlights the need for parents' information meetings and family learning programmes, which will offer opportunities to increase involvement in learning and break down barriers between school and parents. Encouraging parents to participate in their children's school activities, however, has always been difficult, particularly in deprived geographical areas where children are most likely to be at risk (Klitzner, 1990). Also, Greer (1989) points out that there is some reluctance amongst parents to involve very young children in drug education. Parents are presented with warnings and alarming headlines in the media which may promote a 'climate of fear' when dealing with children's questions about

substance misuse. Fears are often expressed as an association between increasing children's knowledge of drugs and increased experimentation (Bui, 1999). Drug education for young children, which takes the form of a partnership between health professionals, teachers and parents, however, can help to alleviate parents' concerns about the extent and appropriateness of drug prevention programmes in schools.

The PS/PC HL initiative aimed to strengthen partnership working between health professionals, teachers and parents with the intention that the professionals would impart their knowledge of health promotion and education. In turn, all three groups would then provide and reinforce a consistent and accurate message to young children. This article explores the effectiveness of this initiative, in particular, the parental involvement in substance misuse and health education of primary school children, and the children's understanding of drugs and health issues.

Methods

The PS/PC HL initiative, launched in 1998, aimed primarily to develop links between primary and community health care professionals, and primary school children in order to increase the children's knowledge and understanding of a range of health issues. The initiative sought to empower children by developing their social skills and self-esteem to enable them to make informed decisions about their own health. Forty-seven projects were developed throughout England, following a national tendering process that offered successful bids £20 000 each year for two years to develop and implement the project. This involved project coordinators in developing diverse programmes of health education activities as part of primary schools' emerging PSHE and Citizenship policies. All project coordinators (there were 43 project coordinators for the 47 projects, since some projects had the same coordinator) were encouraged to make particular efforts to engage parents. This was undertaken by means of parent evenings, coffee mornings, health fairs as well as sending information sheets home with the children. Several projects used the money to fund a project coordinator's position. Other projects bought resources; paid for health professionals' time and/or supply teacher

time; funded visits, displays, health promotion and information packs.

The evaluation comprised a multi-method approach involving three Phases (Stark *et al.*, 2003). During Phase 2 a questionnaire was sent out to six groups of key stakeholders involved in the initiative. This article outlines some of the questionnaire findings focusing on two of these groups: parents and children. The aim of the parents' questionnaire was to establish how often parents and children talked about health issues and where they thought children obtained most of their health information. In consultation with a small group of primary school teachers ($n = 5$) and health professionals ($n = 4$), the project team compiled a list of terms to describe health issues that children, in particular, would recognize. (A lack of space on the questionnaire prevented detailed qualification of the terms and it is acknowledged that some phrases had broad meanings that could have been interpreted in different ways.) Parents and children were asked how often these issues were discussed at home and at school. The aim of the children's questionnaire was to measure the level of young people's knowledge, skills and attitudes towards a range of health issues, including healthy eating, safety and substance misuse. Questions were designed to be simple to understand and in most cases children were required to provide a tick-box response. The questionnaire was printed with coloured sections and pictures to make it visually interesting, and questions were kept to a minimum. A pilot questionnaire was sent to primary school classes in two separate schools and some minor adjustments were made to two questions. As comparator information was required, some questions from the *Health Related Behaviour Questionnaire (HRBQ)* (primary version 10) (SHEU, 2002a) were also incorporated. This enabled the team to compare the data in relation to healthy eating, exercise, drug misuse, alcohol misuse, smoking and growing up with the wider population, some of which is presented later. The questionnaires collected both qualitative and quantitative data. The latter were analysed using SPSS. The qualitative data provided by the questionnaires was typed out in full. Statements were then analysed using thematic analysis whereby common topics, activities, opinions were identified and collated under a specific theme (Aronson, 1994).

The sample

All the project coordinators ($n = 43$), geographically spread throughout England, received eight questionnaires for parents and 25 for children for distribution, together with other questionnaires for key personnel involved in the projects. A letter for the project coordinators was enclosed, which gave guidelines for the questionnaire distribution. The parents' questionnaire had a prepaid envelope attached, addressed to the evaluation team. The children's questionnaires were completed in school. Instructions for the children to put their completed questionnaire in the envelope held by the administrator were given. The administrator then sealed the envelope and sent it back to the evaluation team, or, on several occasions, the envelopes were picked up by the evaluators themselves. All the projects were requested to participate in the questionnaire, thus, there was no attempt to randomize sampling within or between projects. It was presumed that project coordinators would be most likely to distribute questionnaires amongst individuals with a positive approach to the project and schools, which demonstrated 'best practice'. (Verbal feedback from several coordinators verified that this was the case.)

The response rate from parents was 69 completed questionnaires. This represented 19% of the total number of questionnaires sent out. Seventeen projects were represented. A total of 464 questionnaires were received from children aged 7–11 years representing 20 different projects. This represented 40% of the total number of children's questionnaires sent out by the evaluation team to the coordinators. The sample was equally split between boys and girls and 77% of the children were aged 10 or 11 years. All the respondents remained anonymous.

The low response rate was due to several factors:

- Some projects had come to the end of their two-year funding and the projects had subsequently ceased.
- Some projects had experienced a loss of their project coordinator, so the questionnaires failed to be distributed.
- Irrespective of our request, a few projects had targeted very young children (below the age of 7). These were not included in the sample as this age group were not included in the HRBQ and so comparisons could not be made with the wider population.

- One project had not yet involved schools and other areas had merged projects, using the same coordinator and stakeholders. Where several projects were being directed by a single project coordinator, the response rate was lower. In effect, some project coordinators targeted only a proportion of their project participants and this reduced the response rate considerably.

A control group was not used in this research since all the PS/PC HL projects were so diverse a 'control group' would be meaningless. Further, the health input in schools was not standard either e.g., the PSHE and Citizenship input varied considerably, as did the presence of the National Healthy Schools Scheme in schools. Since only participants in the PS/PC HL projects received questionnaires, it was expected that parents and children might have been more aware, and involved in health education than some sectors of the population.

Results

The results are presented under several key headings.

How much do parents think their children know about health issues?

The data indicated that while most parents were confident that their children were knowledgeable about healthy eating, exercise, keeping safe and the dangers of smoking, they felt they knew less about, arguably, the more contentious issues of alcohol and drug misuse, and dealing with risks. For example, over 65% of parents reported that they thought their children knew a lot about exercise and keeping healthy compared to less than 20% of parents who thought their children knew a lot about alcohol and drug misuse. A more surprising result was that only 10% of parents reported that their children were well informed in first aid (Table 1).

How often do parents talk to their children about health issues?

The data highlighted that parents were most likely to talk to their children about the less sensitive subjects of healthy eating and exercise, and

Table 1 Level of children's knowledge of health issues according to parents ($n = 69$)

| | Knowledge level ... | | |
|--------------------------------------|---------------------|----------|-----------------|
| | A lot (%) | Some (%) | Very little (%) |
| Healthy eating | 66 | 32 | 2 |
| Drug misuse | 12 | 64 | 25 |
| Dangers of smoking | 57 | 36 | 7 |
| Alcohol misuse | 19 | 59 | 22 |
| Puberty and growing up | 26 | 52 | 22 |
| First aid | 10 | 56 | 34 |
| Safety of medicines | 36 | 49 | 15 |
| Exercise | 67 | 29 | 4 |
| Keeping healthy | 65 | 32 | 2 |
| Keeping safe | 46 | 45 | 9 |
| (avoiding accidents) | | | |
| Dealing with risks | 7 | 68 | 25 |
| Who/where to ask for help and advice | 33 | 55 | 12 |

Table 2 Frequency of conversations on health issues between parents and children ($n = 69$)

| | Talk to children ... | | |
|--------------------------------------|----------------------|---------------|-----------------|
| | Often (%) | Sometimes (%) | Hardly ever (%) |
| Healthy eating | 67 | 29 | 4 |
| Drug misuse | 3 | 67 | 30 |
| Dangers of smoking | 28 | 61 | 12 |
| Alcohol misuse | 6 | 58 | 36 |
| Puberty and growing up | 19 | 59 | 22 |
| First aid | 3 | 52 | 45 |
| Safety of medicines | 10 | 55 | 35 |
| Exercise | 46 | 46 | 7 |
| Keeping healthy | 58 | 36 | 6 |
| Keeping safe | 49 | 48 | 3 |
| (avoiding accidents) | | | |
| Dealing with risks | 20 | 57 | 23 |
| Who/where to ask for help and advice | 22 | 65 | 13 |

only sometimes discussed substance misuse and risk-taking (Table 2). Several parents commented that they used opportunistic events to discuss substance misuse, particularly smoking. Examples of comments made by parents included:

A relative visited who smokes and my daughter didn't like the smell and we discussed how bad it was for your health.

Kimmy tells people ‘my nana doesn’t smoke anymore because it made her ill.’

Another parent utilized reports in the media to reinforce the dangers of drug misuse:

... explaining pictures they have noticed in the newspaper, showing on various occasions a teenage girl dead from a drug overdose.

Comparing the two tables it appears that parents believe their children know a lot about the dangers of smoking, but the majority of parents only sometimes talk with their children about it. This implies that children are learning about these dangers from other sources, such as their teachers or the media e.g., television advertisements. Similarly the majority of parents feel their children know about keeping medicines safe, but 35% of parents hardly ever talk to their children about this topic.

Children’s main source of information about health issues

Health professionals, teachers and parents involved in the evaluation of the PS/PC HL initiative were asked about children’s main sources of information about health issues (Table 3).

Each group responded that they thought children received most of their information from them, particularly, concerning substance misuse. Children, however, when asked who had talked to them about health issues, including drug misuse, were more likely to say their parents than teachers or health professionals. Further, the majority of children in our questionnaire (80%) reported that they would prefer to discuss health problems with

Table 3 Children’s main source of information about particular health issues as reported by parents ($n = 69$)

| Source of information | Drug misuse (%) | Dangers of smoking (%) | Alcohol misuse (%) |
|-----------------------|-----------------|------------------------|--------------------|
| Parents | 41 | 61 | 51 |
| Teachers | 41 | 32 | 36 |
| Visitors in class | 30 | 22 | 17 |
| Friends | 3 | 3 | 3 |
| Other family | 1 | 6 | 1 |
| TV or magazines | 12 | 12 | 7 |
| Projects and clubs | 0 | 0 | 0 |
| Not sure | 13 | 6 | 16 |

their parents, confirming data from the HRBQ questionnaire results (SHEU, 2002b).

Some parents felt that they shared responsibility with teachers and health professionals and so ticked more than one box, therefore the total exceed 100%. However, the majority of parents (61%) indicated that they believed themselves to be the main source of information for their children about smoking and also most parents (51%) believed they were the main source of information about alcohol misuse. However, the figures concerning drug misuse were not as clear with equal numbers (41%) selecting themselves and/or teachers as the main source of information; 13% of parents were not sure from where their children were receiving their information. Given that our findings also revealed parents felt that their children were less knowledgeable about these issues than other health issues, coupled with the fact that they were less likely to talk to their children about these topics, it could be argued that parents either (i) lack confidence to have these discussions with their children; (ii) feel their children do not need to have this information at this age; (iii) believe they do not have the knowledge to discuss these topics with their children or (iv) it may never occur to parents to talk to their children about these health topics. Given the statistics, it could be argued all four reasons may play a part, particularly in relation to drug misuse. One parent explained why she was reluctant to discuss substance misuse with her children:

It’s not that I don’t have the time but that I feel I don’t know enough to be of help because schools have the correct information which I don’t always have and know who to contact for information they don’t have.

And another said:

I must admit it’s something I haven’t brought up with them yet. I still feel they’re so young, I’m protecting them ... it can be a bit scary.

Ten per cent of parents were not sure from where their children obtained general information about health issues, but 12% of parents thought that the media was an important source of information for children on smoking and drug misuse although only 7% thought that the media had informed their children about alcohol misuse.

Table 4 Percentage of children reporting that they discussed health topics at home ($n = 464$)

| Topic | Percentage |
|-----------------------------------|------------|
| Healthy eating | 65 |
| Drug misuse | 38 |
| Dangers of smoking | 51 |
| Alcohol misuse | 43 |
| Keeping safe (avoiding accidents) | 71 |
| First aid | 30 |
| Growing up | 67 |
| Safety of medicines | 34 |
| Exercise | 52 |
| Keeping healthy | 62 |
| Dealing with risks | 37 |

Children's conversations about health issues

Children were given a list of health topics and asked 'Do you talk about any of these things at home?' The results showed that most of the children reported that they did talk about these issues at home, with 'keeping safe' being the more frequently discussed subject. The children claimed that substance misuse was not frequently talked about at home with only 38% reporting that they had discussed this subject. The data also suggested that parents and children were more likely to talk about the dangers of smoking than drug and alcohol misuse. The results highlight that just under half of the primary school children reported that they had spoken with their parents about drugs, alcohol and/or smoking at home (Table 4).

Children and smoking

As stated earlier, 51% of children surveyed, reported that they had talked about smoking at home. We then asked the children to give an example of a conversation they had had at home about smoking. Most of the responses concentrated on their concern about family members who smoked and their fear of the consequences.

My dad smokes so I talk a lot about smoking.

My grandma smokes, she gave up for a while but she still smokes.

I told my stepdad to stop smoking because he could die, but he doesn't.

I was trying to stop my mum from smoking.

Despite this indication that some children may have concerns about the dangers of smoking, the questionnaire data also showed that a small minority of 10–11 year-old children (3%) continued to smoke and 16% of boys as well as 8% of girls had smoked once or twice. Comparative data from the HRBQ (SHEU, 2002b) showed that in the wider population 13% of boys and 11% of girls reported that they had smoked once or twice.

Children were asked 'How would you describe someone of your own age who smoked cigarettes?' Unanimously, anyone who smoked was described negatively, for example:

A weirdo who is trying to kill themselves because they know smoking kills them.

Coughing a lot, unhealthy and a very bad person.

Dirty, disgusting, sick, horrible, silly, stupid.

I think they might be a bit sad because they probably have nothing else to do or just want to be cool (which they're not).

Really stupid, if my mum and dad caught me smoking (not that I would!) they would go ballistic.

Apart from two children, smoking was condemned by all of the children who commented, including those who had tried smoking.

Children and alcohol

In relation to alcohol we asked the children 'Have you had an alcoholic drink (more than just a sip) in the last 7 days'. This question also appears on the HRBQ questionnaire. Children aged 10–11 years who completed the PS/PC HL questionnaire were more likely to report that they had had an alcoholic drink, that was more than just a sip, in the last seven days than those in the wider population as reported in the results from the HRBQ questionnaire (2002b). Although the data for girls were similar, 32% of boys in the PS/PC HL questionnaire compared to 20% in the wider population reported that they had had an alcoholic drink. The data do not provide information about the circumstances of the alcohol consumption. It could be that some parents were aware and present at the

time – it being a case of ‘having a try’ as a way to demystify alcohol.

Children aged 10–11 years were also asked if they had had an alcoholic drink (more than just a sip) in the *last month*; 50% of boys and 40% of girls aged 10–11 years had consumed alcohol in the last month. There are no comparable data and although no details about the circumstances were sought, it could be argued that this is an alarmingly high figure and reinforces the need for continued health education in this area.

After asking the children about their alcohol consumption, we then asked a follow-on question which was simply ‘what happened?’ Comments reporting the adverse effects of alcohol were made by 24 children who represented 5% of the whole sample. While most children reported that nothing happened because they had had ‘a tiny sip’ or ‘it was weak shandy’ or ‘I only had a glass of wine’, a small number of children reported other effects; ‘I was drunk’, ‘I was legless’, ‘I was sick’, ‘I felt awful’.

Similarly to the question related to smoking, the children were then asked to describe someone of their age who drank alcohol. Although smoking was seen as unacceptable by all of the children surveyed, this was not the case with alcohol consumption. Seventy eight per cent of children described someone of their age who drank alcohol as ‘silly’, ‘stupid’ or ‘unhealthy’, but 11% thought that as long as they did not drink a lot that it was alright. Eight per cent thought that it was normal or fine for someone their age to drink alcohol and 3% reported that they did not know how to describe someone.

Some examples of comments suggesting that a little alcohol was alright included:

Fine as long as they don’t go over the top.

Fine there is nothing wrong with drinking.

I don’t mind because alcohol isn’t that bad.

If they drink a lot stupid, but not if they only drink once a month.

Discussion

The findings from the evaluation of the PS/PC HL initiative and the SHEU (2002b) highlight that the majority (80%) of primary school children would most like their parents to talk to them about health

issues. However, data from the PS/PC HL questionnaire indicated that only 38% of children reported conversations at home about drugs, and conversations about smoking (51%) and alcohol (43%) took place only slightly more frequently. This suggests that parents can play an important role in the education of their children in this area and that there is a clear need to expand this role. Parents may not be aware of how important their input and influence is, or could be. In addition, since health professionals and teachers believe they are the main source of information for children, they may underestimate the importance and potential of parents in relation to the education and influence they have in this area. One of the reasons for a lack of parental involvement in their child’s health education put forward in the literature is that parents may lack confidence in this area (Winnail *et al.*, 2000). Government initiatives such as the PS/PC HL initiative, that encourage health care professionals to work in collaboration with primary schools, children and parents are one way that parents can become educated in health issues alongside their children. As a consequence they may be more confident in their ability to provide and reinforce information. The health professionals have the expert knowledge of drugs misuse; the teachers have expertise about how to educate the age groups concerned and the parents have the relationship and family context in which to effectively and meaningfully impart this knowledge, based on the expertise of the two professional groups. However, the theory of partnership working is often more difficult to execute given the realities of professional contexts. For example, in the current culture of accountability in schools, with inspections, attainment targets and competing demands for curriculum time, teachers are often reluctant to share the education process in fear of damaging their quality and standards, and hence reputation. Professional rivalry also existed between some teachers and health care professionals as evidenced in the data of this evaluation. Parents, too, can be reluctant to intrude upon the professionals’ territory, assuming that teachers will have a more comprehensive grasp on drug education and substance misuse and for some parents it may be a relief to pass the responsibility of handling difficult issues on to teachers (Shucksmith and Wood, 1998). Unfortunately, attempts to include parents in health education programmes have, in the past, had little success

and the value of short-term funded projects is questionable (Wanless, 2002). Whilst the need for partnership working with schools is recognized and supported by the authors, the reality of power inequalities and the competing priorities within professional contexts should not be disregarded when considering such recommendations.

There is currently an expansion of government initiatives that promote partnership working between organizations, agencies and individuals. However, the PS/PC HL initiative was only funded for two years. While it is hoped that the positive practice from this initiative will be continued within the National Healthy School Scheme, the issue of short-term funding can seriously hinder progress made by such initiatives and can have a negative effect on engaging parents in future initiatives.

In relation to the dangers of smoking, the findings here showed that parents believed their children were knowledgeable. Children had clearly remembered messages given to them at school and home. However, the percentage of children in this evaluation who had tried smoking was no lower than the wider population as reported by SHEU (2002b) three years previously. The government has had a clear anti-smoking campaign over the last few years, but while parents and children are aware of the health risks, many are still choosing not to act upon the information. Further, it appears that children can receive mixed messages from their parents, in particular, parents who smoke, with many children expressing their fears and concern about parents and grandparents who continue to smoke. Indeed, Werch *et al.* (1991) indicated that one of the most important factors in shaping children's responses to drug use are parents' own substance use behaviours. Any effective strategy for drug prevention, therefore, has to take into account parental attitudes and knowledge about substance misuse. One could argue that there has been less media coverage on the dangers of alcohol misuse and this may, in part, explain the attitudes of children in our survey, being more accepting of alcohol consumption.

It is evident from our data that many parents, whilst recognizing that they have an important part to play in their children's health education, may decide not to discuss issues such as substance misuse at home. Reasons for this have been well documented in the literature and are likely to be the fear of encouraging experimentation by giving

too much information at a too early age, a lack of knowledge of the extent of substance misuse amongst young children and a belief that the formality of school lessons is more likely to reinforce health messages, particularly in homes where parents smoke and drink themselves (Shucksmith and Wood, 1998; Vincent, 1997). Indeed, healthy eating is also an issue which is, perhaps, more comfortable to talk about but more difficult to put into practice. It is possible that some parents feel intimidated by perceived expectations of healthy living that they feel unable to maintain.

Parental involvement in their children's education is a challenge in all areas and health education is no exception (Rudiger, 2000). While parents and children do have many discussions about health issues, the evaluation findings have highlighted that they tend to focus on healthy eating, exercise and keeping safe. Helping parents to educate children on the less comfortable, 'risky' topics is vital.

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